Violence in Suffolk

A PUBLIC HEALTH APPROACH AND ANALYSIS

FEBRUARY 2019
Contents
Executive summary ......................................................................................................................................... 3
Introduction ...................................................................................................................................................... 8
   Aims of this profile ........................................................................................................................................8
   Stakeholder voices ......................................................................................................................................8
   Background ..................................................................................................................................................8
   Violence as a public health issue ..............................................................................................................9
   Cost of violent crime in Suffolk .................................................................................................................11
Part 1: Epidemiology: Who is at risk of violence? ......................................................................................14
   The national burden of violence .............................................................................................................14
   Risk factors for violence ..........................................................................................................................16
   Early adverse life experiences ................................................................................................................16
   Severe behavioural problems in childhood ...........................................................................................17
   Peer relationships and gangs ...................................................................................................................18
   Deprivation and income inequality .........................................................................................................21
   Homeless populations ...............................................................................................................................28
   Alcohol and drugs .....................................................................................................................................30
   Cultural and social norms supportive of violence .................................................................................32
   Disability .......................................................................................................................................................35
   Mental ill health ..........................................................................................................................................37
   Brain injury ...................................................................................................................................................41
   Genetics ......................................................................................................................................................42
Part 2: How much violence does Suffolk experience? ............................................................................43
   Recorded crime ........................................................................................................................................43
   Comparisons to statistical neighbours – crime severity score .............................................................47
   National comparison data .......................................................................................................................51
   Victim crime data (national) ....................................................................................................................55
   Offender data ............................................................................................................................................56
   Location mapping .....................................................................................................................................56
   Domestic violence and abuse .....................................................................................................................60
   Drug and gang violence, and county lines networks .............................................................................61
   Personal robbery .........................................................................................................................................61
   Hate crime ...................................................................................................................................................62
   Suffolk Youth Justice Service (SYJS) .........................................................................................................62
   Safeguarding data .......................................................................................................................................67
   Schools data ................................................................................................................................................71
   Overview of violence from health service datasets ................................................................................74
Executive summary

What is this report about?
This profile report looks at the epidemiology, evidence and research available on violence in Suffolk, and nationally. The profile takes a public health approach to violence, exploring key opportunities for prevention and early intervention, and largely mirrors the format of the Lambeth needs assessment on serious violence produced in 2015(1).

There are opportunities where public health practice can make a significant contribution towards reducing crime and improving wellbeing: violent crime and young people, reported crime, hospital admissions and attendances at A&E, and domestic violence including intimate partner violence(2).

This report looks the aforementioned areas alongside a wider determinants of health approach. This encompasses issues that public health may not have a direct impact upon, but where targeted and collective action may provide reductions in levels of violence.

In Suffolk:
Suffolk has long been a very safe place to live, with very low rates of recorded crime, including violent crime. For example, Suffolk has statistically significantly lower rates of admissions to hospital for violence-related injuries compared to the national rate. However, in the last few years there is some evidence that this picture has begun to change. Violence relating to urban street gangs (USG) and County Lines Networks (CLN) is part of that changing picture.

Wider ranging violence data indicates that in relation to recorded crime, there are increases in both violence with injury and violence without injury. Violence related offences have risen by 16% between 2017 and 2018.

Statistics from 1 March 2017- 31 March 2018 from Suffolk Constabulary show there were 404 reported incidents involved weapons such as knives, axes, blades, swords and machetes. This is a 35% increase from 300 recorded incidents involving knives, reported to the police for the same period a year previously.

It is vital to take into account changes and improvements in crime data integrity. Suffolk Constabulary continue to report improvements in data quality, and there have been improvements in encouraging victims to come forward more frequently. Services are more joined up with better recognition of, and response to violence related crime. There is ongoing work to verify and validate trend data.

With these points in mind, the findings of this report indicate that Suffolk doesn’t experience the same levels of violent crime as more urbanised /metropolitan areas. Whilst it may not be appropriate to introduce specialised violence reduction units (akin to Glasgow and the recently announced plans for London), there is a need for a sustained public health approach to violence reduction.

Risk factors for violence:
Violence is a major public health problem(3), but it is also predictable, and therefore preventable (4). A lifecourse approach provides an appropriate public health perspective to assist in violence prevention. This is because of its view that health is a product of risk behaviours, protective factors, and environmental agents that we come across throughout our lives and that have cumulative, additive, and sometimes multiplicative impacts(1).

Some strategies can be used to address risk factors for violence and promote protective factors across the lifecourse, some can be implemented universally and others are targeted specifically.
towards at risk groups (5). This report looks at specific risk factors, across the lifecourse, and their prevalence in Suffolk. A summary of these is provided below. The figure summarises risk factors for different forms of violence in the UK, and the risk for Suffolk, it has been adapted from the Local Government Association’s recent report on public health approaches to reducing violence (6).

Figure 1: A summary of risk factors for violence

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### Violence in Suffolk

**A public health perspective**

**Risk factors:**
- Unplanned pregnancy
- Single parent household
- Young, poor parents
- Socially isolated parents
- Parental alcohol consumption and drug use
- Domestic violence in the home
- Child disability or illness
- Child behavioural problems

- Male gender
- Neglect and abuse in childhood
- Personality traits (hyperactivity/conduct disorder)
- Poor family functioning
- Domestic violence in the home
- Delinquent peers and gang involvement
- Living in a high crime area
- Alcohol consumption
- Social inequality

- Female gender
- Younger age
- Lower household income
- Being single, co-habiting, separated or divorced
- Living in areas of high physical disorder
- Alcohol consumption (perpetrators and victims)
- Controlling and jealous partner
- Childhood abuse (perpetrators and victims)
- Gender inequality
- Cultural norms tolerant of violence

- High levels of dependence
- Mental and congenital disorders
- Carer alcohol consumption and drug use
- Carer financial problems
- Carer burnout
- Social isolation
- Lack of social support

**Related Suffolk risk statistics:**

- 76,500 0-17 year olds in Suffolk could be exposed to at least one adverse childhood experience (ACE). 13,800 could be exposed to four or more ACEs.
- It is estimated that nearly 6,000 Suffolk children have a conduct disorder.
- Approximately 33,000 children are in poverty after including for housing costs.
- The main needs of children entering care are reported to be due to abuse or neglect, family dysfunction, family stress and absent parenting. In 2016/17 family dysfunction as a primary need was higher among Suffolk children (26%) compared with the national average (15%).
- 4 out of 7 local authorities in Suffolk are social mobility ‘coldspots’. The coldspots indicate where people from disadvantaged backgrounds are least likely to make social progress.
- As of 2017, Suffolk Police have made over 2,500 arrests in connection with drug related crime over the a two and half year period.
- 2017 data indicates that 25,400 of people aged 18-64 are estimated to be alcohol dependent in Suffolk, and 14,400 are estimated to be drug dependent.
- Quality and Outcome Framework (QoF) data for 2016/17 in Suffolk indicates that 3,849 people in Suffolk are registered as having a learning disability.
- In Suffolk, QoF data indicates a higher registered prevalence of depression compared to England (9.7% vs 9.1%), equating to 6,000 people.
- In Suffolk in 2016/17 there were 7,200 individuals with a recorded diagnosis of dementia.
- It can be estimated that 6,600 older people are subject to elder abuse, and 700 people within that will experience physical abuse.

Source: (6)
Section summary: Epidemiology: Who is at risk of violence?

- There are many risk factors for violence, and Suffolk residents may experience the factors outlined above—putting them at increased risk of violence as either a perpetrator or victim.
- The impact of violence in Suffolk can have a detrimental effect upon physical and mental health and quality of life.
- A large proportion of Suffolk’s children aged 0-17 years could be exposed to at least one ACE.
- The numbers of children in care in England continue to increase and this same pattern is reflected in Suffolk. The main needs of children entering care are reported to be due to abuse or neglect, family dysfunction, family stress, and absent parenting.
- Both County Lines Networks (CLN) and Urban Street Gangs (USG) are present in Suffolk. The two groups are discrete. Members of these networks and gangs are likely to experience a complexity of issues, including poor mental health, and the impact of exploitation.
- Although Suffolk experiences below average levels of deprivation compared to nationally, there are pockets of highly deprived Suffolk residents. Additionally, gross weekly pay for Suffolk workers and residents, and social mobility for young people in the area is low. Local data indicates that Suffolk has a higher proportion of NEET young people.
- In Suffolk social care assessments of young people who are in need, subject to a child protection plan, or are in care, 6–9% of all young people had a reported substance misuse issue. This is approximately 3x higher than the general population.
- Certain groups of individuals may be at increased vulnerability to violence (due to characteristics of that group). For example SEND individuals, others with disabilities, and vulnerable elderly populations.
- The interplay between poor mental health and violence risk (both as a perpetrator and victim) is a significant factor that should not be overlooked.

Section summary: How much violence does Suffolk experience?

- Suffolk data for the year ending 31 March 2018 indicates just over 53,000 recorded offences.
- Comparing this year and last, percentage change data for 2018 compared to 2017 indicates a 16% increase in recorded violence related offences in Suffolk.
- The rate per 1,000 population of all crime, and violence against the person, remains lower in Suffolk compared to the England rate.
- Local data shows an increasing trend for recorded violence with or without injury as well as sexual offences. This may be due to actual crime number rises, but individuals may also be reporting these types of crime more than previously. Improvements in crime data integrity are also likely to play a pivotal role. Nationally, The ONS report that long-term reductions in violent crime supported by other data such as the most recent admissions data for NHS hospitals.
- When looking at crime types by contribution to overall offences, there have been changes in the makeup of crime in Suffolk over the last 15 years. These changes are more obvious in the crimes related to violence, for example violence with or without injury, and sexual offences.
- Many patterns of variation in crime (such as increasing crime severity scores) appear to be mirrored in other geographically similar areas. This indicates that Suffolk doesn’t appear to be an outlier. However, violence against the person and sexual offences in Suffolk are a public health concern.
- Changes in legislation, reporting behaviours and increased data accuracy and recording can all contribute to changing patterns of crime.
- National data indicates that males, and adults age 16-24 are most likely to be victims of CSEW violent crime. There is no reason to believe that Suffolk would differ from this national picture.
• Heat mapping of crime data at small area level indicates that generally, urban areas of Suffolk were more affected by violence and possession of weapon offences.
• As of 2017, Suffolk Police have made over 2,500 arrests in connection with drug related crime over the a two and half year period.
• 2017 research highlighted that Suffolk Police were aware of over thirty County Lines trafficking drugs into Suffolk from several different urban centres.
• There is a gap in our knowledge around local data regarding hate crime offences.
• The numbers of children in care in England continue to increase and this same pattern is reflected in Suffolk.
• The main needs of children entering care are reported to be due to abuse or neglect, family dysfunction, family stress and absent parenting.
• Although small in number, there is evidence of sexual exploitation of both children and adults in Suffolk.
• Monitoring of adult social care data monitors indicates that Suffolk is not an outlier in relation to its statistical neighbours.
• 2017/18 data indicates that for concluded Section 42 enquiries, physical and sexual abuse were mentioned in a sizeable proportion of enquiries.
• Modelled estimates suggest that over 6,000 people aged 66+ could be subject to elder abuse in Suffolk.
• A cohort of both teachers and students experience physical violence in school settings in Suffolk. Although relatively low in number, this still reflects an unacceptable risk for what should be a safe environment.
• There is no standard way to capture violence in schools in Suffolk.
• Support to keep as many students in main stream education may be beneficial in reducing their risk of engaging in CLN.
• There may be an opportunity to recreate the recent London based violence research into patterns and times of violent crime against young people using Suffolk data.
• Hospital admissions for violence in Suffolk are statistically lower compared to the England rate, and the same is true for districts and boroughs in Suffolk.
• Data relating to A&E attendances and emergency admissions for assault among residents of Suffolk County during financial years 2015/16-2017/18 indicate that the greatest proportion of health-service activity for this cause related to assaults affecting young white adult males in more urban areas in the county, with the majority of A&E attendances for assault resulting from incidents in public places and the home.
• Data relating to ambulance call-outs for assault among registered patients in Ipswich and East Suffolk CCG and West Suffolk CCG also showed that the highest rates of this form of health-service activity were for assaults affecting young adult males.
• Further analysis of A&E attendances for assault in the home might be informative about domestic violence in the county.

Section summary: Intervention and best practice: what works?

• There are effective interventions that can help to reduce violence across the lifecourse. However, the key opportunities exist in childhood, and in the provision of a safe, nurturing and stable environment.
• There is good evidence that early intervention programmes can work to prevent violence, even for those most at risk, provided they are not focused on ‘scare tactics’.
• There is some evidence that councils are increasingly having to divert funding away from preventative work into services to protect children who are at immediate risk of harm, which would result in a detrimental impact on the ability to provide prevention and early intervention programmes.
• There is no ‘quick fix’ solution to reducing levels of violence in the population. Prevention and reduction need to be consistent, at scale, and across the lifecourse over a sustained period of time.
• Ending youth violence requires an end-to-end approach, from prevention to rehabilitation.
• Effectively addressing the relationships between gang-affiliation and poor mental health requires co-ordination of services in a strong, collaborative manner.
• Awareness raising campaigns can be effective in detecting and targeting issues and measures to mitigate risk (for example in domestic abuse and elder abuse).
• Violence reduction initiatives in urbanised areas such as Glasgow and London may not be applicable to Suffolk, but elements of the public health approach, in combination with local knowledge and understanding may help in providing an effective ‘Suffolk approach’.

**Concluding points:**
In Suffolk, much coordinated work and action is already happening, and there are many early intervention and prevention workstreams in existence already. However, anecdotal evidence from colleagues across Suffolk indicates that there is a need to communicate the work that partners are undertaking in a more effective manner, to reduce duplication of efforts, and also to identify exactly what work is being done, where, and what impact it is having on those most vulnerable to violence.

Data and intelligence plays a major part in identification, communication and strategic targeted action, but information sharing can be fragmented and incomplete. There is a need for the sharing of information to be simplified and consistent to maximise the impact that a joined up working can have in Suffolk.

There is no single, overarching strategic approach to violence reduction and prevention in Suffolk. Different partners across the Suffolk system are already working in a more joined up way to address violence prevention, but there is no ‘whole system approach’ to address underlying risk factors.

Action to prevent violence can be taken by public agencies, the voluntary sector and by communities and individuals. However, Public Health England (PHE) note that to have the greatest impact, actions need to be co-ordinated and targeted where they will have the greatest effect(2). Tackling and preventing violence is not something that can be done in isolation, and requires concerted, strategic commitment across organisations in Suffolk to effect change and reduce violence.
Introduction

Aims of this profile

This profile identifies key data and risk factors surrounding violence, by using an evidence based public health approach, the findings of this profile should be used to identify opportunities to reduce serious violence in Suffolk.

The profile integrates the public health model of violence prevention, and should inform a framework for protective and preventative services to reduce serious violence across Suffolk in a collaborative manner.

“Violence affects a significant proportion of the population. It threatens the lives and physical and mental health of millions of people, overburdens health systems, undermines human capital formation, and slows economic and social development.

Alongside the deaths it causes are the significant consequences of non-fatal violence: injuries and disabilities, mental health and behavioural consequences, reproductive health consequences, other health consequences, and the impact of violence on the social fabric”(4).

Stakeholder voices

Due to the rapid nature of this report, primary data collection was not possible. However, throughout the document quotes from research have been provided to illustrate key points. These are local voices that have been referenced from other documents that have been recently produced. These provide an insight into views and experiences.

Background

Suffolk has long been a very safe place to live, with very low rates of recorded crime, including violent crime. However, there has been recent cause for concern around the number of violent incidents in Suffolk, and in the last few years there is some evidence that this picture has begun to change. There are several areas that are receiving more interest at the time of writing this report:

- Violence relating to urban street gangs (USG) and County Lines Networks (CLN)
- Domestic violence / intimate partner violence
- Related offences

Whilst discrete strategies exist that aim to tackle and prevent violence (for example the Violence Against Women and Girls, Men and Boys (VAWGMB) strategy), there is no single, overarching strategic approach to violence reduction and prevention in Suffolk. Different partners across the Suffolk system are already working in a more joined up way to address violence prevention, but there is no ‘whole system approach’ to address underlying risk factors. Reaffirming work that has been undertaken in Lambeth; “while reactive interventions designed to support victims and manage offenders will continue to be essential, we need to achieve a better coordinated and more strategic proactive and preventative approach”(1).
Violence as a public health issue

Why adopt a public health approach?

Public Health England (PHE) assert that living without the fear of violence is a fundamental requirement for health and wellbeing. The effects of violence being detrimental at both an individual and community level, as well as being financially draining health services, the criminal justice system and the wider economy(2).

A key assertion is that violence is predictable, and therefore preventable(4). The Faculty of Public Health assert that violence is a major public health problem(3). They note that a public health approach to violence prevention involves:

- measuring health needs arising from violence
- determining causes and solutions to problems
- advocating effective interventions and mobilising partnerships to improve health and prevent or control the harmful effects of violence(3)

The Department of Health (DH) notes that by adopting a public health approach, violence can be prevented. Public health programmes aiming to reduce a particular form of violence can be targeted to particularly relevant risk or protective factors (6).

Public health approaches focus on the health, safety and wellbeing of entire populations, the approach strives to provide the maximum benefit for the largest number of people(7). No single risk factor can be taken in isolation to explain why individuals engage in violent behaviour(8).

The lifecourse

A lifecourse approach can be an appropriate public health perspective to assist in violence prevention. This is because of its view that health is a product of risk behaviours, protective factors, and environmental agents that we come across throughout our lives and that have cumulative, additive, and sometimes multiplicative impacts(1).

Public health approaches provide a framework that seeks to understand what causes violence and responding with population based interventions to prevent or reduce violence5. A public health approach can identify risk factors and protective factors in relation to violence.

Risk Factors
Predict an increased likelihood of violence. For example, communities with higher unemployment are at higher risk of experiencing increased violence.

Protective Factors
Reduce the likelihood of violence. For example, communities with low unemployment may be at less risk of experiencing high levels of violence.

Source: (6,9)

There are a range of different opportunities for intervention across the lifecourse that can reduce an individual’s propensity for violence, lower the chances of those involved in violence being involved again, and ensure those affected by violence get the support they need(5).

Some strategies can be used to address risk factors for violence and promote protective factors across the lifecourse, some can be implemented universally and others are targeted specifically towards at risk groups (5).
“The cyclical nature of violence means that primary prevention approaches that prevent people from becoming victims or developing violent tendencies can protect them from violence throughout life. A comprehensive violence prevention strategy must integrate the types of interventions outlined in this document with criminal justice policies and strategies directed at macro-level social factors such as access to education, employment opportunities and income equality” (5).

The public health approach is a four-step process rooted in scientific method. It can be applied to violence and other health issues that affect populations. It is summarised in Figure 2 and includes:

1. Surveillance
2. Identification of risk and protective factors
3. Development and evaluation of interventions
4. Implementation

The benefit of adopting this style of approach is that there is a shift from typical ‘response’ only interventions to violence, to ones that also focus on primary prevention.

The figures overleaf summarise some of the key risk factors for violence. The World Health Organization (WHO) conceptualised some of the risk factors for violence in an ‘ecological model’, is shown in Figure 3.

Figure 2: A public health approach to reducing violence

Source: (6,9)
Violence and the impact of violence extends beyond one organisation, it cuts across services from police, health and care, social services and wider. Action to prevent violence can be taken by public agencies, the voluntary sector and by communities and individuals. However, PHE note that to have the greatest impact, actions need to be co-ordinated and targeted where they will have the greatest effect(2).

Cost of violent crime in Suffolk
The economic and social costs of crime are important in helping to develop an understanding of the wider costs and benefits associated with changes in the number of crimes(10). The Home Office estimate the total costs of crime in England and Wales in 2015/16 to be approximately £50bn for crimes against individuals (and £9bn for crimes against businesses).

The Home Office note that violent crimes make up the largest proportion of the total costs of individual crime (almost ¾), yet they form only 1/3 of the number of crimes - due mainly to the higher physical and emotional costs to the victims of violent offences. Costs are high for crimes that are more likely to result in emotional injuries, such as rape and violence with injury. Homicide has the highest estimated cost (£3.2m), rape has the highest estimated unit cost of non-fatal offences (£39,360).

Table 1 is taken from the Home Office report and looks at a selection of crime costs that could be commonly associated with violence (either directly or indirectly) for England and Wales. The data considers three main cost areas:

- Costs in anticipation of crime, for example the cost of burglar alarms
- Costs as a consequence of crime, for example the cost of property stolen or damaged
- Costs in response to crime, for example costs to the police and criminal justice system

These costs have then been calculated for Suffolk, using 2015/16 Police Recorded Crime data for consistency. The unit costs of crime capture all crimes and not just crimes recorded by the police.
The Home Office’s multipliers have been applied to calculate a more accurate cost for Suffolk in order to try to account for unrecorded crime. The summarised results are shown in table 2.

The multiplier can also serve as an indicator as to how much underreporting of crime occurs. Particularly concerning are the high multipliers for sexual offences (16.5) and rape (3.4). Putting this into context, and by way of example, if 100 sexual offences were reported in a year, the true figure of sexual offences is likely to be 16.5 times higher - i.e. 1,650 offences were likely to have actually occurred.

Applying the multipliers contained within table 2 to Suffolk, there could be an estimated 57,200 violence related crimes in Suffolk (when unreported crime is modelled as well). This would equate to one violent offence for every 13 people in Suffolk.

The costs of crime that are likely to be related to violence in Suffolk (based on data in table 2), range from £160m (recorded offences) to £481m (estimated actual offences). This further reinforces the need to invest in violence prevention at the earliest stage. It helps to evidence that public health approaches to violence prevention could be highly cost effective in relation to violence prevention.

Table 1: Crime costs for England and Wales, by main cost area, 2015/16

<table>
<thead>
<tr>
<th>Crimes</th>
<th>Costs in anticipation of crime</th>
<th>Costs as a consequence of crime</th>
<th>Cost in response to crime</th>
<th>Total (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Defensive expenditure</td>
<td>Insurance administration</td>
<td>Value of property stolen/</td>
<td>Lost output</td>
</tr>
<tr>
<td>Homicide</td>
<td>£91,060</td>
<td>£10</td>
<td>£2,002,430</td>
<td>£254,710</td>
</tr>
<tr>
<td>Violence with Injury</td>
<td>£330</td>
<td>£10</td>
<td>£8,240</td>
<td>£2,080</td>
</tr>
<tr>
<td>Violence without Injury</td>
<td>£110</td>
<td>£10</td>
<td>£2,310</td>
<td>£670</td>
</tr>
<tr>
<td>Rape</td>
<td>£370</td>
<td>£10</td>
<td>£24,390</td>
<td>£3,900</td>
</tr>
<tr>
<td>Other sexual offences</td>
<td>£150</td>
<td>£10</td>
<td>£3,700</td>
<td>£1,120</td>
</tr>
<tr>
<td>Robbery</td>
<td>£190</td>
<td>£140</td>
<td>£1,030</td>
<td>£2,360</td>
</tr>
<tr>
<td>Domestic burglary</td>
<td>£320</td>
<td>£390</td>
<td>£1,400</td>
<td>£1,190</td>
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<tr>
<td>Theft of Vehicle</td>
<td>£1,010</td>
<td>£720</td>
<td>£4,140</td>
<td>£270</td>
</tr>
<tr>
<td>Theft from Vehicle</td>
<td>£110</td>
<td>£10</td>
<td>£140</td>
<td>£60</td>
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<tr>
<td>Theft from Person</td>
<td>£20</td>
<td>£10</td>
<td>£180</td>
<td>£410</td>
</tr>
</tbody>
</table>

Source: (10)
<table>
<thead>
<tr>
<th>Crimes relating to the individual</th>
<th>Total unit cost</th>
<th>Number of recorded crimes in Suffolk in the 12 months Ending March 2016</th>
<th>Multiplier applied</th>
<th>Recorded crime cost calculation for Suffolk</th>
<th>Total estimated cost to Suffolk 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicide</td>
<td>£3,217,740</td>
<td>2</td>
<td>1.0</td>
<td>£6,435,480</td>
<td>£6,435,480</td>
</tr>
<tr>
<td>Violence with Injury</td>
<td>£14,050</td>
<td>4,762</td>
<td>2.6</td>
<td>£66,906,100</td>
<td>£173,955,860</td>
</tr>
<tr>
<td>Violence without Injury</td>
<td>£5,930</td>
<td>6,927</td>
<td>1.5</td>
<td>£41,077,110</td>
<td>£61,615,665</td>
</tr>
<tr>
<td>Rape</td>
<td>£39,360</td>
<td>502</td>
<td>3.4</td>
<td>£19,758,720</td>
<td>£67,179,648</td>
</tr>
<tr>
<td>Other sexual offences</td>
<td>£6,520</td>
<td>1,105*</td>
<td>16.5</td>
<td>£7,204,600</td>
<td>£118,875,900</td>
</tr>
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<td>Robbery</td>
<td>£11,320</td>
<td>230</td>
<td>4.3</td>
<td>£2,603,600</td>
<td>£11,195,480</td>
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<td>Domestic burglary</td>
<td>£5,930</td>
<td>1,384</td>
<td>3.6</td>
<td>£8,207,120</td>
<td>£29,545,632</td>
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<td>Theft of Vehicle</td>
<td>£10,290</td>
<td>519</td>
<td>0.8</td>
<td>£5,340,510</td>
<td>£4,272,408</td>
</tr>
<tr>
<td>Theft from Vehicle</td>
<td>£870</td>
<td>2,169</td>
<td>2.6</td>
<td>£1,887,030</td>
<td>£4,906,278</td>
</tr>
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<td>Theft from Person</td>
<td>£1,380</td>
<td>412</td>
<td>5.9</td>
<td>£568,560</td>
<td>£3,354,504</td>
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<tr>
<td><strong>Total:</strong></td>
<td><strong>£159,988,830</strong></td>
<td></td>
<td></td>
<td><strong>£481,336,855</strong></td>
<td><strong>£3,354,504</strong></td>
</tr>
</tbody>
</table>

Source: (10), (11) * Includes other serious sexual offences and other non-serious sexual offences.
Part 1: Epidemiology: Who is at risk of violence?

This section utilises the Lambeth Needs Assessment framework to report on the burden of violence, risk factors for violence, and the prevalence of these risk factors in Suffolk.

The national burden of violence

Violence and its impact is a major cause of morbidity and poor wellbeing in England, with actual violence as well as fear of violence affecting many individuals in society(1). The Lambeth needs assessment notes that specific types of violence have a disproportionate effect on particular communities such as domestic violence, elder abuse, and gang-related violence.

PHE research has found that(2):

- Groups of people most likely to suffer violence are also people who are very likely to be affected by other factors that cause illness or poor health
- Where there is deprivation, the risk of experiencing violence as a victim or as a perpetrator is much greater
- Violence is strongly related to inequalities, with the poorest fifth of society suffering rates of hospital admissions for violence five times higher than those of the most affluent fifth(12)
- Where there is increased violence, the likelihood of requiring emergency services is also increased

The DH notes that violence prevention is fundamental in tackling other public health issues(5):

- Violence impacts upon mental wellbeing and quality of life (also see appendix 1)
- It can prevent people from using outdoor space and public transport
- It inhibits the development of community cohesion

It is clear that beyond the impact on the individual, violence also has a significant impact on the wider environment, health and care services, and wider services, draining both resources and finances.

The national cost of violence

Annual figures on the extent and cost of violence to society highlight the substantial cost it imposes on health care systems and to wider society. Table 3 indicates that the cost is almost £3 billion to health services, and almost £30 billion in societal costs. This further reinforces the benefits of the adoption of an evidence-based approach to the prevention of violence, both in relation to improved population health and reduced health care costs(5).

