Trials

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Cross-agency working when conducting a pragmatic RCT for older victims of crime: our experiences and lessons learned

Marc Serfaty[1,2*], Jessica Satchell[1], Gloria K. Laycock[1], Chris R. Brewin[1], Marta Buszewicz[1], Gerard Leavey[3], Vari M. Drennan[4], Jonathan Cooke[5] and Anthony Kessel[6,7]

Abstract

Background With the population ageing, more victims of community crime are likely to be older adults. The psychological impact of crime on older victims is significant and sustained, but only feasibility trials have been published regarding potential interventions. The integration of public health and care services and cross-agency working is recommended, but there is little information on how this should be undertaken. Our recent Victim Improvement Package (VIP) randomised controlled trial (RCT) involved cross-agency collaboration between our university, a police service and a mental health charity. However, as the VIP trial only managed to recruit 131 out of 226 participants, we hope our reflections will help those wishing to conduct research in this population.

Methods The trial management group (authors) and partners organisations identified the challenges and lessons learned from conducting the VIP trial in which the police identified and screened victims of reported community crime, aged 65 years or over, for distress. In the VIP trial, three screening methods were used: (1) visits by safer neighbourhood teams (SNTs), (2) police telephone screening and (3) employment of a university researcher embedded within the police service. Staff from the mental health charity were trained to deliver a manualised cognitive-behaviourally informed Victim Improvement Package (VIP) to be compared against treatment as usual (TAU).

Lessons learned Factors promoting successful screening included simple IT systems, building rapport with the police and maintaining contact with participants. However, policy and staff changes within the police service and altered public confidence in the police compromised screening. The delivery of therapy was impaired by waiting times, therapist availability and the quality of therapy. Conducting research within an existing busy clinical service was challenging, but the COVID-19 pandemic demonstrated the acceptability and feasibility of offering online therapy to older victims.

Conclusion SNT screening was an effective way to identify distressed victims, but service demands question whether it is viable for working police staff and the delivery of the therapy proved challenging in the context of a traditional RCT. Ways in which to strengthen research in this pioneering area of work are discussed.

Keywords RCT, Police screening, Impact of crime, Older people, CBT delivery

*Correspondence:
Marc Serfaty
m.serfaty@ucl.ac.uk
Full list of author information is available at the end of the article

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General background

With the population ageing, more victims of community crimes are likely to be older adults [1]. Community crimes, which are those perpetrated by strangers or acquaintances [2], have been overlooked in older victim research compared with elder abuse or domestic violence (e.g. [3, 4]). Our recent systematic review [5] found that community crime has a significant impact on older victims, but only four feasibility intervention studies, 2 in the UK and 2 in the USA respectively, have been published to date addressing this problem [6–9].

Through feasibility and pilot work [6] in the UK, we found that home visits from police community support officers were more successful in identifying and engaging older victims in research (91%) than leaflets (5%) or telephone calls (37%) from the police or the charity Victim Support. We secured funding [NIHR-PHR; 13/164/32] to conduct a randomised controlled trial (RCT) testing the clinical and cost-effectiveness of a manualised cognitive behaviour therapy (CBT) informed Victim Improvement Package (VIP) for treating older victims with significant continued depressive and/or anxiety symptoms. This was undertaken in collaboration with a large police service and a mental health charity [10, 11]. Our secondary aim was to determine whether the police signposting patients to their general practitioner (GP) (family physician) for help was effective (reported in [12]).

The recent Health and Care Act [13] advocates the integration of public services with the NHS to improve public health. This includes recommendations that emergency services, such as the police, ensure the wellbeing of vulnerable adults is well managed. This recent Act has also allowed for greater input from non-traditional providers such as the voluntary sector [14]. Despite the impact of crime gaining recognition as a significant public health concern [15, 16], there is little information available about this approach in the context of older crime victims. In this article, we reflect on the successes and challenges of cross-agency working to support this population for the benefit of other researchers in the field.

VIP trial methods

The VIP trial was pre-registered on the ISCRTN registry (16929670) and approved by the University College London Research Ethics Committee (6960/001) on the 17th March 2016.

We briefly summarise the VIP trial here; for full details see Serfaty et al. [10]. An outline of the overall trial design is presented in Fig. 1.

> Step 1: Older victims were identified through the police crime reporting system and screened for depressive (PHQ-2) [17, 18] and/or anxiety (GAD-2) symptoms within 1–2 months of reporting a community crime. Older victims who scored above a cut-off of 2 or more on the GAD-2 and/or 3 or more on the PHQ-2 were considered to be significantly distressed. The police also collected sociodemographic data and obtained consent to data share with and contact from VIP researchers.
>
> Step 2: Older victims were rescreened at 3 months by VIP researchers using the same measures to determine whether they were still distressed. Those who were still distressed were assessed for their eligibility for the RCT and, if eligible, invited to participate.
>
> Step 3: An RCT compared the VIP plus treatment as usual (TAU) with TAU only for treatment of continued psychological distress in older victims of community crime aged 65 or over. The VIP intervention was delivered by a mental health charity.

