HAVoC Study

Helping Aged Victims of Crime

Funded by

Research for Patient Benefit programme 2009-12
£250,000 (US$ 358,000)

Conflict of interest: None

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HAVoC Study - Multidisciplinary team

Grant Holders:
Dr M Serfaty: Clinical Reader in Psychiatry (Psychiatrist and CBT therapist)
Dr M Blanchard: Senior Lecturer in Psychiatry of old age, UCL (Psychiatrist of old age)
Prof G Laycock: Director UCL Jill Dando Institute of Crime Science (Criminologist)
Prof C Brewin: Professor of Clinical Psychology, UCL. (Traumatologist)
Prof A Kessel: Director of Public Health for Camden PCT. (Delivery of Health Services)
Prof V Drennan: Director of 1ry Care Nursing Research, St Georges MS, London (Nursing and primary care)
Dr G Leavy: Director of Research, Northern Ireland. (Sociologist)
Dr Paul McCrone, Insititute of Psychiatry (Health Economist/Statistician)
Victim Support UK (Users and delivery of Services)
London Metropolitan Police.

Collaborator:
Saskia Ohlin (CBT therapist)
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HAVoC Study
Background

- Depression is common in older people: 20%

- Previous work on depression in older people suggested crime was a trigger for their depression
  - (Serfaty et al, 2009)

- Post burglary
  - 25% depressed and 13% Anxious
    - (McGraw and Drennan, 2006)
  - 9% PTSD
    - (Thornton et al, 2003)

  - 2 years later, 2.4 x more likely to have died or moved into residential care.
    - (Donaldson, 2003)

- Older people take longer to recover from crime
HAVoC Study

Background

• 2005-6
  – London Boroughs of Barnet, Camden, Enfield, Haringey and Islington
  – > 5,222 people over 65 years victim of reported common crime
    • Circa 3.4% are a victim of crime.

• Risk in older people of being a victim of crime lower than the average population

• Perception of risk is greater
  – Socially deprived, women, ethnic minorities, physically ill, living alone.
  – 1 in 8 older people feel trapped in home after dark
  – 1/3 older people feel crime adversely effects their quality of life.

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Government white paper 2004
Building communities, beating crime

- **Neighbourhood policing teams** were set up in every neighbourhood, supported by PCOs by end 2008

- **Primary Care Trusts** - statutory duty and the Crime and disorders ACT 1998 to work with other agencies to provide
  - Protection
  - Support

- **Usual support given by**
  - Victim Support
  - Primary care teams, but often not accessed out of shame

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What evidence is there to date

• Very limited data on prevalence of psychiatric morbidity.

• No data on why people became unwell.

• Virtually no data on
  – Optimum interventions
  – Outcome from interventions
Aims

1. **Quantitative:**
   - Prevalence of psychological disorder at 3 months.

2. **Qualitative:**
   - Information about crime and the intervention:
     - (a) Pre intervention
       - To explore factors associated with psychological disorder at 3 months
       - whether these have changed post intervention by covering themes;
         - experience of crime,
         - beliefs about crime,
         - coping behaviours
         - use of support and NHS services
     - (b) Post intervention
       - Experience of receiving VIP and inform modifications.

3. **Combined methods:**
   - Test feasibility of RCT Victim Improvement Package *(VIP)* vs Treatment As Usual *(TAU).*
Methods- recruitment

• A 2 year study.

• Recruitment:
  – Victims of common crime, within the last month, identified
    • Victim Support,
    • the police,
    • self referral
    • GP referral
    • Safer Neighbourhood Teams
  – Originally targeted $\geq 65$ years
  – also tried $\geq 55$ years or over as part of pilot.
Methods- Screening

• Screened for significant psychological disorder on any of the following
  • within 1 month and 3 months post crime using

  – K6 (Kessler -6; Kessler et al, 2003)
  – GAD-2 (General Anxiety Disorder Scale; Kroenke et al 2007)
  – PHQ-2 (Patient Health Questionnaire; Kroenke et al, 2003)
  – PTSD (Post Traumatic Stress Disorder Screen; Prins et al, 2004)


Methods

Entry criteria for HAVoC study

a) **Inclusion criteria:**
   (i). A DSM-IV diagnosis using a structured clinical interview schedule (SCID-I); of:
   a) Depressive disorder,
   b) Post Traumatic Stress Disorder (PTSD)
   c) Anxiety disorder
   (ii) Confirmation that the current distress is subsequent to the crime.