Table 3: The annual national cost of violence, 2011/12

<table>
<thead>
<tr>
<th>Key national figures on the extent and cost of violence</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual number of violence incidents</td>
<td>2.5 million</td>
</tr>
<tr>
<td>Annual number of emergency department attendances for violence</td>
<td>300,000</td>
</tr>
<tr>
<td>Annual number of emergency hospital admissions for violence</td>
<td>35,000</td>
</tr>
<tr>
<td>Annual cost of violence to society</td>
<td>£29.9 billion</td>
</tr>
<tr>
<td>Annual cost of violence to health services</td>
<td>£2.9 billion</td>
</tr>
</tbody>
</table>

* England; all other figures cover England and Wales. Data from the North West Public Health Observatory, Centre for Public Health. * calculated by London School of Economics, see Appendix available separately.

Source: (5)

Data about violence can be sourced from many areas, including police data, national crime survey data (the Crime Survey for England and Wales - CSEW), locally held data, and health
service data. However, this data is not often linked together, and many cases of violence go unreported. As some people may not report violence to the police, but may seek help from health services (as a result of injury due to violence), analysis of health data is important to help identify the true extent of violence(1).

The Office for National Statistics (ONS) report that for the latest data available (year ending March 2018)(13):

- A fall in overall levels of crime has been observed over recent decades
- However, variation in crime type has been hidden by looking at overall levels of crime on its own
- Over the last year, rises in some types of theft and in lower-volume but higher-harm types of violence have been observed, balanced by a fall in the high-volume offence of computer misuse

Key facts about violence:

- 2018 data indicated a continued rise in the number of offences involving knives or sharp instruments, police recorded 16% more offences in 2018 compared with last year. Provisional NHS data show a small proportion of these offences result in an admission to hospital, with admissions for assaults involving a sharp instrument increasing by 14% for England in the last year.
- Although homicides are rare, following a long term decline the number of homicides recorded by the police showed a fourth consecutive rise, increasing by 12% in 2018 compared with the previous year.
- Violence related offences such as knife crime and homicide tend to be concentrated in London and metropolitan areas.
- 26% of women age between 16-59 report having experienced some kind of domestic abuse as adults, and 15% of men report the same.
- At the time a child starts school, at least one child in every class will have been living with domestic abuse since they were born.
- In 2016/17 there were 642,000 incidents of violence at work.
- Nationally, the CSEW 2017 estimated that 5.6% of children aged 10-15 (359,000) were a victim of violent crime in the previous 12 months, showing no statistically significant change from the previous year’s survey.
- Approximately 85,000 women and 12,000 men are raped in England and Wales every year. Rape crisis report that in 2017/18, 3,236 of service users were aged 15 or under.

Sources: (13–17)
Risk factors for violence

The risk factors outlined in the report have been developed from an evidence review by Southwark and Lambeth Public Health Team in relation to the main risk factors for violence(1). In addition, to improve the local evidence base on violence, information has been added on child sexual exploitation, homelessness, and the impact of social media.

The main risk factors identified in the Lambeth Needs Assessment are outlined below, additions to add to the local evidence base are shown underlined:

- Early adverse life experiences
- Severe behavioural problems in childhood
- Peer relationships and gangs
- Deprivation and income inequality
  - Social mobility
  - Income and unemployment
  - Young people Not in Education, Employment or Training (NEET)
- Homelessness
- Alcohol and drugs
- Cultural and social norms supportive of violence
  - Social media and video games
- Disability
- Mental health disorders
- Brain injury

The following section summarises the evidence for the risk factors and where possible, local prevalence.

Early adverse life experiences

Exposure to violence as a child makes individuals more likely to be involved in violence in later life(5). Early life experiences play a large role in an individual’s future, and the risk of violence is shaped by childhood exposure and experience. Children can be at greater risk of maltreatment if they are born to parents that are young, single, who suffer from mental ill health or substance abuse, or have violent relationships(2). The links between these early life risk factors and child abuse can arise from poor bonding between parents and children, and poor parenting skills and resources(2).

Adverse childhood experiences (ACEs) are events that lead to an increased risk of children and young people experiencing damaging impacts on health, or other social outcomes, across the life course(18). The more risk factors (e.g. ACEs) experienced by young people, the greater the likelihood of participation in youth offending(19).

Experiencing neglect and experiencing or witnessing violence or abuse have a major impact on a growing child(20). Some children and young people, (including those who are adopted, are in care or those on the edge of care, those in contact with the youth justice system and substance misusing young people), are more likely to have experienced trauma, both in early years and by cumulative exposure during childhood and adolescence (20).

Children and young people in care are more likely to be more vulnerable to abuse not only from foster or residential carers, but also from their family during access visits and from other children in care settings(21).
Exposure to violence in early life, may increase the risk of that child being involved in violence in adolescence and childhood, perpetuating a cycle of violence (2). There is evidence to suggest that those exposed to abuse, neglect and stress in childhood are more likely to turn to violence to attempt to solve their own problems (3).

A 2014 study (23) found that:

- Nearly half of all individuals in England are exposed to at least one adverse experience during childhood, and 9% experience four or more ACEs
- Having one ACE (versus none) was associated with a significant increase in unintended teenage pregnancy, early sexual initiation, binge drinking, cannabis use, violence perpetration, violence victimization, and incarceration (23)
- Over half of cases of violence perpetration, violence victimization, incarceration, and heroin/crack cocaine use could be explained by ACEs.

Risk factors for ACEs are interlinked and often co-occur, however contextual factors that have been shown to act as risk factors for ACEs include: poverty, low socioeconomic status and disadvantage, unemployment, deprived community environments and social isolation (18).

A recently published report from the Early Intervention Foundation notes that ACEs are not predictive at an individual level, and cannot identify who might need early intervention or other support (24). They note that an ACE score is retrospective, and because the impacts of early life adversity differ widely from person to person, it does not necessarily reflect a person’s current situation, needs or risks. The Early Intervention Foundation assert that ACEs should not be used in isolation to determine who should receive early intervention, and an ACE score is not a substitute for careful assessment of current needs (24).

In Suffolk:

- A cohort of children in Suffolk are likely to be at risk of exposure to multiple ACEs.
- Multiple ACE exposure could lead to increased risk for Suffolk children and young people, and result in damaging impacts on health, or other social outcomes, across the life course.
- Applying national statistics to Suffolk’s population of 0-17 year olds: 76,500 could be exposed to at least one ACE, and 13,800 could be exposed to four or more ACEs.
- ACEs are not predictive at an individual level, and an ACE score is not a substitute for assessment of current needs.

Sources: (23)(21,25,26)

Severe behavioural problems in childhood

Behavioural problems may occur in children of all ages, and vary in severity. Behavioural problems can affect a child’s development, and can interfere with their ability to lead a normal life. When behaviour is this much of a problem, it is called a conduct disorder (27). There is no single cause of conduct disorder. A diagnosis of oppositional defiant disorder may be made in younger children where the disruptive and aggressive behaviours are happening within the home.

The National Institute for Health and Care Excellence (NICE) notes that the major distinction between oppositional defiant disorder and the other subtypes of conduct disorder is the extent
and severity of the antisocial behaviour(28). Isolated antisocial or criminal acts are not sufficient to support a diagnosis of conduct disorder or oppositional defiant disorder.

Children with a conduct disorder may get involved in more violent physical fights, may steal or lie, and not show any sign of remorse or guilt when they are found out. Additionally, they refuse to follow rules and may start to break the law, and teenagers with conduct disorder may also take risks with their health and safety(27).

The Royal College of Psychiatrists note that a young person showing signs of conduct disorder at an early age is more likely to be male, have Attention Deficit Hyperactivity Disorder (ADHD) and lower intelligence. The earlier problems start, the higher the risk for the young person being involved with violence and criminal acts. This may also be related to friendship groups, gangs and use of illegal substances(27).

In Suffolk:

- The prevalence of conduct disorders increases throughout childhood and they are more common in boys than girls. For example, 7% of boys and 3% of girls aged 5-10 years have conduct disorders; in children aged 11-16 years the proportion rises to 8% of boys and 5% of girls. Conduct disorders commonly coexist with other mental health problems.

- Table 4 applies the NICE prevalence of conduct disorders to the Suffolk population. It can be estimated that nearly 6,000 Suffolk children have a conduct disorder.

<table>
<thead>
<tr>
<th>Boys</th>
<th>Girls</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-10 years</td>
<td>1,926</td>
<td>787</td>
</tr>
<tr>
<td>11-16 years</td>
<td>2,001</td>
<td>1,205</td>
</tr>
</tbody>
</table>

Sources: (28,29)

Peer relationships and gangs

Gangs and peer relationships affect young people’s risk of involvement in violence(1), and over the last ten years street gangs and associated serious violence have been a growing concern in the UK(30). Gang related youth violence imposes a considerable financial burden not only across the criminal justice system but across the health economy (2).

Only a minority of young people are involved with gangs, but gang members account for disproportionate levels of crime in affected communities and are at increased risk of involvement in violence as both perpetrators and victims(31).

There is no single definition of a gang or gang member or of youth violence. This report utilises the definitions used by the Early Intervention Fund, and the definition adopted by the Home Office Ending Gang and Youth Violence programme. The definitions and risk factors can be found in Appendix 2.

Urban Street Gangs are predominantly street-based groups of young people who engage in criminal activity and violence, identify with or lay claim over territory, have some form of identifying structural feature and are in conflict with other, similar, gangs.
County Lines Networks supply class A drugs from an urban hub into rural towns or county locations. This is facilitated by a group who may not necessarily be affiliated as a gang, but who have developed networks across geographical boundaries to access and exploit existing drugs markets in these areas (32). CLN operate as drug dealing businesses and are motivated by profit (33). The exploitation of young and vulnerable persons is a common feature, and they often use high levels of violence and intimidation.

County lines and/or gang involvement is a safeguarding issue because a child or young person may have suffered, or may be likely to suffer, significant harm (33). All agencies which have contact with children and families have a responsibility to intervene to reduce risk from county lines and/or gang activity and to act when there is a significant risk of harm from such activity (33).

It may be difficult for professionals to recognise when a young person who is actively involved in gang or CLN activity is being exploited and/or manipulated. This dual role of victim and perpetrator where young people may not fit neatly into just one ‘box’ is one of the reasons that work with this group is complex and requires a collaborative and multi-agency approach.

The 2018 Suffolk County Council (SCC) report on ‘safeguarding children and young people at risk of county lines or gang involvement’ (33) identifies risks for CLN involvement and potential barriers that may prevent individuals asking for help. These can be found in Appendix 3.

“There are 2 main crews Nacton and J-Block. J-Block is more established; made up of mainly young white and black men, (they have) ready access to London support (gang members) who are living and staying up here dealing under the J-Block banner. Nacton is more young black and Asian men. Nacton used to be vehemently anti Class A but now they’re openly dealing on estates”. (Respondent 1)

“There’s a big drug market in Ipswich and moves towards improving the business with better quality gear available 24/7. Brand names go out by text such as ‘I’m with best of both’ or ‘3 for 2’ the business model of County Lines is very good”. (Respondent 10)

“Social changes saw young lads emerge who were aimless, not academic, but saw a niche in gang culture promoted through the media which gave them the means to earn a few quick quid. Knife carrying was unusual in the past but now 8 out of 10 people dealing have a weapon ...They have overt disrespect for the police and authority generally. It’s been a quick transition to a dangerous situation over the last 5 years”. (Respondent 9)

“In my eyes, there’s only a few things that can happen, either you end up in prison, you end up seriously hurt or you end up dead. Right? And you end up, doing something that is not in your nature. You can become a killer when you aren’t a killer. To me, none of these boys, the boys that I’ve met through my son trust me, they’re not killers they’re not even bad. The truth of it is they’re not even bad lads, they’re just lads who have had no-one, no family. The difference with my boy is he has a family and I feel he was drawn into it more because of ... how to describe it, he shut me down”. (A parent in Ipswich)

Source: (34)
Mental health and gang violence

Community violence can have adverse impacts on individuals' emotional and mental health wellbeing, even if they are not directly victimised themselves (2). Young people living in communities affected by gang violence and crime (such as muggings) may be in constant fear for their own safety in public places (2). Community violence exposure through victimisation, witnessing or even just hearing about violence has been associated with post-traumatic stress and internalising (for example anxiety), and externalising (such as aggression), problems in young people (2).

The links between gang-affiliation and poor mental health can operate in both directions, for example: Poor mental wellbeing can draw young people to gangs while gang involvement can negatively impact on an individual's mental health (31).

Young people involved in gangs have much higher rates of a broad range of mental health problems (compared to both the general and young offender populations) including (30):

- Conduct disorder (in children and adolescents) and antisocial personality disorder in young adults, possibly due to common risk factors for gang membership and conduct disorder
- Anxiety disorders, possibly due to fear of violent victimisation
- Psychosis, possibly due to high cannabis use
- Suicide attempts, possibly due to impulsive violent acts directed inwardly

Additionally, young people involved in gangs have higher rates of drug and alcohol misuse (30).

Work by the Home Office (around recognising gangs and youth violence as an issue affecting mental health), has highlighted that mental health professionals are not consistently asking questions about risk arising from gangs and serious youth violence (20).

Deprivation and income inequality

Evidence establishes that the risk of experiencing violence as a victim or perpetrator is much greater in areas of deprivation(2). There is a strong relationship between deprivation and violence, this is likely to reflect a collection of risk factors for violence in poorer areas (unemployment, teenage parenting, low education, lone parent families, higher crime rates and substance use)(5).

Children who grow up in areas where there are high levels of socio-economic deprivation and crime are at increased risk of involvement in violence, and gangs tend to be concentrated in areas with high deprivation and attract disadvantaged and excluded youths(5).

The Equality Trust asserts that there is a very strong relationship between high levels of income inequality and low levels of social mobility(39). For example, children of highly paid people are more likely to be highly paid, children of low paid people more likely to be low earners. The ecological framework identifies gender, social and economic inequality as a societal risk factor for violence, as well as low socioeconomic household status as a relationship risk factor (see figure 2) (6,9). There is a well established link between economic inequality and violent crime, with violence rates higher in more unequal societies(40).

The WHO ecological framework identifies poverty as a societal risk factor and high unemployment as a community risk factor for violence. However, there is also a widely assumed and accepted link between youth unemployment and violence - both criminality and youth participation in political violence and armed groups(41). Yet, a 2016 literature review found that robust evidence of such a link is lacking. It is not that available data disproves a link but rather, that there is insufficient data to establish a link(42). Some studies reviewed indicate that youth unemployment...
is only one of a mix of factors contributing to violence(42). Additionally, other studies have found that that inequality is more important for predicting violence than poverty(1,43).

Social mobility

In June 2017 the Social Mobility Barometer poll of nearly 5,000 residents across the UK was published(44). The findings highlight that(44):

- 48% of people believe that where you end up in society today is mainly determined by your background and who your parents are. Only 32% believe everyone has a fair chance to get on regardless of their background.
- 79% believe that there is a large gap between the social classes in Britain today.
- A large majority of people believe that poorer people are held back at nearly every stage of their lives - from childhood, through education and into their careers.
- 71% of respondents felt there are ‘fairly or very’ large differences in opportunity depending on where you live in the country.
- 51% of people aged 18-24 believe that where you end up in society is largely determined by who your parents are, the report authors reflect that this indicates feelings of deep social pessimism.
- The authors note the link between social pessimism and the facts young people are experiencing. Individuals born in the 1980s are the first post-war cohort not to start their working years with higher incomes than their immediate predecessors. Home ownership, (the aspiration of successive generations of ordinary people), is in sharp decline. In the last ten years, the number of under-25-year-old home owners has more than halved.

In the UK, The Social Mobility Index can be used to identify hotspots and coldspots of the country, it is compiled of 16 indicators for every life stage - from the early years through to adulthood, and assesses the education, employability and housing prospects of people living in each of England’s 324 local authority areas (45).

The latest Social Mobility Index report was published in 2017 and highlighted the following points(46):

“\textit{A stark social mobility postcode lottery exists in Britain today where the chances of someone from a disadvantaged background succeeding in life is bound to where they live...The index finds that the worst performing areas for social mobility are no longer inner city areas, but remote rural and coastal areas, and former industrial areas. Young people from disadvantaged backgrounds living in these areas face far higher barriers than young people growing up in cities and their surrounding areas - and in their working lives, face lower rates of pay; fewer top jobs; and travelling to work times of nearly four times more than that of urban residents}.”
“Schools in highly deprived coastal rural areas have a significantly higher proportion of unqualified secondary school teachers than do those in affluent inland rural areas (7% compared with 4.6%). Young people then have limited post-16 opportunities – many of the worst-performing areas are about an hour each way from the nearest university by public transport – and often even further from a selective university. With the exception of Copeland and Suffolk Coastal, all coastal areas are in the bottom decile for working lives” (46).

Young people not in education, employment or training (NEET)

An individual is considered to be in education or training if any of the following apply(47):

- They are enrolled on an education course and are still attending or waiting for term to (re)start
- They are doing an apprenticeship
- They are on a government-supported employment or training programme
- They are working or studying towards a qualification
- They have had job-related training or education in the last four weeks

A recently produced ‘changing the NEET mindset’ report noted that is a well-documented range of wider factors which can cause disengagement from education including poor housing, health, drug and alcohol dependency, special educational needs, bullying, caring responsibilities, domestic violence, gang culture, peer pressure, or a cultural context which doesn’t value learning(48).
In Suffolk:

- Suffolk has become more deprived compared to other local authority (LA) areas in England since 2010. Only three counties/unitary authorities worsened by more places in the rankings than Suffolk. However, Suffolk continues to experience below average levels of deprivation.

- Analysis of the indices of deprivation by Lower Super Output Area (LSOA) show that in Suffolk areas of Ipswich and Lowestoft experience the highest levels of deprivation (within the most deprived 20% of areas in England). However, Felixstowe, Great Comard, Stowmarket, Bury St Edmunds, Mildenhall and Beccles also contain areas with higher levels of deprivation.

Figure 4: Indices of Deprivation, overall rank in Suffolk by LSOA and year

- In 2018, End Child Poverty published new figures (January 2018) on the level of child poverty in each constituency, local authority and ward in the UK.

- LAs with the highest percentages of children in poverty both pre and post housing costs are highlighted in red in the table overleaf. Ipswich and Waveney are the LAs with the highest numbers and percentages of children in poverty.
In Suffolk:

Table 5: Percentage of children in poverty, July-Sept 2017

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>BEFORE HOUSING COSTS</th>
<th>AFTER HOUSING COSTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of children</td>
<td>%</td>
</tr>
<tr>
<td>Babergh</td>
<td>2,285</td>
<td>13.17%</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>1,539</td>
<td>14.63%</td>
</tr>
<tr>
<td>Ipswich</td>
<td>5,534</td>
<td>17.79%</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>2,050</td>
<td>10.58%</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>2,551</td>
<td>11.58%</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>2,769</td>
<td>11.78%</td>
</tr>
<tr>
<td>Waveney</td>
<td>4,056</td>
<td>17.55%</td>
</tr>
</tbody>
</table>

Mapping of child poverty both pre and post housing costs indicates within area variation in LAs in Suffolk. However, the top 3 wards experiencing the highest proportion of child poverty are in Harbour ward in Waveney, Gipping ward in Ipswich and Kirkley ward in Waveney. There are also notable pockets of child poverty in Sudbury East and Holbrook wards in Babergh, as well as Felixstowe South and Leiston wards in Suffolk Coastal.

Table 6: Social Mobility Index rankings for Suffolk LAs, 2017

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Overall score (Hot spots / Cold spots)</th>
<th>Early Years</th>
<th>Schools</th>
<th>Youth</th>
<th>Adulthood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid Suffolk</td>
<td>80</td>
<td>107</td>
<td>133</td>
<td>62</td>
<td>164</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>116</td>
<td>245</td>
<td>152</td>
<td>92</td>
<td>66</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>209</td>
<td>254</td>
<td>106</td>
<td>132</td>
<td>276</td>
</tr>
<tr>
<td>Ipswich</td>
<td>261</td>
<td>201</td>
<td>297</td>
<td>109</td>
<td>261</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>264</td>
<td>196</td>
<td>155</td>
<td>182</td>
<td>318</td>
</tr>
<tr>
<td>Babergh</td>
<td>270</td>
<td>135</td>
<td>256</td>
<td>282</td>
<td>259</td>
</tr>
<tr>
<td>Waveney</td>
<td>314</td>
<td>157</td>
<td>317</td>
<td>204</td>
<td>306</td>
</tr>
</tbody>
</table>

Note: rankings out of 324

Table 6 ranks Suffolk local authorities on the prospects of disadvantaged young people growing up in the areas. Latest data for 2017 indicates no Suffolk LAs in the ‘hotspots’ for social mobility, however 4 of Suffolk’s LAs are social mobility ‘coldspots’. The coldspots indicate where people from disadvantaged backgrounds are least likely to make social progress. Waveney performs particularly poorly, and is the 11th worst performing LA out of all England LAs.
In Suffolk:

- Levels of unemployment have been consistently lower compared to nationally. Data for April 2017-March 2018 shows that 81.0% of economically active people age 16-64 were in employment, higher than Great Britain (78.4%). For the same period, unemployment was 3.5% in Suffolk (approximately 12,900 people), compared to 4.3% in Great Britain.

- Levels of unemployment are higher in younger age groups (16-19 and 20-24) when compared with the 16+ population generally (see figure below). Suffolk has lower levels of young people that are unemployed compared to the East of England and Great Britain.

- Trend analysis indicates a general decline in youth unemployment, in line with overall decline in unemployment.

Figure 5: Unemployment by age group and area, April 2017-March 2018

<table>
<thead>
<tr>
<th>Unemployment rate - aged 16+</th>
<th>Great Britain</th>
<th>East</th>
<th>Suffolk</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2017-Mar 2018</td>
<td>3.5%</td>
<td>4.3%</td>
<td>3.7%</td>
</tr>
</tbody>
</table>

Figure 6: Unemployment by age group in Suffolk, April 2011-March 2018

<table>
<thead>
<tr>
<th>Trend lines shown as dotted lines</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2011-Mar 2012</td>
</tr>
<tr>
<td>April 2012-Mar 2013</td>
</tr>
<tr>
<td>April 2013-Mar 2014</td>
</tr>
<tr>
<td>April 2014-Mar 2015</td>
</tr>
<tr>
<td>April 2015-Mar 2016</td>
</tr>
<tr>
<td>April 2016-Mar 2017</td>
</tr>
<tr>
<td>April 2017-Mar 2018</td>
</tr>
</tbody>
</table>
In Suffolk:

For both Suffolk workers and Suffolk residents, levels of pay are lower than the East of England, and Great Britain as a whole. For example:

- Gross weekly pay for full time workers in Suffolk in 2017 was £528.8, compared to £574.9 for workers in the East of England and £552.7 for workers in Great Britain.
- Average hourly pay for full time workers was £12.92 for Suffolk workers, compared to £14.51 for those in the East and £14.00 for those in Great Britain.

For NEET data, although England data is available for October-December 2017, the latest published local authority data that can be used for benchmarking is from 2016.

- This data shows that Suffolk had a higher proportion of NEET 16 and 17 year olds compared to England.

Table 7: 2016 local authority NEET figures for Suffolk, the East and England

<table>
<thead>
<tr>
<th></th>
<th>Number of 16 and 17 year olds known to the local authority</th>
<th>Total number NEET (inc not known)</th>
<th>Proportion NEET (inc not known)</th>
<th>Proportion of which known to be NEET</th>
<th>Proportion of which activity not known</th>
<th>Ppt* change in overall NEET measure since 2015</th>
<th>Direction of travel</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>1,155,350</td>
<td>69,540</td>
<td>6.0%</td>
<td>2.8%</td>
<td>3.2%</td>
<td>-0.5</td>
<td>▼</td>
</tr>
<tr>
<td>East</td>
<td>130,120</td>
<td>6,330</td>
<td>4.9%</td>
<td>3.0%</td>
<td>1.9%</td>
<td>-0.3</td>
<td>▼</td>
</tr>
<tr>
<td>Suffolk</td>
<td>15,490</td>
<td>1,160</td>
<td>7.5%</td>
<td>3.9%</td>
<td>3.6%</td>
<td>-0.1</td>
<td>▼</td>
</tr>
</tbody>
</table>

*Ppt = Percentage point

- Figure 7 shows locally collected data for 16-18 year olds, it is not comparable with the data above but gives an indication of trends.

Figure 7: Percentage of young people (16-18) in Suffolk that are NEET, August 2016-July 2018

Sources: (49), (50), (51), (45), (52), (53), (54), (55)
Homeless populations
An additional section has been added here to reflect the risk of violence in homeless populations. Homelessness can affect anyone, as a consequence of any number of factors, for example social exclusion, the loss of a job, unexpected serious illness or accident. The health of homeless people is a particular risk(56). Homelessness is very isolating, can be physically dangerous and puts people at high risk of mental ill health and of health behaviours which may provide short term relief but are hazardous in the longer term (e.g. substance misuse)(56).

Not all types of homelessness are immediately apparent (for example sofa surfing), with rough sleeping the extreme (and most visible) form of homelessness. Crisis reports that people sleeping on the street are almost 17 times more likely to have been victims of violence and 15 times more likely to have suffered verbal abuse in the past year compared to the general population(57).

The report highlights that for rough sleepers (57):

- More than 1 in 3 have been deliberately hit or kicked or experienced some other form of violence whilst homeless (35%)
- More than 1 in 3 have had things thrown at them whilst homeless (34%)
- Almost 1 in 10 have been urinated on whilst homeless (9%)
- More than 1 in 20 have been the victim of a sexual assault whilst homeless (7%)
- Almost half have been intimidated or threatened with violence whilst homeless (48%)
- Almost 6 in 10 have had been verbally abused or harassed whilst homeless (59%)

These experiences take a serious toll on people’s mental wellbeing and sense of isolation, leading some to question their self-worth and making it even harder for them to leave the streets(57). Additionally, the same report found that 53% of respondents said they had not reported the last crime or anti-social incident to the police, often because they thought the police wouldn’t do anything about it.

Homelessness and domestic abuse
For some individuals that are living in an abusive home environment, leaving the home environment may be the only option. However, the Guardian reports that the lack of safe, affordable housing comes up as the single biggest barrier to leaving abusive relationships: how can someone leave when there is nowhere to go(58).

Safe Lives highlight that for those made homeless by domestic abuse, the path to stable accommodation is complex, and often depends on the variable response of local housing teams (59). In many cases the survivor must significantly disrupt their life in order to find a safe place to live - over 10% of those supported with re-housing by a domestic abuse service were moved out of their local authority area, with the percentage for those needing emergency accommodation being much higher(59).
In Suffolk:

- It is important to note that not all homelessness is as visible as rough sleeping, and many people who are homeless do not show up in official figures.

- In Suffolk, latest data indicates that:
  - In 2016/17 153 young people aged 16-24 were homeless
  - In 2016/17 60 people were homeless and considered not in priority need
  - In 2015/16 there were 232 statutory homeless households

Source: (60)
Alcohol and drugs

Drug and/or alcohol consumption are risk factors for involvement in violence as victims and perpetrators(1). 2016/17 data from the ONS indicates that victims believed the perpetrator(s) to be under the influence of alcohol in 40% of violent incidents. In 18% of violent incidents, the victim believed the perpetrator(s) to be under the influence of drugs(61).

There is a vast array of published literature about the connection between substance use and violence, and yet establishing why such a connection exists is hard to answer(62). A 2018 meta-meta-analysis found that while drug and alcohol use are both linked to violence, the highest risk occurred when drugs and alcohol were used in combination(63). Male gender, and the presence of psychotic illness also increased associations between substance use and violence. An unexpected finding was that alcohol use was almost as strongly linked to victims of violence as it is to perpetrators of violence(62,63). Abusing alcohol seems to be significantly linked to risk of being physically assaulted or injured, though the link with drug use doesn't appear to be quite as strong(62,63).