Collaborating with the police

Background

Successful recruitment into the RCT component of the VIP trial (step 3) was contingent on the numbers screened by the police at step 1 of the trial. Our feasibility study [6] suggested that out of 120 victims screened as significantly distressed by the police, 26 would be suitable for a RCT trial. Our pre-power analysis indicated 226 people would be required for the VIP RCT [10]. Thus for 226 participants to be recruited, 1043 victims of crime would need be identified as significantly distressed by the police. Despite adapting screening by using three different screening approaches, we only managed to recruit 131 participants out of our target of 226. Changes in police leadership, major incidents (e.g. terrorist attacks, protests) and resource constraints posed challenges to police screening. Translation from screening to recruitment was also dependent on the screening method used. Our reflections aim to help those wishing to conduct research in this population.

Screening methods

- Method 1 (conducted between June 2017 and August 2019), police community support officers aimed to complete home visits with all older victims of community crime.
- Method 2 (conducted between May 2021 and June 2022), two police administrators screened victims over the telephone and tasked community support officers to complete home visits and consent only those found to be distressed.
- Method 3 (conducted between March 17th and 30th June 2023), a police administrator made initial

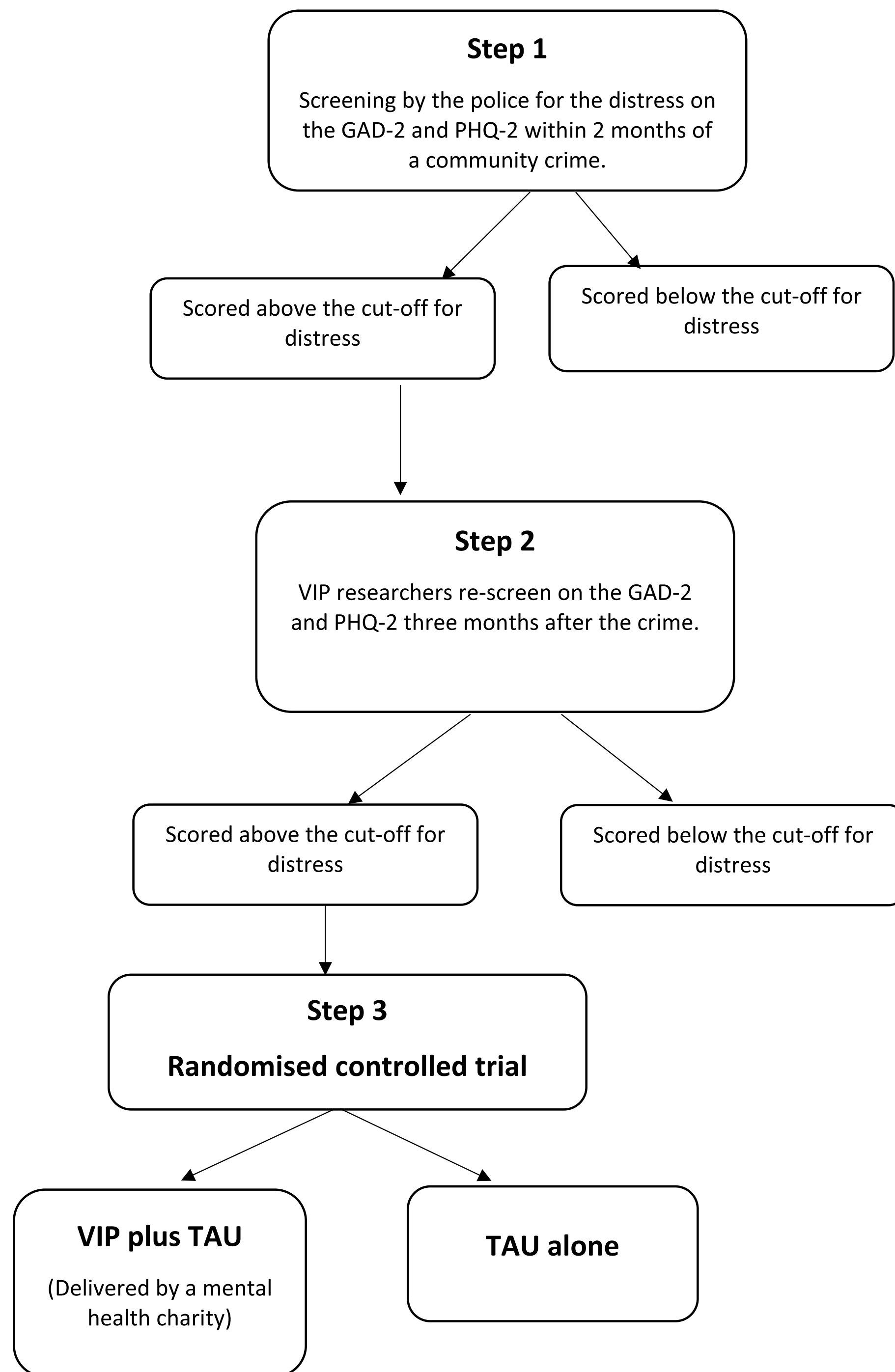

Fig. 1 Flowchart of the VIP trial design

telephone contact and with the victim's agreement, passed their details on to a VIP researcher embedded within the police. They provided information about the trial and then directed community support officers to undertake the home visits to those identified as distressed on telephone screening.

Screening results

- Under method 1: Of the 9391 crimes reported by older victims during this period, 32% (2915/9391) were successfully screened and demonstrated that 40% (1171/2915) scored above the cut-off for distress.

There were differences in screening rates across local authority areas due to varying levels of engagement by police teams, victim factors (such as not speaking English) and the interaction between the victims and the police which affected engagement (e.g. altered public confidence in the police).

- Under method 2: Of the 7680 crimes reported during this period, 17% (1340/7680) were successfully screened. There was a lower screen positive rate of 25% (334/1340) as the administrators only classed older victims as distressed if they scored above the distress cut-off and also agreed to a home visit from a community support officer.
- Under method 3: Of the 1566 crimes reported by older victims in this brief period, only 152 (10%) were successfully screened. Of these, 61 (40%) were screen positive, consistent with method 1. Of these, 27 (45%) agreed to a home visit from the police and were successfully consented and referred to the VIP team.

Our experience

Consistent with our feasibility study [6], home visits (method 1) were more effective at recruiting older victims into research than telephone contacts. The visiting community support officers fed-back that they often detected non-verbal signs of distress and were able to have a wider discussion on the impact of crime with older victims. However, police resource constraints, along with the COVID-19 pandemic, meant it was necessary to employ initial telephone screening to identify distress. This approach was well-received by the community support officers as it targeted their visits to the most vulnerable older victims. However, unlike with face-to-face visits, many victims did not answer the phone. Furthermore, successful screening was dependent on the quality of the interaction between an administrator and older victim. With only two screeners, screening and recruitment is very much determined by the skills of a limited number of screeners.

