Studying the outcomes of children's social care provision for different types of demand

Full report

January 2024

Rick Hood, Allie Goldacre, Keith Clements, Ed Jones, Adam King, Emma Martin, and Calum Webb

Acknowledgements

The Nuffield Foundation is an independent charitable trust with a mission to advance social well-being. It funds research that informs social policy, primarily in Education, Welfare, and Justice. It also funds student programmes that provide opportunities for young people to develop skills in quantitative and qualitative methods. The Nuffield Foundation is the founder and co-funder of the Nuffield Council on Bioethics and the Ada Lovelace Institute. The Foundation has funded this project, but the views expressed are those of the authors and not necessarily the Foundation. Visit www.nuffieldfoundation.org for more information about the trust and its work.

Authors

Rick Hood: Professor of Social Work, Faculty of Health, Science, Social Care and Education, Kingston University

Allie Goldacre: Research Associate, Faculty of Health, Science, Social Care and Education, Kingston University

Keith Clements: Senior Researcher, National Children's Bureau

Ed Jones: Senior BI developer for Social Care Data & Analysis, Ofsted

Emma Martin: Team Leader for Social Care Data & Analysis, Ofsted.

Adam King: Team Leader for Social Care Data & Analysis, Ofsted.

Calum Webb: British Academy Postdoctoral Fellow, University of Sheffield.

Contents

1. Introduction 8
1.1. Background 9
1.2. Aims and objectives 12
1.3. Demand analysis in CSC 13
1.4. Outcomes of CSC provision 15
2. Methods 15
2.1. Ethics and data management 16
2.2. Datasets 16
2.3. Types of demand for CSC services 18
2.3.1. CSC assessments 18
2.3.2. Latent class analysis 20
2.3.3. Descriptive statistics 21
2.4. Consultation with stakeholders 23
2.5. Outcomes 23
2.5.1. Re-referrals 23
2.5.2. Repeat child protection plans 25
2.5.3. Re-entries to care 26
2.5.4. Transitions between classes 26
2.5.5. Educational outcomes at KS2 and KS4 27
2.5.6. Exclusions at age 11 and age 16 28
3. Findings 28
3.1. Types of demand for CSC services in England 28
3.1.1. Results of latent class analysis 28
3.1.2. Description of the classes 30
3.1.3. Child characteristics 36
3.1.4. Intervention pathways 40

3.1.5. Intersection of child characteristics and intervention pathways 47
3.1.6. Variation between LAs 50
3.1.7. Trends in prevalence 51
3.2. Outcomes of provision 53
3.2.1. Re-referral to CSC 53
3.2.2. Repeat CP plans 58
3.2.3. Re-entries to care 63
3.2.4. Transitions and multiple episodes 68
3.2.5. Educational attainment at KS2 73
3.2.6. Educational attainment at KS4 79
3.2.7. Exclusions aged 11 85
3.2.8. Exclusions aged 16 91
4. Discussion and implications 97
4.1. Limitations 97
4.2. Complex needs and demand for CSC 98
4.3. Services for older children and adolescents 100
4.4. Child protection and neglect 103
4.5. Physical abuse and sexual abuse 104
4.6. Disability 106
4.7. Domestic abuse and violence 109
4.8. Parental mental health and substance misuse 110
5. Conclusion and recommendations 112
6. References 118
7. Appendices 126

List of Figures

Figure 3.1 Goodness of fit statistics for latent class models (1-40) 30
Figure 3.2 Bar chart showing 12 demand categories and how often they were recorded in all assessments 2014-21 (n=3.6m) 31
Figure 3.3 Thresholds of intervention for each category differentiated by i) gender and ii) age 48
Figure 3.4 Thresholds of intervention for each category differentiated by i) ethnicity and ii) deprivation 49
Figure 3.5 Kaplan Meier plot showing rates of re-referrals (2015-21) 53
Figure 3.6 Forest plot showing factors associated with re-referral to CSC[1] 58
Figure 3.7 Kaplan Maier plot showing the rate of repeat CP plans (2014-20) 59
Figure 3.8 Forest plot showing factors associated with repeat CP plans 63
Figure 3.9 Kaplan Meier plot showing rates of re-entry to care (2014-20) 64
Figure 3.10 Forest plot showing factors affecting the chances of re-entry to care 68
Figure 3.11 Transition between demand categories for child assessed aged 10 and then again aged 15 72

List of Tables

Table 1.1 Outcome measures used in this study. 15
Table 2.1. Data sources 17
Table 2.2 Frequency of factors recorded in assessments (2014-21) 19
Table 3.1 Conditional probabilities of factors estimated in the 11 latent classes (plus 'other') 31
Table 3.2 Breakdown of demand categories by child characteristics 37
Table 3.3 Breakdown of categories by threshold of intervention 42
Table 3.4. Breakdown of categories by length of episode 44
Table 3.5. Breakdown of categories by type of abuse or neglect (CP plans only) 46
Table 3.6 Variation in demand categories across LAs 50
Table 3.7 Trends in annual prevalence of categories (2014-21) 52
Table 3.8 Factors affecting likelihood of re-referral to CSC (within 12 months) 56
Table 3.9 Factors affecting the chances of a repeat CP plan (within 12 months of a CP plan ceasing) 61
Table 3.10 Factors affecting the likelihood of re-entering care (within 12 months of a care episode ceasing) 66
Table 3.11 Breakdown by demand category for three cohorts of children experiencing multiple episodes of CSC involvement (2015-20) 70
Table 3.12. KS2 fully adjusted regression models showing RR and 95% CI for each characteristic 76
Table 3.13. KS4 fully adjusted regression models showing RR and 95% CI for each characteristic 82
Table 3.14 Exclusions aged 11 fully adjusted regression models showing odds ratios and 95% CI for each characteristic 88
Table 3.15. Exclusions aged 16 fully adjusted regression models showing odds ratios and 95% CI for each characteristic 94

