PhD Thesis

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'The Public Health Contribution to the Development of Policy for the Prevention of Violence and Abuse in England'

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Declaration

I, Dr Joanna Mary Nurse, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signed: *Jo . Nurse*

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Copyright

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Abstract

Introduction: The aim was: "To document the process of policy development to prevent interpersonal violence in England, and explore the implications and potential role of public health". Research gaps addressed include: an insider perspective of the policy process in general, and on the formulation process in particular. Violence and abuse are complex and challenging public health issues and wider lessons were drawn for public health.

Methods: Qualitative research methods of documentary review, mapping and observation were used in the context of a case study of development of policy for violence prevention at regional and national levels in England from 2005- 2010. The research was based upon participatory observation methods as a public health advisor contributing to the policy process. In total 44 documents were reviewed and 157 meetings attended. Content and thematic analysis was conducted with violence, public health and policy frameworks followed by triangulation.

Results: From initiation to publication, the policy process took ten years to complete (2003-2012). Regional policy implementation contributed partially to national policy development. Networks and embedding within wider policy maintained the agenda. Evidence-based public health contributed to the policy, whilst, collaborative working, persistence and communication skills influenced uptake. Internal actors had the most power, especially the Prime-Ministers Office and the Home Office, whilst the Department of Health ensured development of the final policy. Senior leadership and champions drove the policy process and media reporting created windows of opportunity. Policy formulation revealed the importance of consensus and cyclical decision-making.

Conclusions: Lessons include strengthening the art of public health: with clear leadership, communications and collaborative relationships, contributing to the uptake of evidence. Taking advantage of windows of opportunity and creating consensus is important for external actors. An integrated model of policy and the formulation process are presented to enhance understanding between policy and public health.

Executive Summary

Research Question and Aim

This thesis researched the contribution of public health to the development of policy on violence prevention at regional and national levels within England. The research describes the development of policy for violence prevention from the initiation of policy in this area following the World Health Assembly resolution in 2003 until the final publication of the Department of Health violence prevention policy in 2012. During the research period from 2005-2010 I was employed as a Senior Civil Servant in Public Health, advising on violence prevention and leading on public mental health policy within the Department of Health (DH). During this time, I was funded by the DH to undertake a part-time PhD. This provided the opportunity to research the policy making process from an insider perspective and to study and reflect upon the contribution that public health makes to the policy development process with violence prevention acting as the case study. However, this research provides wider lessons for the policy development process and for the public health contribution to policy making in general.

This research question was initially formulated following discussions and public health placements at the London School of Hygiene and Tropical Medicine and the World Health Organisation Violence and Injury Prevention divisions during 2001- 2003. This was further refined at the beginning of the research in 2005 and during the up-grading process in 2007. The scope of the research covered all aspects of inter-personal violence prevention as defined by the WHO, (WHO, 2002).

Essentially, this thesis is an exploration of how public health can better contribute to policy development for a relatively emerging public health challenge. The following aims and objectives were developed to understand the interactions of public health in contributing to policy development in a structured and systematic way:

The Research question of this thesis was: "Why is public health in England not more engaged with the development of policy for the prevention of violence and abuse?"

The aim of the study was: "To document the process of policy development to prevent interpersonal violence in England, and explore the implications and potential role of public health"

Objective one: *To describe the general development of violence and abuse prevention policy in England, over time*

Objective Two: *To describe the public health contribution to violence and abuse prevention policy*

Objective three: *To describe and explore the role of different actors in influencing the policy process for violence and abuse prevention*

Objective Four: *To summarise the policy formulation process*

Objective Five: *To summarise the wider lessons for Policy*

Objective Six: *To summarise the wider lessons for Public Health*

Introduction and Literature Review

The introduction provides an overview on violence and abuse prevention and describes the wider context of this research question. This thesis uses the WHO (2002), definitions and terminology for inter-personal violence as the remit for violence and abuse prevention covered in this research. Whilst, the Faculty of Public Health (UK), and European Action Plan for strengthening Public Health (WHO, 2012) descriptions and definitions for public health are used in this thesis.

The literature review summarises the policy process and outlines key policy models that have informed this thesis, as well as providing an overview of public health and the policy process. In particular, the triangular policy model by Walt, (1994), is used to structure the results chapters and summarise the main conclusions under the main headings of: Content, Context, Actors and Process. Several relevant policy models that described the key components of the policy making process were also identified from the wider literature. These were used to develop a comprehensive policy model describing the initiation, formulation and implementation stages of the policy process, with the main interactions and functions illustrated. This integrated policy model was then used as a tool to collect and analyse data for this thesis. In the conclusions, reflections are made on the model, and an improved version is presented, along with a discussion on the wider lessons for policy and public health.

Methods

This research was based upon a **case study**, of England. During the research period from 2005-2010, I was employed by the Department of Health, providing an 'insider' participatory observational perspective to the policy process. From 2010 – 2013 I arranged a career break from the DH to work with the WHO, however, I remained in contact with the relevant policy lead in order to track the final progress and publication of the policy in 2012. Multiple methods were used to triangulate the results to increase validity and included: **documentary, mapping and observational methods.**

In the documentary review, a total of 44 relevant government reports were identified that mentioned violence and abuse prevention between 2005- 2010. The majority of reports were published by the Home Office, (15 reports), and these had the most influence in the development of policy on violence and abuse prevention. In total, 16 were considered to be key documents, including policy that actively influenced activities on violence prevention. All the policy documents and wider policy activities were recorded in a mapping framework, which captured the domains of prevention across the life-course. This revealed that the main emphasis of policy was on tertiary prevention, including treatment, protection or prosecution. The main gaps were for primary prevention, especially for earlier in the life-course, where prevention can be most cost- effective.

The evidence for the observational research was collected in a total of 13 field dairies, and altogether, diary entries were recorded for 157 meetings related to violence prevention during the observation period from September 2005 until August 2010.

The range of actors observed included policy makers and ministers from a range of government departments, public health professionals and non- governmental organisations.

The **analysis** undertaken in this thesis included the following steps: content and thematic analysis, framework analysis, secondary analysis and triangulation and systems analysis. The content and thematic analysis, described the main content and themes of the research, from the documents, diaries written and observations made. As the volume of data was large and complex, rather than coding data from the documents and diaries, a series of frameworks and mapping tools were utilised to summarise the content and describe emerging patterns and themes. Three main frameworks were developed and used to analyse the content and themes for violence, policy and public health. The annexes include some of the detailed completion of these frameworks and examples of the original data, whilst the results chapters include visual summaries of the framework analysis, with illustrative examples provided in the text.

A violence and prevention framework was developed and used to map the content and focus of violence prevention policy, and captured primary, secondary and tertiary prevention, aligned with the ecological model and the life-course approach. This was completed following documentary review and cross-validated via discussion with relevant policy leads. The policy development process was initially analysed by using the framework of the integrated model of the policy process, under the main headings of initiation, formulation and implementation. Data sources from the documents and diaries were used to inform the completion of the policy framework, summarising the main actors, context, processes and themes for policy making. Additionally, analysis of the documents and diaries was used to complete the public health framework – this framework provides a visual representation of the Faculty of Public Health competency areas and surrounding context. This gave a structured approach to consider the contribution that public health made in the policy development of violence prevention.

Following the framework analysis, a process of secondary analysis and triangulation was undertaken to enhance the validity and reliability of the research and to reduce bias. Triangulation involved comparison of results between the different methods, for example, by comparing the results of the mapping of violence prevention with the policy analysis framework, it was possible to further analyse the motivation, influence and interests of the different actors according to their different focuses on violence prevention. Additionally, secondary analysis was conducted by including reflections and descriptions from other public health professionals and researchers on the policy process and the emergent themes. This helped to identify areas of consistency and divergence of results and conclusions.

The final stage of the analysis process included a systems analysis approach, which involved cognitive and pictorial mapping to understand and summarise visually the complex relationships between events. This approach was used to produce the time- line mapping the main events in the policy process, and to capture the overlap and re-occurrence of key processes. This method was used to produce the policy formulation model presented in the conclusions. Below summarises the main results according to the research questions and objectives of the thesis.

Results

The policy triangle by Walt (1994) was used to structure the results chapters according to the first four objectives, based upon the four areas: content (violence), context (public health), the actors and the process (policy formulation). A summary of the key findings from the results chapter according to each of these four areas is found in Figure 1.

Figure 1 - Summary of the main PhD findings according to the Process and Power Model, (Walt. 1994)
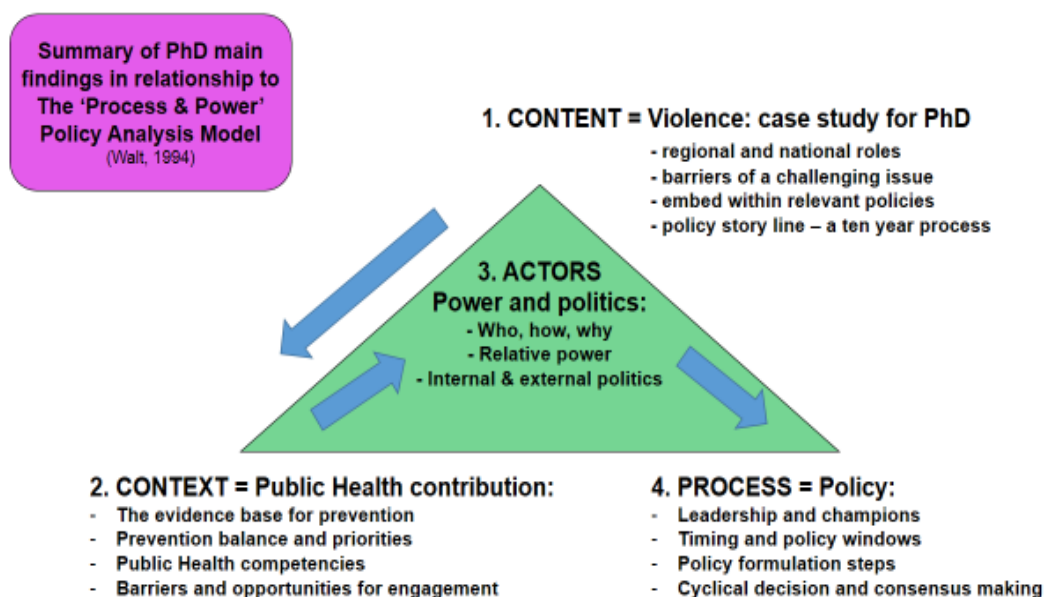
Objective One: To describe the general development of violence and abuse prevention policy in England, over time

The first objective addressed the content of the case study, with an overview of the main steps over time on violence and abuse prevention, and considers the regional versus the national roles of policy making, followed by barriers to challenging issues including the importance of embedding agendas into relevant policy.

The policy story line opens from the initial initiation in 2003, to the formulation and final policy publication in 2012. In total, the policy process for violence prevention described in this thesis summarises a ten-year period of time, of which the specific insider research period was for 5 years, from 2005-2010. Key events from the documentation of the policy process for interpersonal violence and abuse prevention in England, many of the processes were repeated and overlapping, are summarised below:

- 1996-2006: Identification of issue – World Health Assembly, 2003

- 2006-2010: Evidence review and updating – by public health (DH)

- 2006-2010: Engagement with policy leads and influence of other violence policy

- 2006-2010: Ministerial letters and approval – for violence prevention policy (DH)

- 2006-2008: Mapping for gaps and identification of priorities – by public health

- 2008-2009: External consultation and feedback – national event November 2008

- 2008-2010: Policy consensus established – between government departments

- 2009-2010: Policy Clearance Process – multiple steps required in government

- 2010: Cross–Government Agreement – at ministerial and cabinet level

- 2010- 2011: New Government appointed, leading to re-writing of policy, and a repeat of policy consensus and clearance process cycle

- 2012: Launch of final policy report – as a DH publication

The visual 10-year time-line in Figure 2 below, summarises the wider context and main events from initiation to publication of the policy on violence prevention in England, (DH, 2012).

Figure 2 - Time-line for violence and abuse prevention policy in England
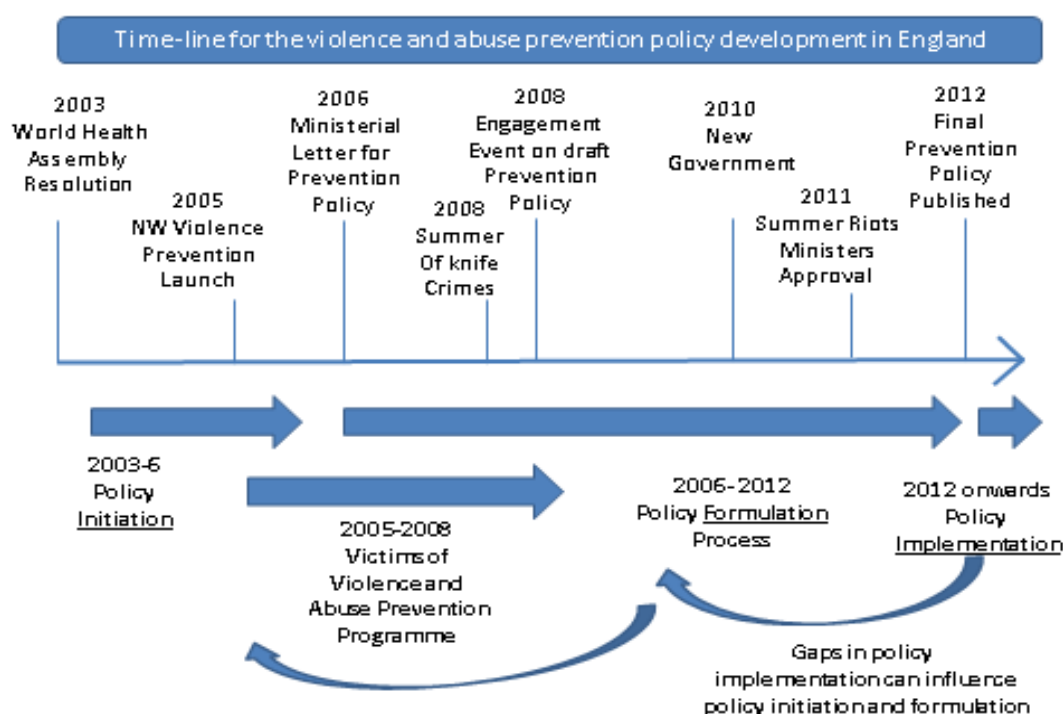
This illustrates that unless there are strong high-level drivers for policy development, it can take a considerable period of time, with the main delays created by the consensus making and clearance process and political cycles. This is especially true for a challenging issue like violence and abuse prevention, which is poorly understood in society, with many aspects being invisible or taboo.

The Regional and national roles of the government offices and the public health contributions are described for the policy process over the research period from 2005- 2010, with the insider perspective of the regional role from 2005- 2008 and the national perspective from 2005- 2010. The regional and local level are usually tasked with the implementation of policy, however, they play a key role in translating national policy and can contribute actively to bringing innovative practice to stimulate policy agenda setting and to be incorporated into the national policy formulation process.

Key barriers and opportunities of the challenging issue of violence and abuse were identified. Much violence and abuse are hidden in society with many aspects of abuse still regarded as taboo to report or talk about. Public health played a role in increasing the visibility for the less visible and more taboo areas of violence and abuse and enhanced understanding of the complexity of early risk factors and outcomes across the life-course. In contrast, knife and gun crime are highly visible aspects of violence and abuse and generate a lot of media attention, this acted to drive forward overall policy development. For example, on two occasions, (in 2008 and 2011), this created windows of opportunity for policy to be developed on violence prevention in general, although the main focus was on knife and gun crime.

Embed within relevant policy: an effective approach to keeping a marginal issue on the policy agenda was found to be embedding it within relevant policies. Developing specific policy on an agenda takes time, especially for a challenging public health issue. By including mention of violence prevention approaches and policy within health and other sector policies at regional and national levels, helped to mainstream a marginal issue and to keep it on the policy agenda. For example, the regional health strategy incorporated cross cutting aspects of violence and abuse prevention, including early child development, school programmes, alcohol related violence and the reduction of youth offending. Whilst at national level, it was possible to incorporate a life course and preventive approach within the Violence against Women and Girls national policy.

Objective Two: To describe the public health contribution to violence and abuse prevention policy in England between 2005- 2010

The second objective describes the context, which in this case is the public health contribution. The main findings for this area cover the evidence base for prevention, the prevention balance and priorities, public health competencies, and barriers and opportunities for engagement.

Prevention balance and priorities: the mapping analysis found that the main policy focus on violence and abuse was on tertiary prevention in adult populations. This includes protection and

containment approaches by the criminal justice system. Secondary prevention, for example, early identification of domestic abuse, was not mainstream, although supportive guidance existed. Primary prevention approaches, including during childhood and adolescence were generally in the form of occasional school based pilot projects. The public health based framework on violence and abuse prevention was used in this research, to identify policy gaps, inform priorities and shift the focus to earlier in the life course, including more primary prevention approaches. These were reflected in the final policy.

Public Health competencies: science and art: the analysis from the public health framework found a strong emphasis of the scientific based public health skills of health needs assessment, reviews of the evidence, strategic priority setting and planning. The scientific public health skills can be seen to be core public health skills or competencies. These were found to be significant in contributing to the development and final publication of an evidence based policy, which was in part due to the public health advisory role on violence prevention played during the research period. However, the 'art' of public health, which can be regarded as generic enablers, were found to be important to ensure the uptake of evidence within policy, and more importantly, to support the policy development process. These skills included: relationship building, collaborative working, persistence, good communication and influencing skills.

The Science- evidence for prevention: a public health evidence based scientific approach of the extent and nature, the impact and risk factors for violence and abuse as well as prevention, was used by the policy leads to inform the policy process and incorporated into the final policy report. The research found that policy makers consider a range of options, like cost, feasibility, risks, media coverage, of which the evidence base is only one option, when making decisions about policy formation. Economic analysis was generally given high priority by policy makers, especially if evidence showed the cost- effectiveness or returns on investment of approaches.

The Art - Barriers and opportunities for engagement: the hidden nature and lack of mainstream public health information on violence and abuse acted as barriers. Whilst the prevention and the public health approach was generally poorly understood and frequently understood as tertiary prevention approaches – for example child abuse prevention was used as a term for child protection procedures. High profile media events provided the main opportunities to advance policy, backed by senior leadership. However this was mainly driven by the criminal justice sector. Applying the art of public health helped to overcome some barriers, for example, by using clear communications and simplifying the complexity of the evidence base to illustrate the relationship of prevalence, risk factors, outcomes and prevention. Developing strong relationships, with regular engagement with policy leads supported the

continuation of the process, along with advocacy and leadership skills allowed advantages to be taken of opportunities.

Objective Three: To describe and explore the role of different actors in influencing the policy process for violence and abuse prevention

The third objective describes findings related to the Actors, whereby a stakeholder analysis was undertaken of the main actors and their motivations. This considers their relative power and the political dynamics between them.

Who, how, why: the main actors with the strongest interest in policy development on violence and abuse was the Home Office and the Attorney General, with occasional high level interest by the Prime-Ministers Office. Strong interest tended to be driven by high profile media events on the visible forms of violence, for example gun and knife crime and riots. However, the Department of Health, including Public Health, were ultimately key actors with lead responsibility in developing the prevention policy for violence, as prevention in this context was seen to come under the Public Health Minister's role. The Criminal Justice System's main motivation was to reduce crime, whilst the health sector aimed to improve health outcomes. Finding common ground with Other Government Departments resulted in positive joint policy approaches, for example, anonymous information sharing of violent injuries presenting in emergency departments that benefited both health and the criminal justice sector. In contrast, by not understanding common benefits, resulted in lower engagement and resistance, for example, for the school based violence and abuse prevention interventions that fell in the remit of the Department of Children, Education and Families. In part this related to the invisible nature of some forms of violence and abuse and the difficulty of understanding the complex relationship of early events in life with later health and social outcomes.

Relative power: the Criminal Justice Sector, (mostly the Home Office), were considered by central government and other sectors as the lead agency for violence and abuse in general, and therefore were seen as the most influential actor in the policy making process. The Department of Health, including public health advisors, were understood to have the lead role in violence prevention especially in terms of policy content. However, they had perceptibly less power, compared to the Home Office in driving the policy process. There were several examples where it was possible to increase this power marginally, by increasing the visibility of the violence and abuse prevention, forging partnerships and ensuring consistent, clear messages. This relative power, however, was superseded by the Prime Minister's Office following the specific media events on riots, guns and knife violence, which in the end proved to be key influences for decisions made by central government. This acted to push the violence

prevention policy forward in general, although with a strong focus on the visible forms of violence, such as gun and knife violence, that had caught the media attention.

Internal and External politics: The process of establishing policy clearance by all the relevant government departments, revealed that any dissent by an actor, whatever their interest, could act to delay or block the policy making process. This research found a relatively high level of internal influence compared to external actors, for example, the overall time allowed for external consultation was months compared to the years that the internal policy actors were involved. Additionally, internal actors ultimately had more levers to influence policy, as they were directly responsible for advancing policy development and ensuring the policy clearance process. In contrast, external actors, including the Voluntary Community Sector, had relatively high interest, with a mixed and limited influence on policy formation; although championing this agenda, strong extreme theoretical views inadvertently contributed to a slowing of policy progression. For example, several of the external organisations holding a strong feminist perspective, considered that risk factors (i.e. childhood abuse or alcohol), equated to transferring blame or taking a deterministic perspective, and were therefore resistant to a life-course perspective or of framing risk factors in prevention policy. In contrast, the Media had temporary high levels of interest and influence, creating important windows of opportunity. Ultimately, though, this research found that the expression of relative power and politics was a fluctuating, interacting and dynamic process.

Objective Four: To summarise the policy formulation process

Lastly, the fourth results chapter considers the Policy Process, where main findings included the role of leadership and champions, the importance of timing and policy windows. A description is given of the policy formulation steps, insight into the cyclical decision and consensus making process that was found by this research.

Leadership and champions: Having strong leadership was observed to be instrumental in driving the policy process, including the initial agenda setting and the subsequent formulation process. Key leaders in the process included the Prime Minister, the Attorney General and Ministers (either Home Office or Health). In contrast, the WHO and the CMO were important for initial agenda setting. Informal networks of policy champions across the Department of Health and Home Office played a role in maintaining interest in the agenda during times of transition and when there was less visible leadership to drive policy development. In contrast, a relative lack of leadership, acted to demotivate and delay the policy process, as were illustrated during times of re-organisation and periods of sickness of key actors.

Timing and policy windows: overall, policy development, including the formulation process, is time consuming, and unless there are strong drivers and leadership, delays can occur. Political timing was important, with General Elections and changes in government found to create delays of policy progression of approximately one year. Conversely, windows of opportunity, such as the media attention of visible forms of violence, acted as key points to push policy development forward. In particular, there were two events during this research that illustrated the importance of windows of opportunity, including the spate of knife and gun crimes in 2008 and the summer riots in 2011.

Policy formulation steps – the policy formulation process was not straightforward or linear. Instead, multiple policy steps were observed to be taken to achieve clearance, and these were repeated until the final policy was endorsed at inter-ministerial level. Much of the policy process was seen as complex by non- policy makers within the system, with a lack of clarity of steps, processes and timescales. For example, the policy process was described by one public health leader within the Department of Health, as being like cloud formation - constantly moving and changing shape. This research mapped the range of policy formation and clearance processes over time, which illustrates the overlap and repeated nature of many aspects of the policy process.

Cyclical decision and consensus making – aside from the final ministerial clearance, there was no one key decision in the overall policy process. It was observed that multiple decisions were made, in an incremental process. It was found that central to policy formulation was the importance of regular internal engagement, with repeated and cyclical consensus making to achieve the final policy clearance. Extremes of views by some components of the Voluntary and Community Sector led to delays in consensus formation at the stage of external consultation, this contributed to delays in the overall progression of policy development in this area.

Conclusions

In the conclusions, initially, the main findings are summarised in the context of Walt's triangular model, to provide an overview of the research and compared with the wider published literature. Next, the wider lessons and generalizability of findings for policy and for public health are considered. The conclusions presents a policy formulation model based upon the findings of this research, and reflects upon and updates the integrated policy model used as an analysis tool in this thesis. This is followed by reflections on the research question and aim based upon lessons from this research. Lastly, the strengths and limitations of the research,

research recommendations, followed by the dissemination of findings from this research are concluded.

Wider lessons for policy

A model on *the policy formulation process* was developed, drawing upon the cyclical policy models described in the literature review and further developed based upon the main findings of this thesis. The model is summarised in Figure 3 with key steps that were found to advance (or block) the process, coloured in blue. Step one, starts with the identification of the issue, followed by the second step of the evidence review and thirdly, engagement with policy leads. The fourth step involved gaining initial ministerial approval to further develop the policy and was considered a key step (highlighted in blue), as this gave the policy official permission to be advanced. The fifth step involved mapping and priority setting, followed by a period of several months' external consultation as the sixth step.

The seventh, eighth and ninth steps included policy consensus, the policy clearance process, followed by cross – government agreement. These were all regarded as key steps in this research, as they were found to be steps where the policy was either allowed to be taken forward, or if stopped at these stages, could involve a reiteration of previous policy steps. The tenth and final step was the launch of the final policy report and only achieved following successful completion of the nine previous steps. Although the main events occurred within a time sequence, many tasks were continued for a considerable time period, and some tasks occurred consecutively, for example, with repeated updates on evidence or cycles of consensus making occurring. Therefore, the model incorporates a series of sequential steps to reflect the overall order that events occurred in; however, the inner circle represents the continuation of these processes.

Figure 3 - A Model of the Policy Formulation Process

A Model of the Policy Formulation Process

- Step 10 Final policy report
- Step 1 Identification of issue
- Step 9 Cross-Government Agreement
- Step 2 Evidence review
- Step 8 Policy Clearance Process
- Step 3 Engagement with policy leads
- Leadership & Governance
- Step 7 Policy consensus
- Step 4 Ministerial approval
- Step 6 Consultation
- Step 5 Mapping & priorities

Nurse J 2013
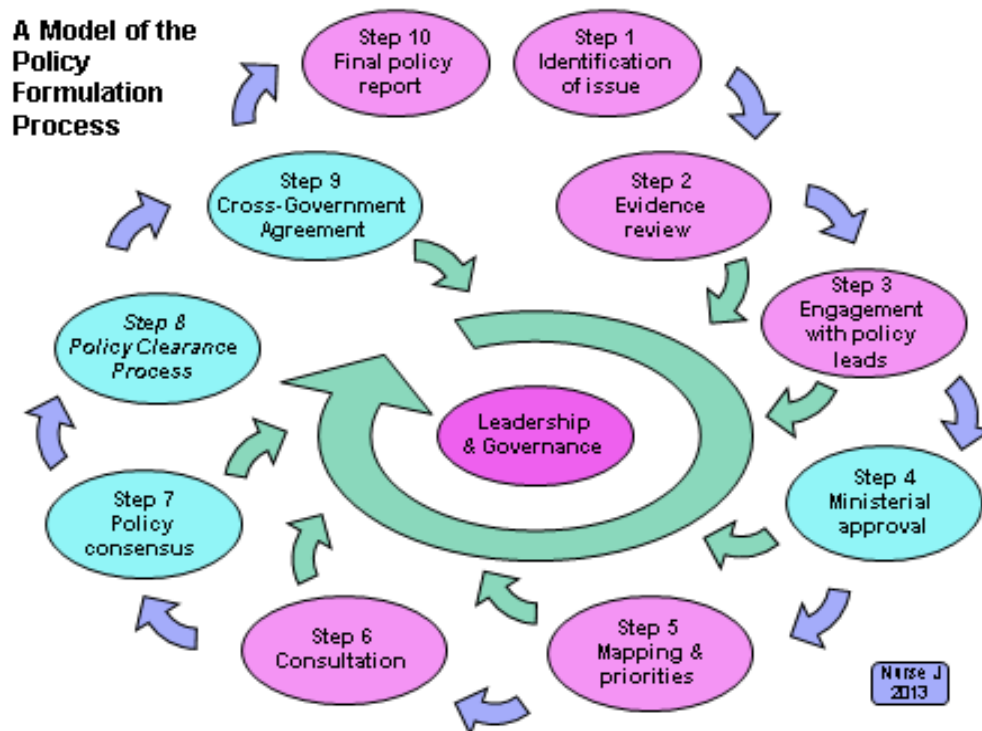
This model is representative of the general policy formulation process in England during the period of time of the research, and can therefore give insight into the policy process for a wider audience and potentially other policy areas. It applies principles of systems science, and simplifies the complexity of the policy process at the formulation level. Visually, it builds upon established cyclical models of the policy process.

Additionally, building on existing models and based upon the research of this thesis, the integrated model of the policy process was further developed and updated. An earlier version of the model was originally developed to describe and analyse the policy process for this research thesis. This integrated model describes the main aspects of the policy process, including the three interacting circles of initiation, formulation and implementation, and includes further detail for each of these stages and the overlapping aspects between them. As part of the conclusions of this thesis, the original model is revisited with reflections from the research findings. These are used to update the final model of the integrated policy process presented in Figure 4.

Figure 4 - An updated 'Integrated Model of the Policy Process', 2014
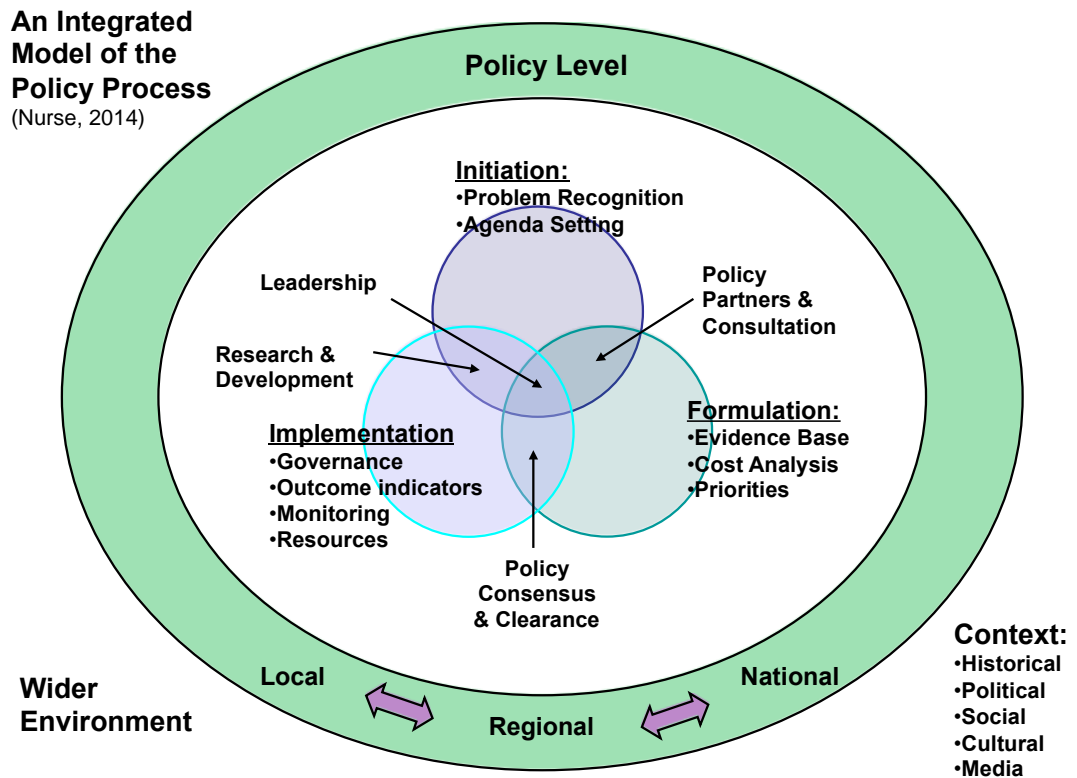
An adapted version of the integrated policy model is also presented in the conclusions for a public health audience, emphasising the public health contribution to the policy process.

Wider lessons for public health

A key conclusion for public health was to balance and develop the art as well as the science of public health, to enhance their leadership, communication and influencing skills. Developing the art of public health helped to bridge the disparity observed between the policy and public health paradigms, and assisted in the interpretation and application of science to a policy setting. Of particular relevance to the research question of this thesis, however, is the interaction between policy and public health. The level of engagement by public health was influenced by a number of cultural barriers between public health and the world of policy makers. These can be described as the differing paradigms of public health and policy, and reflect the divergence between the art and science of public health summarized in Table 1 below.

Table 1 - Balancing the art and science of public health to contribute to policy

The Science of Public Health - core skills	The Art of Public Health - enablers
• Epidemiology • Health Information • Health Needs Assessment • Evidence Based Interventions • Systematic Reviews and meta-analysis • Cost analysis • Priority setting • Systematic and strategic approach	• Leadership and advocacy skills • Able to describe the bigger picture and vision • Creating change • Collaborative working • Building trusted relationships • Communication and influencing skills • Summarising detail and developing key messages

Additionally, there are wider lessons for public health as an external actor, as well as other professions, the voluntary community sector and civil society in order to strengthen their influence in policy-making. These recommendations draw upon insights for violence and abuse prevention in particular, however, they are relevant for other emerging public health challenges. Combining several of the approaches summarised in Table 2 could potentially strengthen the level of policy influence.

Table 2 - Recommendations for External Actors to influence policy

- Forge networks and develop a consensus statement
- Gain the support of high profile champions
- Meet with ministers or high level officials to discuss proposals
- Ensure proposals are brief and have clear benefits
- Create high profile media events to gain coverage (eg national events, engage well-known personalities and leaders as spokespeople)
- Be prepared to compromise on proposals to aide policy consensus
- Identify policy windows to strengthen the timing and appropriateness of messages

Limitations and Contribution to New Knowledge

Despite there being significant agreement or resonance of many individual areas within the published research with that found within this thesis, there are a number of areas that were not found in the literature. Aside from Walt, (1994), the systematic review did not find other comparable or comprehensive policy models specifically from a public health perspective. The majority of public health papers on policy, including on models and frameworks, either advocated or recommended policy, provided an historical overview or presented policy models to predict specific clinical outcomes. However, the wider policy literature contained a number of theoretical models on the policy making process, which this research builds upon, in the development of an integrated policy model. Little literature was found that described the policy-making perspective from an insider perspective, and in particular, on the policy formulation process. The majority of research was from external policy researchers analysing a relatively narrow aspect of the policy making process from the outside. There was little found on the application of public health operations or competencies applied to the development of policy, with the majority of the literature making recommendations for translating evidence into policy.

The main limitations from this research relate to reliability, validity and bias. This study was based upon a case study, therefore, it would be expected that the findings of this research would be very difficult to repeat, even if the same methods were used. This is especially so because of the use of participatory observation as a key approach to undertaking this research, which in itself will have distorted the policy outcomes – creating a positive bias in the contribution that public health has played to policy development in this case study.

However, research findings from multiple settings across the policy remit, have found agreement with individual components of the research findings and analysis of the policy process. This would suggest that although there is considerable variation in settings and research methods, there are general policy processes that are being described from a range of different sources. In this way, this particular piece of research can provide a valuable contribution to further validating the overall range of existing findings. In particular, however, this research contributes to an insider understanding of the policy formulation process, where there is a relative gap in research.

The main limitation related to the internal validity of this study includes the lack of validated research tools for studying the policy process and which, due to the nature of the research, makes it difficult to properly validate the research methods or findings. Cross- validation methods were used with several forms of secondary analysis to help increase the validity of this

research. Additionally, the sequential analysis and triangulation of findings helped to increase saturation of findings to establish common themes, and identify deviant themes. The findings that are probably most generalizable from this research are those related to the policy formulation process, which was observed to be similar for other policies at the time the research was conducted in that particular setting. In comparison, the public health contribution to other policy areas is likely to be variable, depending upon the direct or indirect use of public health advisors. For example, many countries in Europe have very limited public health capacity, so their policy tends to be less influenced by a public health approach.

With regards to violence prevention, some of the insights about how to embed prevention aspects into wider policy, and how to the increase visibility and understanding of a challenging issue are transferable. Additionally, the need to establish consensus and build strong relationships with policy leads, are likely to be reasonably generic lessons for other settings, and for other challenging public health issues. Whilst, the specific findings about overcoming conflicts, including the taboo nature of violence and abuse, and the relative role that particular actors played, will be more relevant to those involved in violence and abuse prevention.

The main form of bias introduced into this research has been in my role of participant observer, which can be described as 'insider research'. The very nature of this research acknowledges the researchers role in shaping the outcome of the research and creating change within the process. However, it needs to be acknowledged that the act of researching on this agenda and the nature of the methods used, are likely to have actively facilitated the development of policy on the prevention of violence and abuse. My role as participatory observer meant that I actively contributed to this process by acting as a driver, champion and advocate, and by collating the evidence base, creating summaries, and persisting with the relevant policy leads. Although a source for distorting research findings and in creating bias, this is considered to be one of the aims of action research, to become actively involved in the change process as well as generating new knowledge, (Heller, 2004).

New learning is presented on the policy process in general, the public health contribution to policy development, and for violence prevention specifically. In particular, new insight into the policy formulation process is described, with the development of a model of the policy formulation process. Building on existing policy models, this research has contributed to a revised policy model of the overall process, including policy initiation, formulation and implementation, which I call 'the integrated model of the policy process'. Lastly, the lessons from this research for a public health audience are summarised in an adapted version of the integrated model of the policy process, called 'the public health contribution to the policy

process'. These models can potentially be used as tools for training and policy analysis. Key lessons for policy and public health are summarised below.

Summary of Key Lessons for Policy and Public Health

Key Lessons for Policy:

- **A Systematic policy approach:** apply a project management approaches to policy development processes for greater transparency of the process to non- policy makers and potentially reduce time scales for policy development.
- **Apply evidence into policy:** to enable policies to better identify and manage risk, establish priorities, enhance effectiveness and increase value for money.
- **Engage Local and Regional Levels in the Policy Process:** by enhancing the engagement of local and regional levels into the policy process potentially improves ownership, relevance, risk management and the sustainability of policy implementation.

Key Lessons for Public Health:

- **Balance the Art and Science of Public Health:** balance the art of public health, including collaboration, communication and leadership, to enhance the uptake of the science of public health and apply a strategic approach to policy.
- **Enhance Engagement:** by increasing engagement with partners it is possible to positively influence policy.
- **Simplify Complexity:** use communication skills and systems approaches to summarise complex messages and communicate evidence in accessible formats for policy makers.
- **Leadership and Advocacy:** by strengthening the leadership and advocacy roles that public health can play can influence policy and maximise opportunities of policy windows when they emerge.

Chapter 1 - Introduction

This thesis emerged from my involvement over many years from a combination of experience in public health, academia, WHO and policy development on violence and abuse prevention. However, having come from a personal background of general public health, I spent some time reflecting on why some topics become adopted as a public health issue or not. Violence and abuse is a relatively emerging field in public health and in many places is not generally seen as a mainstream public health issue. Over time, and following discussions with international experts in the field, I was able to identify the following research question:

- *Why is public health in England not more engaged with the development of policy for the prevention of violence and abuse?*

I chose England as the geographical location for research, as I had the opportunity to study this question further, when I started a new post working with the Department of Health in England. This post included funding for a part time PhD, and part of my role within the South East region and then at national level, was on developing policy for violence prevention.

One of the reasons I was keen to look into this question was that aside from contributing to new knowledge for violence prevention, this research question also had the potential to provide insight about how to improve the public health role in contributing to the policy process in general. Additionally, by answering this research question, also has the potential to provide new understanding about how to bring an emerging public health issue more into the mainstream of public health and policy.

This chapter starts with the background to the research question, followed by a brief outline of why violence and abuse are important public health issues. The next section describes a summary of the research aims and objectives, the overall coherence of the thesis and its contribution to new knowledge. Lastly, an overview is provided on the literature review methodology, which introduces the next chapter that summarises the literature on the policy process.

1.1   Background to the Research Question

A good piece of research should address an important issue, have realistic aims and provide information in order to solve problems, (Crombie 1996). In England along with the majority of

other countries in the world, violence and abuse are important though relatively neglected public health issues. This is despite a clear understanding of the epidemiology, associated risk factors and an evidence base for the prevention that has been collated by the World Health Organisation, (Krug, 2002). Over the past few years, I have had a number of discussions with international and national experts in violence prevention to try and understand why despite the body of research evidence, public health is poorly engaged with this important public health issue.

Following a review of the literature, there was little research found in particular on policy related to violence and abuse, and there were gaps in policy analysis from an insider perspective. More specifically, there is a need for greater understanding of policy formulation processes, (personal discussions with G.Walt), and a lack of tools for policy analysis, (Janovsky, 1996). Policy development is not always a rational process and is strongly influenced by cultural and political contexts, (Barker, 1996). Whilst a potential strength of public health in contributing to policy development is its evidence based, systematic approach to solving problems, (Lin, 2003).

Given that there is already considerable research on the epidemiology and prevention of violence, and that my role within the Department of Health (for England), provided a unique 'insider' research opportunity within a policy setting, the above research question focused on the policy development of violence and abuse prevention, exploring the contribution of public health. This piece of research will potentially provide greater insight into how best to address violence and abuse from a public health perspective in particular, and more generally improve understanding, policy analysis tools and practice in policy development.

1.2   My Role in the Research and Policy Development

Professionally, I trained as a public health consultant, (MFPH, 2003), and have worked in public health in a number of settings, including at local, regional, national and international levels. However, I have had a longstanding academic interest in violence prevention, which initially started at the London School of Hygiene and Tropical Medicine (2000), included a placement with the WHO in Geneva (2003), and continued with undertaking this thesis. Over the years, I have contributed to and led on a number of publications on or related to violence and abuse, including a systematic literature review on sexual relationship violence in adolescence and reviewing the wider literature on violence and abuse (Taket 2003; Nurse 2004; Sethi 2004; Nurse 2006a; Nurse 2006b; DH 2008; DH 2010; Butchart et al 2010; Wood S et al 2010; DH, 2010; DH, 2012; Gracia et al, 2013).

Previously, in 2003, I worked at the World Health Organisation in Geneva, in both the Gender Based Violence and Violence and Injury Prevention Departments, mainly contributing to publications and meetings on Sexual and Relationship Violence prevention in younger people. I continued to contribute to work in this area as an expert advisor, and produced the initial drafts of the WHO report on the primary prevention of Intimate Partner and Sexual Violence, (WHO, 2010). Additionally, I maintained a part-time honorary lecturer post at the London School of Hygiene and Tropical Medicine during the PhD research period (2005- 2010).

In 2005, I commenced a post in the Department of Health in the South East Region of England working as a Consultant in Public Health, a unique research opportunity arose to examine an aspect of this question in more depth. Part of my responsibility in this post was to work with other government sectors in preventing violence and abuse at regional level, and then later at national level. As part of this role, and based upon my academic interest, I provided public health advice for a national programme and publications led by the Department of Health called the 'Victims of Violence and Abuse Prevention Programme' (Itzin, 2006). During the course of this role, I also provided direct public health contributions to a number of national violence reports led by the Home Office, (HM Gov't, 2007; HO 2008).

At the beginning of 2008, I took on a new role as National Lead for Public Mental Health and Well-Being, working nationally within the Department of Health, England. This role enabled the continuation of the development of policy specifically on violence prevention, (DH, 2008; DH 2012). As well as the opportunity to integrate aspects of violence prevention within wider policy development, including on mental health and upon inequalities and health, both led by the Department of Health, (HM Gov't 2009, 2010; DH 2008, DH, 2010). In particular, I led on the initial development of a DH led Violence and Abuse Prevention Framework, including drafting of the initial policy paper, which resulted in a national consultation event (see Appendix II) and report launched for consultation in November 2008 (DH, 2008). Following this event, the workload needed additional support, and I then supervised another public health consultant in the development of policy for preventing violence and abuse between 2009- 2010.

This PhD is informed by earlier research work at the LSHTM and the WHO and the research material is based upon insider research from having been actively involved in developing policy on violence prevention. The research is based upon my roles within the Department of Health at regional and national levels, and uses an action research approach to build upon and learn from the experience of developing policy within this field. It takes a multi-disciplinary approach, including both public health and policy perspectives.

During the research period, I was able to negotiate funding and time as part of my role within the Department of Health to undertake this PhD on a part-time basis at the London School of Hygiene and Tropical Medicine.

From 2010, which is when the research period officially came to an end, I took a three year career break from the Department of Health. During this period, for the first 18 months, I worked in the WHO European region, initially managing countries in the development of assessments and strategies on climate change and health. This was based upon my DH role leading on national heatwave and cold weather planning, (which I undertook on a part-time basis, from 2006-2010, in parallel with the violence and mental health policy). The following 18 months, I led on the implementation of the European Action Plan for Strengthening Public Health Services and Capacity, (WHO, 2012). For both areas, I managed to apply learning from this thesis to support policy development with countries and enhance the public health contribution to this process. In 2014, I returned to the DH, where I am applying research findings within the Strategy Division of Public Health England. Additionally, during this time, I maintained contact with the DH policy lead on violence prevention, so that I could capture the key events before the final policy publication on preventing violence, (DH, 2012).

1.3   Why Violence and Abuse are Important Public Health Issues

Violence and abuse are directly associated with many health outcomes as well as acting as determinants of health. However, they are generally under-represented in public health policy compared to their overall impact. Therefore, this section summarises why violence and abuse can be considered as important public health issues.

Internationally, violence and abuse are associated with a million deaths each year, and are recognised as being an important risk factor for health, (Krug, 2002). The World Health Organisation (WHO) has responded to this by placing violence on the international policy agenda with a series of World Health Assembly Resolutions (WHA: 1996, 1997, 2003). Additionally, the WHO has supported activity to address violence with epidemiological information, evidence of prevention, tools and guidance for country level: (Krug, 2002; WHO 2004; Waters 2004; Butchart 2004; Sethi 2004; Garcia- Moreno 2005; WHO 2006; WHO 2007b; WHO 2009b; WHO 2010).

Violence and abuse affects everyone and are pervasive in our society. Because much of violence and abuse are invisible they act as a hidden and unrecognised determinant underlying

many health outcomes and social problems. In contrast the more visible forms of violence, like youth violence, create a disproportionate impact upon the rest of society because of the fear that it generates. The impact of all forms of inter-personal violence and abuse can continue over the life-course and have numerous detrimental outcomes, which are summarised in Table 3.

Table 3 - Wider public health impacts associated with violence and abuse

- **Poor school achievement -** through withdrawn or disruptive behaviour at school resulting in low educational achievement, school drop-out and exclusions (Hicks and Stein 2010, WHO 2006).
- **Conduct and emotional problems in children** - can be influenced by exposure to violence and abuse (WHO 2006). Childhood conduct disorders are associated with later development of anti-social personality disorders (NICE 2007).
- **Increased anti-social behaviour and health risk taking -** such as drug and alcohol misuse, risky sexual behaviour, anti-social/ criminal activity. (SCMH 2009a, 2009b, Felliti et al 2009).
- **Short and long-term health outcomes-** including physical injuries, teenage pregnancy, sexually transmitted infections, mental ill-health and long-term higher risk of cancers and coronary heart disease. (Felliti et al 1998, 2009, Collingshaw 2007, Bebbington 2004).
- **Violent crime-** experiencing and witnessing violence and abuse can increase risk of re-experiencing or perpetrating violence and abuse. (WHO 2007, 2006).
- **Negative social impacts -** violence and abuse can affect people reaching their full potential. It can also increase levels of community fear. Cultural norms that support violence can reduce community trust and social cohesion and increase levels of social exclusion (McVeigh 2005, WHO 2002).
- **Worsening inequalities and discrimination -** through higher rates in areas of high disadvantage and amongst discriminated groups which can reduce social economic participation, social well-being and health outcomes for people in these groups and areas. (WHO 2002).

1.3.1   Definitions of Violence

This thesis covers all forms of physical, sexual and emotional inter-personal violence, including child abuse, youth violence and bullying, sexual violence, partner abuse and elder abuse, as defined by the WHO (Krug, 2002). The term 'violence and abuse' is used throughout this thesis

to mean 'interpersonal violence' as this was the term adopted by the Department of Health in England.

Violence definition: *Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation. (Krug, 2002)*

The term abuse is used alongside violence, as many forms of violence are referred to as abuse, especially with regards to sexual and child abuse. Figure 5 illustrates the World Health Organisation typology for inter-personal violence, (Krug, 2002). A generic approach to violence and abuse is taken, as many of the risk factors and approaches to prevent violence are very similar for all types of violence and abuse.

Figure 5 - Typology for Interpersonal Violence, (WHO, 2002)
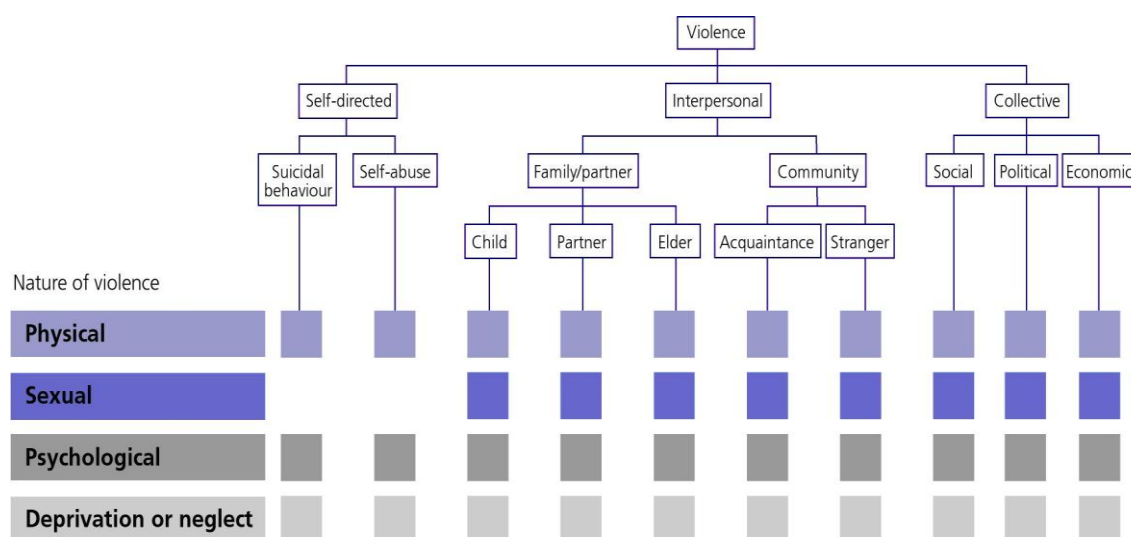
Violence covers a wide range of forms including homicide and serious wounding; gang-related violence involving guns and knives; hate crime; and sexual and domestic violence. This thesis at times refers to some forms of violence and abuse being more or less visible. In general, the forms of violence and abuse that are less visible are those that are more hidden and taboo in nature and often are not revealed to professionals or wider society; for example, child abuse, sexual abuse and intimate partner violence. Whilst other forms of violence can be considered to be more visible, for example, homicides, youth, gun and knife crime, and tend to attract public and media attention. Table 4 provides further definitions of specific forms of violence and abuse used throughout this thesis.

Table 4 - Definitions of violence and abuse used in this report

Child Abuse: refers to the physical, sexual or emotional abuse, maltreatment, neglect and negligent treatment of children, (Butchart, 2006).

Youth Violence: officially includes all forms of interpersonal violence and abuse (sexual, emotional, bullying, and physical) with young people (males and females) between the ages of 10-29. However, youth violence is commonly used to refer to physical violence or bullying between peers, usually boys or young men, in visible settings, for example, gang or street related violence; (Krug, 2002).

Intimate Partner Violence (IPV): "Behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours".

The term covers violence by both current and former spouses and partners. Though women can be violent toward men in relationships and violence exists in same- sex partnerships, the largest burden of intimate partner violence is inflicted by men against their female partners; (Krug, 2002).

Sexual Violence: refers to "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to the home and work".

This definition includes rape, defined as physically forced or otherwise coerced penetration of the vulva or anus, using a penis, other body parts or an object; (Krug, 2002).

Elder abuse can be described as either intentional or unintentional (neglect) and can involve either physical, emotional, financial or sexual forms of abuse resulting in unnecessary suffering, injury or pain and a decrease in quality of life, (Krug, 2002). The definition developed by Action on Elder Abuse in the UK states that:

"Elder abuse is a single or repeated act, or lack of action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. It can be divided into the categories of physical abuse; psychological or emotional abuse; financial or material abuse or exploitation; sexual abuse; or neglect"

1.3.2   Understanding why violence and abuse happens

I found that Violence and abuse tend to be neglected as a public health issue, due to a variety of reasons, including, it's largely invisible, hidden and taboo nature. Additionally, health professionals and policy makers struggled to understand how violence and abuse actually affect health outcomes. To help provide insight into the complexity of multiple determinants affecting behaviour and outcomes across the life-course, I developed and used the following two figures in presentations, to help a wider audience understand these relationships.

Violence and abuse not only impact negatively upon health, but also are associated with poor educational outcomes, anti-social behaviour and violent crime, an increased risk of re-victimisation, fear of crime with detrimental effects on social cohesion and well-being, and a significant cost to the economy, (Nurse, 2006). Understanding why violence and abuse are important from the perspective of sectors other than health will help gain insight into what drives an issue onto the policy agenda and will be explored within this thesis.

The following Figure 6 was developed based upon extensive and systematic reviews of the literature undertaken by others, and myself on violence and abuse. (Nurse, 2004; Taket 2003; Sethi 2004; Nurse 2006a & b; Nurse 2007a).

Figure 6 - Impact of violence & abuse across the life-course, (DH, 2006)
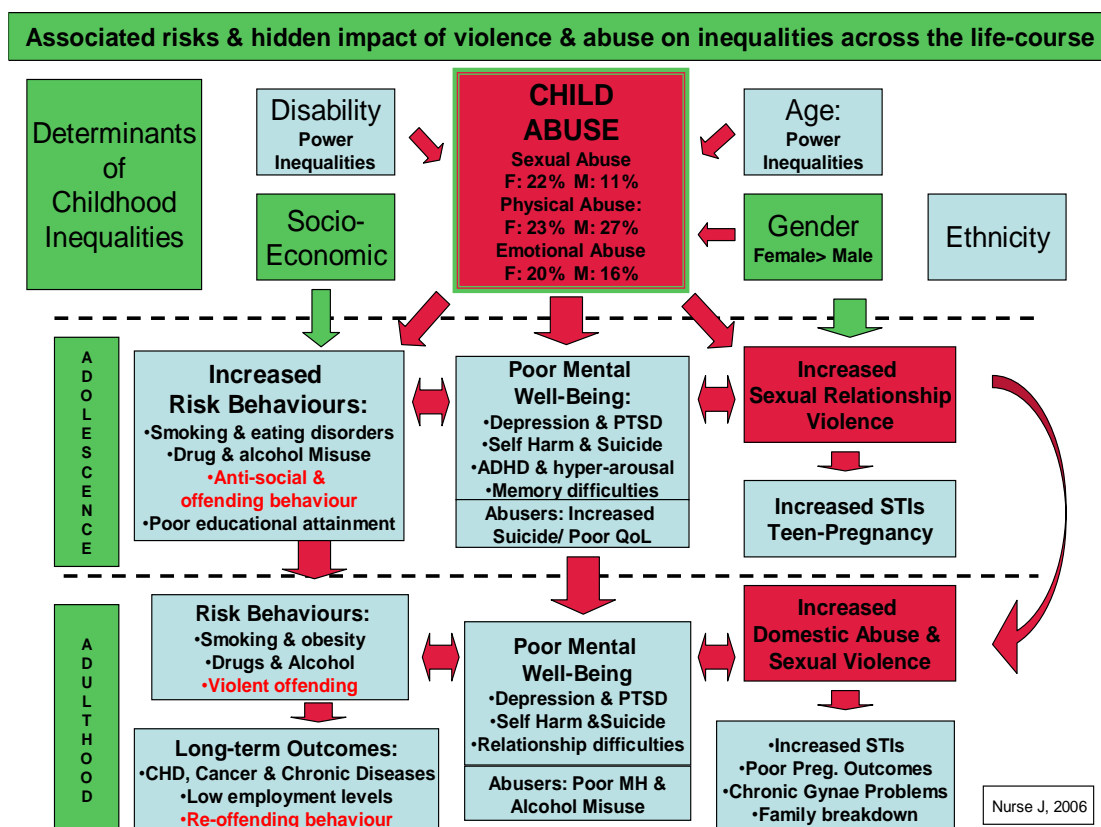
This figure was included in the DH Victims of Violence and Abuse Prevention Programme, (DH, 2006). The above figures were included in a number of presentations I have given on the links between violence and abuse and health, and why it is an important public health agenda. Over time, I improved and refined these figures in response to feedback from the presentations in order to assist future understanding. Additionally, the figures were improved upon following discussion with national and international experts.

Violence and abuse can be seen as risk factors for a number of health outcomes across the life-course. As a relatively new and complex area for public health to address, it provided a good case study to examine wider questions in understanding the policy process and how public health can better contribute to policy, as well as giving insight into improving future policy approaches to violence and abuse prevention.

1.4   Research Questions, Aim and Objectives

The above process helped me to clarify and formulate the research question for this thesis. This was also informed by a wider review of the literature. In particular, the following research gaps emerged that helped to inform the research question, aims and objectives:

- Violence and abuse are important public health issues – however they are not well reflected in public health policy – why was this the case?

- Relatively, little is written about the public health role in policy development; although public health policy is a key driver for shaping the delivery of work at regional and local levels. However, this is not reflected in the literature on the public health role in shaping the policy process, in general, and more specifically for violence prevention.

- The policy process is seen by many public health professionals as complex, confusing and difficult to influence. Evidence and policy recommendations are presented in journals or briefings by researchers, with an expectation that this is incorporated into policy. However, this frequently does not occur – why not?

- Although there are a number of models on the policy process, there is relatively little insider research or models describing the policy formulation process; in particular, policy models provide little insight about where or how to influence the policy process.

The below section, describes the distillation of these reflections into a succinct research question, which is then followed by a series of more specific research questions that help to address the overarching research question. This is followed by the research aims and objectives

that assist in answering the research question of the thesis. These questions, aims and objectives are then returned to throughout this thesis. Firstly, the methods chapter describes models and frameworks designed to help answer the research question. Then, the results chapters present findings according to the first four objectives. Lastly, the concluding chapter discusses the last two objectives and revisits findings of the research in relationship to the overarching aim and research question.

1.4.1 Overarching Research Question

- *Why is public health in England not more engaged with the development of policy for the prevention of violence and abuse?*

1.4.2 Specific Research Questions

Within the context of the case study of England (national level) and the SE region (regional and local levels) during the time- period 2005- 2010:

1. *What has been the general development of violence and abuse prevention policy, over time?*

2. *What has been the public health contribution to violence and abuse prevention policy?*

3. *Who have been the main actors, and what have been the key factors that have influenced violence and abuse prevention policy?*

4. *What are the implications for understanding the policy formulation process?*

5. *What are the wider lessons for policy?*

6. *What are the wider lessons for public health?*

1.4.3 Aim

"To document the process of policy development to prevent interpersonal violence in England, and explore the implications and potential role of public health"

1.4.4 Objectives

1. To describe the general development of violence and abuse prevention policy in England over time

2. To describe the public health contribution to violence and abuse prevention policy

3. To describe and explore the role of different actors in influencing the policy process for violence and abuse prevention

4. To summarise the policy formulation process

5. To summarise the wider lessons for Policy

6. To summarise the wider lessons for Public Health

1.5 Overall Coherence of the PhD

'The Public Health Contribution to the Development of Policy for the Prevention of Violence and Abuse in England'

Figure 7 below provides a summary diagram of the overall relationship of the PhD's aim and objectives with the research methods used and which chapters they occur in.

Figure 7 - Overall Coherence of the PhD
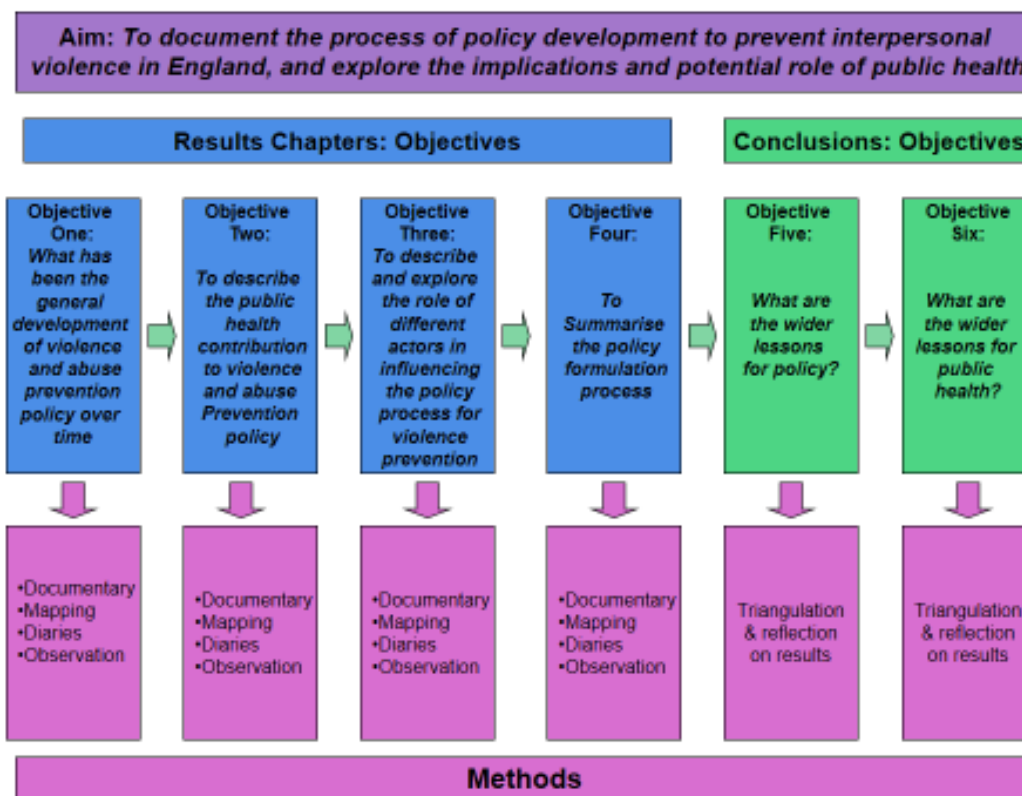
1.6   Contribution to New Research Knowledge

This piece of research will potentially provide new understanding and knowledge for a number of areas, including providing:

- Greater insight into policy development specifically related to addressing violence and abuse

- Knowledge of the contribution that public health can make to policy for the prevention of violence and abuse specifically, and

- Understanding into the wider contributions that public health can potentially make to policy development in general

- Further knowledge of the relative contributions, motivations and dynamics of differing actors and sectors in forwarding policy development in general and specifically for violence and abuse prevention

- Improve understanding, and practice in policy development in general, and for the policy formulation process in particular.

- The development and improvement of policy models and policy analysis tools created specifically for this thesis.

1.7   The Literature Review - Methodology

The below section outlines the process of the literature reviews taken. The following chapter summarises the literature review on policy. Whilst the literature review on violence and abuse within England contributed to the evidence summarised in the consultation report, (DH, 2008) and for the final policy report, (DH, 2012). Parts of this evidence review are provided as examples that form the case study for this thesis, and are summarised in the first results chapter.

1.7.1   The Violence and Public Health Literature

Specific reviews on violence and abuse prevention were undertaken during the research period to support the development of the violence and abuse prevention policy that I was involved in developing, of which relevant aspects have been summarised in this thesis. These included a review of the wider violence and abuse literature, including consultation with international WHO experts; a systematic review on school based violence prevention interventions and a

systematic review on dating violence prevention interventions. Additionally, a review and economic analysis was commissioned on the economics and cost effectiveness of violence and abuse prevention interventions from the London School of Economics and contributed to the final policy report, (Knapp, 2011 and DH, 2012).

A process of wider stakeholder engagement and peer review occurred with feedback from experts on various drafts of the violence and abuse prevention policy including the intervention review and economics summary. Aside from the specific reviews of published literature, this work also drew upon a number of wider sources including: NICE guidance; WHO reports; Publications of the Department of Health and other Government departments; ONS and other national surveys; Faculty of Public Health Briefings; North West Public Health Observatory regarding data, maps and graphs; and case studies of promising practice. The evidence for the interventions outlined in the violence and abuse section of this report were graded according to the following types of evidence:

- A = meta-analysis or systematic review

- B = evidence from one or two RCTs

- C = evidence from non-RCT epidemiological studies

- D = high level evidence exists for determinants or risk factors but health outcomes are not available

- E = qualitative research or promising interventions needing further epidemiological research

The quality and types of evidence were found to vary across the different parts of the violence prevention policy report. Where RCTs were not available, a wider range of literature and evidence types was reviewed to assess whether a consistent conclusion could be drawn. To aid this process and to ensure a balanced view was taken of the available evidence, the following criteria were also considered, including the effectiveness and cost effectiveness of the intervention; the population impact – the percentage of population that are benefited by intervention combined with effect size; the potential for wider gains, or co-benefits, including health, education, employment, societal, crime, and improved physical health, and the impact and benefits across the life course. Additional factors that were also considered, included the feasibility of implementation, for example, the ability to mainstream an intervention within existing services or systems, as well as any potential harm from the intervention or barriers or obstacles in delivery of interventions. Finally, the sustainability of interventions, both in terms of resources and upon the environment were also considered. The criteria for prioritising future

public health risks included the size of potential risk – e.g. the number of people affected (mortality/ morbidity); the cost of harm and the likelihood of the risk. Summaries of the evidence base in relationship to violence and abuse prevention can be found in the published government reports, (HM Gov't 2010; DH 2012).

1.7.2   The Policy Literature

A review of the policy literature was undertaken to support the work in this thesis. This included discussion with experts in the field of key texts including books and publications, which are referred to for summaries of the policy process, including policy models and methods for policy analysis. Additionally, a further systematic review was undertaken of peer-reviewed journals on the following subject keywords:

- Public Health; Health Policy; Policy; Policy Models; Policy Process; Policy Delivery; Strategy; Complex Adaptive Systems; Systems Science; United Kingdom; Violence; Abuse; Alcohol

The following search engines were searched from 1980 – 2010:

- Lib Cat; AMED; BNI; EMBASE; HMIC; MEDLINE; PsychINFO; CINAHL; HEALTH BUSINESS ELITE

Abstracts were reviewed for relevant articles, and full articles obtained and read on subject areas of relevance to the thesis. Key findings from the policy literature review are summarised in the following chapter. The review has been further updated following discussion and feedback from international experts.

The next chapter summarises the main findings from the policy literature review. Whilst the findings for the violence review were mainly used to inform policy development (DH, 2008; DH 2010). Examples from the violence and abuse review of how evidence was used to influence policy are summarised in the second results chapter on public health.

Chapter 2 - Literature Review – The Policy Process

This section summarises the main aspects of the current literature around the policy process. The introduction defines policy and gives an overview of theories of decision-making and describes key components of the policy process. This is followed by a summary of the literature on public health and the policy process, and the violence and abuse policy literature. The next section then goes on to describe a range of different policy models and approaches to policy analysis. Building on the literature, the following chapter then provides a description of frameworks that I developed as research tools to assist in the methods used for data collection and analysis for this thesis.

This literature review helped to identify gaps in knowledge to inform the focus of research by this thesis. In particular, gaps identified by discussion with experts include the relative lack of research on the policy formulation process and research on the policy process from an insider perspective.

2.1   Definitions and Theories of Policy

The meaning of the term policy is somewhat variable and has changed over time with multiple understandings for policy including: proposals, decisions, authorisation, purpose, programmes, outcomes, process and theories. Earlier definitions of the term included the term 'craftiness', this maybe a reflection of the origins of the word policy being linked to the word 'politics' (Parsons, 1995). However, today there is a perceived greater sense of rationality and transparency regarding the process of how decisions are made. Parsons defines policy as:

> *'A policy is an attempt to define and structure a rational basis for action or inaction'*
> *(Parsons, 1995)*

Walt's understanding of the term policy focuses on process and power, and sees how decisions are made as central to this. Therefore, Walt frequently uses the term decision interchangeably with policy to emphasise this relationship, (Walt, 1994). The centrality of the decision process and what comes forth following when a decision has been made, is captured well in Barker's definition of policy:

> *'Policy is the process of taking decisions, the production of statements and the making of plans, or the development of an approach, and implementation' (Barker, 1996)*

Whilst Axford's (2002), description of policy sees decision making as one of three steps, starting with intentions, followed by decisions which lead to consequences or actions. The three aspects of the policy process are described in Table 5 below:

Table 5 - Three steps to decision making in policy, (Axford 2002)

- The **intentions** of political and other key actors
- The way **decisions** or non-decisions are made
- The **consequences** of these decisions

In contrast, the WHO guidance for violence prevention policy, identifies a relatively detailed definition, and describes a policy as an identifiable document setting the high level goals, objectives and priorities with a focus on prevention as well as harm reduction:

> *'A policy on violence and injury prevention is a document that sets out the main principles and defines goals, objectives, prioritised actions and co-ordination mechanisms, for preventing intentional and unintentional injuries and reducing their consequences' (WHO, 2006b)*

The WHO guidance (WHO, 2006b), distinguishes a policy as being the what and why, compared to a strategy as framing the how, and an action plan providing the detail for delivery. However, for the purposes of this thesis, where violence and abuse are seen as the case study, ***the definition of policy used in this research,*** is based upon the combination of descriptions of policy from the literature, where the decision making process is seen as central to the process:

> *'The process of clarifying purpose, making decisions and plans on how to deliver stated intentions'*

As decision making is seen as central to the policy making process, a number of theories on decision making developed in the policy literature to try and understand this process more clearly. The following Table 6 summarises the main theories for decision-making (Axford, 2002).

Table 6 - Summary of theories of decision-making for policy, (Axford, 2002)

- **Rationality:** a scientific approach that assumes the ability to make a decision, prioritise and rank, and to choose the best solution in a rational way. It also assumes that the process is repeatable given a similar situation.
- **Cost Benefit Analysis:** an economic method for balancing and assessing policy options according to costs and benefits.
- **Incremental Theory:** describes how fundamentally different decisions are rare, and there are usually incremental adjustments to existing policy. Policy tends to develop in a piecemeal and gradual way with ad-hoc disjointed changes. The policy process is not logical or strategic, rather a continuous and cumulative process which has been described as 'the science of muddling through'. Incrementalism restricts innovation and the uptake of new agendas.
- **Innovation and Mixed Scanning:** This theory describes a mixture of a rational approach combined with creativity, innovation and idealism, and is expressed in the form of 'Think Tanks', 'Blue Sky Thinking', 'Horizon Scanning' and brain-storming workshops.
- **Organisational and Bureaucratic Models:** focuses on the role of organisations and bureaucracy in the policy process. This model describes how the organisational culture and bureaucracy of the civil service creates a slow policy making process which is subject to maintaining the status quo and influences the agenda of incoming politicians.
- **Ideology:** describes how decision-making is based upon political or interest group ideologies.

These theories are divergent in their nature, spanning from logical, sequential approaches, to incremental and cumulative approaches on one axis. In contrast on another axis, political ideology drives policy and decision making versus the creation of innovative solutions and options for decision making, for example, via think tanks.

2.2   Summary of the Policy Process

The below review explores further detail on theories and approaches to understanding the policy process, including: incremental vs. rational approaches, the role of power, actors, networks and the wider context including the impact of globalisation. The following section then describes the role of public health and violence and abuse in the policy process followed by policy models and approaches for policy analysis that help to inform the methods used in the research carried out for this thesis.

2.2.1   Incremental vs. Rational Approaches

The **rational approach** to policy applies a logical step-by-step approach to decision making. It involves a unitary perspective, which tends to not acknowledge the existence of conflicting interests, it needs consensus and a corporate transparent and logical approach to decision making. (Hunter, 2003). Walt (1994), outlines the main steps of the rational approach in Table 7.

Table 7 - Steps to the rational approach to policy making, (Walt, 1994)

1. Problem identification and definition
2. Clarification of goals, values and objectives
3. Identify range of options to address the problem
4. Cost benefit analysis of range of options
5. Option analysis
6. Select best option based upon maximising attainment of goals, values and objectives

Although, most outsiders may perceive that policy would be made in a rational systematic way, as described in the above steps, the reality is often different. For example, issues may be complex and difficult to define and there is usually existing policy, which means there often is not a full range of options. Additionally, policy makers frequently do not have sufficient time to gather information and consider the full range of options and individual policy makers often have their own values, which may influence the overall shape of the policy formed; (Walt, 1994).

In contrast, **the incremental approach** – is seen as a better description of the real world of policy making that can be seen as 'muddling through'. Incremental policy making ends up being relatively conservative creating only small changes and results in serial policy making to address unresolved problems. Key elements of the incremental approach are described in Table 8.

Table 8 - Key aspects of the incremental approach to policy making (Walt, 1994)

- Goals or objectives are not clarified, in part to avoid conflict
- A small range of options are considered that only differ marginally from existing policy
- A narrow range of consequences are considered
- The option chosen depends on the one where most agreement can be made by policy makers

Incremental policy-making can be seen as un-rational and non- linear and involves a greater level of 'wheeling and dealing'. This pluristic model sees different stakeholders as having differing interests and levels of power and that an equilibrium or compromise has to be obtained in new policy formation, (Hunter, 2003). However, neither approach necessarily describes public health policy-making, where the reality potentially falls somewhere between these two approaches.

It can be argued that there is an artificial debate and separation between rationalism and incrementalism. For example, Smith and May (in Hill, 1997), describe, the mixed scanning approach and the normative optimum model as potentially more integrated approaches to policy formation. The **mixed scanning approach** includes a broad sweep of policy options, then decisions are made incrementally of detailed aspects to form the final policy. Whilst, the **normative–optimum model for policy making**, acknowledges the lack of rationality, (and the role of values and intuition) in policy making and seeks to increase the rational content.

Hunter (2003), highlights the need to develop a new policy paradigm to bridge the formulation process with the implementation stage of policy. He argues that the policy making process needs to be more transparent and rational vs. the complexity of much policy development that reflects a compromise between competing interests. Hunter (2003), also calls for a new paradigm in policy formation to accommodate the complexity of improving health and that acknowledges the power dynamic of the policy making process.

2.2.2   Power and the Policy Process

Even within democratic societies, policy decisions and the power to change things at macro level is held by a relatively small number of people. Walt (1994) outlines the following types of policy and level that power is expressed as being either macro policy or micro policy. **Macro policy** can be described as high politics and includes cross –governmental policy. Whilst, **micro policy** can be described as low politics and includes policy developed on one area by a single government department.

Additionally, the power of decision making within the policy making process can be described as either elitist or pluralist. **Elitist** is where policy choice and change is dominated by a particular social and economic group, whose aim is to continue their dominance and power base. Whilst, **pluralist** policy decisions are made by a wide variety of groups in society and power is evenly diffused, leading to decisions that are for the collective public interest. (Walt, 1994).

Clearly, the power of policy making is frequently somewhere between these two extremes, which Walt describes as the state of '***bounded pluralism'*** whereby macro policy is made by elites, and micro policy takes a more pluralist approach, (Walt, 1994). It can be argued that the assumption of the linear, rational model of policy making is insufficient, ignoring covert power plays between stakeholders and the complexity of policy making and implementation. (Hunter, 2003). Power is more evident when there is observable conflict. For example, despite a large body of evidence and policy documents on addressing the upstream health inequalities, there has been little shift in macro- policy to address this. This occurs by maintenance of the established system- this is not observed but the power of the status quo, (Hunter, 2003). Hunter (2003) goes on to describe how the strength of the power base of the current policy system creates difficulties in changing policies to improve health as opposed to maintain health care systems.

The issue of timescales is one of the key issues that exerts power in deciding the content and scope of policy. Government works on a short time frame, for example, political timeframes are usually for 4-5 years during which time fast gains are needed to be able to show success and win votes. Whilst, changing health care systems tends to be on a longer time- frame, and improving health especially needs an even longer time scale to show success. Resolving this tension constitutes a major policy dilemma, especially for public health, (Hunter, 2003). Although, it is generally assumed that investment in most public health interventions have longer-term gains, a recent review highlights a wide range of public health interventions, including for violence and abuse, where returns on investment occur within 0-5 years, (WHO, 2014).

Health care almost always wins out in the competition of resources over health improvement, due to perceived immediate gains as opposed to future gains, with prevention only receiving an average of 3-4% of health sector budgets compared to treatment, (WHO 2012d). Creating a shift from health care services to improved health is almost impossibly difficult because there is insufficient power to change the status quo. Additionally, traditional policy and management models (mechanistic, reductionist, command and control orientated), are inappropriate for the complexities needed to develop policy for health improvement (Hunter, 2003).

Policy networks and pressure groups can have a range of access to power and influence in the policy process. Although, the civil service/ bureaucracy often maintains the status quo and holds a strong power base in the control and formation of policy, for example, in their role of drafting policy and briefing ministers. This contrasts with the interests of the power of the business world, where their aim is to make profit versus public services, whose main aim is to

improve the well-being of society. Conflicts frequently arise in policy formation when these perspectives are combined. (Hill, 1997).

2.2.3   Actors

Actors can be considered as those involved in setting the policy agenda, formulating policy or implementing policy. Different actors have varied amounts of power in influencing each of these stages and according to the specific type of policy that is being developed, (Walt 1994). Examples of the range of actors in the policy process can be seen in Table 9.

Table 9 - Actors who can influence health policy, (Walt, 1994)

- Governmental Ministers
- Civil Servants
- International Organisations – for example the World Health Organisation
- Academics
- The Business Community
- The Media
- The Voluntary Community Sector
- The Royal Colleges – for example, the Faculty of Public Health and other representative bodies for public health professionals
- The NHS and health professionals
- Users of the NHS and the general public

The civil service are recognised as key actors in the policy making process, with their primary responsibility being to develop of government policies. However, they need to meet the needs of two divergent client groups – ministers and public service users. Historically, the civil service has been seen to be populated by traditionalists, who are resistant to change and senior posts are over represented by 'generalist' fast-streamers who do not represent the range of experiences within the general population; (Pyper, in Jones et al, 2001). However, the civil service are instrumental in setting policy agendas and developing policy and they play a key role in managing external actors expectations and in influencing what the minister finally decides, (Walt, 1994). In this respect, insider research within the civil service can give a valuable insight into the policy formation process.

2.2.4 Networks

Policy networks consist of the interaction of different actors and exist in a number of different forms. Essentially, they are a network of sub-government level people that have access to influencing policy formation. Sub –government includes individuals within interest groups, bureaucratic agencies and government, including the civil service. Networks relate to the 'pluralist model of policy making' (Walt 1994). Networks exist on a continuum from informal interpersonal relationships on the one side, to existing within a formally structured set-up on the other. There is a continuum of policy network between that of an 'issue network' to that of a 'policy community network' as described in Table 10.

Table 10 - Characteristics of issue and policy community networks, (Marsh, 1998)

Issue Networks	Policy Community Networks
• Only covers policy consultation and not negotiating further policy formation • Large number of participants with fluctuating and variable engagement • An absence of consensus- with conflicting views • Unequal power relationship, many participants having little resources and access to shape the process.	• A limited number of members with some groups consciously excluded • Frequent and high quality interaction between those members of the community • Common values, and consensus decision making • Members have resources which they use to bargain and negotiate with • There is a balance of power, though not necessarily equally so and where hierarchy exists there is compliance with leadership values.

To promote civil society engagement in policy, approaches like the Advocacy Coalition Framework and the Institutional Analysis and Development Frameworks have been set up to aid the analysis of group membership and participation in the early stages of policy development, (Sobeck, 2003). Policy networks can change over time, and certain groups may dominate in the network. Policy networks are generally perceived as influencing and affecting policy formation, though the extent to which this happens may vary according to the setting and type of network. (Marsh,1998).

2.2.5   Context and the Impact of Globalisation

Policy occurs within a wider political, economic, social, cultural and environmental context, (Walt, 1994). Ultimately, policy is shaped by the wider context, including via the international and global arena. Globalisation can be defined as the:

> *'processes that are changing the nature of human interaction across a wide range of spheres including the socio-cultural, political, economic, technological and ecological' (Lee, 2001)*

For example, outside events- like September 11th 2001 played a role in changing the profile and importance of public health, especially from a health security perspective. In this situation, after the terrorist attacks, ministers developed policy on health protection, which raised the profile of public health up the policy agenda. (Hunter, 2003). The impact of globalisation on health has become wide ranging, influencing inequalities and many determinants of health. Table 11 describes further examples from the wider global context, which potentially influence national policy on violence and abuse policy.

Table 11 - Examples of the global context that influence policy on violence and abuse; (adapted from Lee et al, 2002)

- Global economic crisis in 1990s and 2007 onwards, led to decreases in spending in the health sector.

- The challenges to international health responses around trafficking

- The impact of conflict and wars on health

- The impact of trans national companies – for example, the alcohol business and gun traders

- Increasing inequalities in health and wealth – and their impact upon violence

- Increased communications and information technology impacts upon intellectual thinking and ideas which are largely dominated by the west- this also includes political and religious ideologies

- Impact on diet and lifestyle- smoking, drugs, alcohol and drug consumption

- Human rights and UN role in health and globalisation of health policy, need for global health governance

- Impact of global policy networks, universities and international aid, NGOs and UN/ WHO

organisations- policy elite, power and influence on health policy

- Global debate and shifting cultural acceptance around violence – eg violence against women

- The role of the internet in transferring policy publications and ideas and also in the perpetration of violence and abuse, for example via internet pornography.

2.2.6 Policy Windows:

A key aspect of the advancement of the policy process relates to the way certain opportunities arise in agenda setting. This is described by John Kingdon's work on the way a range of policy streams coincide, in order to create policy windows, whereby significant advances are made for a policy agenda (Kingdon 1984). Kingdon's research is based upon the interview analysis of health and transport policy in the 1970s, and describes the chaotic nature of the policy process, with a number of policy problems and solutions coalescing together into a 'garbage dump'. Rather than a logical or systematic approach being taken in bringing together problems and solutions, Kingdon describes this soup like mixture intermingling and interacting as three streams that influence agenda setting:

- **The Problem Stream:** a problem can emerge as a policy issue either because of government data or performance targets highlight an issue. Additionally, a particular event or disaster may arise as a problem and push a policy agenda;

- **The Policy Stream:** policy officials and networks advance a policy solution that emerges from the soup – these may be further advanced by policy entrepreneurs;

- **The Political Stream:** whereby, the policy agenda is driven by political parties, ministers, and lobby groups; these are influenced by media events and public opinion, and require consensus building.

Kingdon (1984), describes how these three streams at times, merge and align to form a policy window, where it is possible to establish a policy agenda or effect a key policy decision. This is usually driven by alignment of a problem and political stream, followed by advancement of the opportunity within the policy stream. For example, the relative lack of the mainstreaming of the health inequalities agenda into effective cross sector policy environments can be framed as a lack of alignment of these three policy streams. In particular, the failings in advancing windows of opportunity that emerged and the relative inability to translate research findings into policy have been highlighted (Exworthy 2012).

2.3   Public Health and the Policy Process

2.3.1   The Public Health Role in Policy Making

Historically, health policy in many countries has tended to focus just on medical care policy rather than the broader aspects of public health (Ham 2009). This has potentially been reinforced by the main focus of Health Systems policy in WHO being upon health services rather than for public health (WHO 2000). Although, Navarro recognises the importance of a public health perspective and in 2007, described addressing the wider determinants of health, including lifestyle determinants and empowering people, as key components to include in health policy. More recently, and of greater relevance for England, the WHO European Region has adopted a resolution and action plan on strengthening public health services and capacity as part of a health systems strengthening approach (WHO 2012a).

Historically, within England, since the re-organisation in 1974, public health has been tied to managing the NHS- health care services, and has had few levers to manage the wider determinants of health. This has served to re-enforce the predominance of health care services in policy and therefore, the downstream agenda (Hunter 2003). However, the recent health policy reforms since 2010, return public health more firmly within Local Authorities, which gives the potential to influence the wider determinants of health.

An overview of the development of post war health policy highlights the realignment of the system towards a primary care led NHS. Since the 1970's, successive governments have introduced policy and tried to shift resources away from cure towards prevention. However progress has been restricted by socio-economic factors, complex logistics, administrative problems and ethical issues (Wall and Owen 1999). Whilst over the last ten years, health policy has driven up the GDP proportion of funding for the health sector to reach the European average, however, the majority of the additional funding has gone towards salaries and hospital services, with an overall reduction in the proportion spent on primary health care. Fortunately, public health budgets during this time have largely been protected.

