



Department  
for Education

# **Children in need census**

**Additional guide on the factors identified  
at the end of assessment**

**November 2019**

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## **The purpose of collecting the factors identified at the end of assessment data**

The effective assessment of an individual child's needs is a process requiring the skills, knowledge and professional judgement of practitioners. This is in order to ascertain the child's needs, the parent's ability to meet those needs, and the impact of wider family and environmental factors.

Recording this data after assessment means that the professional skills taken to complete the assessment can be utilised to record findings, from the assessment, systematically in a manner which facilitates analysis and service planning based on the social worker's understanding. For example, the prevalence of domestic violence and substance misuse has an impact on the services (including multi-agency services) needed. It can also be used to gain an understanding of the impact of services over time for example by looking at what happens to children where there are these factors present and by looking at trends of prevalence. It means that information informed by professional skills about the needs of children can then inform other process such as the joint strategic needs assessment and the work of the local safeguarding children board and health and wellbeing board.

## The process of selecting this data

The [Children's Safeguarding Performance Information Framework \(CSPIF\)](#) is a development of the performance information table included in Professor Eileen Munro's final report. The CSPIF was published 12 June 2012, following a full public consultation, and agreement by the Department for Education's Star Chamber Scrutiny Board for new data to be collected.

For many children assessed following a referral or whose families seek help, the issues of concern may be relatively straightforward, parents will be clear about requiring assistance and the impact on the child will not be difficult to identify. For a smaller number of children, the causes for concern will be serious and complex and the relationship between their needs, their parents' responses and the circumstances in which they are living, less straightforward.

The framework for assessment is a conceptual map which describes that assessment should take account of the three domains:

- the child's developmental needs
- the parents' or caregivers' capacities to respond appropriately
- the wider family and environmental factors

While it is in no way exhaustive we have included the key things which have been suggested in terms of facilitating service planning and that would become evident through the assessment process. This is in terms of an analysis of the needs of the child and parenting capacity within their family and community context as a basis for formulating a plan for the child.

We have included key factors which affect the child's health and development and are factors which mean the child may be at risk of harm. The needs of the parents and carers are an integral part of assessment. Providing services which meet the needs of the parents or carers is often the most effective means of promoting the welfare of children. We have also included key issues which research has shown affects parents' ability to respond appropriately to the child's needs in terms of the ability to nurture their children, protect them from risk and support their development<sup>1</sup>. In addition, we have included some environmental and family factors which play a role in reducing or increasing the stresses on families, depending on the support available to them.

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<sup>1</sup> Cleaver, H., Unell, I. and Aldgate, J. (2011) Children's Needs – Parenting Capacity. Child Abuse: Parental Mental Illness, Learning Disability, Substance Misuse and Domestic Violence. 2nd edition. London: The Stationery Office.

## Changes made to published annex in the CSPIF

Changes have been made to the annex published in the CSPIF in 2012 as a result of development work around the collection of the data.

1. Child welfare and child development concerns have both been removed as a category. Feedback was that it would be relevant in most cases where following referral an assessment was found necessary so it would be less useful data in terms of what it would tell us.
2. Criminal behaviour is now included within socially unacceptable behaviour
3. Feedback from the groups was that capturing the following data would be useful in terms of planning and commissioning services:
  - learning disability of the child, parent or another person living in the household
  - the child's involvement with gangs
  - child sexual exploitation
  - risks related to cultural beliefs (this has not been included at this stage due to probably small numbers but we will keep this under review)
  - children who are unaccompanied asylum seekers, young carers and privately fostered children. The Department used to collect data on numbers of young carers and privately fostered children who were also children in need but these items were removed from the CIN census due to the burden of collection. Feedback was that collecting the data in the way outlined i.e. following an assessment would not create such a burden.
  - to reduce the number of items recorded accommodation/low income has been removed although low income remains a primary needs code.

We have included a 'no factors identified category' although in practice it is unlikely that no factors would be identified though an assessment. **We would only expect this category to be used in cases which were closed following assessment where it was determined the child was not in need.**

## Definitions and research evidence

Our knowledge and understanding of children's welfare – and how to respond in the best interests of a child to concerns – develops over time, informed by research, experience and the critical scrutiny of practice. Sound professional practice involves making judgements supported by evidence: evidence derived from research and experience about the nature and impact of maltreatment, and when and how to intervene to improve outcomes for children; and evidence derived from a thorough assessment of a specific child's health, development and welfare, and his or her family circumstances.

This document covers a definition of the factors described and why these data are important to understand in order to improve practice and ultimately outcomes for children.

## Definition of alcohol misuse (code 1A-1C)

There are three main types of alcohol misuse which are defined as:

1. Hazardous drinking – a person drinks over the recommended weekly limit of alcohol (21 units for men, 14 units for women)
2. Harmful drinking – a person drinks over the recommended weekly limit of alcohol and experiences health problems directly related to alcohol such as:
  - Depression
  - Alcohol-related accident, such as head injury
  - Acute pancreatitis
3. Dependent drinking – a person feels they are unable to function without alcohol, and consumption of alcohol becomes an important, sometimes the most important, factor in their life<sup>2</sup>.

Drinking alcohol affects different individuals in different ways. For example, some people may be relatively unaffected by the same amount of alcohol that incapacitates others. The primary concern therefore is not the amount of alcohol consumed, but how it impacts on the individual and, more particularly, on their role as a parent.

## Why is the data important?

### Parenting capacity and alcohol

Parental problem drinking can be associated with violence within the family and the physical abuse of children, but who has the alcohol problem is relevant. Alcohol misuse by a father or father figure can be related to violence and the physical abuse of children, while mothers with an alcohol problem are more likely to neglect their children<sup>3</sup>. The adverse effects of parental alcohol misuse on children are less likely when not associated with violence, family discord, or the disorganisation of the family's day to day living.

### Alcohol and pregnancy

Many of the problems associated with problem alcohol use during pregnancy can be helped by good ante-natal care but pregnant women with alcohol problems may not attend ante-natal care until late in pregnancy because they fear professionals will judge them.

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<sup>2</sup> NHS Choices

<sup>3</sup> Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development*. 2nd Edition. London: The Stationery Office

The effect of drinking on the developing foetus is related to the amount and pattern of alcohol consumed by the mother, and the stage of gestation. The foetus is most vulnerable to damage during the first three months but is at risk throughout pregnancy. Drinking during pregnancy, particularly in the first three months, is associated with an increased rate of miscarriage. Heavy drinking can cause Foetal Alcohol Syndrome (FAS) or Foetal Alcohol Spectrum Disorder. Most mothers with alcohol problems however do give birth to healthy babies. Only approximately 4% of pregnant women who drink heavily give birth to a baby with Foetal Alcohol Spectrum Disorder<sup>4</sup>.

## Alcohol and babies

Once born, babies may be likely to suffer significant harm. When alcohol problems result in parents being pre-occupied with their own feelings and emotions they may fail to notice or respond appropriately to their baby.

Chronic alcohol problems may limit the mother's capacity to engage with and stimulate her baby. A consistent lack of warmth can result in the infant becoming insecurely attached. Supervision is essential to keep the more mobile infant safe from harm, but harmful drinking can affect parents' concentration and lead to a lack of oversight. Chronic drinking may also mean parents fail to recognise when their baby or infant is unwell, or delay seeking medical help for minor injuries if these have resulted from a lack of supervision. The infant's health may also be affected because high levels of alcohol consumption can depress appetite, and parents may fail to respond to their child's need for food. Research suggests parental problem drinking may also impact on the young child's cognitive development.

Babies and infants are more likely to be protected from significant harm when one parent does not have an alcohol problem and is able to respond to the emotional and cognitive needs of the child, there is sufficient income and good physical standards in the home and the parent who is drinking at harmful levels acknowledges their problem and receives treatment<sup>5</sup>.

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<sup>4</sup> Abel, E.L. (1998) 'Fetal Alcohol Syndrome: The American Paradox.' *Alcohol and Alcoholism* 33, 3, 195-201

<sup>5</sup> Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development*. 2nd Edition. London: The Stationery Office

## Alcohol and children

Parental alcohol problems continue to affect the health and development of children during middle childhood. For example, children's health may be endangered because, although alcohol consumption is not common during this period of childhood, maternal drinking increases the likelihood that children aged 10 years will start drinking<sup>6</sup>.