Acronyms

ACE	Adverse Childhood Experience
AIC	Akaike Information Criterion
BIC	Bayesian Information Criterion
CIN	Child(ren) in Need
CLA	Child(ren) Looked After
CSC	Children's Social Care
CP	Child Protection
DAV	Domestic Abuse and Violence
DfE	Department for Education
DHCLG	Department for Housing, Communities and Local Government
IMD	Index of Multiple Deprivation
KS2 / KS4	Key Stage 2 / Key Stage 4
LA	Local Authority
LCA	Latent Class Analysis
LSOA	Local Layer Super Output Area
MASH	Multi Agency Safeguarding Hub
NAO	National Audit Office
NPD	National Pupil Database
ONS	Office for National Statistics
PBA	Performance-Based Accountability
PHE	Public Health England
PMR	Pupil Matching Reference
SEND	Special Educational Needs and Disabilities
SRS	Secure Research Service
UPN	Unique Pupil Number

1. Introduction

Children's social care (CSC) refers to a variety of services for children and families, ranging from preventative services such as family support, Early Help and children's centres to statutory services such as child protection (CP) and provision of out-of-home care. In England, these are principally delivered by local authorities (LAs), and sometimes by agencies in the voluntary or private sectors. This report is mainly concerned with the range of statutory services that may be offered following a referral to CSC and assessment by a social worker. In England, these 'child and family assessments' aim to:

- identify any risks and needs;
- determine whether these are to do with the child, the care they receive, or the wider social environment;
- analyse their likely impact on the child's development; and
- recommend any actions or areas requiring further professional support.

Not all children who are assessed are deemed to be a 'child in need' (CIN) as defined by the 1989 Children Act. Those who are assessed as 'not CIN' are ineligible for statutory CSC services but will often be signposted to other services in the community. Those who are eligible are allocated a social worker to coordinate services and support under a multi-agency CIN plan. Children subject to CP investigations may also become CIN and a minority of them will end up having a CP plan and/or an episode of care. Children in care are formally designated 'children looked after' (CLA). The latest government figures show that on 31 March 2023 there were 50,780 children on protection plans (equivalent to a rate of 43 per 10,000 children) and 83,840 children looked after (a rate of 71 per 10,000).

Social work assessments clearly play a fundamental role within the CSC system and its tiered model of thresholds and interventions. The risks and needs identified in assessments show how demand for CSC is operationally defined by child welfare professionals. These definitions play a crucial role in determining intervention pathways, i.e. what type of services children receive, which may have a bearing on outcomes for the child. In England, administrative data on risk factors are recorded by social workers on completion of an assessment. This report presents findings from a quantitative study of CSC administrative data for all of England, based on a national dataset including over 3.6 million assessments with factors recorded between 2014 and 2021. Since most cases involve a combination of multiple and overlapping factors, the study aimed to identify categories of demand based on commonly co-occurring risk factors. Having identified these categories, the study

proceeded to examine the outcomes of provision for each type of demand, including educational attainment data from the National Pupil Database (NPD). The work was carried out by researchers based at Kingston University, in collaboration with the CSC data team from Ofsted, the inspectorate for children's social care, and research co-production experts at the National Children's Bureau (NCB).

In this introductory section we discuss the background to the study, outline its aims and objectives, summarise existing evidence for the types of demand that are referred to, and assessed by, child welfare services, and compare different approaches to measuring the outcomes of provision.

1.1. Background

Among the consequences of the Covid-19 pandemic in England has been an increase in the needs of, and risks to, vulnerable children (Bradbury-Jones and Isham, 2020; Teo and Griffiths, 2020). However, CSC services were overstretched even before the pandemic, having seen a large rise in the use of protective interventions over the past decade (Hood *et al.*, 2019). Provision of services is marked by stark inequalities, with a steep social gradient in demand as well as an inverse care effect (Bywaters, 2020). With local government budgets still under huge strain, a vicious circle of rationing and spiraling demand has threatened to overwhelm services for vulnerable children (Hood et al., 2019; ADCS, 2018; Action for Children, 2017). In a 2019 review of the sector, the National Audit Office highlighted high levels of variability in LA provision and challenged the government to achieve a better understanding of demand (NAO, 2019). In response, the Department for Education (DfE) published a study of drivers of activity in CSC, which refuted some of the NAO's findings, showing that a substantial part of local authority variation in demand could be explained by the characteristics of children, families and neighbourhoods (Fitzsimons *et al.*, 2022). However, the report also acknowledged that intersections between these characteristics and children's presenting needs was not well understood, nor was their significance for the effectiveness of provision or outcome for the child after receiving services.

Social gradient

A social gradient in health means that the higher one's social position, the better one's health is likely to be. Here it is used to mean that children living in more deprived neighbourhoods are more likely to be subject to welfare interventions than children living in less deprived neighbourhoods. The gradient itself refers to the upward slope in intervention rates when measured against deprivation. The steepness of the social gradient varies between different local authorities, and among different groups of children.