Although, there have been improvements in health outcomes related to prevention, especially with regards to the reduction in Cardio-Vascular Disease (WHO 2012b), it is difficult to correlate these improvements to direct changes in policy. Whilst, in terms of the success of public health policy, Hunter argues that there has been a failure for public health policy to be implemented. Hunter (2003) identifies a number of reasons for policy failure in addressing health inequalities, these are outlined in Table 12.

Table 12 - Reasons for policy failure in addressing inequalities in health

- The competing agendas and priorities from health care services versus public health – resulting in a mismatch between policy and management priorities.

- The failure to re-direct resources and pooling of budgets.

- Long-term public health outcomes are difficult to measure- need for intermediate milestones.

- The need to mainstream approaches rather than the creation of small-scale projects and pilots, for example, the Health Action Zones and Regeneration funding.

- Constant change is unsettling and damages commitment and a sustained approach to improving health/ addressing inequalities.

- A wide agenda of inequality issues to tackle with no clear strategic priorities.

- Tension exists between utilitarian concepts of improving health versus egalitarian concepts of addressing inequalities.

- Evidence based approaches are difficult to synthesise, put into context and integrate into the mainstream.

Reviewing the literature specifically on *public health and policy*, the main focus of papers was on micro- policy, i.e. specific public health topics, rather than the macro- public health policy for example, overall health policy or cross-sector policy. Although, there was a wide range of public health subjects, most papers were either making policy recommendations on specific research findings, for example, (Millstone and Russell 1995; Michael et al 1998); or advocating for (Vanderveen, 1989) or against a particular policy (Woolf 1994).

There were papers reporting the use of decision modelling to inform policy development on specific health care interventions, for example, (Colice 1990). One paper on modelling health outcomes to inform policy recognised the need to ensure simplicity to provide understandable mechanistic explanations for real world policy makers, (Regan and Wilson, 2008). An analysis of the history of smoking (Wynder 1988), and alcohol policy, (Mosher, 1983; Drummond, 2004; McLean, 2009) revealed the discrepancies between research findings and policy formation, and indicates the role of other influences and interests (for example, industry) in policy formation.

However, there were several papers on different aspects of inequalities in health, including the impact of policy on health and socio-economic inequalities (Lee1999) the disparity of relative resources to address health inequalities (Powell and Exworthy 2001), advocacy, (Baum 2004), or were descriptive in nature (Dievler and Pappas 1999; Buckland and Doyle 2002). Research gaps and the lack of evidence for policy to reduce health inequalities, were also identified by the review (Whitehead 2004; Petticrew 2004). Additionally, conceptual models for policy makers to tackle social determinants of health were found, (Exworthy, 2008), and one paper analysed the impact of policy upon health services (Lehman 1998).

Shiffman and Smith (2007), apply a framework to assess factors for whether global health initiatives have received appropriate attention and prioritisation. This framework consists of four factors, including: the strength of actors; communications approach; the political context; and the characteristics of the specific issue. They applied this framework to maternal health and mortality, and describe difficulties in all these categories that have influenced the relative lack of progress of this initiative over the last 20 years and recommend similar application of this framework to support policy advocacy for other public health challenges (Shiffman 2007).

There were a number of papers that identify the difficulties for policy makers if there is a lack of support by practitioners (Loewenson 1994). Variation in scientific findings (Cornel 2005), and the need for greater scientific consensus was also found (Palmer 1985; Ashwell 2008). Additionally, barriers to policy implementation on the ground were identified (Baille 2009), and a call for greater involvement of health care professionals in policy formation to ensure greater appropriateness of policy formation was made (Phaladze, 2003).

Clearer communication by scientists to inform policy messages and avoid mis-representation by the media, was identified as an issue (Watterson, 1994). Hunter (2003) also recommends improving the translation of evidence for policy makers, a perspective, which is also upheld in the European Action Plan for strengthening Public Health Services and Capacity (WHO 2012a). As a high proportion of papers found in this review related specifically to aspects of evidence based policy, a separate section summarising the literature in this area is found below.

2.3.2   Evidence Based Policy Making

Evidence based medicine has largely been driven by Public Health and emerged in the 1980s in the context of reduced financial resources and increased public demand for transparency about decision making. During the late 1980s a House of Lords Select Committee report highlighted that research was driven by researchers and did not necessarily produce information that was relevant to clinicians, managers or policy makers. This report led to the development of the

NHS Research and Development Programme. (Gray, 2000). Although, there was an initially slow uptake of evidence-based approaches within the policy arena, there has been a gradual increase in uptake in the development of evidence-based policy from the late 1990s, (Behague et al, 2009).

However, there is considerable variation in the degree that research findings are incorporated into policy, with some policy being developed with very little evidence base. This is in part due to the way research findings are presented and communicated to the policy world. As most public health research is government funded, there is the potential to increase the relevance of research for policy. This could be enhanced if there was a greater degree of co-creation between researchers and policy makers in the development of future research agendas to ensure greater relevance to policy making (Hunter 2009).

Furthermore, there are a number of obstacles of scientists and policy makers working together. They have different career paths, language, goals and attitudes towards information. Additionally, their differing disciplines leads to a lack of mutual understanding and trust, and differing views on the production and use of evidence. Translational scientists, organisational change and acknowledging the complexity of the policy process is proposed to aid knowledge transfer and understanding between these different disciplines. (Choi et al, 2005).

Although evidence based policy approaches utilise both quantitative and qualitative forms of evidence, interestingly, single studies and evaluations are more commonly used to support policy than systematic reviews. Policy makers use qualitative data to provide an emotional story that can be more memorable and persuasive for ministers and the general public, than factual numbers in making policy changes (Brownson et al, 2009). Although more complex to apply to policy, examples of quantitative meta-analytical approaches have been used to inform the development of policy models to address issues such as drug abuse, (Lipsey, 1997). However, it can be argued that the most effective approach is to combine both quantitative and qualitative evidence to have a stronger influence on policy making, (Brownson et al, 2009).

Although quantitative economic analysis has been used successfully for specific health interventions to inform public health policy making (Hinman 1997), until recently, economic evaluations have had little influence in shaping policy decisions. Funding for services have been decided by such things as the degree of advocacy, colloquial evidence, values or politics, with some policy areas having actively resisted the use of economic analysis in making policy decisions, (Grosse et al, 2007). However, economic evaluations are becoming a more recent influence in shaping public health policy, (Adeoye et al, 2007).

Bowen and Zwi (2005) highlight the lack of evidence-based policy-making and outline in Table 13 a number of different models of how policy makers use evidence:

Table 13 - Approaches for applying evidence into policy, (Bowen and Zwi, 2005)

- **The Knowledge Driven Model** – emergent research is directly applied to policy formation, with new knowledge driving the policy agenda.

- **Problem Solving Model** – policy draws upon research to solve a policy problem.

- **The Interactive Model** – the search for knowledge to inform policy draws upon a number of sources such as politics and interests and reflects the complexity of the policy making process.

- **The Political Model –** research findings are only applied to policy unless it serves political gain.

- **The Enlightenment Model** – cumulative research shapes the policy agenda and influences the way people think about social issues.

- **The Tactical Model** – evidence (or a lack of it) is used to justify government inaction on a policy issue.

One of the issues of over-reliance on evidence based policy, is that a lack of evidence can cause inaction in an area that may be an important emerging public health issue. Policy makers and public health professionals can reduce problems to technical issues, for example, by arguing that insufficient evidence is a reason for inaction or gathering of further evidence (Hunter 2003).

The conceptual base of policy versus researchers and the public health community can be seen to be opposite each other. For example, conceptually, the evidence base utilises a linear rational approach to inform strategic decisions, whilst the policy process tends to occurs in the context of complex systems; (Parsons, 2002). These two approaches are based upon two different paradigms and do not always provide a coherent approach to policy making. To overcome this conceptual barrier, it has been suggested that evidence should be applied to the policy context (Dobrow et al, 2003), and form one part of a comprehensive approach to policy making (Parsons, 2004), rather than realign policy making to a linear, rational paradigm. More recently Evidence Based approaches have sought a variety of techniques to ensure greater relevance of

findings to real life situations, and include tools such as health impact assessment, systematic reviews, community fit and feasibility, (Fielding and Briss, 2006).

In summary, although the role of evidence based science is a central concept to public health and the scientific medical community. However, it tends to be more appropriate for single treatments and narrow focused interventions and is less easy to apply to the more complex multi-factorial interventions, including health policy. Historically, government policy-making has been driven by a number of factors, of which evidence based policy-making is a relatively recent concept. There is also a challenge in translating specific evidence based interventions and combining approaches to formulate joined up policy. (Hunter, 2003).

2.4   Violence and Abuse, and the Policy Process

The history of violence and abuse prevention as a public health issue started mainly in the 1980s, for example, a key instigator was the Centres for Disease Control, (CDC), in the USA, where a change in policy to address wider determinants of health beyond non- infectious diseases occurred,(Jason, 1984). This lead to a call for public health policy for preventing violence based upon an epidemiological approach from the early 1990s with the development of a centre on violence and injury prevention being established at CDC.

During 1993, CDC identified the public health contribution to violence prevention policy as having a greater understanding on different levels of prevention and being able to turn science into action, Additionally, the public health role was seen to provide leadership and integrate the efforts of a diverse range of disciplines, organisations and communities to work together and solve problems such as violence. (Mercy et al, 1993). Since that time, the WHO in collaboration with CDC, has been a key advocate in highlighting the public health role on policy for violence prevention, with the first World Health Assembly Resolution on preventing violence being agreed in 1996.

A review of the literature on *violence and abuse and policy*, found a wide range of published literature either making policy recommendations following a specific research study and / or advocating for policy changes on violence and abuse prevention, most of which were on particular categories of violence and abuse. There were only 3 published studies found that provided a more detailed policy analysis related to violence and abuse prevention. These studies included one of a high level editorial on factors influencing placing violence and abuse on the policy agenda; secondly, an analysis on documents of a range of organisations, examining the emphasis given to prevention within a violence against women remit; and lastly,

a study in South Africa on factors influencing the uptake of evidence into policy for violence prevention. The three studies are summarised in more detail below:

Firstly, the editor of the British Medical Journal on Injury Prevention wrote an article following the international Safety Conference in 2008, where he commends the visible presence of ministerial officials. A comprehensive analysis of the factors that influence the uptake of a public health agenda as a global health initiative is outlined and applied to violence and abuse prevention (in italics). The main factors for the success of a particular issue are outlined in Table 14.

Table 14 - Factors that influence global agenda setting as applied to violence and abuse prevention, (Johnston, 2008)

- It is easy to describe with epidemiological methods – *violence and abuse are.*

- It applies itself to the relevant political context and takes opportunities of policy windows to help raise its profile – violence *and abuse has only done partially.*

- It has good leadership and strong champions from mainstream public health – *violence and abuse agenda keeps a silo'd approach and is weak on gaining mainstream public health champions and support.*

- It frames ideas appropriately, to engage internal and external audiences, to gain a clear internal policy consensus, and externally, is able to link itself to topical and wider public health policy issues, for example climate change. *Multiple splits in the field of violence and abuse make it difficult to link to wider policy and public health issues. (Johnston, 2008).*

Secondly, Koss and White (2008), provide a policy analysis of 11 national and global institutions' violence against women's agendas between 1990 – 2006. The most common agenda found between them all was 'prevention' which was mentioned by 29% of institutes. A consensus analysis found the recommendation 'prevention' in 48% of at least four reports. The analysis included 10 policy reports by a range of international and US organisations, including six from a health perspective. Agendas, ways forward and recommendations were extracted from the policy reports and a list of key words was analysed for the proportion of times they were included and the degree of consensus found. Themes were considered over time and between global and national levels.

Thirdly, an analysis of how public health research findings have stimulated violence and injury prevention policies was based on two case studies in South Africa, (Seedat and Nascimento, 2003). One study was of a provider of injury data and the other an advocacy group for gun control. The studies used a combination of focus groups, interviews, including of political figures and documentary analysis. Key findings regarding significant factors that influence prevention policy are summarised in Table 15.

Table 15 - Factors influencing the translation of evidence into policy for violence prevention, (Seedat and Nascimento, 2003)

- **Capacity** - sufficient institutional capacity of policy leads is needed to interpret data and evidence based information

- **Accessible information** - data needs to be presented and packed and disseminated in accessible, non-jargonised ways

- **Timing of data release** – the release of data needs to be at a time that it will be read – not in a festive season

- **Personal motivation and connection to the problem** – social actors who had strategic connections to the policy world facilitated uptake by policy

- **Political responsiveness** – gaining wider political support of the agenda helped uptake of research into policy

- **Institutional reputation** – if the research body was well regarded uptake of research findings was improved

- **Multiple sources of influence** – scientists represented only one source of data intake by policy makers

- **Compromise** - advocacy groups needed to be prepared to take a compromise position for policy to be adopted

The study summarised key findings according to Walt's policy triangle based on context, content and process. Whereby, context related to gaining political support and interest to science; content emphasised the accessibility of information and process identified the importance of timing for the dissemination of information.

2.5 A Summary of Policy Models

Reviewing the literature on policy, there was relatively little outlining how to actually influence or shape policy development from a from a public health perspective. In particular, there was a relative lack of insider research on the policy formulation process, nor of policy models that could be used as the basis for research tools on the policy process. However, there was a wider literature on policy in general to draw upon, and the below section provides an overview of the main policy models found in the literature. These form the theoretical basis that were built upon for the frameworks and models developed for undertaking the research of this thesis and are described in the following chapter.

2.5.1 The Black Box Systems Approach

The predominant understanding of the policy process in the 1960s-70s was of a 'System's Approach' described by Easton. The strength of this model was that it placed the policy process firmly within a wider environmental and political context. Policymaking was seen as a system that interacts with the wider social environment, and is driven by demands, which result in decisions, actions and outcomes. These outputs were seen to generate a feedback loop, influencing further drivers or inputs; see Figure 8 that is based upon the description of Easton's model in Parsons, (1995).

Figure 8 - Summary of Easton's Systems Approach to understanding the Policy Process
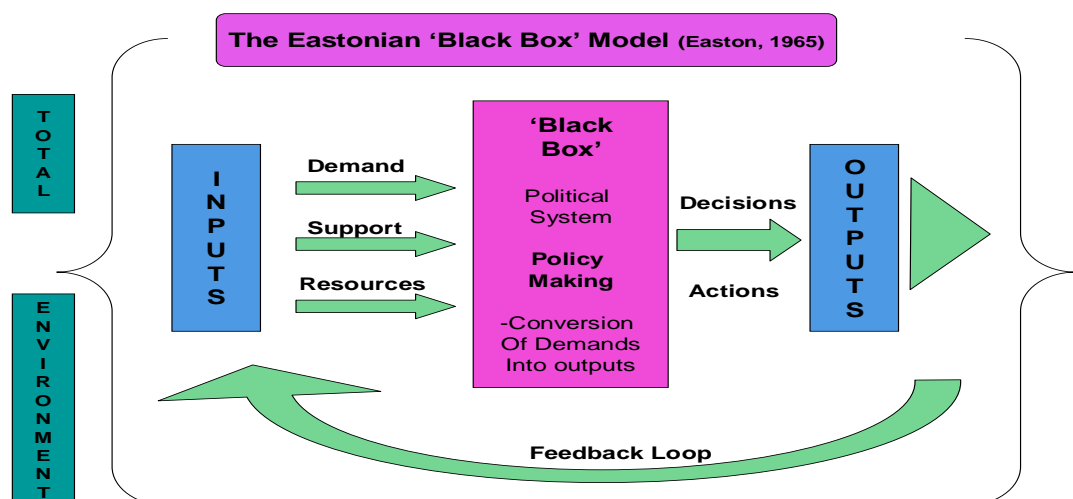
However, the critique of this model of the policy process was its emphasis on inputs and outputs. It was less clear about how the decision-making process actually happened, which led to the description of this approach being a 'Black Box Model'. (Axford, 2002).

2.5.2 The Stages and Sequential Models

The Black Box approach made a number of assumptions that decisions were made in a rational way with clear objectives and goals. The Stages or Sequential models that emerged in its wake during the1980s attempt to describe in more detail the process of what was understood to occur within the 'Black Box', (see Figure 9). There are similar sequence models which also incorporate the implementation and evaluation stages as opposed to focusing mainly on the decision making process, (Barker, 1996).

Figure 9 - The Sequential Model of Policy Decision Making

Sequential Model of Policy Decision Making
Hogwood & Gunn (1984)

Deciding how to decide

Issue Definition

Forecasting

Setting Objectives

Deciding to Decide

Formulating Alternatives

Making Decisions

Policy Formulation

Correction & Addition
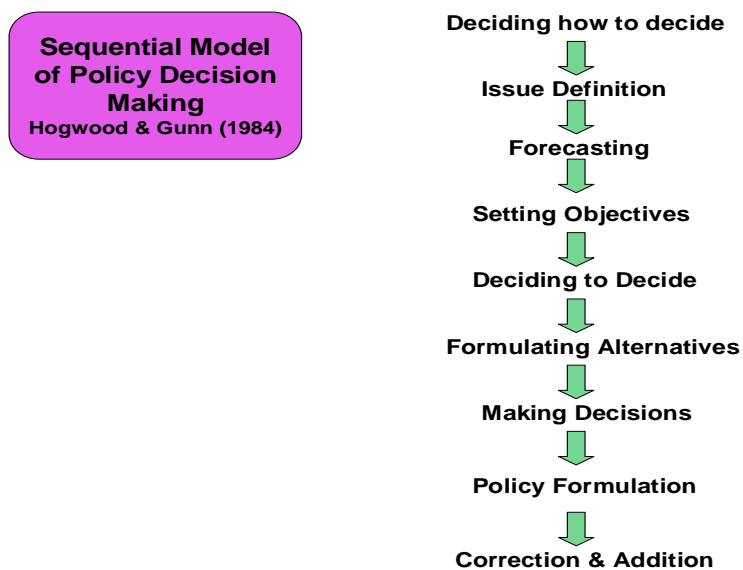
The advantages of the stages and sequential models to policy-making are that they provide an outline of logical steps to describe the policy process. There are a number of such models, which in general include variations around the stages of: agenda setting, policy formulation, implementation and evaluation, of which Hogwood and Gunn's model (1984), is one of the better known models. In particular, Hogwood and Gunn highlight factors influencing agenda setting by describing the process of issue definition and filtration as well as emphasising the multiple decisions that occur during the policy process. This is done within the context of the main policy stages of: agenda setting (framed as issue definition), formulation, implementation and evaluation (correction and addition). This model outlines the multiple steps taken in the policy process, however it conveys a top-down approach and assumes that logical and systematic decisions drive the policy process, (for example, forecasting, setting objectives, formulating alternatives), whilst omitting the interaction of external actors and other influences.

The main critique of the stages models includes their reductionist approach to understanding the policy process, which when compared to reality, is much more complex, fluid and interacting. The stages and sequential models however, do provide a systematic approach to start to understand the policy process (Parsons 1995), even if it is an aspirational and somewhat scientific description, it allows a structured approach to frame a more complex reality, which was an important advance on the 'black box' model (Easton 1965). Moreover, they inform the cyclical policy models, which apply the main components of the sequential models, whilst recognising and reflecting the interactive and complex nature of the policy process (Parsons1995).

2.5.3   The Policy Life Cycle

The stages model is based upon the assumption that policy making is made in a linear, rational and sequential way. However, observation suggests that the policy process is more interactive and incremental. This led to the development of understanding a 'policy life cycle', which is an adaptation of the rational stages approach, combining the concept of interaction and a feedback loop; (see Figure 10).

Figure 10 - The Policy Life Cycle
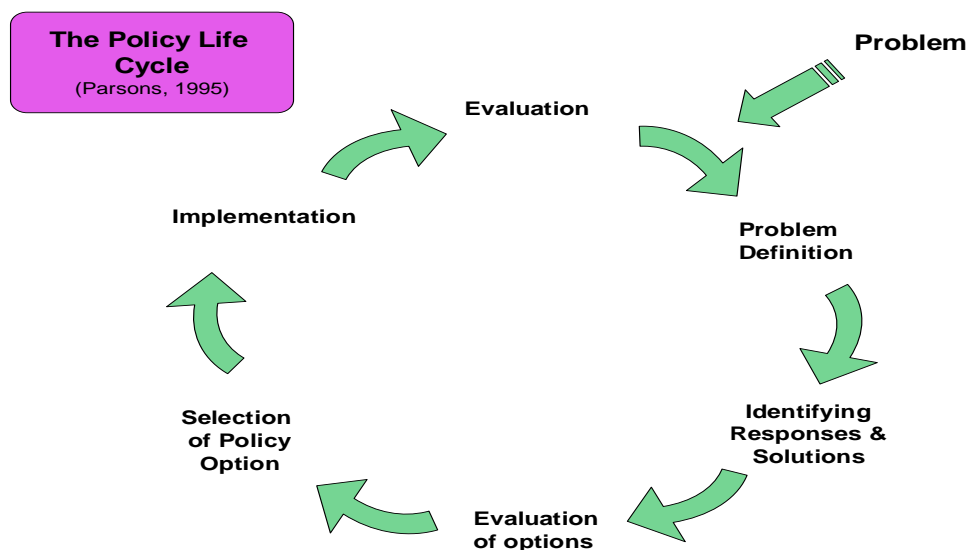
2.5.4   Walt's Model – Process and Power

Gill Walt (1994), centres her Health Policy Model around process and power. This represents an important shift away from the logical sequential models, (whether linear or cyclical), towards an appreciation of the wider context influencing the policy process. Walt explores how power dynamics influence the different stages of the policy process. For example, Walt

considers how different political systems distribute power in society, and how this influences whether an issue is placed upon the policy agenda. A key aspect of Walt's approach is the identification and understanding of relative power between various stakeholders or 'actors' in the policy process. Walt describes that the policy making process tends to be orchestrated by small elites who hold significant power in determining policy. A summary of Walt's Health Policy Model is illustrated in Figure 11, of which power is a dynamic that influences all the aspects of the model.

Figure 11 - Walt's Process & Power Health Policy Model
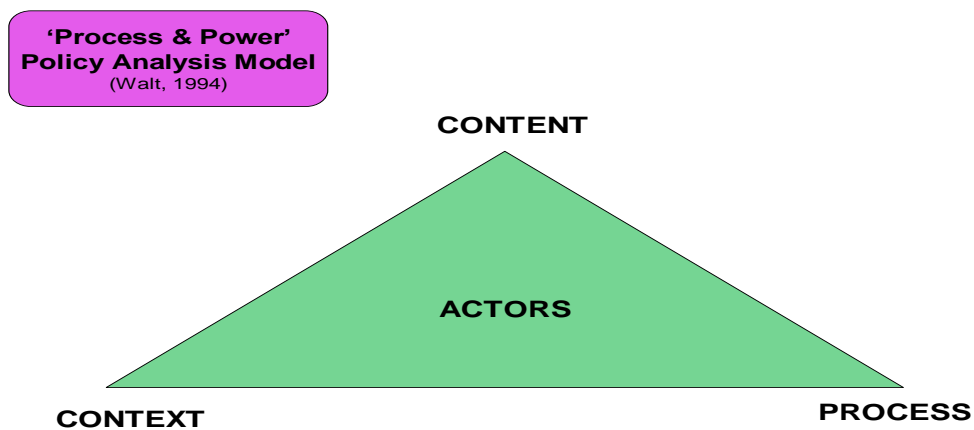
Walt describes the context of the policy process as occurring at international, national or local levels, and how actors at these levels interact and transfer policy. Policies are also broken down into the categories of 'High Politics' or 'Low politics'; whereby high politics includes macro or systemic policies made at national or regional levels, whilst low politics tend to be made at micro or sectorial levels within a particular organisation or department. This thesis examines the development of policy for violence prevention at the 'high politics level', in that it was cross-sector and systemic, and examines the dynamic of policy formation at national and regional levels. For this research, the content of the policy was framed as violence and abuse prevention, and the context was considered to be Public Health at national and regional levels. Whilst, the policy process was examined as a whole, the main emphasis was on the policy formulation process.

2.5.5   Department of Health and WHO Policy Guidance

Figure 12 summarises the key guidance steps for Department of Health civil servants involved in making policy. The Department of Health (England), bases its understanding of the policy making process upon the rational sequential models. Although this model provides a useful overview of some of the key policy formulation steps and considerations for implementation, it

visually separates out policy-making skills, implementation tools and the wider strategic context, without showing how they relate or interact.

Figure 12 - Department of Health, England, Policy Making Guidance, (2006)
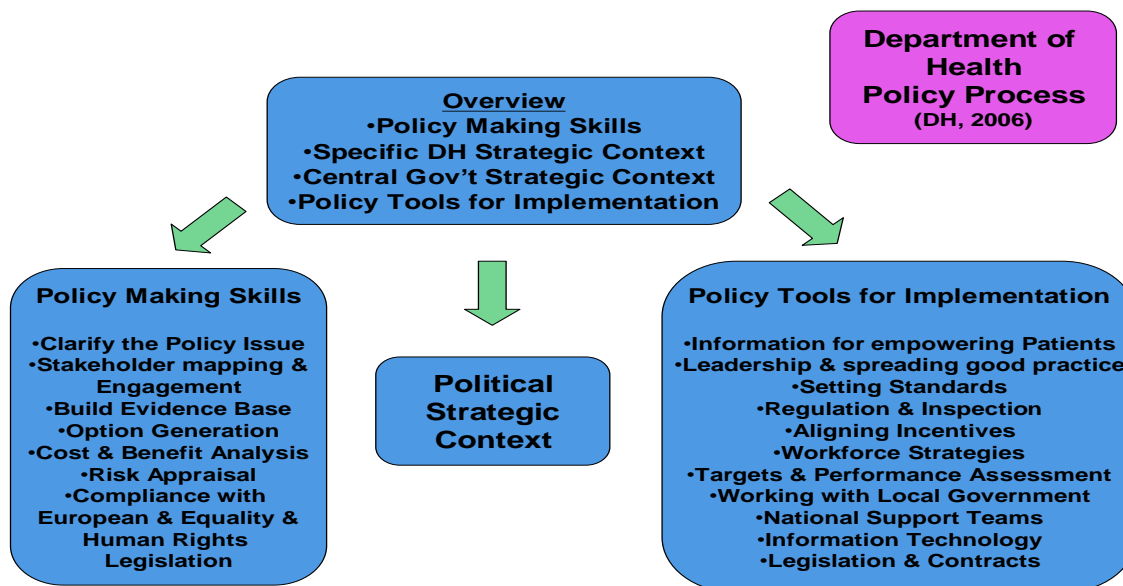
In recent years there has been a shift away from policy making behind closed doors or purely based upon ideology, to a greater degree of transparency in the process. This process aims to draw upon the evidence base to inform policy decisions, and seeks to incorporate a greater degree of participation, with the inclusion of large public consultations in recent policy-making.

In contrast, the WHO guide to policy for violence prevention, (WHO 2006b), identifies three main phases of the policy making process, where phase one is initiating the policy development process, including: assessing the situation, leadership, raising awareness and involving stakeholders. Phase two is formulating the policy, including defining a framework, set objectives and interventions, and identify the delivery process. Whilst phase three, seeks approval and endorsement and includes stakeholder and government approval. This guide has many elements in common with previous models described, although it mainly focuses on the agenda setting and formulation process, ending the process with state endorsement, and frames strategy as distinct from policy and responsible for the implementation process.

2.6   Approaches for Policy Analysis

The previous section outlined a number of policy models that can be used or adapted from to analyse policy. Whichever approach is used, the important thing is the need to use a theory, framework or model to make sense and analyse the complexity of policy-making. This next

section outlines approaches and theoretical models that can be used as the basis for policy analysis and helped to inform the frameworks and models developed to answer the research questions for this thesis.

There are a variety of examples of policy modelling and analysis that have been applied to single issues (Stuhlmacher, 1994; Reinhardt et al, 2009) or specific case studies, the latter highlights the need to strengthen the capacity of policy makers in policy analysis, (Tarin et al, 2009). As the main focus on existing approaches for policy analysis was considered to be very narrow or specific, or very general, other relevant disciplines were reviewed in order to apply them to a policy setting. Of particular relevance was the wider literature on the process of change, ecological approaches, complexity and systems science, which are described next.

2.6.1   The Change Process

Change and the ability to influence and shape change is a key issue in the policy process, (Walt, 1994).   Some policy arenas are relatively stable, for example in agriculture. However, health policy is an area that is subject to constant change, and from a public health perspective, change creates numerous opportunities to improve health. Therefore, understanding factors that influence policy change is important for policy analysis and in helping to shape future change. Table 16 below summarises a range of models and approaches that explain policy change: (John 1998).

Table 16 - Models of the change process in relationship to policy, (John, 1998)

- **Stages models** - describes a sequential linear model that the policy process goes through, it assumes clear cut, logical stages in decision making- models of this sort are often too simplified to take account the complexity of factors which tends to occur in a more incremental way.

- **Incremental models -** examines the complexity in the influences and circularity of the policy making process. The balance of whether linear or incremental approaches occur in real life depends upon a range of cultural and political settings.

- **Institutional approaches -** political organisations, for example, parliament, legal systems and civil service structure policy decisions and outcomes

- **Group and network approaches -** formal and informal networks and relations outside of the political structure influence the shape of policy decisions and outcomes

- **Socio-economic approaches** – the influence of the business community can have a

> significant impact on shaping policy decisions
>
> - **Rational Choice Theory**- preferences and the bargaining of actors is seen to explain decisions and outcomes based upon rational choices
>
> - **Ideas based approaches** - that ideas and ideologies can influence culture and policy making

Individual behavioural change does not occur in a linear or rational approach, but occurs in the context of complex systems, (Renicow and Vaughan, 2006), and needs to understand underlying influences of behaviour and motivations for change to occur, (HM Gov't, 2010).

Organisational change can be influenced by leadership styles (Mullin, 1999), for example, by creating a shared vision and goals and the change that is needed to achieve this. Additionally, establishing clear objectives and a culture that fosters innovation are important, as are acting as a visible champion or advocate of an issue. (Adair, 2002; Landsberg, 2002; Owen, 2009).

Whilst societal change can often be achieved effectively by changing the environment and cultural context that people operate within, (Thaler and Sunstein, 2009). A key aspect of understanding and influencing societal or large-scale change is understanding the role of trendsetters in shifting the change curve to create early adopters and then mainstream uptake of a new behaviour (Bridges, 1995). The shift from trend setters to early adopters can be described as 'the tipping point' which is enhanced by having trusted communicators and making the desired change memorable or 'sticky'. (Gladwell, 2000).

2.6.2   Complexity, Systems and Ecological Approaches

The command and control management style that is popular in Health Protection, is inappropriate for developing and implementing complex policy, which needs to be understood within a systems approach. For example, the competing priorities of the health care services with public health agendas frequently do not sufficiently include issues like addressing health inequalities. Taking a systems approach can help to ensure that public health issues are embedded within related policies (Hunter 2003). This reflects a 'health in all policies' approach, (WHO, 2013).

Organisational theories, that adopt a systems approach, have been used historically to help inform the development of health policy to strengthen community health services in Canada, (Crichton, 1993). Whilst the ecological model used as the basis to frame risk and preventive approaches in violence is now well established, (Krug, 2002). The below section outlines the more recent approaches of ecological and complexity sciences that can be used to help understand the policy process.

Ecological public health models have been increasingly used since the mid 1990s. These frameworks typically incorporate aspects of positive and negative determinants at social, economic, cultural and environmental levels and also recognise the interaction of biological and behavioural aspects, (Kuntz et al, 2009).

There is a growing awareness that human societies interact with the social and economic and environmental systems and have complex, interdependent relationships. It can be understood that there are core ecological principles, which underpin how systems at different levels work, and are related to understanding complexity. These are described in Table 17.

Table 17 - Core ecological principles, (Nurse et al, 2010)

- **Networks** – interconnectedness and communication

- **Partnership** – symbiosis and interdependence

- **Cycles** – constant transformation of energy, matter, water and waste

- **Dynamic Balance** – ecosystems are constantly fluctuating with feedback loops maintaining flexibility and balance

- **Solar energy** – solar energy is the basis of all energy

- **Diversity** – provides stability and resilience

Policy operates within a complex, non-linear system and ecological approaches and complexity science have been applied to policy analysis and organisational change in a number of different disciplines outside of environmental sciences, including political and social settings ((Rocheleau, 2007) and economics, (Plummer and Armitage, 2006). Additionally, complexity has been applied to the delivery of clinical care and settings, and help to illustrate how individual or micro behaviour occurs within a wider or macro setting, (Greenhaulgh et al, 2010). An article in the BMJ outlines complexity in relationship to health and clinical care, and

describes key components in table 15. Here, it can be seen that there is a close relationship to ecological principles with concepts of complexity, for example, how health is maintained by the dynamic balance of cycles.

Table 18 - Complexity in relationship to health, (Wilson and Holt, 2001)

- Humans are composed of and operate within multiple interacting and self- adjusting systems

- Illness arises from the dynamic interaction between these systems, not from the failure of a single component

- Health can be maintained by establishing a balanced system that recognises and adjusts for unpredictable and emergent effects.

The science of complexity is gradually being applied to understanding how health systems work, and is seen as an approach that more accurately describes the real world, where things do not tend to occur in a linear and logical order, (Martin, 2010). Complexity Science represents a growing body of inter-disciplinary knowledge about the behaviour, structure and dynamics of change. Whilst Complex Adaptive Systems describes how systems evolve in relationship to the larger environment and adapt to change in order to survive the system. (Berry and Keil, 2002). These principles of Complex Adaptive Systems are of greater relevance to how the policy process works, as they equate to how organisations and larger systems operate.

Health systems can be described as complex adaptive systems that require flexible leadership with systems of incentives and dis-incentives rather than centralised command and control mechanisms. Other features of a complex adaptive system include the ability to self –organise, a system that is outcome and value driven and has a matrix style of organisational delivery (Rouse 2008). Complex adaptive systems emerged from increasing multi-disciplinary thinking from the mid 1980s, and provided an alternative to the predominant reductionist approaches in mainstream scientific theory.

Complex Adaptive Systems can be defined generally as: dynamic systems able to adapt *in* and evolve *with* a changing environment (Chan 2001). Some of the key characteristics are described from observing biological, physical and social systems, and include features such as networks of multiple agents that are in continuous transition, learning to evolve with its environment in a way that can be described as an ecosystem (Dodder and Dare 2000).

Health care systems have become increasingly recognised as complex in their nature, which in part relates to the changing understanding of the nature of disease and health, from one that is reductionist, to one that appreciates the interaction of social, economic and environmental determinants with health. Within the context of health, whether describing a physiological system, a disease outbreak, a family or community, or primary health care service, a complex adaptive system can be defined as 'a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent's actions changes the context for other agents' (Plsek and Greenhalgh 2001).

Recognising that health and health systems operate as a complex adaptive system enables the practitioner, planner or policy maker to respond accordingly, and to appreciate that altering one component will lead inevitably to a systemic and interacting response which is not always predictable (Plsek and Greenhalgh 2001). This is especially true for complex social and environmental challenges including public health issues, which can be described as 'wicked problems', whereby conventional linear processes fail to tackle the challenge and may even exacerbate the situation (Camillus 2008).

Rittel and Webber first described the concept of a wicked problem in 1973 in relationship to social policy and planning, as being one that has multiple causes, is difficult to describe and has no straightforward answer, and thus, can be seen as an early description and appreciation of the nature of complexity. Understanding how ecosystems operate can help in the identification of solutions to these complex systems, including the application of collaborative, flexible and innovative approaches within the context of promoting sustainability and responding to wicked problems with '5th wave' solutions that apply principles of ecological public health (Lueddeke 2015).

Complexity science and Complex Adaptive Systems both relate to ecological principles and organisational theories, and they help to describe the real world occurrence of change within complex interacting systems. The key characteristics that can be used to define Complex Adaptive Systems are found in Table 19.

Table 19 - Characteristics of Complex Adaptive Systems, (adapted from Rouse, 2000; OECD, 2009)

- **Non- linear systems** – change occurs in dynamic, chaotic, random and non- proportional ways

- **Interaction of independent agents** – interactions occur between different agents which

increases overall diversity and adaptability

- **Intelligence** – agents constantly learn and change their behaviour with experience, this changes the overall system over time

- **Self –organising** – independent agents interact and self-organise which helps create change

- **Emergent behaviours** – novel patterns arise at a systems level which helps generate valuable innovations

- **Phase transitions** – behaviour or events can change suddenly as tipping points emerge

- **Heter-archical** – there is no single point of control and no one overall is in charge, therefore, it is easier to influence rather than control change.

A number of tools have been developed to help to understand, analyse and predict complex systems, for example, multi-agent models, network analysis, scenario- modelling, sensitivity analysis and dynamic systems modelling. As policy development operates in a complex system, the policy analysis used in this thesis will apply methodologies that reflect these principles. In particular, these approaches have been used to develop the frameworks used for data collection and analysis. Additionally, systems methodologies have been applied in the development of policy models in this thesis, which are based upon the literature and research findings.

2.7 Gaps in the Current Policy Research

I found that although there is a strong body of literature on policy in general, the majority of it describes structural aspects, for example of governments and the civil service and organisational infra-structure. Books tend to focus on high-level policy processes, outlined above, whilst published papers mainly address specific aspects of the policy process, or advocate for policy to be developed in a particular area or topic.

Regarding health policy, some of the most comprehensive literature is summarised by Buse et al (2005) and Gill Walt (1994), who provides a conceptual model that describes the context and detail of the policy making process. Additionally, the WHO has published a guide to policy makers on violence prevention (WHO, 2006b) that provides a high-level outline of how to create policy on violence prevention.

Whilst there is relatively less published literature in the following areas:

- Detailed descriptions of the policy process, especially that reflect the reality of day to day policy making and the necessary steps to formulate policy

- Policy models that help to understand the reality of the process and can be used to inform and influence future policy making in a meaningful way – most of the exiting models are either mostly conceptual, or describe an ideal process rather than provide a description of reality – thus limiting their utility in practice

- The policy making process is a complex process, and many models over- simplify this process, which makes it difficult to know how to influence the process. Bringing in more learning from complexity science and systems approaches has the potential to develop more accurate descriptions and models of the policy process.

- There is little in the way of tools to assist analysis of policy for research

- How best to actually influence and shape the policy making process from a public health perspective

The next chapter provides an outline of different models and frameworks that build upon the existing literature, that I developed to assist in answering the research question of this thesis and that help to address some of the above gaps.

Chapter 3 - Models and Frameworks Developed as Research Tools for this Thesis

This chapter outlines the three frameworks on violence prevention, public health and policy developed by the author to assist in answering the research question of this thesis. Walt's policy model (1994), provided the overall structure for these three frameworks on violence, public health and policy: with content equating to violence and abuse; context relates to public health; and process to the policy formulation process. At the centre of this model lie actors, which each framework considers from its own perspective. This overall structure is illustrated in Figure 13 below.

Figure 13 - The three frameworks in relationship to Walt's Policy model, (1994)
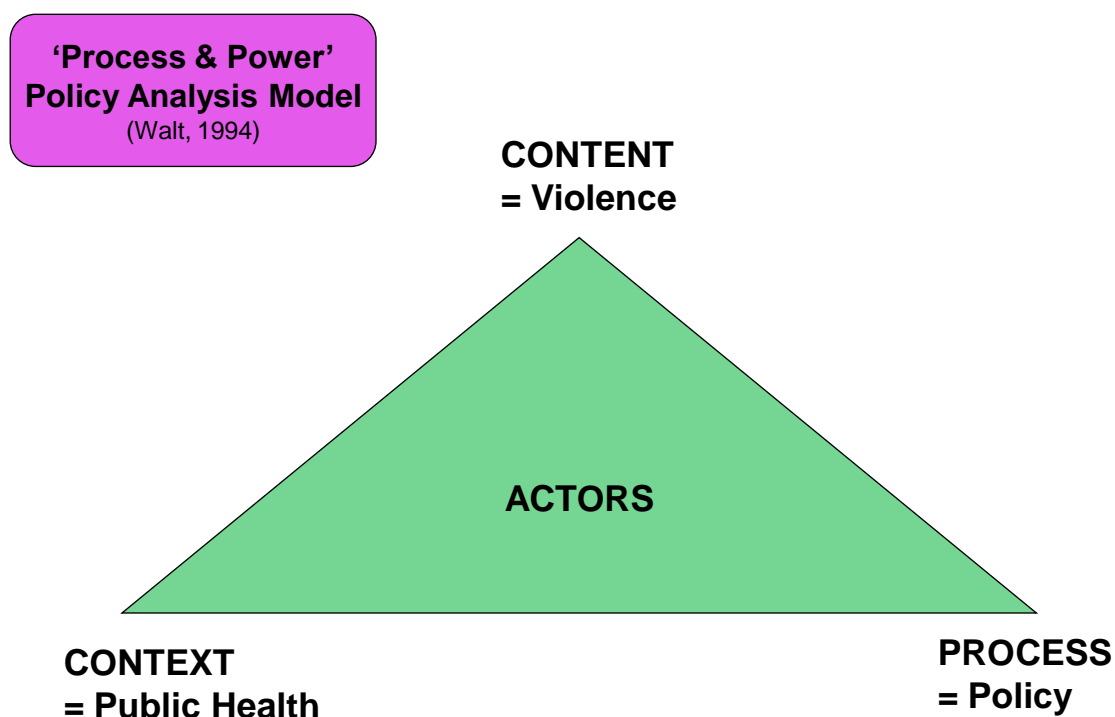
The first framework on violence and abuse prevention, was developed to help collect data for the research in a systematic way on violence and abuse policy and coverage. This was created to enable the mapping exercise to document policy coverage and facilitate the identification of gaps in violence prevention interventions. Additionally, this framework was used to identify the main prevention areas of interest by different actors or sectors. The framework for public health was originally developed in 2004, to describe the public health skills, functions and methods and how they interact with the main drivers and influencing factors. It has been adapted for the

PhD as a tool to aid analysis for the contribution of public health to violence prevention policy. The main headings were also used to inform the observational analysis tool. The policy framework builds upon existing policy models and developed for this thesis to provide an integrated overview of the policy process. The model was used to create a framework consisting of the main headings for the observational analysis tool to form a systematic approach to summarise and analyse a large volume of complex data. The policy framework was later updated based upon findings in this research and is presented in the conclusions. The below section describes each of the three frameworks in further detail.

3.1   The Violence and Abuse Prevention Framework

The violence and abuse prevention framework was developed over several years in the lead up to developing the research question for this thesis. The first version of this framework was developed in 2003, as a summary figure of a report on the prevention of sexual and relationship violence in adolescents whilst I was on secondment at the WHO, based with the Violence and Injury Prevention team in Geneva. This also followed a review of the wider literature on violence and abuse prevention, for a WHO report that I contributed to (Sethi, 2004).

The framework was then further adapted whilst working as a consultant in public health, in 2004, in the capacity of public health advisor to the DH for violence and abuse with the aim of it providing a visual summary of the main interventions for preventing violence and abuse. The main headings included were based upon a review of the evidence base, and following discussion and feedback from a range of international and national experts in violence and abuse prevention, including from the WHO. The framework was then used as a regional level factsheet (DH, 2006c), on violence and abuse, and for multiple presentations and workshops as a public health consultant for the Department of Health during the research period to provide an overview of the approaches to preventing violence and abuse.

A summary of effective interventions for the prevention of violence and abuse based upon World Health Organisation reports (Krug, 2002; Butchart 2004) and cross- validated by WHO experts. These were positioned according to their position within the life course, prevention and ecological domains. The dividing line across the framework reflects the perceived emphasis on interventions to the right hand side of the line, and the need to balance this with interventions on the left hand side of the line that are earlier in the life course and represent primary and secondary preventive interventions. See Figure 14 for the violence and abuse prevention framework.

Figure 14 - A framework for violence and abuse prevention

Violence & Abuse Prevention Framework

Prevention Focus
Primary | Secondary | Tertiary

CHILDHOOD
ADOLESCENCE
ADULTHOOD

Nurse J, 2004

Societal & Community Interventions

Legislation
-Alcohol
-Inequalities

Improve Nutrition

Partnerships CDRPs

Alter Environment

Community Awareness Campaigns

Information

Help Lines

Home Visitation Programmes/ Parent Skill Training

Social Development Training & Pre-School Enrichment

School Based Child Bullying & Abuse Prevention

School Based Skills and Education
•Positive Relationships & Communication
•Protective Skills & Abuse Awareness
•Conflict resolution skills
•Anti-Bullying programmes
•Seeking Help & Peer Support
•Educational enrichment

Links with Health Promotion:
•Substance Abuse & Alcohol
•Mental & Sexual Health

Research needed on Opportunities with Ante-natal classes:
-Conflict resolution
-Communication
-Protection

Child & Family Therapy

Identify high Risk Groups: abuse/ abusers & intervene early

Early Identification of Abused for:
•Therapy/ support
•Protective skills
•Family Therapy
•Mentoring

Early Identification of Abused:
•Safety skills and procedures
•Support & manage related issues
•Therapy and preventive skills
•Referral to support agencies

Child Protection Procedures

Identification & early Intervention Of Abusers

Containment & Restriction Of Abusers

Intervene & Manage Abusers:
-Alcohol Treatment

Protection & Containment

Ecological Model
Societal | Community | Relationship | Individual

The violence prevention framework provides a visual summary of the evidence based for violence prevention, and in its structure and layout builds upon existing public health concepts. It includes the public health concept of prevention on the top horizontal axis; the life-course approach on the vertical axis. The framework also includes the WHO ecological model domains on the bottom horizontal axis that approximately equates to the prevention focus. These theoretical approaches are described in further detail below.

The top horizontal axis is based upon the public health concepts of prevention. There are three main levels of prevention, these range from improving the overall health of the population (primary prevention) to improving treatment and recovery (tertiary prevention); see Table 20for a fuller description of prevention, (Donaldson and Donaldson, 2000).

Table 20 - Description of Prevention levels applied to violence (adapted from Donaldson and Donaldson, 2000)

- **Primary prevention** is depicted on the left hand side of the framework and includes promoting well being and stopping health problems from occurring in the first place - usually includes addressing wider determinants, upstream approaches targeting the majority of the population

- **Secondary prevention** covers the interventions more to the middle of the framework and includes early identification and halting the progression of health problems once they are established – for example, screening and targeting high-risk groups with effective interventions that are more intensive than those used for primary prevention– this is important to reduce inequalities in health

- **Tertiary prevention** covers interventions described on the right hand side of the framework, this approach involves working with individuals with established health problems to promote recovery and reduce risk of relapse, using evidence based cost effective approaches to improve services. For the purposes of violence and abuse prevention it also includes criminal justice approaches that involve protection and containment

The Life course approach – forms the vertical axis, with the framework transitioning between the main stages of the life-course, from childhood, to adolescence to adulthood. A life-course approach means understanding influences that happen earlier in life that can either act as risk factors for health related behaviour or develop into health problems at a later stage in an individual's life, (Davey Smith G, 2000). Life-course factors, which influence later health outcomes, have been found to be associated with nutritional and physiological determinants, (Barker, 1997). Additionally, the wider determinants of health including socio-economic and psychosocial influences have been described as factors affecting health across the life-course, (Naess, 2004; Hertzman, 1998).

There are two main theories, which explain influences on health across the life-course. The first emphasises 'biological embedding' of physiological functions, which develop into health problems later in life. For example, low birth weight related to intra-uterine growth due to the mothers health, appears to 'set' the body's physiological function to be pre-disposed to high blood pressure and insulin resistance later in life, (Barker, 1997). This theory is called the 'Latency Model'. The other main theory is called the 'Pathways Model' which emphasises the importance and accumulation of certain life events upon critical periods in child development,

combined with continued negative socio-economic/ psycho-social conditions throughout the life cycle, (Hertzman,1998).

The experience of violence and abuse during childhood or adolescence can be seen to relate to both models. For example, the stressors like inter-partner violence during pregnancy can potentially set the bodies physiology to be prepared for lifetime stresses, as per the latency model, (DH, 2010a). Whilst, an example of the impact of the pathways model, includes how sexual abuse in childhood or early adolescence increases the risk for later experiencing sexual relationship violence, sexual assault and domestic violence in adolescence and adulthood, (Coid J, 2001).

The ecological model domains run along the bottom horizontal axis. The violence prevention department within the WHO has been a relatively early adopter of ecological models, as described in the previous chapter, as applied to the violence setting, (Krug et al, 2002). The ecological model is used in this framework, as it is the predominant model used by the WHO to frame risk and interventions for violence and abuse prevention. The main principles of the ecological model are considering the interactions of an issue or challenge from the perspectives of the individual, the family or relationship, the community and from societal levels. The ecological model of violence prevention was originally adapted from research on sexual abuse. It has successfully formed the basis for understanding risk factors and describing interventions for the prevention of violence at the individual, family, community and societal levels, (Krug 2002), (see Figure 15 below).

Figure 15 - The ecological model applied to violence and abuse prevention, (WHO 2004a)
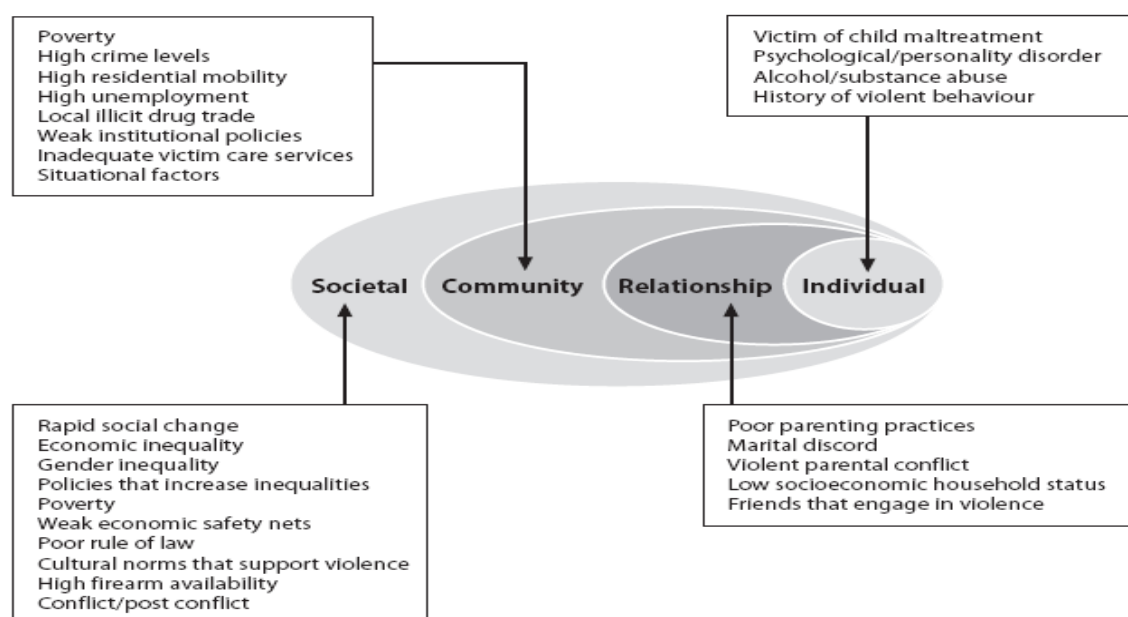
The ecological model runs along the bottom axis of the violence framework used in this thesis, in parallel with the public health prevention levels along the horizontal top axis. Interventions and approaches at societal and community levels relate mostly to primary prevention and some secondary prevention approaches. Whilst relationship or individual levels mostly relate to secondary or tertiary prevention level approaches. This framework was used as a basis for mapping violence and abuse prevention policy documents and activities in England. The main headings in this framework, were summarised in a series of tables to collect data, according to societal & community interventions and age groups divided into primary, secondary and tertiary prevention and targeted interventions for high risk groups. The structure of the tables can be found in annex II.

The framework was then used to provide a map of the contribution of different sectors to violence prevention, including the health sector. The framework was used to map overall coverage of policy on violence prevention to identify gaps. These tables were completed from a review of policy documents and consultation with governmental experts. These were then used to help inform priorities for policy development. The findings from the mapping exercise are presented in annex V and with summary diagrams based upon the framework included in the results chapters on public health and on the role of different actors.

3.2   A Public Health Framework

The 'Framework for the Delivery of Public Health' was developed in 2004 and published in (Nurse J, 2007). This framework was developed whilst I was a consultant in public health at Portsmouth PCT between 2003-2005. It was developed in order to structure the formation of the city public health strategy, and was drafted following a series of discussions with the Director of Public Health, and improved upon after further consultation with public health experts. It has since been used in a wide variety of workshops to identify the drivers, barriers and enablers and the contribution of public health competencies for a range of public health issues and challenges, including for violence and abuse at local and regional levels. The framework is used as a structure to be filled out by workshop participants and then discussed as a wider group and gaps and priorities identified to develop and take forward. The public health framework has since been published (Nurse J, 2007), and was used to structure the findings and analysis for the public health contribution to violence and abuse prevention policy. The theoretical basis and application of this framework is outlined below.

This framework provides a structure that brings together the multiple components of public health, relates them to key influencing factors to provide clarity, balance and direction for the effective delivery of public health. It has been applied to a range of public health issues and

settings, and used as a training and priority setting tool. It has been used in this thesis as the basis for analysing the public health contribution to violence and abuse prevention described in the public health results chapter.

The Faculty of Public Health describes public health as being population based, it emphasises the collective responsibility for health and it includes protection, health improvement and disease prevention within a health services context. Additionally, it recognises the key role of the state, to address the underlying socio-economic and wider determinants of health, as well as disease and emphasises the role of partnerships with all those who contribute to the health of the population. (FPH, 2009, www.fph.org.uk). The commonly held definition of 'Public Health' used in the UK by the Faculty of Public Health (FPH), is:

> ***The science and art of improving the population's health through the organised efforts of society,*** *(Acheson,1988).*

This definition has also been adopted by the WHO European Region in the 'European Action Plan for Strengthening Public Health Services and Capacity' (2012a), which I was responsible for implementing in my WHO role in 2012-2013. Based upon this work it can be understood that a Public Health approach usually involves the following steps outlined in Table 21.

Table 21 - Public Health Steps to Protect Health and Promote Well-Being

- **Describe the problem –** prevalence, risk & protective factors

- **Identify solutions –** evidence based & cost effective approaches

- **Address root causes –** upstream thinking, wider determinants, inequalities

- **Develop strategies & policy** – based upon the above information

- **Provide leadership & work collaboratively -** to achieve change and implement policy

- **Monitor & evaluation- workforce** development and sharing good practice.

An important element of public health is the ability to search for the underlying problem rather than focusing upon the more visible 'symptoms' in order to develop and test effective approaches to improve health. This is essentially the principle behind prevention – to stop something before it even occurs and ideally to promote greater health and well-being. The Public Health approach to prevention entails taking a multi-disciplinary approach and involves

working in partnership with other agencies to be most effective. It does this by using public health principles to draw upon other disciplines to understand and find solutions.

The UK Faculty of Public Health has outlined ten key 'Standards' to assess competency for public health training, and to guide Continued Professional Development. The main components of these standards are reflected in the ten Essential Public Health Operations that form the basis of the European Action Plan for Public Health, (2012a). The ten key standards used to inform the Public Health Framework are summarised in Table 22.

Table 22 - The Ten Key Standards of Public Health

- Surveillance and assessment of the population's health and well-being

- Promoting and protecting the population's health and well-being

- Developing quality and risk management within an evaluative culture

- Collaborative working for health

- Developing health programmes and services, and reducing inequalities

- Policy and strategy development and implementation.

- Working with and for communities.

- Strategic leadership for health

- Research and development

- Ethically managing self, people and others.

These standards create an important baseline to develop a rounded portfolio of public health competencies. In order to make the competency areas easier to remember and follow in a logical order, the key components of the competency areas were framed under the headings: Public Health Skills, Public Health Functions, and Public Health Methods. The core components of public health (skills, functions, and methods), are placed in the centre of the framework, symbolised by an ancient Greek temple to represent the structure of organisations or partnerships which public health sits within. Each component is part of a larger entity, for which the overarching vision (the top triangle of the roof) provides the sense of direction. The temple can represent either a setting or a public health issue, and the steps allow space to place either the objectives of an organisation or those of the public health issue.

Public health does not exist in isolation. The features surrounding the Greek Temple are all factors that influence public health. In the sky, the clouds contain *National Drivers*; the ground represents *Local Drivers*; to the sides, *Enablers* represented by a tree. Lastly *Quality* is represented by a rainbow; with national quality mechanisms in the clouds above the rainbow, whilst the flower head symbolises regional quality assurance, and the roots and leaves contain community and user-lead quality elements (that also feed into local drivers at the ground level). Enablers can also be interpreted as Opportunities, and Quality as Barriers. (Nurse J 2007). See Figure 16 for the public health framework.

Figure 16 - The Framework for the Delivery of Public Health (Nurse J, 2007)
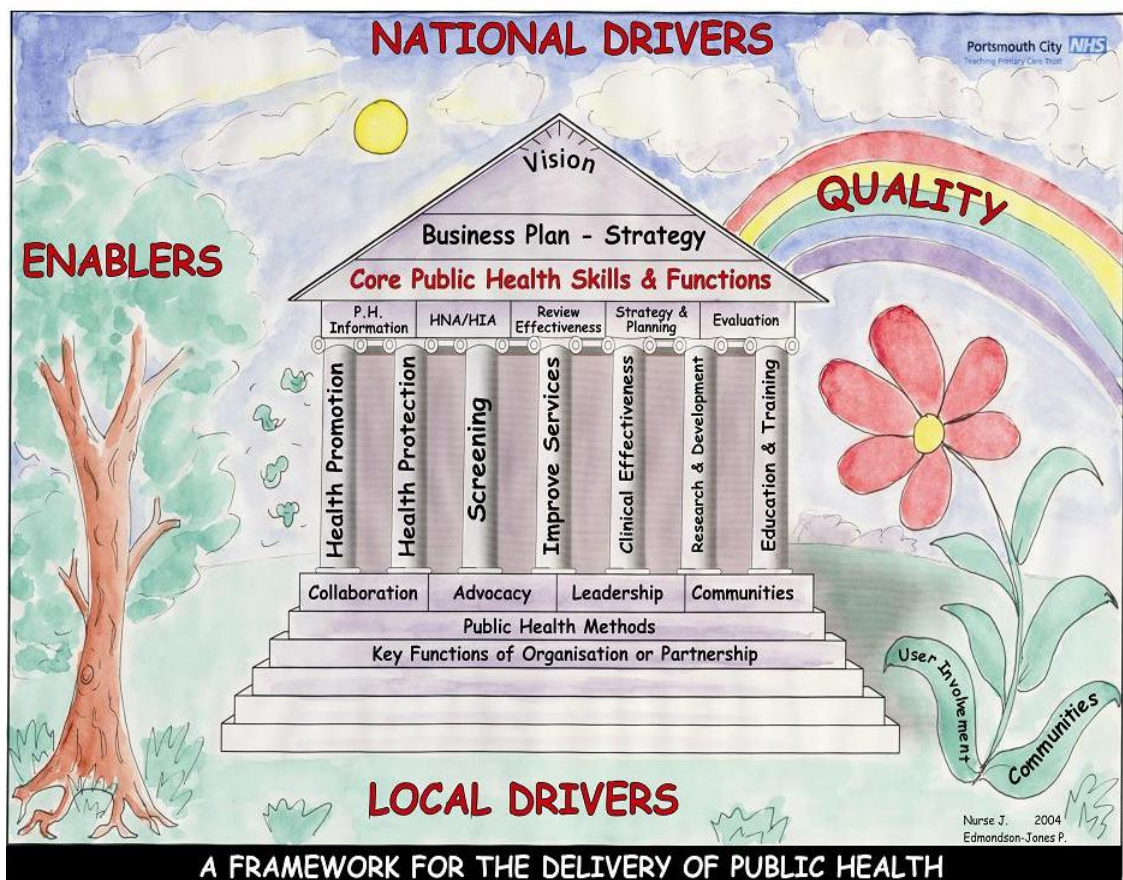
This framework was used as a tool for workshops at local, regional and national levels for public health policy analysis by placing the issue of violence and abuse within the framework in order to understand the public health contribution to policy in this area. Additionally, it was used to inform the integrated policy model presented below.

3.3   The Policy Framework

A policy model was developed for this thesis and made into a framework to collate research findings and structure the analysis. The framework was developed as the existing models were considered to be either to high level or incomplete in describing the policy process or not sufficiently comprehensive enough to be used as a tool for data collection and analysis for this research. The policy model builds upon the theory and models outlined in the previous chapter on the policy process. Additionally, the below describes further the approach and theoretical basis used to develop the model.

All the previous policy models described have been developed within the context of understanding the policy process more fully. However, each model can also be used as a tool for policy analysis and furthers understanding of the policy process. Models or frameworks can be described as either explanatory, normative or ideal. Essentially, a model or framework is always going to be symbolic or conceptual and can never represent a true picture of reality; (Parsons, 2001). Therefore, each model or framework must be understood within this context.

3.3.1   Key points of the policy process

Following on from the historical approaches to understanding policy, the policy process can be divided into three main stages, as described in Table 23. (Jones, 2001; Parsons, 2001):

Table 23 - The three main stages of the policy process (adapted from Jones, 2001; and Parsons, 2001)

- **Policy initiation:** includes problem recognition, advance of demands and agenda setting. Those most central to political power tend to have greatest ease in influencing policy initiation.

- **Policy Formulation:** is the central process of decision-making in the policy process, and includes making decisions on defining the problem, identifying solutions and choosing options.

- **Policy Implementation:** how policy is delivered, managed, monitored and evaluated.

3.3.2   An integrated policy model

Reviewing the literature, the main specific public health policy model was by Walt, (1994). Whilst, health policy models were found to focus primarily on improving the clinical treatment

of specific health conditions; (Unal et al, 2006; Rauner and Brandeau, 2001; Rauner, 2002). For example, these sorts of health policy models have been used to incorporate the best scientific evidence, to consider a variety of viewpoints, permit sensitivity analysis and uncertainty within the models to inform clinical outcomes and treatment responses, (Matchar and Samsa, 1999). However, they were found difficult to apply to analysing the wider policy making process required by this research.

Therefore, the general policy models were reviewed for their suitability as an analysis tool for this research. However, the main limitations found of existing policy models is that they either focus unduly on the sequences of the decision making process, which in reality is rarely a linear process and conveys a top –down approach to policy. Alternatively, existing models focus upon the wider context, which creates difficulty in understanding how the process actually works in detail; (Parsons, 2001). Therefore, for the purposes of this thesis, and building upon the strengths of existing models, I developed an 'Integrated Model of the Policy Process' (Figure 17).

Figure 17 - An integrated model of the policy process
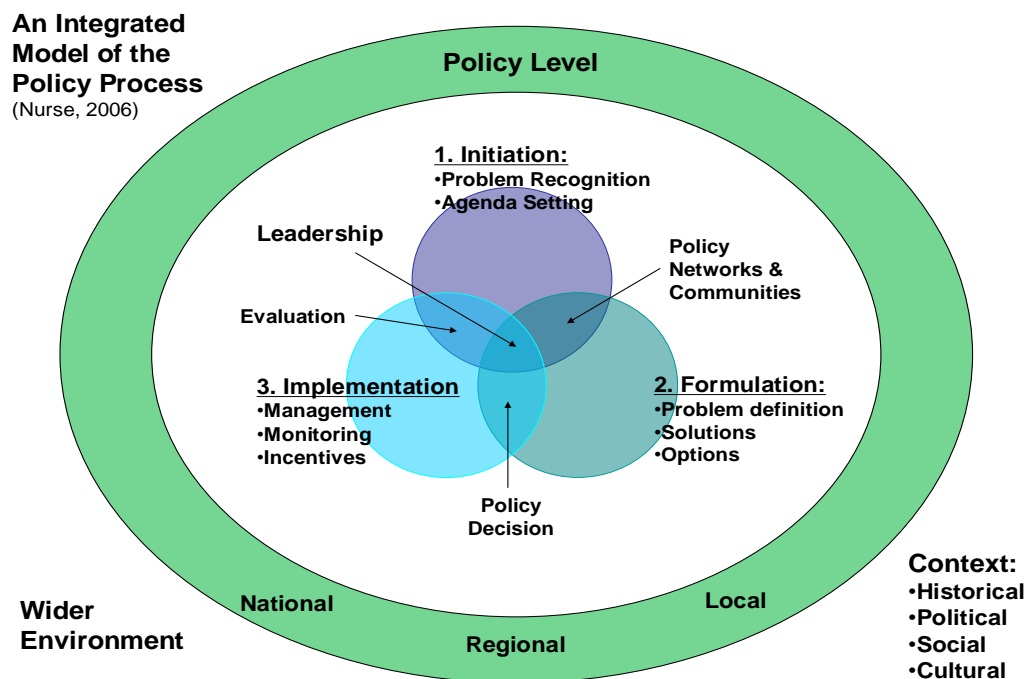
This model was developed by a process of cognitive mapping, drawing and redrawing conceptual arrangements and their relationships to each other of the existing models. The process was also informed by the public health framework and insights gained from workshops held and feedback given. The main concepts and headings used in the model were then adapted into a template which was completed as a structured set of tables with the main headings from the policy model, This was used for the observational analysis, and hence is also referred to as

the policy framework, the structure of the framework can be found in annex III. The process of undertaking the research then led to revisions in the original policy model, which are presented in the conclusions.

The 'Integrated Model of the Policy Process' draws upon the descriptive element of the steps in the policy process, (implementation, formulation and implementation). However, they are displayed in the form of inter-locking circles to convey that the process is frequently interactive and overlapping, as opposed to sequential. Additionally, the main aspects of the context of the policy process are included in the model, with the wider circles conveying the influence of environmental, cultural, political and social contexts. The policy level (ie national or local) is included as part of the context to aide thinking of the interaction between international, national, regional and local levels in the policy making process.

Key actors are also identified within the model – in the centre under leadership, and where the first and second circles overlap and describe policy communities and networks. Placing leadership within the centre of the model, assists in identifying key actors and the influence of power in the policy process, and additionally filled a gap in previous models to consider what motivates and drives the policy process, and why policy moves from one stage to the other, (Parsons, 2001). Leadership in many respects equates to the concept of power in Walt's model (1994), however, it can be seen to be a more active driver of the policy process, which is why it is placed in the centre.

An aspect of this thesis has been the exploration of the public health contribution to policy development. As the policy model was being developed, it was reviewed from the perspective of public health, and the Framework for Public Health was compared to this in order to see what commonalities existed in these approaches. This process revealed that there was in fact much common ground, albeit distinctions in the use of some of the terminologies were identified, (eg Delivery instead of Implementation).

Key distinctions from the policy model to public health, are its emphasis on what would be regarded as a 'rational' or evidence based approach to policy making, and the identification of particular public health functions in the implementation or delivery of policy. Headings and concepts from all these models/ frameworks have been used to structure the policy analysis tables or templates, for which the completed version can be seen in the annex VII.

The above models are used in this study to provide frameworks for the analysis and findings that are summarised in the Appendix VII. The next section is the methods chapter, and describes further how these frameworks were used to collate and analyse research findings. Summaries of findings and analysis are found in the relevant results chapters. The policy model developed specifically for this thesis, was updated based upon reflections from this research and the finalised version can be found in the conclusions.

Chapter 4 - Methods

This chapter summarises a review of the literature on methods. It starts with the context of the case study and discusses the rationale and strengths and weaknesses for the methods selected for this piece of research. This is followed by the scope of the study, research tools, ethical issues, analysis and scientific rigour. See summary Table 24 for an overview of methods and analysis used in this research.

Table 24 - Overview of methods and analysis used

Objective	Methods	Data Source	Analysis
One: To describe the general development of violence and abuse prevention policy over time	Documentary Mapping Observation	44 governmental policy documents 13 field diaries and 157 meetings and diary entries	Content - Timeline Violence Prevention Framework Cross validated with policy leads
Two: To describe the public health contribution to violence and abuse prevention policy	Documentary Mapping Observation	44 governmental policy documents 13 field diaries and 157 meetings and diary entries	Violence Prevention framework Public Health Framework Cross validated with PH experts
Three: To describe and explore the role of different actors in influencing the policy process for violence and abuse prevention	Documentary Mapping Observation	44 governmental policy documents 13 field diaries and 157 meetings and diary entries	Stakeholder analysis Violence Prevention framework Policy Framework Cross validation with PH policy expert

Objective	Methods	Data Source	Analysis
Four: To summarise the policy formulation process	Observation	13 field diaries and 157 meetings and diary entries	Policy Framework Cross validation with PH policy expert
Five: To summarise the wider lessons for policy	Documentary Mapping Observation	44 governmental policy documents 13 field diaries and 157 meetings and diary entries	Policy Framework Triangulation of results Cross validation with PH policy expert
Six: To summarise the wider lessons for public health	Documentary Mapping Observation	44 governmental policy documents 13 field diaries and 157 meetings and diary entries	Policy Framework Public Health Framework Triangulation of results Cross validation with PH policy expert

4.1   Policy Research Methods - Overview

Research methods were selected to best answer the research questions.

A key aim of this research was to describe and analyse the role of public health within the policy process, of which Violence and Abuse can be seen as a topic area or case study to illustrate this process. As the policy process is complex and multi-dimensional, the research methods chosen need to be able to reflect this as accurately as possible, multiple research methods produce more reliable data as they can be cross- validated. A range of qualitative research methods, for example, documentary analysis, observation and mapping are well suited for researching the policy process. (Barker, 1996). Therefore, a variety of qualitative methods were selected, in order to provide as comprehensive a research coverage of the policy process and topic area as possible.

4.1.1   Qualitative Versus Quantitative Methods

This research study mainly focused on the process of policy development, (as opposed to outcomes), therefore qualitative research methods were chosen to explore this research subject, (Green, 1998). Decision making in policy formation is an interactive on-going process, rather than being based on a concrete linear decision making process by a defined group. (Rist, 1995). Therefore, qualitative methods were chosen as being more appropriate to evaluate the process elements of policy formulation.

Qualitative research methods are very good at providing insight and meaning into values, beliefs and behaviour, why things happen (or not) in a particular way, and is well suited to understanding complex issues like policy. Additionally, qualitative research methods are responsive and exploratory, and provide opportunities to study phenomena in their natural environment, capturing perspectives of the wider context that the research sits within. (Green, 1998). Weaknesses of qualitative methods include their subjective understanding of the research topic and its inability to eliminate bias. (Barker,1996). Case studies provide the ability to explore in-depth the circumstances, context, complexity and dynamics of a single case and is a useful approach for researching policy, (Bowling, 1997; Hartley, 2004).

In contrast, quantitative methods provide evidence of what works and is outcome focused. However, quantitative research methods were not considered suitable for this research due to as the complex nature of the policy process, and quantitative research assumes an outside stable and value free reality that can be objectively observed. Additionally, quantitative research applies a reductionist approach, which limits the scope of the research to a handful of outcomes, and findings are not always easily transferable from the experimental setting to the real world. (Black,1998; Smith 2005).

4.1.2   Insider Versus Outsider Research

As I was employed by the Department of Health to work on the development of policy for violence and abuse prevention, (along with other objectives), at the same time as researching this agenda, a unique opportunity presented itself to study the public health contribution of policy from an insider perspective. The advantages of being an 'insider' include: the ability to easily access people, documents and meetings, gain their trust that an outsider would struggle to obtain. An insider potentially brings insight to a research area that could take an outsider many years to gain. However, having an inside role potentially reduces objectivity, and raises potential issues regarding consent and confidentiality; (Barker, 1996).

Importantly, the key issue is to recognise the strengths and weaknesses of having an insider role and to reduce the effects of potential weaknesses. This involves, maintaining a reflective and analytical perspective, ensuring transparent and detailed methods and where feasible gaining consent and maintaining individual confidentiality for the research elements of the work. (Green 2004). Additionally, it includes recognising the researchers own 'insider bias'. These include a potential positive contribution of public health to the violence and abuse prevention agenda. For example, by being positively motivated to place the neglected public health issue of violence and abuse on the policy agenda and in the process of doing so to I acted as a public health champion.

It can be argued that objectivity within policy analysis is difficult to truly obtain, as opinions and values are central to all individuals and fundamental to understanding the policy process – the key is to maximise strengths of the insider role, reduce weaknesses including recognition of the impact that the researcher has on the research subject, (Barker, 1996). The practical implications are discussed further under the sections on observation and ethical issues.

Due to the dual 'insider' work and research role, there are elements of this case study, which equate to an action research approach. Action research has its history in community development work, and takes a participatory approach, with the aim of changing practice, not just observing it as an 'outsider'. It is essentially a form of reflective practice, described as a process of critical self reflection, combining problem solving and the production of knowledge with the process of changing practice, (Waddington, 2004). The action becomes part of the research with the research and setting interacting, with gains in knowledge and understanding influencing actions in a cyclical fashion. (Green, 1998 & 2004).

This form of research was originally developed by post world war II social scientists to find the easiest way to change behaviour of critical gatekeepers who make decisions, (Heller, 2004), and is therefore a method that is well suited to examining the policy process. This research method takes a multi and trans-disciplinary approach and combines qualitative and ethnographic methods, (Brewer, 2004). Participatory Action Research is a way of describing the 'insider' role, and places a greater emphasis on creating change and reflecting upon this process than just the generation of knowledge. (Heller, 2004).

4.1.3   Pilot research

As part of the initial piloting for this research, a focus group meeting was performed with national, regional and local public health specialists with an interest in violence and abuse in the summer of 2006. The aim of the meeting was to provide exploratory material to clarify the

research question and generate ideas to examine more deeply within the research study. A summary of the findings can be seen in the results chapter.

The questions used to structure discussion in the group acted as a pilot study to help inform the research question, objectives and focus of the methods used in the thesis, (Flick, 2009; Oppenheim, 1992).

4.1.4   Methods Selected

The case study and insider research approaches provide a wider context in which a combination of specific research methods were used to study the research subject in more detail. As I already had experience in the qualitative methods of interviews and focus groups (Nurse, 2003), I wanted to develop skills in additional qualitative research methods. Therefore, the following research methods were selected as appropriate for investigating this thesis. They provide a balanced view of the research subject in order to reduce bias and include repetition of data collection from differing perspectives in order to cross check validity of results with triangulation, (Barker 1996). The methods chosen for this research included:

- *Documentary review:* systematically reviews official governmental and statutory organisation documents of national and regional policy

- *Mapping:* systematic process for recording patterns of violence & abuse prevention activity at policy level

- *Observation:* provides a subjective analytical in-depth insight into what actually happened

Observational methods are more subject to observer and reporting bias, however, they provide rich (which can also be described as 'thick data'), in-depth material which assist interpretation of the more objective data systematically collected from the mapping and documentary analysis. (Johnson, 2004).

Additionally, I selected the use of a case study as a research method, as it provides a useful approach to providing in-depth analysis to the policy process, for example, the case study research conducted on health service implementation provides insight into the process of decision making to inform hospital managers (Caton and Bach 1990). A key weakness though, in the use of case studies is their generalizability to other settings and situations, hence the last two objectives of this thesis focus on the wider lessons for policy and public health in order to tease out the application of this research.

Social science and policy research frequently includes the use of interviews in combination with a range of other qualitative methods, to allow for in-depth understanding that can be triangulated to enhance insight and reduce bias (Boeije 2010). For example, over two hundred interviews were conducted by Kingdon (1984), in order to inform his research describing policy streams and policy windows in agenda setting. At the outset of this research, I had included interviews as a research method in combination with mapping, documentary and observational analysis. However, as the research progressed, I decided not to include interviews as a research method for this thesis for several reasons:

I realised that the data I had started to gather from the observational research was richer and more in-depth than I had initially anticipated. Following discussion and reflection of the amount of time and capacity available, I considered that the additional data from interviews in combination with observation, mapping and documentation, would only provide limited additional information for this research. In particular, as I had previously conducted qualitative research using both open and semi-structured interviews (Nurse 2003), I also wished to extend my qualitative research skills with the use of observational methods.

Observational research methods have the ability to collect primary data from their natural environment, whilst interviews can be regarded as secondary data, and therefore, a key strength of observational research, as outlined in section 4.4. is that it can be described as a relatively pure form of qualitative research (Green, 2004). Additionally, a relative strength of this thesis included the ability to research the policy process over a number of years. Therefore, compared to interviews, observational methods were considered to be a particularly appropriate method for this research, as they allowed for the gathering of data over a period of years, whilst interviews tend to provide a snap-shot perspective of the policy process in time (Flick 2009).

The section below describes each method in further detail, including potential strengths and weaknesses of each method. This includes the scope of the research methods, and where relevant the sampling framework, timeframe and geographical coverage of the research.

4.1.5   Timeframe of the Research

The documentary study and mapping were conducted in the earlier part of the research process, mainly between 2006- 2008. Whilst the observational analysis, consists of insider research of working within the Department of Health, from 2005- 2010, and includes an analysis of the authors diaries written during that time period.

4.1.6   Geographical Coverage - National and Regional Levels

The research uses England as a case study at national level, and the South East of England at regional level.

4.2   Documentary Review

Documentary review refers to a range of written sources of mainly secondary data related to the research topic, and includes items such as: Governmental reports, newspapers, minutes, local or regional reports, (Rowlinson, 2004). The purpose of documentary review in this research study was to provide a relatively objective view of historic and current government policy on violence and abuse prevention.

The advantage of documentary analysis is that sources are relatively abundant and easy to access, and do not require ethical approval if in the public domain (which since the Freedom of Information Act, includes letters, minutes and emails). Limitations of documentary analysis include the degree of reliability and validity of the documents analysed, for example a potential issue of importance with media material. It is for this reason that mainly government and official reports were reviewed, (Green, 2004). Additionally, some softer data from letters and emails were reviewed, especially to help identify contextual issues regarding the decision making process.

I initially identified governmental documents that related to violence and abuse by discussion with policy leads in the Department of Health, the Home Office and the Department of Children, Schools and Families. These occurred in the context of a series of early exploratory meetings that took place on cross- governmental responses to violence prevention. A structured search was also made of the main government departments websites to identify further documents that referenced violence or abuse. Websites searched included: the Department of Health; the Home Office; the Department of Children, Schools and Families; the Department for Communities and Local Government and the Department for the Environment, Farming and Rural Affairs.

Initial national documents that were reviewed included the period between 2006- 2008 as part of the draft policy report that was circulated for consultation. An update of government documents was then made to cover the period from between 2008 to 2010. This was done by consultation with policy leads and cross-referencing of documents cited in recently agreed violence and abuse prevention policy.

An initial content analysis was undertaken - documents were searched by hand and electronically, to see if violence and abuse were referenced within the report. Documents were summarised by date and government department and timeline and can be found in annex IV. Following discussion with policy leads, key governmental documents were identified for further thematic analysis. Key documents were identified as those that played a significant role in advancing violence and abuse prevention, rather than just mentioning the concept once or twice.

In total, 44 relevant government reports were identified that mentioned violence and abuse prevention between 2005- 2010. The majority of reports were published by the Home Office, (15 reports), and these had the most influence in the development of policy on violence and abuse prevention. In total, 16 were considered to be key documents, including policy that actively influenced activities on violence prevention.

Documents and policy activities were then recorded in the mapping framework. The relevant parts of the content of documents were used to fill out the violence prevention mapping framework, for example whether policies were mainly primary, secondary, or tertiary prevention approaches and what stage of the life course they targeted.

Robustness and validity: there were a number of steps in the process of the documentary review that were undertaken to ensure that all the main governmental documents were included, and that key documents were identified for further analysis. These included initial discussion with policy leads to identify documents, followed by searching of governmental websites. After documents were found and listed, policy leads were asked to identify any further gaps. Additionally, policy leads were asked independently to identify and list key documents for violence and abuse prevention policy. A final consensus of a summary of key and wider documents that reference violence and abuse work by policy leads was gained to clear the publication of the draft 'violence and abuse prevention framework' (2008).

Annex IV, provides a summary of Governmental documents that include mention of violence and abuse prevention, key governmental documents that make recommendations for further work on violence and abuse prevention are highlighted in bold. Significant excerpts from key governmental documents that provide evidence for analysis are also included in the results chapters.

I conducted much of this work as part of their role in advising the 'Victims of Violence and Abuse Prevention Programme'; the findings were used to inform the mapping to help identify gaps in current policy and were used to provide a summary of key government documents that

contained reference to previous violence and abuse work. This work was used to inform the mapping exercise conducted and then to build the development of the draft violence and abuse prevention framework launched in November 2008 as part of the consultation process for this policy.

4.3   Mapping

Mapping originates from a rapid ethnographic technique for identifying community activity, problems and resources, ((Green 2004). Mapping is now commonly used in high- income countries in order to gain a clearer picture of current activity, programmes and services, and to be able to identify any gaps; (McDonald et al, 2004). In this research study, a mapping exercise was undertaken of national violence and abuse prevention policy and included an estimation of progress or coverage of implementation. This was used to gain insight into the balance of prevention policy across primary, secondary and tertiary prevention approaches across the life-course for violence and abuse, and to identify gaps and priorities in policy. Additionally, it provided a useful picture of the relative contribution of different actors.

It included a comprehensive review of existing policy from the documentary review and was cross-validated with policy makers. Mapping potentially provides a relatively objective picture of policy. However the main weakness is if an incomplete mapping exercise is taken as it will only reflect the data collected, and not the true degree of policy or activity on the ground. Therefore, after initial completion, which was based upon my insider knowledge and review of policy documents, data was validated by experts and policy leads in the violence and abuse prevention field.

The mapping exercise was conducted between 2006-2007. During this time, I was working in the SE regional public health group for the Department of Health and some of this work draws upon regional level observations of the implementation process. However, the main mapping exercise was conducted at national level and was done within the context of my role of public health advisor to the 'Victims of Violence and Abuse Prevention Programme'. This involved a mapping exercise of the prevention aspects of the work to inform future actions of the programme. The information collected by the mapping exercise was used to directly inform gaps and priorities for the Department of Health 'violence and abuse prevention framework', and helped to shape the future prevention policy itself.

I developed the research tool / framework for mapping violence prevention with the aid of expert consultation from the WHO. The mapping tool – referred to as the violence prevention framework, used the key headings from the framework as the basis to collect data in the form

of a series of tables. I filled out the tables based from findings from the documentary review. Additionally, experience from the SE region was used to fill out the initial draft of the coverage column on progress and coverage. This was then cross- validated with policy leads from the cross- governmental meetings that I attended as part of my advisory role. See Annex V for the completed mapping tables.

The mapping exercise included policy coverage of interventions for preventing inter-personal violence and abuse across England. The scope of this method was defined by the 'violence and abuse prevention framework', which formed the basis for collecting and later analysing the findings. The scope of the framework includes interventions across the life-course according to primary, secondary and tertiary prevention.

Between, 2005 – 2008, the Victims of Violence and Abuse Prevention Programme – led by the Department of Health, Mental Health division, ran a three-year programme. This contained a component to take forward work on violence and abuse prevention, for which I was the health advisor. As part of this process, I attended a series of cross –government officials meetings to provide a public health perspective on the violence and abuse agenda and explore the feasibility of developing policy on violence and abuse prevention. These meetings were led by the Home Office and included DH and Department of Children, Families and Schools officials. Meetings discussed an overview of concepts of prevention, a life course perspective of violence and abuse and a short summary of the evidence base. The mapping framework was completed during this time and cross-validated by officials during these meetings.

The series of tables in Annex II used to map documents and policy, are based upon headings from the violence prevention framework, with the completed tables found in Annex V. There are eight tables in total divided according to community and societal interventions and then life course stages with general population and risk populations. These reflect the frameworks main domains of primary, secondary, tertiary prevention equating with the ecological model across the life-course. Each table then has based the following headings: interventions; policy; delivery agents and lastly progress or coverage.

Robustness and validity - was improved by using more than one research method to fill out the mapping tables, for example, including data from the documentary analysis as well as feedback from policy leads. This was further strengthened by a second wave of feedback from cross – governmental policy leads and then later included a one to one meeting with a senior health policy lead to go through the tables' contents in detail.

Mapping as a tool was especially useful in developing an objective view of the coverage of different violence prevention interventions, and who was responsible for each of these policy areas. This information was used to help cross validate the documentary review. However, importantly, the information gathered was used to identify policy gaps and priorities for policy development, and in this context can be framed as action research.

The main findings from the mapping exercise are found in Annex V and summaries are presented in the results chapter on the contribution of public health, (results 2) and the role of different actors, (results 3).

4.4   Observation

The purpose of using observational methods is to be able to understand actions and phenomenon at first hand, compared to gaining insight second hand, for example, from interviews. Observation is regarded by some qualitative researchers as the 'gold standard' due to its ability to collect primary data from its natural environment, hence being viewed as close to the truth of understanding a process as can be gained, (Green, 2004). The purpose of observation in this research was to provide in-depth data and insight into the policy-making process and included participation and observation of relevant meetings, workshops and conferences, which were recorded as notes in my personal diary.

