Violence Prevention

Executive summary

Introduction

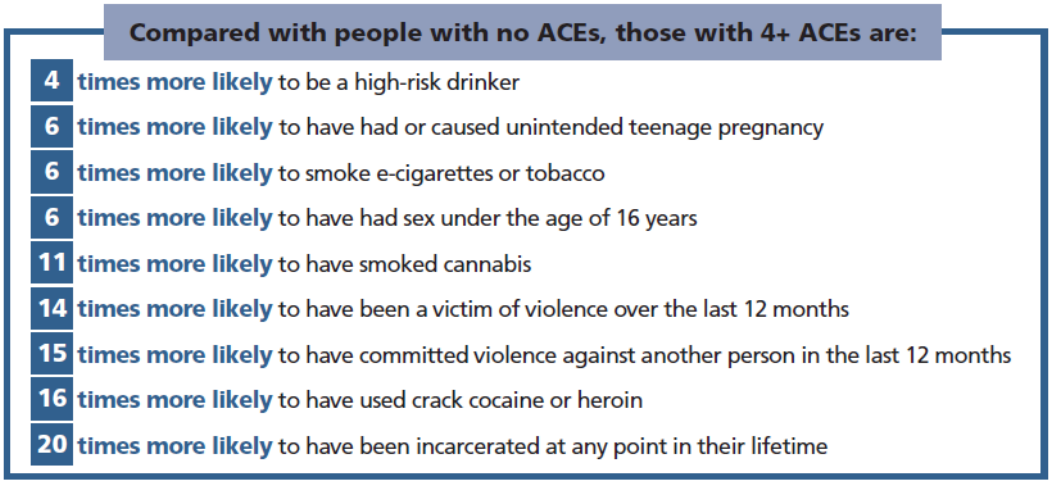
Violence is a major public health issue that is linked with significant costs to health and social care as well as lost output associated with absence from work. Amongst victims, it is linked with an increased risk of health-damaging lifestyle behaviours such as smoking, alcohol and drug abuse. Violent crime can range from minor assaults (such as pushing and shoving), harassment and abuse (that result in no physical harm) through to wounding and homicide. It also includes sexual offences such as rape and sexual assault (Office for National Statistics, 2018).

The Serious Violence Strategy (Home Office, 2018) reports increases in some types of violent crime such as knife crime, gun crime and homicide at a national level since late 2014. It emphasises the importance of partnerships across different sectors such as education, health, housing and social services. In Derby, there were 20.3 violent offences per 1,000 population (n=5,190) in 2017/18. This needs analysis considers violence in its widest sense, and includes domestic violence, hospital admissions for violence and anti-social behaviour.

Research demonstrates that there is a clear link between childhood adversity and victimisation and criminality in adulthood. The evidence suggests that by targeting those most at risk of experiencing adversity in childhood and supporting people in the criminal justice system who have been affected by adverse childhood experiences, agencies can reduce re-offending and prevent intergenerational crime and victimisation (Scottish Government, 2012).

Unmet need and gaps

Reports suggest that 67% of the population have at least one adverse childhood experience (ACE). Those who experience 4 or more adverse childhood experiences are at a significantly greater risk of the following (Bellis et al 2012):



Local Council services are not designed to address violent crime per se but do seek to address the wider health and social inequalities experienced as a result of childhood adversity.

The Public Health nursing service delivers universal services to all children in the city aged 0 – 19 years alongside early intervention children's social care services. These are ideally placed to identify children and families deemed to be at risk. Schools and exclusion units have a key role in identifying children experiencing trauma within the family home.

Children and adult safeguarding services are designed to adopt a multi-disciplinary approach to sharing risk information. They aim to bring together the key partners required to protect children and adults from harm.

Specialist Public Health services are also ideally placed to identify at-risk adults who access these services. Illicit drug use, problematic alcohol use and/or risky sexual behaviour in adulthood are often symptomatic of childhood trauma.