These issues point to the need to connect areas of evidence that are usually separated in time and place. They include: 1) the drivers of demand, 2) differential trajectories of provision, and 3) outcomes for children after services have ceased. In addressing these gaps in knowledge, the work reported here followed up a three-year mixed-methods study, also funded by the Nuffield Foundation, which examined the link between system conditions and welfare inequalities in CSC (Hood *et al.*, 2020a). This work showed how the design and organisation of CSC, combined with external constraints and pressures, was linked to systematic inequalities in provision. It included a detailed analysis of demand based on administrative data from six English local authorities (LAs), which found common categories of risk and need across all the LAs (Hood *et al.*, 2021). Deprived children were more likely to receive an intervention than less deprived children and this 'social gradient' was particularly steep for cases of neglect, as well as for younger children and White British children.

Some of these findings were subsequently verified through analysis of national CSC data for all England LAs (Goldacre and Hood, 2022), which showed that the social gradient of intervention became steeper at higher thresholds of intervention and was particularly pronounced for child protection (CP) plans. The findings suggested that CSC services faced many challenges when it came to addressing the socio-economic drivers of demand. On an organisational level, services were preoccupied with 1) regulatory pressures, generally linked to Ofsted inspections but periodically exacerbated by public inquiries into deaths from child abuse (Hood and Goldacre, 2021); and 2) fiscal pressures, exacerbated by a decade of cuts to local government budgets under the banner of austerity policies (Hood *et al.*, 2019). These pressures had contributed to a vicious circle of screening and rationing, with resources concentrated on investigating concerns, coordinating protection plans, and providing out-of-home care (Action for Children *et al.*, 2017; Bilson *et al.*, 2017; Association of Directors of Children's Services (ADCS), 2021). There were also challenges on a practice level; the

core tasks of assessment and casework continued to be delivered on an individual basis, with a tendency for multiple hand-overs between practitioners and social work teams, high rates of re-referrals, and a proliferation of thresholds designed to screen out demand (Hood *et al.*, 2020b).

Demand categories

Demand categories refer to the types of problems that are commonly assessed when children come into contact with social care services. This could mean a single need for support, e.g. the child's mental health, or an overriding concern, such as domestic violence or sexual abuse. However, most child and family assessments record a combination of needs and risks, while complex needs are more prevalent in cases leading to statutory interventions such as child protection plans. In this study, an evidence-based typology of demand was developed using administrative data on the factors identified in social work assessments.

Drawing on their analysis of social work assessments in six English LAs, Hood *et al.* (2021) suggested that administrative data on assessments offered an opportunity for services to connect professional definitions of risk and need with local knowledge of neighbourhoods and communities. While studies have often highlighted social workers' tendency to overlook families' socio-economic circumstances in their assessments (Jack and Gill, 2003; Mason *et al.*, 2020), Hood et al. (2020) found that practitioners were often very knowledgeable about social issues such as poverty, housing and crime in their local area – but this knowledge only became apparent when they were asked about what was driving demand for services, rather than about how they would assess risks to children. Hood et al. (2021) further argued that demand categories offered a way to bridge this gap – 'a systematic way to combine risk factors with child characteristics and other variables to produce evidence about specific child welfare problems that can be examined in their own right and with a view to strategic prevention'. In other words, the 'screen and intervene' approach that is most prevalent in child safeguarding could be augmented by broader measures designed to tackle adversities and vulnerabilities experienced by children and young people in their social environment. Following Sparrow (2008), the scope of such problems – and their solutions – lay in the middle ground between macro issues such as poverty and inequality, which are generally the remit of social policy, and the micro issues addressed by practitioners in their work with families. A few examples of this type of mid-range approach are already evident in CSC, such as contextual safeguarding models

designed to help young people exposed to extra-familial harm (Firmin, 2020; Wroe and Lloyd, 2020) or multi-agency partnerships aiming to tackle 'county-lines' drug crime (Williams and Finlay, 2018; Robinson *et al.*, 2019). These approaches are mid-range because they focus on a defined problem within the field of child welfare/youth justice, with a view to strategic prevention and intervention. This contrasts with the usual approach taken by CSC services, which is to establish a 'filter-and-funnel' system to deal with all types of cases based on eligibility or risk thresholds. However, any effort to identify specific problem areas within the overall spectrum of demand for CSC services requires a robust and evidence-based methodology.

1.2. Aims and objectives

The aim of the study was to use national administrative datasets to investigate the outcomes of CSC provision for different types of demand, and to understand the role of child characteristics and other contextual factors in shaping those outcomes.

Specific objectives and research questions:

1. *To identify and profile the underlying types of demand for CSC services in England.*
    a. What are the underlying case typologies for demand based on factors assessed by social workers?
    b. What are the typical intervention pathways for each demand type?
    c. How do demand types and intervention pathways vary according to child characteristics and LA context?
2. *To explore the intermediate outcomes of provision.*
    a. How are differences in intermediate outcomes, such as re-referrals or repeat periods of care, linked to demand type, child characteristics and the type of provision?
    b. How do children's needs evolve over time for those receiving multiple episodes of intervention?
3. *To explore the longitudinal outcomes of provision, differentiated by demand type and intermediate outcomes?*
    a. What are the gaps in educational attainment of children who receive statutory services compared with a range of comparator groups.
    b. What are the factors associated with exclusions for children who receive statutory services compared with a range of comparator groups?

