Hidden Harm Needs Assessment
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This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.
Executive summary

Hidden Harm is abuse or neglect experienced by a child or young person living with parents, carers or another adult because of that adult’s substance misuse or poor mental health, because of domestic abuse or because of a combination of these.

The adverse consequences for children experiencing Hidden Harm are multiple and cumulative and will vary according to the child’s stage of development. They include failure to thrive; blood-borne virus infections; incomplete immunisation and otherwise inadequate health care; a wide range of emotional, cognitive, behavioural and other psychological problems; early substance misuse and offending behaviour; and poor educational attainment (Drugs & Office 2003).

Suffolk County Council wants to ensure that it gives the optimum support to children and families experiencing Hidden Harm so as to minimise their distress and optimise their life chances. This report includes an assessment of their needs, along with those of young carers and of people affected by fetal alcohol spectrum disorder.

Most of Suffolk has low population density. There were 159,900 children aged 5 to 18 years in Suffolk in 2013. The proportion of children aged 0 to 14 years and adults aged 25 to 39 years is lower than in the East of England as a whole. Suffolk is more affluent than England; areas of greatest deprivation are concentrated in Ipswich and Lowestoft, with small pockets in the smaller towns in the County, including Bury St Edmunds, Felixstowe, Haverhill and Sudbury. Barriers to housing and services are a feature of deprivation in rural Suffolk and affect a large proportion of the population of the County.

The health and wellbeing of children in Suffolk is generally better than the England average, but educational attainment in the County lags behind the average for England.

Based on data from the General Lifestyle Survey (2012), estimation of prevalence of higher risk drinking is less common in Suffolk than the average for England. Fifty-one percent of the alcohol treatment population in Suffolk have no child contact, compared with 44% for the alcohol treatment population of England, a statistically significant difference. Possible explanations of this finding include that fewer parents in Suffolk have alcohol problems, or that parents entering alcohol treatment are less likely to live with a child or that people living with a child avoid going into treatment, perhaps fearing loss of contact with the child. Data suggest that at the time of this report the alcohol service in Suffolk may be less accessible to clients than the average in the East of England.

Rates of use of opiates and crack cocaine in Suffolk among people aged 15 to 64 years are considerably lower than for England. Ipswich, Suffolk Coastal and Waveney have the highest number of parental drug users. Suffolk has a higher percentage of self-referrals and fewer people reaching treatment
through the criminal justice system; this may reflect either a good level of accessibility of the service among the general public or under-referral from other services such as primary care. Suffolk has a significantly lower percentage of known drug users in treatment than the East of England region or England, and fewer pupils have taken drugs in Suffolk than in the East of England. However Suffolk is in the lowest quarter of local authorities for the proportion of young people in drug and alcohol treatment referred from children or family services, while the proportion referred from the criminal justice system was the highest in the region (46.9% compared with 31.6% for East of England).

Suffolk has lower risk factors for severe mental illness and lower rates of psychosis in adults than the East of England or England as a whole.

A lower proportion of Suffolk children and young people are known to be in need than in most other local authorities in the East of England, and England as a whole. Fewer suffer unintentional and deliberate injuries than the national average. Between April 2014 and May 2015, there were 4,736 Common Assessment Framework (CAF) referrals made to Suffolk County Council Children and Young People Services (SCC CYPS). Of these, 8257 risk factors were identified in the common assessment frameworks of children considered potentially at risk. Two thousand and ninety-three were related to domestic violence, 856 to drug misuse, 1033 to alcohol misuse and 1931 to mental illness within the household. In 429 cases, there was a young carer within the household. Acute stress, family dysfunction and abuse or neglect together accounted for 72% of children in need cases and 85% of child protection plans.

Suffolk County Council spends just over £600 million per year on services for children and young people. Almost 80% of these funds are for the delivery of core services, such as schools, early help and social care for children. Of the remainder, a little more is spent on prevention than on specific provision of services to those with Hidden Harm. Just over 3% of spending is allocated to administration and to strategic and business development.

Services for those affected by Hidden Harm are provided by statutory and third sector organisations. Programmes to prevent Hidden Harm and existing service approaches in Suffolk include:

- **Family Nurse Partnership**, providing support to pregnant women under 20 during their pregnancy and for the first two years after childbirth. There is a team based in Waveney and another in Ipswich.

- **Suffolk Family Focus**, providing support to families meeting Government criteria of troubled families.

- A range of services delivered by voluntary sector organisations. Both commissioned and independently provided.

- **MARAC (multi-agency risk assessment conference)** process for women at risk associated with domestic abuse
This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.

- A range of evidence based parenting support and programmes.
- Suffolk Positive Choices which aims to support women subject to Hidden Harm factors and who have had one or more children removed because of this
- Suffolk County Council Children’s Services has recently adopted the Signs of Safety approach to working with families and has apparently been appropriately implemented in the County. Early review has shown that families find it helpful and enabling.
- Suffolk County Council commissions their strategic partner Suffolk Family Carers to work with schools across Suffolk in the early identification of young carers and their onward referral as appropriate.
- School nurses use the framework of the national Healthy Child Programme to help meet the needs of young carers and those affected by Hidden Harm factors.

This report summarises evidence about the effectiveness of different approaches to identifying, preventing and managing Hidden Harm, emphasising the importance of early intervention. There is strong evidence for Family Nurse Partnerships and the troubled family programme as clinically and cost effective early interventions, whereas the evidence to support Signs of Safety is materially less reliable.

This report also considers fetal alcohol syndrome and summarises what is known about young carers in Suffolk.

This report attempted an economic analysis of Suffolk activity. In common with the country as a whole, the County has not published data to enable this, so no detailed analysis was possible.

Conclusions

Understanding the extent of Hidden Harm

It is difficult to be clear about the number of children and young people in Suffolk affected by Hidden Harm. The problem has only been recently defined and recognised, and is by definition hidden. There are few national data sources and local data are also sparse. This makes it hard to delineate the population at risk of, and damaged by, Hidden Harm, the first stage in understanding and meeting their needs.

Urban and rural differences

Information on Hidden Harm appears more readily available in urban areas than in rural parts of Suffolk. People in rural areas affected by Hidden Harm
may not come forward, or may find no services available if they do. This reflects a concentration of services in the County’s towns and especially in Ipswich.

Influences on outcomes

We found little analysis of which factors influence the outcome for neglected or abused children. It is believed that those affected by Hidden Harm need social care for longer than those whose needs arise for other reasons, but this has not been proven by the analysis of data. This means that decisions about individual children’s care is less well-informed and that resources are not demonstrably well-targeted.

Financial analysis

There is understandable uncertainty about the balance of expenditure between preventive interventions and programmes, and about how much is spent on people already affected by Hidden Harm. There are a number of reasons for this: lack of evidence as to the cost-effectiveness and payback from different ways of spending money, difficulties with understanding the exact nature of interventions and spending already in place and at whom they are aimed, and pressure to respond to children already at risk or affected, rather than divert resources upstream.

Effective services

Some conclusions can be drawn from the available literature about the prevention and treatment of Hidden Harm, e.g.

- Services are most effective when they are focused on the whole family, offering support for all family members and providing parents/carers with therapeutic support as well as training, skills and resources to improve their parenting.

- Services should be flexible enough to adapt to the emerging issues and needs of clients once they have started to engage. They need to be available for longer than six months, with the opportunity to extend that duration and to return for further support according to client needs.

- The most effective interventions are child-centred, meaning that they develop children’s social capital and extend children’s networks of support outside the immediate family. They are focused on the child’s safety and their ability to communicate outside the home.

- Services require strong leadership and management, and should work in partnership with adult services and universal services, particularly schools.

- Services should include elements which improve communication between parents/carers and children and which enable children to build networks of support with other adults in the community. Therapeutic
services and those offering youth groups and therapeutic group activities reduce children’s feelings of isolation and can help develop their resilience.

Recommendations

1. Service development to ensure support and interventions are provided equitably across the county.

- We recommend the extension of existing effective programmes so that they are available throughout the County. Awareness of Hidden Harm appears lower in rural parts of Suffolk, and preventive programmes and other interventions are more readily available, or only available, in Ipswich or other larger settlements. However, Hidden Harm occurs in all communities, and services need to reflect this.

- We recommend extending the implementation of programmes such as Family Nurse Partnership to women not able to access the programme at present because of geographical location or eligibility criteria. This could include, for example, all pregnant women with one or more of the Hidden Harm characteristics.

- We recommend that SCC maps the geographical access to services preventing and responding to Hidden Harm for children, young people and families, to identify where there are gaps and how this could be addressed so as to achieve equitable outcomes across the county.

2. Service development to ensure support and interventions are effective, based on evidence, research and practice based feedback.

- We recommend maintaining and further developing the school nurse teams as part of the work to provide support to those experiencing Hidden Harm. School nurses should be present in all schools, with time to provide a safe and trusted source of help to pupils and, where appropriate, parents.

- We recommend reviewing the interventions recommended in the Allen Report (2011), and mapping the interventions used in Suffolk to ensure that the optimum use is made of these well evidenced programmes.

- We recommend active implementation of the findings of the Suffolk Carers Needs Assessment: Young Carers and Young Adult Carers Supplementary Report, to include monitoring of progress, review of services using the intelligence from young people and front-line staff, and communicating the success of the available interventions, which will encourage young people to seek help. We also recommend that the Council's Adult and Children's
This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.
4. Establish a process for cost benefit analysis of interventions for Hidden Harm to inform service development and future commissioning.

- We recommend that Suffolk County Council analyses which factors about a child and his/her family influence their prognosis, in terms of duration of care, expenditure and eventual outcomes. This will enable better targeting of resources.

- We recommend that Suffolk County Council analyses its expenditure on Hidden Harm, to show the balance between prevention and treatment, how much is spent on specific programmes and the outcomes achieved.

5. Further develop and maintain data collection relating to Hidden Harm, across organisations and utilising audit to further understand the correlation between incidence, intervention and outcome.

- We recommend that Suffolk County Council maintains the level of data analysis presented in the report so that it can continue to monitor and identify trends and the impact of its policies.

- We recommend that Suffolk County Council assesses whether each at-risk child is affected by Hidden Harm, and if so, places them on a “Hidden Harm register”. Interactions with services including costs and outcomes could then be mapped and Hidden Harm evaluated more fully in future.

- We recommend that the predictive factors for Hidden Harm, including poverty, multiple disadvantage and ethnic and minority considerations are mapped across to population groups to enable proactive and preventive work with these families.

- We recommend further work to understand why some parents do not use alcohol services within the County and why such a high proportion leave treatment without completing it.
Hidden Harm Needs Assessment
Full Report

What is Hidden Harm? Why is it important for Suffolk?

Suffolk County Council identified Hidden Harm as an area of health and social care need that is currently not well understood and therefore where needs may not be adequately met. Hidden Harm is abuse or neglect experienced by a child or young person living with parents, carers or another adult as a result of that adult's substance misuse or poor mental health, of domestic abuse, or of a combination of these.

The adverse consequences for children experiencing Hidden Harm are multiple and cumulative and will vary according to the child’s stage of development. They include failure to thrive; blood-borne virus infections; incomplete immunisation and otherwise inadequate health care; a wide range of emotional, cognitive, behavioural and other psychological problems; early substance misuse and offending behaviour; and poor educational attainment (Drugs & Office 2003).

Children and young people living with a parent or carer suffering from a Hidden Harm factor may take on the role of young carer, further compounding the potential detrimental impact.

There is growing national and local concern that these children and young people are not receiving the support appropriate to their needs. Suffolk County Council established a stakeholder group to assess the extent of Hidden Harm as a first step to commissioning services to properly meet their needs.

This needs assessment will help identify where better data is needed to allow good commissioning of appropriate services. Included in this assessment are children and young people up to age 19 years, or where appropriate up to age 25. Those in the older age band include people with learning disabilities or young carers, who may remain in contact with services beyond age 18 where they and the person being supported agree.

The key groups reviewed were families with

- Substance (Drug and alcohol) misuse among adult family members
- Mental illness among adult family members
• Domestic abuse within families
• Young carers
• People affected by fetal alcohol spectrum disorder.

Which population is this needs assessment about?

This chapter reviews the size and growth of the resident population of Suffolk. Knowledge of the size, structure, past and future development of a population is fundamental to an understanding of its health and wellbeing.

Geography of Suffolk
Suffolk is a rural county in eastern England. It has borders with the counties of Cambridgeshire, Essex and Norfolk and a coastline facing the North Sea. Figure 1 shows a map of Suffolk, including geographical features and the boundaries of the local authority districts.

Figure 1: Map of Suffolk showing district council boundaries


Suffolk has seven local authority districts: Babergh, Forest Heath, Ipswich Borough, Mid Suffolk, St Edmundsbury, Suffolk Coastal and Waveney.

There are three clinical commissioning groups (CCGs) in Suffolk: Ipswich and East Suffolk CCG, West Suffolk CCG and Great Yarmouth and Waveney
CCG (part of which is in Norfolk) (Figure 2). The County has two acute hospitals: Ipswich Hospital and West Suffolk Hospital. The James Paget Hospital is based in Great Yarmouth but also services residents in the Waveney area.

Figure 2: CCG boundaries and hospitals, Suffolk

The largest urban areas in Suffolk are the county town of Ipswich and the towns of Bury St. Edmunds and Lowestoft. Elsewhere in Suffolk people live in smaller market towns and villages and in more isolated settlements in the countryside and along the coastline.

Demographic profile

Figure 3 shows that most of Suffolk has low population density, with even the towns not in general densely populated. The rurality of the County presents challenges to commissioners in ensuring effective and equitable services across the county.
Figure 3: Population density, Suffolk, 2015


Source: ONS; Suffolk Observatory

Table 1 shows the gender breakdown of all ages by local authority districts across the county. Across all local authority districts, the gender split is approximately 50:50.
Table 1: Estimated resident population by gender and local authority districts, Suffolk, 2013

<table>
<thead>
<tr>
<th></th>
<th>Males of all ages</th>
<th>Females of all ages</th>
<th>Persons of all ages</th>
<th>Persons of all ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>43,100</td>
<td>45,200</td>
<td>88,300</td>
<td>12.0%</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>30,700</td>
<td>30,600</td>
<td>61,200</td>
<td>8.3%</td>
</tr>
<tr>
<td>Ipswich</td>
<td>67,100</td>
<td>67,600</td>
<td>134,700</td>
<td>18.3%</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>48,500</td>
<td>49,500</td>
<td>98,000</td>
<td>13.3%</td>
</tr>
<tr>
<td>St. Edmundsbury</td>
<td>56,100</td>
<td>55,800</td>
<td>111,800</td>
<td>15.2%</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>60,700</td>
<td>63,700</td>
<td>124,400</td>
<td>16.9%</td>
</tr>
<tr>
<td>Waveney</td>
<td>56,400</td>
<td>59,600</td>
<td>116,000</td>
<td>15.8%</td>
</tr>
<tr>
<td><strong>Suffolk County</strong></td>
<td><strong>362,400</strong></td>
<td><strong>372,100</strong></td>
<td><strong>734,500</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Source: ONS 2013 mid-year population estimates

In 2013, the estimated population of Suffolk was 734,500 persons. The gender split across the county is fairly equal, with 49.4% of the population (362,400) being male and 50.6% (372,100) female.

Suffolk has more people in the 65 to 69 age band than other parts of the East of England region (Figure 4). The proportion of children aged 0 to 14 years and adults aged 25 to 39 years is lower than in the rest of the East of England.

Figure 4: Population structure, Suffolk and East of England, 2013

Source: Office for National Statistics
Table 2 shows the population of Suffolk County 2013.

**Table 2: Population of Suffolk, 2013**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Under 1</th>
<th>1 to 14</th>
<th>15 to 24</th>
<th>25 to 44</th>
<th>45 to 64</th>
<th>65+</th>
<th>All ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>4,000</td>
<td>59,700</td>
<td>42,800</td>
<td>87,800</td>
<td>95,500</td>
<td>72,500</td>
<td>362,400</td>
</tr>
<tr>
<td>Females</td>
<td>4,000</td>
<td>56,900</td>
<td>39,400</td>
<td>86,600</td>
<td>99,700</td>
<td>85,500</td>
<td>372,100</td>
</tr>
<tr>
<td>Persons</td>
<td>8,000</td>
<td>116,600</td>
<td>82,200</td>
<td>174,400</td>
<td>195,200</td>
<td>158,000</td>
<td>734,500</td>
</tr>
</tbody>
</table>

Source: ONS 2013 mid-year population estimates

Tables 3 and 4 below show the number of 5 to 18 year olds in Suffolk in 2013, and the percentage of the total population of all ages in the age bands 5 to 10 years, 11 to 15 years and 16 to 18 years. There were 117,400 children aged 5 to 18 years in Suffolk in 2013, of which 51.3% were male, and 48.7% were female.

**Table 3: Population aged 0 to 18 years by age and sex, Suffolk, 2013, numbers**

<table>
<thead>
<tr>
<th>Gender</th>
<th>0-4 years</th>
<th>5-10 years</th>
<th>11-15 years</th>
<th>16-18 years</th>
<th>All aged 0-18 years</th>
<th>All ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>21,700</td>
<td>25,400</td>
<td>21,100</td>
<td>13,800</td>
<td>82,000</td>
<td>362,400</td>
</tr>
<tr>
<td>Females</td>
<td>20,700</td>
<td>24,300</td>
<td>19,900</td>
<td>12,800</td>
<td>77,700</td>
<td>372,100</td>
</tr>
<tr>
<td>Persons</td>
<td>42,400</td>
<td>49,700</td>
<td>41,000</td>
<td>26,700</td>
<td>159,800</td>
<td>734,500</td>
</tr>
</tbody>
</table>

Source: ONS 2013 mid-year population estimates

Sixteen per cent of the County’s population was aged between 0 and 18 years in 2013 (Table 4).

**Table 4: Population aged 5 to 18 years by age and sex, Suffolk, 2013, proportions**

<table>
<thead>
<tr>
<th>Gender</th>
<th>0-4 years</th>
<th>5-10 years</th>
<th>11-15 years</th>
<th>16-18 years</th>
<th>All aged 0-18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>6.0%</td>
<td>7.0%</td>
<td>5.8%</td>
<td>3.8%</td>
<td>22.6%</td>
</tr>
<tr>
<td>Females</td>
<td>5.6%</td>
<td>6.5%</td>
<td>5.4%</td>
<td>3.5%</td>
<td>20.9%</td>
</tr>
<tr>
<td>Persons</td>
<td>5.8%</td>
<td>6.8%</td>
<td>5.6%</td>
<td>3.6%</td>
<td>21.8%</td>
</tr>
</tbody>
</table>

Source: ONS 2013 mid-year population estimates
In 2013, the proportion of 0 to 4 year olds in Suffolk was 0.5% less than in England and in the East of England, and the proportion of 0 to 9 year olds in the County was 1.1% below the East of England and England figures. In Suffolk, 12.3% of school children were from minority ethnic groups, much less than the East of England region which itself, at 20.9% has a far smaller proportion than England as a whole (27.8%). Life expectancy at birth for both boys and girls is above the regional and national figures.

Table 5: Numbers and proportions of children, Suffolk, East of England and England, 2012-14

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Suffolk</th>
<th>East of England</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live births</td>
<td>7,792</td>
<td>71,309</td>
<td>664,517</td>
</tr>
<tr>
<td>Children aged 0 to 4 years</td>
<td>42,500</td>
<td>373,400</td>
<td>3,414,100</td>
</tr>
<tr>
<td>Children aged 0 to 9 years</td>
<td>167,400</td>
<td>1,415,100</td>
<td>12,833,200</td>
</tr>
<tr>
<td>School children from minority ethnic groups, 2014</td>
<td>10,549 (12.3%)</td>
<td>155,800 (20.9%)</td>
<td>1,832,995 (27.8%)</td>
</tr>
<tr>
<td>Children living in poverty (age under 16 years), 2012</td>
<td>15.1%</td>
<td>15.9%</td>
<td>19.2%</td>
</tr>
<tr>
<td>Life expectancy at birth, 2011-2013</td>
<td>80.7 yrs</td>
<td>80.3 yrs</td>
<td>79.4 yrs</td>
</tr>
<tr>
<td>Life expectancy at birth, 2011-2013</td>
<td>84.1 yrs</td>
<td>83.8 yrs</td>
<td>83.1 yrs</td>
</tr>
</tbody>
</table>


Figure 5 below shows the ethnic composition of each local authority district and of Suffolk at the 2011 Census. Forest Heath and Ipswich Borough have more ethnically diverse populations compared with the other districts and with Suffolk.
For the non-white British ethnic groups, the district populations have some distinct characteristics (Table 6):

- Babergh has the highest proportion of Irish residents (11.9% of ethnicities other than White British).
- Suffolk Coastal has a higher proportion of Indian residents (10.1% of all non-white British) compared to 6% in the County as a whole.
- Ipswich has the highest proportion of mixed white and black Caribbean residents (11.3% of all non-white British), which is greater than that of the County, East of England and England.
- Gypsy or Irish travellers are more numerous in Mid Suffolk and Waveney districts.