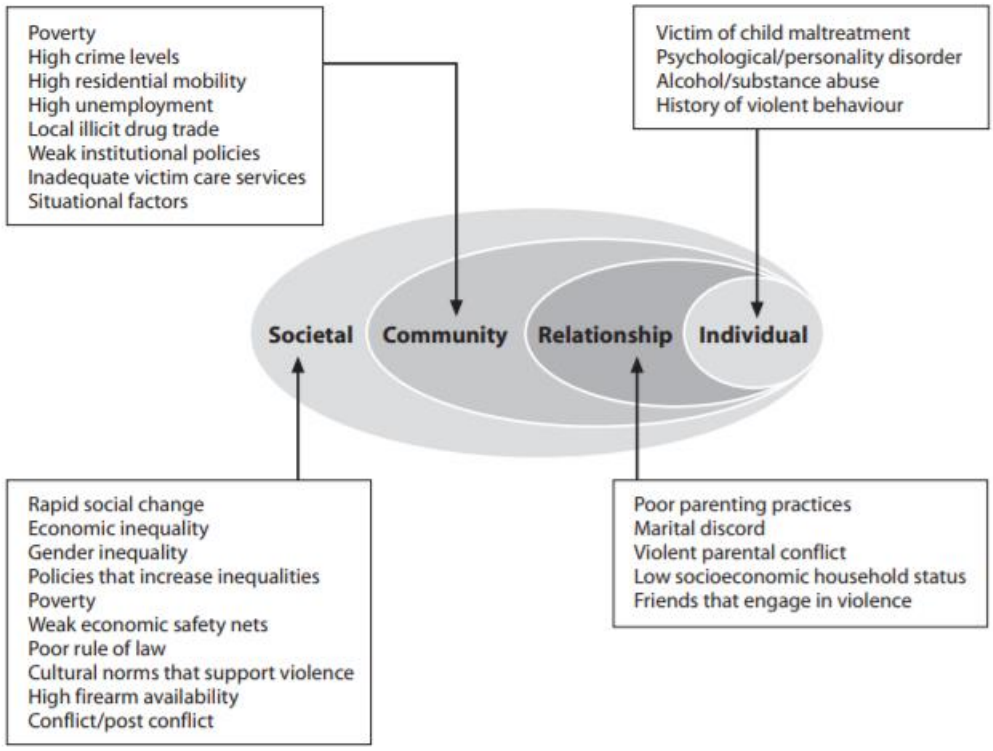
What do we know?

1) Who is at risk and why?

The World Health Organization (2004) propose an ecological model in which the risk factors for violence are interrelated at the individual, relationship, community and societal level. For example, drug use is linked with both an increased risk of perpetrating and being a victim of violence. At a community level, violence has a strong inequalities gradient in which poverty is positively correlated with its incidence. National data suggests that emergency hospital admission rates for violence are approximately five times higher amongst the most deprived communities than the most affluent (Bellis et al. 2011). This will undoubtedly have a lasting impact on a range of health, social and economic outcomes. These include poor school achievement, substance abuse and reduced economic prospects (Department of Health and Social Care, 2012).

Figure 1 illustrates the shared risk factors across different types of interpersonal violence.

Figure 1: Ecological model of the shared risk factors for interpersonal violence



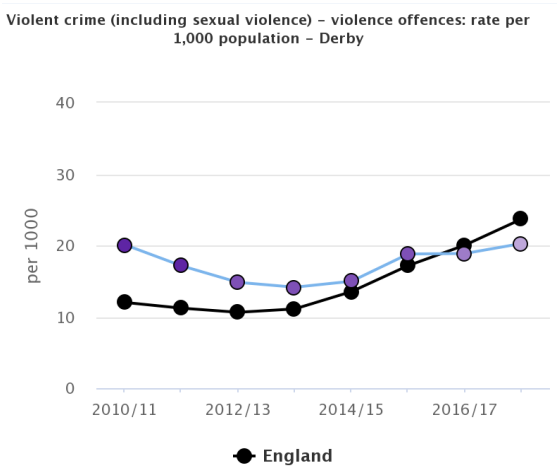
Specific risk factors for domestic and sexual violence include being female, of a younger age and childhood abuse (amongst perpetrators and victims). Other sub-groups that are at an increased risk of abuse include disabled children and adults, and older people. Abuse of the latter may be exacerbated by carer burnout, social isolation and high levels of dependence (Department of Health and Social Care, 2012).