Method 1 also had the advantage of streamlining consent into a single point, whereas method 2 required older victims to consent over the telephone to home visits, and again to data-sharing during the visit. Method 3 required consent for the VIP researcher to speak to them, as well as to the visits and to data sharing. Each extra consent point and the gap between telephone calls and home visits increased the chances of attrition. This meant that, although methods 2 and 3 were a more effective use of police resources, they were a less effective use of research funding resources. Projections of the numbers telephone screened at step 1 using method 3 suggested that there would be insufficient numbers of victims referred for step 2 rescreening at 3 months. It was therefore jointly agreed with the funders to end screening and analyse those recruited through methods 1 and 2. This meant the trial was underpowered.

What worked well

Although we did not achieve our target sample size, our methods show that the police were able to use a screening tool to identify older victims in distress. We used four brief screening questions from the PHQ-2 [17, 18] and GAD-2 [19] to minimise demands on police time. Embedding screening into routine practice was feasible for officers and some valued this as a return to traditional community policing. Undertaking screening during SNT welfare visits was also consistent with Ministry of Justice guidelines to offer support for at-risk crime victims [20].

The police integrated their crime reporting system with an in-house software package which was used to send tasking requests to community support officers. This was effective at identifying our target population and could easily be adapted to focus on specific crime types and ensure screening was evenly spread across boroughs.

Challenges

Staff turnover

Our trial was overseen by the Commander for Community Policing, a role which is regularly rotated, and which meant we had eight different commanders over the course of the project. Each new commander required new relationships and a fresh agreement for the VIP trial. The commanders who recognised the value of our project ensured successful screening by providing the approvals we needed, delegating senior officers to oversee the screening, facilitating training and expanding study sites. However, commanders who did not recognise the value of our research delayed or suspended screening until a revised methodology was proposed.

Lesson learned 1 If staff across the police are to engage with a project, there needs to be good rapport and engagement from senior members of the police and researchers. We developed relationships with senior members through visits at police headquarters and with community support officers by accompanying them on home visits. To ensure continuity of study procedures across staff turnover, we recommend that a Memorandum of Understanding is agreed and signed-off at the highest level possible to avoid the need to repeatedly reach new agreements.

Major incidents

Several concurrent challenges (terrorist incidents, climate change protests, knife crime) required police community support officers to be diverted away from the project to assist ('abstraction'), causing delays to screening and obtaining participant consent. The COVID-19 pandemic during screening method 2 presented further challenges. Police administrators needed training on communicating with older victims and experienced absences due to sickness and lockdowns.