Additionally:

- Alcohol use is a risk factor for involvement in youth violence(64)
- Qualitative research in the US found alcohol to be a central part of gang culture and to be strongly linked to violence(64)

More than a third of alcohol-related incidents take place in the home and ministers are concerned that drink is a factor in ‘hidden’ crimes such as domestic violence, sexual abuse and rape(65). As a result the Government are set to launch a crackdown on the causes of alcohol-fueled violence as part of a new strategy(65). The interplay between alcohol and violence has already been outlined in the 2016 modern crime prevention strategy(66).

The role of the night-time economy

The link between the night-time economy (NTE), alcohol, and crime is not explored in detail in this report but key elements have been summarised below.

- Violent behaviour in and around pubs and clubs on weekend nights presents a significant public health, criminal justice and urban management problem, and alcohol is often associated with violence in the NTE (67).
- Consuming/drinking alcohol in the NTE can have many benefits: from generating economic activity and employment, bringing people together to socialise, and being an enjoyable pastime that many people value(68).
- However, there are also potential costs, some (e.g. noise, pollution), occur because the trading times in the NTE conflict with many people’s daily routine/sleep. Other costs, e.g. crime and injury, are facilitated by alcohol, which is often highly traded in the NTE(68).

The Government’s serious violence strategy produced in 2018 notes that a substantial proportion of serious violence is linked in some way to alcohol(69). The strategy notes that evidence-based interventions targeting alcohol-related violence and domestic abuse are likely to help bring serious violence levels down.

The strategy highlights that a highly influential criminological theory; that crime can be driven by opportunity (for example, more people in confined pubs and clubs consuming alcohol increases the opportunity for provocation and violence). However, the authors note that there is no strong evidence that the current increase in violent crime is being driven by night-time economy violence (69).
In Suffolk:

- Pooled data for 2014/15-2016/17 indicates that there were 176 hospital admissions due to substance misuse in Suffolk for those aged 15-24 years. This equates to a directly standardised rate of 74.4 per 100,000 population (significantly lower than England - 89.8).
- National data indicates that 31% of men and 16% of women drank at a level indicating increased or higher risk of harm (more than 14 units a week). Applied to the Suffolk population age 16+ this would equate to 94,400 men and 50,600 women drinking at higher risk levels in Suffolk.
- 2014/15 data indicated that there were 1,530 adults in specialist drug misuse services in Suffolk.
- National data indicates that in 2016/17, around 1 in 12 (8.5%) adults aged 16 to 59 in England and Wales had taken an illicit drug in the last year. If this percentage is applied to the Suffolk resident population age 16-59, it can be estimated that approximately 34,100 Suffolk residents will have consumed an illicit drug in the last 12 months.
- Additionally, 2017 data indicates that 25,400 of people aged 18-64 are estimated to be alcohol dependant in Suffolk, and 14,400 are estimated to be drug dependant.

The Suffolk needs assessment looking at young people and substance misuse highlighted:

- In the Suffolk survey of young people, 80% had ever drunk alcohol and around 16% had ever taken drugs. The rolling total of young people in Suffolk in substance misuse treatment in the most recent 12 months was between 99 and 167 people. This is much lower than would be expected if the national figures are applied to Suffolk’s population, (using this approach 224 young people would be estimated to be in specialist substance misuse services per year).
- Within vulnerable populations in Suffolk, prevalence of substance misuse varies considerably. However, the extent of vulnerabilities in relation to substance misuse appears to be rising in Suffolk.
- In Suffolk social care assessments of young people who are in need, subject to a child protection plan, or are in care, 6 - 9% of all young people had a reported substance misuse issue. This is approximately 3x higher than the general population.
- In Suffolk, no referrals come to specialist substance misuse services from A&E departments, despite the rising rates of attendance for overdose and poisoning related incidents.
- In relation to the NTE, Norfolk and Suffolk Constabularies report that alcohol consumption and the night-time economy will continue to be a key demand area for policing, and that policing the NTE is a resource intensive operation. They assert that drug use in the night-time economy should be monitored to see if it has an impact on the levels of violence.
- Further research around the link between alcohol and violence in Suffolk may be beneficial in fully understanding the relationship between the two.

Sources: (70), (71), (72), (73), (74), (75), (76), (77)
Cultural and social norms supportive of violence

**Cultural norms**

PHE note that rules and expectations of behaviour in specific cultures or social groups can support violence and maintain harmful traditional practices such as forced marriage, female genital mutilation (FGM) and honour-based violence(2).

Additionally:

- Cultural acceptance of violence as a private affair hinders outside intervention and prevents victims from gaining support, while in many cultures victims of violence feel stigmatised, stopping incidents from being reported(2)
- Cultural intolerance, dislikes and stereotyping of ‘different’ groups within society based on nationality, ethnicity or sexual orientation, can also contribute to violent or aggressive behaviour towards such groups(2)
- Social and cultural views of disabled people may increase the risk for domestic abuse(78)

**Ethnicity**

The 2017 Race Disparity Audit for England and Wales found that ethnic minority groups were more likely than their white counterparts to be both suspects and victims of crime(79). The audit also found that of all young people in custody, a larger proportion of non-white offenders had committed offences of violence against the person (40%), robbery (27%) and drugs(13%) than White offenders (30%, 23% and 4% respectively)(80).

- A 2016 report from the Ministry of Justice (MoJ)(81) found that adults from the Asian or Asian British (1.0%) ethnic group who were less likely have been a victim of violence than adults from the White ethnic group (1.8%).
- Additionally, ONS data reported in 2018 that women identifying with Mixed/Multiple ethnicities were more likely to have experienced partner abuse in the last 12 months (10.1%), than any other ethnic group(82).

**Migrant populations and refugees**

- 2013 research indicated that neither asylum seeking populations or A8 migrants (people from countries that joined the European Union in 2004) were associated with statistically significant changes in levels of violent crime(83,84).
- However, 2018 news reports highlight that victims of serious crime face arrest over immigration status, with more than half of UK police forces handing over victims of crime to the Home Office for immigration enforcement(85). This could result in vulnerable people not coming forward to report violent crime.
Social media

‘Social media’ in its current form has, for most people, become a part of everyday life. Checking Facebook activity, responding to Tweets, sharing your latest picture on Instagram or Snapchat has become a normal activity, particularly for those in younger age groups.

“For many young people, their self-esteem is increasingly based not on what they think about themselves but on what others think about them.” (33,86)

For the majority of people, social media is used innocuously, to keep up to date with friends and family and to share activities and information. However, some also use it to perpetrate crime, and it has been linked to violence. The development of hidden forms of media such as ‘WhatsApp’ and ‘Snapchat’ allow posting of videos which quickly disappear, and may also facilitate the idea of ‘anonymous’ criminal activity.

In late 2017, UNESCO released a study on youth an violent extremism on social media, providing global mapping of research (mainly during 2012-16) into the assumed roles played by social media in violent radicalization processes(87). The research concluded some possible understandings, but no definitive link. Rather than being initiators or causes of violent behaviours, the internet and social media specifically can be facilitators within wider processes of violent radicalization(87).

Media reports highlight a growing phenomenon is the use of social media in glamorising gang violence and fuelling resentment and reprisals from rival groups(88). The status activities and rivalry of gangs are often played out over various social media forums. Social networking sites offer gangs a way of enhancing their reputation, status, and branding, while diminishing the standing of rival groups through negative commenting, posting provocative videos and direct threats of harm. This activity can also facilitate recruitment of other young people seeking to feel part of something, and they may feel enticed by the excitement and glamour of what is being presented to them online(33).

The 2017 report ‘Social Media as a Catalyst and Trigger for Youth Violence’ notes that the integration of social media into the daily lives of young people has left ‘online– offline’ boundaries increasingly blurred(89). They note that for young people, social media is commonly perceived to be hidden from adults, so a virtual free-for all space has emerged in which a small minority of young people share various forms of material - that both display and incite serious incidents of violence in real life. The report also notes the emergence of ‘drill music’ as a distinct genre that threatens and provokes individuals and groups from rival areas(89). However, they note that violent intent is the exception rather than the norm.

A 2017 report by HMI Probation looking at the work of Youth Offending Teams (YOT) found that in one in four of the cases inspected, the young person’s use of social media was directly related to the offence they had committed(33,86). Additionally, they report that it had been a catalyst for some of the most serious and violent offences particularly in relation to gang involvement.

In Suffolk, local young people associated with gangs and county lines activity have produced and publicised music videos on YouTube. While these videos were initially filmed in the local community and openly referred to drug dealing they have evolved over time to include reference to other rival individuals, mention weapons and violence, and have been filmed in ‘trap houses’ with the visible ‘cooking up’ of substances taking place in the background(33).

Recent qualitative research into young people in the UK and their perceptions of gangs and experiences with social media gave an insight into ‘gang culture’(90). Key findings of this include:
• The use of professionally made ‘trap rap’ videos posted on YouTube—often high quality and with product placement—are examples of a clear marketing campaign—‘brand strategy’ and ‘impression management’. The investment of illicit drug sale money into the production of these videos promotes gang business and creates a cycle. This means that tales of ‘going county’ enable a gang to ‘go viral’.

• Focus group work revealed a movement away from violence and a primary focus on the ‘business’ of making money: “Money, money, money that's what it's all about now. It ain't about all this violence and shanking anymore, that was lie 2008”.

• The research found that young women could be especially vulnerable to online flattery via social media—drawing the woman in to be exploited. Many respondents asserted that gang members only befriend girls to take advantage of them criminally or sexually. Additionally, screenshots/images and voice notes are often kept by advanced gang members—leading to a real fear in girls of being ‘exposed online’.

• Girls may also be sent in to test the viability of CLN.

One conclusion made by researchers is that expressive aspects of young people’s social media should not be trivialised because they don’t conform to conventional standards of communication.

**Video games and violent behaviour**

For many years, the link between video game playing (specifically violence focused games) and violent behaviour was hotly debated.

In 2015, the American Psychological Association Task Force report asserted that violent video game play is linked to increased aggression in players, but insufficient evidence exists about whether the link extends to criminal violence or delinquency(91). The report also noted a consistent relationship between violent video game use and increases in aggressive behavior, aggressive cognitions and aggressive affect, and decreases in prosocial behavior, empathy and sensitivity to aggression(91).

More recent findings from researchers at the University of York stated that there is no evidence to support the theory that video games make players more violent(92). A series of experiments, with more than 3,000 participants, found that that video game concepts do not ‘prime’ players to behave in certain ways and that increasing the realism of violent video games does not necessarily increase aggression in game players.
Disability

Both children and adults with disabilities are at much higher risk of violence than their non-disabled peers. Based on two systematic reviews published in the Lancet, the studies provide the strongest available evidence on violence against children and adults with disabilities (99).

Key findings indicated (99):

- Children with disabilities are 3.7 times more likely than non-disabled children to be victims of any sort of violence, 3.6 times more likely to be victims of physical violence, and 2.9 times more likely to be victims of sexual violence.
- Children with mental or intellectual impairments appear to be among the most vulnerable, with 4.6 times the risk of sexual violence than their non-disabled peers.

In Suffolk:

- The latest data available for ethnicity is 2011 Census data. Due to the length of time that has passed since the Census these figures should be interpreted with caution, although they remain the most reliable estimate. At the time of the 2011 Census Suffolk was less ethnically diverse than England and Wales, with 4.8% of residents identifying with a non-white ethnicity.

- Limited data is available in relation cultural norms in Suffolk. However, in Suffolk 2017/18 there were 10 reported cases related to FGM. In 2016/17 where there were 15 reported cases related to FGM. Most of the cases were reported by NHS organisations (obstetrics, gynaecology and midwifery). Disability statistics are provided later in the document.

The Suffolk Cyber Survey undertaken in 2017, found that:

- Children are accessing social media before the minimum age limit; 80% of 13-year olds had a social media profile.
- 15-year olds are taking more risks and exposed to harmful content, more than any other age group.
- 44% of 15-year olds had seen pro-anorexia sites at least once or twice; 42% had seen sites promoting violence, hatred or racist views; 29% had seen sites encouraging self-harm.

- A consistent and persevering concern, are the links between gaming, mental health and holistic wellbeing. In 2018 ‘Gaming addition’ was added to the World Health Organization’s 11th International Classification of Diseases (ICD), with a definition of a pattern of persistent or recurrent gaming behaviour so severe that it takes “precedence over other life interests”.

- However, the numbers of individuals impacted are likely to be small, with a recent report suggesting that between 0.3% and 1.0% of the population might qualify for a potential acute diagnosis of Internet gaming disorder. If this percentage was applied to the total population of Suffolk (all ages), it would equate to between 2,300-7,600 individuals.

Sources: (93), (94), (95), (96), (97), (98)
• Adults with a disability were 1.5 times more likely to be a victim of violence than those without a disability, while those with mental health conditions are at nearly four times the risk of experiencing violence.

Additionally, the WHO note stigma, discrimination, and ignorance about disability, as well as a lack of social support for those who care for them, place people with disabilities at higher risk of violence (99). Placement of people with disabilities in institutions also increases their vulnerability to violence, and in such settings (and elsewhere), people with communication impairments can be hampered in their ability to disclose abusive experiences (99).

A 2015 PHE report on disability and domestic abuse asserts that disabled people experience disproportionately higher rates of domestic abuse (78). They also experience domestic abuse for longer periods of time, and more severe and frequent abuse than non-disabled people. Disabled individuals are often in particularly vulnerable circumstances that may reduce their ability to defend themselves or to recognise, report and escape abuse (78).

The table below, extracted from the PHE report highlights differences between disabled and non-disabled individuals, based on individual incidents reported to the police. This does not provide information on the extent and patterns of abuse in people’s lives.

Table 8: Experiences of domestic abuse by disabled and non-disabled people in England and Wales

<table>
<thead>
<tr>
<th></th>
<th>Disabled women</th>
<th>Non-disabled women</th>
<th>Disabled men</th>
<th>Non-disabled men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced any domestic abuse in the last year</td>
<td>15.7%</td>
<td>7.1%</td>
<td>8.4%</td>
<td>4%</td>
</tr>
<tr>
<td>Experienced non-sexual partner abuse in the last year</td>
<td>11.3%</td>
<td>4.9%</td>
<td>4.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Experienced non-sexual family abuse in the last year</td>
<td>4.6%</td>
<td>1.7%</td>
<td>4.3%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Experienced sexual assault in the last year</td>
<td>2.6%</td>
<td>2.2%</td>
<td>0.9%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Experienced stalking in the last year</td>
<td>7.6%</td>
<td>3.8%</td>
<td>5.3%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>


Source: (78)
In Suffolk:

- Quality and Outcome Framework (QoF) data for 2016/17 in Suffolk indicates that 3,849 people in Suffolk are registered as having a learning disability.
- Census data indicates that 17.9% of the Suffolk population had a long term health problem or disability on Census day.
- 2017 Department for Education data indicates 2,511 children with learning disabilities, and 1,331 children with autism are known to Suffolk schools.
- 2017 data indicates that approximately 45,500 Suffolk adults age 18-64 are predicted to have a moderate or severe disability.
- In terms of levels of special educational needs and disabilities (SEND) locally for school age young people, 12% had an education, health and care (EHC) plan, 6% had a statement and 26% were receiving SEND support.
- Nationally, 18% of sentenced young people in custody had a statement of SEND compared to 3% of the general population.
- 66-90% of young offenders had below average speech, language and communication skills, with 46-67% having skills which were poor or very poor. This would suggest that young people at risk of offending are likely to need support to be able to access education and employment opportunities.
- Local data indicates that the prevalence children with SEND in Suffolk is increasing, and is forecasted to increase further. This cohort is potentially vulnerable to becoming a victim of violence, and is an area that needs monitoring.

Sources: (100),(101)

Mental ill health

Mind note that often, links are made between violence and mental health, particularly in the media, this focus can be unhelpful as it supports myths and creates stigma (102). The association of violence and mental ill health has received widespread attention and publicity (103). It may lead to anyone who experiences mental ill health being deemed dangerous, whether or not there is any risk of them being violent (102).

1 in 4 people in any one year will experience mental ill health, encompassing a wide range of conditions, including more common diagnoses such as depression and anxiety, as well as less common diagnoses such as bipolar disorder and schizophrenia (102).

Mind describe research that shows an increased risk of violence in those living with schizophrenia when compared to the general population, but the size of the risk varies, and the vast majority of people with schizophrenia will never be violent (102).

There is also an increased risk of violence in people with anti-social personality disorder (ASPD), but criminal/violent behaviour are symptoms used to diagnose ASPD - therefore it is expected that this diagnosis would be associated with higher risk (102). Studies that have investigated the prevalence of violence in psychiatric patients show wide variability, in accordance with the treatment setting in which they were conducted. Outpatient settings have the lowest prevalence rates of violence, with involuntary committed patients having the highest (103). The highest level of risk occurs when a person experiencing mental ill health (102):
• Is experiencing psychosis or delusions
• Is not adhering to drug or therapeutic treatment
• Is misusing drugs and/or alcohol

A recent study found that the rate of violence over a four-year period among those with severe mental ill health was 2.88% compared to 0.83% in the general population. However, rather than mental illness causing violence, the two were found to be connected mainly through the accumulation of other risk factors, such as substance abuse and childhood abuse/neglect (104,105).

In relation to ex-offender populations, reoffending and presence of psychiatric disorders are common in prisoners worldwide. A recent Lancet study looked at the association between psychiatric disorders, including substance use disorder, and violent reoffending in Sweden (106). The study found that certain psychiatric disorders are associated with a substantially increased hazard of violent reoffending, and that the hazard of violent reoffending increased in a stepwise way with the number of diagnosed psychiatric disorders.

When an individual comes into contact with the criminal justice system, there is a Liaison and Diversion (L&D) service that exists to identify offenders who have mental health, learning disability, substance misuse or other vulnerabilities (81). National data indicates that the most common offences committed by those using these L&D services were violence against the person (28%), followed by public order – nuisance (11%), and theft (9%).

Figure 9: Offenders using national liaison and diversion services by mental health need and ethnicity (percentages), 2016/17

The above information largely focuses on the evidence in relation to mental ill health as a causative factor for violence. Whilst over a third of the general public think people experiencing mental ill health are likely to be violent, people with severe mental ill health are more likely to be victims, rather than perpetrators, of violent crime (107).

Although anyone has the potential to experience mental ill health, prevalence is not equally distributed and varies across social groups (108). A number of groups of young people are at particular risk of developing mental ill health: children living at a socio-economic disadvantage,
children with parents who have mental health or substance misuse problems, and children in care (108,109). In adults higher risk of mental ill health was identified in people that have been homeless, adults with a history of violence or abuse, Travellers, asylum seekers and refugees, and isolated older people (108,109).

People who experience several complex and interrelated issues, who are referred to as having ‘complex needs’, are at higher risk of mental health problems (108). The Joseph Rowntree Association assert that poor mental health is a significant cause of wider social and health problems, including low levels of education achievement and work productivity, poor community cohesion, high levels of physical ill health, premature mortality, violence, and relationship breakdown (108).

Additionally, in relation to domestic violence, the relationship is bidirectional, with research suggesting that women experiencing abuse are at a greater risk of mental health conditions and that having a mental health condition makes one more vulnerable to abuse (104,110).

Over half of women who are both in poverty and have experience of extensive violence and abuse meet the diagnostic threshold for a common mental disorder – a rate three times higher compared to women in poverty who have little or no experience of violence (104). All the aforementioned information reinforces the complexity of the relationship between mental ill health and experiencing violent behaviour as a perpetrator or target.
In Suffolk:

- QoF data indicates a higher registered prevalence of depression compared to England (9.7% vs 9.1%), equating to 61,000 people.
- Severe mental illness (including schizophrenia, bipolar affective disorder and other psychoses), affects around 6,800 Suffolk residents. However, these are likely to be underestimates, as not everyone experiencing mental ill health will seek medical help.

**Figure 10: Summary of mental ill health in Suffolk, mixed dates**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Suffolk</th>
<th>Region England</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated prevalence of mental health disorders in children and young people: % population aged 5-16</td>
<td>2015</td>
<td>-</td>
<td>9.1%*</td>
<td>8.0%*</td>
</tr>
<tr>
<td>Depression recorded incidence (QoF): % of practice registered aged 15+</td>
<td>2016/17</td>
<td>-</td>
<td>9.076</td>
<td>1.4%*</td>
</tr>
<tr>
<td>Depression recorded prevalence (QoF): % of practice registered aged 16+</td>
<td>2016/17</td>
<td>-</td>
<td>61,035</td>
<td>9.7%</td>
</tr>
<tr>
<td>Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 15+</td>
<td>2016/17</td>
<td>-</td>
<td>1,409</td>
<td>13.6%*</td>
</tr>
<tr>
<td>Depression and anxiety among social care users: % of social care users</td>
<td>2013/14</td>
<td>-</td>
<td>48.8%</td>
<td>53.2%</td>
</tr>
<tr>
<td>Long-term mental health problems (GP Patient Survey): % of respondents aged 16+</td>
<td>2016/17</td>
<td>-</td>
<td>600</td>
<td>6.3%</td>
</tr>
<tr>
<td>New cases of psychosis: estimated incidence rate per 100,000 population aged 16-64</td>
<td>2011</td>
<td>-</td>
<td>83</td>
<td>18.4%</td>
</tr>
<tr>
<td>Severe mental illness recorded prevalence (QoF): % of practice register all ages</td>
<td>2016/17</td>
<td>-</td>
<td>6,778</td>
<td>0.86%*</td>
</tr>
<tr>
<td>ESA claimants for mental and behavioural disorders: rate per 1,000 working age population</td>
<td>2016</td>
<td>-</td>
<td>10,090</td>
<td>24.7%</td>
</tr>
</tbody>
</table>

Source: (111)
Brain injury

A traumatic brain injury (TBI) is the result of a blow to the head which might be caused by anything; a simple trip to a collision on the sports field to a major road accident or assault(112). TBI and violence is complicated by the fact that violence can not only a be a cause, but also a consequence of TBI(113). For example:

- Violent assault is one of the three top causes of TBI, a major cause of disability and death worldwide(114).
- A TBI may cause long term changes in many areas, including changes in behaviour and personality e.g. mood fluctuations, ability to control emotions(114).
- An eight-year study found that young people who have sustained a head injury are more likely to engage in violent behaviour, and young people who suffered a recent head injury (within a year of being questioned for the study) were even more likely to report violent behaviour(115).
- People who have ever experienced a head injury before young adulthood report more interpersonal violence than participants who have never had a head injury(1).
- Additionally, there is a very high prevalence of TBI in offenders in custody relative to the general population(1).
- A 2011 systematic review and meta-analysis concluded that TBI modestly increased the risk of violence, and that comorbid psychopathology was associated with violence(116).

In Suffolk:

2013/14 data from Headway indicates the following rates of admissions for head injury:

- Great Yarmouth and Waveney Clinical Commissioning Group (CCG): 151 per 100,000 population (323 admissions)
- Ipswich and East Suffolk CCG: 215 per 100,000 population (850 admissions)
- West Suffolk CCG: 264 per 100,000 population (591 admissions)

The East of England admission rate for the same period was 220 per 100,000 population.

More recent data indicates that on average there are just over 2,100 hospital admissions each year in Suffolk. Over a 3 year period, the majority of head injury admissions were in those aged 65+.

Table 9: numbers of hospital admissions with any diagnosis of head injury among residents of Suffolk County in financial years 2015/16-2017/18

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17</td>
<td>352</td>
<td>342</td>
<td>321</td>
</tr>
<tr>
<td>18-64</td>
<td>608</td>
<td>635</td>
<td>573</td>
</tr>
<tr>
<td>65+</td>
<td>1189</td>
<td>1237</td>
<td>1139</td>
</tr>
<tr>
<td>All ages</td>
<td>2149</td>
<td>2214</td>
<td>2033</td>
</tr>
</tbody>
</table>

Sources: (117), (118)
Genetics
Over recent years there has been lots of research as to the influence of genetics in relation to violence and aggression.

Two genes associated with violent repeat offenders were the monoamine oxidase A (MAOA) gene and a variant of cadherin 13 (CDH13)(119). The MAOA gene has been nicknamed the "warrior gene" because of its link to aggressive behaviour.

Research in Finland attributed 5–10% of all severe violent crime in Finland to the MAOA and CDH13 genotypes(120). The article asserted that maltreatment (specifically in childhood) didn’t affect the risk in any way, but substance intoxication was a crucial factor in interacting with the genetic element to produce impulsive aggression(121). However, the potential "perfect storm" of genetic and environmental factors to influence on the behaviour of an individual (such as childhood abuse, nurture, etc) should not be discounted(122).

Section summary
- There are many risk factors for violence, and Suffolk residents may experience the factors outlined above- putting them at increased risk of violence as either a perpetrator or victim.
- The impact of violence in Suffolk can have a detrimental effect upon physical and mental health and quality of life.
- A large proportion of Suffolk's children aged 0-17 year olds could be exposed to at least one ACE.
- The numbers of children in care in England continue to increase and this same pattern is reflected in Suffolk. The main needs of children entering care are reported to be due to abuse or neglect, family dysfunction, family stress and absent parenting.
- Both County Lines Networks (CLN) and Urban Street Gangs (USG) are present in Suffolk. The two groups are discrete. Members of these networks and gangs are likely to experience a complexity of issues, including poor mental health, and the impact of exploitation.
- Although Suffolk experiences below average levels of deprivation compared to nationally, there are pockets of highly deprived Suffolk residents. Additionally, gross weekly pay for Suffolk workers and residents, and social mobility for young people in the area is low. Local data indicates that Suffolk has a higher proportion of NEET young people.
- In Suffolk social care assessments of young people who are in need, subject to a child protection plan, or are in care, 6 - 9% of all young people had a reported substance misuse issue. This is approximately 3x higher than the general population.
- Certain groups of individuals may be at increased vulnerability to violence (due to characteristics of that group). For example SEND individuals, others with disabilities, and vulnerable elderly populations.
- The interplay between poor mental health and violence risk (both as a perpetrator and victim is a significant factor that should not be overlooked.
Part 2: How much violence does Suffolk experience?
The following section presents an overview of violence and violent incidents in Suffolk. Data is limited to what was available at the time of writing this report. Data is collated from a range of sources, and therefore totals may not be directly comparable with each other in each section.

Recorded crime
Suffolk Police is made up of many departments working together to help keep the residents of Suffolk safe, secure and informed. There are 18 Safer Neighbourhood Teams (SNTs), who work in the heart of local communities to tackle policing issues and prevent more serious issues occurring. Suffolk Police works closely with other organisations to effectively tackle crime and anti-social behaviour, and to deliver a service that is visible, accessible and responsive to what local people need.

Figure 11: Total number of offences recorded by the police, Suffolk Police Force Area, 2008-2018

![Graph showing trends in the number of recorded offences in Suffolk from 2008-2018](image)

Source: (123)

Figure 11 shows trends in the number of recorded offences in Suffolk from 2008-2018, not all offences will be reported to the Police. Data for the year ending 31 March 2018 indicates just over 53,000 recorded offences. A breakdown of the core violence related offences is shown in overleaf.

Figure 12 gives a more detailed trend analysis for three core offence types: violence with or without injury, all types of burglary and sexual offences. This shows an increasing trend for violence with or without injury as well as sexual offences. This may be due to actual crime number rises, but individuals may also be reporting these types of crime more than previously, and more individuals are engaged with reporting practices, local trust in the police may have also improved.

As mentioned above, it is vital to take into account changes and improvements in crime data integrity. Suffolk Constabulary continue to report improvements in data quality, and there have been improvements in encouraging victims to come forward more frequently. Services are more joined up with better recognition and response to violence related crime. There is ongoing work to verify and validate trend data.
Figure 12: Numbers of offences recorded by the police, by main violent offence group, for Suffolk Police Force Area at year end on March 31 of each year, 2008-2018

Source: (123)

Figure 13: Trend analysis for core crimes in Suffolk, 2003-2018

Source: (123)
When looking at crime types by contribution to overall offences, there have been changes in the makeup of crime in Suffolk over the last 15 years (see figure 14). These changes are more obvious in the crimes related to violence, for example violence with or without injury, and sexual offences.

