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Final Report

Identifying and understanding the link between system conditions and welfare inequalities in children's social care services

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Contents

List of Figures

List of Tables

Acronyms

ADCS	Association of Directors of Children's Services
ADHD	Attention Deficit Hyperactivity Disorder
BAME	Black and Minority Ethnic
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Service
CIN	Child(ren) in Need
CSC	Children's Social Care
CP	Child protection
DV	Domestic violence / Domestic abuse
DfE	Department for Education
IMD	Index of Multiple Deprivation
EH	Early Help
FSW	Family Support Worker
LA	Local authority
LAC	Looked After Child(ren)
LSOA	Local Super Output Area
MASH	Multi Agency Safeguarding Hub
NSN	Nearest Statistical Neighbour
ONS	Office for National Statistics

1. Introduction

This report presents the findings from a study of the organisational and institutional context of statutory children's social care (CSC) in England and its contribution to inequalities in provision. It builds on work carried out by the Child Welfare Inequalities Project (CWIP, also funded by the Nuffield Foundation), which found strong evidence that a child's chances of being subject of a child protection plan or being in public care differs greatly according to indicators of social disadvantage (Bywaters *et al.*, 2018). Other work carried out by Hood *et al.* (2016a) found that the rise in demand for child protection intersected with deprivation-related differences in rates of intervention. This research builds on the inequalities agenda established by CWIP, focusing on system conditions in CSC. In this introductory section we discuss the background to the study, outline its aims and objectives, and provide an overview of the CSC system.

System conditions refer to the underlying factors that shape the way services are organised and delivered. They can affect performance in services and may reflect attitudes and assumptions about how services should be organised and managed.

Child welfare inequalities occur when children and/or their parents face unequal chances, experiences or outcomes of involvement with child welfare services that are systematically associated with structural social dis/advantage and are unjust and avoidable.

1.1. Background

Children's social care includes a range of local government services that promote and safeguard the welfare of children. Government statistics[1] show that over the last fifteen years local authorities in England are doing more and more child protection work. However, this is not primarily due to an increase in referrals. While referral rates can vary considerably from one year to the next, they have not risen substantially over the longer term. Referrals to children's social care in 2018-19 were only 7% higher than in 2001-02. Over the same period, rates of child protection investigations more than doubled from 63 to 168 per 10,000 children (0-17 years), rates of child protection plans increased by 90%, and rates of care orders increased by 55%. The figures[1] suggest that children who were referred into the system in 2018-19 were much more likely to receive a protective intervention than they were in 2001-02[2].

[1] Source: Department of Education statistics: https://www.gov.uk/government/collections/statistics-children-in-need

[2] Prior to 2008-09, information on referrals, assessments and child protection plans was collected through the aggregate 'Child Protection and Referrals' (CPR3) return. This was replaced by the CIN Census return in 2008-09, which means there was a discontinuity in reporting even though many indicators, including referrals and CP registration/plans, remained comparable in operational terms, i.e. meant the same things in practice.

These changes mainly affect families living in deprived areas. Children who are living in poverty are much more likely to be in care, or subject to a child protection plan, than children who are from well-off families (Bywaters *et al.*, 2014). The usual reason given for this is that while child abuse and neglect are rare among poor families, they are more likely to occur than among rich families (Bywaters *et al.*, 2016). This phenomenon is called the 'social gradient', referring to the role that socio-economic inequality plays in the life-chances and outcomes between different groups of people as household income and wealth increases. The concept is commonly associated with the field of public health, where researchers have found that the poorest individuals in society tend to have the worst health outcomes (Marmot and Sapolsky, 2014). In children's services, a similar social gradient is found in the chances of receiving a child welfare intervention, i.e. the lower the socio-economic status of a child the more likely they are to receive an intervention.

Welfare inequalities are highlighted by an additional finding of the CWIP. As CSC services are provided by local authorities (LAs), the CWIP research team investigated the effect of average deprivation levels in LAs on the provision of services (Bywaters *et al.*, 2018). They found that when children at an equivalent level of deprivation (using neighbourhood deprivation as a proxy) were compared across different LAs, the chances of an intervention went *down* as LA-level deprivation increased. This tendency, called the 'inverse intervention law', is usually obscured by higher overall (i.e. unadjusted) rates of intervention in more deprived LAs. In other words, while more deprived LAs tend to have more child protection plans and more children in care than less deprived LAs, they actually have lower rates of CP plans and care episodes when comparing children who are similarly deprived. Very deprived LAs end up with more demand overall because they have such large numbers of deprived children living there.

Social gradient of intervention means that the more deprived a child is the more likely they are to receive a child welfare intervention. It tends also to mean that demand is more concentrated in poor neighbourhoods. The social gradient is found in all LAs but to a differing extent, as the inverse intervention law makes clear.

The inverse intervention law states that child-level (LSOA proxy) deprivation and LA-level deprivation both affect rates of intervention but in opposite ways: as child-level (LSOA proxy) deprivation increases the chances of intervention go up, but as LA-level deprivation increases the chances of an intervention go down (after adjusting for child-level (LSOA proxy) deprivation).

Welfare inequalities matter because a child's chances of being subject to a protection plan, or being taken into care, depend on factors over which they have no control and which stem from the socio-economic circumstances of their family. By definition, systematic inequalities are the product of a system, rather than just random human error or 'poor practice'. The problem is that we do not know enough about the children's social care system, about the nature of demand and how agencies respond to it (National Audit Office, 2019). Deprivation is not the only factor influencing the provision of services. Other factors are important too, such as expenditure, caseloads, workforce characteristics, Ofsted inspections, and changes in legislation. When there is a crisis in confidence in

the system, as happened after the 'Baby P' scandal of 2008, it also affects what referrals are made and what is done with them. These factors are known as 'system conditions', because they shape how the system works in particular areas at particular times.

1.2. Overview of the CSC system

Frontline practice in CSC is generally structured around teams of social workers, often supported by other practitioners, who carry out assessment and intervention aligned with some or all of the thresholds listed below. Requests for a service start off as a contact about a particular child, usually from other agencies and professionals, sometimes from individuals in the community. If the referral is accepted, information about the child is assessed via a series of 'filters and funnels' (Gibbons *et al.*, 1995) in order to determine the appropriate form of provision. Although services are configured differently in each local authority, certain common thresholds are suggested by the legislative underpinning of CSC. Local authorities collect administrative data on cases that meet (and do not meet) these thresholds and report them to the Department for Education (DfE) on an annual basis. Statistics on care proceedings are collected and reported by the Children and Family Court Advisory and Support Service (CAFCASS). The main exception is data on pre-proceedings work, which at the time of writing is neither routinely collected nor publicly reported except in research (Masson and Dickens, 2019). On this basis, the main thresholds following referral to CSC are as follows (Hood *et al.*, 2019a):

1. No further action taken.
2. A child and family assessment is carried out.
3. Following assessment, the child is found not to be 'in need'. Such cases may be referred to a non-statutory service or 'Early Help' provision[3].
4. Children in need (CIN) – following assessment, the child is found to be 'in need' as defined in Section 17 of the 1989 Children Act (CA1989). CIN often have complex needs and are entitled to receive a statutory service, usually a multi-agency plan coordinated by a social worker. CIN plans are reviewed regularly in a multi-agency meeting involving the family, whose consent is required.
5. Child protection – Section 47 of the CA1989 sets out the local authority's duty to investigate, which includes cases where they have 'reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm'. This duty overrides consent (although statutory guidance emphasises that agencies should seek to work in

[3] Early Help refers to a range of preventative services that provide support to children and families at the stage when needs are identified, in order to pre-empt intervention at a later stage when problems have escalated. Examples of Early Help include family hubs, children's centres, family support work, parenting groups and courses, mentors and positive activities for young people, and relationship support.

partnership with families). CP interventions encompass strategy meetings, Section 47 investigations, CP case conferences and CP plans. CP plans are reviewed in multi-agency ('core group') meetings as well as in CP conferences.

6. Public law outline (PLO) – statutory guidance (DfE, 2014) sets out the duties of local authorities who are considering an application to court to ask for a Care Order or Supervision Order in respect of a child. This is sometimes described as 'initiating care proceedings'. Care proceedings should take no longer than 26 weeks, although the PLO also encompasses pre-proceedings work with the family. A court will only make a Care or Supervision Order if it is satisfied that the threshold criteria in Section 31 of the CA1989 have been met, so the local authority will have regard to these criteria when deciding whether or not to initiate care proceedings.

These thresholds serve a dual purpose. First, they ensure that CSC services comply with the legislation and statutory guidance. For example, the distinction between services provided under Sections 17 and 47 of the 1989 Children Act serves as a legal marker of the shift from consent to coercion, prevention to protection, family support to parental policing. Decisions relating to this threshold tend to be made by professionals and managers, while the threshold criteria in Section 31 require legal advice and ultimately a court order. Underpinning these thresholds is the idea of procedural checks and balances, to ensure that children are supported by the state and protected from abuse while guarding against disproportionate interference in private family life. In this way, thresholds can be seen as an effort to manage what Devine and Parker (2015) have called the 'welfare-policing' dichotomy in CSC.

The same thresholds also serve a second purpose, which is to manage demand. Each threshold corresponds to a different level of need, so that more complex and acute cases are referred 'up' to appropriate specialists in the higher levels (e.g. child protection and court teams), targeting expertise and resources at those children who most need it (Hardiker *et al.*, 1991). Since these CP services are more expensive, managing demand is also a way of managing cost. CSC can be considered a specialist tier of provision within children's services as a whole, since it usually requires a referral from another agency, but also operates its own internal tiers, which correspond to the thresholds listed above. Once a referral is accepted, a child is moved between different teams and social workers depending on how their needs and risks are assessed and acted on. 'Eligibility' for CP and other types of higher tier provision, e.g. family recovery projects, requires the child to be judged at risk of harm. When this risk is no longer present, the child is 'stepped down' to less intensive (and intrusive) services with a view to closing their involvement with CSC. Intervention pathways therefore range from very brief (a referral receives no further action) to very lengthy: multiple assessments, care plans, escalations, and step-downs across different thresholds over several months or even years.

1.3. Aims and objectives

This two-year study aimed to establish whether and in what way system conditions in CSC were contributing to welfare inequalities, and on the basis of the knowledge gained to suggest the kind of system change needed to reduce those inequalities.

Its objectives were to:

- Identify the characteristics of local authorities, neighbourhoods, and individuals that are associated with particular pathways of intervention for children receiving children's social care services.
- Understand from the perspective of practitioners and managers why there might be different patterns of demand and provision in their own services and in the sector as a whole.
- Use the empirical findings to understand the link between system conditions and welfare inequalities in children's social care.
- Engage with professionals, policy makers, politicians and the public to disseminate the study's findings and promote a holistic understanding of performance that takes into account the social context of intervention.

2. Methods

The research used a convergent mixed methods design in order to explore a range of factors in the organisational and institutional context of statutory children's social care in England and their potential link to welfare inequalities.

There were three main strands of data collection and analysis, which were designed as interconnected studies as set out below:

- *Quantitative study of national data returns for CSC*. For this study, the team carried out a quantitative analysis of performance indicators, Ofsted ratings, and contextual variables (e.g. deprivation rates, ethnicity, workforce data) for all LAs in England. It aimed to find out how demand fluctuated between LAs with different levels of overall deprivation, how LAs managed this demand, and whether characteristic patterns of intervention were evident in the aggregated data.
- *Quantitative study of child-level administrative data in six local authorities*. For this study, the team carried out a quantitative analysis of all children referred to statutory social care services in six local authorities over a four-year period. The analysis focused on associations between system variables, deprivation indicators, intervention pathways and outcomes for children. It aimed to find out whether children with certain characteristics (e.g. age, gender, ethnicity, deprivation) tended to receive certain types of intervention, and whether this contributed to the inequalities observed for children as a whole.
- *Qualitative study of system conditions in CSC*. For this study, the team carried out two rounds of interviews (n=60) with managers, practitioners and senior administrators (n=36) in the same LAs that provided administrative data. The aim was to gain an 'inside perspective' on the key factors affecting patterns of demand and provision in each LA area, both in a

general sense and with reference to the quantitative findings. This helped the researchers identify commonalities in system conditions across LAs as well as the differences between them.

2.1. Ethics and research governance

Ethical permission for the research was obtained from the Faculty Research Ethics Committee (Faculty of Health, Social Care and Education) of Kingston University and St Georges, University of London. The study was also approved by the research group of the Association of Directors of Children's Services (ADCS). Research governance approval was obtained from participating LAs and a data sharing agreement made with each agency in relation to the quantitative part of the study. All participants in the qualitative research were asked to sign a consent form that explained data management, confidentiality and anonymity.

2.2. Quantitative study of national data returns for CSC

This study sought to understand broad patterns of demand for and provision of CSC services in England. It did so by combining and analysing various sets of administrative data, aggregated to LA level, which are published annually by the Department for Education and Cafcass. The main categories of data and their sources are listed below in Table 1. For a more comprehensive overview of these indicators see Hood et al. (2016 & 2019)

Table 1. Categories of data and their sources

Category	Source	Indicators
Services provided to Children in Need (CIN)	CIN Census	Number of referrals Referrals within 12 months of a prior referral Referrals not assessed Continuous Assessments Referrals assessed but deemed not CIN Number of children starting an episode of need Number of Children in Need (CIN) at March 31st Number of CIN during the year Number of CIN ending an episode of need CIN Cease times (<3 months, 3-5 months, 6-11 months, 1-2 years, 2+ years) Numbers of Section 47 investigations Number of CP conferences Number of CP plans at March 31st Number of CP plans that started during the year Number of CP plans ceased CP plan cease times (<3 months, 3-5 months, 6-11 months, 1-2 years, 2+ years) CP plans where children had a prior CP plan
Services provided to Children Looked After (CLA)	SSDA903 returns	Number of children taken into care Number of Section 20s
	Cafcass	Care Proceeding rates per 10,000 children

Deprivation	Office for National Statistics (ONS)	2015 Index of Multiple Deprivation (IMD)[1]
Expenditure	Section 251 outturn	Total Spend on children[2] Spend on children's safety[3]
Workforce	Children's Social Care Workforce data collection (CSCW)	Social work vacancies[4] Turnover of social workers[4] Agency workers[4] Caseloads[5]

Notes

[1] The main IMD measure used for the analysis was average score for the local authority.

[2] Total spend on children includes looked after children, safeguarding, other children and families services, family support, youth services and youth justice.

[3] Spend on children's safety is safeguarding expenditure only, which includes social work, commissioning and children's services strategy and local safeguarding children board. This may be presented as per LA child population or as per CIN.

[4] As a proportion of permanent social workers employed at one full-time equivalent.

[5] Experimental statistics

The methodology used the procedures outlined in Hood et al. (2016a & 2019). Demand indicators (see Table 1) were converted to rates per 10,000 child population and expenditure items were adjusted for inflation using the government's 2016-17 GDP deflator index (HM Treasury, 2017). Analysis focused on trends and correlations across key indicators. For the correlation analysis, Spearman's rank correlations were used to establish associations between variables, and this was done separately for each year in order to check for stability in the period in question (2014-17). P-values were obtained for the correlations, effectively testing if they could have arisen by chance from an uncorrelated population. Results from the analysis of trends and correlations were compared with the previous five years (2009-14), a period seen as broadly comparable in terms of the consistency of reporting requirements.

2.3. Quantitative study of child-level administrative data

This study sought to understand the relationship between LA characteristics, child characteristics and intervention pathways through the CSC system. To do this, child-level administrative data were collected from a sample of six local authorities, combined and cleaned, then analysed using three methods: bivariate cross-tabulation, latent class analysis and multilevel logistic regression.

2.3.1. Sample of LAs

Before the project started, a simulation using R software was used to estimate the necessary sample size to carry out the planned analysis. The outcome of the simulation was that a total sample size of

approximately 2,800 children would be necessary, requiring data from six local authorities[4]. The initial criterion for sampling was overall deprivation using the 'rank of average score ranking' for the 2015 Index of Multiple Deprivation. All 152 English LAs were ordered into tertiles according to their IMD rankings with a view to recruiting two LAs from each tertile to take part in the study. Based on this frame, a convenience-based sample was developed to facilitate the level of contact required for the qualitative part of the study. In practice, this meant approaching LAs in London and Southeast England, excluding those LAs whose demographic composition (e.g. BAME child population) or intervention rates (e.g. rates of CIN or CP plans) were in the top or bottom decile nationally. Two of the LAs who were initially approached to take part in the study declined to do so. The characteristics of the final LA sample are summarised in Table 2.

Table 2. Characteristics of the LA sample

Characteristic	Range	Comments
Location and type	All the LAs were in Greater London or Southeast England: Two unitary authorities in Inner London Three unitary authorities in Outer London One county council in Southeast England	London unitary authorities are much smaller than county councils, both in terms of geographical size and population. For example, the child population of LA0 was roughly equivalent to the other five LAs put together.
Deprivation	Using the 2015 IMD rank of average score as a measure of deprivation, the sample had a spread of 94 ranks from least deprived (LA0) to most deprived (LA5). The average deprivation rank of the sample was 60, i.e. lower than average for England as a whole. The two 'high deprivation' LAs in the sample (LA4 and LA5) were not among the 30 most deprived in England, whereas the two 'low deprivation' LAs (LA0 and LA1) were among the 30 least deprived.	The deprivation range reflects the relative affluence of London and SE England compared with the rest of England. Also, some of the most deprived areas in London could not be included in the sample because they have an unusually high proportion of BAME children in their population compared with the majority of English local authorities.
Demographics	Ethnicity varied from over 90% White British to less than 40% White British. Two LAs had over 30% Asian or Asian British children, and one LA	There was a lot of ethnic diversity amongst the London LAs, although there was only one LA where White

[4] Drawing on findings from Hood et al., 2016a, the model focused on re-referrals as the outcomes indicator (percentage of referrals re-referred within 12 months). The hypothetical analysis was to compare three groups of children, so that one group would be found at the third quartile of local authorities' proportions of re-referrals in a given year (26% in 2013) and the other two at the median (21% in 2013). The groups would then be compared with multilevel logistic regression, allowing LAs to differ as a random effect, and with 300 iterations for each potential sample size. The outcome of the simulation was that a total sample size of approximately 2,800 children would be necessary to achieve sufficient analytical power (80%) in the modelled analysis. Based on the total numbers of referrals in 2013 (where the median number was 536 per LA), this would mean a sample of six local authorities.

	had over 20% Black or Black British children. Gender and age were broadly similar across all LAs.	British was not the largest ethnicity group.
Service provision	Rates of service varied a lot between the LAs. Referral rates ranged from 400 per 10,000 to 700 per 10,000 children and CP Plans ranged from 20 per 10,000 children to 80 per 10,000 children. Spend on Children's Safety per LA children ranged from £100 per child to £400 per child. CIN per Social Worker ranged from 10 to 25.	The sample reflects the very large variation in measures seen nationally, e.g. across all English LAs referrals ranged from 223 to 1,092, CP Plans ranged from between 22 and 156 per 10,000 children, and spend on children's safety per LA child ranged from £69 to £587.
Urban/rural classification	5 LAs are described as *Urban with Major Conurbation (<26% rural including hub towns)*, and one is described as *Urban with Significant Rural (rural including hub towns 26-49%).*	Urban with Major Conurbation is the most common classification throughout Inner and Outer London LAs.
Ofsted rating	LAs in the sample had received a range of ratings from their last Ofsted inspections, from inadequate to outstanding.	There are four possible ratings from an inspection: inadequate, requires improvement, good, and outstanding.

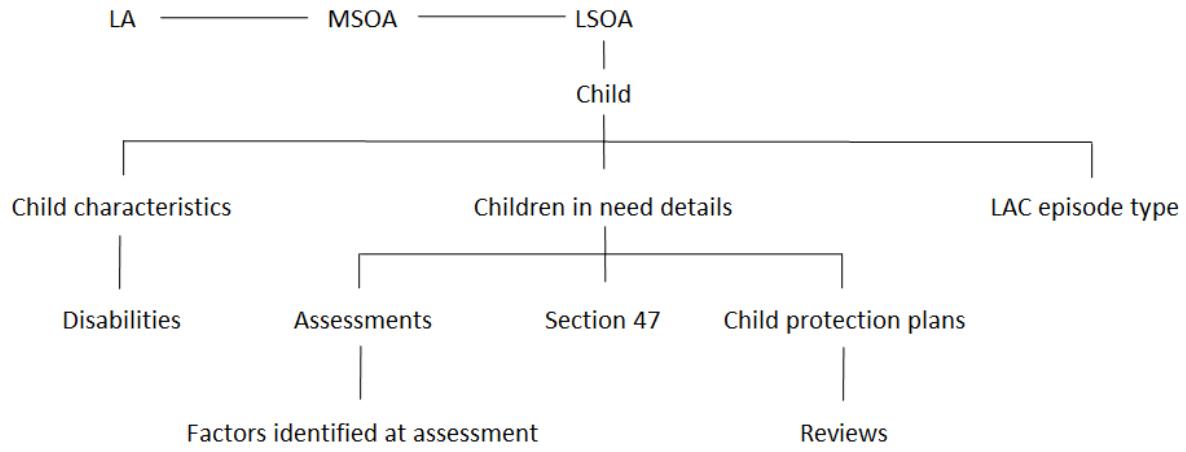
After ethics, access and governance procedures were completed, administrative data on CSC episodes was collected from all six participating LAs as described below.

2.3.2. Data collection

The CIN census and LAC census comprise multiple tables based on a relational model of the data (see Figure 1). The analysis in our study considers all CSC events experienced by each child; events are defined as any point of contact in the system and include all start dates and end dates. A CSC referral marks the start of an episode, and forms the basis of an episode-level data extract. The unique episode identifier links all events occurring within the start and end date of the episode. Episodes are the smallest unit from which data was analysed, and all event information was built into the episode-level dataset as a large set of flags and derived fields. Data from six LAs were included in the extract covering the years 2013/14 - 2017/18.

Geographical codes were used to link additional administrative data. Lower Super Output Area (LSOA) codes were used to link data including the Index of Multiple Deprivation (IMD) scores and estimates of the population size by age and gender. Middle Super Output Area (MSOA) codes were used to link data on ethnicity. LA codes link LA-level contextual variables, including the average IMD scores for each LA.

Figure 1. Linking administrative data for CSC



2.3.3. Bivariate cross-tabulation

Bivariate cross-tabulations (crosstabs) were used to examine intervention pathways, consisting of all actions or decisions that took place between referral and case closure an individual episode.

Likelihood comparisons were done in two parts: first, the likelihood of a child in the LA being referred to CSC based on four child characteristics: age, gender, ethnicity and deprivation; and second, the likelihood of particular outcomes for children following referral. The likelihood of a child being referred from the LA population was shown by comparing rates between different demographic groups. The likelihood of particular intervention pathways following referral was calculated by tabulating a wide range of CIN measures and child characteristics with one another in order to compare all the relationships between them. Children who were re-referred during the four year period had each episode considered separately. Differences between children with single and multiple episodes were also considered as part of the analysis. Significant patterns were identified based on confidence intervals and odds ratios in relation to child characteristics, thresholds and other variables.

Findings from the crosstab analysis (see Section 3.3) were included in an individual report to each participating LA and used as the basis for second round interviews to obtain qualitative feedback on the results (also in Section 3.3).

2.3.4. Latent class analysis

Latent Class Analysis (LCA) is a statistical method for identifying an unmeasured, unobserved construct – a 'latent variable' – that has been derived from several categorical and/or continuous indicators (McCutcheon, 1987; Vermunt and Magidson, 2002; Collins and Lanza, 2009). In this study, LCA was used to create typologies of demand based on the needs identified in social work assessments ('factors at assessment'). The rationale for doing so was twofold. Firstly, indicators such as factors at assessment often represent an underlying concept (e.g. need or risk) that is being

approximated. A latent variable that is constructed from several such indicators can therefore provide a better approximation of the underlying concept. Secondly, this method also addresses one of the challenges of predictive modeling, namely how to deal with multiple predictors in a model when they are related to each other ('multi-collinearity'). LCA helps to overcome this problem by combining multiple indicators of the same underlying construct into a single variable. The analysis therefore served two objectives: first to identify underlying categories of demand and study their characteristics; second to incorporate an evidence-based picture of demand into a subsequent analysis using predictive models (see Section 2.3.5). [5]

The LCA concentrated on 'factors identified at the end of assessment', part of the CIN Census child-level data collected for the study (see Section 2.3.2). There are 40 potential factors that can be listed (see Appendix A). Each assessment can have multiple factors and each episode can have multiple assessments. In total there were 91,309 assessments carried out, 80,448 of which had factors recorded at assessments. The factors from each assessment in a single episode were combined in order to flag all factors that were listed in the overall episode. Factors relating to another person, private fostering, UASC, and trafficking were excluded from the LCA due to very low numbers (counts of less than 10). 'Other' was also excluded as some LAs reported 'no factors' as 'other' (particularly in cases that were Assessed not CIN). The analysis was run on a sample of 2,500 episodes from each LA (approximately the size of our smallest LA), meaning 15,000 in total. The balanced sample addresses the problem of biased estimates for larger LAs, particularly for the analysis carried out on LAs independently (i.e. not split by group). Cross-validation was done to ensure that the latent classes weren't just an artefact of that specific random sample.

The analysis was run on all six LAs independently. Fit statistics were used to identify the optimal number of classes and to establish whether the LCA models estimated the same number of classes for each LA (Nylund *et al.*, 2007). Ten models were calculated for each LA, differing only in the

[5] There are several types of algorithm that can be used for clustering, e.g. K-means, hierarchical clustering and factor analysis. The main advantage of LCA over the others is that the analysis can accommodate both numeric and categorical variables whereas most can only accommodate numeric variables. For example, K-means cluster analysis can only be applied to interval or ratio data and does not provide robust set of criteria to judge the suitability of solutions. Hierarchical clustering usually uses continuous variables only and it is not easy to judge what the final number of clusters should be, while factor analysis is based on covariance between continuous variables with normal distributions. LCA is often used in health and social sciences research where many variables are not found on a continuum (Collins, 2009; Stamovlasis, 2018).

In LCA, cases are randomly assigned to a pre-determined number of classes. A statistical summary of means and measures of variation are computed for each cluster along with the measure of the distance between each observation and between each cluster. The probability of class membership for each case is computed along with size of each cluster (as the average of the probabilities). The process of computing the distance between each observation and revising the class solutions is repeated in a continuous cycle until the class solutions stabilize; this process is known as iteration and convergence. In LCA the iteration process can be repeated hundreds or even thousands of times until convergence is reached (McCutcheon, 1987; Vermunt et al, 2002).

number of classes. The models were examined for overall fit using BIC and AIC scores.[6] Invariance testing was carried out to check the assumption that the class solutions can be applied equally across different groups (LAs), or whether each group should have their own class solutions (Kankaraš *et al.*, 2012). The invariant models assume that the latent classes have equal loadings. This means that the class membership is associated with the indicator variables in the same way in all groups (LAs).[7] These models were also examined for best fit using Bayesian information criterion (BIC) and Akaike information criterion (AIC) scores. The results showed that the 7-class model, invariant across all LAs, was the best fit for the data (see Table 3).

Table 3. Fit statistics showing AIC/BIC invariance testing

Class size	**Configural**		**Invariant**	
	AIC	**BIC**	**AIC**	**BIC**
6	155851.5	162332.5	160396.5	161508.4
7	154994.9	162709.7	159149.5	160474.7

Based on the 7-class invariant model each episode was assigned a class membership, which was extracted as a latent variable for multilevel modelling with other variables. The description of the seven latent classes, and their relationship with other variables (Vermunt, 2010), are covered in the findings (Section 3.4).

2.3.5. Regression analysis

Regression analysis was used to explore the interaction between 'child-level' and LA-level deprivation (explanatory variables) in terms of their effect on intervention rates (outcome variables) in different parts of the system. Since CSC services do not collect administrative data on the socio-

[6] Several considerations were given to the usage of these scores. Firstly, it is not uncommon that the AIC and BIC continues to decrease for each additional class added, which makes it hard to determine whether the decrease of BIC and AIC values is substantially important or not. For this reason we explored diminishing gains in model fit using *elbow* plots, similar to the scree plots of Eigen values used in Factor analysis. Secondly, neither the AIC and BIC scores are guaranteed to arrive at the same lowest value corresponding to the number of classes. Both scores apply a different penalty for the number of model parameters included. However, simulation studies have generally found that BIC scores more consistently identify the correct model over other information criteria, so it was decided to use BIC is the main information criteria for comparing models (Nyland, 2007). Lastly, the elbow plots were found to be different for each LA; the models indicated that there were either 6 or 7 classes in each LA. Therefore the decision was taken to run invariance tests for both class sizes 6 and 7.

[7] Restricting models with invariance reduces the number of estimated parameters, whereas freely estimating them increases the number of estimated parameters. AIC and BIC impose a penalty for the number of parameters estimated (Nyland, 2007). If the same LCA solution fits well for all LAs the penalty applied for freely estimating parameters should outweigh the additional predictive power of these additional estimates, and the AIC and BIC should decrease - this means that LAs have similar class structures and implies that they have similar types of 'common cases' and/or recording practices.

economic status of children or their families/households, IMD scores for small neighbourhoods called 'Local Super Output Areas' (LSOAs) was used as a proxy for the deprivation level of all children within those neighbhourhoods. These areas vary in size and population but on average include 361 children across 672 households (Census, 2011).

The type of regression model used for this analysis was negative binomial regression, which is appropriate for working with non-normally distributed data and in order to predict outcomes that are rates (i.e. numbers per 10,000 population in each LSOA). The model uses log rates for the outcome variable so that the result is multiplicative, i.e. a percentage change (or odds change) in the outcome variable operates cumulatively with each step change in the predictor variable(s). Initial unadjusted relationships between explanatory and outcome variables were obtained via tabulation and stratification before the confounding and interaction effects were investigated. Regression analysis was then used to provide estimates for two predictors (child-level/LSOA proxy and LA-level deprivation) on an outcome (e.g. referral rates), with the results then stratified by a third predictor variable, e.g. age or gender. This approach made it easier to separate out the main effects while reducing problems due to sparse data. The analysis was carried out using a random-intercept multilevel model in order to adjust for LA-membership and account for clustering within LAs. The point estimates, standard errors and log-likelihood obtained from a random effects model all take account of intra-LA clustering. The predictor variables, child-level/LSOA proxy IMD scores and LA-level IMD scores, were decile ranked and ordered (1) least deprived to (10) most deprived. The models calculated how the decile rank changes in child-level/LSOA proxy deprivation and LA-level deprivation affected the rates of intervention.

The first part of the analysis examined whether the social gradient and inverse intervention effect was more prominent in certain parts of the system. The second part of the analysis examined whether the effects were stronger for particular groups of children e.g. younger children or White British children, or for different types of episodes. The third part of the analysis examined whether the effects were stronger for particular types of episodes, e.g. different needs identified at assessment and categories of abuse for CP Plans. The detailed breakdown by different demographic subgroups and episode subgroups showed the relative strengths of the social gradient and inverse intervention effect. A comprehensive set of odds ratios and confidence intervals were presented graphically in forest plots. In the findings (Section 3.5) the forest plots are shown with the odds on the y-axis, with connecting lines added to illustrate the relative changes in odds from one categorical value to the next.

The decision was taken to report on proportional odds without cross-level interaction effects because: a) the sample size at level-two (LA-level) was too low which affected statistical significance and gave very wide confidence intervals; b) the nature of carrying out many smaller regression models meant an increased likelihood of mistaking a chance finding for evidence of interaction (Type I Error); and c) the evidence on interaction was weak based on the analysis of tabulation and stratification. More LAs would be needed in order to: a) explore the heterogeneity of the effect i.e. whether the inverse intervention effect was more pronounced for more deprived children compared with less deprived children; and b) test whether other LA-level variables might confound the effect.

2.4. Qualitative study of system conditions and intervention pathways

The qualitative study was designed to explore system conditions for CSC in the same six LAs that had provided administrative data for the study described above (Section 2.2). Its aim was to get an inside perspective from senior practitioners and managers on the key factors affecting patterns of demand and provision. Following ethics, access and governance approvals, five managers and senior practitioners in key CSC service areas were approached in each LA to take part in two rounds of qualitative interviews, about five or six months apart. Generally the same people were interviewed twice; if someone left the LA after the first interview then their replacement in the post was invited to do the second. In total 60 interviews were carried out with 36 participants, as summarised in Tables 4 and 5.