Lesson learned 2 Community support officers are under considerable pressure and service demands are routinely prioritised over research. Use of dedicated administrators within the police reduced the impact of abstraction on screening, but community support officers were still needed to obtain consent for the purpose of the research. Community support officer input needs to be ringfenced for the duration of a significant research project unless there are exceptional reasons to abstract the staff.

Policy changes

In the early phases of the trial, there was a general recognition that the police needed to do more to support older victims, and good practice guidelines advised officers to conduct needs assessments to identify those who were most vulnerable [21]. As our screening methods were compatible with policing priorities at this time, it was supported by senior leaders within the police, and screening gained momentum. An increase in knife crime attracted publicity shortly after the project began (e.g. [22]), which placed competing pressures on the police. Consequently, our project was considered less of a priority and screening was suspended. Although the police have recently committed to training officers in compassionate, evidence-based victim care [23], the extent the police should be involved in supporting people with mental health problems remains a topic of public interest [24]. Public pressure and media attention appears to influence policing priorities, their direction of resources and correspondingly their engagement with our research.

Lesson learned 3 Seeking to increase governmental and public awareness of the need for further research into the impact of crime is a long-term approach which may be promoted through supporting organisations for older people such as Age UK, Victim Support, and through articles in the public media [25]. Support from the victims' commissioner and the Mayors' Office, who fund some police services and were able to promote the project as a priority, was also welcomed.

Public confidence in the police

Major incidents concerning the police (e.g. the murder of George Floyd in the USA and Sarah Everard in the UK by serving officers) adversely impacted the reputation of the police. Concerns were also being raised about poor police response times and low conviction rates [26]. Our research thus took place at a time when public confidence in the police was especially low [27, 28] and this appeared to make it challenging for the officers involved in our trial to engage with older victims.

We conducted qualitative interviews and found that, although many older victims recognised the police were under considerable pressure, some participants felt there had been a lack of empathy from the officer they had contact with or that they had been dismissive during their initial crime report [29]. Some of the participants interviewed attributed their ongoing distress to feeling let down by initial police communication.

Lesson learned 4 Whilst it may not be realistic to immediately improve police response time and conviction rates, police training on empathic communication when handling crime reports could still help older victims and crime victims in general to feel heard and their distress acknowledged, which may be an important part of helping them to deal with the situation.

Representative samples of victims

We aimed to ensure that our population was representative of older victims. However, 60–70% of all crimes go unreported [30, 31]. Victims from ethnic minorities or with complex care needs may be less likely to report crime [32, 33], and older victims of property crimes may be more likely to report crime for insurance claims [34].

Lesson learned 5 As the integrated software package was effective at identifying our target population, this could be filtered to target groups known to be under-represented. Future researchers may also consider partnering with charities (e.g. Victim Support) alongside the police to identify older victims who have not reported their crime.

Collaborating with a mental health charity

Background

Health researchers are increasingly encouraged to conduct pragmatic RCTs, which involves testing interventions using existing services, so that they can be scaled-up if found to be effective [35]. We partnered with a mental health charity to delivery our therapy as the older victims in our feasibility study [6] found that this was more acceptable than traditional mental health services, and they operated in the same local authority areas

covered by our police screening. Older victims of crime consented and randomised to the VIP were then referred to the mental health charity for up to 10 sessions of an individually delivered CBT informed VIP. Details of the methodology are available in our published protocol [36].

Our experience

We trained 49 therapists to develop and apply their CBT skills to older victims. Many therapists welcomed the additional training and the feedback after the sessions indicated high satisfaction. The charity was able to deliver the therapy at no cost to the funders as they acknowledged that the participants would have potentially been accessing their services. We assessed satisfaction from participants who received the VIP [36] (Serfaty et al., in preparation) on a five-point scale (very unsatisfied to very satisfied). Satisfaction was 3.9/5 (SD = 1.5) (N = 43) and some participants requested therapy to continue after 10 sessions of the intervention had been delivered. Therapy was delivered remotely during the COVID-19 pandemic to ensure participants did not miss any sessions, and this was popular with participants even after lockdown restrictions were lifted.

What worked well

Therapists were enthusiastic about treating older victims of crime and offered therapy at no cost. Victims liked therapy being provided in a non-mental-health setting. They also fed back that remote online therapy was practical and minimised disruption to every-day living.