For example when comparing 2003 data to 2018 data:

- **Overall recorded crime** increased by 6% (50,315 in 2003 compared to 53,116 in 2018).
- **Recorded burglary** formed 12.4% of overall crime in 2003, compare to 8.6% in 2018. This equates to a fall of 30% between 2003 and 2018.
- **Recorded sexual offences** formed 1.3% of overall crime in 2003, compare to 4.0% in 2018. Approximately four times the number of incidents are now being reported compared to 2003.
- **Violence with or without injury** formed 12.2% of overall crime in 2003, compare to 25.2% in 2018. Approximately double the number of incidents are now being reported compared to 2003.
- **Stalking and harassment** formed 0.4% of overall crime in 2003, compare to 7.5% in 2018. In 2018 there were approximately 22x the number of recorded incidents compared to 2003. Legislation changes giving police more power in relation to stalking and harassment charges could be a major driver of this change, however people may feel they can report this type of offence more. Additionally, it is worth reinforcing that this still represents a small number of total recorded crimes.
As mentioned above, some of this change may be due in part to changes in reporting and recording, or more of an awareness of the crime type and people perhaps being more willing to come forward (especially for sexual offences, stalking and harassment), this is apparent in national data (124). Nevertheless, the data also suggests that the nature of crime has evolved over the last 15 years, especially in relation to violent incidents.

Comparing this year and last, percentage change data for 2018 compared to 2017 indicates a 16% increase in recorded violence related offences in Suffolk1 (125). The rate per 1,000 population of all crime, and violence against the person, remains lower in Suffolk compared to the England rate (see table below).

Table 10: Police recorded crime by offence group, rate of offences per 1,000 population, year ending March 2018

<table>
<thead>
<tr>
<th>Area Name</th>
<th>Total recorded crime (excluding fraud)</th>
<th>Violence against the person</th>
<th>Sexual offences</th>
<th>Robbery</th>
<th>Theft offences</th>
<th>Criminal damage and arson</th>
<th>Drug offences</th>
<th>Possession of weapons offences</th>
<th>Public order offences</th>
<th>Miscellaneous crimes against society</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENGLAND</td>
<td>83.0</td>
<td>23.7</td>
<td>2.5</td>
<td>1.4</td>
<td>34.5</td>
<td>9.9</td>
<td>2.3</td>
<td>0.7</td>
<td>6.4</td>
<td>1.6</td>
</tr>
<tr>
<td>East</td>
<td>71.8</td>
<td>21.0</td>
<td>2.2</td>
<td>0.7</td>
<td>29.6</td>
<td>8.9</td>
<td>2.0</td>
<td>0.7</td>
<td>5.2</td>
<td>1.4</td>
</tr>
<tr>
<td>Suffolk</td>
<td>70.7</td>
<td>22.3</td>
<td>2.7</td>
<td>0.5</td>
<td>25.4</td>
<td>9.6</td>
<td>2.1</td>
<td>0.5</td>
<td>6.2</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Source: (125)

Statistics from March 1 2017, to March 31 2018 form Suffolk Constabulary show there were 404 reported incidents that involved weapons such as knives, axes, blades, swords and machetes (126). This is an increase from 300 recorded incidents involving knives reported to the police for the same period a year previously.

Data is available at small area level (LSOA), for June 2018, with outcomes added for some offences. This data indicates that in June 2018 there were 1,868 offences that were recorded as ‘violence and sexual offences. 72% of these incidents were still under investigation at the time of compiling this report. This is to be expected, as only a relatively short period of time has passed from the incident occurring. For 6% (118) of the offences it was deemed that ‘formal action would not be in the public interest’ (127).

The LSOAs with the highest number of recorded violent/sexual offences in June 2018 was E01033125, this covers the town centre area of Ipswich, and recorded 53 offences of this type.

Special collection data

The ONS note that proportions of offences involving the use of a knife or sharp instrument are calculated based on figures submitted in a special collection, and other offences exist that are not shown in this table that may include the use of a knife or sharp instrument (128).

Data in table 13 below indicates that recorded offences in Suffolk for this type of crime are low, and trend data from 2010 indicates that these types of offences remain low volume in Suffolk.

---

1 This definition includes Homicide, violence with or without injury, stalking and harassment and death or serious injury – unlawful driving.
### Table 11: Knife and sharp instrument offences recorded by the police for selected offences, by police force area, year ending June 2018

<table>
<thead>
<tr>
<th>Area Name</th>
<th>Total of selected serious offences</th>
<th>Attempted murder</th>
<th>Threats to kill</th>
<th>Assault with injury &amp; assault with intent to cause serious harm</th>
<th>Robbery</th>
<th>Rape and sexual assault</th>
<th>Homicide</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of offences involving a knife</td>
<td>% involving a knife</td>
<td>Number of offences involving a knife</td>
<td>% involving a knife</td>
<td>Number of offences involving a knife</td>
<td>% involving a knife</td>
<td>Number of offences involving a knife</td>
</tr>
<tr>
<td>Total</td>
<td>40,464</td>
<td>6</td>
<td>339</td>
<td>35</td>
<td>2,946</td>
<td>11</td>
<td>18,555</td>
</tr>
<tr>
<td>Total Suffolk</td>
<td>158</td>
<td>2</td>
<td>2</td>
<td>10</td>
<td>6</td>
<td>2</td>
<td>92</td>
</tr>
<tr>
<td>Total England</td>
<td>2,625</td>
<td>4</td>
<td>35</td>
<td>4</td>
<td>265</td>
<td>10</td>
<td>1,276</td>
</tr>
<tr>
<td>Total East</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td></td>
<td>12</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

Source: (128)

### Comparisons to statistical neighbours – crime severity score

In October 2018 the ONS produced experimental statistics on crime rates and severity. Comparisons with Suffolk’s most similar police forces (most similar groups- MSGs) can also be made in this tool.

The crime severity score gives more severe offence categories a higher weight than less severe ones. Weights have been calculated for each offence in the published police recorded crime series based on sentencing information (129).

Using this method, the latest data indicates that Suffolk has a lower offence rate compared to England and Wales, and the third highest offence rate compared to its MSG police force areas (PFA), it has the fourth highest crime severity rate compared to MSG areas, but this is lower than England and Wales.

### Table 12: Crime severity score and offence rate per 1,000 population all crime, Suffolk and its MSG police force areas, June 2018

<table>
<thead>
<tr>
<th>Geography</th>
<th>Crime Severity Score</th>
<th>Offence rate per 1,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Devon and Cornwall</td>
<td>9.5</td>
<td>60</td>
</tr>
<tr>
<td>Norfolk</td>
<td>10.2</td>
<td>63</td>
</tr>
<tr>
<td>North Wales</td>
<td>13.2</td>
<td>77</td>
</tr>
<tr>
<td>North Yorkshire</td>
<td>7.8</td>
<td>50</td>
</tr>
<tr>
<td>Warwickshire</td>
<td>12.0</td>
<td>73</td>
</tr>
<tr>
<td>West Mercia</td>
<td>11.2</td>
<td>66</td>
</tr>
<tr>
<td>Wiltshire</td>
<td>9.5</td>
<td>81</td>
</tr>
<tr>
<td>Suffolk</td>
<td>11.1</td>
<td>70</td>
</tr>
<tr>
<td>England and Wales</td>
<td>13.6</td>
<td>85</td>
</tr>
</tbody>
</table>

Source: (129)
Table 13: Crime severity score and offence rate per 1,000 population **violence against the person**, Suffolk and its MSG police force areas, June 2018

<table>
<thead>
<tr>
<th>Geography</th>
<th>Crime Severity Score</th>
<th>Offence rate per 1,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Devon and Cornwall</td>
<td>3.0</td>
<td>22</td>
</tr>
<tr>
<td>Norfolk</td>
<td>2.6</td>
<td>21</td>
</tr>
<tr>
<td>North Wales</td>
<td>3.8</td>
<td>30</td>
</tr>
<tr>
<td>North Yorkshire</td>
<td>2.0</td>
<td>14</td>
</tr>
<tr>
<td>Warwickshire</td>
<td>3.2</td>
<td>21</td>
</tr>
<tr>
<td>West Mercia</td>
<td>2.9</td>
<td>22</td>
</tr>
<tr>
<td>Wiltshire</td>
<td>2.3</td>
<td>19</td>
</tr>
<tr>
<td>Suffolk</td>
<td>2.8</td>
<td>23</td>
</tr>
<tr>
<td>England and Wales</td>
<td>3.6</td>
<td>25</td>
</tr>
</tbody>
</table>

Source: (129)

Table 14: Crime severity score and offence rate per 1,000 population **sexual offences**, Suffolk and its MSG police force areas, June 2018

<table>
<thead>
<tr>
<th>Geography</th>
<th>Crime Severity Score</th>
<th>Offence rate per 1,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Devon and Cornwall</td>
<td>3.9</td>
<td>3</td>
</tr>
<tr>
<td>Norfolk</td>
<td>4.1</td>
<td>3</td>
</tr>
<tr>
<td>North Wales</td>
<td>5.8</td>
<td>4</td>
</tr>
<tr>
<td>North Yorkshire</td>
<td>3.1</td>
<td>2</td>
</tr>
<tr>
<td>Warwickshire</td>
<td>3.6</td>
<td>2</td>
</tr>
<tr>
<td>West Mercia</td>
<td>4.2</td>
<td>3</td>
</tr>
<tr>
<td>Wiltshire</td>
<td>3.5</td>
<td>2</td>
</tr>
<tr>
<td>Suffolk</td>
<td>4.4</td>
<td>3</td>
</tr>
<tr>
<td>England and Wales</td>
<td>4.1</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: (129)

Suffolk has the second highest recorded crime rate for violence against the person in June 2018, compared with its MSG PFAs, however it has the fourth lowest crime severity score. In relation to sexual offences, Suffolk has the third highest rate of offences, and the second highest crime severity score for this offence type compared to its MSG.
Change over time

Figure 15: All crime, rate for Suffolk and MSG PFAs, 2003-2018

When looking at the overall crime rate between 2003-2018, Suffolk has experienced a general decline in overall crime (figure 15). However, the four most recent data points contradict this overall downward trend. The crime severity score for all crime in Suffolk has increased between 2003-2018 (not charted). There have been significant improvements in data quality over the last 15 years, and this is likely to have an impact.

Source: (129)
Crime rates for violence against the person between 2003-2018 indicate that Suffolk has experienced a general increase in this offence type. The crime severity score for violence against the person in Suffolk has increased between 2003-2018, from 1.6 to 2.8 (not charted). Although this represents a 75% increase between 2003-2018, this is not the largest increase compared to similar PFAs. Warwickshire experienced a 112% increase and North Yorkshire experienced a 107% increase over the same period.

Sexual offence rates between 2003-2018 show an increase in this offence type in Suffolk. The crime severity score for sexual offences in Suffolk has increased between 2003-2018, from 1.1 to 4.4 (not charted). This represents a 287% increase between 2003-2018. However, this is not the largest increase compared to MSG PFAs, with 4 PFAs (North Wales, Warwickshire, Devon and Cornwall and West Mercia) all experiencing a larger percentage increase.
The findings of this section further highlight changing patterns of crime in Suffolk. However, many of these patterns (such as increasing crime severity scores) are mirrored in other geographically similar areas. This indicates that Suffolk doesn’t appear to be an outlier. Changes in reporting behaviour and data integrity are likely to play a role in this explaining some of this change, however longer term monitoring of data is required. Violence against the person and sexual offences in Suffolk are a public health concern.

National comparison data
The Crime Survey for England and Wales (CSEW) has measured crime in since 1981, and measures crime by asking members of the public, about their experiences of crime over the last 12 months (124). The survey records all types of crimes experienced by people, including those crimes that may not have been reported to the police, and therefore provides a more thorough picture of the extent of crime.

The ONS report that the latest figures show no change in the total level of crime, but this hides variation in different crime types. Over the last year, there have been rises in some types of theft and in some lower-volume but higher-harm types of violence. However, this is balanced by a fall in the high-volume offence of computer misuse and no change in other high-volume offences such as overall violence, criminal damage and fraud(124).

The ONS assert that the CSEW provides the best measure of trends for overall violent crime. This is because it has used a consistent methodology since 1981, and as the survey covers crimes that are not reported to, or recorded by, the police and so tends to provide the better measure of more common but less harmful crimes. Additionally, unlike police recorded crime statistics the CSEW is not affected by changes in recording practices and police activity(124).
Please note: CSEW data from both 2017 and 2018 is used, as some analysis has not yet been made publicly available for 2018, namely the ONS report on the nature of violent crime.

Figure 18: Crime in England and Wales, year ending December 1981 to year ending June 2018

Source: (124)
Note: New victimisation questions on fraud and computer misuse were incorporated into the CSEW from October 2015.

Figure 19: Trends in police recorded and Crime Survey for England and Wales violent crime, year ending December 1981 to year ending March 2017

Source: (61)
A comparison of CSEW and recorded crime data is depicted in Figure 19, and highlights differences in volumes of violent crime. The most recent data (depicted in Figure 20), indicates long-term reductions in violent crime but little change in recent years using CSEW data. The ONS report that long-term reductions in violent crime supported by other data such as the most recent admissions data for NHS hospitals. They also assert that homicides have increased (even when accounting for the recording of incidents with multiple victims – such as the London and Manchester terror attacks), but they remain a low volume crime.

Figure 20: Crime Survey for England and Wales violence trend data

Source: (124)

The ONS note that recording improvements have had a big impact on police recorded violence, with anecdotal evidence suggesting that the improvements have had a larger effect on relatively less harmful types of violent crime, and less impact on more harmful subcategories, such as homicide and violent offences involving weapons (see figure 21) (130).

The ONS report that although the number of crimes recorded by the police has risen each year for the past four years to 5.7 million in the year ending September 2018, this is largely due to police forces improving their recording practices, and more victims have come forward to report crimes. CSEW data indicates a decrease in overall crime over the same time period (131).

Proportions of offences involving the use of a knife or sharp instrument are calculated based on figures submitted in additional special collection (124). The past four years have seen a rise in the number of recorded offences involving a knife or sharp instrument, following an initial downward trend. Analysis indicates that crimes involving knives and sharp instruments are most often assaults with injury, or assault with intent to cause serious harm, and robberies (124).

Recent analysis shows that knife crime disproportionately affects London. Data for the year ending September 2018 indicates 35% of crime involving a knife or sharp instrument happened in London. For the same period, the knife crime rate for the Metropolitan Police force area was 168 offences per 100,000. In Suffolk the rate was 26 offences per 100,000 population – the 6th lowest of police forces in England and Wales (131).
Figure 21: Volume of violent crime being recorded by the police

Source: (130)

Notes:
1. Police recorded crime data are not designated as National Statistics.
2. Data on homicide and death or serious injury - unlawful driving data are not included in this figure due to the relative low number of offences.

In relation to domestic abuse, the ONS assert that police figures do not currently provide a reliable indication of current trends in relation to domestic abuse related offences (due to recording and identification of offences). They note that figures from a self-completion module in the CSEW have shown little change in the prevalence of domestic abuse in recent years. However, the cumulative effect of changes resulted in a small, significantly lower prevalence for the year ending March 2018 (6.1%) compared with the year ending March 2005 (8.9%).

In addition, a new offence of coercive or controlling behaviour in an intimate or family relationship was introduced on the 29 December 2015, as part of the Serious Crime Act 2015, and offences are now flagged where children have been sexually abused or exploited (124).

Police recorded domestic abuse continues to rise, with the 2015 ‘Her Majesty’s Inspectorate of Constabulary and Fire & Rescue Services report’ concluding that recent increases in the number of domestic abuse-related crimes were due, in part, to police forces improving their recording of domestic abuse incidents as crimes (in addition to forces actively encouraging victims to come forward to report) (130).
Victim crime data (national)
The ONS report that the likelihood of being a victim of crime has fallen considerably over the long-term, from around 4 in 10 adults 1995, compared to less than 2 in 10 adults in the year ending June 2018 (124,130).

CSEW data for the year ending March 2017 data indicated that (61):

- **Men** were more likely to be victims of CSEW violent crime than women (2.1% of males compared with 1.3% of females).
- **Adults aged 16 to 24** were more likely to be victims of CSEW violence than those in older age groups (4.1%).
- Those who were **single** (3.2%) were more likely than adults of other marital statuses to be victims, except for those who were separated (2.6%) where there was no significant difference.
- Adults who were **unemployed** (4.4%) were more likely to be victims of violent crime than those who were employed (1.8%).
- Adults living in the **20% most deprived output areas** were more likely to be victims (2.2%) than those living in the 20% least deprived output areas (1.2%) and other output areas (1.6%).

Figure 22: Characteristics associated with being a victim of violence, year ending March 2017 Crime Survey for England and Wales

Source: Crime Survey for England and Wales, Office for National Statistics

Source: (61)
Offender data
Victims of Crime Survey for England and Wales (CSEW) violent crime were able to provide some
detail about the perpetrator(s) (based on the victims' recollection and perception)(61):

- Perpetrators were most likely to be male (reported to be the perpetrator in around three-
  quarters of violent incidents) (78%).
- Perpetrators were most likely to be aged between 25 and 39, (the perpetrator was
  believed to in this age group in 37% of violent incidents).
- In 76% of violent incidents a sole perpetrator was reported to have been responsible.
- Only 5% of domestic violence incidents involved more than one perpetrator, compared
  with 24% of incidents of acquaintance violence and 33% of incidents of stranger violence.
- Incidents of violence against children were most likely to be committed by someone known
  well to the victim (53% of incidents), with a small proportion of incidents being committed
  by strangers (11%). The perpetrator was a pupil at the victim’s school in 72% of violent
  incidents, and was most likely to be male (72% of incidents) and aged between 10 and 15
  (78%).

Data can also be used to identify relationships between victims and offenders. 2017 CSEW data
indicates that the most common perpetrators of violent crime were strangers (43%, 531,000
offences), with 37% of offences (462,000) perpetrated by an acquaintance, and the remaining
20% (246,000 offences) categorised as domestic violence (61). Domestic violence here is defined
as incidents reported through the face-to-face interview that were perpetrated by a partner, ex-
partner or a family member.

In recent years, stranger violence has shown the largest reduction in number of incidents,
acquaintance violence fell by 75% from the peak of 1.8 million offences in the year ending
December 1995 to an estimated 462,000 offences in the year ending March 2017. The ONS report
this is an important driver of changes in overall violence (61).

For prisoners in custody, violence against the person (VATP) offences accounted for the highest
proportion of prisoners at the end of March 2018 (25%)(132).

Location mapping
Police.UK data for September 2017-August 2018 (latest available) has been used to create heat
mapping of crime hotspots in Suffolk by LSOA. Data has been cleaned to remove LSOAs not
located in Suffolk, and offences that could not be matched to an LSOA have also been removed.
The data on the maps represent numbers of offences rather than rates. There were 19,859 violent
or sexual offences that were reported between September 2017 and August 2018.

The LSOA with the highest number of offences was in Ipswich, encompassing the main town
centre area (Museum Street / Com Exchange). 525 offences were recorded for this LSOA
representing 2.6% of all offences recorded of this nature. A high proportion of the offences were
located in Ipswich LSOAs, and violence and sexual offences in Ipswich accounted for 29.2%
(5,802) of total offences recorded in this period of this type.
Figure 23: Violence and sexual offences by Suffolk LSOA, September 2017-August 2018

Source: (133)

Figure 24: Ipswich, violence and sexual offences by Suffolk LSOA, September 2017-August 2018

Source: (133)
Figure 25: Lowestoft, violence and sexual offences by Suffolk LSOA, September 2017-August 2018

Source: (133)

Figure 26: Weapon offences by Suffolk LSOA, September 2017-August 2018

Source: (133)
Weapon offences in Suffolk are relatively low in volume, nevertheless 411 offences were recorded over the period September 2017-August 2018. A high proportion of the offences were located in Ipswich LSOAs, and weapon offences in Ipswich accounted for 29.7% (122) of total offences recorded in this period. Outcome data indicates that 18% of total offences were awaiting court outcome, 14% were under investigation, in 13% of offences police records indicate they were unable to prosecute, and in 13% formal action was deemed not to be in the public interest.

“It is timely for me ... In Suffolk we have seen of late I am afraid a great spike in assaults on police officers. We had an increase from 193 in 2016 to 281 offences in 2017. A very high increase.... These are very significant increases that have caused a great deal of concern in the county and in my constituency. When we talk about assaults on police officers this comes at a time when I have been particularly concerned about very obvious increase in violent crime....” (South Suffolk MP James Cartlidge)

“Any increase is unwelcome and I share people’s concerns...Suffolk remains a safe place, but we can’t be complacent...A lot of emphasis has gone on dealing with gangs and violence, and I believe raising the profile will help improve reporting”. (Police and Crime Commissioner Tim Passmore)

“I think this is the biggest threat without question facing Suffolk at the moment,” (on youth gangs and drug violence)...We need to treat this like a public health epidemic and the reason I say that is because we need to have a multi-agency approach...There’s an education side, parents, we have to look at housing, jobs, opportunities for youngsters.” (Police and Crime Commissioner Tim Passmore)

“We are seeing improvements in traditional crimes like theft and burglary - but it’s important to remember that if you’re a victim, that’s the crime that matters to you. We make the victim centre to any investigation.” (Deputy Chief Constable Rachel Kearton)

Sources: (134–136)
Domestic violence and abuse

Domestic violence and abuse (DVA) can affect anyone regardless of their age, gender identity or reassignment, race, religion, class, sexual orientation and marital status, and is not limited to physical violence or confined to instances within the home(137). The abuse can encompass (but is not limited to): physical, psychological, sexual, financial and/or emotional abuse. The Local Government Association notes(138):

- It accounts for 8% of all crime with an estimated two million victims a year.
- Victims are predominantly women, one in four women experience a form of domestic abuse in their lifetime.
- DVA also significantly affects those children and young people who witness such incidents of violence and control.
- Children and young people also suffer because of such violence and abuse, with significant risk to the child’s physical, emotional and social development. There is also an increased risk they themselves will become victims of abuse themselves, or even perpetrators. Their experience of DVA can lead to intergenerational cycles of vulnerability and perpetration.

Norfolk and Suffolk Constabularies assert that a diverse range of crimes can evolve from domestic abuse, including offences such coercive and controlling behaviour which are not always immediately apparent(139). They also note that the increase in domestic crime has been attributed to a change in recording practices. Additionally, historically the police have needed a victim to progress a criminal investigation, but now the police are able to pursue with an investigation without the victim being involved. Demand on both Norfolk and Suffolk forces is likely to increase due to more recorded crimes requiring investigation and appropriate safeguarding. Increasing confidence and encouragement to report is also a factor in increasing demand, as these crimes are under-reported.

Police reporting indicates that the 12 month rolling average of domestic abuse related incidents in Norfolk & Suffolk is 15% higher than the 3 year rolling average. Conversely, a decline has been seen in the volume of recorded domestic abuse incidents. When combined the volume of “domestic demand” (incidents and crimes) has remained relatively stable over the three year period(140).

CSEW data from 2016 showed that 8.1% of Suffolk’s population aged 16-59 were victims of domestic abuse in the preceding year (32,000 victims).

ONS data for the year ending March 2017 reports 9,629 domestic abuse related incidents and crimes, equivalent to 13 incidents for every 1,000 people in Suffolk(141). 52% of domestic abuse-related incidents and crimes were subsequently recorded as crimes (compared to 46% for England and Wales), and domestic abuse crimes represented 11% of all crimes in Suffolk (the same as the England proportion). Compared to statistical neighbours, Suffolk had a lower number and rate of domestic abuse related incidents and crimes.

Data for Suffolk indicates(142):

- For the financial year ending 31 March 2018, a total of 6,024 reports were logged by police, an increase of 27% against a three-year average and the equivalent of 16 a day.
- 18% of those cases were solved, which is down 10.5%. More than half of victims (54%) did not support a police investigation.
- At an accountability and performance panel meeting the Deputy Chief Constable asserted that there was a direct correlation between an increase in reporting, and the dramatic rise (13%) in victims not wanting to support a prosecution. He said the same amount of staff were dealing with investigations, but police were seeing fewer people wanting to engage.
The Suffolk Violence Against Women and Girls, Men and Boys (VAWGMB) strategy and action plan notes(22):

- The outreach service in Suffolk gets approximately 108 referrals per month. 34% of referrals come from the Suffolk Multi Agency Safeguarding Hub and 92% of all cases are for female service users. The most referrals come from the west of the county and the largest type of support offered by outreach is intensive support.
- The Independent Domestic Violence Advice (IDVA) service referred an average of 159 cases per month totalling 1,912 cases in 2017. The highest volume of referrals come from Ipswich (35%) and 64% of service users were White British, 89% of service users were female and 88% of referrals were from the Police Domestic Abuse team.
- The Multi Agency Risk Assessment Conference reports they currently seeing approximately 130 cases a month across Suffolk. 80% of referrals come from the police domestic abuse team, 92% of victim referrals were female and 33% of victims were aged between 21 and 30 years old.

Sources:(22)

Drug and gang violence, and county lines networks
As of 2017, Suffolk Police have made over 2,500 arrests in connection with drug related crime over a two and half year period. Suffolk Police have brought the county’s three area drug operations Volcanic (South), London (West) and Boulevard (East) together under the ‘umbrella’ of Velocity(34).

Personal robbery
Robbery is different to theft from the person in that, unlike robbery, theft from the person does not involve violence or threats to the victim. Robbery is typically a low volume offence, accounting for only 1-3% of crimes recorded (140).

Norfolk and Suffolk Constabularies report that robbery is more common in urban areas, 57% of robberies recorded in Suffolk were committed in Ipswich. An average of 7 robbery offences a week are recorded in Suffolk equating to one extra robbery a week, compared to the 3-year average. In 38% of crimes, the offender was known to the victim. Robbery has increased locally, in line with national trends. However, there are gaps in understanding of the local reasons for the rise(140). A constabulary strategic review of robbery is underway.
Hate crime
Norfolk and Suffolk Constabulary describe hate crime as:

"Any criminal offence which is perceived by the victim or any other person, to be motivated by hostility or prejudice, based on a person’s disability or perceived disability; race or perceived race; or religion or perceived religion; or sexual orientation or perceived sexual orientation or transgender identity or perceived transgender identity" (140).

This is the common definition applied by both the Police and Crown Prosecution Service.

Norfolk and Suffolk Constabulary report that hate crime is an area of policing in which underreporting is evident, despite a rise in police recording over the past 4 years a gap remains between recorded offences and the levels of hate crime reported via the CSEW. Recent data on hate crime for Suffolk was not known at the time of writing this report. Norfolk’s weekly demand was 24 incidents, as a statistically similar neighbour of Suffolk, it is likely that Norfolk’s figures are similar to Suffolk’s(140).

Reporting from 2012/13 found that hate crimes that occurred between 2005 and 2012 were concentrated throughout the urban centres in Suffolk, notably Ipswich, Bury St. Edmunds, Lowestoft, Newmarket and Sudbury(143). The report also found that Hate Crimes tended to occur in LSOA’s with multiple deprivation and high crime. The report asserted that between 2005 and 2012 there were 4,030 recorded hate crimes, and 1,196 hate crime incidents.

Suffolk Youth Justice Service (SYJS)
Although any young person has the propensity to offend, there are certain groups of young people at higher risk than others. Young people who offend are often known to children’s social care services, and there is a well-established link between experiences of family violence (broadly defined), and participation in youth offending(19).

There are also links between a specific sub-type of family violence and involvement in youth offending, for example, between youth offending and experiencing: sibling violence, violence against women and girls (VAWG), childhood physical abuse, child to parent violence and witnessing domestic violence (19).