Learning may also be affected. Children of parents with chronic alcohol problems are more likely to experience reading problems, poor concentration and low academic performance<sup>7</sup>. When parents are intoxicated they may not be capable of encouraging the child to learn, or of providing sufficient support with schooling.

Alcohol can make parents behave in inconsistent and unexpected ways, loving and caring at one moment and rejecting and cold at another. This can leave children feeling betrayed, let down, angry, and uncertain that they are loved. Middle year children tend to feel guilty and blame themselves for their parents' drinking; emotions which are compounded when parents deny the problem.

A further possible consequence of parental problem drinking is that children may grow up too quickly, having to look after themselves, younger siblings and their alcoholic parent. It should not be assumed that all children in middle childhood who live with a parent with alcohol problems experience emotional and behavioural difficulties. Older siblings and close relatives can provide children with much needed emotional and practical support. Unfortunately, wider family and friends are often unaware of the family difficulties as a fear of stigma and ridicule may keep all family members silent. There is considerable evidence to suggest that the combination of parental chronic drinking with domestic violence causes a more detrimental impact on children than parental alcohol misuse in isolation<sup>8</sup>.

Research suggests young people aged 11-12 years are more likely to use alcohol, cannabis and tobacco if their parents have an alcohol problem<sup>9</sup>. Young people who start drinking at an early age are at greater risk of poor health and being involved in accidents and accidental injury. The relationship between parental problem drinking and young people's drinking patterns is complex, because observing the devastating effect alcohol

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<sup>6</sup> Macleod, J., Hickman, M., Bowen, E., Alati, R., Tilling, K. and Davey Smith, G. (2008) 'Parental drug use, early adversities, later childhood problems and children's use of tobacco and alcohol at age 10: birth cohort study.' *Addiction* 103, 1731-43.

<sup>7</sup> Cleaver, H., Nicholson, D., Tarr, S. and Cleaver, D. (2007) *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers

<sup>8</sup> Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development*. 2nd Edition. London: The Stationery Office

<sup>9</sup> Li, C., Pentz, A. and Chou, C-P. (2002) 'Parental substance use as a modifier of adolescent substance use risk.' *Addiction* 97, 1537-50.



has on their parents' lives may act as a strong deterrent<sup>10</sup>. Chronic alcohol problems may result in parents putting their own needs above those of their children, leaving teenagers feeling let down, angry and worthless. Teenagers may experience physical neglect when drinking takes precedence and there is not sufficient money for household essentials and clothes. Such neglect may jeopardise friendships or lead to bullying. To keep up appearances some young people may resort to stealing or other illegitimate ways of obtaining money to keep up appearances. Others may seek to escape the difficulties within the home by withdrawing into themselves, using alcohol or drugs, or leaving home altogether<sup>11</sup>. Many young people who leave home will experience homelessness which is associated with poorer mental and physical health and an increased likelihood of substance misuse<sup>12</sup>.

It is important not to assume that all young people will have problems just because they grow up living with a parent who has alcohol problems. The majority outgrow their childhood problems<sup>13</sup>. Research suggests that the following factors can support young people:

- sufficient income and good physical standard in the home
- regular medical and dental checks
- a trusted adult
- a mutual friend
- supportive and harmonious family environment
- regular attendance at school, work-based training or a job<sup>14</sup>

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<sup>10</sup> Velleman, R. and Orford, J. (2001) *Risk and Resilience: Adults who were the children of problem drinkers*. Amsterdam: Harwood Academic Publishers.

<sup>11</sup> Velleman, R. and Orford, J. (2001) *Risk and Resilience: Adults who were the children of problem drinkers*. Amsterdam: Harwood Academic Publishers

<sup>12</sup> Quilgars, D., Johnsen, S. and Pleace, N. (2008) *Youth homelessness in the UK. A decade of progress?* York: Joseph Rowntree Foundation.

<sup>13</sup> Velleman, R. and Orford, J. (2001) *Risk and Resilience: Adults who were the children of problem drinkers*. Amsterdam: Harwood Academic Publishers

<sup>14</sup> Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development*. 2nd Edition. London: The Stationery Office

## Definition of drug misuse (code 2A-2C)

Drug misuse is defined as intoxication by or regular excessive consumption of and/or dependence on psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs (including alcohol when used in combination with other substances)<sup>15</sup>.

## Why is the data important?

### Parenting capacity and drugs

Consideration needs to be given to both the type of drug used and its effects on the individual; the same drug may affect different people in different ways. The situation is further complicated because the same drug may have very different consequences for the individual depending on their current mental state, experience and/or tolerance of the drug, expectations, personality, the environment in which it is taken, the amount used and the way it is consumed.

When parents, or others in the home, stop taking drugs children can be particularly vulnerable. For example, the withdrawal symptoms both physical and psychological may interfere, at least for a while, with parent's capacity to meet the needs of their children. Problematic drug use is likely to continue over time, and although treatment may prolong periods of abstinence or controlled use, for some individuals relapse should be expected. Assumptions about the use or abstinence of drugs should not be based on whether or not parents, or others in the home, are engaged with services for their problem drug use.

Parental problem drug misuse is generally associated with some degree of child neglect and emotional abuse. It can result in parents or carers experiencing difficulty in organising their own and their children's lives, being unable to meet children's needs for safety and basic care, being emotionally unavailable and having difficulty in controlling and disciplining their children<sup>16</sup>.

Problem drug misuse may cause parents to become detached from reality or lose consciousness. When there is no other responsible adult in the home, children are left to fend for themselves. Some problem drug using parents may find it difficult to give priority to the needs of their children. Finding money for drugs may reduce what is available to meet basic needs, or may draw families into criminal activities.

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<sup>15</sup> NICE guidance: Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people, 2007

<sup>16</sup> Hogan, D. and Higgins L. (2001) *When Parents Use Drugs: Key Findings from a Study of Children in the Care of Drug-using Parents*. Dublin: The Children's Research Centre - and - Cleaver, H., Nicholson, D., Tarr, S. and Cleaver, D. (2007) *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.)

Poverty and a need to have easy access to drugs may lead families to live in unsafe communities where children are exposed to harmful anti-social behaviour and environmental dangers such as dirty needles in parks and other public places. At its extreme, parental problem drug misuse can be implicated in the serious injury or death of a child. The study of Serious Case Reviews<sup>17</sup> found that in a third of cases there was a current or past history of parental drug misuse.

Such negative scenarios are not inevitable. A significant proportion of children who live with parents who are problem drug users will show no long term behavioural or emotional disturbance. Some problem drug users ensure their children are looked after, clean and fed, have all their needs met and that drugs are stored safely. A caring partner, spouse or relative who does not use drugs can provide essential support and continuity of care for the child. Other protective factors include drug treatment, wider family and primary health care services providing support, the child's attendance at nursery or day care, sufficient income and good physical standards in the home. Many parents, however, who are problem drug users often base their social activities around the procurement and use of the drug and are isolated and rejected by their communities.

Drug related debts and angry neighbours may result in unplanned moves which disrupt children's schooling, community links and friendships. The safety, health and development of a considerable number of children are adversely affected by parental problem drug misuse and would benefit from services to meet the needs of both children and parents.

## **Children who misuse drugs**

Drug misuse can lead to health risks as the drugs are not controlled or supervised by medical professionals. The predominant risks associated with drug misuse among children and young people are drug-related mental health and behavioural disorders<sup>18</sup>. There are significantly higher levels of drug use among those who belong to more than one vulnerable group (defined as those who have ever been in care, those who have ever been homeless, truants, those excluded from school and serious or frequent offenders).

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<sup>17</sup> Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebottom, P., Dodsworth, J., Warren, C. and Black, J. (2009) *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-7*. London: Department for Children Schools and Families

<sup>18</sup> NICE guidance: Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people, 2007

Substance misuse is associated with significant health risks such as anxiety, memory or cognitive loss, accidental injury, hepatitis, HIV infection, coma and death. It may also lead to an increased risk of sexually transmitted infections<sup>19</sup>.

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<sup>19</sup> NICE guidance: Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people, 2007

## Definition of domestic violence (code 3A-3C)

Domestic Violence has been defined by the Home Office as:

“any incident of threatening behaviour, violence or abuse psychological, physical, sexual, financial or emotional between adults who are or have been intimate partners or family members, regardless of gender or sexuality.”