Challenges

Timely delivery of therapy

The charity was a federation, which meant that the head office had limited oversight of local services, and it underwent reconfiguration during the trial. It was therefore unclear who had overall responsibility for service delivery, resulting in delays for participants to receive therapy. Although we aimed for participants to be seen within 2 weeks of randomisation, some had not received their first session by the 6 months post crime follow-up and dropped out of the trial due to long waiting times. The charity's guidance was that during the COVID-19 pandemic therapy should continue to be delivered, but how it was delivered was changed during different stages of the pandemic, with an element of choice. Where requested, face to face therapy could be delivered using socially distancing procedures. The majority of participants (63.9%, 53/88) had their treatment delivered face to face, 33.1% (30/88) had therapy online and 5.6% (n = 5) had a combination of online and face to face therapy. It is important to note that prior to the COVID-19 pandemic, therapy was offered face to face, during the pandemic, online and only after this was a choice of face to face or online. Online delivery also meant that victims could be offered therapy more quickly by a different area, if they had capacity.

Lesson learned 1 We found that funding a single coordinator within the charity who could liaise with local services was helpful. They could also keep participants updated and arrange for them to be seen by a therapist outside their catchment area where convenient. For example, as therapy was delivered remotely during COVID-19, appointing therapists from alternative areas reduced wait times. The COVID-19 pandemic demonstrated that online therapies can be delivered and that older people can engage with technology [37]. Offers of online therapy should be routinely offered to enhance accessibility to treatment.

Quality of CBT delivered

We aimed to use therapists trained in CBT (BABCP accredited/accreditable), but in practice, although therapists described themselves as being able to deliver CBT, only 3 out of 49 therapists (6%) were formally accredited/accreditable (having undertaken a 2-year course in CBT and practised CBT for 2 years). The remainder were from a humanist background in their core psychotherapy training. Therapists completed a training day, face to face or online, for adapting their CBT skills to older victims of crime and fed-back that this training had increased their knowledge, skills and confidence with working with older victims. We also encouraged therapists to attend online supervision sessions delivered by MS (the chief investigator), up to twice monthly. As part of a measure of quality control for the research, therapists were also asked to upload recordings of their therapy sessions [38] on a secure website to be assessed for quality of using the Cognitive Therapy Rating Scale—Revised (CTS-R) [39]. Half of the therapy sessions delivered (110/221) were uploaded. A random selection of 15% of recordings (n = 16) of therapy sessions were independently rated using the CTS-R according to the trial protocol [36]. The mean CTS-R score was 15.8 (s.d. 16.3) which is well below the cut-off for competence of ≥ 36 [39]. Only two of the 16 ratings achieved competence [40] with CTS-R scores of 38 and 59.

Lesson learned 2 Although psychological therapies are often provided through the Improving Access to Psychological Therapies (IAPT) programme, this was not possible for the VIP trial as services reported already being over-burdened. The use of the voluntary sector is welcomed as part of an integrated care service, for as found in our feasibility work [41], older people welcome the

distancing of therapy from 'mental health' services. However, as our experience shows, the quality of the therapy needs to be strengthened, with close attention to ensuring that a high quality of CBT is delivered and that monitoring and supervision is fundamental to commissioning of services. Where research is concerned, independent therapists may therefore be better suited to delivering therapy under evaluation in an RCT. In a trial by Serfaty et al. [42], they found that independent therapists had greater flexibility, which ensured prompt provision of therapy, a high return rate of therapy recordings and clear deliverables. Whilst independent therapists may not be generalisable to public services, their use helps clarify whether an intervention works, before considering how it is best delivered within the constraints of community services.

Mode of delivery of therapy

The therapy was initially delivered in-person at community centres, but it was necessary to change this to online therapy in response to the COVID-19 pandemic. Although there were concerns about older victims' access to computers and ability to use them for remote therapy, the numbers of older people using the internet is growing [43].

Lesson learned 3 The COVID-19 pandemic demonstrated that, providing online therapies can be securely delivered, many older people can engage with technology [37]. However, social exclusion because of financial reasons remains a concern. Although we funded taxis for victims who were physically house-bound as part of our trial, in a realistic setting, those from poorer socio-economic backgrounds may not be able to afford the transport required, such as taxis, to attend a therapy centre. Furthermore, this group may not always have the means required for 1 h of therapy, delivered weekly, over the internet or telephone. Online therapy also has the disadvantage of allowing people to avoid leaving the house, which we know can occur after a crime [44] On balance, our first priority was to engage participants in therapy and they can then be encouraged to transition to face-to-face therapy if available later in the treatment.

Conclusions

Our research has provided insights into how to conduct research in a vulnerable population, whilst working with the police and the voluntary sector. The VIP trial has indicated that older victims of community crime experience considerable distress. Service demands posed challenges to the capacity to screen potential participants (and thus on recruitment) and to deliver therapy. The quality of the CBT intervention would need to be strengthened in future research to properly evaluate the efficacy of the VIP prior to determining how best to deliver it as part of a public healthcare service.

Raising public awareness about the significant impact of crime in older victims is timely and encouraging community support/police officers to use a screening tool within routine home visits offers an opportunity to quantify this need. However, community policing remains dependent on consistent leadership and is subject to public and media pressure on where and how resources should be directed.