Table 4. Summary of interview participants

Local authority (LA)	**Service areas**	**Total number of interviews with total participants (two interviews were undertaken in pairs)**
LA1	Court and Child Protection; Early help; Locality Social Work team; Referral, Assessment and Intervention	10 interviews with 5 participants (LA1, P1-5)
LA2	Business Support, Planning and Performance; Children in Need; Commissioning; Early help; Post Permanency Support; Referral and Assessment	9 interviews with 9 participants (LA2, P1-9)
LA3	Business Support, Planning and Performance; Children in Need; Referral and Assessment; Specialist Adolescent Worker	12 interviews with 6 participants (LA3, P1-6)
LA4	Business Support, Planning and Performance; Early help; Locality Social Work team; Looked After Children	10 interviews with 6 participants (LA4, P1-6)
LA5	Locality Social Work teams; Looked After Children; Referral and Assessment	9 interviews with 5 participants (LA5, P1-5)
LA0	Early Help; Child Assessment and Safeguarding Teams; Commissioning; Looked After Children	10 interviews with 5 participants (LA0, P1-5)

Table 5. Sample characteristics for interview participants

Local authority (LA)	**Roles**	**Gender**	**SW qualification**	**Post-qualifying experience (for social workers) or relevant experience (for other practitioners)**
LA1	1 Service Manager 3 Team Managers 1 Strategic Manager	3 Females 2 Males	4 Yes 1 No	All 10+ years
LA2	3 Senior Social Workers 5 Service Managers	7 Females 2 Males	5 Yes 2 No	4 -10+ years 2 - 6-10 years

	1 Deputy Service Manager		(2 – no info)	1 – 2-5 years (2 – no info)
LA3	1 Service Manager 1 Manager 4 Officers	4 Females 2 Males	5 Yes 1 No	3 – 10+ years 1 – 6-10 years 2 – 2-5 years
LA4	2 Social workers 1 Team Manager 3 Service Managers	6 Females	5 Yes 1 No	4 – 10+ years 1 – 6-10 years 1 – 2-5 years
LA5	5 Service Managers	2 Females 3 Males	5 Yes	4 – 10+ years 1 – 6-10 years
LA0	1 Service Manager 2 Team Managers 2 Assistant Team Managers	5 Females	3 Yes 2 No	3 – 10+ years 1 – 6-10 years 1 – 2-5 years

All the interviews were carried out by one qualitative researcher, except for four participants interviewed by the principal investigator. For the first round of interviews a semi-structured interview schedule was used to explore participants' experience and perception of the factors shaping CSC services in their area. About five months later, each participant was sent a summary of findings from their own LA, consisting of key themes from first round interviews as well as results from the bivariate crosstab analysis (see Sections 3.2 and 3.3). This summary formed the basis for the second round interviews, focusing on key findings and any other developments in the LA. Interviews were audio-recorded and transcribed before being imported into qualitative data analysis software, NVivo12.

Analysis of first round interviews was based on the Framework method (Ritchie *et al.*, 2013), which has frequently been used for qualitative and mixed methods research in health and social care (Gale *et al.*, 2013; Mason *et al.*, 2018). The procedure was based on the six-stage process outlined by Gale et al. (2013), starting with the transcription of audio-recorded interviews and uploading of transcripts onto Nvivo qualitative analysis software (Nvivo12). Two members of the research team (SG and RH) proceeded to familiarise themselves with the transcribed material before carrying out an open coding of a selection of six transcripts (one from each of the participating LAs). The researchers did this separately to begin with before meeting to compare the codes that had been applied to the data, discuss any differences in interpretation and agree on a working analytical framework. As part of this discussion, individual codes were grouped together into thematic categories; for example, the theme 'socio-economic factors' incorporated a range of codes referring to austerity, cuts, benefits, housing, isolation, and employment. In the next stage, one of the researchers (SG) applied the working analytical framework to the remaining interviews, with the flexibility to add new codes to the framework in discussion with the rest of the research team. The final part of the analysis was to prepare a summary of the framework matrix, using the overall thematic headings as 'columns' and each of the six participating LAs as a 'row', so that each cell contained a synthesis of findings on each theme for each LA. This final version of the framework could be read horizontally to compare themes across LAs, or vertically to create a picture of system

conditions in each LA. The latter contributed to the reports compiled for LAs on findings in their area, while the former established the basis for the findings reported below in Section 3.2.

3. Findings

Findings from each of the three studies are presented below and then examined together in Section 4 of the report, which discusses overall implications for our understanding of welfare inequalities in the context of CSC.

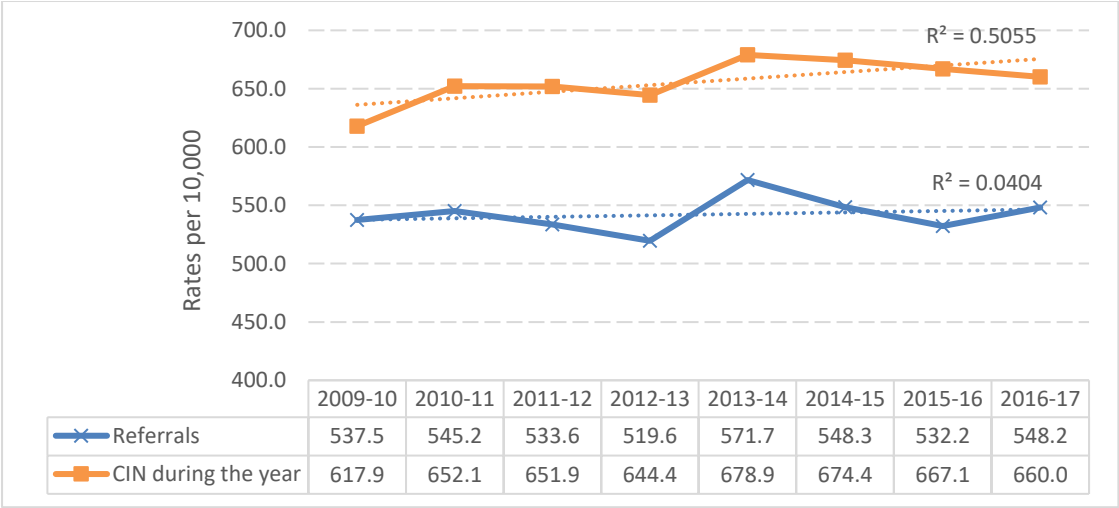
3.1. Demand management in CSC

This section presents findings from the analysis of national data returns for CSC, looking first at trends over the past eight years before explaining what patterns of correlation tell us about how services manage demand for CSC.

3.1.1. Analysis of trends

The analysis of trends examined a range of key indicators over the period 2009 – 17. The analysis showed that rates of child protection interventions and admissions to care have increased much faster than rates of referrals and CIN. This is illustrated below in Figures 2-4, displaying line charts for three sets of indicators. The dotted trend-lines are much steeper for Section 47 investigations, CP plans, care proceedings, and care orders than they are for CIN and referrals. Indeed, referral rates hardly went up at all over the eight year period. Overall the findings show an increasing tendency for CSC services to use child protection interventions relative to the referrals they receive.

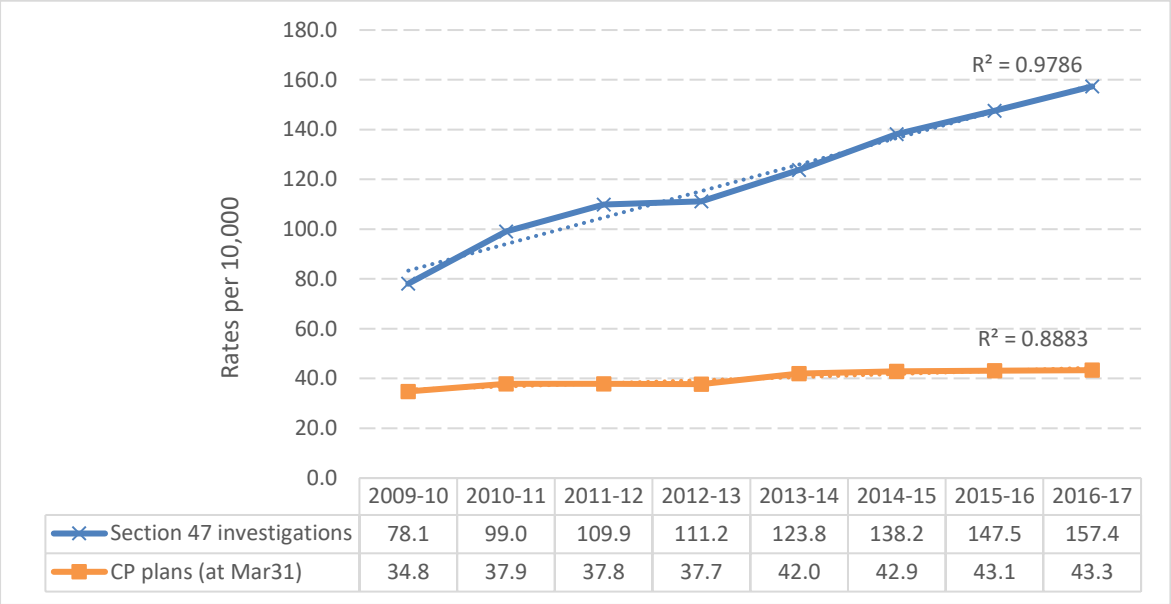
Figure 2. Trends in rates of referrals and CIN (2009-17)



	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Referrals	537.5	545.2	533.6	519.6	571.7	548.3	532.2	548.2
CIN during the year	617.9	652.1	651.9	644.4	678.9	674.4	667.1	660.0

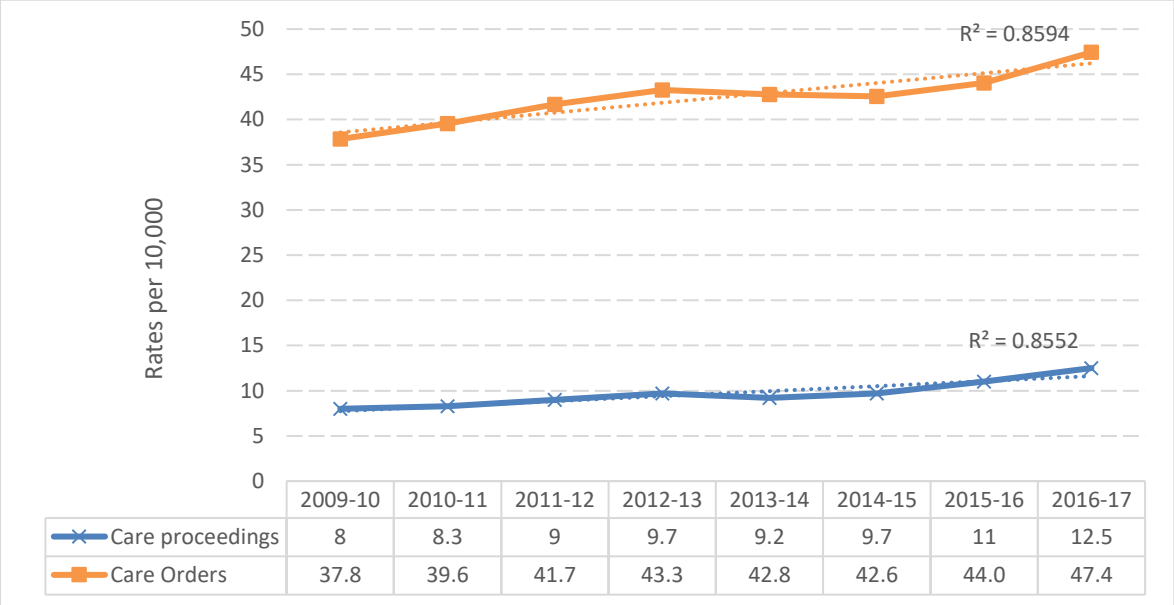
Note: R^2 is a measure of how well the data points fit the line of best fit (0-1, where 1 is an exact fit)

Figure 3. Trends in rates of Section 47 investigations and CP plans (2009-17)



	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Section 47 investigations	78.1	99.0	109.9	111.2	123.8	138.2	147.5	157.4
CP plans (at Mar31)	34.8	37.9	37.8	37.7	42.0	42.9	43.1	43.3

Figure 4. Trends in rates of care proceedings and care orders (2009-17)



	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Care proceedings	8	8.3	9	9.7	9.2	9.7	11	12.5
Care Orders	37.8	39.6	41.7	43.3	42.8	42.6	44.0	47.4

Other findings from the trends analysis were:

- Implementation of the continuous child and family assessment in 2013-14 was followed by an increase in assessment rates and a higher proportion of referrals receiving an assessment.
- Rates of accommodation under Section 20 decreased over the same period that care orders increased.
- Rates of referrals leading to no further action (NFA) decreased over the five year period for which data were available, although the figure in 2016-17 was slightly higher than in the

previous year. In contrast, rates of children assessed as not meeting the threshold for CIN rose over the same period, particularly following the introduction of the continuous assessment.

- The proportion of CP plans relative to CP conferences decreased steadily from 2009 – 2017

3.1.2. Correlation analysis

Correlation analysis focused on the period 2014-17, and findings were compared with those reported in an earlier study using the same methodology (Hood et al. 2016a). Results were reported for associations found to be statistically significant ($p < 0.05$) across all three years (2014-17), or in two out of three years where the same type of correlation (i.e. positive or negative) had been significant in all previous years. As expected, demand indicators across a range of thresholds correlated positively with each other and with average levels of deprivation. In other words, LAs that were more deprived received more referrals (per 10,000 children), carried out more assessments, had more CIN and CP plans, and admitted more children into care. An example of the output is given below in Table 6, which shows the effect size (top row), significance test (middle row), and the number of LAs in the analysis (bottom row), for the correlation of deprivation with demand indicators each year from 2011-17. The highlighted fields are those where the correlation was found to be statistically significant. Of course, this could happen in any given year as a matter of chance but a consistently significant finding over a number of years is very unlikely to be random. Deprivation was positively correlated with almost all demand indicators over the eight year period (see Table 6). The exception was re-referrals (at the bottom of the table), which is interesting since these are a subset of referrals (about 20-25% in most LAs). Re-referrals are discussed again later in this section. The complete correlation matrix can be found on the project website as a supplementary file to this report.

Table 6. Correlation matrix showing IMD Average Score (LA) with demand indicators

Demand indicators		**IMD Average Score (LA)**						
		2011	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Referral	Coefficient	.580**	.543**	.526**	.480**	.520**	.474**	.502**
	Sig. (2-tailed)	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
	N	150	148	149	149	149	150	150
Assessment: Initial	Coefficient	.603**	.536**	.520**	.255**			
	Sig. (2-tailed)	<0.001	<0.001	<0.001	0.003			
	N	150	142	141	130			
Assessment: Core	Coefficient	.488**	.406**	.456**	0.159			
	Sig. (2-tailed)	<0.001	<0.001	<0.001	0.074			
	N	149	142	141	127			
Assessment: Continuous	Coefficient					.461**	.409**	.461**
	Sig. (2-tailed)					<0.001	<0.001	<0.001
	N					150	150	150
CIN at March 31st	Coefficient	.596**	.616**	.648**	.576**	.633**	.603**	.679**
	Sig. (2-tailed)	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
	N	146	148	147	149	150	150	150
CIN starting in year	Coefficient	.597**	.592**	.640**	.621**	.618**	.603**	.650**

	Sig. (2-tailed)	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
	N	144	148	149	148	150	150	150
Section 47s	Coefficient	.469**	.373**	.403**	.379**	.447**	.475**	.499**
	Sig. (2-tailed)	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
	N	146	144	149	150	150	150	150
CP Conferences	Correlation	.581**	.534**	.564**	.463**	.481**	.412**	.471**
	Sig. (2-tailed)	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
	N	146	145	149	150	150	150	150
CP Plan at March 31st	Coefficient	.588**	.559**	.499**	.515**	.555**	.426**	.456**
	Sig. (2-tailed)	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
	N	149	148	149	150	150	150	150
CP Plan starting in year	Coefficient	.573**	.560**	.554**	.486**	.517**	.419**	.485**
	Sig. (2-tailed)	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
	N	150	148	149	150	150	150	150
Care Proceedings	Coefficient	.678**	.696**	.706**	.701**	.629**	.488**	.582**
	Sig. (2-tailed)	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
	N	150	150	150	150	150	150	150
Children taken into care	Coefficient	.765**	.760**	.752**	.744**	.704**	.678**	.662**
	Sig. (2-tailed)	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
	N	150	150	150	150	150	150	150
Section 20s	Coefficient	.256**	.190*	.223**	.223**	.168*	.165*	.176*
	Sig. (2-tailed)	0.002	0.02	0.006	0.006	0.041	0.043	0.035
	N	150	150	150	150	149	150	145
Re-referrals within 12 months	Coefficient	0.014	0.006	-0.014	-0.088	-0.082	-0.118	-0.06
	Sig. (2-tailed)	0.871	0.943	0.863	0.29	0.321	0.152	0.465
	N	135	140	147	148	148	149	150

Notes:
** p-value <0.05*
*** p-value <0.01*

Having established the link between deprivation and demand, the analysis proceeded to examine patterns of service provision in LAs with different levels of deprivation-related demand. These are discussed below under three headings: screening, rationing and workforce churn.

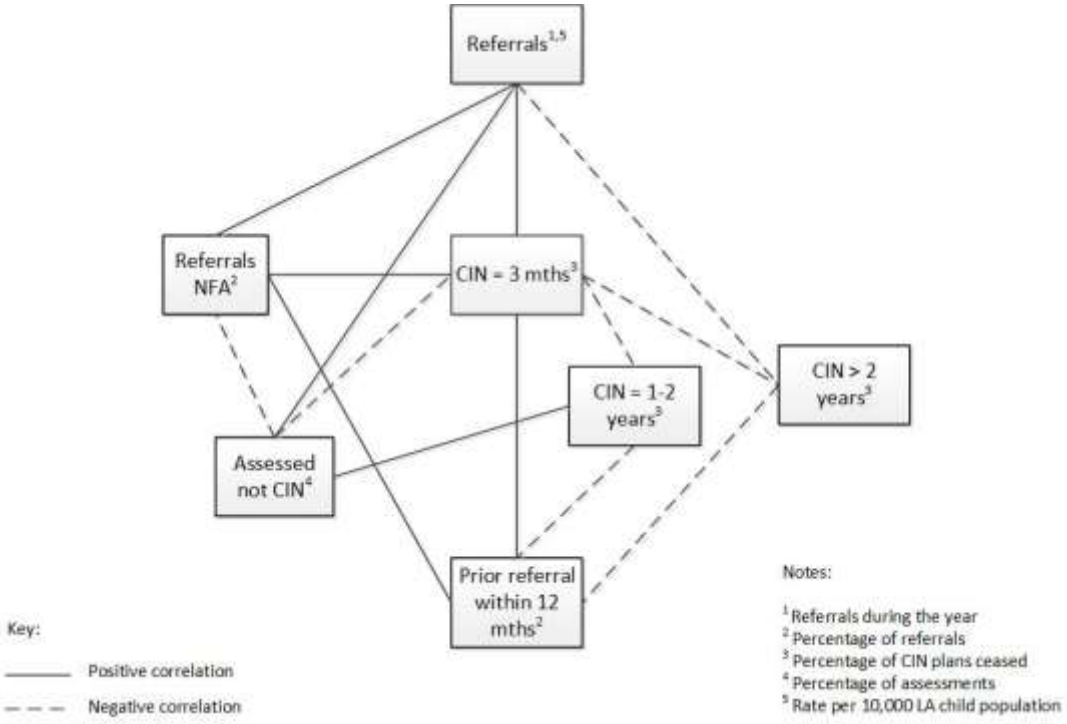
Screening

Patterns of correlations are difficult to interpret from tables so the findings below are shown in the form of network diagrams ('correlelograms'). In these diagrams, consistently positive correlations are represented by solid lines, indicating that if one variable goes up (e.g. rates of assessment) then another variable (e.g. rates of children assessed as 'not CIN') also tends to go up. In contrast, consistently negative correlations are shown by dashed lines, indicating that if one variable goes up (e.g. rates of CIN) then another variable (e.g. the proportion of CIN plans lasting over 2 years) tends to go down.

Using this method, Figure 4 shows a pattern of correlations around the screening of referrals. The solid lines show that LAs with higher rates of referrals also tend to screen out a higher proportion of them, either by taking 'no further action' (NFA) or assessing them as 'not CIN'. The same pattern is found with other demand indicators such as CIN and assessment rates. LAs with more demand also tend to close a higher proportion of CIN cases within three months. Conversely, the dashed lines

show that LAs with higher referral rates tend to have a lower proportion of CIN cases lasting over two years, while LAs that close more CIN cases within 3 months tend to have fewer open for one year or more. There is also evidence that higher levels of screening, as indicated by levels of NFA and early/late case closure, are associated with more re-referrals.

Figure 5. Screening of referrals



Interestingly, Figure 5 indicates that LAs that have more NFAs also close more cases within 3 months, but these LAs also tend to assess fewer cases as 'not CIN'. This pattern suggests a knock-on effect when screening is applied at different thresholds. The correlations shown in Figure 6 explore this effect further, showing the impact of varying levels of demand on screening at successive thresholds in the system.

Figure 6. Impact of demand on screening at different thresholds

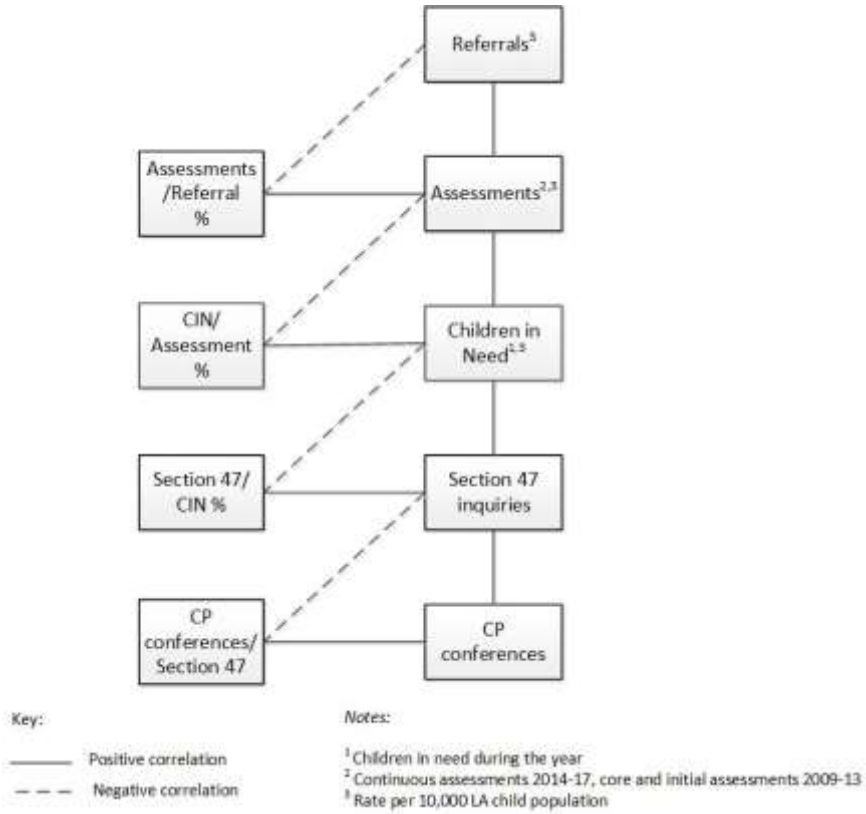
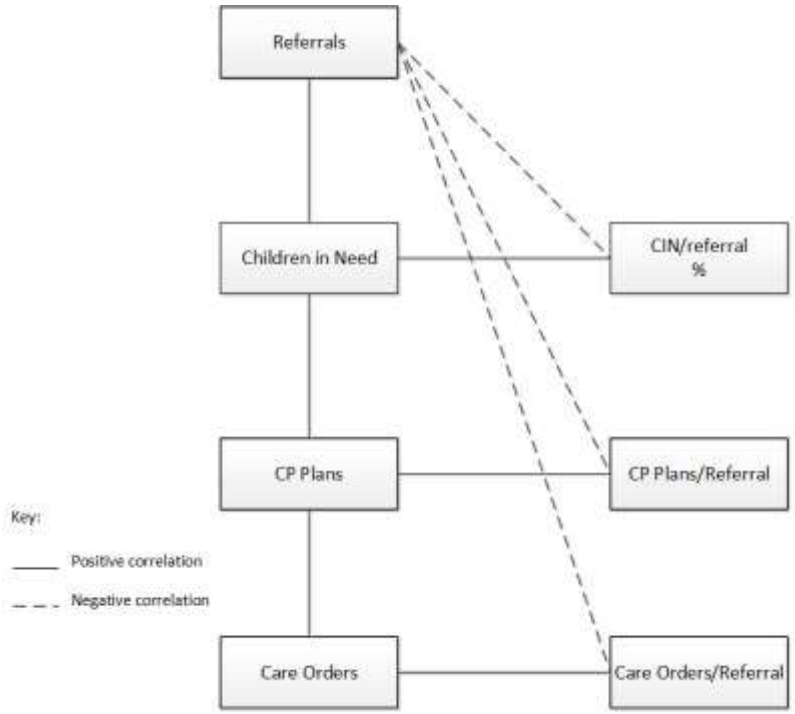


Figure 6 shows an alternating pattern of correlations corresponding to demand being screened in (positive) and screened out (negative). In effect, high levels of demand at a given point in the system was associated with more screening in at that particular threshold – but were then followed by more screening out at the threshold that immediately followed. For example, LAs that assessed more children as CIN tended to end up with higher rates of CIN, but these LAs also tended to carry out fewer Section 47 investigations per CIN. In turn, LAs that carried out more S47 investigations per CIN tended to hold fewer case conferences per S47 undertaken. Although not shown above, the same pattern applied to care applications – LAs with higher rates of CP plans tended to initiate fewer care proceedings per CP plan.

Figure 7 shows how screening operates with respect to external and internal levels of demand. The series of diagonal dashed lines on the right reflect the tendency for LAs with more demand to provide fewer services relative to referrals. Equally, the series of horizontal solid lines show that the less LAs intervene at particular thresholds the less work they end up with at that threshold. These tendencies constitute a screening mechanism whose principal purpose is to manage demand.

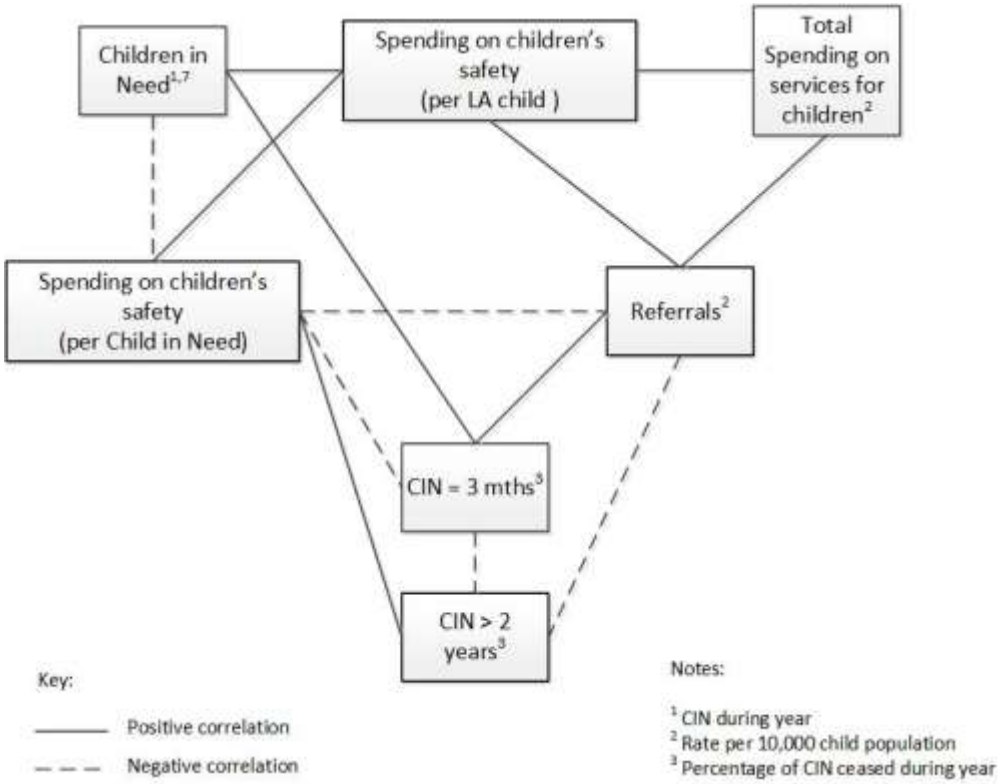
Figure 7. Demand management via screening in/out



Rationing

Since LAs manage demand in relation to the resources available, patterns of provision were studied in relation to the money spent by LAs on services for children. In Figure 8, expenditure is measured in three ways: total spend per LA child, spending on children's safety per LA child, and spending on children's safety per CIN. The correlations show that more demand, i.e. higher rates of referrals and CIN, is associated with higher expenditure per LA child but *lower* expenditure per CIN. In other words, LAs with higher demand tend to spend more money overall but less money on the children who receive services, when compared to LAs with lower demand. This rationing process is linked to the screening mechanism, e.g. LAs that spend less on children's safety per CIN also tend to close cases earlier.

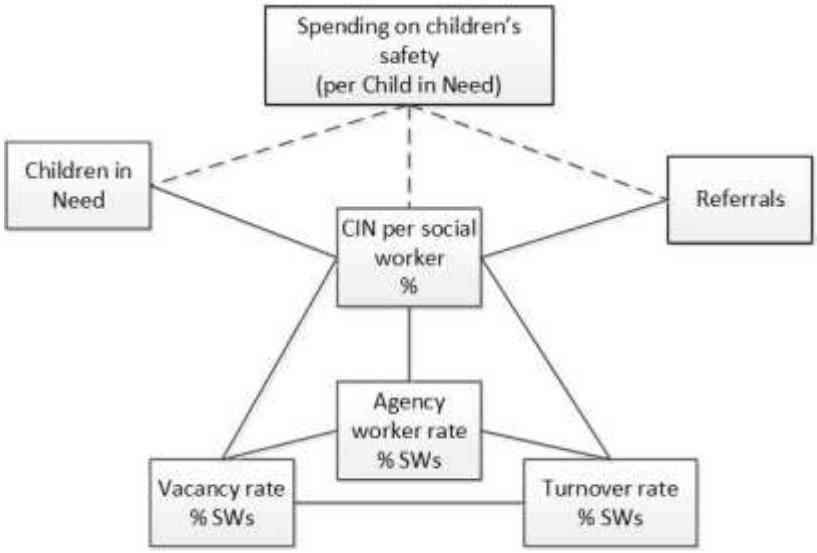
Figure 8. How expenditure relates to demand



Workforce churn

The final pattern of correlations concerns workforce stability, as measured by turnover, vacancies and agency staff (social workers). Figure 9 shows that lower spend per CIN generally leads to more CIN per social worker, which in turn is associated with higher rates of turnover, vacancies and agency staff. This suggests that rationing is linked to workforce churn.

Figure 9. The link between demand, expenditure and workforce stability



3.1.3. Summary

Overall the findings from the quantitative analysis of national datasets can be summed up as follows:

- Rates of CP interventions, care proceedings and care orders rose every year from 2014-17, while rates of referrals and CIN remained largely unchanged. The same period saw implementation of the continuous child and family assessment, coinciding with an increase in assessment rates and a higher proportion of referrals receiving an assessment.
- National trends point to continued escalation in the use of CP interventions by LAs since 2009, particularly Section 47 inquiries and case conferences. Although overall rates of CP plans have risen, CP plans as a proportion of case conferences have fallen over this period.
- Rates of care proceedings increased while rates of accommodation under Section 20 decreased during 2014-17, both continuing trends observed since 2009.
- Correlation analysis provided evidence for three interconnected mechanisms of demand management: screening, rationing and workforce churn.
- Screening refers to the tendency for LAs to either escalate (screen in) or filter (screen out) cases at different thresholds, in response to levels of demand. Overall, higher demand was associated with more screening out, particularly at referral and assessment, and shorter timeframes of work for children in need and children on CP plans.
- Higher demand at particular thresholds was associated both with more screening in at that threshold but with more screening out at the threshold that immediately followed. Such feedback loops allowed the system to respond not only to external but also internal variations in demand as cases progressed through the system.
- *Rationing* refers to the tendency for LAs with higher levels of demand to spend less on the children they work with. LAs with more referrals and CIN had lower levels of expenditure per CIN. These LAs also had higher rates of CIN per social worker, higher caseloads, were more likely to close cases early and less likely to work longer term with children.

- *Workforce churn* arose from the rationing response to high levels of demand, and refers to the tendency for LAs with higher rates of CIN per social worker to have higher rates of agency workers, turnover and vacancies.

Overall, the findings suggest that high demand, high deprivation LAs experience greater financial pressures than low deprivation LAs, which leads them to screen more cases out, work with families for shorter periods, spend less per child on CIN and experience greater workforce churn. In contrast, LAs that are less deprived overall have more resources relative to the level of demand and adopt a more interventionist approach to child welfare.

3.2. System conditions – a qualitative perspective

This section presents findings from the qualitative analysis of first round interviews (see Section 2.4) The main themes identified in the analysis of participants' responses were: demand, finance, Early Help, universal services, multi-agency partnerships, thresholds, workforce, inspections, organisational culture and socio-economic factors.