Note: This definition is under consideration following consultation. The definition is not restricted to behaviour that is inherently violent so some people prefer the term domestic abuse.

The Home Office recommended source of guidance on domestic abuse is '[ACPO: Guidance on Investigating Domestic Abuse](#)'. This guidance provides the police service with detailed information relating to the investigation and policing of domestic abuse cases.

## Why is the data important?

The effect of domestic violence on children should be seen as a child protection issue and professionals should follow the same steps as they would for any other child at risk of harm.

Prolonged and/or regular exposure to domestic violence can have a serious impact on children's safety and welfare, despite the best efforts of parents to protect them. An [analysis of serious case reviews](#) found evidence of domestic violence present in almost two thirds (63%) of cases. Domestic violence rarely exists in isolation. Many parents also misuse drugs or alcohol, experience poor physical and mental ill health and have a history of poor childhood experiences themselves. The co-morbidity of issues compounds the difficulties parents experience in meeting the needs of their children, and increases the likelihood that the child will experience abuse and/or neglect.

Domestic violence has an impact on children in a number of ways. Children are at increased risk of physical injury during an incident, either by accident or because they attempt to intervene. Even when not directly injured, children are greatly distressed by witnessing the physical and emotional suffering of a parent. Children's exposure to parental conflict, even where violence is not present, can lead to serious anxiety and distress. Children can also experience domestic violence through being involved in an abusive relationship or from people other than parents and carers.

Domestic abuse can impact on parenting and caring capacity. A parent (in most families, the mother) may have difficulty in looking after the children when domestic violence results in injuries, or in extreme cases, death. The impact on parenting, however, is often more subtle. Exposure to psychological and emotional abuse has profound negative effects on women's mental health resulting in a loss of confidence, depression, feelings

of degradation, problems with sleep, isolation, and increased use of medication and alcohol. These are all factors that can restrict the mother's capacity to meet the developmental needs of her child. Moreover, belittling and insulting a mother in front of her children undermines not only her respect for herself, but also the authority she needs to parent confidently. A mother's relationship with her children may also be affected because, in attempts to avoid further outbursts of violence, she prioritises her partner's needs over those of her children.

The impact of domestic violence on children increases when directly abused, witnessing the abuse of a parent, or colluding (willingly or otherwise) in the concealment of assaults. Other relevant factors include the chronicity and degree of violence, and its co-existence with other issues such as substance misuse. No age group is particularly protected from or damaged by the impact of domestic violence. Children's ability to cope with parental adversity is related to their age, gender and individual personality. However, regardless of age, support from siblings, wider family, friends, school and community can act as protective factors. Key to the safety of women and children subjected to violence and the threat of violence is an alternative, safe and supportive residence<sup>20</sup>.

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<sup>20</sup> Cleaver, H., Unell, I. and Aldgate, A. (2010) Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition. London: The Stationery Office

## Definition of a mental health disorder (code 4A-4C)

The Mental Health Act 2007 defines mental disorder as any disorder or disability of the mind. This process is broader than mental disorders in capturing where there are concerns about mental health that are not categorised as a disorder or disability.

## Why is the data important?

Poor mental health problems start early and are associated with a broad range of adverse health outcomes, including high levels of health risk behaviours such as smoking, alcohol and drug misuse, and experience of violence and abuse. Eating disorders have a peak age of onset in adolescence. Children with a long-term physical illness are twice as likely to suffer from emotional or conduct disorder problems<sup>21</sup>.

The majority of parents who experience mental illness do not neglect or harm their children simply as a consequence of the disorder<sup>22</sup>. Children become more vulnerable to abuse and neglect when parental mental illness coexists with other problems such as substance misuse, domestic violence or childhood abuse<sup>23</sup>. It is not inevitable that living with a parent/carer with mental health issues will have a detrimental impact on a child's development and many adults who experience mental health problems can parent effectively. However, there is evidence to suggest that many families in this situation are more vulnerable.

## Mental health and parenting capacity

Given the wide range of mental ill health, the effect on parents and the potential impact on their capacity to meet the needs of their children is varied.

Depression can result in the individual experiencing feelings of worthlessness and hopelessness which may lead to everyday activities being left undone. Parents may neglect their own and their children's physical and emotional needs. In psychotic disorders such as schizophrenia, when the person is actively psychotic, they can lose contact with reality, experiencing hallucinations and delusions with consequent inability to understand and respond to their children's needs. In some people with chronic psychotic illness self-neglect in a range of areas of life may be an issue and this may have an impact on their capacity to care for their children.

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<sup>21</sup> Source: Department of Health. No health without mental health: a cross-government mental health outcomes strategy for people of all ages, 2011

<sup>22</sup> Tunnard 2004

<sup>23</sup> Cleaver et al. 2007

Overall, children with mothers who have mental ill health are five times more likely to have mental health problems themselves. Parental mental illness, particularly in the mother, is also associated with poor birth outcomes<sup>24</sup> increased risk of sudden infant death<sup>25</sup> and increased mortality in offspring<sup>26</sup> – probably through complex interaction of sociological, biological and risk behaviours such as smoking. This research indicates that these vulnerable families need additional support and help.

The majority of parents with a history of mental ill health present no risk to their children. However, in rare cases a child may sustain severe injury, profound neglect, or even die. Very serious risks may arise if the parent's illness incorporates delusional beliefs about the child, and/or incorporates the child in a suicide plan. Information from the National Confidential Inquiry into Suicides and Homicides suggests that there are about 30 convictions a year where a parent or step parent kills a child (this excludes those cases where the parent then goes on to commit suicide). In 37% of these cases the parent was found to have a mental disorder including depressive illness or bipolar affective disorder, personality disorder, schizophrenia, and/or substance or alcohol dependence<sup>2728</sup>. In a review of Serious Case Review reports where children had either died or been seriously harmed, current or past mental illness was found in two thirds of cases<sup>29</sup>.

The potential impact of a parental mental illness and the child's ability to cope with it is related to age, gender and individual personality. Prolonged postnatal depression is associated with adverse effects on the mother-infant relationship and the emotional state of the infant. It can also have a negative impact on the cognitive development of the child. Prolonged mental health problems in young women with young families can lead to breakdowns of marriages and disruptive effects on families and young children. The consequences of chronic or relapsing severe maternal psychiatric disorder include the breakdown of parenting and children entering the care system<sup>30</sup>.

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<sup>24</sup> King-Hele S, Webb R, Mortensen PB, Appleby L, Pickles A, Abel KM. Risk of stillbirth and neonatal death linked with maternal mental illness: a national cohort study. *Archives of Disease in Childhood Fetal & Neonatal Edition* 2009; 94: F105-F110

<sup>25</sup> Webb RT, Wicks S, Dalman C, Pickles AR, Appleby L, Mortensen PB, Haglund B, Abel KM. Influence of environmental factors in higher risk of sudden infant death syndrome linked with parental mental illness. *Archives of General Psychiatry* 2010; 67: 69-77.

<sup>26</sup> Webb RT, Abel KM, Pickles AR, Appleby L, King-Hele SA, Mortensen PB. Mortality risk among offspring of psychiatric inpatients: a population-based follow-up to early adulthood. *American Journal of Psychiatry* 2006; 163: 2170-7.

<sup>27</sup> NPSA Alert. Preventing harm to children from parents with mental health needs. NPSA,

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<sup>29</sup> (Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebottom, P., Dodsworth, J., Warren, C. and Black, J. (2009) *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-7*. London: Department for Children Schools and Families).

<sup>30</sup> Source: Royal College of Psychiatrists. Perinatal Maternal Mental Health Services, 2000



## Mental health and babies and infants

For babies and infants post natal depression may hamper the mother's capacity to empathise with, and respond appropriately to, her baby's needs. A consistent lack of warmth and negative responses increases the likelihood that the infant will become insecurely attached. Depression may also reduce the level of interaction and engagement between mother and child. Parents in these circumstances may have greater difficulty in listening to their children and offering praise and encouragement. Mothers who experience psychotic symptoms after giving birth, and those who continue to be depressed at six months after the birth, are more likely than other mothers to regard their babies negatively and ignore cries for warmth and comfort<sup>31</sup>. Women with a history of severe mental illness are at particular risk of relapse post-partum and should be under the care of a psychiatrist, as should any mother who develops psychotic symptoms post birth<sup>32</sup>. Mood swings, a common feature in mental disorders, can result in inconsistent parenting, emotional unavailability and unexpected and unplanned for separations, which infants find bewildering and frightening. Young children can be supported by the vigilance of primary health care workers, the presence of an alternative caring adult, the support of wider family, and good community facilities.