2) Size of the issue locally

In 2017/18, the estimated cost of violent crime to Derby city was approximately £224,719,567.00 (Derby city council, 2018). The information below is extracted from the Public Health England fingertips profiles (2019).

In 2017/18, there were 5,190 violent offences in the local population, which equates to a rate of 20.3 per 1,000. This is significantly lower than the national average, but significantly higher than the regional average. Recent trends indicate that this has increased since 2013/14.

Figure 2: Crude rate of violence against the person (including sexual violence) offences per 1,000 population

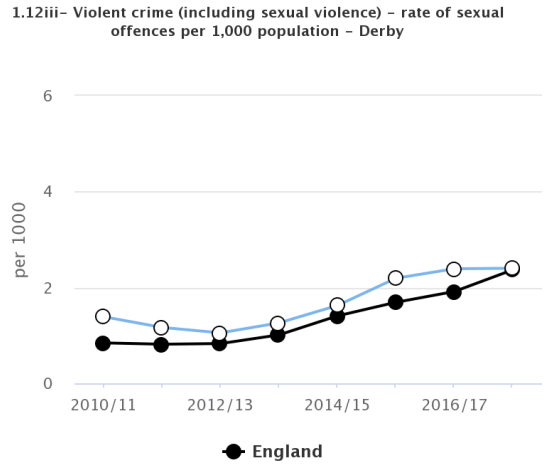


Period		Count	Value	Lower CI	Upper CI	East Midlands	England
2010/11		4,904	20.1	19.5	20.7	11.9	12.0
2011/12		4,235	17.1	16.6	17.7	11.3	11.2
2012/13		3,689	14.8	14.3	15.3	10.4	10.6
2013/14		3,545	14.1	13.7	14.6	10.2	11.1
2014/15		3,763	15.0	14.5	15.5	11.9	13.5
2015/16		4,742	18.8	18.3	19.3	13.6	17.2
2016/17		4,791	18.9	18.3	19.4	15.6	20.0
2017/18		5,190	20.3	19.7	20.8	18.2	23.7

Source: Figures calculated by PHE Knowledge and Intelligence Team (North West) using crime data supplied by the Home Office and population data supplied by Office for National Statistics (ONS).

There has been a gradual increase in the rate of recorded sexual offences since 2012/13. In 2017/18, there were 2.4 per 1,000 (n=615) recorded sexual offences in Derby. Figure 3 suggests that this has gradually increased since 2012/13:

Figure 3: Crude rate of sexual offences per 1,000 population

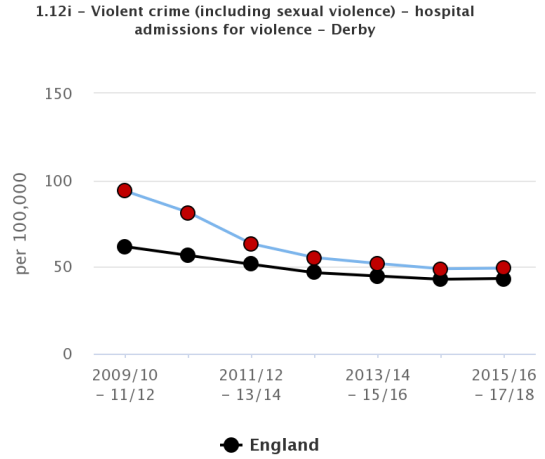


Period		Count	Value	Lower CI	Upper CI	East Midlands	England
2010/11	○	339	1.4	1.2	1.5	0.9	0.8
2011/12	○	288	1.2	1.0	1.3	0.8	0.8
2012/13	○	262	1.1	0.9	1.2	0.8	0.8
2013/14	○	316	1.3	1.1	1.4	0.9	1.0
2014/15	○	408	1.6	1.5	1.8	1.3	1.4
2015/16	○	553	2.2	2.0	2.4	1.6	1.7
2016/17	○	607	2.4	2.2	2.6	1.8	1.9
2017/18	○	615	2.4	2.2	2.6	2.1	2.4

Source: Figures calculated by PHE Knowledge and Intelligence Team (North West) using crime data supplied by the Home Office and population data supplied by Office for National Statistics (ONS).