3.2.1. Demand

Participants in all the LAs identified increasing demand for CSC in their area, particularly for CP and care. This was perceived as a major challenge for services, particularly given the financial pressures (see below). There were commonalities and differences in the factors driving demand. Common factors included the impact of austerity policies and growth in child poverty, a general rise in the local child population (experienced in all areas but particularly in LA5), more demand from adolescents, and the prevalence of domestic abuse along with parental substance misuse and mental illness (the so-called 'toxic trio'). Demand was particularly concentrated in districts with high levels of deprivation, and was differentiated in terms of age, gender, and ethnicity. The intersection between neglect and parental risk factors was the principal concern for younger age groups, particularly under 5s, and predominantly in poorer areas:

> *'The cycle that the parents are in, the drink, drugs, mental health, they do have a big impact on the children and domestic violence. None of those areas you could say are unique to areas of deprivation, they're just well-hidden in other places.' (P1, LA2)*

> *'I think our bread and butter is neglect, not managing children's behaviour, beyond parental control, domestic abuse.' (P3, LA0)*

In relation to adolescents needing statutory services, there was agreement on the main presenting issues, namely vulnerability to child sexual and/or criminal exploitation (CSE/CCE), gang affiliation, involvement in 'county-lines' drug supply, substance misuse and mental health problems. Some issues were more dependent on local context, such as numbers of unaccompanied asylum-seeking children (LA3 and LA5). Overall there was a perception that teenagers with complex needs were now more likely to be accommodated in public care, putting pressure on placements and the cost of

services for Looked After Children (LAC). For some issues, particularly CSE/CCE, demand drivers (i.e. new or growing risks to adolescents) were allied to supply-side factors, such as increased awareness among agencies and a higher public and political profile, contributing to the rise in intervention. Nonetheless, there was also widespread recognition that conventional statutory procedures for children at risk of harm – multi-agency CP plans focused on partnership working with the family – were less effective for teenagers, for whom the safeguarding context encompassed peer groups and other adults outside of the family (see below). Some participants (particularly in LA1, LA2 and LA5) drew attention to the combination of learning difficulties and behavioural problems, which if not addressed in primary school would escalate in the transition to secondary school (post-11). Such children often ended up being excluded from mainstream provision, effectively dropping out of school and becoming vulnerable to exploitation and grooming by older peers and gangs. This pattern was thought to increase the risk of young people entering care. Participants in most areas also expressed concern about the rising incidence of adolescent self-harm and mental illness, compounded by a lack of therapeutic services (see below).

3.2.2. Finance

Participants in all the LAs spoke of the financial pressures on services due to the combination of rising demand and huge cuts to local government funding over the past eight years. Most LAs had responded by protecting core statutory services and retaining targeted Early Help (see below) while reducing spend on externally commissioned services and universal/community-based provision. The resulting instability had affected long-term planning and even the viability of some community providers, and had restricted the options for social workers drawing up care plans for children:

> *'Resources that we can refer out to have gone down hugely so I think where a Social Worker might have been able to direct a family towards a charity or some kind of voluntary sector service, they don't have that capacity to anymore because either the service isn't taking referrals because they're at capacity or they're just not working anymore with families, so Social Workers are feeling the pressure to do a lot of that work themselves'. (P1, LA5)*

The biggest pressure on LA budgets was placements for LAC, particularly in residential care where average placement costs are in the region of £2,000 - £3,000 per week. The LAC profile in some areas (particularly LA2, LA3 and LA4) was felt to be increasing in age and complexity of need, creating demand for more specialist placements at a time when LAs were trying to reduce their number. This dilemma was encouraging LAs to explore new strategies for addressing CP concerns for young people, including edge-of-care teams (LA2) and specialist adolescent teams (LA3).

3.2.3. Early Help (EH)

Despite the funding cuts, all the LAs had retained some form of EH provision, having brought together a range of preventative services as 'Integrated EH or as an 'EH Hub'. EH was therefore being managed as a non-statutory function of CSC, and referrals to this function had largely replaced the earlier practice of undertaking assessments and care planning under the Common Assessment Framework (CAF). EH is designed to cover both Tier 2 (children with an additional need that cannot

be met by universal services), and Tier 3 (children with more complex needs requiring a multi-agency response but below the threshold for statutory intervention). In areas where EH had been integrated with CSC for some time (LA1, 2, and 6), it seemed to be used mainly for Tier 3 and children on the 'borderline' of statutory CIN provision. Where this development was more recent (LA3) EH was still seen more in terms of Tier 2 provision. Currently LAs were operating EH using a similar referral and 'screen and intervene' model to statutory CSC, ensuring that only children with an appropriate level of need would receive a service.

> *'We've got different thresholds. [Level] One is obviously our universal level; Level 4 is children's services, like statutory children in need, and in between we've got Levels 2 and 3, which is our early help service. And we've got the Family Support Service who kind of do targeted intervention, but they're not statutory children's services, if that makes sense, so that's like targeted Early Help.' (P3, LA0)*

Participants who were managing or working in EH services thought that LAs on the whole did recognise the importance of EH but were constrained by the need to prioritise statutory services. EH was therefore perceived as vulnerable to cuts, with the higher tier services being in a better position to evidence their effectiveness, e.g. through the prevention of referrals to CSC, and therefore more likely to be maintained. Some LAs (e.g. LA0 and LA4) had family support workers based in locality or district teams, although their role was mainly to help with CIN work (i.e. prevent escalation to CP). Other LAs (e.g. LA2 and LA3) were developing intensive support around adolescents as part of 'edge of care' provision, as well as moving towards a locality model where EH provision would be aligned with clusters of schools (LA2) or districts (LA1) rather than being centrally organised. Overall there seemed to be a lot of flux and experimentation in EH, reflecting efforts to find an adequate preventative model to deal with rising demand under acute financial constraints.

The main sources of demand for EH were considered to be families under stress and/or in conflict, parents experiencing difficulties in meeting their children's needs, parents struggling to manage their children's behaviour (particularly teenagers), and mental health problems experienced by parents and children alike. Due to the level of demand there were waiting lists for EH in some LAs and resources seemed to be geared increasingly towards assessment and coordination rather than providing a service. Some LAs operating a hub model (e.g. LA4 and LA5) had retained the ability to intervene directly to support families, whereas others (e.g. LA1 and LA3) had focused more on mobilising capacity among their partner agencies. Overall there was a sense that EH had become more targeted and was dealing with more complex issues:

> *'The Early Help Team would say that the types of cases that they're getting are far more complex so essentially the threshold is higher for them, you know, they are getting complex cases, which they might not have [in the past]' (P1, LA5)*

> *'I think Early Help is probably one of the most effective areas but they're complex, whereas before it would have been people who needed support rather than managing complex situations.' (P5, LA0)*

The refocusing of EH around Tier 3, or children with complex needs, meant that fewer resources were available for Tier 2, i.e. families presenting to services for support with a single issue, such as

financial difficulties, or problems managing a teenager's behaviour. In many LAs, EH had replicated the refer-assess-coordinate model used by statutory services, similar to earlier practice under the Common Assessment Framework. Under this model, an EH practitioner would complete an assessment which would then go to either a manager or a panel for a decision on eligibility. If deemed appropriate, the next step was usually told hold a Team around the Family meeting to formulate a plan of action, which would be reviewed at one or more subsequent meetings. Other LAs had tried to retain an element of direct preventative work within EH while ensuring this would be targeted at families with more complex needs. In LA2, it had been noticed that a lot of predictable demand was coming from schools, leading to plans to concentrate EH provision in school-based clusters. Effective partnerships and buy-in from other agencies were thought to be crucial for the success of an EH model that had shifted away from direct work and towards assessment and care planning.

3.2.4. Universal services

Participants in all LAs noted the effect of cuts to universal provision in their areas. They reported partial or full closure of children's centres, family centres, community centres, youth clubs and other facilities in the community. Funding of voluntary sector agencies and school budgets for pastoral care and education welfare were also thought to have been reduced in most areas. Funding constraints were affecting women's refuges and other services for survivors of domestic violence, as well as organisations providing support to young carers. There were fewer services for social workers to signpost families to and less capacity in the remaining areas of provision.

> *'Certainly the biggest impact was Children's Centres going and when I first moved into this district there was a lot of ill feeling from a lot of schools, particularly the infant schools who were seeing Year 4 children coming in and those parents hadn't been able to access nurseries, for example. So schools that had a nursery and those parents who could have just walked down to the local Children's Centre and talked about speech and language and talked about parenting and done all of this, that has completely gone. You've got the odd kind of charity who are […] filling the gaps, local church groups who are putting on parenting courses to try and fill that gap at universal. And because now parents have to be referred to access a lot of our parenting groups, they have to have an actual form that the parent signs and is then sent to us. And we hear a lot from pre-schools and nurseries, parents are not going to sign that paperwork, they don't want to sign a form. It's almost like they are opening themselves up, potentially, to something and they don't want to sign it.' (P1, LA3)*

> *'A lot of really fantastic services like transitions work and young people's groups in the area, diversionary work, there wasn't the staff to do it or the money to do it, so you would see a lot more of that cohort. I do think there was a rise in mental health need around the same time and that has stayed. We have teenagers come through who are suicidal now […] mental health in teenagers I would say you get a difficult, sad case probably monthly.' (P3, LA5)*

Overall, participants thought that the reduction in universal services was reducing assets, capacity and support networks within communities. Along with the economic impact of recession, cuts to benefits, housing shortages, rising rents, exploitative landlords, and other social problems such as gang recruitment in certain areas, the cumulative impact was leading to greater social isolation and a rise in mental health problems for both children and parents. This was widely perceived as a multi-agency problem, as other services, including health visitors, primary schools and especially CAMHS, were struggling with capacity. The result in many areas was increasing demand at the front door of statutory CSC as the 'last resort' for problems that could not be addressed elsewhere.

3.2.5. Multi-agency partnerships

Participants pointed to good examples of multi-agency partnerships as well as the challenges. The focus was on joint working between CSC and health, education, police, youth offending, mental health, and the voluntary sector. A common theme was the perceived reluctance of some of these agencies to take some of the responsibility for safeguarding, which they saw as being the remit of CSC. This took different forms across the LAs; for example, in LA1 it had proved difficult to engage some organisations – especially schools – in the EH pathway, particularly as EH was now geared more towards assessment and case management than direct support. In LA3 and LA4, concerns were expressed about other professional groups, particularly in health services, not always participating in safeguarding meetings, training programmes or strategic discussions. Such tensions were exacerbated in times of high demand and resource constraints:

> *'I think that when you start to put services under pressure, which they are at the moment, then you've got social care, children's services, reaching out to other services to say you've got to start taking responsibilities. I think that becomes very difficult for organisations to accept, because they are so entrenched, that this is our core piece of work: "why should we be taking on that?" So there's that tendency to want to pass things over more and I think that causes a real problem with the system'. (P2, LA0)*

Familiar issues such as problems with interprofessional communication and information sharing were also raised, not helped in some respects by recent changes to data protection regulations. As well as the usual examples (schools, GPs and CAMHS), the link between adult mental health and children's services was raised by some participants, e.g. the lack of a procedure for notifying CSC when a parent was admitted to hospital under the Mental Health Act. Even arrangements set up explicitly to foster partnership working, such as multi-agency safeguarding hubs (MASH) or multi-agency risk assessment conferences (MARAC), were not immune from silo effects, such as incompatible IT systems. Such arrangements were mostly designed around individual cases, and particularly decision-making on risk and thresholds,

There were some interesting examples of multi-agency efforts to tackle specific safeguarding issues. One was a project to reduce suicide rates in LA1:

> *'We had a horrendous couple of serious incidents a year ago where young people were committing suicide, and for us any death is terrible. And from that we've had a positive mental health awareness week, we've had better commissioning*

arrangements, we've got school nurses that have now come under the auspices of Public Health within the [LA], no longer out with an NHS provider. So we can make more effective use of that, they could go in and do workshops in the holidays, and we've had additional commitment from CAMHS.' (P2, LA1)

This project also points to the rising profile of safeguarding concerns in relation to teenagers and young people across the LAs, predominantly around mental illness, gang involvement, drugs/county lines activity, child sexual and criminal exploitation, child trafficking, and going/being missing from home. Most of the LAs in London had set up specialist gangs units as well as dedicated posts for CSE/CCE/missing children, and were seeking to integrate some of the various multi-agency panels spread across CSC and youth offending services.

3.2.6. Thresholds

Commentary on thresholds was mainly concerned with two issues: the general level of complexity and risk that was being managed in EH and referred to CSC; and the amount of cases going through to CP and LAC. Participants also discussed the problem of inappropriate referrals from partner agencies, potential drift in CIN cases as practitioners prioritised their CP and LAC caseloads, professional and institutional anxiety about risk, variation in thresholds between teams, and the unsuitability of standard CP procedures for dealing with at-risk adolescents.

As noted already (see Section 3.2.3), participants from EH were reporting a shift in their service from dealing with Tier 2 (additional needs) to Tier 3 (multiple complex needs). The general expectation was that referrals to statutory services (Tier 4) would need to show clear evidence of risk to children's welfare and a greater likelihood of being assessed and meeting the threshold for CIN. Three key strategies used to maintain the referral threshold were the integration of EH within CSC, training and consultation with CP leads in partner agencies to reduce inappropriate referrals, and setting up a front door service, or 'initial point of contact' (IPOC), in order to triage incoming calls, or 'contacts'. Most LAs had also set up a Multi-Agency Safeguarding Hub (MASH) to carry out initial checks on potential child welfare cases. Effectively this meant that one or two layers of screening would take place before any decision was made to record a referral:

'We have a front door service that is called the 'Initial Point of Contact', so IPOC, which is like triage. So somebody will ring up, we might raise a call, they'll take information and pass it to a Social Worker. We also have the MASH [Multi-Agency Safeguarding Hub]. So the MASH is like the second level of triage if we're unclear about where this case needs to go, and that will involve the appropriate officers who will meet to discuss the case and say "well we think it is a major issue, we need to carry out a Section 47 or a Section 17". So that then gets passed to the Referral and Assessment Teams to carry out those types of assessments but they can also be passed upstairs to the CIN Teams to do that as well because they also carry out Section 17s and Child Protection enquiries' (P1, LA2).

Several LAs were focusing on the threshold for CIN, mindful of the pressure exerted on their social workers from the volume of CP and LAC in the system. A common strategy was to develop a CIN review process that would be overseen by a service manager for a limited period, aiming to inculcate

a more targeted approach to completing work and stepping down statutory involvement. One LA had funded a designated 'CIN reviewer' post, while another had created a toolkit for reviewing CIN cases (known informally as the 'closure tracker' by practitioners). Of course, part of the reason for doing this was to accommodate work that might conceivably meet the threshold for CP but where there were doubts about the suitability and effectiveness of conventional CP procedures. This seemed to be a common view when it came to adolescents for whom the main risks lay outside of the family home, e.g. because they were 'out of parental control' and/or vulnerable to CSE/CCE:

> *'There was kind of a culture which was not, you know, not written down – but when they're 16 what's the point in putting them on a CP Plan? So a lot of those were managed more under Child in Need. What are you going to achieve by putting them on a Child Protection Plan, you know, is it the parent we're concerned about or is it the child's behaviour, so are we penalising the parent because they've tried everything they can? Because normally you'd be thinking "Child Protection Plan" and there's parental issues going on. So I think that kind of culture was around that – what is that going to really achieve for the young person or the family?' (P5, LA4)*

Such views were not always explicit but sometimes expressed as an interest in 'contextual safeguarding', while maintaining that cases that did meet the threshold (for significant harm) would go to CP no matter what age the child. A key consideration was the extent to which parents of older children were seen as cooperative (with professionals) or neglectful (of their child's wellbeing and safety):

> *'If mother is not reporting her missing then that would be like "is she neglecting to protect her child by not doing that", but on the other hand you hear that she is depressed, so again I believe it's going to depend on how much is the mother willing to engage with you and to take advice on board, and to recognise your concern.' (P4, LA5)*

Most LAs had responded to the rise in demand from adolescents by setting up specialist teams to provide support to families with teenagers in crisis, seeking to complete assessments as quickly as possible and arrange support workers and mentors for young people before problems escalated.

3.2.7. Workforce

Workforce issues were discussed by participants in all of the LAs. Stability and retention constituted a key challenge in a sector well known for high turnover and vacancy rates and overreliance on agency staff. Moreover, while these were general problems in CSC, they were particularly marked in London and Southeast England. All the LAs were therefore aiming for a higher proportion of staff on permanent contracts, which they hoped would create more stability within social work teams and continuity of care for children. Barriers to achieving this goal included the limited availability of suitable staff and stressful work conditions associated with high levels of sickness and turnover. Recruitment and retention were described more positively in LAs that had recently received a good or outstanding rating from Ofsted and more negatively in LAs recovering from the aftermath of an inadequate rating. Others described having to compete with neighbouring LAs that were providing

large financial incentives to attract new staff (sometimes seen as necessary in order to offset poor inspection outcomes). Use of temporary agency staff was widespread and associated with similar problems everywhere, i.e. higher turnover, short notice period, and the experience for families of frequent changes in social worker. Several LAs had tried to improve the stability of their workforce via overseas recruitment drives, especially South Africa, Canada and Australia. The combination of high turnover and skills shortages means that social workers progressed to management more quickly than was previously the case, while social work teams often operated with a higher proportion of newly qualified social workers and less experienced staff.

> *'If you've got a team of say ten Social Workers and seven are AYSEs that's inevitably going to impact on the quality of the paperwork, the reports. It puts huge pressure on the three staff who are not AYSEs for example, and there's some evidence of an imbalance between our teams. So some teams are well stocked with people who've got more than five years' frontline experience, and other teams where there isn't a single person with more than five years' experience.' (P1, LA3)*

> *'I think there's also a lack of experience within the profession. What I've seen over the years is that the experienced workers tend to want to move into areas that are not frontline anymore, so they're moving to a quality assurance type role, or they move into a more, an independent role doing assessments etc. And maybe because I've been around too long, I'm coming across fewer and fewer social workers that have got experience under their belt, so I'm now seeing people become managers after only a few years of practice, I'm seeing Senior Social Workers in the team who have only got maybe three or four years practice [experience]. When I first started, as a social worker, I remember joining the team and, you know, the Senior Social Workers had 25 years plus under the belt and you could go and speak to them and they would tell you exactly how to do things and what to do. You, that's a rarity now, you don't find people with the length of experience to be able to guide and help support, not just Social Workers coming into the profession, but also Social Workers who have been in the profession for a short period of time.' (P5, LA1)*

Another prominent theme was caseloads (number of children allocated to a social worker), which was felt to be a critical factor for workforce stability. There was quite a lot of variation on this, both across LAs and between different functions within LAs. Work was often concentrated in certain teams, usually referral and assessment and the CIN/CP teams particularly if they were covering a locality associated with high rates of demand (and deprivation). Perhaps surprisingly, participants from more affluent LAs did not report low caseloads; participants from LA5 (the most deprived) consistently reported lower caseloads than those in LA1 and LA0, which were the least deprived. LA5 also seemed to have been most successful at retaining staff and keeping experienced social workers in frontline teams. Overall, high caseloads were seen as a problem to be addressed via restructuring services and implementing new ways of working. For example, LA4 and LA0 had both adopted some features of a 'pod' model (based on the 'Hackney' model) with small teams of practitioners jointly working on cases. LA1 and LA4 had also moved to locality-based working, with the latter shifting to quite large social work teams covering wider geographical areas. However, the impact on caseloads

was quite variable with an initial reduction to be expected in the immediate aftermath of a restructure but difficult to sustain in the longer term – mainly due to the challenges outlined above.

3.2.8. Inspections and quality assurance

During the period that interviews were conducted, the CSC inspectorate, Ofsted, began a new inspection cycle under the 'Inspection of Local Authority Children's Services' (ILACS) framework. Four of the participating LAs had an ILACS inspection during this period. For participants from LAs that had recently been given good or outstanding judgements by Ofsted, whether under ILACS or the previous framework, the process was felt to be stressful but the outcome would contribute to staff morale and provide a boost to recruitment and retention. Conversely, LAs that had struggled in recent inspections came under great pressure and experienced problems with morale and workforce stability. Institutional anxiety about inspections was common to all areas, reflected in a range of internal audit processes as well as a general preoccupation with quality assurance and performance management. Case audits, file reviews and mock inspections were routinely implemented and this activity would be intensified in periods when an inspection was thought imminent, or in the aftermath when areas for improvement had been identified:

> *'I've come back just as we're due the next one, so there's been a definite push around specific key areas to be focusing on and that's included smart care planning, case summaries, chronologies, management oversight, statutory visits […] so there's been quite a lot of auditing and identifying of areas that need to be focused on. I've also been… there's an improvement team that was identified so I've been part of that in terms of being paired with an intake team'. (P5, LA3)*

> *'We do mini peer inspections, so every year, or every six months, we're audited, so they have a team of people from across the county that come into each district. You can volunteer and do it, I've done one before, and you go and you look at another district and you audit what Ofsted would be looking at.' (P3, LA0).*

Alongside the main Ofsted inspection framework, CSC services also take part in Joint Targeted Area Inspections (JTAI) of services for vulnerable children and young people, which are carried out by Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary, and Her Majesty's Inspectorate of Probation. The JTAI is an in-depth evaluation of provision in a particular area, and in the experience of participants had focused on themes such as neglect, domestic violence, adolescents and child sexual exploitation. Recommendations from the JTAI required an action plan that was reviewed by Ofsted, which could spur LAs to innovate around specific types of demand, e.g. to develop an integrated approach to child criminal exploitation (LA1) or screening tools for domestic abuse and neglect (LA3).

Some participants thought that Ofsted inspections, with their focus on performance and accountability, magnified the institutional and professional anxiety that already existed in CSC, reinforcing a tendency towards risk averse practice:

> *'Risk averse… we probably are, yeah, probably yeah... I think it comes a bit from Ofsted, I think it comes a bit from serious case reviews, I think it comes a bit from*

accountability in terms of, you know, cases you heard in the media and, you know, this Director got struck off and this Social Worker's been slammed and that manager, and I think external pressures probably it's come from more.' (P4, LA4)

'And actually, all it becomes, is that one bit that you're doing wrong. It doesn't matter that everything else is going really well – that bit's going wrong. And that's what Ofsted can feel like, that actually, we're just covering our arses, we've seen this child and they're safe, job done. So, yeah, I think there's a focus on being very risk averse, because nobody wants the next Baby P.' (P3, LA3)

Pressure to manage risks to children in a robust fashion were felt even more acutely in LAs that had received an inadequate rating, where efforts to tighten up practice in areas criticised by inspectors would lead to a more interventionist approach:

'If you look at looked-after children, I think when I joined, which was about 5 years ago, there would have been probably around 200 looked-after children, and we've gone up by about 120, which is pretty significant. Part of that was about an approach to risk which Ofsted found to be inadequate and that was essentially I think something about we don't offer a service to adolescents. That's obviously changed, we do offer a service to adolescents now and I suspect we've gone a little bit too far in terms of the front door.' (P3, LA2)

'You would also find that there's a sort of a pendulum effect, so once you've had a very bad inspection in that particular Borough or authority, your CP numbers and LAC numbers will shoot up because then cases will be seen for the risks that they really are. There was a time when there was a strong emphasis on just doing what's good enough and the legacy we have now are teenagers that are coming into our care systems because we didn't do enough.' (P1, LA1)

3.2.9. Organisational culture and practices

The organisational context of CSC was discussed in relation to models of practice, innovation initiatives, leadership, operational structures and LAs' general risk-orientation towards safeguarding issues. The tension between prevention and intervention was a common theme, with LAs seeking to work proactively to stem the tide of child protection investigations while dealing appropriately with risk. In organisational terms, efforts to achieve this balance took the form of integrating EH services within the CSC operational management structure, as well as adopting or developing social work practice models. The latter usually emphasised solution-focused and strengths-based practice and the importance of relationships. The most common model was Signs of Safety, sometimes combined with other frameworks such as 'restorative practice' or 'systemic practice'. One LA had developed its own eponymous approach, incorporating many of the elements found in other 'branded' frameworks (e.g. building relationships, holding strengths-based conversations). Another had used DfE innovation funding to invest in a programme of intensive training in systemic methods for practitioners:

''There's a huge focus on working systemically, so part of that is the training but also we have a clinician based in each of the teams, so a family therapist who will do consultations with Social Workers and will do some work with families, the idea being that they're supporting Social Workers to be practicing systemically, and we do reflective team meetings' (P1, LA5)

Whichever model of practice was being employed in the LA, participants were generally positive about the underlying theory and principles and able to give examples of how it was helping to improve frontline practice, e.g. writing assessments in a more family-friendly way or using direct work tools to explore children's experiences and perceptions. However, there was little indication that any of the models had affected rates of demand or the tendency to use CP interventions to address particular types of demand:

'So it's a very different way of working…..I don't know whether it has had an impact [on intervention rates] as yet because it's still quite early days' (P1, LA0)

'I think we're forced to be interventionist by the cases that we're presented with but I think if we can work with people in the lower level, that's a preventative approach' (P1, LA2)

Participants in several of the LAs mentioned the importance of stable leadership and the level of knowledge that senior managers had about the LA context and the issues driving demand for services. The latter was often reflected in responsiveness and willingness to engage with frontline issues; for example, a senior manager in one LA agreed to meet with a young person in care to explain why her children's home was being shut down. Conversely, the tendency for assistant directors to move on every few years was widely seen as a driver of workforce churn and a catalyst for organisational restructures.

3.2.10. Socio-economic factors

The link between socio-economic factors and demand for child welfare services was a common perception, although it took different forms in different areas. Financial hardship among families was generally thought to have increased over the past eight years, owing to factors such as stagnant earnings for those in work and cuts to benefits for the unemployed, while the introduction of universal credit had increased levels of personal and household debt for some families. Participants thought these factors impacted negatively on family relationships, parental stress and conflict, contributing to higher levels of domestic abuse and mental illness, as well as family breakdown. Particularly for people living in London boroughs, lack of affordability and the poor quality of rental accommodation were linked to deteriorating home conditions and increased risk of homelessness. Densely populated urban areas with high rates of deprivation were the main geographical sources of demand for CSC. Some participants thought that risk to children, including neglect, emotional abuse, alcohol misuse and domestic violence, did exist among materially well-off families but were less likely to be picked up; such families were better able to conceal problems, buy in support with childcare (e.g. nannies) and to avoid involvement with services. Cases featuring 'middle class'

families often related to acrimony between parents and the impact on children of divorce and parental separation.

Participants with experience of rural districts thought that the dispersal of people and services meant that there was perhaps less surveillance and oversight of families than in urban areas, so that some issues could go undetected. Cuts to community and preventative services over recent years had thinned out their coverage, with further barriers to attendance created by the lack of public transport (also subject to cuts) and affordable childcare. Social inequality also played a part, since even areas that generally were seen as affluent could have pockets of deprivation that were often quite isolated from support services, such as parenting groups and children's centres. Moreover, since these services were more likely to be frequented by middle class parents in affluent areas, they might not be perceived as accessible by more deprived or marginalised groups. Similar problems were experienced by families relocated to social housing on affluent estates that lacked the necessary infrastructure (e.g. children's centres, play spaces) to meet families' needs. Most participants thought that isolation and social exclusion contributed to the high levels of mental health problems among families.

> *''I think that some of the issues that they experience in terms of social economic stuff is magnified… when you live on the doorstep of people that are doing very well financially and come from a higher social economic background. That can kind of bolster difficulties for you. I think there are issues about access to employment, access to training and general kind of social mobility issues in terms of some of our different communities and I guess those issues, you know, do lead to kind of things around addiction, whether it be through alcohol, drugs, gambling, which definitely have an impact on families and can add to stress in their environment which all serve to make things more difficult and lead to family breakdown more and more'. (P2, LA2)*

Several LAs noted a rise in the number of families without recourse to public funds, which was associated with a range of presenting needs, e.g. gang involvement in LA4, homelessness in LA5, or self-harm in LA1. An increase in risks to adolescents was noted in all LAs, particularly in more deprived areas, and while much of this was attributed to the growing threat posed by organised criminal networks, underlying social problems were also thought to be contributing to this trend.

Participants with experience of working with young people spoke of growing disillusionment, a lack of identity rooted in community and work, which exacerbated their vulnerability to exploitation, abuse and mental illness. The ubiquity of social media could lead to more emotional and psychological strain on young people, particularly those who were exposed to bullying, while schools were putting more pressure on young people in relation to their achievement in coursework and exams (as this reflected the schools' own performance). These factors were all thought to have contributed to an increase in mental health problems and self-harm, including young people from materially well-off families. Children with special educational needs, particularly those with ASD/ADHD and unrecognised learning issues were thought to be a particularly high risk group, not helped by the practices of some schools in relation to 'off-rolling' pupils with challenging behaviour

and low grades. Some participants thought the latter had become more widespread in recent years with the shift to academies and schools' preoccupation with their performance in league tables.

3.2.11. Summary

- *System conditions* identified by participants included: demand, finance, Early Help, universal services, multi-agency partnerships, thresholds, workforce, inspections, organisational culture and socio-economic factors
- *Demand* for CSC was perceived as increasing in all areas, particularly for CP and care, mostly concentrated in areas with high levels of deprivation. The intersection between neglect and parental risk factors was the principal concern for younger age groups, whereas for older children the focus of concern was increasingly on vulnerability to CSC/CCE. In some LAs, school exclusion was felt to play a role in the trajectory of children with problematic behaviour and/or learning difficulties, who subsequently became vulnerable to exploitation by gangs.
- *Financial pressures* were reported everywhere due to the combination of rising demand and huge cuts to core funding from central government. Most LAs had responded by protecting core statutory services and retaining targeted Early Help, while reducing spend on commissioned services and universal/community-based provision. There were concerns about the rising cost of placements for LAC, especially with respect to residential care and specialist provision for older children with complex needs.
- *Early Help* was the designation for a range of preventative services that had been brought together under CSC, often described as 'Integrated EH or 'EH Hub'. The general sense was that EH had become primarily a Tier 3 service, focusing on families with complex needs, so that fewer resources were available for Tier 2, i.e. families presenting to services for support with a single issue. In some LAs, EH was moving towards an information-sharing and care coordination role rather than providing services directly.
- *Universal services* were widely thought to have borne the brunt of government cuts, including partial or full closure of children's centres, family centres, community centres, youth clubs and other facilities in the community. The reduction in community assets and support networks was reflected in the dwindling capacity of other children's services, such as health visitors, primary schools and CAMHS, to provide additional support, in turn leading to increased demand at the front door of statutory CSC.
- *Multi-agency partnerships* included health, education, police, youth offending, mental health, and the voluntary sector. Capacity issues meant that some of these agencies were increasingly inclined to pass on safeguarding issues to CSC. Partner agencies had an important role in EH provision but had less incentive to engage where CSC was seeking mainly to assess and case manage rather than provide services directly. Alongside arrangements for multi-agency casework and decision-making, some LAs had developed strategic collaborations around problem clusters, e.g. suicides, county-lines.
- *Thresholds* were discussed in relation to the level of complexity and risk being managed in EH and referred to CSC and the amount of cases going through to CP and LAC. Other common issues included inappropriate referrals from partner agencies, potential drift in CIN cases as social workers prioritised CP and LAC cases, institutional anxiety about risk, variation in thresholds between teams, and the unsuitability of CP procedures for dealing with at-risk adolescents.
- *Workforce* issues centered around stability and retention, a key challenge in a sector known for high turnover and vacancy rates and overreliance on agency staff. Factors affecting workforce

stability included working conditions (e.g. caseloads), availability of experienced staff, inspection outcomes, financial incentives (including competition from neighbouring LAs), and continuity of senior leadership. A combination of high turnover and skills shortages meant that social workers progressed to management more quickly and social work teams in some LAs often operated with a higher proportion of newly qualified social workers and less experienced staff.

- *Inspections and quality assurance* were primarily concerned with Ofsted's inspection framework, under which four participating LAs were inspected during the course of the study. Good or outstanding judgements contributed to staff morale and provide a boost to recruitment and retention, whereas LAs receiving inadequate or 'requires improvement' ratings came under pressure and experienced problems with morale and workforce stability. Quality assurance and performance management was intensified in the run-up to an inspection or in its immediate aftermath. Inspections were perceived to amplify institutional anxiety and therefore to reinforce risk-averse practices, particularly in LAs with poor ratings.
- *Organisational culture* around safeguarding was influenced by models of practice, innovation initiatives, leadership, operational structures and general risk-orientation. LAs sought to work proactively to stem the tide of child protection investigations while dealing appropriately with risk. A commitment to prevention was reflected in the integration of EH within CSC and the adoption of models emphasising solution-focused, strengths-based and relational practice.
- *Socio-economic factors* included financial hardship among families, driven by stagnant earnings, cuts to benefits and higher levels of debt. Lack of affordable housing, deteriorating home conditions and increased risk of homelessness were also associated with stress and conflict within families, contributing to family breakdown, domestic abuse and mental illness. Social inequality also played a part, since deprived families living in otherwise affluent areas could be quite isolated from support services, such as parenting groups and children's centres.

3.3. Intervention pathways in CSC

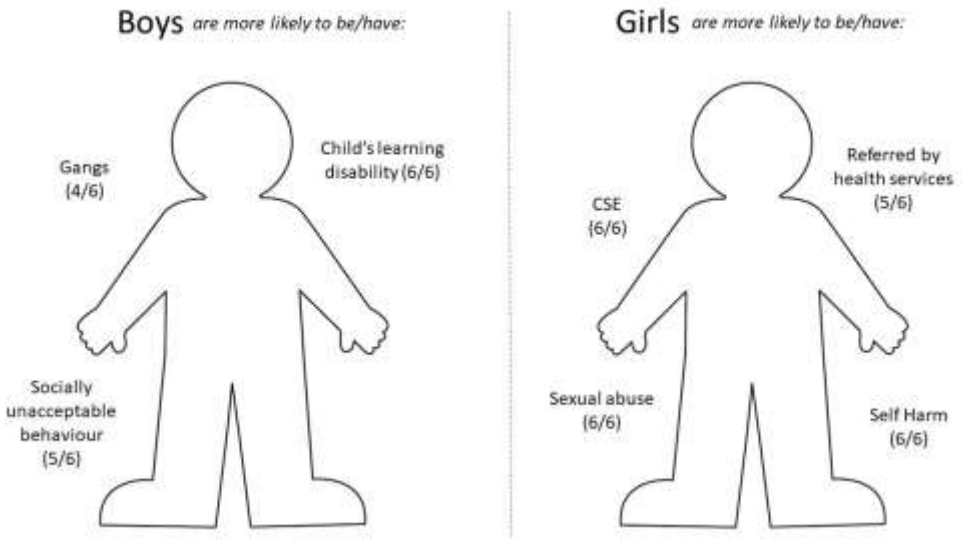
The cross-tabulation analysis enabled a detailed exploration of intervention pathways and how these related to children's characteristics and needs. The study was designed so that a confidential report on these findings for each LA could be sent to participants before the second round of interviews. In what follows, the quantitative and qualitative findings for these parts of the study are reported in relation to four child characteristics: gender, age, ethnicity and deprivation. For each of these categories, the analysis established the relative likelihood of receiving a particular type of provision, e.g. whether male or female children were more likely to be referred or to be assessed with a particular type of need. Only differences found to be statistically significant are reported.