1.3. Demand analysis in CSC

Analysis of demand in CSC often starts by aggregating children's involvement in the system at different thresholds, e.g. the number (or rate per child population) of referrals, assessments/investigations, children receiving help and/or protection, or children in care. Such measures are effectively a quantification of work done, which allows service managers, policymakers and other stakeholders to monitor trends over time and examine patterns of demand and provision (Hood *et al.*, 2016; Association of Directors of Children's Services (ADCS), 2021; Fitzsimons *et al.*, 2022). Beyond trends and fluctuation in referrals, assessments or interventions, demand analysis also focuses on the main problems and issues that professionals are required to address. This might include the assessed needs of the child, concerns about safety, factors affecting parental capacity, family and peer relationships, and other relevant factors in the child's social environment. Before examining these further, it is worth considering some definitional issues.

Perhaps the first question to consider is *who* does the defining (of needs, concerns, parenting capacity, etc.) and how this affects what type of demand is measured and why. Most obviously, there is a difference between 'demand' that is not actually handled by services but could reasonably be inferred from representative population surveys, as in the self-reported prevalence of childhood abuse or neglect (Radford *et al.*, 2011), or adverse childhood experiences (Spratt *et al.*, 2019; Tregeagle *et al.*, 2019). So-called 'substantiated' demand, i.e. cases of work undertaken by child welfare agencies, tends to be much smaller than the underlying demand indicated by these surveys, which points not only to differences between what is being measured but also to the 'hidden' (i.e. undisclosed and unreported) aspect of demand, i.e. children that should probably be receiving help and/or protection but for various reasons are not. Operational definitions and judgements deployed by social workers and other child welfare professionals differ in important ways from both retrospective self-reports and research-based health indicators such as the ACE (although see Edwards et al. 2017, for a critique of the evidence underlying ACEs). As Spratt et al. (2019) point out, thresholds for statutory intervention are particularly sensitive to immediate risks to the child. Not all children whose current circumstances place them at risk of negative outcomes in the future, whether because they live in poverty or score highly on an ACE questionnaire, will meet the eligibility criteria for services – particularly in areas where screening and rationing effects are most pronounced (Hood et al., 2019). Moreover, professional assessments may not align with what children and their families want services to do for them (Hood, 2019), while the stigma associated with CP means that families may be reluctant to engage with CSC services. Analysing 'demand' in

such circumstances is therefore a tricky and contentious business – choices have to be made about what to measure, leading to unavoidable compromises.

Research into ACEs indicates that children experiencing multiple adversities are more likely to experience harmful outcomes in later life (Boullier and Blair, 2018). The literature on child maltreatment shows a similar consensus on the significance of multiple parental risk factors (Sidebotham *et al.*, 2001; Hindley *et al.*, 2006; Dubowitz *et al.*, 2011; Frederico *et al.*, 2014; Vial *et al.*, 2020). Meta-analysis of serious case reviews, which examine serious injuries and deaths from child abuse, has drawn particular attention to the combination of domestic violence, parental substance misuse and mental health problems (Brandon *et al.*, 2008; Brandon, 2009; Brandon *et al.*, 2012). Outside of SCRs, little is known about the extent to which these factors actually co-occur, or the extent to which they interact with other contributing factors to maltreatment, so it is a matter of concern that the term 'toxic trio' is being deployed as a shorthand for child protection concerns despite this paucity of evidence (Sidebotham, 2019; Skinner *et al.*, 2020; Hood *et al.*, 2021). Part of the problem is that administrative data on co-occurring risk factors are generally not reported, even though social work assessments often identify multiple, overlapping needs. This makes it easier for simplistic labels such as the 'toxic trio' to gain traction – they speak to the multiplicity of need even if they are poorly aligned with the lived experience of children and families and do not accurately reflect the variety of demand.

In this report, the analysis of demand will mainly focus on operational definitions, i.e. the needs and risks identified by social workers after completing a child and family assessment. The rationale for this is to connect types of demand to child characteristics and intervention pathways, as well as longitudinal outcomes in the form of educational attainment (see Section 1.4). Factors at assessment relate directly to the reasons for providing statutory services (or not) and for distinguishing between different thresholds of intervention. They are also the most appropriate measure for connecting intervention pathways to the direct impact of providing a service (termed 'intermediate outcomes' in this study) and are relatively straightforward to link to education data within educational attainment data (see Sections 1.3 and 3.3.1). Nonetheless, it should be noted that administrative data on assessed risk factors are separate from the written assessment itself. They take form of a checklist of forty factors, which range from alcohol misuse to abuse linked to faith or belief (see Section 2.2.3 and Appendix 1). As with other demand indicators, the data is mainly used to produce aggregated annual figures for individual factors, which can be compared over time or across LAs. For example, government statistics for England in 2021-22 showed that the most common factors were

‘concerns about the child’s parent/carer being the victim of domestic abuse’ and ‘concerns about the mental health of the child's parent/carer’ (DfE, 2022).