The following figure from the Local Government Association summarises protective and risk factors.
Figure 28: protective and risk factors for family violence and youth offending

Protective factors influencing the link between family violence and youth offending

<table>
<thead>
<tr>
<th>Individual factors</th>
<th>Family factors</th>
<th>Community factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>High self-esteem</td>
<td>Good sibling relationships</td>
<td>Good peer relationships</td>
</tr>
<tr>
<td></td>
<td>High quality relationships with supportive adults</td>
<td>Safe school environment</td>
</tr>
</tbody>
</table>

Risk factors influencing the link between family violence and youth offending

<table>
<thead>
<tr>
<th>Individual factors</th>
<th>Family factors</th>
<th>Community factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low social competency</td>
<td>Running away from home</td>
<td>Delinquent peers</td>
</tr>
<tr>
<td>Experience of depression</td>
<td></td>
<td>Verbal and physical abuse with peers</td>
</tr>
<tr>
<td>Failure at school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiences of family violence that start in or persist into adolescence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance abuse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: (19)

Data is available from quarterly reporting, with the latest information available covering January-March 2018. The reports key findings are outlined below(144):

- The latest results show Suffolk has again seen a reduction in the number and rate of first time entrants to 234 per 100,000 10-17 year-olds in Suffolk. Older trend data is presented overleaf.
- The reoffending frequency continues to fluctuate more in Suffolk than national and regional figures. Suffolk has seen a deterioration in the latest quarter measured with the frequency increasing from 4.30 to 4.57offences per reoffender. Older trend data is presented overleaf.
- The custody rate has increased in this quarter and at 0.26 per 1,000 of the 10-17 population has just dipped above Suffolk’s target rate of 0.25 for the first time in recent years.

Figure 29: Rate per 100,000 for first time entrants to the Youth Justice System

Source: (144)
The Diversion Programme

The University of Suffolk (34) report outlined the need to proactively engage with young people that are within gangs or on the fringe of gang related or county line activity. The countywide Diversion Programme means that there is already a clear referral pathway and established process in place to intervene early with this group of young people. The Diversion Programme is a joint initiative between Suffolk Constabulary and SYJS.

Many (but not all) children and young adults involved in gang activity will be known to the Youth Justice Service or Probation due to having been convicted of a criminal offence or referred to the Diversion Programme. Agencies should check with these services to see if an individual or a suspected perpetrator is known to them to ensure a joined-up approach (33).

Latest quarterly data indicates that of the court outcomes with Suffolk Youth Justice Service supervision and caution referrals 13% were female and 9% identified as being in a Black and Minority Ethnic (BAME) Group. 25% were recorded as being a child in care. Of the diversion referrals 29% were female and 9% were BAME. 10% were recorded as being a child in care (144).

The Diversion Programme seeks to prevent children and young people from offending or re-offending by diverting them away from the criminal justice system by assessing and delivering targeted interventions at an early stage. This approach is consistent with the current evidence base. The programme is voluntary, and this along with the aims and principles of the programme should be explained clearly to children/young people and their parents/carers by both police officers and youth justice practitioners (145).

An evaluation reviewed the first 12-months of the Diversion Programme in Suffolk. Qualitative interviews indicate “universal support for the Diversion Programme in its aims to reduce the criminalisation of young people”. Interviews were conducted with young people, parents, police officers and early help practitioners (145).

Based on 819 referrals in the 12-month period, evaluators of the programme suggest that young people receiving an intervention are less likely to offend than those who declined intervention or were released with no further action. The number of referrals received was evenly distributed across regions, suggesting a consistent approach to implementation across the county.
The authors report a cost saving (after accounting for programme costs) of around £70,000 over the period 1 October 2016 to 30 September 2017 (145).

Quotes from young people who took part in the programme (145):

“...and open-minded, like before I wouldn’t think about things. It was a wake-up call and made me realise how it’s affecting me and the relationships around me, and that. It was really helpful.” (Young person, 15 year old)

“It went from me just coming downstairs and shouting, throwing kicking and smashing things to the point where mum had to call the police. Whereas now I feel like if I get pissed off yes I’ll probably be very unpleasant and you won’t really want to be around me but I’m not doing anything which is harming anybody, including myself, whereas I definitely was back then.” (Young person, 17 year old)

The evaluation did highlight the need for increased levels of multi-agency communication, noting that creating a formal strategy of feeding back information into Children and Young People’s services may also prove beneficial, particularly with the introduction of the preventative strand to the Diversion Programme. They also noted that potentially, not all police officers were aware of the Diversion Programme, asserting that further promotion may be necessary.
Section summary

- Suffolk data for the year ending 31 March 2018 indicates just over 53,000 recorded offences.
- Comparing this year and last, percentage change data for 2018 compared to 2017 indicates a 16% increase in recorded violence related offences in Suffolk.
- The rate per 1,000 population of all crime, and violence against the person, remains lower in Suffolk compared to the England rate.
- Local data shows an increasing trend for recorded violence with or without injury as well as sexual offences. This may be due to actual crime number rises, but individuals may also be reporting these types of crime more than previously. Improvements in crime data integrity are also likely to play a pivotal role. Nationally, The ONS report that long-term reductions in violent crime supported by other data such as the most recent admissions data for NHS hospitals.
- When looking at crime types by contribution to overall offences, there have been changes in the makeup of crime in Suffolk over the last 15 years. These changes are more obvious in the crimes related to violence, for example violence with or without injury, and sexual offences.
- Many patterns of variation in crime (such as increasing crime severity scores) appear to be mirrored in other geographically similar areas. This indicates that Suffolk doesn’t appear to be an outlier. However, violence against the person and sexual offences in Suffolk are a public health concern.
- Changes in legislation, reporting behaviours and increased data accuracy and recording can all contribute to changing patterns of crime.
- National data indicates that males, and adults age 16-24 are most likely to be victims of CSEW violent crime. There is no reason to believe that Suffolk would differ from this national picture.
- Heat mapping of crime data at small area level indicates that generally, urban areas of Suffolk were more affected by violence and possession of weapon offences.
- As of 2017, Suffolk Police have made over 2,500 arrests in connection with drug related crime over the a two and half year period.
- 2017 research highlighted that Suffolk Police were aware of over thirty County Lines trafficking drugs into Suffolk from several different urban centres.
Safeguarding data
The Multi-Agency Safeguarding Hub (MASH) is made up of a range of organisations in Suffolk who are responsible for safeguarding adults and children(146). These organisations include:

- Suffolk County Council
- Suffolk Police
- Health services
- District and Borough Council Housing Services
- Education
- Probation
- The Youth Offending Service / SYJS

The MASH consists of around 60 professionals.

In addition, Suffolk’s Safeguarding Children Board is a statutory body made up of partners and stakeholders from a range of agencies across Suffolk who are committed to safeguarding and the welfare of children(147). The role of the Board is to provide guidance and support as well as challenge and scrutiny of safeguarding practice. An equivalent Board exists for adults: Suffolk’s Safeguarding Adults Board(148).

Child safeguarding data

Suffolk County Council (akin to other LAs) has corporate parenting responsibilities, which include having a duty under the Children Act 1989 to safeguard and promote the welfare of the children they look after. This includes eligible children and those placed for adoption, and includes the promotion of the child’s physical, emotional and mental health and acting on any early signs of health issues(21,149).

The term “child in care” includes all children being looked after by a local authority, including those subjects to care orders under section 31 of the Children’s Act 1989 and those looked after on a voluntary basis through an agreement with their parents (21).

As mentioned earlier in the document, the numbers of children in care in England continue to increase and this same pattern is reflected in Suffolk. As of 31st March 2018, a total of 861 children were looked after by Suffolk County Council, (comprising of 790 non-Unaccompanied Asylum Seeking Children (UASC) and 71 UASC children)(21).

A Child in Need (CIN) is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled (150). In Suffolk in March 2018, there were just over 2,100 CIN excluding those on Child Protection Plans (CPP). There were 436 children on CPP in Suffolk in the same period.

The main needs of children entering care are reported to be due to abuse or neglect, family dysfunction, family stress and absent parenting. In 2016/17 family dysfunction as a primary need was higher among Suffolk children (26%) compared with the national average (15%).

Suffolk children who received support from the designated edge of care service (who are predominantly CIN or CPP) had similar common features such as parental behavioural issues, families who have had previous (unresolved) referrals, long term neglect, emotional abuse and children who have had several moves in family life. The two most prevalent factors associated with being a CIN, were domestic violence for half of the children assessed (49.6%) and mental health, (including both parental and child) in 36.6% of all assessments.
CIN assessment factors

Suffolk County Council collects assessment data on contributory factors to a child’s CIN status. Many of the factors overlap and are hard to define. However, they do provide an overview of indicators related to violence.

The table below looks at selected factors identified at the end of assessment for CIN for 2016/17 and 2017/18. These are factors associated with the risk of violence (based on the evidence presented in this document).

- There were 6,565 assessments completed in 2016/17 and 6,018 assessments completed in 2017/18.
- The percentage represents the proportion of assessments the factor was mentioned in.
- More than one factor may be identified in an assessment, and as the coding is recorded by different social workers, there may be some subjectivity, or differences in recording between assessments.
- Nevertheless, this gives an overview of factors affecting the CIN cohort in Suffolk. Mental health, domestic violence and emotional abuse have remained in the top three in both years assessed. Substance misuse in family members and in the child being assessed also appears to be a key issue.

Table 15: Proportion of completed CIN assessments in 2016/17 and 2017/18 in Suffolk, where specific violence risk related factors were mentioned

<table>
<thead>
<tr>
<th>Factors identified at the end of assessment</th>
<th>Proportion of completed assessments this factor was mentioned in 2016/17</th>
<th>Proportion of completed assessments this factor was mentioned in 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health: parent/carer</td>
<td>26.8%</td>
<td>30.2%</td>
</tr>
<tr>
<td>Domestic violence: parent/carer subject</td>
<td>29.2%</td>
<td>28.8%</td>
</tr>
<tr>
<td>Abuse or neglect - emotional abuse</td>
<td>26.9%</td>
<td>26.4%</td>
</tr>
<tr>
<td>Abuse or neglect - neglect</td>
<td>26.7%</td>
<td>24.8%</td>
</tr>
<tr>
<td>Mental health: child</td>
<td>11.7%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Drug misuse: parent/carer</td>
<td>10.6%</td>
<td>11.9%</td>
</tr>
<tr>
<td>Alcohol misuse: parent/carer</td>
<td>11.9%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Abuse or neglect - physical abuse</td>
<td>10.4%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Domestic violence: child subject</td>
<td>10.8%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Domestic violence: another person subject</td>
<td>8.3%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Learning disability: child</td>
<td>6.9%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Socially unacceptable behaviour</td>
<td>6.5%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Drug misuse: child</td>
<td>5.4%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Young carer</td>
<td>5.7%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Physical disability or illness: parent/carer</td>
<td>5.0%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Mental health: another person</td>
<td>4.3%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Physical disability or illness: child</td>
<td>3.7%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Abuse or neglect - sexual abuse</td>
<td>5.4%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Child Sexual Exploitation</td>
<td>4.9%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Learning disability: parent/carer</td>
<td>2.8%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Drug misuse: another person</td>
<td>3.2%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Alcohol misuse: child</td>
<td>2.6%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Alcohol misuse: another person</td>
<td>3.1%</td>
<td>2.3%</td>
</tr>
</tbody>
</table>
### Child Sexual Exploitation

Child Sexual Exploitation (CSE) can be defined as when an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child under 18 into sexual activity (152). Although there is no typical case of CSE, the average age when concerns about CSE are first identified are between the ages of 12-15, most identified cases relate to young females. Sexual exploitation can happen to any young person – whatever their background, age, gender, race or sexuality or wherever they live. The risk factors include a history of abuse, particularly sexual abuse, recent bereavement or loss, homelessness, low self-esteem being in or leaving care, living in gang affected neighbourhoods and lacking friends from the same age group (153).

This study noted that children who go missing are at risk of sexual exploitation. The Suffolk system has a good reporting system for missing episodes, but it is important to explore why children go missing and raise awareness of the risks for sexual exploitation.

Due to challenges around recognition and reporting as well as a lack of definitional and data clarity, PHE can’t (at the moment) offer a definitive count of how common CSE is (152).

It is important to summarise CSE in respect to county lines/CLN. In 2013 The Office of the Children’s Commissioner (OCC) produced their Inquiry into Child Sexual Exploitation in Gangs and Groups (154). It notes:

- Young people may be at risk of sexual violence: sexual assault, rape, indecent images being taken and shared as part of initiation revenge or punishment.
- ‘For some of these children and young people, sexual violence – rape – is seen as a simple fact of everyday life, an inevitability from which there is no route out.’
- In gangs, sexual violence may be used as an initiation activity. It is often peer on peer and boys or young men may be pressured into acts of sexual aggression by others in the gang (e.g. boy in a gang forced to rape a girl as a punishment to her).
- Young people may also be coerced into performing sexual acts to repay drug debts owed to dealers following loss through arrest, robbery or personal use.
- Exposure to sexual violence can cause multi-layered long-lasting effects including; depression, low self-esteem, feelings of helplessness, panic and anxiety disorders, self-harm and increased suicide risk (33, 154).
Adult safeguarding data

Safeguarding adults means protecting a person’s right to live in safety, free from abuse and neglect. An adult at risk is any person aged 18 or over and at risk of abuse or neglect because of their needs for care and or support (155). If an individual is over 18 but still receiving children’s services and a safeguarding issue is raised, the matter should be dealt with by the adult safeguarding team (155).

The Safeguarding Adults Collection (SAC) monitors safeguarding activity with reference to the Care Act 2014 at local authority level (156). Data for 2016/17 indicates that compared to its nearest statistical neighbours, Suffolk does not appear to be an outlier in terms of concerns received and Section 42 enquiries.

Figure 31: Adult safeguarding cases, 2016/17

Internal 2017/18 data for Suffolk indicates:

- There were 3,008 safeguarding concerns received in Suffolk.
- 59% of these concerns were for females.
- 81% of these concerns were for people of White ethnic origin, ethnicity data was not known in 16% of cases. For BME groups, the largest number of concerns were for individuals that are Black / African / Caribbean / Black British (1% of cases).

In the Care Act (2014), Section 42 requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry
should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom (157).

- There were **1,454** individuals involved in Section 42 safeguarding enquiries in 2017/18.
- **100%** of all enquiries that commenced in Suffolk in 2017/18 were Section 42 enquiries.

For concluded Section 42 enquiries, the type and source of risk are recorded. Individuals may experience more than one risk, and therefore figures presented here will not sum to the Section 42 total. Summary data indicates:

- Physical abuse was recorded 489 times (28%)
- Sexual abuse was recorded 280 times (16%)
- Domestic abuse was recorded 117 times (7%)
- Reported incidents of sexual exploitation, modern slavery discriminatory abuse and organisational abuse were recorded 89 times (5%). These figures have been combined due to disclosivity.

In relation to the source of the risk, the largest numbers (39% of the total) were at risk in their own home.

**Elder abuse**

“Elder abuse is an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult” (158).

Elder abuse may take many forms including: physical or sexual abuse, emotional or psychological abuse, neglect or exploitation.

Age UK note that perpetrators of abuse or neglect are often people who are trusted and relied on by an older person, such as family members or care staff, but anyone can commit abuse or neglect (159). Additionally, women over the age of 70 who are dependent, frail and alone are particularly vulnerable to abuse, which takes multiple forms (159). Factors that may lead to elder abuse include: social isolation, patterns of family violence, alcohol, drug and mental ill health, poor quality long term relationships and dependency (160).

The prevalence of elder abuse has been found to be approximately 4.0% (160), physical abuse prevalence was about 0.4%. Applied to the Suffolk resident population age 66+ (to be consistent with the study cohort), it can be estimated that 6,600 older people could be subject to elder abuse, and 700 people within that will experience physical abuse.

**Dementia**

In Suffolk in 2016/17 there were 7,200 individuals with a recorded diagnosis of dementia (161). Dementia is not covered in detail in this report. However, it is important to note that people with dementia may sometimes behave in ways that are physically or verbally aggressive (162). This can be distressing for everyone involved, from the individual with dementia, to carers and family members alike. It may also make them more vulnerable to being victims of abuse, such as elder abuse.

**Schools data**

There is no routine dataset that collects incidents of violence in schools, and at the time of writing there was no reliable data that could capture Suffolk children and young people’s worries in relation to crime, violence and bullying. The Healthwatch Suffolk report ‘My Health Our Future’ examined stressors in relation to mental health and emotional wellbeing and collected over 6,800
responses from eight schools across the county (163). This found that stress around being bullied and peer pressure decreased with age (from age 11-17).

- **At age 11**: around 1 in 3 young people felt stressed about being bullied, this reduced to about 1 in 5 by age 15.
- **At age 11**: around 4 in 10 young people felt stressed about peer pressure, this reduced to about 3 in 10 by age 15.

**School exclusions**

The Department for Education is currently reviewing exclusions of pupils from schools. In 2015/16, 0.08% of children were permanently excluded from state funded schools in England but the rates for some children are much higher, with pupils from some ethnic backgrounds being disproportionally more likely to be excluded from school. This review is due to be published by the end of 2018(164).

Questions have been raised as to whether school exclusions could be fuelling rises in youth violence, through fragmented use of interventions and exclusion orders: continuation of this fragmented approach is unlikely to deliver safer schools and more responsible adults(165). The author notes that better data is required, as this could help to identify children in need in the early years and support efforts over teen years, and better knowledge of problem solving or disciplinary processes in schools is also needed.

A recent report into CLN found that a common characteristic of those on the fringes of, or involved in CLN (166) was that they were not in mainstream education – with many in pupil referral units (PRUs). The author notes that children rarely move back into mainstream education even where the movement to a PRU was meant to be temporary. The report notes PRUs provide “fertile ground for recruitment and continuing involvement in a variety of negative activities including county lines”(166). A child’s exclusion from school appears to be a highly significant trigger point for the escalation of county lines involvement for children who might be on the fringes of such activity.

Anecdotal reports from Essex indicate that CLN members are actively targeting PRUs – and waiting outside school gates to recruit excluded, vulnerable and disengaged young people.

**Violence in schools**

Violence should not be a part of school life, yet both students and teachers are affected every day.

- UK statistics indicate a general upward trend in violence in UK classrooms, with physical violence against pupils and staff, and verbal abuse of staff commonly feature (165).
- The Labour Force Survey found that there was an average of 8,000 attacks on school staff annually over a six-year-period, and that secondary school staff are three times more likely to face violence at work than the average UK worker(168).

Violence is experienced through physical and emotional forms of harassment, and the effects can negatively impact pupils’ educational success and later employment and health prospects(165). Recent media reports also suggest that children now receive less support than they used to and staff have no time to deal with issues, hence an increase in anxious students lashing out(169).
Violence after school - new research

Recent reporting also highlights that there are a growing number of under 16s that are victims of knife crime (170).

Age, gender and deprivation status are potent influences on the risk of violent injury in young people. Royal London doctors found that the time when under-16s are in the greatest danger of being stabbed is between 4pm and 6pm on weekdays - with almost half of under-16s were stabbed on their way home from school (171). The authors note that this distinct pattern represents an opportunity for targeted preventative strategies in this population. They also note that the sharp increase in stab injuries between the ages of 14 and 16 indicates that educational programmes and other preventative interventions are best delivered in primary or early secondary education (171).

In Suffolk:

- There are nearly 120,000 children and young people of school age in Suffolk (5-18 inclusive), as well as approximately 5,290 full-time equivalent teachers in Suffolk, and 2,760 full-time equivalent teaching assistants.
- Reporting indicates that in Suffolk, in the last three years the total number of assaults was 649 - equivalent of one teacher being attacked for each day of the academic year. Latest data, recorded at the county’s schools in 2015, 2016 and 2017, reveals more than 300 incidents were reported at primary schools.
- Other reporting highlights that the number of fixed period exclusions for physical assaults against adults in primary, secondary, and special schools in Suffolk rose by 46% in a year, from 340 in 2014/15 to 498 in 2015/16. The overall number of all fixed period exclusions rose by 16%, from 3,720 to 4,300 in Suffolk.
- In 2017, Suffolk data indicated that there were 654 exclusions for children in need (including CPP/CiC). Nearly two thirds of these were for physical assault or threatening behaviour towards an adult. Data for 2018 indicates a drop in exclusions to 409 for CIN, with a similar proportion of exclusion for physical assault or threatening behaviour towards an adult.
- The Suffolk Make A Change (MAC) team, work to identify young people at risk of abuse through CSE. They report has been a 30% increase in the number of referrals and activities received, and a 20% increase in the average caseload held over the last year. The two Ipswich localities had the highest overall levels and largest percentage increases of MAC activity this year. CSE is the most common risk in referrals and activities received for females, but the least common for males. Gangs was the opposite, being very common in referrals and activities for males and appearing very rarely for females.
- Local data from the Suffolk Youth Justice Service caseload for 2017 shows that 26% of those of statutory school age (SSA) had been permanently excluded from school at some point. The Home Office Serious Youth Violence Report 2018 also highlights a link between exclusions and offending nationally.

Sources: (29),(172),(173),(174),(175),(176)
Overview of violence from health service datasets

The use of health data in relation to violence prevention is essential, however there is variation in the availability, quantity and quality of data available at the time of writing. This section summarises key data available publicly via the PHE Fingertips tool, and internally accessed data via CCGs and Hospital Episode Statistics (HES).

Emergency hospital admissions due to violence

Between 2014/15 and 2016/17 there were 457 hospital admissions in Suffolk for violence. This equates to a directly standardised rate (DSR) of 21.9 per 100,000 population (177). This is statistically significantly lower than the England rate (42.9 per 100,000 population). This rate has fallen significantly from a DSR of 29.6 per 100,000 population in 2009/10-2011/12 (623 admissions).

District and Borough data (shown in the table below), indicates that although raw numbers of violence related hospital admissions are highest in Suffolk and St Edmundsbury, the DSR's are all statistically significantly lower than England (denoted by the green indicator preceding the area name).

The higher numbers of violence related hospital admissions in Ipswich and St Edmundsbury is likely to be linked to the presence of the County’s two major towns of Ipswich and Bury St Edmunds. Both towns have a night-time economy of bars and clubs, where alcohol consumption is common place (see the NTE section earlier in this document).
**Table 16: Violent crime (including sexual violence) - hospital admissions for violence, 2014/15-2016/17**

<table>
<thead>
<tr>
<th>Area</th>
<th>Count</th>
<th>Value</th>
<th>LCI</th>
<th>UCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>31</td>
<td>13.1</td>
<td>8.8</td>
<td>18.8</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>62</td>
<td>32.2</td>
<td>24.5</td>
<td>41.5</td>
</tr>
<tr>
<td>Ipswich</td>
<td>138</td>
<td>32.4</td>
<td>27.2</td>
<td>38.4</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>33</td>
<td>13.5</td>
<td>9.3</td>
<td>19.0</td>
</tr>
<tr>
<td>St. Edmundsbury</td>
<td>94</td>
<td>29.2</td>
<td>23.6</td>
<td>35.7</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>43</td>
<td>13.1</td>
<td>9.3</td>
<td>17.8</td>
</tr>
<tr>
<td>Waveney</td>
<td>56</td>
<td>18.2</td>
<td>13.7</td>
<td>23.6</td>
</tr>
</tbody>
</table>

*Source: (177)*

**Health-service activity relating to assault**

Data relating to ambulance call-outs for assault in Great Yarmouth and Waveney CCG was not received at the time of writing this report.

**Ambulance call-outs for assault in Ipswich and East Suffolk CCG and West Suffolk CCG**

This section describes the distribution of ambulance call-outs for assault among registered patients in Ipswich and East Suffolk CCG and West Suffolk CCG.

In 2015/16-2017/18 for Ipswich and East Suffolk CCG:

- A total of 1,416 ambulance call-outs for assault (assault/sexual assault (code 4); stab/gunshot (code 27)) among registered patients.
- Age was not recorded in 151 of these records.
- A total of 87.7% (1242/1416) of these ambulance call-outs were for assault or sexual assault.
- Annual numbers of ambulance call-outs for assault during the period were 547 in 2015/16, 429 in 2016/17 and 440 in 2017/18.
- A total of 65.8% (932/1,416) of ambulance call-outs for assault in Ipswich and East Suffolk CCG were among males.

The figure overleaf shows the distribution by age of numbers and rates of ambulance call-outs for assault among registered patients in Ipswich and East Suffolk CCG during the period. The highest ambulance call-out rate for assault occurred in persons aged 20-29 years: 27.7 ambulance call-outs per 10,000 registered patients. In this age group a total of 70.5% (263/373) of ambulance call-outs for assault occurred among males.
In 2015/16-2017/18 in West Suffolk CCG:

- A total of 772 ambulance call-outs for assault (assault/sexual assault (code 4); stab/gunshot (code 27)) among registered patients.
- Age was not recorded in 43 of these records.
- A total of 90.4% (698/772) of these ambulance call-outs was for assault or sexual assault.
- Annual numbers of ambulance call-outs for assault during the period were as follows: 317 in 2015/16, 251 in 2016/17 and 204 in 2017/18.
- A total of 64.9% (501/772) of ambulance call-outs for assault in West Suffolk CCG were among males.

The figure overleaf shows the distribution by age of numbers and rates of ambulance call-outs for assault among registered patients in West Suffolk CCG during the period. The highest ambulance call-out rate for assault occurred in persons aged 20-29 years: 27.9 ambulance call-outs per 10,000 residents. In this age group a total of 70.5% (160/227) of ambulance call-outs for assault occurred among males.
This section describes the distribution of first Accident and Emergency (A&E) attendances for assault among residents of Suffolk.

- In 2015/16-2017/18, a total of 2,721 first A&E attendances for assault (HES A&E patient group code 20) among residents of Suffolk County was recorded in the Hospital Episode Statistics database. Age was not recorded in 110 of these records for 2017/18.

- Numbers of first A&E attendances for assault among residents of Suffolk appear to be increasing: in 2015/16 there were 727 attendances, rising to 992 in 2016/17, and reaching 1,002 in 2017/18. However, the data for earlier years may be incomplete.

- A total of 71.2% (1,936/2,721) of A&E attendances for assault among residents of Suffolk County in 2015/16-2017/18 were among males.

The figure overleaf shows the distribution by age of numbers and rates of A&E attendances for assault among residents of Suffolk County during the period. The highest A&E attendance rate for assault occurred in persons aged 20-29 years: 38.1 A&E attendances per 10,000 residents. In this age group, a total of 73.1% (699/956) of A&E attendances for assault occurred among males.

Source: (178)
Table 17 shows the distribution of A&E attendances for assault among residents of local authorities in Suffolk in 2015/16-2017/18. Most A&E attendances for assault during the period occurred among residents of the more urban districts of Ipswich, St. Edmundsbury and Waveney.