3.3.1. Child characteristics

Gender

The crosstab analysis showed that gender was associated with significant differences in provision for children in contact with statutory services. Some of these were common across all or most of the local authorities, as indicated in Figure 10 and Table 8 below. Male children referred to CSC were more likely to have a learning disability, to be involved with gangs, and to be assessed with socially unacceptable behaviour. Females referred to CSC were more likely to be referred by health services, and to be assessed in relation to sexual abuse, child sexual exploitation (CSE) and self-harm.

Figure 10. Differences in relation to gender[1]



Note: [1] Figures in brackets indicate the number of LAs (out of six) in which each difference was found

Other differences were observed in some LAs and not others. For example, in three LAs (LA2, LA3, LA4) girls were more likely to be detained on CP grounds whereas this was the case for boys in LA0. Girls were more likely to be the subject of S47 inquires in three LAs (LA2, LA4 and LA0) although there were no LAs in which boys were more likely to have a S47. Boys were more likely to have a LAC episode in LA2 and LA0, while in LA3 older LAC tended to be girls and younger LAC tended to be boys. In LA2, girls were more likely to be on CP plans, whereas in LA4 and LA0 the tendency was for boys to be on CP plans for neglect. There were no clear associations between gender and ethnicity, which seemed to differ between each of the LAs.

Table 7. Differences in relation to gender

GENDER (male and female)	**Odds ratios (OR) and confidence intervals (CI) in each LA[1,2,3]**					
	LA0	**LA1**	**LA2**	**LA3**	**LA4**	**LA5**
Factors at Assessment						
Child sexual exploitation	OR 2.74 (CI 2.40-3.14)	OR 2.84 (CI 1.84-4.39)	OR 2.10 (CI 1.66-2.67)	OR 3.02 (CI 2.17-4.21)	OR 3.63 (CI 2.65-4.96)	OR 3.41 (CI 1.99-5.85)
Self-harm	OR 1.63 (CI 1.39-1.92)	OR 1.42 (CI 1.15-1.75)	OR 1.42 (CI 1.09-1.85)	OR 1.87 (CI 1.46-2.39)	OR 2.83 (CI 2.09-3.84)	OR 1.85 (CI 1.15-2.97)
Sexual abuse	OR 1.41 (CI 1.31-1.53)	OR 1.53 (CI 1.17-2.00)	OR 1.79 (CI 1.36-2.35)	OR 1.51 (CI 1.15-1.98)	OR 1.83 (CI 1.48-2.25)	OR 2.21 (CI 1.31-3.70)
Socially unacceptable behaviour	OR 0.73 (CI 0.68-0.79)	OR 0.84 (CI 0.68-1.03)	OR 0.77 (CI 0.68-0.87)	OR 0.70 (CI 0.57-0.86)	OR 0.58 (CI 0.45-0.75)	OR 0.50 (CI 0.37-0.67)
Child's learning disability	OR 0.53 (CI 0.48-0.59)	OR 0.60 (CI 0.49-0.75)	OR 0.69 (CI 0.54-0.89)	OR 0.55 (CI 0.46-0.66)	OR 0.44 (CI 0.38-0.52)	OR 0.64 (CI 0.48-0.85)
Gangs	OR 0.33 (CI 0.18-0.61)	OR 1.31 (CI 0.70-2.48)	OR 1.02 (CI 0.79-1.31)	OR 0.64 (CI 0.42-0.97)	OR 0.27 (CI 0.20-0.38)	OR 0.54 (CI 0.37-0.78)
Referred by health services	OR 1.06 (CI 1.01-1.11)	OR 1.31 (CI 1.18-1.47)	OR 1.13 (CI 1.02-1.25)	OR 1.00 (CI 0.89-1.12)	OR 1.21 (CI 1.10-1.32)	OR 1.21 (CI 1.05-1.40)
CP plan category: Sexual abuse	OR 1.95 (CI 1.54-2.48)	OR 2.31 (CI 1.12-4.74)	OR 1.84 (CI 0.93-3.62)	OR 2.59 (CI 1.17-5.74)	OR 3.59 (CI 1.44-8.93)	OR 2.17 (CI 0.20-24.18)

Notes

[1] Relative likelihood once referred by gender

[2] Male children are the reference group, i.e. OR>1 means females are more likely than males and OR<1 means males are more likely than females.

[3] Statistically significant differences are highlighted in orange (girls) and blue (boys)

Qualitative feedback

Participants remarked on how differences in factors at assessment reproduced commonly held assumptions about gendered behaviour, particularly in relation to externalised ('acting out') behaviours being associated more with boys while the internalising of negative emotions was associated more with girls.

> *'You can definitely see the difference between the boys and the girls, and I'd say that was quite representative, so we have a lot more boys with the gang involvement and things like, and the girls tend to have a lot of the emotional mental health whatever, so self-harm, and then going missing. But a lot of the boys go missing, especially if there's gang involvement.' (P3, LA3)*

Whether these differences reflected children's actual presenting needs or was down to the gendered interpretation and assessment of their behaviour by professionals was open to question. There was a consensus that that girls were more likely to present as exposed to CSE, sexual abuse and self-harm. However, some participants (e.g. B1, Wand1) thought that these problems might be somewhat hidden for male children, particularly where gang activity was the main reason for contact with services. For example, initiation rituals and power dynamics within gangs might involve coercive sexual acts particularly with new or younger members but given this was unlikely to be disclosed, professionals would tend to focus on the gang involvement itself rather than potential sexual abuse or exploitation:

> *'Where it's probably coming up more is the gang involvement, because usually if there are any sexual, if there is a sexual element to it with the gangs it's usually some type of initiation or something they're being asked to do and they probably then categorise it under gangs rather than actually it's something which is to do with CSE, so maybe that's why it's probably not showing up as much.' (P4, LA4)*

The finding that boys were more likely to be assessed with socially unacceptable behaviour was attributed by participants to their greater involvement in gangs, drugs, county lines and criminal activity, including knife crime. Problematic drug use was more likely to be assessed for boys in two relatively affluent LAs (LA0 and LA1) where Early Help services were receiving numerous referrals of adolescent boys in relation to cannabis. Overall, however, socially unacceptable behaviour was linked by most participants to children's family history, with the typical pattern being for behavioural problems to surface in adolescence as a result of parental neglect during childhood. Similarly, absent parenting was raised as a common issue for boys with troubled behaviour, often in relation to fathers, although the emphasis differed between LAs, e.g. in LA5 unaccompanied asylum seeking children were a prominent group separated from their parents, while in LA0 absent parenting was also seen in more affluent families where parents' physical and emotional availability to their children was constrained by their work commitments. When problems at home were accompanied by low educational attainment and truancy or exclusion from school, children were particularly at risk of gravitating towards alternative sources of identity, status and belonging:

> *'I think I would say generally it's when there's been a history of either neglectful parenting or absent parenting. […] It tends to be the adolescent boys that are more*

at risk of the exploitation and the drug dealing and the gangs etc, and often they are single parent families with a mum that has struggled to meet the needs of their son before they hit teenager, and then often they get bigger so the mum's like, "I can't control him now'. And then it's linked into poor education as well, so not going to school, we tend to see that link.' (P1, LA0)

In contrast, social workers were more likely to foreground ideas around exploitation and grooming when assessing girls' involvement in gangs, drug selling and criminal activity. This was particularly apparent in two local authorities (LA3 and LA5):

'I think we see it through a lens of exploitation. Unless there are girls that got into kind of recruiting other girls, then you might be getting described as dangerous or criminalised, but also with a kind of discourse about, "Well, that young person would have been a victim of grooming as well", and you have to kind of move into a grooming role so you can avoid being forced into other activities and keeping whoever it is that's forcing you to do that sweet.' (P5, LA5)

The assessment of socially unacceptable behaviour amongst boys and CSE among girls was also associated with different referral pathways, with boys more likely to come to the attention of Youth Offending services prior to contact with CSC professionals:

'What we've found is that the girls' and boys' presenting behaviour is very different. So the girls, you know, sometimes when there's a change in their behaviour, they present a bit more withdrawn, they're a bit dishevelled, they might not be going to school…they're regularly going missing. There's a shift in their behaviour which has then raised professional concerns and the schools are referring them in with "they've got a new boyfriend or they've got a new group of friends." We then start to immediately think, are they being sexually exploited…. With the boys, sometimes the way that they're presenting is…. a little bit more anger and aggression. They're then being picked up for things they're getting involved in and entering into the Youth Offending service so they've come to notice from becoming involved in criminality.' (P6, LA3)

Another pathway associated more with boys was when behavioural problems were linked to learning difficulties (see Section 3.2.1). The quantitative findings showed that boys referred to CSC services were significantly more likely than girls to have an assessed learning disability. Participants attributed this to the salience of conditions such as Autism Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD), which were generally thought to be more common in boys and when combined with problems with parental care increased the risk of challenging behaviour, poor educational achievement and eventual exclusion from school.

Self-harm, on the other hand, was found to be more prevalent among girls. Participants connected this type of demand to the pressures on teenagers in relation to self-esteem, physical appearance, social media, bullying and peer relationships. Educational achievement and exam pressures were additional sources of anxiety. For adolescents to manage such strong negative emotions required strong family relationships and parental support, which were often found to be lacking in children

referred to CSC services. Self-harm was also discussed in relation to family history, i.e. as a response in the teenage years to a childhood history of neglect and abuse.

> *'Usually there's been a history of neglect in the family, dysfunction between parents, witnessing domestic abuse. They get into secondary school, get into the wrong crowd so to speak, and then it's about being beyond parental control, and the parents not being able to do much, and then we will find they're coming in. Usually with the self-harm, when we track it back it's usually born out of some type of severe emotional abuse, sexual abuse, which we're not aware of, and then as they get older then it manifests itself in terms of self-harm.' (P4, LA4)*

As with the concept of exploitation, some participants saw a gendered distinction in the way that self-harm was used to frame the presenting issues of girls. A case could be made for its applicability to boys even when the presenting behaviour was externalised, i.e. aggressive and antisocial, along with the more readily understood symptoms of psychological distress:

> *'Boys don't talk about their mental health as easily as girls do. The danger that we have….I mean, boys will act on their suicidal tendencies…….they won't sit in a corner and cry, they'll throw rocks at passing cars…..you know, that's kind of the way we're wired, I suppose, we just deal with things differently.' (P2, LA1)*

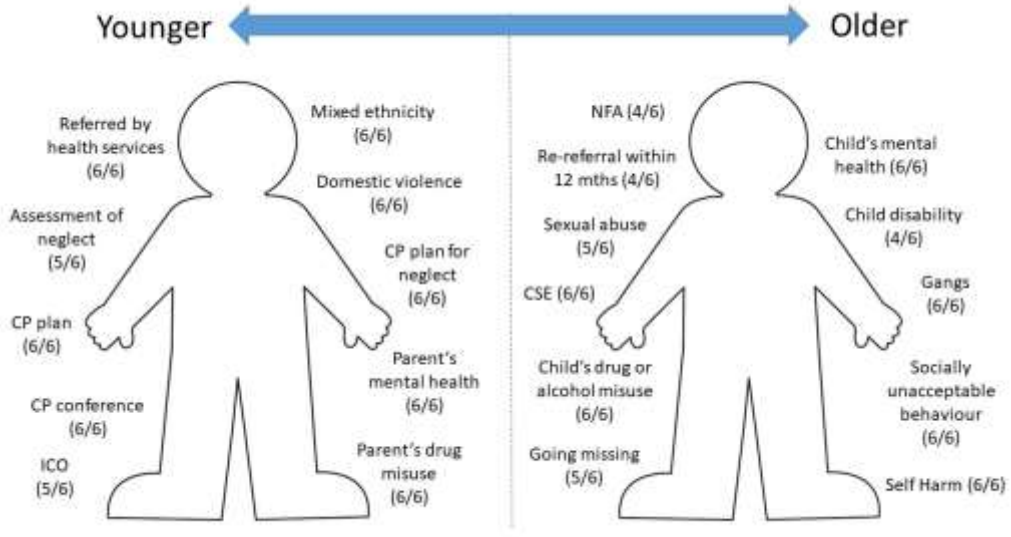
Patterns of communication and disclosure among peer groups was thought to play a role in whether children's practitioners such as teachers or school nurses would be alerted to self-harm. Girls were considered more likely than boys to tell their close friends about strong negative feelings, cutting themselves, or suicidal impulses, and their friends were then more likely to tell a responsible adult. However, even when professionals were alerted to such problems, it was often difficult for services to respond in a timely or appropriate manner given the resource and capacity issues discussed earlier (see Section 3.2). Nonetheless, referrals from health services were significantly more likely for girls than for boys, and this was linked also to the greater readiness of girls to access sexual health clinics and GPs.

Age

The crosstab analysis showed that age was associated with significant differences in provision for children in contact with statutory services. For ease of interpretation, age was categorized into three groups of equal size. Nearly all of the differences associated with age were found on a continuum (i.e. youngest to oldest). As there were very few distinct findings on the middle age group, as compared with both the lowest and highest age groups, only the latter two groups are presented in Table 11. More so than for gender, there were many common findings across all or most of the local authorities, as indicated in Figure 11 and Table 9. Younger children were more likely to be referred by health services, to be subject to a CP conference, CP plan, and/or interim care order (ICO). Younger children were also more likely to be assessed with needs around parental drug misuse, mental health, domestic violence, and neglect. Older children were more likely to be assessed with a

range of needs including: sexual abuse, going missing, self-harm, socially unacceptable behaviour, gang involvement, and child's mental health.

Figure 11. Differences in relation to age



Other differences were observed in some LAs and not others. For example, in three of the LAs (LA1, LA3 and LA4) older children were more likely to be accommodated under Section 20, whereas in LA2 this was more likely for younger children. In LA1 and LA0, younger children were more likely to be detained on CP grounds, whereas in LA3 and LA4 this was more likely for older children.

Table 8. Differences in relation to age

UNDER 5s[1]	**Odds ratios (OR) and confidence intervals (CI) in each LA[2,3]**					
	LA0	**LA1**	**LA2**	**LA3**	**LA4**	**LA5**
Thresholds						
NFA	OR 0.88 (CI 0.84-0.92)	OR 0.87 (CI 0.77-0.97)	OR 0.73 (CI 0.64-0.82)	OR 0.94 (CI 0.82-1.07)	OR 0.82 (CI 0.71-0.95)	OR 1.07 (CI 0.94-1.22)
CP Conferences	OR 1.42 (CI 1.35-1.50)	OR 1.57 (CI 1.39-1.77)	OR 1.43 (CI 1.27-1.61)	OR 1.36 (CI 1.18-1.57)	OR 1.13 (CI 1.01-1.26)	OR 1.82 (CI 1.49-2.22)
CP Plans	OR 1.47 (CI 1.39-1.55)	OR 1.65 (CI 1.45-1.88)	OR 1.50 (CI 1.32-1.71)	OR 1.41 (CI 1.22-1.63)	OR 1.30 (CI 1.14-1.48)	OR 1.93 (CI 1.55-2.40)
Interim Care Order (ICO)	OR 4.33 (CI 3.61-5.18)	OR 2.65 (CI 1.85-3.81)	OR 2.46 (CI 1.59-3.79)	OR 2.88 (CI 1.93-4.29)	OR 1.91 (CI 1.30-2.78)	N/A
Re-referrals within 12 months	OR 0.93 (CI 0.90-0.96)	OR 0.85 (CI 0.77-0.95)	OR 0.82 (CI 0.74-0.90)	OR 0.87 (CI 0.79-0.96)	OR 0.77 (CI 0.69-0.87)	OR 1.19 (CI 1.03-1.38)
Factors at Assessment						
Child's alcohol misuse	OR 0.16 (CI 0.11-0.23)	OR 0.61 (CI 0.46-0.81)	OR 0.11 (CI 0.03-0.45)	OR 0.20 (CI 0.11-0.36)	OR 0.97 (CI 0.51-1.84)	OR 0.26 (CI 0.06-1.17)
Child's drug misuse	OR 0.12 (CI 0.09-0.16)	OR 0.35 (CI 0.25-0.51)	OR 0.11 (CI 0.06-0.21)	OR 0.20 (CI 0.14-0.29)	OR 0.22 (CI 0.13-0.37)	OR 0.20 (CI 0.10-0.43)
Parent's drug misuse	OR 1.72 (CI 1.59-1.86)	OR 2.51 (CI 2.07-3.05)	OR 1.73 (CI 1.39-2.14)	OR 2.13 (CI 1.81-2.50)	OR 1.69 (CI 1.39-2.05)	OR 1.57 (CI 1.20-2.06)
Domestic violence	OR 1.90 (CI 1.81-2.00)	OR 2.14 (CI 1.89-2.42)	OR 2.27 (CI 2.04-2.52)	OR 2.26 (CI 2.00-2.54)	OR 2.41 (CI 2.19-2.65)	OR 1.88 (CI 1.59-2.21)
Child's mental health	OR 0.20 (CI 0.17-0.23)	OR 0.28 (CI 0.23-0.34)	OR 0.23 (CI 0.17-0.32)	OR 0.30 (CI 0.24-0.37)	OR 0.20 (CI 0.14-0.28)	OR 0.23 (CI 0.16-0.34)
Parent's mental health	OR 1.34 (CI 1.26-1.42)	OR 1.53 (CI 1.35-1.74)	OR 1.25 (CI 1.08-1.44)	OR 1.55 (CI 1.36-1.77)	OR 1.21 (CI 1.06-1.37)	OR 1.33 (CI 1.10-1.60)
Going/being missing	OR 0.09 (CI 0.05-0.16)	OR 0.13 (CI 0.06-0.26)	OR 0.28 (CI 0.17-0.46)	OR 0.22 (CI 0.14-0.34)	OR 0.07 (CI 0.03-0.15)	OR 0.20 (CI 0.08-0.50)
Child sexual exploitation	OR 0.14 (CI 0.11-0.18)	OR 0.11 (CI 0.05-0.26)	OR 0.32 (CI 0.24-0.43)	OR 0.16 (CI 0.10-0.27)	OR 0.08 (CI 0.04-0.15)	OR 0.14 (CI 0.06-0.31)
Gangs	OR 0.21 (CI 0.10-0.47)	OR 0.22 (CI 0.08-0.61)	OR 0.46 (CI 0.34-0.62)	OR 0.40 (CI 0.24-0.67)	OR 0.09 (CI 0.05-0.17)	OR 0.26 (CI 0.16-0.42)
Socially unacceptable behaviour	OR 0.44 (CI 0.40-0.48)	OR 0.35 (CI 0.27-0.46)	OR 0.51 (CI 0.45-0.59)	OR 0.33 (CI 0.26-0.43)	OR 0.28 (CI 0.20-0.40)	OR 0.30 (CI 0.21-0.44)
Self-harm	OR 0.24 (CI 0.19-0.31)	OR 0.20 (CI 0.14-0.27)	OR 0.46 (CI 0.34-0.63)	OR 0.28 (CI 0.21-0.39)	OR 0.20 (CI 0.13-0.31)	OR 0.21 (CI 0.10-0.42)
Neglect	OR 1.48 (CI 1.41-1.55)	OR 1.50 (CI 1.26-1.79)	OR 1.15 (CI 1.02-1.29)	OR 1.28 (CI 1.09-1.51)	OR 1.43 (CI 1.26-1.63)	OR 1.23 (CI 0.92-1.63)
Physical abuse	OR 1.00 (CI 0.95-1.06)	OR 1.05 (CI 0.90-1.23)	OR 0.63 (CI 0.54-0.75)	OR 0.81 (CI 0.69-0.95)	OR 0.68 (CI 0.61-0.77)	OR 0.70 (CI 0.54-0.91)
Sexual abuse	OR 0.69 (CI 0.63-0.75)	OR 0.60 (CI 0.45-0.82)	OR 0.85 (CI 0.65-1.12)	OR 0.63 (CI 0.47-0.85)	OR 0.61 (CI 0.48-0.76)	OR 0.60 (CI 0.35-1.03)
Referred by health services	OR 1.92 (CI 1.83-2.01)	OR 1.46 (CI 1.31-1.63)	OR 1.72 (CI 1.56-1.90)	OR 1.89 (CI 1.69-2.11)	OR 2.05 (CI 1.88-2.25)	OR 1.60 (CI 1.39-1.84)
CP plan category of Neglect	OR 1.47 (CI 1.31-1.64)	OR 1.29 (CI 1.01-1.65)	OR 1.67 (CI 1.28-2.17)	OR 1.42 (CI 1.08-1.89)	OR 1.29 (CI 1.00-1.67)	OR 1.98 (CI 1.24-3.15)
Record of disability[4]	OR 0.28 (CI 0.25-0.30)	OR 0.45 (CI 0.37-0.55)	OR 0.35 (CI 0.26-0.47)	OR 0.66 (CI 0.54-0.82)	OR 0.75 (CI 0.59-0.95)	OR 0.94 (CI 0.74-1.18)
Least deprived tertile[5]	OR 0.83 (CI 0.81-0.86)	OR 0.79 (CI 0.72-0.87)	OR 0.83 (CI 0.74-0.94)	OR 0.73 (CI 0.56-0.96)	OR 0.98 (CI 0.74-1.30)	OR 0.77 (CI 0.52-1.12)
Mixed Ethnicity[8]	OR 1.30 (CI 1.18-1.43)	OR 1.30 (CI 1.14-1.48)	OR 1.41 (CI 1.27-1.56)	OR 1.40 (CI 1.24-1.59)	OR 1.53 (CI 1.36-1.73)	OR 1.53 (CI 1.33-1.75)
TWELVE PLUS[6]	**Odds ratios (OR) and confidence intervals (CI) in each LA[7, 9]**					
	LA0	**LA1**	**LA2**	**LA3**	**LA4**	**LA5**
Thresholds						
NFA	OR 1.25 (CI 1.20-1.31)	OR 1.10 (CI 0.99-1.24)	OR 1.47 (CI 1.30-1.65)	OR 1.20 (CI 1.05-1.37)	OR 1.25 (CI 1.09-1.43)	OR 1.09 (CI 0.95-1.26)
CP Conferences	OR 0.67 (CI 0.63-0.71)	OR 0.60 (CI 0.52-0.68)	OR 0.74 (CI 0.65-0.85)	OR 0.68 (CI 0.58-0.80)	OR 0.83 (CI 0.74-0.93)	OR 0.40 (CI 0.30-0.53)

CP Plans	OR 0.62 (CI 0.58-0.66)	OR 0.55 (CI 0.47-0.64)	OR 0.70 (CI 0.61-0.81)	OR 0.63 (CI 0.53-0.75)	OR 0.69 (CI 0.59-0.80)	OR 0.34 (CI 0.25-0.47)
Interim Care Order (ICO)	OR 0.14 (CI 0.10-0.20)	OR 0.55 (CI 0.36-0.85)	OR 0.52 (CI 0.30-0.89)	OR 0.26 (CI 0.14-0.49)	OR 0.70 (CI 0.45-1.09)	N/A
Re-referrals within 12 months	OR 1.02 (CI 0.98-1.06)	OR 1.23 (CI 1.11-1.37)	OR 1.34 (CI 1.22-1.47)	OR 1.27 (CI 1.15-1.40)	OR 1.26 (CI 1.12-1.41)	OR 0.87 (CI 0.74-1.03)
Factors at Assessment						
Child's alcohol misuse	OR 8.99 (CI 6.87-11.76)	OR 1.57 (CI 1.23-2.01)	OR 10.5 (CI 4.31-25.5)	OR 5.78 (CI 3.82-8.75)	OR 2.29 (CI 1.24-4.23)	OR 4.68 (CI 1.56-14.02)
Child's drug misuse	OR 10.80 (CI 9.04-12.92)	OR 4.16 (CI 3.11-5.55)	OR 7.67 (CI 5.30-11.1)	OR 5.44 (CI 4.15-7.14)	OR 11.82 (CI 7.5-18.5)	OR 4.09 (CI 2.50-6.70)
Parent's drug misuse	OR 0.51 (CI 0.47-0.57)	OR 0.36 (CI 0.28-0.47)	OR 0.57 (CI 0.44-0.75)	OR 0.51 (CI 0.42-0.62)	OR 0.58 (CI 0.46-0.73)	OR 0.45 (CI 0.31-0.65)
Domestic violence	OR 0.49 (CI 0.46-0.52)	OR 0.39 (CI 0.34-0.44)	OR 0.38 (CI 0.33-0.43)	OR 0.38 (CI 0.34-0.44)	OR 0.43 (CI 0.39-0.48)	OR 0.45 (CI 0.37-0.54)
Child's mental health	OR 4.56 (CI 4.15-5.01)	OR 3.96 (CI 3.40-4.61)	OR 4.40 (CI 3.51-5.51)	OR 2.68 (CI 2.27-3.17)	OR 4.66 (CI 3.68-5.91)	OR 4.05 (CI 3.06-5.35)
Parent's mental health	OR 0.75 (CI 0.70-0.80)	OR 0.66 (CI 0.58-0.75)	OR 0.88 (CI 0.75-1.02)	OR 0.69 (CI 0.60-0.80)	OR 0.85 (CI 0.74-0.98)	OR 0.84 (CI 0.68-1.04)
Going/being missing	OR 10.23 (CI 7.29-14.35)	OR 5.21 (CI 3.50-7.74)	OR 3.54 (CI 2.48-5.07)	OR 3.99 (CI 2.90-5.49)	OR 17.0 (CI 10.6-27.3)	OR 3.82 (CI 2.08-7.02)
Child sexual exploitation	OR 8.50 (CI 7.38-9.80)	OR 6.98 (CI 4.41-11.05)	OR 3.18 (CI 2.54-3.99)	OR 6.01 (CI 4.33-8.33)	OR 9.37 (CI 6.76-12.9)	OR 6.81 (CI 4.07-11.39)
Gangs	OR 7.41 (CI 4.12-13.33)	OR 4.52 (CI 2.28-8.94)	OR 3.00 (CI 2.33-3.86)	OR 3.88 (CI 2.53-5.96)	OR 13.40 (CI 9.2-19.4)	OR 4.31 (CI 2.99-6.20)
Socially unacceptable behaviour	OR 2.25 (CI 2.09-2.43)	OR 2.39 (CI 1.94-2.94)	OR 2.32 (CI 2.04-2.64)	OR 2.74 (CI 2.23-3.36)	OR 3.61 (CI 2.79-4.67)	OR 3.32 (CI 2.48-4.43)
Self-harm	OR 4.29 (CI 3.64-5.05)	OR 5.25 (CI 4.19-6.58)	OR 2.71 (CI 2.08-3.51)	OR 3.72 (CI 2.92-4.75)	OR 6.93 (CI 5.09-9.43)	OR 4.84 (CI 3.00-7.82)
Neglect	OR 0.65 (CI 0.62-0.69)	OR 0.55 (CI 0.45-0.67)	OR 0.68 (CI 0.59-0.77)	OR 0.73 (CI 0.61-0.88)	OR 0.64 (CI 0.55-0.74)	OR 1.15 (CI 0.85-1.57)
Physical abuse	OR 0.77 (CI 0.72-0.82)	OR 0.68 (CI 0.57-0.80)	OR 1.03 (CI 0.87-1.21)	OR 0.93 (CI 0.79-1.10)	OR 0.83 (CI 0.74-0.94)	OR 0.78 (CI 0.59-1.04)
Sexual abuse	OR 1.37 (CI 1.26-1.49)	OR 1.78 (CI 1.36-2.32)	OR 1.34 (CI 1.02-1.76)	OR 1.52 (CI 1.16-2.00)	OR 1.66 (CI 1.35-2.04)	OR 1.33 (CI 0.80-2.21)
Referred by health services	OR 0.72 (CI 0.68-0.76)	OR 1.06 (CI 0.95-1.19)	OR 0.75 (CI 0.67-0.83)	OR 0.74 (CI 0.65-0.84)	OR 0.72 (CI 0.65-0.79)	OR 0.92 (CI 0.79-1.08)
Record of disability[4]	OR 1.90 (CI 1.79-2.02)	OR 1.30 (CI 1.10-1.54)	OR 1.63 (CI 1.31-2.04)	OR 1.22 (CI 1.00-1.49)	OR 0.79 (CI 0.62-1.01)	OR 0.86 (CI 0.66-1.12)
Least deprived tertile[5]	OR 1.18 (CI 1.14-1.23)	OR 1.19 (CI 1.09-1.31)	OR 1.23 (CI 1.10-1.39)	OR 1.79 (CI 1.38-2.32)	OR 0.93 (CI 0.69-1.25)	OR 0.80 (CI 0.52-1.21)
Mixed Ethnicity[8]	OR 0.66 (CI 0.59-0.74)	OR 0.83 (CI 0.72-0.96)	OR 0.70 (CI 0.62-0.78)	OR 0.60 (CI 0.52-0.70)	OR 0.67 (CI 0.59-0.77)	OR 0.66 (CI 0.57-0.77)

Notes

[1] Characteristics, pathways and outcomes most associated with children aged under 5
[2] Reference group: children in the other two age groups (6-11, 12+)
[3] Highlighted areas were found to be significant positively (orange) or negatively (blue) – only the former results are reported under 'younger children' in Figure 10
[4] Reference group: no record of disability
[5] Reference group: other two tertiles
[6] Characteristics, pathways and outcomes most associated with children aged twelve and above
[7] Highlighted areas were found to be significant positively (orange) or negatively (blue) – only the former results are reported under 'older children' in Figure 10
[8] Reference group: White British children
[9] Reference group: children in the other two age groups (Under 5s, 6-11)

Qualitative feedback

The findings in relation to age were largely what participants expected to see, with parental risk factors (domestic violence, substance misuse and mental illness) predominating for younger children referred to CSC and factors relating to the young person's own behaviour (e.g. anti-social behaviour, self-harm or substance misuse) being more frequently assessed in older children. The association between neglect and younger children was attributed to the greater impact of parenting capacity on children's welfare in early and middle childhood. Moreover, parental risk factors affecting their ability to provide appropriate care for younger children were described as easier to identify – more 'concrete' in the words of one participant (S1) – than the range of contextual factors, including peer networks and the wider social environment, which are relevant to the needs of older children in contact with services. Younger children were also seen as more physically vulnerable than older children, less able to protect themselves from the immediate threat of violence and in the case of pre-school children less subject to professional monitoring. Such issues meant that younger children were more vulnerable to harm and therefore more likely to require a CP conference or CP plan:

> *'I think the younger the child is, the more reliant that child is on the care giver for protection, for support. And, if there was activity within the house, or within the household that is putting that child at risk, that child might not have the level of ability to self-protect, or to seek help. So therefore I could see the [local] authority thinking, we have to step in, we have to try to help to resolve this situation, we need to be present, to monitor. Whereas if it's an older child, there might be some ability to call someone or to defend themselves or to report to someone. So I could understand why younger children tend to fall more under CP plans and CP conference. I think it is a reflection of the level of vulnerability that a younger child would have in a situation where there is family conflict and family problems.' (P4, LA5)*

On the other hand, some participants thought that focusing too much on the risk of physical harm to young children meant that increasing age would be implicitly seen as conferring resilience, i.e. a greater ability to cope with an adverse home environment. This might lead professionals to overlook or underplay aspects of emotional and psychological harm when it came to older children:

> *'We put more responsibility on older children to be able to keep themselves safe. You know, what are you going to do if mum and dad start having a big old row? Okay, you're able now to physically take yourself to a place of safety and so it's not [pause], the physical risk of it is obviously less, but that's not to say the emotional [harm] isn't there.' (P4, LA3)*

> *'My only fear sometimes is that older children are kind of seen as resilient, "they can cope with this", and we see an increase in mental health [problems]. I wonder, is that because we view them as resilient because of their age? Actually they're not resilient and they do need to be in a more robust plan, but we look at this young person who has lived with what's going on in their home for years, and think they can now cope with it. Is that a justified reason to not put them on a CP plan?' (P1, LA0)*

Several participants discussed the influence of age on ideas about responsibility and the locus of control, particularly in relation to neglect. For younger children, neglect was almost always assessed as a direct protective concern while parental attitudes and behaviour were assumed to be the prime determinants of children's welfare. Adolescent children, on the other hand, were perceived as agents of change in their own right, with their experience of neglect in early childhood one of a range of contextual factors giving rise to the immediate presenting need, e.g. gang involvement or self-harm:

> *'I suppose all parenting issues, but particularly neglect, quite often when they're younger it's about what the parent does to the child. Whereas, when they're getting older it's about... you know, parents are either enabled or not, and so the child is now the doer. And my feeling is we can disproportionately put responsibility onto young people who have experienced neglect and other complicating factors as younger children.' (P4, LA3)*

As discussed in Section 3.2.6 there were differing views on the appropriateness of CP processes with older children. Some participants expressed concerns about CP plans being overly punitive towards parents who were willing to work with CSC services to support and manage their child behaviour, as well as being largely ineffective in terms of engaging young people to make changes in their lives. From this perspective, the close monitoring and accountability provided by CP plans added little value and could often be counterproductive:

> *'I think there's the idea that the child protection system doesn't really kind of fit exploited adolescents, it isn't about unreasonable parenting or abuse within a family or within a household, it's about a more complicated set of contexts, really. And I don't necessarily think the CIN system really kind of fits it that well, either. But CP, I think, is increasingly perceived as a bit of a kind of mismatch for, you know, gang involvement or the young person's own alcohol or substance misuse, it doesn't really fit as a way of responding to that' (P5, LA2)*

Ethnicity

Findings on ethnicity were complicated by the different demographic make-up of the LAs, which ranged from mainly White-British child populations (e.g. LA0 and LA1) to highly diverse populations (e.g. LA4). Moreover, ethnic groups were present to varying degrees in different LAs, e.g. Black/Black British African children formed 4% of the population in LA1 and 13% in LA4; Asian Indian children formed 2% of the population in LA2 and 16% in LA3. This means that the broad categories used in the DfE classification (e.g. Black/Black British or Mixed) have to be used carefully in order not to conflate different groups and communities. Given the numeric disparity in most LAs between White British children and children from other ethnic backgrounds, it was decided to use White British ethnicity as the reference category with which to compare each other ethnic group. The reference category for White British children was all other children, including other White groups. In what follows, only findings that were broadly comparable across LAs are reported.