My role as researcher within a work setting, was a form of participatory observation, which can be described as a sociological auto-biography, with a reflexive insider account of my personal experience. Participatory observation involves the generation of knowledge and action between the subjects (informants) and the researcher. It allows first hand study of experiences and behaviour in the situation of the subjects and incorporates the informants and researchers motivations and interpretations of reality. This method relies on the researcher having good critical self-reflection or reflexivity skills. (Waddington, 2004).

There are a number of advantages regarding the in-depth insight gained from insider observation as outlined earlier. However, these need to be balanced by the ability to maintain an analytical approach to understanding, in order to gain the greatest insight with minimal bias, (Green 2004). Bias potentially emerges from the presumptions and values of the observer, and the interaction as a participant. However, it can be argued that nobody can be truly objective as an observer, especially as they need to interact with the process as part of the observation, (Rice, 1999). Therefore, the perspective and impact of the researcher on the process forms part of the discussion in the conclusions.

The methods used for the observational research included a combination of sources, which used a variety of approaches to improve observational skills, (Green 2004; Bowling 2002): Meetings – attendance of meetings related to violence and abuse prevention, where the observation of the dynamics involved in the policy making process was observed – especially focusing on interpretation of meanings, identifying the decision making process, the interaction of relationships and non-verbal communication and contextual factors. Emails – key emails that described aspects of the policy formulation process with regard to violence and abuse prevention were filed for later analysis. This helped to identify key decision points and actions and steps required to progress the policy process. Diaries – personal diaries of meetings attended and personal reflections on the policy making process were kept, these were used to describe key decisions and reflect upon interactions and dynamics within meetings, including contextual factors, participation and the timing of meetings.

Relevant observations were made in my personal work diary, prior to, during and after meetings and when attending workshops and conferences. Diary entries were recorded during my employment at the Department of Health, which covered the research period, between 2005- 2010. Table 25 summarises the sampling framework used.

Table 25 - Sampling framework for observational analysis

Regional Level	Form and timing of observation
National	Personal Diaries between 2005- 2010, recording information on violence and abuse from: • Meetings • Workshops • Conferences • Personal Reflections related to the PhD thesis Additionally, key emails were saved.
Regional - SE	Personal Diaries between 2005- 2007, recording information on violence and abuse from: • Meetings • Workshops • Conferences • Personal Reflections related to the PhD thesis

In total 13 field dairies were completed during the entire observation period from September 2005 until August 2010. The range of people observed included policy makers, ministers, public health and health professionals, stakeholders involved in the policy making process, including from the public sector, private sector and from non- governmental organizations.

A sample of diary entries is provided in annex VI over a three-month period of time during 2009. This includes all entries to the diary during that time period that related to violence and abuse prevention. It provides a typical range of the sorts of diary entries made across the study period. The sample of entries covers a variety of different sorts of observations, including: notes from meetings, workshops, conferences, task lists and personal reflections related to the PhD thesis.

I attended at least 157 meetings in the process of the observational research, these meetings are captured in the diaries. Key emails were kept that described aspects of the policy formulation process and illustrate the incremental nature of the policy process, involving the many steps and the need to build upon previous policy. They also illustrate the contribution of public health

to the process of violence and abuse prevention policy, and the overall complexity of the policy process. Some of these emails are used to illustrate findings across the results chapters.

4.5   Scientific Rigour

Policy analysis is a complex field to study, dependant upon the individual contextual and political setting of a particular situation. This creates a number of challenges and limitations for the scientific rigour of a policy analysis: in that the main research methods suitable for policy analysis are qualitative and based around individual case studies. As described, qualitative research methods are more subject to bias, and findings from case studies can be difficult to generalise to other settings. (Janovsky,Ed. 1996).

Scientific rigour involves a systematic approach to research design, collection, analysis and interpretation of data. The central tenets of rigour can be captured by the concepts of: Reliability – the repeatability of findings using the same methods. Validity, including internal validity which is the extent to which research methods measure what they set out to measure; and external validity, which is the generalisability of research findings to other settings. Bias – which is understood as the deviation in one direction from the true value of the construct being measured and can by introduced in the form of design, assumption, observer, interviewer, selection, reporting and non-response bias. (Bowling, 1997).

Research findings from secondary observation from three independent sources were used to improve the validity and robustness of the overall thematic and process analysis for this thesis. This approach included secondary observation evidence from the following areas: Secondary Thematic Analysis of my diaries – by a research student (see Annex VIII); Secondary Observation of the policy process in general – from a Public Health Trainee, (incorporated into the results chapters on the public health contribution and on the policy process); Secondary Observation on the policy process for Violence and Abuse Prevention - from a Public Health Consultant (incorporated into the results chapter on the policy process).

In order to ensure this research study was performed as rigorously as possible, the following good practice guidelines for qualitative research were adhered to, (see Table 26 below).

Table 26 - Good Practice Guidelines for Qualitative Research
(Adapted from Green 2004, Bowling 1997 and Cohen 1994; Boeije, 2010)

Criteria	Method	Used
Transparency	• Ensure clear descriptions of methods used	Yes
	• Maintain comprehensive records for data collection and analysis	Yes
Bias	• Non –response bias – ensure saturation of findings	Yes
	• Design bias – reduce observer, recall & reporting bias by triangulation of methods	Yes
	• Selection bias – use of multiple methods and triangulation of results	Yes
Validity	• Deviant data was examined	Yes
	• Sufficient background and context was provided to allow independent interpretation of findings	Yes
	• Multiple methods and triangulation of results to reduce weaknesses of individual methods and increase overall validity	Yes
Reliability	• Results comprehensively recorded	Yes
	• Frequency counts of themes identified	Yes
Comparisons	• Compare findings with other studies	Yes
Reflexive	• Account for role of researcher in research	Yes
	• Discuss and record decisions made in research process	Yes

4.6   Ethical Issues

Ethical considerations are an important aspect of all research studies (Boeije, 2010). Key ethical points include the following areas: voluntary and consenting involvement by participants in the study, with the ability to freely withdraw at any point; benefits should clearly outweigh any potential harm caused by the research study; measures should be taken to reduce

the risk of harm and participants should be made aware of any risk or harm; researchers should be highly experienced and qualified and research should be withdrawn or terminated if any undue harm or discomfort is caused to the participant; confidentiality of contributions by participants should be respected. (Green, 1998).

Ethical aspects of the research were discussed with the Department of Health. There was no formal guidance, aside from ensuring that normal professional and Department of Health and Civil Service codes of conduct were respected, and that ethics committee clearance was obtained from the research institution. Following the up-grading seminar I gained ethical approval from the London School of Hygiene and Tropical Medicine ethics committee.

This research study did not include any lay volunteers or experimentation, and therefore was not considered to cause serious harm. With regards to this research study, the main ethical considerations include the following issues:

Possible emotional discomfort for those who may have personal histories of abuse – although this was minimised, as most discussion was with professionals who were used to discussing difficult issues, some of which will relate to them personally. Additionally, the nature of discussion was on high-level policy, factual or conceptual issues, with no reference to personal experiences or emotional aspects to violence and abuse.

Covert observation – although managers were informed of the nature of the research, much of the observation happened in the context of my day-to-day work role, and therefore consent to observe the process was inappropriate to ask for and would have been disruptive to the work undertaken. Much of the observation was in effect 'reflective practice' (Green 2004), and could be considered an aspect of personal development within my work role. However, I ensured that observations recorded in the thesis did not include personal or identifiable details unless the information was already in the public domain. Additionally, in order to maintain personal and professional respect and confidentiality, the focus of the analysis described was on process factors. Any sensitive material that emerged was not included in the write up of this thesis.

4.7   Overview of Analysis

The data generated by this research study underwent a combination of different forms of analysis, mainly using forms of thematic content analysis followed by triangulation, which are the most suitable analysis methods for this piece of research (Green 2004). Additionally, triangulation was conducted on the results and analysis of the different methods, and systems

analysis applied to generate summary tables and diagrams. These steps and their relationship to each other are outlined below.

Policy is based upon complex systems, as opposed to a rational linear approach. Hill (1997), describes two key elements of policy analysis: analysis of policy content and thematic analysis of the remit of a particular policy. The mapping and documentary analysis provided the main overview of the content and themes of violence and abuse prevention policy, with further detail from the diaries. Secondly, process or thematic analysis involves analysis of the inputs and transformational processes that determine the construction of policy. It acknowledges external and internal drivers, explores the potential constraints and the balance of power interests. This aspect is mainly provided by the observational analysis. The analysis undertaken in this thesis included the following steps, which are described in further detail in the following section:

Content and Thematic Analysis, which describes the main content and themes from the documents, mapping and diaries from the observational analysis. This includes frameworks to provide a more structured analysis of the content and themes, including their inter-relationship. The three frameworks used for analysis in this research, include: i) violence prevention, ii) public health and iii) policy, and are outlined in the conceptual frameworks section at the end of the literature review.

Triangulation was undertaken to enhance validity and reliability and reduce bias, as well as clarifying the relationships between different themes. Triangulation involved comparison of results between the different methods and secondary analysis by other researchers, to identify areas of consistency and divergence of results and conclusions. Additionally, systems research principles were applied, and involved cognitive and pictorial mapping to understand the complex relationships between events, and were used to develop the policy formulation model presented in the conclusions.

4.8   Content and Thematic Analysis

Content analysis essentially describes the content within the research data and is one of the more basic methods of qualitative analysis. Whilst thematic analysis identifies themes that emerge from within the content, (King, 2004). These methods are frequently combined, and were done so within this research. Thematic content analysis involves examining the content of data and categorising these into recurrent themes. (Green, 2004).

The documentary analysis and mapping involved a content analysis, in order to describe the development of policy for violence and abuse prevention over a period of time. Whilst the

observational analysis combined content and thematic analysis to explore factors that influenced violence and abuse policy development.

Personal diaries from between 2005- 2010 were read through to identify all aspects relevant to violence and abuse prevention. These pages were marked and scanned, with personal names covered. Scanned copies were printed out and collated in date order. These were read through thoroughly to familiarise myself with the overall content and to identify key themes. Themes were highlighted with a marker pen and collated with a tally in a separate document.

The diaries were then read independently by a research student who summarised key themes from the research material, their summary can be found in Annex VIII. Additionally, key emails that had been saved were re-read and key themes and processes were identified. Some of these emails are given as examples in the results chapters and mainly illustrate the main steps in the policy formulation process. Table 27 summaries the early themes and divergent areas identified by this process, they are listed in order of frequency of themes occurring, with the most frequently mentioned themes earlier.

Table 27 - Summary of early themes identified from observational analysis

General Observations and Reflections from Diary entries

- *The need for clear leadership and allies – <u>divergence</u> – except for discrediting leaders which can be damaging*

- *Not always evidence based! – media and minister driven*

- *Conceptual difficulties regarding prevention and life course perspective by non – public health actors*

- *The need to create visibility & raise understanding on violence as a public health issue*

- *Simplify messages and increase relevance - focus on priorities – <u>divergence</u> - highlight multiple impacts and gains*

- *Integrate into other relevant policies*

- *The power of tangible examples and personal case studies*

- *Promote partnership approaches – violence needs multi- sector approaches*

Content and thematic analysis can be conducted with computer packages to assist in the reliability of the analysis. I investigated the feasibility of this approach with the research

methods chosen. Because of the multiple and complex sources of data and methods used to conduct the research, it was considered that the use of a computer package would not be feasible nor benefit substantially the overall analysis process.

Therefore, I used the series of frameworks and secondary analysis to ensure the overall robustness of the process and to aid the interpretation of the research data to maximise its external utility. Additionally, although thematic content analysis is good for exploratory research and for identifying emerging themes, it tends to be less good at linking themes with theory and wider contextual issues; (Green 2004). Therefore, further structured content and thematic analysis was undertaken with the three frameworks on violence, public health and policy to assist in identifying relationships.

Framework analysis was specifically designed by the National Centre for Social Research for policy analysis. It involves a content analysis, which classifies data within thematic frameworks, and goes several steps further in exploring and interpreting results compared to a straightforward thematic content analysis. Following the identification of themes, they were mapped onto the frameworks in order to explore the relationships between different themes emerging from the research, and also the relationship with the wider context, theoretical approaches and outside research findings. This process aims to draw out practical strategies and policy implications. (Green 2004), as was used in this research. Framework analysis is similar to 'template analysis' that involves an organised approach via the creation of a template to analyse data to explore relationships, (King, 2004).

As described in the previous chapter, three frameworks were developed to aide analysis. The frameworks used results from the mapping, documentary and observational results to segment the research material into themes to aid a structured approach to exploring the research question of this thesis. The previous chapter on conceptual models and frameworks used as research tools provides details on the research tools developed for this thesis.

The results from the mapping and documentary review were analysed with the violence and abuse prevention framework tool and cross validated by the observational methods. Initial analysis provided an overview of different interventions according to the main actors involved to provide a summary of policy emphasis and gaps. These were illustrated visually on the violence prevention framework. The gaps were then used to inform discussions with senior public health colleagues and helped to shape the priorities that were turned into the policy for preventing violence and abuse. This information was then used to help identify the main priority areas for developing the draft ***violence and abuse prevention policy*** that was launched for consultation in November 2008**.**

The main contributions for each sector, (see Table 28), were then highlighted in a separate colour within the violence prevention framework to make it easier visually to see which sectors contributed to which interventions for the prevention of violence and abuse. This information was used to describe the interest and role of different actors to complete the stakeholder analysis outlined in the third results chapter. The main findings are summarised in the results chapters on the role of public health and of other actors.

Table 28 - Analysis of the violence prevention role of different actors

- Criminal Justice System - mainly the Police, the Home Office and the Ministry of Justice

- The Health Sector – the NHS and the Department of Health

- Those responsible for Children and Young People – mainly the Education Sector

- The Local Authority Role and the Department of Communities and Local Government

- The Voluntary Community Sector

The policy framework used the main headings from the integrated policy model to provide a structured approach for capturing reflections on the main policy process themes. See Annex III for the headings used in the policy framework, which provided a structure for summarising observational evidence and analysis. I completed the observational policy framework template based upon a review of diary entries and observations from the period from 2005 – 2009, by describing specific examples in relationship to the main headings in the template. The findings completed within the policy framework analysis can be found in annex VII, whilst examples of relevant evidence and analysis are presented across the results chapters.

The Public Health Framework builds upon the completion and analysis of the other two frameworks, and was completed last. The Public Health Framework was filled out initially by hand and then discussed and cross- validated with public health colleagues. The final version was then completed electronically. The framework was used as a structure to reflect upon the relative contribution of public health skills, functions and enablers (based upon the Faculty of Public Health descriptions) in relationship to violence and abuse prevention. The main findings and analysis are described in the second results chapter and discussed further in the conclusions.

4.9   Triangulation

Triangulation was used to help to reduce bias and strengthen validity of research findings by identifying areas of consistency and divergence within the research, and helped to ensure the scientific rigour of the research. Triangulation of multiple methods and settings (national and regional levels), were of assistance in interpreting relationships between themes, (Cohen, 1994). The data from the different research methods of mapping, documents and observation were all compared and triangulated to assess for consistency and deviance of content and themes. Additionally, as part of the triangulation process, in order to improve the overall reliability and validity of the analysis (Bowling, 1997), secondary observations from public health professionals were included. This involved two written contributions of observational accounts of the policy process.

Additionally, personal diaries were reviewed independently with the identification of emerging themes by a research student, (see Annex VIII). To strengthen the overall coherence and robustness of the research findings, analysis and interpretation, a public health consultant who was involved in the process of developing policy for the prevention of violence and abuse read through the overall thesis to identify areas of agreement and any gaps or areas of deviance.

The process of triangulation was applied to the analysis to identify common and recurrent themes and processes across different research methods, and include the identification of common themes that emerged across the different research methods. A comparison of the relatively objective findings from the mapping and documentary review was made with the more subjective findings from the observational analysis, to increase the robustness of overall findings. Finally, the creation of summary tables and diagrams were developed from the triangulation process to aid understanding and simplify the complex and multiple data sources, and relationships between different themes. (Nurse 2003; Green 2004).

The principles of systems science were applied at the triangulation stage of analysis and involved an approach to analysing how complex systems interact and work. Systems analysis draws upon analytic induction and sequential analysis. Inductive research assumes that the researchers' initial observations are the starting point to formulate the hypothesis, (Johnson, 2004). Whist the method of analysis used by sequential analysis involved a progressively cyclical approach to analysing the data to produce a summary of the analysis.

Additionally, it builds upon the cumulative analysis developed by triangulation and framework analysis and attempts to explain and predict from these frameworks. For example, with the presentation of theoretical explanations or models of the variety of data found from

observation, (Johnson, 2004). I applied this technique to the analysis process by taking progressively incremental stages to the process of analysis. Table 29 below describes the stages adapted in this research from systems analysis and is based upon Walsh and Clegg, (2004).

Table 29 - Stages of systems analysis; (Walsh and Clegg, 2004)

Stage 1: examine problem situation

Stage 2: construct a 'rich' picture to describe the situation

Stage 3: describe relevant systems and root causes

Stage 4: develop a conceptual model

Stage 5: test and revise the conceptual model

Stage 6: use the model to implement change

I used these principles to initially identify the research question, constructed diagrams of the situation, used the frameworks to analysis themes and relationships. Finally, I used cognitive mapping and pictorial representations as analytical methods to describe the complex relationships between content, process and themes; (McDonald, Daniels and Harris, 2004; Stiles, 2004). This approach was used to develop a policy formulation model, and to cross check and further develop the integrated model of the policy process. The conclusions presents a revised integrated policy model based upon the results of the research. Table 30 summarises the main steps taken in the analysis stages of this research.

Table 30 - Summary of stages and steps taken in analysis

First Stage: Content and Thematic Analysis

Step One: involved reading of results from single research methods (documents, diaries), highlighting and writing out of emerging themes and processes.

Step Two: used three frameworks to structure analysis from the documents, diaries and observations, according to the:

- Violence and abuse prevention framework (mapping framework)

- Public Health Framework

- Policy Framework

Step Three: Re- read and discussed all the research results until saturation of the findings was reached, that is no new information was found.

Stage two: Triangulation

Step Four: Cross-validation of emerging themes between the three methods used, this involved comparison of documents and mapping methods and involved a research student read through the diary entries who drew up a list of emerging themes from their perspective. Similarities and divergence in themes were discussed and themes identified were adapted accordingly. Additionally, a public health trainee and public health consultant provided a summary of the policy process from their observations, this provided independent material to cross- validate research findings.

Step Five: A further wave of analysis was conducted, by reflecting on and refining the findings, comparing similarity and divergence between findings across the different methods to clarify the main themes, processes and connections. This was then followed by the development of cognitive and pictorial maps to help identify common themes, clarify processes and identify relationships between themes. This process resulted in the development of the policy formulation model.

Step Six: Further secondary analysis and cross- validation of all the findings in the thesis was done by the consultant in public health who worked on developing the last stage of the violence and abuse prevention policy. They read through the entire thesis and identified any areas of variance from their own experience. These areas were discussed and an interpretation agreed upon.

The following section of this thesis is the Results section, describing the main findings and analysis of this research.

Results Section – An Overview

The following four results chapters summarise the main findings under headings for the first four objectives. They incorporate findings from all the results from the different research methods and forms of analysis used, including the mapping, documentary and observational analysis, as summarised in the table at the beginning of the methods chapter. The relationship of the results chapters to the objectives are structured around the Process and Power policy model, (Walt, 1994), which is a triangular policy model consisting of the headings: Content, Context, Actors and Process. The following results section is divided into four separate chapters and presents findings according to objectives one – four, with the main relationship to Walt's model in capitals:

1. **CONTENT: To describe the general development of violence and abuse prevention policy in England over time**

2. **CONTEXT: To describe the public health contribution to violence and abuse prevention policy**

3. **ACTORS: To describe and explore the role of different actors in influencing the policy process for violence and abuse prevention**

4. **PROCESS: To summarise the policy formulation process**

The results chapters, each objective summarises findings aligned with Walt's main headings, whereby objective one on the 'Content' describes the overview of the development of violence and abuse prevention policy from the perspective of participatory observation formulated from this case study.

The 'Context' is described under the second results chapter, and examines the public health contribution to violence and abuse prevention policy. The role of 'Actors' are then explored in the third chapter, whilst the fourth results chapter on 'Process' presents findings on the policy formulation process. These are summarised in Figure 18 below.

Figure 18 - Relationship of results chapters to the objectives and Walt's model, (1994)
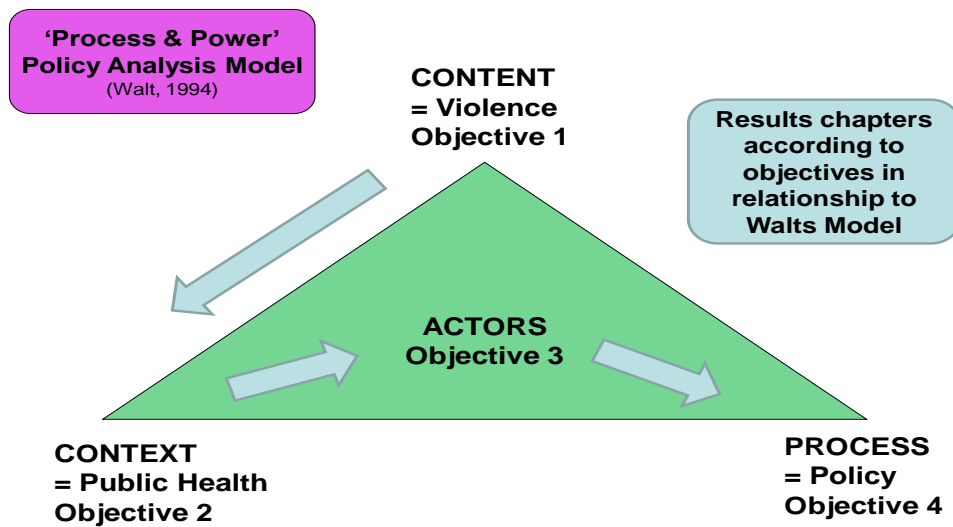
The model by Walt (1994), has been used to structure an in-depth analysis and explore the main interactions that occur within the policy process, where the actors play a central role, and in particular, in the context of this work, my role as participatory observer of the process is reflected upon. Although, this research is based upon a specific case study, the wider application of this work is potentially of importance, and will be discussed in the concluding section. However, it is helpful to contextualise this case study within the wider policy making process, for which the wider literature is summarised in the literature review on the policy process and chapter on the models used for the research.

In particular, the model created to analyse the research of this thesis, 'An Integrated Model of the Policy Process', (described in the chapter on the models used in the thesis), has been used as a framework in the analysis process, the results of which are summarised in annex VII. This model, also provides an overview of the policy making process, which include the wider context of the process, consisting of the historical, political and social context, and the levels (the outer circle), in terms of regional, national and international levels. The introductory chapter of this thesis outlines the wider context, whilst the first chapter describes the first results chapter describes the regional and national levels, and touches upon the international level.

The inner three circles, then describe the interacting process of the three main policy areas under the headings of: 'Initiation', 'Formulation' and 'Implementation'. The main actions for each of these three areas are described in the main circles, with the interacting aspects of the policy process explained in the overlapping circles, which are explored across the results chapters, (See Figure 19).

As this model was used as an analytical framework, these main areas are covered in the four results chapters, however, the majority of the focus of this research has been on the policy formulation process (the second circle), as this is a relative gap in the research. The first chapter covers the policy levels, and provides an overview of the historical development of the policy process for violence and abuse through the stages of initiation, formulation and implementation.

Figure 19 - An integrated model of the policy process
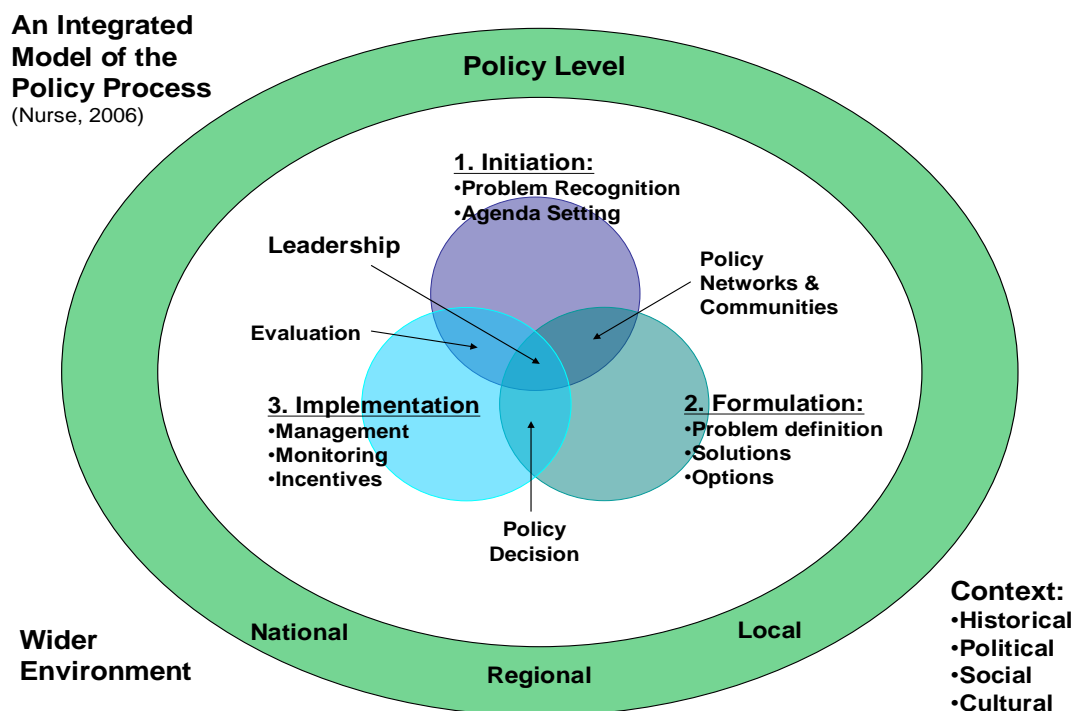
The Table 31 provides an overview of how each of the results chapters presents evidence and reflects on the key components of Walt's policy model and the relationship of each chapter to the integrated model of the policy process (Nurse, 2006), which was used to structure the analysis of this thesis. The conclusions discuss the relevance of this model for understanding policy, reflections are made based upon this thesis and an improved version of the model is presented.

Table 31 - Overview of the Results Chapters in relationship to Walt's policy model and the Integrated model of the Policy Process

Objective	Relationship with Walt's Policy Model	Relationship with the integrated model of the policy process
1. To describe the general development of violence and abuse prevention policy in England over time	CONTENT: Violence prevention	Policy Level: - Regional - National Overview of: - Wider context - Policy initiation - Policy formulation - Policy implementation
2. To describe the public health contribution to violence and abuse prevention policy	CONTEXT: Public Health	Initiation: - Problem recognition Formulation: - Problem definition Solutions & Options Implementation: - Barriers & Opportunities
3. To describe and explore the role of different actors in influencing the policy process for violence and abuse prevention	ACTORS: Internal and external	Initiation: - Agenda setting Formulation: - Relative roles, power and influence of actors Wider Context: - Interaction of external and internal actors
4. To summarise the policy formulation process	PROCESS: The policy formulation process	Formulation: - Problem definition - Solutions & Options Intersecting circles: - Leadership - Policy networks - Consensus and decision making

The historical view of this is given through the eyes of the participatory observational process, whereby, there was considerable interaction between the implementation stage and the initiation stage at the start of this process. This is conveyed historically in terms of the role of the regional levels, which were mostly responsible for the translation and implementation of policy. Therefore, the regional role is described initially in chapter one, which also reflected the time sequence of where I was based in the Department of Health. This describes how this agenda was pushed from other sectors, and finds a relative national policy gap for violence and abuse prevention, and thereby, leads to the initiation and then development stages of the policy process at national level.

Chapter two, then moves on to describe the public health contribution to the policy process, and includes the role of the WHO in the initiation and problem recognition process. The role of public health is then described, mostly for the policy formulation process, whereby, the differing emphasis on levels of prevention and the use of public health competencies in respect to the science and art of public health are explored. Lastly, the relative barriers and opportunities encountered are outlined, especially in relevance to the implementation of policy by influencing public health delivery.

Chapter three, explores in depth the role and interaction of the main actors in the policy making process in the development of violence and abuse prevention policy. This analyses the relative influence and power of different actors at the different stages of the policy process, with the main emphasis of this research being placed upon the formulation stage. External actors, including the WHO, the VCS and the media, as well as Ministers with a particular agenda, played the most important role in agenda setting at the initiation stage. In contrast, the formulation stage was mostly influenced by the internal actors of Ministers and civil servants, of which there was a varying degree of influence and interest expressed by different government departments and occasional external influences, mostly in the context of the media. Whilst the role of actors in the implementation process, from the perspective of the formulation process, (which this research is mainly focused on), is conveyed in the context of external engagement in order to lower risks and enhance the feasibility and sustainability of policy delivery.

Finally, chapter four, on the policy formulation process, as suggested by the title, explores in depth the policy formulation stage (the second circle in figure….). The introduction outlines insights into the policy initiation process of agenda setting. The overlapping circles are then explored, with the central role of leadership and champions or advocacy in driving the overall process. This was facilitated by policy networks, which assisted in sustaining momentum in the development of policy, and at times played a championing role. It then explores in depth the

central tasks of the formulation process, including the problem definition and the development of solutions and options. Lastly, the process for decision making and consensus formation are described, which proved to be key in securing the final policy report, (DH, 2012).

Chapter 5 - Results – One: What Has Been the General Development of Violence and Abuse Prevention Policy, Over Time? - *CONTENT*

Research Question: To describe the general development of violence and abuse prevention policy in England over time

In order to contribute to the research question, of **why is public health in England not more engaged with the development of policy for the prevention of violence and abuse,** this chapter provides the overarching story and timeline of the policy process for this case study. In the process of doing so, it identifies some of the key barriers and opportunities found within the policy making process, with a focus on violence and abuse, of which pivotal points are described in particular detail. The remaining results chapters explore further the role of public health (chapter two), the main actors (chapter three) and a detailed description of the policy formulation process (chapter four).

Figure 20 - Timeline for Violence and Abuse Prevention Policy in England
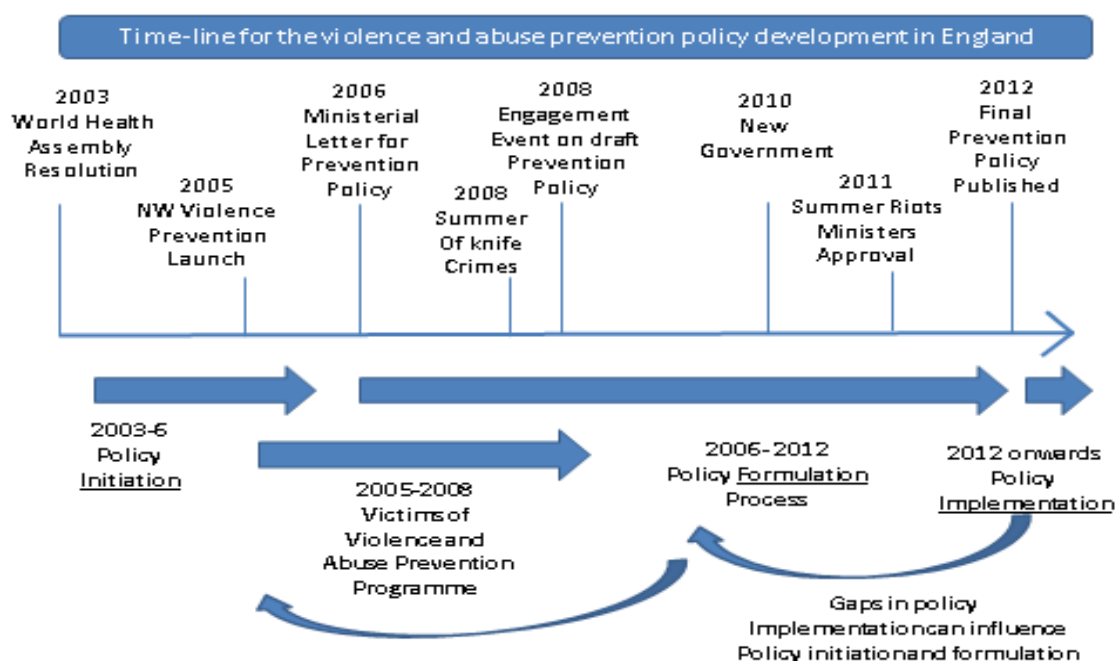
This chapter describes the development of violence and abuse prevention policy, mainly between the years 2005- 2010, during the period of time that the research was conducted, however, reflections on the process are also included from 2003- 2012 in order to complete the timeline of the process of developing policy. An overview of key events is summarised in the timeline in Figure 20.

Violence and abuse prevention provide a case study to examine the public health contribution to the policy development process. However, specific findings are described that are relevant to the development of violence and abuse prevention and transferable to other public health challenges within other settings.

This chapter first describes and examines the regional role of the Department of Health in relationship to policy development on violence and abuse prevention. This mainly relates to how policy translation and delivery identified gaps, and with the push of other actors, led to policy initiation at national level. The next section, then describes the national development of policy for violence and abuse prevention, providing an outline of the overall process, and emphasising key events that took place. The following chapters then describe in more depth the specific contribution that public health made to the policy development (chapter two), the role and interaction of different actors (chapter three) and detailed insight into the policy formulation process, (chapter four).

In 2003, following an attachment on violence prevention at the London School of Hygiene and Tropical Medicine, (LSHTM), at the end of my public health training, I was seconded to the World Health Organisation, (WHO), in Geneva, attached to the violence and injury prevention and gender based violence teams. At the LSHTM I contributed to research on documenting interpersonal violence prevention programmes (Sethi, 2004), whilst at the WHO, I under-took a joint project and publication on the primary prevention of sexual and relationship violence in young people, (Butchart et al, 2010). This interest and experience in public health and violence prevention, along with my appointment as a civil servant, resulted in being requested to become an advisor to the Victims of Violence and Abuse Prevention Programme.

Although, the overall process of policy development for violence and abuse prevention is described, as a participatory observer in this research, I played a key role at various stages of the process, which I describe in the results chapter and highlight my role in the summary Table 32 as either observer, contributor or active participant where I directly led on an area.

The Table 32 summarises the timeline of key events in the initiation of policy for the prevention of violence and abuse in England, of which the most pivotal events are underlined. This is further described under the national case study section.

Table 32 - Overview and timeline of key events in the Initiation of violence and abuse prevention policy in England

Date	Event and Context	Main Actor	My role: Observer Contributor Directly led
2003	World Health Assembly Resolution on the Prevention of Violence	WHO	Observer
2004	Chief Medical Officer appoints a national lead on violence prevention in the NW region	CMO/ DH	Observer
2005	The NW region hosts a national event on violence prevention and publishes a report on the situation in England	NW Region	Observer
2005-2008	The Department of Health operates a Victims of Violence and Abuse Prevention Programme, responsible for wider engagement and a series of publications – the violence prevention work becomes part of this programme.	DH	Observer
2005	National launch of the Home Office lead report: 'Improving outcomes for victims of sexual violence: A strategic Partnership Approach'	Home Office	Contributor
2005	Launch of 'Responding to Domestic Abuse: a Handbook for Health Professionals'	DH	Observer
2006	Publication of the Victims of Violence and Abuse Prevention Programme implementation guide	DH	Contributor

In particular, in my role as a Department of Health civil servant and because of my historic interest in violence and abuse and experience gained from my placement at the WHO Violence and Injuries and Gender Based Violence Programmes, I was asked by the Director, to be a Public Health Advisor for the DH Victims of Violence and Abuse Prevention Programme. This role existed for the duration of the programme, from 2005- 2008. During this time, the extent of my role varied, initially attending and presenting at meetings and later in the drafting of the

initial policy report on violence and abuse prevention, which was disseminated for wider consultation at a workshop in 2008.

From 2009- 2011, as the workload to follow up from the consultation and then development of the final policy was more than could be expected from an advisory role, an additional public health consultant was brought in by the policy lead for violence and abuse. I continued to provide advice to the policy lead and supervised the work of the public health consultant until 2010, when I went on career break from the DH to work with the WHO. The insights from the public health consultant's engagement in the policy process provided additional secondary observational data. The autumn of 2010, marked the official end of my insider research period, however, as will be seen, the violence and abuse prevention policy had not yet been published. Continued email contact with the public health consultant and policy lead has enabled completion of the story until the final publication of the report in November 2012, which is described in this chapter.

These research findings draw upon results from the mapping, documentary and observational analysis, which can be found in, annexes IV- VIII. Specific examples are embedded within the chapter itself to support the evidence of the findings presented in this chapter.

The regional part of the case study (from 2005- 2007), initially describes what was seen as the main role of regional government offices in implementing and ensuring delivery of policy. A key challenge at regional (and local levels) is the interpretation and practical application of policy, therefore this section also describes the process of policy translation for local and regional delivery. This process in itself led to innovative approaches that were not reflected in national policy, therefore, the last part describes how a pilot project ended up influencing national policy.

The national part of the case study then describes the time line of key events that influenced the final development of national policy for violence and abuse prevention, covering a ten year time period from 2003- 2012. In 2003, the agenda was set with the World Health Assembly resolution on violence prevention, which reinforced the previous WHA resolutions and specified that countries develop national policies for violence prevention. The following years then track the story of the policy formulation process for policy specifically on violence and abuse prevention, with the final publication of: 'Protecting people, Promoting health – A public health approach to violence prevention for England' (DH, October 2012).

As part of this story and the process for developing an area of specific policy, violence and abuse prevention was also embedded within relevant policies in health and other sectors to

ensure that it was still part of the policy agenda and to ensure partners were engaged with relevant aspects of prevention. Barriers and opportunities to the formulation of policy on violence and abuse prevention are described throughout the chapter and summarised at the end.

The opportunity afforded by my insider research status has resulted in a description of the *general development of violence and abuse prevention policy in England over time* that is essentially from my perspective, the implications of which will be discussed in the conclusions. Therefore, my role as an insider in participatory observational research, meant that at times during this process it appeared to some, that I was actively driving policy for the prevention of violence and abuse and understood to be the main lead within the Department of Health. However, as the story unfolds, it becomes clear that there were many actors in a process that can be understood to have many complex and interacting layers over a prolonged timescale.

5.1   The Case Study - An Overview

A case study is a useful research approach to understanding the dynamics of policy development. A research opportunity arose within the context of my work role between 2005-2010 being employed as a Consultant in Public Health and Senior Civil Servant, by the Department of Health for England whilst funded to undertake a part-time PhD at the London School of Hygiene and Tropical Medicine.

This role involved a regional role within the SE region between 2005- 2007 and additionally a national role from 2005- 2007 providing national advice for the DH Victims of Violence and Abuse Prevention Programme, (Itzin 2006). I then moved to a full national role for the Department of Health in England, between 2008- 2010 as National Lead for Public Mental Health and Well-Being. Whilst in this role, I continued to have a supervisory and advisory role for the violence prevention policy.

Therefore, England will be used as the national level case study, with the South East region providing an opportunity to study the policy dynamic at regional and local levels. The following section describes the role I played in policy development at regional level and then at national level.

5.2   Policy Initiation - The International Role: 2003 - 2005

During 2003, the World Health Assembly endorsed a resolution on violence and injury prevention, signed up to by the UK government, and supported by a substantial evidence based

report (Krug et al, 2002). This gave the Public Health community the mandate to take forward action on violence prevention, including the development of a national plan of action on violence and abuse prevention, (point 6 of WHA 56.24), see Table 33.

Table 33 - World Health Assembly, 2003, Resolution WHA56.24 on implementing the recommendations of the World report on violence and health

1. Increasing the capacity for collecting data on violence

2. Researching violence – its causes, consequences and prevention

3. Promoting the primary prevention of violence

4. Promoting gender and social equality and equity to prevent violence

5. Strengthening care and support services for victims

6. Bringing it altogether – developing a national plan of action

This resolution builds upon previous WHA resolutions, and commits countries to supporting and implementing the recommendations of the resolution. However, the WHA resolutions are not legally binding, unless member states have the political will to develop their own legislation or policy in relationship to the resolution. Essentially, signing up to a WHA resolution, puts a topic or issue on the agenda for countries to consider relevant action, however, it is not seen as an obligation to take forward substantive action in an area, and is largely seen as political intent.

The CMO appointed the NW region to take forward and champion the work on violence prevention following this WHA resolution. This led to a national event in 2005 where the NW launched a report on the state of violence and abuse in England, and later played a pivotal role in providing public health information and evidence to inform policy work in this area, including the final publication of the policy report in 2012. This illustrates the importance of regional roles in influencing policy development. The following section describes my participatory observation at regional and then national levels, firstly describing my regional role, which reflects upon the interaction of regional policy translation and implementation in influencing national policy initiation and formation.

5.3 The Interaction of Regional Policy Implementation and with National Policy Initiation (2005- 2007) - The SE Regional Case Study

In 2005, I took on the role of Consultant in Public Health for the Department of Health in the South East Region, based within the Government Office from 2005 until the end of 2007. This role involved leading on Mental Health and Well-Being, which included violence prevention, offender health and learning disability; Housing and Health. This provided an opportunity for me to take forward work on preventing violence and abuse prevention and applying the knowledge that I had gained at the LSHTM and WHO on this area. Additionally, I gained permission as part of my Personal Development Plan to undertake a part time PhD funded by the Department of Health and chose the public health contribution to violence and abuse prevention policy as my research area.

This role involved working in partnership with Other Government Office colleagues on areas of common interest to achieve mutually beneficial goals. Additionally, it involved the implementation and translation of national policy for a regional and local setting and publishing reports that described the profile of health needs in the SE region. Regarding the violence prevention work, a variety of approaches were taken and included raising awareness, partnership working, and mainstreaming into relevant strategies. These are outlined in the following paragraphs before specific examples are described in further detail.

One of the early challenges in this role, was the relative lack of detailed policy for the prevention of violence and abuse prevention. Aside from the endorsement of the WHA resolution and mention of preventing violence and abuse in the context of the DH Victims of Violence and abuse prevention programme within 'Choosing Health' (2004), there was no guidance or specific policy on the prevention of violence and abuse. In 2004, as a Public Health expert with an interest in violence and abuse, I was asked by the Director of the programme, to become an advisor for the prevention aspect of the DH Victims of Violence and Prevention Programme. Therefore, I acquired the role of informing policy development at national level and then in 2005 when I officially started my employment with the DH, the translation of this at regional level.

In the early stages, there was very little perception of violence and abuse prevention being a health issue, nor of its relevance to other sectors aside from the Criminal Justice system. In contrast, the Home Office at Regional and national levels, drove the agenda and were keen for other sectors to also engage in the identification and prevention of violence and abuse. In order

to raise awareness and understanding of violence and abuse prevention as a public health issue, under the guidance of the Regional Director of Public Health, with other colleagues who I supervised, I organised a series of presentations and workshops, outlining the public health impacts of violence and abuse and potential responses. To assist in the translation of policy and the evidence base for a regional and local audience, I developed a regional factsheet on preventing violence and abuse which outlined why it was important, patterns of violence and abuse, what works in terms of prevention, ways forward for local and regional levels, and further resources and information. (www.sepho.org.uk).

Partnership work was taken forward with Other Government Departments, for example, a joint project, which was initially driven by the Home Office on anonymous information sharing on the location and timing of violence related admissions to Emergency Departments. This involved gaining the endorsement of the Regional Directors for the Home Office and for Public Health, who were highly supportive of this joint initiative as it gave visible results for both agendas. The main role of the regional government offices was to support the delivery of policy – via translation of national policy for regional and local contexts, and in monitoring progress of targets. However, part of the wider context of the regional government offices was to facilitate partnership working to achieve beneficial outcomes.

Additionally, relevant violence and abuse aspects were incorporated within relevant strategies and reports, for example, on mental health and well-being, offender health, sexual health, alcohol and the regional health strategy. The South East Public Health Observatory supported the development and publication of information based reports on the main health programmes in the region. For example, for mental health, (which I lead on for the region), involved joint working with a team of information analysts in the collation of a range of information sources that affected the determinants of health, for which, we included data on violence and abuse in the final report, (SEPHO, 2006).

The below section illustrates how violence and abuse was incorporated into relevant strategies, including a regional health strategy and offender strategy. In order to embed violence and abuse within mainstream public health approaches, I led the section on safer communities in the Health Strategy for the SE region (DH, SE region, 2008). It highlights the main regional priorities for preventing violence and abuse and provides case studies of work delivered at regional level that also influenced national policy. For this strategy, I incorporated regional level data on the patterns and risk factors for violence, and a summary of the evidence for preventing violence and abuse.

5.3.1 Mainstreaming Violence and Abuse within Relevant Strategies

In the summer of 2006 there was an NHS reorganisation, which resulted in a merger of Strategic Health Authorities, (SHAs), to ensure alignment with the Regional Government Office boundaries, all except the SE region, which due to the large size of the region, (8 million) it divided into two SHAs. The Regional Public Health Directors changed to take on the wider NHS along with the Government Office Role. As the Regional Directors appointed in the South East region had no previous experience in the Government Office, they decided to develop a SE Regional Health Strategy for the Government Office role, which was finally published in 2008, (DH, 2008d).

As this was a Government Office Strategy, the main sections reflected areas where there were good opportunities to work in partnership with other sectors to achieve health and other outcomes. Therefore, there were chapters on Children and Young People, Employment, the Built Environment, Safer Communities, and Older People. I was asked by the Directors, to lead on the part of the strategy on Safer Communities, which identified the following five evidence based priorities outlined in Table 34 that regional and local organisations, by working in partnership to prevent violence and abuse and make their communities safer and more sustainable:

Table 34 - Priority areas relevant to violence prevention in the SE England, Regional Health Strategy, (DH, 2008d)

- Increase safe, sustainable and green spaces

- Improve coordination and sustainability of parenting programmes

- Increase individual skills to reduce violence and abuse – targeting young people and high risk groups

- Reduce alcohol and illegal drug-related harm by improving partnership working, the identification of and services

- Improve the health of offenders and ex-offenders

In partnership with the Home Office, I took this work forward in a series of workshops and presenting a public health perspective of patterns and risks for violence and the evidence base for prevention. We met jointly before the workshops to plan the agendas, location and who to invite. Invitations to workshops were sent out via email, circulated mainly to public sector and VCS audiences with the ability to influence the planning and delivery of the main priority

areas, proposed in the draft chapter on safer communities. Additionally, a handful of experts would be invited to give relevant presentations.

Engaging other sectors including the voluntary community sector was found to positively strengthen the public health approach. For example, one workshop on violence prevention, involved working closely with a VCS organisation, who translated into a story the range of risk factors across the life –course and subsequent behaviours and negative health and social outcomes. This provided a very powerful and memorable message. At this same conference, the national DH policy lead on the Victims of Violence and Abuse Prevention Programme was also invited to speak – this process helped to strengthen engagement and relationship with the policy lead, whilst also providing the opportunity to inform them on the wider context of prevention.

However, during the course of this work, a number of barriers were encountered, which in part relate to the hidden nature of violence and abuse. For example, presenting the statistics on levels of child abuse from population surveys showing approximately one in four children experienced some sort of abuse, compared to numbers from case reporting which gave an estimate of one in 800 children experiencing abuse; I would describe the visible or known number of children experiencing abuse compared to the numbers from population surveys, as the tip of the iceberg. Although, those from the VCS found this presentation helpful to their work, and would cite estimated data to support their own work, when this was presented to an audience of regional children's leads, the presentation led to disbelief at the size of the numbers and a subsequent reluctance to engage with the prevention approach.

Some professionals from the safety and protection perspective, were overwhelmed by the statistics and the potential implications of what it would mean if approached from the usual service response – of child protection procedures. Whilst some health and education professionals were sceptical or even denied the data based upon their own perspective and were reluctant to see the relevance of preventing violence and abuse. Although difficult to substantiate, some of this resistance is possibly related to the relatively hidden nature of many types of abuse, resulting in only the tip of the iceberg becoming visible to wider society. Additionally, personal experience of abuse, societal attitudes and the taboo nature of sexual abuse in particular, can lead to denial and distorted perspectives by professionals, which can act as a barrier in taking this work forward from a policy perspective. These issues were discussed with colleagues committed to violence and abuse prevention. By applying a public health approach was found to help to objectify the data and allow it to be present in a more visible and mainstream context.

Aside from raising awareness and understanding on violence and abuse as a specific public health issue and the role of prevention of different sectors, there were a number of opportunities to embed violence and abuse prevention within mainstream areas of work. One example was where I was asked by the Regional Director for the National Offender Management Strategy, (NOMS), to chair the regional offender health group, (as I led the regional offender health work as part of my regional role), which provided an opportunity to contribute to the regional offender strategy. In this role, I supervised the development of an offender health factsheet, highlighting the links of offending with violence and abuse across the life course and ifs prevention. This group involved working in collaboration with partners in offender management, probation, criminal justice, mental health, housing, drugs and alcohol misuse, and those responsible for offender health. The roles of different partners were discussed and summarised, along with national and regional policy, and gave examples of best practice and summarised effective interventions, (DH, 2008).

The main points from this factsheet were then incorporated into the SE Regional Reducing Reoffending Strategy, (SE, 2006). It emphasised how early intervention at any stage has the potential to prevent violence and abuse, as well as reduce risk and vulnerability. For example, with offenders and ex-offenders, co-ordination between health, social care, probation and criminal justice systems can create opportunities for early intervention at any point in an offending pathway to reduce risk factors for violence and promote social inclusion. Figure 21 provides a summary of this work.

Figure 21 - Relationship between risk factors for offending behaviour and opportunities where public health intervention can prevent offending and promote social inclusion, (SE, 2006)
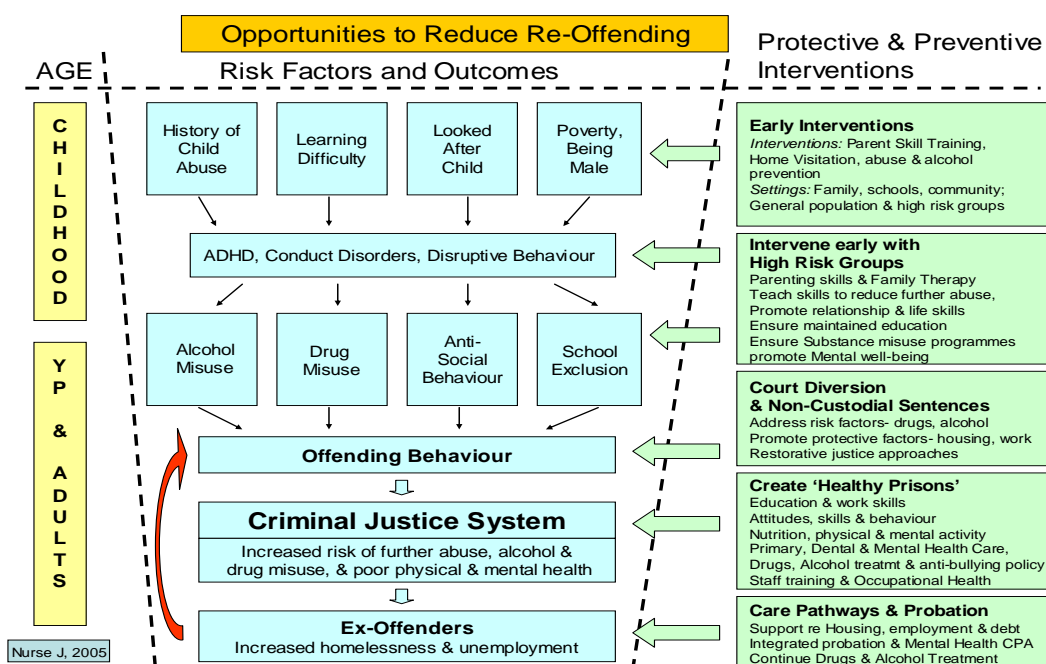
This figure, (SE, 2006) illustrates an approach in embedding violence and abuse prevention into regional policy. However, although this approach was incorporated into the regional strategy, and there was general support for the conceptual approach in the Regional Board for Reducing Re-Offending, resistance was received from some of the members of the health working group and the Regional Director for NOMs. This resistance was generated from attempting to apply the implications of this upstream prevention approach to changes in the offender health committee that would have engaged relevant sectors who would be able to address the key prevention determinants. Some of the members in the group, whose main focus was on the treatment and containment aspects and perceived that their role would not be seen as so relevant and had a vested interest in continuing with the treatment versus prevention paradigm.

The Regional Director for Offender Management who had originally supported this approach, was concerned about any potential conflict, and therefore asked me to leave my role as chair. The Regional Director for Public Health intervened, supporting the prevention approach, however, to ensure good future collaborative working, did not pursue reinstatement of my chairing role, and by this time I was mostly working at national level, so it was perceived as more diplomatic to replace the chair. Despite this episode, the regional factsheet on Offender Health, (DH, 2008c), was still supported and published by a range of partners, including the National Offender Management Strategy, with the Health Sector, especially SHAs in particular appreciating this publication to inform planning in this area. This instance reflects the general resistance encountered in changing systems with a vested interest in the status quo, which has since been observed in other public health areas that attempt to shift from a treatment to a prevention paradigm.

5.3.2   How Local and Regional Innovation Influenced National Policy

Although, the regional role in the DH is primarily one of delivering policy, the local and regional organisations are closer to the public health challenges on the ground and have more flexibility and understanding on how to develop innovative and integrated approaches to address these challenges. Despite this, policy is mainly made at national levels and can be detached from these experiences and develop policy that is not feasible to implement. The example, below provides an illustration of how innovative and evidence based approaches developed at local level were further piloted at regional level and then incorporated into national policy. This illustrates a bottom up approach to policy formulation, and how when there are perceived gaps in policy from the implementation actors, they are able to influence agenda setting and formulation.

The Regional Home Office team initially approached the public health team asking for joint support in addressing increasing levels of violent crime related to alcohol consumption following recent legislative changes to enhance the night time economy. This resulted in the public health team undertaking a review of effective interventions, which considered a number of approaches, but in particular, this review found the work of Jonathon Shepherd in Cardiff, (Shepherd, 2001), to be considered robustly evidence based as well as relevant and relatively straightforward to transfer to other settings. This intervention was based upon sharing anonymous information on violent assaults with the police and local authorities, with an evaluation revealing a reduction of assaults presenting in the Emergency Department by 40% over a 5 year period, (Shepherd, 2001; Warburton, 2004).

Jonathan Shepherd was invited by the SE regional Home Office jointly with the Department of Health, to give presentations at a handful of early workshops with some of the Emergency Departments and PCTs with an initial interest in this approach. These Emergency Departments piloted this approach in their own setting, and found that they showed promising results in reductions in emergency admissions. Based upon the relative success of these early pilots, with the regional Director of Public Health's support, it was decided to visit Cardiff to discuss the approach with Jonathan Shepherd and key partners involved, in order to develop a standard model of this work to make it easier to transfer and scale up more widely in the South East region. The text in Table 35 and figure 22 provides a summary of this approach which was also reflected in the SE Regional Health Strategy, (DH, 2008d), and was provided in briefing materials, presentations and included in the draft National Violence and Abuse Prevention Framework, (DH 2008).

Table 35 - Model created for information sharing on violence prevention for Emergency Departments

- **Data Collection:** Emergency Department reception staff collect information on patients presenting with assaults – including: patient gender and age, assault type (including weapon), number of assailants, gender of assailants, whether attacked by the assailant before, assault location, time and date. Patients are seen on their own to ensure confidentiality and safety.

- **Data Analysis:** anonymous data is collated and passed on to the police analyst who uses it to describe community patterns of violence

- **Partnership Working:** the summary of violence patterns are shared at a local partnership meeting with police, local authority, health, education and voluntary sector. This informs local strategic action, for example, police coverage of high-risk locations,

> alcohol licensing, environmental changes to diffuse street violence, school and health visiting programmes.
>
> - **Feedback and Health Sector Action:** information is feedback to health and reception staff. Assaults on females are followed up by a health worker to offer support for intimate partner violence and investigate if there are child protection issues.

Data was collected by either an electronic system, or by using a paper-based system. Data collection systems and training of reception staff took place in as little as 2 weeks with minimal resource implications. Local leadership by health professionals was key for championing and adoption of this work, and was perceived as a practical, evidence based approach for addressing a problem with increasing costs to the NHS and community.

Initially, a series of workshops were held in the SE region in order to promote uptake of this work which lead to the early adoption of this approach in 3 pilot emergency departments. Following joint funding with the Home Office in the SE region, it was possible to roll out the pilot to further Emergency Departments across the SE. By 2008, there were 25 out of the 32 Emergency Departments adopting this approach. The Home Office were very keen on developing and supporting this work as it addressed the increasing political concern of dealing with serious crimes – of which violent crime was a key aspect of this agenda.

In contrast to this intervention, there was a similar approach developed in the NW Region of England, which had not been included earlier due to it not being peer reviewed at that time, however, as it was a comparable example, and gave promising results, it was also cited in the draft Violence and Abuse Prevention Framework, (DH, 2008). This also helped to ensure good engagement of the NW of England, who had been assigned the lead role in violence and abuse prevention by the CMO. The information sharing approach, was also used to address youth violence and intimate partner violence, including the development of a standardised protocol for health professionals. This work led to increased service provision to respond to health needs made visible by this process; and informed national policy and the replication in other regions, (HO, 2008). The Figure 22 below summarises the approach of how a local partnership used a public health approach to reduce alcohol-related violence.

An important policy window of opportunity occurred after several months of high media coverage on knife and gun crime during the summer of 2008, (described later from the national perspective). Following pressure from the Home Office and Prime-Ministers Office, the Department of Health rolled out anonymous information sharing based upon the pilot from the

SE region in approximately 100 Emergency Departments across England by 2010. This illustrates the potential influence of local and regional initiatives in informing national policy.

Figure 22 - Reducing Alcohol Related Violence and Promoting Safer Communities; (DH, 2008c and d)

However, this required ready access to policy making process centrally, persistence on the part of the champions for this work with repeated meetings with the DH and the Royal College of Emergency Medicine to ensure that they could see the advantages and were on board with this approach. This process was facilitated by national alcohol policy leads having regular meetings with regional leads, which allowed sharing of good practice and influencing of national policy and access to other relevant policy leads.

A particular area of resistance in the process, was found in influencing the new establishment of the NHS IT system, with a view to embed questions into the Emergency Department IT system – this involved a series of meetings with relevant policy leads and the need to make a business case in the region of £1million pounds, that was beyond the scope of the regional leads to take forward.

The next section describes the national development of the violence and abuse prevention policy.

5.4 Policy Formulation 2006- 2012: A National Case Study on Violence and Abuse Prevention within England

This national case study describes the development of policy on violence and abuse prevention within England between the years 2005- 2010 from a participatory observational perspective. During this period of time, I was initially, primarily based within the South East region as described above, however, during the years 2005- 2007 I had a national public health advisory role for the Department of Health led initiative, the Victims of Violence and Abuse Prevention Programme, (DH 2006). During this period of time, I attended a number of governmental meetings and provided public health expertise for a range of aspects of this programme, including informing the development of Home Office policy, for example, on Sexual Violence.

Then between the years 2008- 2010, I took on the national lead role for Public Mental Health and Well-Being. This post was based centrally within the Department of Health and gave the opportunity for me to be more engaged in the role of developing policy on the prevention of violence and abuse for the department of health. Initially, this role, took the shape of writing the evidence-based draft of the violence and abuse prevention framework, which was launched at a consultation event during November 2008, (DH, 2008).

Additionally, I continued to provide public health advice on developing Home Office led policy on the prevention aspects of violence and abuse. From 2009 - 2010, I supervised another public health consultant who took on the lead role for collating feedback from the draft policy report on violence and abuse prevention and with the support of policy and public health colleagues, helped to take this work through to the final policy processes. The report was finally published by the Department of Health in November 2012, (DH, 2012).

Despite my instrumental role in actively driving and shaping policy in violence and abuse prevention, there were many other important actors in the process, and below summarises the timeline of the main events in the policy development for the violence and abuse prevention framework and related policy. The Table 36 below summarises the timeline of key events in the formulation of policy for the prevention of violence and abuse in England, of which the most pivotal events are underlined.

Table 36 - Overview and timeline of key events in the Formulation of violence and abuse prevention policy in England

Date	Event and Context	Main Actor	My role: Observer Contributor Directly led
2006	<u>Ministerial approval gained by the Public Health Minister for developing a National Violence and Abuse Prevention Strategy</u>	DH	Observer
2007	Launch of the Cross Government Action Plan on Sexual Violence and Abuse	Home Office	Contributor
2007-2008	Raising awareness of the issue of violence and abuse as a public health issue	DH – Public Health	Directly led
2008	Publication of the Home Office Action Plan on Tackling Violent Crime	Home Office	Contributor
Summer 2008	<u>Number Ten Downing Street engagement on violence due to series of knife killings</u>	Prime Minister's Office	Observer
November 2008	<u>National consultation of the Violence and Abuse Prevention Framework draft</u>	DH	Directly led
2008	Publication of 'Health Inequalities and Next Steps' - included violence prevention	DH	Contributor
2009	Publication of DH Guidance for Sexual Assault Referral Centres	DH	Observer
March 2010	Publication of the Cross- Government Strategy on Violence Against Women and Girls	Home Office/ Cross – gov't	Contributor
2009-2010	Updating, establishing policy consensus and policy clearance for the violence and abuse prevention framework	DH	Contributor
March 2010	<u>Violence and abuse prevention framework nearly cleared and rejected due to technicalities and closeness to general election</u>	DH/ Cross-gov't	Observer
March – May 2010	Purdah and general election held, followed by a change of government	Prime-Ministers Office	Observer
June 2010- March 2011	Policy updated for new Government	DH	Observer

Date	Event and Context	Main Actor	My role: Observer Contributor Directly led
April 2011	Policy nearly approved and then rejected at cross- ministerial level	DH	Observer
Summer 2011	Summer riots with adverse publicity	External /Media	Observer
October 2011	Riots lead to Ministerial approval for violence prevention policy	DH	Observer
Nov- Dec 2011	Establishing policy consensus – again	DH	Observer
Jan –Sept 2012	The final redraft and clearance	DH	Observer
Oct 2012	Final clearance achieved for DH publication of the violence and abuse prevention policy	DH	Observer
Nov 2012	Final publication of the Violence and Abuse Prevention Framework on the DH website	DH	Observer

5.5   A summary of National Policy Development on Violence and Abuse Prevention

5.5.1   Initiation

In 2003 the World Health Assembly Resolution on the Prevention of Violence was endorsed and agreed by the UK Government. This gave a high level political commitment to put violence prevention on the policy agenda at national level, although it does not provide any legal or other powers to ensure that action is taken forward. In response to the resolution, in 2004 the Chief Medical Officer appointed the NW Regional Director of Public Health to lead nationally on violence prevention for the Department of Health. Centrally, it was often seen that these regional policy lead roles (each region was given lead areas on different topics) were given to areas that were not seen as high profile or desirable by central policy teams. They were often referred to as orphan policy areas and it was often difficult for them to be embedded into the central policy making process. This was in part because of geographical distance and sometimes (as in this case), the assigned leads were not part of the civil service and tended to be seen as outsiders by central policy leads.

In 2005 the NW region hosted a national event on violence and abuse and launched a public health observatory publication: 'Violent Britain'; (NWPHO, 2005). This involved a wide public health audience and a small handful of interested policy officials and helped to raise visibility of violence and abuse as a public health issue. However, due to the outsider status of the public heath observatory, little further action was followed up by policy officials. This illustrates the arms -length nature of the public health observatories to a lot of the central policy making process. Additionally, many of the committed policy leads who attended this event were especially interested in addressing sexual and domestic violence, which was not so comprehensively addressed in the Violent Britain report, and may have affected the perceived relevance to national policy development at that time.

A key event in the placing violence and abuse on the policy agenda, and initiating the policy formulation process, occurred with the national Victims of Violence and Abuse Prevention Programme, which was run from the Department of Health, from within the Mental Health division. This was a three year programme running from 2005-2008, with several project areas covering services to address victims and perpetrators of child abuse, domestic violence, sexual violence and prevention. The structure included a number of working groups and a Delphi consultation process in order to engage wider partners, including NGOs and researchers in the process. This was generally well received by stakeholders, who were largely NGOs and academics with an interest in these areas, however, they became increasingly frustrated by the perceived delays in publishing final results. Additionally, some stakeholders found the relative dominance of the DH in the decision making process difficult. At a later stage, the work of this programme was partly undermined as a consequence of a period of illness by one of the policy leads, which resulted in perceived unprofessional behaviour. This acted to discredit the wider work of this programme both by external stakeholders and other policy leads.

With regards to the prevention component of the Victims of Violence and Abuse Prevention programme, there was little prior development or understanding about how to take forward the prevention agenda when I was asked to become a public health advisor to this programme. In 2005, a US CDC expert had been invited to give a presentation about prevention early on in the programme, which I attended, and as I had recently been appointed to the Department of Health, I was asked to become the public health advisor for this part of the programme.

In 2005 the Home Office led the National launch of the report: 'Improving outcomes for victims of sexual violence: A strategic Partnership Approach', (HO 2005); which I contributed to from the Department of Health side and presented the public health approach at the ministerial launch of the report. This was an important early event to build personal credibility and forged the development of relationships and informal policy network acting on violence

across government departments. The event also raised wider publicity and engagement with external stakeholders and awareness about the prevention approach to violence and abuse policy.

As the public health advisor, during 2005- 2008, I attended a series of exploratory cross – government officials meetings to provide a public health perspective on the violence and abuse agenda and discuss the feasibility of developing policy on violence and abuse prevention. These meetings were initially relatively informal and led, chaired and hosted by the Home Office and included DH and Department of Children, Families and Schools officials. Table 37 gives an example of the agenda's of one of the earlier meetings.

Table 37 - Agenda of an informal Inter-Departmental Meeting on Violence and Abuse Prevention, 2006

> ### National Inter- Departmental Violence and Abuse Prevention Strategy Group
> ### - Exploratory Meeting-
>
> ### 12th June 2006
> ### Home Office
>
> 1. Introductions and apologies
>
> 2. Discuss purpose of the meeting/ group:
>
>   - To bring together an integrated approach for current work-streams of different areas of violence and abuse prevention work
>   - An integrated approach brings greater efficiency, synergy and wider gains: different expressions of violence and abuse have many risk factors in common and similarities in what works for prevention.
>   - To oversee and develop a joined up strategic approach to violence and abuse prevention at national level
>   - To identify potential gaps in current work, and areas needing future development.
>
> 3. Presentation: Jo Nurse- update of Violence and Abuse Prevention Factsheet.
>
> 4. Violence Prevention Framework – who's doing what
>
>   - Outline main areas covered and gaps for future development
>   (Jo Nurse with contributions from group).
>
> 5. Ways forward: Circular diagrams- Discuss role of different Government Departments, VVAPP and Respect Agenda
>
> 6. Next meeting:
>
>   - ? ToR
>   - ? National conferences/ meetings
>   - ? Strategy document
>   - ? Ministerial agreement
>   - - Date and membership
>
> 7. AOB

At these meetings we discussed an overview of concepts of prevention, a life course perspective of violence and abuse and a short summary of the evidence base. Additionally, in my DH role, I gave a number of presentations on the public health approach to violence and abuse to government officials in all three departments, to help raise awareness of the issue. The

mapping work summarised in the Appendix, was developed and cross-validated by officials during these meetings and helped to identify policy gaps and priorities to develop and incorporate into relevant policy to strengthen the prevention component of the Home Office policy on violence.

Relatively, violence had increased its profile within the Home Office with a greater focus during the Labour Government on serious crime compared to volume crime. This agenda was driven by a number of committed Home Office Ministers and later the Attorney General. In order to support this work there were sexual violence and domestic violence inter-ministerial groups, supported by policy leads, which oversaw the policy development in these areas. In general, of those who attended, these meetings were exploratory and collaborative in their nature, and brought together an informal network of policy leads from a range of government departments who were relatively interested and committed in taking this agenda forward.

The main challenge earlier on, which as will be seen resulted in residual obstacles for policy progression, was a relative lack of engagement at the right level of the Department of Children and Families. This was reflected in lack of attendance at meetings, or sending of junior policy officials who were unable to make decisions or commitments. To try and improve engagement, separate one to one meetings were held initially with committed external champions who had good insight and influence within the Department and advised which policy leads to meet with.

Additionally meetings were then held with the relevant policy leads to try and increase their engagement on the prevention agenda and the role that schools and education could play. In general, although there was interest, there was perceived to be little flexibility within the educational curriculum due to high workloads and their main focus politically was to increase educational attainment. Moreover, because of these challenges, although there was interest by policy leads, they were keen to relate the prevention approaches to policy that already existed, like the Social and Emotional Literacy Programme. Although, this did indeed provide some of the resilience supporting violence prevention, it did not adequately address protective skill development for different forms of violence and abuse experienced by children and young people.

Although, the Home Office were mostly leading on violence policy, they were keen to enhance cross- government engagement to address violence and abuse, and paid for a Home Office policy official to work within the Department of Health in order to strengthen the role that the DH took on addressing violence and abuse. Initially at this time the main focus was on addressing domestic and sexual violence, and this led to the publication of relevant HO and DH policies and guides to address these issues. For example, in December 2005 the Launch of

'Responding to Domestic Abuse: a Handbook for Health Professionals', (DH, 2005), with a foreword by the Public Health Minister. Although, generally well received, some aspects of the press reported negatively on this policy – with the recommendation of routine enquiry (Tagget, 2003), being seen as too intrusive. Although, the policy lead had to develop urgent briefing to respond to the negative media coverage, the programme was not put at risk due to committed ministerial and political support to address gender based violence.

Then in early 2006 the implementation guide for the Victims of Violence and Abuse Prevention Programme implementation guide, was published, (DH, 2006). This included a public health approach to prevention, and laid the ground for taking forward further work on violence and abuse prevention. The policy official taking this work forward was key to embedding prevention within this work and acted as a strong advocate for introducing myself as advisor, into cross governmental meetings, informal policy networks and later for gaining ministerial support and a letter committing to taking the prevention work forward. However, a period of sickness at a later stage acted to slow the policy process for the violence prevention agenda, and illustrates the individual nature of how for some areas, policy can be driven by highly committed policy leads. This was observed to especially be the case for violence and abuse policy with a number of highly committed policy leads within the Home Office and Department of Health who formed an informal network that ensured continued momentum in this policy area. As such, this was not routinely seen to be the case in other policy areas, where policy leads could at times be indifferent to the topic area they are working on.

In June of 2006 a Ministerial Round Table on Domestic Violence was organised in Madrid by the Home Office and Department of Health and supported by the British Embassy with joint ministers and officials from England and Spain. The purpose was to share learning, and I presented a public health perspective and had the opportunity to informally brief and talk to the English Home Office Minister at this event. This was an important event in building informal policy networks and strengthening relationships between policy officials in the UK, as well as being able to informally influence thinking and gain support from a Minister who later became the Attorney General. Information was also shared with Spanish officials and the violence and abuse prevention factsheet I had developed for the SE region was translated into Spanish.

5.5.2   Formulation

A key event in the policy development process occurred in July 2006, when the DH policy lead for the Victims of Violence and Abuse Prevention Programme briefed the public health minister on the prevention aspects of this work and gained ministerial approval to develop a National Violence and Abuse Prevention Strategy. This was followed up by presentations of a

public health approach to violence prevention at the Inter-Ministerial Groups on Domestic Violence and Sex Offending and a Ministerial letter from the Public Health Minister to the Home Office Minister, outlining a proposal to develop a strategy on the primary, secondary and tertiary prevention across all areas of violence and abuse. This acted as an important driver and a pivotal point to take this work forward, and to take it from informal policy discussions to a position where it was embedded within the formal policy making process, including ministerial approval, and oversight by an inter-ministerial group and the briefing of the CMO's office (see Table 38). This also marks the transition of the responsibility of the prevention aspect of violence policy shifting from the Home Office to the Department of Health. However, this progress was relatively weakened when the Public Health minister changed posts and following the prolonged sickness of the policy lead who had gained the approval.

Table 38 - Briefing note to senior DH official in August 2006 summarising progress of work on violence and abuse prevention

DH has been leading on the development of a cross-government National Violence and Abuse Prevention Strategy as part of the 'Cross government strategy for tackling the root causes of physical and mental ill health in child abuse and domestic violence' in Choosing Health (p. 50).

This has originated out of the work of the DH/NIMHE Victims of Violence and Abuse Prevention Programme (VVAPP) established under the direction of Professor CI in partnership with the Home Office Victims Unit, Sexual Crime Reduction Team, Youth Justice and Children's Unit, Domestic Violence Unit and Criminal Law Policy Unit. The programme guide Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Abuse was published in February 2006 and launched by Caroline Flint at a conference in June 2006. (See the attached IDMG SO Update for further information about the VVAPP).

The Violence & Abuse Prevention Strategy has been taken forward with Dr. Jo Nurse Public Health Consultant in the SE Regional Government Office and with the HO officials leading on domestic and sexual violence through a Strategy Steering Group chaired by BM. More recently steps have been taken to broaden the strategy to cover all elements of violence and abuse (violent crime, drugs and alcohol etc.) and to work with DfES. The VVAPP and the prevention strategy are being taken forward as part of the DH contribution to the government's RESPECT agenda.

Approval for this work was sought from the IDMGs on DV and SO in July and it was agreed with Ministers that Caroline Flint should lead on this for Ministers across

government in her capacity as Public Health Minister. A letter went from her to HO Ministers Tony McNulty, Baroness Scotland and Vernon Coaker at the end of July in advance of a meeting of officials in September to develop a project brief for Ministers in the autumn. Following the September meeting, Caroline Flint will be writing to all government ministers asking them to identify their relevant officials to contribute to this work.

With the 2006 reorganisation of Regional Health tiers, there was an opportunity to hold a round table discussion with senior Public Health colleagues on how to take the violence and abuse prevention agenda forward was held in August 2006 with two regional Directors of Public Health. The main notes from the meeting are given in the results chapter on public health. This provided a clearer outline of how to raise this as a more central public health issue.

In November 2006 I attended a Reception at Number Ten Downing Street that was held for stakeholders who had contributed to the Domestic Violence agenda. This event was hosted by the Home Office Minister, (who later became the Attorney General), and attended by a number of senior ministers and the prime-minister's wife, with the Prime-minister cancelling at the last minute due to urgent business. This acted as a strong advocacy event raising the profile and awareness of the importance of domestic violence across governmental ministries and acted to raise the visibility, status and the moral of policy makers and external stakeholders and partners. It also helped to strengthen networks and relationships of those involved in violence and abuse, including within the NGO community.

This illustrates the high level of support for addressing domestic violence at that time seen within the labour government and reflected in a series of further policy reports (see Table 39) to address sexual and domestic violence, these were actively driven by committed Home Office ministers and supported by dedicated policy leads. However, their main focus as will be described in the next chapters, was on what can be considered to be tertiary prevention.

Table 39 - Home Office policy, which contributed to violence and abuse prevention

The Home Office Strategic Plan, 2004- 5;

http://www.homeoffice.gov.uk/documents/strategicplan.pdf

Domestic violence: a national report, HO; 2005

http://www.crimereduction.gov.uk/domesticviolence/domesticviolence51.htm

Improving outcomes for victims of sexual violence: A strategic partnership approach, HO; 2005 http://www.crimereduction.gov.uk/sexual/sexual23.htm

Respect Action Plan. HO. 2006. http://www.homeoffice.gov.uk/documents/respect-action-plan

'A Five Year Strategy for Protecting the public and Reducing Re-offending' and 'The National Reducing Re-offending Delivery Plan' Home Office 2006 www.noms.homeoffice.gov.uk; http://www.noms.homeoffice.gov.uk/news-publications-events/publications/strategy/noms-five-year-strategy2?view=Standard&pubID=380057

'Cutting Crime – a new partnership' – the Home Office crime strategy, 2007; http://www.homeoffice.gov.uk/documents/crime-strategy-07/

HM Government 'Cross Government Action Plan on Sexual Violence and Abuse' 2007; http://www.homeoffice.gov.uk/documents/Sexual-violence-action-plan

Saving Lives. Reducing Harm. Protecting the Public. An Action Plan for Tackling Violence, 2008- 11.

http://www.homeoffice.gov.uk/about-us/news/violent-crime-action-plan

For example, in early 2007 the Home Office launched the Cross Government Action Plan on Sexual Violence and Abuse – which I contributed to, with the successful inclusion of concepts of prevention and school based interventions, (following on from the individual meetings held with Department of Education policy leads). During 2007, I gave a series of regional and national presentations, including to officials to help gain policy and public health support for violence and abuse prevention to raise interest and gain support for developing policy specifically on this agenda. During this time I also embedded violence and abuse prevention within the regional public health strategy. However, periods of sickness by the key DH official leading on the Victims of Violence and Abuse Prevention Programme delayed policy progress nationally on this agenda. Following a pause of activity, and discussions with the over-arching

Director responsible for the Victims of Violence and Abuse Prevention Programme, it was possible to further progress the violence prevention work. As the DH was now seen to be leading the prevention aspect of violence policy, an internal DH meeting was held with relevant policy officials to present the draft policy report and discuss the involvement of different leads, see Table 40 for the agenda for this event.

Table 40 - Agenda for internal DH meeting to discuss the development of violence and abuse prevention policy

PREVENTING VIOLENCE AND ABUSE

A meeting to discuss the DH role and opportunities in the development of a Cross Governmental Strategy to Reduce and Prevent Violence

A G E N D A

Room 152 Richmond House – Video Conferencing Suite

6th September @ 11.45 – 13.00, 2007

Chair: Director of Health Inequalities and Partnership

Confirmed attendees:

NW Regional Director Public Health & national lead for HO/violence
Consultant in Public Health, DH, SE Regional Public Health Group
Programme Director, Mental Health, DH
Director for NW Public Health Observatory/ Professor JMU, Liverpool
Violence and Abuse Programme Director, DH
Head of Children, Families and Social Inclusion, DH
Senior Development Manager, DH, SE Regional PH Group
Alcohol Team, DH
Health Improvement Directorate
Violent Crime Unit, Home Office

1. **INTRODUCTIONS**

2. **BACKGROUND TO THE MEETING:**
   - Overall purpose of meeting – Jo Nurse
   - Role of the NW RDPH as Violence Prevention Lead
   - VVAPP programme
   - Home Office Violent Crime Strategy

3. **SUMMARY OF VIOLENCE, ITS IMPACT UPON HEALTH AND PREVENTION – JN**
   - The impact of violence and abuse on health
   - What works in terms of prevention – examples from NW and SE Region

> **4. OPPORTUNITIES AND THE POTENTIAL ROLE OF HEALTH**
> - Benefits of developing a prevention strategy
> - Potential priority actions – discussion and comments about health related areas
>
> **5. NEXT STEPS**
> - Time frame re Violent Crime Strategy
> - Drafting prevention input
> - Other DH colleagues to consult

This was followed by a series of smaller, informal meetings with key DH policy leads, including the Director to discuss how to take this work forward. At times, it felt like no clear decisions were being made, however, over a period of time and with repeated meetings, there was a gradual shift in commitment, largely related to higher level political drivers that will be described later. The slowness of decision making was perceived to be mainly related to a relative lack of resources and capacity to take forward this work.

In January 2008 I was appointed as National Lead for Public Mental Health within the Department of Health. This enabled me to take a more central Department of Health role in developing policy on violence and abuse, where before I had been viewed as an advisor, I was now in a position where I could more actively influence and shape policy development on violence and abuse prevention. Additionally, the previous regional role meant that I had limited time and capacity to influence the policy agenda centrally. Becoming centrally located also meant that I could attend more meetings and strengthen policy networks in this area as part of my Public Mental Health role. The Victims of Violence and Abuse Prevention Programme policy lead continued to have periods of sickness, and other DH policy leads who had been committed to this agenda retired or moved to other Departments, which weakened the policy drive within the Department of Health on taking forward this agenda.

In the Spring of 2008 a key overarching policy report was published by the Home Office: An Action Plan on Tackling Violent Crime – Saving Lives, Reducing Harm, Protecting the Public, an Action Plan on Tackling Violence, (HO, 2008). I was involved in shaping this report, (including the title to make it more relevant to a health audience) with the lead Home Office Official. I attended a number of individual meetings with the Home Office lead official and follow up emails on drafts of the report, to shape the content and ensure inclusion of the violence and abuse prevention work and provided technical advice on concepts of prevention.

In the summer of 2008 there were a series of visible media death and reports on gun and knife crime, which resulted in high Number Ten Downing Street engagement on addressing violence.

This included senior DH and other Government Department policy officials (at Director level), attending weekly task force meetings to drive the policy agenda on preventing gun and knife crime. The Home Office chaired the meetings and collated the cross government response for the Prime- Ministers office. This required regular Department of Health contributions on violence, and helped to raise the profile and capacity of violence prevention work within the Department, with the appointment of a senior policy lead to take forward further work related to the Victims of Violence and Abuse Prevention Programme which had since finished. The significance and consequences of this high media profile event is illustrated by the following letter from the DH minister to regional Strategic Health Authorities.

From the Rt Hon Alan Johnson MP
Secretary of State for Health

(DH) Department
of Health

SofS50020

Dr Geoffrey Harris
Chair
South Central SHA
First Floor, Rivergate House
Newbury Business Park
London Road, Newbury
Berkshire RG14 2PZ

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000

1 6 JUL 2008

Dear Geoffrey

Recent fatal knife crime incidents, particularly among young people, are causing us all considerable concern and the Home Secretary has recently announced plans to tackle this, including the creation of a Knife Crime Programme, to provide support in 8 police force areas to deal with knife crime.

Some of these areas - Metropolitan Police, Essex, Lancashire, West Yorkshire, Merseyside, West Midlands, Greater Manchester and Thames Valley - are within your SHA area. I am therefore writing to draw your attention to some particular points in the programme being announced by the Home Office today and to ask you to take a personal interest in ensuring that the NHS in your area plays a full part in tackling these important issues. A copy of the press notice issued by the Home Office is attached as an annex to this letter.

The Department of Health recognises that knife crime can have multiple negative consequences upon the health and wellbeing of victims. In recognition of this, the DH is working in partnership with the Home Office and Other Government Departments to develop a violence and abuse prevention plan that will address early risk and protective factors in order to prevent violence and abuse occurring in the first place.

There is a key role for the NHS in tackling knife crime. In particular, I would ask that you ensure that NHS Trusts are working closely with other local partners to report knife wounds. Where there is risk to public safety, individual cases may need to be reported to the police as is already outlined in GMC guidance. Additionally, aggregated anonymous information sharing on violent assaults may be considered at local level to inform partnership working with the police and Crime and Disorder Reduction Partnerships to help to build up a more comprehensive local picture of risk areas and appropriate actions to prevent violence. In the 8 areas which the Knife Crime Programme covers, I am keen to for you to engage with NHS organisations to explore whether certain information about knife-related injuries can be reported to the police in the interests of public safety.

TB 15/07

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Department of Health

The General Medical Council (GMC) has issued guidance on the issue of information sharing in the interest of public safety. Please can you ensure that health professionals in NHS Trusts are aware of this guidance and use it to report knife-related injuries to the police where appropriate. In promoting information sharing DH would like to clarify that as per the GMC guidance, (see Annex B) confidentiality should be maintained as far as possible. For example information on the sex, age, location and time of incident may be shared but the victim's name may not be required. Consent should be sought on, and the victim informed about, what information is being shared. This is in line with guidance published by the General Medical Council (GMC) and the Department of Health. The GMC is reviewing its guidance on information sharing with a view to including a specific section on reporting of knife wounds to the police.

I would also ask that you engage with local partners, in particular Youth Justice Boards, to ensure appropriate governance arrangements are made and to examine how the NHS can best play a role in the development and delivery of knife referral projects

Yours Sincerely

Alan

ALAN JOHNSON

TB 15/07

Although, largely a reactive response, this placed violence and abuse firmly as an issue that the health sector should take responsibility for, whilst before, it had largely been seen as the responsibility of the Criminal Justice Sector. The Number Ten Downing Street interest, resulted in the extension of an adapted version of 'Cardiff Model' of Emergency Department information sharing on violence, described in the regional section of this case study, to approximately 100 Emergency Departments across England. To facilitate this process, I contributed with advice for briefings and contacts on the information sharing work with lead DH officials. This significant media event followed by high level political interest, illustrates the importance of timing and the opportunity of being able to push a policy agenda forward when there is high level ministerial and policy support.

