Brief Report
October | 2018
www.utas.edu.au/tiles

Tasmanian Institute of Law Enforcement Studies (TILES), University of Tasmania, Australia, CRICOS Provider Code 00586B

Law Enforcement and Public Health Workshop Series Report No. 2 – Developing Shared Measures

Isabelle Bartkowiak-Théron, Danielle Campbell, Rikki Mawad, Romy Winter, Sancia West, Grant Blake, Val Kitchener and Roberta Julian

"It is people who make up 'data'. Their lived experience is and should be paramount in (collective impact) approaches to law enforcement and public health"

Background

In November 2017 the Tasmanian Institute of Law Enforcement Studies (TILES) released an Issues Paper on 'Law Enforcement & Public Health' (LEPH). The Issues Paper invited responses from the Tasmanian community about using Collective Impact (as a possible, among others) approach for integrated service delivery and collaboration in law enforcement and public health issues (such as mental health, drug and alcohol use or addiction, violence, disease, road trauma, emergency and disaster management).[1]

In addition to the preparation of a Final Report, TILES initiated a series of consultations and workshops on collective impact and collaborative models.[2] The Collective Impact Workshop Series sought to transform research and discussions into action. The second workshop in the series, on which this report focuses, aimed to discuss and develop shared measures for collective impact approaches in law enforcement and public health. The workshop was held at the University of Tasmania on 01 October 2018.

Figure 1- Preconditions for Collective Impact.
Source: Kania and Kramer, 2011.

The workshop was attended by 18 stakeholders and included guest speakers from ForensiClinic, the Office of the Ombudsman, the Tasmanian Institute for Law Enforcement Studies and the University of Tasmania.

Attendees shared their insights and experiences regarding shared measures, data collection and information. Discussions revolved around what and how shared measures would work in a collective impact approach to law enforcement and public health.

This report summarises the intersecting themes discussed by panellists and participants and seeds a deeper conversation about the shared data and evaluation measures required for a collective impact approach in law enforcement and public health.

Collective Impact "is a framework to tackle deeply entrenched and complex social problems. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organisations and citizens to achieve significant and lasting

social change".[3] Various models for community change and vibrant service delivery exist throughout the world. There are several preconditions to design functioning collective impact approaches, as shown in Fig 1. Two of the three preconditions for successful Collective Impact collaborations, identified in previous studies[4] are noticeable in the Tasmanian context: a sense of urgency about the need for change, and influential champions. The third precondition – adequate financial resources – remains a local challenge but one that is inherently tied to the impetus for change.[5]

Linking Quality Data, Lived Experience and Developing Shared Measures

Sancia West from the University of Tasmania School of Rural Health opened the panel session by discussing the results of a mapping exercise, in which she identified initiatives, strategies and services that have directly involved Tasmania Police in the provision or promotion of public health. West found at least 33 initiatives intersected and noted that the greatest areas of overlap between agencies and services were in alcohol and drugs, youth and mental health.[6] Discussing law enforcement and public health as part of the World Health Organisation's social determinants of health[7], West also emphasised that the education level of a child's mother as a critical factor in determining that child's life trajectory in the first 12 months.[8] As a Registered Nurse, West also shared the difficult logistics of getting meaningful and integrated data about patients, particularly in the acute care setting. West suggested that linked and holistic information about someone's overall health would ensure that clinical staff would be able to respond to immediate care requirements, as well as be in a position to understand how patients ended up in hospital, and comprehensively assess ongoing health risk factors, if any.

West and the second speaker, Grant Blake, a Psychologist from ForensiClinic, both spoke of the challenges of obtaining medical histories and patient information, particularly where people are from outside the local, geographical jurisdiction. Both framed the even greater challenge in linking and sharing data between agencies. It was suggested by workshop participants that a life course approach[9] could be used as a starting point to bridge the nexus between public health and criminal justice, particularly for data used by frontline staff to create shared risk or advocacy profiles. Panellists and participants at this stage also discussed the importance of the lived experience of consumers to a full data set – which resonated with the third workshop presentation by Val Kitchener from the Office of the Ombudsman.

Blake identified challenges encountered by clinical psychologists when working with clients in the criminal justice system. Those challenges are due to data gaps, information silos and resource constraints. Blake acknowledged the tensions between an individual's right to privacy alongside the information practitioners need to make a proper assessment about that individual and public safety. A key part of Blake's contribution focused on the challenges of Tasmania's fitness to plead laws, data sharing between jurisdictions about health records or past offending, and the need for better criminogenic risk assessment tools in the justice system.

Val Kitchener then spoke about the fundamental human rights of mental health patients and the importance of bringing the notion of ***lived experience*** into law enforcement and public health evaluation methodologies. Kitchener highlighted the absence of a human rights charter in Tasmania, and indeed Australia, as a fundamental hurdle for people with mental illness interacting with police and health services. Kitchener suggested there was a lack of recognition within law enforcement and public health that people with mental illness are living and experiencing this illness 24/7, not just in business or service delivery hours. Referring to her research into lived experience methodology and her work as an Official Visitor with the Tasmanian Ombudsman, Kitchener stressed that the person engaging with health professionals and police as the expert in his or her own experience.[10] Kitchener concluded that lived experience and other qualitative data should be considered as valuable as quantitative data and that using that data effectively also required shared language.