The decision on how best to reduce distress in older crime victims requires further research. Although we remain enthusiastic about the potential of CBT, conducting a randomised controlled trial does not appear cost-effective in this hard-to-reach population. Single-case experimental design (SCED) studies may be more appropriate as they can achieve statistical power through repeat-testing smaller numbers of people [45]. Delivering therapy quickly and of high quality for the purposes of conducting an RCT using existing models of care is challenging. Though unpalatable to some, we would advocate considering the use of privately funded therapists to evaluate the efficacy of treatment. This may be the most cost-effective way of evaluating a particular therapy rather than conducting a pragmatic RCT.

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Authors' contributions
MS was CI and put together the concept of the VIP trial. MS, GKL, CRB, MB, GL, VMD and AK were involved in trial design. They plus JS and JC were involved in the running of the trial. TL and VV undertook the statistical analysis. All authors were involved in the interpretation of the results and write up.

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Data availability
As this is a lessons learned paper, the views expressed are those of the trial team. We however are keen to maintain anonymity of the services involved.

Declarations

Ethics approval and consent to participate
The VIP trial was registered with the University Data Protection Office on the 26th February 2016. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. All procedures involving human participants were approved by the UCL Research Ethics Committee on the 17th March 2016 (6960/001). Signed informed consent was obtained for all

participants. The International Standard Randomised Controlled Trial Number is ISRCTN16929670: https://doi.org/https://doi.org/10.1186/ISRCTN16929670.

Consent for publication
All the authors in this paper consented to publication. We have purposefully maintained anonymity of the services involved in this work.

Competing interests
The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Author details
[1]Division of Psychiatry, Department of Epidemiology and Applied Clinical Research, University College London, 6th Floor, Maple House, 149 Tottenham Court Road, London W1T 7NF, UK. [2]Priory Hospital North London, London, UK. [3]Bamford Centre for Mental Health & Wellbeing, University of Ulster at Belfast, Belfast, UK. [4]Centre for Applied Health & Social Care Research & School of Nursing, Allied and Public Health, Kingston University, London, UK. [5]PPI Member, London, UK. [6]Faculty of Public Health and Policy, London School of Hygiene & Tropical Medicine, London, UK. [7]NHS England and NHS Improvement London, London, UK.