Table 17: All age, first A&E attendances for assault, local authorities in Suffolk County
Pooled data for financial years 2015/16-2017/18

<table>
<thead>
<tr>
<th>District</th>
<th>Number of first A&amp;E attendances for assault</th>
<th>% distribution of A&amp;E attendances for assault</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>222</td>
<td>8.2%</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>275</td>
<td>10.1%</td>
</tr>
<tr>
<td>Ipswich</td>
<td>628</td>
<td>23.1%</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>252</td>
<td>9.3%</td>
</tr>
<tr>
<td>St. Edmundsbury</td>
<td>565</td>
<td>20.8%</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>236</td>
<td>8.7%</td>
</tr>
<tr>
<td>Waveney</td>
<td>543</td>
<td>20.0%</td>
</tr>
<tr>
<td>Suffolk County</td>
<td>2721</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 18 shows the distribution of A&E attendances for assault in Suffolk in 2015/16-2017/18 by broad ethnic group. The distribution of A&E attendances for assault by broad ethnic group in Suffolk during the period broadly reflects the ethnic composition of the population as a whole. In a large percentage of HES records of A&E attendances for assault in this population: 28.9%, ethnic group is not stated or not known.
Table 18: All age, first A&E attendances for assault residents of Suffolk County
Pooled data for financial years 2015/16-2017/18, distribution by broad ethnic group

<table>
<thead>
<tr>
<th>Broad ethnic group</th>
<th>Number of first A&amp;E attendances for assault</th>
<th>% distribution of A&amp;E attendances for assault</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>1732</td>
<td>63.7%</td>
</tr>
<tr>
<td>White Other</td>
<td>112</td>
<td>4.1%</td>
</tr>
<tr>
<td>Mixed</td>
<td>24</td>
<td>0.9%</td>
</tr>
<tr>
<td>Asian of Asian British</td>
<td>17</td>
<td>0.6%</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>21</td>
<td>0.8%</td>
</tr>
<tr>
<td>Chinese or other ethnic group</td>
<td>28</td>
<td>1.0%</td>
</tr>
<tr>
<td>Not stated</td>
<td>185</td>
<td>6.8%</td>
</tr>
<tr>
<td>Not known</td>
<td>602</td>
<td>22.1%</td>
</tr>
</tbody>
</table>

All broad ethnic groups         2721                      100.0%

Source: (178)

Table 19 shows the distribution of A&E attendances for assault in Suffolk in 2015/16-2017/18 by incident location type. Most A&E attendances for assault in Suffolk during the period resulted from incidents in public places or the home.

Table 19: All age, first A&E attendances for assault, Suffolk residents, pooled data for financial years 2015/16-2017/18, distribution by incident location type

<table>
<thead>
<tr>
<th>Incident location type</th>
<th>Number of first A&amp;E attendances for assault</th>
<th>% distribution of A&amp;E attendances for assault</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>541</td>
<td>20.1%</td>
</tr>
<tr>
<td>Work</td>
<td>185</td>
<td>6.9%</td>
</tr>
<tr>
<td>Educational establishment</td>
<td>83</td>
<td>3.1%</td>
</tr>
<tr>
<td>Public place</td>
<td>1367</td>
<td>50.8%</td>
</tr>
<tr>
<td>Other</td>
<td>379</td>
<td>14.1%</td>
</tr>
<tr>
<td>Not known</td>
<td>137</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

All incident location types    2692                      100.0%

Note. A total of 29 records for 2017/18 did not have a valid incident location type code.
Source: (178)

Emergency admissions for assault in Suffolk County

This section describes the distribution of emergency admissions for assault among residents of Suffolk County.

- In 2015/16-2017/18 a total of 452 emergency admissions with any diagnosis of assault\(^2\) among residents of Suffolk.
- There was little change in annual numbers of emergency admissions for assault among residents of Suffolk County during the period: in 2015/16 there were 154 admissions, in 2016/17 there were 154, and there were 144 in 2017/18.
- Of these emergency admissions for assault a total of 79.6% (360/452) were among males.

\(^2\) (ICD-10: X85-Y09; 2\(^{nd}\)-11\(^{th}\) diagnosis codes) recorded in the Hospital Episode Statistics database
Figure 33 shows the distribution by age of numbers and rates of emergency admissions for assault among residents of Suffolk during the period. The highest emergency admission rate for assault occurred in persons aged 20-29 years: 5.1 emergency admissions per 10,000 residents. In this age group a total of 82.2% (106/129) of emergency admissions for assault occurred among males.

Figure 33: Emergency admissions for assault in Suffolk

Table 20 shows the distribution of emergency admissions for assault among residents of local authority districts in Suffolk County in 2015/16-2017/18. Most emergency admissions for assault during the period occurred among residents of the more urban districts of Ipswich and St. Edmundsbury.

Table 20: All age emergency admissions with any diagnosis of assault, residents of local authorities in Suffolk, Pooled data for financial years 2015/16-2017/18

<table>
<thead>
<tr>
<th>District</th>
<th>Number of emergency admissions for assault</th>
<th>% distribution of emergency admissions for assault</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>29</td>
<td>6.4%</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>51</td>
<td>11.3%</td>
</tr>
<tr>
<td>Ipswich</td>
<td>147</td>
<td>32.5%</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>37</td>
<td>8.2%</td>
</tr>
<tr>
<td>St. Edmundsbury</td>
<td>96</td>
<td>21.2%</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>44</td>
<td>9.7%</td>
</tr>
<tr>
<td>Waveney</td>
<td>48</td>
<td>10.6%</td>
</tr>
<tr>
<td>Suffolk County</td>
<td>452</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: (178)

Table 21 shows the distribution of emergency admissions for assault in Suffolk in 2015/16-2017/18 by broad ethnic group. The distribution of emergency admissions for assault by broad ethnic group in
Suffolk during the period broadly reflects the ethnic composition of the population as a whole. In a large percentage of HES records of emergency admissions for assault in this population: 25.7% ethnic group is not stated or not known.

Table 21: All age emergency admissions with any diagnosis of assault, residents of Suffolk, pooled data for financial years 2015/16-2017/18, distribution by broad ethnic group

<table>
<thead>
<tr>
<th>Broad ethnic group</th>
<th>Number of emergency admissions for assault</th>
<th>% distribution of emergency admissions for assault</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>287</td>
<td>63.5%</td>
</tr>
<tr>
<td>White Other</td>
<td>22</td>
<td>4.9%</td>
</tr>
<tr>
<td>Mixed</td>
<td>8</td>
<td>1.8%</td>
</tr>
<tr>
<td>Asian of Asian British</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Chinese or other ethnic group</td>
<td>9</td>
<td>2.0%</td>
</tr>
<tr>
<td>Not stated</td>
<td>36</td>
<td>8.0%</td>
</tr>
<tr>
<td>Not known</td>
<td>80</td>
<td>17.7%</td>
</tr>
<tr>
<td>All broad ethnic groups</td>
<td>452</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Note. Numbers of emergency admissions <6 and percentages calculated from those numbers have been suppressed (*).
Source: (178)

**Section summary**

- Hospital admissions for violence in Suffolk are statistically lower compared to the England rate, and the same is true for districts and boroughs in Suffolk.

- Data relating to A&E attendances and emergency admissions for assault among residents of Suffolk County during financial years 2015/16-2017/18 indicate that the greatest proportion of health-service activity for this cause related to assaults affecting young white adult males in more urban areas in the county, with the majority of A&E attendances for assault resulting from incidents in public places and the home.

- Data relating to ambulance call-outs for assault among registered patients in Ipswich and East Suffolk CCG and West Suffolk CCG also showed that the highest rates of this form of health-service activity were for assaults affecting young adult males.

- Further analysis of A&E attendances for assault in the home might be informative about domestic violence in the county.
Interventions: Other geographic areas

For areas with very high levels of violence, a model of violence reduction pioneered in Chicago is often looked to. This model pioneered by epidemiologist Dr Gary Slutkin, found patterns in clusters of violence – and that it spread similar to a disease. Public health methodology and the use of ‘violence interrupters’, (ex-gang members used as an intermediator between law enforcement and gangs), were employed to tackle the high levels of homicide and violence in Chicago (179). Crime in the pilot area of West Garfield, dropped significantly, and soon the project was being adopted across other troubled parts of the city (179).

**Glasgow (Violence Reduction Unit Scotland)**

The Violence Reduction Unit (VRU) emerged in 2005 in response to the high levels of violent crime, particularly knife crime (Glasgow was at one point the murder capital of Europe), and was influenced by the WHO’s report on violence and health (180). The approach was public health in nature, and required joint working between colleagues such as those in health, education and social work in order to achieve long-term attitudinal change in society.

The VRU has also supported training community members such as vets and hairdressers to identify signs of domestic abuse, giving professionals the skills to safely and effectively intervene (180).

The VRU have produced results (181):

- Between April 2006 and April 2011, 40 children and teenagers were killed in homicides involving a knife in Scotland; between 2011 and 2016, that figure fell to just eight.
- Between 2006 and 2011, 15 children and teenagers were killed with knives in Glasgow; between April 2011 and April 2016, none were.

It is noted that Scotland has a different culture of violence, whereby incidents have tended to be over something more immediate and spur of the moment, often involving an encounter that escalated from an insult or argument, rather than the bloody end of a protracted dispute or connected to criminal activity (181).

 Whilst some of Scotland’s success in tackling knife crime is due to factors that are arguably unique to Scotland, others may be more transferrable. The evidence from Scotland suggests that while knife crime may never be eradicated, there needs to be a shift in understanding of the root causes of the problem and, therefore, what a durable solution might look like (181).
London

In September 2018, Mayor Sadiq Khan announced that London would be following the Glasgow model of violence reduction.

An initial £500,000 has been directed to establish the London VRU, forming a cross-city multi-disciplinary team, expanding the work of the Mayor’s Knife Crime Strategy to include wider types of violence and look to address the links between violence in the home and on the street (182). In London’s worst affected areas there are 272 officers focused solely on tackling violence (182).

The Greater London Authority note:

“Glasgow has a population of just over 600,000 compared to a population of almost nine million in London. The Glasgow public health approach, started in 2004 involved white Scottish males aged 14 to 18 with alcohol being a contributory factor in half of all murders. It was also one part of East Glasgow, while violence is concentrated in a much wider number of areas in London.

In 2004/05 there were 40 murders in Glasgow and 4,701 incidents of violent crime.

This compares to 159 homicides in London in 2017/18 and 159,982 recorded incidents of violence in the capital.”

Source: (182)

Gloucester

- In Gloucester, a multi agency project, involving representatives from Gloucestershire Constabulary, Gloucestershire City Council and Gloucestershire County Council’s Youth Support Team, aims to reduce the number of youngsters involved in gangs by offering support to those who are or may be vulnerable (183).
- The ‘Avenger Task Force’ aims to support youngsters and adults who come to its attention and divert them away from gang membership and criminal activity.
- Additional work in Gloucester and Cheltenham has seen tough banning orders and exclusion zones introduced for gang members (184).

West Midlands Violence Prevention Alliance

In the West Midlands, a violence prevention alliance has been created to co-ordinate and target our actions where they will have the greatest effect (185).

The West Midlands Violence Prevention Alliance (WMVPA) is an alliance of organisations in the West Midlands which share the priority of ‘reducing violence’, and have signed up to the Alliance’s aims (185):

- Create, Implement and Monitor a West Midlands regional action plan for violence prevention
- Enhance the capability for collecting data on violence
- Define priorities for, and support on research on, the causes, consequences, costs and prevention of violence
- Promote ‘Primary Prevention’ Responses
- Strengthen responses for victims of violence
- Integrate violence prevention into social and educational policies, and thereby promote gender and social equality
- Increase collaboration and exchange of information on violence prevention
Interventions: Summary
The following section looks at interventions that have ability to be effective in communities and populations to help prevent violence and intervene early.

The Government’s serious violence strategy asserts that(69):

“[their] approach is not solely focused on law enforcement, very important as that is, but depends also on partnerships across a Serious Violence Strategy number of sectors such as education, health, social services, housing, youth services, victim services and others.

In particular it needs the support of communities thinking about what they can themselves do to help prevent violent crime happening in the first place and how they can support measures to get young people and young adults involved in positive activities. **Tackling serious violence is not a law enforcement issue alone and it requires a multiple strand approach involving a range of partners across different sectors.**”

Public health approaches and associated evidence-based interventions have significant merit in delivering improved outcomes for children, adults and communities concerning reductions in violence(6). The following interventions have all been identified as having evidence at level 3 on the Standards of Evidence scale used in this review, i.e. there is good evidence that they may work in reducing violence at different parts of the lifecourse(6):

**Interventions aimed at supporting parents and families**
- The Family Nurse Partnership
- Incredible Years Preschool
- Family Foundations
- Triple P
- Empowering Parents Empowering Communities

**Developing life skills in children and young people**
- The Good Behaviour Game
- Incredible Years Child Training (Dinosaur School)
- Incredible Years Teacher Classroom Management
- Promoting Alternative Thinking Strategies (PATHS)
- Let’s Play in Tandem

**Working with high-risk youth and gangs/community interventions**
- Community Initiative to Reduce Violence (CIRV)

**Identification, care and support**
- Identification and referral to improve safety (IRIS)

**Multi-component interventions**
- Multisystemic therapy
- Sure Start local programmes
Preventing the development of risk factors and promoting mental wellbeing in young people requires a lifecourse approach that supports parents and families, as well as encouraging healthy development from the very earliest stages of life(31).

The largest proportion of outcome evaluation studies concern violence prevention strategies that address risk factors at the individual and close relationship levels, there are fewer outcome evaluations for community- and society-level strategies(186). The WHO note that whilst it is important that prevention efforts target children at an early stage, few longitudinal studies measure the effects of interventions delivered in early childhood on subsequent youth violence outcomes.

The core features of an effective programme are(187):

- They seek to create positive changes in the lives of the young person and/or their families, as well as preventing negative outcomes.
- They used trained facilitators that are experienced in working with families, acting in their professional capacity (e.g. as a teacher / mental health professional).
- They work with young people in their ‘natural environment’ e.g. home/school and include skills practice, parent training and/or therapy dependent on risk level.
- They stick to the programme specification and ensure good implementation quality.

<table>
<thead>
<tr>
<th>Target population</th>
<th>Types of programmes</th>
</tr>
</thead>
</table>
| Universal: for children & young people generally | School Curriculum & Skills-Based programmes  
School-Wide Climate Change programmes  
Classroom Management programmes  
Parent/Family Training programmes |
| Targeted: for at-risk children & young people | School Curriculum & Skills-Based programmes  
Combined School & Family programmes  
Parent/Family Training & Home Visiting programmes  
Other Community-Based programmes |
| Targeted: for high-risk children & young people, or those already involved in gangs, youth crime, & violence | Family-Focused Therapy-Based programmes  
Trauma-Focused Therapy-Based programmes  
Other programmes |

Source: (187)

The 2018 Serious Violence Strategy sets out the Government’s response to serious violence and recent increases in knife crime, gun crime and homicide(69). The authors report that there is good evidence that early intervention programmes can work to prevent violence, even for those most at risk, provided they are not focused on ‘scare tactics’.

However, the LGA’s response to the Strategy noted that Councils are increasingly having to divert funding away from preventative work into services to protect children who are at immediate risk of harm(188). The Chair of the Local Government Association’s Safer and Stronger Communities Board asserted that(188):

“Only with the right funding and powers can councils continue to make a difference to people’s lives by supporting families and young people and help tackle serious violent crime in our local communities.”
Interventions: Learning from Lambeth

The following sections on effective interventions are taken from the Lambeth Serious Violence Needs Assessment (2015)(1), which included an evidence review conducted by the Public Health Team for Lambeth (for full referencing please see the original Lambeth document). The following points must be borne in mind:

- Criminal justice interventions and strategies to mitigate societal risk factors such as poverty and unemployment were not included in the review.
- The review was done from a public health perspective and sought to mitigate violence over the life course given the strong association between being a previous victim of trauma, violence and/or abuse and going on to use violence against others.
- This was first documented in the 2018 Suffolk County Council report on CLN and gang violence(33).

**Early childhood**

Interventions in early childhood can prevent individuals developing a propensity for violence. They can also improve educational outcomes, employment prospects and long-term health outcomes(5).

Programmes such as home visiting, parenting programmes, preschool programmes and school-based social and emotional development programmes can protect children from the risk factors for gang involvement and poor mental health, including parental stress, exposure to violence and behavioural problems(31). Effective interventions are:

- **Home visiting programmes** that provide intensive and long term early years support for vulnerable parents. Outcomes include improved parenting skills, improved maternal mental health, fewer childhood behaviour problems, and reduced child neglect/abuse. New evidence suggests that targeting FNP Programmes towards families with a history of domestic violence would protect a great number of children and be more cost-effective.

- **Recognition and management for children with conduct disorders** - the links between early conduct problems and subsequent criminal behaviour are well-established. One review found that the largest impact on crime reduction could be achieved by the implementation of evidence-based programmes to reduce the prevalence and severity of conduct problems in childhood. NICE guidance on recognition and management of children and young people with conduct disorders should be followed.

- **Universal risk assessments for parenting** - the Department for Education and the Wave Trust recommend an assessment of maternal mental health during pregnancy, universal assessment of parent-infant bonding at 3 to 4 months, and clearly identified care pathways involving pre-natal home visits for those women identified as being at risk.

- **Parenting programmes** – including programmes targeted at parents of children with behavioural problems. The implementation of parenting programmes is key to their effectiveness. A report from the Centre for Mental Health found that improvements in outcomes from well-implemented programmes can be two to three times bigger than outcomes from poorly implemented ones. Programmes which are poorly implemented can make children’s behaviour worse. Parenting programmes bring experienced workers, parents and carers together to discuss issues, share concerns and gain practical advice and information.

The Center for the Prevention and Study of Violence at the US Centers for Disease Control has found that the most effective early childhood programmes have many different elements and are designed to tackle the family’s and children’s relationship to school, the neighbourhood, and the community – not only how the family functions as a unit.
Developing social and life skills in children and young people

There is evidence that programmes that aim to nurture social and life skills in children are effective for prevention of violence and at-risk behaviours particularly when targeted at troubled children and children with deprived backgrounds. Effective interventions are:

- **Pre-school programmes** - that help develop children's social, emotional and cognitive skills. Pre-school programmes targeted at children with early signs of behavioural problems are particularly important.

- **Primary school programmes** - school based programmes which emphasise the importance of social skills can lead to reduced aggression, hyperactivity and disruptive behaviour. One example is the PATHS programme in primary schools. The evidence is not strong for educational or skills-based programmes targeted at older children and young adults, such as programmes on dating and relationship violence.

- **Bullying prevention programmes** - school-based programmes that aim to reinforce social norms and enforce school rules are also effective.

Working with high risk young people

There is some evidence for interventions aimed at high risk youths and gangs, including young offenders:

- **Assessment of health and wellbeing of young offenders** - should be built into local protocols so that young people who are emotionally or socially vulnerable and/or have mental health issues can be identified and helped.

- **Family therapies** - there is evidence in favour of family therapies, particularly Multisystemic Therapy (MST), an intensive intervention for high risk 11-17 year olds and their families.

- **Mental wellbeing** - there is much interest in grass-roots programmes that aim to address mental health problems in high risk young people.

- **Hospital based programmes** - for young people attending A&E who are injured through violence have shown positive results. These programmes involve brief psychological interventions, referrals to specialist services, mentoring, and youth services. A reduction in hospital attendances and admissions for violence has been seen in areas where there are good arrangements between acute trusts, crime reduction partnerships and the police for sharing anonymised data on emergency department attendances for assault.

- **School-based initiatives** - evidence is emerging from the US in favour of school-based diversion initiatives that target young people with mental health. Aiming to build capacity and skills among teachers and school staff to recognise and manage behavioural health crises in schools instead of contacting the police, outcomes include fewer suspensions and expulsions and lower rates of re-offending.

- **Gang-focused strategies** - at the time of writing the Lambeth needs assessment there was little formal research on effective ways to prevent gang involvement, and only limited evidence of effectiveness. The favoured approach, developed in the US and now being adopted in the UK, is that of the Comprehensive Gang Model featuring targeted and group-based social interventions offering support and help, enhanced enforcement against the group as well as individuals, provision of social opportunities for at risk youth and community mobilisation involving agencies and citizens. This model was a key point of reference in the development of Operation Ceasefire, developed in the City of Boston in the 1990s. A modified version has been adopted in the UK in Glasgow and Manchester. As reported earlier in this document, more research is being developed all the time.

- **Community engagement** - Peer review feedback shows that community engagement in the context of gang and youth violence requires an acceptance that universal approaches to engaging the community need to be balanced with targeted interventions and support which address the needs of specific groups. As well as active and former gang members, community engagement strategies should include members of the wider
community, those who are most at risk of violence both as victims and perpetrators, and
victims and local people already affected by the violence(189).

Whilst interventions should be directed to the worst offenders – gang members and young people in violent lifestyles – working with the whole of the community creates the right environment in which violence can be stopped and safety maintained in the long term. Ending youth violence requires an end-to-end approach, from prevention to rehabilitation, which is only possible through collaboration between statutory and non-statutory partners, local residents, community, faith and youth groups, and public agencies and businesses(189).

**Contextual safeguarding:**

Contextual safeguarding has been developing over the past 6 years, and is an approach to understanding, and responding to, young people’s experiences of significant harm beyond their families (190). It recognises young people form a range of relationships outside the family including with peers, schools, their neighbourhood, and online which can feature violence and abuse(191).

- Contextual safeguarding expands the objectives of safeguarding to recognise that young people are vulnerable in a number of contexts and that parents and carers may have little influence over some of these contexts.
- The approach stresses the need for practitioners to engage with individuals and sectors who do have influence over them and recognise that assessment of, and intervention within, these spaces are a critical part of safeguarding practices.

**What works for urban street gangs (USG) or CLN**

“Health services, local authorities, schools, criminal justice agencies and communities all have an important role to play in promoting healthy social and emotional development in children and young people and ensuring vulnerable young people affected by gangs and poor mental health receive the support they require”(31).

There is very little specific information about what works with children and young people involved or on the periphery of USG or CLN because so far relatively little research has been published in this area. There is more good information available for involvement in youth violence and it is reasonable to suppose that these interventions are also likely to work for USG and CLN given the high degree of overlap in risk factors (33). However, the evidence base is developing all the time. For example, in Kent the County Lines Demonstration Pilot Project was funded by the Home Office to test out what might enable vulnerable children to move away from involvement in county lines drug distribution networks(192).

General approaches are summarised below(187):

**Effective interventions for youth violence**

The key features of programmes that have been found to work in the area of youth violence are:

- **Seeking to create positive change** in the lives of young people and/or their families, as well as prevent negative outcomes. For example, some programmes sought to give young people the skills to help them make healthy life choices, resist peer pressure and manage conflict, whilst others aimed to strengthen the ability of families to tackle problems together.
- **Schools-based or family-focused** involving skills practice, parent training, or therapy. These programmes often took wider risk factors into consideration such as peer groups and family problems. The programmes were interactive in nature, enabling young people to practise
the skills they were being taught and families to practise effective communication and problem-solving strategies with guidance and feedback from an instructor/therapist.

- **Family therapy and trauma informed therapy** In the highest risk children and families, both family and trauma informed therapy was noted as effective.
- **Skilled facilitators**: Nearly all of the effective programmes identified required or recommended trained facilitators with experience of working with children and families.
- **Implementation fidelity**: Sticking to the original programme specification and ensuring good implementation quality was often crucial, in terms of both ensuring and/or maximising effectiveness and avoiding harm.

Research of young people’s views on what was helpful to support them to move away from offending suggested what they found helpful was(33):

- Having a trusting relationship with at least one worker who believes they could change
- A sense of belonging
- Personal relationships
- Changing their peer and friendship groups
- Having something to lose (i.e. job, family relationships, if they are a parent themselves)
- Interventions which provide problem solving solutions to use in day-to-day situations
- Well planned restorative interventions

In relation to mental health, gang-affiliated young people may experience particular barriers to engaging with mental health and other services. PHE assert that novel approaches are required, including the provision of holistic support in young peoples’ own environments and the use of key workers or mentors who are able to build trusting relationships with young people involved with gangs(31). Effectively addressing the relationships between gang-affiliation and poor mental health requires co-ordination of services in a strong, collaborative manner.

**What Doesn’t Work**

The following are identified as ineffective or potentially harmful especially for young people at high risk of gang involvement (187,193):

- scare tactics
- prison visits
- militaristic type programmes and boot camps.

A summary infographic is provided overleaf.
Figure 34: Literature summary of prevention of youth violence and gang involvement

<table>
<thead>
<tr>
<th>WHAT WORKS?</th>
<th>WHAT LOOKS PROMISING BUT HAS LIMITED EVIDENCE?</th>
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<tbody>
<tr>
<td>Most of our knowledge about 'what works' to prevent youth violence, crime and associated factors comes from the USA. Among the most robustly evaluated and effective approaches are skills-based and family-focused programmes, which aim to foster positive changes as well as prevent negative outcomes.</td>
<td>Approaches that appear promising but have limited evidence include mentoring and community-based interventions. Many strategies aiming to prevent/reduce gang involvement exist, but very few have been robustly evaluated.</td>
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**SKILLS-BASED** programmes involve demonstrations, practice and activities that aim to develop young people’s abilities to control their behaviour and/or participate in prosocial activities.

- Programmes for children and young adolescents focus on problem solving, self-control, anger management, conflict resolution, and socio-emotional skills. Evidence suggests they are particularly effective with at-risk children, who are experiencing early onset behavioural problems or come from low-income backgrounds.
- Some programmes for adolescents and young adults focus on healthy life choices and preventing relationship violence. Evidence suggests they can increase knowledge and change attitudes, but impacts on behaviour and incidents of violence are unclear.

**FAMILY-FOCUSED** programmes include home visiting, parent training and family therapy. They recognise that creating changes in young people is difficult when they have complex home lives, and therefore take into account family level risk and protective factors.

- Family-focused approaches for infants and young children focus on developing positive parenting skills and strengthening parent/child relationships. Evidence suggests this can reduce early risk factors, such as child conduct problems, and improve parenting practices.
- It is difficult to track the long-term effects of early parent/family interventions through adolescence and adulthood, but initial research suggests they can be effective in reducing delinquency and anti-social behaviour.
- Family therapy is an internationally recognised approach to preventing youth offending and violence, especially with at-risk adolescents and young offenders. It recognises that young people’s behaviours are often influenced by their family situation and peer groups, and seeks to equip the family unit with the skills to tackle problems.
- Like other approaches, evidence suggests that adherence to the original programme design is crucial to maximising effectiveness and avoiding harm, and that the added values of family/therapy-based approaches should be weighed against the quality of existing services.

**MENTORING** programmes typically involve an older or more experienced person offering support and guidance to a young person over time.

- Some reviews suggest mentoring for at-risk and high-risk youth can reduce recidivism rates, delinquency and aggression. However, some of these findings are based on low-quality studies, and did not persist after the mentoring ended. A small number of studies have also found negative effects.
- For youth generally, community-based mentoring can improve behavioural, socio-emotional and academic outcomes, but relationships ending within three months may have adverse effects on at-risk youth. A review of school-based mentoring found minuscule effects.

**COMMUNITY** engagement, data sharing, and partnership building have a role in prevention efforts, but community-based programmes lack robust evaluation.

- Sports programmes in the community aim to engage youth in prosocial activities and increase self-esteem. Preliminary evidence from weaker studies indicates they may have the potential to reduce crime and violence, but more robust research is needed.

**GANG-SPECIFIC** approaches aim to prevent young people from becoming involved in gangs, and to help them find ways out if they do.

- The evidence behind these approaches seems limited or non-existent. Some limited USA-based studies of multi-faceted interventions found very small insignificant impacts on crime outcomes, whilst other studies have focused on attitudinal rather than behavioural changes.

**DETERRENCE & DISCIPLINE**-based approaches aim to deter youth from criminal behaviour via scare tactics (e.g. prison visits) or militaristic programmes (e.g. boot camps).

- Robust reviews and studies consistently indicate that these types of approaches are ineffective, and may even make things worse (e.g. increase the likelihood of offending)—particularly for at-risk or delinquent youth. More broadly, evidence suggests that, grouped together during implementation, deviant peers may encourage deviant behaviour, and undermine interventions effects.

Source: (187)
**Interventions: other topic areas**

Note: there is a lot of overlap with general violence prevention, therefore detail is not provided in this section.

**CSE and abuse**

Children and young people (particularly those from homes where there is the potential for multiple ACEs), need co-ordinated support to help them to get their lives back on track following sexual abuse and exploitation. However, few children and young people obtain timely, evidence-based therapeutic intervention or support following sexual abuse and exploitation(194).