Source: ONS 2011 census
This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.

Table 6: Proportion of ethnic groups other than white British by local authority district, Suffolk, 2011

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Babergh (%)</th>
<th>Forest Heath (%)</th>
<th>Ipswich (%)</th>
<th>Mid Suffolk (%)</th>
<th>St Edmundsbury (%)</th>
<th>Suffolk Coastal (%)</th>
<th>Waveney (%)</th>
<th>Suffolk (%)</th>
<th>East of England (%)</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladeshi</td>
<td>1.6</td>
<td>0.7</td>
<td>7.4</td>
<td>1.0</td>
<td>1.3</td>
<td>1.9</td>
<td>2.0</td>
<td>3.4</td>
<td>3.8</td>
<td>4.1</td>
</tr>
<tr>
<td>Chinese</td>
<td>4.0</td>
<td>0.8</td>
<td>2.9</td>
<td>4.0</td>
<td>3.1</td>
<td>6.1</td>
<td>6.3</td>
<td>3.2</td>
<td>3.9</td>
<td>3.5</td>
</tr>
<tr>
<td>Indian</td>
<td>4.4</td>
<td>2.2</td>
<td>7.9</td>
<td>4.3</td>
<td>6.1</td>
<td>10.1</td>
<td>3.7</td>
<td>6.0</td>
<td>10.1</td>
<td>13.0</td>
</tr>
<tr>
<td>Other Asian</td>
<td>6.2</td>
<td>4.6</td>
<td>5.9</td>
<td>6.6</td>
<td>6.9</td>
<td>7.1</td>
<td>6.6</td>
<td>6.0</td>
<td>6.8</td>
<td>7.6</td>
</tr>
<tr>
<td>Pakistani</td>
<td>0.2</td>
<td>1.0</td>
<td>1.1</td>
<td>0.4</td>
<td>1.3</td>
<td>1.5</td>
<td>1.2</td>
<td>1.0</td>
<td>7.7</td>
<td>10.4</td>
</tr>
<tr>
<td>African</td>
<td>3.3</td>
<td>2.7</td>
<td>4.5</td>
<td>4.1</td>
<td>4.6</td>
<td>3.5</td>
<td>4.3</td>
<td>3.9</td>
<td>8.1</td>
<td>9.1</td>
</tr>
<tr>
<td>Caribbean</td>
<td>2.2</td>
<td>1.3</td>
<td>6.8</td>
<td>3.2</td>
<td>2.7</td>
<td>2.7</td>
<td>2.1</td>
<td>3.8</td>
<td>3.9</td>
<td>5.5</td>
</tr>
<tr>
<td>Other Black</td>
<td>1.0</td>
<td>5.5</td>
<td>2.3</td>
<td>2.0</td>
<td>2.0</td>
<td>1.0</td>
<td>1.3</td>
<td>2.6</td>
<td>1.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Other Mixed</td>
<td>5.2</td>
<td>5.9</td>
<td>4.2</td>
<td>5.6</td>
<td>3.6</td>
<td>4.5</td>
<td>5.9</td>
<td>4.7</td>
<td>3.2</td>
<td>2.6</td>
</tr>
<tr>
<td>White and Asian</td>
<td>5.3</td>
<td>3.0</td>
<td>2.8</td>
<td>7.5</td>
<td>4.3</td>
<td>6.2</td>
<td>7.0</td>
<td>4.2</td>
<td>3.7</td>
<td>3.1</td>
</tr>
<tr>
<td>White and Black African</td>
<td>2.3</td>
<td>2.0</td>
<td>2.9</td>
<td>3.0</td>
<td>2.3</td>
<td>2.9</td>
<td>4.1</td>
<td>2.7</td>
<td>1.8</td>
<td>1.5</td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>7.5</td>
<td>2.0</td>
<td>11.3</td>
<td>7.8</td>
<td>4.2</td>
<td>6.2</td>
<td>7.9</td>
<td>7.1</td>
<td>4.3</td>
<td>3.9</td>
</tr>
<tr>
<td>Any Other Ethnic Group</td>
<td>3.1</td>
<td>3.9</td>
<td>4.3</td>
<td>2.2</td>
<td>1.9</td>
<td>2.1</td>
<td>2.3</td>
<td>3.3</td>
<td>2.1</td>
<td>3.1</td>
</tr>
<tr>
<td>Arab</td>
<td>0.2</td>
<td>0.1</td>
<td>0.7</td>
<td>0.2</td>
<td>0.8</td>
<td>0.7</td>
<td>0.2</td>
<td>0.5</td>
<td>1.2</td>
<td>2.1</td>
</tr>
<tr>
<td>Gypsy or Irish Traveller</td>
<td>1.3</td>
<td>0.8</td>
<td>0.7</td>
<td>1.9</td>
<td>0.8</td>
<td>0.7</td>
<td>1.9</td>
<td>0.9</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td>Irish</td>
<td>11.9</td>
<td>4.3</td>
<td>2.7</td>
<td>8.7</td>
<td>7.5</td>
<td>7.7</td>
<td>8.4</td>
<td>5.6</td>
<td>6.5</td>
<td>4.8</td>
</tr>
<tr>
<td>Other White</td>
<td>40.3</td>
<td>59.3</td>
<td>31.7</td>
<td>37.6</td>
<td>46.8</td>
<td>35.1</td>
<td>35.0</td>
<td>41.1</td>
<td>30.2</td>
<td>22.6</td>
</tr>
</tbody>
</table>

Source: ONS 2011 census

Population projections
Future trends in the demand for health services in Suffolk can be discerned by assessing recent trends in population growth and changes in population demographics over the last few years, and using that information to project the future population.
This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.

The population of Suffolk is increasing by about 0.5% per year. From 2014 to 2021, the County’s population is forecast to increase by four percent to 768,100.

Deprivation

Figure 7 shows the distribution of Index of Multiple Deprivation 2015 scores for lower super output areas in Suffolk. Areas of greatest deprivation are concentrated in Ipswich and Lowestoft with small pockets in the smaller towns in the County, including Bury St Edmunds, Felixstowe, Haverhill and Sudbury. Relatively high levels of deprivation affect some of the rural areas in the east of the County where access to services is poor. Variations exist in all areas, however. Not every person in a highly deprived area is deprived; equally, there will be some deprived people living in the more affluent areas.
In England, Index of Multiple Deprivation 2015 scores at LSOA level ranged from 0.48 (least deprived) to 92.6 (most deprived). The median score was 17.4. In Suffolk, IMD 2015 scores at LSOA level ranged from 2.03 to 84.6 (median: 15.6). These figures show that Suffolk is more affluent than England as a whole. A total of 11.8% (52/441) LSOAs in Suffolk fell into the 20% most deprived of LSOAs in England. These LSOAs were located mainly in the large towns: Ipswich, Lowestoft, Bury St Edmunds, Haverhill, Sudbury, Newmarket, Felixstowe, Beccles and in some parts of the rural areas, mainly in eastern Suffolk.

The Index of Multiple Deprivation provides a ranking of local authorities within regions where 1 is the most deprived. Ipswich is the most deprived local authority in Suffolk, and is ranked 87th out of 326 Local Authorities in England. Deprivation levels in Suffolk are lower than in Norfolk but higher than in Cambridgeshire, Essex and Hertfordshire.
Table 7: Deprivation rankings of local authorities, Suffolk, 2015

<table>
<thead>
<tr>
<th>Local authority (LA)</th>
<th>LA rank</th>
<th>Quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>200</td>
<td>Second best 20%</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>140</td>
<td>Middle 20%</td>
</tr>
<tr>
<td>Ipswich</td>
<td>74</td>
<td>Second worst 20%</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>239</td>
<td>Second best 20%</td>
</tr>
<tr>
<td>St. Edmundsbury</td>
<td>196</td>
<td>Second best 20%</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>220</td>
<td>Second best 20%</td>
</tr>
<tr>
<td>Waveney</td>
<td>95</td>
<td>Second worst 20%</td>
</tr>
</tbody>
</table>

Source: Department for Communities and Local Government

*Income deprivation* is the proportion of the population in an area experiencing deprivation from a low income. The number of income-deprived persons can be calculated for each LSOA in England by summing these indicators:

- Adults and children living in families receiving income support
- Adults and children living in families receiving income-based jobseeker’s allowance
- Adults and children living in families receiving pension credit
- Adults and children living in families receiving child tax credit but not income support, income-based jobseeker’s allowance or pension credit, and whose income excluding housing benefits is below 60% of median before housing costs
- Asylum seekers in England in receipt of subsistence support, accommodation support or both.
Income domain scores ranged from 0.02 (Mid Suffolk) to 0.47 (Waveney); the median was 0.09. Income deprivation is most prevalent in the large towns of Suffolk, although areas of rural Suffolk, particularly in the north-east of the County, were in the second most deprived quintile for income deprivation (Figure 8).

The IMD2015 barriers to housing and services domain measures the physical and financial accessibility of housing and local services (Figure 9). The domain indicators are divided into two sub-domains: geographical barriers, which relate to physical proximity of local services, and wider barriers, which include access to housing, including affordability. The geographical barriers sub-domain includes road distance to a GP surgery, a supermarket or convenience store, a primary school and a post office. The wider barriers sub-domain includes

- Household overcrowding: proportion of households within an LSOA judged to have insufficient space to meet the household’s needs
This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.

- Homelessness: rate of acceptances for housing assistance under homelessness provisions of the 1996 Housing Act (at local authority district level)

- Difficulty of access to owner-occupation (local authority district level): proportion of households aged under 35 years who have insufficient income to afford to enter owner-occupation.

**Figure 9: IMD2015 Barriers to Housing and Services domain by super output area, with ward and district boundaries, Suffolk**

In Suffolk, the IMD2015 barriers to housing and services domain scores at super output area level ranged from 2.15 (Suffolk Coastal) to 55.19 (St Edmundsbury). The median score was 21.24. Barriers to housing and services are a feature of deprivation in rural Suffolk and affect a large proportion of the population of the County. However, rural areas are affected by income deprivation as well, although poverty is less widespread there than in the large towns of the county.

**Childhood needs**

*Child poverty*
Child poverty means growing up in a household with low income and can be defined as children living in families that “lack the resources to obtain the types of diet, participate in the activities and have the living conditions and amenities which are customary, or are at least widely encouraged and approved, in the societies in which they belong” (Professor Peter Townsend 1973). Child poverty can affect physical, cognitive, social and cultural development and impact the life chances of children who experience it.

The health and wellbeing of children in Suffolk is generally better than the England average (Figure 10). The prevalence of child poverty in Suffolk is 15.1%, lower than the England average of 19.2%.

**Figure 10: Children living in poverty, East of England with Suffolk outlined, 2010**

Source: HMRC, Child Poverty Statistics

**Disability in children**

The number of disabled children in England is estimated to be between 288,000 and 513,000 (Thomas Coram Research Unit & Institute of Education, 2008), with an average in each local authority estimated to be between 3.0% and 5.4% (Parker 2000). If applied to the population of Suffolk this would equate to between 4,200 and 7,600 children experiencing some form of disability. The table below shows estimated numbers for mild disability. Children aged 0 to 4 years display lower prevalence than older children.
Table 8: Prevalence of long-standing illness or disability, children and young people, Suffolk, 2011

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>3,052</td>
<td>2,665</td>
</tr>
<tr>
<td>5-9</td>
<td>5,075</td>
<td>3,492</td>
</tr>
<tr>
<td>10-14</td>
<td>4,340</td>
<td>3,895</td>
</tr>
<tr>
<td>15-19</td>
<td>4,050</td>
<td>3,344</td>
</tr>
<tr>
<td>0-19</td>
<td>16,517</td>
<td>13,396</td>
</tr>
</tbody>
</table>

Source: National Child and Maternal Health Intelligence Network (ChiMat), ONS publication The health of children and young people, Chapter 10, Table 10.1, percentage with longstanding illness or disability applied to latest population for that age group

By contrast, estimates of severe disability are higher in children aged 0 to 4 years (Table 9).

Table 9: Prevalence of severe disability, children and young people, Suffolk, 2011

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>33</td>
<td>16</td>
</tr>
<tr>
<td>5-9</td>
<td>24</td>
<td>10</td>
</tr>
<tr>
<td>10-14</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>15-19</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>0-19</td>
<td>81</td>
<td>38</td>
</tr>
</tbody>
</table>

Source: unpublished analysis of Family Fund Trust statistics

Education
Suffolk County Council has long been aware that educational attainment in the County lagged behind the national average, and behind that of comparable places. League tables in 2010 and 2011 showed that Suffolk was in the bottom ten of 150 local education authorities for GCSE results, and third from bottom for primary school performance.

In 2012, the County Council established an improvement programme for schools called Raising the Bar and invested £2.4m to raise standards over the following two academic years.
Table 10 below shows that, while progress had been made since an Ofsted inspection in 2013, the County had still not reached the levels of schools in England, and remained the same number of percentage points behind. On the specific measure of the percentage of pupils achieving level 4b or above in reading and maths tests and level 4 or above in writing (teacher assessment) Suffolk in 2014 was 5 percentage points behind England’s schools, indicating that there are unresolved challenges in both primary and secondary schools in the County.

**Table 10: Performance at Key Stage 2, Suffolk, 2014**

<table>
<thead>
<tr>
<th></th>
<th>% achieving level 4 or above in reading, writing and maths</th>
<th>% achieving level 4b or above in reading and maths tests and level 4 or above in writing TA</th>
<th>% making expected progress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2013</td>
<td>2014</td>
</tr>
<tr>
<td>England - all schools</td>
<td>75%</td>
<td>75%</td>
<td>78%</td>
</tr>
<tr>
<td>England - state funded schools only</td>
<td>74%</td>
<td>75%</td>
<td>78%</td>
</tr>
<tr>
<td>Suffolk</td>
<td>68%</td>
<td>70%</td>
<td>74%</td>
</tr>
</tbody>
</table>

Source: Department for Education, School and college performance tables http://www.education.gov.uk/schools/performance/geo/la935_all.html

The results for secondary school pupils at GCSE are poorer than for England as a whole. In 2014, the last year for which figures were available, the gap between Suffolk and England as a whole had narrowed since 2011, but the proportion achieving at least five GCSE passes at grades A* to C (or equivalent) including English and maths GCSEs was still more than 1.5 percentage points lower in Suffolk than the wider Country (Table 11).

**Table 11: Performance at Key Stage 2, Suffolk and England, 2014**

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This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.

Suffolk schools experience greater overall absence of pupils than England as a whole (Table 12)

**Table 12: Pupil absence, maintained secondary schools, Suffolk and England, 2013-14**

<table>
<thead>
<tr>
<th></th>
<th>Overall Absence (%)</th>
<th>Persistent Absence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>England - all schools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>5.2</td>
<td>5.3</td>
</tr>
<tr>
<td>Suffolk</td>
<td>5.5</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Persistent absence is absence for more than 15% of school time.

Source: Department for Education, School and college performance tables
http://www.education.gov.uk/schools/performance/geo/la935_all.html

The link between poor school attendance and low attainment and the presence of Hidden Harm factors in the child’s home environment is well evidenced, as is the impact of services to prevent and respond to Hidden Harm in improving a child’s ability to attend, learn and achieve in their educational and home setting.
Factors underlying Hidden Harm: the toxic trio.

What data do we have?

Mental illness, domestic abuse and alcohol and drug misuse are the underlying causes of Hidden Harm. In this section, we review our current understanding of the prevalence of these factors and their effect on children and young people in Suffolk.

National and regional data

It is often assumed that problematic use of alcohol and particularly of drugs is associated with poverty and exclusion, but research examining the links in detail is relatively sparse. A recent review by the Joseph Rowntree Foundation reported that (Harkness 2012):

- 0.9% of adults in the UK are problem users of heroin or crack cocaine
- 3.8% are dependent on alcohol, some being problem users of both drugs and alcohol
- 250,000 benefit claimants are problem drug users (7% of claimants)
- 160,000 benefit claimants are dependent drinkers (4% of claimants).

Poverty, drug use and alcohol use are all complex social issues in their own right. Problem substance use can also lead to wider harm to others and to society. The research by the Joseph Rowntree Foundation highlights the importance of looking at the issue not solely in terms of an individual user but also at the effect on their family and society more widely.

Although relative poverty by itself is not the cause of drug problems, there is a strong association between the extent of drug problems and a range of social and economic inequalities. Narrowing these inequality gaps should contribute significantly to a reduction in high levels of damaging drug use. The Advisory Council for the Misuse of Drugs concluded in 1998 that, “while there is no correlation between whether people have ever tried illegal drugs (with the possible exceptions of heroin and crack cocaine) and deprivation, there is a clear link between problematic drug use and deprivation.”

This does not mean all problematic drug users come from deprived areas or backgrounds, though a disproportionate number do.

Alcohol misuse in adults

Table 13 below is taken from the 2012 General Lifestyle Survey using respondents answers to estimate prevalence of behaviours in the general population. Figures given in the Table would indicate that Mid Suffolk and Ipswich have the highest estimated percentages of people drinking at higher risk levels in Suffolk, but it should be noted that these are estimations only.

---

This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.

### Table 13: Prevalence of alcohol consumption in Suffolk, 2012

<table>
<thead>
<tr>
<th>District</th>
<th>Abstain (%)</th>
<th>Lower (%)</th>
<th>Increasing (%)</th>
<th>Higher (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>13.23</td>
<td>72.67</td>
<td>20.62</td>
<td>6.71</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>15.36</td>
<td>73.17</td>
<td>19.96</td>
<td>6.87</td>
</tr>
<tr>
<td>Ipswich</td>
<td>17.21</td>
<td>73.78</td>
<td>19.04</td>
<td>7.19</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>13.16</td>
<td>71.58</td>
<td>21.00</td>
<td>7.43</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>13.51</td>
<td>72.35</td>
<td>20.84</td>
<td>6.81</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>13.90</td>
<td>72.78</td>
<td>20.49</td>
<td>6.73</td>
</tr>
<tr>
<td>Waveney</td>
<td>15.14</td>
<td>74.00</td>
<td>19.31</td>
<td>6.69</td>
</tr>
</tbody>
</table>

Source: General Lifestyle Survey

Increasing risk drinkers are men who regularly drink more than 3-4 units a day (equivalent to a pint and a half of 4% beer) but less than twice this amount, or women who regularly drink more than 2-3 units a day (equivalent to a 175ml glass of 13% wine) but less than twice this amount. Higher risk drinkers are men who regularly drink more than eight units a day (equivalent to four pints of 4% beer) or 50 units a week, or women who regularly drink more than six units a day (equivalent to three 175ml glasses of 13% wine) or 35 units a week.

The prevalence of alcohol dependence (defined as a score of 16 or more on the Alcohol Use Disorders Identification Test (AUDIT) in adults in Suffolk is 3.8% [NHS Information Center 2007].

In Suffolk, 4% of adults are mildly alcohol dependent, 0.5% are moderately dependent and less than 0.1% severely dependent (Table 14).

### Table 14: Estimated prevalence of alcohol dependence, Suffolk, 2007

<table>
<thead>
<tr>
<th>Alcohol dependence</th>
<th>Prevalence (%)</th>
<th>Estimated number of people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>3.192</td>
<td>18,479</td>
</tr>
<tr>
<td>Moderate</td>
<td>0.532</td>
<td>3,079</td>
</tr>
<tr>
<td>Severe</td>
<td>0.076</td>
<td>439</td>
</tr>
</tbody>
</table>

Source: 2007 adult psychiatric morbidity survey(National Center for Social Research, University of Leicester 2007)

All local authorities in Suffolk have a lower prevalence of binge drinking than England as a whole. Rates are highest in Babergh and Forest Heath (Table 15).
Table 15: Estimated prevalence of binge drinking, Suffolk, 2012

<table>
<thead>
<tr>
<th>Local authority</th>
<th>Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>17.3</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>18.0</td>
</tr>
<tr>
<td>Ipswich</td>
<td>17.0</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>15.5</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>16.5</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>15.6</td>
</tr>
<tr>
<td>Waveney</td>
<td>15.5</td>
</tr>
<tr>
<td>England</td>
<td>20.0</td>
</tr>
</tbody>
</table>

Source: General Lifestyle Survey

In Suffolk, as elsewhere, alcohol-specific and alcohol-related admissions rose between 2008/9 and 2014/15, though the County’s prevalence is lower than its statistical neighbours (Shelton 2014). Among men, Forest Heath had the greatest number of months of life lost from alcohol misuse compared to the similar local authorities. All Suffolk districts apart from Forest Heath have shown rising alcohol-related violent crime, though only Ipswich has a level more than one standard deviation from the benchmark mean.