1.4. Outcomes of CSC provision

Outcome measures for this study were based on a rapid review of the literature, which is summarised in Appendix 1 (outcome frameworks) and Appendix 2 (longitudinal outcomes). The evidence points towards a combination service-level measures, which tell us what kind of service was provided and the extent to which needs and risks were successfully addressed from a professional/organisational perspective, with broader measures of health and wellbeing that are only partially attributable to anything that CSC services may have done (or not done). The two sets of indicators are reflected in the outcome measures presented in Table 1.3. Intermediate outcomes are service-level measures indicative of (in)effective provision, in the form of re-referrals, repeat CP plans and re-entry to care. These measures appear in most of the outcome frameworks discussed in Appendix 1; other than Ofsted judgements, they are the only ‘quality of service’ measure routinely collected by CSC. Longitudinal outcomes are the main indicators of educational attainment available in the NPD, which include scores in standardised tests taken by children in the last year of primary school (KS2), the GCSE exams taken in the last year of secondary school (KS4), as well as exclusion from school.

Table 1.1 Outcome measures used in this study.

Intermediate outcomes	**Longitudinal outcomes**
Re-referral to CSC	KS2 results
Repeat CP plan	KS4 results
Re-entry to care	Exclusion from school

2. Methods

The research was designed as a secondary quantitative analysis of administrative data from the NPD, including the CIN census, CLA returns, and School Census. In England, each LA is responsible for providing CSC services. All 152 LAs record event-level information as part of their case management process. The CIN and CLA data is treated as sensitive, personal data and is held by the DfE. Ofsted, the national inspectorate for CSC, holds a limited number of years of CIN and CLA data for analysis to support its statutory remit. For this study, access to the data was agreed with Ofsted and the DfE. Stakeholder engagement was carried out in collaboration with the DfE, Ofsted, and the NCB.

2.1. Ethics and data management

Ethical permission for the research was obtained from the Faculty Research Ethics Committee (Faculty of Health, Science, Social Care and Education) of Kingston University. The main ethical and research governance issues concerned data protection and data privacy in relation to case-level data from the NPD, including the CIN Census and CLA Returns. A data protection impact assessment (DPIA) was undertaken and a data sharing agreement was signed with Ofsted (and also reviewed by the DfE) to enable a named analyst based at Kingston University access to an anonymised extract from the CIN Census and CLA Returns. Access was via a secure encrypted Ofsted laptop, so that the data was stored and retained on Ofsted servers and any processing remained within the Ofsted environment. Outputs were checked to ensure that they were at a sufficiently high level of aggregation to make it impossible for individuals to be identified, e.g. through a combination of geographical and personal characteristics. Outputs from the analysis of Ofsted data are reported in Sections 3.1.1 to 3.2.4.

The analysis of educational attainment and exclusion data was carried out within the ONS Secure Research Service (SRS). As part of the SRS application, permission was obtained from the Department for Education to study anonymised extracts from the NPD, which includes the datasets (1-3) outlined below in Section 2.2. All analysis was carried out on the SRS system, to which only Hood and Goldacre, who are SRS accredited researchers, had access. Outputs from the analysis of SRS data are reported in Sections 3.2.5 to 3.2.6 and have been cleared for publication.

2.2. Datasets

The following administrative datasets were used for this study:

1. CIN Census - The CIN Census is an administrative dataset on children referred to social care services in England. The CIN Census includes case-level information on the assessed needs of children, and whether they received social care support.
2. CLA Returns - The CLA Returns contain detailed information about children in care, including the number of placements, type of placements, and their legal basis.
3. NPD (School Census) - The School Census contains information on educational attainment up to the age of 16 for all children, and up to age 21 for some children (e.g. care leavers), as well as exclusions and absences, Special Educational Needs and Disabilities (SEND), and eligibility for free school meals.

4. LSOA-level and LA-level data available from the ONS and Public Health England, including the Index of Multiple Deprivation (IMD) scores.

The CIN Census contains case-level information about all interactions with CSC from the point of referral onwards, including assessments, Section 47 enquiries, and child protection plans. The CIN data was linked to the CLA data by using a unique LA child identifier (a concatenation of LA ID and Child ID), which is recorded in both datasets. The CLA data includes information on care characteristics, such as placement type, placement provider, reason for looked after episode, and reason episode ceased. The CIN and CLA data are part of a set of child and pupil-level data collections held by the DfE. The spine of this collection is the NPD, which contains information about individuals aged 2-21 in state-funded schools. The CIN and CLA data was linked to the NPD using Pupil Matching Reference (PMR) numbers, which is derived from the unique pupil number (UPN). The School Census data used in this research included attainment at KS2 (children aged 11), KS4 (children aged 16), fixed-term / permanent exclusions, SEND, and eligibility for free school meals.

Lower Super Output Area (LSOA) codes recorded in the School Census were used to link additional information, including Index of Multiple Deprivation (IMD) scores. LA codes were used to link LA-level contextual variables, including the average IMD scores for each LA. A variety of LA-level measures from the Department for Education (DfE), the Department for Housing, Communities and Local Government (DHCLG), the Office of National Statistics (ONS), and Public Health England (PHE) were appended to the data. A summary of the indicators used in the research is shown in Table 2.1.