b) **Exclusion criteria:**
   (i) Intense suicidal intent.
   (ii) A diagnosis of alcohol misuse or drug dependence.
   (iii) A history of bipolar affective disorder.
   (iv) The presence of hallucinations or delusions.
   (v) Insufficient command of English.
   (vi) Cognitive deficits (a score of less than 25 on the Mini-Mental State).
   (vii) Receipt of CBT within the last year.
   (vii) If relevant, not taking a stable dose of psychotropic medication for at least 2 months prior to randomisation.

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Methods
Baseline measures

a) Demographic and other factors
   Age, gender, ethnicity, marital status, previous occupation of the main salaried person, education, previous diagnosed mental illness, time of year, medication.

b) police category of crime;
   (i) against the person (Violence Against the Person, Sexual Offences, Robbery) or
   (ii) property (Burglary, Theft, Fraud, Criminal Damage).

c) season:
   Seasonal effects may influence behaviour; older people may be reluctant to go out on dark nights)
Measures for pilot RCT

<table>
<thead>
<tr>
<th>Measures</th>
<th>Time post crime</th>
<th>Baseline</th>
<th>End therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main outcome</strong></td>
<td></td>
<td>3 months</td>
<td>6 months</td>
</tr>
<tr>
<td>World Health Organisation Disability Assessment Scale-II (WHODAS-II)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Secondary</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beck Depression Inventory (BDI-II)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Beck Anxiety Inventory (BAI)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>PTSDS</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>CSRI</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Measures of potential bias</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants group preference</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expectations of therapy</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blindness</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attrition</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Prescribed medication</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Other psychological treatments</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Qualitative</td>
<td>✓</td>
<td></td>
<td>(VIP only)</td>
</tr>
</tbody>
</table>

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Random allocation will be to one of the two groups:

1. **Victim Improvement Package (VIP):**
   Up to ten 50-minute sessions of VIP were offered over 3 months.

2. **GP Treatment As Usual (TAU):**
   GP informed that the participant was a victim of crime and that he/she is suffering from distress as a result.
   GP advised to use any appropriate treatment, but discouraged from using CBT during the trial period.
Data collection: Qualitative

• In depth interviews
  – why patients become distressed after crime
  – To help with development of the VIP.

• All 26 participants randomised into the study, VIP or TAU, were interviewed qualitatively.

• Key areas and issues
  – (i) the participant’s life-world prior to the crime;
  – (ii) their experience of the criminal act;
  – (iii) its impact on physical and mental health;
  – (iv) beliefs about crime and safety;
  – (v) personal and social consequences;
  – (vi) post-incident coping behaviours and strategies;
  – (vii) awareness and use of existing community and statutory agency support mechanisms.

• All interviews were tape recorded to ensure that participants’ words are preserved accurately. Data were transcribed and analysed using qualitative methods.
Participants’ views of VIP (after the intervention)

• Re-interviewed all participants following the VIP.

• Enquired about
  – experience of the VIP
  – satisfaction with its delivery
  – Satisfaction with content.

• We re-explored themes to ascertain any changes in beliefs and behaviours which may inform practice and outcome measurements in our future RCT.
Victim Improvement Package (VIP)

A manual of cognitive behaviour therapy for Helping Aged Victims of Crime (HAVoC) with anxiety, depression and post-traumatic stress.

Authored by: Marc Serfaty, Saskia Ohlin, Martin Blanchard
Manualised victim improvement Package (VIP)

Manual consisting of 3 sections

• **Section I:** Introduction about CBT in older people and information on crime.

• **Section II:** the intervention

• **Section III:** materials

• Appendix.  

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Manualised victim improvement Package (VIP): Contents

- Offered up to 10 sessions of weekly standard Beckian CBT each of one hour, including:
  
  - **Session 1**: Assessment in light of crime
  
  - **Session 2**: Psycho-education about depression/anxiety/PTSD
  
  - **Session 3**: Shared formulation and exploring beliefs around crime
  
  - **Sessions 4-8**: Challenging negative thoughts and behavioural techniques.
  
  - **Sessions 9-10**: Relapse prevention.