The number of people in alcohol treatment services in Suffolk was 826 in 2013/14 (a crude prevalence of 112 per 100,000 population) compared with 114,877 people for England (a crude prevalence of 216 per 100,000 population).

The Suffolk prevalence of people in alcohol treatment services is therefore less than half that of England, although indicators of alcohol-harm such as problem drinking and binge drinking show a smaller difference; for example, the prevalence of binge drinking is 16.5% in the County compared with 20% in England as a whole. Problem drinking in Suffolk is slightly less common than elsewhere in England, but treatment rates are less than half. It appears that many people who would be treated if they lived elsewhere in the UK may not receive treatment in Suffolk; this group is likely to include some parents of children and young people.

Table 16 shows the number of adults (some but not all of whom are parents) in alcohol treatment who live with children, parents in treatment not living with children, and those who are not parents.

Table 16: Adults in alcohol treatment by parental status and residence with children, Suffolk and England, 2013/14

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2 Prevalence’s calculated for this report from figures from the Alcohol JSNA support pack (Shelton 2014) and the ONS report: Overview of the UK Population (ONS 2015)
This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.

### Category of parental status and residence

<table>
<thead>
<tr>
<th>Category of parental status and residence</th>
<th>Number</th>
<th>Proportion in treatment (%)</th>
<th>M/F split (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Living with children (own or other)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suffolk</td>
<td>199</td>
<td>24%</td>
<td>17:34</td>
</tr>
<tr>
<td>England</td>
<td>31,360</td>
<td>27%</td>
<td>22:36</td>
</tr>
<tr>
<td><strong>Parents not living with children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suffolk</td>
<td>193</td>
<td>23%</td>
<td>27:17</td>
</tr>
<tr>
<td>England</td>
<td>30,631</td>
<td>27%</td>
<td>28:24</td>
</tr>
<tr>
<td><strong>Not a parent and/or no child</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suffolk</td>
<td>424</td>
<td>51%</td>
<td>54:47</td>
</tr>
<tr>
<td>England</td>
<td>50,887</td>
<td>44%</td>
<td>47:39</td>
</tr>
</tbody>
</table>

Source: Alcohol data: JSNA support pack (Shelton 2014)

It is notable that 51% of the alcohol treatment population in Suffolk have no child contact, compared with 44% for the alcohol treatment population of England, a statistically significant difference. Possible explanations of this finding include that fewer parents in Suffolk have alcohol problems, that parents entering alcohol treatment are less likely to live with a child, or that people living with a child avoid going into treatment, perhaps fearing loss of contact with the child.

Among the population of Suffolk with known alcohol misuse and in treatment, approximately 4% were also using opiates or crack (the same as the England average), 13% were using cannabis (England average 10%) and 12% were using other drugs (England average 10%).

Figure 11 shows alcohol misuse indices for Suffolk compared to East of England region.
Figure 11 indicates that:

- Suffolk had 725 adults in alcohol treatment who were parents, 48% of the total of those in treatment and the lowest in the East of England.
- Suffolk had the lowest percentage of adults in alcohol treatment who self-referred (34.5%); the average in the East of England was 53%.
• It is also notable that 415 people (37%) of those in treatment in Suffolk made an unplanned exit from that treatment, where the best in the East of England region was 14%.

• Only 2.3% in Suffolk received inpatient alcohol detoxification, the lowest figure in the East of England; the average was 5.8%.

These figures indicate concerns about alcohol treatment services within Suffolk. Those affected by these apparent problems in access to high quality alcohol treatment services are likely to include some parents, although the specific figures for parents or people living with children are not available. Since the data reported here were gathered, a new integrated drugs and alcohol service has been commissioned and begun delivering services which will be monitored for their effectiveness in improving the above findings.

Figure 12 shows the number of adults in contact with drug and alcohol treatment services categorised by co-residence with children in the East of England (Health et al. 2007). It indicates that most alcohol and drug service clients either are not a parent or, if they are, do not live with a child.

**Figure 12: Adults in contact with drug and alcohol treatment services by co-residence with children, East of England, 2012/13 and 2013/14**

![Graph showing number of adults in contact with drug and alcohol treatment services by co-residence with children, East of England, 2012/13 and 2013/14](source: NDTMS East reporting outputs 9/10/14)

Figure 13 shows Suffolk residents in drug and alcohol treatment services who live with children according to local authority. It shows that Ipswich, Suffolk...
Coastal and Waveney have the highest number of parental drug users and the numbers are lower in 2012/13 compared to 2011/12 for all three council areas. Although Suffolk Coastal is in the top three authorities for drug service use by parents, it has one of the lowest figures in Suffolk for alcohol service use by parents. Since drug and alcohol misuse are correlated, this may indicate unmet need in Suffolk Coastal alcohol-misusing parents.

**Figure 13: Numbers of people with children living at home in treatment 2011/12 and 2012-13, by local authority of residence**

These data suggest that the alcohol service in Suffolk may be less accessible to clients than the average in the East of England. Suffolk appears to retain clients less well too. The data suggest that people with children may avoid treatment for fear of losing the right to contact with their children if they present to the service. There is relatively little inpatient detoxification available in Suffolk.

**Drug misuse in adults**

Rates of use of opiates and crack cocaine in Suffolk among people aged 15 to 64 years are considerably lower than for England (Table 17). This may be due to under-counting or may reflect local substance availability, drug culture, enforcement and/or price.

---

This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.
Table 17: Prevalence estimates for substance misuse, rates per thousand, Suffolk and England, 2011-12

<table>
<thead>
<tr>
<th>Category of misuse</th>
<th>Suffolk</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate and/or crack use</td>
<td>5.22</td>
<td>8.4</td>
</tr>
<tr>
<td>Opiates alone</td>
<td>4.66</td>
<td>7.32</td>
</tr>
<tr>
<td>Crack alone</td>
<td>2.13</td>
<td>4.62</td>
</tr>
<tr>
<td>Injecting</td>
<td>1.97</td>
<td>2.44</td>
</tr>
</tbody>
</table>

Source: Drug Data JSNA Support Pack 2015

Suffolk has reported treatment proportions similar to those of England (Table 18: Proportion of known substance users).

Table 18: Proportion of known substance users treated, Suffolk and England, 2014

<table>
<thead>
<tr>
<th>Treatment penetration</th>
<th>Suffolk</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate and/or crack use</td>
<td>54%</td>
<td>53%</td>
</tr>
<tr>
<td>Opiates alone</td>
<td>59%</td>
<td>60%</td>
</tr>
<tr>
<td>Crack alone</td>
<td>41%</td>
<td>39%</td>
</tr>
<tr>
<td>Injecting</td>
<td>54%</td>
<td>54%</td>
</tr>
</tbody>
</table>

Source: Drug Data JSNA Support Pack 2015

The routes into drug treatment appear to differ in Suffolk compared to England as a whole. Suffolk has a higher percentage of self-referrals (57% versus 43%), while fewer people reach treatment through the criminal justice system (29% versus 32%). Self-referrals may reflect either a good level of accessibility of the service among the general public or else under-referral from other services such as primary care.

Suffolk has a significantly lower percentage of known drug users in treatment than East of England region or England as a whole (Figure 14).
Figure 14: Adults in treatment at specialist drug misuse services: crude rate per 1000 population, Suffolk, East of England and England, 2013/14

<table>
<thead>
<tr>
<th>Area</th>
<th>Count</th>
<th>Value</th>
<th>95% Lower CI</th>
<th>95% Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>193,252</td>
<td>5.0</td>
<td>5.0</td>
<td>5.0</td>
</tr>
<tr>
<td>East of England region</td>
<td>15,342</td>
<td>3.6</td>
<td>3.6</td>
<td>3.7</td>
</tr>
<tr>
<td>Bedford</td>
<td>583</td>
<td>5.2</td>
<td>4.8</td>
<td>5.7</td>
</tr>
<tr>
<td>Cambridgeshire</td>
<td>1,510</td>
<td>3.3</td>
<td>3.1</td>
<td>3.5</td>
</tr>
<tr>
<td>Central Bedfordshire</td>
<td>480</td>
<td>2.5</td>
<td>2.3</td>
<td>2.8</td>
</tr>
<tr>
<td>Essex</td>
<td>3,090</td>
<td>3.1</td>
<td>3.0</td>
<td>3.2</td>
</tr>
<tr>
<td>Hertfordshire</td>
<td>2,518</td>
<td>3.1</td>
<td>3.0</td>
<td>3.3</td>
</tr>
<tr>
<td>Luton</td>
<td>950</td>
<td>6.6</td>
<td>6.2</td>
<td>7.1</td>
</tr>
<tr>
<td>Norfolk</td>
<td>2,437</td>
<td>3.9</td>
<td>3.8</td>
<td>4.1</td>
</tr>
<tr>
<td>Peterborough</td>
<td>1,010</td>
<td>7.7</td>
<td>7.2</td>
<td>8.2</td>
</tr>
<tr>
<td>Southend-on-Sea</td>
<td>842</td>
<td>6.8</td>
<td>6.4</td>
<td>7.3</td>
</tr>
<tr>
<td>Suffolk</td>
<td>1,487</td>
<td>2.9</td>
<td>2.7</td>
<td>3.0</td>
</tr>
<tr>
<td>Thurrock</td>
<td>425</td>
<td>3.8</td>
<td>3.4</td>
<td>4.1</td>
</tr>
</tbody>
</table>

Source: National Drug Treatment Monitoring System

Figure 15 provides information on adult substance misuse in Suffolk. A lower proportion of Suffolk drug users in treatment live with children compared with England and significantly less than East of England (17.6% versus 28%). By contrast, Suffolk has a greater percentage of adults in drug treatment who are not a parent or have no contact with their child. This may indicate that a number of parents misusing drugs are not coming forward for treatment, suggesting that Suffolk should review routes of referral and access to services and encourage people to use those services, for example by making services more readily accessible.

The numbers of adults in drug treatment who self-refer was the highest in the region, (55.2% versus an average of 48.2%), in contrast to adults in alcohol treatment services. This may suggest that either confidence in the service is high in Suffolk or that outreach services are particularly effective. However, unplanned exits from services are the highest in East of England.
This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.

Alcohol and substance misuse in children and young people

The adverse consequences for children experiencing Hidden Harm can include early substance misuse and offending behaviour, and poor educational attainment (Drugs & Office 2003).

Data for Suffolk on alcohol and substance misuse in children and young people are available in the 2013 Young People Substance Misuse Needs Assessment, (http://www.healthysuffolk.org.uk/assets/JSNA/Suffolk-YP-needs-assessmentv1.0Feb2014.pdf). According to a national survey in 2012, the proportion of pupils who drank alcohol was lower in London than...
elsewhere in England; 31% of pupils in London had ever drunk alcohol, and 7% had drunk it in the last week. Outside London, the proportion of pupils who had ever drunk alcohol ranged from 36% in the West Midlands to 51% in the North East, and the same pattern was seen for drinking alcohol in the last week. In the East of England, the figures are 47% and 10%, similar to England as a whole (Health and Social Care Information Centre 2013). Children and young people consuming alcohol may be at risk of Hidden Harm, but these data are only available at national level.

There was little variation by region in the proportions of pupils who had taken drugs in the last year or the last month. In the East of England, 17% of pupils had taken drugs and 11% had done so in the past year.

The proportion of pupils who had ever smoked varied across regions from 22% in London and the East and West Midlands to 30% in the North East. The proportion of pupils who said that they smoked at least one cigarette a week varied from 3% to 6%. The figures for the East of England were 24% and 4% respectively.

Figure 16 shows that fewer pupils have taken drugs in Suffolk than in the East of England (5% compared with 8.8%); indeed, the County had the lowest figure in the region. School exclusions for substance misuse in Suffolk were also lower than the regional average (2.0% compared with 3.1%). The number of young people in drug or alcohol treatment in 2012/13 was 184, 2.4% of population, compared with 2.5% for the East of England overall.
Figure 16: Drug and alcohol misuse profile in under 18s, Suffolk, 2012/13

Figures for Suffolk in this domain are either better than or similar to the average compared to local comparators. However Suffolk was among the lowest quarter of local authorities for the proportion of young people in drug and alcohol treatment referred from children or family services (29.1% compared to 38.5% for East of England). This has been a consistent trend over several years. The proportion referred from the criminal justice system was the highest in the region (46.9% compared with 31.6% for East of England).

Referral from child and family services is a route to services particularly applicable to children at risk of Hidden Harm, so low levels of referral may indicate a missed opportunity for appropriate and timely support for children either because children who are engaged with child services are not being referred or else children with substance misuse problems have not come to the notice of children’s services in Suffolk. That a high proportion of referrals
come from the criminal justice system suggests that an important opportunity is being missed to avert escalating harm relating to the onset of criminal activity and subsequent interaction with the criminal justice system. However, it may also reflect the service provision of having young people substance misuse workers co-located with the youth offending Service, thereby facilitating timely referral.

In Suffolk, under 18s hospital admissions attributed to alcohol fell between 2009 and 2013. Most districts had lower admission rates compared to statistical neighbours apart from Waveney where, despite falling over several years, the level remains high compared to the benchmark.

### Mental illness in adults

Table 19 shows incidence estimates for psychosis, the most severe form of mental illness. Suffolk has lower rates than the East of England, and is statistically significantly lower than England as a whole (18.4 per 100,000 population compared with 19.9 and 24.2 per 100,000 respectively. The rate is third lowest among the eleven East of England local authorities.

**Table 19: Estimated incidence of new cases of psychosis per 100,000 aged 16-64, Suffolk, East of England and England, 2011**

<table>
<thead>
<tr>
<th>Area</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>24.2*</td>
<td>23.8</td>
<td>24.7</td>
</tr>
<tr>
<td>East of England</td>
<td>19.9*</td>
<td>19.3</td>
<td>20.0</td>
</tr>
<tr>
<td>Bedford</td>
<td>22.4*</td>
<td>21.5</td>
<td>23.4</td>
</tr>
<tr>
<td>Cambridgeshire</td>
<td>20.2*</td>
<td>19.4</td>
<td>21.0</td>
</tr>
<tr>
<td>Central Bedfordshire</td>
<td>17.6*</td>
<td>16.7</td>
<td>18.6</td>
</tr>
<tr>
<td>Essex</td>
<td>17.9*</td>
<td>17.0</td>
<td>18.8</td>
</tr>
<tr>
<td>Hertfordshire</td>
<td>20.4*</td>
<td>19.5</td>
<td>21.4</td>
</tr>
<tr>
<td>Luton</td>
<td>36.0*</td>
<td>34.5</td>
<td>37.5</td>
</tr>
<tr>
<td>Norfolk</td>
<td>16.0*</td>
<td>14.8</td>
<td>17.2</td>
</tr>
<tr>
<td>Peterborough</td>
<td>23.8*</td>
<td>22.6</td>
<td>25.0</td>
</tr>
<tr>
<td>Southend-on-Sea</td>
<td>21.2*</td>
<td>20.2</td>
<td>22.3</td>
</tr>
<tr>
<td>Suffolk</td>
<td>18.4*</td>
<td>17.4</td>
<td>19.4</td>
</tr>
<tr>
<td>Thurrock</td>
<td>22.3*</td>
<td>21.4</td>
<td>23.3</td>
</tr>
</tbody>
</table>

Figure 17 shows information about the incidence and prevalence of mental illness from the three CCGs in Suffolk, and comparators from elsewhere in the East of England. The population of West Suffolk appears to have better mental health than average for the region, whereas Ipswich and East Suffolk are closer to average. Mental illness appears more common than average in Great Yarmouth and Waveney, though this CCG has a substantial population of Norfolk residents.
Figure 17: Incidence and prevalence of mental illness, East of England CCGs, 2012/13

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>England</th>
<th>East NHS region</th>
<th>NHS Basildon And Brentwood And…</th>
<th>NHS Cambridge And…</th>
<th>NHS Castle Point And Ro…</th>
<th>NHS Great Yarmouth And…</th>
<th>NHS Ipswich And East Su…</th>
<th>NHS Mid Essex CC…</th>
<th>NHS North East Essex CC…</th>
<th>NHS North Norfolk CCG</th>
<th>NHS Southend CCG</th>
<th>NHS South West Essex CCG</th>
<th>NHS West Norfolk CCG</th>
<th>NHS West Suffolk CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression: QOF prevalence (18+)</td>
<td>2012/13</td>
<td>5.8</td>
<td>6.7</td>
<td>5.6</td>
<td>4.9</td>
<td>6.7</td>
<td>6.4</td>
<td>4.4</td>
<td>5.7</td>
<td>4.8</td>
<td>5.5</td>
<td>6.0</td>
<td>5.3</td>
<td>6.6</td>
<td>5.8</td>
</tr>
<tr>
<td>Depression: QOF incidence (18+)</td>
<td>2012/13</td>
<td>1.0</td>
<td>1.6</td>
<td>1.0</td>
<td>1.2</td>
<td>1.2</td>
<td>1.0</td>
<td>0.7</td>
<td>1.1</td>
<td>0.8</td>
<td>1.2</td>
<td>1.8</td>
<td>1.3</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Depression and anxiety prevalence (GP survey)</td>
<td>2012/13</td>
<td>12.0</td>
<td>11.1</td>
<td>11.7</td>
<td>10.0</td>
<td>10.0</td>
<td>11.3</td>
<td>11.3</td>
<td>10.7</td>
<td>11.0</td>
<td>10.0</td>
<td>10.0</td>
<td>10.0</td>
<td>10.0</td>
<td>10.0</td>
</tr>
<tr>
<td>Mental health problem: QOF prevalence (all ages)</td>
<td>2012/13</td>
<td>0.84</td>
<td>0.77</td>
<td>0.79</td>
<td>0.75</td>
<td>0.55</td>
<td>0.92</td>
<td>0.78</td>
<td>0.64</td>
<td>0.87</td>
<td>0.33</td>
<td>0.62</td>
<td>0.73</td>
<td>0.66</td>
<td>0.68</td>
</tr>
<tr>
<td>% reporting a long-term mental health problem</td>
<td>2012/13</td>
<td>4.5</td>
<td>3.5</td>
<td>4.1</td>
<td>3.4</td>
<td>4.0</td>
<td>3.8</td>
<td>4.2</td>
<td>4.4</td>
<td>4.3</td>
<td>6.7</td>
<td>4.2</td>
<td>5.0</td>
<td>3.6</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Source: Public Health England

Figure 18 provides an explanation of these findings, showing a lower than average incidence of risk factors for severe mental illness. For all the indices, Suffolk has a better than average score for both the East of England region and England as a whole.
Figure 18: Indicators of mental illness risk, Suffolk, East of England and England, 2011 to 2014


For many other indicators of mental health, Suffolk is similar to or better than the England average: for example numbers of contacts with a community psychiatric nurse, numbers of total contacts with mental health services, admissions for self-harm and excess under 75 mortality rate in adults with serious mental illness.

There are data on those at risk from Hidden Harm among the information recorded about new births. Between 2009/10 and 2014/15, there were 1516 women admitted to hospital to give birth who had secondary mental illness diagnoses (Table 20). 938 of these women had recorded mental ill health due to substance misuse, while most of the remainder had experienced a mental
health problem. The data would suggest that some of these women’s babies will grow up to suffer Hidden Harm.

Table 20: Hospital admissions with diagnosis of mental and behavioural disorders among pregnant women, Suffolk 2009/10 to 2014/15

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organic mental disorder</td>
<td>*</td>
</tr>
<tr>
<td>Mental disorder due to psychoactive substance use</td>
<td>938</td>
</tr>
<tr>
<td>Schizophrenia and delusional disorders</td>
<td>12</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>307</td>
</tr>
<tr>
<td>Neurotic, stress related and somatoform disorders</td>
<td>182</td>
</tr>
<tr>
<td>Behavioural syndromes associated with psychological disturbance</td>
<td>20</td>
</tr>
<tr>
<td>Disorders of adult personality and behaviour</td>
<td>17</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>*</td>
</tr>
<tr>
<td>Disorders of psychological development</td>
<td>31</td>
</tr>
<tr>
<td>Childhood behavioural disorders</td>
<td>8</td>
</tr>
<tr>
<td>Unspecified mental disorder</td>
<td>*</td>
</tr>
<tr>
<td>Total</td>
<td>1516</td>
</tr>
</tbody>
</table>

Source: HES

* Number under 6 suppressed to protect patient confidentiality

Positive Choices is a project in Suffolk which aims to support women who have had one or more children removed from their care or who are at risk of having further children removed. It is intended to help these women take control of their lives, to reduce the likelihood of them becoming pregnant again until they are in a position to parent effectively, and to assist them in then parenting successfully.