Table 2.1. Data sources

Category of data	**Indicators**	**Data source**
Child characteristics	Age	CIN / CLA / School Census
	Ethnicity	CIN / CLA / School Census
	Gender	CIN / CLA / School Census
CIN Census	Start and end dates for all CIN activity	CIN Census
	Type of service provision (e.g. NFA, CIN, S47, CPP)	CIN Census
	Primary need identified at assessment	CIN Census
	Factors recorded at assessment	CIN Census
	Reason for case closure	CIN Census
	CP Plan category of abuse	CIN Census
	Source of referral	CIN Census
	Re-referrals / repeat CP Plans	CIN Census

Category of data	Indicators	Data source
CLA census	Start and end dates for all CLA activity	CLA 903 returns
	Reason for new episode of care	CLA 903 returns
	Legal status (e.g. accommodated under Section 20)	CLA 903 returns
	Placement type (e.g. children's home, foster care)	CLA 903 returns
	Placement provider (e.g. LA provision, private provision)	CLA 903 returns
	Reason episode ceased	CLA 903 returns
	Repeat periods of care	CLA 903 returns
NPD (School Census)	KS2 and KS4 attainment scores	School Census
	Special educational needs	School Census
	Eligibility for free school meals	School Census
	Exclusions and absences	School Census
LSOA characteristics	IMD scores	DHCLG
LA characteristics	CSC Expenditure (251 outturn	DfE
	CSC Workforce (CSWW data)	DfE
	Demographic indicators (various) IMD (average score for LA)	ONS, PHE DHCLG

2.3. Types of demand for CSC services

2.3.1. CSC assessments

Data on social work assessments were used to identify and profile the underlying types of demand for CSC services in England. A limited extract from the CIN census covering all children who received a social work assessment over a 7-year period (2014 to 2021) was created. The data was accessed by specifying queries in Microsoft SQL Server. The CIN tables were linked using unique LA and child identifiers which are recorded by LAs as part of their case management process. In the assessment data there were 4.3 million assessments and 2.4 million children who had at least one assessment. As part of an assessment social workers are required to record all factors identified as being relevant to a case. These factors are recorded in the form of a checklist, which is broadly consistent over time. As of 2021, there were 42 factors recorded at social work assessments. Assessments where at least one factor was recorded were identified in the data (n=3,600,320). Assessments with no factors identified (Code 21) were flagged and saved for later analysis (n=682,720). The remaining 41 factors included a combination of risks inside the home (e.g. domestic violence), risks outside the home (e.g. gangs), different types of abuse (e.g. neglect, physical, and sexual abuse), and other indicators

concerning the child's health and well-being (e.g. learning disability). A full list of factors identified at assessment is published annually in government guidance to LAs (DfE, 2020: 42).

The factors identified at assessments was first introduced in the 2014-15 CIN census. Since then the recording of data has improved over time, as social workers are encouraged to record all potentially relevant factors; 84% in 2021, up from 80% in 2015 (see Appendix 2). The average number of factors recorded at assessments has also increased; 2.8 in 2021, up from 2.5 in 2015 (see Appendix 3). There have also been a number of minor changes to the code-set since 2015. For this study the code-set was unified in order to be consistent across years. For example, the privately fostered factors (codes 8B, 8C, 8D, 8E, and 8F) were grouped as a single factor in order for later years to be consistent with the earlier years. Parent-on-child and child-on-child abuse were also combined into single factors for physical abuse and sexual abuse in order to be consistent with earlier years. Appendix 4 provides an overview of data available on the factors recorded at social work assessments, by year. Following the data cleaning process and unifying codes to be consistent across years there were 34 factors in total. The most commonly recorded factor was the parent/carer being the victim of domestic violence, which was identified in one third of all assessments.

The overall dataset comprised 4.2 million assessments, with at least one factor recorded in 3.6 million of these (84%). After the data was cleaned and coding was checked for consistency between each year of collection (2014-21), 34 factors were taken forward as indicators for the LCA model. Assessments in which 'other' was the only factor recorded were reserved as an a-priori class outside of the LCA. Factors and the frequency with which they occurred within the dataset are shown in Table 2.2.

Table 2.2 Frequency of factors recorded in assessments (2014-21)

Indicators	**N**	**%**
Domestic violence: concerns parent(s)/carer(s) is the victim	1,151,570	32%
Mental health: concerns about the parent(s)/carer(s)	970,940	27%
Emotional abuse	750,450	21%
Other	731,400	20%
Neglect	651,490	18%
Alcohol misuse: concerns about the parent(s)/carer(s)	495,510	14%
Physical abuse	480,590	13%
Drug misuse: concerns about the parent(s)/carer(s)	475,880	13%
Domestic violence: concerns child is the victim	441,100	12%
Mental health: concerns about the child	428,050	12%
Learning disability: concerns about the child	311,620	9%

Indicators	N	%
Socially unacceptable behaviour	289,190	8%
Sexual abuse	214,000	6%
Domestic violence: concerns another person is the victim	210,170	6%
Physical disability: concerns about the child	169,630	5%
Drug misuse: concerns about the child	169,020	5%
Physical disability: concerns about the parent(s)/carer(s)	165,210	5%
Self-harm	159,500	4%
Mental health: concerns about another person	139,640	4%
Child sexual exploitation	132,880	4%
Young carer	119,200	3%
Drug misuse: concerns about another person	117,540	3%
Going/being missing	108,180	3%
Learning disability: concerns about the parent(s)/carer(s)	96,410	3%
Alcohol misuse: concerns about another person	87,920	2%
Alcohol misuse: concerns about the child	87,220	2%
Gangs	66,810	2%
Learning disability: concerns about another person	47,080	1%
Physical disability: concerns about another person	39,460	1%
Unaccompanied asylum-seeking child	19,530	1%
Trafficking	15,180	0%
Privately fostered	13,710	0%
Abuse linked to faith or belief	9,560	0%
Female Genital Mutilation	4,980	0%
Total number of assessments	**3,600,320**	**100%**