Romy Winter from the Tasmanian Institute of Law Enforcement Studies (TILES) rounded out the panel session sharing insights across her experience in evaluation research. Winter emphasised the importance of clean and complete data, and place-based approaches to evaluation. She discussed the difference between outputs and outcomes, and the need not only to improve collection, entry, storage and linkages between data, but also to resource partnerships and agree

on shared language. Winter also talked about data gaps and missed opportunities, noting that while national minimum data sets are useful, these still do not give us a full picture. Winter called for greater education around how to collect, share and maintain quality data and for informing policy and operational practice in real time, or as quickly as possible.

Finding, Sharing and Using Data in Law Enforcement and Public Health

Participants were asked to work in smaller groups to answer the following questions about law enforcement and public health data that may inform a collective impact approach:

Questions Discussed at the Workshop

- What questions do we want answered?
- What is the best way to find out these answers?
- Who has data? What format is it in?
- What will we use as baseline data?
- What new measurements will be required?
- How will we share the data? What are the barriers for sharing data?
- What will we do with the data?

Responses suggested several major themes relating to shared measures. The lived experiences of both clients and practitioners were heavily discussed across tables. According to the "*There is nothing about us without us*" mantra, the need to include consumers and the qualitative insights of practitioners is paramount to any good evaluation and methodology protocol. A life course approach was the favourite angle to adopt, with a 'social-determinants of health' lenses useful, but not as robust as alternate life course measures. Participants agreed that clean, quality and linked data, collected ethically and underpinned by lived experience should be the basis for any collective impact approach. There was broad support for an action research project embedding social workers and other allied health workers with police.

An analysis of documents produced during the discussion sessions indicates that there are large LEPH data sets that could be used. Specifically, the baseline data sets such as the household survey, the ABS, the ASSAD, the IDRS, the EDRS, the NMDS and the PHT/outcomes were mentioned. It was also recognised that none of these are comprehensive (although they are as much as can be currently), in real time or well linked up together to provide a 'full picture' of cases. The conjunction of these databases also generates as many gaps as does redundancies.

One opportunity arose when a group of participants suggested a pilot project, which focused on police employing social workers to attend calls to violent incidents. The rationale, mimicking models of mental health crisis intervention teams in other jurisdictions[11], was to allow for immediate collaboration across services, and generate immediate better quality outcomes for police, improved legitimacy in law enforcement, and economic benefits across agencies due to better responses and outcomes. Social workers could be co-located with and employed by police but are not sworn officers (inter-disciplinary approach). Using clinical information in interviews and referral options as well as charges if and where appropriate.

As an ideal framework, participants agreed that place-based, rights focused, early intervention models to improve mental health, reduce family violence and prevent and address drug and alcohol addiction were all areas in which a collective impact approach between law enforcement and public health could be piloted. However, it was also noted that collective impact approaches, even if intended to address one 'pre-defined' problem, are in essence 'catch all' initiatives which are useful to unveil pre-existing issues, situations or conditions that need addressing, upstream of reactive approaches to social problems (see report 1).

As part of co-designing this approach, participants and stakeholders are invited to continue the conversation at the next workshop focused on 'Backbone Organisations' on Monday 15 October 2018 from 9am to 1pm in Room 460, Hytten Hall, University of Tasmania, Sandy Bay campus.

For further information about the TILES LEPH Collective Impact Workshop Series please visit - http://www.utas.edu.au/tiles/research/research-streams/law-enforcement-and-public-health or email leph.tiles@utas.edu.au.

References

Barker, D. J. (2007). The origins of the developmental origins theory. *Journal of internal medicine, 261*(5), 412-417.

Bartkowiak-Théron, I, Campbell D, Julian, R and Hughes, C, 'Law Enforcement and Public Health Issues Paper' November 2017 at http://www.utas.edu.au/__data/assets/pdf_file/0006/1047453/LEPH-Issues-Paper-2017-Final.pdf.

Bland, R., Tullgren, A. 2016. Lived Experience and Mental Illness in *Psychosocial Dimensions of Medicine* (ed. Fitzgerald, J., Byrne, G.) BPA Print Group, Melbourne.

Collaboration for Impact, (2017) available at http://www.collaborationforimpact.com/collective-impact/ accessed September 2018.

Edmonton Chamber of Voluntary Organisations (2016), "Edmonton's out of school time collaborative: Collective Impact in action", https://ecvo.ca/wordpress/wp-content/uploads/2016/04/OST- March2016-final.pdf.

Kania, J. and Kramer, M. (2011), "Collective Impact", Stanford Social Innovation Review, 9 (1).