In Suffolk in the year to May 2013, over 30% of the children taken into care were under 1, with most removed at or near birth, often in circumstances where a previous child had been removed. From April 2011 to March 2012 in Ipswich Hospital, 34 babies were removed at birth. Twenty-four of the mothers had already had babies removed from previous pregnancies, and four had had at least six previous babies.

Table 21 shows recent data, which shows improvement in the number of women who have had a previous live birth and the subsequent birth of an at-risk baby.
Table 21: Outcomes of Suffolk Positive Choices project

<table>
<thead>
<tr>
<th></th>
<th>Risk to baby recognised before birth (number)</th>
<th>Mother with at risk baby with previous live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>127</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>96</td>
<td>32</td>
</tr>
<tr>
<td>2013</td>
<td>93</td>
<td>29</td>
</tr>
<tr>
<td>2014</td>
<td>100</td>
<td>19</td>
</tr>
</tbody>
</table>


Rates of concurrent contact with mental health and substance misuse services were 17.8% for drug misuse and 22.5% for alcohol misuse, both close to the average for England (Figure 19).

Figure 19: Substance misuse service use, Suffolk and England, 2013/14

Domestic abuse

Victims of domestic abuse thought to be at risk of harm are referred to the Multi-Agency Risk Assessment Conference (MARAC) through an established process. Data on domestic abuse has been gathered through the MARAC process since 2008. Between March 2014 and March 2015, the average number of cases being discussed at its meetings rose from 49 to 81. Of these, 20 were repeat cases (i.e. those with the same victim and the same perpetrator), an increase from an average of 8 per meeting.

More than 70% of MARAC cases were referred by the Police, 6% by Children’s and Young People’s Services, 5% by the NHS, 3% by the Probation Service and 2% from the Lighthouse, a charity supporting women and children at risk of domestic violence. Ninety-five per cent of MARAC cases are women, and almost 90% are white. Based on referrals from April 2014 to March 2015, 368 children were in households where there was a referral to MARAC.

The number of referrals to the Suffolk Multi-Agency Safeguarding Hub (MASH) rose from 3738 in 2012/13 to 4400 in 2014/15. However, in the last quarter of 2014/15, there was a fall in police notifications of children resident in homes where they had been called to a domestic abuse incident, via Form 848, from 1134 in 2013/14 to 811 in 2014/15. Police have noted that the numbers of domestic abuse cases where another factor within the toxic trio is present has risen for each year of recording since 2012/13. This is thought to be due to improved training and awareness among staff coupled with improved technique when interviewing potential victims, making it easier for them to trust the public services and receive an offer of support.

The proportion of domestic abuse victims who are female has remained at around 10% of cases for the last ten years. 93% of victims of domestic abuse within Suffolk are from a White background, 1.9% are Black, 1.3% are of Mixed ethnicity, 1.1% are Asian, and 0.8% of other ethnicity.

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3 The revised definition of domestic violence and abuse has been adopted in Suffolk and states:

“Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.” This can encompass, but is not limited to psychological, physical, sexual, financial and emotional abuse. Controlling behaviour is a range of acts designed to make a person subordinate and/ or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. The Government definition, which is not a legal definition, includes so called ‘honour’ based violence, female genital mutilation and forced marriage.

4 95% population in Suffolk was white at the 2011 Census (ONS data, found online at http://www.ons.gov.uk/ons/search/index.html?newquery=ethnicity+suffolk
The Equality and Human Rights Commission highlighted the lower level of reporting of domestic abuse for all minority groups, both ethnic and religious. The main exception is the comparatively high level of black victims compared to the population profile. It is thought that this is linked to the higher rates of offences in Ipswich where the black population is higher, and in part due to the younger age profile of BME communities. Ipswich shows the highest levels of BME victims, with 11% from a BME background, in line with the population profile.

Victims’ age profiles are shown in Table 24.

**Table 24: Age profile of victims who are experiencing and reporting domestic abuse over time**

<table>
<thead>
<tr>
<th>Age</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 16y</td>
<td>2.3%</td>
<td>1.5%</td>
<td>1.1%</td>
<td>1.5%</td>
<td>1.5%</td>
<td>1.6%</td>
</tr>
<tr>
<td>16 – 18y</td>
<td>2.6%</td>
<td>2.3%</td>
<td>2.2%</td>
<td>2.2%</td>
<td>2.4%</td>
<td>2.4%</td>
</tr>
<tr>
<td>18 – 29y</td>
<td>33.2%</td>
<td>34.5%</td>
<td>35.8%</td>
<td>33.9%</td>
<td>33.9%</td>
<td>34.2%</td>
</tr>
<tr>
<td>30 – 39y</td>
<td>21.2%</td>
<td>21.6%</td>
<td>20.9%</td>
<td>21.1%</td>
<td>20.8%</td>
<td>21.1%</td>
</tr>
<tr>
<td>40y+</td>
<td>40.8%</td>
<td>40.1%</td>
<td>40.1%</td>
<td>41.3%</td>
<td>41.4%</td>
<td>40.8%</td>
</tr>
</tbody>
</table>

Source: DA Partnership Report

Police data published in March 2015 showed some change in the numbers of reported domestic abuse cases in each District of Suffolk. St Edmundsbury experienced a 12% rise in case numbers over the previous year, Waveney a rise of 8% and Babergh an increase of 7%. By contrast the case numbers in Mid-Suffolk reduced by 11%. These changes appear substantial but may reflect better recording, a greater willingness of people to come forward to the police in some parts of the County, or better training and practice by some parts of the police force to elicit information on domestic violence.

Table 22 shows domestic abuse offenses for 2014/15, grouped by the HMIC crime tree.
Table 22: Domestic abuse offences, Suffolk, 2014/15

<table>
<thead>
<tr>
<th>Offence</th>
<th>Babergh</th>
<th>Forest Heath</th>
<th>Mid Suffolk</th>
<th>St Edmundsbury</th>
<th>Ipswich</th>
<th>Suffolk Coastal</th>
<th>Waveney</th>
<th>Suffolk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence with injury</td>
<td>50</td>
<td>119</td>
<td>79</td>
<td>0</td>
<td>64</td>
<td>71</td>
<td>190</td>
<td>573</td>
</tr>
<tr>
<td>Sexual offences excluding rape</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>Rape</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>11</td>
<td>35</td>
</tr>
<tr>
<td>Total serious domestic abuse</td>
<td>56</td>
<td>128</td>
<td>88</td>
<td>0</td>
<td>70</td>
<td>77</td>
<td>209</td>
<td>628</td>
</tr>
<tr>
<td>Violence without injury</td>
<td>130</td>
<td>106</td>
<td>100</td>
<td>213</td>
<td>442</td>
<td>156</td>
<td>406</td>
<td>1552</td>
</tr>
<tr>
<td>Criminal damage and arson</td>
<td>27</td>
<td>33</td>
<td>23</td>
<td>50</td>
<td>112</td>
<td>29</td>
<td>128</td>
<td>402</td>
</tr>
<tr>
<td>Public disorder</td>
<td>23</td>
<td>20</td>
<td>14</td>
<td>30</td>
<td>76</td>
<td>30</td>
<td>66</td>
<td>259</td>
</tr>
<tr>
<td>Total lower level domestic abuse</td>
<td>180</td>
<td>159</td>
<td>137</td>
<td>293</td>
<td>630</td>
<td>215</td>
<td>569</td>
<td>2213</td>
</tr>
<tr>
<td>Total other flagged domestic abuse crimes</td>
<td>23</td>
<td>21</td>
<td>11</td>
<td>26</td>
<td>56</td>
<td>14</td>
<td>68</td>
<td>221</td>
</tr>
<tr>
<td>Non-crime</td>
<td>349</td>
<td>382</td>
<td>333</td>
<td>763</td>
<td>1684</td>
<td>620</td>
<td>1850</td>
<td>5981</td>
</tr>
<tr>
<td>Non notifiable</td>
<td>9</td>
<td>11</td>
<td>13</td>
<td>19</td>
<td>34</td>
<td>17</td>
<td>47</td>
<td></td>
</tr>
</tbody>
</table>

Source: Annual report of the Police and Crime Commissioner for Suffolk, presented at the Suffolk Domestic Abuse Partnership

This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.
Children at risk
The March 2015 common assessment frameworks (CAF) monthly report noted that:

- Case numbers stood at 2654.
- 461 new cases were opened in March 2015, with the highest number among the 0 to 11 year olds.
- One urban secondary school had 55 open cases and one primary school 18 open cases.
- 571 cases were closed, of which 55 were transferred to social care.
- There is an over representation of white and black Caribbean families with open CAFs.

These figures suggest an active approach to case management by the CAF agencies. However, the report found that agreed timings were not fully observed, and some measures had worsened, e.g. first contact with assessor and first contact with parent/carer. Figures for the timing of first intervention had improved.

These findings suggest that there are important areas for urgently improving services. The poorer first contact time is particularly worrying. Swift contact between the young person or family in need and the professional supporting them is often cited by families as an important indicator of the seriousness with which their concerns are being taken. In some cases it may be crucial, such as where stress on a family needs to be quickly relieved; examples include severe domestic violence or some mental illnesses.

Between April 2014 and May 2015, there were 4,736 CAFs undertaken through which 8257 assessment factors were identified, of which 2093 were related to domestic abuse, 856 to drug misuse, 1033 to alcohol misuse and 1931 to mental health within the household (Figure 20). In 429 cases, there was a young carer within the household.
This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.

Figure 20: Concerns noted within common assessment frameworks 1 April 2014 to 31 May 2015, Suffolk

Source: Common Assessment Framework (CAF)

Suffolk Police data for 2011/12 showed that fewer Suffolk children and young people under 17 had suffered unintentional and deliberate injuries than the national average. The differences between the local authority areas are not statistically significant.

Figure 21: Unintentional and deliberate injuries in children aged 0-17 years per 10,000 population aged 0-17 years, 2011/2012

Source: VIPER data 2011/12 (Suffolk Police)
Impact of services

It is not possible to definitively state that the work around Hidden Harm to date has achieved a reduction in the number of children becoming looked after or requiring child protection, because of the multiple strands of work contributing to this outcome and the way that data relating to Hidden Harm factors is collected. We can only use proxy measures to give a sense of how services are identifying and intervening earlier, such as:

- evidence of identification of Hidden Harm through referrals to services (an increase should be seen as positive as it is likely to indicate identification rather than an increase in need in the population, given that we know prevalence is higher than demand would indicate. Several interviewees agreed with this interpretation of an increase in referral numbers).

- evidence of joint working through case audits, qualitative feedback from staff and service users

- referrals to adult services under the ACCORD protocol for substance misuse, domestic abuse and adult mental health problems

- evaluation of specific Hidden Harm-related projects, e.g. Positive Choices, (page 48) and Iceni service (page 61)

There has been improvement in data collection, an example of which is the monthly reporting of the CYP Integrated Access Team activity, which includes Hidden Harm factors within the primary presenting issue reason for referral (Figure 22).
It is likely that a proportion of those children referred for abuse / neglect will be experiencing at least one of the Hidden Harm factors, and it may well be that for those children referred for mental health difficulties Hidden Harm is a contributory factor.

The County Safeguarding Manager provides a quarterly breakdown of presenting factors in child protection cases. Parental drug and alcohol use, adult mental health problems and domestic abuse are common, both for those children who are coming onto the register for the first time (Figure 23) and for those who are being re-registered (Figure 24).
Figure 23: Prevalence of risk factors, child protection registrations, January to March 2013, Suffolk

Figure 24: Prevalence of risk factors, child protection re-registrations, January to March 2013, Suffolk

Source: Suffolk County Council

The CYP Integrated Access Team ceased functioning in 2014 with the inception of the MASH, but data has continued to be collected specific to Hidden Harm factors through the MASH, safeguarding and CAF reporting.
The continuing collection and analysis of these data are of great importance in helping understand the prevalence and impact of Hidden Harm.

Section 17 of the Children Act 1989 defines a child as being in need in law if:

- He or she is unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the LA, or

- His or her health or development is likely to be significantly impaired, or further impaired, without the provision of services from the LA, or

- He or she has a disability.

Hidden Harm is a subset of children in need since they will at least fall into category 1 and 2 of the legal definition described above.

Figure 25 indicates that fewer Suffolk children are known to be in need than in most other local authorities in the East of England, and England as a whole.

**Figure 25: Children in need per 10,000 children, Suffolk and the East of England, 2012**

Source: Public Health England
Figure 26 indicates a similar pattern for children in need because of abuse or neglect.

Figure 26: Children in need because of abuse or neglect per 10,000 children, Suffolk and the East of England, 2012

Some looked-after children (LAC) are in care because of Hidden Harm factors within the household. Children and young people are categorized using four standard categories:

- No cause for intervention
- Child in need (CiN)
- Child protection plan (CPP)
- Looked-after children (LAC).

Table 23 shows the primary reason that the child was placed in the CiN and CPP categories. Those most closely associated with Hidden Harm are families in acute stress, family dysfunction and abuse or neglect. These categories together accounted for 72% of CiN cases and 85% of CPP ones.
Table 23: Primary reason for children entering child in need and child protection plan categories, Suffolk, 2011 to 2015

<table>
<thead>
<tr>
<th>Primary need</th>
<th>CiN 4 year (number)</th>
<th>CiN 4 year (%)</th>
<th>CPP 4 year (number)</th>
<th>CPP 4 year (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low income</td>
<td>95</td>
<td>0.3%</td>
<td>9</td>
<td>0.1%</td>
</tr>
<tr>
<td>Absent parenting</td>
<td>469</td>
<td>1.3%</td>
<td>55</td>
<td>0.7%</td>
</tr>
<tr>
<td>Other</td>
<td>754</td>
<td>2.1%</td>
<td>62</td>
<td>0.8%</td>
</tr>
<tr>
<td>Parental illness/disability</td>
<td>779</td>
<td>2.2%</td>
<td>99</td>
<td>1.2%</td>
</tr>
<tr>
<td>Socially unacceptable</td>
<td>1073</td>
<td>3.0%</td>
<td>168</td>
<td>2.1%</td>
</tr>
<tr>
<td>Family in acute stress</td>
<td>5306</td>
<td>14.7%</td>
<td>202</td>
<td>2.5%</td>
</tr>
<tr>
<td>Child’s disability</td>
<td>6835</td>
<td>18.9%</td>
<td>873</td>
<td>10.7%</td>
</tr>
<tr>
<td>Family dysfunction</td>
<td>8000</td>
<td>22.1%</td>
<td>1659</td>
<td>20.4%</td>
</tr>
<tr>
<td>Abuse or neglect</td>
<td>12844</td>
<td>35.5%</td>
<td>5008</td>
<td>61.6%</td>
</tr>
<tr>
<td>Total</td>
<td>36155</td>
<td></td>
<td>8135</td>
<td></td>
</tr>
</tbody>
</table>

Source: ORBIT, data drawn from CareFirst

Of children made subject to a child protection plan in Suffolk in 2011 to 2015, 49% were had been subject to neglect, 39% to emotional abuse, 7% to physical injury and 5% to sexual abuse.

The prevalence of different reasons for deeming a child to be CiN are shown in Figure 27; no clear trends are present. In about one third of cases, one key factor is identified that needs services; in 72% of CAFs there were fewer than five factors serious enough to record\(^5\) (Figure 28).

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\(^5\) This excludes those CAFs where no factor was recorded
Data provided by Iceni, a Suffolk service provider, (see Appendix 2 for service description) records the transition of the people whom they support between these categories of social care and support. During 2014, 97 of their clients had no social care support or intervention. Forty-six of the people whom Iceni supported were classified by CAF as CiN. By the end of 2014, 36 of these no longer needed social care support, six remained as CiN, and four had been reassessed as at higher risk and had a CPP (Figure 29).
Iceni supported 51 children and young people with a CPP at the start of 2014. By the end of the year, 21 no longer needed social care support, 13 had reduced their risk and transitioned to CiN and four were reassessed as at greater risk and moved to become LAC. The service is only available in Ipswich and so these results are only representative for this defined geographical area.
Of the 16 LAC whom the organisation supported at the beginning of 2014, four had no need of social care support by the end of the year, two had reduced their risk to CPP and ten continued to be LAC.

In 2013/14, Suffolk had one of the lowest rate of CiN of a group of similar local authorities. The County’s rate of at 231 per 10,000 children is also below the England average of 346 per 10,000. The comparative data on CPP shows that Suffolk is at the average for all comparators, and is close to the England average.

Suffolk’s rate of children starting an episode of need is 376 per 10,000 children, very similar to the England average of 373 per 10,000 and in the mid-range of comparable local authorities. The County had a slightly higher rate of children ending an episode of need than these authorities, though East Sussex had a much higher rate of ending episodes of needs than the other statistical neighbours and Suffolk may wish to contact them to understand how this was achieved. Rates of ending episodes of care show a similar pattern (Figure 30).

**Figure 30: Rates of children ending episodes of care, Suffolk and comparator local authorities, 2013-14**

![Figure 30: Rates of children ending episodes of care, Suffolk and comparator local authorities, 2013-14](image)

Source: ORBIT, provided by Suffolk County Council
Expenditure on Hidden Harm

For this report, Suffolk County Council analysed its children and young people expenditure to inform a discussion about whether the spend was appropriately split between prevention and the provision of services for children and young people in need. Expenditure was categorised as:

- general, universal services, such as schools
- services to prevent problems, especially Hidden Harm
- services providing children and young people with social support needs, especially likely to be used by those with Hidden Harm
- services that straddle prevention and service provision, such as school nurses, who provide advice as well as interventions and support.

While this approach did not identify the resources allocated to Hidden Harm specifically, it provides an indication of the relative spends on prevention and support to children and young people through the Children and Young People’s Services budget in the current year. If the Hidden Harm group is more clearly delineated, a similar process could be used to distinguish expenditure on prevention and services, aiding discussions on commissioning resource allocations in the future when the relative importance of prevention and services would be better informed.

Figure 31 shows the result of the analysis, which is only for indicative purposes.
This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.

Figure 31: 2015/16 indicative budget allocations for children and young people’s services, Suffolk County Council

This Figure led to useful discussion on Suffolk County Council’s spending patterns. Staff were keen to understand how other councils divided their resources, and agreed that this analysis could be usefully repeated in future years to assess the impact of the funds invested, and to inform any proposals to alter the current balance between prevention and services to meet known need.

It should be noted that this financial breakdown is drawn from aggregated areas of spend and is therefore indicative and not completely detailed in reflecting spend across the whole county.
Responding to Hidden Harm in Suffolk

Suffolk County Council services for children, young people and families include models of delivery from which children and young people experiencing Hidden Harm benefit. These include:

*Family Nurse Partnership*

The Family Nurse Partnership (FNP) is a programme of support funded by central Government aimed at first-time young mothers. Evidence from the United States, where it began, shows that this programme is associated with healthier pregnancies, improved child development and better relationships. Women achieve more of their goals and aspirations and have children with better school careers than their peers.

In Suffolk, the programme began in the Waveney locality and has now been extended to cover the Ipswich area. It is available free to women under 20 who are expecting their first baby and are registered with a GP in those areas.

Local NHS Trusts refer women to FNP and about 75% accept the offer of support. Most eligible women register with FNP by eight weeks of pregnancy and begin weekly visits by an assigned nurse. After the sixth visit, the nurse and expectant mother compile a list of key issues to be tackled within the two-year window that FNP provides.

Suffolk’s FNP lead believes that about 66% of women in the programme have Hidden Harm with risk factors from the toxic trio. Some women have themselves been supported within the social care system, for example as looked-after children. The nursing team liaises closely with teams who can provide skilled and experienced support for challenges such as domestic abuse, and drug and alcohol misuse within the household – either including the pregnant woman, her partner, or any other people living within the household.

More robust data is needed before sharing and using it to inform decisions. Plans to collect this are in place.

*Signs of Safety*

Signs of Safety has been adopted by Suffolk County Council Children’s Services as the overarching practice framework for all of its work with children and families. It describes a purposeful and collaborative way of working with families to secure the best outcomes for children and young people. It is known locally as Suffolk Signs of Safety and Wellbeing (SoS).

Signs of Safety was developed in Australia and builds on using the experience of what works in helping individuals and families to change their
behaviour. Often this begins by acknowledging what is working in the present situation, and then imagining what life would be like if things worked better, sometimes using the device of identifying aspects of life in different houses drawn as paper templates. This approach is now well-documented, and its success well-attested. For Suffolk, it builds on work drawn together by the Suffolk Youth Offending service in July 2011 in which the authors noted the importance of positive approaches when working with young people and of using examples of successful interventions as a useful guide to further use in similar situations (Meade and Dix 2011).