This was a key event in raising the profile of the work on violence prevention, as each Government Department had to report weekly to the Prime Minister's office on how they were contributing to reducing the impact of knife related crime, this amongst other policy areas, became one of the solutions presented from the Department of Health. This event therefore, helped to give impetus to developing the next step of the policy process, with a public consultation event arranged for in November of that year. This was an opportunity to raise the profile of violence prevention as a health issue, to increase engagement in the response and to present the draft violence and abuse prevention framework / policy for public comments and feedback.

This event was organised following a series of meetings with the Director of the Division overseeing the violence work, and the organisation and follow up was supported by policy officials in this division. In the late summer, and early autumn, I completed the rewrite of the draft violence and abuse framework for an in-house presentation with Department of Health colleagues on the 18th September for their feedback and suggestions on the draft report. This was followed by an email circulated to relevant DH colleagues from the Director of the Division, for them to add comments to ensure alignment with existing and developing policy. See the email in Table 41 below requesting for DH contributions. Once feedback had been collated from DH colleagues, it was then circulated to relevant colleagues in Other Government Departments, for them to add contributions and ensure alignment with their policy areas, as was the usual procedure for all cross- governmental policy making. The strength of this process is that consensus and coherence is developed across multiple policy areas.

Table 41 - Email requesting contributions from policy officials

Dear All,

Reminder for contributions by 7th Oct

Please find attached a draft Framework for Violence and Abuse Prevention for your comments and views.

This initiative arose from work across government that led to the publication of the Tackling Violent Crime Action Plan earlier this year. The commitment to work on violence prevention was reiterated in *Health inequalities: Progress and Next Steps* in June this year. The need to work on violence prevention has been given added impetus by the work of Knife Crime Taskforce over the summer.

The estimated cost of violence to the health service is over £2 billion each year - greater than alcohol, smoking and obesity. The Department of Health and its delivery partners have a significant role in the early prevention of violence and abuse and there is much to gain in health and well-being as well as economic benefits.

The attached draft report takes a public health approach and summarises the scale and nature of the problem, the impact upon well being (including health), risk factors and includes a summary of the evidence base. Based upon previous policy mapping and considering the most effective approaches for early prevention, the last section contains potential priority areas to take forward under the following headings:

- Ensure a Positive Start - connected families
- Skills for Safe, Connected Individuals and Relationships
- Create Safe, Green, Connected Communities
- Working Together for Safer Communities

I should be grateful for your comment and contributions to the whole draft, but focusing particularly on the final section to:

- **comment on the potential priority areas**
- **provide a summary paragraph of current related policy initiatives and developments and, if relevant, provide a case study or good practice example**
- **identify gaps in policy where further work could be developed to prevent violence (this will not necessarily be included in the final document)**

Please forward on to other DH colleagues where their work covers any of the above areas

As we are on a tight timescale - we plan a significant engagement event on 25th November - I should be grateful for feedback **by 7th of October at the latest.** This will then be circulated to OGDs for further comment before the 25th November event.

Please send comments to ………. (………..@dh.gsi.gov.uk) and cc Jo Nurse, (Jo.Nurse@dh.gsi.gov.uk) - <u>NOT TO ME</u>.

Many thanks for those who have already contributed to this process and who attended the workshop on the 18th Sept.

Director of Health Inequalities and Partnership

However, this approach means that policy tends to develop incrementally under any particular government, with a general levelling of policy content, which represents the middle ground rather than new or extreme perspectives. Moreover, this process requires resources (a temporary staff member had to be hired to assist with the process), and is very time consuming and therefore not so flexible in its response to urgent issues. As different Departments have varying priorities and agendas, and perspectives on utilising evidence, the emphasis given to the evidence base within policy is not placed as the central factor for making decisions about which areas to include or not – this will be explored more in the chapters on the role of public health and actors. A particular weakness of the consensus style of policy making, is that multiple policy players make contributions, which can lead to a document that is relatively un-strategic and unclear, with multiple priorities covering many agendas.

As a consequence of the summer riots, in November 2008 the consultation event was held to present and discuss the draft Violence and Abuse Prevention Strategy and allowed for feedback and comments from external stakeholders, both during the event and afterwards on the website. This was framed by policy officials as the main external consultation process on this policy – all policy requires a period of public consultation, usually for a minimum period of 3 months. The event involved presentations by Health and Home Office Ministers, the WHO and the NW region and by myself where I presented an outline of the draft report. Workshops were also held to collate feedback on the report; (see the ministerial briefing and agenda for the consultation event below). Further email feedback was collated by a policy official and informed the next stages of re-drafting this report taken forward by policy leads with the support of a public health consultant who was hired to facilitate the next steps for this work.

The ministerial briefing, see table 39 for the consultation event was prepared by one of the policy officials in the Division covering violence and is routinely cleared by Divisional Directors. This is filled out in a typical template for completing ministerial briefings. In this

case, the briefing recommends that the minister gives a speech with the background context and description of the day's proceedings, including whom the main speakers and events are and the main messages they will be conveying. In order to influence the ministerial perspective, the use of experts and evidence in the briefing is used to convey the robustness and credibility of this work. The majority of briefings also mention the economic costs of an issue, which although relatively low down at point 9, it is positioned as the final convincing point, in case the minister needed any further persuasion.

Table 42 - Ministerial briefing for the Violence Prevention Consultation and Engagement event

To: PS (H)

From: Head of Children,
Families & Social Inclusion Programme
Child, Families & Maternity Partnership

Date: 19th November 2008

Cleared by: Director of Health
Inequalities and Partnership

Violence & Abuse Prevention Framework Engagement Event, 25th November

Issue

You have been asked to speak at the Violence & Abuse Prevention Framework engagement event, on 25th November, 2008 in London.

Timing

1. Routine.

Recommendations

2. That you accept. The final agenda is attached at Annex A, and suggested draft speech is attached at Annex B

Background

3. The engagement event will be held at Prospero House, 241 Borough High Street, SE1 1GA. The purpose of the day is to set out the context and work to date on the Violence & Abuse Prevention Framework and to gain input and engagement from stakeholders

across the public and third sectors. It provides an evidence-based framework for the best areas to intervene to prevent violence and abuse from occurring in the first place.

4. Experts will present on the global impact of violence and some good news stories / egs of what works in reducing youth violence, World Health Organisation (WHO) typology/ definitions, prevalence, trends, cost, educational, crime and health impacts of violence and abuse. There will be workshops in the afternoon with leading experts such as Professor Jonathon Shepherd and his violence prevention work in Cardiff. The workshops and afternoon plenary session will provide an opportunity for questions and discussion, there will not be a Q&A session.

5. The order of the day includes Dr. David Meddings, from the WHO in Geneva, will be speaking in the morning, setting out the global perspective on violence prevention. The Attorney General will provide an overview of the Governments response to violence and abuse, and in the morning session a video will be shown, 'Leaving,' a social film drama with Bafta Best Actress nominee Kierston Wareing. 'Leaving' was produced in partnership through the Wiltshire PCT, Police, Council, NSPCC, Probation, Home Office, Swindon Women's Refuge, and others to highlight the attempts of a victim to leave an abusive relationship. It is used as a training tool and was produced by Glennie McIntosh and Omni Productions. It has just won the short film award at the International Film Festival in London. Dr. Jo Nurse will provide an overview of the Violence and Abuse Framework. The morning session ends at 12:30.

6. In the afternoon, the Director of Health Inequalities and Partnership will chair the session and provide the opening remarks from 13:30-13:40pm. You have been asked to provide a ministerial speech for 10 minutes from 13:40pm-13:55pm, outlining health's contribution to addressing violence and abuse.

7. Following your speech there will be a performance from the Kids Company. The Kids Company is a charity founded by Camila Batmanghelidjh in 1996 in order to provide practical, emotional and educational support to vulnerable inner-city children. Many of the 12,000 children who come to Kids Company have experienced severe and multiple trauma. Often these are 'lone children' living in chronic deprivation, with little or no support from the adults in their family; some are young carers struggling to look after younger siblings or parents who are unable to care for them. Five girls (year eleven) have prepared a performance on gangs and knife crime, including a song that they have written for this event. Their performance ends at 14:25pm followed by a coffee break.

8. This Violence & Abuse Prevention Framework arose from work across government that led to the publication of the Tackling Violent Crime Action Plan earlier this year. The commitment to work on violence prevention was reiterated in *Health inequalities:*

Progress and Next Steps in June this year. The need to work on violence prevention has been given added impetus by the work of Knife Crime Taskforce over the summer.

9. The estimated cost of violence to the health service is over £2 billion each year - greater than alcohol, smoking and obesity. The Department of Health and its delivery partners have a significant role in the early prevention of violence and abuse and there is much to gain in health and well-being as well as economic benefits. It is anticipated that following the discussion and engagement, further revision of the Violence & Abuse Prevention Framework will take place before final publication.

Conclusion

10. That you attend and speak. The agenda is attached at Annex A and suggested draft speech is attached at Annex B.

Handling

11. There may be some media interest linked to the International End Violence Against Women Day, and pending any announcements on a national cross-government Violence Against Women (VAW) Strategy. Refuge is hosting a sixth Annual Conference on Domestic Violence on the 25th that the Solicitor General is speaking at.

Head of Children, Families & Social Inclusion Programme

Child, Families & Maternity Partnership

ANNEX A

(Department of Health logo: DH Department of Health)

Final Agenda

Towards Healthier, Fairer and Safer Communities
- Connecting People to Prevent Violence

A Framework for Violence and Abuse Prevention

Prospero House, 241 Borough High Street, SE1 1GA

Tuesday 25th November from 10:00 - 4:00pm

9.30 – 10.00 Registration & Coffee

10.00 – 10.10 Opening remarks by the Chair
Christine Mann, MA, RGN, CMB, RHV, BAC (Accred)

10.10 – 10.40 Violence and abuse trends and impact in England
Professor Mark Bellis, Director of NW Public Health Observatory

10.40 – 11.00 A global perspective of violence and abuse
Dr David Meddings, FRCPC (C) MHSc, Department of Violence & Injury Prevention and Disability Noncommunicable Diseases & Mental Health, World Health Organisation, Geneva

11.00 – 11.30 Ministerial address
Providing an overview of Government responses to Violence and Abuse
The Attorney General, the Rt Hon the Baroness Scotland QC

11.30 – 12.00 Screening of the powerful social film drama *Leaving*
Introduction by Ian Glennie, MA (Cantab), Dip M, MCIM, MIPR Managing Director, Glennie McIntosh and Executive Producer, Social Film Drama

12.00 – 12.30 The Framework for Violence and Abuse Prevention
Dr Jo Nurse, Consultant in Public Health, National Lead for Public Mental Health and Well Being, DH

12.30 - 13.30 Lunch

13.30 - 13.40 Opening remarks by the Chair
Mark Davies, Director - Health Inequalities and Partnership

13.40 – 13.55 Ministerial address
Providing an overview of health responses to Violence and Abuse
Ann Keen, Parliamentary Under Secretary for Health Services, DH

13.55-14:25 Performance by the Kids Company
Kids Company is a charity founded by Camilla Batmanghelidjh in 1996 in order to provide practical, emotional and behavioural support to vulnerable inner city Children and Young People.

14.25 – 14.40 Tea & Coffee

14. 40 – 15:45 Workshops

Workshop format
Presentation for 15-20 minutes followed by discussion and feedback about how to take this work forward for 40-45 minutes

1) Ensure a Positive Start – Connected Families
Kevin Browne, Ph.D., C.Psych (foren), C.Biol, Professor of Forensic and Child Psychology, University of Liverpool

2) Skills for Safe, Connected Individuals and Relationships
Graham Robb, Member of the Youth Justice Board, former Head teacher and adviser to DCSF on behaviour in schools

3) Create Safe, Green, Connected Communities
Professor Phil Wheater, Head of Department, Environmental and Geographical Sciences, Manchester Metropolitan University

4) Working together for Safer Communities
Jonathan Shepherd CBE FMedSci, Professor of Oral and Maxillofacial Surgery, Director, Violence Research Group, Cardiff University

15.45 – 15.55 Plenary session

15:55 – 16:00 Closing remarks by the Chair

It can be seen that a lot of emphasis is placed upon ensuring a positively visible event for ministers to attend, which is why the event was held to coincide with the International Day on Violence Against Women. At the end of the relatively dry evidence based presentations, a powerfully emotionally based video was shown to stimulate greater engagement of stakeholders on the importance of this policy area and facilitate discussion as partners broke for lunch. In order to stimulate a feel good factor and positive end to the day, a children's theatre company came to perform. This illustrates the need for ministers to ensure positive media coverage and avoid risky negative coverage, as essentially, their political position is vulnerable to electorate opinion. Section 11 describes the media handling of the event, where at times, this

section is used to describe possible media risks, which was not perceived to be the case for this event.

Additionally, in the autumn of 2008, the report 'Health Inequalities and Next Steps' was published, this set the framework for future inequalities work within the Department of Health – which was seen as a higher level, cross-cutting policy agenda. Within the report, it highlighted the impact of violence and abuse on health and stated that the Home Office and Department of Health will lead on the development of a Violence and Abuse Prevention Strategy, focusing on early intervention approaches. I was involved in a series of regular discussions with officials and meetings with the lead official on how to take this work forward, which involved negotiating what was feasible to do from a policy perspective and what was reasonable to ask Health and Local Authorities to do. This report helped to bring violence prevention into the mainstream public health agenda and further embed this into the expectation of future policy development.

One of the key challenges up until this stage, was the relative lack of capacity to take this agenda forward. However, following on from the violence prevention strategy consultation event, at the beginning of 2009 until the end of 2010, the Division responsible for violence, hired a Full -Time Public Health Consultant to work on violence and abuse prevention – previously I had been doing this work on approximately 1-2 days a week as part of my public mental health role. By increasing capacity on this agenda allowed the violence and abuse prevention framework to be developed to the next stage and taken through all the policy clearance processes described in fuller detail in the results chapter four on the policy process. The Inequalities and social inclusion division paid for and directly line managed the public health consultant; (they lead on the violence and abuse policy – it was moved from the mental health directorate when the director who supervised the Victims of Violence and Abuse Prevention Programme moved to head up the inequalities and social inclusion directorate).

This illustrates a greater degree of commitment by the Directorate to take this agenda forward and importantly, the longer term ownership of this policy area. I continued to maintain a role on the violence and abuse prevention policy work by joint -supervising the public health consultant and advising the main policy lead. However, this reflected a key point in that there was a policy lead now responsible for taking forward the development of the violence and abuse prevention policy. This ensured longer term commitment to this agenda within the DH, and the continuity of this policy development after I took a career break in 2010.

However, during 2009 there were multiple reactive policy requests to contribute to Home Office Policy, which delayed taking forward the violence and abuse prevention policy. The

Home Office had a new minister who actively championed the development of a cross governmental strategy on violence against women and girls. This policy agenda, along with the completion of long overdue guidance for Sexual Assault Referral Centres and continued input into the knife and gun crime agenda created significant work load for the public health consultant, who had to respond to constant short deadlines and reactive demands. Unfortunately, these policy areas made little contribution to the prevention aspect of violence and abuse, mainly focusing on treatment and containment. However, it meant that a public health approach was incorporated into mainstream violence and abuse policy, and was seen to be of value by the policy leads supervising this work.

In the run up to the General Election the following year, the Home Office Minister who was driving the policy work on sexual violence ensured the publication of the Guidance for Sexual Assault Referral Centres – led by the Home Office in the autumn of 2009, (HO, 2009). This was followed shortly by the publication of the Cross- Government Strategy on Violence Against Women and Girls (Home Office led) in March 2010; (HO 2010). Both these policy reports had considerable input from the public health consultant and again helped to embed a public health approach within mainstream cross governmental violence policy.

However, these time consuming and demanding policy agendas, compromised the timing on completing the updated version of the violence and abuse prevention policy. During 2009 – 2010, due to multiple competing deadlines and perceived relative higher priorities, by the policy lead, the violence prevention strategy was updated at a relatively slow pace. The Public Health Consultant, ensured the comments from the consultation event were incorporated and circulated the revised version to policy leads in the DH and Other Government Departments.

The repeated concerns raised by many of the Non – Government Organisations from the consultation event focused on four main areas, including: 1) the gender neutrality/power imbalance – with the need to convey more the relative gender imbalance in how violence and abuse are experienced and perpetrated. 2) the discomfort with the cycles of violence model – which was a model conveying the life course perspective on patterns of violence and abuse – this was perceived as being too deterministic; 3) the links made between alcohol and the causality of violence and abuse - though reported as associated rather than causal, they were interpreted by some feminist NGOs as meaning that alcohol could be seen as an excuse for perpetrating violence; 4) the absence of feminist and voluntary sector references – which had not been included as this was an evidence based report, and most studies from this background were insufficiently evaluated, however, good practice case studies by NGOs had been included. These illustrate the contrasting perspectives from the feminist NGOs with the public health evidence based approach, which are explored further in the next chapters.

However, the views of the policy leads in the Department of Health and Other Government Departments, relatively took more precedence than those from the external consultation, which were generally perceived as representing more extreme sectors of society compared to the mainstream electorate. Despite this, their concerns were perceived as important to sufficiently address, as they could generate negative publicity for the final policy.

It was decided by the Director of the division to aim for a cross- government policy as many of the levers for prevention were outside of the health sector. Therefore, the draft policy was circulated for comments to policy leads in the Department of Health, the Home Office, the Ministry of Justice, Department for Communities and Local Government, Department for Environment, Food and Rural Affairs. Gaining feedback from policy leads included a mixture of comments on the draft document and holding individual meetings with relevant leads to ensure policy consensus and accuracy of data. The process of gaining policy consensus and clearance mechanisms were highly repetitive and time consuming and are outlined in detail in the fourth results chapter. Additionally, without strong ministerial backing and expectation to drive this process, other priorities took precedence which slowed this process down. As will be seen, unfortunately, these competing demands, essentially, compromised the ability to finalise this policy document within the political term of the Labour Government.

As was usual practice, from the end of March 2010 the period of purdah started before the general election held in May 2010. The violence and abuse prevention report had very nearly achieved all the final clearances for publication by the end of February, as can be seen by the ministerial letter from the Department of Health to the Secretary of State for Justice. This letter formally requests cross- governmental ministerial clearance of the final policy report, after it had been cleared by all the relevant policy leads. Although, the Department of Health were seen to lead on policy for violence prevention, the Ministry of Justice /Home Office were still seen to be the overarching leads on violence policy, which is why the letter is addressed to the most senior minister in the Ministry of Justice and copies in the Prime- minister and Ministers from Other Government Departments.

From Ann Keen MP
Parliamentary Under Secretary of State for Health

DH Department
of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
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The Rt Hon Jack Straw MP
Lord Chancellor and Secretary of State for Justice
Ministry of Justice
102 Petty France
London
SW1H 9AJ

2 5 FEB 2010

Dear Jack,

Publishing the violence prevention document *Creating healthier, fairer and safer communities: a framework towards preventing violence and abuse*

I am writing to seek DA Committee agreement to publish the document *Creating healthier, fairer and safer communities: a framework towards preventing violence and abuse* which we plan to publish shortly. I would be grateful for responses to this letter by 15th March 2010.

An engagement event was held on 25th November 2008 to present existing evidence and information on violence prevention and to encourage wider stakeholder involvement. Producing an updated violence prevention framework document is a DH action within the cross government *Saving Lives, Reducing harm, Protecting the Public- an action plan for tackling violence 2008-11.One year On.*and *New Horizons-shared vision for mental health.* In addition, a number of other policy documents have highlighted the importance of violence prevention and abuse.

We propose to publish the document and a summary leaflet that are intended as an evidence base to support work that tackles violence and abuse across government, as well as with other organisations, sectors and partnerships. To support this we propose that the document is branded as a cross-government document and seek your agreement to this.

I would like to thank departments who have contributed to the document. If you have any queries, I ask that your officials please contact Damian Basher on damian.basher@dh.gsi.gov.uk 0207 972 3717.

I am copying this letter to the Prime Minister, members of DA Committee, and Sir Gus O'Donnell.

ANN KEEN

Despite, the high level of political support that the violence prevention policy had entertained earlier in the Labour Government's term of election, seeking to gain clearance at this late stage proved to have unfortunate consequences. During the round of ministerial clearances, the report was blocked by the Home Office and Department of Children, Schools and Families at the last minute on minor technical issues, for relatively minor concerns on whether the latest Home Office figures had been used, (even though this had been previously cleared by Home Office policy officials). More importantly, however, this reflects that ministers were becoming increasingly 'twitchy' at clearing policy just before purdah. This illustrates how the timing of policy clearance is key, ideally, most policy is developed and finalised at least 6 months – one year before a general election, as policy makers and politicians become less confident about being able to commit to a policy in the lead up to a general election. This emphasises the importance of following and influencing political cycles, ideally placing a topic on the policy agenda at the beginning of a political cycle as the policy process takes such a long time.

A new coalition government was formed with the Conservatives and Liberal Democrats in May 2010. As is usual practice, following a change of government in the subsequent months all the previous Governments' policy is archived, reviewed, changed and updated according to the new political party's agenda. Therefore, from June 2010 – March 2011 the violence and abuse prevention policy had to be re-edited to ensure consistency with the new Governments policy and all previous policy references were taken out of the document and replaced with newly developing policy areas. The report then had to be re-circulated to cross- government officials for final comments and clearance by them. The public health Minister was briefed by the DH policy lead who had worked on the policy under the previous Government. This policy lead managed to gain clearance by the Minister for the document before it was forwarded for clearance by the Sub- Cabinet Inter-ministerial Public Health Group and the Health Secretary of State.

The following section has been added following communication with the relevant DH policy lead after the completion of the official research period ended in September 2010 when I left the Department of Health on Career Break to work with the WHO.

During April 2011 the violence and abuse prevention policy had nearly been approved again as a cross governmental policy, however, this time under a new Government with a new set of Ministers. At this point, the Violence and abuse prevention policy had been approved by officials and Ministers in the Department of Health, the Home Office, the Ministry of Justice, Department for Communities and Local Government, Department for Environment, Food and Rural Affairs. However, the Secretary of State for the Ministry for Education did not approve the report, as the policy was seen by this Minister as not relevant to Education.

Additionally, at that time, this was within the context of when number ten cabinet office was denying a number of policy reports, as there were seen to be too many policies and that this would be considered to be an unnecessary burden on Local Authorities.

Because of one Minister not giving approval, confidence in the report was lost, and at this point the Department of Health Public Health Minister also withdrew their support, and the policy was withdrawn, apparently completely. There were a number of discussions held between policy leads, about how best to incorporate this work into other relevant policy areas, for example the work on inequalities, offender health, families with multiple problems and also on gender based violence which was still supported by the new government. However, although it was important to incorporate relevant aspects into other policies (as had already been done), this weakened the comprehensive approach on the prevention of violence and abuse by not having a specific policy that brings together actions on a wide range of violence and abuse. This illustrates the power of consensus making in the policy making process, although agreement had been gained by six ministers from different government departments and their related policy officials, it only took one minister to object for the whole process to be completely rejected.

Then during the summer of 2011, a series of violent riots erupted across London and other major cities across England. This generated a lot of publicity and the media and political expectation for the Government to do something about it. This created an important window of opportunity for the violence prevention policy, and briefing was provided by the DH policy officials on the Violence and Abuse Prevention policy as part of the solution to prevent such events in the future. This acted as a key driver for high level political interest in this agenda again and enabled ministerial support to bring the violence and abuse prevention policy back to life. Once government had officially returned in the autumn, of October 2011, the Secretary of State for the Department of Health gave his approval for developing the Violence and Abuse Prevention work, this time only as a Department of Health policy rather than a cross-governmental policy.

A repeat of the policy making process ensued, following the Secretary of State approval, and during November - December 2011 policy consensus was again established. This was done by circulating the document to relevant policy officials and data was updated, first starting with other divisions within the Department of Health. Unfortunately, in order to ensure policy coherence, one division requested that the document undergoes the complete approval process again, including consulting other government departments on every policy that involved them. This in effect slowed the whole process down as the report now had to go through the complete policy clearance process again and illustrates the importance of consensus making in the policy

process, this time with one relatively junior policy official being able to stall and influence the whole process. This request could potentially have jeopardised the final completion of this policy, as the Government Departments were all undergoing major transformation and significant cut backs, with a reduction in DH staff from approximately 5,000 – 3,000. It was particularly fortunate that the policy lead who had responsibility for the violence prevention policy since the consultation event in 2008 still remained and continued to be personally committed to ensuring its final publication.

The period from January – September 2012 involved updating and rewriting the violence and abuse prevention policy. As the complete cross- governmental policy clearance process would have taken too long, it was decided to keep the violence and abuse prevention policy as a Department of Health policy only, and to minimise the risk of it being rejected again. Additionally, as there were significant cut backs to staffing levels within the Department of Health, including the public health policy advisor / consultant who had worked on this, (who had left in March 2011), it was decided to ask the NW Public Health Observatory to update the report. It was then circulated for policy feedback and to complete the final clearance process.

With the continued backing of the Secretary of State for health, eventually, in October 2012, the final clearance was achieved for the DH publication of the violence and abuse prevention policy: 'Protecting people promoting health – a public health approach to violence prevention for England' – this time with no further obstacles. In November 2012, the final publication of the Violence and Abuse Prevention policy on the DH website occurs. This is done without any official launch event or publicity of the event.

This report was jointly published as a NW Public Health Observatory publication, and framed as the evidence base to support health and local authorities to act on violence and abuse prevention. The status of the policy can be seen to be relatively low level, with no political commitments or funding streams assigned to this work. By framing it as a Public Health Observatory publication, it also can be perceived as less of a responsibility of central government and of less relevance to Other Government Departments. However, this reflects and is in accordance with the general approach to policy of the Conservative – Liberal Democrat coalition Government, which places greater emphasis on de-centralising responsibility.

Public Health England was officially launched in April 2013, as a Department of Health Agency tasked with the implementation of policy. Contact with the DH policy lead on violence says that Public Health England plans to establish a task group to take forward the work on

Violence Prevention. The early structure of Public Health England includes a programme on Injury prevention, which includes taking forward the violence and abuse prevention policy.

5.6   Discussion and General Reflections

This timeline illustrates the long process for the development of national policy, originally initiated with the World Health Assembly resolution and governmental commitment to strengthen approaches on violence prevention in 2003, followed by the first official Ministerial letter to develop a public health strategy on violence prevention in 2006. However, the formal process for gaining policy consensus across several sectors is extremely time consuming, with the additional changes in emphasis brought in by a change in government, which lead to the policy clearance process needing to be re-done from the beginning. The power of one sector or person from the policy clearance process not giving their approval essentially broke the whole process, twice.

Lastly, the importance of jumping at windows of opportunity to push a policy agenda can be seen as highly fruitful – and gaining the most senior ministerial support in this process to ensure that commitment continues to the very end. From a less visible perspective however, the continued persistence of a handful of dedicated policy leads and advisors, throughout the process was instrumental in ensuring the final publication of this report. These committed individuals, came and went, changing over the passage of time, of which I played one part, in an informal network of committed civil servants. The whole process took ten years from 2003 – 2012 to complete from putting on the policy agenda to publication of the final policy report.

The regional and national case studies also illustrate the importance and relationship of incorporating relevant aspects of a subject within mainstream strategies and policies to raise background awareness to wider audiences in high level policy and assist in delivery. However, it also strengthens the approach to a particular subject to develop a focused policy on that particular subject area i.e. the violence and abuse prevention policy – which gives particular attention and commitment to the topic and increases understanding of the subject matter.

Additionally, the regional case study illustrates the translation of national policy into the delivery of policy at regional and local levels, and the role that local and regional level good practice can influence upwards (albeit with persistence), the formation of national policy. Whilst the national case study provided opportunities to understand the policy making process from an insider perspective and provided deep insight into the process. The fourth results chapter provides more detail of the policy formulation process and the interactions that occurred around them that give further insight into the policy making process.

5.6.1 Barriers and Opportunities of a Challenging Issue

At regional level, there were a number of opportunities and barriers that influenced the uptake of violence and abuse prevention approaches and policy development. The main opportunities related to support from the Home Office who drove and funded many partnership activities and opportunities to mainstream relevant aspects at national level and into the regional health strategy and the offender strategy. A reoccurring challenge was the difficulty in conveying the complex and multi-factorial issues of violence and abuse that are difficult to understand, especially the relationships of risk and prevention approaches across the life course. This acted as a conceptual barrier with many NGOs and a challenge for Government Department officials who mainly responded to the immediate challenges of the consequences of violence and abuse.

A wider cultural barrier relates to the taboo nature of violence and abuse that led to reactions of disbelief and denial that the prevalence of abuse was so high – especially compared to the relatively small numbers reported to child protection services. Additional barriers included the lack of awareness of the issue as much of it is hidden, and a lack of perception of violence and abuse as a public health issue with many of the levers being seen to be outside of the health sector. In contrast, however, the relatively rare but highly visible forms of violence, including gun and knife crime, acted as windows of opportunity to drive this agenda forward and gain high level political support which proved to be instrumental in this policies final publication.

Key findings for objective one on what has been the general development of violence and abuse prevention policy over time is summarised in the Table 43 below. The next chapter goes on to explore the specific contribution that public health made to this policy development, and is then followed by a chapter on the particular role of different actors. The last results chapter, provides a more in-depth analysis of the policy formulation process.

Table 43 - Summary of key findings for results one: What has been the general development of violence and abuse prevention policy over time?

- **Regional and national roles:** regional and local level are usually tasked with the implementation of policy, however, they play a key role in translating national policy and can contribute actively to bringing innovative practice to stimulate policy agenda setting and to be incorporated into national policy formulation process.

- **Barriers and opportunities of a challenging issue:** much violence and abuse are hidden in society and public health has a role in increasing visibility and understanding to ensure action and preventive measures can be taken. However, knife and gun crime are highly visible and generate a lot of media attention – on two occasions this created windows of opportunity for policy to be taken forward on violence prevention.

- **Embed within relevant policies:** developing specific policy on an agenda takes time, especially for a challenging public health issue; by including mention of violence prevention approaches and policy within relevant health and other sector policies helps to mainstream a marginal issue and keep it on the policy agenda.

- **Policy story line – a ten year process:** the policy development process, from the initial initiation, to the formulation and final publication, can take a considerable period of time, with delays created by the consensus making and clearance process and political cycles. This is especially true for a challenging issue like violence and abuse prevention, which is poorly understood in society.

Chapter 6 – Results - Two: To describe the public health contribution to violence and abuse prevention policy

Research question: What has been the public health engagement with violence and abuse prevention policy?

Objective two describes the main ways that public health has contributed to violence and abuse prevention policy. This chapter starts by outlining the public health contribution to the content of violence and abuse prevention policy, with an overview of the main findings from the mapping and documentary analysis. It examines the different levels of prevention according to the ecological model used in violence prevention, and primary, secondary and tertiary prevention used in mainstream public health. This research helped to inform gaps in policy and helped to shape priorities, and the process for doing so is described. The content and levels of violence prevention in key related violence policy is then analysed to illustrate the wider contribution of public health (or not) in the formation of violence policy that formed part of the journey to the final prevention policy.

Next, the contribution of the UK Faculty of Public Health Competencies (summarised in the Public Health Framework), in the development of violence and abuse prevention policy are described. These focus more on the skills and functions rather than on prevention content. The framework is used to provide a structure for the analysis. This is followed by an in-depth analysis of the role of the scientific, evidence based skills of public health used to inform and influence policy with a description on how this contributed to final policy and is based upon observational and documentary analysis. Lastly, what can be described as the 'art' of public health is explored, with a discussion on the barriers and opportunities for public health to contribute to this agenda. This is based upon observational and documentary analysis and the main findings from a public health expert round table presented. The following chapter, objective three describes in more depth the relative contribution, dynamics and role of the main actors, including the public health actors.

My role in as senior civil servant and senior policy advisor in this process is specifically described where relevant in progressing this policy. However, wider reflections are made from observations of the overall policy making process.

6.1 The Public Health Contribution to Different Levels of Prevention in Violence and Abuse Policy – *Prevention Balance and Priorities*

The following section summaries main findings from the mapping based upon the violence and abuse prevention framework. It firstly illustrates the main areas of policy emphasis according to different government departments, then within the framework itself, highlighting the areas of prevention coverage by primary, secondary and tertiary prevention. Then the main gaps in policy coverage are illustrated according to the different prevention levels, followed by how this informed priority areas for the development of the violence and abuse prevention policy. These priorities also informed how public health contributed to other relevant policy areas, some of the key policies are described as examples. Annex V summarises the results from the mapping exercise, which are based upon the following headings in Table 44 below:

Table 44 - Summary of headings for the violence prevention mapping, (see annex V)

Area related to the ecological model/ life-course	Evidence for violence prevention	Policy/ programmes and approaches	Delivery agents/ actors	Progress/ Coverage
Societal and community interventions relevant for all age groups				
Children 0-10 years – general population				
Children 0-10 years – high risk populations				
Adolescents 11-19 years – general population				
Adolescents 11- 19 years – high risk populations				
Adults – general population				
Adults – high risk populations				

I reviewed the research findings from the documentary analysis and cross validating them with the mapping work in order to develop the below Table 45. This summarises the main policy emphasis (in 2009), related to the different groupings of violence prevention that are frequently used in public health approaches to violence and abuse prevention (Krug, 2002). The lead Government Department for each policy area is also described. A number of gaps were identified, and reflected in the blank parts of the table and include dating violence, and bullying and violence in the workplace.

Table 45 - Main areas of policy coverage for violence prevention

Type of Violence/ Abuse	Policy emphasis and lead department
Child Sexual Abuse	**Child Protection focus – Department for Children, Schools and Families, DCSF**
Child Emotional Abuse	
Child Physical Abuse	
Neglect	
Bullying - Children	**Schools main focus - DCSF**
Youth Violence	**Knife, gang and gun – Home Office**
Dating Violence	
Sexual Assault	**Sexual Violence Action Plan – Home Office**
Partner Violence/ domestic violence	**Violence Against Women and Girls Strategy – Home Office**
Bullying – Work place	
Violence – Work place	
Alcohol related violence/ Night time economy related violence	**Alcohol Strategy - Department of Health - DH**
Elder abuse and Learning Disability	**Protection focus (DH)**

The main areas of policy emphasis found in 2009 were then mapped onto the violence and abuse prevention framework, using red highlights in the text to visually illustrate where the

main emphasis in policy was according to the life course and different levels of prevention, (see Figure 23). Overall, this illustrates that there are a number of primary prevention (or societal and community approaches from the ecological model), across the life course.

These are mainly led by the Home Office, and include partnership working in the form of Crime and Disorder Reduction Partnerships, community awareness campaigns and help lines. The main contribution to primary prevention from the health sector was in the form of work on addressing inequalities and home visitation and parent training programmes. Many of these programmes are targeted on high risk groups and merge into secondary prevention, for example, brief interventions for alcohol reduction.

Figure 23 - A summary of emphasis of policy content according to different levels of prevention for violence and abuse; (note -framework developed in 2007; policy highlights relevant to 2009)
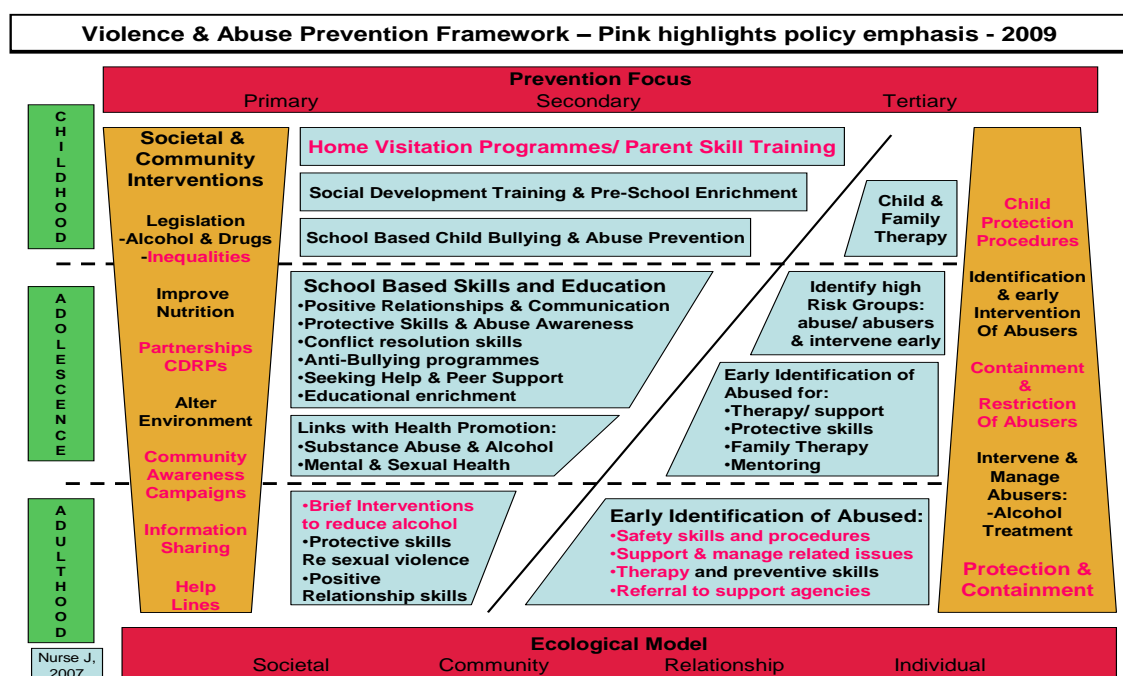
The analysis found that the coverage of prevention policy was very patchy, with the main emphasis by the government department leading on violence and abuse (the Home Office), as one of tertiary prevention, with its main focus on containment. Additionally, the Department of Children, Schools and Families, mainly focused on policy for tertiary prevention with the main emphasis on child protection. The Department of Health's main policy involvement in preventing violence has focused on identification and treatment for victims and the protection of vulnerable individuals.

Other departments (Department for Communities and Local Government and the Department for Farming and Rural Affairs) saw violence and abuse as less central to their policy areas.

However, they had more potential influence on addressing the wider determinants with primary prevention approaches. The following chapter explores in further detail the role of different actors and sectors in violence and abuse prevention.

The following stage of analysis identified the main gaps in policy or policy coverage from the mapping tables, (see appendix for further details). This was further validated by discussion with policy leads. A summary of gaps of violence and abuse interventions are highlighted in pink (with font in white) in Figure 24. There is some overlap of areas that are relative gaps and areas where policy was being emphasised as this was an area identified as a relative gap, for example on information sharing and partnership working.

Figure 24 - Mapping of Gaps in Policy on the Prevention of Violence and Abuse
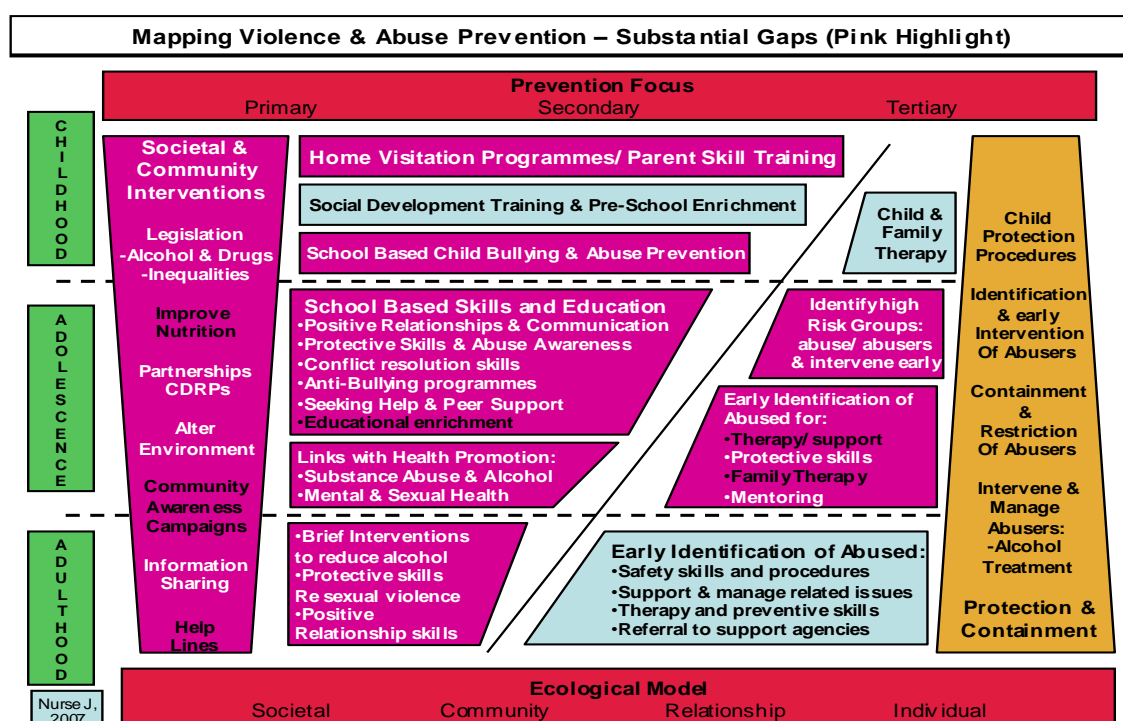
Overall, the main areas where there is little policy coverage in comparison to the evidence based areas summarised in the violence and abuse prevention framework, included interventions with a greater focus on primary and secondary prevention that occur earlier in the life – course. As described earlier, as the main Home Office data is on the adult experience of violence and abuse as opposed to that experienced in children and young people, much of the activity focuses on adults. However, the international literature highlights that most violence and abuse occurs in earlier years, and therefore interventions for prevention need to focus earlier on in the life course. A key part of the public health contribution was to provide evidence of this relationship and facilitate a shift in intervening earlier. This was achieved by

repeated presentations and discussions with key policy leads, especially in the Home Office and Department of Health.

In particular, the relative gaps in evidence compared to policy coverage found for Societal and Community interventions, included: legislation to reduce availability to alcohol; progressive taxation policies to address inequalities; altering the built environment to make safer communities; and information sharing, for example, anonymous information sharing of violent assaults in Emergency Departments with the Police and Local Authorities to inform local strategic action – this was extended as policy after this mapping was conducted.

Whilst the relative gaps in evidence compared to policy coverage found for children and young people, included: Home Visitation Programmes and Parent Skills Training – some targeted programmes existed, however, this was against a backdrop of year on year reductions in health visitors. School based programmes to address bullying and abuse in younger children and develop skills in violence prevention in adolescents tended to be project orientated with short term funding, had variable coverage and were not substantially incorporated into the national curricula. The other relative gap was in intervening early with high risk groups with protective skills and mentoring, for example for children in foster care.

There was greater coverage in policy found for adults, however the main relative gaps were in the areas of developing training for staff, protective and positive relationship skills, especially for high risk groups, for example, those with disabilities, serious mental illness and the elderly. Additionally, coverage for brief interventions for alcohol was mostly in the pilot stage and at that time had not been scaled up substantially.

The gaps identified helped to inform priority areas for the development of the next stage of the policy development on violence and abuse prevention. The gaps and potential priorities were discussed with senior public health colleagues, one of whom recommended establishing not more than four priority areas to improve the ability of people to remember them more easily. Based upon this and discussion and agreement with policy leads the following four priority areas were initially decided upon: Ensure a Positive Start – Connecting Families; Skills for Safe, Connected Individuals and Families; Create Safe, Green, Connected Communities and Working Together for Safer Communities.

These priority areas were then incorporated into the framework in Figure 25, which then formed the structure of the draft violence and abuse prevention policy, (DH, 2008). These areas are still reflected in the final violence and abuse prevention policy, 'Protecting people

promoting health' (DH, 2012). However, particular emphasis was given to gang and youth violence, following the summer riots.

Figure 25 - Priority areas for Public Health Policy on Preventing Violence and Abuse
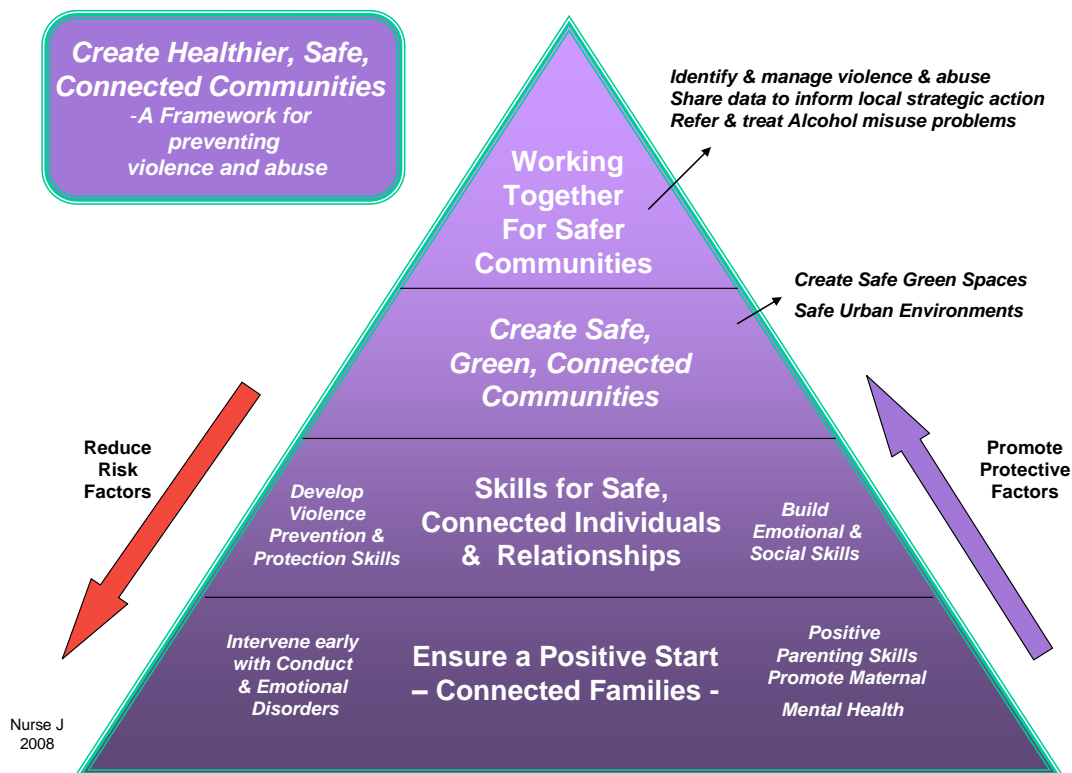
Additionally, these priority areas and a public health approach were used with variable success to shape other relevant policy areas that influenced violence and abuse prevention. Examples are given below from the documentary analysis, to illustrate the main areas that a public health approach to prevention was able to contribute to related policy. However, aside from the Public Mental Health policy (that I led on), there was limited success in addressing policy gaps identified and in embedding a substantial approach to public health and prevention. This was mainly related to the agendas and prime drivers for the related policy areas being focused more on issues related to reducing risk, tertiary prevention, containment and protection, and essentially dealt with the visible consequences of violence and abuse.

For example, the earlier guidance document, Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Abuse' Programme Implementation Guide for the Victims of Violence and Abuse Prevention Programme (VVAPP); (DH/ NIMHE/ HO, 2006). The main focus of this document and programme was on improving services for victims of domestic violence and sexual abuse, mainly covering tertiary prevention approaches. However, the

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Public Health angle was used as part of the central justification and aim for the programme (see Table 46 below), and laid the ground for developing the Violence and Abuse Prevention policy.

Table 46 - Excerpt from the Victims of Violence and Abuse Prevention Programme, 2008

> *The Victims of Violence & Abuse Prevention Programme (VVAPP), was established in 2005 until 2008 and was developed in response to the high prevalence of domestic and sexual violence and abuse and the evidence of mental and physical ill health associated with this. The intention of the programme is to tackle the root causes of mental and physical ill health in child abuse and domestic violence as set out in the Public Health White Paper's (2004) cross government strategy on these issues.*

This was followed by a series of DH led guidance documents that tended to focus on tertiary prevention, for example, links between sexually abusive behaviour and severe personality disorder, (DH 2006); the treatment of young people who sexually abuse, (DH, HO, 2006); and guidance on responding to domestic abuse, (DH, 2005). Because of the primary focus on these documents being on treatment of victims or abusers, there was little scope to influence a prevention angle from a public health perspective.

There was also a series of related policy areas that included aspects that contribute to the prevention of violence, for example, the Drugs strategy, (HO, 2008); the Alcohol strategy (DH, 2007); the child health promotion programme, (DH 2008). However, these links were rarely explicitly made in the documents, and drafts were not necessarily shared for comment with policy officials or myself as the policy lead for the report would not necessarily perceive the relevance of their agenda in contributing to violence and abuse prevention.

Additionally, there were also a series of Home Office documents that included specific public health contributions from myself in my public health advisory role. For example, earlier on, I contributed to the report: Improving outcomes for victims of sexual violence: A strategic partnership approach, (Home Office, 2005). I gave a public health presentation at the national launch of this document, however, this was an early stage of building relationships with the relevant Home Office policy leads, so there was little mention of a prevention approach within the document itself.

At a later stage, when I had built a more active relationship with the HO policy leads and explained a number of times the public health perspective, I was able to include a section on school based violence prevention interventions for dating and sexual violence as part within the

HM Government 'Cross Government Action Plan on Sexual Violence and Abuse' (Home Office, 2007). However the majority of the document focused upon tertiary prevention.

One of the more substantial public health contributions I was able to make was within the over-arching violence policy developed by the Home Office in 2008. On behalf of the DH, I had a series of individual meetings with the HO policy lead that influenced some of the eventual content and focus of this work. I spent some time explaining what was meant by prevention from a public health perspective, as prevention was mostly understood to mean what would be described as tertiary prevention by Home Office officials. They were keen to engage other sectors in their work, and I was able to change the title to: Saving Lives. Reducing Harm. Protecting the Public. An Action Plan for Tackling Violence, 2008- 11. (Home Office, 2008) in order to increase the relevance to a health audience. The plan mentioned the DH taking forward work on developing a violence and abuse prevention plan, however, there was minimal mention of primary or secondary interventions and the main document focused upon tertiary prevention approaches of containment and protection.

It was easier to influence policy reports that were the direct responsibility of the violence policy lead, as this facilitated understanding of the issues and relationship building, so that I would be actively asked for comments on related reports, for example, the Health Inequalities Progress and Next Steps (DH, 2008) summarised the main achievements in health inequalities since the Acheson Report published ten years previously. It also highlighted the next steps and included reference to the impact upon health of early adverse experiences in childhood, including abuse, and states that a Violence and Abuse Prevention Plan will be developed.

The process for including these and other similar policy components, involved a mixture of feedback on email, and follow up meetings to identify and agree the exact wording with the relevant policy lead. At times, this could then be altered or withdrawn by a more senior policy lead. Depending on the reason for withdrawal or alteration, and upon the strength of relationship with the policy lead, it was sometimes possible to reinsert relevant text. I observed that a number of policy leads, (and learnt to do so myself), with a strong interest in ensuring their area was included in a particular policy, would actively ask to check the very final version to make sure their area had not been withdrawn at the last minute.

When the public health consultant was appointed in 2009, to work within the violence team it was easier to contribute substantially to the development of policy reports, for example, the guidance document on Sexual Assault Referral Centres, (DH, HO, 2009). They also became a resource to forward on draft Home Office reports to compile DH comments, which provided the opportunity to contribute and influence a public health approach. For example, the Cross

Government Strategy to End Violence Against Women and Girls, (Home Office, 2009). The key contribution to this report, from a public health perspective, was the inclusion of girls as opposed to the initially proposed adult focus, in the strategy – in recognition of the epidemiological patterns of domestic violence and sexual abuse mainly affecting girls and young women. However, minimal mention of primary or secondary interventions were made, the main document focuses upon tertiary prevention.

In summary, a key to success in contributing from a public health perspective was based upon building trusting relationships with committed policy leads. Although many documents on violence and abuse used the term prevention, the main focus of prevention tends to be on interventions and approaches that would be called tertiary prevention, and highlights the misunderstanding around the term prevention in non- public health trained professionals. In general a small number of minor public health contributions were possible to make within relevant policies that helped to keep prevention of violence and abuse on the agenda.

However, it was only on areas that myself of the public health consultant in the violence team were actively leading on that it was possible to make substantial contributions from a public health perspective to violence and abuse prevention policy. For example, I led the public mental health policy within the Mental Health Division, and was able to incorporate significant aspects of violence and abuse prevention under the evidence based framework I developed which included a life course approach and a section on safe secure communities; (DH, 2010). Table 47 illustrates some of the policy process insights from a public health trainee attached to the public mental health programme and provides a secondary observation and cross validation of the observations I made myself for this research thesis. The insights on the role of the evidence base and the art of public health negotiation will be explored in further depth in the next section.

Table 47 - Feedback from a public health perspective to the policy process from a Public Health Trainee following their placement at DH, Oct 2009

I have gained a greater understanding of the public health importance of, the effective and cost effective interventions for, and the implementation difficulties in improving the mental health and well-being of the whole population but in particular children and young people. In contrast to some areas of public health, the evidence of the effectiveness for some of the key interventions is very strong. There is a large amount of evidence to support the effectiveness of early intervention, improving parenting, social and emotional skills training, whole school approaches, intensive support for vulnerable parents (eg family nurse partnership) family approaches (eg think family). However despite evidence, there are implementation challenges and issues which include:

- raising awareness of the evidence; evidence based commissioning; joined up working across agencies; training of the workforce; strong leadership; measurement and monitoring.
- Local areas are sometimes unwilling to take on the challenge of public mental health as it requires a joined up approach, the financial benefits do not always fall on the organisation (budget) which provides the intervention, it can take years for full benefits to be realised and the benefits are difficult to measure / attribute to the intervention.

Through all aspects of my work I have strengthened my understanding of:

- The art of public health negotiation. Public health can have a huge influence and impact by contributing to the discussion and development of national policy and guidance, PH is outside the formal civil service structure and its most effective power base is "expertise" and "ability to generate respect and empathy" (French and Raven categories)
- Importance of evidence base and effectiveness in terms of influencing policy and guidance and ultimately in having maximum impact on the health of the population
- Cost-effectiveness as an important lever in making business cases. The change in the economic climate has meant a move away from "invest to save" to a "save to save" approach, i.e. models of investment need to show savings in the very short term, 1 to 3 years.

6.2   The Contribution of Public Health Competencies

The earlier sections in this chapter describe how public health has contributed to policy development on violence and abuse prevention, mainly focusing on the contribution in terms of the content and focus of policy, in relationship to priorities and levels of prevention.

This section focuses on the contribution that Public Health Competencies have played in assisting policy development (or not). These are based upon the Faculty of Public Health Competencies that existed at the time of the research, and have been translated visually into the Framework for the Delivery of Public Health (Nurse, 2004), described earlier in the methods section. This provides a visual structure to analyse the relative strengths and weaknesses of the contribution of public health competencies to the violence and abuse prevention policy formation.

The framework (see Figure 26) was filled out initially at a sub-regional workshop in the SE region, discussed with policy leads and then updated following review of the mapping, documentary and observational analysis. The central building reflects the public health competencies and red highlights have been added to the framework to show the main areas that have contributed to the violence and abuse prevention policy. These are discussed further below. This is followed by a description of the barriers and opportunities for public health contributing to this agenda, and mainly relates the drivers, enablers and quality headings in the diagram. This also draws upon the results of a round table of public health experts that is summarised at the end of the chapter.

The framework has been filled out from the perspective of violence and abuse prevention policy, with violence prevention as the vision. The section in the centre of the 'pantheon' highlights public health core skills and functions in red that have contributed to policy development for violence and abuse prevention. The findings reveal that the majority of the public health skills (the stones above the pillars), have been used to inform policy development. These especially included the use of public health information, health needs assessment, effectiveness reviews that have been used to inform a strategic approach to planning, including priority setting, as described in the earlier parts of this chapter. These can be seen as core public health competencies and tend to be framed as the 'science of public health' and have been actively used to inform the development of the violence and abuse prevention policy. Figure 26 provides a summary illustration of the public health framework completed with findings from the research on factors contributing to public health engagement with violence prevention policy.

Figure 26 - The contribution of public health competencies to the violence and abuse prevention policy. (Adapted from Nurse, 2004)
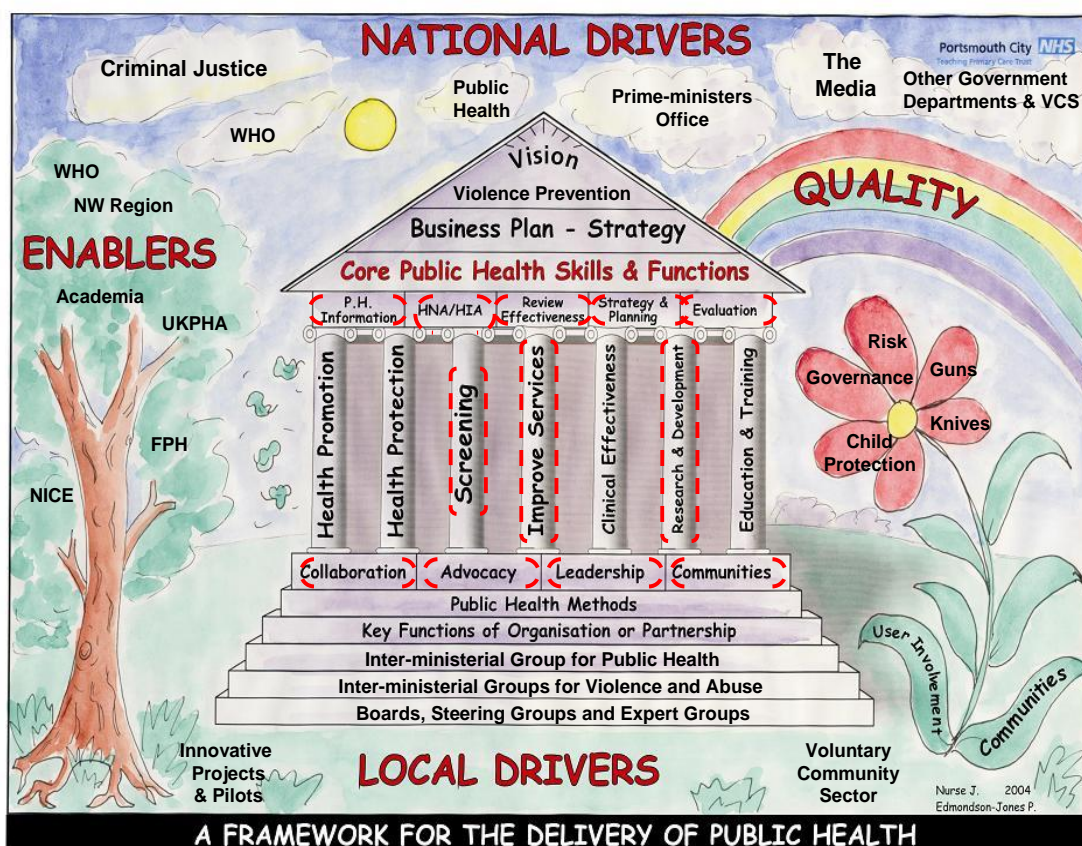
For example, public health information was used from the NW observatory for policy development, additionally information came from the Home Office. Translating and simplifying the evidence base, and the development of key messages also helped the adoption of violence and abuse as public health policy issue. This information was used to inform the assessment of health needs, along with the review of evidence of effectiveness conducted by myself, the public health consultant and also specific reviews were commissioned, including cost effectiveness studies. The main findings were then included in the draft violence and abuse prevention policy, and reflected the priority setting exercise based upon the mapping of evidence based policy gaps described earlier in the chapter.

However, a key challenge has been the relative lack of data and information on violence and abuse within the public health mainstream. In comparison, there is a lot of information from the criminal justice system and research findings, however, much of this has not been translated into a public health setting. Additionally, there are specific information gaps, for example on violence and abuse in childhood; longitudinal studies; and health outcomes of violence and abuse and following interventions.

The relative invisibility of the health impacts has then had consequences on the degree to which violence and abuse have been prioritised in comparison to other health outcomes. For example, from a mainstream public health perspective, the main causes of death in England are from cardiovascular diseases and cancers, being responsible for 100,000s of deaths each year. In contrast violent homicides account for 100s of deaths yearly, which from a public health perspective can be seen as a relatively small number, and contributes to violence and abuse being seen as a relatively marginal issue.

When mainstream public health audience's considered violence and abuse as a health issue, the main perception has tended to be upon its impact on tangible health outcomes. However, the evidence base suggests that most of its impact upon health is as a determinant of health rather than an outcome. This perception is compounded by the relative high visibility of a relatively small proportion of health outcomes are directly linked to highly visible forms of violence, for example, homicides, gun and knife violence. These receive a disproportionate amount of profile, in contrast the overall health burden is much larger when violence and abuse are also considered as a determinant of health outcomes; (Felletti et al 1998)

The contribution of the main Public Health functions, labelled in the pillars, to shaping the policy on violence and abuse prevention, however, were more limited. These pillars can be seen as the implementation areas of public health services, and were therefore less relevant to policy development and are more relevant to policy delivery. Although, the evidence for screening, or routine identification for violence and abuse within the health setting is an area that has been debated, (Taget et al 2003), it is recommended in DH guidance on domestic violence, (DH, 2005). This was in part due to pressure to take action from those (VCS, Ministers and policy leads) with an interest in Gender Based Violence, but also more importantly, due to a different paradigm about the relative importance of the evidence base compared to the need to take visible action. For improving services and clinical effectiveness, activities mainly focused upon tertiary prevention approaches, for example, guidance for Sexual Assault Referral Centres, and were developed by the public health consultant.

Additionally, the health promotion and health protection public health functions have been less engaged in contributing to violence prevention policy development. For Health promotion, some links were made with health promoting schools regarding anti- bullying programmes and violence prevention within schools, however there was little engagement with wider health promotion activities. This was partly because of lack of capacity and also the silo'd approach to developing policy and delivering health promotion programmes that made it difficult to bring in a cross cutting area like violence prevention, which can be seen as a determinant for many of the risk factors addressed in health promotion programmes. The challenge of working across

different programme areas, including across health promotion and addressing the wider determinants of health is illustrated by the observations made by a public health trainee on placement in the Department of Health in Table 48.

Table 48 - Policy Observations from Public Health Trainee at DH, Oct 2009

> Through talking and meeting with policy leads in other governments departments and through attending the cross-government drafting group I have learnt about the strengths and barriers to cross government working. Interventions to improve public mental health lie across the responsibility of multiple government departments including DCSF,CLG, DEFRA, DWP . However, close working is hampered by:
>
> - Silo working – fewer links than desirable even within the DH eg between linked areas of policy such as the Child Public Health Policy group and New Horizons as well as between DCSF and DH.
>
> - Different cultures in different departments,
>
> - Concerns around shared working leading to reductions in budgets
>
> - Civil servant positions change frequently so that organisational memory is lost and there is a time lag as new relationships are forged
>
> - Civil servants do not necessarily have a professional training in their policy area

The culture of silo'd working tended to be reflected in policy development, however the need to gain consensus and policy coherence discussed in chapter four, acts to overcome some of the natural barriers to joint working. Despite this, many lower level policies are developed on single issues, with variable links made to related areas, this potentially contributes to the delivery of relatively vertical programmes for health promotion. This silo'd approach to policy development and delivery was perceived to make it more difficult to bring in cross- cutting determinants of health like violence. This was understood as being related to the need to build and maintain relationships for each relevant area, which requires capacity and time, and although on the whole, it was possible to establish positive relationships, sometimes there was a degree of territorial resistance. In contrast, the smaller size of the regional government offices meant that it was possible to forge strong and effective relationships across programme areas more easily than at national level, where it may take time to even establish who a policy lead is for a particular programme.

The public health function of health protection mainly covers infectious disease control, emergency planning, which were not seen to be so relevant for violence and abuse prevention

within England, (though they would be within countries with high levels of HIV and AIDS). However some environmental health aspects of the health protection function did contribute to violence and abuse prevention policy, especially with regards to the built environment and the RESPECT policy, which was in part delivered by Environmental Health officers.

Education and training of violence and abuse prevention from a public health perspective was undertaken informally, with a series of workshops and presentations given to a wide range of policy and public health audiences. However, further integration into health sector curricula is needed for policy delivery, and there is scope to incorporate general public health approaches into policy officials training programmes.

Further research needs were identified and used to inform research priorities with the relevant policy leads, however, evaluation was the main public health skill that has not been used significantly during this policy development. Ideally, an evaluation of the policy would be undertaken once it was published. In general, evaluations are variably commissioned on specific programmes and pilots, however complete policies are rarely evaluated.

The supporting stones under the pillars describe public health methods that can be seen as fairly generic methods, however, they were key to contributing to the development of policy on violence and abuse prevention. This research found that all the methods of working in collaboration, advocacy, leadership and being influenced by or working with communities had contributed to public health being successful in influencing the development of violence and abuse prevention policy. These methods can be described as the 'art' of public health.

The steps of the building describe which processes existed for embedding the vision within its governance structures, and included inter-ministerial groups, expert and steering groups. A key gap in this structure was a particular governance structure for overseeing the work specifically on violence and abuse prevention within the policy setting. This may have contributed to the variable degree of leadership and momentum seen throughout the policy development process on this area, in comparison to other public health areas that had established steering groups, for example on public mental health.

6.3   The Science of Public Health - the Role of the Evidence Base

This next section explores in more depth what is generally seen as the core skills of public health – an evidence based approach, and the role evidence played in the development of

violence and abuse prevention policy. This relates to the top stones (Public Health Skills), in the Public Health Framework in Figure 26 illustrated in chapter 3. In this section their contributions are explored in more detail under the headings of: the evidence on the impacts, the patterns, and interventions for prevention. This then moves into the next section, which reflects upon the role of what can be described as the 'art' of public health, in how this enabled taking forward the evidence base. Analysis of the barriers and enablers for public health in the context of this case study are explored, this provides further understanding on the aspects that relate to the 'art' of public health, which provides insight into how applying the art of public health can assist in policy development. This will be returned to in the conclusion.

The Violence and Abuse Prevention policy took an upstream, primary preventative approach that takes a public health perspective, focusing upon early intervention and tackling wider social and economic determinants, such as inequalities and deprivation that can influence patterns of violence and abuse. The report set out effective interventions and approaches in order support delivery of prevention.

During the research period, it was observed that policy was influenced to a varying degree by the evidence base, either written or in the form of individual advice, an expert or advisory group. However, evidence is used variably according to political interest and pressure from lobby groups that may have financial or political leverage. For example, policies that have ignored the evidence base include those on alcohol and the TB badger cull, with the Chief Scientific Officer going against scientific evidence.

Many policy leads come from an arts background, and are not familiar with scientific thinking or public health methods for assessing or interpreting evidence. This often leads to unscientific approaches to priority setting or identifying policy options. In general, policy leads will see the scientific evidence base as just one option amongst a range of other options for policy development. Other options may come from ministerial agendas, media pressure or from industrial or economic interests.

The Government under Labour, put greater emphasis on the use of an evidence base, especially around cost effectiveness; which became even more pertinent following the economic crash in 2008. The DH has a strategy unit that aims to influence policy making by using a more robust scientific approach – however, this unit does not influence the development of all policies and strategies across the DH. In general, there was greater emphasis given to the economics of whether something was cost effective, than the scientific evidence base regarding whether something worked or not.

A shift in direction in the policy process has taken place during 2008- 9. This included a greater emphasis on engagement, co-production and subsidiary with national policy supporting and enabling local and regional autonomy. A new unit in DH was developed to oversee all new policy and strategy formation, which viewed the use of evidence in policy as marginal and considered this to be the responsibility of NICE. However, although NICE produces comprehensive evidence reviews on specific health related interventions, including public health, it does not include all subject areas, (eg violence prevention), nor does it attempt to prioritise interventions. Additionally, the evidence reports from NICE were generally too complex for policy officials to understand.

Most departments make good use of information specialists and analysts to show overall trends and up to date figures regarding their area of interest. However, many of the policy experts (and ministers) come from an arts background and may not always accurately interpret information provided. Within the DH, there is generally good use of Health information to inform policy decisions. However, public health observatories frequently are not responsive to requests made and generally are not able to deliver information within the tight time-frames of the policy world. Specific larger pieces of work for the observatories need to be commissioned by the DH.

Additionally, where there are gaps in information this distorts what policy is emphasised – ie there is little information on child abuse, which tends to make this an invisible area that is dominated by child protection procedures. A lack of routine and regular data on an area limits subsequent activity and policy and conversely, generating information in an area can stimulate action to address issues that become visible because of robust data sources, for example, ONS surveys have revealed many associations of health risk behaviour with poor mental health scores.

The following section outlines the main evidence shared with policy makers on violence prevention, it used a framework for presenting a public health approach to the prevention of violence. The impacts of violence and abuse were described first, both to health and other sectors to engage policy makers in the relevance of the issue to their work, this was followed by a description of the patterns of violence and abuse in the population, risk factors and then interventions for prevention, with a focus on primary prevention. The roles of different sectors were then described to enhance the relevance to different audiences. The key aspects used to influence policy makers are described below, and the final policy report on violence and abuse prevention captures these main areas, (DH, 2012).

6.3.1   Impacts of Violence and Abuse

The hidden nature of many forms of violence and abuse contributes to many professionals and policy makers not understanding the links between violence and abuse with different health and social outcomes. Public Health information was presented to many audiences including repeatedly to policy makers to illustrate the impact that occurs across the life-course to assist in understanding the links.

For example, the Adverse Childhood Experiences studies and a wide range of evidence from WHO, (WHO 2002, 2006, 2007, Fellitti et al 2009) suggests that experiencing, or even witnessing, violence and abuse at an early age can negatively affect a wide range of health, social and economic outcomes. This can continue to affect people and their communities, sometimes across generations, with on-going economic and public health implications. Violence and abuse can also have implications for other public health programmes aimed at improving health and social well-being. The results from the Adverse Childhood Events (ACE) study were particularly powerful in showing how the experience of multiple adverse events in childhood, including violence and abuse, can increase the risk of on-going health and social disadvantage by affecting health seeking behaviour and health outcomes throughout life, (see Table 49) and were included in the final report, (DH, 2012). However, those from a child protection background tended to be sceptical about these studies, and considered that it was not relevant for current generations of children. One of the challenges of the scientific evidence base, is that there are always areas in any research that can be questioned regarding the robustness or validity of the research, which those from a scientific background accept and interpret the information accordingly.

Table 49 - Impact on health risk behaviour and long-term health outcomes of experiencing four or more Adverse Childhood Events (ACEs)

Risk behaviours	Odds ratio
Severe obesity (Body Mass Index > 35)	OR 1.6;
Alcoholism	OR 7.4
Illicit drug use	OR 4.7
Injecting drug use	OR 10.3
Long term risk factors	
Ischaemic Heart Disease	OR 2.2

Any Cancer	OR 1.9
Stroke	OR 2.4
Chronic bronchitis or emphysema	OR 3.9

Source: Felletti et al 1998

However, it was observed a number of times that those without an epidemiological training, could be easily influenced by one person saying with certainty one problem with the research. This would sometimes result in the evidence being perceived as not valid and discredited, even if it was a relatively minor aspect of how the evidence could be interpreted. It would at times, be very difficult to regain credibility for the scientific work as the explanations by necessity end up being too detailed and complex for a non- scientific audience to comprehend. This illustrates the significance of policy makers being able to understand and interpret scientific studies.

Economic impacts and analysis were generally given precedence in influencing decisions compared to the other forms of evidence base. For example, presenting the below information on the costs of violence and abuse proved a powerful method for engaging interest by policy makers. This also led to the DH commissioning a cost effectiveness review on interventions for the prevention of violence, conducted by the LSE. The main findings from this review were used in the final violence and abuse prevention report, (DH, 2012) and have since been used to support the economic case for investing in public health across the WHO European region. Violence and abuse have huge costs that are borne, not only by victims but also by services, businesses and communities and the wider society; see Table 50. Primary and secondary prevention approaches in particular, have the potential to reduce the numbers of people exposed to violence and reduce the costs associated with managing the health, social and criminal justice impacts.

Table 50 - Estimated annual costs of different forms of violence and abuse

Type of violence/abuse	*Estimated Cost*	*Source*
Domestic violence	£15.4 billion	Walby 2009
Child Maltreatment	£1 billion	HO 2005
Youth Violence	£12.5 billion	HO 2005

Sexual Violence	£8.5 billion	HMG 2007

Domestic violence is conservatively estimated to cost the economy £15.4 billion. This includes £1.9 billion in economic loss, £3.7 billion in service costs and £10 billion in social and emotional costs (Walby 2009). Violence and abuse create recurring costs for a range of health and social services. For example, women who have suffered domestic violence have about twice the level of usage of general medical services and three to eight times the usage of mental health services than those who don't (Walby 2004). Domestic violence cost services £3.7 billion in 2008 (Walby 2009). Often, victims continue using services without reporting their abuse and it can remain unrecognised. As such, services are not likely to fully meet their health needs and this can reduce service effectiveness and wider health outcomes (DH 2009).

The Figure 27 below shows a 2007 study, prepared by the NW Observatory and updated in the final publication, (DH 2012), that estimated violence cost health services alone, more than smoking or alcohol and twice the cost of obesity. This proved to be valuable in influencing policy makers and the wider public health community of the importance of addressing violence and abuse – it helped to compare these costs with what were considered to be mainstream public health issues that action was already been taken on, and to emphasise that violence cost more than these as a justification to develop policy on this area.

Figure 27 - Estimated annual costs of burden of violence for health services
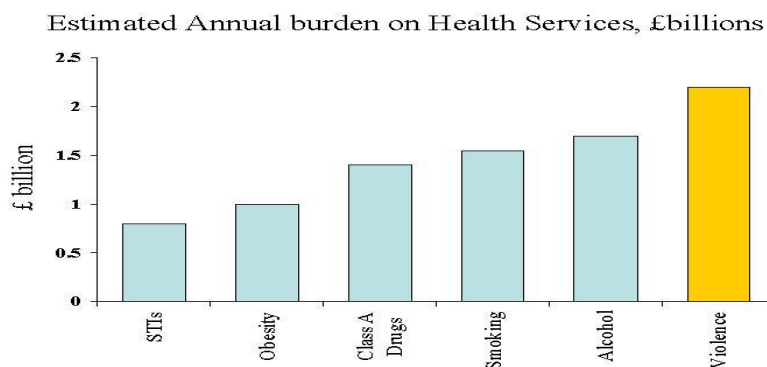
Centre for Public Health, WHO Collaborating Centre for Violence Prevention, 2007

6.3.2   Patterns of Violence and Abuse

By providing data on the types of violence and abuse, where and how they happen and who is affected helped policy audiences to appreciate how common this frequently hidden issue is, and the size and scale of the impacts. Data suggest that there are large numbers of people who have

experienced violence and abuse mostly in childhood and younger adulthood. Some types of violence, such as sexual and domestic, also show gender and age inequalities with young people and women experiencing higher rates.

Violence and abuse are widely under-reported, with many crimes, especially domestic and sexual violence, go unreported to police or official sources. The Home Office conduct annual British Crime Surveys that assist in creating more visibility to hidden crimes. For example, an estimated 40% of rape victims told no one about their assault and that only 11% of rapes are reported to the police (GEO 2010). Only 39% of crime carried out by acquaintances (as opposed to family or strangers) was reported (Walker et al 2009). Under-reporting of childhood abuse is likely to be very high, however there was no data collected on child abuse in the British Crime surveys, which tend to focus criminal justice activity on adult victims of crime. Probably only 1 in 70 cases of child abuse are known or reported. For child sexual abuse, this figure is much less, with around 1 in 800 cases reported, (Cawson 2000).

This unrecognised burden of harm can act as a silent determinant across a range of poor health and social behaviours. This can affect people's ability to participate or to access support and opportunities. People exposed to violence may also use services more often (Walby 2004). If their violence is undisclosed this can reduce the effectiveness of services to meet their needs and improve outcomes. In policy meetings and for presentations on this area it was helpful to illustrate that we only see the tip of the iceberg with many forms of hidden abuse, to aid understanding on the wider impacts it has as a hidden determinant.

However, as described earlier, audiences from the Children's sector tended to disbelieve these statistics, in part as it did not correspond with their experience of dealing with child protection issues – they often could not comprehend that there were so many more cases. This disbelief may have related to a professional and personal denial, in that if the figures were true, it would mean enormous consequences for their current service model for responding to abuse. This state of mind and denial was sometimes difficult to move people on from, with discussions on what can be done to prevent it. Whereas, the more receptive audiences tended to be those who were not directly involved in child protection issues, for example, some of the NGOs working on child abuse, applied this evidence to their own work to strengthen their case.

However, feedback from the consultation event and from the public health round table described later, revealed that a particular challenge of engaging the NGOs was in how they interpreted the evidence of associated risk factors for violence and abuse. The evidence clearly shows associations of violence and abuse with alcohol, age, gender, early childhood

experiences, mental health and disability, these were summarised in the Public Mental Health policy, (DH, 2010).

However, these relationships are complex and interacting, and were at times misinterpreted by a non- scientific audience as being causal rather than associated risk (or protective factors). In particular, some of the more feminist and human rights aspects of the NGO community, considered from their theoretical perspective that the public health approach was perceived as too deterministic. For example, they would interpret associated risk as being casual, which then places too much expectation on a child being abused then becoming an abuser or abused in adulthood. From their perspective, they understood that everyone has a choice and a responsibility not to abuse, and therefore, the associations with alcohol consumption were rejected as they were perceived as being used as an excuse. This acted as a temporary conceptual barrier for taking forward aspects of the violence and abuse prevention policy, and discussions with the policy lead following the consultation event, revealed concerns at how to address these differences in interpretation. This in part may have contributed to some of the delays in taking forward the policy following the consultation event in 2008, with the final version only being submitted for clearance just before the general election in 2010.

Use of the evidence base was also variably used by policy makers, whose primacy of interest was to ensure consistency with the current political agenda. This tension in the use of the evidence base resulted in the violence and abuse prevention framework not receiving clearance from the new government in 2010. For example, at the end of the summer in 2010, it became apparent that despite the evidence on alcohol pricing, there were requests for these references to be removed by Treasury. This indicates the higher governmental level interest in financial impacts, despite the evidence. However, the use of evidence for the control of alcohol was controversial even under the labour government, and reflects the needs to balance industrial interests with public health outcomes.

6.3.3   Preventing Violence and Abuse - What Works

As described, one of the main challenges for developing policy on violence and abuse prevention was to convey the complexity of previous events in life impacting upon outcomes across the life course and therefore points to intervene from a prevention perspective. The Child safety and Home Office policy leads tended to focus on the event and securing safety, containment and punishment as a response. Although they used the term prevention, they tended to mean what would be described as tertiary prevention from a public health perspective. I developed and presented a number of simple visual diagrams that explored this relationship to make this easier to understand.

For example, the Figure 28 below summarises how wider social determinants of violence and abuse as well as personal and family risk factors can interact to maintain existing inequalities or continue risk. These factors can influence behaviour and outcomes at every stage of the life course. This figure shows that there are opportunities where public health approaches and effective interventions can provide support at any stage of life, to stop violence and abuse before it starts or prevent it from re-occurring.

Figure 28 - The relationship between a life-course perspective, wider determinants and the prevention of violence and abuse
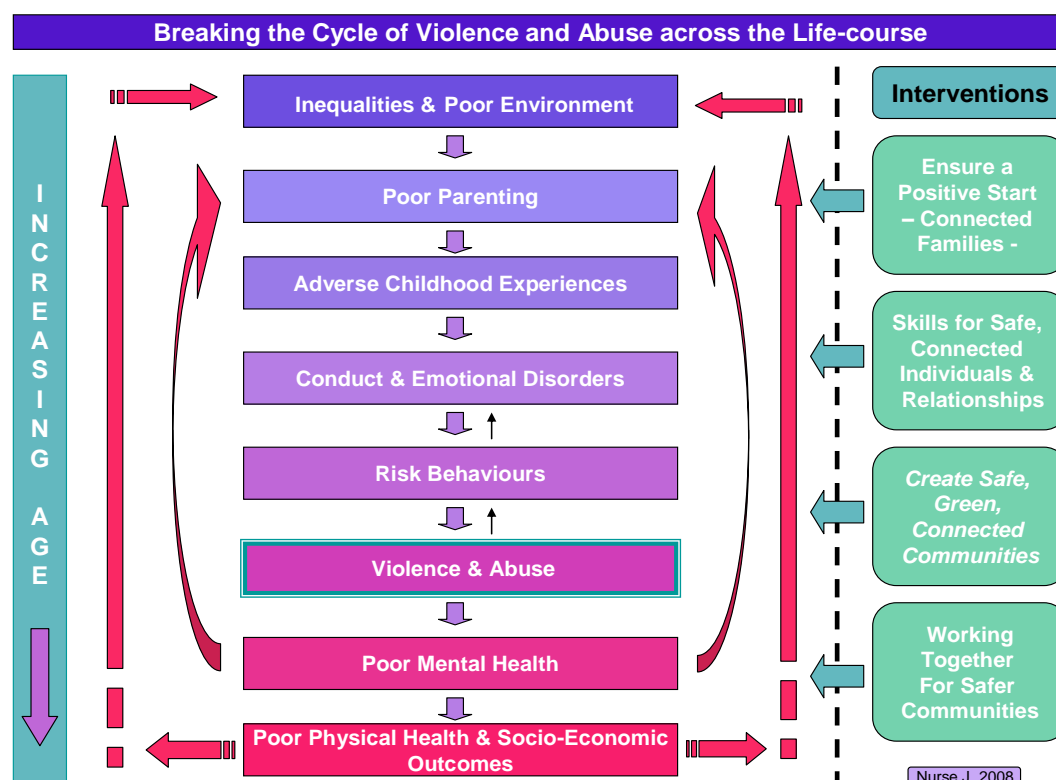
Although, this diagram was understood and provided insight into the associated risk factors across the life course, it was received with opposition by the VCS, many of who interpreted this as conveying a deterministic approach to early experiences of abuse directly leading to the perpetration or experience of violence and abuse. This illustrates how complex epidemiological associations can be difficult to convey in a meaningful way to a wider audience. In contrast, however, the other approach that worked well in helping audiences to understand the complex connections between earlier life adverse life events, risk taking behaviour and outcomes was to present these in the form of an individual story.

For example, I discussed this at length with an NGO that I asked to give a presentation at an event on preventing violence and abuse in the SE region. They constructed a story of a young

girl and boy who had experienced child hood abuse, and then proceeded to describe what happened to them and why in terms of their later life events and outcomes. This proved to be a very powerful and memorable way of conveying these complex interactions and opportunities to intervene. I met someone who had attended this conference a few years later, who remarked about this particular presentation and how they could still remember the impact it had on them.

For the violence and abuse prevention policy, we summarised public health interventions that can be effective in preventing violence and abuse based upon four key headings. I was advised by a senior public health colleague leading the violence and abuse public health work from the NW region to identify not more than four key areas, as this was easier for partners implementing work to remember. I identified these four headings based upon the gaps found from the mapping exercise described, these were adapted in the final report on violence and abuse, (DH 2012), and applied to the public mental health policy (DH 2010). The earlier drafts included the following four headings which run alongside the right hand side of figure…. and include: 1) Ensure a positive start: connected families; 2) Skills for safe, connected individuals and relationships; 3) Create safe green, connected communities; 4) Work for safer communities and connected professionals. These headings were used to communicate how the interventions addressed different risk factors across the life- course.

The development of this policy was at part during the economic and financial crisis with the subsequent lead up to the austerity measures. Therefore, emphasising the economic benefits of interventions was seen to be a powerful way of influencing the adoption of policy by policy leads. A cost effectiveness review was commissioned by the policy lead to provide further evidence to support policy development in this area. This showed that benefits can accrue to all sectors; either through resource/cash releasing or improvement in outcomes. Economic analysis (Knapp et al 2010) shows how prevention can be highly cost effective. Examples of cost-effective programmes supported the policy development on violence and abuse prevention, and key messages were included in the final policy, (DH 2012). Policy leads and those implementing policy described the importance of measures that gave a return on investment within 1- 3 years, due to the demands of political and planning cycles. However, at this time the evidence was less available to influence this agenda, and a lot of the economics work was perceived as too complex to relate to policy so has not been applied as much as it could.

6.4   The Art of Public Health

We have seen that an evidence based approach although highly valuable in policy development, was at times, complex and difficult to understand. In contrast, some of the success for the final publication of this policy report can be seen to be related to the softer aspects of public health –

that can be described as the 'art' of public health, including the skills of collaboration, leadership, advocacy and communication. These softer skills can be applied strategically to overcome barriers and take advantage of opportunities. The barriers and opportunities are described below, whilst the role that the art of public health can play will be further described in the conclusions.