White British children overall were *more* likely (than all other groups combined) to be/have:

- CP plan (4/6)
- CP plan for neglect (5/6)
- Re-referral within 12 months (5/6)

- Assessment of child's alcohol misuse (5/6)
- Assessment of parental alcohol or drug misuse (6/6)
- Assessment of child's mental health (5/6)
- Assessment of CSE (4/6)
- Assessment of socially unacceptable behaviour ((4/6)
- Assessment of self harm (5/6)
- Assessment of sexual abuse (4/6)
- Referred by individuals (4/6)

White British children overall were *less* likely (than all other groups combined to be/have:

- Section 47 investigations (4/6)
- Detained on CP grounds (4/6)
- Referred by Schools (6/6)
- Assessed with Physical Abuse (6/6)
- CP plan for Physical Abuse (4/6)

Table 9. Differences in relation to ethnicity (White British only)

WHITE BRITISH CHILDREN[1]	Odds ratios (OR) and confidence intervals (CI) in each LA[2,3]					
	LA0	LA1	LA2	LA3	LA4	LA5
Thresholds						
Section 47s	OR 0.82 (CI 0.78-0.87)	OR 0.75 (CI 0.68-0.82)	OR 0.83 (CI 0.75-0.92)	OR 1.00 (CI 0.89-1.12)	OR 0.78 (CI 0.67-0.91)	OR 0.94 (CI 0.78-1.13)
CP Plans	OR 0.94 (CI 0.86-1.03)	OR 1.20 (CI 1.05-1.37)	OR 1.09 (CI 0.93-1.28)	OR 1.63 (CI 1.39-1.90)	OR 1.31 (CI 1.04-1.65)	OR 1.64 (CI 1.24-2.17)
Detained on CP Grounds	OR 0.43 (CI 0.29-0.65)	OR 0.59 (CI 0.36-0.96)	OR 0.27 (CI 0.09-0.89)	OR 0.50 (CI 0.31-0.81)	OR 0.40 (CI 0.15-1.08)	N/A
Re-referrals within 12 months	OR 1.26 (CI 1.19-1.33)	OR 1.59 (CI 1.43-1.78)	OR 1.12 (CI 1.00-1.25)	OR 1.43 (CI 1.28-1.60)	OR 1.39 (CI 1.14-1.69)	OR 1.03 (CI 0.82-1.29)
Factors at Assessment						
Child's alcohol misuse	OR 1.61 (CI 1.05-2.47)	OR 1.90 (CI 1.44-2.50)	OR 4.90 (CI 2.43-9.87)	OR 1.66 (CI 1.11-2.49)	OR 2.14 (CI 0.89-5.10)	OR 5.98 (CI 1.72-20.79)
Parent's alcohol misuse	OR 1.34 (CI 1.18-1.52)	OR 2.45 (CI 2.05-2.94)	OR 2.28 (CI 1.85-2.81)	OR 1.71 (CI 1.45-2.03)	OR 2.93 (CI 2.33-3.67)	OR 3.46 (CI 2.52-4.76)
Parent's drug misuse	OR 1.70 (CI 1.46-1.97)	OR 2.40 (CI 1.90-3.01)	OR 1.55 (CI 1.22-1.99)	OR 2.28 (CI 1.92-2.71)	OR 2.10 (CI 1.57-2.81)	OR 1.73 (CI 1.22-2.46)
Child's mental health	OR 1.42 (CI 1.21-1.68)	OR 1.60 (CI 1.36-1.88)	OR 1.86 (CI 1.46-2.36)	OR 2.05 (CI 1.71-2.45)	OR 0.82 (CI 0.51-1.32)	OR 1.98 (CI 1.40-2.80)
Parent's mental health	OR 1.19 (CI 1.08-1.32)	OR 1.59 (CI 1.40-1.81)	OR 1.17 (CI 0.99-1.39)	OR 1.59 (CI 1.37-1.84)	OR 1.55 (CI 1.25-1.93)	OR 1.03 (CI 0.78-1.36)
Child sexual exploitation	OR 1.44 (CI 1.16-1.80)	OR 2.62 (CI 1.64-4.17)	OR 1.53 (CI 1.18-1.97)	OR 1.82 (CI 1.34-2.47)	OR 1.34 (CI 0.86-2.10)	OR 1.35 (CI 0.71-2.56)
Socially unacceptable behaviour	OR 1.71 (CI 1.48-1.96)	OR 1.53 (CI 1.23-1.91)	OR 1.21 (CI 1.04-1.41)	OR 1.72 (CI 1.39-2.15)	OR 0.89 (CI 0.54-1.47)	OR 0.91 (CI 0.59-1.40)
Self-harm	OR 1.71 (CI 1.26-2.33)	OR 1.43 (CI 1.15-1.77)	OR 2.04 (CI 1.54-2.71)	OR 1.51 (CI 1.16-1.97)	OR 1.76 (CI 1.16-2.67)	OR 1.72 (CI 0.94-3.15)
Physical abuse	OR 0.72 (CI 0.67-0.78)	OR 0.40 (CI 0.35-0.47)	OR 0.50 (CI 0.39-0.63)	OR 0.58 (CI 0.47-0.72)	OR 0.38 (CI 0.29-0.51)	OR 0.16 (CI 0.08-0.32)
Sexual abuse	OR 1.85 (CI 1.57-2.17)	OR 1.50 (CI 1.13-1.99)	OR 1.61 (CI 1.20-2.15)	OR 1.58 (CI 1.19-2.11)	OR 1.23 (CI 0.86-1.77)	OR 0.96 (CI 0.45-2.05)
Source of referrals						
Individuals	OR 1.50 (CI 1.37-1.65)	OR 1.29 (CI 1.01-1.65)	OR 1.38 (CI 1.14-1.66)	OR 1.09 (CI 0.91-1.31)	OR 1.23 (CI 0.96-1.56)	OR 1.41 (CI 1.06-1.88)
Schools	OR 0.87 (CI 0.82-0.92)	OR 0.74 (CI 0.67-0.81)	OR 0.78 (CI 0.69-0.88)	OR 0.85 (CI 0.76-0.96)	OR 0.48 (CI 0.39-0.59)	OR 0.49 (CI 0.37-0.65)
CP Plan category: Neglect	OR 1.21 (CI 1.02-1.43)	OR 1.70 (CI 1.31-2.20)	OR 0.99 (CI 0.71-1.36)	OR 2.06 (CI 1.53-2.77)	OR 1.83 (CI 1.17-2.86)	OR 2.11 (CI 1.22-3.66)
CP Plan category: Physical abuse	OR 0.45 (CI 0.35-0.57)	OR 0.23 (CI 0.15-0.36)	OR 0.88 (CI 0.49-1.57)	OR 0.35 (CI 0.18-0.71)	OR 0.81 (CI 0.44-1.50)	OR 0.28 (CI 0.10-0.81)

Notes

[1] Characteristics, pathways and outcomes most associated with children whose ethnicity was recorded as White British

[2] Reference group: children in all other recorded ethnic categories (including other White groups)

[3] Highlighted areas were found to be significant positively (orange) or negatively (blue)

Other White children (including Irish, Irish Traveller, Gypsy/Roma and 'other groups') were more likely (than White British children) to be/have:

- LAC episode (especially 'other groups') (4/6)
- Primary need of 'absent parenting' (especially Traveller and 'other groups') (5/6)
- Assessment of physical abuse (especially 'other groups') (5/6)

Black/Black British children (including African, Caribbean and 'other groups') were more likely (than White British children) to be/have:

- Section 47 inquiry (especially African and 'other groups') (5/6)
- Assessment of physical abuse (especially African and 'other groups') (5/6)
- LAC episode (especially African) (4/6)
- Primary need of family in acute stress (especially African and 'other groups') (4/6)

Asian/Asian British children (including Indian, Pakistani, Bangladeshi and 'other groups') were more likely (than White British children) to be/have:

- Section 47 inquiry (especially 'other groups') (6/6)
- LAC episode (especially 'other groups') (4/6)
- CP plan (especially 'other groups') (4/6)
- Assessment of physical abuse (different groups in different LAs) (5/6)

Children of mixed ethnicity (including White/Black African, White/Black Caribbean, White Asian and 'other groups') were more likely (than White British children) to be/have:

- Section 47 inquiry (especially White/Asian and 'other groups') (5/6)
- LAC episode (especially White/Black Caribbean and 'other groups') (6/6)
- Interim Care Order (especially White/Black Caribbean and 'other groups') (4/6)
- NFA (especially 'other groups') (4/6)
- Assessed not CIN (especially White/Black Caribbean and 'other groups') (4/6)
- Referred from schools (particularly White/Black Caribbean and 'other groups') (5/6)
- Primary need of absent parenting (especially 'other groups') (4/6)

Qualitative feedback

Several participants commented on the assessment of physical abuse in different ethnic groups. Most thought that physical chastisement was more prevalent among Black Caribbean and Black African families as well as certain Asian groups (depending on local demographics). Local authorities responded to this by working closely with families to help parents to understand cultural differences and develop appropriate forms of discipline. When preventative measures did not lead to any change in parenting practices, particularly where implements were being used to physically chastise a child, referrals of physical abuse were likely to escalate quickly into CP:

'We see the cultural viewpoint on physical chastisement and things like that, so we tend to, in Early Help we tend to have cases that are stepped down to us from Level 4, either on CIN or on CP, where physical chastisement and parenting has been an issue.' (P1, LA0)

'There might be something about patterns of using an implement of some sort that takes it across a threshold and gets more attention. And I suppose re-referred as well, so there might be stuff about trying to work in a CIN context but it feels like that's not been effective and so you get re-referred in an escalated CIN, so child protection." (P5, LA5)

A few participants noted that in Asian families with very traditional ideas about gender roles there could be a generational gap in cultural expectations around appropriate behaviour, particularly when it came to adolescent girls. This type of family conflict might lead to physical abuse and violence, especially if girls were seen as defying their fathers or bringing the family's name into disrepute. Some participants observed that the transmission of cultural norms around physical chastisement could combine with intergenerational conflict to produce child-on-parent violence, often involving adolescents who had been beaten as children and/or had been exposed to domestic violence. In LA4, which had a very diverse population, referrals about honour-based violence and forced marriage were usually associated with Asian families, while concerns about female genital mutilation were linked to East African families, e.g. from Somalia.

Several participants commented on the association between White British families and child protection concerns around neglect, parental substance misuse and self-harm. These results were surprising in some respects but also thought to be linked to deprivation and inter-generational cycles of poor parenting, compounded by isolation, lack of extended family support and large sibling groups. Self-harm and particularly cutting was recognised as a response to psychological distress mostly found among White British girls:

'Probably if we looked at it stereotypically, probably, a lot more white females we get self-harming at a teenage age, you don't usually get in the mixed population that same level of self-harm.' (P4, LA4)

One participant (LA4, P4) described how professionals sought to deal with different cultural understandings of parental practices. She gave the example of a Black Caribbean family whose adult family members were struggling to reconcile their customary cuisine and diet with the health needs of a diabetic child. With certain communities, Traveller groups being a notable example, the difficulty of engaging families tended to exacerbate concerns about neglect, with school attendance being a particular issue.

'They have their own culture, they have their own way of dealing with things and you know, a lot of the time if we work with a traveller family, they don't want our involvement.' (P2, LA0)

The integration or exclusion experienced by different ethnic groups within the wider community was thought to influence the reporting of abuse (including domestic abuse) and the extent to which

families were willing to work with CSC services. On the whole, White British families were thought to be have more access to/contact with professionals via statutory and voluntary agencies. Arguably this also meant more monitoring and surveillance, particularly of families from deprived backgrounds. In contrast, members of first-generation immigrant or refugee families often faced more difficulties in receiving help and support, perhaps due to language or cultural barriers, social isolation, or concern about being shamed and stigmatised within their communities:

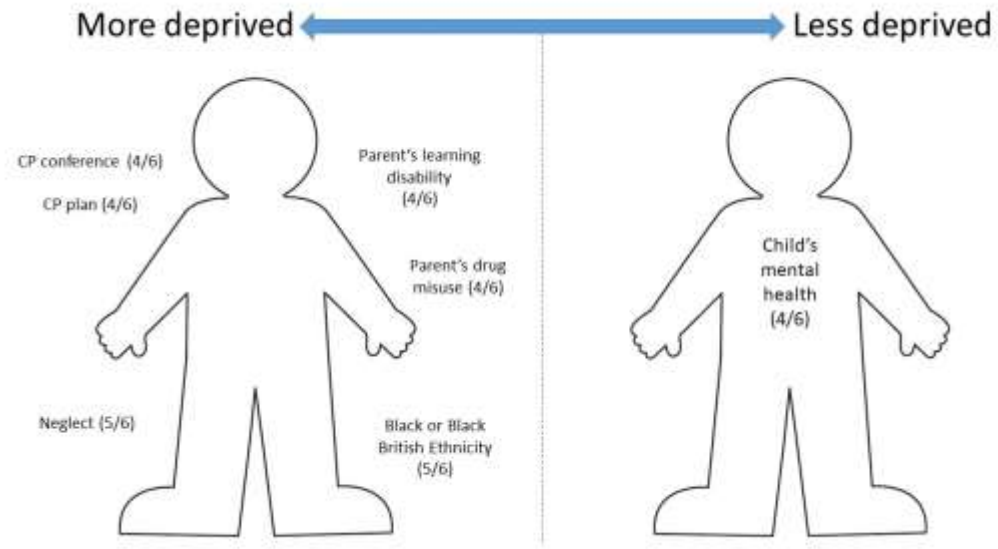
> *'We've got one case that's just come through where there was violence pre- and post-birth, never reported, happening for around 14 months minimum but also in the presence of paternal family who've not reported. And this mum didn't report to us, she communicated via Health…. Whereas I think if that abuse existed with the White demographic then I guess the parts where that information could go is increased. And this mum that we're dealing with, she doesn't speak English so she can't tell anybody. She doesn't know she's allowed to tell anybody. She possibly doesn't know that she doesn't need to tolerate that violence until now' (P2, LA3).*

> *'I think it's a silencing isn't it? A silence thing, even they do talk about it, it's like you're not saying anything, your child is going to be removed so they don't say anything. They keep it between the family, between their society and between their support network, you know, yeah. Bring shame to the family, bring shame to us and things like that.' (P3, LA4)*

Deprivation

The crosstab analysis showed that deprivation was associated with significant differences in provision for children in contact with statutory services. The more deprived children were the more likely they were to be subject to CP conferences and CP plans, to be assessed in relation to child neglect, to have parents with a learning disability, mental health problems and/or drug misuse. In contrast, the more affluent children were, the more likely they were to be assessed in relation to their own mental health problems.

Figure 12. Differences in relation to deprivation



In some respects, it was surprising not to find more commonalities across LAs, given the well-known intersection between deprivation and child welfare. In fact, there was a distinction between three LAs where there was a noticeable emphasis on factors associated with increasing deprivation (LA1, LA2 and LA3) and those where there was a more even spread of factors associated with either rising or falling deprivation (LA0, LA4, LA5). In LA0, children from less deprived background were more likely to be on CP plans for emotional, physical or sexual abuse, which was not found in any of the other LAs. In two LAs (LA4 and LA5) parental alcohol misuse was associated with less deprived children, again not found elsewhere.

Table 10. Differences in relation to deprivation

LEAST DEPRIVED[1]	**Odds ratios (OR) and confidence intervals (CI) in each LA[2,3]**					
	LA0	**LA1**	**LA2**	**LA3**	**LA4**	**LA5**
Thresholds						
CP Conferences	OR 0.77 (CI 0.73-0.82)	OR 0.76 (CI 0.67-0.87)	OR 0.78 (CI 0.64-0.95)	OR 0.60 (CI 0.33-1.07)	OR 0.99 (CI 0.66-1.50)	OR 0.45 (CI 0.16-1.21)
CP Plans	OR 0.74 (CI 0.70-0.79)	OR 0.79 (CI 0.69-0.91)	OR 0.80 (CI 0.65-0.99)	OR 0.59 (CI 0.32-1.09)	OR 0.86 (CI 0.50-1.48)	OR 0.54 (CI 0.20-1.48)
Re-referrals within 12 months	OR 0.81 (CI 0.78-0.84)	OR 0.82 (CI 0.73-0.91)	OR 1.05 (CI 0.92-1.20)	OR 1.13 (CI 0.83-1.53)	OR 0.98 (CI 0.64-1.52)	OR 0.31 (CI 0.13-0.70)
Factors at Assessment						
Child's mental health	OR 1.43 (CI 1.30-1.56)	OR 1.22 (CI 1.04-1.42)	OR 1.56 (CI 1.17-2.09)	OR 1.46 (CI 0.90-2.36)	OR 1.55 (CI 0.75-3.19)	OR 2.92 (CI 1.43-5.97)
Parent's drug misuse	OR 0.83 (CI 0.77-0.91)	OR 0.63 (CI 0.50-0.79)	OR 0.84 (CI 0.59-1.19)	OR 1.04 (CI 0.62-1.75)	OR 0.98 (CI 0.46-2.12)	N/A
Parent's learning disability	OR 0.60 (CI 0.46-0.78)	OR 0.51 (CI 0.27-0.96)	OR 0.46 (CI 0.14-1.47)	OR 0.47 (CI 0.06-3.37)	OR 1.02 (CI 0.32-3.23)	N/A
Neglect	OR 0.72 (CI 0.68-0.75)	OR 0.66 (CI 0.54-0.80)	OR 0.75 (CI 0.62-0.91)	OR 1.25 (CI 0.76-2.03)	OR 0.70 (CI 0.39-1.24)	N/A
Black or Black British Ethnicity	OR 0.82 (CI 0.73-0.93)	OR 0.63 (CI 0.54-0.73)	OR 0.77 (CI 0.68-0.88)	OR 0.88 (CI 0.57-1.36)	OR 0.21 (CI 0.14-0.32)	OR 0.30 (CI 0.12-0.74)
MOST DEPRIVED[4]	**Odds ratios (OR) and confidence intervals (CI) in each LA[5,6]**					
	LA0	**LA1**	**LA2**	**LA3**	**LA4**	**LA5**
Thresholds						
CP Conferences	OR 1.33 (CI 1.26-1.40)	OR 1.31 (CI 1.16-1.48)	OR 1.38 (CI 1.22-1.55)	OR 1.45 (CI 1.25-1.67)	OR 0.99 (CI 0.88-1.10)	OR 0.97 (CI 0.76-1.23)
CP Plans	OR 1.39 (CI 1.32-1.48)	OR 1.16 (CI 1.01-1.33)	OR 1.50 (CI 1.32-1.71)	OR 1.41 (CI 1.21-1.63)	OR 1.02 (CI 0.89-1.17)	OR 0.93 (CI 0.72-1.20)
Re-referrals within 12 months	OR 1.19 (CI 1.15-1.23)	OR 1.22 (CI 1.09-1.35)	OR 1.07 (CI 0.98-1.17)	OR 1.28 (CI 1.16-1.41)	OR 1.43 (CI 1.26-1.61)	OR 1.14 (CI 0.95-1.36)
Factors at Assessment						
Child's mental health	OR 0.73 (CI 0.66-0.81)	OR 1.01 (CI 0.86-1.18)	OR 0.67 (CI 0.53-0.84)	OR 1.16 (CI 0.98-1.37)	OR 0.98 (CI 0.77-1.23)	OR 0.82 (CI 0.60-1.12)
Parent's drug misuse	OR 1.23 (CI 1.13-1.33)	OR 1.46 (CI 1.20-1.78)	OR 0.92 (CI 0.74-1.15)	OR 1.31 (CI 1.11-1.54)	OR 1.21 (CI 0.99-1.50)	OR 1.66 (CI 1.15-2.40)
Parent's learning disability	OR 1.65 (CI 1.32-2.07)	OR 3.40 (CI 2.05-5.65)	OR 2.06 (CI 1.15-3.67)	OR 1.95 (CI 1.24-3.06)	OR 0.81 (CI 0.60-1.09)	OR 1.16 (CI 0.50-2.66)
Neglect	OR 1.34 (CI 1.28-1.41)	OR 1.45 (CI 1.22-1.74)	OR 1.40 (CI 1.25-1.57)	OR 1.29 (CI 1.10-1.51)	OR 0.99 (CI 0.87-1.13)	OR 1.69 (CI 1.14-2.49)
Black or Black British Ethnicity[7]	OR 1.16 (CI 1.03-1.31)	OR 1.07 (CI 0.93-1.23)	OR 1.46 (CI 1.34-1.58)	OR 1.50 (CI 1.32-1.70)	OR 2.32 (CI 2.13-2.51)	OR 1.66 (CI 1.35-2.04)

Notes

[1] Characteristics, pathways and outcomes most associated with children in the least deprived tertile
[2] Reference group: children in the other tertiles (middle and most deprived)
[3] Highlighted areas were found to be significant positively (orange) or negatively (blue) – only the former results are reported under 'less deprived' in Figure 11
[4] Characteristics, pathways and outcomes most associated with children in the most deprived tertile
[5] Reference group: children in the other tertiles (middle and least deprived)
[6] Highlighted areas were found to be significant positively (orange) or negatively (blue) – only the former results are reported under 'more deprived' children in Figure 11
[7] Reference group: White British children

Qualitative feedback

The finding that child protection interventions were more likely for children from more deprived backgrounds was not a surprise to participants. It was attributed to a number of factors (see also Section 3.2.10): parental stress, financial hardship and poor quality housing, social exclusion and lack of support networks, low educational achievement and employment opportunities, families being (or feeling) 'trapped' in neighbourhoods with high levels of crime, gang activity and anti-social behaviour, and the experience of racism and discrimination for some ethnic groups. Some participants noted that an intergenerational 'cycle of poverty' could be observed in families with a long history of involvement with child welfare. Such structural issues were compounded (or manifested themselves) in individual families through additional problems that were known to affect parenting capacity, such as substance misuse, mental or physical health problems and learning difficulties, often leading to concerns about neglect:

> *'I think common sense says if you have a more deprived family they've got less of a support network, less money obviously, more stress, then yeah, it's more than likely they'll have, if you've got other factors as well such as mental health or substance abuse then for sure you're going to be known to children's services." (P1, LA3)*

> *'I think when there's more deprivation, there's probably, I would say there's probably more of a link to neglect and it might not be deliberate neglect, just due to the kind of family circumstances. And that would be picked up at a younger age by the schools, by neighbours, by the community and will be more likely to be referred into the service for investigation.' (P4, LA0)*

In urban areas, the link between deprivation and neglect would sometimes intersect with concerns about gangs and child criminal exploitation, with children from low income families being recruited to sell drugs and carry weapons for older peers and adults. In LA4, with a very diverse child population, this seemed to be particularly associated with young people from Black African and Black Caribbean backgrounds. Moving vulnerable children out of particularly deprived or gang associated areas was mentioned by some participants as a protective strategy when conventional CP procedures were not effective, particularly in relation to gangs and drugs in but also for situations of domestic violence (H3, B1, HA2). In a large county (LA0) the most common safeguarding issues experienced in different districts were linked to varying levels of deprivation but also the resources and facilities available to families:

> *'You see a lot more, generally speaking, neglect in [District A]. So you have a lot more children coming, looking unkempt, dirty, not particularly fed very well in [District A]. than you would in [District B]. You do get them in [District B] but that is much more prevalent in [District A], that we have seen. Difficult to know why except that you walk around, you look at the… I know they're trying to regenerate the town centres and things like that. It's just a general feel. We've have lots of communication with youth groups running out of elements of [District A] and they're seeing some really, some really angry families that are saying, "We've just been left and look at where we're living," and they're all kind of grouped together.*

So a lot of poor housing is in one particular area. Yeah, so it's interesting when you speak to other agencies of what they're seeing. So a lot of money is put into [District A], and rightly so, but they have a lot more neglect, a lot more ASB, a lot more young people with low aspirations. In [District B], not much funding is put in but then you're seeing more debt, more mental health, more isolation because families can't get to services as easily.' (P1, LA0)

While mental health problems, including self-harm, were recognised as widespread issues that cut across demographics, they were also seen as the most likely reasons for children and young people from less deprived ('middle class') households to be referred to children's social care services. One participant (in LA0) thought that schools with more affluent catchment areas might be less well equipped to deal with these problems than schools in deprived areas, which were used to providing more pastoral care and interventions for pupils with emotional and psychological needs. Concerns about parental alcohol misuse was also associated with less deprived children in three LAs (LA0, LA4 and LA5) although there was little consensus about why this should be the case. Several participants talked about finding it more difficult to engage middle class parents (in LA0 and LA1), a greater tendency for disguised compliance (LA4) and the potential for social workers to feel intimidated by parents who were wealthy or well educated:

'I think sometimes Social Workers are intimidated. They shouldn't be, but they are and they go out and someone is quite well spoken, quite well educated, you know, it's probably showing them that they understand A B C and D, and they probably don't probe as much as with somebody who isn't as able to express themselves verbally. I don't know why, but I think there is that level of intimidation that comes into play, where they might be able to get a lot more information from the other families they're not able to get. And also I think the more information you give the more opportunity you've given for probing, for people to find out more. Whereas I think when they're going into those families it's just like, well this is what the current situation is, this is what I'm telling you, and then I think it doesn't really tend to go much further.' (P4, LA4)

In four of the LAs (LA0, LA1, LA2, LA3), the least deprived children in contact with services were significantly more likely to be older (the reverse pattern was not quite as clear for the most deprived children). Some participants commented on the increasing problems that children with physical or learning disabilities might pose to parents as they grew older and harder to manage, making it more likely for safeguarding concerns to arise:

'So, for instance, particularly with our ASD children, we wouldn't necessarily have them open. However, what tends to happen is there's a build-up of, as the child gets older the parents struggle more and more to maintain, to sort of contain them and to maintain them. And then we end up into safeguarding issues because they're running away or they're being, they become violent and they end up through Children's Services door. And then we have to sort of manage it and it's sort of presented as a safeguarding issue rather than, actually, it's a disability.' (P4, LA3)

3.3.2. Intervention pathways

Many of these findings have already been included in the foregoing discussion of child characteristics, so a summary is given here:

- *No further action (NFA)* was *more* likely for children who were older (4/6) or referred by individuals (4/6); and *less* likely for children who were younger, referred by schools, or of Asian/Asian British ethnicity.
- *Assessed not CIN* was *more* likely for children referred by schools (4/6) or police (5/6) and less likely for children referred by individuals (4/6), LA and housing services (4/6).
- *CIN (without CP or LAC)* was *more* likely for children who were older (4/6), referred by individuals (4/6), with a physical or learning disability (6/6), assessed with socially unacceptable behaviour (5/6), as young carers (5/6), self-harm (4/6), child's drug misuse (4/6), parent's mental health (4/6), or child's mental health (4/6); and *less* likely for children who were younger (4/6) referred by police (5/6), or assessed with neglect (6/6) or physical abuse (5/6).
- *Section 47* inquiries were *more* likely for children who were assessed with any category of abuse or neglect (6/6), domestic violence (4/6) or child sexual exploitation (4/6), and for children who were referred by schools (4/6) or whose ethnicity was recorded as Asian/Asian British (4/6) or Mixed (4/6); they were *less* likely for children whose ethnicity was recorded as White (4/6), who were referred by individuals (6/6) or health services (6/6), and for children with a physical or learning disability (4/6).
- *CP conferences* were *more* likely for children who were younger (6/6), more deprived (4/6), re-referred within 12 months (5/6), assessed with any type of abuse or neglect (6/6), parental drug or alcohol misuse (6/6), domestic violence (6/6), parental mental health (6/6), parental learning disability (6/6), CSE (4/6), or whose ethnicity was recorded as Mixed (4/6).
- *CP plans* were more likely for children who were younger (6/6), more deprived (4/6), re-referred within 12 months (5/6), assessed with neglect or emotional abuse (6/6), physical abuse (4/6), parental drug or alcohol misuse (6/6), domestic violence (6/6), parental mental health (6/6), parental learning disability (6/6), or whose ethnicity was recorded as Mixed (4/6) or White (4/6). CP plans were *less* likely for children who were older or whose ethnicity was recorded as Black or Black British (4/6).
- LAC episodes were more likely for children who re-referred within 12 months (5/6), referred by LA and Housing services (6/6), assessed with neglect or emotional abuse (6/6), physical abuse (5/6), parental drug or alcohol misuse (6/6), child's alcohol misuse (4/6), going/being missing (6/6), parental mental health (5/6), parental learning disability (5/6), CSE, (4/6), trafficking (4/6), gangs (4/6), and self-harm (5/6), or who had a CP plan for neglect. LAC episodes were *less* likely for children who were referred by police (4/6), or who had a CP plan for emotional abuse (4/6).

Qualitative feedback (vignettes)

In order to provide a qualitative perspective on intervention pathways, participants were asked to discuss three fictional but practice-near vignettes of families featuring a range of child welfare issues. Their responses focused on the main risk factors highlighted in the scenario and the types of interventions and services that might be offered by CSC in response. A full description of each vignette can be found in Appendix B.

Vignette 1

The vignette concerns Sabina (15 years old) who has been running away from home and has an 18 year old boyfriend who is known to the police and may be taking drugs. Sabina's mother is a single parent who suffers from mental health problems and has three younger children also living at home.

All participants agreed that this situation would warrant a child and family assessment and subsequent action would depend on the information that was gathered. A likely focus of the assessment would be the ability of Sabina's mother to support all of her children's needs, i.e. not just Sabina but also her younger siblings. Information would also be gathered about Sabina's boyfriend, such as his involvement with the police and drug-related crime as well as the and in terms of the sexual nature of their relationship. The willingness of Sabina and her mother to work alongside CSC would also be important in determining what happened next. There was general agreement across participants in all LA's that this would be most likely to be managed at CIN. However, in four LA's (LA0, LA1, LA2, LA3) it seemed possible that this kind of case could reach the threshold for CP or even go on to be LAC:

> *'Well, that would definitely be an assessment, Sabina. She'll go missing, going overnight, she's got an older boyfriend, she's taking drugs, you'd look at exploitation, you'd link in with the [CSE specialist] team and then if it met the threshold, you'd go child protection on that one, depending on what her links are. But that's, yeah, that's quite a typical one we get, going missing overnight, and it's going out for long periods.' (P3, LA0)*

Responses to this vignette were particularly likely to mention the use of risk assessment tools or specialist services for vulnerable young people. In two areas (LA0 and LA3) a specific CSE tool would be used to evaluate Sabina's situation at the stage of initial assessment or MASH. All the LAs had put in place a multi-agency process for running police checks and consulting with schools for referrals of this nature. Participants in three LAs discussed the use of multi-agency panels to share information about the family and discuss risk and protective factors (LA1, LA2, LA3). One participant described how the 'CSE and Missing' team would map the vulnerable child's networks, draw on the help of an 'Edge of Care' team and consider a Family Group Conference to involve Sabina and her family in drawing up a safety plan:

> *'It's a bit of a classic Edge of Care one, I would think, actually. So they might, she might come up to us on a CIN plan with Edge of Care, referral already made to Edge of Care, then it's more of a getting together with the family thinking about family group conferences, safety plans for her, involving her very much in the safety plan, finding out a bit much, more about the older boyfriend. CSE and Missing team have got a very good link to the police.' (P7, LA2)*

If Sabina was assessed as a child in need (CIN), it was likely that designated services for vulnerable adolescents, such as Edge of Care teams, would work alongside CIN social workers to support the family and prevent the situation from deteriorating (LA0, LA2, LA3, LA5). Another form of intervention was described in LA5, where clinical consultation and other services were being made available directly to the family while the assessment was being carried out.

Vignette 2

The vignette concerns Ehan, Ayan and Amina (6 months, 3 years and 9 years old), who live in a high-rise block of flats on a deprived estate. The flat is overcrowded, damp and untidy and the health visitor reports that the children rarely go outside the flat.