There are now questions included for families to review the use of this methodology. Feedback is very positive and demonstrates how families have often gained insight into their challenges and felt a growing confidence to deal with their situation with the support of professionals. One user commented

“…absolutely brilliant, I don’t know what I would have done without her, she’s non-judgemental, never looked down on me, she’s got her own children and was full of empathy, not textbook but the real world, she was amazing”.

Another said

“Much better, she gained his confidence, he wasn’t going out, and he’s doing a course now, which we didn’t think would happen. She helped him to use public transport. She helped him to believe in himself.”

A third noted

“They made me feel much better about things, I had been through hell and did not have much faith in anyone, and they were brilliant. I was chuffed at how much effort they put in.”

Suffolk Family Focus

Suffolk Family Focus (SFF) is the local name for the Government funded programme known as Troubled Families which aims to work intensively with families identified as having at least one of the following

- At least one family member claiming an out-of-work benefit
- Over the previous academic year, a child with more than 15% unauthorised absence or who fits specific exclusion categories
- Over the previous six months, a child who has committed a crime or been offered youth offending prevention, or any family member has received antisocial behaviour sanctions.

Suffolk Family Focus includes access to clinical psychologists who work with front-line staff already engaged with the families to boost their knowledge,
skills and confidence. The psychology team works with the family’s key worker and facilitates multi-agency or complex case discussions within existing structures, e.g. using Team Around the Child or Core Group meetings. The psychology team augment the relationships between integrated delivery teams, community mental health teams and educational psychologists. The Signs of Safety Approach is used for SFF as well as by other service delivery teams across the County for consistency and maximum impact.

1150 families were identified as meeting the criteria for Suffolk Family Focus in the first phase of the programme. A small SFF Team of co-ordinators and the clinical psychologists support core service practitioners, including voluntary sector, local authority and police colleagues, to work with these families, using a key worker approach to assess the needs in the family and work with colleagues to plan and implement care. An holistic approach is used to tackle Hidden Harm whenever identified, using root cause analysis for those families where a young person or child is not attending school, is unemployed or has committed a crime. The SFF team works with front-line staff build effective relationships and to capitalise on work already in progress.

The SFF team is used by all parts of the County, and at the time of this report greatest use was in Waveney (Figure 32) and least use in Sudbury, South, Central and Mid Suffolk, and Suffolk Coastal.

**Figure 32: Use of Suffolk Family Focus Team by area, October 2013 to December 2014**

![Graph showing use of Suffolk Family Focus Team by area from October 2013 to December 2014](image)

Source: Suffolk Family Focus Evaluation Report, February 2015
The SFF Team’s presence in Ipswich, Bury St Edmunds and Lowestoft is believed to account for the greater use in these areas. The visibility of the service is greater in these towns. This highlights the difficulty in providing services in rural parts of the County.

The 12+ integrated team made greatest use of the SFF team, followed by the 0 to 11 Child in Need team. This may reflect the visibility of the SFF team to these services. In all, staff within Suffolk County Council CYPS make greatest use of the SFF team (78% time spent), with external partners such as housing trusts and Police using the remainder. The 12+ team has now been integrated with other services.

Figure 33 shows that consulting with the front line staff accounts for two thirds of the clinical psychologist’s time, 291 episodes of the 386 recorded. Similarly, just under one third of psychologist’s time is spent on direct family contact or attending meetings, leaving 5% of their time, approximately 20 sessions, available for training other professionals engaged in working with the eligible families. It should be noted that the main remit of the clinical psychologists is to provide consultation to frontline staff and training to skill up and empower them to make psychologically informed assessment and support planning.

**Figure 33: Activity completed by the Suffolk Family Focus Psychologists, October 2013 to December 2014**

Source: Suffolk Family Focus Evaluation Report Feb 2015
The service was informally evaluated by canvassing the views of staff who used the SFF clinical psychologist’s services and found that they were valued and added confidence and better communication between disciplines, to the advantage of the families and the professionals working with them. Staff could work more directly with families, though this might lead to much greater pressure on the staff and could disturb the balance of the use of their time detrimentally, by removing the time currently allotted to close team working, training and facilitation of case work. The team of clinical psychologists working to support SCC children’s services is being expanded over the coming year.

The views of families, and of children and young people using this service, are sought at family meetings within the Signs of Safety model (see above). The feedback is almost universally positive.

The SFF team has focused attention on school attendance for children and young people as a key measure to improve their life chances. The improvement of educational attainment has been locally agreed as a key measure of success. Analysis of local data suggests that poor mental health and emotional wellbeing impedes educational attainment for the children and young people, and the SFF Team believe that investment in mental health services to build confidence and help relationship-forming are important to improve outcomes.

The SFF Team has noted that where there are services to deal with drug and alcohol misuse for both adults and young people, outcomes are better than where these are lacking. They seek to augment these services in Newmarket, Bury St Edmunds and in rural areas. They recognise that low-wage employment, together with a paucity of employment opportunities and poor public transport are likely to continue to make life difficult for many of those living in Suffolk, but understand that, with better education, young people are in a stronger position to take up what jobs and careers are on offer.

**Listening and engagement**

Suffolk County Council has a Survey Monkey questionnaire open continuously through which people supported by social care services and the multi-agency integrated teams can give their views anonymously. These are reviewed quarterly. The response rate is just over 40%, and is substantially higher for parents than for young people. In some districts, no children responded over a three-month period.

Typical parent comments are: “They explained everything very clearly and listened to my family without judgement”; “Always there to talk to and gives lots of advice & help. Very good and positive with the children”; “We have been so supported and have not felt let down at any stage”. Some parents commented on the stretched nature of services and the waiting time for mental health services.
Child comments included “I was listened to and understood”; “I know how to handle things better”; “Don’t know when meeting were, never written down for me or told”.

Young people’s comments included “Helped me with self-esteem and confidence and gave me good advice”; “I would always be allowed to speak my mind and show how I felt towards something, my decisions and choices were always respected.”; “I felt I could trust them”; “No longer having suicidal thoughts”.

Over the last two years, Suffolk County Council has developed a ProFile database for use with the CAF to streamline reporting on work with children and young people. The database follows cases through the referral and assessment processes, and then tracks progress through the management and oversight of all cases. There is customer feedback from families and individuals when a case is closed. The feedback is collated monthly and fed back to the CAF team members. About half of those who have received support respond to the feedback request, and the ProFile team calls some young people to obtain their views, especially for children in need and those within child protection where responses were commonly low. Questions are varied over time and have informed development work for services. The comments echo those from the Survey Monkey feedback shown above.

Suffolk County Council is keen to inform its commissioning decisions by listening as openly and consistently as possible to children and young people. Front-line staff in services run by Suffolk County Council and services run by third sector providers strive to use consistent systems to listen to the experiences of those whom they support. Indeed, in the Signs of Safety approach, families are asked about their journey through the services with which they have come into contact, with the adults, young people, and children being listened to separately in an effort to gain the clearest possible understanding.

There are examples of good practice from other authorities which have gone further in establishing dialogue between children and young people, commissioners and service providers, especially in those areas where great sensitivity is needed to encourage the honest feedback that is needed to inform service development. During this needs assessment process there was discussion about an approach that allows children and young people to comment anonymously and in real time on discussions between commissioners and people using local services. The model relies on computer software and enables the young people to use a laptop, mobile phone or other device to log in to a discussion at an agreed time. The commissioners can then either pose questions to the group, such as “Is there a key aspect of your service that you found got in the way of making progress?” or “Tell us how to help people trust us?” Staff can also develop questions suggested by dialogue with the young people themselves. Answers can be explored anonymously, and commissioners can then agree to further sessions to review progress and to build a means of hearing from young people in a way they find easy and comfortable.
Examples from other sectors where there are similar difficulties, such as the police dealing with young people committing crimes to finance substance misuse, have found this approach to be valuable and to have led to service developments that have not increased cost but have led to greater effectiveness.

Arranging group online fora like these has a cost and Suffolk County Council will wish to decide if the benefits will be worth the funds needed.

Additional services

Additional services available to children, young people and families in Suffolk suffering Hidden Harm provided by local government, the NHS and the third sector are described in Appendix 2. The list is not exhaustive but helps to demonstrate the range of support that is provided. Some staff from cross-sectoral bodies such as the MARAC, those involved with CAFs and Young Offenders Services said that support and intervention would be more effective if coordination between organisations and localities were improved. Some people thought that such coordination might improve the pace of response, allowing earlier intervention in a wide range of circumstances.

Matching service location to need

In this section, we review some of the key determinants of health on those suffering Hidden Harm.

A recent study provided an analysis of severe and multiple disadvantage in England, defined as the problems faced by adults suffering a combination of homelessness, substance misuse, involvement with the criminal justice system and poverty (Bramley et al 2015). In most cases, the people living with severe and multiple disadvantage had experienced childhood trauma, were very poor, had difficult family relationships and poor educational experience. These people are found throughout England but are more frequent in seaside towns. Those with mental ill health are socially isolated.

Although people facing severe and multiple disadvantage are commonly thought of as single, most either live with their children or have contact with them. Severe and multiple disadvantage appears to be highly correlated with areas of deep poverty and economic decline. Suffolk could benefit from mapping the location of this group and working with them and their families to prevent Hidden Harm and to support them improving their quality of life.

Figure 34 superimposes the location of NHS acute hospitals on a map of deprivation for Suffolk. While some of the most deprived areas of the County lie in the towns where the hospitals are situated, other severely deprived LSOAs are far from them. This presents a challenge for people in Suffolk to access services they may need.
NB: People in Waveney can access the James Paget Hospital and those near the Cambridge border can access Addenbrooks Hospital.

Figure 34: NHS acute hospitals and levels of deprivation, Suffolk, 2015

Source: Department for Communities and Local Government

The Domestic Abuse County Partnership
The Domestic Abuse County Partnership has developed a Domestic Violence and Abuse Strategy 2015 – 2018. The priorities in the strategy are

- Prevention and early intervention
- Provision of services
- Partnership working
- Justice responses and risk reduction.

The locally agreed framework comprises four levels of activity:
At each level there is a range of agencies that may respond to the needs of an individual. The strategy is supported by evidence from a recent Suffolk study commissioned by the Police and Crime Commissioner for Suffolk recording the experiences of 63 women and six men who were victims of domestic violence and abuse, alongside the views of 40 professionals from Police and services for people who had worked directly with the victims (Bond 2015). The report states:

“Domestic violence and abuse often goes unreported, or is under-reported, and this is well known to both the professionals and police officers who took part in the Suffolk study. The abuse often continues or increases after separation, and frequently worsens during pregnancy. Mental health problems are often associated with domestic violence and abuse for both the survivor (depression and self-harming), and for the perpetrator (violent and psychotic episodes). The impacts of domestic violence and abuse are serious, long-term and highly damaging, and the long-term consequences for children witnessing domestic violence and abuse have been well documented.”

Victims viewed the police as often (but far from always) helpful and understanding, but found the court process lengthy, stressful, intimidating and with uncertain outcomes. They expressed concerns about the Family Courts’ pro-contact ideology for children and young people with perpetrators of domestic abuse, which they saw as potentially harmful to children and to adult survivors. Service provision was confusing and fragmented with a paucity of services available in rural areas. Independent domestic violence advisers were almost unanimously viewed very positively.

Professionals were particularly concerned at the dearth of services for children and young people in domestic abuse households. There was agreement on the importance of clear, consistent and frequent communication
between agencies, and for training and updating of training for all professionals working with victims of domestic abuse.

Key recommendations within the report pertinent to children and young people were:

- A systematic review of services for children and young people, to ensure they are readily available to all children and young people and are tailored to their needs

- Key outcomes of services to support these children and young people are the ability to form good relationships, engage positively with their families and communities, and take best advantage of educational opportunities

- Information and advice should be offered and the children and young people encouraged to talk freely about their experiences, feelings, worries and hopes about relationships. Support should focus on opportunities to challenge unhelpful stereotypes and reinforce positive relationship characteristics

- Schools should be a key setting for the provision of support.

- There should be a comprehensive programme of education for all children and young people to raise their awareness of domestic abuse, encourage them to develop appropriate attitudes and behaviours in their relationships and to develop a culture that challenges domestic abuse.

The findings of these extensive interviews mirrored the national SafeLives analysis of 35,000 adults experiencing domestic abuse and 1500 children living in households with domestic abuse present (SafeLives 2015).

The Police and Crime Commissioner invests in schemes to complement the policing of the County. Approximately 2% of the policing budget is allocated to the office of the Police and Crime Commissioner, whose roles include working with partners to prevent and tackle crime and reoffending; and to invoke the voice of the public, the vulnerable and victims. As part of meeting these objectives, the Commissioner has sought to test schemes aimed at supporting children and young people in building confidence and forming strong relationships. The intent is to support those with Hidden Harm, and others, in developing behaviours and attitudes that help them reach adulthood with greatest resilience and emotional robustness. Recent examples relevant to Hidden Harm include:
<table>
<thead>
<tr>
<th>Dates</th>
<th>Sum invested</th>
<th>Project</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| 2014/15 | £50,000      | Triage pilot for Youth Offending team        | First time Entrant rate to Youth Offending Services fell and is continuing to fall in Suffolk  
Re-offending rate for Triage continues to be lower than the re-offending rate for statutory pre-court disposals  
Restorative Justice was delivered for all Triage cases where there was an identified victim  
100% of cases where there was an assessed substance misuse issues received an appropriate intervention  
Where there was an issue with school attendance, 67% had evidenced an improvement by the end of the intervention |
| 2014/15 | £85,000      | Suffolk Positive Futures is a sports-based intervention for young people aged 10 - 19 | Success measures were agreed covering:  
• Project attendances  
• Number of young people working with the assigned team  
• Upskilling vulnerable young people  
• Delivering activity sessions  
• Providing activities, especially in the evenings  
• Encouraging volunteering  
All but one were exceeded (28 young people who not in education or excluded from mainstream school were working towards a recognised qualification where the target had been 30). |
It should be noted that there are a number of services in place which aim to prevent domestic abuse and provide care and support to victims when it does happen. These include the Domestic Abuse Outreach Service, Women’s Aid Refuges in Bury St Edmunds, Ipswich and Lowestoft, Independent Domestic Abuse Advisors and the Multi Agency Referral and Assessment Panels (MARAC). The County Domestic Abuse Partnership and locality based Domestic Abuse Forums work in communities and schools to raise awareness and also work collaboratively with partners in statutory and voluntary services to deliver programmes for victims such as “The Freedom Programme” and “Strengthening Families”. There are also programmes specifically for perpetrators of domestic abuse to help them understand and overcome their actions, for example the “Caring Dads Programme”.

A “Deep Dive” Review of the system wide response to Domestic Abuse has been commissioned to be undertaken in early 2016.

Evidence review – what works elsewhere

Search strategy

National policies and guidelines

We used web search and searched relevant health and social sciences research databases on the search term separately and combining “Hidden Harm/s, “Early Intervention”, Safeguarding children, alcohol and substance misuse. We examined reference lists and citation indexes along with citation frequencies to identify key documents.

Hidden Harm research

We used web search and searched relevant health and social sciences research databases on the search term Hidden Harm. Since the term is relatively new, coined in 2003 and also is specific to the United Kingdom, we broadened the search term definition to focus on “early intervention” as well as “adverse childhood experience”.

We examined reference lists of key papers and used citation indexes along with citation frequencies to identify later key papers, which referenced the earlier ones.

National policies and guidelines

Hidden Harm: Responding to the needs of children of problem drug users estimated that there are between 250,000 and 350,000 children of problem drug users in the UK, about one for every problem drug user (Drugs 2007). The report suggested that reducing the harm to children from parental problem drug use should become a main objective of policy and practice, and that effective treatment of the parent can have major benefits for the child.
Another report, from the Advisory Council on the Misuse of Drugs, concluded that “through joined-up working, services can take many practical steps to protect and improve the health and wellbeing of affected children” and that “the number of affected children is only likely to decrease when the number of problem drug users decreases” (Advisory Council on Misuse of Drugs 2007).

Looking back: the history of Hidden Harm

In 2003, the Advisory Council on the Misuse of Drugs (ACMD) published a report identifying Hidden Harm in children associated with parental drug misuse (Advisory Council on Misuse of Drugs 2003). The report estimated there are between 250,000 and 350,000 children of problem drug users in the UK. It suggested that parental problem drug use can and does cause serious harm to children at every age from conception to adulthood.

The report was the output of a three-year inquiry by the ACMD. It revealed a disturbing picture about the nature and extent of actual and potential harm to babies and children born to and living with parental drug misuse, and the inadequate response in the UK to this problem. Its 48 recommendations cut across the drugs, children’s, health and criminal justice sectors, and addressed a broad range of issues including joint working, research, identifying and recording needs, staff training, dedicated provision and protection for children affected.

The report recommended:

- reducing the harm to children from parental problem drug use should become a main objective of policy and practice.
- effective treatment of the parent can have major benefits for the child.
- working together, services can take many practical steps to protect and improve the health and well-being of affected children.
- the number of affected children will only decrease when the number of problem drug users decreases.

Following the report, the Council of the ACMD set up a working group to monitor and promote the implementation of the recommendations in the four countries of the United Kingdom.

Four years later, the ACMD published a follow-up report of the progress relating to these recommendations (Drugs 2007).

In 2010, the prime minister commissioned Frank Field MP to undertake an independent review of poverty and life chances (Field 2010). The report concluded that poor children can be prevented from becoming poor adults. It has concluded that the UK needs to address the issue of child poverty in a fundamentally different way if it is to make a real change to children’s life chances as adults.
The report found overwhelming evidence that children’s life chances are most heavily predicated on their development in the first five years of life. It is family background, parental education, good parenting and the opportunities for learning and development in those crucial years that together matter more to children than money, in determining whether their potential is realised in adult life. The things that matter most are a healthy pregnancy; good maternal mental health; secure bonding with the child; love and responsiveness of parents along with clear boundaries, as well as opportunities for a child’s cognitive, language and social and emotional development. The report also concluded that “good” services matter also (health services, Children’s Centres and high quality childcare) and that although later interventions to help poorly performing children can be effective, the most effective and cost-effective way to help and support young families is in the earliest years of a child’s life.

There were two overarching recommendations.

- To establish a set of “Life Chances” Indicators that measure how successful we are as a country in making more equal life outcomes for all children
- To pursue policies enabling parents to achieve the aspirations that they have for their children.

To drive this policy, the review proposes establishing the ‘Foundation Years’ covering the period from the womb to five. “The Foundation Years” would become the first pillar of a new tripartite education system, leading to school years, leading to further, higher and continuing education.

In 2011, Professor Eileen Munro was commissioned by the Secretary of State for Education to respond to the question “What helps professionals make the best judgments they can to protect a vulnerable child?” (Munro 2011).

The report recommended a reform to the child protection system, specifically from being over-bureaucratised and concerned with compliance to one that keeps a focus on children. Specific recommendations included:

- Government should remove the specific statutory requirement on local authorities for completing assessments within often artificial set timescales.
- Local services which work with children and families should be freed from unhelpful government targets. There should be a duty on all local services to coordinate an early offer of help to families who do not meet the criteria for social care services.
- Problems should be addressed before they escalate to child protection issues.
- Ofsted inspections of children's services should add more weight to feedback from children and families.
- Experienced social workers should be kept on the frontline even when they become managers so that their experience and skills are not lost.
• Each local authority should designate a Principal Child and Family Social Worker to report the views and experiences of the front line to all levels of management.

Professor Munro also said that individual recommendations should not be taken forward in isolation but that change needs to happen across the system.

In 2011, an independent report on next steps relating to early intervention was undertaken, headed by Graham Allen MP (Allen & Team 2011). This report considered Early Intervention as an approach which “offers a real opportunity to make lasting improvements in the lives of children, to forestall many persistent social problems and end their transmission from one generation to the next, and to make long-term savings in public spending”.

The report defines early intervention as covering a range of tried and tested policies for the first three years of children's lives to give them the essential social and emotional security they need for the rest of their lives. It acknowledged that the provision of successful evidence-based Early Intervention programmes remains persistently patchy, and dogged by institutional and financial obstacles.

The report asserted that in consequence, there remains an overwhelming bias in favour of existing policies of late intervention at a time when social problems are well established.

*Allen report*

The Allen report drew up a list of the 80 most effective Early Intervention Programmes that could be found in the literature and considered their cost effectiveness. Allen et al focused on the evidence of brain development in the first three years of life, when 80% of the brain is thought to develop. This was employed as the motivation for recommending interventions in early years. The report then explored the social and economic benefits of Early Intervention, it categorised the interventions, placing 25 in the top category.