2.3.2. Latent class analysis

Any number of factors can be recorded at a single assessment, meaning the combinations of needs and risks can found in the data was very large (n=134,058). Classification-based analysis, or cluster analysis, can be used to summarise such complex, heterogenous data. Latent class analysis (LCA) is one such technique that aims to identify distinct, homogenous, and 'hidden' sub-groups within a population, based on patterns of responses to observed variables (Hagenaars & McCutcheon, 2002). The purpose for using LCA in this study was to identify a finite number of mutually exclusive and distinct types of demand for CSC services, each comprising one or a combination of factors, which predictably occur across the entire population of cases.

The unit of analysis was assessments. All assessments containing at least one factor identified at assessment were included in the LCA (n= 3,600,320). Assessments containing 'other' only (n=470,170) were incorporated as a 'known' class i.e. they were pre-assigned their own class a-priori and, as such, could not to be assigned to any other class or classes. The main reason for this is that it

is practically impossible to give 'other' any substantive meaning, due to wide-ranging (potentially contradictory) interpretations by social workers. Consideration was given to collapsing the factors into a smaller number of indicators (e.g. grouping alcohol misuse and drug misuse into a single 'substance misuse' category), which might absorb nuisance dependencies and reduce the possibility of model misfit, but this was later ruled out as each factor was deemed to be of substantive interest. Given the size of the dataset it was not deemed necessary to exclude or group together factors on the basis of low numbers.

A crucial part of LCA is choosing the optimum number of latent classes. In order to do this we assessed the relative fit of 40 nested models, differing only by the number of classes (1 to 40). Goodness of fit statistics were calculated, including Bayesian information criterion (BIC) and Akaike information criterion (AIC). For both AIC and BIC a lower score indicates a better fit. If the AIC and BIC continues to decrease for each additional class added then Elbow plots can be used to seek a point of inflection or plateauing (Nylund et al., 2007). The entropy (R2) was also calculated for each model), a measure of class separation, which can help inform the choice of class number by indicating how distinct the latent classes are; a higher entropy indicates better distinction in class membership. It is important to note, however, that the goodness of fit indices inform (rather than dictate) the final number of classes. The interpretability of the classes is also an important consideration – competing models were qualitatively assessed in terms of their intra-class homogeneity and interclass heterogeneity. Further information on invariance and sensitivity testing are provided in Appendix 7.

LatentGOLD version 6.0 was used to carry out the LCA. The R and SPSS scoring code is included in the supplementary information on the project website, which can be used to classify new observations based on the latent class model used in this report.

2.3.3. Descriptive statistics

Each assessment is assigned to a latent class based on the modal posterior probability (i.e. the highest probability of belonging to a latent class). The end result is a mutually exclusive categorical variable (sometimes called a 'latent variable'), where each assessment assigned to one of twelve categories. This enabled us to examine the relationship between the latent classes and external or auxiliary variables, such as child characteristics (gender, age, and ethnicity), subsequent provision (CIN, CPP, CLA), and other variables of interest.

It is important to note that children may have multiple assessments as part of a CSC episode, and that some children may have multiple CIN episodes, an issue that is addressed at various points in the report (see Section 2.5.4 and 3.2.4). The factors recorded at assessments were not amalgamated for children who had multiple assessments, as this would distort time-varying properties (i.e. children may have assessments at different times for different reasons). For the majority of subsequent analysis, CIN episodes were used as the primary unit of analysis, as this was considered more informative for studying patterns of demand for services. Each CIN episode, or 'case', has an opening and closure date, and all social care activity is carried out as part of an overall episode. Once a CIN episode is closed any new social care activity must be carried as part of a new CIN episode. Where appropriate, sensitivity analysis was carried out in order to check the consistency of results where data is aggregated up to CIN episodes or to the child-level – for example, comparing analyses based on the first or last assessments within CIN episodes, or comparing analyses based on latest social work assessment for a child.

Cross-tabulation analysis was carried out to look at intervention pathways. The intervention pathway for each CSC episode was summarised in a single variable with four mutually-exclusive hierarchical groups:

- *None* – episodes in which an assessment was carried out but the child was not found to be 'in need' and therefore did not receive a statutory CSC service.
- *CIN only* – episodes in which children were assessed as being 'in need' and went on to receive statutory CSC services, but were not subject to CP plans or have an episode of care.
- *CP plan* – episodes in which children were made subject to a CP plan.
- *CLA* – episodes in which children were accommodated in care.

Included in the analysis were all CSC episodes that started between April 1st 2014 and March 31st 2018 (n = 2,550,850). The main reason for restricting the cohort to referrals that began before March 31st 2018 is because of a time lag between the point of referral and subsequent escalation to CP plans or admission to care; it was found that nearly all CP plans and periods of care occurred within two years of the referral (cumulative frequencies for CPP and CLA are shown in Appendix 5).