The consensus among participants was that this case would not meet the threshold for statutory CSC. Most thought that it would be referred to Early Help, although some participants questioned whether the family would get any additional support:

> *'Just the fact of being overcrowded and in a high-rise flat with damp is not enough to push a case into our team because there are plenty of families like that who don't have a social work service. I think it's all about the needs of the children and whether or not they're being met and if there's any reason why the parents haven't been able to... Or are hampered for some reason other than just circumstances and being over-crowded. But it might not even meet an Early Help threshold to be honest, if there weren't any worries about the parenting of those children.' (P1, LA5)*

As this quote makes clear, lack of concerns about parenting made it unlikely that this case would progress to a social work assessment. In one area where EH was becoming targeted for children with complex needs (LA0), this referral might be interpreted as being for a single additional need (better quality housing) and so not appropriate for EH. In this case the likely response would be to signpost and close without further action, so that the health visitor would continue supporting the family. To be eligible for EH under such circumstances would require evidence that the parents should be supported to improve the home environment or to access activities for the children. In other areas (e.g. LA1), participants thought it would be worth conducting some checks, e.g. in relation to the oldest child's school attendance, to see if the family's problems ran deeper than the referral would seem to suggest.

Most participants agreed that the family would probably be referred to EH and receive some form of response, although views varied about whether this would come in the form of an EH assessment (LA1), housing support (LA4), or a multi-agency panel (LA3) to consider options for supporting the family:

> *'I would anticipate that this would go to that panel, with a view to looking at probably an outreach worker from children's centres trying to engage with the family and support any applications around housing, possibly consider Home Start coming in regarding the home environment. You know, is there anything else, support-wise? Getting them involved, getting them out to children's centres.' (P4, LA3)*

It was widely acknowledged during the interviews that housing (either poor standard of accommodation or overcrowding) did have a significant impact on the wellbeing of many families, but also that CSC services did not have the resources to support families where housing was the primary need.

Vignette 3

This vignette concerns Bradley (3 years old), who lives with his mother (who is Polish and has been living in England for 4 years) and his father Robert. A referral has been made by the police following an incident of domestic violence and there are additional concerns about the mother's alcohol misuse.

This vignette received a consistent response from participants, producing widespread agreement that this case would be likely to have a s47/CP response. Some participants also thought that immediate action might be taken to remove the child from the parents' care:

> *'Oh, okay, she was drunk on the social worker's visit? Really? Okay, I think what we would then do is immediately we'd have a… this would be a Section 47. We would be concerned about the safety of that child overnight, so effectively we would be saying to her, 'Look, who's your mum? Who's your dad? Who's your aunt? Who's your uncle? Who can your child go and stay with? You're not in a fit state to look after this child.' We'd probably end up having a legal planning meeting. At the very least it would be a child protection conference, at the very least.' (P2, LA1)*

> *'I would say we'd be looking at care proceedings on this one. She's drunk with a three year old, it's a serious risk, so yeah, that would come in immediately as a child protection, it would then go for a legal strategy meeting. She can't even stop drinking for the Social Worker visiting, she's got someone official coming in – what's she like the rest of the time? So I would say definite child protection with a view to looking at care proceedings for that one.' (P2, LA0)*

Several respondents discussed the need to look for alternative childcare provision for Bradley and described looking to family members who may be able to look after Bradley until there was a safety plan in place. One respondent also discussed the need to examine the mother's history prior to moving to England in order to find out if there was any history of violence or whether she had left other children in Poland. The main risk factors were identified as domestic violence and substance misuse, compounded by the mother's inability to recognise the seriousness of the situation and act to protect the child. The age and vulnerability of the child, who would not be able to protect himself from violence, also raised the level of risk:

> *'That's the evidence right there, you know, and the domestic violence and also the child is quite young and vulnerable, you know, he's three, he can't talk, he can't contact the police, you know. And then she's in denial, she lacks insight, she's minimising the risk, you know, so, yeah, that would be a red.' (P3, LA4)*

The circumstances that would reduce the risk would be if the mother was willing to engage with CS's; agree a safety plan which would include the father's removal; and address her substance

misuse. Two LA's (LA2 and LA3) discussed specific domestic violence prevention programmes that they would want parents to attend in order to support them and minimise risk.

3.3.3. Summary

The findings from bivariate comparisons revealed significant differences in the assessed needs and interventions for children with different characteristics. Qualitative feedback on the results in each LA were obtained from practitioners and managers.

Gender

- Male children referred to CSC were more likely than females to have a learning disability or to be assessed with gangs or socially unacceptable behaviour. Female children were more likely than males to be referred by health services, and to be assessed for CSE, sexual abuse or self harm.
- Qualitative feedback on these findings was that they reflected real differences as well as gendered interpretations of children's needs. Boys were thought more likely to externalise (act out) negative thoughts and feelings, seeking status and identity in peer groups and gangs, leading them to be characterised as a risk to others. On the other hand, girls were perceived through the lens of internalising negative emotions (self harm) and to be at risk of sexual abuse.
- Participants also highlighted the combination of behavioural problems and learning difficulties in boys. Participants attributed this to the salience of conditions such as Autism Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD), which were generally thought to be more common in boys and when combined with problems with parental care increased the risk of challenging behaviour, poor educational achievement and eventual exclusion from school.

Age

- Younger children referred to CSC were more likely to be assessed in relation to parental risk factors such as substance misuse, mental illness or domestic violence, as well as neglect. In contrast, older children were more likely to be assessed in relation to their own mental health, risk-taking behaviour, e.g. going missing or using drugs and alcohol, or posing a risk to others, e.g. socially unacceptable behaviour or gang involvement.
- Qualitative feedback on these findings was that a focus from parental risk factors to the child's own actions and behaviour could be expected as children grew older. Younger children were more vulnerable to the impact of adverse home conditions, especially in terms of their physical health and safety. A potential pitfall here was a more general assumption that age conferred resilience, which might lead professionals to overlook or underplay emotional and psychological harm when it came to older children.
- The association between neglect and younger children was also considered to be understandable in some respects and problematic in others. Neglect of a young child was almost always assessed as a direct protective concern, where parenting was the primary locus of control and therefore of change. While older children were still susceptible to deficits in their home

environment, they were becoming less dependent on parental care and more influenced by their peer groups as well as other contextual factors (e.g. exclusion from education, social media). Standard CP procedures, with their emphasis on working with parents to meet their children's needs, were arguably less effective at engaging young people and addressing risks in their wider social environment.

Ethnicity

- Findings on ethnicity were complicated by the different demographic make-up of the LAs, which ranged from mainly White-British (White British) child populations to highly diverse populations. The broad categories used in the DfE classification (e.g. Black/Black British or Mixed) had to be differentiated in order not to conflate different groups and communities, but this made it harder to find significant differences for groups with low numbers. Moreover, the results were not stratified by deprivation, i.e. it is possible that different patterns would be observed if the comparison was between children with the same socio-economic status.
- White British children, who made up the largest single group in all the LAs, were generally more likely (than all other groups combined) to be on a CP plan (particularly for neglect) and to be re-referred within 12 months. White British children were also more likely to be assessed in relation to sexual abuse/CSE, self-harm, parental substance misuse, child's mental health, and socially unacceptable behaviour. They were less likely to be subject to Section 47 investigations, to be on a CP plan for physical abuse, or detained on CP grounds.
- Black/Black British children, particularly those recorded as B/BB African, were more likely (than White British children) to have a Section 47 inquiry, LAC episode, or an assessment of physical abuse.
- Children of Mixed White/Black Caribbean ethnicity were more likely (than White British children) to be referred from schools, to have a LAC episode, or to be assessed as 'not CIN'.
- Findings on Asian/Asian British children were very variable between the LAs.
- Qualitative feedback picked up on the findings in relation to physical abuse, which participants felt was reflected in efforts to address cultural differences around physical chastisement and methods of disciplining children. The general view was that preventative measures were preferable but that referrals of physical abuse could quickly escalate to CP in some circumstances, e.g. where an injury was sustained or implements were involved. In some families, intergenerational differences about expectations of behaviour, particularly where adolescent girls were concerned, could exacerbate the risk of physical abuse.
- The associations between White British children, neglect, parental substance misuse and self-harm were thought to be linked to deprivation and inter-generational cycles of poor parenting, compounded by isolation, lack of extended family support and large sibling groups.

Deprivation

- More deprived children were more likely to have CP conferences and CP plans, to be assessed in relation to child neglect, or to have parents with a physical disability or mental health problems and/or substance misuse. In contrast, more affluent children were more likely to have a

disability and/or mental health problems themselves, and/or to be assessed in relation to self-harm

- The quantitative findings also pointed to a distinction between LAs where there was a noticeable cluster of factors associated with increasing deprivation and others where there was a more even spread of factors associated with either rising or falling deprivation.
- Qualitative feedback focused on the various ways in which deprivation had a negative impact on children's welfare, often intersecting with concerns about neglect, compounded by issues such as substance misuse or learning difficulties, and in some cases manifested through successive generations of parents and their children. In urban areas, the link between deprivation and neglect would sometimes intersect with concerns about gangs and child criminal exploitation.
- Mental health problems, including self-harm, and parental alcohol misuse, were recognised as the most likely reasons for children and young people from less deprived ('middle class') households to be referred to children's social care services. There was little consensus as to why this should be the case.

Thresholds

- The quantitative findings on thresholds have mainly been mentioned already, e.g. the tendency for older children to receive services as CIN and for younger children to have CP interventions.
- Qualitative feedback from vignettes gave some insight into risk assessment, decision-making around thresholds and the resources available in different LAs to meet certain types of presenting need. The referral of Sabina, a fifteen year-old girl who had run away from home and was potentially vulnerable to CSE, was located at the intersection between CIN and specialist services, such as 'Edge of Care' teams, which would work alongside vulnerable young people and with their families and networks in order to put in place a safety plan and prevent admission to care. The vignette of Bradley, a three-year-old boy about whom there were immediate concerns to safety due to domestic violence and parental alcohol misuse, was likely to be met with a CP response and potentially even removal from parental care. The vignette of a family living in poor quality housing, whose children were reported to rarely go outside, was considered barely to meet the threshold for Early Help.
- The vignette responses reflected some of the quantitative findings, such as the reliance on CP procedures to work with at-risk younger children while more specialist resources were available for vulnerable adolescents. When individual risks to children were readily identifiable, there was little interest in finding out about social and environmental factors. When the main concerns were about housing and social isolation, participants highlighted the need for evidence of parenting deficits.

3.4. Demand typologies: evidence and characteristics

This section presents findings from a latent class analysis of the main presenting needs recorded in social work assessments of children referred to CSC (see Section 2.3.4).

3.4.1. Demand typologies

The LCA found seven classes, i.e. typologies of associated factors at assessment, across the six LAs:

- *Neglect*—episodes where neglect was assessed in 100% of cases with very few other factors recorded
- *Domestic violence*—episodes where domestic violence was assessed in 100% of cases with very few other factors recorded other than emotional abuse (9%) and alcohol misuse (9%)
- *Physical abuse*—episodes where physical abuse was assessed in 100% of cases with very few other factors recorded other than emotional abuse (14%) and neglect (7%)
- *Out-of-control/highly vulnerable/sexual abuse*—episodes characterised by a range of factors including socially unacceptable behaviour (26%), child's mental health problems (21%), sexual abuse (16%), CSE (12%), child's drug misuse (10%) and/or self-harm (9%).
- *Multiple complex needs I*— episodes characterised by domestic violence relating to the parent (43%), parental mental health problems (42%), parental alcohol (25%) or drug (21%) misuse, and emotional abuse (24%).
- *Multiple complex needs II*—episodes characterised by higher percentages for all the categories in Class 5, particularly domestic violence relating to the parent (76%) and emotional abuse (60%), as well as additional factors, notably physical abuse (41%), neglect (41%), child's mental health (35%) and domestic violence relating to the child (46%).
- *Disability and mental health*—episodes characterised mainly by children with learning (42%) and physical (25%) disabilities and/or children with mental health problems (16%) but also parents with mental health problems (25%) and/or physical (14%) or learning (5%) disabilities.

These seven classes were found to be statistically consistent in terms of their composition across all the LAs in the study but accounted for different proportions of demand, as shown in Table 12.

Table 11. Proportion of episodes in each demand class (all LAs)

Classes	**LA0**	**LA1**	**LA2**	**LA3**	**LA4**	**LA5**	**Total**
1. Neglect	17%	5%	16%	4%	8%	3%	13%
2. Domestic violence	15%	15%	20%	19%	22%	27%	17%
3. Physical abuse	13%	9%	8%	7%	15%	8%	12%
4. Out-of-control/highly vulnerable	20%	25%	29%	20%	18%	19%	21%
5. Multiple complex needs I	26%	32%	21%	29%	25%	30%	26%
6. Multiple complex needs II	3%	7%	1%	8%	2%	3%	3%
7. Disability and mental health	6%	8%	6%	11%	10%	11%	7%
Total	100%	100%	100%	100%	100%	100%	100%

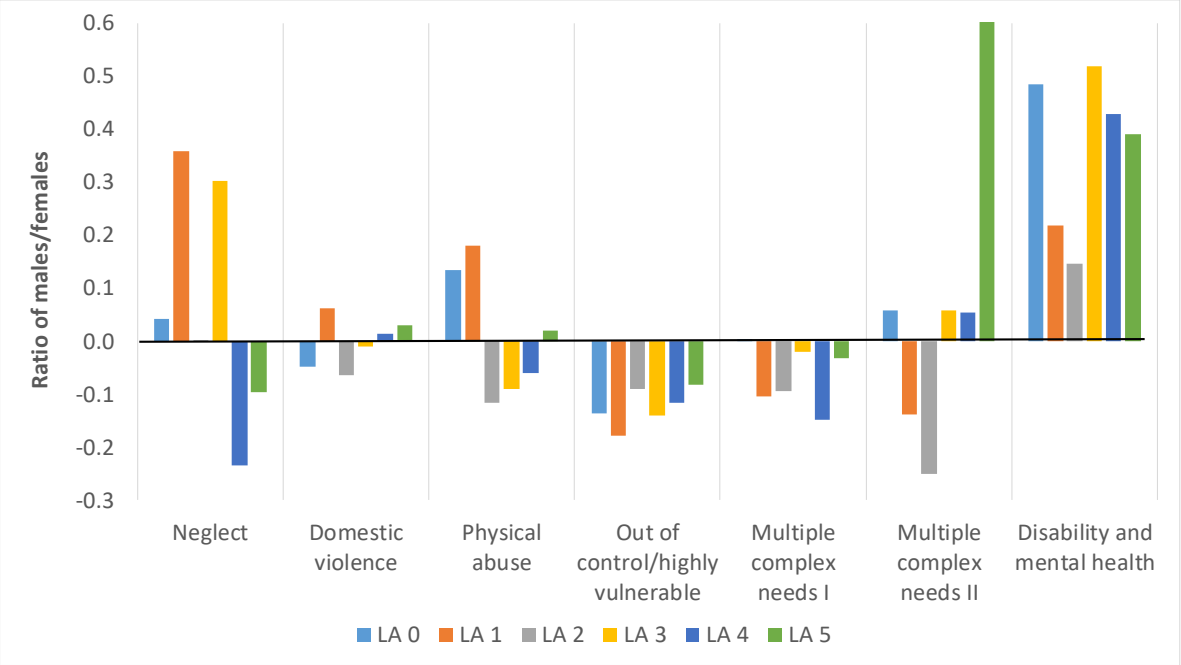
Table 12 shows that the most common type of demand in almost all of the LAs was Class 5 (Multiple complex needs I) followed either by Class 4 (Out-of-control/highly vulnerable) or Class 2 (Domestic violence). The category suggestive of acute multiple risks to children, Class 6 (Multiple complex needs II), was the smallest category overall, and in every LA except LA3, where it constituted 8% of all episodes.

3.4.2. Child characteristics

Gender

Figure 13 shows the ratio of males/females in each class based on intervention rates in each LA. It suggests that rates were consistently higher for boys in the Disability/mental health class and higher for girls in the Complex needs I and Out-of-control/highly vulnerable class. Results for the other classes varied between the LAs. For example, children in the Neglect class were more likely to be boys in LA1 and LA3 but more likely to be girls in LA4. In the Multiple complex needs II class, intervention rates were much higher for boys in LA5 but higher for girls in LA1 and LA2. In the Physical abuse class, rates were higher for boys in LA0 and LA1 but higher for girls in LA2, LA3 and LA4.

Figure 13. Ratio of male/female intervention rates in each class (per LA)

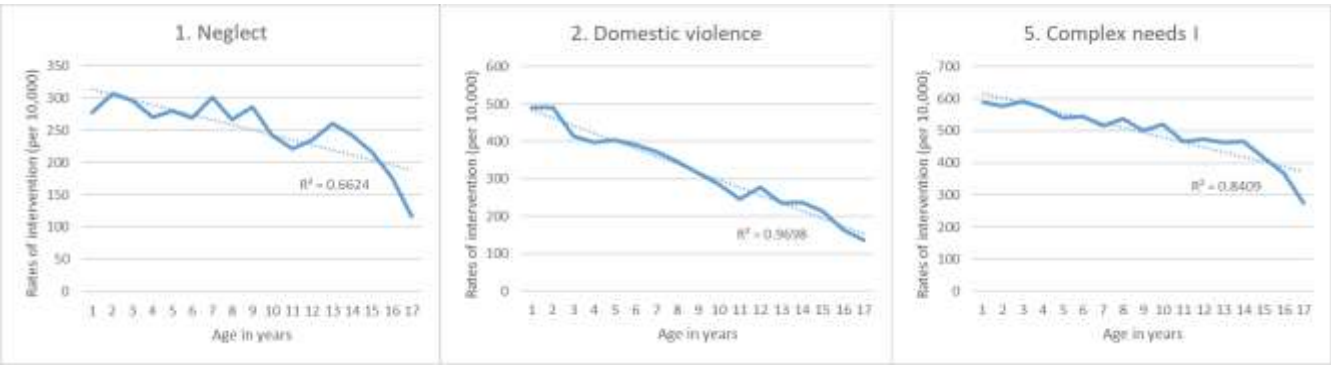


Age

Rates of intervention for children and young people in each class were calculated for yearly age groups from 1-17 (using ONS child population data as the denominator). The findings indicated three distinctive age profiles for the demand classes, which were consistent in all the LAs:

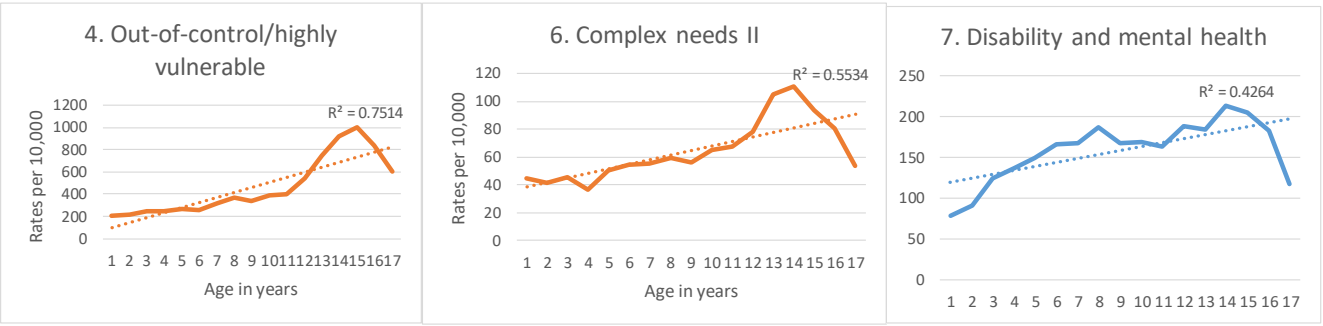
- *Younger children* – Figure 14 shows that rates of intervention for Neglect, Domestic violence and Complex needs I tended to decrease with each additional year of age. This trend was particularly evident for Domestic violence and Complex needs I. Rates of intervention for Neglect declined more steeply after the age of 13.

Figure 14. Intervention rates for yearly age groups in Classes 1, 2 and 5 (all LAs)



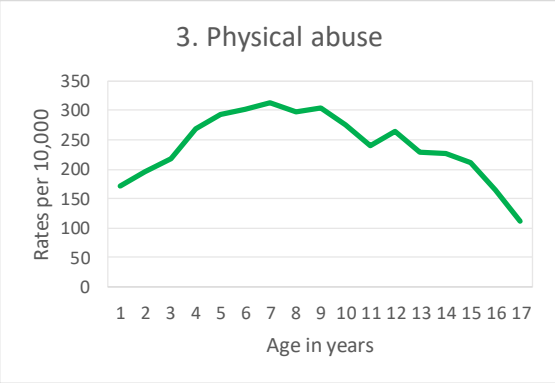
- *Older children* – in contrast, intervention rates for the classes in Figure 14 increased with every year of age up to the age of 14 or 15 before going down again. This creates the 'hump' at the end of the trend lines. The distinction between Multiple complex needs I and II was therefore linked to age as well as presenting needs. The trend for children in the Disability/mental health class was not quite as linear as the other two and suggested two peaks in demand, first in primary school around age 8 and then again in secondary school around age 14.

Figure 15. Intervention rates for yearly age groups in Classes 4, 6 and 7 (all LAs)



- *School-age children* – the age profile for the Physical abuse class (see Figure 16) was different from the others in that intervention rates showed an initial upward trend to a peak around 5—9 years before decreasing in successive age groups after that. Rather than a linear trend, this convex or 'humped' profile suggests that this type of demand was particularly associated with school-age children.

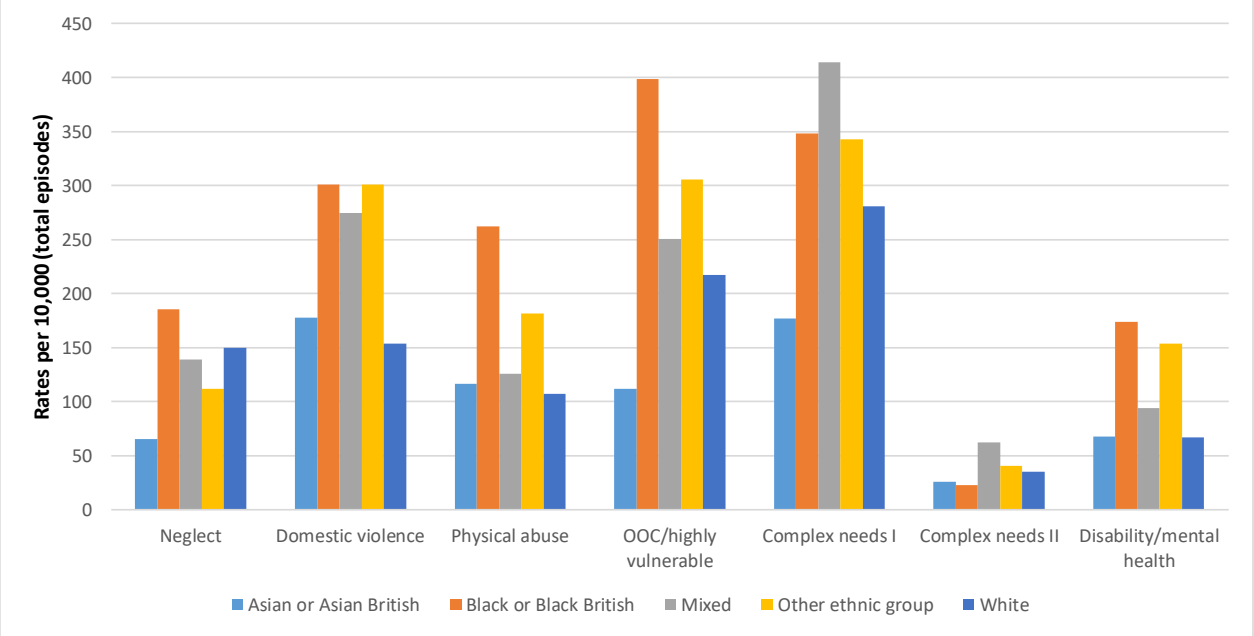
Figure 16. Intervention rates for yearly age groups in Class 3 (all LAs)



Ethnicity

Figure 17 below shows the split between broad ethnic categories (using DfE classifications). It shows intervention rates to be higher for Black/Black British, Mixed and Other ethnic groups in most demand classes, particularly domestic violence, physical abuse, out-of-control/highly vulnerable and disability/mental health. In contrast, rates of intervention for Asian/Asian British children were lower than other groups for most classes, while those for White children tended also to be relatively low except for the Multiple complex needs II and Neglect classes. However, it should be noted that these findings reflect rates rather than numbers. White British children formed the large majority of demand in all the LAs except LA4. Moreover, the focus on BAME children is less apparent when deprivation is taken into account (see Figure 16).

Figure 17. Rates per 10,000 population for each class broken down by ethnicity (all LAs)



Deprivation

Table 12 shows the breakdown of demand categories for children from different deprivation groups across all six LAs. The results point to a fairly even representation across deprivation tertiles for almost all the classes. The exception is Class 1 (neglect) which is associated more with children from the most deprived neighbourhoods. There is a decline in the most deprived tertile of children associated with Class 2 (domestic violence) compared to less deprived tertiles.

Table 12. Proportion of episodes in each tertile of deprivation in seven Classes of demand (all LAs)

Classes	**1 (least deprived)**	**2 (middle tertile)**	**3 (most deprived)**	**All children**
1. Neglect	10%	11%	15%	13%
2. Domestic violence	19%	19%	16%	17%
3. Physical abuse	12%	12%	12%	12%
4. Out-of-control/highly vulnerable	22%	21%	21%	21%
5. Multiple complex needs I	26%	27%	26%	26%
6. Multiple complex needs II	3%	3%	3%	3%
7. Disability and mental health	8%	8%	7%	7%
Total	100%	100%	100%	100%

A more nuanced picture emerges in Table 13, which shows the results of a regression model where 'child-level' deprivation (using IMD scores for small neighbourhoods called LSOAs as a proxy – see Section 3.5) was used to predict rates of intervention for each class. The results show that a rise in child-level (LSOA proxy) deprivation increased the odds of being assessed in all of the seven demand classes. In all the LAs except one (LA3) assessments in the neglect category were the most sensitive to child deprivation. This finding will be seen again in the later analysis of social gradient (see Section 3.5.1). There were differences between the LAs. For example, the 'Complex needs II' Class (which includes a high 'neglect' component) was particularly associated with child-level (LSOA proxy) deprivation in LA3 but less so in LA4 and LA5. The Classes least affected by child deprivation seemed to be out-of-control/highly vulnerable and disability/mental health, although this was only relative to other Classes and again varied between LAs.

Table 13. Effect of a rise in child-level (LSOA proxy) deprivation on the chances of being assessed in each demand class (all LAs)

Classes	**Neglect**	**Domestic violence**	**Physical abuse**	**OOC/ highly vulnerable**	**Complex needs I**	**Complex needs II**	**Disability/ mental health**
LA0	+33%	+21%	+24%	+23%	+24%	+27%	+17%
LA1	+32%	+13%	+14%	+15%	+22%	+28%	+30%
LA2	+35%	+26%	+29%	+26%	+27%	+22%	+27%
LA3	+20%	+20%	+23%	+18%	+30%	+42%	+19%
LA4	+22%	+24%	+22%	+16%	+18%	+16%	+17%
LA5	+62%	+25%	+30%	+38%	+32%	+16%	+34%

3.4.3. Intervention pathways

Table 14 shows the intervention pathways associated with each demand class, using the main thresholds following referral to CSC. The highlighted figures were statistically significant in all six LAs, and consistently found across the sample. As might be expected, cases in the Complex needs II class were highly likely to meet the threshold for CP or LAC—if anything it is surprising that just under half of them did not—and this was one of only two types of demand where 'assessed not CIN' was not the most common outcome (the other was Disability/mental health). Table 12 also suggests that the Physical abuse class was particularly likely to meet with a 'not-CIN' assessment, while disability and mental health episodes were likely to have a CIN (not CP) pathway.

Table 14. Breakdown of episodes within each class at different thresholds (all LAs)

Classes	Assessed Not CIN	CIN (no CP)	CP Plan	LAC	Total
1. Neglect	55%	24%	15%	6%	100%
2. Domestic violence	61%	30%	9%	1%	100%
3. Physical abuse	65%	22%	10%	4%	100%
4. Out-of-control/highly vulnerable	59%	32%	6%	3%	100%
5. Multiple complex needs I	50%	29%	17%	5%	100%
6. Multiple complex needs II	18%	29%	37%	15%	100%
7. Disability and mental health	44%	49%	5%	2%	100%
Total	55%	30%	12%	4%	100%

Table 15 shows how membership of classes varies when comparing episodes that are re-referrals (within 12 months) with all other episodes. The Complex needs II class features the highest proportion of re-referrals (one third) compared to an average of 25% for all classes combined. The Physical abuse class was had the lowest proportion of re-referrals. This was a consistent pattern across all the LAs, except in LA5, where the Neglect class had the lowest proportion of re-referrals (only 5%).

Table 15. Breakdown of Class membership for re-referred episodes (all LAs)

Classes	Episodes not re-referred (%)	Episode re-referred within 12 mths (%)	Total
Neglect	71%	29%	100%
Domestic violence	78%	22%	100%
Physical abuse	81%	20%	100%
OOC/highly vulnerable	76%	24%	100%
Complex needs I	72%	28%	100%
Complex needs II	67%	33%	100%
Disability/mental health	78%	22%	100%

Total	75%	25%	100%

Table 16 shows how membership of classes varies when comparing episodes that had different sources of referral. The Physical abuse class features the highest proportion referred by Schools and Education services (over half) compared to an average of 24% for all classes combined. Domestic violence had the highest proportion of referred by Police (over half) compared with the average of 29% for all classes combined. This pattern was consistent across all the LAs.

Table 16. Breakdown of Class membership for sources of referral (all LAs)

Classes	Individual	Schools and Education Services	Health Services	LA and Housing Services	Police	Other	Total
Neglect	8%	28%	17%	15%	18%	14%	100%
Domestic violence	5%	11%	11%	9%	54%	11%	100%
Physical abuse	6%	56%	8%	8%	14%	9%	100%
OOC/highly vulnerable	8%	24%	13%	14%	31%	10%	100%
Complex needs I	8%	16%	20%	13%	30%	14%	100%
Complex needs II	8%	25%	11%	16%	28%	11%	100%
Disability/mental health	18%	23%	22%	15%	10%	12%	100%
Total	**8%**	**24%**	**15%**	**12%**	**29%**	**12%**	**100%**

3.4.4. Assessed needs and child protection categories

For children subject to a CP plan, we found that the categories used to classify the CP plan (neglect, emotional abuse, physical abuse or sexual abuse) were not always aligned with the factors recorded at assessment (see Table 17). For example, nearly a quarter of CP plans under the category of 'Neglect' did not have neglect recorded as a factor at assessment, while over 50% of CP plans under the category of 'Emotional abuse' did not have emotional abuse recorded as a factor at assessment.

Table 17. Match between CP plan categories and assessed needs

CP Plan Category	Category also recorded as a factor at assessment
Emotional abuse	47%
Neglect	76%
Physical abuse	61%
Sexual abuse	71%

Unlike factors at assessments, only one category can be recorded at CP Plan stage. The demand classes described earlier are similar to CP plans in being mutually exclusive groups. Table 18 therefore shows the breakdown of each demand class by CP Plan category of abuse, i.e. covering only those episodes within each class that resulted in a CP plan. We found that neglect was the most likely CP plan category in all classes with the exception of domestic violence, which tended to be recorded as emotional abuse. However, it is worth noting that 27% of CP plans within the domestic violence class were for neglect, even though not a single one of these episodes had neglect recorded as a factor at assessment. Overall, these findings seem to show that neglect can be identified (or 'added') as a primary concern at the stage of a CP conference, when a decision is made to place a child on a CP plan.

Table 18. Breakdown of Class membership by CP plan category

Classes	CP plan category					
	Emotional abuse	Neglect	Physical abuse	Sexual abuse	Multiple abuse	Total
Neglect	13.4%	81.4%	3.1%	2.0%	0.1%	100.0%
Domestic violence	57.2%	27.1%	13.4%	0.6%	1.6%	100.0%
Physical abuse	25.5%	39.6%	33.5%	1.0%	0.5%	100.0%
OOC/highly vulnerable	26.5%	34.4%	6.0%	33.0%	0.2%	100.0%
Complex needs I	37.8%	54.1%	7.0%	0.9%	0.2%	100.0%
Complex needs II	32.8%	55.9%	7.3%	3.2%	0.7%	100.0%
Disability/mental health	26.3%	62.2%	7.2%	4.0%	0.4%	100.0%
Total	32.2%	53.0%	9.6%	4.8%	0.4%	100.0%

3.4.5. Summary

- Seven mutually exclusive demand classes were found consistently in all the LAs: Neglect, Domestic violence, Physical abuse, Out-of-control/highly vulnerable, Complex needs I, Complex needs II, and Disability/mental health.
- Neglect, Domestic violence, and Physical abuse were dominated by one factor at assessment whereas the other four classes were characterised by a combination of multiple factors.
- Overall, children in the Complex needs II and Disability/mental health classes were more likely to be boys, whereas those in the OOC/highly vulnerable class were more likely to be girls.
- Neglect, Domestic Violence and Complex needs I were associated with younger children; OOC/highly vulnerable children and Complex needs II were associated with older children; Physical abuse was associated with school age children
- Intervention rates were higher for Black/Black British, Mixed and Other ethnic groups in most demand categories, particularly for domestic violence, physical abuse, OOC/highly vulnerable and disability/mental health. In contrast, intervention rates for Asian/Asian British children were lower than other groups for most classes, while those for White children tended also to be relatively low except for the Multiple complex needs II and Neglect classes.