Figure 36 shows the list of top 25 of an evolving list of evidence-based early intervention programmes.

Figure 36: Allen Report’s top 25 Early Intervention programmes
1. **Figure 1: Effective interventions by age**

Source: Allen 2011

Figure 2 shows how this is applied in Nottingham.

This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.
The Tickell (Tickell 2011) review of the Early Years Foundation Stage (EYFS) then set out to improve early years provision by setting standards for children’s learning and development from birth to age five, providing evidence for the importance of early learning and care. It argued that parents/primary caregivers have the largest influence on children’s development, and that the home learning environment is more important for a child’s intellectual and social development than parental occupation, education or economic circumstances. It emphasised the fact that a good quality early years setting can compensate where the home learning environment is not strong.

In 2013, the Annual Report of the Chief Medical Officer Our Children Deserve Better: Prevention Pays raised the profile of prevention and supporting and building resilience in children (Lemer 2013) pointing to a clear evidence base for the cost effectiveness of this approach to improving the population health.

Looking forward
Since these policy reviews, there have followed a number of national initiatives, including:

- a government commitment to reducing child poverty
- increasing the number of health visitors by 2015
- doubling the numbers accessing the Family Nurse Partnership and a refocusing of Sure Start Children’s centers on disadvantaged children
- the transfer of the commissioning of public health services for children aged 0-5 years from NHS England to local authorities from October 2015. The Healthy Child Programme for 0-5 year-olds includes health visiting services and Family Nurse Partnership services.

Most recently, the Big Lottery Fund has committed £215 million over the period 2015-2025 in the *Fulfilling Lives: A Better Start* programme. The expectation of this programme is the implementation and testing of different models of early intervention in five disadvantaged areas across England, enabling these areas to make structural changes to the way in which they identify and work with families at risk of poor outcomes, and to introduce a range of preventive interventions focusing on pregnancy and the first three years of life, with the aim of improving children’s nutritional, socio-emotional and language/learning outcomes.

In March 2012, the Department of Health published *Getting it right for children, young people and families. Maximising the contribution of the school nursing team: Vision and Call to Action* (DH 2012). This document sets out the national principles and framework for school nursing. It states that the service should be visible, accessible and confidential; and deliver universal public health services, which ensure that advice and support is available to meet the needs of children and young people, parents and carers.

**Other prevention programmes**

Life-long consequences of drug and alcohol misuse appear to be associated with maternal substance intake even before birth (Webster-Stratton & Taylor 2001). This underlines the scientific rationale for Early Intervention, which is now strong (Felitti et al. 1998). The seminal study that illustrates this was the California Adverse Childhood Experiences Study, which was one of the largest investigations ever on links between childhood maltreatment and later life, health and well-being. As part of this study, 17,000 participants had comprehensive physical examinations and provided detailed information on childhood abuse, neglect and family dysfunction. The study found that adults who had adverse childhoods showed higher levels of violence and antisocial behaviour, adult mental health problems, school underperformance and lower IQs, economic underperformance and poor physical health. These problems then led to high expenditure on health support, social welfare, justice and prisons, and lower wealth creation.
A further seminal study on prevention was a randomised controlled trial of a programme of prenatal and early childhood home visits by nurses. The study suggested that this can reduce the number of subsequent pregnancies, the use of welfare, child abuse and neglect, and criminal behavior on the part of low-income, unmarried mothers for up to 15 years after the birth of the first child (Olds 1997).

The research delineated in the strategic reports described above shows how the evidence about early intervention and the multitude of approaches has evolved.

Evidence about specific programmes is not generalisable, and the reports and related toolkits, recently made available to commissioners, focus on the structural elements and themes that must exist in and between the armory of programmes and services (henceforth referred to as meta-programmes) that necessarily coexist in a locality to support child health and wellbeing.

Structural elements and themes which exist in successful programmes and meta-programmes include:

*Best Start at Home*

The Best Start at Home report (Axford et al. 2015), commissioned by the Early Intervention Foundation (EIF), examined over 100 different programmes and developed a framework for considering different approaches to early intervention.

Axford et al described a framework for describing existing programmes for evaluation. Programmes could be divided into:

- **Attachment and parental sensitivity** – programmes that focus on promoting parental sensitivity and parent-infant/toddler interaction, with the aim of promoting secure attachment
- **Social, emotional and behavioural development** – programmes that focus on parent-child interaction, with the aim of improving the social, emotional and behavioural functioning of young children
- **Language and communication skills** – programmes that focus on promoting parents’ playing and reading with children, with the aim of promoting children’s language and communication in particular but also their wider development (e.g. cognitive, socio-emotional).

The types of prevention programme described in The Best Start at Home report are shown in Figure 35.

*Figure 35: Types of prevention programme described in The Best Start at Home report*
Axford et al define two categories of intervention:

*Universal interventions* are for the whole population (i.e. not identified on the basis of risk), and includes interventions that are intended to promote healthy development (promotion) and/or prevent problems (universal prevention). Many if not most interventions at this level do both, so we use the term ‘universal prevention’ to denote both.

*Targeted interventions*: Within the wider health and prevention literatures, it is useful to distinguish between two important forms of targeting of services:

- Early intervention targeted at individuals or population sub-groups on the basis of the elevated general level of risk of development problems. For example, infants who are judged to be more likely to have attachment problems because their mothers are depressed, or children living in a socio-economically deprived area who for that reason are considered to need additional support with early language development. The technical term for this is selective prevention.

- Early intervention targeted at individual children on the basis of detectable signs or symptoms in development foreshadowing mental, emotional, or behavioural disorder but before the children concerned have been diagnosed with a disorder. For example, children who are identified in pre-school or by parents as having behaviour problems but who do not have a formal diagnosis of conduct disorder. The technical term for this is indicated prevention.
The Comic Relief Hidden Harm Toolkit Case study projects

The Comic Relief toolkit provides an evidence-based strategic approach, along with numerous resources for local authorities to plan and integrate their Hidden Harm strategies (McWhirter & Madill).

This website (www.alcoholhiddenharmtoolkit.org.uk) contains a series of guides to improving alcohol Hidden Harm services, plus a feature which will indicate those sections which are most relevant to the user's needs. It also reports the evaluation of five initiatives that were funded by Comic Relief:

- The Bristol Drug Project works with children and young people whose parents were misusing alcohol by expanding their family therapy work, extending their mentoring programme for 9-15 year olds and introducing a new programme of group work for 5-9 year olds.

- CASA Family Service supports families where parental alcohol misuse is an issue, including
  - developing the capacity of generic children and family services in Islington to address the impact of alcohol Hidden Harm;
  - reducing the perceived stigma associated with an ‘alcohol and drugs service’ by developing the capacity of other agencies to respond to Hidden Harm
  - increasing referrals for families who are not in contact with Children’s Social Care or adult treatment provision and provide direct services to children and young people in families referred via this route.

- DISC (Developing Initiatives Supporting Communities) supports families with parental alcohol misuse by
  - delivering an eight week programme for parents misusing alcohol to support them in identifying the impact of their drinking on their children
  - delivering an eight-week programme to the children of these parents –with a dedicated children’s worker who seeks to enable them to voice their needs;
  - bringing parents and children together for a joint activity at the end of the programme.

- HertSpeak supports families where parental drug misuse was an issue by
  - developing family-focused support packages for those affected by parental drug or alcohol use
o developing parenting support via 1:1 and group programmes across community-based treatment

o increasing referrals into treatment/support for parents/families where children and young people are at risk.

o offering family therapy, couples counseling, and filial play coaching, parenting support and child/play therapy sessions.

- Lifeline – Step2 was intended to be delivered with and through four partner agencies who themselves work with vulnerable groups affected by domestic violence, young carers and young homeless people including runaways and refugee and asylum seekers. Lifeline planned to offer one-to-one and group work for children and young people.

Other toolkits
There are a number of published toolkits relating to prevention programmes that help local authorities implement local Hidden Harm strategies.

The Early Start toolkit is a live resource that evaluates early interventions, divided into 12 relevant categories, in terms of cost, evidence and duration of impact. It is a useful resource to ensure commissioning is evidence-based and up to date.

*Early Years Toolkit*

The early years toolkit, launched in 2015 provides a live regularly updated resource of programmes and approaches to supporting early years learning for disadvantaged children (Education Endowment Foundation).

Although not specifically directed at Hidden Harm, this resource provides a high-level visual picture of the cost/benefits of twelve categories of intervention in the early years for learning disadvantaged children that will also be relevant to children subject to Hidden Harm (Figure 37).
Figure 37: Twelve categories of intervention in the early years for learning disadvantaged children, evaluated in terms of cost, evidence and duration of impact

<table>
<thead>
<tr>
<th>EARLY YEARS TOPIC</th>
<th>COST</th>
<th>EVIDENCE</th>
<th>IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication and language approaches</td>
<td>£ £ £ £ £</td>
<td>6 mo</td>
<td></td>
</tr>
<tr>
<td>Early literacy approaches</td>
<td>£ £ £ £ £</td>
<td>4 mo</td>
<td></td>
</tr>
<tr>
<td>Early numeracy approaches</td>
<td>£ £ £ £ £</td>
<td>5 mo</td>
<td></td>
</tr>
<tr>
<td>Parental engagement</td>
<td>£ £ £ £ £</td>
<td>5 mo</td>
<td></td>
</tr>
<tr>
<td>Digital technology</td>
<td>£ £ £ £ £</td>
<td>4 mo</td>
<td></td>
</tr>
<tr>
<td>Earlier starting age</td>
<td>£ £ £ £ £</td>
<td>6 mo</td>
<td></td>
</tr>
<tr>
<td>Extra hours</td>
<td>£ £ £ £ £</td>
<td>3 mo</td>
<td></td>
</tr>
<tr>
<td>Physical development approaches</td>
<td>£ £ £ £ £</td>
<td>2 mo</td>
<td></td>
</tr>
<tr>
<td>Self-regulation strategies</td>
<td>£ £ £ £ £</td>
<td>7 mo</td>
<td></td>
</tr>
<tr>
<td>Physical environment</td>
<td>£ £ £ £ £</td>
<td>0 mo</td>
<td></td>
</tr>
<tr>
<td>Play-based learning</td>
<td>£ £ £ £ £</td>
<td>3 mo</td>
<td></td>
</tr>
<tr>
<td>Social and emotional learning strategies</td>
<td>£ £ £ £ £</td>
<td>3 mo</td>
<td></td>
</tr>
</tbody>
</table>

Source: Education Endowment Foundation (2015)

Literature review of economically evaluated responses to Hidden Harm

Kuklinski et al published a cost-benefit analysis of the Communities That Care, a public health approach to reducing risk, enhancing protection, and reducing the prevalence of adolescent health and behaviour problems in the United States (Kuklinski et al. 2015). The analysis concluded that the approach is a cost-beneficial preventative intervention and a good investment of public funds, even under very conservative cost and benefit assumptions. It prevents initiation of delinquency, alcohol use and tobacco use.

Cost-effectiveness of nurse family practitioners has been clearly established (Olds et al 1997). In the United States, benefit to cost ratios fall in the range of 3:1 to 5:1, depending on the study. Within the UK context, a social benefit to cost ratio of 1.84 has been calculated: the estimated value of total benefits to society, per £1 spent.

Evidence Review of programmes in use in Suffolk

There are three key strands of work delivered in Suffolk by the Local Authority Children’s Services of particular importance in addressing Hidden Harm: Signs of Safety, the Family Nurse Partnership and Suffolk Family Focus. We also summarise below an audit of the assessment of children at risk.
**Signs of Safety**

Signs of Safety has been adopted by Suffolk County Council Children’s Services as the overarching practice framework for all of its work with children and families. It describes a purposeful and collaborative way of working with families to secure the best outcomes for children and young people. It is known locally as Suffolk Signs of Safety and Wellbeing.

Suffolk has embarked on a three-year programme to implement and embed this approach, and has commissioned University Campus Suffolk to conduct an impact evaluation.

The Signs of Safety is described on its website as

> "An innovative strengths-based, safety-organised approach to child protection casework. The model of its approach was created in Western Australia by Andrew Turnell and Steve Edwards, who worked with over 150 front-line statutory practitioners and based it on what those practitioners know works well with difficult cases. The Signs of Safety approach has attracted international attention and is being used in jurisdictions in North America, Europe and Australasia." (Turnell & Edwards n.d.)

This approach deals with how child protection professionals actually build partnerships with parents where there is suspected or substantiated child abuse or neglect. It includes:

- expanding the investigation of risk to encompass signs of safety that can be built upon to stabilize and strengthen the child's and family's situation
- ten practice principles that serve as guiding beacons for child protection workers as they traverse the rough waters of abuse and neglect investigation
- a new child protection assessment and planning protocol that allows for comprehensive risk assessment incorporating both danger and safety and the perspectives of both professionals and service recipients (parents)
- practical, hands-on strategies for building a partnership with parents, which may, in the long run, prevent abuse and family dissolution (Turnell & Edwards 1999).

The Signs of Safety approach in England was recently evaluated positively by the NSPCC (Bunn 2013). This evidence review considered literature that evaluated the effectiveness of the programme in the following terms:

- Practitioner perception
- Assessment of risk
- The link between good working relationships/partnerships and child protection outcomes
• Case outcomes
• Implementation issues
  o managers and supervisors
  o consistency of implementation.

Bunn reports that case outcomes evaluation, which is the critical area of evaluation, is based on only two datasets from Minnesota, USA. One was from Olmsted County Child and Family Services, but could not be found even among the key references available on the Signs of Safety website. The other was from Carver County Community Social Services (Koziolek 2007a).

The findings for Olmsted were reported to show that the programme halved the number of children taken into care and halved the number of families taken to court (Turnell 2008, cited by Wheeler and Hogg 2012). Olmsted also recorded a recidivism rate of 2% (measured through state/federal audit), compared to an expected federal standard in the US of 6.7%.

The findings for Carver County (Turnell 2008, cited by Wheeler and Hogg 2012) were a change in the number of families experiencing termination of parental rights, with 21 families in 2004 and 2005 going through this process compared to just four in 2006/7. Koziolek (2009 personal communication, cited by Wheeler and Hogg 2012) also recorded a reduction in the number of children being placed as a result of a maltreatment report.

It is notable that all benefits have been reported by the founder of the programme, apart from one personal communication (Koziolek 2007b). There is little evidence of a relationship between the implementation of Signs of safety and improved child protection. Bunn et al said:

“Conclusions about outcomes from the Signs of Safety model are at a relatively early stage in development and global/country changes may take years to occur due to the time it takes to implement any model effectively. Some trends do seem to correlate in some areas and countries that have introduced Signs of Safety, but at the moment more research is needed to be conclusive about these findings and how change might be occurring.” (Bunn 2013 p57)

➢ Evidence to support the Signs of Safety approach is still limited.

Family Nurse Partnership

The Family Nurse Partnership (FNP) is a non-profit organisation operating in the United States which arranges for home visits from registered nurses to low-income first-time mothers. The visits are available to women under 20 and begin where possible during pregnancy and continue for two years following
birth. FNP intervention has been associated with improvements in maternal health, child health, and economic security. (Anon n.d.)

In the US, benefit to cost ratios fall in the range of 3:1 to 5:1, depending on the study. Within the UK context, a social benefit of £1.84 has been calculated, achieved at a cost of £1.

A workforce evaluation (Robinson et al. n.d.) and an economic evaluation (Apteligen 2012) have been undertaken for the UK scheme.

The economic evaluation suggested that the average total cost of delivering an established FNP team (year 2 onwards) is £3,083 per case per annum, varying between £2,500 and £3,600.

Donkin et al reviewed the evaluation literature for FNP, finding that over 30 years of research in the US on FNP has shown significant benefits for vulnerable young families in the short, medium and long term across a wide range of outcomes. They concluded that there are positive effects on breastfeeding, smoking, mental health, emergency visits (with a third fewer visits at age two and four), cognitive and language development and children’s behaviour (including attention, impulse control, and sociability). The 15-year follow-up randomised controlled trial (Olds 1997) showed the ongoing positive impacts in terms of fewer arrests, fewer teenage pregnancies, households less likely to be on welfare and less child abuse. The best outcomes are seen for children of mothers with low emotional intelligence and/or poor mental health prior to programme participation.

There is strong evidence for Family Nurse Partnerships as a clinically and cost effective early intervention in the US but the recent UK evaluation suggests that this may not be replicable in the UK, (Robling et al, 2015).

The researchers undertook a non-blinded, randomised controlled, parallel-group trial in community midwifery settings at 18 partnerships between local authorities and primary and secondary care organisations in England. They screened 3251 women between June 2009 and July 2010. After enrolment, 823 women were randomly assigned to receive FNP and 822 to usual care. The authors concluded that FNP shows no effect after two years on smoking cessation, birthweight, rates of second pregnancies, and emergency hospital visits for the child and that programme continuation was not justified on the basis of available evidence.

This trial’s results were unexpected and not easy to reconcile with previous research. It may be that the intervention was not implemented with sufficient fidelity, or that there was benefit in terms of other outcomes. It may be that the higher level of social support available routinely in the UK decreases the difference the programme can make or because the UK research only covers the first few years of implementation as oppose to the longitudinal research possible in the USA, there has not been time to fully establish the practice and achieve the outcomes seen in America. The National FNP Unit will be working with local implementation sites to review and contextualise the findings of the research.
Troubled Families Programme (Suffolk Family Focus)

Suffolk Family Focus is the name of the local implementation of the Troubled Families Programme.

In December 2011, the Prime Minister launched a new programme to turn around the lives of 120,000 troubled families in England by 2015. The aims of the Troubled Families Programme was to get children back into school, reduce youth crime and anti-social behaviour, put adults on a path back to work and bring down the amount that public services currently spend on them.

For the purposes of qualifying to be part of the Troubled Families Programme, a troubled family is defined as meeting three of these criteria:

1. Are involved in youth crime or anti-social behaviour
2. Have children who are regularly truanting or not in school
3. Have an adult on out-of-work benefits
4. Cause high costs to the taxpayer.

This programme is relevant to Hidden Harm in Suffolk since it is highly likely that families with parents exhibiting one of the toxic trio will fulfill these criteria.

A key feature of the 1995 Dundee Families Project (Casey 2012, p8), the project upon which a later 50 site roll-out was based, was an assertive worker for families with a contract of support and sanctions. The evaluation (Dillane et al. 2001), concluded that the project succeeded in producing change in many of the families it served, in overcoming local opposition and in co-operating with a range of other agencies. Among its key ingredients were

- the commitment to inter-agency partnership at strategic and case levels
- the systemic, intensive and supportive yet challenging approach in its direct work
- an array of specific intervention types that are tailored to individual families’ needs
- good management.

The report also concluded that some factors merited consideration in relation to the aims of this project and potential imitators. These include:

- the need for financial security
- use of the term ‘anti-social behaviour’
- the lengthy assessment process
- relationships with social work, health and drug misuse services
- the balance of residential and preventive work.
- The Troubled Family Programme has a convincing evidence base to support its validity, providing it is implemented in accordance with the programme evaluation recommendations.

Voluntary Sector Services

*Parents under Pressure programme*

The Parents under Pressure (PuP) programme is a national programme delivered by the NSPCC, aimed at supporting parents who are dependent on drugs or alcohol by providing them with methods of managing their emotional regulation, and of supporting their new baby's development. An evaluation of the PuP programme in Australia with parents on methadone maintenance who had children aged 3 to 8 years found significant reductions in child abuse potential, rigid parenting attitudes and child behaviour problems (Dawe & Harnett 2007).

A recent economic evaluation suggested that, assuming the most conservative estimate of one in five cases of maltreatment prevented, it cost £24,451 per case of potential maltreatment prevented. This is significantly less than the estimated mean lifetime cost of a case of child maltreatment of £110,000. For 100 families in the study population treated with PuP, there would be a net present value saving of an estimated £1.7 million (Dalziel et al. 2015).

PuP delivered by the NSPCC is currently the subject of a randomised controlled trial (Barlow et al. 2013). The recruitment to the randomised controlled trial was due to finish in October 2015, with final reporting due by the end of 2016.

Note: The NSPCC also delivers Smiles and DART which are specific to parental mental health and domestic abuse respectively.

Review of CAF assessments

In March 2015, 1676 of 1800 open cases to SCC children and young people services were in the hands of the integrated teams, suggesting the engagement of the integrated team as the local norm.