The local rate of hospital admissions for violence remains significantly higher than the national and regional average, although this has steadily reduced in recent years.

Figure 4: Age-standardised rate of emergency hospital admissions for violence per 100,000 population

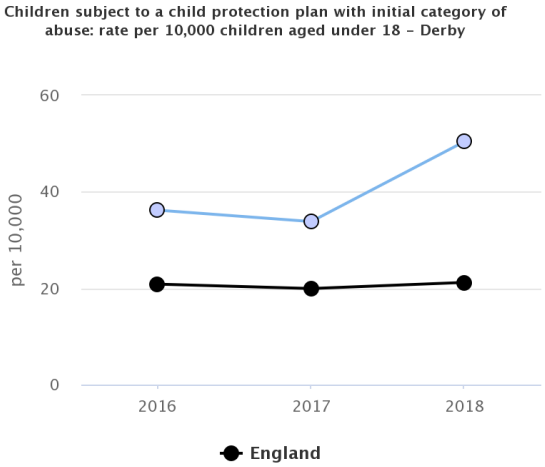


Period		Count	Value	Lower CI	Upper CI	East Midlands	England
2009/10 - 11/12	●	764	93.8	87.2	100.8	53.5	61.7
2010/11 - 12/13	●	668	81.5	75.3	88.0	47.0	56.7
2011/12 - 13/14	●	521	63.4	58.0	69.1	40.5	51.5
2012/13 - 14/15	●	456	55.4	50.4	60.8	36.9	46.7
2013/14 - 15/16	●	430	52.0	47.1	57.2	36.4	44.8
2014/15 - 16/17	●	399	49.0	44.2	54.1	35.8*	42.9
2015/16 - 17/18	●	399	49.3	44.5	54.5	36.7*	43.4

Source: Hospital Episode Statistics (HES), Health and Social Care Information Centre for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2019, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

In Derby, 50.4 per 10,000 children were the subject of a child protection plan with an initial category of abuse (n=301). Figure 5 indicates that this has recently increased, although this may be due to an improvement in data capture.

Figure 5: Rate per 10,000 children subject to a child protection plan with initial category of abuse



Period		Count	Value	Lower CI	Upper CI	East Midlands	England
2016		213	36.2	36.1	36.3	23.7	20.8
2017		201	33.8*	29.3	38.9	22.4	19.9
2018		301	50.4	44.9	56.5	23.7	21.2

Source: Children in need statistics https://www.gov.uk/government/collections/statistics-children-in-need

Between April 2018 – September 2018, 278 domestic violence referrals were received by the Derby city Adult Safeguarding team (Derby city council, 2018). In the same period of the previous year, 254 referrals were received, which reveals an increase of 9.5%. Local data indicates that the majority of service users referred into the team were female (92.8% in 2017/18 and 90.3% between April 2018 and September 2018).

3) Current activity, service provision and assets

In Derby City Council, Public Health is responsible for commissioning a range of community interventions that provide support and thus reduce the likelihood of violence. Services such as substance misuse treatment, school nursing and health visitors, sexual health and behaviour change provide effective evidence based interventions that protect individuals and their families from harm. These interventions: 1) support parents and families, 2) develop life skills in children and 3) involve work with vulnerable individuals to reduce the harms caused by drugs and alcohol misuse. These contribute towards reductions in crime, social inequality and health harming behaviours.