## Mental health and children

Parental mental disorders affect children in middle childhood rather differently. Children react to parenting difficulties which result from mental disorders with an increased level of behavioural problems. Some children experience depression and anxiety disorders<sup>33</sup> while others show high rates of conduct disorder<sup>34</sup>. It is widely accepted that boys are more likely to act out their distress with anti-social and aggressive behaviours while girls tend to respond by internalising their worries. Children of this age can escape into fantasy to cope with disturbing parental behaviour, or use more down to earth methods such as withdrawing into themselves, or escaping to a safe place. Relatives, particularly grandparents, can provide children with the emotional and practical support they need. However, children of this age are acutely aware of the social stigma of mental illness and consequently maybe reluctant to talk about family problems. Relatives and other adults who would be able to offer help and support may be unaware of what the child is experiencing. Same age friendships can also be supportive, although a fear of ridicule could keep children from discussing their circumstances with friends. Nonetheless, play and the companionship of friends can offer children respite from family concerns.

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<sup>31</sup> (Egeland, B. (2009) 'Taking stock: Childhood emotional maltreatment and developmental psychopathology.' *Child Abuse & Neglect* 33, 1, 22-27.)

<sup>32</sup> NICE (2007) *Guidelines on antenatal and postnatal care*. London: NICE.

<sup>33</sup> (Tunnard, J. (2004) *Parental Mental Health Problems: Key Messages from Research, Policy and Practice*. Dartington: Research in Practice.)

<sup>34</sup> (Klein, D., Clark, D., Dansky, L. and Margolis, E.T. (1988) 'Dysthymia in the offspring of parents with primary unipolar affective disorder.' *Journal of Abnormal Psychology* 94, 1155-1127.

The prevalence of mental ill health in children increases with the advent of adolescence. A survey of children's mental health suggests 11% of children aged 11-16 years have a mental disorder<sup>35</sup>. Parental mental ill health exacerbates the likelihood of young people experiencing psychological and behavioural symptoms<sup>36</sup>. The volatility of this age group means that the impact of parental mental illness, while similar to that at a young age, maybe more intense. Teenagers whose mothers suffer from depression show more behaviour problems than those whose mothers are well<sup>37</sup>. Conduct disorders, depression and a preoccupation with family problems affect young people's ability to concentrate and education and learning may be impaired. Education may also be interrupted when parental mental health problems become severe and young people stay at home in order to look after their parent or younger siblings.

Although relationships between parent and child may suffer as a result of parental mental illness, the opposite may also be true. As children reach adolescence, and their understanding and empathy develops, parental mental health problems may strengthen the bond between them. However, this can also result in accelerating the normal pace of emotional maturity, resulting in a loss of childhood. Young people may not only become responsible for shouldering the burden of practical tasks, but also assume the emotional responsibility for a parent or younger siblings. To do this young people may curtail their leisure time and restrict their friendships. Friendships can be a great source of support, but an acute awareness of the stigma of mental illness may result in young people coping alone. It is essential that the needs of young carers are assessed to ensure they receive the support they need. Many families in these circumstances would benefit from practical and domestic help. Young people value the support of sympathetic and trusted adults with whom they can discuss sensitive issues, a mutual friend and knowing who to contact in the event of a crisis regarding their parent.

It is important not to assume that all young people will have problems just because they grow up living with a parent who has mental ill health. Research has shown that the adverse effects on children and young people are less likely when parental disorders are mild, last only a short time, are not associated with family disharmony and do not result in the family breaking up. Children may also be protected from harm when the other parent or a family member can respond to the child's needs, and the child or young person has the support of friends and other caring adults<sup>38</sup>.

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<sup>35</sup> (Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2005) *Mental health of children and young people in Great Britain, 2004*. London: Office for National Statistics.)

<sup>36</sup> (Weissman, M.M., John, K., Merikangas, K.R., Prusoff, B.A., Wickramaratne, P., Gammon, G.D., Angold, A. and Warner, V. (1986) 'Depressed parents and their children: General health, social and psychiatric problems.' *American Journal of Diseases of Children*, 801-805.)

<sup>37</sup> (Somers, V. (2007) 'Schizophrenia: The Impact of Parental Illness on Children.' *British Journal of Social Work* 37, 8, 1319-1334.)

<sup>38</sup> Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development*. 2nd Edition. London: The Stationery Office.

Advice to services in responding to the needs of families where there is parental mental ill health is found in the NPSA Alert <sup>39</sup> and in practice guidance produced by SCIE<sup>40</sup>.

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<sup>39</sup> *National Patient Safety Agency (2009) Rapid Response Report NPSA/2009/RRR003: Preventing harm to children from parents with mental health needs. London: National Patient Safety Agency. See [the NPSA website](#).*

<sup>40</sup> *Social Care Institute for Excellence (2009) Think child, think parent, think family. London: SCIE.*

## Definition of a learning disability (code 5A-5C)

The Department of Health's definition of learning disability encompasses people with a broad range of disabilities.

Learning disability includes the presence of:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); with
- a reduce ability to cope independently (impaired social functioning);
- which started before adulthood, with a lasting effect on development<sup>41</sup>.

[Mencap](#) also provides a clear description of learning disability:

*“A learning disability is caused by the way the brain develops. There are many different types and most develop before a baby is born, during birth or because of a serious illness in early childhood. A learning disability can be mild, moderate, severe or profound, but all are lifelong. Many people with a learning disability, however, live independent lives.”*

## Why is the data important?

It is important not to generalise or make assumptions about the parenting capacity of parents with learning disabilities. Virtually all the available research suggests most parents with a learning disability provide adequate care and with sufficient support parental learning disability does not affect child outcomes<sup>42</sup>.

Parents with learning disabilities will need support to develop the understanding, resources, skills and experience to meet the needs of their children. Such support is particularly important when parents experience additional stressors such as having a disabled child, domestic violence, poor physical and mental health, substance misuse, social isolation, poor housing, poverty and a history of growing up in care. It is these additional stressors when combined with a learning disability that are most likely to lead to concerns about the care and safety of a child.

A study of children living with learning disabled parents who had been referred to local authority child's social care services highlighted the need for collaborative working between children's and adults' services and support for the family that lasts until the

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<sup>41</sup> Cm 5086 (2001) Valuing People: A New Strategy for the Learning Disability for the 21<sup>st</sup> Century. London: The Stationery Office. Cm 5086 2001, p.14, paragraph 1.5.

<sup>42</sup> Cleaver, H., Unell, I. and Aldgate, J. (2011) *Children's Needs – Parenting Capacity. Child Abuse: Parental Mental Illness, Learning Disability, Substance Misuse and Domestic Violence*. 2nd edition. London: The Stationery Office. Page 64

children reach adulthood<sup>43</sup>. There are many examples of positive practice in supporting parents with learning disabilities<sup>44</sup>.

## Learning disability and babies and infants

Parental learning disability may impact on the unborn child because it affects parents in their decision-making and preparation for the birth. Many women with learning disabilities are poorly informed about contraception and the significance of changes in their menstrual pattern and, as a result, may fail initially to recognize their pregnancy. The quality of the woman's ante-natal care is often jeopardized by late presentation and poor attendance. When women with learning disabilities do attend antenatal care they may experience difficulty in understanding and putting into practice the information and advice they receive

For new-born babies to thrive they need love, adequate nutrition, sleep, warmth, and to be kept clean. Mothers with learning disabilities may not know what is appropriate food for the baby and developing infant and experience difficulty in establishing a beneficial routine. Health checks may be missed and when the baby is unwell a mother with learning disabilities may not recognise the seriousness of the illness.

As the infant develops and becomes more mobile, parents with learning disabilities may not realise the importance of supervising bath times and ensuring the infant is protected from potential dangers within the home. The on-going support and advice from their wider family and health workers will be essential to ensure parents adapt to their babies changing needs.