Suffolk County Council regularly audits the CAF assessments which it carries out, generating data which is not usually available from other social services departments. The March 2014 CAF report described the case audit and case closure evaluation carried out by agencies which are members of the multidisciplinary CAF teams. The majority were not carried out by the integrated teams. Fifty-four per cent were judged good or outstanding, but 43% were judged as requiring improvement or inadequate. Sixty-eight percent were deemed comprehensive, leaving some room for improvement. Receiving teams had developed and built on the CAF assessments. Key measures such
as child-centred practice show mixed findings; 63% of the assessments were judged good or outstanding but 32% were inadequate or required improvement.

More than 90% of the audits noted the positive building of relationships with parents, while only 77% of workers were building trusting relationships with children. This has been picked up by the CAF team as a challenge to tackle. Ninety-five percent of audits had a focus on building resilience, safety and wellbeing and showed evidence of teams involving other workers and agencies.

The commonest reasons for closing a CAF were that desired outcomes had been met (67% over the previous 12 months) or transfer to social care (5% over the previous 12 months). Among young people and adults, more than 93% agreed that services had come at the right time, dropping to 86% for children. No child or young person thought that the provision of services had worsened their situation, with only a modest number feeling things were much the same.

Suffolk County Council has a plan to address all key concerns in the audit reports, with milestones and lead people responsible for proposing actions, gaining sign-up and implementing these. The role of monitoring and audits has grown and is now important to all member agencies, and there is evidence of working together to improve services, e.g. responsibilities and auctions are spread across several agencies for many of the issues of concern.

**NB:** In April 2015 the integrated teams were evolved into the Early Help teams as part of SCC programme of Making Every Intervention Count. Service delivery is essentially the same but the make-up of the multi-agency teams is different.

This new focus on tightening up the processes by which children and young people with Hidden Harm are helped, together with monitoring of outcomes and of the satisfaction of those families who use the range of services, should improve the interventions and their coordination, and thus the experience of this group. Some of those interviewed hoped that improvements would be noted by people using services and that trust in the interventions and systems within the County would improve. Three people wondered if, therefore, a rise in the numbers seeking help should in future be seen as a success or a failure.
Evaluation of return on investment

Methodology
There are many vagaries in the identification of costs which impede complete and accurate identification of costings for any specific service. This is most difficult where services are delivered to small numbers of people, such as those with fetal alcohol syndrome, or those where services are delivered across several sectors, for example child neglect, where health, social care, criminal justice and third sector organisations are commonly engaged in service delivery.

We sought national estimates that can be extrapolated to Suffolk. We have endeavored to draw together costs of services from the organisations providing services to those suffering Hidden Harm, setting out where those costs can be readily ascertained, where they cannot be reliably identified and where they are partially known, along with any assumptions or discrete factors that will allow Suffolk County Council to understand how close to actual costs each figure comes.

Where possible, we have researched the cost of services to those suffering Hidden Harm from other parts of the UK, to allow the Council to understand where local spending either resembles its peers or materially varies from that of peers. We have focused on finding costings from locations where services are well-regarded, for example ones where regulators or inspectors have rated services highly over a period of years.

Suffolk County Council is interested in the potential social and economic return in investment for this group. Data on these was not available in a form that was useful for local commissioning. However, we examined and reviewed national and local data to improve understanding of the impact of any investment in health and in financial terms.

These calculations are uncertain, since many forces and drivers that have no direct causal link to outcomes can bear on both the costs and benefits of services.

We also examined national figures from Section 251 returns (Anon 2014) in the form of outturn data to compare Suffolk spend with neighbouring LAs in the East of England. We examined money spent on services for under 5s and calculated the cost per child for comparison with counties in the East of England based on 2014 population estimates.

Results
Data were highly incomplete; concerns have been raised about their quality and validity (FactCheck Channel 4 http://blogs.channel4.com/factcheck/how-dodgy-stats-could-decide-our-childrens-future/8400). Figure 38 shows the spend per child on services for under 5s for upper tier local authorities in the
East of England (Anon 2014). Suffolk’s spend was the second highest in East of England for 2013/14 and was at the 80th percentile for England as a whole.

**Figure 38: Spend per under 5 child, East of England, 2013-14**

![Spend per under 5 child, East of England, 2013-14](image)


Because children and young people affected by Hidden Harm are not separately counted and analysed, we cannot tell how much of Suffolk’s expenditure is allocated to them.

We used prevalence data to calculate the spend per opiate and crack cocaine service user, using prevalence estimates for Glasgow (Hay et al. 2009); the spend figures were for the whole service. Suffolk appears very similar to regional comparators.
Figure 39: Estimated per opiate and crack cocaine service user, local authorities in East of England, numbers of users 2011/12, costs 2012-2013.

Source: NTA Prevalence estimates and funding figures were also obtained from NTA (http://www.nta.nhs.uk/uploads/drugfunding12-13v.xls)
Fetal alcohol spectrum disorder

Fetal alcohol spectrum disorder (FASD) is the term for the effects of prenatal exposure to alcohol (British Medical Association, 2007 British Medical Association (2007) Fetal Alcohol Spectrum Disorders: A guide for healthcare professionals. London: British Medical Association). Alcohol is a teratogen, a substance that causes malformations in a fetus and interferes with its development. When a pregnant woman drinks, the alcohol in her bloodstream passes freely through the placenta into the fetus’ blood. Because the fetus does not have a fully developed liver, it cannot filter out the toxins from the alcohol as the mother can. Instead, the alcohol circulates in the fetus’ blood system causing harm, including facial dysmoria and brain damage. Fetal alcohol exposure is the leading known cause of intellectual disability in the Western world. In the USA, one in every 100 children is born with FASD (Autti-Ramo 2002, British Medical Association 2007, May and Gossage 2001, Plant 1985, Plant et al 1999, Sampson et al 1997). In other countries the prevalence is estimated to be higher. For example, in Italy the estimated prevalence is 2 to 4% (May 2006); in Russia, estimates vary between 2% and 4.5% (Popova 2013). FASD is more common than Down’s syndrome, cerebral palsy, cystic fibrosis and spina bifida combined. In a culture which sees binge drinking on the increase (Donaldson 2009), the number of children with FASD is set to rise.

FASD includes:

- fetal alcohol syndrome (FAS) – the most easily recognisable condition due to characteristic facial features (commonly including a thin upper lip, a flat philtrum (the groove between the nose and upper lip) and smaller eye openings)
- partial fetal alcohol syndrome (PFAS) – some but not all of the criteria for FAS are met
- fetal alcohol effects (FAE) – the symptoms are not usually visible (e.g. behaviour disorders, attention deficits, etc.)
- alcohol-related neurodevelopmental disorder (ARND) – can include attention deficits, behaviour disorders, obsessive/compulsive disorder.

Based upon the estimated prevalence in the United States, the lowest estimate found in this review of the evidence, there are likely to be 6,000 to 7,000 babies born with FASDs of varying severity in the UK each year, and about 80 babies with FASD born each year in Suffolk across the spectrum of severity. Hospital episode statistics for Suffolk show 27 diagnoses in the period 2009/10 to 2014/14, of which 25 were dysmorphic fetal alcohol syndrome (FAS).

Out of every five children with FASD, four are fostered or adopted, because their mothers are, or frequently go on to become, unable to care for them.
because of excessive drinking. This is the largest group of children in England going into fostering and adoption and constitute the largest group of adolescents going into the criminal justice system.

A diagnosis of FAS is not necessarily an indication of the severity of the impairment, which varies considerably. The severity of presentation (e.g. facial dysmorphia) may not indicate severe impairment (Stratton et al, 1996). For a diagnosis of FAS, four criteria must be met: growth deficiency, characteristic facial features, central nervous system damage and confirmed alcohol exposure.

The outlook is bleak for young people across the spectrum of FASD. Mental health problems are seen in 87% of children (O'Connor 2002); disrupted school experience in 60% over the age of 11 years (Riley 2003); trouble with the law in 60% of teenagers (Kelly 2009); and imprisonment in 50%. They also can show inappropriate sexual behaviour, problems with dependent living and with employment (Streissguth 1997). They also are at increased risk of developing addictive behaviours such as alcohol misuse, thereby potentially continuing the cycle of FASD into the next generation (Baer 2003). Streissguth and colleagues in the USA found that 3% of 6 to 11 year olds, 12% of 12 to 20 year olds, and 23% of adults from a cohort of 415 subjects diagnosed with FAS or FAE had attempted suicide, a figure five times greater than the US national average (Streissguth 1996).
Young carers

The definition and classification of a young carer and young adult carer is recognised as being important because it carries with it certain legal rights for the individual and responsibilities for local authorities. The Children and Families Act 2014 introduces a system of support for young carers and young adult carers which extends from birth to 25, while the Care Act 2014 deals with adult social care for carers over the age of 18. This means the cohort of young adult carers aged 18 to 25 are entitled to support through both these pieces of legislation.

Suffolk Family Carers, Suffolk County Council’s strategic partner for delivering young carers and young adult carers services, defines access to their young carers services as being for anyone aged 9 to 15 years and young adult carers services as being for anyone aged 16 to 24 years. In practice, however, there is flexibility around the upper and lower age thresholds applied, with children as young as 6 or 7 years presenting and young adult services continuing to offer light touch support to some young adult carers after their 24th birthday.

According to the 2011 Census, 1,497 young people in Suffolk aged 0 to 15 identified themselves as an unpaid carer, as did a further 3,216 young carers/young adult carers aged between 16-24. 495 of these young carers and young adult carers reported they were delivering 50 or more hours of unpaid care per week (ONS 2011). However, these prevalence figures are likely to be an underrepresentation of need, as many young carers come from hidden and marginalised groups, including children caring for family members with mental illness and parental drug or alcohol dependency. Caring has significant impact on many young people, especially on their educational outcomes and employment opportunities (Children’s Society 2013). Young and young adult carers under 25 represent 6.0% of the overall number of unpaid carers in Suffolk (77,745), which is lower than the East of England (6.7%) and England (7.6%) average. Local surveys suggest that there are approximately 18,850 carers under 25 years in Suffolk, roughly breaking down into 12,860 young adult carers aged 16-24 years and 6,000 young carers aged 15 years and under. These figures are much higher than those from the Census.

As of November 2014, 1,444 young people had registered with commissioned services (1,009 young carers and 435 young adult carers) (Table 25).
Table 25: Service Activity Data from Suffolk Family Carers Young and Young Adult Carers Services

<table>
<thead>
<tr>
<th></th>
<th>April 2011</th>
<th>April 2012</th>
<th>April 2013</th>
<th>April 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>YCs and YACs</td>
<td>638</td>
<td>857</td>
<td>1038</td>
<td>1285</td>
</tr>
<tr>
<td>Registered</td>
<td>Active</td>
<td>Registered</td>
<td>Active</td>
<td>Registered</td>
</tr>
<tr>
<td>April 2011</td>
<td>330</td>
<td>530</td>
<td>701</td>
<td>944</td>
</tr>
</tbody>
</table>
| Source: Suffolk County Council

Figure 40 shows that the highest proportion of young adult carers aged 16-24 years identified through the 2011 Census reside in Ipswich (5.6%) and the lowest proportion reside in Suffolk Coastal (3.2%). When considering young carers aged 0-15 years, the majority again reside in the Ipswich area (2.4%), whereas the smallest proportion resides in Mid-Suffolk (1.5%).

**Figure 40: Proportion of people providing unpaid care aged 0 to 15 years and 16 to 24 years, Suffolk, by local authority district**

Figure 41 helps to illuminate the percentage of people under 25 providing unpaid care by lower-layer super output area (LSOA) in Suffolk, as reported in the 2011 Census. LSOA areas allow for more accurate comparison between areas than electoral wards, as they are composed of a more similar
population size (1500 people on average) (ONS 2014). The darker shades of green in Figure 41 highlight the LSOA areas where there are higher numbers of people under 25 delivering unpaid care.

**Figure 41: Proportion of people providing unpaid care aged 0 to 15 years and 16 to 24 years, Suffolk, by lower level super output area**

Figure 42 shows that the majority of unpaid carers under 25 who self-identified through the 2011 Census are female (55.2%), aged 16-24 years (68.2%) and delivering between 1-19 hours of unpaid care per week (76.3%).
Figure 42: Demographics of young and young adult carers providing unpaid care

Suffolk also uses nationally gathered data to estimate the numbers of young carers in the County. In 2013, the Children’s Society published *Hidden from View: the experience of young carers in England*, a six-year longitudinal study (Children’s Society, 2013). The main findings included:

- One in 12 young carers is caring for more than 15 hours per week. Around one in 20 misses school because of their caring responsibilities.
- Young carers are 1.5 times more likely than their peers to be from black, Asian or minority ethnic communities, and are twice as likely to not speak English as their first language.
- Young carers are 1.5 times more likely than their peers to have a special educational need or a disability.
- The average annual income for families with a young carer is £5000 less than families who do not have a young carer.
- There is no strong evidence that young carers are more likely than their peers to come into contact with support agencies, despite government recognition that this needs to happen.
• Young carers have significantly lower educational attainment at GCSE level, the equivalent to nine grades lower overall than their peers e.g. the difference between nine Bs and nine Cs.

• Young carers are more likely than the national average to be not in education, employment or training (NEET) between the ages of 16 and 19.

Research in Nottinghamshire published in 2013 (Sempik and Baker 2013) confirmed these findings, and added that

• Almost 40% of young carers reported a mental health problem

• School was a key location for identifying and supporting young carers, even though some carers found their caring responsibilities meant that they missed school from time to time.

• Post-secondary education was key for these young people, with 51% being unemployed.

Suffolk County Council commissioned a short film, Bed Bugs6, to highlight some of the challenges young carers face and to encourage them to seek support.

Suffolk Young Carers reported that 28.6% of carers who left school from years 12 to 14 in 2014 went on to no employment, education or training (NEET). The national figure for NEET is 6.2%, and for Suffolk is 6.4% for those aged 16 to 18 (Suffolk Community Health Profile 2103). This highlights the serious impact that their role brings.

**Commissioned services for young carers**

Suffolk County Council and their CCG partners are working together to respond to important legislative changes relating to young carers and young adult carers set out in the Children and Families Act 2014, Care Act 2014 and NHS England’s recent planning guidance Forward View into Action: planning for 2015/16 (NHS England 2014). Suffolk County Council has invested in work in schools to meet the challenges of these young people. The County Council has worked with primary care and post-secondary education bodies to provide support to young carers to help them reach their potential as far as possible.

Specialist support for young carers and young adult carers is commissioned by Children & Young Peoples’ Services, Suffolk County Council and provided by the Young Carers and Young Adult Carers projects at Suffolk Family Carers. This involves:

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6 Trailer online at https://www.youtube.com/watch?v=GNEKC5Pcw88
- Information, advice and guidance using face to face, phone and social media such as Tumblr and Facebook
- Group activities and residential programmes
- One-to-one assessments with annual review, and intervention work
- Supporting schools and colleges to provide a young carer-friendly ethos, including case specific work and drop-ins
- Core support for Young Adult Carers, including transport, advocating within CAF, TAC and CiN meetings
- Employment support aimed at avoiding becoming NEET
- Wellbeing and empowerment.

Suffolk has several special projects to support young carers:

**Big Lottery BOOST Project**

This project comprises events and activities targeting confidence and self-esteem, building peer groups, working in teams and building confidence. This project has an additional target outcome of reaching rural and BME groups.

**Henry Smith Project**

Suffolk has obtained funds for a project manager post to identify hidden and hard-to-reach young adult carers, isolated and minority groups. As of January 2015, 305 young and young adult carers from minority groups have been identified by the project.

**Pilot Project for the younger (5-8) age group**

The 2011 Census identified 1,497 young carers aged 0-15 years. The County Council suspects that there is a body of young carers under the age of 9. A small investment has allowed Suffolk Family Carers Young Carers Team to explore how best they can respond to the needs of this younger age group.

**Young Adult Carer - Mental Health Project**

Over 40% of the 400 young adult carers registered with the Young Adult Carer Team support a family member with mental health issues or drug or alcohol misuse. Some of these young adult carers report issues with their own
mental health and wellbeing, and require support with managing stress, anxiety, and poor sleep pattern. They are provided with relevant training and education to improve their mental wellbeing.

Schools Award

The Schools Award supports schools to develop a young carer-friendly ethos with procedures and protocols in place to identify and support young carers.

Schools Research Project with University Campus Suffolk

UCS is to undertake a research project to investigate how the provision of support to young carers in schools might impact positively on attainment, attendance, health and well-being, and confidence levels. The research will examine three schools that have not previously engaged with the Schools Award programme and will take a baseline of qualitative and quantitative data at the outset, introduce different types of support for young carers to the school and then examine the impacts and soft and hard outcomes after a school year. The data will inform the strategy for supporting schools in the future and may also help the Young Carers Team to launch a package of support for schools which would help the project to become self-sustaining in the future.

The Suffolk Carers Needs Assessment: Young Carers and Young Adult Carers Supplementary Report was published in May 2015. It recommended improving case finding and early identification of young carers, reducing inequalities in education, attainment and employment, and improving young carers mental health, wellbeing and access.
Workshop results

On 22 July 2015, PHAST organised two workshops in Ipswich to obtain feedback on local services for people with Hidden Harm. Invitees are listed in the Appendix.

The morning session covered:

- What are commissioning to achieve? Service provision versus prevention
- How do you set priorities? Data / knowledge and process
- Whose voices exert greatest influence? How do commissioners, providers and people supported communicate?
- What data would most help commissioning decisions? What can be grown locally and what nationally?

The afternoon session covered:

- Which Hidden Harm C&YP are least well served?
- How could communication become more open and allow greater sharing of information between H&SC professionals?
- How can front line services, the people supported, and commissioners communicate better?
- Are there data that should be gathered nationally?
- Can we map the Suffolk system?

The following themes emerged:

Who is not well served?

- Rural communities, especially those in social housing and those reliant on public transport
- Male victims of domestic abuse
- Young people with complex additional needs (16+ years)
- Children on autistic spectrum and their families
- People with a dual diagnosis
- Maternal mental health – new mums, across county
• Children not attending school
• Young men with mental health problems
• Young people leaving school
• Families with under 5s. They find it difficult to access some services because some services do not allow children in building. Therefore parents will not or cannot attend.
• Survivors in transition – sexual trauma – only available in Ipswich
• New Beginnings – sexual trauma – available Colchester/Ipswich
• People with ADHD.

Data gaps
• What people think of our services
• Miscarriage information for health visitors
• Referrals made to community via acute settings
• Inappropriate referrals made to services – lack of training?
• Under 18s alcohol abuse via A&E
• Suicide attempts from under 16s and how many are referred to services
• Post termination group
• Adults with mental health problems who are also carers
• Self-harm, not all seen in A&E
• Male victims of domestic abuse
• Ethnic minority victims of domestic abuse
• Children who are violent toward parents/carers

Priorities
• Services
  o Detoxification beds in small rural hospitals
  o Transport to bring people to services
- Home visiting – outreach

- Data needed
  - The sources of referrals
  - CYP, parent/carer views – use the signs of safety information aggregated
  - How far would people be prepared to go to access services? How much support do they need to access them?

- Blocks
  - Rigidity of services
  - Childcare
  - Capacity
  - Time
  - Volume of work at early intervention level
  - Costs e.g. of maintaining mobile outreach e.g. buses
  - Time taken by 1:1 home visits in rural areas
  - (Lack of) recognition of impact/seriousness of situation and need for support e.g. alcohol
  - Rural areas – can be need for anonymity; cultural differences
Conclusions

Understanding the extent of Hidden Harm

It is difficult to be clear about the number of children and young people in Suffolk affected by Hidden Harm. The problem has only been recently defined and recognised, and is by definition hidden. There are few national data and local data are also sparse. This makes it hard to delineate the population at risk of, and damaged by, Hidden Harm, the first stage in understanding and meeting their needs.

Urban and rural differences

Information on Hidden Harm appears more readily available in urban areas than in rural parts of Suffolk. People in rural areas affected by Hidden Harm may not come forward, or may find no services available if they do. This reflects a concentration of services in the County’s towns and especially in Ipswich.

Existing patterns of service

Some services in Suffolk for vulnerable children and families equally apply to those affected by Hidden Harm and are of high quality. The Signs of Safety programme in particular has apparently been appropriately implemented in the County. The Young Carers programme and Suffolk Family Focus approach have also been shown to be successful, and the school nurses in Suffolk provide a valuable service. One of the strengths of these services is that they provide face-to-face interventions, rather than relying solely on virtual engagement and social media.

Influences on outcomes

We found little analysis of which factors influence the outcome for neglected or abused children. It is believed that those affected by Hidden Harm need social care for longer than those whose needs arise for other reasons, but this has not been proven by the analysis of data. This means that decisions about individual children’s care is less well-informed and that resources are not demonstrably well-targeted.
Financial analysis

There is understandable uncertainty about the balance of expenditure between preventive interventions and programmes, and about how much is spent on people already affected by Hidden Harm. There are a number of reasons for this: lack of evidence as to the cost-effectiveness and payback from different ways of spending money, difficulties with understanding the exact nature of interventions and spending already in place and at whom they are aimed, and pressure to respond to children already at risk or affected, rather than divert resources upstream.