Within the Derby treatment service, certain groups of women who have experienced 4 or more ACEs (adverse childhood experiences) have been identified as being at a higher risk of early death. Other risk factors include domestic violence, criminal behaviours linked to temper control, escalation in substance misuse and a loss of accommodation which is compounded by removal of children from their care. Interventions such as Pause involve working alongside vulnerable women in order to prevent the consequences of children being taken into care. An independent evaluation carried out by McCracken et al. (2017) showed that for each £1 spent on the programme, £1.38 was saved by children's services departments alone. Furthermore, reductions in the number and severity of incidents of domestic violence are linked with an average saving of between £350 and £1,180 per woman on the Pause programme per year.

The 'Cardiff' data collection model has been fully embedded within Royal Derby Hospital data systems for over 5 years. The data recorded identifies the correlation between the

evening and night time economy and alcohol related attendances for assaults. This tends to demonstrate a peak in incidents occurring between the early hours of Saturday morning and late on Sunday evening. The Street Pastors also operate within the night time economy, ensuring that revellers, some of whom may have been assaulted, receive the appropriate level of health care. Street Pastors often place those who are vulnerable in taxis to ensure that they get home safely. Recently, work has begun to capture these instances as these, in addition to the hospital's records, are often not reported to the Police. The hospital systems also contain ISTV (information sharing to tackle violence) data, which records health attendances as a result of violence that are not necessarily linked to alcohol. Further work is required to embed this new mechanism for data capture within the wider hospital system.

The Partnership Engagement and Enforcement Programme (PEEP) is underpinned by a collaboration of support and enforcement agencies. A dedicated co-ordinator addresses 'street culture' activities that are driven by illicit drug use in and around the city centre. One of the key identifiers for PEEP intervention is aggressive and anti-social behaviour that is likely to cause others alarm or distress. The propensity for violence whilst under the influence of drugs or alcohol is also increased. PEEP has provided support to over 58 individuals to access treatment for drugs and alcohol and offers of accommodation since June 2017. Those who persistently refuse these offers of support and continue to commit crime or anti-social behaviour are managed through the use of appropriate enforcement tools.

There is some scope to ensure that 'routine enquiry' is commonly adopted by the existing Public Health commissioned services. The outcome of the routine enquiry may lead to an assessment of adverse childhood experiences. The subsequent delivery of strengths and/or resilience building programmes would enhance the delivery of existing and currently commissioned interventions.

Operation Encompass involves an information sharing partnership between the police and schools to ensure that children who experience or witness domestic abuse receive immediate support. It is currently being rolled out in Derby, and should ensure that children receive enhanced safeguarding against the effects of domestic abuse.

4) Evidence of what works

The Home Office (2018) advocate the use of universal and targeted interventions to prevent people from becoming involved in serious violent offences. They define universal interventions as those that build resilience, critical thinking and life skills in young people. These would involve supporting positive choices, improving critical thinking skills and providing healthy, stable and supportive frameworks in the home or school. An example of this is the National Citizen Service (NCS), which is available to all young people aged 16-17. The NCS provides residential activities and the chance to lead a social action programme and build skills and confidence. Targeted interventions are broken down into the following:

1. Targeted selective and
2. Targeted indicated interventions

Targeted selective interventions build resilience and support for young people who may be at risk of being drawn into crime. Targeted indicated interventions are designed for those at the greatest risk of criminal involvement or who may have already been involved in crime. These may incorporate a 'teachable moment' when the young person is most willing to listen and engage.

A range of different interventions throughout the life course can reduce an individual's risk of becoming violent, lower the chance of those involved becoming involved again and ensure that those affected receive the support that they need. For example, home visiting programmes provide intensive early years support for vulnerable parents whose children are at risk of poorer outcomes. There is evidence that these can lead to improved parenting practices, maternal mental health and reduced child maltreatment (Department of Health and Social Care, 2012).

Programmes that develop life skills in children and young people can protect them from violence by enhancing their social and emotional abilities, and teaching conflict-avoidance skills. For example, social development programmes (usually delivered in schools) help children to form positive relationships by developing children's social skills.