- Children in the Multiple complex needs II class were much more likely than any others to meet the threshold for CP or LAC. This was one of only two types of demand where 'assessed not CIN' was not the most common outcome (the other was Disability/mental health).
- Children in the Physical abuse class were particularly likely to meet with an 'not-CIN' assessment, while disability and mental health episodes were likely to have a CIN (not CP) pathway.
- The Complex needs II class had the highest proportion of re-referrals (one third) compared to an average of 25% for all classes combined. The Physical abuse class had the lowest proportion of re-referrals.
- CP plan categories were not always aligned with factors at assessment; in nearly a quarter of CP plans for neglect, the social work assessment had not identified neglect as a cause for concern.

3.5. The social gradient in CSC

Findings from the regression analysis showed the relative strength of the social gradient of intervention in different parts of the system and for different types of children. The analysis of social gradient was based on Index of Multiple Deprivation (IMD) scores and how they influenced the likelihood of child welfare interventions. The results in this section show how deprivation operates at two levels. The first was 'child-level' deprivation, using IMD scores for small neighbourhoods called 'Local Super Output Areas' (LSOAs) as a proxy for the socio-economic status of all children within those neighbhourhoods. The second was LA-level deprivation using average IMD scores for the whole local authority. The primary focus is on the differences between children of equivalent child-level (LSOA proxy) deprivation living in different LAs.

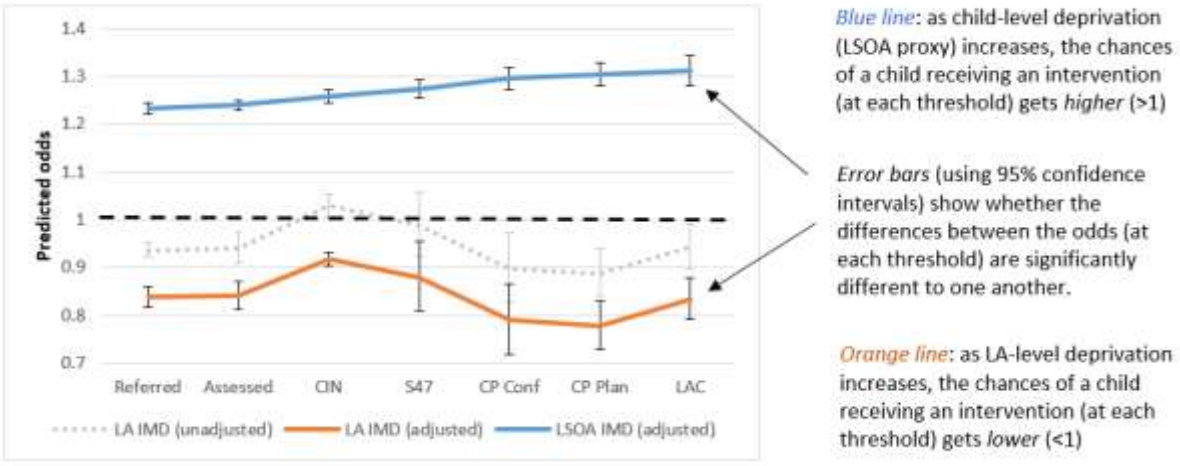
Child-level (LSOA proxy) deprivation and LA-level deprivation both affect intervention rates but in opposite ways: as child-level (LSOA proxy) deprivation increases the chances of intervention increase (after the adjustment for LA-level deprivation), and as the LA-level deprivation increases the chances of an intervention decrease (after the adjustment for child-level (LSOA proxy) deprivation). The latter is sometimes called the 'inverse intervention' effect as it tends to be obscured by higher overall (i.e. unadjusted) rates of intervention in more deprived LAs.

3.5.1. Intervention pathways

Figure 18 shows how changes in deprivation affect the chances of intervention at seven thresholds: referral, assessment, CIN, Section 47 inquiry, CP conference, CP plan, and LAC episode. These predictive models were used to calculate how the decile rank changes in child-level (LSOA proxy) deprivation and LA-level deprivation affected rates of intervention at each threshold. The graph illustrates the change in odds ratios when a) the child is more deprived, using LSOA IMD as a proxy (blue line) and b) the LA is more deprived (orange line). As an example, the graph shows that episodes in which a child becomes subject to a CP plan have a) a predicted increase of x1.31 (31% increase) with each decile increase in child-level (LSOA proxy) deprivation and b) a predicted decrease of x0.78 (22%

decrease) with each decile increase in LA-level deprivation. The graph shows the odds ratios at each threshold and the confidence intervals around each point enable us to see whether the odds were significantly higher (or lower) when comparing across different thresholds. Also shown are the unadjusted and adjusted coefficients for LA-level deprivation to compare the difference in the odds ratios before and after. At every threshold, child-level level deprivation negatively confounds the effect of LA-level deprivation. This finding is consistent with the findings on inverse intervention reported elsewhere.

Figure 18. Change in predicted odds of receiving an intervention with every step-change in deprivation (all LAs)



The results can be summarised as follows:

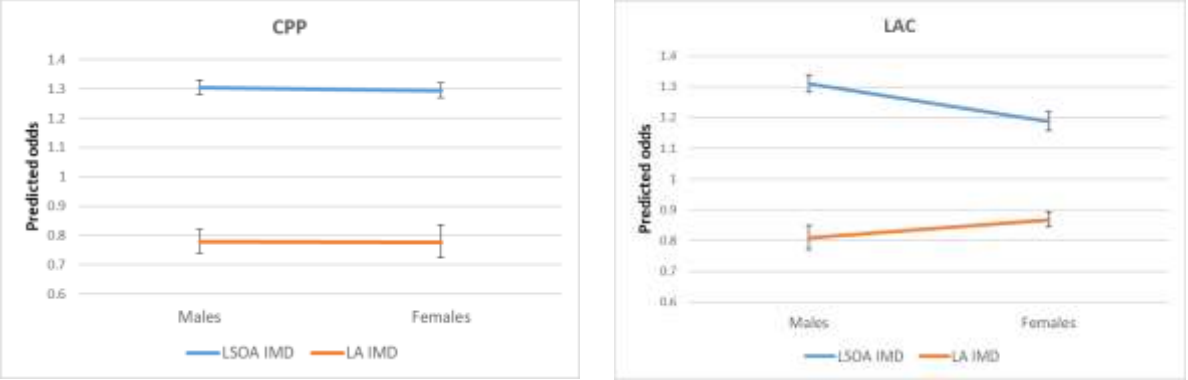
- The social gradient of intervention increases in the later stages of intervention (this is shown by the upward gradient of the blue line). In other words, the tendency for more deprived children to have higher rates of intervention increases at each threshold from referral to CIN to CP to LAC.
- The inverse intervention effect, in which children who are similarly deprived have a higher chance of intervention in LAs that are less deprived overall, also increases in the later stages of intervention, and particularly at the points where a decision is made to hold a CP conference or place a child on a CP plan.

3.5.2. Child characteristics

Gender

The results for gender (based on a binary classification of male or female) are shown for CP plans and LAC episodes in Figure 19. The social gradient and the inverse intervention effect were both present to the same degree for male and female children who were subject to CP plans (as suggested by the straight blue and orange lines). The results for referrals and CIN (not shown) were similar, i.e. showed no difference for boys or girls. However the results for LAC episodes suggested that both effects (social gradient and inverse intervention) reduced for girls in this part of the system.

Figure 19. Change in predicted odds of receiving an intervention comparing male and female children (all LAs)[1]

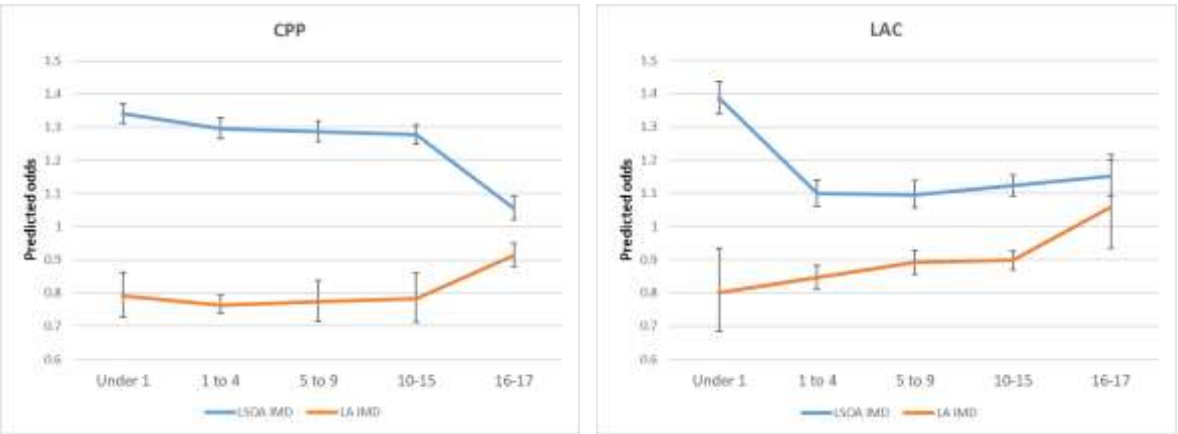


Note: [1] Connecting lines are for illustrative purposes, indicating the relative changes in odds from one categorical value to the next.

Age

The results for age (based on a categorisation of year groups) are shown for CPP and LAC episodes in Figure 20 below. For CPP the social gradient was lower for older children and this was particularly the case for 16/17 year olds. The inverse intervention effect did not change very much except for 16/17 years olds when it weakened significantly. For LAC episodes the pattern was different. The social gradient was much higher for under 1s than other age groups but was slightly higher for 16/17 years olds than for younger age groups. The inverse intervention effect weakened with increasing age and even disappeared entirely for 16/17 years olds.

Figure 20. Change in predicted odds of receiving an intervention comparing age groups (all LAs)

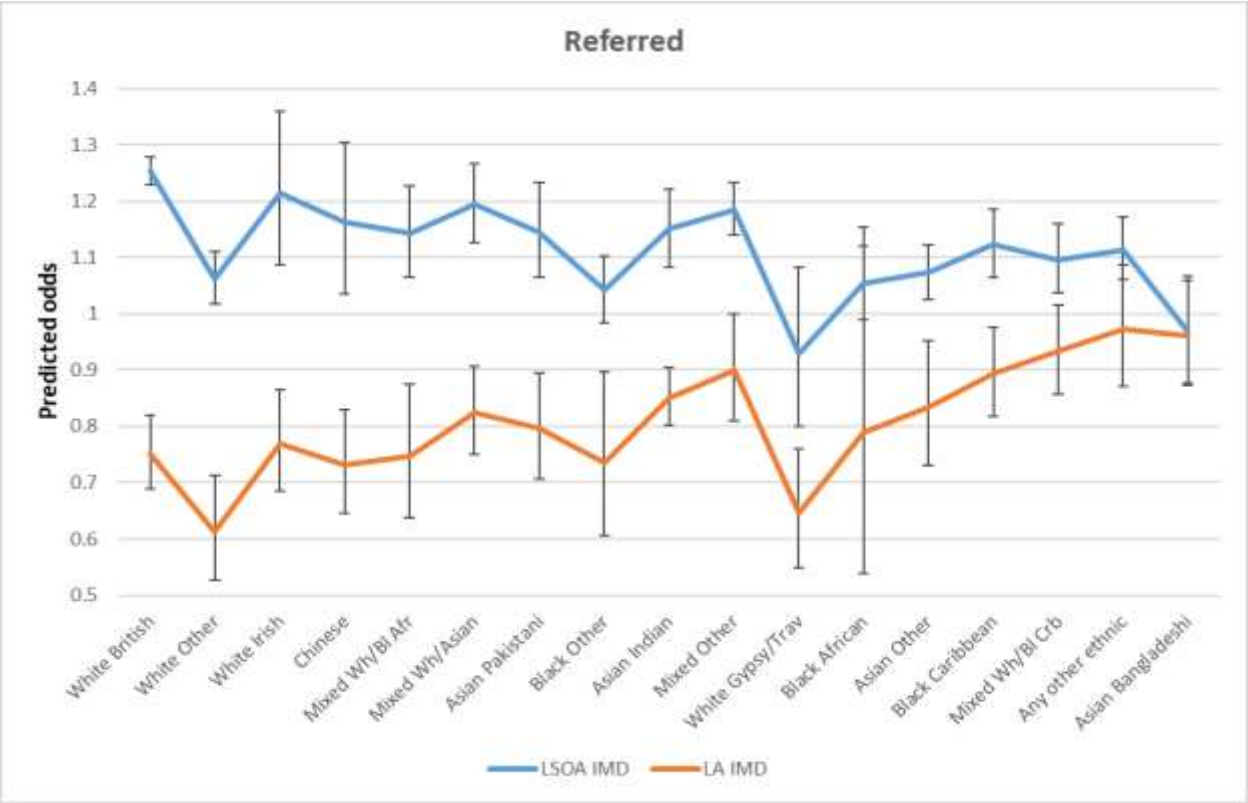


Ethnicity

Comparative analysis of intervention rates for different ethnic groups was made difficult by the presence of low numbers for some groups, particularly in later stages in the system (i.e. CP and LAC), and/or uneven distribution across neighbourhoods in the LA. Using broader ethnic categories (e.g. Asian/Asian British) can obscure differences in the socio-economic circumstances of different groups within those categories, e.g. Asian Indian families tend to experience lower rates of deprivation than Asian Bangladeshi families.

For these reasons, the results shown in Figure 21 are those for referrals, where numbers are highest, based on a full breakdown of DfE categories. They show that the social gradient was particularly high for White British children and this was a consistent finding at other thresholds too (i.e. CIN, CP plans and LAC). There was a lot of variation among other ethnic groups, with quite wide error bars for groups where numbers were low and unevenly distributed. Interventions for Asian Pakistani children seemed to have a higher social gradient in later stages of the system (CP and LAC) while the lowest social gradient at all thresholds was found for Asian Bangladeshi children.

Figure 21. Change in predicted odds of receiving an intervention comparing children from different ethnic groups (all LAs)[1]



3.5.1. Episode needs

Demand classes

The results for demand typologies (based on the latent class analysis) are shown for Assessments and

CIN in Figures 22 and 23. They show that the social gradient was particularly high for the Neglect and the Complex needs II classes and this was a consistent finding at other thresholds too (i.e. CIN, CP plans and LAC). Differences among the other classes were not as noticeable, although the social gradient was present for all of them. The inverse intervention effect seemed to be weakest for the domestic violence and disability/mental health classes.

Figure 22. Change in predicted odds of receiving an intervention comparing children from different demand classes (all LAs): Assessments

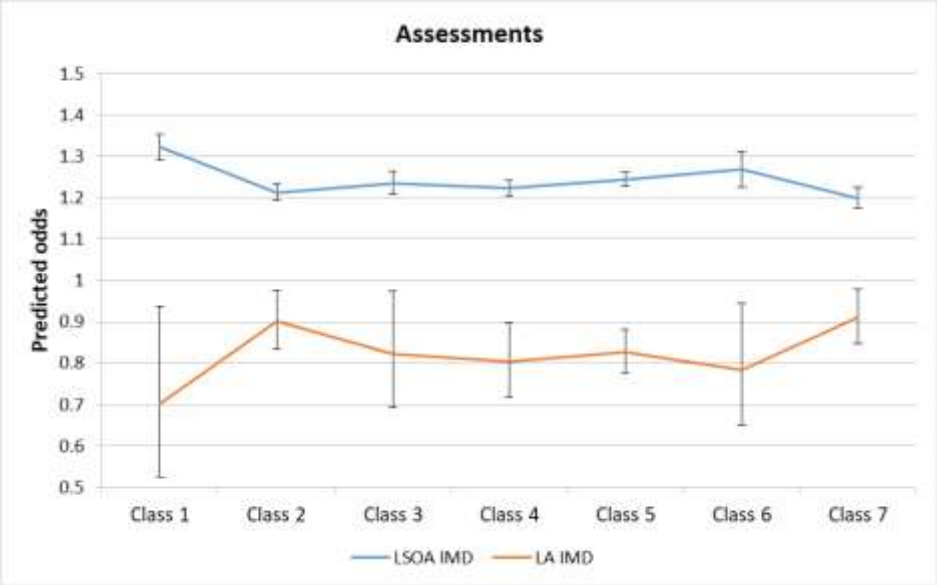
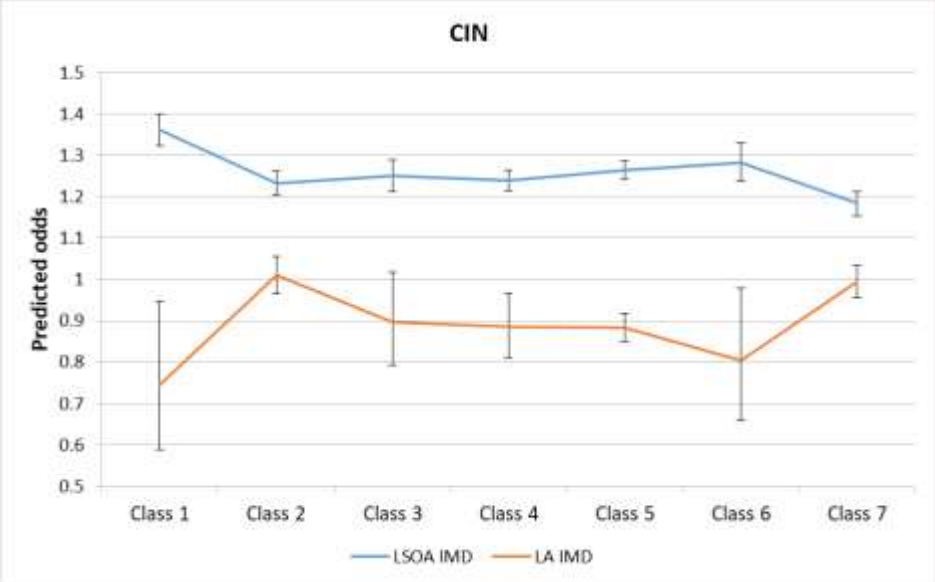


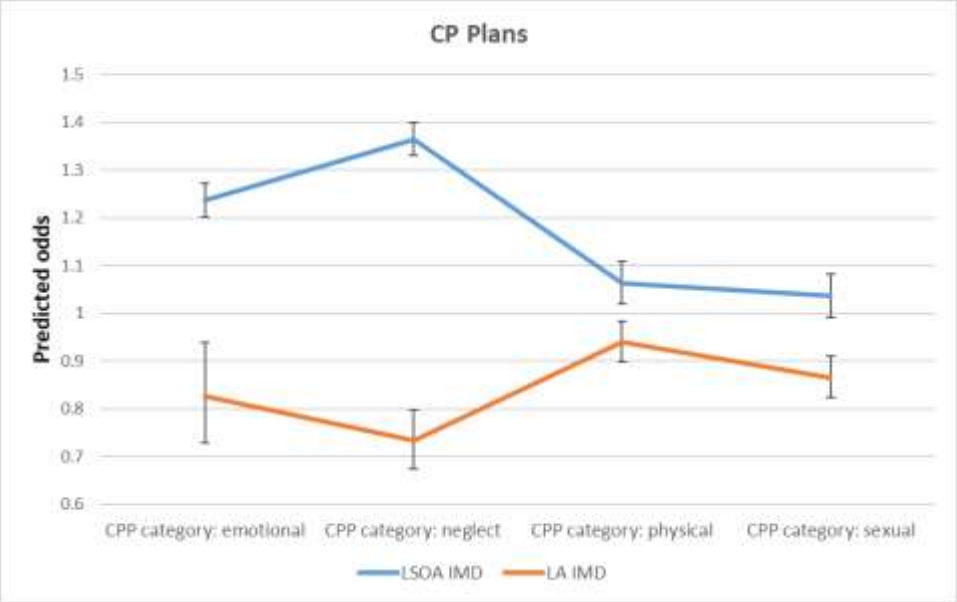
Figure 23. Change in predicted odds of receiving an intervention comparing children from different demand classes (all LAs): CIN



CP Plan Latest Category of Abuse

The results for latest CP Plan category of abuse in Figure 24 show that the social gradient and inverse intervention effect was particularly high for the Neglect, which echo the findings from the demand classes.

Figure 24. Change in predicted odds of receiving a CP Plan comparing children subject to different categories of abuse (all LAs)



3.5.2. Qualitative feedback

3.5.3. Summary

- The social gradient of intervention increases in the later stages of intervention, i.e. the tendency for more deprived children to have higher rates of intervention increases at each threshold from referral to CIN to CP to LAC.
- The inverse intervention effect, in which children who are similarly deprived have a higher chance of intervention in LAs that are less deprived overall, also increases in the later stages of intervention, and particularly at the points where a decision is made to hold a CP conference or place a child on a CP plan.
- The social gradient effect seems to increase at each successive threshold. However, the inverse intervention effect is lower for children who are assessed as CIN than at the referral and assessment stage, and lower for LAC than for children on CP plans.
- The social gradient and the inverse intervention effect were both present to the same degree for male and female children at almost all thresholds of intervention, i.e. showed no difference for boys or girls. The exception was LAC episodes—both effects (social gradient and inverse intervention) weakened for girls in this part of the system.
- For CPP the social gradient was lower for older children, particularly 16/17 year olds. The inverse intervention effect did not change very much except for 16/17 years olds when it

weakened significantly. For LAC episodes the social gradient was much higher for under 1s than other age groups but was slightly higher for 16/17 years olds than for younger age groups. The inverse intervention effect weakened with increasing age and even disappeared entirely for 16/17 years olds.

- The social gradient was particularly high for White British children at all thresholds, i.e. referral, assessment, CIN, CP plans and LAC. There was a lot of variation among other ethnic groups. Interventions for Asian Pakistani children seemed to have a higher social gradient in later stages of the system (CP and LAC) while the lowest social gradient at all thresholds was found for Asian Bangladeshi children.
- The social gradient was particularly high for the Neglect and the Complex needs II classes at all thresholds, i.e. referral, assessment, CIN, CP plans and LAC. Differences among the other classes were not as noticeable, although the social gradient was present for all of them. The inverse intervention effect seemed to be weakest for the domestic violence and disability/mental health classes.

Overall, the findings found welfare inequalities to be particularly apparent in protective services for young children and White British children, and in cases of child neglect. The analysis was carried out on a limited sample of six LAs and so would need to be replicated on a larger dataset to check its generalisability.

4. Discussion and implications

Welfare inequalities arise because CSC services are more likely to intervene with some children than others, and these differences are systematically linked to deprivation. However, these patterns can be masked by other contextual factors that lead to differences in intervention rates between LAs. The findings allow us to disentangle some of these effects and give an insight into how the system might reinforce or mitigate them. The findings also provide a detailed breakdown of demand and provision, showing where differences exist and where inequalities are concentrated. In what follows, these points are further elaborated in order to inform policy and practice with the aim of reducing avoidable inequalities.

4.1. Differential intervention and welfare inequalities

Overall the findings present a complex picture of demand and provision in children's social care. Differential intervention rates in LAs were found to produce welfare inequalities insofar as deprivation (at the child and LA level) affected the chances of involvement with child welfare services. However, contextual factors other than deprivation were also thought to influence rates of intervention. In order to disentangle the complexity of causal effects, it is helpful to use the concept of mechanisms found in realist theories of causation (Sayer, 2010; Maxwell, 2012; Pawson, 2013). In this context, mechanisms are the combination of causal tendencies that in specific contexts produce effects that can be observed empirically. The 'inverse intervention law' identified by the Child Welfare Inequalities Project (Bywaters *et al.*, 2015; Bywaters, 2017) is an example of such an empirical pattern. The study of system conditions in CSC enabled the research team to identify some

of the mechanisms of differential intervention, which gave an insight into the emergence of welfare inequalities. Drawing on the findings and supporting evidence elsewhere in the literature, a set of key mechanisms are discussed below: screening and rationing, austerity and cuts, inspection and regulation, organisational factors, and demand factors.

4.1.1. Screening and rationing

The study of national datasets (Sections 2.2 and 3.1) found evidence of screening, rationing and workforce churn mechanisms, through which local authorities strove to manage demand for CSC services. Since higher deprivation was strongly associated with higher demand, utilitarian calculations in more deprived areas created pressure for more rationing, earlier screening out and a tendency to work for shorter time periods with children in need (see Hood et al., 2016, 2019). Screening and rationing help to control demand for intensive (and expensive) statutory interventions. Because current funding arrangements are providing LAs that are less deprived overall with more resources relative to the level of demand, they are able to adopt a more interventionist approach to child welfare. The strong correlation between deprivation and demand, screening and rationing drive patterns of differential intervention that exacerbate welfare inequalities.

On the supply side, these differences arise from the way families' problems and needs are interpreted in relation to legal, organisational and professional criteria for action and support (see Sections 3.2.6 and 3.4.3). While CSC services have a duty to provide services to children in need and protect children who are at risk of significant harm, statutory thresholds are subject to operational definitions on the part of social workers and their managers. We return to this issue in the discussion of neglect below (Section 4.3). However, there is likely to be a demand side to such patterns too. The literature on health inequalities (Wilkinson and Pickett, 2010; Marmot and Sapolsky, 2014) discuss psychosocial mechanisms, such as stress, stigma and exclusion, through which status differences in a social hierarchy influence the health and wellbeing of individuals – and by extension their family life. Inequality might therefore be expected to exacerbate the effects of poverty when it comes to children's welfare (see Bywaters et al., 2016, and Section 4.3 below). In other words, child poverty will incur a greater risk of negative outcomes in areas of high inequality. New research by Webb et al. (forthcoming) shows that the most unequal places in England tend also to be the most affluent places. Their research also suggests that income inequality is itself a key driver of the type of differential intervention that leads to welfare inequalities.

4.1.2. Austerity and cuts

The impact of government austerity policies and the resulting cuts to local authority budgets was a common theme across all the LAs, where it was perceived to be a major cause of spiralling demand for child welfare services (see Sections 3.22 and 3.2.10). The consensus was that budgetary pressures have forced LAs to cut universal and preventive services in order to protect core statutory provision. In turn, the removal of community-based support has made it more likely that problems will escalate to the point where statutory intervention becomes necessary. This perception reflects a common narrative in recent reports on the sector (Action for Children *et al.*, 2017; ADCS, 2018; National Audit Office, 2019), where the rising cost of CSC – particularly for child protection (CP) and

care – has been linked to a decade of austerity and 'state shrinkage' that began soon after the 2008 financial crisis.

These issues are relevant to welfare inequalities because austerity policies have disproportionately affected the most deprived areas of the country (Webb and Bywaters, 2018). In a broad sense, it could be argued that de-industralisation in the 1980s created a greater reliance in those areas on public sector investment, so that retrenchment has had a comparatively greater impact. However, changes to the funding formula for local authorities post-2010 has also led to deprived regions and cities bearing the brunt of government cuts (Jordan and Drakeford, 2012; O'Hara, 2015; Centre for Cities, 2019). In combination with the continued mismanagement of social policy in relation to housing and benefits, the effect has been to compound the hardship faced by families (O'Hara, 2015), which in turn exacerbates the risk factors associated with child abuse and neglect (Bywaters *et al.*, 2016). On the supply side CSC has seen a shift to 'late intervention', with spending on child protection and children in public care increasing even as other forms of provision have been stripped back (Hudson, 2004).

Evidence from national statistics shows that the rising tide of CP and care has not been confined to deprived areas and has affected all LAs. Indeed, the findings from this study suggest that less deprived LAs have experienced considerable problems managing the increase in demand due to their tendency to be more interventionist in their approach to child welfare issues. There was certainly no sense from the relatively affluent LAs involved in the study that they had perceived any benefit from the unfair distribution of cuts. Instead, they were seeking to curb the rise in CP and care through measures that were already familiar in more deprived areas: integrating and resourcing Early Help, adopting preventative/solution-focused models of social work practice, and formulating strategic responses outside of conventional CP procedures for vulnerable adolescents (see Sections 3.2.1 and 3.4.2).

Overall, the findings suggest that austerity policies have largely served to aggravate welfare inequalities: the less deprived LAs seemed to have been less affected by cuts in that they were more likely to respond in a more interventionist way to increases in demand. However, the picture may now be changing as the level of demand is now perceived as unsustainable even in the most affluent areas.

4.1.3. Inspection and regulation

The process and outcomes of Ofsted inspections were found to be a key system condition in CSC (Section 3.2.8). Institutional anxiety seemed to be ramped up in the immediate prelude and aftermath of an inspection but in many areas also influenced routine audit activity and performance management, e.g. through the practice of mock inspections. The two LAs that received an inadequate Ofsted rating in the previous inspection cycle reported a strong impact on staff retention and morale that lasted for several years as the LA underwent a process of churn in leadership and organisational structures. The inspection regime was also considered to be reinforcing risk averse decision-making, particularly evident in LAs recovering from an inadequate rating. These findings correspond with Hood et al's (2016b) study of performance indicators and Ofsted ratings, which found that LAs with an inadequate Ofsted rating had higher rates of CP interventions one year after their inspection than a comparison group of similarly performing peers.

A tendency for LAs with poor Ofsted ratings to become more interventionist would not necessarily support the type of differential patterns associated with welfare inequalities. Arguably it would only do so if there was evidence that more deprived LAs were likely to receive better ratings than less deprived ones, which would reinforce the 'screening and rationing' mechanism outlined above. In fact, the evidence points the other way – the Child Welfare Inequalities Project found that almost half of children living in low -deprivation LAs had CSC services rated 'Good' or 'Outstanding', more than double the proportion in high deprivation LAs (Webb and Bywaters, 2017). Looked at more closely, however, the underlying factor was found to be expenditure relative to demand; among high or very high-deprivation LAs, those awarded a 'good' or 'outstanding' rating spent on average 20% more per child[8] than those awarded 'inadequate' or 'requires improvement' (Webb and Bywaters, 2017). What this suggests is that the rationing mechanism underlying differential intervention may also have the side-effect of rewarding low deprivation LAs with better inspection outcomes – offering an incentive for those LAs to maintain an interventionist approach despite the financial strain. Correspondingly, for high deprivation LAs found to be inadequate, the obvious path to improvement consists of an injection of additional expenditure to reduce rationing and increase intervention – in effect mimicking the conditions found in more affluent areas. Supporting evidence for increased expenditure on CP in 'inadequate' rated services was also found by Hood et al. (2016b). The overall effect of inspection and regulation may therefore be another contributory mechanism of differential intervention.

4.1.4. Organisational factors

The findings show how organisations were trying to address the problem of rising demand in the context of acute financial constraints and the erosion of preventative services in the community. A common strategy was the integration of Early Help (EH) under the aegis of CSC and the development of targeted EH support to try and deal with child welfare concerns before they escalated to the threshold for statutory services (see Section 3.2.3). While there was a consensus on the importance of EH as a preventative approach, there was ambiguity about its effectiveness. There were several reasons for this. The pressure on statutory budgets meant that funding for EH was often precarious and subject to cost-benefit considerations, which together with an increased focus on complex needs was driving a shift towards targeted, short term casework, assessment and care planning . Over time, integration with CSC was reproducing many of the features of statutory services: referral and gatekeeping procedures, a screen-and-intervene model of delivery, and a preference for case management over direct work. When these operational features are combined with the focus on children with complex needs, EH can be seen more clearly as an additional tier of CSC – in principle sitting below the threshold for statutory services but operating a very similar sort of service. As such,

[8] In 2013-14, the year prior to the Single Inspection Framework cycle of Ofsted inspections.

LAs' investment in EH mirrors the shift to late intervention elsewhere in the system and so may be limited as a preventative strategy.

Another common trend in CSC was the adoption or development of 'badged' models of social work practice (e.g. solution-focused, systemic, restorative) which were principally aimed at improving the quality of professional work but also served other organisational purposes, such as boosting the chances of a good Ofsted report or encouraging staff retention. Perhaps tellingly, these models were often implemented alongside other measures designed to address recommendations from Ofsted (LA2 and LA3), reduce caseloads (e.g. LA0 and LA1) or take advantage of extra innovation funding from the government (LA5). The issue of resources was seldom far from the surface even when the discussion was ostensibly about new ways of working. Equally, few participants made a case for their organisation having fostered a notably protective or preventative approach to child welfare concerns. Instead, organisational culture was dominated by the need to balance prevention and protection in the context of budgetary constraints, regulatory scrutiny and rising demand.

It is interesting to compare these findings with Oliver et al.'s (2001) study of variation in CP and care indicators. Their account puts much more emphasis on the role of organisational factors, such as LAs' approach to working with families, the availability of alternatives to statutory interventions, professional attitudes to 'refocusing' on partnerships and family support, along with demand factors such as the characteristics of children and families in the area (see Section 4.1.5 below). The role of resource constraints appears less significant than in the findings presented here, which may reflect the lower rate of referrals to services at that time (Devine and Parker, 2015) but also the fact that the researchers controlled for the effect of deprivation on intervention rates before seeking qualitive explanations. The evidence accumulated in this study would suggest that organisational factors have become increasingly subordinate to the imperatives of demand management and the inspection regime, perhaps leaving LAs with less room for manoeuvre than was the case twenty years ago.