Effective services

Some conclusions can be drawn from the available literature about the prevention and treatment of Hidden Harm. Services are most effective when they are focused on the whole family, offering support for all family members and providing parents/carers with therapeutic support as well as training, skills and resources to improve their parenting. They should be flexible enough to adapt to the emerging issues and needs of clients once they have started to engage. They need to be available for longer than six months if needed, with the opportunity to extend that duration and to return for further support according to client needs.

The most effective interventions are child-centred, meaning that they develop children’s social capital and extend children’s networks of support outside the immediate family. They are focused on the child’s safety and their ability to communicate outside the home.

These services require strong leadership and management, and should work in partnership with adult services and universal services, particularly schools. Services should include elements which improve communication between parents/carers and children and which enable children to build networks of support with other adults in the community. Therapeutic services and those offering youth groups and therapeutic group activities reduce children’s feelings of isolation and can help develop their resilience.
Recommendations

4. **Service development to ensure support and interventions are provided equitably across the county.**

- We recommend the extension of existing effective programmes so that they are available throughout the County. Awareness of Hidden Harm appears lower in rural parts of Suffolk, and preventive programmes and other interventions are more readily available, or only available, in Ipswich or other larger settlements. However, Hidden Harm occurs in all communities, and services need to reflect this.

- We recommend extending the implementation of programmes such as Family Nurse Partnership to women not able to access the programme at present because of geographical location or eligibility criteria. This could include, for example, all pregnant women with one or more of the Hidden Harm characteristics.

- We recommend that SCC maps the geographical access to services preventing and responding to Hidden Harm for children, young people and families, to identify where there are gaps and how this could be addressed so as to achieve equitable outcomes across the county.

5. **Service development to ensure support and interventions are effective, based on evidence, research and practice based feedback.**

- We recommend maintaining and further developing the school nurse teams as part of the work to provide support to those experiencing Hidden Harm. School nurses should be present in all schools, with time to provide a safe and trusted source of help to pupils and, where appropriate, parents.

- We recommend reviewing the interventions recommended in the Allen Report (2011), and mapping the interventions used in Suffolk to ensure that the optimum use is made of these well evidenced programmes.

- We recommend active implementation of the findings of the Suffolk Carers Needs Assessment: Young Carers and Young Adult Carers Supplementary Report, (http://www.healthysuffolk.org.uk/assets/JSNA/PH-reports/20150104Young-Carers-Supplementary-Reportfinal.pdf ) to include monitoring of progress, review of services using the intelligence from young people and front-line staff, and communicating the success of the available interventions, which will encourage young people to seek help. We also recommend that the Council's Adult and Children's services and their partners adopt the recommendations within the newly drafted Young Carers and Young Adult Carers Strategy to work together to meet the needs of young carers and young adult carers in
accordance with their statutory obligations. As in other areas of this work, it is important to aim for equity of outcomes across all part of the County.

- We recommend engagement with children and young people that have experienced Hidden Harm to further understand what works in supporting them and where improvement could be made. This should be an active on-going process for gaining their input in to service review and development.

- We make three recommendations with respect to fetal alcohol syndrome disorder (FASD):
  - Train midwives to enable them to give support to women during pregnancy to minimise their drinking
  - Train all clinical staff working with birthing mothers to consider FASD and carefully examine the new born for diagnostic signs
  - Train teachers to understand FASD and offer support to pupils with FASD. Schools should have access to specialist approaches, knowledge and resources.

6. **Establish a co-ordinated approach to preventing and responding to Hidden Harm, at strategic, commissioning and operational level.**

- We recommend that Suffolk County Council considers the interoperability and fit of concurrent programmes across age groups and throughout a child’s journey as they grow through childhood and communicates availability to ensure appropriate collaboration and take up. There are many effective early intervention programmes available.

- We recommend that Suffolk County Council reviews the existing forums for overseeing the strategic development of services and collation and analysis of data and intelligence. The Hidden Harm Steering Group and the MARAC group are fora where this might be established, and the local audit service engaged to analyse progress towards measurable outcomes.

- We recommend that the use of the Suffolk ACCORD Protocol is further embedded and monitored to ensure effective collaboration between adult and children’s services across statutory agencies. [http://suffolkscb.org.uk/procedures/lscb-policies-guidance-and-protocols/accord/](http://suffolkscb.org.uk/procedures/lscb-policies-guidance-and-protocols/accord/)

6. **Establish a process for cost benefit analysis of interventions for Hidden Harm to inform service development and future commissioning.**

- We recommend that Suffolk County Council analyses which factors about a child and his/her family influence their prognosis, in terms of
duration of care, expenditure and eventual outcomes. This will enable better targeting of resources.

- We recommend that Suffolk County Council analyses its expenditure on Hidden Harm, to show the balance between prevention and treatment, how much is spent on specific programmes and the outcomes achieved.

7. **Further develop and maintain data collection relating to Hidden Harm, across organisations and utilising audit to further understand the correlation between incidence, intervention and outcome.**

- We recommend that Suffolk County Council maintains the level of data analysis presented in the report so that it can continue to monitor and identify trends and the impact of its policies.

- We recommend that Suffolk County Council assesses whether each at-risk child is affected by Hidden Harm, and if so, places them on a “Hidden Harm register”. Interactions with services including costs and outcomes could then be mapped and Hidden Harm evaluated more fully in future.

- We recommend that the predictive factors for Hidden Harm, including poverty, multiple disadvantage and ethnic and minority considerations are mapped across to population groups to enable proactive and preventive work with these families.

- We recommend further work to understand why some parents do not use alcohol services within the County and why such a high proportion leave treatment without completing it.
This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.
working directly with the service user. It uses a case consultation and training approach to support the existing workforce.

PQA: Performance & Quality Assurance (Board)
PUP: Parents under Pressure Programme [weblink]
SFFPS: Suffolk Family Focus Psychology Service
SDAP: Suffolk Domestic Abuse Partnership
SM: One System Methodology (See Munro Recommendation 9)
TAC: Team around the child
VCS: Voluntary and community Services
WIC: Who’s in charge (Training for Parents-domestic abuse)
YOT: Youth offending team
References


This needs assessment was prepared by the Public Health Action Support Team on behalf of Suffolk County Council.


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Suffolk Young Carers Needs Assessment Supplementary Report 2015 http://www.healthysuffolk.org.uk/assets/JSNA/PH-reports/20150104Young-Carers-Supplementary-Reportfinal.pdf


Thomas Coram Research Unit & Institute of Education (2008), University of London. Disabled Children: Numbers, Characteristics and Local Service Provision.


Appendix 1: focus group participants

Morning
Jennifer Ball, Senior Recovery Worker, TP
Nicki Cooper, Commissioning Manager, SCC Public Health
Lisa Gav, Health Visitor
Sharon Jarrett, Head of Health Improvement CYP and sexual health, SCC
Judith Moore, County Parenting Coordinator, CYP, SCC
Shirley Osbourne, County Lead, Domestic Abuse and Community Safety, SCC
Sue Phillips, Young Carers Lead, SCC
Anne Rawcliffe, Children's Services Practitioner, Parents Under Pressure (NSPCC)
Julie Thurston, Young People's Service Manager, SCC
Brian Tobin, CEO, Iceni

Afternoon
Verity Abrahams, Health Visitor
Debbie Burton, Family Support Practitioner
Steven Bush, Clinical Psychologist
Marion Caulfield, Social Worker (Youth Mental Health)
Kayleigh Clarke, Family Support Practitioner
Nicki Cooper, Commissioning Manager, SCC Public Health
Sue Dodd, Family Support Practitioner, Sudbury Cluster Children's Centres
Danielle Gooch, Mental Health Nurse
Juliet Hand, Mental Health Nurse, Youth Pathway
Belinda Hart, Family Support Practitioner, Bluebell Children's Centre
Clare Hedges, Clinical Team Leader, CAMHS
Holly Hewer, Family Support Officer
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Appendix 2: Services in Suffolk relevant to Hidden Harm

Children’s Centres

Suffolk has 48 Children’s Centres including some offering specialist services, eg for children with learning disabilities.

Home Start

Home Start is a national charity offering support through trained volunteers to families with young children, experiencing difficulty because of factors such as Hidden Harm, deprivation, problems within the family. There are local branches of Home Start in areas of the county such as Ipswich, Mid Suffolk and Suffolk Coastal. Ipswich has a Home Start Nurture Group which operates as a drop-in open to all.

http://www.home-start.org.uk/

Family Contact Centre

Bury St Edmunds has a contact centre with a safe and secure environment for children in local authority care to meet with their parents and siblings under supervision.

Early years provision

Suffolk County Council maintains up-to-date lists of child-minders together with guidance for families wishing to find childcare to suit their needs. Suffolk has 116 day nurseries including provision within acute trusts, following specialist approaches such as Montessori, and with an emphasis on learning in the outdoors where possible. There is advice on those seeking free childcare from age 2.

Primary education

Suffolk has 64 nursery schools, 210 primary schools and 4 middle schools as well as other local authority maintained schools. Local policy is to complete the closure of middle schools when feasible in line with national policy. These schools include 89 supporting pupils with autistic spectrum disorders, 87 supporting pupils with communication difficulties, 83 supporting pupils with a range of health conditions, 89 supporting pupils with learning difficulties, 75 supporting pupils with mental health conditions, 82 supporting pupils with physical disabilities, 70 supporting pupils with sensory impairments.
Secondary school provision

Suffolk has a range of secondary schools such as state-funded schools, academies, schools for pupils with special needs, free schools and 14 pupil referral units, some of which offer support to children of primary school age.

Prevention activity in schools

Schools have a central role in encouraging children and young people with Hidden Harm to trust teachers, pastoral and support staff or school nurses sufficiently to turn to them in their time of need. Evidence from national and local practice has shown that establishing a climate where this can happen means approaching such sensitive topics from the young people’s viewpoint and moving away from didactic set piece sessions in school assemblies or lessons. Sessions on Hidden Harm related factors may evoke a number of responses in a child who is experiencing one or more of those factors and their needs to be sensitive consideration and follow up to ensure that children who need help and support feel able to come forward.

To facilitate this, Suffolk County Council Learning Improvement service developed a series of age-appropriate sessions that include discussions about good relationships and the values and behaviours that should be shown. These debates, usually led by the pupils themselves, allow them to understand the difference between good relationships and poor ones. This is the cornerstone of building trust and allows pupils to go on to lessons where more sensitive topics and behaviours can be explored, which may then facilitate the child sharing concerns with a trusted adult. As schools understand this approach they have become enthusiastic adopters of this way of working, and seek to support pupils with Hidden Harm more fully, using their resources to help them with specific support as needed.

Where this style of approach has been taken feedback has indicated that more pupils have come forward with their problems. It is anticipated that Signs of Safety data will demonstrate both that difficulties are expressed earlier and that families are better able to address problems together and thereby achieve successful outcomes, though data is not yet available to support this assertion.

Closer working between safeguarding services, police and schools has resulted in improved information sharing in both identifying and responding to the needs of children experiencing hidden harm, for example, by establishing a protocol for alerting named staff when a child in their school has been involved in a domestic abuse incident that the police have attended so that appropriate support and care can be in place for that child should they need it.
Suffolk County Council has established a website (www.thesource.me.uk/) aimed at informing young people about services available to them. It provides up-to-date details of

- Education choices, including those at age 13+, 16+ and 17+, work experience, traineeships and apprenticeships
- Preparation for work, including tips on CV drafting
- Careers advice and an app with information about local apprenticeship schemes
- Health - including advice on drugs, alcohol, eating disorders, food and exercise, mental health, sexual health, smoking, gambling and a range of other topics. For each, there is general advice and signposting to local lay available support services.
- Relationships, including advice on family and home, and on bullying including cyberbullying. General advice is accompanied by signposting to local services or national advice sources such as ChildLine.
- Housing, including advice on homelessness, including concerns about becoming homeless, private fostering and on the implications of running away
- Financial advice, eg on post 16 studying, student finance, and debt. Suffolk County Council offers subsidy on fares with the Endeavour Card.
- Leisure and citizenship opportunities, including a befriending scheme with Hub Groups in 6 Suffolk towns
- Transport, including the process for obtaining the Endeavour Card and hints on how best to use local buses and trains, and laws on driving.

This website provides useful advice to young people seeking help in a range of circumstances, including those faced by children and young people suffering Hidden Harm. It signposts them to services that can help them, such as their parents, other adults with authority in their homes and services aimed at addressing challenges facing the whole family together. There was evidence from speaking to senior professionals from Suffolk County Council that many young people were not aware of The Source and that it needs to be more strongly promoted both through schools and directly to young people.

Suffolk has a number of specialist programmes to support children and young people with Hidden Harm:
Support to young carers: There is a range of support spearheaded by Suffolk Young Carers set out earlier in this report. 
http://www.suffolkfamilycarers.org/young-carers.html

Turning Point provides services throughout Suffolk for young people and adults experiencing drug and/or alcohol misuse. The three key locations are in Ipswich, Lowestoft and Bury St Edmunds, but there are services in GP surgeries, pharmacies and other community sites as well as a recovery vehicle that can bring services anywhere in the County. 
http://www.turning-point.co.uk/suffolk-recovery-network-ipswich.aspx

Anglia Care Trust provide the Suffolk Domestic Abuse Outreach Service for victims of domestic abuse and their children. It provides a 24 hour helpline, advice and information, intensive support and crisis support. 

Women’s Aid Refuges. There are three refuges in Suffolk, one in Bury St Edmunds, one in Ipswich and one in Lowestoft. These are for women victims of domestic abuse in crisis and needing a place of safety. Further information can be found on https://www.womensaid.org.uk/ and https://www.womensaid.org.uk/domestic-abuse-directory/

The Ormiston Project is a third sector organisation that supports children and families affected by imprisonment, works with families from Gypsy and Traveller Communities, runs some Children’s Centres and nurseries and supports parents facing challenges including the toxic trio of domestic abuse, drug and alcohol misuse, and mental ill health. 
http://www.ormiston.org/find-help-near-you.html

Iceni is a third sector organisation providing as far as possible a one-stop shop for families or young people in challenging circumstances, including suffering Hidden Harm. Iceni is based in Ipswich and provides services to several hundred families each year within the town.

Iceni focuses on early intervention with families, undertaking parent-centred work. The charity works with approximately 120 families at a time. Much of the work is with families with drug and alcohol misuse within the household.
Work is provided in an approach described as under-one-roof, trying to provide the range of support designed to give the greatest chance for successful outcomes. This approach was driven by listening to families who explained that attending the range of meetings agreed by different agencies proved too burdensome.

Iceni has learned that helping people to lose their dependence on drugs and alcohol is insufficient in turning their lives round. These families need help to build relationships, to take steps towards employment, improving their lives and gaining confidence in living day-to-day. Families work with statutory and third sector organisations if they feel a perceived threat of the removal of their children. The charity therefore invests in long-term support to families and has seen success in moving families to living normal independent lives through this process. They use standard, well-attested programmes such as Triple P, Teen Triple P, Caring Dads, as well as bespoke one-to-one support, and employ experienced therapists and workers from a range of disciplines available to those able to benefit from the centre in Ipswich. For younger parents, Iceni has forged a link with the Paul Hamlyn Foundation for parents aged 25 and under; this group constitutes just under half of those looked after by Iceni.

Much of the support takes place in group settings and covers all aspects of Hidden Harm, including child sexual exploitation, where sensitive listening has led to more families sharing their experience with Iceni and accepting support and treatment for both the children and adult perpetrators.

It is difficult to compare Iceni to other services because there is no direct comparator offering similar interventions to a similar client group. Iceni only operates in Ipswich, creating geographical inequity for those living elsewhere in Suffolk.

http://www.iceniipswich.org/

Parenting Support and Parenting Programmes

SCC CYPS offer a range of evidence based parenting support programmes relevant to parents/carers with difficulties that may be impacting detrimentally on how they care for their children. Parenting support is also offered on a one-to-one basis where assessed as being appropriate.

Information about parenting support and the programmes, including how to attend a programme is available on the parenting Hub.


The SCC parenting support programmes are complemented by programmes delivered by third sector organisations, e.g.

Caring Dads is a programme run in several locations across Suffolk as part of the core offer of parenting support, and is aimed at fathers who need to
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improve their relationship with their children and to end controlling and abusive behaviours. It runs for two hours per week over 17 weeks and is open to fathers aged 16 years or over. Each Caring Dads group is run by two or three trained facilitators from a range of professional backgrounds, including Early Help, Social Care, Probation and Police in collaboration with voluntary organisations such as Waveney Domestic Abuse Forum, Coastal Action Against Abuse, Anglia Care Trust and Compassion, with the support of Community Safety Partnerships and the Police and Crime Commissioner.

The NSPCC provides several services for children and young people with Hidden Harm. These are based in Ipswich, though some support can be provided in locations such as Mildenhall, Haverhill and Brandon. NSPCC is concerned about travel costs and the time taken in visiting rural locations within their allocated budgets. They are also concerned about the unmet need of families outside the urban centres of the County. NSPCC seeks to work with families before they reach a crisis point, and often manage to do so, either in partnership with other services or through their own services alone. They believe that perinatal work would be an important development to avert Hidden Harm, and wish to start a programme such as Baby Steps’ in Suffolk.

http://infolink.suffolk.gov.uk/kb5/suffolk/infolink/service.page?id=uBYtH2xdgK

The NSPCC deliver the following specific programmes in Suffolk, relating to Hidden Harm:

Parents Under Pressure is for parents in drug and substance misuse treatment with a child under 5. The aim is to reduce parental stress and domestic violence. The approach can be used even where there is a baby under 2 in the household to reduce the risk of harm, though it is more commonly used for those between 2 and 5. This programme works with up to 20 families at a time.

Domestic Abuse Recovering Together is a linked group working with mothers and their children when they have suffered domestic abuse for ten weeks or longer, and have children between the ages of 7 and 15. It is a 20 week programme for parents who are on rehabilitation for drug and alcohol misuse. There is a strong accent on building relationships by being honest but non-judgemental.

Family Smiles is a group work programme for children whose parent has a mental illness. The programme chiefly works through an 8-week programme for children aged 8 to 14.

http://www.nspcc.org.uk/services-and-resources/services-for-children-and-families/baby-steps/
Turning the Page is a programme to combat harmful sex behaviour for children and young people between the ages of 5 and 17. This programme comprises an assessment process followed by therapeutic work up to 30 sessions.

Suffolk Young People’s Health Project (4YP) is a third-sector organisation that co-ordinates services that improve the social, emotional, and physical health and wellbeing of 12-25 year olds in Suffolk. It is based in Ipswich but works across the County. Services include

- Youth work with Young People’s Workers (group work, intensive 1:1 support, drop-in workshops, and fun activities)
- Counselling
- Drug and alcohol advice and guidance
- Sexual health advice
- Volunteering and work experience opportunities
- Shower, kitchen, laundry, IT facilities
- A reused-clothes store, including outfits appropriate for job interviews.

http://www.4yp.org.uk/

Health Services - Suffolk Clinical Commissioning Groups (CCGs)

There are three CCGs serving the population of Suffolk: Ipswich and East CCG, West Suffolk CCG and Great Yarmouth and Waveney CCG.

CCGs are responsible for commissioning hospital, community and specialist health services and working with primary care services to ensure the physical and mental health needs of people are met. Health services have a role to play in identifying Hidden Harm and ensuring collaborative working with CYPS to ensure appropriate support and interventions are put in place.

Suffolk Public Health has responsibility for commissioning drug and alcohol services, school nurses, health visitors and Family Nurse Partnership services.

Mental Health Services are provided by Norfolk and Suffolk Foundation Mental Health Trust (NSFT) for adults and children. These are specialist services for which a referral from a GP or other practitioner has to be made.

http://www.nsft.nhs.uk/Pages/Home.aspx
NSFT also provide a service for young people and adults with mild to moderate mental health problems such as anxiety and depression and individuals can self-refer or a practitioner can refer on their behalf. This service may well be appropriate in cases of parental poor mental health that doesn’t meet the eligibility criteria for specialist mental health support.  

Hidden Harm frequently results in emotional or mental health problems in the children and young people affected. NSFT works collaboratively with children’s services to meet the needs of these children and young people, offering consultation through Primary Mental Health Workers linked to schools and GP practices.

This list is not exhaustive. It would be beneficial to work with partners to understand what other services are available and ensure they are held on universally accessible databases such as Infolink.

http://infolink.suffolk.gov.uk/kb5/suffolk/infolink/home.page