Table 51 was written by the Public Health Consultant working on the violence and abuse prevention policy between 2009-2011 and describes key aspects of which aspects facilitated the process and reflects upon areas that would improve policy progression if the process were to be repeated. The majority of these points relate to what can be described more as the 'art' of public health, utilising skills like collaborative working, leadership and advocacy and clear communications, which are explored further below.

Table 51 - Reflections on the Public Health role in engaging in the Policy Process, (secondary observation, Public Health Consultant; August 2010)

- **Gain visible leadership –** with active engagement of a champion of violence and abuse prevention at senior level within government.

- **Ensure senior civil service agreement** and backing (in writing) early on in the process.

- **Agree in writing a clear purpose, objectives and draft content –** early on in the process by key policy leads and stakeholders, and gain ministerial agreement.

- **Project manage the process** – identify the key steps and anticipated time scales that the policy process needs to go through; identify events, people or processes that could block the process and allow extra time for unforeseen events.

- **Build good relationships -** with key policy leads, identify allies and potential barriers and obstacles early on.

- **Identify the support of civil servants -** who can provide support and help guide you through the complexity of the policy process.

- **Gain early personal engagement** with analysts to provide sources of data and information in a timely fashion.

- **To achieve consensus** – take an editorial role rather than an authorship role, coordinating feedback, tone and purpose; however, be firm about inclusion of aspects that relate to your public health expertise.

- **Engage senior civil service input to overcome barriers** – the civil service is very hierarchical and responds to senior input if issues or barriers emerge.

- **Be persistent -** allow extra time, learn from and share with colleagues.

6.4.1   Collaboration

A key aspect observed of the policy process, which was then applied by myself in this case study, was the process of building informal relationships and networks with policy leads with a similar area of interest. This was done through processes like regular emails, informal meetings, sometimes with coffee or lunch, which helped to develop stronger relationships with policy leads which were instrumental to advancing a particular policy area. On a more formal level, forging partnerships with other sectors by establishing common aims was also developed, for example, by production of joint briefings, events or publications. This relationship building was especially advantage with other departments that had resources to take forward the agenda, as long as there was a perceived advantage for them in the process. For example, the Police and Home Office pushed this agenda forward, and had resources for publications, events and to support pilot projects. This facilitated raising the profile and engagement to a public health audience in exchange for an increase in anonymous information sharing and partnership working to achieve their aims of reducing crime levels.

By having maintained a persistent public health advisory role on violence prevention lead to the development of strong allies in the policy making process who could understand the benefits of public health and prevention. This is illustrated by the email, see Table 52 from a DH policy lead on violence, who had no public health background, written to the Home Office describing and persuading them in the importance of taking a public health approach to preventing violence. Interestingly, having used the 'art' of influencing and collaborative skills to persuade this policy lead of the importance the public health approach, helped to facilitate the advancement of a scientific evidence base to address violence and abuse.

Table 52 - Email from DH Policy Lead to Home Office, April 2009

The Violence and Abuse Prevention Framework which we are working on (see draft - I have given the weblink below) also provides evidence of the effectiveness and cost-effectiveness of prevention of all forms of violence. It shows how wider determinants and risk factors can be identified and tackled from an early age. Childhood experience and development can also be influenced by violence and can increase the risk of later risky behaviour and the experience of violence and abuse in adulthood (see ACE Study). Similarly, disruptive family environments, poor childhood mental and emotional health and development, drug and alcohol use, deprivation and other factors can also increase the risk of violence and abuse either as victim or perpetrator.

Early intervention with families and children; for example, parenting and family

intervention programmes, school-based mental and emotional health promotion and early identification and treatment of conduct/emotional disorders can address these risk factors and prevent violence. They can also have positive impacts upon other health and social indicators for young people, families and communities.

I think there is a great deal that we can learn from this if we want to take both a public health and a preventive approach and to apply the principles of evidence-based policy-making. From DH's point of view, it also ties in well with the work that we are doing on prevention of crime generally (we hope to publish something that will show what more can be done from a public health point of view) and links with our strategies on alcohol, Child and Adolescent Mental Health, offender health, emotional wellbeing and mental health programmes such as Multi-Systemic Therapy and Treatment Foster Care (on which there is a Radio 4 programme at 8pm tonight). It would also support an approach to policy that promotes the use of the evidence base and evaluation.

Building significant relationships with policy leads and educating and engaging them in the public health approach proved too be key in ensuring the ownership and motivation by them in taking forward this agenda after I had left, and the final publication of the policy report, despite multiple delays and obstacles.

6.4.2   Leadership and advocacy

Another significant approach that can be regarded as an 'art' of public health, that was observed was the role of public health advocacy and champions. However, the public health contribution to the policy world, aside from my personal role, was mainly limited to external players and had limited impact in the policy process. In contrast, advocacy within the policy world was mainly motivated from a human rights perspective, highly committed champions forwarding work on violence and abuse, including its prevention, and included high-level advocates, including ministers and the attorney general.

However, links were forged with external public health organisations and leaders to assist in mainstreaming this agenda and generate momentum that supported the case for advancing the policy agenda. The persistence of a handful of committed public health professionals and health professionals on the violence and abuse agenda, within the DH, the WHO and the wider public health community helped with ensuring this policy work did not get advanced at various points when it was rejected. Sometimes this was through senior public health leaders writing letters to the CMO or giving personal advice on how to navigate the process, and to discuss alternative options if the policy was completely rejected.

Building significant relationships with policy leads and educating and engaging them in the public health approach proved to be key in ensuring the ownership and motivation by them in taking forward this agenda after I had left, and the final publication of the policy report, despite multiple delays and obstacles.

6.4.3   Communication

In particular, it was observed that there was an art to communicating with both policy leads and ministers that influenced and progressed the policy process. Aside from the formal templates for policy briefings for ministers outlined elsewhere, the informal process of communicating required relationship building. This was generally in a style, which was polite, professional, diplomatic, that at times conveyed hesitancy in decision making, however, there was a general attitude of negotiation to achieve common outcomes, which was usually achieved with gentle persuasion. This style of communication is in contrast to that usually practiced in the public health field, whereby, there tends to be a clearer focus on making decisions, identifying actions and delivery processes. Additionally, communicating to a public health audience frequently is centred around the evidence base, for example, in presentations, and in meetings applies a systematic approach to ensure clear decisions and actions are taken forward.

Therefore, a key to becoming an insider participant observer in this policy making process, was the ability to match the prevalent communication style, and to adopt communication styles that best influenced policy makers and ministers. In general, the most significant difference in the provision of written communications, was to provide short briefings, preferably only 2 sides long for ministers. These briefings summarised succinctly the key issues, including political perspectives, media interest and costs, with a range of options, which guides the decision maker to a preferred option. This is a very different style to the scientific evidence based approach in public health, which is much more based upon solid facts and the presentation of evidence to make decisions. Therefore, the translation of the evidence base into a series of clear and short messages was observed to be an important part of conveying what can be seen to be overly complex and detailed amounts of information. These summaries were then communicated repeatedly in different contexts, for example, with presentations, in meetings, with emails and short summary reports, this helped to reinforce key messages. Table 52 illustrates how this approach resulted in a policy lead from a non- public health background then adopting and advancing the public health perspective to addressing violence and abuse.

In terms of communicating for a public health audience, however, the approach was different. The round table with senior public health leads to discuss how to contribute more to violence and abuse prevention, (see Table 53) discussed a number of areas that were perceived to be

beneficial for influencing a public health audience. These suggestions included summarising the evidence base in public health mainstream language, on the grounds that a lot of the information on prevalence, risk factors, evidence of interventions and cost benefit analysis already exists and just needs to be summarised and presented in a mainstream public health way. It was also suggested to highlight the links of violence and abuse to physical health to help mainstream the relevance of violence and abuse as a central public health issue.

It was reflected that most of the messages on violence and abuse relate to mental health, which acted to further marginalise this as a public health issue. Additionally, it was perceived as beneficial to make parallels with the way data is presented on mainstream public health issues, for example, by comparing health outcomes or costs of CHD, Cancer, Obesity. Presenting this information in a familiar public health way, was also regarded as a way of influencing a wider audience, for example, by expressing information as Numbers Needed to Treat and the relative benefits from different interventions, attributable risk. The outcomes from this meeting were followed up with variable success, for example, a summary factsheet was developed based upon these suggestions, (SEPHO, 2006) that was used to influence the public health community, and later updated and included in the final policy report, (DH 2012). However, limitations of data meant that certain aspects like attributable risk that would have assisted in comparison with other mainstream public health data were not possible at this stage.

6.5 Discussion - Barriers and Opportunities for Public Health Engagement

This section describes the barriers and opportunities that have influenced public health in contributing to the development of policy on violence and abuse prevention. It is based upon the observation analysis undertaken, including a summary of the main findings from the round table (see Table 53), conducted with public health experts to explore how to improve the public health contribution to this agenda. The framework for public health delivery was used to structure findings, with the drivers and enablers encapsulating the opportunities and the quality component was used to identify barriers.

The below meeting note in Table 53 provides evidence and a particularly rich insight into the research question of this thesis. It included a meeting organised by myself with a number of senior public health colleagues, the overall aim of the meeting was to identify next steps to make violence and abuse a mainstream public health issue. The initial part of the meeting captures progress at national and regional levels, discusses barriers and opportunities for the

agenda and suggested ways forward. This meeting note was summarised from notes taken at the meeting and then circulated to participants for comments and validation.

Table 53 - Meeting Notes from Round Table on how to increase the Public Health contribution to Violence and Abuse Prevention, August, 2006

Attendees:

Regional Director for Public Health for the SE region

Regional Director for Public Health for London

Director of Public Health, West Sussex PCT,

Consultant in Public Health, SE Public Health Group, Department of Health

Development Manager, SE Public Health Group, Department of Health

Reason for the Meeting:

Violence and abuse are currently seen as marginal health and public health issues despite their significant impact upon health and well-being.

- How can we increase public health engagement in violence and abuse prevention, and mainstream it more within the wider public health agenda?

Why Violence and Abuse are Public Health Issues:

Summary of National Work:

Overview of Victims of Violence and Abuse Prevention Programme and wider prevention work:

- National DH/ HO programme over 2 years – to finish spring 2007
- Covers Child Sexual Abuse, Domestic abuse and sexual violence; victims and perpetrators; in children, adolescents and adults
- Includes a literature review; mapping of services; Delphi and expert groups consultation to inform future health service response.
- Sexual Assault Referral Centre pilot Home Office initiative
- Prevention Aspect- has been explored in a series of cross government department meetings lead by DH, with HO and DfES colleagues.
- A generic violence and abuse prevention approach has been developed including all forms of inter-personal violence and abuse, as risk factors and interventions have much in common. The Violence and Abuse Factsheet has been used to aid some of this discussion.

- Recent ministerial approval (Caroline Flint and Patricia Scotland) to take this work forward, including the development of a proposal for a national violence and abuse prevention strategy.

Overview of Current SE Regional Work:

- Approximately 3 years ago, the Home Office asked for greater engagement from public health in addressing violence and abuse, especially regarding partnership working on CDRPs and information sharing of health related data.
- Series of sub-regional seminars with Jonathon Shepherd discussing Cardiff model of A and E information sharing with police and CDRPs to help inform local action. Also links with alcohol and violence and implications of the Licensing Act Nov 05.
- A handful of pilot sites visited Cardiff and have implemented a similar model within their own setting.
- A joint bid (money from the HO) of £300,000 to roll this model out across all A & Es' in the SE.
- National work with Connecting for Health to try and ensure integration in future IT systems

London

- Main work on Domestic Violence:
- Met Police approached Public Health asking for better health engagement in addressing domestic violence
- Greater London Domestic Violence Project- established for over 10 years.
- Mayor of London has championed further work on Domestic Violence, eg Taxi receipts and publicity.
- Audit of PCTs found 25% involved in Domestic Violence Forums, and 1 LAA in round one, and 2 LAAs in round two included Domestic Violence- push for greater uptake for round three.
- Patchy work on ANC- little enthusiasm due to time pressures and demand from midwives and less interest still from obstetricians.
- Patchy work in routine enquiry in A & E.
- Pilot of documenting physical abuse with cameras in PHC – little success.
- Some London wide work on ensuring Connecting for Health includes domestic violence.

PCT Level

- A description was given on the 'Worth Project' based in Worthing, which consists of an A & E Domestic Violence project for identifying and responding to victims. This became one of the LAA stretch targets, which if achieved the reward element is worth £900,000. This project depended largely upon the commitment of an individual A and E consultant.

- An outline of work in Scotland highlighted that domestic violence was much more in the public health mainstream: this work was originally championed by a senior Health Promotion lead for Scotland, who enabled domestic abuse to be mainstreamed within a generic national public health needs assessment. The subsequent report demonstrated that this was a health service issue, gained media coverage, and NHS Scotland developed national guidelines. Additionally, domestic abuse was picked up by senior Police who made links with knife crime – it was felt having a non –health champion helped progress work within health.

Historic and current levels of Public Health Engagement in the Violence and Abuse Prevention Agenda – general discussion considering national, regional and local levels re:

Barriers and Obstacles

- Lack of leadership at all levels
- Violence and abuse not perceived as a mainstream issue in Public Health
- Not in Public Health consciousness – eg no memorable headline messages
- No mainstream knowledge of tangible cost benefit analysis- need more on the health economics aspects
- Insufficient known on the evidence base– eg systematic reviews, to convince mainstream public health
- Greater London Domestic Violence Project- established for over 10 years- strength is its history and experience, weakness, is that it is seen as too alternative, and becomes side-lined or dismissed by mainstream organisations. Members have been antagonistic to health colleagues, compromising engagement further.
- VCS in domestic violence tends to reject links with alcohol – this discredits their work as not being scientific and creates tensions with partnership working.
- At local level, as a DPH sitting on a Crime and Disorder Reduction Partnership with no funding to contribute other than technical skills and expertise has felt like a barrier to contributing as an equal partner – this may account for why many DPHs are not well engaged with CDRP partnership work.

- Schools not sufficiently involved with this agenda- presently PHSE tends to be a tick box exercise and work (eg on bullying) is compartmentalised rather than whole school approach.

Opportunities

- Police and HO are currently pushing this agenda forward- they have resources and have already raised the profile and are keen for increased engagement with health.
- Nationally, this is a good time to raise the profile of violence and abuse as a health issues as there is a lot of interest in the wider issues eg ASBOs and the recent RESPECT Action Plan, links in with reducing re-offending etc.
- To make connections with CAMHS and homicide reviews
- To increase the emphasis on risk to children – re the increasing evidence base of children having negative outcomes if in a family where domestic abuse occurs.
- Opportunities to increase awareness and normalise issue- eg having a strap line on every webpage on the NHS website or payslip.
- A lot of the information on prevalence, risk factors, evidence of interventions and cost benefit analysis already exists and just needs to be summarised and presented in a mainstream public health way. (Check WHO, Cochrane and HO literature)
- Need to highlight the links of violence and abuse to physical health – as most of the messages relate to mental health.
- Need to make parallels with CHD, Cancer, Obesity etc. – eg Numbers Needed to Treat and relative benefits from different interventions
- Need to develop digestible and memorable strap-lines to make key messages easier to remember.

Suggested ways to increase public health engagement in the violence and abuse prevention agenda at:

National Level

- Present the key messages in a similar way to other mainstream public health issues
- Ensure violence and abuse sessions within the Faculty and UKPHA national conferences to reach the mainstream audience.
- Need to influence the CMO to take this issue on more centrally.
- Summarise the evidence base for interventions and influence NICE to review areas where there is good evidence in order to raise the profile and importance of violence and abuse prevention.
- Summarise the economic benefits of earlier intervention

- Engage media- as this played a significant part in raising the profile re obesity (which was ahead of the public health response).
- Obtain champions to raise the profile- eg Ministers and George Alberti, Louis Appleby.

Regional and Local Levels

- Embed violence and abuse issues within LAAs
- Share good practice information – eg the roll out of the Cardiff Model within the SE region.
- Strengthen links of the work in the SE region with the CMO project lead in this area.
- Strengthen links with other regional partners, eg Home Office and DfES.
- Strengthen links with children and young people – i.e. wider benefits to schools and educational achievement- this is where much work can be done re earlier prevention.

How to take this agenda forward- summary points

1. **Leadership** – to discuss with CMO re leadership and prioritisation.
2. **Champions** – bring Jonathon Shepherd, George Alberti and Louis Appleby together to discuss their role in championing work in this area.
3. **Summarise the evidence base**- health impact, interventions and economic benefits- present in similar way to other public health issues.
4. **Mainstream issue** within national public health conferences
   - Faculty conference
   - UKPHA
5. **Establish a network** of Public Health colleagues interested in violence and abuse
6. **Connecting for Health** – addressing risk and information governance to enable mainstreaming of A & E information sharing.
7. **Media** and marketing- engage with the media to raise the profile.
8. **Early prevention** – strengthen work with children and young peoples agenda, eg CAMHS, health visiting, parent skills etc.

This section reflects upon the evidence presented in table 53.above, and explores further the reasons why public health has or has not engaged in violence and abuse prevention policy, (the main points are summarised in 54 further below), in order to answer the research question for this objective. One of the main barriers of why public health has not engaged in the violence and abuse prevention agenda, include the taboo nature of violence and abuse, which is exaggerated by the invisible nature of many forms of violence and abuse, especially child abuse, sexual and partner abuse. Due to the taboo nature of abuse, in a health service or research setting, many people are reluctant to disclose their experience of abuse and

professionals may have personal experiences themselves. Additionally, the historic and societal norms towards child abuse, domestic and sexual violence have contributed to this being an area that is private and associated with shame. These attitudes have in part, potentially contributed to the continued perpetration of violence and abuse. The taboo nature and lack of visibility, has meant that its full impact upon public health has not been perceived.

These factors contribute to a lack of data and information, especially within mainstream public health– there is a lot of information from the criminal justice system and research findings, however, much of this has not been translated to a public health setting. Additionally, there are specific information gaps, for example on violence and abuse in childhood; longitudinal studies; and health outcomes of violence and abuse and following interventions.

At the time of the research, in general, violence and abuse were not seen as a health or public health issue by the mainstream. This is in part due to its hidden and taboo nature and lack of data in the public health domain. Additionally, as Violence and abuse has most of its impact as a risk factor or determinant of health behaviours and health outcomes; a relatively small proportion of health outcomes are directly linked to violence, for example, homicides, gun and knife violence. These receive a disproportionate amount of profile although the overall health burden is much larger when violence and abuse are considered as a determinant of health outcomes. However, from a public health perspective, the total number of deaths related to homicide is minimal compared to things like cardiovascular disease or cancers and commonly associated risk factors like tobacco or obesity.

The concepts of prevention and the complexity of how violence and abuse impacts upon health, are generally poorly understood by non- public health professionals. For example, how abuse in early life can have later impacts upon health risk behaviour and outcomes across the life course, makes this a difficult issue to comprehend and understand solutions. Many sectors describe prevention as addressing the most proximal event related to a visible aspect of violence, and find it difficult to make the links for the need to address many upstream risk factors to prevent violence and abuse. Table 54 summarises the main points explored in this section on why public health has or has not engaged with policy prevention of violence and abuse.

Table 54 - Summary of Why Public Health has/ has not engaged with policy for the prevention of Violence and Abuse

Summary of key points of why Public Health <u>has</u> engaged in Violence and Abuse Prevention	Summary of key points of why Public Health <u>has not</u> engaged in Violence and Abuse Prevention
• A small number of committed Public Health Champions and Leaders • The role of the World Health Organisation, an enabler as well as driver • Increased relevance of violence and abuse to public health • Research on the costs of violence and abuse to the health sector • Media Coverage and the Prime-minister • The Home Office and police have pushed the agenda forward	• The Taboo nature of violence and abuse • The invisible nature of many forms of violence and abuse • Lack of data and information • Mostly a determinant of health vs. an outcome • Complex and Multi-factorial issue • Seen as a Criminal or Human Rights issue primarily and not as a health or public health issue

Factors that improve quality, by addressing risks and ensuring governance arrangements are in place acted in as an opportunity and a barrier. High profile media events that can be framed as risks to public services, like knife and gun crime, were used to positively help drive the prevention agenda. However, other risks like child deaths due to abuse reinforced the quality improvement of child protection services and had little impact on facilitating taking forward the prevention agenda.

Violence and abuse are seen as a Criminal or Human Rights issue primarily and not as a health or public health issue – this view is reinforced by the Home Office, Police and Criminal Justice System taking a very visible lead on this agenda; the use of language of violent crime, and the representation in the media of violence rarely portrays violence and abuse as a health issue.

The Voluntary Community Sector played a general role in lobbying government for action against violence which helped to raise its visibility and act as an opportunity for taking forward policy on this agenda, though, little of this focus was on violence prevention or the public health contribution. However, at local and regional level they played a more important influencing role for public health engagement, with specific prevention projects providing tangible examples of how to translate work on violence and abuse prevention into policy.

Although the Voluntary Community Sector in general could be seen as potential allies for addressing violence and abuse, some organisations opposed the public health agenda and interpreted the epidemiological evidence on the links of violence and alcohol as being in contradiction to a rights based or feminist approach.

A lack of leadership or champions on violence and abuse within the public health community or health sector was seen as a fundamental barrier in the round table discussion. This resulted in violence and abuse not been incorporated into mainstream public health agendas, with a subsequent lack of visibility on this as a public health issue. The round table discussion suggested to summarise the existing evidence base and cost effectiveness data in comparison to mainstream public health issues to enhance its relevance, which was undertaken at a later stage. Additionally, a lack of leadership meant there were few drivers to ensure progress, for example, there was no formal governance process to oversee and ensure delivery of this specific agenda on prevention. The leadership and governance structures that existed were primarily driven by the Home Office whose agendas are mostly from the criminal justice perspective.

The main opportunity for public health to advance this prevention policy was from external leadership and drivers, of which the strongest national drivers that influenced public health engagement in violence prevention policy was from the Prime-Ministers office. This in turn was driven by the media, mainly in response to policy demands following a series of high profile knife and gun homicides and at a later date with summer riots. However, there was a general lack of public health leadership that drove this agenda, with the central actors that lead the process being the criminal justice sector, including the Home Office, the Attorney General, the Ministry of Justice and the Police.

The public health ministers letter outlining taking forward a violence and abuse prevention strategy provided a significant opportunity to assist taking this agenda forward in the policy context, although with changing ministers and illness of the policy lead who had ensured the letter was signed, weakened this effect. There were a small number of committed health and public health professionals who provided leadership and actively championed this agenda, and who helped to increase the profile and visibility of violence and abuse as a public health issue, for example via presentations, publications and meetings with Royal Colleges and national champions or 'tsars'. Additionally, persistence and patience were vital personal attributes, as the overall process of developing policy for the prevention of violence and abuse took approximately ten years. However, more senior and active public health leadership would potentially have acted to drive this agenda forward at a quicker pace.

Enablers that facilitated the development of policy on violence and abuse prevention included a range of different organisations such as the North West Public Health Observatory with the provision of violence information and research summaries and by raising visibility with a public health and violence publication and conference. The World Health Organisation, with the World Health Assembly resolutions and the provision of evidence also played an important role in putting violence and abuse on the public health agenda. The UK Public Health Association and the Faculty of Public Health held special interest groups and publications on violence and abuse prevention, and I was able to arrange to give workshops and presentations at national conferences following discussions with presidents with both organisations.

Additionally, research organizations like the London School of Economics were commissioned to develop the reviews and undertake additional modelling on the costs and cost-effectiveness of violence and abuse that informed the final policy report. However, it was difficult to obtain the information in the format that was commissioned affecting its utility for a policy audience. Evidence from the National Institute of Clinical Effectiveness was summarised for the policy review, however, it proved to be a time consuming process to extract the key messages from these evidence reviews in order to make them relevant for a policy context. There were a number of general challenges working with academic organisations to support policy development: most publications are not written in a way that is easy for policy audiences to apply; further translation or specific reviews therefore needed to be commissioned, which takes time and costs money. The style of most academic writing is often focused on single areas, too complex and long for a policy audience, so reviews often needed further interpretation and key messages across multiple areas needed to be summarised. Many academics are not keen to engage in writing directly for policy documents unless they can publish their name, which is not usually included in policy documents.

The below Table 55 summarises the key findings for this chapter, which explored objective two, whilst the next chapter goes on to analyse in further depth who the main actors were, their relative power in the process and the dynamics between them.

Table 55 - *Summary of key findings for Results Two:* **To describe the public health contribution to violence and abuse prevention policy**

- *Prevention balance and priorities:* the mapping analysis found that the main policy focus on violence and abuse was on tertiary prevention in adult populations. The public health based framework on violence and abuse prevention was used to identify policy gaps, inform priorities and shift the focus to earlier in the life course, including more primary prevention approaches; these were reflected in the final policy.

- *Public Health competencies: science and art-* the scientific based public health skills were found to be significant in contributing to the development of an evidence based policy. However, the 'art' of public health was found important to ensure their adoption, including: relationship building, collaborative working, persistence, good communication and influencing skills.

- *The Science: evidence for prevention:* a public health evidence based scientific approach of the extent and nature, the impact and risk factors for violence and abuse as well prevention was used to inform the policy process and incorporated into the final policy report. However, in general, policy makers consider a range of options, of which the evidence base is only one, when making decisions about policy formation. Economic analysis was given high priority by policy makers.

- *The Art: Barriers and opportunities for engagement:* the hidden nature and lack of mainstream public health information on violence and abuse acted as barriers, the prevention and the public health approach prevention was poorly understood and not seen as relevant by some. High profile media events provided the main opportunities to advance policy, backed by senior leadership, which mainly came from other sectors. Applying the art of public health helped to overcome some barriers and take advantage of opportunities.

Chapter 7 - Results - three: To Describe and Explore the Role of Different Actors in Influencing the Policy Process for Violence and Abuse Prevention

Research Question: Who have been the main actors, and what have been the key factors that have influenced violence and abuse prevention policy?

This chapter aims to answer objective three by firstly giving an overview of the main actors involved in the violence and abuse prevention policy. This is followed by an exploration in further depth of the main areas of interest in violence and abuse prevention and the main factors that have influenced these actors, (both public health and non- public health), in their involvement in this agenda.

Next, a stakeholder analysis that was conducted for this research is presented, to consider the relative importance of the different actors in developing violence and abuse prevention policy. This is then followed by a discussion of the relative power and interactions between different actors. In doing so, this chapter describes who, how and why the different actors influenced the violence and abuse prevention policy, and explores their relative power and interest and influence in the process of policy formation.

In order to support the findings, results are presented from a combination of methods, including the documentary analysis, the mapping based upon the violence and abuse prevention framework and excerpts from the diaries that contribute to the observational analysis. The detailed version of the results can be found in annexes IV- VIII, whilst summaries of the results are described in this chapter. The results from this chapter, as with the other chapters have been cross-validated by the consultant in public health who worked on this agenda within the DH from 2008- 2011.

7.1 The Main Actors - An Overview

Actors can be described as stakeholders in public health terms and individuals and groups affected by and capable of influencing the development and implementation of strategy and

policy proposals. The process of identifying actors for the purpose of this thesis, involved drawing up a list of the main actors, (both Governmental and non- Governmental) who had been involved in the process and is based upon all three of the research findings. Actors were considered across all stages of the policy process. The main actors involved in the violence and abuse prevention policy process were identified from their attendance at policy meetings, documentary analysis, mapping and observational analysis. They included mostly governmental departments, especially the Home Office, the Prime Minister's Office, the Ministry of Justice and the Attorney General. The other government departments, played a lesser though important role, including the Department of Health, the Department for Children, Schools and Families/ for Education, the Department for Communities and Local Government, and the Department for the Environment, Farming and Rural Affairs. Figure 29 summarises the main actors involved schematically, and their relative relationships with each other.

Figure 29 - DH organogram outlining the relative relationship of the main actors involved in the violence and abuse prevention policy

The relative relationships of the main actors involved in the violence and abuse prevention policy
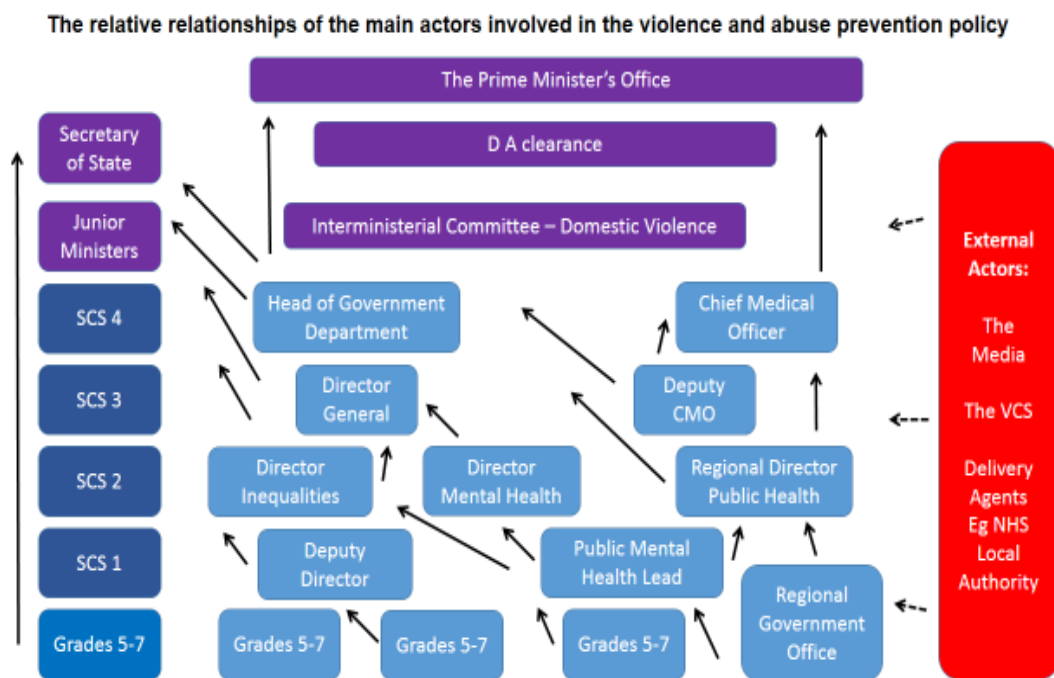
The main external actors were the media and the Voluntary Community Sector, who both featured a lot less in the overall policy making process, however, they played relatively important roles in either speeding up or delaying policy formation. Other external stakeholders included front line health professionals, public health and PCT leads, representatives of which were all invited to the external consultation event, however, they were not perceived as key drivers of this policy agenda.

The Department of Health and Other Government Departments have the same structures and hierarchies in terms of grades, with the Secretary of State and Junior Ministers representing the elected representatives who have ultimate responsibility to the voting population, (purple boxes). The Secretary of States are the most senior minister for a Government Department, who have a variable number of junior ministers reporting to them. In turn the Secretary of State answers to the Prime minister and will often be a cabinet member. It is at Secretary of State level that the final DA clearance is obtained at the last stage of the policy process – this will be described further in the next chapter.

The inter-ministerial committees, as in this case, consists of junior ministers, with the Attorney General chairing the Domestic Violence Inter-ministerial committee that the violence prevention policy reported to. Usually a policy lead attends the inter-ministerial committee to support the minister with briefings and responses if required. Policy leads from the civil service, who prepare briefings to support Ministers can be anything from a grade 5 to 7, or more usually, a Senior Civil Service (SCS) member, depending upon the political importance of the agenda. In the case of the violence prevention policy, briefings were usually prepared by a grade 7 or SCS level 1, and would be cleared by the relevant Director (SCS2). Usually, the more senior staff who were relevant to an agenda, would be included in the copy list of Ministerial briefings or emails where a significant decision or action point was being made.

In order to drive forward all elements of the work on violence a new cross government departmental governance structure was developed, to establish a clear, coherent and effective approaches that promoted partnership working at all levels. This included, but was not necessarily limited to: the Home Office; the Ministry of Justice; Attorney General's Office and the Office of Criminal Justice Reform which supports the three CJS Departments; the Department of Health; the Department for Children, Schools and Families; Communities and Local Government; the Government Equalities Office; and the Department for Culture, Media and Sport. It also included key stakeholders at the highest level. The draft consultation policy stated that outcomes from the Violence and Abuse Prevention Framework were to be monitored by the Domestic and Sexual Violence Inter- Ministerial Group, and Ministers from across Government came together on a dedicated inter-Ministerial Group to lead co-ordinated and concerted action across Departmental boundaries. However, delays in the progression of this policy illustrate that the inter- Ministerial committee did not regard the prevention aspect as central to their interest, and how the prevention agenda frequently gets weakened when put in the same area of responsibility as to the highly visible demands of containment and treatment areas.

Below the Secretary of State and Ministers, the Department of Health was seen to have three senior executive heads: the head of the Civil Service, the Chief Medical Officer, who in effect acts as the Prime-Ministers most senior health advisor, and the Chief Executive of the NHS responsible for the delivery of policy. The Chief Medical Officer (CMO), also has ready access to the Secretary of State and Ministers to advice on health policy, and are seen to provide independent and objective advice. However, this function can change, with the level of policy influence varying according to different political agendas. For example, the Deputy CMOs under the Labour government played a significant role on managing a large team of civil servants and leading the 'Choosing Health' policy agenda (DH, 2004).

The ten Regional Directors of Public Health reported directly to the CMO. However, in reality their roles were multi-fold, in part they played an advisory role to support the work of the CMO, often with specific national topics that they were responsible for. In practice, though, the level of engagement with these roles could be variable, from relatively minimal and nominal contributions, referred to as 'watching briefs' to an area that needed considerable input with both policy development and delivery. In this way the CMO's office and staff, could at times play both an advisory role and one of direct policy formation. Additionally, the Regional Directors of Public Health, (DPH) had at one point a split role in the NHS, providing the senior public health role in Strategic Health Authorities. This meant that the Regional DPHs and their teams could act as policy advisors, direct policy leads in terms of being responsible for policy formation, and also be responsible for policy delivery. My role was essentially caught between the juxtaposition of these 3 roles – at one point I was reporting to the Regional DPH and to civil service Directors, with responsibilities in policy advice, formation and delivery.

This illustrates the complexity and multiplicity of the decision making process within the policy environment. The lines of arrows convey the reporting direction and also the access of multiple players in the policy world to the ministers in being able to influence the decision making process. The Civil Service Directors were generally seen as the gate keepers of access to Ministers with responsibility in signing off briefings. However, the reality was much more blurred, with variable access to Ministers and policy development by what were deemed to be health advisors. This at times created tensions, as the career civil servants would see their role as gatekeepers to ministers and the policy formation process. However, some advisors had direct access to ministers and responsibilities in policy development, which at times could be resented by career civil servants. Whilst at other times, and in particular for 'orphan' policy agendas that none of the central career civil servants wanted responsibility for, the regional health advisors could take a more pivotal role in policy formation.

In the case of the violence and abuse prevention policy, this was seen as a politically important agenda, with the potential for controversy, and was therefore kept under close control by the career civil servants, especially at Director level. This meant that the contribution of the regional office was kept at arms- length and based upon specific requests by the civil servants. As I was based centrally within the Department of Health, I could play an advisory role, with the ability at times to influence the policy formation process, for example, with presentations and drafting the initial prevention policy.

When the wider actors are considered, additional layers of complexity to this were seen for the violence prevention policy. The Department of Health was understood by other government departments to be leading on the Violence and Abuse Prevention Policy, as outlined in ministerial letters presented in chapter one. However, the Home Office was very clearly seen to be the lead for policy development on violence in general, with the overall importance of their role becoming apparent with the stakeholder analysis. As there were multiple actors with an interest and influence on violence policy, and therefore on violence prevention policy, the relative power balance of these different actors was seen to vary at times and to have many layers of interaction. Overall, the role of the internal players in policy making can be seen to be much more predominant than that of the external players – mainly the media, the VCS and delivery agents. In part this is a reflection on who has the most control of the policy making process, and the power to influence this.

7.1.2   Factors that Influenced Actors in Contributing to Violence and Abuse Prevention Policy

The next section explores in further detail the factors influencing the specific actors ranked according to their relative power in contributing to the violence and abuse prevention policy. The below Table 56 provides a summary list of the main actors involved in policy formation on violence and abuse prevention. They are ordered according to their level of engagement in influencing and/ or leading on policy for violence and abuse prevention, ranked approximately according to the stakeholder analysis presented later in this chapter. The following section describes the main influencing factors for each actor in turn according to how they were ranked in order of relative importance. The main Public Health actors had varying degrees of influence and interest, and are collectively described at the end of the section on other actors. They include those within the Department of Health (ranked 2), International actors via the WHO (ranked 3), regional and local public health, (ranked 4), academic public health and national public health organisations (ranked 5).

Table 56 - The main actors in violence and abuse prevention policy according to their estimated relative importance

- Home Office/ the Police
- Number Ten Downing Street
- Ministry of Justice and the Attorney General
- The Media
- The Department of Health
- The Department for Children, Schools and Families/ for Education
- The Voluntary Community Sector
- The Department for Communities and Local Government
- The Department for the Environment, Farming and Rural Affairs

The following section explores factors that influenced non- public health sectors engagement in policy on violence and abuse prevention. It is ordered approximately according to the relative importance of the different actors. Common themes that influence many of the below actors that will be explored are reasons for interest in violence and abuse as a subject area and their motivation and ability to influence the policy agenda. Evidence from the documentary analysis, mapping and observational analysis are presented to support the findings in this section.

Throughout this section, with regard to the term prevention, many different sectors were keen to incorporate this term into work they are doing as it gave a real sense of acting to reduce or stop unwanted outcomes. It is a term that is used in much popular language, however, there is great variation in what is understood by prevention and in the three different levels of prevention. However, the majority of non- public health actors use the term prevention almost interchangeably with the concept of protection, and tend to mean activities that would be regarded as tertiary prevention. Therefore, evidence from the mapping exercise is used to show which areas of prevention interventions different actors mostly focused on, in order to illustrate tangibly their areas of interest in influencing the violence and abuse prevention policy agenda.

This section starts with the main actors from the Criminal Justice System, which primarily includes the Home Office as a Government Department. However, it also includes the role of the Attorney General, who as an individual was a particular advocate for addressing Gender Based Violence, and a supporter of the policy work on violence and abuse prevention. The Ministry of Justice had a particular interest in this agenda, though less influence. However, as these three actors are very intertwined from a policy and delivery perspective, they are considered together.

This is then followed by the role of the Prime-Minister's Office, an occasional though key actor in driving the violence and abuse prevention policy, with the Media described next – which played an important role in influencing the interest of the Prime-Minister's Office. Factors influencing the role of the Department of Health are then considered, followed by the other main Government Departments with an interest and some influence in this agenda. The significance of the Voluntary Community Sector is then explored, although seen as an outsider, and perceived as less important in the policy formulation process, their influence inadvertently slowed the policy process down.

Lastly, factors influencing the main Public Health actors are explored, including the role of the public health consultants within the Department of Health, the WHO, regional and local influences, public health academics and national organisations.

7.2 The Contribution of the Criminal Justice System

The Criminal Justice System, which includes the Home Office, the Ministry of Justice and the Attorney General, frequently worked synergistically together as their areas of interest in policy development and delivery overlap considerably. In the context of the violence and abuse prevention policy, however, the main actor was the Home Office as they had more power on being able to actively influence this agenda, as they were seen to lead on violence policy in general.

In contrast, the Ministry of Justice, which mainly deals with offenders, had a significant level of interest in this agenda as it could contribute to reducing prisoner numbers, which have continued to rise over the last 30 years, however, they had less influence in the policy as their main remit was confined to offenders. Although the Attorney General's role is mainly focused on legislation, the particular actor in place during the majority of the time of this research, was especially committed to making a difference to gender based violence, and was able to see the role that prevention could play to contribute to this agenda, and therefore acted as an important and powerful advocate for this agenda.

The results from the mapping found that the Criminal Justice System mainly focused on policy for the protection of victims and containment of perpetrators and the related legislation, as illustrated in the Figure 30. The text highlighted in red in the diagram shows the main areas of policy interest and influence by the Criminal Justice System, and include most of the areas in the orange columns.

The first orange column on Societal and Community Interventions found that the Criminal Justice System's main contribution to violence prevention was through their interest in legislation, for example, for alcohol and drug control, because of their links to offending. Additionally, they drove the policy development and implementation for increasing partnership working at Local Authority level via the Crime and Disorder Reduction Partnerships and in a similar way, for information sharing to inform planning and police activity eg from Emergency Departments. Both these areas were influenced by the interest in reducing offending rates, which they were measured and judged upon.

Figure 30 - The Contribution of the Criminal Justice System to Violence and Abuse Prevention
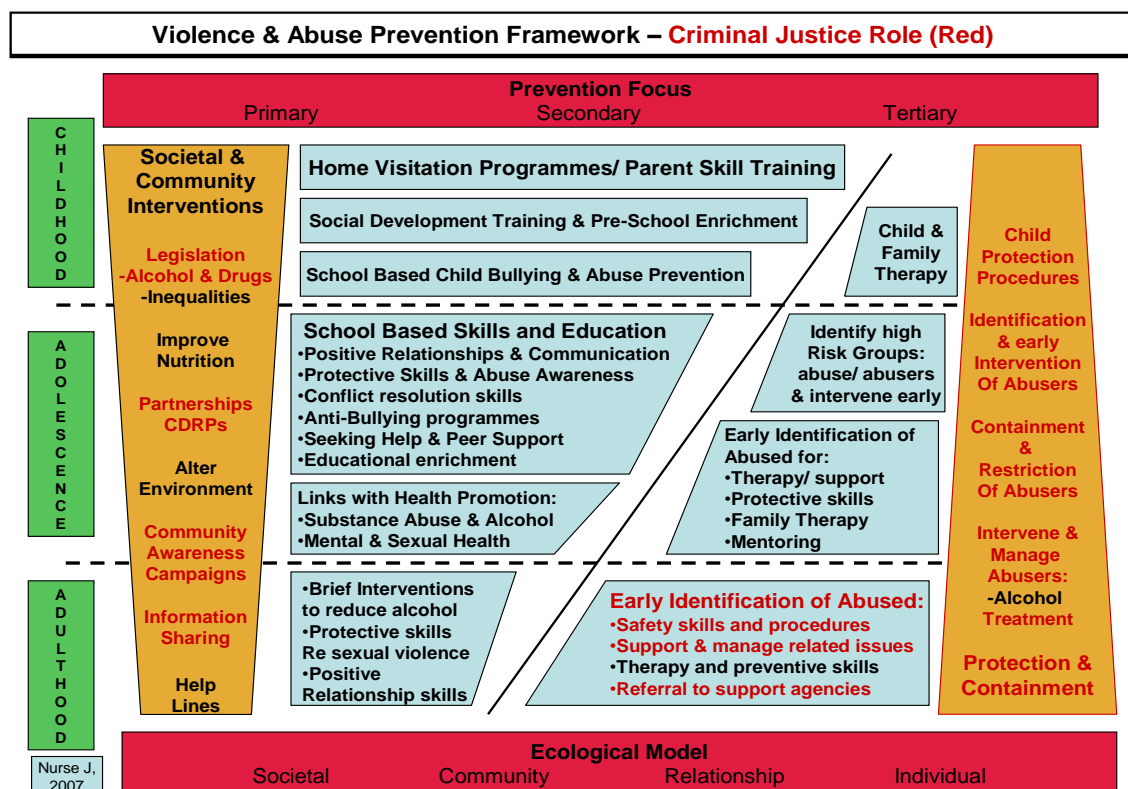
The second orange column included engagement with Child Protection Procedures and the identification and early intervention of abusers. Both of these approaches generally took a protection and containment approach to prevention, for example, by containing, monitoring and the restriction of abusers, and to some extent, managing and treating abusers. In comparison to policy implementation on the containment of perpetrators of violence and abuse, there was relatively little focus on a life-course approach and the early (primary or secondary prevention of violence and abuse) – their main approach being awareness raising campaigns. Additionally, there was little historic policy on the treatment of victims, however, under the Labour Government, there was a relative policy shift to improve approaches for victims of violence and abuse, as can be seen by the policy development described below.

The Home Office were ranked as the most important actor in violence and abuse prevention. Their reasons for interest in this agenda include the way that violence and abuse is mainly framed as a crime issue. This is seen in the use of language, for example, violence is often referred to as 'violent crime'. Additionally, those in the health sector have questioned why health is involved in this issue, as it belongs to the Police or Home Office.

In 2007 the Home Office set out the over-arching principles, the context and the framework for tackling crime over the next three years in Cutting Crime: A New Partnership 2008-2011. Cutting Crime laid the ground for the development of a stronger focus on serious violence. This has been taken forward through new Public Service Agreement (PSA) targets for 2008-11, and in particular those which prioritise most relevant for violence and abuse included: Make Communities Safer, including through reducing the prevalence of more serious violent offences, and prioritising serious sexual offending and domestic violence; and improving the efficiency and effectiveness of the Criminal Justice System in bringing offences to justice.

In addition to the Make Communities Safer and Justice for All PSAs, there were a range of other PSAs that contributed to preventing violence and abuse including: Reduce the harm caused by Alcohol and Drugs; Tackle poverty and promote greater independence and wellbeing in later life; Address the disadvantage that individuals experience because of their gender, race, disability, age, sexual orientation, religion or belief and Young people on the path to success. The Sexual Violence and Abuse Action Plan, 2007, set out how the Government planned to deliver key objectives on sexual violence and abuse, representing an important step in taking forward this Government's agenda on protecting the public and includes aspects of prevention.

In early 2008, the Home Office published: Saving Lives. Reducing Harm. Protecting the Public. An Action Plan for Tackling Violence 2008-11. This was in response to the Cutting Crime report and PSA. This report provided an outline of current related policy and action, introduces a risk based approach and a prevention perspective to tackling violence. It also made a number of commitments to promoting partnership working and improving our response to minimising harm and tackling youth violence, domestic and sexual abuse. The report states that over the course of 2008, the Home Office and Department of Health will lead on the development of a Violence and Abuse Prevention Strategy, focusing on early intervention approaches.

The main driver at national, regional and local level was the police/ home office – this was seen as an agenda actively pushed for and owned by the Criminal Justice System. The Home office led on and published a Tackling Violent Crime Action Plan in Feb 2008. The main Public Service Agreements related to violence are owned by the Home Office, and the Local Area

Agreements related to violence are seen as owned by the Police. The main approach of the criminal justice system though has been punitive, with an increase in prison numbers and sentences for carrying knives, rather than having an approach to prevent violence. Additionally, on occasions they have not worked in collaboration with the health sector and 'pushed' this agenda on them with an expectation of a command and delivery response – eg there is a clash of cultures and approaches.

For example, in the summer of 2008, the Home Secretary announced that perpetrators of knife crime will be visiting victims in Emergency Departments and further Home Office briefings sought to make information sharing between health professionals and police mandatory in cases of violent crime – however, none of this was consulted with the Department of Health or the NHS before the announcement was made. This approach has probably been driven by a particularly charismatic and outspoken senior advisor working in the Home Office/ PM Strategy Unit. This approach was seen as antagonistic by policy leads and did not assist partnership working and created a temporary attitude of resistance, however, as the primary driver was from the Prime-Ministers office, and opportunities were perceived to take forward the prevention work, this resistance did not persist.

Despite the Ministerial letter acknowledging that the Department of Health was the lead for the violence and abuse prevention policy, from the Home Office's perspective, they were considered to be the lead Government Department on violence and abuse in general, and therefore of its prevention. A significant proportion of their policy development is centred on aspects of violent crime, which following the Home Office Strategic Plan (2004-5), gained greater attention. This was due to a change in policy direction from their previous perspective to focus on overall numbers of crimes to those that have the greatest impact upon society. Under the Labour administration, the Home Office was also seen as the lead Government Department in addressing a number of Government Targets and Local Area Agreements that were relevant to violence and abuse in general.

Additionally, the Home Office has had several Ministers who actively followed an interest in developing policy on violence and abuse – initially, focusing on addressing specific policies and plans separately on sexual violence and domestic violence; and later with a cross-governmental strategy on violence against women and girls. This resulted in a series of policies on these agendas. This work was greatly facilitated by the active support of a small number of relatively junior, though highly committed policy officials in writing and developing the policy reports.

The Home Office and the Police actively pushed and requested engagement from the health sector and for public health involvement on violence and abuse both at national and regional levels. In this way it can be seen as a primary driver of policy on violence and abuse within England. This is reinforced by being seen as a relatively high profile Government Department with a high level of interest from the Prime minister's office.

The Ministry of Justice mainly deals with prisons, offenders, criminal legislation and Human Rights. Although, as a Government Department it was not a primary driver in policy on violence and abuse, the Attorney General of the previous Labour administration acted as a key champion for violence and abuse and its prevention. For example, the Attorney General was the most senior Government Minister to launch the draft of the Violence and Abuse Prevention Framework in November 2008. As an individual they were highly committed to driving this agenda forward, and used their senior position to help champion this work, for example, by being the primary host in organising a reception at Number Ten Downing Street to acknowledge stakeholders working on Domestic Violence, and to help raise the profile amongst other Government Ministers.

7.3 The Prime-Minister's Office - Number Ten Downing Street

The Prime Minister is seen as the top of the Government in terms of having the power to influence policy. Although, it is clearly the most powerful part of the policy process in terms of influence, its level of interest is less than that of the Home Office. Number Ten Downing Street are especially concerned by issues that can create negative media attention. It was in this context that the interest from the Prime-Ministers office came from in the summer of 2008, following high profile media coverage of a series of knife and gun related killings in young people, the media profiled this over several months with a call on the Government to take action.

To ensure that the Government is seen to be taking action on an area that had gained considerable media and popular interest, the Prime-minister's office lead on developing a response to this. It pulled in one of the lead civil servants from the Home Office who had worked on violent crime, and had weekly meetings chaired by the Home Office, requiring updates from the main Government Departments, (including the Department of Health), to report on action they were taking.

This high level of interest and expected engagement from Government Departments went on for several months, and resulted in an increase in profile of the agenda within the Department of Health. The main focus of interest from the Prime-Ministers office was to see an immediate change, to tangibly demonstrate that the Government was doing something now. This resulted in the roll out to approximately 100 hospitals of information sharing between Emergency Departments to the police of violent incidents that were treated– with a particular focus on knife and gun crime. This raised profile within the Department of Health also helped facilitate an increase in capacity and interest in the public health prevention work, and could be described as a 'policy window' of opportunity, resulting in the subsequent consultation event and circulation of draft policy on violence prevention in November 2008.

Again, after what looked like the violence and abuse prevention policy was going to be shelved, it was only after strong interest by the Prime Minister's office following the high profile media events of violent riots in the summer of 2011, that the violence prevention policy was given a new lease of life. The Department of Health policy lead for the violence prevention work saw this as a key opportunity to push this agenda forward as a positive policy option. Furthermore, because of the interest of the Prime-Minister's Office, they were able to gain a higher level of support from within the Department of Health, from the Secretary of State for Health, rather than the previous backing from the more junior public health minister, which ensured the final clearance of this document in 2012.

7.4   The Media

The Media's primary interest in violence and abuse as an issue, was perceived as being whether it can make a good story that can 'sell newspapers' or capture a larger proportion of airtime. Discussions with members from the Department of Health's communications team, and observation of how the civil service took notice of media coverage gave the following insights. Stories that are high profile and create a wide public interest are favoured, additionally, the media favours stories that affect individuals and that have an emotional angle – as it makes it easier for people to relate to the story.

Media coverage of high profile events (i.e. knife stabbing or shooting of an innocent bystander), gains disproportionate coverage, and has acted as a key driver in pushing violence up the policy agenda. This is despite the relatively low numbers of knife violence in England, and underlying trends show a reduction in homicides and injuries caused by knives. However media coverage has increased the level of public and political perception of this as an issue. Discussions with senior public health colleagues revealed that historically, the media acted in a similar way to put obesity on the policy agenda.

For example following widespread media coverage of the knife killings, in summer 2008, led to prime-ministerial engagement and prioritisation with weekly cross government meetings at number 10, and letters to Strategic Health Authorities (illustrated in chapter one), to ensure better information sharing between the health and police of knife related attacks. This central leadership also sought active engagement by the Department of Health (and other Government Departments) including demand for weekly reporting of the development of the violence prevention plan, amongst other things.

Frequently, the media focuses on the negative aspects of a story. For example, media coverage of a new mental health policy, which the Department of Health provided positive press briefings for, still resulted in approximately one third of mainstream media coverage as being potentially critical of the Government, (see Appendix V). This is why Government Departments tend to be cautious when dealing with the media.

This means that media topics on violence and abuse usually are represented in a way that captures a sense of horror, fear, outrage or scandal. Conversely, it is very rare to see a mainstream media article of any profile that covers prevention or the health impacts of violence.

Because of the media's ability to influence the voting population and therefore, the likely continued success or otherwise of a Government, it has a very substantial impact on influencing ministers and policy direction. This was also seen in the role of the media pushing for Government action on gun and knife crime in 2008 and then after the summer riots in 2011. Not with-standing this negative media attention however, these episodes created significant opportunities for advancing policy areas that were already well developed but lacked Ministerial support.

7.5   The Department of Health

The main intervention areas that the health sector mainly led on that contributed to violence and abuse prevention are highlighted in blue in Figure 31. The majority of policy focused on providing services for the treatment of victims (and perpetrators), mostly in adult or adolescent age groups. For the Children and Young Peoples Sector, under societal and community interventions, the main focus is on partnership working, for example, in the form of information sharing to support child protection procedures. For childhood specific interventions, the main areas covered were for home visitation and parenting skills, although this was against a background of reducing health visitor numbers, with relatively small and intensive pilot projects, which resulted in patchy population coverage.

Figure 31 - The Health Sector Contribution to Violence and Abuse Prevention
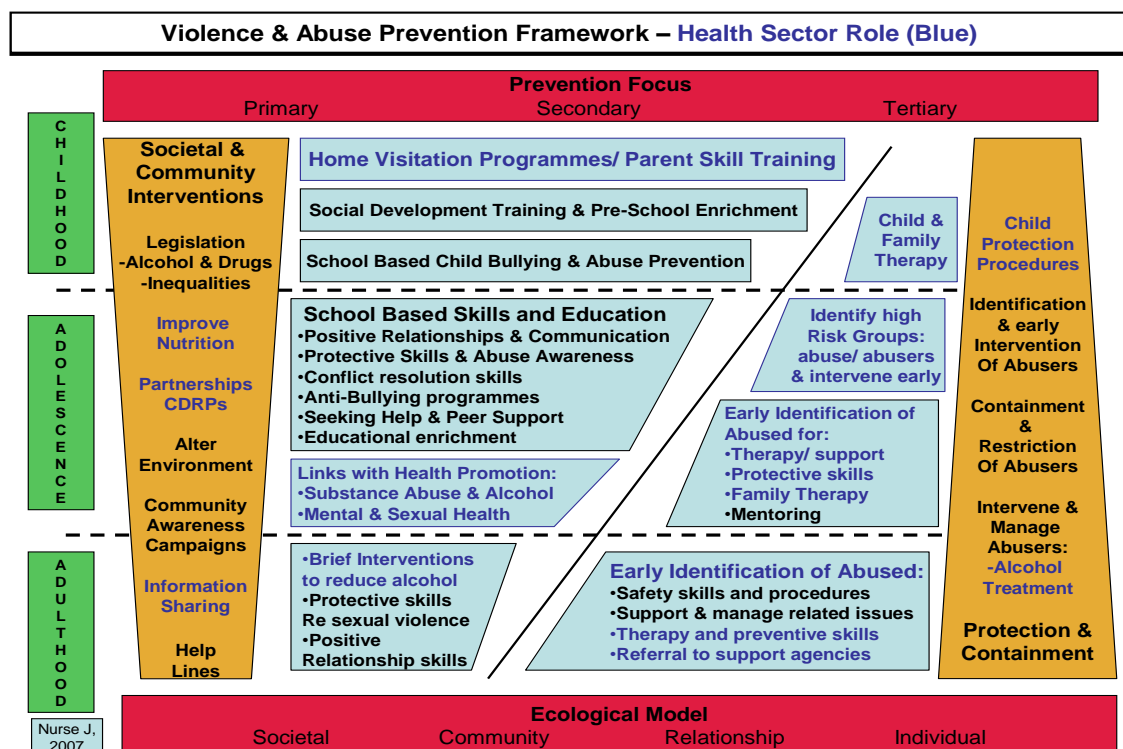
Health professionals contribute to child protection procedures, and refer to and provide many therapeutic services, however, these mainly target adult populations. The mapping exercise found that there was little provision of services or policy to improve treatment for children and young people who have been abused or preventive interventions for those who might be at risk. This finding was further supported by the assessment conducted to support the public mental health policy for children and young people in the SE region, (DH SE, 2008).

The mapping found that although there was relatively good coverage of interventions occurring in adolescence by the health sector, mainly linked with the healthy schools and health promotion programmes, few of these incorporated violence and abuse issues. Schools mostly addressed smoking, drugs, alcohol and sexual health, however, topics could be variably covered, and only occasionally made links to or specifically covered violence and abuse prevention. Additionally, although health workers can play an important role in identifying and intervening early with abused/ abusers and referring for support or interventions, this was not consistently done. For adult interventions the main contribution the health sector made to addressing one of the determinants of violence, was in the referral and treatment of alcohol related problems, however, the experience or perpetration of violence and abuse was not routinely asked about in these settings.

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The Department of Health's interest in violence and abuse has mainly been driven by demands from the Home Office and Number Ten Downing Street. Additionally, aside from the role of the public health consultants described under public health actors, there were a handful of highly committed policy officials, (two from a health service background, one from a children services and one from an academic background). They were instrumental for keeping violence and abuse prevention on the agenda, by ensuring its inclusion in relevant health policy, and by taking forward specific programmes, for example the Victims of Violence and Abuse Prevention Programme, and guidance on Domestic Violence.

In contrast to this however, the majority of officials, who tend to be trained in an arts background, see themselves as generalists who can turn their hand at developing any policy. Therefore, they frequently do not have any specialist knowledge or necessarily a particular interest in health or a specific health related topic. This creates a relatively conservative and unmotivated culture across the civil service, and is reinforced by the experience of having worked for months or years on an area that a minister or senior officials may have wanted, for it then to be dropped altogether.

This attitude and culture, can lead to policy leads exerting what power they can in what at times feels like a disempowering and demotivating work environment. For example, a relatively junior policy lead within the Department of Health insisted that the violence prevention policy re-entered the policy cycle described in chapter four to ensure complete consensus by all the main actors. This resulted in a significant slowing of the policy process in 2011 when there was very little resources or capacity to complete the final version after a series of cut backs within the Department of Health.

This inertia was reinforced by mainstream opinion within the Department of Health that tended to not perceive violence and abuse as a health issue, but as something that the Home Office leads on. As an organisation, the Department of Health tended to see things as related to their policy agenda if they have direct levers on being able to influence them via health services provided via the NHS. This tends to favour the health service agenda as opposed to addressing the wider determinants of public health - including violence and abuse.

However, a significant shift occurred in the wider health policy agenda with the Health Inequalities Progress and Next Steps (DH), 2008 report, which highlighted the impact upon health of early adverse experiences in childhood, including abuse, and stated that a Violence and Abuse Prevention Plan will be developed. It outlined how this will be done in partnership with the Home Office, the Department for Children, Schools and Families, the Department for Environment, Food and Rural Affairs, and Communities and Local Government. The Health

Inequalities report specified how the violence and abuse prevention plan will focus upon early interventions to reduce the risk of all forms of interpersonal violence and abuse, and provide supportive toolkits, protocols, care pathways and commissioning guidance. This report placed violence and abuse clearly as a health related issue, and helped to mainstream this across wider health policy and delivery mechanisms.

Although at a cross- governmental level, the Department of Health was acknowledged to lead on developing the Violence and Abuse Prevention Framework, with the backing of a ministerial letter. However, to gain a cross- governmental logo on this work, the key department that needed to clear this report was the Home Office. Additionally, as will be seen in the next section, to gain cross- governmental support for this work, each of the interested government departments ultimately had an equal level of influence in the final clearance of this policy.

7.6   The Department for Children, Schools and Families/ for Education

The main policy development and delivery areas that the Children and Young People's Sector contributed to the Violence and Abuse Prevention agenda are highlighted in green in Figure 32. Overall, it can be seen that the Department of Children, Schools and Families (DCSF) have the main levers and influence in working with children and young people, with the potential to influence upstream early prevention approaches. However, their main focus of interest in general was on educational attainment and outcomes, and this was the main area that they were visibly measured on.

Figure 32 - The Contribution form the Children and Young Peoples Sector to Violence and Abuse Prevention

Violence & Abuse Prevention Framework – Education Sector Role (Green)

Prevention Focus

Primary — Secondary — Tertiary

CHILDHOOD

Societal & Community Interventions

Legislation
-Alcohol & Drugs
-Inequalities

Home Visitation Programmes/ Parent Skill Training

Social Development Training & Pre-School Enrichment

School Based Child Bullying & Abuse Prevention

Child & Family Therapy

Child Protection Procedures

ADOLESCENCE

Improve Nutrition

Partnerships CDRPs

Alter Environment

Community Awareness Campaigns

School Based Skills and Education
•Positive Relationships & Communication
•Protective Skills & Abuse Awareness
•Conflict resolution skills
•Anti-Bullying programmes
•Seeking Help & Peer Support
•Educational enrichment

Links with Health Promotion:
•Substance Abuse & Alcohol
•Mental & Sexual Health

Identify high Risk Groups: abuse/ abusers & intervene early

Early Identification of Abused for:
•Therapy/ support
•Protective skills
•Family Therapy
•Mentoring

Identification & early Intervention Of Abusers

Containment & Restriction Of Abusers

Intervene & Manage Abusers:
-Alcohol Treatment

ADULTHOOD

Information Sharing

Help Lines

•Brief Interventions to reduce alcohol
•Protective skills Re sexual violence
•Positive Relationship skills

Early Identification of Abused:
•Safety skills and procedures
•Support & manage related issues
•Therapy and preventive skills
•Referral to support agencies

Protection & Containment

Nurse J, 2007

Ecological Model

Societal — Community — Relationship — Individual

The Department of Education, formally known as the Department for Children, Schools and Families under the previous administration, was mainly interested in the violence and abuse agenda from the perspective of child protection and child safety procedures. In this regard, it has been the lead Government Department on developing policy for child protection – (Staying Safe, DCSF, 2008). This has been a relatively high profile policy as one of the five main priorities under the Every Child Matters policy, (DCSF, 2004).

However, the main focus on child abuse, has been on tertiary prevention approaches, and reflects a relatively incremental approach to policy development in this area. Officials in the department expressed reluctance to use prevalence data on levels of child abuse within the general population, expressing uncertainty about the quality of the evidence base. Additionally, concerns from the children's sector have been raised about the implications of these figures upon current child protection services. As with many Government Officials, the wider concepts of prevention regarding primary and secondary prevention approaches were not been well understood or applied to their policy setting.

As the main motivation for the DCSF was to improve educational standards and outcomes, violence and abuse, especially their prevention, tended to be seen as relatively marginal issues.

Additionally, teachers were generally perceived to have full agendas and be under pressure to achieve educational targets and any issue that was seen to take time away from core-curriculum activity was generally met with resistance. This has meant it was difficult to influence uptake of policy on school based violence and abuse prevention programmes. This relative lack of engagement was also reflected by policy leads from the DCSF not always attending internal meetings to discuss the violence and abuse prevention policy, or would send a relatively junior policy lead who could not make decisions at their level.

Despite this relative lack of interest, during the revised policy document in 2010, policy leads did clear the text summarising re the evidence base for violence and abuse prevention in school programmes – though had not supported their incorporation within the national curriculum. However, in 2011, when the policy had been cleared at all previous levels, including the public health minister and several other government ministers, it was the Secretary of State for DCSF who questioned the relevance of violence prevention for schools and did not endorse the policy, leading to a temporary rejection of the policy at that stage, until it was revived following the summer riots later that year.

7.7 The Department for Communities and Local Government and the Department for the Environment, Farming and Rural Affairs

The main policy areas that the Local Authority/ Department of Communities and Local Government and the Department for the Environment, Farming and Rural Affairs, contributed to the Violence and Abuse Prevention agenda are highlighted in purple in Figure 33.

Figure 33 - The Contribution from the Local Authority Sector to Violence and Abuse Prevention
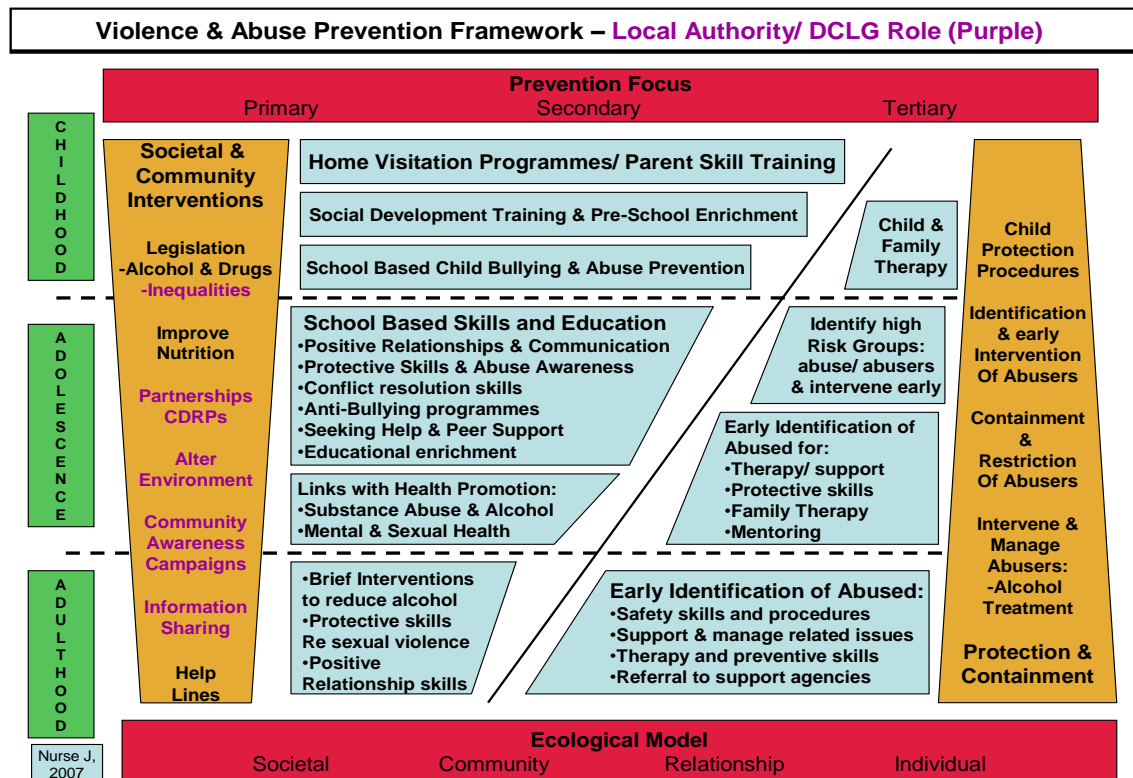
Both these government departments had some degree of interest in supporting the violence and abuse prevention policy, as it helped them to fulfil some of their wider objectives, for example of partnership working, sustainability and social cohesion. They were relatively engaged in meetings and supported policy drafts during the circulation of different versions of the policy for comments from different government departments. However, their main area of influence turned out to be relatively weak, compared to other government departments.

Their main contribution to violence prevention policy related to areas in the first orange column, addressing some of the wider determinants for violence, including approaches that address inequalities, partnership working across local government and partners and altering the urban environment to make it safer. Both of these departments have some degree of interest in the violence and abuse agenda – mainly via connections with their larger aims to promote communities and improve the environment. However, violence and abuse were perceived to be a relatively marginal area for their wider policy priorities, and therefore did not receive a lot of active interest in violence and abuse prevention policy. Their ability to influence the agenda on violence and abuse prevention by addressing inequalities was limited by treasury and wider political policies, however, their ability to create alterations in the build environment was probably larger than the perceived relevance for their own agenda. Therefore, although there has been some support from these departments, they were not as influential as they could have been.

7.8   The Voluntary Community Sector

The main intervention areas from the mapping exercise that the Voluntary Community Sector contributes to the Violence and Abuse Prevention agenda are highlighted in pink in Figure 34, which summarises these graphically.

The Voluntary Community Sector represents a diverse range of stakeholders with multiple interests in violence and abuse. In summary though, the main areas for engagement of the VCS in violence and abuse included community based programmes mainly for victims, providing protection, therapy, support, and rehabilitation from the impacts of violence and abuse. There were also a number of VCS groups that had a campaigning and awareness raising component, and a small handful involved in preventive activities, including school based prevention programmes.

Figure 34 - The Contribution form the Voluntary Community Sector on Violence and Abuse Prevention
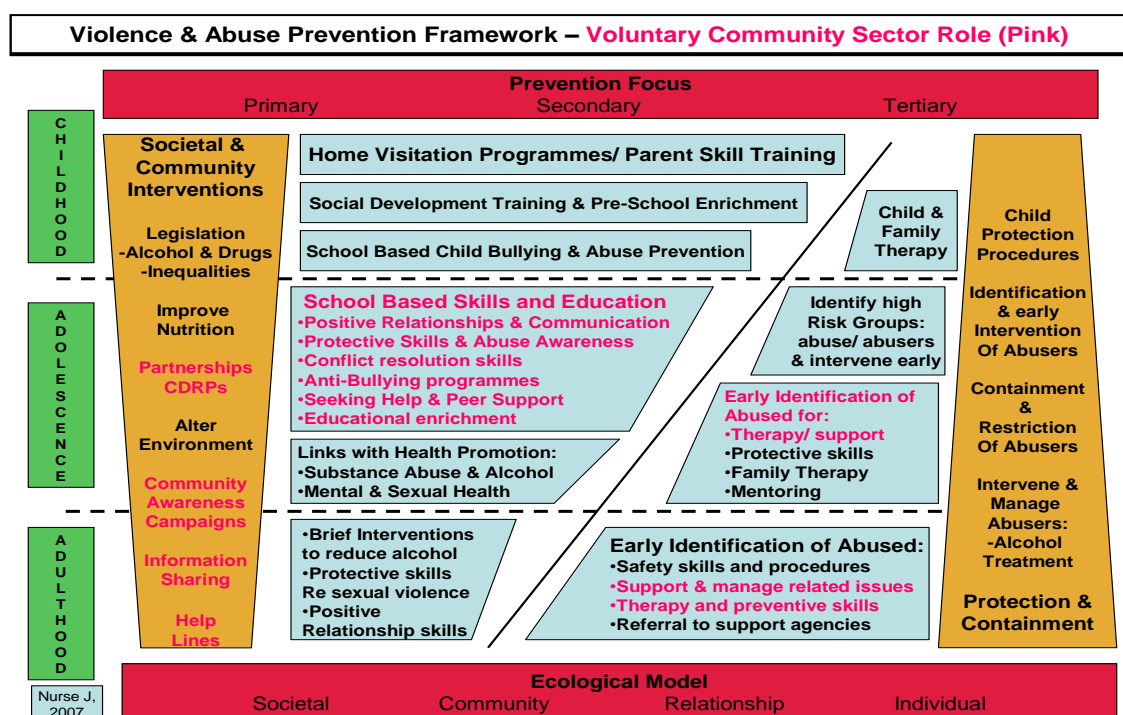
The VCS were actively engaged with in the DH Victims of Violence and Abuse Prevention Programme, (2005- 2008); where many of them were members of different working groups and consulted in Delphi exercises. This proved to be a valuable way of engaging their main areas of interest in this agenda in supporting victims of violence and raising awareness to ensure adequate services and funding.

However, the violence prevention agenda proved to be more controversial to engage this audience with. Feedback from the consultation event and draft document in November 2008, although conveying general support for work on prevention, revealed significant contrasts in theoretical approaches to addressing violence and abuse, see Table 57. The majority of feedback came from the feminist orientated components of the VCS, who perceived the public health prevention framework to be relatively lacking in a gendered perspective, and considered the epidemiological associations describing links with violence and abuse and alcohol and across the life-course as being too deterministic.

Table 57 - Summary of Feedback from Violence and Abuse Prevention Framework, January 2009

- Gender neutrality/power imbalance (should be a more central theme)

- Discomfort with the cycles of violence model (as perception that it blames victims)

- Alcohol and causality of violence (resistance to risk factor concepts)

- Absence of feminist and voluntary sector references (due to lack of evidence)

The majority of the VCS in violence and abuse came from a feminist theoretical background, which tends to be based on a Human Rights perspective. For example, some of the feedback cited the United Nations work on Human Rights, including key resolutions or agreements that the UK government has signed, for example, the UN Convention on the Elimination of All Forms of Discrimination Against Women, 1979; and the UN Convention on the Rights of the Child, 1989.

At times, the public health approach to violence prevention was perceived by the VCS to be in contradiction to the human rights model. In part this may have been due to different theoretical backgrounds and understanding of scientific and public health evidence. For example, prevention was generally perceived to be about treatment, service provision and restorative justice, which were the main areas that the VCS were engaged in. Although there was already plenty of policy on these areas already, of which many of them were engaged in, they wanted the treatment and protection aspects reiterated again. This may have been because this was their main focus of interest, it may also have been as this was perceived as ensuring sustainable funding streams for some of their already existing work.

The other main area of controversy that was described in the feedback for the violence and abuse prevention policy from the VCS surrounded their interpretation of evidence showing

associated risks for violence and abuse. In several instances, this was interpreted negatively as meaning causation, and was understood as being deterministic and in contradiction to a human rights and feminist perspective. Although, different philosophical approaches by some sectors of the VCS created resistance to evidence put forward by a public health approach to violence and abuse prevention, a number of innovative VCS organisations have realised the advantages of prevention, and have actively developed these as areas in reports and delivery of services.

In general, the VCS and external partners were seen as supportive partners, with the policy lead advice to the minister regarding the consultation event describing them as a low risk audience with high interest and high warmth in this agenda. At local and national level the Voluntary Community Sector acted partially as a driver, mainly advocating this as an issue. They also organise annual national conferences with the Home Office and sometimes DH speakers, and their main funders are from the Home Office (ie from the Victims fund).

However, their more radical stance at times marginalised them and made it difficult for mainstream public health to engage in this agenda on the same platform. The nature of the VCS in general, and especially for the violence and abuse agenda, is to take a more extreme position than normally would be accepted by mainstream organisations. This can create tensions in negotiating consensus for policy, which by its very nature is more conservative and represents what will be acceptable to the mainstream. In this case study, the strongly expressed concerns about the perceived deterministic public health approach to alcohol and the life course, and the inclusion of violence and abuse experience and perpetration for both genders, (as opposed to a purely feminist perspective), contributed to a slowing down of the next stages of the policy development process. The policy lead responsible for taking this forward found it challenging to sufficiently reach a consensus approach to these very divergent perspectives, and ultimately had to wait for higher level drivers to overcome what might have been perceived as public opposition to this policy.

The VCS as an external stakeholder, had less ability to influence the policy agenda than government departments. However, if the VCS provides a unified position on a policy area, it can act as a powerful influencer in shaping policy. The ability of the VCS to influence and shape policy is improved if there are personal or formal links into the policy world, for example, by the incorporation of representatives within governance structures, as expert or advisory groups or by active engagement in the consultation process.

7.9   Factors that Influenced Public Health Actors in Contributing to Violence and Abuse Prevention Policy

The below section explores factors that influenced the main actors within the public health community who have contributed to the violence and abuse prevention agenda. They are described in approximate order of the relative importance of different actors as identified in the stakeholder analysis at the beginning of this chapter. The role of the World Health Organisation, although distant, played an important role in setting the mandate and setting evidence based standards on violence prevention. However, the North West Observatory on behalf of the DH in the NW region and the Public Health consultants within the Department of Health played the most important public health role, by directly influencing and shaping policy in this area. Whilst local good practice examples helped to raise the profile of this work and with persistence, ended up being seen as policy solutions in response to one of the media events. The role of academics producing evidence based research in violence prevention and of national public health organisations in normalising and championing this agenda are also considered.

The World Health Organisation acted as an initial key actor in setting the agenda and driving the public health approach to violence prevention. This role is especially important for an emerging public health issue like violence prevention, which was not previously seen as a health issue. The role of the WHO is to provide information and evidence based reports, set standards, guidelines and tools to assist countries in responding to challenges like violence and abuse. The WHO also plays an important role by facilitating changes of norms across public health agendas, by setting evidence based standards, raising awareness and by putting the agenda on the World Health Assembly for discussion and endorsement.

For example, the WHO had a series of resolutions at World Health Assemblies, initially with the purpose of raising the profile and understanding of violence and health, and more latterly with the aim of increasing active engagement by countries and prompting action and commitment on an agenda. The main motive or aim of the WHO is to improve global health outcomes, for which it had identified injuries as a key contributor to Disability Adjusted Life Years. Although, overall violence related DALYs are less significant in the UK, the act of having signed the World Health Assembly played an important role in putting violence and abuse on the national public health agenda. This gave the mandate for further action for interested actors. However, aside from the International Health Regulations, endorsing a WHA resolution does not obligate a country to take any action legally or otherwise. Therefore, the power of the WHA is mainly by providing a mandate for countries to act if they already have

an interest; additionally, if enough countries take action, this creates some degree of peer pressure for countries that are not acting.

In the UK this resulted in a generally positive response, after returning from the WHA in 2003, the Chief Medical Officer nominated the NW Regional Director for Public Health as the national lead for addressing violence prevention. The NW lead role has provided a senior champion role on violence and abuse prevention, for example by holding a regional conference in 2005 and publishing a couple of observatory books on violence prevention. They also ensured that Violence was profiled within the CMO annual report in the regional updates for most years from 2004 onwards, and have contributed significantly to a number of WHO reports on violence prevention.

However, as most of this role was delegated to the North West Public Health Observatory, which was outside of the Department of Health, they made little contribution to policy development on violence prevention within the Government, except at the very end of the policy process in 2012.

The role of the two public health consultants physically based within the Department of Health acted as key drivers in actually developing the policy the first and subsequent drafts of the violence and abuse policy. They also worked alongside and actively engaged policy leads within the Department of Health and with other Government Departments, attending frequent meetings, giving presentations, briefings and being instrumental in gaining ministerial support and ensuring the consultation event took place.

As both internal public health advisors left the Department of Health by 2011, the policy lead responsible for this work, commissioned the final version of the policy to the NW Observatory to complete. One of the key challenges of the Public Health Observatories was their geographical and cultural differences from that of the Department of Health. This meant that they were generally seen as outsiders, whose evidence based work was useful, however, they were not generally included in policy discussions or the policy making process. Additionally, the funding system of the observatories, meant that they had no additional capacity to contribute actively to policy information requests unless specific funding was available.

However, there were a handful of key Public Health champions or actors at regional and local level that helped to mainstream this work within the established public health agenda. For example, the North West Public Health Observatory spoke at conferences, produced information, reports and publications for a public health audience on the impact of violence and abuse – some of this information has contributed to national policy formation. Additionally, the

work championed in Cardiff on anonymous information sharing of Emergency Department data on violence, (described in the regional case study), resulted in a pilot and roll out based upon the 'Cardiff Model' across the SE region.

For example, a series of meetings with senior officials, including the Emergency Department Tsar, facilitated by a regional public health development manager, chaired by myself, helped to influence policy on connecting for health. Following the series of high media profile events on knife and gun crime, which resulted in Number Ten Downing Street directly becoming engaged in policy on this agenda, an adapted version of this model has been rolled out to approximately 100 Emergency Departments across England. As described already, however, the driving force behind this work was ultimately the Home Office.

The main contribution from academia in policy making on violence and abuse prevention has generally been an indirect one, via the use of the evidence base in shaping and informing policy reports. For example, a number of reviews of the literature were undertaken to contribute to the earlier drafts of the Violence and Abuse Prevention policy, these were either undertaken or supervised by myself, and also some economics reviews were commissioned from the London School of Economics. Although, these evidence reviews were a key part of the wider work in shaping the policy, feedback from policy leads requested that only a summary be included in the main report.

Additionally, specific reviews were commissioned by the Department of Health to contribute to the Violence against Women and Girls Strategy, however, these specific reviews had minimal impact on shaping the policy for the violence against women and girls strategy.

Individual academics have had little direct impact unless they took a championing or advocacy role as with the 'Cardiff Model'. A group of health economists have made presentations of their work to policy leads on cost effective approaches to preventing violence and abuse, however, their reports have had a marginal impact on shaping policy as they were too complex for most policy leads to understand with no clear conclusions or policy options developed. The following diary entries in February 2009, see Table 58 are personal reflections illustrating the cultural differences between the academic and policy worlds and the difficulties of applying evidence for policy settings.

Table 58 - Diary Entry 17th February 2009 - Personal Reflections following a Meeting with WHO and Attendance at a Conference on Neuro-science and Violence

PhD
Relaxation

① - Researchers are poor at translating their findings into policy implications
→ + what does it mean for individuals, communities etc

② - Policy makers are poor at interpreting research findings for policy

③ → Need greater training / discussion / joint workshops to aid translation of work.

eg NICE is good eg (don't summarise findings as just state evidence + don't consider that to be their role however, policy makers / planners often limited time + skills to do that translation).

+ Researchers studying areas that are descriptive + not necessarily amenable to change. - Ie need animal research
→ Natural tendency re humans to be aggressive ∴ need to change surrounding environment to mitigate this impact.

‖ → Also Research / Funding Bodies need to stipulate 'implications for Policy + prevention' as outcome Not just dissemination. + Research ammenable to making changes

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PhD Reflections

① Neuroscience / understanding of violence

→ Each Research area has a very narrow
focus — Not making links to wider
connections — eg No clear overview or
consensus re the role of different

hormones + neurotransmitters + the way
they interact.

② Driven by profit potential → ie
animal experiments on neuroscience
driven by + funded by pharmacological/
drugs companies in the search for
new drugs.

→ ie substantial funding + research at
this end — not linked c prevention / PH
agenda.
— in search of Drug Fix
↳ Discussion included eg, that were
based on 'scared straight' approaches
shown to do more harm —

③ Silo'd approach to research. Narrow focus
+ little cross disciplinary re PH / prev.
Nor digestion of 'so what'.

These entries were made whilst attending an international conference on Neuro-Science and Violence held in Switzerland, which aimed to provide in-depth understanding about the roots of violent behaviour in order to be able to intervene across the life-course. There were presentations on the origins of violent behaviour in mammals and upon the neuro- anatomy and physiology of violent behaviour in humans and links made to the development of conduct disorders and emotional intelligence. The implications of inequalities on health and what could be done regarding prevention were also explored. These reflections are also based upon discussions held with the Injury Prevention team at WHO Geneva in 2009.

A key limitation of this conference was that it largely targeted academics, who did not adequately consider or explore the potential policy implications, however, this is a critique

observed of the majority of conferences, unless they are specifically framed as targeting policy makers. Despite this, academia in this area has helped to shape public health thinking for health advisors involved on violence and abuse, who acted to translate the evidence base for policy makers. However, conferences are rarely attended by policy makers, most presentations are focused on relatively narrow research topics and they rarely have presentations on how research can be applied to shape national policy.

Aside from the general limitations of translating the evidence for policy makers, by academics, another compounding factor is that policy makers are generally trained in the arts, and struggle to interpret scientific evidence based findings. They appreciate a range of options with benefits, risks and economic costs written in a straightforward and clear style. Additionally most academic reports are far too long for policy makers to have time to read and interpret, and the nature of research tends to focus on a relatively narrow area or single issues, whilst policy needs to consider the feasibility and political and public acceptability of delivering programmes and services within complex interacting systems.

The Main National Public Health Organisations within the UK have all contributed to raising the profile of violence and abuse as a public health issue. Although their direct impact on policy making has been relatively minimal, they have each made significant contributions in mainstreaming violence and abuse within the wider public health agenda and therefore in assisting the future delivery of policy on violence and abuse. For example, the Chartered Institute of Environmental Health, made visible the links of their legislative powers to the delivery of policy with the control of anti-social behaviour and the licensing of alcohol premises. To assist this, after discussions with their president, at their annual conference in 2006 they held a series of presentations and workshops on the role of environmental health in reducing night time economy violence.

The Faculty of Public Health, supported the normalisation of violence and abuse as a public health issue by publishing a briefing statement on alcohol and violence in 2005, and by profiling violence and abuse in their news journal and after discussions with their president, profiling violence and abuse as one of their key note sessions at their annual conference in 2009. Likewise, following discussions with the UK Public Health Association they held a debate on violence at the 2007 annual conference, with a workshop chaired by the Regional Director of Public Health in the NW at the 2008 conference, followed by the formation of a Special Interest Group on Violence in 2008.