The infant's cognitive development may be delayed due to an inherited learning disability. However, the environment can still make a difference; children brought up in a warm and stimulating environment will have better outcomes than those with inherited learning disabilities that are not<sup>45</sup>. Mothers with learning disabilities may experience difficulty in engaging with and providing sufficient stimulation for the infant's development and learning. For example, a learning disability may curtail parents' ability to read simple stories to their children and result in a restricted repertoire of nursery rhymes and other songs. Finally, babies and infants may be left with unsafe adults because parents fail to

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<sup>43</sup> Cleaver, H. and Nicholson, D. (2007) *Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

<sup>44</sup> Working Together with Parents Network (2009), *Supporting parents with learning disabilities and difficulties: stories of positive practice* Norah Fry Research Centre.; DH/DCSF Joint Good Practice Guidance on Supporting Parents with a Learning Disability.

DH\_075119; [SCIE Knowledge Review on disabled parents and parents with additional support needs](#).

<sup>45</sup> Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development*. 2nd Edition. London: The Stationery Office.

recognise the threat they pose, or lack the self-confidence to prevent them having access to the child. Babies and young children can be supported by the presence of a nonabusive, caring adult, other responsible adults such as grandparents involved in the care of the child, on-going support for the parent, stable home, adequate finances, and harmonious family relationships<sup>46</sup>.

## Learning disability and children

The impact of parental learning disability on children becomes more evident during middle childhood<sup>47</sup>. Children's health may suffer because of a lack of hygiene and a poor diet. Health problems may not be recognised or adequately dealt with, for example dental and doctor's appointments may be missed.

Learning may also be affected. Parents with literacy and numeracy problems will have difficulty in helping with school work and encouraging learning. Children's school attendance may be erratic or frequently late. Parents' own poor school experiences may mean they are reluctant to attend school events, and they may experience difficulty in understanding and putting into practice the advice teachers give them.

A learning disability may affect parents' capacity to set boundaries and exert authority as their children reach middle childhood; a situation that can be exacerbated if the child is more able than their parent. Children's self-image and self-esteem may be affected if parents do not understand the importance of recognising the individuality of their children.

Parental learning disabilities may also affect children's relationships within the family and with their peers. Inconsistent parenting can cause children to become anxious and uncertain of their parents' affection; emotions which will be exacerbated if parents fail to protect their children from childhood abuse. The consequences of abuse and neglect, particularly in relation to hygiene, low self-esteem, and poor control over emotions and behaviour, may result in children being rejected and bullied by their peers.

Finally, growing up with parents with learning disability may mean that an able child assumes a major caring role within the family, and as a consequence loses out on his or her own childhood. Positive outcomes for middle year children are associated with the provision of emotional and practical support by relatives, particularly grandparents, regular attendance at school, empathic and vigilant teachers, sufficient income, good physical standards in the home, and belonging to organised out of school activities<sup>48</sup>.

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<sup>46</sup> Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development*. 2nd Edition. London: The Stationery Office.

<sup>47</sup> Cleaver, H. and Nicholson, D. (2007) *Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

<sup>48</sup> Cleaver, H. and Nicholson, D. (2007) *Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers. <sup>48</sup> James, H. (2004)

'Promoting Effective Working with Parents with Learning Disabilities.' *Child Abuse Review* 13, 1, 31-41.

Teenagers of parents with learning disabilities may be left to cope alone with the physical and emotional changes that result from puberty. Parents themselves do not fully understand the significance of puberty and they may fail to educate, support or protect their children. The problems are compounded when parents need to care for an adolescent child with profound learning and physical disabilities. Physical and emotional neglect, low self-esteem and inadequate supervision increases the likelihood that young people will engage in risky behaviour, such as drinking and drug taking, self-harming, and early sexual relationships. When children are more intellectually able than their parents, acting effectively and setting boundaries as they reach adolescence becomes more difficult<sup>48</sup>. The likelihood that education will suffer continues into adolescence. Learning disabilities can result in parents not attending meetings and other school events and not having the capacity to support teenagers through the stress of examinations. Research suggests that many children of parents with learning disabilities experience school related problems such as being suspended for aggressive behaviour, truancy, frequent punishment, being bullied and having few friends<sup>49</sup>. Teenagers who are more able than their parents are increasingly likely to take on the parenting role, becoming responsible for housework, cooking, correspondence, dealing with authority figures, and the general care of their parents and younger siblings. When parents become increasingly dependent on their teenage children it may lead both parties to feel resentful and angry. For many teenagers peer friendships are a source of great support, but low self-esteem and behavioural and emotional problems can make it more difficult for teenagers to make friends. Young people whose parents have a learning disability will benefit from factual information about sex and contraception, a trusted adult or peer with whom they can discuss sensitive issues, a good friend, and regular attendance at school.

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<sup>49</sup> Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development*. 2nd Edition. London: The Stationery Office.

## Definition of physical disability or illness (code 6A-6C)

Some of the information about the child's disability will already be captured as part of the characteristics of the child within the CIN census. In addition, there may be overlap between recording a physical disability or which impacts on parenting capacity and means support is needed and the child being a young carer recorded below. This is to record where there are concerns about the impairment to the child's health or development due to their physical disability or illness or concerns about the capacity of a parent to respond to the child's needs because of the parent's physical disability or illness. Please include where the concern is a result of physical or sensory disability or [acute] illness.

## Why is the data important?

The [Disability Discrimination Act 2005](#) puts a general statutory duty on public bodies, including Government, to eliminate unlawful discrimination, and to promote equality and good relations towards disabled persons. For this reason, it is important that the Government is able to monitor the impact of its social work service to ensure that it meets the needs of all children and that no one group is at a disadvantage. This information is part of enabling a picture to be built of the disability status (via the CIN census characteristics) and understanding better what happens to children who are assessed as having a physical disability or illness or where parenting capacity is impacted by physical disability or illness.

## Parenting capacity

As with learning disabilities and mental health it is important not to generalise or make assumptions about the parenting capacity of parents with physical disabilities or illness. Needs relating to the illness and disabling barriers would need to be addressed before making judgements about parenting capacity and it is beneficial for children's and adults' services to work together.

Depending on the nature of the physical disability or illness additional support may be needed to ensure that disabled parents' can access the information and support that benefits all parents or will require additional assistance to carry out parenting tasks. For example, the provision of appropriate equipment to assist with looking after babies or ongoing personal assistance to help parents look after their children. In addition a change in the illness or disability may create an equal change in need for support. The role of extended family and community networks can be an important support mechanism for these groups of parents<sup>50</sup>.

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<sup>50</sup> [SCIE Knowledge Review on disabled parents and parents with additional support needs.](#)



## Disabled children

Disabled children are far more likely than non-disabled children to be subject to assessments by health, education and social services. There are several reasons for this including that there are; more disabled children in groups already socially disadvantaged and disabled children are more likely to have a number of experiences that may trigger assessment. Disabled children face an increased risk of abuse<sup>51</sup>; and of school exclusion and social exclusion in its widest sense<sup>52</sup>. Disabled children are also more likely to live away from home: to be accommodated on a short or long-term basis and/or to be in state-funded residential education.

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<sup>51</sup> (Westcott, 1993; Westcott and Cross, 1996; Westcott and Jones, 1999)

<sup>52</sup> Middleton, 1999

## Definition of young carers (code 7A)

Young carers are:

Children and young persons under 18 who provide or intend to provide care assistance or support to another family member. They carry out on a regular basis, significant or substantial caring tasks and assume a level of responsibility, which would usually be associated with an adult. The person receiving care is often a parent but can be a sibling, grandparent or other relative who is disabled, has some chronic illness, mental health problem or other condition connected with a need for care support or supervision<sup>53</sup>.

Helping to care for a family member is something that many young people are happy and proud to do. It helps them develop a sense of responsibility and skills they will use later in life. Taking on a caring role can strengthen family ties and build maturity and independence<sup>54</sup>. However, inappropriate or excessive levels of caring by young people can put their education, development or health at risk and may prevent them from enjoying their childhood in the same way as other children:

*“A young carer becomes vulnerable when the level of care-giving and responsibility to the person in need of care becomes excessive or inappropriate for that child, risking impacting on his or her physical well-being or educational achievement and life chances<sup>55</sup>.”*

## Why is the data important?

Estimates vary but there could be as many as 700,000 young carers in the UK. Many of these are providing essential help to their loved ones, but are not getting the recognition or support they require or enjoying the same opportunities as other children and young people their age. Their caring responsibilities can include caring for parents who are disabled, physically or mentally ill or parents dependent on alcohol or involved in drug misuse.