A Department of Health and Social Care pilot highlighted several key findings(194):

- The needs of parents need to be considered. Good support for parents is vital to the recovery of their children, and to boosting resilience in the whole family. This should be reflected in any assessment of need, and provision of services.
- Child sexual abuse and CSE should be considered together rather than having separate care pathways and services.
- Care pathways and services need to recognise the significant overlap between different forms of abuse and the frequency of revictimisation, as well as the concurrence an cumulative impact of multiple ACEs.
- There was evidence that having a case-holder - a reliable, caring, compassionate, trusted adult - able to contain and ‘hold’ the child or young person - might avoid the need for more intensive, specialist services. Although case-holding can support families, it cannot and should not replace the therapeutic intervention that may be needed.
- Lack of specialist services remains a limiting factor.
- To ensure sustainable services and to bring about the further improvements in access that the projects identified the need for, all practitioners working in this and related areas and all relevant agencies need to understand trauma and its impact and to be more aware of the impact of trauma on every aspect of children and young people’s lives.
- In order to avoid repeat assessments and to ensure that the child and family do not have to repeat their story, clear information sharing protocols between the agencies concerned are required.
- The project found clear advantages in agencies pooling budgets, rather than having several separate funding streams owned by individual agencies, and in having joined-up commissioning of services.

PHE note that Public health has a critical role to play in reducing children and young people’s risk to CSE, and intervening when it does happen(152). They have developed a resource to help Directors of Public Health structure their approach to CSE.

The principle role of public health in this space is to lead prevention and early intervention work, understand the population and those who are most vulnerable, and act. The PHE CSE Pathway gives advice on the critical role of the school nursing service and how this can help prevent and identify CSE. Some authorities are also using their Licensing Act powers to address CSE both proactively and reactively when considering licenses(152).
Environmental design

There is much interest in how the design and use of the built environment can reduce fear and incidence of violence. Research has considered how crime can be “designed out” of the built environment, building on principles such as defensible space, CPTED (Crime Prevention Through Environmental Design), situational crime prevention and broken windows theory. Several studies in the US have found a strong association between violent crime and vacant properties and abandoned land. Other research has shown how green space can help to improve cognitive function, self-discipline, reduce aggression and reduced crime(33).

Changing social and cultural norms that support violence

There is a lack of good evidence for interventions that challenge social and cultural values and aim to make violence less acceptable. This includes the use of mass media for delivering violence prevention messages.

Social media

In relation to social media, a Catch 22 report identified prevention recommendations including(89):

- All professionals working with young people, including teachers, social workers, foster carers, youth workers and the police, should be provided with sufficient, up-to-date mandatory training on social media.
- Detailed research should be commissioned on the links between activity on social media and the exploitation of young women, to generate concrete recommendations for policy and practice, and inform the future training.
- The Home Office should develop online resources explaining the basics of the main social media platforms, as well as the importance of parents and carers providing oversight of their children’s activity on social media.

Brain injury and violent behaviour

The Lambeth needs assessment notes that good practice interventions include(1):

- Violence risk assessments for people who have experienced a traumatic brain injury, particularly for those in higher risk groups such as offenders and people who are engaged in alcohol or substance misuse.
- A single comprehensive health screening tool for young offenders which includes assessment of neurodisability.
- Tools and training for agencies and services involved with young people so that there is early identification and referral for neurodisability.
- Access to specialist services and local diversion and liaison services for young offenders with neurodevelopmental disorders.
- Multi-agency forums as an effective way of considering a set of complex interconnected issues.

Youth offending

The Local Government Association reviewed interventions that are available to prevent offending among children and young people who have experienced family violence. They found there is good evidence that the following may work in reducing violence(19):

- Family Nurse Partnership
- The Sexual Abuse: Family Education and Treatment Program
- Big Brothers Big Sisters community-based mentoring programme
- Functional Family Therapy (FFT)
multisystemic therapy for child abuse and neglect.

The Local Government Association assert that decision-makers should consider commissioning and funding interventions such as those mentioned above, that aim to prevent and/or reduce offending among children and young people with experience of family violence.

Multi-Systemic Therapy (MST) focuses on 12-17-year olds at risk of placement in care or custody due to severe behavioural problems. Trained therapists with small caseloads (4– 6 families) provide families with weekly contacts for 3–5 months (60 hours). MST seeks to improve parenting skills, children’s academic and vocational performance, peer relationships, and families’ support networks. The Government’s Serious Violence Strategy reports that most studies show significant benefits of MST over standard YOS interventions. However, most of these studies are from the US. When UK only studies are considered, the results are inconclusive (195,196).

Reoffenders

A Lancet study noted that certain psychiatric disorders are associated with a substantially increased hazard of violent reoffending, and that as these disorders are prevalent and mostly treatable, improvements to prison mental health services could counteract the cycle of reoffending and improve both public health and safety (106). The authors assert that national violence prevention strategies should consider the role of prison health. Local policy makers should be cognisant of the impact of serious mental ill health and the risk of violent reoffending.

The findings of research studies that have asked adult offenders about what helped them to stop committing crime or “desist” include (175):

- Desistance may be provoked by life events. This might include getting a job, education or training.
- Desistance requires wider opportunities to make progress in the world. This suggests an advocacy role for practitioners seeking to support change and again underlines the need for opportunities for stable and suitable education or employment.

Alcohol and drugs

Measures to limit access to alcohol and reduce alcohol consumption among hazardous and harmful drinkers can have significant violence prevention impacts (5). Interventions that focus on harmful and hazardous drinkers can have benefits in preventing violence (5).

More intensive programmes have also reported positive results, for example, cognitive behavioural therapy with non-dependent drinkers has been found to reduce their risks of perpetrating abuse (5,197).

Since 2013 Directors of Public Health have been included as responsible authorities under the Public health and the Licensing Act 2003 (198). Through this lever, public health has the opportunity to:

- Contribute to local licensing decisions
- Use the Licensing Act to improve local public health
- Identify what issues or potential harms might be linked to the different types of applications
- Decide which types of application are priorities for public health

In relation to drugs, getting users into effective treatment reduces levels of offending (66,199). PHE note that as well as drug problems, many people committing crimes are also more likely to have a range of other problems, such as homelessness, unemployment, lack of qualifications and
dysfunctional family backgrounds. Often a holistic approach to treatment is needed, and just treatment alone may not resolve an issue.

Prevention of drug misuse early on is key. In the UK, although some drug prevention programmes have been evaluated, the majority have not, with little high-quality evidence of ‘what works’ in preventing illegal drug use, although some good quality evidence is emerging(200). In schools, drug education alone is ineffective at changing behaviour, but programmes that aim to develop the skills required to support healthy decision making can be effective in preventing alcohol, tobacco and some types of illegal drug use(200).

**Mental ill health**

A growing repertoire of risk assessment tools means that mental health professionals are often expected to predict and manage violent behaviour, especially in an acute care setting(103).

Adequate treatment, including management of comorbid substance use, leads to better outcomes for patients with severe mental illness, and can lower the risk of violence, even up to that seen in the general population(103).

The relationship between mental illness and violent behaviour has serious implications from a public health perspective, and as current evidence is not adequate to suggest that severe mental illness can independently predict violent behaviour, public efforts are required to deal with the discriminatory attitude towards patients suffering from mental illness as potential violent offenders(103). The role of individual and contextual factors in mediating violence remains to be explored further, and appropriate intervention strategies need to be formulated(103).

The NICE quality standard on the short-term prevention and management of violent and physically threatening behaviour among adults, children and young people with a mental health problem, applies to settings where mental health, health and social care services are provided. This includes community settings and care received at home. It describes high-quality care and priority areas for improvement(201).

**The role of nurses**

Recent research asserts that nurses may also have a role to play in violence prevention. The authors note that prevention of complex societal problems, such as gang violence, requires substantial effort and sustained commitment from many sectors and disciplines. Having an understanding of the research on gang violence prevention will make nurses more equipped to help lead such efforts(202).

Nurses can use the research available to inform decisions about gang violence prevention and to guide implementation of prevention strategies and thus reducing the health consequences of violence in their community. Nurses who provide care for gang-affiliated youth in hospitals may have the opportunity to refer their patients to community programs upon discharge(202). However, there is a need for rigorous evaluation of programs for gang involved youth(202), and given that nurses are already highly stretched for capacity, there may be a need for this to be a specialist role rather than a ‘bolt on’ to existing duties.

**Data and intelligence**

The Local Government Association assert that there is good evidence that the public health approach to gathering and using data on violence can contribute to efforts to reduce violence at the population level(5):
• Emergency department and hospital admissions data can give a more accurate picture of some kinds of violence than police records alone. By developing systems for specifically and consistently collecting the most useful kinds of data, and for sharing it effectively between relevant agencies, interventions can be designed and targeted to maximise their impact.
  o The Cardiff Model is an example of this: Reception staff in emergency departments collect data about violent incidents from patients presenting with assault-related injuries, including location, time and day, and weapon used.
  o The data is anonymised, analysed and combined with police intelligence, and shared with a group of representatives from many agencies such as local government, police, licensing regulators, licensed businesses, ambulance services and mental health support services. The data is used to predict, prevent and prepare for violence across the local area.

Domestic abuse

The Early Intervention Foundation assert that there are a number of innovative approaches that offer promise for preventing domestic violence and abuse(203). These include:

• Approaches in schools to develop a zero tolerance approach to domestic violence and abuse.
• Prevention through augmentations to parenting programmes and through support to the quality of parenting relationships.

However, the authors note that these require further development and testing using rigorous evaluation methods, as much of the available evidence has methodological limitations, and is restricted to very limited groups, and further research is needed. There is also a need for improved identification of domestic violence and abuse(203).

It is also noted that among early intervention and the children’s sector more generally, there is wide variation in screening tools used and guidance provided on dealing with domestic violence and abuse (203). Additionally, the authors found some evidence that perpetrator programmes that target domestic violence in a culturally specific context, or at the same time as tackling other issues such as mental health problems and drug and alcohol misuse, have had some success (203).

In 2015 and 2016, Cheshire and Merseyside utilised recommendations from NICE Guidance PH50. Local public health directors delivered the ‘Be a Lover not a Fighter’ public health social marketing campaign across areas in the North West. They participated in a local strategic multi-agency partnership to prevent domestic violence, and abuse linking to partners from local authorities, NHS, domestic abuse services, police and others(204).

The campaign had a reach of nearly 1 million people, and survey findings indicated people thought more about domestic abuse (specifically the importance of talking about it), and it helped people to realise its everyone’s responsibility(204). Respondents felt that the impacts on children were a strong motivator in ending domestic abuse, contributing to the recommendation to refocus the campaign around both children and wellbeing in 2016(204).

The ‘Business in the Community’ domestic abuse toolkit for employers notes that taking a proactive and supportive approach can help prevent domestic abuse. They note that there are clear and comprehensive steps that employers can take to help prevent domestic abuse, and be as supportive as possible when an employee is affected by domestic abuse(205).

The main conclusion of the Early Intervention Foundation is that locally, councils, police and crime commissioners, CCGs, public health organisations, and partnerships such as health and wellbeing...
boards, should ensure that the prevention of domestic violence and abuse is central to local strategies on crime prevention, health and wellbeing and children and young people. This should include ensuring that prevention and Early Intervention on domestic violence and abuse is represented in local strategies and plans related to Early Help and/or Early Intervention, and that this is informed by the latest evidence and guidance on what works, and in particular the NICE Guidance(205).

Disability

PHE notes that whilst there are some prevention strategies for disabled people that haven’t been evaluated for transferability, (from applying to non-disabled populations), these strategies have been shown to be broadly effective and to address specific risk factors for disabled people, so they are likely to have a positive impact(78):

- **School-based education** has the potential to increase disabled people’s knowledge about healthy relationships, boundaries and consent, and to decrease domestic abuse.
- **Economic empowerment interventions** are valuable tools that may be transferrable to prevent domestic abuse experienced by disabled people.
- **Group-based empowerment training** may also be potentially promising.

PHE note that a comprehensive response from services is needed for disabled people who experience domestic abuse, this includes training of professionals, improved support, and improved identification and disclosure of abuse.

Learning disabilities

NICE provides a quality standard that encompasses care and support for adults, young people and children with a learning disability and challenging behaviour. It also includes support for families and carers and describes high-quality care in priority areas for improvement (206). A key statement in this is an initial assessment to identify possible triggers, environmental factors and function of the behaviour.

Elder abuse

A 2016 Cochrane review of interventions for preventing abuse in the elderly (207), found that a paucity of trustworthy evidence to assess the effects of elder abuse interventions on occurrence or recurrence of abuse, although there is some evidence to suggest it may change the combined measure of anxiety and depression of caregivers.

The authors note there is a need for high-quality trials to determine whether specific intervention programmes, (and which components of these programmes), are effective in preventing or reducing abuse episodes among the elderly. However, potentially abusive carer behaviours need to be detected at an early stage so that preventive interventions can be introduced to avert caregiving situations deteriorating into serious cases of elder abuse(208).

Awareness raising campaigns may help in detecting issues. An Australian media campaign to raise awareness of elder abuse and reports to the Elder Abuse Helpline was evaluated, and the evaluation that notifications of elder abuse to the helpline rose by 64%, with an increase of 6% in notifications from family and friends(209).
Other strategies that may be effective include (209):

- Using multidisciplinary teams where professionals pooled expertise to resolve cases of alleged elder abuse.
- Providing helplines and websites that provide information to potential victims.
- Monitoring by financial institutions for suspicious patterns to identify older adults at risk of financial abuse.

Further reading: The Centre for Public Health at Liverpool John Moore’s University hosts a useful database of evidence and literature related to violence prevention.

Section summary

- There are effective interventions that can help to reduce violence across the lifecourse. However, the key opportunities exist in childhood, and in the provision of a safe, nurturing and stable environment.
- There is good evidence that early intervention programmes can work to prevent violence, even for those most at risk, provided they are not focused on ‘scare tactics’.
- There is some evidence that councils are increasingly having to divert funding away from preventative work into services to protect children who are at immediate risk of harm, which would result in a detrimental impact on the ability to provide prevention and early intervention programmes.
- There is no ‘quick fix’ solution to reducing levels of violence in the population. Prevention and reduction need to be consistent, at scale, and across the lifecourse over a sustained period of time.
- Ending youth violence requires an end-to-end approach, from prevention to rehabilitation.
- Effectively addressing the relationships between gang-affiliation and poor mental health requires co-ordination of services in a strong, collaborative manner.
- Awareness raising campaigns can be effective in detecting and targeting issues and measures to mitigate risk (for example in domestic abuse and elder abuse).
- Violence reduction initiatives in urbanised areas such as Glasgow and London may not be applicable to Suffolk, but elements of the public health approach, in combination with local knowledge and understanding may help in providing an effective ‘Suffolk approach’.
Part 4: Gap analysis: How are resources currently used to prevent violence locally?

This section aims to summarise current core local provision, as well as identifying potential gaps. The information provided here is collated from existing resources and through meeting with stakeholders embedded across the system. However, it is not a complete mapping review of all services (which is why gaps here have been referred to as potential gaps). We have requested the mapping tool from Lambeth, and will revise and update this section upon receipt.

Early childhood

Patterns:

- **Triple P** (Positive Parenting Programme / teen group / seminars). Increases understanding of children’s behaviour and development with practical strategies given to improve family relationships and to manage challenging situations.
- **Incredible Years / Webster Stratton** (including Baby, Toddler and School Age programmes). Weekly 2 hour sessions for parents of babies, toddlers and children up to 10 years. Encourages strong relationships through play, praise, positive attention and setting appropriate boundaries.
- **Solihull Group Programme** For parents of children aged 0 to 19 years. Focuses on parent and child relationships. Improves parental sensitivity, responsiveness and understanding of emotional containment, reciprocity and behaviour management. There is also a **Solihull for Foster Carers programme**.
- **Suffolk Family Nurse Partnership (FNP):** A free and voluntary service for under 20’s who are, expecting their first baby, registered with an Ipswich GP. A specially trained family nurse will visit frequently during the antenatal and postnatal period, until a child is 2 years old. There is also an FNP team in Lowestoft and Waveney.
- **Children’s Centres** provide early support for parents with children, particularly those aged 0-3, providing both universal and targeted health and parenting support services.
- **Early Help** forms part of the recently launched Emotional Wellbeing Hub, providing emotional wellbeing support to young people and their families when young people are identified as needing intervention but do not meet the threshold for mental health services.
- In east and west Suffolk, the **Suffolk Perinatal Mental Health Service** provides specialist care to women with conditions such as serious post and ante-natal depression and psychosis. It is available to women during pregnancy, at the time of birth and up to a year following the birth of their baby (210). In Waveney the service is provided as part of the Community Perinatal Mental Health Service.

Potential gaps:

- Increasing demand for children and young people’s services because of increasing population and large cuts to funding (211).
- There is an opportunity to provide more information about emotional wellbeing to new mothers and their birthing partners (212), this may assist in helping to provide the best start in life.
- A 2016 needs assessment found that available services for children and adolescents with emotional, behavioural, and/or mental health difficulties are diagnosis and age specific meaning they are not flexible to the needs of the children. Additionally, tier 2 services tended to reject referrals for primarily behavioural difficulties (a key indicator of conduct disorder) (213).
Social and life skill development in children and adolescents

Patterns:

- **Triple P Stepping Stones**: 9 week group programme for parents of children with a physical or learning disability. Strategies for reducing parental stress and increasing parenting effectiveness.

- **Triple P Family Transitions**: 5 session group programme for parents experiencing personal distress from separation or divorce, which is impacting on their parenting. Focus on skills to resolve conflicts, cope positively with stress and help children understand changes. To be followed by Group Triple P or Teen Triple P programme.

- **Strengthening Families**: For parents of children aged 10 to 14 years and parents/careers attend with their young people. Using DVD, discussion and fun activities to build family relationships, set boundaries and understand pressures on parents and young people during the teen years.

- **SCC** is aiming to improve outcomes for children in care whilst managing the increasing demand through its **Sufficiency Strategy**. As a result of strategic and operational work, children in care outcomes are improving in many areas. For example, the comprehensive and prompt provision of services and support for Unaccompanied Asylum Seeking Children (UASC), despite their challenging needs, Suffolk’s children in care educational progress and improvements in levels of initial health assessment completion. Additionally, there have been vast improvements in accommodation provision and support (including children’s homes) and a substantial amount of work has been undertaken to improve outcomes for care leavers.

Potential gaps:

- Suffolk does not have enough specialist education places to meet the needs of children and young people with SEND currently, and some children are travelling long distances to education, which could have a detrimental impact on relationships and wellbeing.

- Despite this positive work around SEND, health behaviour and health issues of this group of children require further improvement. A large proportion of children in care are likely to have a long-term condition or disability which can affect their outcomes and future potential. Professionals working with children in care and service providers have a role to play to promote and support healthy eating, physical activity and reduce risk taking behaviour such as substance misuse, sexual activity and crime.

- For CiC, young people, professionals, and service providers have raised concern about the difficulties of accessing mental health services, mainly referring to Child and Adolescent Mental Health Services (CAMHS). A principal challenge for CAMHS is the management and treatment of children in care who are not quite meeting the criteria for diagnosis of a ‘mental health condition’.

- It is difficult to assess how underlying issues that contribute to children and young people’s mental health disorders should be addressed in Suffolk. Issues such as family dysfunction, emotional abuse, anti-social behaviour, and family in acute distress may contribute to the children and young people’s mental health needs. There is no reliable data to show the level of need or access to services for the children and young people who, while not having a mental health disorder, may nevertheless need Tier 1 mental health support.
In addition, key summary findings from the mental health needs assessment for Suffolk (215), (many of which are highly relevant to children, young people and their families), are:

- Young people have increasing levels of self-harm and suicide which should be addressed.
- Emergency admissions for self-harm are significantly higher in Suffolk than England as a whole.
- Deprivation is having an impact on levels of mental health and service demand in Suffolk.
- Dual diagnosis requires a more holistic approach to care with alcohol and drug use not a barrier to accessing mental health support.
- A profile of Crisis has identified key issues which should be fed into planning new provision, including increased levels of need in the summer, and between 6pm and midnight and in the East of the county.
- Existing mental health services do not clearly meet the needs of patients with personality disorders and the role of mental health services should be clarified.
- Mental health and physical health services should be better integrated.
- The physical health of people living with serious mental illness must be improved to reduce deaths.
- Some older people in the community and residential care have undiagnosed depression which should be treated effectively.
- Future estimates may underestimate the mental health challenges of the next 5 years due to the impact of depression in older people and levels of self-harm in the young.
- Future wellbeing will be adversely affected if the needs of children and young people and of the increasing older population are not addressed.

Great Yarmouth and Waveney CCG are also reviewing the mental health needs of their residents, in conjunction with Norfolk County Council and other Norfolk and Waveney Sustainability and Transformation Partnership (STP) colleagues. Suffolk County Council through Public Health are also supporting this process, working closely with Norfolk County Council and the CCG as required.

High risk youth and gangs

Patterns:

- Organisations such as SCC which offer or commission services to vulnerable children and adults are already working extensively with young people at risk of or involved in gangs and county lines activity.
- SCC’s Early Help team:
  - Use the Signs of Safety model to establish the young person and family’s network of connected helpful people to ensure sustainable support is in place beyond the duration of children and young people’s intervention.
  - Provide direct coaching support to move NEET young people into employment, education or training
  - Deliver Interpersonal Counselling (IPC) as an intervention with young people suffering depression.
- Fresh Start - new beginnings is a charity working therapeutically with children who have disclosed sexual abuse (216).
- Multi-agency delivery team (MAT): The MAT is a two-year initiative. It is intended to swiftly develop expert multi-agency practice through co-location, intensive development and encouragement of innovation.
  - The MAT has a preventative arm in relation to its Police Youth Gangs Prevention Unit. The unit is already in existence and will continue to focus primarily on enforcement activity, with some prevention and awareness raising activity also being delivered.
  - The unit is funded by the Constabulary. The only exception is the Intelligence Development Officer which is a new post. The MAT also has a countywide performance, information sharing and analytical co-ordination capacity.
SCC, Ipswich Borough Council, Suffolk Constabulary and the Police and Crime Commissioner's Office have taken joint responsibility for responding to the known consequences of CLN and USG crime.

**For urban street gangs and CLN**

Staff should adhere to the principles of Signs of Safety and wellbeing. Since children and young people also tell us how difficult it is to make this move, workers will need to be persistent and optimistic about their capacity to change.

In relation to urban street gangs and CLN in particular, the 2017 University of Suffolk research piece identified the need for a joined up multi-agency approach (217). Partners have worked collaboratively to develop a Strategic Action Plan (SAP) and a specific Tactical Action Plan (TAP) for Ipswich to respond effectively. Whilst this work was focussed on Ipswich much of the activity aimed at CLNs is relevant across the county.

The **Strategic Action Plan** lists the tactical actions for each priority and Tactical Action Plan lists individual activities to achieve the tactical action have been developed following workshops with managers and practitioners from the Public and Voluntary Sectors (35). The plan prioritises 5 strategic areas. Each theme has a theme lead and tactical objectives further broken down into actions. Theme leads are responsible for co-ordinating delivery of the tactical objectives across the partnership (193).

**Figure 35: Summary of tactical objectives**

<table>
<thead>
<tr>
<th>Urban Street Gangs and County Lines Networks</th>
<th>Young and Vulnerable</th>
<th>The Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undermine, disrupt and deter Ipswich USG and Suffolk CL networks, removing their capacity to: dominate drug supply, exploit vulnerable persons and commit anti-social &amp; violent acts within communities.</td>
<td>Reduce the threat to young and vulnerable persons at risk from the sexual, violent and coercive influences of USG and CL networks, providing: safeguarding, support and exit opportunities to those already implicated.</td>
<td>Make Ipswich and Suffolk communities safer and reassured, reducing the harm caused by violent, anti-social and exploitative USG and CL crime: building community confidence with constructive engagement and transparent communications.</td>
</tr>
</tbody>
</table>

**Drug Users**

Reduce the risks and harm to high risk drug users, decreasing the potential for their exploitation, while creating realistic opportunities for treatment, recovery and wider demand reduction.

**Response Partnerships**

Provide the collaborative Ipswich and Suffolk response to USG and CL crime with the most informed, cohesive and co-ordinated resources and influences to maximise efficiency, impact and change.

Source: (35)

Lead Managers for each of the priorities has been identified from across the range of partners – Suffolk County Council, Ipswich Borough Council and Suffolk Police. A multi-agency team is in place to assist delivery of the Plans, this will consist of:

- The Police Urban Street Gangs Unit
- A core team of practitioners from a variety of teams and organisations
- Performance, information sharing and analytical co-ordination capacity

More information about the principles of the multi-agency response, vision and work so far can be found in **Appendix 4**.
Potential gaps:

- Relatively little evidence-based research is available about what works to prevent gang involvement and to help those already involved to leave. There is more (though still limited) evidence for what works to prevent youth violence and it is reasonable to assume that this may also be effective in the context of gangs.
- Local practitioners noted that funding of preventative work is an issue in Suffolk. This mirrors national concerns, for example the LGA assert that Youth Offending Teams (YOTs) have been a victim of their own success (218). They state that as the number of young people in the system has fallen, so too has the youth justice grant. There is a real risk that this long-term decline will stall or even reverse if teams are less able to carry out the preventative work that has been so effective over the last decade.
- Local practitioners also highlight that it would be beneficial to have consistent Police and Crime Commissioner representation on quarterly board meetings in relation to SYJS and the Diversion programme to maintain communication. Having different plans in different geographies can complicate data sharing, and communication of what’s happening in each area.
- Decreases in budgets, over many years to support young people’s substance misuse treatment has impacted on the ability to deliver universal prevention initiatives across the county.

Youth offending Patterns:

- The countywide Diversion Programme means that there is already a clear referral pathway and established process in place to intervene early with this group of young people. The Diversion Programme is a joint initiative between Suffolk Constabulary and SYJS.
- In Suffolk, the police and youth justice service strive to not charge young people for lesser offences, but instead offer programmes to help divert them from the criminal justice system. However, even if a young person is not convicted or cautioned for an offence, depending on what type of offence they have committed and how it was recorded, it might still be revealed in a future DBS check.
- The Boyhood2Manhood programme has been used as an exemplar by the LGA (218). The following information is extracted from their case study review:
  - SYJS identified that a lack of positive male role models, and certain perceptions of masculinity, were resulting in negative behaviours among some young men in the county, including involvement in youth crime.
  - SYJS worked with the council’s Early Help team and a local drug and alcohol service to develop a programme, Boyhood2Manhood, which gave young men a safe space to discuss their beliefs and opinions, and to be challenged safely by their peers and facilitators.
  - The programme runs in several different forms to suit participants and according to the details of their referral, from 11 weekly after-school sessions, to term-time lessons in school or alternative provision, to shorter, more intensive school holiday courses. More than 90 young men were supported through the course in 2017, with consistently high feedback from those taking part, as measured through Signs of Safety.
- There is a preferred list of SYJS effective interventions and resource descriptions.
Potential gaps:

- There is a concern that young people being reported for less serious offences can end up missing work opportunities due to offences being disclosed as part of Disclosure and Barring Service (DBS) checks, even if they were never charged (see point above)(219).
  - The police follow recording standards when first logging a suspected offence. These recording standards do not match the charging standards. For example, according to recording standards, any physical assault that causes bleeding will be recorded as ‘Section 20 GBH minor wound’.
  - However, upon investigation the charge might be dropped to common assault which is a much less serious offence. It is unclear which offence may be disclosed in any future DBS check (if at all). This depends on several different criteria, including what outcome is eventually given, whether the offence is on the non-filtered list etc.
  - This is a system issue rather than individual recording practice, but highlights some of the challenges.