7.10   Stakeholder Analysis

This next section builds upon the previous sections and presents the findings from a stakeholder analysis conducted to support this research, which provides an overview of the relative power the different actors had in the violence and abuse prevention policy. This is then followed by an in-depth exploration of the interest and influence and relative power of each of the main actors.

The following stakeholder analysis framework was used to assess the level of importance of different actors. Essentially, it summarises the strength of interest and the level of influence on a score of 0- 4 of each actor and then adds up the final score to assess which actors have the highest level of influence in the policy process. This approach was used within the Department of Health itself as a tool for stakeholder analysis at the time that this research was conducted. This framework is similar to other stakeholder analysis methods, for example, the methodology described by Buse, Mays and Walt, in Making Health Policy, (2005).

Interest was defined by the Department of Health, as how much interest it was thought that the stakeholder legitimately had for policy objectives, irrespective of whether or not they were aware of the policy/proposals or have any views on it. For each stakeholder, the level of interest was identified with a score of 0-4, where: 0 = no interest; 1 = low interest; 2 = medium interest; 3 = high interest and 4 = very high interest.

Whilst 'influence' was defined as how much influence the stakeholder could exert on the Department's ability to deliver the policy or proposal and implementation of the objectives. Again the level of influence was scored between 0-4, where: 0 = no influence; 1 = low influence; 2 = medium influence; 3 = high influence and
4 = very high influence.

A stakeholder analysis was conducted for the violence and abuse prevention policy by myself and cross validated by the public health consultant working on this agenda. This also includes analysis of the relative level of importance (or power) of the public health actors. A summary of findings is given in Table 59. The scores for interest and influence were estimated in turn for each actor, then the total score added up in the third column, as in accordance with the Department of Health stakeholder methodology, this score was then divided in two and finally a rank score was given. As it was possible for more than one actor to have the same score, it was also possible that they had the same ranking.

Table 59 - Analysis of level of importance of actors for the development of policy for violence prevention

Actors	Interest 0 - 4	Influence 0-4	Total Score 0- 8	Divided by two 0-4	Rank
Non- Public Health Actors					
Number Ten Downing Street	3	4	7	3.5	2
Home Office/ the Police	4	4	8	4	1
Ministry of Justice and the Attorney General	4	3	7	3.5	2
The Media	2	4	6	3	3
The Department of Health	2	3	5	2.5	4
The Department for Children, Schools and Families/ for Education	2	3	5	2.5	4
The Department for Communities and Local Government	2	2	4	2	5
The Department for the Environment, Farming and Rural Affairs	2	2	4	2	5
The Voluntary Community Sector	4	1	5	2.5	4
Public Health Actors					
Public Health within the Department of Health	4	3	7	3.5	2
The World Health Organisation	4	2	6	3	3
Regional and Local influences	4	1	5	2.5	4
Academic Public Health	3	1	4	2	5
National Public Health Organisations	2	2	4	2	5

Interpretation of the summary results can help to understand the relative level of engagement in and power to influence the policy process. The figure below outlines one of the Department of Health tools on stakeholder analysis that illustrates the level of active engagement that is sought and therefore, the relative importance that different actors are given during the policy process. As the numbers reflect the total score from the analysis on level of interest and influence, and

were then divided by two, they can be seen only to be an estimate that act as a guide and is not to be seen as a definitive process. For example, although the media scores high overall, mainly due to its power to influence policy agendas, engagement with the media is often guarded, controlled or minimal, due to risk of the media creating negative publicity.

The different actors were placed into the four quadrants according to their total divided score, with no action taken for scores of '0', and the recommended level of engagement taken with stakeholders with scores between 1- 4, these are described in further detail in Figure 35.

Figure 35 - Stakeholder analysis tool used by the Department of Health, (2009)

Applying findings within the policy process from stakeholder analysis

1. INFORM- Proactively provide information to keep stakeholder informed	**2. CONSULT** Get feedback on formulated plans, proposals or decisions
3. INVOLVE- Allow stakeholder to participate in shaping and planning activities	**4. PARTNER**- Collaborate consistently with stakeholder in decisions, as well as planning and activities.

0. NO ACTION- There are no grounds to pay attention to the stakeholder. However, particularly in Government this is most unlikely unless you have selected a stakeholder who is not relevant at all or their stake in your work is being dealt with by an intermediate or national organisation.

The Department of Health guidance then gave the level of suggested engagement in the policy process, (see Table 60) with different actors based upon the scoring undertaken. This illustrates that in principle, how the power of different actors can be explicitly acknowledged and acted upon by policy makers. However, in reality, different levels of engagement were made for external versus internal stakeholders. Essentially, all internal stakeholders were treated as partners with varying levels of interaction according to their perceived power in influencing the agenda.

Table 60 - DH guidance on suggested engagement with stakeholders according to their overall score for influence and interest; (2009)

1. Inform: Provide Information for example:

- Material on websites
- Email bulletins
- Press release
- Conferences

2. Consult: Discuss plans in the form of:

- Briefings
- Workshops
- Market Research
- Internet surveys

3. Involve:

- 1 to 1 meetings at senior level
- Progress reports, or specific stakeholder updates
- Representatives on project boards

4. Partner:

- Funded ventures
- Joint submissions
- Ministerial working groups
- Shared delivery planning

For example, level one stakeholders would represent the general population and organisations with a low level of interest or influence – for these stakeholders the level of engagement was seen as an obligation to inform them of activities and policy formation. This is why conferences, press releases and information placed on the website are undertaken, mainly targeting external stakeholders. For level two stakeholders, (which in the analysis includes Public Health organisations and academia as external actors and DCLG and DEFRA as internal actors), the recommendation is to consult, with more active engagement in the form of workshops, internet consultations, surveys and market research.

In reality, level one and level two actors are framed more as external stakeholders and were informed and consulted in the same set of processes. For example, the consultation conference

that was held in November 2008, included discussion in workshops, circulation of the draft policy on the website and distribution via email to external actors for their comments and feedback over a 3 month period. This information was then collated to inform the next version of the policy, and used to identify risks and approaches for how to best frame the final policy report. Some other policy areas had funding for market research, especially if audiences were hard to consult via conferences and workshops.

Levels 3 and 4, mainly consisted of internal actors, and other government departments, which were much more actively engaged in the policy making process, for example, with meetings, workshops, inclusion on project boards and working groups. For external actors, the level of active engagement varied according to different policy areas and the perceived level of engagement needed by different external actors to ensure the final success of the policy. For example, the media was generally handled with caution as there was always the possibility of negative publicity, whilst the Voluntary Community Sector would be more actively engaged with, though this would depend upon their perceived level of influence.

Generally, internal actors, from other government departments were more actively engaged in the policy formation stages, with longer periods open for engagement, and as will be seen in the next chapter, even those departments with less interest, could end up having significant influence in policy formulation process. Those considered as partners, (level 4) only consisted of key internal actors, including the Home Office, and consisted of joint policy formation, with shared submissions, inter-ministerial working groups and policy delivery processes. The relative importance and power of each actor and factors affecting their influence are explored further later in this chapter.

In order to triangulate the stakeholder analysis with a more objective process, the documentary analysis summarised in annexes IV and V, was also considered to provide supporting evidence for the level of influence of the interested internal actors, in the form of government departments. The documentary analysis included an electronic search of documents from Governmental Departments made in the summer of 2008. The search selected documents that contained the words violence and/ or abuse in the context of violence, and is ordered by Governmental Department and each section was ordered by date. Government policy documents included either mention of violence and abuse specifically, addressed risk factors for violence and abuse or detailed approaches that have an impact upon prevention.

Additional documents were added following review by DH policy leads. The search was primarily between the years 2005- 2008, however, if little was found between these dates the website was searched further back until relevant policy reports were found. Additionally,

reports outside of these dates were suggested by policy leads. Key documents have been highlighted in bold and italics in annex IV and the weblinks for these documents can be found at the end of the reference section. The end of annex IV also contains an update of policy reports relevant to violence and abuse between 2008- 2010.

In total, 43 relevant government reports were identified that mentioned violence and abuse prevention between 2005- 2010. Of these, 16 were considered to be key documents (and are highlighted in italic in the appendix). The majority of reports were published by the Home Office (14 reports, of which 5 refer more substantially to prevention). This is in concordance to the stakeholder analysis, with the Home Office being perceived as the main specific government department leading on violence and abuse policy in general. Although, in the stakeholder analysis, the Prime- Ministers office and the Attorney General were found to be key stakeholders with significant power to influence and interest to address violence and abuse, there were no publications from these offices. However, the Prime-Ministers office does not usually publish its own reports, but delegates the leadership to a particular Government Department, which in this case was the Home Office rather than the Ministry of Justice.

In contrast, the Department of Health published 11 policy reports that mention violence and abuse prevention, of which two reports can be seen to be most relevant to the violence and abuse prevention agenda. The remaining either concentrating on treatment responses to violence and abuse or mostly focusing on determinants that influence violence and abuse. However, the main aim of documents addressing determinants of violence and abuse, in general would not be perceived as being centrally relevant to violence and abuse prevention. For example, see Table 61, which provides an excerpt from one of the key policy, documents on violence and abuse, here it is possible to see that the main emphasis is on the treatment of victims (and perpetrators). The text that mentions violence prevention is highlighted in italics, and although it conveys particular importance on the prevention agenda, citing it as the overarching aim of this policy, it is the only part in the whole of the document that mentions prevention, whilst the rest of the document describes in significant detail the programme for treating victims and addressing perpetrators.

Table 61 - Excerpt from 'The Victims of Violence and Abuse Prevention Programme', Department of Health, 2005-2008

(Bold and italics highlight areas specifically to violence and abuse prevention)

The Victims of Violence & Abuse Prevention Programme (VVAPP) has been established in response to the high prevalence of domestic and sexual violence and abuse and the evidence of mental and physical ill health associated with this. The intention of the programme is to tackle the root causes of mental and physical ill health in child abuse and domestic violence as set out in the Public Health White Paper's (2004) cross government strategy on these issues.

Additionally, the purpose of the VVAPP programme is to ensure that services and professionals in all sectors and settings are equipped to identify and to respond to the needs of those whose mental and physical health has been affected by domestic and sexual violence and abuse.

The VVAPP is a two-year programme, which began to come on stream from January 2005. It is jointly located within the Department of Health and the National Institute for Mental Health in England (NIMHE). The programme is tied into the relevant branches of the Department of Health: adult mental health, sexual health, child health and mental health, women's health and public health. Key elements of the programme are being taken forward jointly with the Home Office Domestic Violence Unit, Juvenile Offenders Unit, Sexual Crime Reduction Team, the Victims and Confidence Unit and the Criminal Law Policy Unit.

The VVAPP terms of reference are to address:

- *the mental and physical health implications of child sexual abuse, domestic violence, and rape/sexual assault – and the links between them*

- *professionals and services identifying and responding to the needs of:*

    i.   *adult domestic violence victims, survivors and perpetrators;*

    ii.   *adult survivors of intra and extra-familial child sexual abuse;*

    iii. *adult victims and survivors of rape and sexual assault;*

iv.   *child and adolescent victims of domestic violence and child sexual abuse, including child sexual exploitation;*

v.   *adolescent and adult sexual offenders (and sexual abusers not in contact with the criminal justice system).*

vi.   *Victims of pornography, prostitution and trafficking.*

Expert Groups have been established in each of these areas and there are now over 130 experts advising the programme.

The VVAPP includes a number of components, to ensure future policy and practice is built upon evidence, is responsive to the needs of victims and developed appropriately within mainstream service provision. The main stages of the programme include:

- ***Review of the literature- re prevalence, harmful effects and effective interventions***

- ***Mapping of policy and current service delivery responses***

- Delphi Consultation of stakeholders, including survivors

- Development of policy and guidelines

- Service planning, redesign and development

- Improve practice and new ways of working

- Evaluating outcomes for individuals

The joint Home Office and Department of Health national service guidelines on the development of *SARCs* (Sexual Assault Referral Centres), is one of the first publications arising out of the work of this programme scheduled for 2005.

Aside from service re-development, new ways of working to address and prevent violence and abuse, will include improved partnership working. At national level, this involves cross-government working with the DH, DfES and the Home Office through Inter-ministerial Groups on Domestic Violence and Sexual Offending, and in the wider context, of new legislation on domestic violence, sexual offences and mental health. At

> *regional and local levels, the Regional Government Offices and CDRPs will play a key role in reducing risk factors, prevention and ensuring appropriate multi-agency responses to domestic violence, sexual assault and abuse.* In this context, the violence and abuse voluntary sector (eg Women's Aid, The Survivors Trust, Respect) are the major providers of specialist services for victims, survivors and abusers).
>
> Anticipated outcomes of the VVAPP include reducing mental illness, self harm, suicide and physical injury associated with victimisation; improving the mental and physical health and quality of life of those who have been victimised; seeking to minimise revictimisation; and reducing continued and new offending. *The overarching objective is the prevention of this violence and abuse and its adverse effects.*

The Department for Children, Schools and Families had 7 relevant policy documents, which mainly related to policy about child safety rather than prevention, although Every Child Matters, (2005), included aspects affecting the determinants of violence and abuse. In contrast, although the Department of Communities and Local Government had published 8 policy reports, these were around Community Cohesion, Social Exclusion, Cleaner, Safer, Greener Communities, the Respect agenda and Sustainable Communities. All these areas influence the wider determinants of violence and abuse, and were seen to be more distally related to the policy agenda which is why they scored less in the stakeholder analysis than the Children, Schools and Families Department, who had a more proximal and tangible interest in ensuring the safety of children from abuse. Although, policy leads in the Department of Environment, Farming and Rural Affairs, conveyed a lot of interest in supporting the violence and abuse prevention agenda, only one policy report on sustainable development was deemed to be specifically relevant to the violence and abuse prevention agenda.

The draft Violence and Abuse Prevention Framework (DH, 2008) for consultation, cited that it supported a range of policy areas, including in Table 62, by providing a comprehensive overview of risk factors for violence and abuse and of the evidence base of what works in the early prevention of violence and abuse.

Table 62 - Policy contributing to violence and abuse prevention, cited in the Draft Violence and Abuse Prevention Framework (DH, 2008)
(italics were reports given emphasis as being especially relevant in the report)

- *Cutting Crime: A New Partnership 2008-2011; including relevant Public Service Agreements; (Home Office)*
- *Saving Lives. Reducing Harm. Protecting the Public. An Action Plan for Tackling Violence 2008-11. (Home Office)*
- *The National Domestic Violence Delivery Plan 2007/08, (Home Office)*
- *The Sexual Violence and Abuse Action Plan, 2007, (Home Office)*
- *The Health Inequalities Progress and Next Steps, 2008, (Department of Health)*
- Staying Safe Action Plan, 2008, Department for Children, Schools and Families
- The Child Health Promotion Programme, Pregnancy through the First Five Years of Life, 2008, Department of Health
- Think Family, 2008, Department for Children, Schools and Families
- Every Child Matters, 2004, and the Children's Plan, 2007, Department for Children, Schools and Families
- Aiming High for Young People: A ten year strategy for positive activities; 2007; Department for Children, Schools and Families & Treasury;
- The Children's Plan, Building Brighter Futures, 2007, Department of Children, Schools and Families
- Youth Crime Action Plan, 2008, Home Office
- Tackling Knives Action Programme, 2008, Home Office
- Next Steps in the Alcohol Strategy – Safe. Sensible. Social, 2007, Department of Health
- Drugs Strategy 2008, Home Office
- Responding to domestic abuse, a handbook for health professionals, 2005, Department of Health
- Respect Action Plan, 2006, Home Office
- Social Exclusion Action Plan, Department of Communities and Local Government
- Government Sustainable Development Strategy 2005, Department for the Environment, Farming and Rural Affairs
- 'No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse', 2000, Department of Health.

The outline of the draft report, described how key findings were summarised and implications outlined to aide a jointed up approach in partnership working as well as clarifying specific roles for different sectors. It also mentioned that it provided toolkits and additional resources to help front line practitioners in their role of preventing violence and abuse.

Additionally, the preamble in the draft Violence and Abuse Prevention Framework (DH, 2008) heavily referred to other published Government documents on domestic violence, including; the third *National Domestic Violence Delivery Plan 2007/08,* www.crimereduction.co.uk and the House of Commons Home Affairs Committee '*Domestic Violence, Forced Marriage and honour-based violence' Sixth Report of Session 2007-09, Appendix 59.* The draft policy then goes on to describe how Government work on domestic violence is brought together in the cross-government National Domestic Violence Delivery Plan and how in 2005 the Home Office published its first National Report on Domestic Violence.

This illustrates how important politically addressing Gender Based Violence was under the Labor Government of that time, which to some extent made it difficult to develop a comprehensive prevention approach for all forms of violence and abuse.

7.11   Discussion: Relative Power and Politics of Actors

We have seen in the previous sections that the main actors with the strongest interest in policy development on violence and abuse in general, was the Home Office, with the Attorney General playing a particular role and receiving occasional high level interest by the Prime-Ministers Office, driven by high profile media events. However, the Department of Health and Public Health were ultimately key actors with lead responsibility in developing the prevention policy for violence. Whilst, the Criminal Justice System's main motivation was to reduce crime with a focus on containment and protection, this contrasted to the health sectors main interest to improve health outcomes, with a greater focus on upstream prevention. Finding common ground with Other Government Departments resulted in positive joint policy approaches, whilst not doing so resulted in lower engagement and resistance, which can be seen in part, as an expression of negative power.

The stakeholder analysis makes explicit how relative power in the policy making process can be seen as the combined level of interest and influence for the specific policy agenda. This can be considered as a form of positive power, as those with most interest and influence wish to actively drive a policy agenda. In regards to the relative power observed in the process of policy development for violence and abuse prevention, the criminal justice sector, (mostly the Home Office), was considered by central government and other sectors as the lead agency for

violence and abuse in general and therefore were seen as the most influential actor in the policy, making process. Generally internally within the civil service, there was a recognized power hierarchy between different government departments, though this varied according to different policy areas regarding who was perceived to lead on which area.

This relative power, however, was observed to be superseded by the Prime Minister's Office following media events that proved to be key influences for decisions made by central government pushing the violence prevention policy forward. This reveals that ultimately, central government, including the key players of the Number Ten Downing Street, the Cabinet office and to a lesser extent the treasury, were generally seen as being most powerful in influencing policy decisions. In this case, the Criminal Justice Service generally had the most interest and influence in driving the violence policy agenda, however this could be over- ruled by higher government.

The Home Office and police were actively seen to have pushed the agenda forward, and the exertion of this influence had increased power when it had the active backing and demand from central government. For example, following the series of gun and knife crimes in the summer of 2008, the Home Office was able to actively push the information sharing role of Emergency Departments without having previously negotiated this with the Department of Health. This can be seen as an active expression of power by the Home Office whilst under pressure from Number Ten Downing Street. However, follow up discussions by policy leads helped to balance this exertion of power, with a feasible policy solution developed, and a regaining of relationships by policy leads.

The complex and multi-factorial nature of violence and abuse, was seen to make this a difficult issue to comprehend and understand solutions. For example, many sectors describe prevention as addressing the most proximal event related to a visible aspect of violence, and find it difficult to make the links for the need to address many upstream risk factors to prevent violence and abuse. Additionally, violence and abuse is mostly framed as a Criminal or Human Rights issue primarily and not as a health or public health issue. This view is reinforced by the VCS, the Home Office, the Police and Criminal Justice System taking a very visible lead on this agenda; the use of language of violent crime, and the representation in the media of violence rarely portrays violence and abuse as a health issue.

Although, the Department of Health, including public health advisors, were understood to have the lead role in violence prevention especially in terms of policy content, they had perceptibly less power, compared to the Home Office, (or higher government) in driving the policy process. The relative power of the public health approach to violence is observed to have a

double challenge, as it is seen as relatively marginal within the mainstream violence policy dominated by the Home Office's focus on containment and protection, and also is perceived as marginal within the wider Public Health community.

Although, there were a small number of committed Public Health Champions and Leaders who were instrumental in increasing the profile and visibility of violence and abuse as a public health issue, this issue was still perceived as a more marginal public health agenda. Violence and abuse had to compete against many higher-level priorities with higher levels of Burden of Disease in a relatively crowded public health scene. Potentially, the WHO could have played a more powerful role in driving this policy, in its role as both an enabler as well as policy driver. However, England already has a wealth of international experts, and the WHO has relatively little resources to support every country, therefore, the relative influence of the WHO for this particular policy, has been on agenda setting rather than policy development. Whereas, the WHO prioritises effort in countries with less expertise, and plays a more important role in capacity building for a range of public health issues, including on violence and abuse.

As Violence and abuse were not perceived as a mainstream issue in Public Health, the round table in chapter two, considered that it is not generally seen to be a part of the Public Health consciousness, with few memorable headline messages and generally little knowledge of the evidence base. As violence and abuse were seen mostly by the health sector to be the domain of the Criminal Justice System, it meant that there was little ownership or resources for violence prevention within the health sector. As Public Health had few levers or funding to contribute to the agenda other than technical skills and expertise, this acted as a barrier to contributing as an equal partner with other sectors and affected the overall perception of power by other actors. In contrast, the round table of public health experts, Table 53 based upon previous public health experience, considered that it was possible to increase awareness and influence, by increasing visibility of the agenda, increasing the relevance to mainstream public health, forging partnerships and ensuring consistent, clear messages.

Discussions with public health experts and policy leads revealed other approaches to increase the relative power and influence of public health in taking forward this prevention policy still further. A policy lead advised to increase the relevance and relative significance of this policy by emphasising risks, with the suggestion being on the risks in child protection. For example, the increasing evidence base of children having negative outcomes if in a family where domestic abuse occurs is an opportunity to emphasise the potential risk of not taking more proactive action with these families, including preventive responses. By focusing on risk helps to bring in the more cautious actors within the mainstream as opposed to the 'change agents'. Whilst, if an actor has relatively little power, or needs to increase their power for a policy goal,

by forging partnerships with other sectors, it is potentially possible to enhance influence by strengthening and aligning approaches with other relevant partners, both internal and external.

The above section on the whole, describes the relative power and interactions of those actors who have high levels of both interest and influence in the agenda, and this was generally expressed as positive power, as their main motivation was to take this policy agenda forward. In contrast, however, it was observed that those actors with either less interest or influence, could at times, whether intentionally or not, exert negative power on this agenda, which acted to slow down or even reverse the policy process. Motives for being involved in this policy agenda were seen to be mixed, and this can be understood as an expression of gaining political or even of personal power.

Establishing policy clearance by all the relevant government departments, revealed that any dissent by an actor, whatever their level of interest, could act to delay or block the policy making process, illustrating the relatively high level of internal influence compared to external actors. In contrast, external actors, including the Voluntary Community Sector had relatively high interest, with a mixed and limited influence on policy formation; although championing this agenda, strong extreme theoretical views inadvertently contributed to slowing policy progression.

From a 'big' political perspective, the change from a Labour to a Conservative- Liberal Democrat coalition government in 2010 saw a renewal of Ministers with differing political agendas and motivations and affected the wider policy making context, with a shift to relatively less central government policy. This was seen to contribute in part to the rejection of the violence and abuse prevention policy in 2011, by DCSF, who expressed high influence with little interest in the agenda. However, the relatively invisible and taboo nature of violence and abuse potentially also influenced the lack of policy clearance by DCSF at this stage, as the Minister was unable to perceive the relevance of this agenda to the policy remit of Children, Schools and Families. This perspective may have been reinforced by some professionals in this field who were encountered to have clearly felt uncomfortable about discussions on violence and abuse and actively tried to deny or belittle its prevalence and impact.

The invisible nature of many forms of violence and abuse, due in part to the taboo nature of this area, has contributed to a general societal reluctance to discuss these issues openly and fully, which has influenced how this agenda is dealt with in a professional or policy context. This lack of visibility has in turn, has meant that its full impact upon public health and other outcomes has not been perceived. As described, most of the data is from those few seeking services or from a criminal justice perspective, rather than a health or educational perspective,

which has created a distorted view of the patterns, determinants and outcomes of violence and abuse and affected the ability to influence a wider range of audiences. A distorted understanding of violence and abuse affects both the focus on service delivery to one of downstream, tertiary prevention, as is largely provided by the health and VCS.

For example, it was recognised that the role of the VCS in policy for violence and abuse, who had a high degree of interest with less ability to influence the agenda, was mainly to raise the profile of this agenda, primarily to raise support, including resources for services for victims. Therefore, they expressed a high level of interest in the violence and abuse agenda in general, however, in contrast, they had mixed views and interest in the prevention agenda, which could potentially be seen to be in conflict of their own agenda. As has been seen in this policy context, and also as expressed by the Public Health round table in chapter two, the Voluntary Community Sector can actively oppose the public health view. It was observed that members of the VCS were antagonistic to the public health approach, for example, about the role of alcohol in violence and the life course approach.

In contrast, the scientific and policy community have considered the VCS views to be too extreme and non-scientific, and therefore not representing mainstream public views, which has compromised the level of engagement by mainstream organisations, including public health. Whilst in this case study, the disagreement expressed by the VCS on the role of alcohol and the life- course perspective following the consultation event, acted to slow policy development in this area. This may have been intentional by the VCS, however, this influence was likely to have been inadvertent, as although there was controversy expressed about the approach to prevention, they VCS were largely seen to support the overall principle. This illustrates how a high level of interest, with variable influence can potentially distort negatively the policy process.

Another consequence of the distortion of visible information on patterns of violence and abuse, can be seen by the relatively high level of interest in the Media in personal stories of extreme horror or tragedy in order to sell their communication products. This was seen to lead to high levels of repeated media coverage on knife and gun crimes, which are highly visible, though relatively rare forms of violence, at least in England. The media coverage on knife and gun crime during 2008, and then the summer riots in 2011, led to number 10 Downing Street (with the Home Office as lead department) driving a policy response. This portrays the relatively powerful degree of influence the media has, especially as an external actor in pushing a policy agenda forward. This media coverage drove a high level political response demanding regular press releases and weekly contributions from the relevant Government Departments to address violence and abuse. However, although the media influence is potentially very powerful, it can

be seen to be relatively fickle, moving from one high visibility area to another. Ultimately, the role of the media proved to be a powerful one, with its temporary, but very high level of interest and influence, it was able to create two important windows of opportunity to propel this policy agenda forward.

However, the Media interest in an agenda is more on problems rather than solutions, of which the prevention approach can be framed as a solution, and media influence can lead to the creation of reactive policies. Additionally, from a political perspective, they exert their power by increasing visibility and influencing voter views, which can be a potential risk for government popularity, with the potential of repeated negative publicity affecting voter direction. Akin to advertising, their influence is stronger if they repeatedly publish headline messages.

Ultimately, though, the expression of relative power and politics can to be seen to have been a fluctuating, interacting and dynamic process, with different actors playing relatively different levels of influence at varying stages of the process. Whereas, the criminal justice actors and Department of Health were seen to be the primary actors throughout the whole process, both expressing relatively high levels of interest and influence although with differing views on the balance of preventive approaches. These can be framed as high levels of positive power, in that they consistently advanced the policy agenda. Whilst, the Prime-Minister's office temporarily had a couple of periods with very high levels of interest and influence, which followed similarly short, though high levels of media interest in this agenda, creating a spike of high influence by the media. This in itself interacted with the relative power of the other actors, with the Home Office and the Department of Health in particular taking advantage of these policy windows of opportunity. This gave the Home Office a relatively higher level of importance at this time, by chairing the input from other government departments and directly reporting to the Prime Ministers' Office. In one of these instances, the Home Office was seen to express its higher level of power more overtly, by independently announcing an action that was in the health sector domain without prior discussion. In contrast, other actors, both internal and external, with either less interest or influence, were still seen to have particular periods where they were able to exert considerable negative power and influence resulting in a stalling of the policy process. This sometimes occurred intentionally or inadvertently, and was observed to be either part of 'big' politics, or related to extreme theoretical perspectives, or to the exertion of personal power.

From an insider perspective, this gave the appearance of a constantly variable and dynamic process. There were multiple actors in the overall process, all with varying and fluctuating degrees of power, which were observed to be in a constant interface of interacting power

dynamics, interspersed with periods of time with little progress and diffuse decision making. The public health consultant who worked on the violence and abuse prevention policy captures this sense well, with a reflection on the experience of working within the policy environment, (see Table 63).

Table 63 - Final Reflections by a Public Health Consultant on the Policy Process in Developing the Violence and Abuse Prevention Framework, 2010

But… Don't be surprised if, despite having done all of the above, someone arrives at the last minute to say it's no longer needed, it's wrong, or that it cannot be cleared until it has been through another process. You are in Planet Government: a sometimes strange world of connected ecosystems, micro-climates and complex food chains, populated by a wide variety of species, groups and behaviours but all living together and adapting to changes in supply and demand, random weather patterns, seasonal fluctuations and the occasional cataclysmic event.

7.12   Summary

The main factors affecting different sectors engagement in contributing to policy on this agenda included the risk of negative media publicity, this was especially driven by high profile violence incidents and was a key influence for decisions made by central government. Policy development was seen as the key domain of government, with the criminal justice sector considered by central government and other sectors as the lead agency for violence and abuse prevention. Successful policy development occurred with other government departments when policy was seen to benefit key outcomes of interest by different sectors, however, when no benefit was seen, resistance and blocks to policy formation occurred.

The main contribution of the public health organisations and VCS was to advocate for a relatively neglected area and bring it into mainstream policy, however, extreme theoretical stances inadvertently slowed policy progression. A summary of the main findings for objective three on which set out to describe and explore the role of different actors in influencing the policy process for violence and abuse prevention are outlined in Table 64below.

Table 64 - A summary of results three on factors influencing actors - Power and politics

- **Who, how, why:** the main actors with the strongest interest in policy development on violence and abuse in general, in particular, was the Home Office and the Attorney General, with occasional high level interest by the Prime-Ministers Office, driven by high profile media events. However, the Department of Health and Public Health were ultimately key actors with lead responsibility in developing the prevention policy for violence. The Criminal Justice System's main motivation was to reduce crime, whilst the health sector aimed to improve health outcomes. Finding common ground with Other Government Departments resulted in positive joint policy approaches, whilst not doing so resulted in lower engagement and resistance.

- **Relative power:** the criminal justice sector, (mostly the Home Office), were considered by central government and other sectors as the lead agency for violence and abuse in general and therefore were seen as the most influential actor in the policy, making process. The Department of Health, including public health advisors, were understood to have the lead role in violence prevention especially in terms of policy content, however, they had perceptibly less power, compared to the Home Office in driving the policy process. It was possible to increase this power marginally, by increasing visibility of the agenda, forging partnerships and ensuring consistent, clear messages. This relative power, however, was superseded by the Prime Minister's Office following media events that proved to be key influences for decisions made by central government pushing the violence prevention policy forward.

- **Internal and External politics:** those with less interest or influence in the agenda, were at times, seen to exert more negative forms of power, which can be understood to be an expression of gaining political or even personal power. Establishing policy clearance by all the relevant government departments, revealed that any dissent by an actor, whatever their interest, could act to delay or block the policy making process, illustrating the relatively high level of internal influence compared to external actors. In contrast, external actors, including the Voluntary Community Sector had relatively high interest, with a mixed and limited influence on policy formation; although championing this agenda, strong extreme theoretical views inadvertently contributed to slowing policy progression. In contrast, the Media had temporary high levels of interest and influence, creating important windows of opportunity. Ultimately, though, the expression of relative power and politics was a fluctuating, interacting and dynamic process.

The next results chapter presents results for objective four and explores in further depth the policy formulation process.

Chapter 8 - Results - Four: To Summarise the Policy Formulation Process

Research Question: What are the implications for understanding the policy formulation process?

The research findings from the previous chapters reveal that the policy process is a highly complex process. This chapter goes on to explore further the main observations made of the policy formulation process, which are based upon the main findings from the Observational Analysis Framework, this is supported by further evidence from secondary observations and emails made on the policy process. See annexes VI- VIII for findings, of which relevant summaries and examples are provided in this chapter. Then the key steps in the policy formulation process are outlined, based upon the timeline presented in objective one, and observational and secondary analysis of the policy process undertaken and described in the first section of this chapter

The chapter first explores the role of different actors in placing violence and abuse on the policy agenda in the first place, this is followed by a description of the importance of strong leadership and champions observed in driving the policy process. Another key factor in forwarding (or delaying) this policy development was of timing and making the most of particular policy windows. Next, the key policy tasks or steps that need to be achieved towards the end of the final clearance process are described. Lastly, the cyclical nature of the policy decision making process and repeated consensus formation, which was seen as a key finding in this research, is described.

8.1   Observations of the Policy Formulation Process

In this case study, it was observed that if a minister (or PM) has a particular interest, they are in a strong position to individually place this on the policy agenda and push for its final development and delivery. Civil servants can also play a role by creating awareness of an issue and gaining departmental and ministerial support – the more senior position they are, the easier this is. Pressure groups or lobby groups can potentially play a strong role in placing a policy agenda item, however, this was not observed to be the case for the prevention of violence, however, the response for victims was more significantly influenced by the VCS acting as pressure groups.

The WHO World Health Assembly resolutions can be seen to have played an important role in setting a policy agenda, with governmental endorsement to take forward action in a particular area, as was the case for violence prevention. However, the level of action can be extremely variable in response to WHA, with no legal influence or heavy reporting obligations, at times this influence was observed to be not very tangible. Action is usually taken if already intended to do so by a country, however, it probably helps to bring forward an agenda, and advances awareness, brings about evidence based standards and guidance for emerging public health issues.

As has been seen, in this case, policy was frequently driven by media pressure – of highly visible issues that generate media attention of a problem and set the policy agenda, which happened with obesity in the UK and also has been observed regarding the riots and knife crime pushing violence policy.   However, pressure groups can also play a role in presenting a problem and pushing an agenda, (eg British Medical Association re the Medical Training Application Service – following the unemployment of junior doctors when the new computer service came in, (Carlisle, 2007); and frequently use the media to gain extra leverage.

Royal Colleges play a credible role in opinion forming and expert advice, however they were rarely proactive in their approach to push for a policy agenda, at least in this case, and did not play a significant role in violence and abuse. Expert Advisors to the Government in some areas, were seen to be highly influential in persuading ministers and pushing an agenda, for example, the role that Sir Richard Layard played with the roll out of cognitive behaviour therapies. This was especially supported by making a clear economic case for developing policy in this area. Likewise, the economics studies on violence prevention conducted by the London School of Economics could potentially have been used to better advantage if the evidence was presented in a more persuasive fashion appropriate for Ministers and policy makers.

Advisory Groups, like scientific advisory groups commissioned to investigate an area at the request of the government, can act as drivers to place an issue as a policy agenda. For example, by presenting negative performance monitoring reports, i.e. health care commission, scrutiny boards or Public Service Agreements (eg on fuel poverty) that illustrate a failure of reaching established targets. This frequently generates negative media attention that can act to drive a policy agenda. However, this was not observed in the case of the violence and abuse agenda specifically.

8.2   Leadership and Champions

Good, clear and senior leadership is a key to progressing policy work in general and specifically with violence prevention. For example, during a period of reorganisation during 2006/ 7 for almost a period of a year, changes in senior public health leadership roles resulted in a stasis of policy progression in this area. At first it was not clear who was leading on violence prevention nationally, once this was established, it was unclear who had what role and what the relative contributions should be or what the roles should entail. Lack of clear leadership was a repeated theme found in the diaries and in the observational analysis, (for example, see diary entry 13th April 2009 in Table 65).

Table 65 - 13th April 2009 - PhD Reflections

For eg New Unit developed to oversee
this new policy process now putting
emphasis of EB on NICE - that this
isn't part of role of strategy / policy
to provide the EB
→ ie Policy should be supporting / enabling
local + regional autonomy.

This was frequently found to result in unclear decision making that inadvertently slowed the policy making process. On reflection, some of this may have been a way of stalling the process to wait and ensure good consensus formation by senior policy leads. In contrast, stronger and more decisive leadership was generally expressed by Ministers, who had the authority to make decisions.

Clear leadership roles were found to be important for providing sufficient authority to take forward pieces of work and policy development and to avoid duplication of work. Leadership was better if it was expressed visibly, for example, championing the work of violence at the reception held at 10 Downing Street in September 2006. Additionally, useful leadership actively progressed or delegated work, whilst leadership in name but nothing else, could act as a barrier or inertia to progressing work. Observations found that when strong leadership championed the work, it helped to give authority and permission to others, provided a clear vision and sense of direction and facilitated clear decision making regarding the policy process.

Ministers vary considerably in their backgrounds and experience, identifying and working closely with ministers who support and champion this agenda was important in gaining senior and cross departmental support and leadership. Ministers change roles every so often, so this influence can be lost, however, those with a real interest in championing this work furthered work in their new roles and have acted as important leaders.

Even when there were periods of unclear leadership and a fragmented approach to how policy development was taking place (which resulted in policy inertia), networks of policy champions maintained violence and abuse prevention 'bubbling' as a potential policy issue. During this time, policy champions would have occasional meetings and discuss forthcoming policy opportunities and activities. These champions were not labelled or identified as such, but their actions were observed to ensure continuity of policy development at times when there were relative lapses in visible leadership driving this process.

This largely informal group of committed policy leads, acted as an informal network that would occasionally meet or email to address a specific issue, either as individuals and at times as a

formal or informal group. They were individuals who were observed as being highly committed to addressing violence and abuse and had a remit in their work agenda to address violence and abuse. This resulted in continuation of violence prevention work being reflected in relevant wider policy areas – for example, in the Home Office Tackling Violence Action Plan. When the timing was not right to progress specific policy work on violence prevention, the support of these informal policy networks was observed to be important to maintain the energy and enthusiasm of policy champions.

The policy process was significantly influenced and shaped by policy champions with an interest and commitment in this agenda – this was found specifically for the violence and abuse agenda, but was noticed in other fields as well. There were also many policy makers who have this as part of their work remit and are dedicated and committed in their work generally, whether it was on violence or another topic.

In contrast, there were key actors in leadership and policy lead positions whom could have more visibly taken forward the violence and abuse prevention agenda, who were observed to not actively progress this work. This was often related to busy workloads, of which violence and abuse was perceived as an additional area and not always a priority compared to competing work pressures. This was at times observed to demotivate progression of policy for those under their influence.

Alternatively, some actors in the civil service were seen to be more motivated by career progression, managing Ministers' expectations and workloads or controlling the policy process for a sense of personal power. Many policy makers have no specific knowledge or expertise in the content of a particular policy area that they have been assigned to, and therefore, may have variable interest and commitment to a particular agenda. After observing the long and repetitive nature of the policy formulation process, outlined later in this chapter, it can be seen that this process may act to de-motivate policy leads, who may take a passive or indifferent attitude to this process, after seeing it repeated over many years.

8.3   Timing and Policy Windows

The political context is highly relevant to the policy process – with larger political agendas influencing the policy context. For example, a right wing government focuses on reducing the role of the government and the public sector and tends to result in a constraint and punishment approach to dealing with violence. Whilst a left wing government is more concerned about human rights and equality and the role the government plays to ensure society can all benefit. At the end of the research period, the government changed from a left wing to a centre-right

political party in May 2010. This was observed to create a major shift in policy emphasis, from one that was highly supportive of violence and abuse prevention at ministerial level, to one that had a variable view about why the government should play a role in this at all.

However, the right timing of pushing a policy agenda appeared to be very important, with a couple of key 'policy windows' emerging in the summer of 2008 and 2011, when violence was high on the political agenda. This enabled high-level political support to push for further policy progression on violence prevention. One of the key challenges for this policy area was that for most of the time, most forms of violence and abuse are not that visible, or do not make good media stories, as the media tends to be more interested in personal stories compared to longer term prevention or strategies. Therefore, general approaches to prevention suffer from a lack of media interest, and a sense of quick returns so are often not seen as politically very important.

However, the media in the UK are generally very interested in the visible aspects of violence, including gang violence, riots, knife and gun crime. When these events occurred, they provided excellent opportunities to push violence prevention up the policy agenda, driving action from the Prime-Ministers office. Politicians need to reduce negative publicity and be seen to be taking action on any negative public events as it can easily influence their popularity and chances of being re-elected.

Additionally, most health services (and other sectors) focus most of their energy and resources on immediate problems resulting in a reactive approach to visible problems. This is illustrated in points 2 and 3 in diary reflections in Table 66, which goes on to further describe how this creates challenges to longer-term prevention approaches. This reactive approach tends to result in policy being made in a relatively incremental and minimal way for the majority of the time, that is until a significant policy window occurs, which can be driven by political or ministerial changes, and high level media events.

Table 66 - 29th January 2009 - Personal Reflections for PhD

PhD Reflections   2nd Jan 09.

① . Lack of clear direction / leadership
     from policy lead
     - 'keeps changing mind' / indecisive

   2 Influenced by previous Personality +
     Difficult Hx.

② . Agenda driven by Home Office
     - ie VAW / HO driven

   + Knife crime HO / PM lead

   → Tends to focus on problem, be reactive
   + look for immediate short term solutions.

③ Prevention message — difficult to understand
     the wider / upstream determinants message
   + to make case — ie complex / multi-factorial

   - Policy desire for 'single bullet'
     ie   x problem → x - solution +
   difficulty if don't have levers ie favours
   health sector response, opposition from others
   if expectation

④ . General policy (Civil Service Approach   ) De
   to keep things quiet, not create more   Gregor
   work, down attention, ends up being
   minimal / reactive, incremental vs
   strategic policy created

Historically, although there is now generally less taboo in discussing violence and abuse, there are still individuals, including professionals who 'deny' the statistics or consider that this is not an issue for them to address. Some of this resistance reflects in part the discomfort in dealing with these issues and also limiting the implications of having to deal with them. This created an additional barrier in taking forward violence and abuse policy, which possibly made policy windows a particularly significant opportunity.

Another key barrier that held back and affected the timing of the policy making process was the change in Government in May 2010. The period leading up to a general election is known as Purdah, and is essentially a period of 2-3 months before an election when no policy decisions or announcements are made. This is essentially because policy commitments will not be possible to deliver upon, and also as it can be seen as influencing the democratic process as policy announcements can be seen as part of an electioneering campaign. The period of Purdah, with the general election followed by realignment of new government policy caused delays and

held up the policy clearance for the violence and abuse prevention policy by approximately one year, as outlined by the secondary observations of the public health consultant described in Table 67.

Table 67 - March -August 2010 – Policy Alignment with new Government; (secondary observation, public health consultant)

DA process and 'purdah' March 2010

The DCSF and HO refused clearance during DA process in March 2010. Because this had happened close to 'purdah' – the period before the election when ministerial approval/sign-off activity is restricted – it was not possible to complete the amendments needed in time. So, the VAPF could not be endorsed and had to be shelved until after the election.

After the election of a new government in May there was a delay of about 30 days during which new policy was being disseminated. This also required a re-editing of the VAPF to remove references to old policies and structures and align it to new government objectives.

The VAPF was updated to reflect new revised HO data as well as evidence from other sources regarding national programmes (e.g. Tackling Knives Action Plan) as well as WHO sources relating to serious youth violence.

The VAPF was passed to the DH analytical process to be cleared by both DH and HO Analyst teams. This was completed in early August.

Ministerial approval was given at this time for the VAPF to go through the new cross-government process – the Domestic Affairs committee (DA), now called the Home Affairs (HA) process. This has the same function of high-level scrutiny but also includes a Ministerial Public Health Committee.

The timing of engagement within the policy process was seen to be key to affecting the degree of influence that can be exerted in the policy process. On the whole, engagement with external stakeholders was limited to certain times, which tended to be relatively early on in the shaping and formulation of policy. At later stages, most of the policy decisions are kept within Government, namely, policy officials and ministers. This allowed policy coherence and consensus to be achieved and to ensure that it is taken through the formal policy clearance processes without undue interruption. However, late negative feedback by policy officials (in any Government Department) was seen to be used unintentionally or intentionally to slow or

even block policy clearance, despite strong Ministerial directives. Although, the use of policy windows were used to full advantage, the complexity behind achieving policy clearance meant that the final policy still took over a full year to be published in November 2012 after the summer riots in 2011.

8.4   Policy Formulation Steps

In this case study, policy formulation was seen to be based upon repeated and cyclical processes, which initially were about gaining engagement with external stakeholders and policy coherence across government departments. This is seen in the time period following the feedback received from the consultation process, from April 2009, until September 2009. This period of time involved embedding the Violence and Abuse Prevention Framework (VAPF) into other relevant policy areas to ensure alignment with wider policy, and gaining engagement and agreement from policy leads on the shape of the developing policy. This process is described in the secondary observation in Table 68.

Table 68 - April-September 2009: Update process of the draft policy after consultation feedback; (secondary observation from Public Health Consultant)

We scoped the document.

- collating the responses from a wide range of commentators
- identifying what information was most relevant for a public health approach
- deciding on a 'factsheet format' as a practical resource for influencing policy.

We approached policy leads in other government departments (OGDs) to highlight the relevance of the VAPF work and align it to their own policy areas and objectives.

The VAPF work ran alongside other violence-related work with more detailed research and discussion with DH and OGDs (e.g. work on the cross-government Tackling Violence Action Plan (TVAP) and a Department of Health guidance document on Sexual Assault Referral Centres (SARCs)

The VAPF was also included in objectives for other government workstreams such as TVAP, policy work for (The cross-government HO-led strategy for Tackling Violence Against Women and Girls and 'New Horizons' - the cross government Mental Health Strategy that included a Public Mental Health (PMH) evidence base document.

> We also attempted to link violence and abuse prevention into the ongoing Marmot Review of Inequalities (but this was not included in their final report).
>
> **Communication on drafts with policy leads in DH and OGDs**. This was to highlight the relevance of prevention to those whose policy was most aligned to the work and would have a major role in delivering interventions and programmes. These included Home Office (HO), Department for School and Families (DSCF) – now Department for Education (DfE), Ministry of Justice (MoJ), Department for Communities and Local Government (DCLG), Department for Environment, Food and Rural Affairs (DEFRA) and to internal DH stakeholders.

This then moved into the more definite stage of acquiring approval of the near final document from policy leads across the different government departments. The period from September to December 2009 involved a process of repeated engagement with policy leads, this time with a view to gain approval after their earlier comments had been incorporated. Once this had been agreed and with the endorsement of the Home Office as the overarching lead department on violence policy, it was possible to gain provisional endorsement of this document in the form of cross – governmental department logos. At this stage the main changes to the policy were about ensuring the most up to date data was used in the figures on violence and abuse included in the policy. See Table 69 summarizing secondary observation of this process.

Table 69 - September –December 2009: Policy lead approval; (secondary observation by Public Health Consultant)

> **Approval from individual Depts.**
> DCSF and DEFRA agreed content of document and gave endorsement through their departmental logos. Follow-up with HO (incl. Violent Crime Unit and National Violence Taskforce Forum) continued.
>
> **Permission to produce the VAPF as a cross-government document.**
> HO as lead department for crime and violence policy agreed to VAPF being badged as cross government document (and Domestic Affairs process). Single departmental endorsement was no longer needed.
>
> **Continuing to update evidence base and information**
> In response to comments from cross-government endorsement we included and updated the evidence base work from the Public Mental Health programme, recently released HO data, WHO prevention review and more detail on cost-effectiveness and relationship to inequalities.

Once this level of provisional agreement had been made with policy leads across the different government departments, it was possible to take the policy through the formal policy clearance steps. At this stage, there are a number of policy procedures that the document needs to pass through, including the Equality, Financial and NHS impact assessments, followed by the analytical approval to ensure all figures in the document are correct, then lastly gateway approval, which is given by the communications and publications department. Each of these steps involved a substantial amount of work by the policy leads, for example, for the impact assessments, they usually required the development of separate reports outlining the impacts upon cost, equality and on the NHS, that are published at the same time as the final policy report. Once these stages have all been cleared, the process involved agreement initially by a health minister, followed by ministers from the other government departments and cabinet office, in the form of the Domestic Affairs process. These steps are outlined in Table 70.

Table 70 - January-March 2010: Main policy clearance steps; (secondary observation, Public Health Consultant)

Progress through cross government endorsement process

The cross-government endorsement process involves

Before DA approval, the document is examined for its impact and accuracy.
This includes

Equality Impact Assessment (EqIA). how the document will further equality objectives and work. The document and action plan is signed off at Director General level and approved by the EqIA team.

Financial Impact Assessment. What are the potential financial implications of the work upon DH or other government departments.

NHS Impact Assessment. What are the financial implications for the NHS? There is a threshold value, under which proposals can be approved by the NHSIA team.

Analytical Dept. sign off: the proposal/document is reviewed for accuracy of data and signed off by the departmental Analytical Team. This is then shared with key Analytical Teams in OGDs

Gateway approval: The governmental publishing process ensures that any document is in line with government policies and has met the previous impact assessment processes. It also links in with the document production process to approve formats (e.g. printed and electronic forms and dissemination processes).

Ministerial approval

- that the content of the VAPF is appropriate and relevant to governmental objectives.

> • that the VAPF can proceed to the Domestic Affairs Committee stage.
>
> **The Domestic Affairs (DA) process** involves high-level scrutiny by departmental policy leads and then sign off by an inter-ministerial group headed by Cabinet Office lead, (was Jack Straw, now Nick Clegg)

As described earlier, further progression of these policy steps was stalled at this stage due to purdah and the change in government. However, the email in Table 71 below from a policy lead in the summer after the general election, summarises the main policy clearance processes so far achieved on the document, with a view to potentially gaining early clearance of the document for the international Safety Conference that September 2010. Unfortunately, the report was not given final approval by ministers as it was so close to the new government having been in place, therefore there was a degree of hesitancy by the new government on approving new policy unless it was seen to very directly support their wider policy agenda. However, this email illustrates the main policy clearance steps that needed to be achieved for the final agreement of the policy.

Table 71 - Email summarising the progress of policy clearance on the Violence and Abuse Prevention Framework, (VAPF) July 2010

> FYI
>
> 1. Gateway have approved the VAPF (12912)
> 2. EqIA (Equality impact assessment) have approved the EqIA (subject to our Dir. sign off)
> 3. DH analysts have approved the VAPF (this version contains all the recently updated data and comments of HO's BCS and Stats Analyst Teams)
> 4. I understand that N L in DfE (Department of Education) is OK with the VAPF
> 5. N sent the completed HA *(Home Affairs)* letter yesterday
> 6. We don't need Comms Panel Control. They have said that now no-one is allowed to have formal printed copies of their document. But, we could have a small number of lower quality (but still good) Reprographic copies to hand out at the event. I've agreed to this as it allows the VAPF to go straight to COI as soon as the HA process is complete, saving time.
> 7. COI (DH publications clearance) have said they can get the document done in time for S2010 assuming that we get it to them before Sept 2nd (and assuming there are no huge re-writing issues following HA). I am in regular touch with them.
>
> Kind Regards

In this case study, the key policy clearance tasks had to be repeated a number of times as the policy was rejected at the final DA/ HA clearance stage of the cross government ministerial approval stage. The first time the clearance steps were achieved are those described above in 2010, these steps then had to be repeated in 2011, ensuring policy coherence with the new government. As this was rejected at this stage, the policy clearance steps had to be repeated a third and final time, after the summer riots gained ministerial approval, however, a relatively junior policy lead at this stage requested a repeat of this policy clearance process. Clearly, the process itself was time consuming and required capacity to undertake, which was becoming increasingly difficult to achieve in the wider context of cut backs on government staff.

Despite the complexity and repeated nature of the policy making process in this case study, a timeline of the key policy formulation steps is summarized in Table 72 below, with a view to make the policy making process more transparent and easier to understand.

Table 72 - Timeline of key policy formulation steps

- **1996- 2006: Identification of issue – 1996: WHA resolution agreed on preventing violence – a public health priority; 2006: Health Minister letter calling for the development of a Prevention strategy on violence and abuse**
- **2006- 2010: Evidence review and updating**
- **2006- 2010: Engagement with policy leads and influence of other violence policy**
- **2006- 2010: Ministerial letters and approval**
- **2006- 2008: Mapping for gaps and identification of priorities**
- **2008- 2009: External consultation event and feedback**
- **2008- 2010: Establish policy consensus**
- **2009- 2010: Policy Clearance Process:**
    - **Equality Impact Assessment**
    - **Financial Impact Assessment**
    - **NHS Impact Assessment**
    - **Analytical Sign Off**
    - **Communications Control Panel**
    - **Gateway Approval**
- **2010- 12: Cross – Government Agreement (Home Affairs Process)**
- **2012: Launch of final policy report**
- **2012 onwards: Communications plan, Dissemination and Implementation**

However, from the insider experience of this research, it was possible to record that the policy process did not occur in incremental steps moving smoothly from one process to the other, as conveyed by the time-line. Observation revealed that many of the steps progressed for substantial periods of time during the policy process. For example, multiple cycles of engagement with policy leads and clearance of draft policy reports were needed to establish consensus.

There was no clear point where just one single decision was made resulting in the final policy, instead, the process involved a continual process of consensus formation and incremental decision making. This occurred at all levels, with junior and more senior policy leads and with ministers. This clearly makes the overall policy process very interactive and complex as a process to understand and influence.

Additionally, the process can be seen to be mainly dominated by internal actors, who were mainly civil servants in the main government departments that were involved (the Department of Health, the Home Office, the Department for Children, Schools and Families). However, the views of external stakeholders or actors were important in identifying the acceptability of the draft policy and helped to shape much of the initial work via expert groups for the Victims of Violence and Abuse Prevention Programme. For some policy areas, external actors are represented within governance structures for the formulation and delivery of policy. None- the less the overall formal consultation period with external actors tends to be a defined and short period.

Table 73 below illustrates the prolonged and overlapping time-lines of each of the key policy tasks identified from the timeline and policy formulation process. It also illustrates the iterative and repeating process of many of the steps of the policy formulation process, including the repeated process of ministerial approval, withdrawal of approval and entering into the main policy formulation tasks once more.

As described in chapter one, the final publication happened after the summer riots occurred in 2011, when the Secretary of State for Health gave their support for this policy to be developed. This eventually lead to the final agreement of the policy, with consensus across the key governmental departments, however, the final publication in November 2012 was as a DH policy only as opposed to a cross- governmental policy.

Table 73 - A summary of the policy formulation process for the Violence and Abuse Prevention Framework

Key Processes	2006	2007	2008 Jan-June	2008 July-Dec	2009 Jan-June	2009 July-Dec	2010 Jan-June	2010 July-Dec	2011	2012
Identification of Issue 1996- 2006	■ (red)									
Evidence Review	■ (blue)	■ (blue)	■ (blue)	■ (blue)	■ (blue)	■ (blue)	■ (blue)			
Engagement with policy leads	■ (yellow)	■ (yellow)	■ (yellow)	■ (yellow)	■ (yellow)	■ (yellow)	■ (yellow)	■ (yellow)	■ (yellow)	■ (yellow)
Ministerial approval	■ (green)	■ (green)	■ (green)	■ (green)	■ (green)	■ (green)	■ (green)	■ (green)		■ (green)
Mapping & Priorities	■ (cyan)	■ (cyan)	■ (cyan)	■ (cyan)						
Consultation with stakeholders				■ (magenta)	■ (magenta)					
Policy Consensus				■ (purple)	■ (purple)	■ (purple)	■ (purple)	■ (purple)	■ (purple)	■ (purple)
Policy Clearance Process						■ (teal)	■ (teal)	■ (teal)	■ (teal)	■ (teal)
Cross Government Agreement							■ (blue)	■ (blue)		
Launch of final policy report										■ (orange)

8.5 Cyclical Decisions and Consensus Making

From a central perspective, the Cabinet Office and Ministry of Finance concerns take political priority in policy solutions and options and have more weight in decision making about policy formation than other departments. Although, there is usually a search for policy consensus within and across departments, to ensure government does not come out with contradictory messages/ policy, these departments take precedence, and include the Prime Minister's office, with their main focus upon the economy.

A series of options are usually given as part of a ministerial submission and generated by the policy lead in the area. They may be influenced to a varying degree by the evidence base, an expert or advisory group. However, evidence is used variably according to political interest and pressure from lobby groups that may have financial or political leverage (eg policy on alcohol, TB badger cull have been counter to the evidence base). Many policy leads come from an arts background, and are not familiar with scientific or public health methods for assessing evidence. This often leads to in-coherent theoretical frameworks for formulating solutions and a variable use of the evidence base to inform policy decisions.

This incremental and changeable nature of the policy process is reflected by the comment in Table 74 from a senior public health colleague reflecting on the policy process:

Table 74 - Reflection on the changeable nature of policy making

Policy- making is like cloud formation, where the priorities and content keep changing, merging and moving. With the end policy often looking very different from the initial remit....

Additionally, tangible, short -term results that are cost effective are favoured – this tends to lead to pilots and programmes rather than long-term sustainable approaches – which is a problem for prevention approaches. The political term is approximately 4- 5 years, with policy being formulated and delivered in that time frame, often resulting in 3-year policy time frames and favours quick wins rather than taking a longer more strategic view. The below diary entry in Table 75 from a policy training day on the use of evidence, illustrates the predominance of interest on using cost effectiveness evidence to influence Ministerial decisions and public acceptance of a policy.

Table 75 - 16th April 2009 - DH Policy Day, Evidence and Policy Making

Options usually present the pros and cons for each area including financial and communications advice. Ministerial submissions are usually very short, with 1-2 sides making the main case, with a series of annexes for further information. See Table 76 below an outline of a standard template of a ministerial submission:

Table 76 - Standard template for a ministerial submission, Department of Health, 2009

- **Purpose of Submission**

- **Timing of Response**

- **Recommendation(s)** (summary only)

- **Issues** (i.e. outline why the submission is necessary)

- **Analysis** (covering finance, evidence/arguments to support options)

- **Options**

- **Recommendation(s)** (in full)

- **Presentation** – this MUST include Communications' advice

This illustrates the relative significance of financial issues and media concerns in helping inform the Ministers decision. Key decisions are usually made by ministers, based upon the advice of senior policy leads. This usually involves regular meetings between officials and ministers to make decisions regarding policy development. A key decision point is when a minister makes a new announcement. This is usually done with media coverage to help raise the profile of the political party and illustrate to the electorate improvements that are being made. Therefore, ministerial announcements prefer to have good news messages that will gain the support of the electorate. A ministerial announcement amounts to a political commitment and therefore carries a lot of importance in the decision making process.

This process allows for highly motivated ministers to champion a particular cause, for example one of the Home Office ministers drove the development of a cross- governmental Violence Against Women Strategy within a very tight timeframe. Conversely, it also means that to some extent, senior policy leads can potentially push forward an agenda that they have an interest in, if they are able to influence an interested Minister to agree to policy decisions.

However, usually, career senior civil servants attempt to maintain reasonable expectations, workload and reduce the risk of undue negative media interest, by managing both upwards and downwards. This influences the range of options presented to a minister and the emphasis given of potential risks to guide the minister in taking a recommended decision. The precautionary risk adverse approach favoured by civil servants was observed and tends to lead to policy being made incrementally and being relative conservative due to the consensus making process. Ministerial concerns for making policy decisions are outlined in the diary notes in Table 77 below, and include the importance of establishing consensus (discussed later), and the preference for a range of 3- 4 options to choose from. Other concerns described by policy leads, included the feasibility of a new policy, and the impact upon inequalities and potential co-benefits.

Table 77 - 12th Feb 2009 - Meeting at London School of Economics on Prioritisation

PhD
- Importance of key stakeholders having a consensus re ways forward / interventions
- when there is divided opinion on an area then politicians stay away.
- only when everyone is saying the same thing then politicians say we ought to be doing this.

Mtg called to review strategic approach for choosing which interventions we should go for.

- Policy makers / Ministers like 1-2 out of choice of 3 top areas to go for + to announce.

- The other key aspect to consider is feasibility ie do you have to establish new systems vs work with mainstream - ie already systems + capacity.

- Also to consider impact on inequalities + co-benefits

In contrast to the frequently conservative approach of policy leads, Ministers may push for more substantial policy jumps. Some Ministers were seen as precarious in what they would say and commit to in public, stating things that they were not briefed on and may not be feasible to deliver. Therefore, in these circumstances, some civil servants would try to reduce opportunities for Ministers who were seen to make impromptu commitments in public that may be counter to other policy or uncertain if the commitment could be upheld.

There was observed to be a strong emphasis on the need to have policy coherence, that is, that any new policy builds upon and is consistent with historic and existing policy according to a particular political party. New policy should not contradict other policy, either within ones own department or with other departments. Again, this leads to a tendency to incremental policy making, with a reiteration of existing policy and a handful of new areas that are being forwarded in any new policy. Any new policy being developed is reviewed and circulated internally within the lead department and other government departments to ensure coherence and consistency. Policy that is developed in a fast time frame or has insufficient capacity for

formation, risks inconsistencies or contradictions in policy that can lead to negative media and stakeholder feedback.

Therefore, there was considerable emphasis on ensuring there were internal and external checks in place. For example, all DH policy was required to publish an **impact assessment** at the same time as any new policy. This includes details of changes in resources or workload that any new policy will place upon other government departments and the health sector. Clearly, any policy that places an undue burden upon stakeholders will be reviewed and potentially not agreed. This process increases the importance of cost analysis of recommended interventions and policy decisions, as illustrated in the diary entry in Table 78 from the policy-training day below.

Table 78 - 16th April 2009 - DH Policy Day, Impact Assessment

The other factor influencing decision making was **engagement and co-production** with stakeholders. This reflected a general shift away from a top down approach of policy making to a more democratic process. The degree of engagement and co-production however, was observed to be variable and to some extent depends upon the availability of time, capacity and resources. Processes include holding listening events, national and regional consultation or engagement events, and circulation of draft reports for feedback. External expert and task

groups were also developed engaged to peer review evidence and inform priority development. Additionally, stakeholder views were used to help shape what sort of policy report or products are most helpful to them. See the diary entry in Table 79 from the policy training day describing the four principles of creating policy change of: co-production, subsidiarity, ownership and leadership, and system alignment. The central diagram also illustrates the role of the evidence base, however, from the following notes, it can be seen that again the main emphasis was on cost effectiveness. This reflected the economic challenges that were just starting to be entered into in 2009.

Table 79 - 16th April 2009 – Notes from an in-house Department of Health, Senior Civil Service Day on Policy

See Table 80 for secondary observations of the policy making process by a public health trainee that I supervised, generally reflects the observations made by this research. In particular,

points two below illustrates the shift in policy from one that is top-down to one that emphasises co-production and subsidiarity. This aspect was understood to be especially important in the run up to an election, ensuring wide stakeholder endorsement with an approach to facilitate long-term survival of a policy approach, described as 'election –proofing' in the third point below. The first point is also in agreement with observations made in this research, that career civil servants do not always have external experience in the policy area that they are working on and frequently come from an arts background, so have limited understanding of applying an evidence based approach to policy development. The public health trainee, wrote these reflections at the end of their placement in the Department of Health.

Table 80 - Policy Observations from Public Health Trainee at DH, Oct 2009

Through all aspects of my work I have strengthened my understanding of:

- Culture of the civil service. Civil servants have core skills that can be applied intelligently to a range of areas and they regularly move positions often between depts. They are highly trained and articulate but do not always have a strong background in the policy area or its local delivery. They are not trained in a systematic, needs based, evidence based public health approach.

- The DH approach of "guiding" as opposed to the historical approach of "standards" associated with money and targets. There is a tension between this approach and the interest at regional / local level in specific guidance, ie "we agree with strategy direction so what should we do". Conversely, to be most effective, local areas need to tailor national strategy to their needs, service strengths etc.

- Election proofing. The impending election and likely change in government has meant that "election proofing" strategies has been of particular importance both through showing a clear evidence base for effectiveness and cost-effectiveness but also through working with stakeholders so that the strategy has the widest possible support base, much of it independent of government and therefore with greater validity.

Observation of the process in real life, found that in general formal and structured stakeholder mapping procedures were not undertaken, (the stakeholder analysis presented in chapter 3 was conducted for this research). However, decisions about who to engage with and levels of engagement were usually made by a process of informal and iterative discussion, both within meetings, one to one sessions and via email. During this process, emphasis was given to civil

servants who had the power to sign off or block the policy process and relates to the process of consensus making.

The engagement of outside actors was seen as important however, as it helped to provide legitimacy for a policy, and external actors frequently have a role in delivering a policy. Therefore, agreement of external actors was needed in the earlier direction setting of the policy and for key aspects for example, where their engagement would be crucial for policy implementation. It was also seen in chapter three, how external actors could inadvertently slow policy progress by proposing extreme policy options that were difficult to establish a wider consensus on.

A formal or informal consultation process is frequently undertaken for significant pieces of policy to ensure endorsement by external actors and to identify and address any issues that could be seen as contentious. Ministers tend to be especially concerned by the views of the external stakeholders, as they represent the voting electorate, and will be a guide to adverse media responses. This is illustrated in the observation in Table 81.

Table 81 - Comments by civil servants on the concerns of Ministers

Regarding Consensus – if a minister sees any conflict or disagreement on a proposed policy area, they will avoid it; they will only forward a policy area when they can see a clear consensus on an issue.

Regarding concern of media response – Ministers are mainly concerned as to whether a policy will make them look good, whether it provides good media coverage, and whether it helps them win votes.

Although different actors could be seen to have different levels of importance in the policy making process, overall, the development of consensus was crucial to the success or not of a policy being taken forward. This meant that if there is substantial visible levels of conflict in policy direction, either from external or internal actors, there was a considerable risk that the policy will not go forward, or could be stalled for prolonged times until a consensus was reached. This can be seen by the example of the many years it took to agree a consensus for the latest Mental Health Act, (DH, 2009).

Additionally, the fluidity of achieving consensus amongst policy makers can be subject to trends in public or political opinion, and can be influenced by perceptions of how commonly expressed a policy approach may be heard – see Table 82 as an example of this.

Table 82 - 'Civil Servant Saying on establishing Consensus' – Summer 2009

If you hear something from:
1 person's its seen as a Crank
2 People its seen as a pressure group
3 people its seen as public opinion – and it becomes policy

However, certain approaches if perceived as being too extreme or outspoken, or advocated by individuals, who become professionally discredited for their wider behaviour, could act to discredit policy development and consensus formation in an area. For Example - the Home Office approach re bringing perpetrators into visit victims in Emergency Departments was probably driven by a particularly charismatic and outspoken senior advisor working in the Home Office/ PM Strategy Unit, but also reflects the culture of the Home Office (ie command and control) and resulted in resistance in addressing this in the health sector.

A further example, is how the mainstream health sector can discredit some of the approaches or views of the voluntary sector as being too extreme regarding feminist theory and lacking in scientific evidence (for example re alcohol). This in some situations led to a lack of engagement by the health sector and interfered with the consensus formation needed to take forward policy.

Ultimately, achieving consensus with key actors was seen as a key aspect at all stages. External actors play a more important role on establishing a policy agenda and can influence initial drafts of policy formulation. However, internal actors were seen to be the main players in the later development and clearance stages. Consensus formation on a policy area determined its success, or conversely, its failure.

8.6   Summary

The main areas explored in this chapter which describe the policy formulation process, include the important role of leadership and champions, and how timing and windows of opportunity

can influence policy development. The key policy tasks or steps that have to be taken to achieve clearance are outlined, and the cyclical nature of the decision making and consensus building process are described in order to finalise the policy. The key points for each of these areas are summarised in Table 83.

Table 83 - Results Four: To summarise the policy formulation process

- **Leadership and champions:** Having strong leadership was observed to be instrumental in driving the policy process, including the initial agenda setting and the subsequent formulation process. Informal networks of policy champions played a role in maintaining interest in the agenda when there was less visible leadership to drive policy development. In contrast, a lack of leadership can act to demotivate and delay the policy process.

- **Timing and policy windows:** overall, policy development, including the formulation process, is time consuming, and unless there are strong drivers, delays can occur. Political timing was important, with general elections and changes in government creating delays of policy progression of approximately one year. Conversely, windows of opportunity are key points to push policy development forward, and was found to successfully do so twice in this research.

- **Policy formulation steps** – the policy formulation process was not straightforward or linear, instead, multiple and complex policy steps were observed to be taken to achieve clearance, and these were repeated until the final policy was endorsed at inter-ministerial level.

- **Cyclical decision and consensus making** – aside from the final ministerial clearance, there was no one key decision in the overall process, it was observed that multiple decisions were made in an incremental process. It was found that central to policy formulation was the importance of regular internal engagement, with repeated and cyclical consensus making to achieve final policy clearance.

This marks the end of the results section, and the following part of this report moves on to the conclusions of this research thesis.

Chapter 9 - Conclusions

This concluding chapter brings together the main findings from the research and analysis of this thesis. The main findings from this section are summarised in the context of Walt's triangular model, to provide an overview of the research. Each of the main findings are then described according to each of the original research objectives and reflects upon how these compare with the wider published literature.

Objectives

1. To describe the general development of violence and abuse prevention policy in England over time

2. To describe the public health contribution to violence and abuse prevention policy

3. To describe and explore the role of different actors in influencing the policy process for violence and abuse prevention

4. To summarise the policy formulation process

Next, the wider lessons and generalizability of findings for policy and for public health are considered:

5. To summarise the wider lessons for Policy

6. To summarise the wider lessons for Public Health

This section presents a policy formulation model based upon the findings of this research, and reflects upon and updates the integrated policy model used as an analysis tool in this thesis. Then the following part of the chapter brings together all the learning from this work to reflect upon the overarching research question of the thesis:

> **The overarching research question:**
>
> **Why is public health in England not more engaged with the development of policy for the prevention of violence and abuse?**

Additionally, reflections are made on the overall aim of the thesis and conclusions are drawn based upon Walt's triangular model.

The aim of the thesis:

"To document the process of policy development to prevent interpersonal violence in England, and explore the implications and potential role of public health"

The last part of this chapter then concludes with the strengths and limitations of the research, research recommendations, followed by the dissemination of findings from this research.

9.1   Reflections on the Objectives and Findings - in Comparison with the Literature

The headings of the main findings summarised at the end of each of the results chapters are described in the adapted triangular policy model by Walt (1994) in Figure 36, to provide an overview of the main findings. The first objective addressed the content of the case study, on violence and abuse prevention, and considers the regional versus the national roles of policy making, followed by barriers to challenging issues, the importance of embedding agendas into relevant policy, and the long time scale of policy development. The second area is the context, which in this case is the public health contribution, the main findings for this area cover the evidence base for prevention, the prevention balance and priorities, public health competencies, and barriers and opportunities for engagement.

The third area of findings includes the Actors, which described the main actors and their motivations, and considered their relative power and political dynamics between them. Lastly, the fourth results chapter considers the Policy Process, where main findings included the role of leadership and champions, the importance of timing and policy windows, a description of the policy formulation steps and insight into the cyclical decision and consensus making that was found by this research.

Figure 36 - Summary of the main PhD findings according to the Process and Power Model, (Walt. 1994)
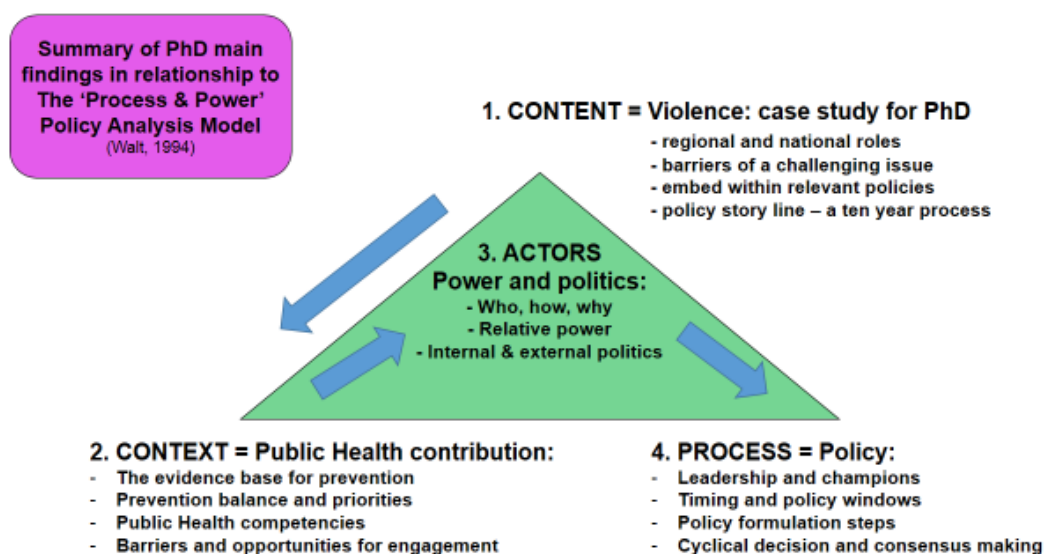
The following section considers each of these main findings according to their relevant objective, and compares these results to findings in the published literature.

9.1.1 Objective One: To describe the general development of violence and abuse prevention policy in England over time

The overall timeline of this case study on the development of violence and abuse prevention policy, was estimated to take ten year, starting in 2003 with the World Health Assembly Resolution and completing in 2012 with the final publication of the violence and abuse prevention policy, (DH 2012). The main factors influencing this process are described from the perspective of an insider as a public health advisor in the policy making process, with key events, like ministerial decisions, media drivers and consultation events highlighted in more detail. Although, a number of authors note that the policy making process is a complex and multi-factorial issue (Walt, 1994, Hunter, 2003, Kuntz et al, 2009), this research provides a detailed description and insight of the process and timelines for a particular case study.

The policy development process, from the initial initiation, to the formulation and final publication, can take a considerable period of time, with delays created by the consensus making and clearance process and political cycles. This is especially true for a challenging issue like violence and abuse prevention, which is poorly understood in society.

In particular, this case study in policy development is likely to have taken longer than some other topic areas because of the challenges faced by taking forward a public health issue with wider social taboos. As much violence and abuse are hidden in society and most information is presented within the criminal justice context, a public health approach was able to contribute by increasing the visibility and understanding of this issue. Despite the invisibility of much violence and abuse, however, it was found that although relatively rare events, knife and gun crime are highly visible and generate a lot of media attention and on two occasions this created windows of opportunity for policy to be taken forward on violence prevention.

However, this lack of visibility created a further challenge in that violence and abuse were not perceived as mainstream public health issues. In this context, following the international injuries conference, Johnston calls for increasing the relevance of violence and abuse to public health (Johnston, 2008). An additional barrier found was the complexity of the subject, with multiple determinants and risk factors occurring over the life-course, therefore repeated and clear communications were made for policy makers to overcome resistance. This is in agreement with a relatively parallel piece of research in South Africa also recommended the translation and simplification of the evidence base on violence prevention for policy makers, (Seedat and Nasciemento, 2003). In particular, the South African research along with other authors note the benefits of forging partnerships with other sectors with common aims, (Mercy et al, 1993, Hunter, 2003, Seedat & Nascimento, 2003); which in this research was observed to be especially helpful in overcoming barriers and widening opportunities.

This research found that regional and local level are usually tasked with the implementation of policy, however, they were found to play a key role in translating national policy. Additionally, they were able to contribute actively in bringing innovative practice to stimulate policy agenda setting and also to be incorporated into national policy formulation process. However, this was feasible because of the established regional topic networks with national co-ordinators, which allowed access and relationship building with relevant policy leads for this process to happen. The wider literature mainly reflected a call for specific interventions, often produced at local level, to be adopted into policy, however, aside from a statement usually made in the last section of a publication, there was little understanding about how to facilitate this process. The only specific paper that provided any further insight, recommended health care professional involvement in policy formation to assist in the implementation process and to ensure more appropriate policies are developed, (Phaladze, 2003). Whereas this research found that local and regional influences to national policy was enabled by the use of senior champions, regular meetings with policy leads, and translating the approach into a transferable model that made it straightforward to scale up. Ultimately, though the success of expanding the anonymous

information sharing model nationally, was determined by a policy window of opportunity, following a media campaign on gun and knife crime.

Developing specific policy on an agenda was seen to take time, especially for a challenging public health issue like violence and abuse. For both regional and national levels, a key approach to ensuring that violence and abuse were kept on the policy agenda and mainstreamed within wider policy was to embed aspects within relevant policies. Johnston also notes that violence and abuse are not perceived as a mainstream issue (Johnston, 2008), whilst a number of authors comment that in general, for other topics, there is little mainstream public health knowledge of the evidence base by policy makers, (Hunter, 2003 & 2009, Bowen & Zwi, 2005, Choi et al, 2005, Behague, 2009). This research agreed with this observation, however, in particular, it also found that by including mention of violence prevention approaches and policy within relevant health and other sector policies helped to mainstream a marginal issue and kept it on the policy agenda. In contrast, no specific recommendation was found in the literature on this approach, instead the main recommendation was to summarise the evidence base in public health mainstream language (Collice, 1990, Seedat & Nascimento, 2003, Hunter, 2009).

9.1.2   Objective two: To describe the public health contribution to violence and abuse prevention policy

The mapping analysis found that the main policy focus on violence and abuse was on tertiary prevention in adult populations. The public health based framework on violence and abuse prevention was used to identify policy gaps, inform priorities and shift the focus to earlier in the life course, including a greater focus on primary prevention approaches; these were reflected in the final policy, (DH, 2012).

Although, the wider literature finds that prevention is generally considered a popular vision (Mercy et al, 1993, Wall & Owen, 1999, Koss & White, 2008), this research added further analysis on the focus of both content and levels of prevention. For example, the research conducted by Koss and White, on gender based violence, looks for the mention of prevention in policy text as part of a thematic analysis, however, no further analysis is conducted by what is meant by prevention. So although it was generally found within this research thesis, that there was wider support for including the term prevention in a number of policy reports, there was generally a poor understanding by what was really meant by prevention, and that the main focus ended up being on tertiary prevention. This bias towards tertiary prevention is also described by Hunter, who writes that health care services tend to get the lion's share of resources compared to preventive measures. Hunter (2003), reflects that this is difficult to

change because of the immediacy of health services compared to the longer term timescales required by prevention.

This research examines the public health competencies used to develop this policy, and found that the scientific based public health skills were found to be significant in contributing to the development of evidence based policy, as evidenced within the final report, (DH, 2012). The WHO and Centres for Disease Control also advocate the importance of the provision of Public Health expertise in developing approaches to violence prevention. (Mercy et al, 1993). However, the use of public health skills may have been exaggerated in this particular case study, as the insider participatory research was conducted by public health experts who significantly influenced the policy content, including the use of evidence. In particular, especially following the start of the economic crisis in 2008, it was observed that policy makers placed relatively high emphasis on the outcomes of economic analysis in making decisions, with specific studies in this area being commissioned. Wider research has also reports on the increasing influence of economic evaluations in shaping policy in the health sector, (Adeoye et al, 2007).

Whereas, in general, policy makers were observed to consider a range of options, of which the evidence base was only one, when making decisions about policy formation. In particular, risks of adverse publicity and wider political interests and perspectives were seen to influence the content of policy, for example, driving policy on information sharing, and weakening policy on the links with alcohol. This is in accordance with insights of how policy makers use evidence, including the relative importance of evidence compared to other options, including political or other agendas taking priority, (Bowen and Zwi, 2005).

However, in comparison to other areas of policy, because of the relatively strong public health influence, the final policy was significantly underpinned by the evidence base. In contrast, researchers have commented on how there is generally a lack of understanding and considerable variability of evidence based policy making, (Hunter, 2003), (Choi, 2005).

The ability to incorporate a complex range of evidence into this policy, however, depended upon repeated presentations and meetings with policy makers, where there was time to explain, adapt and translate messages according to their perspective. Additionally, this involved summarising multiple interventions into a handful of straightforward policy areas. This approach reflects the policy insights by Dobrow (2003) and Parsons (2004), who describe how policy and evidence are based on two differing paradigms, with evidence consisting of a reductionist and narrow perspective, whilst policy consists of complex interacting systems, and highlight the need to apply and adapt evidence to the policy context. These insights are in

agreement with others who emphasize the limitations of the evidence base, in particular, in relationship to its single intervention focus, compared to the systems approach required by policy; (Gray, 2000, Choi et al, 2005, Hunter, 2003 & 2009, Brownson et al, 2009).

In addition to the scientific public health skills, this research also found that the 'art' of public health was found to be particularly important to forward the policy process, in particular, this included relationship building, collaborative working, persistence, good communication and influencing skills. The hidden nature and lack of mainstream public health information on violence and abuse acted as barriers, whilst the prevention and the public health approach was poorly understood and not seen as relevant by some. The public health round table recommended the adaption of messages for mainstream public health messages to normalise the issue and to communicate information in a memorable and understandable fashion, which is in agreement with a range of authors, (Collice, 1990), (Hunter, 2009), (Lee, 2001), (Wilson and Holt, 2001), (Ross and White, 2008).

Applying the art of public health helped to overcome some barriers and take advantage of opportunities, in particular, by building strong working relationships with key policy leads, and forging partnerships with other sectors with common aims. These qualities are also recognised by other researchers who advocate developing personal relationships and common goals to assist in policy progression; (Adair, 2002), (Landsberg, 2002), (Owen 2009), (Mercy et al, 1993), (Hunter, 2003), (Seedat & Nascimento, 2003).

9.1.3   Objective Three: To describe and explore the role of different actors in influencing the policy process for violence and abuse prevention

The criminal justice sector, (mostly the Home Office), were considered by central government and other sectors as the lead agency for violence and abuse in general and therefore were seen as the most influential actor in the policy, making process. The Department of Health, including public health advisors, were understood to have the lead role in violence prevention especially in terms of policy content, however, they had perceptibly less power, compared to the Home Office in driving the policy process.

It was found that the main actors with the strongest interest in policy development on violence and abuse in general, in particular, was the Home Office and the Attorney General, with occasional high level interest by the Prime-Ministers Office, driven by high profile media events. High political influence, including from the prime-ministers' office and media interest are also observed by others to be key in shaping and driving policy; (Waterson, 1994), (Hunter, 2003), (Walt, 1994), (Wall & Owen, 1999), Pyper in (Jones, 2001), (Johnston, 2008). The civil

service were seen to be key actors in the policy making process, influencing the policy agenda, and managing ministerial and external expectations, this finding is in agreement with how Walt (1993) describes their role, however, ultimately, ministers and the Prime-Ministers office was considered to exert more power.

Others have described the role of the World Health Organisation, as both an enabler as well as a driver, (WHO, 1996 and 2004), (Lee, 2001), (Krug et al, 2002); however, in this policy study, the role of the WHO was mainly relevant in contributing to the initial agenda setting.

In contrast, the Department of Health and Public Health were ultimately seen to be key actors with designated lead responsibility in developing the prevention policy for violence. The Criminal Justice System's main motivation was to reduce crime, which resulted in Home Office policy mainly focusing on protection and containment, whilst the health sector aimed to improve health outcomes with a greater focus on primary and secondary prevention approaches. Other research highlights the challenges of contrasting agendas when taking forward a policy area which is not primarily seen as a health or public health issue, (Lee, 2001, Hunter, 2003). Additionally, as in common with other public health areas, there was little funding or levers by public health, aside from expertise, to contribute to the agenda (Hill, 1997, Hunter, 2003), which affected their perceived power and influence.

Therefore, finding common ground with Other Government Departments was sought and resulted in positive joint policy approaches, whilst not doing so resulted in lower engagement and resistance. It was possible to increase power marginally, by increasing the visibility of the agenda, forging partnerships and ensuring consistent, clear messages. This relative power, however, was superseded by the Prime Minister's Office following the media events that proved to be key influences for decisions made by central government pushing the violence prevention policy forward.

Those with less interest or influence in the agenda, were at times, seen to exert more negative forms of power, which can be understood to be an expression of gaining political or even personal power. Walt describes the interplay of power according to macro policy which is described as high politics, and includes cross governmental policy, versus micro policy, which is seen as low politics, meaning policy in one area in a single government department (Walt, 1994). It can be seen that the violence and abuse prevention policy moved from a higher position of influence, initially starting as macro policy, and then after Ministerial rejection, shifted to a lower position of power being finally published only by the Department of Health, described as micro policy. This can be seen to be due to the interplay of power between different government departments.

Establishing policy clearance by all the relevant government departments, revealed that any dissent by an actor, whatever their interest, could act to delay or block the policy making process, illustrating the relatively high level of internal influence compared to external actors. As in common with other research, civil servants were observed to be generalists, relatively traditional and do not reflect the wider societal experience, (Jones, 2001). In this research, policy making was observed to be made by relatively small number of people, which Walt (1994) describes as elitist policy making, versus pluralist policy making. A pluralist approach in contrast, is influenced by a wide variety of groups in society, where power is evenly diffused, reflecting the populations needs and interests in a more democratic fashion. The reality in this research was observed to be somewhere in between, which Walt describes as bounded pluralism, where macro policy tends to be made by elites and micro policy is developed with a wider consultative or pluralist approach.