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RESULTS
21,230 leaflets distributed to victims of crime aged ≥ 55 in 7 London boroughs over 18 months (Police= 16,885; researchers=3,840; VS= 505) VS also inform 366 victims by phone

1,058 individuals consented to contact Police (%) =873(82.5); VS=166(15.6); Other=19(1.9)

Within 1 Month of a crime
149/581 Significant, using K6, PC-PTSD, PHQ-2, GAD-2, on any one tool
Police referred (%) =520 (89.4); VS=50 (9.1); Other=9 (1.5)

Three months post-crime
120/486 screened using same measures and were significant on any one tool

Assessed for selection into RCT
80 consent to diagnostic assessment SCID; WHODAS II; BDI-II; BAI; PDS; MMSE

Of those significant at 3 months: 22 withdrew; 18 excluded

After three month screening: 22 withdrew; 22 excluded; 3 unavailable for follow-up

After asking for consent: 6 withdrew; 1 died

Consent to randomisation (n=26)
21,230 leaflets distributed to victims of crime aged 55 in 7 London boroughs over 18 months (Police = 16,885; researchers = 3,840; VS = 505). VS also informed 366 victims by phone. 1,058 individuals consented to contact. Police (%) = 873 (82.5); VS = 166 (15.6); Other = 19 (1.9). Within 1 month of a crime, 581 screened (K6, PC-PTSD, PHQ-2 and GAD-2). Within one month of crime (time 0), Police referred (%) = 541 (89.4); VS = 55 (9.1); Other = 9 (1.5) (149 significant on any one tool). Three months post-crime, 486 screened using same measures (120 significant on any one tool). Assessed for selection into RCT. 80 consent to diagnostic assessment (SCID; WHODAS II; BDI-II; BAI; PDS; MMSE). 33 meet selection criteria. Consent to randomisation (n=26). Qualitative interviews n=26. After asking for consent: 6 withdrew; 1 died. Baseline. TAU n=12. After randomisation 1 withdrew. Post intervention (6 months post crime) TAU n=12. Qualitative interviews n=6. Baseline. TAU + VIP n=14. After randomisation 1 withdrew 5 declined therapy. Post intervention (6 months post crime) TAU + VIP n=6. After three month screening: 22 withdrew; 22 excluded; 10 unavailable for follow-up. Of those significant at 3 months: 22 withdrew; 18 excluded. After baseline screening: 59 not followed-up; 32 unavailable for follow-up; 18 withdrew; 8 excluded; 2 died. After initial contact: 453 unavailable for follow-up 24 did not complete screens. Participant flow at randomisation. m.serfaty@ucl.ac.uk
<table>
<thead>
<tr>
<th>Sample Characteristics</th>
<th>HAVoC N (%)</th>
<th>2001 Census Borough Data 55+ N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Total n=605</strong></td>
<td><strong>Total n=317,118 †</strong></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>334 (55.2)</td>
<td>175,953 (55.5)</td>
</tr>
<tr>
<td>Male</td>
<td>271 (44.8)</td>
<td>141,165 (44.5)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>518 (86.5)</td>
<td>262,975 (82.9)</td>
</tr>
<tr>
<td>Minority Ethnic</td>
<td>81 (13.5)</td>
<td>54,147 (17.1)</td>
</tr>
<tr>
<td><strong>Marital status</strong> *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/cohabiting</td>
<td>241 (39.8)</td>
<td>155,974 (51.7)</td>
</tr>
<tr>
<td>Widow/Widower</td>
<td>152 (25.1)</td>
<td>68,377 (22.7)</td>
</tr>
<tr>
<td>Single</td>
<td>104 (17.2)</td>
<td>38,502 (12.8)</td>
</tr>
<tr>
<td>Divorced/separated</td>
<td>106 (17.5)</td>
<td>38,602 (12.8)</td>
</tr>
<tr>
<td><strong>Level of education achieved</strong> *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary / Secondary (10-16 yrs)</td>
<td>224 (37.3)</td>
<td>122,240 (53.4)</td>
</tr>
<tr>
<td>Further (17-19 yrs)</td>
<td>89 (14.8)</td>
<td>61,879 (27)</td>
</tr>
<tr>
<td>Degree / Post-Graduate (21 yrs +)</td>
<td>288 (47.9)</td>
<td>44,922 (19.6)</td>
</tr>
<tr>
<td><strong>Current living arrangements</strong> *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owner/occupier</td>
<td>416 (69)</td>
<td>171,168 (55.4)</td>
</tr>
<tr>
<td>Rented</td>
<td>187 (31)</td>
<td>137,858 (44.6)</td>
</tr>
</tbody>
</table>