4.1.5. Demand factors

The study found considerable evidence that intervention pathways differed according to child characteristics (see Sections 3.3 and 3.4). By extension, it could be expected that demographic differences in the child population would also affect rates of intervention. For example, a comparison of LA0 and LA4 would show the former to be an affluent county with a mainly White British population, and the latter to be a deprived London borough with a very diverse population. LA0 had a higher proportion of neglect cases involving young children and a more interventionist approach to CP, whereas in LA4 there was more of a focus on young people vulnerable to gang involvement and child criminal exploitation, and a greater tendency to work with cases through CIN. Indeed, while LA4 had almost double the rate of CIN in 2017/18 than LA0, and carried out double the rate of Section 47 investigations, the local authorities ended up with very similar rates of CP plans and LAC. Other contextual factors are also likely to be relevant here, e.g. LA4 had lower workforce stability and spent much more on children's safety per CIN. However, the significance of demand factors was corroborated by the overall findings on latent classes and the social gradient (see Section

3.5.2 and 3.5.3), which showed that welfare inequalities were particularly apparent for certain groups of children. All this indicates that differentiated demand also gives rises to differential intervention and therefore points to a potential opportunity for strategic thinking about provision, (see Section 4.4.). Yet while practitioners and managers clearly understand a great deal about the nature of demand for CSC in their area, administrative data is used almost exclusively to look at aggregates at different thresholds, e.g. CP plans or care orders. One of the contributions of this study has therefore been to show how information gathered during social work assessments can produce a more sophisticated understanding of demand.

4.2. Understanding demand: beyond the toxic trio

Findings from the latent class analysis (Section 3.4) found robust evidence that demand for child welfare services can be differentiated, i.e. there are identifiable clusters of presenting issues linked to particular child characteristics and associated with different intervention pathways. This is a different way of conceptualising demand from the conventional approach, which is to aggregate numbers or rates at particular thresholds and to study trends and movements between them (see Hood et al., 2016a, 2019). The former approach has a number of benefits over the latter. It does a better job of connecting performance data with professional understandings of the needs of children, as confirmed by the qualitative responses from practitioners and managers. Second, it avoids an overly individualistic interpretation of risk factors, instead aggregating the latter in combination with child characteristics to produce a problem cluster, a 'type' of child that is consistently provided with a service and may be associated with a particular neighbourhood, locality or community. Third, the question of how many children meet a given threshold for intervention is given a different focus, namely how many of *what type* of children meet the threshold. All of these offer strategic advantages for planning and resource allocation, as discussed in Section 4.4.

From a practice point of view, the breakdown of demand typologies casts doubt on the 'toxic trio' discourse that has come to dominate the way we think about familial risks to children's welfare (Brandon *et al.*, 2008; Frederico *et al.*, 2014). The analysis in Section 3.4 did show that domestic violence, mental illness and substance misuse were implicated in the two demand classes (complex needs I and II) with the highest proportion of CP and LAC outcomes. However, the highest risk category (complex needs II) had many other factor loadings (including physical abuse, neglect and child's mental health) and made up only 3% of episodes on average. The other complex needs category was both much more prevalent and overwhelmingly likely to be either assessed not CIN (50%) or addressed under a CIN plan (29%), which hardly suggests that a combination of these three factors was not necessarily seen by practitioners as indisputable evidence of significant harm.

Disquiet about the 'toxic trio' formulation has long been voiced by academics, professionals and service user groups (Featherstone *et al.*, 2014). As Morris et al. (2018: 368) note, its ubiquity in contemporary child protection work as shorthand for a combination of risk factors seems to owe more to the 'notion of toxicity rather than knowledge of the specific harms'. In a recent blogpost, Peter Sidebotham, one of the co-authors of the analysis of serious case reviews (SCRs) in which the term originally appeared (Brandon *et al.*, 2008), has also recognised its counterproductive impact: 'as a label it is deeply stigmatising and does not help in appraising the real nature of any family

dynamics, and of any support or protection needed for the child or family' (Sidebotham, 2019). In a more recent triennial reports on SCRs (Sidebotham *et al.*, 2016), the term 'cumulative risk of harm' is preferred, acknowledging that while these three risk factors do feature prominently in cases of child maltreatment, they are neither necessary nor sufficient and focusing exclusively on them may unwittingly overlook the risks posed by other factors in the family and wider social environment. The analysis presented here demonstrates how agencies can use their own knowledge of assessed need to go beyond the toxic trio formulation and arrive at an informed picture of demand.

In a similar vein, the findings also shed light on the overlap between domestic abuse and child maltreatment and its implications for demand management in CSC. As noted above, domestic violence (DV) was a high factor loading in the two 'complex needs' classes, suggesting that it was part of a cumulative picture of risk to these children. Elsewhere DV was found in a class of its own with very few other presenting needs recorded and a high likelihood that the case would be assessed not-CIN (Section 3.4.3). The implicit distinction is between a 'DV-only' category and two 'DV plus maltreatment' categories, notwithstanding the fact that children in the 'complex needs I' category were also likely to be assessed as not-CIN. While the distinction has some support in the literature (e.g. Hartley, 2002) it arguably been superseded by the view that domestic violence is less a risk factor for abuse than direct evidence of abuse (emotional if not physical). The picture is further complicated by the different forms that domestic abuse can take (Johnson, 2010) as well as its intersection with other inequalities, notably class and ethnicity (Ferguson *et al.*, 2019). The demand analysis carried out in this study suggests that operational definitions, e.g. of the threshold for significant harm, may be helping to map out this complex and ambiguous territory but it is unclear on what theoretical basis.

4.3. Neglect, poverty and deprivation

The complex interrelationship between poverty and neglect is one of the most well-known and controversial aspects of the evidence-base on child maltreatment (Bywaters *et al.*, 2016). From a practice perspective, the conventional view is that the association is not particularly useful for making decisions about risk because of the baseline prevalence of poverty in the child population (Munro, 2008). Indeed, a key reason for the 'toxic trio' of parental risk factors assuming such importance has been the promise of more predictive power for individual assessments. As a result, social and environmental factors have tended to assume secondary importance in social work assessments if they are mentioned at all (Jack and Gill, 2003; Featherstone *et al.*, 2017). This was reflected in the discussion of practice vignettes, for example (Section 3.2.2), in which the wider social context of the family's lives was rarely brought up. Of course, it may be observed that the vignettes exercise itself replicates the institutional tendency in CSC to deal with child welfare issues on a case-by-case basis. When participants were invited to discuss overall demand for services, on the other hand, they did speak about the impact of poverty and austerity on families in the area. One interpretation is that structural issues such as deprivation are more relevant to discussions of aggregate demand than to individual casework. However, a similar argument could be made for substance misuse and mental illness, which are social problems even if services tend to see them

primarily as parental risk factors. In contrast, socio-economic circumstances are not treated as an individual factor at assessment – at least not explicitly.

The evidence from this study – along with the wider body of work from the CWIP – suggests that attitudes to poverty are indeed bound up with differential intervention rates, and that the key mechanism for this is the assessment of neglect, particularly in families with young children and White British children. The findings on demand typologies (Section 3.4) and on the relationship between assessed needs and CP plan categories (Section 3.5.1), indicate that when neglect is combined with other parental risk factors (including mental health, substance misuse and domestic abuse) an escalated statutory response is more likely than when those risk factors are found on their own (i.e. without neglect). In considering these results, it is worth noting two things. First, the systematic nature of these patterns suggests that there are different operational practices in affluent vs deprived LAs when it comes to 'seeing' neglect in poor families. Second, these operational practices are bound up with the system conditions discussed earlier, such as screening and rationing, i.e. they cannot just be ascribed to cognitive bias or 'poverty blindness' among frontline practitioners but are also the product of institutional and policy drivers. Taking demand management as an example, an unsustainable rise in CP interventions due mainly to an increase in substantiated neglect and emotional abuse could reasonably be expected to influence operational definitions of neglect and emotional abuse in areas where demand was highest (or increasing the most).

Changing what happens at the sharp end of practice is a natural focus for addressing welfare inequalities. For example, a recent anti-poverty practice guide published by the British Association of Social Worker (BASW) encourages practitioners to incorporate a more sophisticated understanding of the nature and impact of poverty in their assessments and to rebuild connections with the communities they serve. At this same time, the report acknowledges that implementing such measures will require systemic change:

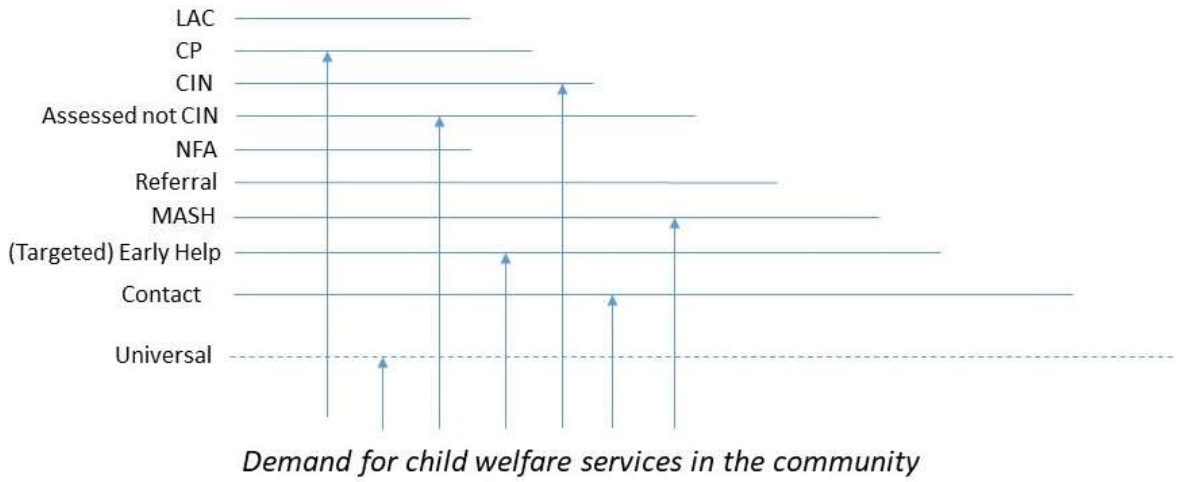
> *'[…] it is critical to note that the issues being addressed are driven by social policies, and individual practices alone are insufficient to change wider systemic patterns and the consequences of economic policies.' (BASW, 2019: 17)*

Social workers consulted for the guide often wanted to work an 'anti-poverty way' but felt constrained both by their statutory role and the lack of resources available to support families in financial need. An old aphorism from the human relations literature springs to mind: if you want people to do a good job, give them a good job to do. While it is certainly true that reducing welfare inequalities will require social workers to understand and deal with poverty in a different way, this can only be achieved by changing the system in which they operate. In the spirit of 'double-loop learning' advocated in the Munro review, this means questioning some of the fundamental assumptions that govern the system in its current form. Otherwise, unrelenting pressure on services in times of austerity and hardship will continue to push resources into policing families rather than into community development and family support (Gillies, 2013).

4.4. A problem-based approach to welfare inequalities

The underpinning legislation for CSC services is the Children Act 1989, which provides a statutory basis for the thresholds at the heart of operational structures (see Section 1.2). Functional specialisation in CSC has also aligned itself along these thresholds: referral and assessment teams, CIN teams, CP and court teams, etc. Social workers in these teams focus on needs and risks at a particular point in the child's intervention pathway. Gibbons *et al.* (1995) described this operating model as a 'filter and funnel' system, although it also reflects the framework for targeted intervention outlined by Hardiker *et al.* (1991). The model serves three interrelated purposes: (1) manage demand (and therefore cost); (2) make sure specialist interventions, which are more expensive, are undertaken only with children who need them; and (3) comply with statutory requirements, e.g. to balance consent and coercion in the best interests of the child. Following a public health approach, the statutory tiers can also be seen as part of a broader preventative system for children's services (Parton, 2006), comprising universal services provided to the whole population as well as Early Help and other services for children with additional needs (Hood, 2015). The result is a pyramidal structure comprising many horizontal tiers. This is illustrated in Figure 25, which shows the range of thresholds used by CSC to manage demand. It is worth noting that only the topmost three layers (CIN, CP and LAC) are directly linked to the legislation – the others are essentially a form of triage. The upward arrows represent demand in the form of individual children and families in the community, each matched to an appropriate threshold of need and risk. Child welfare concerns are managed case-by-case, going through various layers of triage and assessment to ensure that the right service is provided. Multi-agency collaboration is geared towards assembling professionals in decision-making forums (e.g. CP conferences) or coordinating their work in relation to a specific child.

Figure 25. Horizontal tiers: the filter and funnel



The assumptions underlying the tiered model in Figure 25 are sufficiently entrenched that performance issues are attributed to managerial and professional shortcomings to be addressed within the existing structure. For example, LAs responded to the problem of rapidly rising rates of CP

and care either by adjusting thresholds at existing tiers and/or developing new tiers to absorb work at an earlier stage. A common example was the integration of Early Help – usually in the form of targeted casework – as an additional layer of CSC just under the threshold for referral to statutory services (see Section 3.2.3), leading eventually to an increase in the level of need and complexity managed by EH. Other demand management strategies included the development of initial points of contact (IPOCs) and multi-agency safeguarding hubs (MASH) in order to undertake pre-referral triage and assessment (Section 3.2.9). A common assumption was that effective prevention would require additional resourcing and indeed extra layers of functions geared primarily towards gatekeeping ('targeting') and managing demand. Similarly, the tendency to react to regulatory pressure from Ofsted inspections by tightening up thresholds and doing more CP work was seen as standard practice (Section 3.2.8).

The institutional dominance of the tiered model means it is implicated in the emergence of welfare inequalities. Most obviously, the mechanisms of differential intervention outlined earlier (Section 4.1) are exacerbated by a filter-and-funnel design that uses thresholds to manage demand and respond to institutional pressures. Dealing with demand on a case-by-case basis also means that social problems tend to be seen through the prism of individual risk factors, each to be targeted with a professional intervention. The 'disaggregation' of demand from its social context is particularly noticeable for concerns about neglect, which in child and family assessments are largely decoupled from poverty and analysed in relation to parenting deficits, potentially leading to an escalated response (Sections 3.4.3 and 3.5.1). In essence, the combination of a stratified, threshold-based system with individualised assessment and case management allows welfare inequalities to emerge from what frontline practitioners would consider to be perfectly reasonable judgements about need and risk.

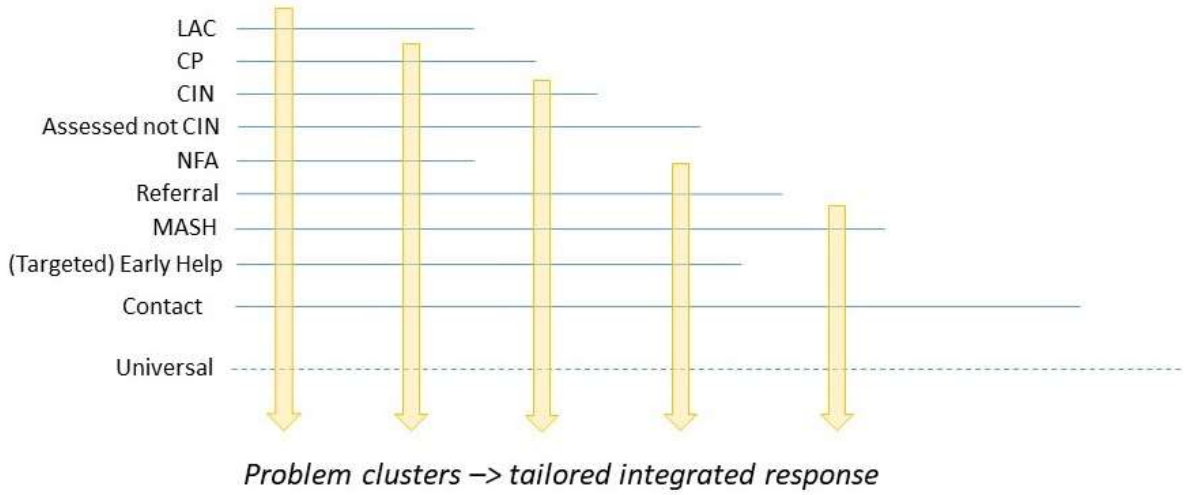
An alternative approach was evident in some areas, particularly when it came to adolescents involved with gangs or county lines activity, and young people at risk of CSE/CCE. For such problems, conventional CP procedures were seen as ineffective and so many LAs were trying to develop a more strategic response in collaboration with the police and other organisations. The initiative to reduce suicide rates in LA1 (Section 3.2.5) was another example of a child welfare issue receiving a more tailored response than mainstream procedures would allow. A reference point here is Herman Goldstein's concept of problem-oriented policing (Goldstein, 1979) and its development by Sparrow (2000, 2008) into a broader framework for social regulation. Sparrow observes that all regulatory agencies face the quandary of finding an organisational form that is optimised for the harms they seek to reduce:

> *'The answer, somewhat disturbing at first, is that whatever form of organisation one selects, it will be the wrong one most of the time. If an agency organises around ecosystems, one might predict that the next problem requiring attention would not be ecosystem-shaped; it would concern one industrial group, or an invasive species, or a drinking water problem. But if the agency organised by industry group, that would not help them deal effectively with radon in homes, or airborne deposition from other countries, or endangered species.' (Sparrow, 2008: 97)*

CSC services, whose regulatory role (i.e. child protection) is concerned with harms that are generally hidden within private family life and may be deliberately concealed by perpetrators, are very likely to encounter problems for which standard procedures are ineffective. Such problems may be identified by community sources or police intelligence, as with county lines/CCE, or else emerge in the wake of child abuse scandals, as was the case with CSE (Jay, 2014). Importantly, such problems require tailored analyses and operational solutions – standardised risk assessment and care planning, undertaken 'one child at a time', is unlikely to be effective unless it is part of a strategy to tackle the problem 'as a coherent whole' (Sparrow, 2008: 97). An obvious example is the existence of criminal networks who abuse and exploit children and young people. However, the evidence from this study is that a range of problem clusters are readily identifiable in the everyday work of CSC services. Demand typologies compiled from social work assessments (Section 3.4) suggest that there is plenty of scope for LAs to develop strategic innovations based on their own data.

Figure 26 illustrates the difference between threshold-based demand management and an alternative approach based on problem clusters. The former has been characterised as 'horizontal' because the service received by a child depends on the threshold to which their needs correspond. The latter has been characterised as 'vertical' because defining a problem and experimenting with solutions require an integrated response, involving a range of organisations, professionals and service users. As LAs reported about their work with teenagers, it may turn out that the most effective solutions lie outside of the established threshold-based system.

Figure 26. Vertical integration: identifying problem clusters



There are good reasons to believe that a problem-based approach to demand would help to reduce welfare inequalities. Dealing with problem clusters necessarily leads to greater emphasis on social and environmental factors; that is, understanding who these children are, where they live, what else they have in common, and what kind of preventative support might make a difference to them – collectively rather than just on an individual level. Problem clusters reflect not just common elements in the difficulties faced by children and families but point to the contextual conditions that mean such difficulties are regularly and systematically experienced. For example, families living in

isolated ‘pockets’ of deprivation in generally affluent rural areas will require a differently shaped service than families living in densely populated and deprived urban neighbourhoods. The association between neglect and poverty, in particular, becomes more useful for service planning, since LAs can consider how to support certain types of family or certain kinds of places that predictably contribute high levels of demand for services. As the qualitative findings demonstrated, such contextual knowledge is already held by experienced practitioners and managers; it can be leveraged to good effect when combined with the type of quantitative demand analysis illustrated in Section 3.4.

Earlier it was suggested that reducing welfare inequalities would need LAs to become less reliant on screening and rationing to manage demand (Section 4.1.1). Within the current system, efforts to develop preventative strategies often end up adding extra horizontal layers, such as MASH or targeted Early Help, to an already stratified system. This increases the number of thresholds and the amount of gatekeeping activity, in turn exacerbating the conditions for differential intervention, while also increasing barriers to access for service users. In contrast, problem clusters require a strategic multi-agency response operating on a range of levels including the community. The experience of LAs in dealing with ‘new’ (or at least newly topical) concerns around CCE/CSE suggest such approaches are more likely to bypass standard processes in favour of a more bespoke solution, and accordingly place less emphasis on screening for eligibility. As Sparrow (2008) points out, this type of activity is often lauded as ‘innovation’, i.e. experiments in problem-solving undertaken separately from the organisation’s core business. What gets called innovation in mainstream CSC services – new practice models, Early Help hubs, CIN closure trackers, and so on – is perhaps better described as performance improvement. Inspection reports also tend to encourage performance improvement as opposed to innovation, with recommendations strongly oriented towards process issues and compliance with standards (Hood *et al.*, 2019b). In Argyris’ terms, this is ‘single-loop’ organisational learning (Argyris, 1999) since it leaves fundamental assumptions unchanged, e.g. that demand is equivalent to contacts/referrals at the front door and should be managed on a case-by-case basis via a series of filters and funnels.

The ‘double-loop’ in this case stems from what should be an obvious premise: that poverty and its impact on families’ psychosocial functioning should be at the forefront of the planning and delivery of CSC services. Poverty is not ‘just’ about low income but is a multi-dimensional experience that shapes almost every aspect of people’s circumstances, including their emotional wellbeing, the quality of their relationships, and their need for, and access to, support to improve their lives. Protecting children and promoting their welfare cannot therefore be achieved by policies that simply treat deprivation and inequality as a fact of life that families should surmount via approved lifestyle choices and parenting skills. In fiscal terms, current inequities in the funding formula urgently need to be addressed so that resources for the most deprived local authorities are commensurate with the needs and hardships faced by their communities (Webb and Bywaters, 2018). At the same time, while investment in preventive and community services is a prerequisite, it should be used to do more than shore up an imbalanced, unfair system that is failing even on its own terms In a near half-century of scandal and reform following the death of Maria Colwell in 1973, child protection has become an adversarial and risk-focused enterprise, in which a rhetoric of partnership, strengths and

relationships sits uneasily with the experience of most families at the sharp end of intervention. The role of community social work in promoting children's welfare has withered away over the years despite its potential importance for preventive work, intelligence-gathering, and building community assets. Instead, the system has become rigid and uncompromising, focused on managing the 'front door', assessing risk and doing short-term casework. This situation is not something that social workers can address through good practice alone, and so we join Featherstone et al.'s (2018) call for a more fundamental rethink of the sector.

4.5. Limitations

The research had some limitations. Its intensive mixed-methods design required a relatively small sample of local authorities, which constrains the extent to which the findings can be generalised to the sector as a whole. The qualitative findings relied on a purposive sample of practitioners and managers, which even when triangulated with quantitative data may not have yielded a complete picture of system conditions in the respective areas. This was especially true of the large county (LA0) where it was not possible to interview people in every district (see Section 2.4). The findings on demand management (Section 3.1) were national in scope but derived from national data returns that were aggregated to LA level; this necessarily limits the extent to which inferences can be made about individuals receiving services in each LA. Sample size also affected the analysis of social gradient in CSC (Section 3.5) by restricting the explanatory power that could be given to LA-level variables.

Finally, perhaps the biggest limitation with this study – as with all similar projects – is the lack of reliable data on the socio-economic circumstances of children and parents receiving CSC services. It is true that social work records may contain qualitative information on social and environmental factors such as housing, employment and income. However, such information is collected inconsistently if at all (Jack and Gill, 2003; Morris et al., 2018) and is scattered across a range of assessments, referral forms, case notes and other summaries. Researchers are therefore obliged to use IMD, a measure of deprivation in neighbourhoods (LSOAs), as a proxy for the individual children living in those neighbourhoods. This creates a risk of ecological fallacy, i.e. that findings might obscure differences in outcomes for children living in areas where they have been grouped together for the analysis. Overcoming this limitation would require agencies to systematically collect socio-economic data at the point of referral or assessment, or for researchers to link CSC records with other datasets, e.g. housing or benefits.

5. Recommendations and conclusion

This report has presented the methods and findings from a two-year study of CSC, which set out to identify some of the key system conditions in statutory services and understand their potential link to welfare inequalities. In the first part of the research, an analysis of national datasets confirmed that local authorities manage demand by screening referrals and rationing specialist services, using a

series of thresholds based on the legislative framework set out in the 1989 Children Act. Since demand for services was highly correlated with average levels of deprivation, this meant that affluent local authorities were more likely to use statutory interventions (including CP plans) to deal with referrals, and to spend more money on the children they worked with. Deprivation-related patterns of differential intervention were argued to be a key driver of welfare inequalities.

In the second part of the study, differential intervention was studied more intensively with the help of six local authorities with varying deprivation rates. A detailed analysis of intervention pathways was combined with a qualitative investigation of system conditions in each local authority. The results were then combined across the whole sample in order to shed light on the 'social gradient' of intervention, i.e. the extent to which a change in socio-economic status affects a child's chances of receiving services. Welfare inequalities were found to be more noticeable in younger children and White British children from more deprived neighbourhoods who were assessed in relation to neglect, and were particularly likely to occur at the point where a decision is made to place a child on a CP plan. The clustering of demand (according to assessed needs) also challenged the dominant 'toxic trio' discourse on risk factors in child protection and gave some insight into the complexity of domestic abuse issues handled by child welfare agencies.

Based on these findings and their implications for children's social care, the following suggestions are made for policy, management and practice:

Design and management of services

- There is an imbalance in the resources that local authorities have to meet demand for child welfare services, which is contributing to the tendency for less deprived (and more unequal) local authorities to be more interventionist. Current inequities in the funding formula should therefore be addressed so that resources for the most deprived local authorities are commensurate with the needs and hardships faced by their communities.
- The system needs to be rebalanced from its unsustainable emphasis on high-cost late intervention. This will require a lot more investment in preventive services. As Early Help has become increasingly focused on assessment, complex needs, and targeted casework, the main priority for investment should the rebuilding of capacity and resources in communities. Better mapping of universal and preventive services and their long-term effect on demand for statutory interventions is also needed to build an economic as well as ethical argument for funding these services.
- There is a huge gap in services for children and young people with mental health problems. Currently CSC is the default provider of services to many vulnerable young people who need therapeutic care. A public health strategy is urgently needed to address the burgeoning crisis of mental ill-health among adolescents.
- Services are currently designed around multiple tiers of triage and assessment, which contribute to welfare inequalities because they emphasise screening and rationing, and de-contextualise children from their social circumstances. Alternative designs are needed that focus on strategic concerns, or problem areas, using detailed demand analysis combined with local knowledge of safeguarding issues in local communities. Specialist functions could be developed around these

strategic concerns, in order to complement the coordination of work around statutory thresholds.

Service improvement and inspection

- Local authorities currently use their administrative data to manage performance and monitor activity at different thresholds of intervention. This study has shown there is scope for CSC services to undertake more in-depth demand analysis to assist with strategic planning and service development. Given the importance of social and environmental factors in driving demand for CSC, it would help if services collected reliable socio-economic data on children and their parents. If this is not feasible, publicly available indicators of neighbourhood-level deprivation could be added to the administrative dataset and incorporated in the analysis.
- Ofsted currently operates a proportionate and risk-based approach to inspections under the ILACS framework. There is evidence that inspections are linked to greater use of child protection interventions, especially in local authorities given a poor rating. While such adjustments may be entirely appropriate, they may also reflect the effects of institutional anxiety about inspections. To mitigate these effects, the inspection process could give greater recognition to shortfalls in funding and resources in areas of high (or increasing) deprivation, support local authorities to rebalance services towards Early Help and community-based prevention, and encourage multi-agency taskforces to develop tailored strategic responses to safeguarding issues in the community.
- The realities of frontline child protection work make it hard to practice in a way that acknowledges and alleviates the impact on families of poverty and social exclusion. While practice models often emphasise the importance of empathy, relationships and the search for solutions, the institutional context of CSC encourages a technocratic, adversarial mode of working. It might help if practice models were more explicit about the system conditions needed to underpin new ways of working, so that the responsibilities of frontline practitioners were aligned with those of administrators and policymakers. For example, the role of community social work in child welfare practice could be strengthened in order to implement new preventive strategies and complement individual risk assessment and casework.

In conclusion, the institutional context and organisational structure of children's social care is contributing to systematic inequalities in provision. Addressing these issues will require policymakers to pay more attention to the link between neglect and poverty, and agencies to develop more flexible and community-oriented types of provision.

Further information

To find out more about the study, please visit the project website or contact:

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Appendices

Appendix A: Factors at Assessment

Factors at assessment (Department for Education, 2018: 41-43)

Code	*Description*
1A	Alcohol misuse: concerns about alcohol misuse by the child.
1B	Alcohol misuse: concerns about alcohol misuse by the parent(s)/carer(s).
1C	Alcohol misuse: concerns about alcohol misuse by another person living in the household.
2A	Drug misuse: concerns about drug misuse by the child.
2B	Drug misuse: concerns about drug misuse by the parent(s)/carer(s).
2C	Drug misuse: concerns about drug misuse by another person living in the household.
3A	Domestic violence: concerns about the child being the subject of domestic violence.
3B	Domestic violence: concerns about the child's parent(s)/carer(s) being the subject of domestic violence.
3C	Domestic violence: concerns about another person living in the household being the subject of domestic violence.
4A	Mental health: concerns about the mental health of the child.
4B	Mental health: concerns about the mental health of the parent(s)/carer(s).
4C	Mental health: concerns about the mental health of another person in the family/household.
5A	Learning disability: concerns about the child's learning disability.
5B	Learning disability: concerns about the parent(s)/carer(s) learning disability.
5C	Learning disability: concerns about another person in the family/household's learning disability.
6A	Physical disability or illness: concerns about a physical disability or illness of the child.
6B	Physical disability or illness: concerns about a physical disability or illness of the parent(s)/carer(s).
6C	Physical disability or illness: concerns about a physical disability or illness of another person in the family/household
7A	Young carer: concerns that services may be required or the child's health or development may be impaired due to their caring responsibilities.
8B	Privately fostered: concerns that services may be required or the child may be at risk as a privately fostered child - overseas children who intend to return
8C	Privately fostered: concerns that services may be required or the child may be at risk as a privately fostered child - overseas children who intend to stay
8D	Privately fostered: concerns that services may be required or the child may be at risk as a privately fostered child - UK children in educational placements
8E	Privately fostered: concerns that services may be required or the child may be at risk as a privately fostered child - UK children making alternative family

	arrangements
8F	Privately fostered: concerns that services may be required or the child may be at risk as a privately fostered child - other
9A	UASC: concerns that services may be required or the child may be at risk of harm as an unaccompanied asylum-seeking child.
10A	Missing: concerns that services may be required or the child may be at risk of harm due to going/being missing.
11A	Child sexual exploitation: concerns that services may be required or the child may be at risk of harm due to child sexual exploitation.
12A	Trafficking: concerns that services may be required or the child may be at risk of harm due to trafficking.
13A	Gangs: concerns that services may be required or the child may be at risk of harm because of involvement in/with gangs.
14A	Socially unacceptable behaviour: concerns that services may be required or the child may be at risk due to their socially unacceptable behaviour.
15A	Self-harm: concerns that services may be required or due to suspected/actual self-harming child may be at risk of harm.
16A	Abuse or neglect – 'NEGLECT': concerns that services may be required or the child may be suffering or likely to suffer significant harm due to abuse or neglect.
17A	Abuse or neglect – 'EMOTIONAL ABUSE': concerns that services may be required or the child may be suffering or likely to suffer significant harm due to abuse or neglect.
18A	Abuse or neglect – 'PHYSICAL ABUSE': concerns that services may be required or the child may be suffering or likely to suffer significant harm due to abuse or neglect.
19A	Abuse or neglect – 'SEXUAL ABUSE': concerns that services may be required or the child may be suffering or likely to suffer significant harm due to abuse or neglect.
20	Other
21	No factors identified - only use this if there is no evidence of any of the factors above and no further action is being taken.
22A	Female genital mutilation (FGM) - concerns that services may be required or the child may be at risk due to female genital mutilation.
22B	Abuse linked to faith or belief - concerns that services may be required or the child may be at risk due to abuse linked to faith or belief.

Appendix B: Vignettes

Sabina – age 15

Sabina has been running away from home and staying out for long periods, including overnight and her mother does not know where she is. Her mother is a single parent, who suffers from depression and has three younger children. She says she finds Sabina too difficult to handle and does not know what to do with her. Sabina's school say that she does not always attend and, when she does, she seems very tired and is falling behind with her schoolwork. Sabina has an older boyfriend who is 18, is known to the police and is thought by her mother to be taking drugs.

Ehan – age 6 months, Ayan – age 3, Amina – age 9

The children's mother, Safaah has been visited by a health visitor who has made a referral to Children's Social Care. The family live in a high-rise block of flats on a deprived estate. The children live in a small two bedroom flat with both parents and one set of grandparents. The flat is very untidy and the children do not seem to be going outside. It is summer and there is a strong smell of damp in the flat. Safaah says that her husband has rung the council but they are not able to do anything about it.

Bradley – age 3

Bradley's mum Saskia is Polish. She is 25 and has been living in England for the last four years. She and Bradley's father, Robert, have been involved in a series of domestic incidents. In the last incident both parents were reported as drunk and arguing outside their flats. They had a fight and this resulted in Saskia's wrist being broken. Following this incident Saskia maintained that it was not Robert's fault and although she said she would stay away from Robert, she is thought to be in contact with him. She was also drunk on a social worker's visit during the day and does not want to engage about her alcohol misuse.