The role of external actors was seen to be relatively limited, although the Voluntary Community Sector had relatively high interest, they had a mixed and limited influence on policy formation. Although championing this agenda in general, strong extreme theoretical views inadvertently contributed to slowing policy progression. Similar policy research in South Africa also found that the Voluntary Community Sector can oppose the public health view, (Seedat & Nascimento, 2003). The research highlighted the relative power that internal actors had in the policy making process compared to external actors, which Hunter (2003) considers to result in the reinforcement of the status quo and makes it more difficult to develop new policies. However, there was a complex interaction between external and internal actors which was observed to drive and delay the policy making process to varying degrees. For example, Ministers were observed to exert leadership to bring about policy in areas of high interest, whilst, the Media had temporary high levels of interest and influence, creating important windows of opportunity. Ultimately, though, the expression of relative power and politics was seen to be a fluctuating, interacting and dynamic process.

9.1.4 Objective Four: To summarise the policy formulation process

Having strong leadership was observed in this research to be instrumental in driving the policy process, including the initial agenda setting and the subsequent formulation process. Most of this leadership came from Ministers who actively drove the process, whilst there were a few key senior public health advocates and champions who played a variable role in supporting this policy rather than actively driving it. Authors with an interest in violence prevention also highlight the importance of advocacy and persistence for this agenda and that a small number of committed Public Health champions and leaders have helped to advance this work; (Jason, 1984), (CDC, 1993), (Mercy et. al. 1993), (Johnston, 2008). Aside from the violence agenda

however, the wider literature also recognises that leadership is an important tool to advance work, (Adair, 2002, Landsberg, 2002, Owen, 2009).

In contrast, a relative lack of leadership was observed in this research, especially during periods of re-organisation and transition, to act to demotivate those involved and delay the policy process. The round table of public health experts highlighted the general lack of leadership in this area, which also resonates with Johnston's editorial on international violence prevention where he comments that there is a general lack of leadership at all levels, (Johnston, 2008) and calls for greater advocacy and champions. The wider literature on management and leadership highlights the importance of credible leaders and their role in ensuring clear roles and a strong vision to motivate people, manage change and drive forward work; (Bridges, 1995); (Mullins 1999), (Adair, 2002), (Landsberg, 2002), (Owen 2009).

Despite this, when there was less visible leadership to take forward policy development, informal networks of policy champions were observed to play a key role in maintaining interest in the agenda. The policy literature also describes the importance of policy networks in influencing policy, however, reflects that they can fluctuate and change over time, be internal or external, formal or informal, (Marsh 1998). Yet, a relative lack of leadership in an area, may have important implications for advancing a policy field, indeed, it could be speculated that if there had been more visible leadership supported by high level governance structures specifically for violence prevention, the policy process may not have taken so long. Interestingly, the role of leadership in the wider policy literature is mainly captured by the relative power of differing actors, however, their significance in advancing policy is not adequately reflected in policy models, which will be considered later.

Overall, policy development, including the formulation process, was observed to be time consuming, and unless there are strong drivers, delays can occur. This research in particular, contributes insights into the timescales and processes of policy development in one field, with little found in the wider literature of comparable research. Whereas, timing in general is seen to be important in policy by several authors, (Walt, 1994), (Hunter, 2003), (Seedat & Nascimento, 2003). This research found that political timing was especially important, with general elections and changes in government creating delays of policy progression of approximately one year. Other factors influencing delays in the policy process observed included reorganisations and a relative lack of clear leadership; sickness of key actors; competing agendas and a lack of capacity; in earlier stages, not achieving consensus by external actors and then at a later stage, by internal actors. Little in the policy literature was found on delays in policy development, the majority of insights are related to a lack of capacity and the interplay of power between different actors, (Walt, 1994).

Conversely, windows of opportunity are key points to push policy development forward, and was found to successfully do so twice in this research. These two windows of opportunity were relatively unpredictable in terms of timing, and were created by high media interest in knife and gun crime in the summer of 2008 and then again by violent riots in the summer of 2011. Indeed, these events led to high-level political interest and tension surrounding negative media coverage and the potential impact that this may have on political popularity and voting patterns. As a consequence, this led to the Prime-Ministers office having high though temporary interest and influence in forwarding a positive policy response to address the perceived negative media coverage.

Several authors highlight the significance of taking advantage of policy shifts that create openings, referred to as policy windows of opportunity, (Walt, 1994), (John, 1998), (Johnston, 2008). In this study, as described above, two windows of opportunity presented themselves, however, it should not be overlooked that this necessitated timing along with key actors in a position to take advantage of these openings. As such, in this case, a range of policy options were presented by a variety of policy leads from different departments, of which the violence prevention approach was one of several options. Rather than selecting the violence prevention option primarily, the Prime-Ministers office preferred options that gave more immediate and tangible responses, for example, the Emergency Department information sharing project. Moreover, this policy window could have been neglected, if the policy leads involved specifically on the violence prevention agenda had not taken active advantage of this situation, by providing relevant briefings to ministers, and thereby influencing them of the adoption of this longer term solution.

It can be reflected that taking advantage of a policy window of opportunity involves a number of key aspects that are ready for when they occur, including having a draft policy option ready, including the assessment of risks and sense of consensus for adopting a policy agenda, and importantly ensuring that policy leads are proactive in briefing ministers to influence the agenda. In contrast, from the perspective of external actors, the role of persistence, policy windows and opportunities has also been highlighted, (Johnson, 2008). Yet in this situation, the main role of external actors was not highly visible, and could have been enhanced by providing media responses to champion the prevention approach. Moreover, senior champions, ideally with established contacts with relevant ministers or policy leads, could potentially provide presentations or materials to support briefings that might influence ministerial decisions. In conclusion, to take advantage of a window of opportunity necessitates considerable previous preparation and a high degree of readiness.

In contrast, to occasional windows of opportunity, the majority of the policy development was observed to be a complex process of repeated consensus building with cyclical decisions making. As such, at times it appeared to be like playing a complicated game of snakes and ladders, with occasional opportunities in the form of a ladder which allowed the agenda to be advanced, with the potential pitfall of a number of snakes which could cause significant delays and the need to re-start the policy formulation process, including repeated consensus building and decision making, once more. A wide range of authors have recognised the importance of achieving consensus to take achieve policy development, (Palmer, 1985), (Wait, 1994), (Hunter, 2003), (Ashwell et al, 2008), (Johnston, 2008), (Koss & White, 2008).

To some degree, comparable studies were found on the difficulties for policy makers if there was a lack of support and consensus on the science, (Cornel, 2005) or from practitioners (Loewenson, 1994), however, there was little insight found on how this interplayed on the policy development process.

Although, the relative advantage of a policy window or ladder in reality acted to provide greater expectation and drive for the policy process, it did not provide the option to jump certain policy clearance processes, again requiring multiple decisions and consensus formation. In contrast, a snake could cause a delay or slowing of the policy process, or more drastically, a major disagreement in consensus formation would mean having to re-enter the policy formulation process again.

In comparison to what was observed and documented, the policy literature describes the rational approach to policy making, consisting of a series of logical steps in decision making (Walt 1994). However, it has been recognised that policy making is more complex than this due to conflicting interests and the need to establish consensus. (Walt, 1994), (Hunter 2003). In contrast, the description of the incremental approach to policy making is considered to be a greater reflection of real life policy-making, which is one of muddling through, relatively conservative and highly consensus driven (Walt, 1994). The incremental approach is a pluristic model that understands the differing interests and levels of power, and the need to establish a new equilibrium to achieve consensus for a new policy to emerge, (Hunter, 2003).

Although, the reality observed in this case study, most closely reflects the incremental approach, there were certain steps that had to be passed through, which suggests a degree of consistency with the rational approach. Reality may exist between both models, and has been described as a mixed scanning approach, consisting of a broad sweep of policy options, followed by incremental decisions for detail; this is called the normative – optimum model, and recognises the lack of rationality and relative role of values (Hill, 1997).

However, where the real life situation from this case study observed a divergence from both these models, in that policy development was observed to go back and forth, with periods of delay, and at times backward steps, with the need to re-enter policy tasks and achieve consensus once more, and occasional opportunities which helped to speed up the process.

Aside from the final ministerial clearance, there was no one key decision in the overall process, it was observed that multiple decisions were made in an incremental process that could move back and forth along a sequence of required policy clearance mechanisms.

A key finding that was central to policy formulation was the importance of regular internal engagement, with repeated and cyclical consensus making to achieve final policy clearance. This process mainly occurred internally, and was influenced substantially by wider political contexts and upon the development of good personal relationships and alignment of common goals. This is also recognised within the policy literature, (Walt, 1994), and also the wider literature on leadership; (Adair, 2002, Landsberg, 2002, Owen 2009).

A key insight of this research is that the policy formulation process was not straightforward or linear, instead, multiple and complex policy steps were observed to be taken to achieve clearance, and these were repeated until the final policy was endorsed at inter-ministerial level. Not only is the policy process complex, at times, it also appears to be intangible, with constantly changing shapes and positions, in this respect the policy formulation process can be likened to that of cloud formation. Although the complexity of the policy making process is well recognized in the literature, (Walt, 1994, Wall & Owen, 1999, Rouse, 2000, Lee, 2001, Wilson & Holt, 2001, Berry & Keil, 2002, Hunter, 2003, Fielding & Briss, 2006, OECD, 2009, Greenhalgh, 2010); this research particularly provides in-depth understanding about how the process actually works and the key formulation steps that need to be passed through. Thus, this research contributes new insights into the policy formulation process from an insider perspective, which makes the process easier to understand and potentially influence.

The next section explores in further detail the wider learning on the policy formulation process gained from this research, and based upon the understanding of the processes documented and observed, presents a policy formulation model which can potentially assist future policy making and research in this field.

9.2 Wider Lessons for Policy

9.2.1 Objective Five - To summarise the wider lessons for policy

This part of the chapter answers the fifth research question on what the wider lessons are for policy. To answer this question, a model on the policy formulation process is presented, based upon the research findings of this thesis, this has been identified as a relative research gap and in particular contributes to further research in this field. Following this, the integrated policy model presented in the introduction that was developed at the outset of this research to assist as a policy analysis tool is revisited and improved upon. Aside from a tool for analysis, this model has potential utility as a training tool to aid understanding of the wider policy process. Lastly, based upon this research, wider recommendations for policy are made.

9.2.2 A Systems Model of the Policy Formulation Process

The research from this thesis found that the policy process is a complex system that was difficult to describe and co-ordinate even by those who have a central role in developing policy. This makes the policy process difficult to understand and influence by external actors or those coming into the civil service as experts. Multiple authors have also identified the complexity of the policy making process (Walt, 1994), (Wall & Owen, 1999), (Rouse, 2000), (Lee, 2001), (Wilson & Holt, 2001), (Berry & Keil, 2002), (Hunter, 2003), (Fielding & Briss, 2006), (Kuntz et al 2009), (OECD, 2009), (Greenhalgh, 2010). The similarities of the policy process with complex systems include their nature as non-linear, chaotic, dynamic and changing systems consisting of multiple interactions by independent, intelligent agents, whereby events can change suddenly as tipping points emerge; (Rouse, 2000), (OECD, 2009). Whilst the natural conservatism of the policy process tends to inhibit the development of innovative or emergent behaviour or policy, (Berry and Keil, 2002).

Applying systems approaches to complex systems can assist our understanding and ability to influence these systems, and has been done in a number of other disciplines, (Rocheleau, 2007), (Plummer and Armitage, 2006), including health policy, (Crichton, 1993). The essence of a systems approach is the recognition that there are multiple interacting and self-adjusting systems, (Wilson and Holt, 2001). Systems can be seen to be based upon ecological principles, consisting of interacting networks, partnerships, and cycles, which seek a dynamic balance, based upon feedback mechanisms, (Nurse, 2010). In a similar way, the policy formulation process can be seen to be an interaction of multiple actors, often working in partnerships, at times in the context of networks; the policy steps are achieved in a cyclical fashion with consensus formation acting as a feedback mechanism.

The main limitations of the policy models described in chapter two, are that they either present an unrealistic or incomplete view of the policy process, for example, by describing the process in a sequential fashion, (Hogwood and Gunn, 1984), even if described within a cyclical model, (Parsons, 2005). The earlier 'Black Box' model considers the wider environment or context that policy develops within, and applies a basic concept of how policy operates within a system with a feedback loop included, however, the processes that occur in the formulation stages are not articulated, (Easton, 1965). In contrast, the Department of Health policy model provides more detail of key policy steps, framed as either skills, however, the model fails to show the interaction between the different stages of the policy process. The most useful policy model for this research was the triangular model on process and power, produced by Walt (1994). However, all of these models do not sufficiently describe the real life policy process, either in terms of the detail of the main tasks that need to be achieved, or in terms of the sequence or interaction of these tasks or stages.

Therefore, a key contribution of this thesis is the application of a systems approach to describe the policy process and based upon the findings, the development of policy models for both the formulation process and of the overall policy process. These models, could be used by both policy makers and public health professionals to improve understanding and the ability to positively contribute to the policy process. Based upon the findings presented in the fourth results chapter, a summary of the main tasks or key steps for the policy process in general is given below. Outlining these key tasks in a systematic way, as described in Table 84 can potentially be used to inform future policy making and has been developed into a policy formulation model.

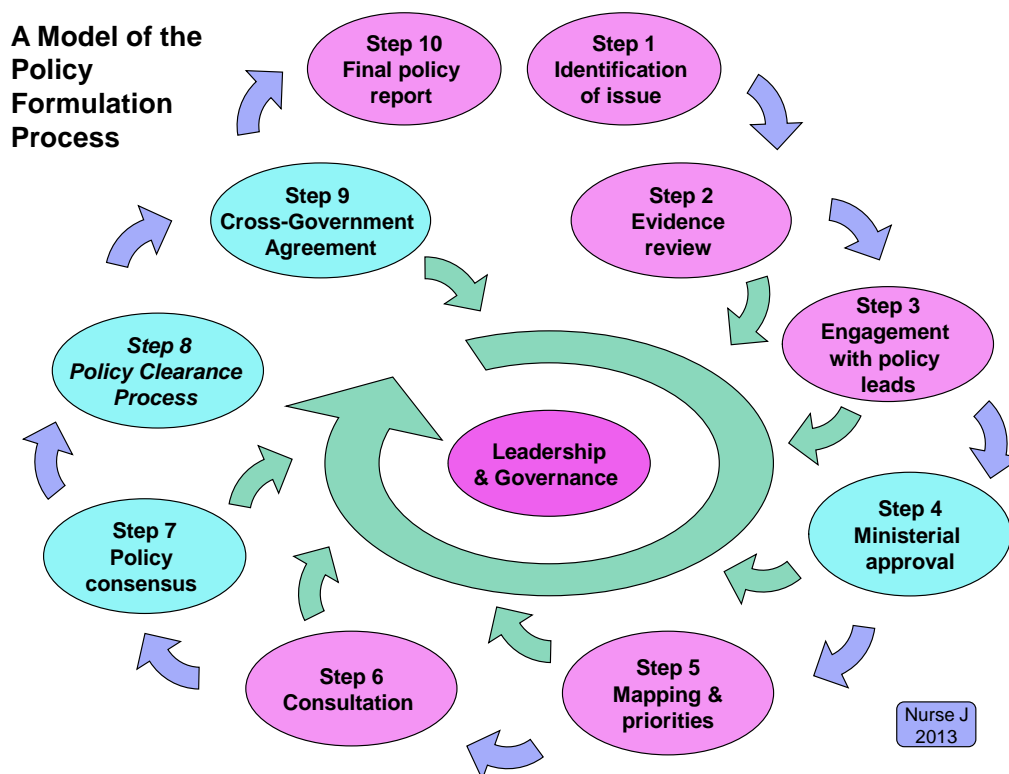**Table 84 - Summary of key steps in the Policy Formulation Process**

- Identification of issue
- Evidence review
- Engagement with policy leads
- Ministerial approval
- Mapping and priorities
- Consultation
- Policy consensus
- Policy Clearance Process:
    - Equality Impact Assessment
    - Financial Impact Assessment
    - NHS Impact Assessment
    - Analytical Sign Off
    - Communications Control Panel
    - Gateway Approval
- Cross – Government Agreement
- Launch of final policy report

The policy formulation model in Figure 37 is based upon findings from documenting the policy process for violence and abuse prevention. It starts from the identification of the issue, summarises the sequential policy formulation steps consisting of the identification of issue, evidence review, engagement with policy leads, ministerial approval, mapping and priorities, consultation, policy consensus, the policy clearance process, followed by cross – government agreement and the launch of the final policy report. Although the main events occurred within a time sequence, many tasks then continued for a considerable time period, and some tasks occurred consecutively, with repeated cycles of consensus making also occurring. Therefore, the model incorporates a series of sequential steps to reflect the overall order that events occurred in; however, the inner circle represents the continuation of these processes.

The policy clearance processes represent a substantial amount of work that can potentially block or hold up the continuation of policy being completed. Therefore, because of the importance of these processes, these circles are highlighted in blue. The inward arrows also illustrate how the policy cycle occurred in a repeating cycle if sufficient consensus was not reached at any point within this cycle. A key contribution of this policy model is the central role identified by leadership and a governance process to oversee and drive the policy process.

When this is weak, the process is slowed or stalled, and conversely, when there is strong leadership, the policy process is escalated.

Figure 37 - A Model of the Policy Formulation Process

A Model of the Policy Formulation Process

Step 10 Final policy report

Step 1 Identification of issue

Step 9 Cross-Government Agreement

Step 2 Evidence review

Step 8 Policy Clearance Process

Step 3 Engagement with policy leads

Leadership & Governance

Step 7 Policy consensus

Step 4 Ministerial approval

Step 6 Consultation

Step 5 Mapping & priorities

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Presentations of this model have been given, and include the additional details of the policy clearance process, consisting of the Equality Impact Assessment, the Financial Impact Assessment, the NHS Impact Assessment, Analytical Sign Off and the Communications Control Panel and the final Gateway Approval. In order to improve validity, the model was cross- validated with the other public health consultant working within the violence prevention policy context. The purpose of creating a generic policy formulation model is to aid future public health professionals (and policy makers) in understanding and navigating and influencing the policy process more effectively for future policy development.

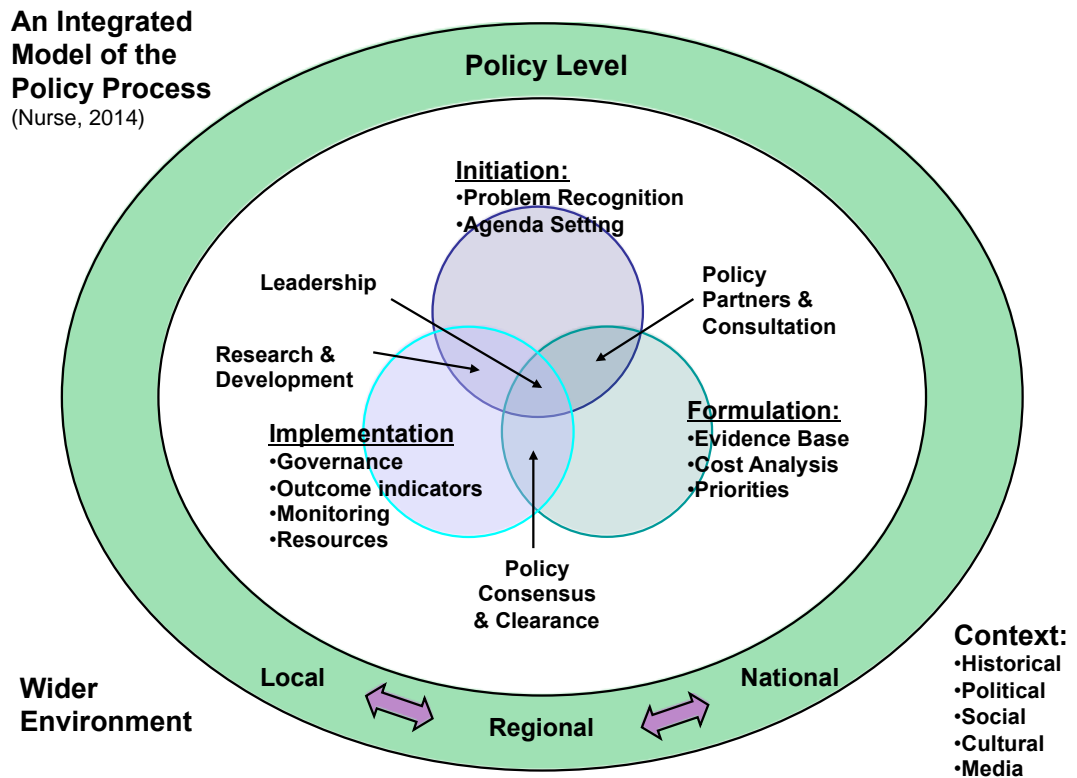### 9.2.3 The Integrated model of the policy process

When considering the wider context that policy sits in, the current policy models presented in the literature review have a number of limitations. In most of the current models, the distinct stages of initiation, formulation and implementation are unclear or not specified, with only Parson's cyclical model describing these, (Parsons, 1995). The sequential model, mainly describes the formulation process, however, not in sufficient detail to the real life situation,

(Hogwood and Gunn, 1984). Whilst Easton's model that mentions the wider environment is weak on describing the formulation process, (Easton 1965). In contrast, Walt's model includes the wider context and focuses on the interaction of power and process, however, although this model is useful as an analysis tool, it is difficult to apply to understand the sequence of the policy process.

In summary, each of the existing models bring particular insights into the policy process, however neither of them provides a comprehensive overview of the process. Hunter calls for a more transparent and rational approach to policy making versus the current complexity, which appears to be based upon a compromise between competing interests. Additionally, Hunter identifies the need to develop a new policy paradigm bringing together the formulation and implementation aspects of policy (Hunter, 2003). A key contribution of this research is to bring together a clearer understanding of the overall policy process, building on existing models and comparing these with observations, documentation and mapping of a real life situation.

Based upon the research of this thesis, the integrated model of the policy process has been developed and updated. The model was originally developed to describe and analyse the policy process for this research thesis, and is described in the introduction. This integrated model describes the main aspects of the policy process, including the three interacting circles of initiation, formulation and implementation, and includes further detail for each of these stages and the overlapping aspects between them. The model was used as a framework to structure the thematic analysis. As part of the conclusions of this thesis, the original model is revisited with reflections from the research findings, these are used to update the final model of the integrated policy process. The next section provides a detailed outline of the changes made to the model and why they were made, based upon the findings and insights from this research. Figure 38 presents an updated version of the Integrated Model of the Policy Process.

Figure 38 - An updated 'Integrated Model of the Policy Process', 2014

The original version on the integrated model of the policy process, has been updated and improved upon based upon the learning from this thesis. The colour of the model has been made lighter to make it clearer to see the overlap of the different policy process areas. The overall structure of the overlapping circles has stayed the same.

In the outside of the circle, under the heading 'Context' the word 'media' has been added to the list as it was observed to have such a powerful influence on policy development, with the creation of windows of opportunity. Within the green circle, titled, 'policy level' the terms 'National' and 'Local' have been swapped around to reflect the main level of engagement with the corresponding levels with the approximate areas in the inner circle. For example, local levels are tasked with the implementation of policy, whist regional levels tend to be tasked with policy translation to assist implementation and the national level is predominantly responsible for policy formulation. However, arrows have been incorporated to show the interaction between all three different levels, conveying how local and regional good practice can influence national policy.

Within the three overlapping circles, the title 'Initiation' has stayed the same in the first circle.

However, within the overlap between the first and second circles, the wording has changed from 'Policy Networks' and 'Communities' to 'Partners' and 'Consultation'. This is to reflect the use of language found within the policy setting of England. Policy networks and communities were not terms that were heard within the context of the civil service during the research period, whilst partners in policy and consultation were the most equivalent commonly used terms.

In the second circle, the heading 'formulation' has stayed the same, whilst the terms problem definition, solutions and options were changed to the more commonly referred to terms of, 'Evidence Base', 'Cost Analysis' and 'Priorities'. These terms reflect the stages that policy makers would apply to the policy formulation process.

Although the definition of policy is about making decisions, for the violence and abuse prevention policy, the process did not appear to depend upon one key decision, but a series of decisions that involved a process of consensus making over several years. This was then followed by several steps of policy clearance processes, which are outlined in the model of the policy formulation process. Therefore, in the overlap between the second and third circles, the term 'policy decision' was changed to 'Policy Consensus and Clearance'.

The third circle has kept its title of 'implementation', although the term 'delivery' could have been used as an alternative term. However, the terms in the implementation section changed from 'management', 'monitoring' and 'incentives' to 'Governance', 'Outcome Indicators', 'Monitoring' and 'Resources' as these were the terms observed to be most in use when describing the implementation process.

However, it is recognised that in the policy and planning world, terms come in and out of fashion, in part, reflecting differing political agendas, and that in the future these terms may be further amended to reflect the norms of the time. From a central policy perspective, the terms in circle three, were more relevant to discussions of the policy implementation stage. Some of these functions were delegated to the regional level of government. However, the change in government (2010), has seen further changes in approaches to implementing policy, with the development of Public Health England, an agency of the Department of Health tasked with implementing policy.

The term 'Evaluation' in the overlap between the third and first circles, has been replaced by 'Research and Development' as this ensures inclusion of concepts of evaluation within 'research' along with wider functions. It also includes the important role of training and development of the workforce. In addition, this includes identifying future research gaps,

influencing research funders and organisations. Research gaps that are found can also be used to help influence and shape future policy areas, and feed into the agenda setting stage to start new cycles of the policy making process.

The central section of the three overlapping circles, on 'leadership' had the addition of the term 'and role clarity' as this was found to be an important issue in the policy making environment. This was especially the case in determining the relative roles of central government compared to the regional and roles. Additionally, identifying the responsibility for roles in the policy process was found to assist the progression of policy development throughout the process.

This integrated model of the policy process has been used as an analysis tool for this research thesis, however, it potentially could be used in a wider context to assist understanding of the policy process. For example, it has already been used as a training tool on the policy process and helped to inform planning in different settings. The limitations on the use of this model in a wider setting surround the generalisability of the terms used, as they are based upon a specific case study within England. However, the terms used were generic for the policy setting within an English context, so will have direct application for England, although the terms may need to be changed for other countries and settings, the concepts have a wider relevance.

9.2.4 Recommendations for Policy

The main recommendations from this research for policy are to utilise a more systematic approach for policy formulation, for example, with the use of policy models; to improve the application of the evidence in policy making and lastly to engage local and regional levels more in the policy process.

A Systematic policy approach:

It is recommended that a systematic approach to project manage policy is adopted.

This research shows that the policy process is a complex system that is difficult to understand and interact with, a finding that resonates with multiple authors.

The previous sections have presented two models on the integrated model on initiation, formulation and implementation, and a further model detailing the policy formulation process. These models, build upon existing policy models, research findings from this thesis and their development was further informed by understanding of how complex systems work (Berry and Keil, 2002), (Rouse, 2000), (OECD, 2009). Furthermore, these models applied a systems

approach to better understand the dynamic interactions and reflect better real-life cycles and patterns, (Hunter, 2003), (Greenhaulgh, 2010), (Nurse, 2010).

The intention of these models is to assist both insiders and outsiders in understanding the key components and interactions of the policy process. The need to adopt a more systematic approach to policy making has already been recognised by the current government, (2013), with the uptake of project management tools in current Department of Health policy development; (personal communication, DH, 2013).

Applying evidence into policy:

It is recommended that policy further increases its application of evidence into policy to manage risk, establish priorities, enhance effectiveness and value for money.

By better applying scientific evidence to policy has the potential to improve the overall effectiveness of policy, and in particular, to enhance cost effectiveness and value for money. Moreover, by taking a public health strategic approach, it is possible to improve the identification and management of risks, and to establish a systematic way for identifying priorities. However, as we have seen, policy makers tend to come from arts backgrounds and therefore, tend to have limited training or understanding of how to apply the evidence base to policy development, (Choi, 2005). This finding was also observed in this research, additionally, the main focus on evidence is upon cost –effectiveness based approaches. However, most career civil servants do not have the skills to fully understand or apply scientific analysis to their work, and have competing agendas in how they apply evidence, (Bowen and Zwi, 2005). Further training and education is recommended on how and why the evidence base can contribute to their work and who and how to access support in summarising and applying evidence to a policy.

The current arrangement within the English Civil Service, is that experts are given the role and title of 'advisors', so for example, public health professionals will be described as 'public health advisors'. This role division has also been observed in India, (Tarin et al, 2009).

This can significantly limit and undermine the role of public health within the policy development process. Some individuals manage to work around this by becoming employed directly as civil servants; however, this is not possible for the way that most experts are employed. The consequences of this means that experts and their opinions can be marginalised within the policy making process, despite being employed by the civil service. This is in part due to the difference in background and culture of the experts compared to career civil servants.

However, this approach could be supported by greater interaction of policy makers with public health experts and academics, so that they can communicate and translate both their needs more easily. One approach could be to have policy placements for academics and public health professionals, so that they can comprehend the overall relevance and strategic nature of policy-making. Additionally, the inclusion of public health professionals within policy positions would assist a greater understanding of the relevance of the evidence base to policy making. Public Health professionals have been trained for many years and they have experience of the delivery of policy, therefore, they are able to make a valuable contribution to population health, of which national policy setting is a key way of using this experience.

Additional recommendations are to hold joint training, meetings and workshops with academics, public health professionals and policy makers on the policy making process, and what sort of information and styles of communication are required for the evidence base to help inform policy making. Conversely, policy makers could receive basic training on the value and limitations of evidence, how to assess and apply evidence to inform policy making and where to source summary information. Improving the translation of evidence in a fashion suitable for policy making is recognised as key area in the European Action Plan for Strengthening Public Health, that needs to be further developed, including the application of systems approaches to make information more relevant to policy; (WHO, 2012a), (WHO, 2012b).

Engage Local and Regional Levels in the Policy Process:

It is recommended to enhance the engagement of local and regional levels to the policy process to improve ownership, relevance, risk management and sustainability.

Having comparing policy formulation and implementation at regional and national level, it was possible to see how these levels interact in the overall policy making process. It is generally assumed that policy formation and implementation are two distinct and separate things. This is based upon the notion that the government produces policies, whilst local and regional levels implement policy. However, it can be argued that they both need to be considered to ensure successful formation and implementation, (Phaladze, 2003). In order to ensure successful implementation of policy, there needs to be a balance and interaction between a top-down and bottom up approaches at design and implementation stages. (Hunter, 2003).

Policy tends to be developed by career civil servants who may have very little or no experience of working within the health sector or at the delivery end of policy, (Jones, 2001). Public Health is one of the few health disciplines that is able to bring experience from local or regional levels into the policy arena. By better engaging local and regional experience into the policy

making process can help to ensure that policy is much more appropriate to the audience that has to implement it, and improves ownership, sustainability and assists in managing risks; see Table 85 for a summary of key benefits.

Table 85 - Benefits of engaging local and regional levels in the policy process

- **Ownership:** working with other actors increases a sense of owning a stake in the policies and improves joint working to deliver shared objectives successfully.

- **Relevant to Audience:** effective stakeholder engagement can help to make policies and their delivery more appropriate to the audience.

- **Sustainable:** policies developed with stakeholders and partners are more likely to be sustainable because the process allows ideas to be tried, tested and refined before adoption.

- **Manage Risk:** engaging stakeholders meaningfully and effectively also helps identify and manage risks in developing and implementing a policy.

The next section explores the implications of this research on the wider lessons for public health.

9.3   The Wider Lessons for Public Health

9.3.1   Objective Six - To summarise the wider lessons for public health

This part of the chapter answers the sixth and final research objective on the wider lessons for public health. Initially, a discussion on the barriers and opportunities for public health to contribute to policy in general is made, comparing findings to the published literature and considering the transferability of these findings for public health in regards to its contribution to policy in other situations. Next, a summary of the main public health competencies to this policy agenda is provided, including a public health version of the integrated policy model. This is based upon the integrated policy model developed for this research, however, the terms are adapted for a public health audience in order to make the model more understandable, and also aid insight of which areas public health can potentially contribute to policy development in the future. Lastly, recommendations for public health are made to assist future contributions of public health in policy development, these include balancing the art and science of public

health, in particular by strengthening leadership and advocacy, and enhancing engagement and simplifying complex evidence for policy makers.

9.3.2 Barriers and opportunities for Public Health contribution to Policy

The first part of this section summarises barriers public health encountered in contributing to policy on violence and abuse prevention. This is then followed by the main opportunities that occurred and enabled public health's contribution to policy in this area. The majority of the findings discussed here are transferrable for public health in contributing to other policy areas and potentially to other settings. The main issues that can be considered to be particularly specific to the topic area of violence and abuse, were the barriers encountered in achieving consensus with the VCS and the taboo nature of violence and abuse, and are more generalizable to other similar challenging public health issues.

Barriers encountered by public health in contributing to policy

The below section discusses the key factors as to why public health struggled to become actively engaged in the policy process. One of the most important factors identified by this research was the complexity of the policy making process, a finding which resonated with many authors in the literature; (Walt, 1994, Wall & Owen, 1999, Rouse, 2000, Lee, 2001, Wilson & Holt, 2001, Berry & Keil, 2002, Hunter, 2003, Fielding & Briss, 2006, OECD, 2009, Greenhalgh, 2010). The policy process was often described as complex and muddled in the literature, and was observed in this research, with no clear overall plan or project management in place to develop policy. It was observed that this mystique would at times, be perpetrated by some policy makers to help maintain the importance of their role in decision making. By developing a trusting working relationship between the expert and key policy makers was key to helping break down this gate-keeping role and enabled working collaboratively towards a common goal, which helped to navigate the complexity of the policy process. Fortunately, for much of the time in developing the violence and abuse prevention policy, this was the case, to the extent that the policy clearance processes and briefings were all undertaken by the public health consultant under the supervision of the policy lead.

However, the complexity of the policy process meant that overall there was a lack of a clear plan with timescales, objectives, policy tasks or roles defined. The process described in the formulation model was described after having proceeded through these stages, rather than being obtained from any documentation or guidance. In retrospect, the complexity of the system and the lack of an overall plan to guide through the process, acted to slow the policy completion and acted as a barrier for public health engagement as many tasks had to be

repeated and it was difficult to prioritise work as the agenda appeared to keep changing. This complexity also affected the relative lack of clear roles and leadership, despite the clear levels of hierarchy within the civil service, it can also be described as a complex, network organisation, (Handy, 1993). For example, the Department of Health was headed up by three leads, the CMO, the head of the NHS and the head of the health civil servants, with no clear overall leadership role. This culture had an impact on establishing clarity of roles and leadership for a policy agenda (including violence). Many senior servants are skilled in managing, rather than in leadership, and the need to establish consensus on policy reinforces this approach. However, this management versus leadership style can reinforce the status quo within an organisation, (Bridges, 1995; Mullins 1999), and made it difficult to bring a new policy agenda like violence, into the arena.

A generic barrier to policy development, which was not specific to public health, however, was important for a public health approach to navigate, was the slow and repeated process of achieving consensus. In order to achieve policy clearance, essentially meant that all the relevant ministers, policy leads and officials, analysts, and those in charge of the policy clearance process had to be in agreement with the proposed policy. This can lead to 'patchwork policy' where policy leads insist on the inclusion of their particular agendas, which can lead to a disjointed policy report. Additionally, gaining consensus by so many players tends to result in diluted, risk adverse and conservative policies. Achieving consensus has been described by many authors as a key challenge within the policy process, of which, in particular, Johnston writes about the importance of achieving consensus views for violence and abuse prevention; (Palmer, 1985, Wait, 1994, Hunter, 2003, Ashwell et al, 2008 Johnston, 2008, Koss & White, 2008). In this research, in particular, with regards to the violence and abuse prevention work, there were opposing views on alcohol and some of the life course perspectives of the public health approach; additionally, some policy officials from the Department of Children, Schools and Families did not favour the use of prevalence statistics of child abuse in Government Publications. Additionally, account had to be taken of external stakeholders views of policy and the likely media coverage, which in the case of the VCS stakeholders, disagreement with the public health approach to violence and abuse prevention acted to slow the policy process down, as has been documented in a comparable case study in South Africa, (Seedat & Nascimento, 2003). This finding may well be relevant for other controversial or challenging public health issues, and highlights the importance of international organisations like the WHO in establishing a recognised standards and a consensus on the evidence base.

The process of consensus formation, in itself needs considerable capacity, time, communication skills, persistence and patience in general, for which, having sufficient capacity and time to develop policy has been described in the literature, (Walt, 1994). However, this research also

observed that not having sufficient public health capacity led to a slowing down of the policy process, due mainly to competing demands on other related policy areas. This is compounded by the degree to which policy is responsive and demand driven, which meant that at the start of a new policy area being developed, there is frequently insufficient capacity to do justice to the work until resources have been justified.

Timing is consequence of lack of capacity and the need to build consensus in an area, and was seen to become an area of resistance on several occasions, in this research. There were substantial delays created by the political timetable, with Purdah, elections and holiday recesses. The timing of policy according to political timescales and taking advantage of windows of opportunity are described in the literature; (Walt, 1994, Hunter, 2003, Seedat & Nascimento, 2003). However, the use of timing in this research was also found to have important implications in slowing the policy process down and acting as a barrier. For example, it was observed that by delaying feedback on a policy area could enhance the power of that feedback, by giving negative comments at the last minute could end up blocking a policy going through at the last minute. Additionally, some senior policy officials would delay making a policy decision which either intentionally or unintentionally acted to slow policy progression. Potentially, by having clearer planning, governance processes and stronger leadership would help to overcome or reduce the impact of some of the barriers encountered by timing and a lack of capacity.

The limitations of the evidence base was an area very specifically related to public health's ability to contribute to policy, mainly due to its reductionist approach which consists of a different paradigm to that needed by policy makers; (Gray, 2000), (Brownson et al, 2009). Although, there were requests for the evidence base from policy leads, in general, the evidence produced was more complex than most policy professionals had the skills to interpret, a finding also observed by Choi, (Choi et al, 2005). The evidence base tends to provide far too much detail and focuses on individual interventions or small programmes rather than providing succinct policy options and answers. Moreover, the use of discrete evidence based interventions tends to result in the development of small pilots that are frequently not scaled up, rather than creating systems change, (Hunter, 2003 & 2009). Key messages from the evidence base need to be developed, and short summaries provided to help influence policy makers and were recommended by the public health experts in the round table. Additionally, policy makers tend to give greater importance to the political context of the evidence base than necessarily being guided purely by what the evidence says, and greater understanding of the wider agendas motivating policy leads would potentially assist in using the evidence base more effectively to influence policy, (Bowen and Zwi, 2005). Despite these challenges, however, it was possible to achieve an evidence based policy on violence prevention, (DH, 2012), in particular, to achieve

this, the art of public health in terms of communicating and influencing skills played a significant role and will be discussed later.

A key factor, which further compounded the barrier of public health evidence being taken up into policy consisted of the cultural tensions observed between policy leads and experts and advisors. Experts often come from a different background, with experience from the field and a more scientific education, and particular expertise in the field that they have been brought in to advice. In contrast, career civil servants, tend to enter the civil service early in their career, as highly qualified arts graduates, and may have little understanding of the translation of policy in the real world, or detailed knowledge of their subject area or the skills to interpret scientific evidence. These cultural tensions of a scientific versus arts background have also been observed by other authors; (Parsons, 2002, Seedadt & Nascimento, 2003).

Furthermore, in some situations, policy makers were observed in this research, to use this distinction in role to keep experts at arms-length and to use evidence and the expert when it was convenient for a particular piece of policy work, a feature also described by others, (Bowen and Zwi, 2005). This in itself, contributed to another barrier for public health to be more actively engaged with the policy process. The distinction of roles of health advisor versus policy decision maker, has also been documented by Tarin, (2009), whereby, the majority of experts or professionals with outside experience are employed by the civil service as 'advisors'. This means that the role of briefing ministers and influencing decisions is kept in the hands of career civil servants. This division of roles has probably been established as part of the civil service culture and maintains the power of decision makers in the hands of those who are considered long-term career civil servants.

The following section describes some of the solutions found to overcoming these barriers as well as opportunities encountered and skills that enabled a greater public health contribution to this policy process.

Opportunities that occurred and enabled public health's contribution to policy

The below factors summarises the key factors as to why public health was able to become actively engaged in the policy process in the context of this case study, implications are explored for public health to contribute to other challenges and settings.

The initial demands of the Home Office at both regional and national levels acted as an opportunity for public health to become engaged in the policy process for violence and abuse prevention. This was then later further enabled by the windows of opportunity presented by the

Media and Prime Minister's office. A number of other authors have also commented on how other actors, especially high level actors, can create demand for a policy engagement, and that this should be seen as an opportunity; (Walt, 1994, Wall & Owen, 1999, Pyper in Jones, et al 2001, Hunter, 2003, Johnston, 2008). This can be seen to be a particularly important opportunity for a public health issue like violence and abuse, where the main ownership is perceived to be outside of the health sector. Additionally, it can be reflected that as the civil service tends to be conservative, reactive and non-strategic, it is therefore potentially easier to forward a policy area that is being pushed by a stronger department than to push for a new policy area, especially from below. However, the relative disadvantage of the agenda being driven by a different department, was that their main policy focus was one of protection and containment rather than of prevention. The prevention approach was further distorted by the media interest on highly visible but relatively rare forms of violence and abuse. Nevertheless, these drivers acted as overall opportunities to advance the prevention agenda, which although it longer to influence, was eventually feasible to achieve.

A key aspect that helped to enable taking advantage of this opportunity was the development of good personal relationships and common goals with the Home Office, both at regional and then at national levels. It was found that policy engagement was especially fruitful when a good personal relationship and rapport was developed with relevant policy officials. This was observed to be especially the case with a handful of career civil servants who were personally committed to make a difference in their policy area. Other authors have also commented on the importance of developing personal relationships and common goals to advance a policy area, (Adair, 2002, Landsberg, 2002, Owen 2009). It can be further considered, that the forging of good relationships, then enabled the uptake of the public health evidence base, despite the natural resistance encountered by policy leads on utilising scientific information. This will be further reflected on in the recommendations under balancing the art and science of public health.

As has already been explicitly described, another key opportunity for public health encountered was a couple of policy windows of opportunity, of which Kingdon, Walt, John and Johnston also emphasise the importance of taking advantage of policy shifts that create openings (Kingdon, 1984, Walt, 1994, John, 1998, Johnston, 2008). By ensuring the timing of key policy decisions with other policy or external events that facilitate a policy decision was observed to be key. However, this opportunity could only be taken advantage of if sufficient background preparation had occurred and coincided with the astute readiness of relevant policy leads. These opportunities occurred within the background context of where policy was generally made incrementally, unless it was being driven actively by a minister, held high media presence, or was seen as an urgent priority. In general, an emerging policy area relies on the

gradual acceptance and consensus formation of an issue becoming adopted as a policy issue. For example, by holding repeated meetings, presentations backed up by opportunities to include mention of the issue within other policy areas that were being published to reinforce commitment by Government Departments to take an area forward.

In reality, although policy windows represent important opportunities, they are relatively rare and unpredictable events, and necessitate a high level of background preparedness and readiness to act when they occur. Several authors have commented on the need for leadership and persistence in general and also specifically for violence prevention, (Jason, 1984, Mercy et al, 1993, Adair, 2002, Landsberg, 2002, Johnston, 2008, Owen, 2009), and this policy was indeed observed to be actively supported by a small group of champions. However, it could be hypothesised that stronger leadership in this field could have made more advantage of the windows of opportunities when they occurred, and could be more strategically anticipated with a plan of action to help forward a policy agenda. This is an important lesson for other public health issues wishing to advance a policy agenda, and needs identification of potential risks and high media events that might create windows of opportunity, the development of draft policy and plan of action, as well as the forging of relationships with key policy leads.

The above areas can all be seen as taking advantage of emerging opportunities, whilst the below discussion focuses on making good use of the traditional public health expertise which can be seen to contribute to policy development, namely, by contributing the evidence base and to advance an approach on prevention. The provision of Public Health expertise is seen as particular contribution in the wider field of violence prevention, (Mercy et al, 1993), and in this research, a key opportunity emerged when I was approached by the policy lead for the Victims of Violence and Abuse Prevention Programme to provide public health expertise on the prevention aspects of the programme. In discussions with both Department of Health and Other Government Departments, the concept of prevention was generally perceived as a popular vision. Many policy officials and ministers like the use of the term 'Prevention' it has popular currency with the media and appears that the Government is doing something to improve things.

This makes it easier for public health to be engaged in the initial stages to advice on what prevention actually means. The concept of prevention as a popular vision, has also been commented on by others, who advocate making good use of this as an opportunity; (Mercy et al, 1993, Wall & Owen, 1999, Koss & White, 2008). Prevention can be seen as part of a bigger vision - the concept of prevention used as a common goal by many and helps to gain support from wider actors, public health has a role in extending understanding and approaches on the different levels of prevention. However, in this case study, and in wider observations, the

limitation of this approach is that the concept of prevention tends to be not well understood, and once detailed discussions are ensued, they tend to pivot around tertiary prevention approaches.

Nonetheless, public health expertise was requested by policy leads for contributions for a number of briefings and for technical advice, contributed especially on health service and local delivery aspects as most career policy officials had little or no experience of the health service or work at local level. In particular, though, a key to the adoption of public health evidence and a preventive approach was the ability of public health experts to translate and simplify information. Policy officials are aware of the power of using facts and figures and especially of cost-effectiveness data, (Adeoye et al, 2007), in persuading ministers, as long as they were provided in short summaries that were easy to understand. The importance of translating the evidence for policy makers is a key recommendation discussed later, and resonates with the wider literature on violence prevention specifically, (Seedat and Nasciemento, 2003) and for public health evidence in general, (WHO, 2012).

9.3.3   Summary

The main barriers of why public health struggled to contribute to policy found that a key issue was that the policy world is a complex environment to engage with. This complexity and the culture of the civil service made it difficult for health advisors to understand levers and influence the policy agenda. This was further exaggerated by the impact of complexity on leadership and role clarity as well as the amount of time and capacity required to achieve consensus; all these aspects acted to slow the potential policy contribution of public health in general. More specifically, the differing backgrounds and paradigms of public health advisors compared to policy leads limited the understanding and speed of uptake of an evidence-based, preventive approach. Although an evidence based policy report was finally achieved, this took considerable time to communicate and present the evidence base in a fashion which was able to eventually positively influence policy makers.

Translating and simplifying the evidence base, and the development of key messages also helped the adoption of violence and abuse as a public health policy issue. As did using the term of prevention, however, this needed considerable conceptual clarification in order to shift the focus away from tertiary prevention. Experience from the inside, revealed that successful approaches to navigating the policy world included identifying key allies and building trusting relationships. Once good relationships had been established, policy leads were able to see the value of using facts and figures, especially with costs, to influence Ministerial decisions, as long as they were presented in accessible formats. Additionally, the persistence and patience of

a small group of committed public health experts and policy leads, were seen as vital attributes; the overall process of developing policy for the prevention of violence and abuse took over ten years.

In contrast, key opportunities which actually helped to take the agenda forward positively, included the Home Office who acted as key drivers in pushing public health engagement in policy formation on violence and abuse prevention. This was further benefited by taking advantage of the occasional windows of opportunity created by the media and subsequently the Prime-Ministers office. The key barriers and opportunities for public health to contribute to policy development are summarized in Table 86.

Table 86 - Barriers and Opportunities for Public Health contributing to policy for the prevention of Violence and Abuse

Opportunities for Public Health in contributing to policy development	Barriers for Public Health in contributing to policy development
• Demand by the Home Office and Number Ten Downing Street • Personal relationships and common goals • Persistence, Policy Windows and Opportunities • Acting as a credible champion • Provision of Public Health expertise • Prevention a popular vision • Translation and simplification of the evidence base	• The complexity of the policy making process • Lack of clear roles and leadership • Achieving Consensus • Capacity • Timing • Limitations of the Evidence Base • Cultural tensions - Science vs Arts • Health Advisor Role vs Policy Decision Maker

The next section discusses more specifically the main public health competencies that contributed to the policy agenda, and presents an adapted version of the integrated policy model, highlighting the potential public health contribution to policy.

The Contribution of Public Health Competencies to the Policy Process

This section summarises the key public health competencies that contributed to this policy agenda, which are based upon the Faculty of Public Health Competencies, as applied to the public health framework illustrated in figure 16. This is followed by an adaption of the integrated policy model, with relevant text changed to highlight the potential public health

skills and competencies to the policy process. The intention of this public health version of the policy model is to illustrate the wider lessons for public health to contribute to the policy.

The literature review did not reveal any other studies that mapped out the contribution of the full range of public health competencies to the policy process. The most related area of published studies includes a reviews summarising 41 country assessments on public health capacity and services in general, (not in relationship to policy), across Europe; (WHO, 2012b). This found that the main public health competencies related to the traditional functions of health protection services, along with the supporting surveillance and monitoring functions. In contrast, the areas framed as public health enablers, which can be considered to be the 'art' of public health, were relatively weak across Europe.

In comparison, for this research, the findings revealed that all the main public health skills have been used to inform policy development, including: using public health information; assessing health needs; reviewing effectiveness (including cost effectiveness); informing strategy and planning, with the identification of priorities. The main skill not significantly applied was related to evaluation, which reflects the stage of the policy process that this study informed.

In contrast, Public Health functions were more variably applied to this policy, with the functions that contributed most to shaping policy on violence prevention, including 'screening' (or routine identification), improving services, and research and development. Whilst, functions that have been less engaged included: health promotion; health protection; clinical effectiveness and education and training. Whereas, all the public health methods, which can be described as the 'art' of public health, and included working in collaboration, advocacy, leadership and communication, were found to have contributed significantly to public health in influencing the development of violence and abuse prevention policy, including the adoption of the evidence base in the final report.

The below section outlines the wider lessons for public health based upon the research conducted in this thesis and informed by reflection of the updated policy model on the public health contribution of competencies to the policy process.

Public health competencies and their contribution to policy

Despite there being significant agreement or resonance of many individual areas within the published research with that found within this thesis, there are a number of areas that were not found in the literature. Aside from Walt, (1994), there were no other comprehensive policy models specifically from a public health perspective that were found. The majority of public

health papers on policy either advocated or recommended policy, provided an historical overview or presented policy models to predict specific clinical outcomes. Little literature was found that described the policy making perspective from an insider perspective, the majority of research was from external researchers analysing a narrow aspect of the policy making process. In this context, there was no research found which examined the role of different public health competencies to the policy process.
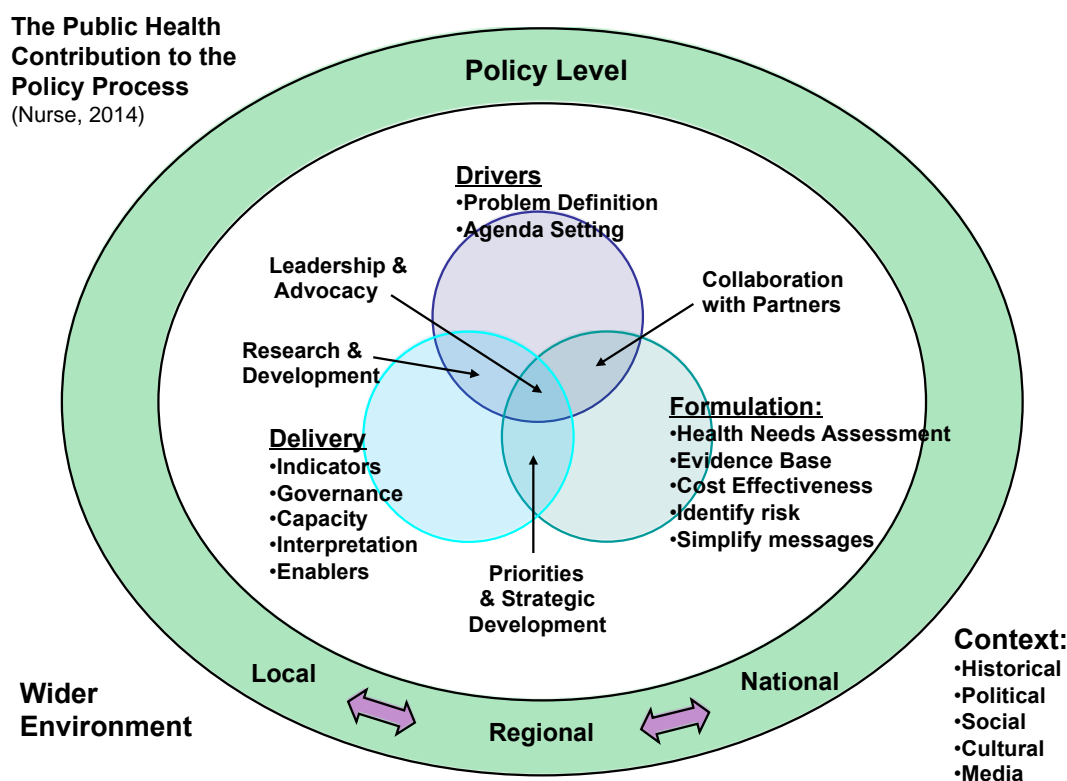
Based upon the 'integrated model of the policy process' presented under objective five earlier, the main terms and headings have been considered from a public health perspective, in order to make the policy making process more relevant for a public health audience. It also draws upon key lessons for public health from the findings of this research.

This adapted model uses public health language to describe the main aspects of the policy process.

The below section provides a detailed description of the changes made to the model of the integrated policy process, based upon reflections on this research from a public health perspective, describing why they were made and a comment on the potential public health contribution to the policy process. The purpose of this model is to act as an educational tool to inform the wider lessons for public health in contributing to future policy. The public health version of the integrated policy model can be seen in Figure 39, and is called the 'public health contribution to the policy process'.

The levels and the context are consistent with the integrated policy model. Whilst, the first circle is labelled 'drivers' as opposed to 'initiation' to convey the more active role that public health can play in establishing a policy agenda, for example, the role that the WHO plays with World Health Assembly resolutions. The terms problem definition and agenda setting are clear to a public health audience and have therefore stayed the same. Whilst, the overlap between the first and second circles has changed from policy partners and consultation to collaboration with partners. This is to convey the importance of public health in forging strong relationships internally to influence policy leads, and externally, in order to strengthen common goals and assist in establishing a consensus view for a policy area.

Figure 39 - The Public Health Contribution to the Policy Process, 2014

The Public Health Contribution to the Policy Process (Nurse, 2014)

Policy Level

Drivers
•Problem Definition
•Agenda Setting

Leadership & Advocacy

Collaboration with Partners

Research & Development

Formulation:
•Health Needs Assessment
•Evidence Base
•Cost Effectiveness
•Identify risk
•Simplify messages

Delivery
•Indicators
•Governance
•Capacity
•Interpretation
•Enablers

Priorities & Strategic Development

Context:
•Historical
•Political
•Social
•Cultural
•Media

Wider Environment

Local   Regional   National

The second circle text describes more specifically the traditional science based public health competencies that can contribute to policy, including the additions of health needs assessment, and an emphasis on identifying risk as well as costs, as both are influential for policy. Lastly, a key addition is made, signifying the importance of communicating and simplifying evidence based messages. In particular, providing cost effectiveness evidence in an understandable way, was found to have an important influence for both policy makers and ministers in making decisions. Additionally, by identifying and emphasising potential risks in an area was observed to strengthen the case for a particular policy area and to ensure a wider range of options are taken into account; in general, policy makers and ministers are sensitive to potential risks in informing policy, because of their negative impact from the media and the voting population. Simplifying evidence-based messages is also an important aspect that public health could contribute more significantly to, and has the potential to influence policy. The ability to communicate evidence and risks in a clear and concise way is key to influencing policy makers, who do not generally have the time nor skills to interpret detailed scientific data.

The overlap between the second and third circles has been changed from consensus and clearance (internal functions of policy leads) to the potentially positive contribution that public health can make at this stage in helping to clarify priorities and by taking a more strategic approach before the policy is finally cleared. However, it is important for the public health

community to be aware of the significance of reaching consensus in a policy area, and the potential delays that can result from a lack of clear consensus by external partners. A potentially powerful approach to influence policy positively, is for a range of interested partners to develop and agree a consensus statement, manifesto or similar on a particular policy area that is signed and given to Ministers and discussed with policy leads. Additionally, from a public health perspective, a short but well-argued proposal or brief strategy paper, outlining the problem, risks and the economic evidence base of a range of options to a particular public health challenge, was observed to be highly influential in other policy areas.

Next the third circle on implementation, aside from the same concepts as the policy model of governance and indicators, has the additional emphasis on capacity and enablers to support the delivery of policy, as well as the role of policy interpretation for regional and local implementation. In particular, Public health can play an important role in providing reliable indicators that can help to monitor and drive delivery of a new policy area. Whilst senior public health at both local and regional levels are able to help deliver policy through their governance structures, establishing governance is an important aspect of ensuring organisations are accountable to the delivery of policy or indicators related to policies. Whilst public health is often responsible for identifying the capacity needs and resources to shape services to reflect their needs to support policy implementation. Regarding interpretation, national policy often needs to be translated for regional and local settings, this is usually done by regional and local public health professionals. Lastly, for enablers, public health is often good at working collaboratively with partners and making use of multiple sources of information to facilitate delivery of a policy area.

The term 'Research and Development' has a similar meaning as for the policy model and therefore has stayed the same. However, Public Health training tends to include very little on the policy making process and applying a balanced combination of skills regarding the art and science of public health has the potential to influence the contribution to policy-making. Additionally, transferring knowledge of the specific lessons for the violence and abuse prevention community, or for wider public health challenges, on how to influence policy could improve their collective ability to engage and influence the policy process.

The central role in the inner overlap, of 'Leadership' has changed to also include 'Leadership and Advocacy'. This is an area that was found to be a particular gap in other policy models, and from the research in this field, played a key role in driving and formulating policy. Leadership and advocacy are also key public health skills in ensuring effective delivery of policy. Advocacy was added to emphasise the role that public health plays in driving a new policy area that is recognised by the public health community to be an emerging public health issue.

The following section outlines the main recommendations to enable public health to contribute further to the policy process.

9.3.4 Recommendations for Public Health

The main recommendations to enhance the public health contribution for future policy mainly surround balancing and strengthening the 'art' of public health in order to increase its ability to communicate the 'science' of public health and thus influence the policy process. In particular, by emphasising the art of public health in relevant under-graduate and post- graduate training on the policy making process in general, and more specifically, the public health contribution to this process are recommended. This section first makes an overall recommendation on improving the balance between the art and science of public health, and then makes particular recommendations on enhancing engagement, simplifying complexity and lastly strengthening leadership and advocacy.

Balance the Art and Science of Public Health:

It is recommended to balance the art of public health, including collaboration, communication and leadership, to enhance the uptake of the science of public health and apply a strategic approach to policy.

One of the main roles that public health has played in contributing to policy development has tended to focus upon providing and summarising the evidence base for policy. However, by applying a combination of the scientific skills to a policy issue, public health can help policy makers develop a more systematic and strategic approach to developing solutions. Internationally, this systems approach has been applied to policy guidance on violence and abuse prevention, (Butchart, 2010).

However, this research further supports evidence on the limitations of the evidence base in the context of policy, due to differing paradigms, backgrounds and skills; (Gray, 2000, Choi et al, 2005, Hunter, 2003 & 2009, Brownson et al, 2009). Although, Public Health is defined as 'The science and the art of improving the population's health through the organised efforts of society' (Acheson, 1998), the main focus of training and application is of the science of public health. The below Table 87 summarises the key aspects of art and science related to public health, based from insights of this research.

Table 87 - Balancing the art and science of public health

The Science of Public Health	The Art of Public Health
• Epidemiology • Health Information • Health Needs Assessment • Evidence Based Interventions • Systematic Reviews and meta-analysis • Cost analysis • Priority setting • Systematic and strategic approach	• Leadership and advocacy skills • Able to describe the bigger picture and vision • Creating change • Collaborative working • Building trusted relationships • Communication and influencing skills • Summarising detail and developing key messages

It can be acknowledged that the scientific approach to influencing policy has its benefits, however, the understanding of scientific findings and the relative importance that policy makers give to them are not as significant as for the public health and academic community. In order to improve the effectiveness of public health, especially within the policy setting, a balance is recommended between developing and applying both the art as well as the science of public health.

In conclusion, appreciating the relative benefits of the science of public health, including the concepts of an evidence- based approach (Sackett 1996; Gray 1997), to ensure a systematic and transparent approach to the policy process, has considerable potential to enhance the effectiveness of policy. However, in order to successfully influence the policy cycle throughout the key components of agenda setting, formulation and implementation, the skills described by political science, and described as the 'Art of Public Health' in table 87, are best integrated with the scientific approach. This research found that these 'soft skills' greatly enhanced the continuity of the policy agenda, along with the uptake of an evidence-based policy. These included an appreciation of communicating complex evidence into clear messages, building consensus and collaborative relationships, understanding how to create change and act on emerging opportunities and policy windows. Additionally, the application of a range of leadership skills, ranging from high level advocacy and transformational leadership styles, to softer collaborative and influencing skills, (Nurse tbp), within an integrated public health and political science approach are recommended in order to effect positive policy change.

This integrated approach resonates with Shiffman's policy research (2007) on factors that assisted on country prioritisation of policy, in relationship to maternal mortality, which revealed that the following areas determined success: international recognition with technical and financial resources; coherence of approaches by policy communities; national champions and advocacy events, credible evidence to influence policy makers, with a range of feasible policy options. Although these factors highlight the benefits of the scientific aspects of public health (regarding credibility, ability to convey impact and policy options), they illustrate the enhanced impact of incorporating the art of public health, including leadership, advocacy, communications, collaboration and consensus building.

It can also be reflected that certain public health challenges are better positioned to take advantage of windows of opportunity, because of their nature, they are more likely to receive occasional media or high level political attention (Kingdon 1984). This has been observed a number of times in this research with violence related events. Likewise, with the increasing frequency of climate related extreme weather events, public health communities could take better advantage of communicating the links with climate change in order to drive forward related policy responses as these policy windows emerge. However, it can be noted that other long term public health challenges like obesity, non-communicable diseases or inequalities (Exworthy 2012), tend to have less adverse media events which might limit policy windows. This may act as a barrier for agenda setting and policy responses, and calls for an enhanced application of the art of public health in order to influence, advocate and communicate the impact of these issues for ministers and policy makers.

Enhance Engagement:

It is recommended that public health enhances its engagement with partners to positively influence policy. By identifying key actors from other sectors and understanding factors influencing their reasons for being involved in a policy area was seen to help improve the appropriateness and impact of a policy. This was used to help tailor public health messages to increase the relevance of working towards a common goal. Conversely, by understanding variations in motivation of different actors, can help to identify divergence in approaches and conflict earlier on, which is a potential risk to consensus development for policy. By engaging actively with other sectors was found to assist in mainstreaming a public health approach to a wider audience for action. Having influenced other actors on the benefits of a public health approach to their work, it was then possible to embed relevant aspects into a range of policies that impacted upon the wider determinants of health.

Making allies with champions was seen to be a key approach for taking forward and increasing wider ownership on the violence and abuse prevention policy. A handful of committed champions especially in government were seen to act as powerful partners in developing policy on violence and abuse prevention. Building trust and personal relationships was effective in influencing key policy leads, additionally they later became advocates for an evidence based approach. By providing policy leads with relevant information, helped to overcome barriers and develop solutions for their work.

Simplify Complexity

It is recommended that systems approaches are used to simplify complexity and evidence is communicated in accessible formats for policy.

One of the limitations of public health focusing on the evidence base as its main contribution to policy has been that most policy makers do not have the skills to interpret and translate scientific evidence into something meaningful for policy. Therefore, a key lesson for public health, is the role it can play in simplifying complex and detailed evidence into high level key messages that are appropriate for the relevant audience. If this is done effectively, it can help to develop memorable messages that are instrumental in creating change within an organisation or policy network. It also helps to improve the ability of public health to influence the agenda and outcomes within meetings. Simplifying key messages can also be applied successfully to aid priority setting and the inclusion of text within policy reports. Applying communication skills to develop memorable key messages, presented in a range of formats also helped to raise awareness and relevance of a complicated issue. Additionally, translating complex interactions across the life-course, into the form of a personal story, increased engagement and understanding of a challenging issue.

Evidence for an emerging public health issue also benefited from being summarised and presented in public health mainstream language, for example, by making the links of a determinant of health to risk factors and health outcomes. By making parallels with the way data is presented on mainstream public health issues helped to increase awareness and normalise a relatively new public health challenge.

Leadership and Advocacy

It is recommended to strengthen the leadership and advocacy role that public health can play to influence policy and take opportunities of policy windows.

One of the key findings from the research from this thesis is the important role that leadership played in all stages of the policy process, and has therefore been placed centrally in the policy models. Conversely, poor leadership and lack of clarity of leadership roles acted to slow the policy process within the violence and abuse prevention context.

Aside from influencing the internal policy making process, Public Health organisations can play an important leadership and advocacy role as external actors. In particular, greater advantage could be made of windows of opportunity, by strategically identifying when they are likely to occur and having a plan of action in response to a policy window. Leaders of public health organisations potentially can influence policy by meeting regularly with ministers and senior policy leads. Additionally, external public health leaders can influence the policy agenda by gaining high media coverage on an issue. The impact is potentially strengthened by presenting to ministers and policy leads, a concise proposal, outlining the issue, risks, options and cost -effectiveness, (ideally on 2 sides, with additional briefing), which has the endorsement from a range of organisations.

The other key area observed to strengthen leadership and the development of policy, is to establish, or become part of existing governance structures for public health policy. For example, an inter-ministerial public health group, and steering groups or committees for specific topics. Public health leaders can help to drive the process by clarifying roles, setting timescales and objectives, and reporting on, or asking for regular updates that monitor the policy process. Additionally, public health leaders can support capacity building and training for policy makers and public health, and arrange exchange placements for public health and policy leads to understand each others' environments to forge collaborative working and the development of policy friendly communications.

The following section reflects on this research thesis in regards to the overall aim and research question.

9.4   Reflections

This section summarises how the initial research question has been answered by this thesis. The above research question was broken down into six component angles that related then to the six objectives. The results have presented findings for the first four objectives in turn, whilst, the conclusions chapters have discussed this research and explored the wider lessons for policy and public health, (the fifth and sixth objectives). The following part of the chapter, reflects upon the overall research question:

"Why is public health in England not more engaged with the development of policy for the prevention of violence and abuse?"

And considers the overview of this research in response to the aim of this thesis:

"To document the process of policy development to prevent interpersonal violence in England, and explore the implications and potential role of public health"

In terms of the wider literature, this research makes particular contributions to both the policy world and to improving the public health contribution to the policy process. There were only three studies, (Johnston, 2008); (Koss and White, 2008); (Seedat and Nasciemento, 2003), found that analysed the policy process from a violence and abuse perspective, and none of these are substantially similar to the research presented in this thesis. In summary, although there was significant agreement with most individual aspects of the findings of this research, there was no comparable research that as a whole, was directly relevant to the research question of this thesis. Nonetheless, the triangular policy model by Walt (1994), was found to be useful in summarising the main interactions of content, context, actors and process described by this research. The Figure 40 summarises the main concluding points based upon Walt's framework. The main conclusions for each of these factors have been described earlier in this chapter.

Figure 40 - Summary of the conclusions in relationship to the Process and Power Policy Model, (adapted from Walt, 1994)
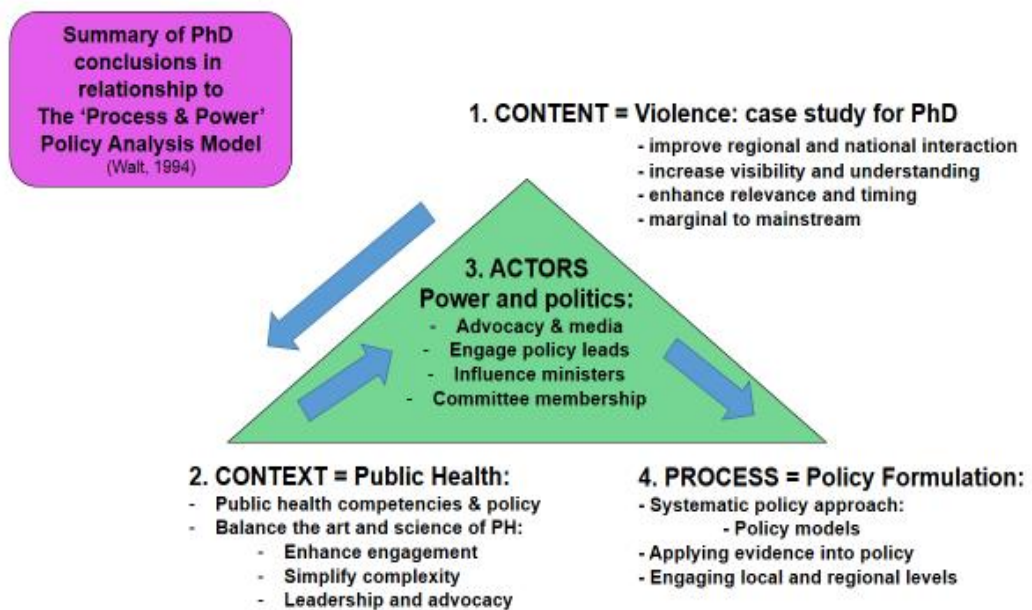
The headings for the four objectives related to content, context, actors and process are described in the adapted triangular policy model by Walt (1994), to provide an overview of the main conclusions. The first objective addressed the content of the case study, on violence and abuse prevention, and concludes that enhancing interactions between the delivery process at regional and local levels could improve national policy. Insights in relationship to violence in particular, include the importance of increasing the visibility of a relatively invisible public health challenge. By improving the relevance of information to mainstream public health and policy makers assisted in embedding violence and abuse into related policy, increased visibility and kept the issue on the agenda, to take advantage of policy windows.

The second area related to the public health contribution to policy, of which strengthening the public health competencies considered to be the art of public health are recommended in order to enhance the uptake of the science of public health into policy. Recommendations are made on enhancing engagement, simplifying complexity and improving leadership. The third area makes recommendations to enhance engagement with key actors, (policy makers and ministers) in the policy process. This can be achieved by personal relationships, in particular, influencing ministers, for example, via official committee and governance positions or by the use of advocacy and media.

Lastly, the fourth area considers the policy process, and recommends the use of systematic approaches to develop policy, for example, applying the policy models presented. Increasing the use of evidence, especially on cost-effectiveness could strengthen the rationale for policy. Training and education and placements in public health settings and vice versa, are recommended to enhance understanding and mutual benefits between public health and policy.

Of particular relevance to the research question of this thesis, however, is the interaction between policy and public health. The level of engagement by public health was influenced by a number of cultural barriers between public health and the world of policy makers. These can be described as the differing paradigms of public health and policy. Key variations between these professional disciplines and their organizational cultures include, being reactive versus a strategic long-term view; an incremental, consensus approach, versus a systematic perspective. Policy makers tend to be adaptable generalists versus detailed experts, however, many advisors have experience of delivering policy, whilst career civil servants do not always have implementation experience at local or regional levels.

These different paradigms lead to different ways of working and at times a sense of mistrust or misunderstanding between these two different cultures. The implication of this is the need to promote a more integrated approach to bring together the strengths of these two different

worlds. Assisting in greater collaborative working between both these two paradigms has the potential to achieve greater social and health benefits. To achieve this, from the policy perspective, training, placements and the application of tools to appreciate how a scientific approach can help to develop a more systematic and cost- effective approach to policy making is recommended. The policy models developed by this research aim to contribute to comprehending and navigating the complexity of the policy process, in order to benefit future policy making.

Whilst, a key conclusion for public health was to balance and develop the art as well as the science of public health to enhance their leadership, communication and influencing skills. Developing the art of public health helped to bridge the disparity observed between the policy and public health paradigms, and assists the interpretation and application of science.

Additionally, there are wider lessons for external actors including public health and also for the voluntary community sector, to strengthen their influence in policy-making. These recommendations draw upon insights for violence and abuse prevention in particular, however, they are relevant for other emerging public health challenges. Combining several of the approaches summarised in Table 88 could potentially strengthen the level of policy influence.

Table 88 - Recommendations for External Actors to influence policy

- Forge networks and develop a consensus statement
- Gain the support of high profile champions
- Meet with ministers or high level officials to discuss proposals
- Ensure proposals are brief and have clear benefits
- Create high profile media events to gain coverage
- Be prepared to compromise on proposals to aid policy consensus
- Identify policy windows to strengthen the timing and appropriateness of messages

In conclusion, the overall answer to the research question has to be that public health was engaged sufficiently with policy development on violence and abuse prevention, as witnessed by the final publication of the evidence based policy report on violence prevention, (DH, 2012). However, it needs to be acknowledged that the role of the researcher as participant observer, at times, significantly influenced the development of this policy, and that it could be speculated that if this role had not existed, neither would the violence and abuse prevention policy, or at least it would likely to have taken a different shape and course. Whilst from another perspective, in retrospect, if public health had been more actively engaged in policy development, and in particular, had shown greater leadership, and took greater advantage of

policy windows, this policy may have been produced earlier and had cross-governmental ownership. The wider lessons from this thesis can potentially be applied in order to enhance the public health contribution to future policy development.

The following section reflects upon the strengths and limitations of this research.

9.5   Strengths and Limitations of the Research

Any piece of research, whether quantitative or qualitative in nature has relative strengths and limitations. Essentially, the aim of much research is to understand how and why something happens or whether or not something works. The process of research in itself will always have limitations in its ability to understand these things in the context of how the wider world actually works in real life. (Flick, 2009)

It is within this context that the relative strengths and limitations of any research needs to be understood, and the need for any researcher to appreciate and reduce the impact of research limitations (Richards, 2009). This section outlines the reflections of this piece of research's strengths, this is followed by the main limitations of the research with a discussion of how the impact of research limitations was reduced.

9.5.1   Strengths of the Research

A key challenge and strength of this research, was the application of multi-disciplinary methods to the research question: in essence this was a thesis on both policy and on public health, of which the case study was on violence and abuse. Therefore, the methods used for examining the policy aspects of the thesis were from a political science background, which uses more qualitative perspectives in examining a research question, and a critical analysis style of analysis. Whilst, the public health approach to examining the public health contribution to policy, utilised more structured and objective frameworks and mapping techniques to understand the levels of prevention and competencies used. This at times presented challenges of how best to present and discuss the findings, as these are essentially two different disciplines and paradigms.

However, in itself, having applied these two divergent disciplines to answer a complex and multi-disciplinary research question, has been rewarding from a personal development respect, and in particular, has given richer insights into the research question, as well as contributed lessons both for policy and for public health. Having examined the especially challenging public health issue of violence and abuse, has also allowed for useful insights in how to

overcome barriers and increase the relevance of a difficult or emerging public health issue. Some of these reflections have been applied professionally into my other work areas of other emerging public health issues, for example, on climate change, where I have applied findings from this research to help mainstream this as a public health issue and how to influence wider policy formation on this agenda.

The particular strengths of this thesis includes the participatory observational method used to study policy from an insider perspective. This has provided unique insights into the policy process in general, and in particular, into policy formulation. It has also allowed the development of a policy formulation model, and the testing and updating of an integrated model for the policy process. However, the use of participatory observational methods has resulted in the active contribution to the policy process for violence and abuse prevention, therefore, it can be argued that some of these insights are distorted by the process of participating in the research that was also being observed. To try and reduce this impact, secondary observation accounts have been used, and a variety of research methods, which also include relative objective methods, like mapping and documentary analysis, as well as more subjective methods like the observational analysis.

The range of qualitative methods, including mapping, documentary and observational analysis, used in this research were triangulated to increase the robustness and validity of the research findings, and to reduce some of the impact of this research being conducted with participatory observation methods. However, despite this, it has to be recognised that the act of participating in the research that was being observed will have distorted the research outcomes and findings. The key area that is likely to have been affected is the public health contribution to the policy perspective, as this was an important area of expertise that I was asked to contribute on. This means that compared to research on the policy process from an observer who did not have a public health background, the findings may well have showed that the evidence base was incorporated less into the final policy, and additionally, the prevention focus may have been more on tertiary prevention, which was the predominant tendency observed for policy on violence. The other key reflection, is that the violence and abuse prevention policy may not have even been developed, or would have become a different sort of policy document, if my role had not existed, or someone else had been adopted as a public health advisor for this policy area.

The use of frameworks, including the violence and abuse framework, the public health framework and the model of the integrated policy process, allowed for a structured and relatively objective approach to mapping policy content, public health competencies and a systematic schema to analyse the observations from this research. The application of these

models for future public health and policy analysis is limited for the violence and abuse prevention framework, which is very specific to this case study. However, the public health framework has already been published (Nurse, 2007), and aspects of this have been used by CDC, and adapted for the WHO European Action Plan on Public Health, (WHOa, 2012).

The integrated policy model developed for this research was considered to be useful to provide structured headings to capture observations, which have been summarised in the annex, and used to inform the results chapters. It is anticipated that the updated policy model will be published, and a simplified and adapted versions of this model from a public health perspective, has already been used as a training package for policy and strategy development for the WHO Europe. The simplicity of the model by Walt (1994) can be seen as advantageous as it is easier to transfer and apply to other settings, additionally the wording is likely to stay more relevant than the more complicated models created for this research, as the use of language evolves and changes.

9.5.2   Limitations of the Research

The main limitations of any research that are described in the methods chapter, fall under the headings of:

- **Reliability** – the repeatability of findings using the same methods

- **Validity** – the extent to which research methods measure what they set out to measure and the generalisability of research findings to other settings

- **Bias** – deviation in one direction from the true value of the construct being measured; (Bowling, 1997).

In regard to this research the main limitations related to these areas are:

Reliability – *the repeatability of findings using the same methods.*

This study was based upon a case study that occurred at a point in time set within a particular geographical, cultural and political context. Therefore, it would be expected that the findings discovered in this research would be very difficult to repeat, even if the same methods were used. This is especially so because of the use of participatory observation as a key approach to undertaking this research, which in itself will have distorted the policy outcomes. In terms of the detailed findings from the research, this is very likely to be the case and this is one of the key weaknesses of using a case study of this sort.

However, research findings from multiple settings across the policy remit, have found agreement with individual components of the research findings and analysis. This would suggest that although there is considerable variation in settings and research methods, there are general policy processes that are being described from a range of different sources. In this way, this particular piece of research can provide valuable contributions to the overall range of findings, and in particular to the policy formulation process, where there is a relative gap in research.

Validity – *internal: the extent to which research methods measure what they set out to measure; external: the generalisability of research findings to other settings.*

The main limitation related to the internal validity of this study includes the lack of a validated research tools for studying the policy process. Therefore, the author had to create analysis frameworks and policy models for the research process. These were shaped by expert opinion, however, due to the nature of the research it is difficult to properly validate the research methods or findings. The author used cross- validation methods with several forms of secondary analysis to help increase the validity of this research, additionally, the sequential analysis and triangulation of findings helped to increase saturation of findings to establish common themes, and identify deviant themes.

Regarding external validity, as this research is based upon a single case study within a particular context and timeframe, the overall repeatability of this research is likely to be limited. However, detail is provided on the contextual factors which will enable other policy makers or academics to compare the common factors and see those that are unique to this particular case study. The findings that are most generalizable from this research are those related to the policy formulation process, which was observed to be similar for other policies at that time in that setting.

In comparison, the public health contribution to other policy areas is likely to be variable, depending upon the direct or indirect use of public health advisors, for example, many countries in Europe have very limited public health capacity, so their policy tends to be less influenced by a public health approach. With regards to violence prevention, some of the insights about how to embed prevention aspects into wider policy, and how to increase visibility and understanding of a challenging issue, and the need to establish consensus and build strong relationships with policy leads, can be considered to be reasonably generic lessons for other settings, and also for other challenging public health issues. Whilst, the specific findings about overcoming conflicts, including the taboo nature of violence and abuse, and the

relative role that particular actors played, will be more relevant to those involved in violence and abuse prevention.

Bias – *deviation in one direction from the true value of the construct being measured – and can by introduced in the forms of design, assumption, observer, interviewer, selection, reporting and non-response bias.*

The main form of bias introduced into this researcher has been in my role of participant observer, which can be described as 'insider research'. The very nature of this research acknowledges the researchers role in shaping the outcome of the research and creating change within the process. It is appreciated that if this role of participant observer had not existed within that setting, the outcomes examined would have potentially been very different. Although, the insights gained by having used this research method are potentially valuable for both policy makers and public health professionals.

However, it needs to be acknowledged that the act of researching on this agenda and the nature of the methods used, are likely to have actively facilitated the development of policy on the prevention of violence and abuse. My role as participatory observer meant that I actively contributed to this process by acting as a driver, champion and advocate, and by collating the evidence base, creating summaries, and persisting with the relevant policy leads. Although a source for distorting research findings and in creating bias, this is considered to be one of the aims of action research, to become actively involved in the change process as well as generating new knowledge, (Heller, 2004).

However, this can be described as design or observer bias. Clearly, it is not possible within this context to reduce this form of bias, and it can be argued that the insights gained by insider research made this a particularly valuable form of research. However, the bias introduced into the process needs to be understood so that its impact can be interpreted in a meaningful way by other researchers. Therefore, every effort to make my role in the research process transparent was made throughout the thesis, with a clear description of the wider context and the role I took at different stages in the research and policy development process. Additionally, the practice of self-critical or reflexive recording in personal diaries and during the analysis stage, helped to make the nature of this bias clearer and thereby allow interpretation by an outside reader.

9.6   Summary of Key Learning and Contribution to New Research Knowledge

The comparison of the published literature with the main findings in respect to the research question, found that there was general agreement in the literature for each individual area. However, the gaps in the literature were found to be around:

- The application of systems science to research on the policy process and in particular, to understanding policy formulation

- A number of policy models exist, however, there was limited application of these models to public health policy analysis

- There were only three studies found that described a policy analysis of violence and abuse prevention

- There was very little in the literature about the contribution of public health to the policy process, most of this focused on a particular aspect of the policy process (for example, the evidence base) or advocated or made recommendations for policy changes

- There was a lack of 'insider' research within the context of the policy setting – this gave particular insights that have been used to inform the below contributions to new research.

Therefore, it can be considered that the main new learning that this research brings to the field, includes the following areas:

- The development of an improved policy model *'the integrated model of the policy process'* – that has been tested and improved upon in a real life setting,

- The development of a model on *the contribution of public health to the policy process* – which is adapted from the integrated policy model, this will potentially help to improve understanding by public health professionals on how the policy process works and how they can best contribute to the policy agenda.

- The development of a model on *the policy formulation process* – this model is based upon the main findings of the research process on documenting the policy process, and applies principles of systems science. It has potential utility for policy makers and public health professionals in simplifying and understanding the complexity of the policy process at the formulation level. However, it may need to be adapted for other settings.

- Learning on *policy development for violence and abuse prevention* – this study provides a valuable contribution to this field, which has little published policy analysis. In particular, findings include the levels of prevention emphasised in policy, whilst key levers for influencing policy development in this area includes the importance of good leadership, taking advantage of policy windows, increasing the relevance of violence to health outcomes and mainstreaming violence and abuse prevention across public health and other sectors.

9.7   Research Recommendations

The main future research priorities identified by this research include the following:

- **Policy**- the further application of systems science to develop policy models and the analysis of the policy process; further 'insider' research on the policy process; more research is especially needed on the complexity of the policy formulation and implementation process.

- **Public Health**- the role and contributions to public health in the policy setting; effective approaches for simplifying and transferring knowledge and simplifying key messages; the uptake of research findings within policy; how public health can best influence and engage with the policy process; the balance of research methods that reflect and help develop the 'art' of public health alongside the 'science' of public health.

- **Violence and abuse** – further research on the policy process within the context of violence and abuse prevention; specific gaps in evidence base that would support the development of violence and abuse prevention policy include, prevalence levels, health behaviours and health outcomes of all forms of child abuse and violence within adolescence; long-term outcomes including health and health related outcomes following school based interventions for the prevention of all forms of violence and abuse; more research on the wider determinants of violence and abuse, including the effectiveness of related interventions on violence and abuse and health outcomes. Improve the evidence base of NGOs – working in partnership with academic bodies.