Alcohol related violence

Patterns:

- The Suffolk alcohol strategy 2014-2022 has been endorsed by the Suffolk Health and Wellbeing Board (HWB). Suffolk are working in partnership with the Local Government Association prevention at scale initiative to deliver the strategy.
- The “Reducing the Strength” campaign was launched in 2012 to tackle problem street drinking. The campaign encourages retailers not to stock very strong lagers, beers and ciders and has been successful in cutting anti-social behaviour associated with street drinking. By December 2013, 94 off-licence premises in Ipswich had signed up to the Reducing the Strength scheme and been declared “super strength free”(220). In year one of the initiative, police recorded a drop from 341 to 261 events (a 23.5% decrease) related to street drinking reported by the public(221). As the voluntary sign up of retailers in Ipswich further increased into the summer of 2014 (to 71%), likewise the reduction in street crime committed by street drinkers continued (by 43% over a one year period)(222).
- The Drug & Alcohol Recovery Outreach Service (DAROS) identifies and addresses the needs of substance misusers who are homeless/rough sleeping. The service supports people who are drinking and using drugs on the streets to access mainstream treatment services to address addiction.
- Acute hospital services include a Suffolk-wide alcohol treatment service and specialist consultants and nurses. In the primary care setting, NHS Health Checks (a free check-up of overall health offered to 40-74-year olds) include an alcohol-risk assessment tool called the AUDIT-C questionnaire.

Potential gaps:

- Despite inroads made, opportunities remain to further develop the alcohol intervention strategies across both primary and secondary care sectors. Whilst recognising there are multiple target groups, interventions can be combined at individual, community and population-levels.
- Vulnerability to and harm from substance misuse is increasing. Using estimates reported in the Young People and Substance Misuse in Suffolk needs assessment, applied to the Suffolk children in care population, an estimated 30-50 children may have substance misuse problems. However, many young people may not perceive themselves to have a substance misuse problem, and thus do not access treatment. Therefore, this may be an area of potential unmet need with further work required, especially as prevalence could be higher amongst older age groups including UASC.
- Access to quality treatment intervention and recovery services will be pivotal in achieving a better relationship with alcohol for communities and individuals in Suffolk.
Changing cultural norms

Patterns:

- **Caring Dads (by referral only): For parents of children aged 0 to 19 years.** 17 week intensive programme for men who have been perpetrators of domestic abuse. Raises awareness of the effects of this behaviour and supports fathers to build better relationships with their children and their children’s mothers to enhance their safety and wellbeing (223).

- **The PCC has commissioned Lighthouse Women’s Aid** to deliver the Independent Domestic Violence Advisory Service. This is a specialist service which supports high risk victims of domestic abuse. The service has been in place since February 2015 and supports victims of domestic abuse with safety planning and assessments to keep them safe and reduce the risk. The service works effectively with the Constabulary’s Domestic Abuse Team and also supports victims through the criminal justice process (224).

- **Norfolk and Suffolk Constabularies** report that frontline officers attend domestic incidents when a call is made. Where relevant, a domestic risk assessment will be completed and submitted to be assessed by the relevant teams. In Suffolk the domestic abuse teams are based in the ‘Protecting Vulnerable Persons’ service, alongside Independent Domestic Abuse advisors and other staff.

- **Survivors In Transition** support men and women (18+) from across Suffolk who have experienced sexual abuse, exploitation or violence in childhood, through a range of trauma informed, psycho-educational activities including one to one and group therapy, counselling, advocacy, research and training to become empowered and improve self-esteem and resilience (216).

- **Suffolk Rape Crisis** is a local, specialist service providing support to women and girls aged 14 and above who have experienced any form of sexual violence, they offer the service in Ipswich, Bury St Edmunds, Lowestoft and Brandon (216).

**Suffolk Violence Against Women and Girls, Men and Boys**

The Suffolk VAWGMB strategy notes that the impact of violence against women, girls, men and boys is devastating and often long-term. The strategy asserts that a reduction in violence of this nature in all its forms should occur by 2021, and through the following actions (22):

1. Developing a shared and richer understanding of current and emerging threats.
2. Developing the capability and capacity of a) early intervention, b) prevention and c) crisis services. Ensuring a focus on perpetrators as well as survivors.
3. Building and draw upon an evidence base and best practice when framing strategies and plans.
4. Developing the ability of both front-line staff and the system to recognise, record and respond to victims of VAWG.
5. Ensuring the commissioning and use of services is coordinated and that efficiency and effectiveness is challenged through evaluation and victim’s voice.
6. Developing clear links with partners to understand how the wider VAWG system can influence and add value to the criminal justice response.

There are a range of commissioned services available in Suffolk. These are outlined below with more detail in the strategy:

- Independent Domestic Violence Advisor (IDVA)
- Domestic Abuse Outreach Service (DAOS)
- Domestic Abuse Refuge
- Specialist Domestic Abuse Refuge
- Support for survivors of childhood sexual abuse - Survivors in Transition
- Support for children and young people who have reported being sexually abused - Fresh Start New Beginnings
- Support for survivors of rape and sexual abuse - Suffolk Rape Crisis
- Sexual Assault Referral Centre
Potential gaps:

- The provision of services may be limited by geographical coverage, particularly in more rural areas. Outreach services may help to target those gaps.

Identification care and support for victims

Patterns:


- Suffolk Constabulary have a rural crime strategy that supports the Police and Crime Plan priorities to:
  - Protect vulnerable people
  - Focus on prevention and early intervention
  - Cut crime and anti-social behaviour
  - Improve victim care
  - Support the rural economy
  - The strategy particularly notes that domestic violence, serious sexual offences, child sexual exploitation, illegal immigration including human trafficking, modern day slavery, forced labour and cyber-crime can be under reported by victims through rural isolation.

- Violence with injury can be a visible crime (through the act and injuries), new technology such as body worn video can be beneficial in capturing crucial evidence, protecting officers and supporting victims through to prosecution.

- Following the murder of five street sex workers in Ipswich in December 2006 a multi-agency strategy was developed in response to the risk of exploitation posed to young women in the town. The launch of the Make A Change (MAC) Team in 2007 was a consequence of this strategy and brought police, health, Suffolk County Council and others together to work directly with young women at risk of such exploitation:
  - The MAC team is a multi-agency team including police liaison officers and support workers. The team is part of Suffolk County Council and works closely with children and young people’s services to identify young people who are at risk of abuse through sexual exploitation. The team’s purpose is to help people at risk of sexual exploitation or people who are, or were involved in sex work.
  - The team is able to offer support to young people at risk of child exploitation and their families in a number of ways. There are two main methods used to make the MAC Team aware of young people who are potentially at risk:
    - **Referrals** - These are sent in by social workers or other agencies to request intensive support when they have concerns about a child’s welfare and vulnerability relating to child exploitation. All new referrals are looked at in depth by the MAC Team before a decision is made on the best way to approach the concerns raised.
    - **Activities** - These are automatically generated and sent to the team via the CareFirst6 system when a risk-factor is identified during a Social Work Assessment or Return Interview.

- An increase in referrals indicates that the Make a Change team are more embedded in the everyday practice of social workers and Family Support Practitioners, and that there is an awareness of child exploitation risks and a familiarity with when to make a referral to the team. However, this may also be indicative of a ‘real’ increase in demand.
• Intervention from the Make a Change team has shown to be effective in helping to lower the risk a young person is subject to, as defined by the CSE toolkit. This has been shown in the significant decreases in risk-level between the start and end of MAC intervention, and the decrease in the numbers of re-referrals received throughout the year.

Potential gaps:

• The MAC team are concerned that the distribution of young people at risk of CE is becoming increasingly concentrated in the Ipswich localities. The Team note that while there is a higher population density in Ipswich, the percentages have risen almost solely in those two localities, and could also indicate a risk that other localities are being under-represented.

• The MAC team also note that gang risk has increased across the county. Every locality saw an increase in activities highlighting gang risk, with the highest seeing an increase of 15% compared to last year. This suggests the growing influence gangs are having on the young people across Suffolk, bringing with them the extra risks of drugs, violence and criminality.

Public health response: What needs to be done?

Those who are most at risk of becoming directly involved in violence include some of the most vulnerable in our society, and a systemic approach to addressing the issue involves a high degree of collaboration and communication is required to make an impact(33).

As outlined at the beginning of this document there are 4 core elements in a strong public health approach (and implementation of interventions) to reduce violence(6):

1. Surveillance.
   • What is the problem – Define the issue including a robust needs assessment.

2. Identify risk and protective factors. What are the causes?
   • This includes taking an evidence-led approach to understanding which risk and/or protective factors cause the violence issue and how they interplay.

3. Develop and identify interventions. What works for whom?
   • Develop an anti-violence or reducing violence strategy. Critically, this strategy should respond to identified need in the population under consideration and focus on addressing the causes of violence.
   • Commission and fund evidence-based interventions that have been shown to reduce violence.
   • Don’t be afraid to innovate.

4. Implementation. Scaling up effective programmes and interventions
   • Implement interventions ensuring that fidelity is maintained in line with what has been demonstrated to work.
   • The implementation of interventions takes time to embed in practice and to achieve outcomes.
   • Evaluate and monitor the success of public health interventions.
   • Robust evaluation can save money by clearly identifying models and practice that work, but also showing what does not work. Knowing this can save money and use scarce resources more effectively in the long-term.

This report should assist in providing a more comprehensive response to items 1 and 2, and much work is already underway in relation to items 3 and 4 - across the Suffolk system. However, there is a defined need to communicate and evaluate the impact of existing and proposed interventions in a more coordinated and integrated manner.
Summary and conclusions

Violence is a serious and enduring public health concern. However, tackling and preventing violence is not something that can be done in isolation, and it requires concerted, strategic commitment across organisations in Suffolk to effect change and reduce violence.

Suffolk has long been a very safe place to live, with very low rates of recorded crime, including violent crime. For example, Suffolk has statistically significantly lower rates of admissions to hospital for violence-related injuries compared to the national rate. However, in the last few years there is some evidence that this picture has begun to change, especially with the emergence and proliferation of urban street gangs and County Lines Networks.

From a public health lifecourse perspective there are a number of touch points at which violence risk can be elevated. Examples include:

- **Childhood:**
  - Adverse childhood experiences (including abuse and exploitation)
- **Adolescence:**
  - Youth violence / gang violence
- **Adulthood:**
  - Domestic abuse
  - Violent crime exposure (particularly in the night time economy)
- **Older age:**
  - Elder abuse

There are also many underlying risk factors that increase the propensity of violence, for example increased deprivation, unemployment, poor mental health, alcohol and drugs. For many factors, the risk could be both a cause and effect.

There are opportunities where public health practice can make a significant contribution towards reducing crime and improving wellbeing: violent crime and young people; reported crime; hospital admissions and attendances at A&E; and domestic violence including intimate partner violence.

In Suffolk, a lot of multi-agency coordinated work and action is already happening, and there are many early intervention and prevention workstreams in existence already. However, anecdotal evidence from colleagues across Suffolk indicates that there is a need to communicate the work that partners are undertaking in a more effective manner, to reduce duplication of efforts, and also to identify exactly what work is being done, where, and what impact it is having on those most vulnerable to violence.

Data and intelligence plays a major part of this communication role, and information sharing can be a complex and lengthy process. There is a need for the process to be simplified to maximise the impact that a joined up working can have in Suffolk. This profile is a start in the provision of the robust evidence base in taking a public health approach to violence, but full service mapping has not been completed, and it may be beneficial for this to be explored going forward.

Interventions in Suffolk have provided promising results, for example the use of early years, parenting and family programmes may also help to break intergenerational cycles of adversity and ill health. Additionally, early indicators suggest that young people who are currently engaged or have completed an intervention on the Diversion Programme are less likely to offend after referral, compared to those who declined intervention or received no further action. But the awareness of such programmes needs continued promotion to ensure consistent use.

The public health response advocates a four step process of surveillance, risk identification, intervention development and implementation. This document assists in providing an overview of
surveillance and risk, and much of the intervention work is already being undertaken in Suffolk. However, there needs to be continued efforts to coordinate and evaluate the effectiveness in relation to the interventions in place.

References


139. Norfolk and Suffolk Constabularies. Domestic Abuse MOBILE - Suffolk Data Set (Internal Email). 2018.


Acronyms

A&E: Accident and Emergency
ACE: Adverse Childhood Experiences
ADHD: Attention Deficit Hyperactivity Disorder
ASPD: Anti-Social Personality Disorder
BAME: Black and Minority Ethnic
CAMHS: Child and Adolescent Mental Health Services
CCE: Child Criminal Exploitation
CCG: Clinical Commissioning Group
CIC: Children in Care
CIN: Children in Need
CLN: County Lines Network
CPP: Child Protection Plan
CSE: Child Sexual Exploitation
CSEW: Crime Survey for England and Wales
CPTED: Crime Prevention Through Environmental Design
DAOS: Domestic Abuse Outreach Service
DAROS: Drug & Alcohol Recovery Outreach Service
DH: Department of Health
DBS: Disclosure and Barring Service
DVA: Domestic Violence and Abuse
DSR: Directly Standardised Rate
EGYV: Ending Gang and Youth Violence
EHC: Education, Health and Care
FGM: Female Genital Mutilation
FNP: Family Nurse Partnership
FPH: Faculty of Public Health
HES: Hospital Episode Statistics
IDVA: Independent Domestic Violence Advice
IMD: Indices of Multiple Deprivation
IPC: Interpersonal Counselling
LA: Local Authority

L&D: Liaison and Diversion
LSOA: Lower-layer Super Output Areas
MAC : Make a Change (Team)
MAOA: Monoamine Oxidase A
MASH: Multi Agency Safeguarding Hub
MAT: Multi Agency Team
MHCLG: Ministry of Housing, Communities & Local Government
Moj : Ministry of Justice
MSG: Most Similar Groups
MST: Multisystemic Therapy
NEET: Not in Education Employment or Training
NICE: National Institute for Health and Care Excellence
NTE: Night-time Economy
OCC : Office of the Children’s Commissioner
ONS: Office for National Statistics
PCC: Police and Crime Commissioner
PFA: Police Force Area
PHE: Public Health England
PRU: Pupil Referral Unit
QoF: Quality and Outcomes Framework
SAC: Safeguarding Adults Collection
SAP: Strategic Action Plan
SCC: Suffolk County Council
SEND: Special Educational Need and Disability
SNT: Safer Neighbourhood Team
SSA: Statutory School Age
SUG: Sustained Action Group
SYJS: Suffolk Youth Justice Service
TAC: Tactical Action Plan
TBI: Traumatic Brain Injury
Appendices

Appendix 1:

Schematic overview of risks to mental health over the lifecourse, violence highlighted

Source: adapted from (227–230)
Appendix 2:

A peer group: “a relatively small, unorganised and transient group composed of peers who share the same space and a common history. Involvement in crime will be mostly non-serious in nature and not integral to the identity of the group” (231,232)

Youth violence: community/public space violence committed by young people under the age of 25 (187). Youth violence can take many forms including bullying, gang violence, sexual aggression, and assaults occurring in streets, bars and nightclubs (64).

Gang:
“A gang is ‘a relatively durable, predominantly street-based group of young people who:

- See themselves (and are seen by others) as a discernible group
- Engage in criminal activity and violence

and may:

- Lay claim over territory (this is not necessarily geographical territory but can include an illegal economy territory)
- Have some form of identifying structural feature
- Be in conflict with other, similar gangs” (187).

Violence is an inherent part of gang culture, with gang members at increased risk of involvement in violence as both perpetrators and victims (31).

There are a number of risk factors associated with gang involvement and youth violence, these are outlined in the table below. The Home Office and Early Intervention Foundation note that risk factors relating to past behaviour tend to be stronger predictors than explanatory risk factors, i.e. factors that may be associated with or “cause” behaviour (187). They also note that researchers who have considered risk/protective factors often group their findings into five different domains (187):

1. **Family** - Family-specific factors are particularly important amongst the younger age groups, but their importance appears to diminish as people grow older
2. **Individual** - Across the age groups 7-9, 10-12, 13-15 and 16-25 factors relating to individuals are found to be the most powerful risk factors.
3. **School** - School and community factors both relate strongly to children aged 10-12.
4. **Peer group** - Family and peer group factors are not found to be as strongly associated with gang membership as individual factors.
5. **Community** - Community-specific factors, while often included in studies of youth violence, are not identified as strong risk factors. However, it should be noted that community factors may influence individual, family, peer and school factors.

They also assert that:

- Based on existing evidence, some risk factors are age specific and their importance will change over time.
- The time periods over the life course in which people will be exposed to risk factors will not remain static.
- The risk factors identified were based on existing research.
- In the UK context there is limited high quality quantitative research into risk/protective factors in relation to gang involvement.
Appendix table 1: Risk factors strongly associated with youth violence and gang involvement*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Strong risk factors for youth violence (age group)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Troublesome (7-9; 10-12)</td>
</tr>
<tr>
<td></td>
<td>High daring (10-12)</td>
</tr>
<tr>
<td></td>
<td>Positive attitude towards delinquency (10-12)</td>
</tr>
<tr>
<td></td>
<td>Previously committed offences (7-9)</td>
</tr>
<tr>
<td></td>
<td>Involved in anti-social behaviour (10-12)</td>
</tr>
<tr>
<td></td>
<td>Substance use (7-9)</td>
</tr>
<tr>
<td></td>
<td>Aggression (7-9)</td>
</tr>
<tr>
<td></td>
<td>Running away and truancy (7-9; 10-12; 13-15; 16-25)</td>
</tr>
<tr>
<td></td>
<td>Gang membership (13-15; 16-25)</td>
</tr>
<tr>
<td></td>
<td>Low self-esteem (13-15)</td>
</tr>
<tr>
<td></td>
<td>High psychopathic features (13-15)</td>
</tr>
<tr>
<td>Family</td>
<td>Disrupted family (7-9; 10-12; 13-15)</td>
</tr>
<tr>
<td></td>
<td>Poor supervision (10-12)</td>
</tr>
<tr>
<td>School</td>
<td>Low commitment to school (13-15)</td>
</tr>
<tr>
<td>Peer group</td>
<td>Delinquent peers (7-9; 10-12; 13-15)</td>
</tr>
<tr>
<td>Community</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strong risk factors for gang involvement (age group)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana use (10-12)</td>
</tr>
<tr>
<td>Displaced aggression traits (13-15)</td>
</tr>
<tr>
<td>Anger traits (13-15)</td>
</tr>
<tr>
<td>Aggression traits (13-15)</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Low academic achievement in primary school (10-12)</td>
</tr>
<tr>
<td>Learning disability (10-12)</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Marijuana availability (10-12)</td>
</tr>
<tr>
<td>Neighbourhood youth in trouble (10-12)</td>
</tr>
</tbody>
</table>

Source: (187)* Note please see original document for references in brackets in the table above

Appendix table 2: Protective factors for youth violence

<table>
<thead>
<tr>
<th>Domain</th>
<th>Protective factors for youth violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Belief in the moral order</td>
</tr>
<tr>
<td></td>
<td>Positive/prosocial attitudes</td>
</tr>
<tr>
<td></td>
<td>Low impulsivity</td>
</tr>
<tr>
<td>Family</td>
<td>Good family management</td>
</tr>
<tr>
<td></td>
<td>Stable family structure</td>
</tr>
<tr>
<td></td>
<td>Infrequent parent–child conflict</td>
</tr>
<tr>
<td>School</td>
<td>High academic achievement</td>
</tr>
<tr>
<td>Peer</td>
<td>None</td>
</tr>
<tr>
<td>Community</td>
<td>Low economic deprivation</td>
</tr>
</tbody>
</table>

Source: (187)

In 2012 the Home Office funded Ending Gang and Youth Violence (EGYV) programme was launched (37). The programme aims to support communities and local areas to respond and build resilience against both violence and the exploitation that often comes with it. There are currently 52 areas that the Home Office are working with, and Ipswich joined the programme in 2014.
Risk factors for CLN involvement include:

- **Boys and young men aged between 12-18 years** are the most common group involved although younger children, girls and young women may also be recruited.
- CLN networks deliberately target **children and young people who appear to be easier to exploit** because of existing vulnerabilities or who they believe will escape detection. Those with learning difficulties, mental health and/or substance misuse problems, or those who have experienced family conflict/breakdown or trauma may be at increased risk.
- **Children in care**, in the youth justice system and those not in mainstream education or excluded from school are at increased risk as are those who have older siblings and/or parents or partners who are actively involved or associated with either CLN or USGs or live in communities affected by USG activity.
- **Locations** where groups of vulnerable young people are found such as children’s homes, pupil referral units (PRUs), special education needs provisions and supported lodgings may also be targeted for recruitment.
- A small number of Suffolk young people are in custody. However, there are very few Young Offenders Institutions (YOIs) / Secure Training Centres (STCs), meaning they are **placed far from home**, and at risk of exposure to CLN and/or USG members from other gang affected areas. This can increase their risk of involvement on release.
- Children and young people from other areas who are already gang involved are sometimes placed in Suffolk by their home local authority. This can be because they are at risk in their home area, as part of a **gang exit strategy** or as a way of managing their risky behaviour. They may remain engaged or resume in the behaviour that led to them being placed out of their home area in the first place.
- **Immigrant populations** may also be at risk due to previous exposure to violence, high levels of deprivation and being socially isolated.
- In some cases, children with **no obvious vulnerabilities** and no previous criminal or anti-social involvement will be targeted as they are considered less likely to attract the attention of authorities. They are sometimes known as ‘clean’.

Source: (33)

Additionally, the Suffolk document ‘Safeguarding children and young people at risk of county lines or gang involvement’ (33) produced in Suffolk in July 2018, contains a warning signs check list that can be used to alert professionals to the fact that a child or young person may be involved or becoming involved. The check list can support decision making and indicate where a further assessment is required. It does not replace the need for professional judgement or full assessment in any individual case.
Approach: Not responding to child criminal exploitation (CCE) as a safeguarding concern can put up barriers. Children and young people may have shared their story many times with professionals and be unwilling to do so again. Workers and agencies not being positive, consistent and persistent may also be a barrier.

Reprisals: Children and young people are unlikely to report gang related crime committed against them including sexual violence. They may fear retaliation against them or their families and have a lack of confidence in the authorities’ ability to protect them.

Control by others: Individuals may also be guided by ‘elders’ as to what they should say and how they should say it or present to agencies with unrelated adults whose role is to ensure they do not disclose what is happening to them. There is some evidence that young people involved in CLN have been coached on what to say if they are picked up by the police for example making ‘no comment’ interviews.

Consequences for them: Individuals may be fearful about what will happen to them if they do disclose for example getting into trouble with the police or breaching a court order.

Mistrust of services: Children and young people with a history of trauma including previous abuse may be mistrustful of adults and services.

Shame: Individuals may be ashamed or embarrassed by what they have done.

Perceptions: Individuals may not see themselves as exploited. On the contrary they may feel a sense of loyalty to those who are exploiting them. They may believe that the CLN or USG is looking after and supporting them. They may also see themselves as an autonomous drug dealer.

Money and status: The child or young person may have money or rewards that they have not had before. They may feel they have status and power.

Structural inequalities: Such as race, gender, ethnicity, class, culture and education can also be barriers to getting help.

Source: (33)

Appendix 4

Principles of a multi-agency response

The following **principles** should underpin a multi-agency response to the exploitation of children and young people by Urban Street Gangs (USGs) and County Lines Networks:

- The safety and welfare of the child or young person is paramount.
- Exploitation of children and young people by USGs and CLNs is primarily a safeguarding issue and the response of agencies should reflect this.
- Children and young people who become affiliated or involved with gang or CLN activity are at risk of physical violence, sexual violence, emotional harm and reduced life chances.
- Children and young people do not make informed choices to enter or remain in a gang or linked with a CLN but do so because of coercion, enticement, manipulation, lack of maturity and/or violence.
- Children and young people who are harmed and who harm others should have their safeguarding needs assessed.
All organisations should ensure that they:

- Are aware of the risk factors that mean an individual child or young person, a group or location or adult are more at risk of involvement in USG and CLN.
- Recognise the warning signs that a child or young person or adult is involved or becoming involved with CLN or USG.
- Be aware of the barriers to disclosing and getting help and work with children and young people in a way which will overcome the.
- Share information and intelligence when appropriate in a timely manner.
- Train and support staff to intervene effectively with children, young people and adults involved with CLN or USG in line with their specific remit.
- Act on serious concerns they have identified and know how to and where to refer a child or young people assessed as at significant risk.
- Work collaboratively with other agencies and professionals.

Information sharing

Professionals in all agencies need to be confident and competent in sharing information appropriately to safeguard children and vulnerable adults at risk of harm through gang activity and/or serious youth violence. An information sharing protocol is currently being developed and a link will be added when it is completed. All agencies are empowered to share information without permission for the purpose of crime prevention under section 115 of the Crime and Disorder Act 1998, although obtaining consent is good practice.

What is the vision?

- To end the impact from Urban Street Gangs and County Lines dominated drug markets in Ipswich and Suffolk communities, prevent exploitation of the young and vulnerable, anti-social behaviour, associated violence and weapons crime.
- Enhance community safety, by making Ipswich and Suffolk a less viable County Lines drugs market, and disrupt Ipswich based Urban Street Gang criminality and harm.
- Safeguard children, young and vulnerable persons from being exploited by urban street gangs and county lines crime and prevent the grooming of new victims.
- Supporting developing local community solutions, promoting collaborative working and community resilience.
- Improve understanding of high harm (heroin and crack cocaine) and gang influenced drug markets in Ipswich and Suffolk and reduce the risks to dependent users and the community.
- Develop and maintain a collaborative response to achieving the tactical outcomes of the Strategic Action Plan in Ipswich and with external partners.

Current Activity

- Tactical Action Plans are being developed in East & West Suffolk.
- Joint communications and community engagement planned and underway, with lead managers for each of the priorities.
- A gangs and County Lines coordinator will be appointed to coordinate a dedicated multi-agency team.
- A Police Youth Gang Prevention Unit & wider Police pro-active enforcement is continuing under Operation Velocity.[33](http://www.suffolkscb.org.uk/assets/Safeguarding-Topics/Gangs/Velocity-Leaflet-County-Lines-Briefing-for-Partners.pdf)
- Suffolk Public Sector Leaders have committed £500K over 2 years to support this work to supplement the resources we have already pledged for Ipswich aimed at tackling the issues of Urban Street Gangs and County Lines.
For a 4 month period detached youth engagement work is being delivered in the IP1 & IP3 areas of Ipswich. The team are engaging with young people in the communities during the evenings between 5-8pm & liaising with local partners.

Alterego Theatre Company are delivering a 2 week tour in October of their County Lines play ‘Out in the Counties’ across Ipswich schools. The focus is years 8 & 9. For more information about the film & producers www.alteregocreativesolutions.co.uk/countylinesoitc

The St. Giles Trust SOS STOP training for partners working in Ipswich is still on going and continues to be very popular. This multi-agency training programme designed & delivered by Junior Smart, explores the complexity of serious violence, gangs & exploitation. Bookings via Eventbrite www.eventbrite.co.uk search IPSWICH PARTNERS ONLY

The County Lines film directed & produced by Henry Blake is returning to Ipswich 12th September for a further 3 screenings / Q&A’s. Bookings via Eventbrite www.eventbrite.co.uk search IPSWICH PARTNERS ONLY

Gangs and County Lines: Train the trainer sessions have been delivered by Youth Offending & Make A Change teams. Future sessions are being organised and will be available via www.suffolkcpd.co.uk

Suffolk County Council are working with schools, partners and local communities to identify training needs, identify gaps and support local solutions.

As part of the coordinated response, six half day practitioner sessions are taking place across the county in October 2018, covering the developing trends and threats from County Lines and or urban street gangs.

Data collection and information
As part of the work to develop better data and intelligence, considerable thought has been given to regular performance reporting and the development of a performance framework for the SAP and TAP. In the short term, all data that is available that relates specifically to the actions within the SAP and TAP have been pulled together to populate the performance report with several caveats that detail how the data and reporting can be improved in the future, which will lead to a more robust understanding of ‘direction of travel’.

In the medium term it is hoped the datasets can be expanded to include key findings about wider vulnerability and the identification of individuals ‘upstream’ for preventative work. Performance will also be reported to the leadership team by the Multi Agency Team when the team is up and running in late 2018 specifically around the cohort of individuals they are working with or are aware of within the community.