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References

1. Kratcoski P, Edelbacher M. Perspectives on elderly crime and victimization in the future. In: Kury H, Redo S, editors. Crime prevention and justice in 2030: the UN and the Universal Declaration of Human Rights. Switzerland: Springer; 2021. p. 85–106.
2. World Health Organisation. The Violence Prevention Alliance: definition and typology of violence. World Health Organisation; [cited 2024 Aug 23]. Available from: https://www.who.int/groups/violence-prevention-alliance/approach#:~:text=Definition%20and%20typology%20of%20violence&text=This%20typology%20distinguishes%20four%20modes,to%20the%20victim%2Dperpetrator%20relationship.
3. Knight L, Hester M. Domestic violence and mental health in older adults. Int Rev Psychiatry. 2016;28(5):464–74.
4. Yunus RM, Hairi NN, Choo WY. Consequences of elder abuse and neglect: a systematic review of observational studies. Trauma Violence Abuse. 2019;20(2):197–213.
5. Satchell J, Craston T, Drennan VM, Billings J, Serfaty M. Psychological distress and interventions for older victims of crime: a systematic review. Trauma Violence Abuse. 2022;24(5):3493–512.
6. Serfaty M, Ridgewell A, Drennan V, Kessel A, Brewin CR, Leavey G, et al. Helping aged victims of crime (the HAVoC study): common crime, older people and mental illness. Behav Cogn Psychother. 2016;44(2):140–55.
7. Acierno R, Rheingold AA, Resnick HS, Stark-Riemer W. Preliminary evaluation of a video-based intervention for older adult victims of violence. J Trauma Stress. 2004;17(6):535–41. https://doi.org/10.1007/s10960-004-5803-y.
8. Tyra PA. Helping elderly women survive rape: using a crisis framework. J Psychosoc Nurs Ment Health Serv. 1996;34(12):20–5.
9. McGraw C, Drennan V. Assessing the needs of older burglary victims: a link nurse scheme. Br J Community Nurs. 2006;11(10):414–9.
10. Serfaty M, Aspden T, Satchell J, Kessel A, Laycock G, Brewin CR, et al. The clinical and cost-effectiveness of a Victim Improvement Package (VIP) for the reduction of chronic symptoms of depression or anxiety in older victims of common crime (the VIP trial): study protocol for a randomised controlled trial. Trials. 2020;21(1):333.
11. Serfaty M, Ohlin S, Blanchard M. Victim Improvement Package (VIP): a manual of cognitive behaviour therapy for Helping Aged Victims of Crime (HaVoC) with anxiety, depression and post-traumatic stress (therapists' version). London UC: Camden & Islington NHS Foundation Trust; 2013.
12. Serfaty M, Billings J, Vickerstaff V, Lee T, Buszewicz M, JKR. S. Help-seeking in older crime victims: mixed-method findings from the Victim Improvement Package trial in collaboration with the Metropolitan Police Service. PLOS Mental Health. 2024 1(3):e0000082. https://doi.org/10.1371/journal.pmen.0000082.
13. Health and Care Act. Integrated care partnerships. UK: UK Legisilation; 2022. Available from: https://www.legislation.gov.uk/ukpga/2022/31/part/1/crossheading/integrated-care-partnerships. Great Britain.
14. Kingstone T, Chew-Graham CA, Corp N. Interventions to identify and manage depression delivered by 'nontraditional' providers to community-dwelling older adults: a realist review. Health Expect. 2022;25:2658.
15. Tan S-Y, Haining R. Crime victimization and the implications for individual health and wellbeing: a Sheffield case study. Soc Sci Med. 2016;167:128–39.
16. Burnes D, Henderson CR, Sheppard C, Zhao R, Pillemer K, Lachs MS. Prevalence of financial fraud and scams among older adults in the United States: a systematic review and meta-analysis. Am J Public Health. 2017;107(8):e13–21.
17. Kroenke K, Spitzer R, Williams J. The Patient Health Questionniare-2: validity of a two-item depression screener. Med Care. 2003;41:1284–92.
18. Kroenke K, Spitzer RL, Williams JBW, Löwe B. The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: a systematic review. Gen Hosp Psychiatry. 2010;32(4):345–59.
19. Kroenke K, Spitzer RL, Williams JBW, Monahan PO, Löwe B. Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. Ann Intern Med. 2007;146(5):317.
20. Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services. The poor relation: the police and CPS response to crimes against older people. UK: Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services. [Published online: 2023 Mar 15]. Available from: https://hmicfrs.justiceinspectorates.gov.uk/publication-html/crimes-against-older-people/.
21. Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services. Understanding the difference: the initial police response to hate crime. UK: Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services.2018. p. 117. Available from: https://assets-hmicfrs.justiceinspectorates.gov.uk/uploads/understanding-the-difference-the-initial-police-response-to-hate-crime.pdf.
22. The Guardian. Surge in young knife deaths amid police cuts and 'a climate of fear'. The Guardian. 2018. [Cited 2024 Aug 23]. Availabe from: https://www.theguardian.com/uk-news/2018/nov/29/surge-in-young-knife-deaths-amid-police-cuts-and-climate-of-fear#:~:text=This%20year%20is%20on%20course,figures%20collated%20by%20the%20Guardian.
23. The Metropolitan Police Service. Turnaround plan 2023–2025. The Metropolitan Police Service. 2023. Available from: https://www.met.police.uk/SysSiteAssets/media/downloads/met/about-us/turnaround-plan.pdf.
24. The Guardian. Met police to stop attending emergency mental health calls. The Guardian. 2023. [Cited 2024 Aug 23]. Available from: https://www.theguardian.com/uk-news/2023/may/28/met-police-to-stop-attending-emergency-mental-health-calls.
25. iNews. Older crime victims remain depressed and anxious for months after incident. iNews. 2019 Aug 14. [Cited 2024 Aug 23]. Available from: https://inews.co.uk/news/health/old-crime-victims-depressed-anxious-trial-study-ucl-326270?srsltid=AfmBOoqgIfTr_X5OjSO29qVTNxC3oX0Zxne7N4HxWqX7rreb5WwE2Wr_.
26. Home Office, Office for National Statistics. Crime outcomes in England and Wales 2021 to 2022. 2022. [Cited 2024 Aug 23]. Available from: https://www.gov.uk/government/statistics/crime-outcomes-in-england-and-wales-2021-to-2022/crime-outcomes-in-england-and-wales-2021-to-2022.
27. The Metropolitan Police Service. The Baroness Casey review final report: an independent review into the standards of behaviour and internal culture of the Metropolitan Police Service. The Metropolitan Police Service. 2023. [Cited 2024 Aug 23]. Available from: https://www.met.police.uk/SysSiteAssets/media/downloads/met/about-us/baroness-casey-review/update-march-2023/baroness-casey-review-march-2023a.pdf.
28. The Police Foundation. A new mode of protection: re-designing policing and public safety for the 21st century. The Police Foundation. 2022. [Cited 2024 Aug 23]. Available from: https://www.policingreview.org.uk/wp-content/uploads/srpew_final_report.pdf.
29. West G, Satchell J, Ford P, Serfaty M. 'It's not like you're delivering Amazon packages': a qualitative study and thematic analysis exploring older victims' perspectives on how the police responded to their crime report. Policing J Policy Pract. 2024;18:paae042. https://doi.org/10.1093/police/paae042.