Work with high risk youth and gangs is crucial in preventing future violence. Strategies that have proven to be effective include talking therapies, family therapies and gang focused strategies. Evidence in the US suggests that a multi-agency approach to gang strategies can reduce violence, including homicides.

Since alcohol consumption is strongly associated with violence, local measures should focus on reducing the availability and harmful use of alcohol. The Cardiff model is an approach to violence prevention in which data from hospitals is shared with the police and local authorities. Receptionists at Emergency Departments record the location and weapon used from people injured in violence. This information is anonymised and combined with police data to inform violence prevention strategy and tactics. Florence et al. (2013) conducted a cost-benefit analysis of a partnership between health services, police and local government in Cardiff. The authors concluded that effective information sharing between these organisations led to significant cost savings for the health service and criminal justice system compared with 14 similar cities where the intervention was not implemented in England and Wales. The cumulative social cost-benefit ratio of the programme from 2003 to 2007 was £82 in benefits for each pound spent on the programme.

Robust evidence of the impact and effectiveness of strengths-based approaches is still emerging, although some models have a longer history and more established evidence base than others, e.g. ABCD and Local Area Coordination.

The evidence base surrounding 'routine enquiry' in respect of ACE is still emerging. In 2013/14, Lancashire Care NHS Foundation Trust developed a training programme on Routine Enquiry about Adversity in Childhood (REACh) (cited in Quigg, Wallis and Butler, 2018). The evaluation identified that broader approaches such as training and support were required to ensure that services and practitioners were ACE-informed.

What does this tell us?

5) Unmet needs and service gaps

The Public Health team gather data to support colleagues in the Police and Licensing Team to ensure that alcohol related violence is managed within the night time economy. Similarly, the commissioned substance misuse services deploy resources to support a partnership approach to reducing street culture activities in the city centre and so are contributing towards keeping the city safe.

6) Knowledge gaps

Note and prioritise gaps in the information available in the area covered by the chapter.

Where possible identify clear tasks to be undertaken in order to improve the quality of needs analysis in future JSNAs.

What should we do next?

7) Recommendations for consideration by commissioners

An ACE strategy will be developed. This will focus upon 3 key themes:

1. Prevention
2. Intervention
3. System Leadership

1. Prevention

The aim of the prevention theme will be:

To reduce the impact of childhood trauma experienced by those individuals accessing or working within Public Health commissioned services

How will we do this?

1. By embedding a culture of 'routine enquiry' into Public Health commissioned services through modification of existing contracts.
2. By piloting a trauma informed assessment in the substance misuse treatment service for a group of 'women at risk' and other high risk groups.
3. By commissioning staff training that integrates knowledge of trauma, resilience and recovery.
4. By supporting staff with self-care and preventing vicarious trauma, promoting positive role modelling and relationship building.
5. To engage staff in identifying best practices and articulating the values and principles of ACE-informed programmes.

2. Intervention

The aim of the intervention theme will be to:

Deliver existing evidence based or best practice interventions with the aim of preventing violence and building resilience amongst those affected by ACE's

How will we do this?

1. Transforming - and where relevant commissioning new services that have resilience and strengths based programmes as part of core service delivery.
2. Evaluate the assessment pilot (women at risk) in order to better understand the needs of the substance misusing population.
3. Understand the local impact of ACE in order to better inform local services.
4. Work with key partners such as Derby Homes, Pause and Probation to maximise the efficacy of the intervention delivered.
5. Commission high return evidence based programmes that are designed to reduce violence in primary school age children.

3. System Leadership

The aim of the system leadership theme will be to:

Embed a culture of trauma informed practice and routine enquiry across the Public Health Services that can influence and serve as an evidence base for larger public sector organisations.

How will we do this?

1. To provide system leadership in respective Public Health Commissioned Services in developing trauma informed services that are ACE inspired.
2. Advocate for policies and funding streams to support comprehensive ACE approaches.
3. Establish and showcase best practice in relation to trauma informed approaches.
4. Attempt to develop a methodology to determine the impact of system-wide trauma informed approaches.

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