The HMG Carers Strategy ([Recognised, valued and supported: Next steps for the Carers Strategy- 2010](#)) has a strong focus on supporting young carers and emphasises:

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<sup>53</sup> Becker, S. (2000). ‘Young Carers’. In Davies, M. (ed.) The Blackwell Encyclopaedia of Social Work. Oxford: Blackwell Publishers Ltd, p. 378.

<sup>54</sup> Aldridge, J. & Becker, S. (1993.) Children Who Care: Inside the World of Young Carers

<sup>55</sup> Frank, J. & McLarnon, J. (2008). Key Principles of Practice for Young Carers and their Families. The Children’s Society.

- the importance of supporting young carers as a key part of the support offered to the family as a whole
- that no care package should rely on a young person taking on an inappropriate caring role
- that 'hidden' carers helping parents with substance misuse and/or mental ill health problems are a particular priority
- the importance of adult and children's services adopting the principles in Working Together to Support Young Carers, a memorandum of understanding published by the Associations of Directors of Adult and Children's Services, and working together with the voluntary sector to ensure that the needs of young carers and their families are identified early to prevent inappropriate caring and problems from escalating.

It should not be assumed that children should take on similar levels of caring responsibilities as adults. Services should be provided to parents to enhance their ability to fulfil their parenting responsibilities. There may be differences of view between children and parents about appropriate levels of care. Such differences may be out in the open or concealed. The resolution of such tensions will require good quality joint work between adult and children's social services as well as co-operation from schools and health care workers. This work should include direct work with the young carer to understand his or her perspective and opinions. The young person who is a primary carer of his or her parent or sibling may have a good understanding of the family's functioning and needs which should be incorporated into the assessment.

Young carers can receive help from both local and health authorities. Where a child is providing a substantial amount of care on a regular basis for a parent, the child will be entitled to an assessment of their ability to care under section 1(1) of the [Carers \(Recognition and Services\) Act 1995](#) and the local authority must take that assessment into account in deciding what community care services to provide for the parent.

Many young carers are not aware that they can ask for such an assessment. In addition, consideration must be given as to whether a young carer is a child in need under the Children Act 1989. The central issue is whether a child's welfare or development might suffer if support is not provided to the child or family. Services should be provided to promote the health and development of young carers while not undermining the parent.

## **Definition of private fostering (code 8A-8F)**

A private fostering arrangement is one that is made privately for the care of a child under the age of 16 (or under 18 if disabled) by someone other than a parent or close relative with the intention that it should last for 28 days or more.

Private foster carers may be from the extended family, such as a cousin or great aunt. However, a person who is a relative under the Children Act 1989 i.e. a grandparent,

brother, sister, uncle or aunt (whether of the full or half blood or by marriage) or stepparent will not be a private foster carer.

## Why is the data important?

Many private fostering arrangements will be safe and beneficial to the child, providing opportunities that the child may not otherwise have or a safe haven, others may leave the child more vulnerable. Privately fostered children remain a diverse and potentially vulnerable group<sup>56</sup> and include both overseas and UK children. Collecting data on those arrangements where the child is deemed at risk of harm is important to support improved targeting and identification of cases of concern. Only those children that are referred to and assessed to be in need of services and are additionally receiving the required statutory visits because they are privately fostered should be recorded. Where a privately fostered child is only receiving the required statutory visits from social care, then it should not be recorded for the purposes of this collection.

From 1 April 2016 the private fostering factor at assessment will be further categorised as the following (and the existing code 8A will cease to be used):

- Privately fostered: Overseas children who intend to return (code 8B)
- Privately fostered: Overseas children who intend to stay (code 8C)
- Privately fostered: UK children in educational placements (code 8D)
- Privately fostered: UK children making alternative family arrangements (code 8E)
- Privately fostered: Other (code 8F)

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<sup>56</sup> Source: Children Act 1989 – DfE guidance on private fostering

## Definition of an unaccompanied asylum seeker (code 9A)

These are children who are separated from their country of origin who are without the care and protection of their parents or legal guardian. In most cases unaccompanied asylum seekers (UASC) will be referred to local authorities by the UK Border Agency (UKBA) shortly after they arrive in the United Kingdom.

## Why is the data important?

Local authorities should adopt the same approach to assessing the needs of a UASC as they use to assess other children in need in their area. The child will not have a parent, relative or other suitable adult carer in the United Kingdom, and will likely to have to be accommodated under section 20 of the Children Act

The status, age and circumstances of these children may all be uncertain, in addition to their having experienced or witnessed traumatic events, and they may be suffering the most extreme forms of loss. The situations in which they are accommodated, albeit on a temporary basis, may be less than adequate.

There is a helpful [Statement of Good Practice](#) (Separated Children in Europe Programme, 1999) which provides a straightforward account of the policies and practice required to act to protect the rights of such children.



## Definition of missing children (code 10A)

Children and young people up to the age of 18 who have run away from their home or care placement, have been forced to leave, or whose whereabouts is unknown ([statutory guidance on children who run away and go missing from home or care](#)).

## Why is the data important?

Children run away for a variety of reasons, such as problems at home or school, mental health problems, gang involvement, problems with a care placement or bullying. They may run away to be closer to their birth family or friends, especially when they are in care and there are issues with contact. There is also the possibility that children might feel that running away is the right thing for them to do, especially if they feel they are at risk of significant harm at home or in their care placement. Research indicates that children in care are particularly at risk of going missing and are three times more likely to run away and young people with drugs and alcohol problems are at least four times as likely to run away as those without.

Missing children and young people are at real risk of harm when missing including from physical and sexual assault. Repeatedly going missing or running away from home is increasingly recognised as a key indicator to agencies that a child may be a victim of child sexual exploitation. Young people who run away can also get caught up in criminality and homelessness and may suffer mental health problems including depression. As well as short term risks, there are also long term implications for children and young people who run away or go missing. Nearly half of sentenced prisoners report of having run away as a child and nearly half of homeless young people at Centerpoint ran away as a child.

Further information and guidance can be found in:

[Statutory guidance on children who run away and go missing from home or care \(2014\)](#),  
[Missing Children and Adults strategy \(2011\)](#)

## Definition of child sexual exploitation (code 11A)

The February 2017 non-statutory guidance '[Child sexual exploitation: definition and guide for practitioners](#)' sets out the definition of child sexual exploitation as follows:

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. Like all forms of child sexual abuse, child sexual exploitation:

- can affect any child or young person (male or female) under the age of 18 years, including 16 and 17 year olds who can legally consent to have sex;
- can still be abuse even if the sexual activity appears consensual;
- can include both contact (penetrative and non-penetrative acts) and non-contact sexual activity;
- can take place in person or via technology, or a combination of both;
- can involve force and/or enticement-based methods of compliance and may, or may not, be accompanied by violence or threats of violence;
- may occur without the child or young person's immediate knowledge (through others copying videos or images they have created and posting on social media, for example);
- can be perpetrated by individuals or groups, males or females, and children or adults. The abuse can be a one-off occurrence or a series of incidents over time, and range from opportunistic to complex organised abuse; and
- is typified by some form of power imbalance in favour of those perpetrating the abuse. Whilst age may be the most obvious, this power imbalance can also be due to a range of other factors including gender, sexual identity, cognitive ability, physical strength, status, and access to economic or other resources.

## Why is the data important?

Local Safeguarding Children Boards should be undertaking robust and reliable risk assessments of the nature and extent of child sexual exploitation in their areas as this is fundamental to tackling exploitation. There are a number of well documented indicators of child sexual exploitation including missing from home, care or education but these are not comprehensive and children and young people do not always recognise themselves as victims of child sexual exploitation which can make it difficult to identify. However, in all cases there is the potential for the child or young person to be suffering or likely to suffer, significant harm.



Guidance and further information can be found in the 2017 guidance ['Child sexual exploitation: definition and guide for practitioners'](#) and ['What to do if you suspect a child is being sexually exploited – A Step-by-step guide for frontline practitioners'](#) published.

## Definition of trafficking (code 12A)

The United Nations Convention Against Transnational Organised Crime to the UN Convention (the 'Palermo Protocol') defines trafficking as

*“the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.”*

Any child transported for exploitative reasons is considered to be a trafficking victim, whether or not they have been forced or deceived.

## Why is the data important?

Trafficked children may not show any obvious signs of distress or abuse, which can make it difficult to identify that they may have been trafficked. However, in all cases there is a likelihood that a child victim of trafficking is at risk of serious immediate harm.