30. Buil-Gil D, Medina J, Shlomo N. Measuring the dark figure of crime in geographic areas: small area estimation from the Crime Survey for England and Wales. Br J Criminol. 2021;61(2):364–88.
31. MacDonald Z. Official crime statistics: their use and interpretation The Economic Journal; 2002. p. F85-F106.
32. McCart MR, Smith DW, Sawyer GK. Help-seeking among victims of crime: a review of the empirical literature. J Trauma Stress. 2010;23(2):198–206.
33. Youstin TJ, Siddique JA. Psychological distress, formal help-seeking behavior, and the role of victim services among violent crime victims. Vict Offenders. 2019;14(1):52–74.
34. Xie M, Baumer EP. Crime victims' decisions to call the police: past research and new directions. Annu Rev Criminol. 2019;2(1):217–40.
35. Patsopoulos NA. A pragmatic view on pragmatic trials. Dialogues Clin Neurosci. 2011;13(2):217–24.
36. Serfaty M, Aspden T, Satchell J, Kessel A, Laycock G, Brewin CR, et al. The clinical and cost-effectiveness of a Victim Improvement Package (VIP) for the reduction of chronic symptoms of depression or anxiety in older victims of common crime (the VIP trial): study protocol for a randomised controlled trial. Trials. 2020;21(1):333.
37. Hill R, Betts LR, Gardner SE. Older adults' experiences and perceptions of digital technology: (dis)empowerment, wellbeing, and inclusion. Comput Hum Behav. 2015;48:415–23.
38. Serfaty M, Shafran R, Vickerstaff V, Aspden T. A pragmatic approach to measuring adherence in treatment delivery in psychotherapy. Cogn Behav Ther. 2020;49(5):347–60.
39. Blackburn I-M, Garland A, James IA, Milne DL, Baker C, Reichelt FK, et al. The revised cognitive therapy scale (CTS-R): psychometric properties. Behav Cogn Psychother. 2001;29(4):431–46.
40. Branson A, Shafran R, Myles P. Investigating the relationship between competence and patient outcome with CBT. Behav Res Ther. 2015;68:19–26.
41. Serfaty M, Ridgewell A, Drennan V, Kessel A, Brewin CR, Leavey G, et al. Helping aged victims of crime (the HAVoC study): common crime, older people and mental illness. Behav Cogn Psychother. 2016;44(2):140–55.
42. Serfaty MA, Haworth D, Blanchard M, Buszewicz M, Murad S, King M. Clinical effectiveness of individual cognitive behavioral therapy for depressed older people in primary care. Arch Gen Psychiatry. 2009;66(12):1332.
43. Mace RA, Mattos MK, Vranceanu AM. Older adults can use technology: why healthcare professionals must overcome ageism in digital health. Transl Behav Med. 2022;12(12):1102–5.
44. Satchell J. Older victims of community crime: psychological impact and coping. Doctoral thesis. University College London. 2024. https://discovery.ucl.ac.uk/id/eprint/10192613/
45. Kazdin AE. Single-case experimental designs. Evaluating interventions in research and clinical practice. Behav Res Ther. 2019;117:3–17. https://doi.org/10.1016/j.brat.2018.11.015. Epub 2018 Dec 2. PMID: 30527785.

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Marc Serfaty Prof MS is a Consultant Psychiatrist and Professor of Psychotherapy Research and an accredited CBT therapist and Fellow of the BABCP. He has led or taken part in research in over 16 RCTs.

Jessica Satchell Dr JS has undertaken a Masters in Forensic Psychology and her PhD studied older victims of crime.

Gloria K. Laycock Prof GKL (OBE) is world expert in crime science and social policy. She has conducted extensive research into crime prevention and founded the Home Office Police Research Group and contributed to a wide range of policing and crime prevention topics and founded the Jill Dando Institute of Crime Science.

Chris R. Brewin Prof CRB is a psychologist and international expert in trauma and its impact. His world-renowned expertise on the cognitive processes underlying the symptoms and psychological impact of posttraumatic stress disorder has been invaluable.

Marta Buszewicz Dr MB is a GP and MRCPsych and clinical academic and who has advised UCLs clinical trials unit. She has also worked as primary care lead for mental health.

Gerard Leavey Prof GL is a social scientist and served as director of research in both England and Northern Ireland.

Vari M. Drennan Prof VMD (MBE) is from a nursing background and also an expert in social policy and advises on healthcare and policy. She has also conducted previous research on the impact of crime in older people and people with mental health problems.

Jonathan Cooke Dr JC is our PPI member who worked for many years in the MRC and provided invaluable insights into the day to day running of the VIP trial.

Anthony Kessel Prof AK is a public health physician who has contributed to the world knowledge of public health, environmental health and the medical humanities. He is a deputy director to NHS England on public health.