Ko G, Shah P, Lee SK, Asztalos E. Impact of maternal education on cognitive and language scores at 18 to 24 months among extremely preterm neonates. Am J Perinatol. 2013;30(9).

Rodrigues MC, Mello RR, Silva KS, Carvalho ML. Risk factors for cognitive impairment in school-age children born preterm: application of a hierarchical model. Arq Neuropsiquiatr. 2012;70(8).

Scottish Government, Healthier Scotland, Mental Health Strategy: 2017-2027 accessed via https://beta.gov.scot/publications/mental-health-strategy-2017-2027/pages/10/ October 2018.

Voss W, Jungmann T, Wachtendorf M, Neubauer AP. Long-term cognitive outcomes of extremely low-birth-weight infants: the influence of the maternal educational background. Acta Paediatr. 2012;101(6).

Wang LW, Wang ST, Huang CC. Preterm infants of educated mothers have better outcome. Acta Paediatr. 2008;97(5).

Weisglas-Kuperus N, Hille ET, Duivenvoorden HJ, et al. Dutch POPS-19 Collaborative Study Group Intelligence of very preterm or very low birthweight infants in young adulthood. Arch Dis Child Fetal Neonatal Ed. 2009;94(3).

Web References

http://www.scotland.police.uk/whats-happening/news/2018/september/mental-health-street-triage-pilot-launched-govan

https://www.bbc.com/news/uk-scotland-glasgow-west-45434310

https://www.strivetogether.org/

Endnotes

[1] Bartkowiak-Théron, I, Campbell D, Julian, R and Hughes, C, 'Law Enforcement and Public Health Issues Paper' November 2017 at http://www.utas.edu.au/__data/assets/pdf_file/0006/1047453/LEPH-Issues-Paper-2017-Final.pdf.

[2] Julian R, Bartkowiak-Theron I, Hallam J, Hughes C, 'Exploring law enforcement and public health as a collective impact initiative: lessons learned from Tasmania as a case study', Journal of Criminological Research, Policy and Practice, 3, (2) ISSN 2056-3841 (2017).

[3] See further http://www.collaborationforimpact.com/collective-impact/.

[4] Edmonton Chamber of Voluntary Organisations (2016), "Edmonton's out of school time collaborative: Collective Impact in action", available at: https://ecvo.ca/wordpress/wp-content/uploads/2016/04/OST- March2016-final.pdf

[5] (http://www.collaborationforimpact.com/collective-impact/).

[6] Pending publication, Bartkowiak-Theron, I & West, S, Mapping Intersecting Responses: Law Enforcement and Public Health in Tasmania.

[7] See further the World Health Organisation definition at http://www.who.int/social_determinants/sdh_definition/en/

[8] The correlation between education levels and life trajectories is advanced by Barker, D. J. (2007). The origins of the developmental origins theory. *Journal of internal medicine, 261*(5), 412-417, Ko G, Shah P, Lee SK, Asztalos E. Impact of maternal education on cognitive and language scores at 18 to 24 months among extremely preterm neonates. Am J Perinatol. 2013;30(9):723–730, Voss W, Jungmann T, Wachtendorf M, Neubauer AP. Long-term cognitive outcomes of

extremely low-birth-weight infants: the influence of the maternal educational background. Acta Paediatr. 2012;101(6):569–573, Wang LW, Wang ST, Huang CC. Preterm infants of educated mothers have better outcome. Acta Paediatr. 2008;97(5):568–573, Weisglas-Kuperus N, Hille ET, Duivenvoorden HJ, et al. Dutch POPS-19 Collaborative Study Group Intelligence of very preterm or very low birthweight infants in young adulthood. Arch Dis Child Fetal Neonatal Ed. 2009;94(3): F196–F200 and Rodrigues MC, Mello RR, Silva KS, Carvalho ML. Risk factors for cognitive impairment in school-age children born preterm: application of a hierarchical model. Arq Neuropsiquiatr. 2012;70(8):583–589.

[9] See further Müller, A (Ed), World Health Organisation Regional Office for Europe 2018 Report, The life-course approach: from theory to practice. Case stories from two small countries in Europe, accessed via http://www.euro.who.int/en/health-topics/Life-stages.

[10] See further Bland, R., Tullgren, A. 2016. Lived Experience and Mental Illness in *Psychosocial Dimensions of Medicine* (ed. Fitzgerald, J., Byrne, G.) BPA Print Group, Melbourne.

[11] Such as those being used in Scotland, see further Scottish Government, Healthier Scotland, Mental Health Strategy: 2017-2027 accessed via https://beta.gov.scot/publications/mental-health-strategy-2017-2027/pages/10/ October 2018 and also https://www.strivetogether.org/ and recent media coverage regarding these approaches at http://www.scotland.police.uk/whats-happening/news/2018/september/mental-health-street-triage-pilot-launched-govan and https://www.bbc.com/news/uk-scotland-glasgow-west-45434310.