Good practice guidance for local authorities and other agencies which are likely to encounter children who may have been trafficked is provided in Safeguarding children who may have been trafficked<sup>57</sup>. This lists indicators which suggest that a child may have been trafficked and sets out the action they should take to safeguard the child.

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<sup>57</sup> [Safeguarding children who may have been trafficked](#) (HM Government 2011)

## Definition of gangs (code 13A)

Being part of a friendship group is a normal part of growing up and it can be common for groups of children and young people to gather together in public places to socialise. Belonging to such a group can form a positive and normal part of young people's growth and development. These groups should be distinguished from 'street gangs' for whom crime and violence are a core part of their identity, although 'delinquent peer groups' can also lead to increased antisocial behaviour and youth offending. Although some group gatherings can lead to increased antisocial behaviour and youth offending, these activities should not be confused with the serious violence of a gang.

## Why is the data important?

Children and young people who become involved in gangs are at risk of violent crime and as a result of this involvement are deemed vulnerable. Agencies and professionals have a responsibility to safeguard these children and young people and to prevent further harm both to the young person and other potential victims. Risks associated with gang activity include access to weapons (including firearms), retaliatory violence and territorial violence with other gangs. Other risks include increased likelihood of involvement in knife crime, sexual violence and substance misuse.

Further advice on the associated risks is provided in the Home Office document <https://www.gov.uk/government/publications/advice-to-parents-and-carers-on-gangs>

## **Definition of socially unacceptable behaviour (code 14A)**

Children and families whose need for services primarily arise out of the child's behaviour impacting detrimentally on the community.

This would include children who require services because they:

- actually offend
- are considered to be at risk of offending
- are below the age of criminal responsibility but would otherwise be breaking the law
- are behaving in such a disorderly way that they cause alarm or disturb the peace.

This would also include another group of children who create concern within the community because they put themselves at unacceptable risk. This category would include the needs of children and young people being served by staff in a Youth Offending Team (YOT) paid from the Social Services Department budget.

This category also includes children who are receiving services as part of the Crime Reduction Strategy, either with or without YOT involvement. However, a referral made by a YOT for reasons that are not connected with the child's offending may indicate that another needs category is more applicable.

A defining factor for this category is that the child's behaviour "pushes at the boundaries" of community acceptance; it has gone beyond the family.

## Definition of self-harm (code 15A)

Self-harm is defined as self-poisoning or self-injury, irrespective of the apparent purpose of the act. Self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm him or herself<sup>58</sup>.

## Why is the data important?

The psychological characteristics associated with risk include depression, hopelessness and continuing suicidal intent<sup>59</sup>.

Self-harm in children and adolescents in England is common, particularly in older adolescents, and paracetamol overdose is the predominant method. Repetition of self-harm is also frequent. Relationship problems are the predominant difficulties associated with self-harm<sup>60</sup>.

Frequent exposure to bullying by peers during childhood increased the risk of deliberate self-harm among adolescents aged 12 years. Factors that increased the risk of self-harm in children who were bullied included a family history of suicidal behaviour, physical maltreatment by an adult, and having co-occurring mental health problems (i.e. conduct disorder, borderline personality characteristics, depressive or psychotic symptoms)<sup>61</sup>.

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<sup>58</sup> Source: NICE guidance: Self-harm – The short-term physical and psychological management and secondary prevention of self-harm, 2004

<sup>59</sup> Source: NICE guidance: Self-harm – The short-term physical and psychological management and secondary prevention of self-harm, 2004

<sup>60</sup> (Source: Hawton K, Bergen H, et al. Epidemiology and nature of self-harm in children and adolescents: findings from the multicentre study of self-harm in England. *Eur Child Adolescent Psychiatry*, 2012)

<sup>61</sup> (Source: Fisher L H, Moffitt E T, et al. Bullying victimisation and risk of self-harm in early adolescence: longitudinal cohort study, *BMJ* 2012; 344:e2683)

## Definition of abuse or neglect (codes 16A-19A)

These are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm or which in itself harms a child.

Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger for example, via the internet. They may be abused by an adult or adults, or another child or children.

## Why is the data important?

Understanding families and the experiences of children within them can be complex and signs of low level abuse and neglect may be misleading. Professionals working in universal services – health, education, police and early years – have a responsibility to identify the early signs of abuse and neglect, to share that information and work together to provide children with the help they need.

We know that the earlier that help is given to vulnerable children and families, the more chance there is of turning lives around and protecting children from harm. Preventative services do more to reduce abuse and neglect than reactive services and the provision of timely, coordinated and transparent help to children and families will secure improved outcomes.

## Definition of neglect (code 16A)

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- protect a child from physical and emotional harm or danger
- ensure adequate supervision (including the use of inadequate caregivers); or
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs<sup>62</sup>.

## Why is this data important?

Neglect is known to be damaging for children in the short and long-term: it can seriously impair children's emotional, physical, cognitive and behavioural development. Neglect is not only damaging in early years. A significant study has provided important insights into

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<sup>62</sup> *Managing individual cases: the framework for the assessment of children in need and their families*

both the effects in teenage years of early neglect and the factors associated with onset of neglect during teenage years<sup>63</sup>.

Severe neglect of young children has adverse effects on children's ability to form attachments and is associated with major impairment of growth and intellectual development. Persistent neglect can lead to serious impairment of health and development, and long-term difficulties with social functioning, relationships and educational progress. Neglected children may also experience low self-esteem, and feelings of being unloved and isolated. Neglect can also result, in extreme cases, in death. The impact of neglect varies depending on how long children have been neglected, the children's age, and the multiplicity of neglectful behaviours children have been experiencing<sup>64</sup>.

More guidance on childhood neglect including training and resource materials and messages from research can be found on the [safeguarding children](#) page.

## Definition of emotional abuse (code 17A)

Emotional abuse is the persistent ill-treatment of a child that causes severe and continual adverse effects on the child's emotional development. It may involve conveying to the child that they are inadequate; worthless or unloved; or valued only as far as they meet the needs of another person. It may feature the imposing of age- or developmentally inappropriate expectations on the child. Such expectations may include interactions that are beyond the child's developmental capability. It includes overprotection and limitation of exploration and learning, or preventing the child from participating in normal social interactions. It may involve the child seeing or hearing the ill-treatment of others. It may also involve serious bullying; causing children to frequently feel frightened or in danger; or the exploitation and corruption of children. Some level of emotional abuse is implied in all types of ill-treatment of a child, although it may occur on its own. Use this category when it is the main or sole form of abuse.

## Why is this data important?

There is increasing evidence of the adverse long-term consequences for children's development where they have been subject to sustained emotional abuse, including the

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<sup>63</sup> Stein, M. Rees, G. Hicks, L. and Gorin, S. (2009) *Neglected adolescents: a review of the research and the preparation of guidance for multi-disciplinary teams and a guide for young people*. London: Department for Children, Schools and Families.

<sup>64</sup> (Daniel, B. Taylor, J. and Scott, J. (2009) *Noticing and helping the neglected child*. London: Department for Children, Schools and Families. DCSF-RBX-09-03 - and - 159 Stein, M. Rees, G. Hicks, L. and Gorin, S. (2009) *Neglected adolescents: a review of the research and the preparation of guidance for multi-disciplinary teams and a guide for young people*. London: Department for Children, Schools and Families. DCSF-RBX-09-04. 160 Chapter 6 of the Government's strategy document Carers)

impact of serious bullying<sup>65</sup>. Emotional abuse has an important impact on a developing child's mental health, behaviour and self-esteem. It can be especially damaging in infancy. Underlying emotional abuse may be as important, if not more so, as other more visible forms of abuse in terms of its impact on the child. Domestic violence is abusive in itself. Adult mental health problems and parental substance misuse may be features in families where children are exposed to such abuse.

## **Definition of physical abuse (code 18B-18C)**

### **Child on child physical abuse (code 18B) and adult on child physical abuse (code 18C) collected from 1 April 2020, previously physical abuse (code 18A)**

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child. Adult on child physical abuse [code 18C] involves a person aged 18 or over physically abusing a person under 18.