*<0.001
† source: [www.lho.org.uk](http://www.lho.org.uk)
^ source: [http://www.nomisweb.co.uk/](http://www.nomisweb.co.uk/)
~ borough data for those aged 55-74 only

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<table>
<thead>
<tr>
<th>Sample Characteristics</th>
<th>2001 Census Borough Data 55+ N (%)</th>
<th>HAVoC N (%)</th>
<th>HAVoC N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sample Characteristics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Additional Information</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have anyone close to you? Total n=605</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>516 (85.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>89 (14.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How do you know them? Total n=516</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>199 (38.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>181 (35.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friend</td>
<td>110 (21.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>26 (5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you seen a friend in the last week? Total n=605</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>518 (85.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>87 (14.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever suffered from depression or anxiety? Total n=605</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>295 (48.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>310 (51.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, have you seen a doctor for this condition? Total n=295</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>200 (67.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>95 (32.2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Comparison of police recorded crimes for ages 55+ (n=25,175) and HAVoC total crimes for ages 55+ (n=605). Also included are data for cases at t0 and/or t1 (n=228)

<table>
<thead>
<tr>
<th>Crime type</th>
<th>Police N (%) (April '09 – Dec '10)</th>
<th>HAVoC N (%) (April '09 – Dec '10)</th>
<th>HAVoC cases on K6/PC-PTSD/PHQ-2 or GAD-2 at t0 and/or t1 N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burglary / Attempted / Distraction burglary</td>
<td>7,556 (30.0)</td>
<td>181 (29.9)</td>
<td>67 (29.4)</td>
</tr>
<tr>
<td>Pickpocket / snatch</td>
<td>3,192 (12.7)</td>
<td><strong>139 (22.9)</strong>*</td>
<td>46 (20.2)</td>
</tr>
<tr>
<td>Fraud</td>
<td>996 (4)</td>
<td>72 (12)*</td>
<td>19 (8.3)</td>
</tr>
<tr>
<td>Criminal damage to property</td>
<td>1,190 (4.7)</td>
<td><strong>48 (7.9)</strong>*</td>
<td>18 (7.9)</td>
</tr>
<tr>
<td>Criminal damage to vehicle</td>
<td>1,859 (7.4)</td>
<td>41 (6.8)</td>
<td>18 (7.9)</td>
</tr>
<tr>
<td>Common Assault</td>
<td>1,027 (4.1)</td>
<td>28 (4.6)</td>
<td>17 (7.5)</td>
</tr>
<tr>
<td>Harassment</td>
<td>1,343 (5.3)</td>
<td>26 (4.3)</td>
<td>18 (7.9)</td>
</tr>
<tr>
<td>Theft from motor vehicle</td>
<td>4,47 (17.7)</td>
<td><strong>22 (3.6)</strong>*</td>
<td>5 (2.2)</td>
</tr>
<tr>
<td>Actual Bodily Harm</td>
<td>1,216 (4.8)</td>
<td>21 (3.5)</td>
<td>15 (6.6)</td>
</tr>
<tr>
<td>Theft of motor vehicle</td>
<td>1,300 (5.2)</td>
<td><strong>17 (2.8)</strong>*</td>
<td>4 (1.7)</td>
</tr>
<tr>
<td>Theft of bicycle</td>
<td>627 (2.5)</td>
<td>6 (1.0)</td>
<td>0</td>
</tr>
<tr>
<td>Motor Vehicle Interference &amp; Tampering</td>
<td>311 (1.2)</td>
<td>3 (0.5)</td>
<td>1 (0.4)</td>
</tr>
<tr>
<td>Sexual offence</td>
<td>111 (0.4)</td>
<td>1 (0.2)</td>
<td>0</td>
</tr>
</tbody>
</table>

* Because of multiple comparisons significance is at p<=0.01

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# Screening tool scores at time of crime and 3 months post crime