- **Education and Training** – policy makers need further training on understanding the basic principles of understanding how to apply the evidence base to policy making and where and who to get support from; public health professionals would benefit from further training on the policy process and how to influence it both internally and externally;

Additionally, as has been found by other researchers, there is a need for the translation of the evidence base in appropriate formats for policy makers, and for better engagement between research and policy making bodies to ensure that future research outcomes have clearly defined policy outcomes as an integral part of the research process.

This includes increasing the policy relevance of academic conferences, which tend to focus upon relatively narrow research findings or intervention studies. Presentations that pull together the relevance and feasibility of multiple interventions or programmes, and that address big picture policy issues with a translation of key messages from the evidence base are recommended. Additionally, presentations and posters are rarely seen on the policy process, how researchers can influence this agenda and adapting research methodologies to be of greater relevance to improving the development of policy and policy outcomes. Conference planners could take a more strategic role in shaping the overall programmes to reflect the relative gaps in policy, how to influence policy and to target policy makers to attend. Additionally, joint workshops between policy makers, public health professionals and academics on specific research agendas (for example, violence prevention) would potentially help to increase the relevance of how information is summarised for policy makers and influence the overall research and policy agendas.

9.8   Dissemination of Results

A variety of the main findings of this research thesis have already been disseminated at the following conferences and within the following peer reviewed publications and governmental reports.

9.8.1   Conferences Presented at on Violence and Abuse Prevention and Policy

To aid dissemination of the research findings, during the research period, from 2005- 2010, I have attended and presented at several national and international conferences, including:

- 2006 – WHO Safety Conference, South Africa – Presentation on PhD thesis – literature review on violence prevention

- 2006 – International Conference for International Society for Child Abuse and Neglect, England – Presentation on A Public Health Approach to Child Sexual Abuse and Sexual Violence in Adolescence

- 2007 – UK Public Health Association Conference, Presentation on Violence Prevention Framework

- 2008 – WHO Safety Conference, Mexico – Presentation on PhD thesis – turning research into policy

- 2008 – UK Public Health Association Conference, Presentation on the evidence base for national policy on violence prevention

- 2009 – Faculty of Public Health Conference, Presentation on National Policy on Violence Prevention

Additionally, between 2010- 2013, the policy and public health lessons have been incorporated into training related to my work at the WHO Europe.

9.8.2   Peer Reviewed Publications

The below publications have either incorporated findings from the violence and abuse prevention perspective, or learning from the policy process and analysis that are related to the findings and work of this thesis:

- Gracia LT Fellmeth, Catherine Hefferman, Joanna Nurse, Shakiba Habibula, Dinesh Sethi, 'Educational and skills based interventions for preventing relationship and dating violence in adolescents and young adults' Cochrane Database of Systematic Reviews, June 2013; www.thecochranelibrary.com/

- Butchart A, Garcia-Moreno C, Mikton C, Nurse J, Basher D, Diaz-Granados N, Kleven J, Valle LA, 'Preventing Intimate Partner and Sexual Violence Against Women: Taking action and generating evidence' World Health Organisation/ London School of Hygiene and Tropical Medicine, WHO Geneva, 2010.

- Wood S, Bellis MA, Basher D, Nurse J, Elton P. Prevention of sexual violence: A review of evidence for prevention from the UK Focal Point for violence and injury prevention. Liverpool: Centre for Public Health, Liverpool John Moores University, 2010.

- Wood S, Bellis MA, Nurse J, Sirotkin M. Prevention of youth violence: A review of evidence for prevention from the UK Focal Point for violence and injury prevention. Liverpool: Centre for Public Health, Liverpool John Moores University, 2010.

- Nurse J, Basher D, Bone A, Bird W, "An Ecological Approach to Promoting Population mental health and well-being – A response to the Challenge of Climate Change" Perspectives in Public Health Volume 130 Issue 1, January 2010.

- Campion J, Nurse J 'A Dynamic Model for Well-Being'' 2007; Australian Psychiatry; Vol 15: Sept S24-28.

- Nurse J, Edmondson – Jones P "A framework for the delivery of public health: an ecological approach" Journal of Epidemiology and Community Health 2007; June; 61:555-558.

- 2006 'Mental Health and Well Being in the South East' DH/ CSIP/ SEPHO; http://www.sepho.org.uk/Publications/completedPubs.aspx

9.8.3 Government Reports

The following are government reports that have included a substantial component of violence and abuse prevention work that the author has written or contributed to. They also include a number of regional level factsheets which translate national policy and evidence base for a regional and local level audience.

- 'Preventing Violence and Abuse' A Regional Factsheet, DH/ HO, 2006 and updated 2008

- 'Promoting Mental Health and Well Being' A Regional Factsheet, DH/ CSIP, 2006 and updated 2008

- 'Promoting Mental Health and Well Being in Children and Young People' A Regional Factsheet, DH/ CSIP, 2008

- 'SE Regional Health and Well Being Strategy' Department of Health in the SE, 2008

- 'Healthier, Fairer and Safer Communities - Connecting People to Prevent Violence,Towards a Framework for Violence and Abuse Prevention' Department of Health, 2008.

- 'New Horizons' – Mental Health Policy for England, HM Gov't/ Department of Health, England, 2009

- 'Confident Communities, Brighter Futures – a framework for population well-being' HM Government/ Department of Health, England, 2010.

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9.8.3 Related WHO publications

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- *WHO, September 2012: Review of public health capacities and services in the European Region*, by Jo Nurse, Stephen Dorey, Mary O'Brien, Casimiro Dias, Jordan Scheer, Charmian Møller-Olsen, Maria Ruseva, Jose Martin-Moreno, and Hans Kluge, www.euro.who.int/publichealth

- *WHO, September 2012: Preliminary review of institutional models for delivering essential public health operations in Europe*, by Bernd Rechel and Martin McKee, Jo Nurse, Casimiro Dias, Stephen Dorey, Richard Alderslade, Maria Ruseva, Jose Martin-Moreno and Hans Kluge, www.euro.who.int/publichealth

- *WHO, September 2012: Public health policy and legislation instruments and tools: an updated review and proposal for further research*, by Carlos Dias and Rita Marques, Maria Ruseva, Jo Nurse and Casimiro Dias, Snezhana Chichevalieva Jose Pereira Miguel, Jose Martin-Moreno and Hans Kluge, www.euro.who.int/publichealth

- *WHO, September 2012: Strengthening Public Health Services across Europe: A summary of background documents for the European Action Plan, by* Jo Nurse, Charmian Møller-Olsen, Casimiro Dias, Stephen Dorey, Jordan Scheer, Maria Ruseva, Jose Martin-Moreno and Hans Kluge; www.euro.who.int/publichealth

9.8.4 Topics for Further Publications Based Upon Findings from the Thesis

Key findings have been discussed with senior policy leads. Additionally, the below are further topics that have been drafted, and are based on the findings of this thesis for publication within peer reviewed journals:

- An article on policy models 'An Integrated model on the policy process' – in a Policy Journal

- An article on public health aspects of the policy process: 'The Public Health contribution to policy making' – in a Public Health Journal

- An article on the policy process and Violence and Abuse Prevention – in a Violence Journal

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WHA56.24

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1996 – Prevention of violence: a public health priority, WHA49.25

The full texts of these resolutions are available at:
www.who.int/violence_injury_prevention/resources/publications/en

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DH 'Responding to domestic abuse: A handbook for health professionals' 2005;
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4126619.pdf

DH, 2006 / Itzin C 'Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Abuse' Programme Implementation Guide for the Victims of Violence and Abuse Prevention programme, 2006. DH/ NIMHE/ HO.
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Links between juvenile sexually abusive behaviour and emerging sever personality disorder traits in childhood, DH; 2006;
http://site320.theclubuk.com/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4140126

The needs and effective treatment of young people who sexually abuse: current evidence; DH & HO; 2006;
http://site320.theclubuk.com/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4140125

Safe.Sensible.Social. The Next Steps in the National Alcohol Strategy, 2007; DH, HO, DfES, DCMS; www.dh.gov.uk/publications; dh@prolog.uk.com
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075218

The Child Health Promotion Programme. Pregnancy and the first five years of life. DH,DCSF, 2008 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_083645

Home Office:

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Domestic violence: a national report, HO; 2005
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Reducing Re-offending Delivery Plan' Home Office 2006 www.noms.homeoffice.gov.uk;

http://www.noms.homeoffice.gov.uk/news-publications-events/publications/strategy/noms-
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'Cutting Crime – a new partnership' – the Home Office crime strategy, 2007;
http://www.homeoffice.gov.uk/documents/crime-strategy-07/

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Saving Lives. Reducing Harm. Protecting the Public. An Action Plan for Tackling Violence,
2008- 11. http://www.homeoffice.gov.uk/about-us/news/violent-crime-action-plan

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http://www.homeoffice.gov.uk/documents/youth-crime-action-plan/

Rape and Sexual Assault of Women, Findings from the BCS; 2002;
http://www.homeoffice.gov.uk/rds/pdfs2/r159.pdf

Domestic Violence, Sexual Assault and Stalking; Findings from the BCS; 2004;
http://www.homeoffice.gov.uk/rds/pdfs04/hors276.pdf

Violent Crime Overview: homicide and gun crime, 2004/5 BCS:
http://www.homeoffice.gov.uk/rds/pdfs06/hosb0206.pdf

Youth Justice Board targets to reduce reoffending www.youth-justice-board.gov.uk

The Department of Children, Schools and Families:

Every Child Matters, 2004; http://www.everychildmatters.gov.uk/   Five main strands: Be
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Being.

Choice for Parents – the Best Start for Children: Ten Year Childcare Strategy, 2004; DfES; DTI; DWP; HM Treasury
http://www.everychildmatters.gov.uk/_files/C7A546CB4579620B7381308E1C161A9D.pdf

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http://www.dcsf.gov.uk/consultations/downloadableDocs/STAYING%20SAFE%20-%20FINAL%20FULL%20DOC.pdf

Staying Safe Action Plan 2008: DSCF
http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00151-2008&

Department for Communities and Local Government:

Department for Communities and Local Government: Communities and Neighbourhoods activities around the following:
- **Community Cohesion**
- **Social Exclusion**
- **Cleaner, Safer, Greener Communities**
- **Respect**
- **Civil Renewal**
- **Sustainable Communities**
http://www.communities.gov.uk/index.asp?id=1139865

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Anti Social Behaviour and Housing – Department for Communities and Local Government – Variety of Guidance – relates to RESPECT agenda 2003- 2007
http://www.communities.gov.uk/index.asp?id=1152984

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Improving Opportunity, Strengthening Society, 2005; DCLG; Government's strategy to increase race equality and community cohesion.
http://www.communities.gov.uk/index.asp?id=1502614

Respect Action Plan, 2006. www.respect.gov.uk;

REACH - An independent report to Government on raising the aspirations and attainment of Black boys and young Black men, 2007; DCLG
http://www.communities.gov.uk/index.asp?id=1512161

The Department for the Environment, Farming and Rural Affairs:

Securing the future, delivering UK sustainable development strategy. DEFRA. 2005
http://www.defra.gov.uk/sustainable/government/publications/pdf/strategy/SecFut_complete.pdf

The Cabinet Office:

Reaching Out: An Action Plan on Social Exclusion. Cabinet Office. 2006
http://www.cabinetoffice.gov.uk/social_exclusion_task_force/publications/reaching_out/reaching_out.aspx

Reaching Out: Think Family. Analysis and themes from the Families At Risk Review. Cabinet Office. Social Exclusion Task Force.2008
http://www.cabinetoffice.gov.uk/social_exclusion_task_force/families_at_risk/reaching_out_summary.aspx

Appendices

Appendix I: Agenda for the National Consultation Event for the Draft Violence and Abuse Framework, 2008

DH Department of Health

Towards Healthier, Fairer and Safer Communities
- Connecting People to Prevent Violence

A Framework for Violence and Abuse Prevention

Prospero House, 241 Borough High Street, SE1 1GA
Tuesday 25th November 2008, from 10:00 - 4:00pm

The Department of Health is currently developing a Framework for Violence and Abuse Prevention and I am pleased to invite you to an engagement event on Tuesday 25th November. The Framework outlines the impact of violence and abuse upon health and inequalities. It takes a life-course perspective in understanding why violence and abuse happens and makes links between the different forms of violence and abuse. Lastly, it provides an evidence-based framework for the best areas to intervene to prevent violence and abuse from occurring in the first place.

The purpose of the day is to set out the context and work to date on the Framework and to gain input and engagement from stakeholders across the public and third sectors, to gain views of how the Framework can be best translated into practice.

The event coincides with the UN International Elimination of Violence Against Women Day and we are very pleased that the Attorney General, the Rt Hon the Baroness Scotland QC will provide a keynote address.

The event will be held at Prospero House, which is near London Bridge station and the day will begin at 9:30 (registration) and conclude at 4:00. Lunch will be provided and there is no charge to attend, however spaces are limited so we ask that you RSVP by Friday 31st October 2008. Please see the provisional agenda for further details about the event.

You can register your attendance by completing the booking form below and returning it to Ben.Robins@dh.gsi.gov.uk. If you are unable to attend, please consider a suitable person to replace you. Should you wish to invite two colleagues please ensure they also complete the registration form to confirm their attendance at the event.

Agenda

Towards Healthier, Fairer and Safer Communities
- Connecting People to Prevent Violence

A Framework for Violence and Abuse Prevention

Prospero House, 241 Borough High Street, SE1 1GA
Tuesday 25th November 2008
from 10:00 - 4:00pm

9.30 – 10.00 Registration & Coffee

10.00 – 10.10 Opening remarks by the Chair for the morning
Sheila Shribman, National Clinical Director for Children, Young People and Maternity Services, Department of Health (DH)

10.10 – 10.40 Violence and abuse trends and impact in England
Professor Mark Bellis, Director of NW Public Health Observatory

10.40 – 11.00 A global perspective of violence and abuse
Dr David Meddings, FRCPC (C) MHSc, Department of Violence & Injury Prevention and Disability Noncommunicable Diseases & Mental Health, World Health Organisation, Geneva

11.00 – 11.30 Ministerial address
The Attorney General, the Rt Hon the Baroness Scotland QC

11.30 – 12.00 Performance by the Kids Company

12.00 – 12.30 The Framework for Violence and Abuse Prevention
Dr Jo Nurse, Consultant in Public Health, National Lead for Public Mental Health and Well Being, DH

12.30 - 13.30 Lunch

13.30 - 13.40 Opening remarks by the Chair for the afternoon
Mark Davies, Director - Health Inequalities and Partnership

13.40 – 14.00 Video presentation

14.00 – 15.15 Workshops

Workshop format
Presentation for 15-20 minutes followed by discussion and feedback about how to take this work forward for 40-45 minutes

1) Ensure a Positive Start – Connected Families
Facilitator Claire Phillips, Department of Health

2) Skills for Safe, Connected Individuals and Relationships
Graham Robb, Member of the Youth Justice Board, former Head teacher and adviser to DCSF on behaviour in schools

3) Create Safe, Green, Connected Communities
Facilitator – Professor Philip Wheater, Department of Environment and Geographical Sciences, Manchester Metropolitan University.

4) Working together for Safer Communities
Jonathan Shepherd CBE FMedSci, Professor of Oral and Maxillofacial Surgery, Director, Violence Research Group, Cardiff University

15.15 – 15.35 Tea & Coffee

15.35 – 15.55 Plenary session

15:55 – 16:00 Closing remarks by the Chair

Appendix II: The Mapping and Documentary Analysis Framework

Societal and Community Interventions relevant for all age groups			
Evidence for Violence Prevention/Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Lead Sector/ Delivery Agents**	**Progress/ Coverage**
National Overarching Programmes for Violence Prevention			
Legislation addressing gender inequalities and impact upon gender based violence and abuse, including: Reducing domestic violence and sexual offending and its impact on children, adolescents and adults • Improve access to early and effective health and mental health interventions for victims and survivors • Develop community and criminal justice interventions for perpetrators including children and young people • Ensure implementation of appropriate and effective education and social care protective and preventive measures • Increasing the rate of sexual offences brought to justice			

Media coverage of violence and abuse • limit exposure of children and young people to violence and abuse in the media • media campaigns that challenge cultural norms of violence and abuse behaviour	379		
Address wider determinants: • Reduce poverty especially child poverty, • Address inequalities, • Improve housing & social capital			
Ensure adequate research and information is available on violence and abuse to raise awareness, increase evidence of what works and to inform national and local action			
Reduce alcohol related harm: • Reduce consumption: media, availability, training & education • Increase brief interventions and treatment • Reduce harm related to alcohol: alter environment- plastic bottles			
Review policy and public messages on Alcohol consumption and pregnancy in light of recent evidence re ADHD			

Reduce violent injury related to drug misuse: • Reduce availability of illegal drugs (crack cocaine & opiates) • Increase access to treatment			
Reduce availability of weapons			
Policy and programmes that supports improved nutrition to reduce violence and anti-social behaviour across all age groups, with an additional focus on high-risk groups.			
Provision of helpline services			

Societal and Community Interventions relevant for all age groups **Community Level:**			
Evidence for Violence Prevention/Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Lead Sector/ Delivery Agents**	**Progress/ Coverage**
Community Level: **Partnership working via CDRPs and DAATs** to reduce alcohol related violence (visible and less visible forms of violence): • *Information sharing* of health, police and DAAT data, to inform local strategic approaches to include: • Local Authority responses to alter the environment, eg, lighting, transport, fast food outlets, litter. • Licensing Committee: to ensure			

reduced happy hours, increased staff training, information of risks for public, provision of non-alcoholic drinks, cooling down period	381		
• Joint procedures, referral and communication re Child Protection established			
• Early prevention initiatives with a focus on parenting skills, violence prevention and mental health promotion; ensure diversity, respect and awareness of different forms or abuse (eg forced marriage) are included			
• Tailor service response according to local population need, including violence related to discrimination, eg racial, homophobic hate crimes			
• Provision of brief interventions for alcohol misuse			
• Multi-agency staff training and protocols			
• Neighbourhood & Community Policing teams			

CHILDREN 0-10 YEARS			
General Population			
Evidence for Violence Prevention/ Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Lead Sector/ Delivery Agents**	**Progress/ Coverage**
Parent education programmes: • Warmth, positive regard, empathy • Clear boundaries & positive discipline			
School based Social Development Training Student Education & skill development regarding abuse awareness and prevention, anti-bullying, 'healthy' relationships (family and friends), & seeking help. *Ensure diversity, respect & different forms of abuse are included*			
Whole school approach for bullying & abuse prevention: including staff training on educational & communication styles; prevention policies, including improved nutrition and physical exercise. *Ensure diversity, respect & different forms of abuse are included*			

CHILDREN 0-10 YEARS High Risk Groups			
Evidence for Violence Prevention/ Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Lead Sector/ Delivery Agents**	**Progress/ Coverage**
Home Visiting programmes: Parental sensitivity & attunement			
Pre-school enrichment programmes			
Protective skill training for abuse prevention: for high-risk children for abuse, (eg. looked after children, children with disabilities, families experiencing domestic violence).			
Training of professionals in contact with children (eg health professionals, teachers, social workers), in order to identify high risk and abused children to refer for protection, therapy and protective skill training.			
Early identification of abusive behaviour - eg Conduct Disorder, in children for additional pro-social skills & parenting programme interventions. Train professionals to identify adolescents and adults with patterns of abusive behaviour, in order to refer and intervene early- evidence from the review of young sexual offenders re what works			

Adolescence (11- 19 years old) General Population			
Evidence for Violence Prevention/ Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Lead Sector/ Delivery Agents**	**Progress/ Coverage**
Mainstream integrated violence and abuse prevention -pro-social and protective skill development- within the school curriculum, integrate with mental health, sexual health & substance misuse programmes, ensure development of: • Mutual Rights & Respect in relationships (peers, family & dating) • Challenge Gender norms supportive of Sexual Relationship Violence. (including breaking myths & stereotypes) • Abuse awareness, protective skill development • Communication, conflict resolution skills • Where & how to seek help *Ensure diversity, respect & different forms of abuse are included*			

Ensure a whole school zero violence approach for preventing bullying and abuse & developing respectful relationships between teachers & students; include improved nutrition. *Ensure diversity, respect & different forms of abuse are included*	385		
Improve Parent Skills: key areas that promote adolescent well-being include: • Love and connection • Monitor and Observe • Guide and Limit • Model and Consult • Provide and Advocate			
Ensure low educational drop-out, provide educational enrichment programmes and after school clubs and mentoring programmes			
Provide brief interventions on protective skills re sexual assault to college students			

Adolescents 11-19 years old High Risk Groups			
Evidence for Violence Prevention/Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Lead Sector/ Delivery Agents**	**Progress/ Coverage**
Training of Professionals in contact with young people re abuse issues & develop identification, protocols & referral pathways.			
Ensure educational maintenance & vocational training of young people who are at high risk of violence & abuse.			
Identify high-risk young people for abuse: • Behaviour and Conduct disorders • Looked after children, • Young people with disabilities, • Families experiencing domestic violence • School excludees • Teenage mothers • Young offenders • Substance misusers To provide additional interventions on ***pro-social relationships & protective skill development*** for the prevention of abuse, referral for support & protective skills, drugs or alcohol misuse problems. Maintain in education			

For abused young people: Ensure accessible advice centres & help-lines, with counselling and support services; including where appropriate, family therapy and mentoring, & referral for alcohol or drugs misuse. Ensure interventions on *pro-social relationships & protective skill development* are available.	387		
Containment, education and management of adolescent abusers. (including Restorative Justice and non custodial sentences)			

| Adults | | | |
| **General Population** | | | |
Evidence for Violence Prevention/ Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Lead Sector/ Delivery Agents**	**Progress/ Coverage**
Develop Parent and relationship skills (for men and women) eg by Health visitors or as part of antenatal classes to develop positive relationships within families			
Develop work based conflict resolution & communication skills to include organisational culture & management styles			
Promote workplace anti-abuse and bullying policies and training, and the development of work environments which promote mental health			
Preventing Elder Abuse: Multi-agency support for lay carers including respite care. Training and inspections for care homes re elder abuse. Review of poly-pharmacy & minimise medications prescribed.			

Adults			
High Risk Groups			
Evidence for Violence Prevention/ Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Lead Sector/ Delivery Agents**	**Progress/ Coverage**
Professional education & training to recognise different forms of abuse (Health, SS & Police)			
Early recognition of abused: develop protocols & referral pathways (especially for health services and social care) for: • Sexual Assault • Domestic Abuse • Other abuse –eg forced marriage, trafficked women in prostitution • Elder abuse			
For those who have been abused: Ensure availability of support, counselling & treatment services. Ensure protective skill development provided to minimise risk of further victimisation. Adequate resources for help lines, shelters, crisis centres, and advocacy services, for DV, and the development of Multi-agency Sexual Assault Referral Centres (SARCs).			
Prioritise alcohol treatment for recognised abusers and victims of abuse.			

Abusers: Identification, containment, education and management of abusers	390		

Appendix III: The Observational Analysis Framework

The Observational Analysis Framework

Document/ Notes/ Meeting:

Title of Document/ Notes/ Meeting:

Date:

Sectors involved:

Level/ setting: National/ Regional/ Local

Process I

Main Drivers	- Individual/ sector/ organisation - Document/ legislation - Problem Recognition - Agenda Setting
Key Events	
Context	- Historical - Political - Resources
Motivation	- Objectives - Reasons for engagement
Actors	- Leadership - Other Actors - Networks/ Communities

Content

- Type of violence and abuse – tick relevant areas

- Prevention focus – circle on prevention framework

Type of Violence/ Abuse	Tick areas emphasised
Child Sexual Abuse	
Child Emotional Abuse	
Child Physical Abuse	
Neglect	
Bullying - Children	
Youth Violence	
Dating Violence	
Sexual Assault	
Partner Violence/ domestic violence	
Bullying – Work place	
Violence – Work place	
Alcohol related violence/ Night time economy related violence	
Elder abuse	
Other:	

Process II:

Policy Formulation- General	• Problem definition • Solutions • Options
Policy Formulation- Public Health Contribution	• Information • Health Needs Assessment • Evidence Base
Key Policy Decisions Made	• Key Decisions made • Strategy/ Planning
Barriers	• Risk • Quality
Opportunities	• Enablers • Resources
Implementation	• Management • Monitoring • Incentives • Targets
Delivery - Public Health	• Public Health Functions • Public Health Methods • Other
Other	

Annex IV: A summary of Governmental Documents that are Relevant to Violence and Abuse Prevention

The below section, includes an electronic search of documents from Governmental Departments made in the summer of 2008. The search selected documents that contained the words violence and/ or abuse in the context of violence, and is ordered by Governmental Department and each section is ordered by date. Government policy documents included either mention violence and abuse specifically, address risk factors for violence and abuse or detail approaches that will have an impact upon prevention.

Additional documents have been added following review by policy leads. The search was primarily between the years 2005- 2008, however, if little was found between these dates the website was searched further back until further policy reports were found. Additionally, reports outside of these dates have been suggested by policy leads.

Key documents have been highlighted in bold and italics. The weblinks for these documents can be found at the end of the reference section. The end of the section also contains an update of policy reports relevant to violence and abuse between 2008- 2010.

In total, 43 relevant government reports were identified that mentioned violence and abuse prevention between 2005- 2010. Of these, 16 were considered to be key documents, highlighted in italic. The majority of reports were published by the Home Office (14 reports, of which 5 refer more substantially to prevention), and these had the most influence in the development of policy on violence and abuse prevention outlined below.

In contrast, the Department of Health published 11 policy reports that mention violence and abuse prevention, of which two reports can be seen to be most relevant to the violence and abuse prevention agenda, with the remaining either concentrating on treatment responses to violence and abuse or mostly focusing on determinants that influence violence and abuse, however, the main aim of the document would not be perceived as being centrally relevant to violence and abuse prevention.

Department of Health:

No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. DH, HO. 2000

Violent Britain, People, Prevention and Public Health, NW PHO; 2005 and Follow up www.cph.org.uk *(Public Health Observatory Report, on behalf of the NW region, Department of Health)*

DH 'Responding to domestic abuse: A handbook for health professionals' 2005;

Itzin C 'Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and   Abuse' Programme Implementation Guide for the Victims of Violence and Abuse Prevention programme, 2006. DH/ NIMHE/ HO.

Links between juvenile sexually abusive behaviour and emerging severe personality disorder traits in childhood, DH; 2006;

The needs and effective treatment of young people who sexually abuse: current evidence; DH & HO; 2006;

Safe.Sensible.Social. The Next Steps in the National Alcohol Strategy, 2007; DH, HO, DfES, DCMS; www.dh.gov.uk/publications; dh@prolog.uk.com

The Child Health Promotion Programme. Pregnancy and the first five years of life. DH,DCSF, 2008

Home Office:

The Home Office Strategic Plan, 2004- 5;

Domestic violence: a national report, HO; 2005

Improving outcomes for victims of sexual violence: A strategic partnership approach, HO; 2005

Respect Action Plan. HO. 2006.

'A Five Year Strategy for Protecting the public and Reducing Re-offending' and 'The National Reducing Re-offending Delivery Plan' Home Office 2006

'Cutting Crime - a new partnership' - the Home Office crime strategy, 2007;

HM Government 'Cross Government Action Plan on Sexual Violence and Abuse' 2007;

Saving Lives. Reducing Harm. Protecting the Public. An Action Plan for Tackling Violence, 2008- 11.

Drugs: protecting families and communities the 2008 drug strategy. HO.2008

Drugs: protecting families and communities. Action Plan 2008–2011. HO 2008

Youth Crime Action Plan 2008. HO,MoJ,CO,DCSF

The Department of Children, Schools and Families:

Every Child Matters, 2004; http://www.everychildmatters.gov.uk/ Five main strands: Be Healthy; Stay Safe; Enjoy & Achieve; Make a Positive Contribution; Achieve Economic Well Being.

Choice for Parents – the Best Start for Children: Ten Year Childcare Strategy, 2004; DfES; DTI; DWP; HM Treasury

Outcomes Framework; 2005

The Children's Plan. Building brighter futures. DCSF. December 2007.

Aiming high for young people: a ten-year strategy for positive activities. HM Treasury, DCSF. July 2007

Staying Safe. A Consultation Document 2007; Department for Children, Schools and Families;

Staying Safe Action Plan 2008: DSCF

Department for Communities and Local Government:

Department for Communities and Local Government: Communities and Neighbourhoods activities around the following:

- **Community Cohesion**

- **Social Exclusion**

- **Cleaner, Safer, Greener Communities**

- **Respect**

- **Civil Renewal**

- **Sustainable Communities**

"Living Places - Cleaner, Safer, Greener" 2002; DCLG;

Sustainable Communities: Building for the Future; 2003; DCLG;

Anti Social Behaviour and Housing – Department for Communities and Local Government – Variety of Guidance – relates to RESPECT agenda 2003- 2007

The Economic and Social Cost of Crime against individuals and households, 2003/4. Home Office Report 30/05

Community Cohesion an Action Guide 2004; LGA with the Home Office, the Office of the Deputy Prime Minister, the Commission for Racial Equality, the IDeA, The Inter Faith Network and the Audit Commission.

Improving Opportunity, Strengthening Society, 2005; DCLG; Government's strategy to increase race equality and community cohesion.

Respect Action Plan, 2006.

REACH - An independent report to Government on raising the aspirations and attainment of Black boys and young Black men, 2007; DCLG

The Department for the Environment, Farming and Rural Affairs:

Securing the future, delivering UK sustainable development strategy. DEFRA. 2005

The Cabinet Office:

Reaching Out: An Action Plan on Social Exclusion. Cabinet Office. 2006

Reaching Out: Think Family. Analysis and themes from the Families At Risk Review. Cabinet Office. Social Exclusion Task Force.2008

Additions - Government Policy Documents from 2008- 2010

Additionally, the following policy has been published since the draft violence and abuse prevention framework was launched in November 2008. These additions have been included following information from policy leads and cross-referencing policy documents with the updated version of the violence and abuse prevention framework. They include the below:

- The Action Plan on Domestic Violence 2008, (Home Office)

- Tackling Knives Action Plan 2008 (Home Office)

- Cross Government Strategy to End Violence Against Women and Girls, 2009 (Home Office)

- Guidance for Sexual Assault Referral Centres, 2009, Department of Health

- The Social Determinants of Health (The Marmot Review), 2010, Department of Health

- Confident Communities, Brighter Futures – a framework for population well-being, 2010, HM Gov't / Department of Health

A Summary of Key Governmental Documents that Supports Policy for Further Work on Violence and Abuse Prevention

This section summarises key national policy reports that were considered to be especially important in contributing to or supporting the future policy on violence and abuse prevention. The following section was included in the draft Violence and Abuse Prevention Framework, and was agreed by policy leads from the relevant government departments.

Key Violence and Abuse Policy that Shaped the Violence and Abuse Prevention Framework draft, 2008:

The key policy drivers that have led to this framework on preventing violence and abuse being developed are outlined below:

World Health Assembly Resolutions- our government has signed up to a number of commitments for the early prevention of violence at the World Health Organisations, annual World Health Assembly (see Box 1). These resolutions take a public health perspective to prevention. Essentially this means understanding and acting on risk factors at a population level and across the life course, and intervening early with evidence-based approaches.

Box 1 - World Health Assembly Resolutions on Violence Prevention

World Health Assembly 2003, Resolution WHA56.24 on Implementing the recommendations of the World report on violence and health:

1. Increasing the capacity for collecting data on violence

2. Researching violence – its causes, consequences and prevention

3. Promoting the primary prevention of violence

4. Promoting gender and social equality and equity to prevent violence

5. Strengthening care and support services for victims

6. Bringing it altogether – developing a national plan of action

1997 – Prevention of violence, WHA50.19

1996 – Prevention of violence: a public health priority, WHA49.25

The full texts of these resolutions are available at:
www.who.int/violence_injury_prevention/resources/publications/en

Key National Policy Reports:

In 2007 the Home Office set out the over-arching principles, the context and the framework for tackling crime over the next three years in *Cutting Crime: A New Partnership 2008-2011.*

Cutting Crime laid the ground for the development of a stronger focus on serious violence. This has been taken forward through **new Public Service Agreement (PSA) targets for 2008-11**, and in particular those which prioritise most relevant for violence and abuse included: Make Communities Safer, including through reducing the prevalence of more serious violent offences, and prioritising serious sexual offending and domestic violence; and improving the efficiency and effectiveness of the Criminal Justice System in bringing offences to justice.

In addition to the Make Communities Safer and Justice for All PSAs, there were a range of **other PSAs** that contributed to preventing violence and abuse including: Reduce the harm caused by Alcohol and Drugs; Tackle poverty and promote greater independence and wellbeing in later life; Address the disadvantage that individuals experience because of their gender, race, disability, age, sexual orientation, religion or belief and Young people on the path to success.

In early 2008, the Home Office published: **Saving Lives. Reducing Harm. Protecting the Public. An Action Plan for Tackling Violence 2008-11.** This was in response to the Cutting Crime report and PSA. This report provided an outline of current related policy and action, introduces a risk based approach and a prevention perspective to tackling violence. It also made a number of commitments to promoting partnership working and improving our response to minimising harm and tackling youth violence, domestic and sexual abuse. The report states that over the course of 2008, the Home Office and Department of Health will lead on the development of a Violence and Abuse Prevention Strategy, focusing on early intervention approaches.

The Health Inequalities Progress and Next Steps (DH), 2008 report, also highlighted the impact upon health of early adverse experiences in childhood, including abuse, and stated that a Violence and Abuse Prevention Plan will be developed. It outlines how this will be done in partnership with the Home Office, the Department for Children, Schools and Families, the Department for Environment, Food and Rural Affairs, and Communities and Local Government. The Health Inequalities report specified how the violence and abuse prevention plan will focus upon early interventions to reduce the risk of all forms of interpersonal violence and abuse, and provide supportive toolkits, protocols, care pathways and commissioning guidance.

Additionally, this Violence and Abuse Prevention Framework is referred to in other published Government documents including; the third **National Domestic Violence Delivery Plan 2007/08,** www.crimereduction.co.uk and the House of Commons Home Affairs Committee **'Domestic Violence, Forced Marriage and honour-based violence' Sixth Report of Session 2007-09, Appendix 59.** Government work on domestic violence is brought together in the

cross-government National Domestic Violence Delivery Plan. In 2005 the Home Office published its first National Report on Domestic Violence, containing the framework of the National Delivery Plan, which identified 5 key objectives for 2005/06 to address all aspects of domestic violence, from prevention through to victim care and the response of the criminal justice system. The Delivery Plan enabled the Home Office to achieve a more strategic approach and a greater degree of transparency around Government action to address domestic violence. http://www.crimereduction.homeoffice.gov.uk/domestic violence/domestic violence066.htm.

The Sexual Violence and Abuse Action Plan, 2007, set out how the Government planned to deliver key objectives on sexual violence and abuse, representing an important step in taking forward this Government's agenda on protecting the public and includes aspects of prevention.

Additional policy and guidance that in particular contributes to violence and abuse prevention includes the following:

- The Health Inequalities Progress and Next Steps, 2008, Department of Health

- Staying Safe Action Plan, 2008, Department for Children, Schools and Families

- The Child Health Promotion Programme, Pregnancy through the First Five Years of Life, 2008, Department of Health

- Think Family, 2008, Department for Children, Schools and Families

- Every Child Matters, 2004, and the Children's Plan, 2007, Department for Children, Schools and Families

- Aiming High for Young People: A ten year strategy for positive activities; 2007; Department for Children, Schools and Families & Treasury;

- The Children's Plan, Building Brighter Futures, 2007, Department of Children, Schools and Families

- Youth Crime Action Plan, 2008, Home Office

- Tackling Knives Action Programme, 2008, Home Office

- Next Steps in the Alcohol Strategy – Safe. Sensible. Social, 2007, Department of Health

- Drugs Strategy 2008, Home Office

- Responding to domestic abuse, a handbook for health professionals, 2005, Department of Health

- Respect Action Plan, 2006, Home Office

- Social Exclusion Action Plan, Department of Communities and Local Government

- Government Sustainable Development Strategy 2005, Department for the Environment, Farming and Rural Affairs

- 'No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse', 2000, Department of Health.

The Violence and Abuse Prevention Framework supports all of the above work, by providing a comprehensive overview of risk factors for violence and abuse and of the evidence base of what works in the early prevention of violence and abuse. The key findings are then summarised and implications outlined to aide a jointed up approach in partnership working as well as clarifying specific roles for different sectors. It also provides toolkits and additional resources to help front line practitioners in their role of preventing violence and abuse.

In order to drive forward all elements of our work on violence a new cross government departmental governance structure has been developed, to establish a clear, coherent and effective approaches that promote partnership working at all levels. This includes, but is not necessarily limited to: the Home Office; the Ministry of Justice; Attorney General's Office and the Office of Criminal Justice Reform which supports the three CJS Departments; the Department of Health; the Department for Children, Schools and Families; Communities and Local Government; the Government Equalities Office; and the Department for Culture, Media and Sport. It also includes key stakeholders at the highest level. Outcomes from the Violence and Abuse Prevention Framework will be monitored by the Domestic and Sexual Violence Inter- Ministerial Group, Ministers from across Government have come together on a dedicated inter-Ministerial Group to lead co-ordinated and concerted action across Departmental boundaries.

Additionally, key policy that supports this work and has been published since the draft violence and abuse prevention framework was launched in November 2008, includes the below:

- **The Action Plan on Domestic Violence 2008, (Home Office)**

- **Tackling Knives Action Plan 2008 (Home Office)**

- **Cross Government Strategy to End Violence Against Women and Girls, 2009 (Home Office)**

- **The Social Determinants of Health (The Marmot Review), 2010, Department of Health**

- **Confident Communities, Brighter Futures – a framework for population well-being, 2010, HM Gov't / Department of Health**

Annex V: Results Tables from Mapping the Interventions for the Prevention of Violence and Abuse

Societal and Community Interventions relevant for all age groups - societal level

Societal and Community Interventions relevant for all age groups - societal level			
Evidence for Violence Prevention/Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Delivery Agents**	**Progress/Coverage**
National Overarching Programmes for Violence Prevention	Reducing Crime Strategy 2007 Violent Crime Reduction Act, 2006 **RESPECT Agenda – Action Plan** **Crime Strategy 2007** **Victims of Violence and Abuse Prevention Programme (VVAPP)** **Inter-ministerial groups on DV, Sexual Offending, Trafficking, and Child Protection**	**DH** **HO** **DCLG** **DfES** **(Royal Colleges & ACPO)** **VCS**	Draft Strategy on Violent Crime 2007 Draft Strategy on Violence and Abuse Prevention 2007

Societal and Community Interventions relevant for all age groups - societal level			
Evidence for Violence Prevention/Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Delivery Agents**	**Progress/Coverage**
Legislation addressing gender inequalities and impact upon gender based violence and abuse, including: Policy for reducing domestic violence and sexual offending and its impact on children, adolescents and adults • Improve access to early and effective health and mental health interventions for victims and survivors • Develop community and criminal justice interventions for perpetrators including children and young people • Ensure implementation of appropriate and effective education and social care protective and preventive measures • Increasing the rate of sexual offences brought to justice	Gender Equality Act 2006 Domestic Violence Crime and Prevention Act 2004 Sex Offences Act 2003 Working Together to Safeguard Children (March 2006) National Domestic Violence Action Plan (June 2006) National Cross Government Action Plan on Sexual Violence and Abuse HO/ DH (April 2007) VVAPP National Service Guidelines (April 2006) UK Action Plan on Human Trafficking HO Review of the Protection of Children from Sex Offenders, HO, 2007 Work in Progress: National Framework for the Development of Services for Young People Who Sexually Abuse HO/ DH/ DfES (Draft 2007) Staying Safe – Consultation Autumn 2007 DCFS Safeguarding Children from Sexual Exploitation DfES/ HO/ DH PCT Guidance on Commissioning SARCs DH/ HO PCT Commissioning Guidance on Children's Sexual Violence Services DH/ HO/ DCFS	DH HO DfES Royal Colleges & ACPO Voluntary and Community Sector	High ministerial national priority Substantial work achieved or underway
Media coverage of violence and abuse - limit exposure of children and young people to violence and abuse in the media - media campaigns that challenge cultural norms of violence and abuse behaviour	Child Exploitation Online Protection Centre (CEOP) April 2006 Independent multi- agency body A Rapid Evidence Assessment of the Effects of Extreme Pornographic Material HO/ DH Summer 2007 Home Secretary's Task Force on Child Protection on the Internet HO		***In Development***

Societal and Community Interventions relevant for all age groups - societal level			
Evidence for Violence Prevention/Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Delivery Agents**	**Progress/Coverage**
Address wider determinants: • Reduce poverty especially child poverty • Address inequalities • Improve housing & social capital	Progressive taxation policy Support, education & training for single parents Legislation and policy on discrimination/ equality including BME, disability, sexuality. Urban regeneration, & housing policy Increasing employment levels for those on IB Social Exclusion policy Tackling health Inequalities: a programme for action (2003). Social Exclusion and Mental Health Report, Social Exclusion Unit, ODPM, July 2004; Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts, DCFS; 2007; Valuing people: A New Strategy for Learning Disability for the 21st Century (2001) Care Matters: Time for Change; 2007; DCFS Improving Opportunity, Strengthening Society, 2005; DCLG; Government's strategy to increase race equality and community cohesion. "Living Places - Cleaner, Safer, Greener" 2002; DCLG; Anti Social Behaviour and Housing – Department for Communities and Local Government – Variety of Guidance – relates to RESPECT agenda 2003- 2007	DCLG Treasury DWP DTI DH DT VCS	Policy in place Translation at regional & local level does not always focus on inequalities & high risk groups
Ensure adequate research and information is available on violence and abuse to raise awareness, increase evidence of what works and to inform national and local action	National Programme for Information Technology- NHS British Crime Survey & reported violent crimes HO research NICE – recent reviews including violence prevention for emotional well being in schools	DH HO	

Societal and Community Interventions relevant for all age groups - societal level			
Evidence for Violence Prevention/Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Delivery Agents**	**Progress/Coverage**
Reduce alcohol related harm: • Reduce consumption: media, availability, training & education • Increase brief interventions and treatment • Reduce harm related to alcohol: alter environment-plastic bottles	Safe.Sensible.Social. The Next Steps in the National Alcohol Strategy, 2007; HO, DH, DfES, DCMS Alcohol Harm Reduction Strategy 2003 Choosing Health White Paper 2005 Alcohol Licensing Act Nov 2005 Alcohol, Models of Care	DH DCS NTA VCS	Perceived as low national priority Under resourced and patchy practice at local level In Development
Review policy and public messages on Alcohol consumption and pregnancy in light of recent evidence re ADHD	Safe.Sensible.Social. The Next Steps in the National Alcohol Strategy, 2007; HO, DH, DfES, DCMS	DH RCPysch	Unknown
Reduce violent injury related to drug misuse: • Reduce availability of illegal drugs (crack cocaine & opiates) • Increase access to treatment	Tackling Drugs to Build a Better Britain. The Government's Ten-Year Strategy for Tackling Drugs Misuse (1998). Reducing Drug-related Harm: An Action Plan; 2007;	NTA HO DH/ HPA VCS	On target
Reduce availability of weapons	Guns and Knives Strategy - developing Three Point Plan to Tackle Gun Crime, 2007 Violent Crime Reduction Act, 2006	HO	
Policy and programmes that supports improved nutrition to reduce violence and anti-social behaviour across all age groups, with an additional focus on high-risk groups.	No specific policy, School food programme is an opportunity Some work in Prisons re healthy foods	DefRA DfES DH, HO VCS	Patchy practice & little awareness though opportunities

Societal and Community Interventions relevant for all age groups - societal level			
Evidence for Violence Prevention/Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Delivery Agents**	**Progress/Coverage**
Provision of helpline services	National DV Helpline Child-line Rape Crisis Stop It Now	VCS	

Societal and Community Interventions relevant for all age groups - community level

Societal and Community Interventions relevant for all age groups - Community Level			
Evidence for Violence Prevention/ Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Delivery Agents**	**Progress/Coverage**
Community Level: -**Partnership working via CDRPs and DAATs** to reduce alcohol related violence (visible and less visible forms of violence): • *Information sharing* of health, police and DAAT data, to inform local strategic approaches to include: • Local Authority responses to alter the environment, eg, lighting, transport, fast food outlets, litter. • Licensing Committee: to ensure reduced happy hours, increased staff training, information of risks for public, provision of non-alcoholic drinks, cooling down period • Joint procedures, referral and communication re Child Protection established • Early prevention initiatives with a focus on parenting skills, violence prevention and mental health promotion; ensure diversity, respect and awareness of different forms or abuse (eg forced marriage) are included • Tailor service response according to local population need, including violence related to discrimination, eg racial, homophobic hate crimes • Provision of brief interventions for alcohol misuse • Multi-agency staff training and protocols • Neighbourhood & Community Policing teams	Safe.Sensible.Social. The Next Steps in the National Alcohol Strategy, 2007; HO, DH, DfES, DCMS; • *National Programme for IT (NHS)* • Local Area Agreements • Local Strategic Partnerships & Community Plans • Crime and Disorder Reduction Partnerships • Drug and Alcohol Action Teams • Domestic Violence Forums • Community Wardens	Multi- agency: Police/ CJS Education/ Youth Service Health Local Authority Social Services VCS NTA	Patchy depending upon local awareness & prioritisation: - Alcohol has been under-resourced compared to need and Drugs services. -Many CDRPs have prioritised work on treatment/ protection from domestic violence, with little work on early prevention or other forms of violence & abuse - Little work on aggregate information sharing to inform local practice - Little/ poor engagement with health and education on CDRPs

Children 0 – 10 Years – general population

CHILDREN 0-10 YEARS General Population			
Evidence for Violence Prevention/Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Delivery Agents**	**Progress/Coverage**
Parent education programmes: • Warmth, positive regard, empathy • Clear boundaries & positive discipline Childcare Programmes – including parent skills	Health Visiting: - Targeted Universalism - Intensive Parenting Intervention Pilot Sure Start Programme Pre-school programme for social and emotional development - pilots ChildCare Act 2006; & Ten Year Childcare Strategy 2004: Measures in the act formalise the important strategic role local authorities play through a set of new duties. These duties will require authorities to: • Improve the five Every Child Matters outcomes for all pre-school children and reduce inequalities in these outcomes • Secure sufficient childcare for working parents • Provide a better parental information service	DfES DH VCS	Health Visitor capacity in decline SS - Due to extend coverage *Need to ensure parent skills included, not just parent support*

CHILDREN 0-10 YEARS			
General Population			
Evidence for Violence Prevention/Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Delivery Agents**	**Progress/Coverage**
School based Social Development Training Student Education & skill development regarding abuse awareness and prevention, anti-bullying, 'healthy' relationships (family and friends), & seeking help. *Ensure diversity, respect & different forms of abuse are included*	Social and Emotional Aspects of Learning- SEALs– primary school integrated curriculum programme, voluntary inclusion; aspects relevant to violence prevention: • Peaceful problem solving • Calming down strategies • Understanding emotions • Being assertive • Anti-Bullying	DfES	Estimated 30% schools coverage, with interest from another 30% Extension due to pre-school programme Gaps in SEALS: • Abuse awareness • Abuse protection • Seeking help
Whole school approach for bullying & abuse prevention: including staff training on educational & communication styles; prevention policies, including improved nutrition and physical exercise. *Ensure diversity, respect & different forms of abuse are included*	***Violence Reduction in Schools*** website and national work (voluntary): Main focus has been on addressing bullying, youth violence & violence against teachers, discipline & improved security measures and the safety of surrounding school. ***Ofsted*** assesses anti- bullying measures- national work targets weaker schools ***Healthy Schools***- some work on bullying. More on physical exercise & nutrition. National Standards	DfES DH, VCS	Anti- Bullying Alliance at regional level – patchy coverage locally (? funding comes to an end) Little work on other forms of child abuse Stronger links with nutrition & behaviour could be made

Children 0 – 10 Years – High-risk groups

CHILDREN 0-10 YEARS High Risk Groups			
Evidence for Violence Prevention/Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Delivery Agents**	**Progress/Coverage**
Home Visiting programmes: • Parental sensitivity & attunement	Health Visitor Programme -Varied content of health visitor checks	DH	National Programme Coverage of high risk groups varies according to local arrangements
Pre-school enrichment programmes	Sure Start and increased access to child care	DfES DH, DWP VCS	Varied access to child care and pre- school programmes
Protective skill training for abuse prevention: for high-risk children for abuse, (eg. looked after children, children with disabilities, families experiencing domestic violence).	National Sexual Violence Action Plan (October 2006) Safe Guarding Children's Boards	HO DfES DH LA/ SS VCS	Little work done in this area
Training of professionals in contact with children (eg health professionals, teachers, social workers), in order to identify high risk and abused children to refer for protection, therapy and protective skill training.	Stay Safe component of 'Every Child Matters' 'Safe Guarding Children' Common Assessment Frameworks Local Child Protection Committees	DfES HO DH LA/ SS VCS	More work needed on information sharing, joint protocols & training
Early identification of abusive behaviour - eg Conduct Disorder, in children for additional pro-social skills & parenting programme interventions.	SEALs- do some separate group work with children with behaviour problems (voluntary programme) CAMHS- Child and Adolescent Mental Health Services Children's Family Court Advisory Service CFCAS 'Positive Action for Young People' Eg after school & diversionary activities for young people at risk of offending –	DfES DH YOT VCS	SEALs has 30% coverage of primary schools ? level of group work with high risk children CAMHS – under capacity for need, services tend to focus on ADHD, autism & eating disorders

Adolescents (11 – 19 years old) – general population

Adolescents (11- 19 years old) General Population			
Evidence for Violence Prevention/ Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Delivery Agents**	**Progress/Coverage**
Mainstream integrated violence and abuse prevention -pro-social and protective skill development- within the school curriculum, integrate with mental health, sexual health & substance misuse programmes, ensure development of: • Mutual Rights & Respect in relationships (peers, family & dating) • Challenge Gender norms supportive of Sexual Relationship Violence. (including breaking myths & stereotypes) • Abuse awareness, protective skill development • Communication, conflict resolution skills • Where & how to seek help *Ensure diversity, respect & different forms of abuse are included*	Development of a secondary school version of SEALs currently underway- expected to be launched approximately autumn 2007 PHSE and SRE curriculum – allow for coverage of wider issues of violence & abuse- though local interpretation, varied depth and coverage- Ofsted report on PHSE. Citizenship classes- provide information on accessing local support services VCS initiatives at local and national level (eg Womankind), cover some other aspects of violence and abuse- often link in with PHSE & SRE Healthy Schools – New standards on Sex and mental health promotion allow for better coverage School Nurses- potential point of contact for seeking help *Cross Governmental Action Plan on Sexual Violence and Abuse April 2007*	DfES DH HO VCS	Opportunities with development of secondary SEALs Patchy coverage at local level re PHSE & SRE VCS- good practice, but patchy coverage Violence prevention work tends to be focused on one or two areas – eg bullying or domestic violence. Not always relating to other forms of abuse or integrated with sexual health or substance misuse. Opportunities with extension of Healthy Schools & new standards
Ensure a whole school zero violence approach for preventing bullying and abuse & developing respectful relationships between teachers & students; include improved nutrition. *Ensure diversity, respect & different forms of abuse are included*	***Violence Reduction in Schools*** website and national work (voluntary): Main focus has been on addressing bullying, youth violence & violence against teachers, discipline & improved security measures and the safety of surrounding school. ***Healthy Schools*** *	DfES DH VCS	Opportunities re the extension of Healthy Schools

Adolescents (11- 19 years old) General Population			
Evidence for Violence Prevention/ **Good Practice** *Include diversity throughout*	**Policy, Programmes and Approaches**	**Delivery Agents**	**Progress/Coverage**
Improve Parent Skills: key areas that promote adolescent well-being include: • Love and connection • Monitor and Observe • Guide and Limit • Model and Consult • Provide and Advocate	Early Intervention for Conduct Disorder with Multi System Therapy - Pilots DH VCS Respect Agenda – Parenting Schools	DH HO DCLG DfES VCS	Patchy
Ensure low educational drop-out, provide educational enrichment programmes and after school clubs	Extended Schools ?School Mentoring Volunteering VCS - variable	DfES LA/ SS DCLG VCS	Patchy
Provide brief interventions on protective skills re sexual assault to college students	VCS Cross Government Action Plan on Sexual Violence and Abuse – Alcohol Media Programme ? Role of Sexual Health Clinics & SARCs	HO DH VCS	Patchy Treatment focused

** **Address Underlying Risk Factors for Substance Misuse:** The Evidence base to support school based mental health promotion and violence prevention programmes is much stronger than that to support substance misuse (alcohol, drugs, tobacco), programmes which are largely ineffective. In that some substance misuse is driven by emotional distress, mental health promotion & violence prevention programmes are likely to represent a better investment. (Stewart-Brown S, 2006).*

Adolescents 11 – 19 years old – high risk groups

Adolescents 11-19 years old High Risk Groups			
Evidence for Violence Prevention/Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Delivery Agents**	**Progress/Coverage**
Training of Professionals in contact with young people re abuse issues & develop identification, protocols & referral pathways.	Safeguarding Children Children's Trusts & Local Child Protection Committees	DfES HO, DH VCS	
Ensure educational maintenance & vocational training of young people who are at high risk of violence & abuse.	'Connexions' and Not in Education, Employment or Training targets LAAs	DfES DCLG VCS	Reasonable
Identify high-risk young people for abuse: • Behaviour and Conduct disorders • Looked after children, • Young people with disabilities, • Families experiencing domestic violence • School excludees • Teenage mothers • Young offenders • Substance misusers To provide additional interventions on ***pro-social relationships & protective skill development*** for the prevention of abuse, referral for support & protective skills, drugs or alcohol misuse problems. Maintain in education	? Some good practice re pro-social and protective skills- though highly variable and absent for many Varied access to drugs and alcohol misuse services for adolescent age group Extended Schools- ? targeted at high risk groups School Mentoring Prevention of Youth Offending CAMHS Teen parent co-ordinators Community Volunteering programmes VCS – variable YOTs	DfES LA/ SS HO NTA DH DCLG VCS	Patchy CAMHS and Services variable for high risk groups including early intervention for conduct or emotional disorders, LAC & Young Offenders, & Young people in families with DV, especially young men

Adolescents 11-19 years old

High Risk Groups

Evidence for Violence Prevention/Good Practice *Include diversity throughout*	Policy, Programmes and Approaches	Delivery Agents	Progress/Coverage
For abused young people: Ensure accessible advice centres & help-lines, with counselling and support services; including where appropriate, family therapy and mentoring, & referral for alcohol or drugs misuse. Ensure interventions on *pro-social relationships & protective skill development* is available.	VCS LA/ Youth Services National DV Helpline Child Line CAMHS DAATs services for Young People	DCLG DH DfES HO NTA VCS	Patchy
Containment, education and management of adolescent abusers. (Including Restorative Justice and non custodial sentences)	Violent Crime Strategy & Respect Action Plan Youth Justice Board/ Youth Offending Teams NOMS/ ROMs – variable focus on young offenders	HO, DH DCLG, DfES VCS	Opportunities re the Regional Reducing Offending Strategies

Adults – general population

Adults - General Population			
Evidence for Violence Prevention/Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Delivery Agents**	**Progress/Coverage**
Develop Parent and relationship skills (for men and women) eg by Health visitors or as part of antenatal classes to develop positive relationships within families	ANC Health Visitors Sure Start Respect 'Parenting Academy'	DH DCLG	Reasonable coverage- though more emphasis on actual parenting skills needed
Develop work based conflict resolution & communication skills to include organisational culture & management styles	HSE standards on Stress (voluntary) Corporate Alliance Against Domestic Violence National Employment and Health Innovations Network VCS/ Business community	DWP DH HO Economic Development Agencies	A lot of good practice & resources, though patchy implementation
Promote workplace anti-abuse and bullying policies and training, and the development of work environments which promote mental health	HSE standards on Stress (voluntary) Corporate Alliance Against Domestic Violence National Employment and Health Innovations Network VCS/ Business community	DWP DH HO Economic Development Agencies	A lot of good practice & resources, though patchy implementation - more needed on non-abusive management styles
Preventing Elder Abuse: Multi-agency support for lay carers including respite care. Training and inspections for care homes re elder abuse. Review of poly-pharmacy & minimise medications prescribed.	Residential Care Services PCTs LA and SS HealthCare Commission/ CSCI	DH DWP	Patchy awareness, training, monitoring and access to respite care.

Adults – high-risk groups

Adults - High Risk Groups			
Evidence for Violence Prevention/Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Delivery Agents**	**Progress/Coverage**
Professional education & training to recognise different forms of abuse (Health, SS & Police)	VVAPP Police Training	DH HO VCS	Patchy Need to embed within curriculums & CPD
Early recognition of abused: develop protocols & referral pathways (especially for health services and social care) for: • Sexual Assault • Domestic Abuse • Other abuse –eg forced marriage, trafficked women in prostitution • Elder abuse	DH Domestic Abuse manual and ANC routine enquiry; 12 MH trust pilots who are training health care staff to identify patients who have experienced sexual abuse (CSIP- VVAPP)	DH HO DCLG VCS	Needs consistent local level implementation, extension to other health care areas & Recognition of other forms of abuse
For those who have been abused: Ensure availability of support, counselling & treatment services. Ensure protective skill development provided to minimise risk of further victimisation. Adequate resources for help lines, shelters, crisis centres, and advocacy services, for DV, and the development of Multi-agency Sexual Assault Referral Centres (SARCs).	Interministerial groups on DV and Trafficking, National DV helpline, Rape Crisis helplines VVAPP (MH trusts) Pilot Sexual Assault Referral Centres VCS – shelters and community support MARACs – Multi Agency Risk Assessment Conferences for Domestic Abuse Extension of Independent Domestic Violence Advisors (IDVA) & 57 Specialist Domestic Violence Courts-SDVC Housing teams prioritisation re Domestic Violence Sub regional DV Forums	HO DH DCLG VCS	Gaps in Shelter accommodation if mental health or substance misuse problem Patchy advocacy & support services especially for minority groups,
Prioritise alcohol treatment for recognised abusers and victims of abuse.	DAATs and referral agents (eg Health and Police/ CJS) Brief interventions Safe.Sensible.Social. The Next Steps in the National Alcohol Strategy, 2007; HO, DH, DfES, DCMS;	NTA HO, DH VCS	Patchy and little awareness

Adults - High Risk Groups			
Evidence for Violence Prevention/Good Practice *Include diversity throughout*	**Policy, Programmes and Approaches**	**Delivery Agents**	**Progress/Coverage**
Abusers: Identification, containment, education and management of abusers	Interministerial Group on Sexual Offending VCS eg Stop it Now NOMS/ ROMS Perpetrator Programmes Protection of Children from Sex Offenders, HO, 2007	HO DH DCLG VCS	Patchy and poor conviction rates Opportunities via NOMs

Annex VI: Sample of Notes From Diaries

28th January 2009 – List of Policy Tasks to Progress the Violence and Abuse Prevention Framework

29th January 2009 - Personal Reflections for PhD

(5) EB only one factor
- Not seen as central to policy making
→ More inclined to refer to all previous related policy ie <u>CONTEXT</u> + justify what's happening / defend + incrementally add to this.
- ie Not strategic in looking at problem + solutions -

↑ Response to ask for suggested text + Case Stud

(6) Stakeholder influence
- Eg letter from Women's Network tthea
- Whose critique Prevention framework as not:
being - Gender specific
- Ends up being deterministic / victim blaming by taking life course perspec.
- Ignoring NCS experience / evidence of
→ ie Misunderstood Want prevention vision is about + not seeing contxt of Risk factors / discrimination in wider inequalities agenda.
- ie 'feminist perspective' narrow + ridgid + ends up isolation / polarising issue
→ Policy response though swayed by importance of their lobbying - ie need to take with us.

R&D | → importance of key stakeholders having a consensus re ways forward / interventions
- when there is divided opinion on an area then politicians stay away.
→ only when everyone is saying the same thing then politicians say we ought to be doing this.

Key called to review strategic approach for choosing which interventions we should go for.

§ Policy makers / ministers like 1-2 out of choice of 3 top areas ~~to figure~~ + to announce.

- The other key aspect to consider is / feasibility
ie do you have to establish new systems vs work with a mainstream - ie already system + capacity.

→ Also to consider impact on <u>inequalities</u> + co-benefit.

11th March 2009 - Summary of Findings at a Workshop on Developing Priorities for Public Mental Health

13th April 2009 - PhD Reflections

For eg New Unit developed to oversee
this new policy process now putting
emphasis of EB on NICE – that this
isn't part of role of strategy/policy
to provide the EB
→ ie Policy should be supporting/enabling
local + Regional autonomy.

16th April 2009 – Notes from an in-house Department of Health, Senior Civil Service Day on Policy – (diary until the end)

DH Policy Day   16.4.09

PSAs & DH objectives

4 Principles of Change
→ Co-production
Subsidiarity
Ownership + leadership
System Alignment.

Policy Maker = Decision Maker

(5 ba) cut off all GD''

→ Value for £

– From DH Policy Unit

Effective
Coherent
Adaptive Focused
Deliverable EB
Collaborative
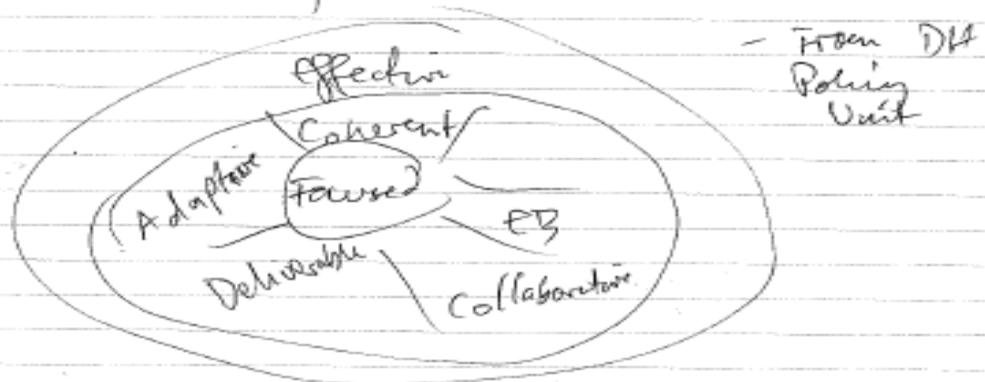
Issues:
ie Policy Proces + steps in it get 'interrupted'
eg by political pressure ie Time
Policy maker therefore needs to judge & Agendas
Risks + Balance Risks
→ + Deal with RISK
Revenue Investent Branch → 'Policy Costing Handbook'
+ Impact Assessments (seperate team)
① Initial Assessment ② Outline ③ Full Costing

16th April 2009 - Policy Tasks – DH Policy Day

Policy Tasks :-

→ Relevant PSAs + DSOs.   JA $ SB
→ HNA → Priority Areas
→ Evidence Base / Effectiveness summary JC

→ Cost Effectiveness → (Cost Calculator).
                                    → Analysts)
→ Policy / Coherence – OGD.
         / Gaps + Practice   SB
                                        Gavin Roberts
→ Impact Assessment / (Cost →   CH
Hilary Stockwell ← + Risks (& Legal Advice) – DH Policy]
→ Equality Impact Assessment   CH

→ Co-production – External   (Consultation)
'Onur Yelekci ← (Map on ← Stakeholders (Guidance)
can facilitate process) Delph.
→ Rpt :- – Writing   Customer Insight
          – Structural Edit   Chris Hyffer
          – Content Edit
Clearance by   – 'Scientific Edit'
Minister   – Grammar Edit /
Dept Board   – Lay Readership
Cabinet office – Graphics + Design
→ Domestic
   Affairs Com
→ Next Steps / New Announcements

→ 'PMH Poog'   – Indicators – LAA etc.
→ Wider Policy.   – JSNA
→ E +T   ] R + D
– WB Literacy.

16th April 2009 - DH Policy Day, Impact Assessment

Impact Assessment: → Gavin Roberts (Economist)

① Requirement – if has cost OR political interest.

② Make contact early with analyst → Cost / Benefit
                                      Options.

③ Check what evidence there is on:
   → QALYs   } Best estimation'
   → Cost of Intervention } is made where
                           there are gaps.

Can just do it based on] Policy maker
current information   (takes responsibility for
as estimate-   impact Assessment
Range of Time 2/7 → 9/12'.

Risk + Legal issues – Need to anticipate Risk +
of policy development.   – Take legal advice be in justification

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16th April 2009 - DH Policy Day, Evidence and Policy Making

16th April 2009 - DH Policy Day, Wider Policy Issues

Annex VII: Observational Analysis Framework Summary

Document/ Notes/ Meeting:

Summary of review of diary notes and observations from attending meetings between Autumn 2005 until April 2009.

Date completed: 13th April 2009

Sectors involved:

Observations of 1:1 and larger meetings, workshops and conferences attended at local and regional level with the health, police and voluntary sector and at regional, national and international level with the Department of Health, the Home Office, the Department of Children and Families and at WHO.

Level/ setting:

International, National, Regional and Local

Process I

Main Drivers	**The Criminal Justice System:** The main driver at national, regional and local level was the police/ home office – this was seen as an agenda actively pushed for and owned by the Criminal Justice System. The Home office led on and published a Tackling Violent Crime Action Plan in Feb 2008. The main Public Service Agreements related to violence are owned by the Home Office, and the Local Area Agreements related to violence are seen as owned by the Police. The main approach of the criminal justice system though has been punitive, with an increase in prison numbers and sentences for carrying knives, rather than having an approach to prevent violence. Additionally, on occasions they have not worked in collaboration with the health sector and 'pushed' this agenda on them with an expectation of a command and delivery response – eg there is a clash of cultures and approaches. For example, summer 2008, the Home Secretary announces that perpetrators of knife crime will be visiting victims in Emergency Departments, (which wasn't consulted with the health sector on) and further Home Office briefings seek to make information sharing between health professionals and police mandatory in cases of violent crime. This approach has probably been driven by a particularly charismatic and outspoken senior advisor working in the Home Office/ PM Strategy Unit. This approach has not aided partnership working and created a culture of resistance. **VCS:** At local and national level the Voluntary Community Sector act partially as a driver, mainly advocating this as an issue. They also organise annual national conferences with Home Office and sometimes DH speakers – their main funders are from the Home Office (i.e. from the Victims fund). However, their more radical (i.e. feminist view of violence and attitudes counter to addressing wider risk factors eg alcohol) stance at times marginalised them and made it difficult for

	mainstream public health to engage in this agenda on the same platform. **Media** coverage of high profile events (i.e. knife stabbing or shooting of an innocent bystander), gains disproportionate coverage, and has acted as a key driver in pushing this up the policy agenda. This is despite the relatively low numbers of knife violence in England, and underlying trends show a reduction in homicides and injuries caused by knives. However media coverage has increased the level of public and political perception of this as an issue. (NB, historically, the media acted in a similar way to put obesity on the policy agenda). **No. 10/ Prime –minister:** For example following widespread media coverage of the knife killings, in summer 2008, led to prime-ministerial engagement and prioritisation with weekly cross government meetings at number 10, and letters to Strategic Health Authorities to ensure better information sharing between the health and police of knife related attacks. This central leadership has also sought active engagement by the health sector (and other sectors) including demand for weekly reporting of the development of the violence prevention plan amongst other things.
Key Events	**Media Coverage** on a series of knife related killings in London – has pushed this from a HO agenda to one headed by the Prime Minister (with transfer of the senior HO official heading the Violent Crime Action Plan, to the Prime Minister's office)
Context	The right timing appears to be very important – i.e. seeking opportunities when this is high on the political agenda to get support to push for further work on violence prevention. One of the problems is that most forms of violence and abuse are not that visible, or do not make good media stories. Approaches to prevention in general suffer from lacking media interest and a sense of quick returns so often not seen as politically very important. Additionally, most health services (and other sectors) focus most of their energy and resources on immediate problems resulting in a reactive approach to visible problems. Historically, there is less taboo in discussing violence and abuse, however, there are still individuals who 'deny' the statistics or consider that this is not an issue for them to address- some of this resistance reflects in part the discomfort in dealing with these issues and also limiting the implications of having to deal with them.
Motivation	The policy process is significantly influenced and shaped by policy champions with an interest and commitment in this agenda – this is usually specifically to the violence prevention agenda, however, also of those who have this as part of their work remit and are dedicated and committed in their work generally. In contrast, there are key actors in leadership positions to take forward the violence and abuse prevention agenda who have little motivation to forward this work. This is often related to busy workloads, of which violence and abuse is an additional area and not always a priority compared to competing work pressures. Alternatively, some actors in the civil service are more motivated by career progression, managing ministers and the policy process as opposed to the specific content of

	any policy area which they may have no particular interest or expertise in.
Actors	**Leadership:** Good, clear and senior leadership is a key to progressing policy work in general and specifically with violence prevention. During a period of reorganisation during 2006/ 7 for almost a period of a year, changes in senior public health leadership roles resulted in a stasis of policy progression in this area. At first it was not clear who was leading on violence prevention nationally, once this was established, it was unclear who had what role and what the relative contributions should be or what the roles should entail. Clear leadership roles are important for providing sufficient authority to take forward pieces of work and policy development and to avoid duplication of work. Leadership also needs to be visible and actively progressing or delegating work (i.e. leadership in name but nothing else – can act as a barrier or inertia to progressing work) – i.e. leadership needs to champion the work, give authority/ permission to others, provide a clear vision and sense of direction and to make active decisions re policy etc. **Other Actors:** Actors outside of the policy arena who also influence and provide visibility to the violence prevention as an agenda, include: Support and championing by wider Public Health colleagues/ peers (eg Faculty/ UKPHA and senior public health colleagues) Royal Colleges and other professional bodies Expert advisors (sometimes academics or senior people in their field) Academics WHO VCS Media Other Govt Depts. especially the HO Within the policy setting, aside from leaders, policy champions exist and are important actors in the process: **Policy Networks and Champions** Even when there were periods of unclear leadership and a fragmented approach to how policy development was taking place (which resulted in policy inertia), networks of policy champions maintained violence and abuse prevention 'bubbling' as a potential policy issue. During this time, policy champions would have occasional meetings and discuss

forthcoming policy opportunities and activities. This acted as an informal network that would occasionally meet or email to address a specific issue, either as individuals or at times as a formal or informal group who were perceived as committed to addressing violence and abuse and had a remit in their work agenda to address violence and abuse. This resulted in continuation of violence prevention work being reflected in relevant wider policy areas – for example, in the Home Office Tackling Violence Action Plan.

When the timing is not right to progress specific policy work on violence prevention, the support of policy networks is important to maintain the energy and enthusiasm of policy champions.

Supportive Ministers

Ministers vary considerably in their backgrounds and experience, identifying and working closely with ministers who support and champion this agenda is important in gaining senior and cross departmental support. Ministers change roles every so often, so this influence can be lost, however, those with a real interest in championing this work have furthered work in their new roles and have acted as important champions.

Discrediting Actors

Certain approaches if perceived as being too extreme or outspoken, or advocated by individuals, who become professionally discredited for their wider behaviour, can act to discredit policy development in an area.

For Example - the Home Office approach re bringing perpetrators into visit victims in Emergency Depts. was probably driven by a particularly charismatic and outspoken senior advisor working in the Home Office/ PM Strategy Unit, but also reflects the culture of the Home Office (i.e. command and control) and resulted in resistance in addressing this in the health sector.

Another example is of a senior official who had championed the work on violence and abuse, acted unprofessionally in a variety of situations. This resulted in much of the wider associated work being discredited and held up policy development on violence and abuse prevention for many months as energy was fragmented and diverted in dealing with surrounding issues.

A further example, is how the mainstream health sector can discredit some of the approaches or views of the voluntary sector as being too extreme regarding feminist theory and lacking in scientific evidence (for example re alcohol). This in some situations can lead to a lack of engagement by the health sector.

Process II

Policy Formulation-General	**Problem Definition**
	Problem is frequently driven by media pressure – of highly visible issues that generate media attention (i.e. innocent bystander shot)
	Pressure groups can play a role in pushing an agenda (eg BMA re MTAS), and frequently use the media to gain extra leverage
	Additionally, a minister (or PM) may have a particular interest (i.e. inequalities), which they push, individually as a policy area.
	Civil servants can also play a role by creating awareness of an issue and gaining departmental and ministerial support – the more senior position they are the easier this is.
	Royal Colleges play a credible role in opinion forming, however they are rarely proactive in their approach to push for a policy agenda.
	Expert Advisors to the Government (eg psychological therapies) can be highly influential in persuading ministers and pushing an agenda.
	Expert/ Advisory Groups – i.e. scientific advisory groups commissioned to investigate an area at the request of the gov't
	Performance monitoring reports – i.e. health care commission, scrutiny boards, PSAs (eg on fuel poverty) or where there is a failure of reaching established targets – frequently generate media attention if public interest.
	Solutions & Options
	A series of options are usually given as part of a ministerial submission and generated by the policy lead in the area. They may be influenced to a varying degree by the evidence base, an expert, expert or advisory group.
	However, evidence is used variably according to political interest and pressure from lobby groups that may have financial or political leverage (eg alcohol, TB badger cull). Many policy leads come from an arts background, and are not familiar with scientific or public health methods for assessing evidence. This often leads to poor/ in-coherent theoretical frameworks for formulating solutions.
	Additionally, tangible, short -term results that are cost effective are favoured – this tends to lead to pilots and programmes rather than long-term sustainable approaches – which is a problem for prevention approaches. The political term is approx. 4- 5 years, with policy being formulated and delivered in that time frame, often resulting in 3-year policy time frames and favours quick wins rather than taking a longer more strategic view.

	From a central perspective, the cabinet office and financial concerns take political priority in how decisions are made and have more weight in decision making about policy formation than other departments. Although there is usually a search for policy consensus within and across departments (to ensure gov't does not come out with contradictory messages/ policy), certain departments take presidence – i.e. the Cabinet office, and BERR, the PM strategy unit, with their main focus upon the economy. Options usually present the pros and cons for each area including financial and communications advice. See below an outline of a standard ministerial submission: **Purpose of Submission** – enumerate each paragraph but not each heading. Headings in bold but not capitals. **Timing of Response** **Recommendation(s)** (summary only) **Issues** (i.e. outline why the submission is necessary) **Analysis** (covering finance, evidence/arguments to support options) **Options** **Recommendation(s)** (in full) **Presentation –** this MUST include Communications' advice
Policy Formulation-Public Health Contribution	**Information:** Most departments make good use of information specialists to show overall trends and up to date figures regarding their area of interest. However, many of the policy experts (and ministers) come from an arts background and may not always accurately interpret information provided. **Health Needs Assessment:** Within the DH, there is generally good use of Health information to inform policy decisions. However, public health observatories frequently are not responsive to requests made and are unable to deliver information within tight time frames. Additionally, where there are gaps in information/ HNA, this distorts what policy is emphasised – i.e. there is little information on child abuse, which tends to make this an invisible area that is dominated by child protection procedures. A lack of routine and regular data on an area limits subsequent activity and policy and conversely, generating information in an area can stimulate action to address now visible issues (eg mental health ONS survey, the A and E info sharing work, and measuring obesity). **Evidence Base** Policy may be influenced to a varying degree by the evidence base, an expert, expert or advisory group. However, evidence is used variably according to political interest and

	pressure from lobby groups that may have financial or political leverage (eg alcohol, TB badger cull – re Chief Scientific Officer going against scientific evidence)

Many policy leads come from an arts background, and are not familiar with scientific or public health methods for assessing evidence. This often leads to poor/ in-coherent theoretical frameworks for formulating solutions.

The Gov't under Blair, put greater emphasis on the use of an evidence base, and the DH has a strategy unit that aims to influence policy making by using a more robust scientific approach – however, this unit does not influence the development of all policies and strategies across the DH.

A shift in direction in the policy process has taken place during 2008- 9. This includes a greater emphasis on engagement, co-production and subsidiary with national policy supporting and enabling local and regional autonomy. A new unit in DH has been developed to oversee all new policy and strategy formation, which views the use of evidence in policy as marginal and considers this to be the responsibility of NICE. However, although NICE produces comprehensive evidence reviews on specific health related interventions, including public health, it does not include all subject areas, (eg violence prevention), nor does it attempt to prioritise interventions. |
| **Key Policy Decisions Made** | **Key Decisions Made**

Key decisions are usually made by ministers, based upon the advice of senior policy leads. This usually involves regular meetings between officials and ministers to make decisions regarding policy development. A key decision point is when a minister makes a new announcement. This is usually done with media coverage to help raise the profile of the political party and illustrate to the electorate improvements that are being made. Therefore, ministerial announcements prefer to have good news messages that will gain the support of the electorate. A ministerial announcement amounts to a political commitment and therefore carries a lot of importance in the decision making process.

This process allows for highly motivated ministers to champion a particular cause, for example one of the Home Office ministers has driven the development of a cross- governmental Violence Against Women Strategy within a very tight timeframe. Conversely, it also means that to some extent, senior policy leads can potentially push forward an agenda that they have an interest in.

However, usually, career senior civil servants attempt to maintain reasonable expectations, workload and reduce the risk of undue negative media interest, by managing both upwards and downwards. This influences the range of options presented to a minister and the emphasis given of potential risks to guide the minister in taking a recommended decision. The precautionary risk adverse approach favoured by civil servants tends to lead to policy being made incrementally. In contrast, ministers may push for more substantial |

policy jumps.

Some ministers are seen as precarious in what they will say in public, and therefore, some civil servants try to reduce opportunities for ministers who are seen to make impromptu commitments in public that may be counter to other policy or uncertain if the commitment can be upheld.

There is increasing emphasis on the need to have **policy coherence,** that is, that any new policy builds upon and is consistent with historic and existing policy. New policy should not contradict other policy, either within ones own department or with other departments. Again, this leads to a tendency to incremental policy making, with a reiteration of existing policy and a handful of new areas that are being forwarded in any new policy. Any new policy being developed is reviewed and circulated internally within the lead department and other government departments to ensure coherence and consistency. Policy that is developed in a fast time frame or has insufficient capacity for formation, risks inconsistencies or contradictions in policy that can lead to negative media and stakeholder feedback.

Therefore, there is greater emphasis on ensuring there are internal and external checks in place. For example, all new DH policy is required to publish an **impact assessment** at the same time as any new policy. This includes details of changes in resources or workload that any new policy will place upon other government departments and the health sector. Clearly, any policy that places an undue burden upon stakeholders will be reviewed and potentially not agreed. This process increases the importance of cost analysis of recommended interventions and policy decisions.

The other factor influencing decision-making is **engagement and co-production** with stakeholders. This reflects a general shift away from a top down approach to policy making to a more democratic process. The degree of engagement and co-production is variable and to some extent depends upon the availability of time, capacity and resources. Processes include holding listening events, national and regional consultation or engagement events, and circulation of draft reports for feedback. External expert and task groups are also engaged to peer review evidence and inform priority development. Additionally, stakeholder views help to shape what sort of policy report or products are most helpful to them.

Below summarises the key decision points for the violence and abuse prevention policy development:

1. Historically our gov't signed up to a World Health Assembly resolution committing to the development of violence prevention plans.

2. The Victims of Violence and Prevention Programme work included Violence Prevention mentioned within the guidance report; (July 2006).

3. This included a ministerial letter from the Public Health Minister to

	the HO about developing the violence prevention plan. (July 2006) 4. This was further agreed and acknowledged in a number of cross-governmental Inter- ministerial groups. 5. It is one of the follow up actions from the HO Tackling Violent Crime Action Plan. (Feb 2008) 6. It is then mentioned in the DH Inequalities Progress and Next Steps report. (June 2008) 7. The Violence Prevention Plan was included several times in the Number 10 weekly reports on addressing knife crime. (Summer 2008) 8. It will be included in the refresh of the Tackling Violence Action Plan. (Spring 2009) **Strategy/ Planning** Reactive vs. proactive Risk adverse Political time frames – short term gains (1- 3 years) Strategic skills - Public Health 'advisory role' – kept at arms length Incremental approach versus project managed delivery orientated approach.
Barriers	**Barriers** Taboo nature of violence and abuse – disbelief, denial Lack of awareness – prevalence, impact, cost Lack of perception as a health issue Silo'd working - Levers for prevention seen as outside the health sector Complex and multi-factorial – difficult to understand life course and prevention **Risk and Quality** Responsibility eg Child Protection - Person/ family centred and Service quality Ministerial submissions and Impact Assessments
Opportunities	**Enablers and Resources** Imbalance of Resource vs. cost to health sector/ health service Policy capacity and resources OGD capacity and resources External capacity and resources – eg NWPHO, NGOs, WHO, CDC, academic institutions/ experts

Implementation	**Shift from targets to Subsidiary** – less targets, greater local and regional autonomy re priority setting and monitoring
	PSAs, LAAs, SHA/ NHS targets
	Importance of valid indicators re prevention and collection of routine data eg A and E data
	Importance of Governance structures to ensure implementation

Annex VIII: Secondary Thematic Analysis of the Diaries

The below box summarises key themes and processes identified independently by a research student who read through the authors' diaries.

Recurring themes identified from the Diaries, August 2010

I: Educating the actors:

1: Influence of an indecisive policy lead: Creating a lack of clear direction and vacillation, often personality driven by a difficult history.

2: Influence of HO driven agenda's: Media and PM, driven by populist pressure, creating reactive policy with a focus on the immediate problem and a search for short-term solutions.

3: Continuing difficulties in understanding of the 'prevention' message: Problem of HO/health sectors and stakeholders in reaching an understanding of upstream and wider determinants, associated with multi-factorial causes and complex interactions.

4: Culture of reactive/minimal/incremental change within policy hierarchy (civil service level): The result of opposition and changing expectations.

With a culture of desiring to: keep things quiet/not create more work and not draw attention, the opportunity for creating strategic long term root cause based policy slips away.

5: Desire for silver bullet solutions: Factors 2, 3 and 4 lead to a focus on finding a solution with close proximity to the cause. This approach misses out an understanding of root causes, which act as distant levers on a current situation.

6: Examining the evidence base is not considered central to policy making: The EB is only one factor considered, in a process which has a greater inclination to refer to all previous related policy and from this context justify/defend what is happening now and only incrementally add to this. This approach is not strategic neither looking at problems nor solutions.

7: Stakeholder influence: Often critical of proposed 'prevention' based framework. Often locked into particular ideological perspectives e.g. feminist analysis critiques of the model, based on the arguments that it is not gender specific and that the life course perspective is overly deterministic and 'blames' the victim This provides a narrow/rigid isolating and polarising perspective ignoring both evidence and experience.

Overall summary: there is an issue of continuing misunderstanding of the 'prevention' vision and an inability to perceive risk factors within that context and the role of discrimination within a wider inequalities agenda.

Solution: There is a need to bring along the different actors in developing their understanding of the wider prevention framework and not alienate them.

II: Applying research findings:

1: Current limitations to the standard academic remit:

a) Research questions commonly stop short of being applied and merely provide descriptive studies e.g. on environments which produce aggressive behaviour in animals.

b) Additionally researchers have a poor history of translating findings into applicable policy, with the knock-on effect that there is less practical ground level uptake of new evidence by individuals and communities.

c) Often research is orientated to asking specific questions linked into producing a profitable/ drug production (silver bullet) outcome.

2: Poor interpretation of research findings by policy makers:

Perceived role limitations: e.g. NICE specialises in 'just' stating the evidence and doesn't summarise its findings, as it does not consider it part of their remit.

Solutions:

a) **Greater joint training of relevant actors:** including trans-disciplinary workshops and discussions of these issues, including how to develop methods to translate/ interpret and apply their work.

b) **Set aside time:** Required to hone the skills of policy makers and planners (e.g. overcoming silo'd thinking).

c) **Change the orientation/bias of research and funding bodies:** i) Need to simply stipulate that the 'implications for policy and prevention' are included as part of the research outcomes and are not only about dissemination of knowledge.

ii) Move away from a drive to profit e.g. animal experiments exploring neuroscience from the perspective of developing drugs to control aberrant behaviour, rather than questioning the root causes/circumstances for behaviours.

d) **Broaden the research base:**

There is a need to develop the ability to make links to wider connections and provide models which give a clear overview of the complexity of interactions, and develop consensus e.g. connecting findings from the micro level e.g. neuroscience (how neurotransmitters/hormones interact to drive behaviour) and how this at the macro level helps us understand violence.

e) **Breakdown silo'd approaches:** Research needs to broaden out from its current and historical narrow focus and increase cross and trans-disciplinary perspectives.

III: Better utilisation of those in leadership positions:

Currently there is a combination of:

1: Unclear leadership within Home Office and Department of Health with mixed motivations and drivers.

2: Contrasting with highly motivated ministers: resulting in the overall need for management along clear time lines and concise delivery programmes.

Solutions: Need for **a coordinated engagement process**, e.g. as applied to changes in the policy process, to increase coherence across and between actors.