#### **Children who physically abuse other children [code 18B]**

Child on child (peer on peer) physical abuse involves a person, or group of persons under the age of 18 physically abusing another person under the age of 18. Only those children that are referred and assessed as being in need of services, should be recorded. This includes the referrals of and services provided to the child perpetrators of serious violence, as well as their child victims. Examples of child on child physical abuse serious enough to instigate a referral to children's social care services include the stabbing of, or beating up another child, or children, which results in serious injury/ harm.

#### **Why is this data important?**

Physical abuse can lead directly to neurological damage, physical injuries, disability or, at the extreme, death. Physical abuse has been linked to aggressive behaviour in children, emotional and behavioural problems and educational difficulties. Violence is pervasive and the physical abuse of children frequently coexists with domestic violence<sup>66</sup>.

Recording and collating data on child on child physical abuse in the 2020-21 CIN census will enable the DfE to estimate the scale of this abuse for the first time. In the longer term, it will help it to identify whether there is a decline or increase in child on child violence.

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<sup>65</sup> Barlow, J and Schrader-MacMillan, A. (2009) *Safeguarding Children From Emotional Abuse – What Works?* London: Department for Education and Skills. DCSF-RBX-09-09.

<sup>66</sup> Montgomery, P. Ramchandani, P. Gardner, F. and Bjornstad, G. (2009) *Systematic reviews of interventions following physical abuse: helping practitioners and expert witnesses improve the outcomes of child abuse.* London: Department for Children, Schools and Families



## **Definition of sexual abuse (code 19B-19C)**

### **Child on child sexual abuse (code 19B) and adult on child sexual abuse (code 19C) collected from 1 April 2020, previously sexual abuse (code 19A)**

Sexual abuse involves forcing or enticing a child to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Adult on child sexual abuse [code 19B] is not solely perpetrated by males over 18, it is also perpetrated by women.

#### **Child on child (peer on peer) sexual abuse [code 19B]**

Sexual abuse can occur between two children of any age and sex. It can also occur through a group of children sexually assaulting or sexually harassing a single child or group of children with or without their consent. Child on child (peer on peer) sexual abuse involves a person, or group of persons under the age of 18 sexually abusing another person or persons under the age of 18. Only those children that are referred and assessed as being in need of services, should be recorded.

Children's sexual behaviour exists on a wide continuum, from normal and developmentally expected, to inappropriate, problematic, abusive and violent. Problematic, abusive and violent sexual behaviour is developmentally inappropriate and may cause developmental damage. A useful umbrella term is "harmful sexual behaviour". Harmful sexual behaviour can occur online and/or offline and can also occur simultaneously between the two.

Sexual behaviour between children can be considered harmful if one of the children is much older (particularly if there is more than two years' difference or if one of the children is pre-pubescent and the other is not). A younger child can abuse an older child, particularly if they have power over them, for example, if the older child is disabled or smaller in stature. The statutory age of consent in the United Kingdom is 16. A child under the age of 13 can never consent to any sexual activity.

Examples of sexual violence serious enough to warrant a referral to local authority children's social care and the provision of services for both child perpetrators and their victims will include children that rape, and or are raped by another child, or children, and children that sexually assault, or are sexually assaulted by another child or children.

In the context of child on child sexual harassment, instances of a sexual nature' serious enough to instigate a referral and provision of services, include physical behaviour such as a child that deliberately brushes itself against another child, interferes with their clothes or touches them in a sexual manner with or without their consent, or displays pictures, photos or drawings of a sexual nature of them. It also includes instances of online sexual harassment such as the non-consensual sharing of sexual images and videos, up-skirting; or sexualised online bullying, and sexual exploitation, coercion and threats.

## Why is this data important?

Disturbed behaviour – including self-harm, inappropriate sexualised behaviour, sexually abusive behaviour, depression and a loss of self-esteem – has been linked to sexual abuse. Its adverse effects may endure into adulthood. The severity of impact on a child is believed to increase the longer the abuse continues, the more extensive the abuse, and the older the child. A number of features of sexual abuse have also been linked with severity of impact, including the relationship of the abuser to the child, the extent of premeditation, the degree of threat and coercion, sadism, and bizarre or unusual elements. A child's ability to cope with the experience of sexual abuse, once recognised or disclosed, is strengthened by the support of a non-abusive adult carer who believes the child, helps the child understand the abuse, and is able to offer help and protection. The reactions of practitioners also have an impact on the child's ability to cope with what has happened, and on his or her feelings of self-worth<sup>67</sup>.

A proportion of adults, children, and young people who sexually abuse children have themselves been sexually abused as children. They may also have been exposed as children to domestic violence and discontinuity of care. However it would be quite wrong to suggest that most children who are sexually abused inevitably go on to become abusers themselves.

Recording and collating data on child on child sexual abuse in the 2020-21 CIN census will enable the DfE to estimate the scale of this abuse for the first time, and over time, to identify whether there is a decline or increase in this behaviour. The majority of children who display harmful sexual behaviours do not become sexual offenders as adults. If both perpetrators and the victims of child on child sexual abuse are supported and receive the correct interventions that they need at an early stage then the likelihood of its reoccurrence will be greatly reduced. The recording of harmful sexual behaviours at an early stage will result in better recording of the needs of children and better understanding of the types of services required in their area.

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<sup>67</sup> For further information see *Child Sexual Abuse: Informing Practice from Research* (Jones, D.P.H. and Ramchandani, P. (1999) *Child Sexual Abuse. Informing Practice from Research*. Abingdon: Radcliffe Medical Press Ltd.)

## Further information

'Key messages from research on child sexual abuse 'Identification and responding to disclosures of child sexual abuse' (2019) - Centre of Expertise on Child Sexual Abuse  
<https://www.csacentre.org.uk/resources/key-messages/>

## Definition of female genital mutilation (FGM) (code 22A)

FGM comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.

FGM has been classified by the World Health Organization into four types:

Type 1 – Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

Type 2 – Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the ‘lips’ that surround the vagina).

Type 3 – Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

Type 4 – Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

These types are for information only and the type of FGM does not need to be recorded.

The FGM factor should be reported when it is known or suspected that a girl has been subjected to FGM, or is perceived to be at risk of FGM. With regard to ‘at risk’, it should only be recorded if the girl herself is perceived to be at risk, not if the only ‘risk factor’ is that her family are from a ‘practising community’.

## Why is the data important?

FGM has no health benefits and harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and hence interferes with the natural function of girls’ and women’s bodies. The practice causes severe pain and has several immediate and long-term health consequences, including difficulties in childbirth, also causing dangers to the child.

Though it has been illegal since the [Prohibition of Female Circumcision Act 1985](#), now under the [Female Genital Mutilation Act 2003](#), no-one has been convicted under this legislation.

It is believed that tens of thousands of girls in the UK may be at risk of FGM, but there is little reliable information on the numbers or on the areas where it may be most prevalent; most prevalence information is based on the presence of families from ‘practising communities’ in an area, without firm data on whether FGM is being carried out in those communities in the UK.

The collection of data may also highlight any correlation or coincidence (or the lack thereof) between FGM and other child safeguarding issues. This may prove a useful tool in considering the potential role of children's social care in protecting girls from FGM.

## Definition of abuse linked to faith or belief (code 23A)

The abuse concerned may be of any form: physical (including excessive physical discipline), sexual, emotional, neglect (including the denial of necessary medical treatment), domestic slavery, sexual exploitation.

This factor should be recorded when a child is perceived to be subject to, or at risk of abuse because of his or her parents or carers' belief system. This includes, but is not limited to, belief in witchcraft, spirit possession, demons or the devil, the evil eye or djinns, dakini, kindoki, ritual or muti murders and use of fear of the supernatural.

The beliefs involved are not confined to one faith, nationality or ethnic community.

The following should be seen as out of scope for the recording of this factor:

- cultural practices that are in themselves a specific form of abuse, for example female genital mutilation or forced marriage;
- child abuse in faith settings which are incidental to the abuse, for example, sexual abuse by paedophiles in a religious community.

## Why is the data important?

Better information on the prevalence of abuse due to such faith or belief systems should help to protect children from that abuse, by raising awareness of where and how such beliefs are leading to abuse.

At present, this factor seems only to be recorded, and then arguably only in relatively extreme cases, by the police, when they are considering potential charges. Those working with the relevant communities believe that such cases are only the tip of the iceberg.

The collection of data may also help to identify the other factors that regularly occur alongside this form of abuse, which may assist practitioners in the early identification of children at risk and early help for those children.



Department  
for Education

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