<table>
<thead>
<tr>
<th>Outcome measures</th>
<th>N available</th>
<th>N(%) cases within 1 month of crime</th>
<th>Mean score (SD)</th>
<th>N(%) cases at 3 months of crime</th>
<th>Mean score (SD)</th>
<th>T value</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kessler-6 (K6)</td>
<td>462</td>
<td>78 (16.8)</td>
<td>5.87 (6.10)</td>
<td>52 (11.2)</td>
<td>4.78 (5.41)</td>
<td>5.9</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Primary-Care Post-Traumatic Stress Disorder Screen (PC-PTSD)</td>
<td>340</td>
<td>101 (29.7)</td>
<td>1.60 (1.42)</td>
<td>71 (20.9)</td>
<td>1.29 (1.35)</td>
<td>5.8</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Patient Health Questionnaire (PHQ-2)</td>
<td>325</td>
<td>63 (19.4)</td>
<td>1.30 (1.75)</td>
<td>61 (18.8)</td>
<td>1.14 (1.68)</td>
<td>1.9</td>
<td>NS</td>
</tr>
<tr>
<td>Generalised Anxiety Disorder Scale (GAD-2)</td>
<td>325</td>
<td>80 (24.6)</td>
<td>1.67 (1.92)</td>
<td>74 (22.8)</td>
<td>1.54 (1.87)</td>
<td>1.49</td>
<td>NS</td>
</tr>
</tbody>
</table>
Primary and secondary outcome measures at 3 months (baseline) and post intervention (6 months) by intervention type

<table>
<thead>
<tr>
<th>Measure</th>
<th>Intervention</th>
<th>N</th>
<th>Baseline (QR upper/lower)</th>
<th>Post intervention (QR upper/lower)</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Health Organization Disability Assessment Schedule II (WHODAS-II)</td>
<td>TAU</td>
<td>12</td>
<td>67.0 (53.3/79.8)</td>
<td>65.0 (49.8/82.3)</td>
</tr>
<tr>
<td></td>
<td>TAU + VIP</td>
<td>12</td>
<td>60.5 (46.5/90.3)</td>
<td>51.5 (40.5/72.8)</td>
</tr>
<tr>
<td>Beck Depression Inventory II (BDI-II)</td>
<td>TAU</td>
<td>12</td>
<td>11.0 (9.3/20.5)</td>
<td>11.0 (5.3/18.3)</td>
</tr>
<tr>
<td></td>
<td>TAU + VIP</td>
<td>12</td>
<td>12.5 (6.8/18.0)</td>
<td>8.0 (4.0/9.8)</td>
</tr>
<tr>
<td>Beck Anxiety Inventory (BAI)</td>
<td>TAU</td>
<td>12</td>
<td>11.0 (8.0/28.0)</td>
<td>12.5 (4.3/18.0)</td>
</tr>
<tr>
<td></td>
<td>TAU + VIP</td>
<td>12</td>
<td>12.0 (6.8/23.0)</td>
<td>9.0 (1.8/13.0)</td>
</tr>
<tr>
<td>Post-Traumatic Stress Diagnostic Scale (PDS) symptom total</td>
<td>TAU</td>
<td>12</td>
<td>9.0 (6.5/11.0)</td>
<td>6.5 (2.8/9.0)</td>
</tr>
<tr>
<td></td>
<td>TAU + VIP</td>
<td>12</td>
<td>6.0 (4.3/11.8)</td>
<td>3.5 (1.3/5.8)</td>
</tr>
<tr>
<td>Post-Traumatic Stress Diagnostic Scale (PDS) symptom severity</td>
<td>TAU</td>
<td>12</td>
<td>16.0 (13.3/23.0)</td>
<td>14.5 (5.3/18.8)</td>
</tr>
<tr>
<td></td>
<td>TAU + VIP</td>
<td>12</td>
<td>12.0 (6.0/25.0)</td>
<td>4.5 (1.5/10.5)</td>
</tr>
</tbody>
</table>
Primary and secondary outcome measures at 3 months (baseline) and post intervention (6 months) by intervention type

<table>
<thead>
<tr>
<th>Measure</th>
<th>Intervention</th>
<th>N</th>
<th>Median of the difference (QR upper/lower)</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Health Organization Disability Assessment Schedule II (WHODAS-II)</td>
<td>TAU</td>
<td>12</td>
<td>-2.5 (10.8/12.0)</td>
</tr>
<tr>
<td></td>
<td>TAU + VIP</td>
<td>12</td>
<td>-5.5 (-22.0/4.8)</td>
</tr>
<tr>
<td>Beck Depression Inventory II (BDI-II)</td>
<td>TAU</td>
<td>12</td>
<td>-2.0 (-5.3/1.5)</td>
</tr>
<tr>
<td></td>
<td>TAU + VIP</td>
<td>12</td>
<td>-5.5 (-10.0/-0.3)</td>
</tr>
<tr>
<td>Beck Anxiety Inventory (BAI)</td>
<td>TAU</td>
<td>12</td>
<td>-3.5 (-7.5/6.8)</td>
</tr>
<tr>
<td></td>
<td>TAU + VIP</td>
<td>12</td>
<td>-7.0 (-11.0/-0.5)</td>
</tr>
<tr>
<td>Post-Traumatic Stress Diagnostic Scale (PDS) symptom total</td>
<td>TAU</td>
<td>12</td>
<td>-3.0 (-3.0/-2.0)</td>
</tr>
<tr>
<td></td>
<td>TAU + VIP</td>
<td>12</td>
<td>-2.5 (-5.5/-0.5)</td>
</tr>
<tr>
<td>Post-Traumatic Stress Diagnostic Scale (PDS) symptom severity</td>
<td>TAU</td>
<td>12</td>
<td>-6.0 (-9.8/-1.3)</td>
</tr>
<tr>
<td></td>
<td>TAU + VIP</td>
<td>12</td>
<td>-7.0 (-12.0/-1.25)</td>
</tr>
</tbody>
</table>
VIP compared to TAU for functioning
VIP compared to TAU for depression
VIP compared to TAU for anxiety
VIP compared to TAU for PTSD
Summary

• 1st Study to investigate psychological impact of common crimes

• Over a 1/5 were distressed at 3 months

• Distress continued at 6 months

• Criminal damage and pick-pocketing seemed to be over represented in distressed people

• All outcome measures showed a trend towards improvement with the VIP

• 6.9 (SD.2.9) out of 10 sessions of VIP were taken up.
The main themes from qualitative interviews

- Criminals have no right to behave in such a way
- Arbitrary criminal acts (which most experienced) were worse than planned ones.
- Thoughts
  - Feeling naïve or “duped”.
- Emotional negative responses
  - Feeling fragile, panicky or isolated are negative.
- Behavioural changes accompanying these emotions seen as helpful
  - Taking more care when out and about,
  - Need to secure homes
  - Leave London or the UK all together.
- Talking to the police/receiving advice from family and friends
  - Helpful but
  - Some well-intentioned advice (particularly from police officers) perpetuate the individual’s sense of fear and legitimise their safety behaviours.
- Modern society is failing with regards to rising levels of crime (incorrect perception).
- Gangs of youths were a particular problem
- Small proportion of victims displayed empathy towards the criminals
  - They must have a very low quality of life to have considered committing such an act.

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In progress: “VIP trial”

A randomised controlled trial into the clinical and cost effectiveness of a developed cognitive-behaviourally based Victim Improvement Package (VIP) for the treatment of depression and anxiety in older victims of crime.

Funded NIHR PHR programme: Research costs £1,080,584.00 (US$ 1,532,785)


Post hoc analysis suggests at 90% power and P<0.05 significance that the numbers required using as outcome are:

- PTSD = 480
- WHODAS-II = 108
- BDI = 78
- BAI = 24

Therefore our RCT will use a combined BDI and BAI as our main outcome measure.

• Recruitment of participants will be through Safer Neighbourhood schemes.

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Combine BDI-II and BAI and standardise these for a common scale.

Power: To detect a (‘true’) average difference of 0.5 on the standardised joint scale with 90% power at p<0.05 (2-sided) requires a total sample-size (N) of 168.

Therapist clustering: assuming a cluster-size of 8 and ICC=0.02 implies an (overall) ‘cluster-adjustment’ of 1.14, N=192.

Allowing for 15% dropout: N=226.

Using data from the pilot study, the ‘target’ standardised difference of 0.5 implies changes in both BAI and BDI-II of the order of 4.
That's all Folks!