Cross-tabulation analysis was carried out to see whether the breakdown of the demand categories varied on the basis of child characteristics, including gender, age, ethnicity, and local area deprivation. Data on local area deprivation (IMD scores) was only available for children who could be matched to PMR numbers in the NPD, and restricted to children aged 5 to 15 only. Following

bivariate analysis, further stratification of the data was carried out in order to examine intervention pathways. This involved cross-tabulating the demand categories by each latent class *and* by each child characteristic. This level of stratification enabled us to see how intervention pathways varied according to demographic characteristics when the presenting needs were held constant - i.e. it provided an overview of potential inequalities in provision on the basis of child characteristics.

Other crosstabulations included the breakdown of the demand categories by year showing annual trends in numbers and proportions of assessments in each category over time, as well as the breakdown of the demand categories by LA which enabled us to identify variation in factors at assessment recorded by social workers across different LAs.

2.4. Consultation with stakeholders

The research team consulted with a range of stakeholder groups in order to describe and label the categories appropriately. This was particularly important for categories that comprised multiple factors at assessment and therefore had more latitude for interpretation. Online meetings to explain and discuss the LCA findings were undertaken with five groups: parents with lived experience of CSC services (n=5); young people with lived experience of CSC services (n=6), practitioners and team mangers in CSC (n=5), senior managers and administrators in CSC (n=3), and managers of LA data and performance teams (n=6). Engagement with families and young people was carried out via NCB's existing research advisory groups involving experts by experience. Social workers and managers, as well as experts in social care data and business intelligence, were approached via the team's professional networks. An indicative summary of findings was distributed to participants in advance. Separate meetings were held with each stakeholder group, and examined how the categories should be labelled, whether they were relevant to people's experience of providing or receiving CSC services, and what gaps and limitations were evident, e.g. in relation to particular areas of need and risk. The feedback received from stakeholders was used to refine how the categories were understood and described, as reflected in the findings reported below.

2.5. Outcomes

2.5.1. Re-referrals

The analysis considered all CIN episodes where a social work assessment was carried out and that ended between 1st April 2014 and 31st March 2020, excluding children who were transferred to adult social care services (code RC6) or died (code RC2). Children who were adopted (code RC1) or

transferred to services of another local authority (code RC5) were also excluded as it is not possible to follow-up children who are assigned a new unique LA child ID following adoption or transfer to another LA. Children covered by these codes were low in number (under 1%). Cases where the child turned 18 within one month of the closure date were also excluded due to the rounding of dates in the underlying data (day of birth was not available). The data included all 152 LAs in England with responsibility for providing children's services. City of London and the Isles of Scilly were excluded due to very small population sizes. Dorset, Bournemouth, and Poole, were also excluded due to boundary changes during the study period.

Survival analysis methods (Clark *et al.*, 2003) were used to identify the factors associated with re-referrals following case closure. The observation window for the analysis was defined as the duration between the initial CIN episode ending and a new CIN episode starting. Children that were not re-referred within the observation window were denoted as censored; their duration was calculated as being the amount of time from initial CIN episode ending to the end of the study period (March 31st 2020). Children who reached the age of 18 were also denoted as censored; their duration was calculated as being the amount of time from initial CIN episode ending to their 18th birthday (as they were no longer 'at risk' of a referral to CSC from this point forward).

The cumulative probability of children being re-referred following case closure was estimated using Kaplan-Meier curves. For each child and CIN characteristic, a Cox proportional hazard model was fitted. For the regression models we focused only on re-referrals that occurred within one year of case closure. This was for two reasons: 1) It was preferable to compare each yearly cohort (2014 to 2020) with an equal follow-up time (12 months); 2) A shorter period of follow-up was more likely to be more relevant to social work practitioners. All child and CIN characteristics, including age, gender, ethnicity, IMD, length of CIN episode, referral source, and factors identified at assessment (using a latent variable) were included in a single multivariable Cox regression model. The multivariable analysis was carried out within a multilevel framework to adjust for the non-independence of multiple referrals, and the clustering of children within local authorities (Robson and Pevalin, 2015). Hazard ratios from the univariate and fully adjusted models are reported with along 95% confidence intervals. These results are presented in tables and illustrated using forest plots. IMD was limited to children aged 5-15 so the decision was taken to run a separate model and then include the results for IMD from this alternative model. This showed the effect of IMD adjusted for by other variables., whereas the coefficients for all other variables were not adjusted for by IMD (owing to the extent of missing data for under 5s). IMD was omitted from the main multivariable models; instead the hazard

ratios for IMD were obtained from a separate model among individuals with complete IMD data. Owing to the extent of missing data, the findings on deprivation should be treated with caution. Only 5% of children had more than one assessment and less than 1% had different factors recorded, so the effect of choosing either first or last assessment within the episode was minimal. The decision was taken to report on each child's first assessment (following referral) for the main multivariable models.

2.5.2. Repeat child protection plans

A similar analysis was carried out to look at factors associated with repeat child protection plans.. The analysis considered all CP plans that ended between 1st April 2014 and 31st March 2020, excluding children who were transferred to adult social care services (code RC6) or died (code RC2). Children who were adopted (code RC1) or transferred to services of another local authority (code RC5) were also excluded as it is not possible to follow-up children who are assigned a new unique LA child ID following adoption or transfer to another LA. Given that 'reason for CP plan closure' does not exist as a variable this information was taken from the CIN closure dates for cases where the CP plan closure date was within one month of the CIN closure date. This is effectively a buffer period, whereby most CP plans cease either on or before the CIN episode closure date (i.e. if a child is deemed not to be in need of CSC services); Conversely, it is not possible for the CIN closure date to occur before the CP plan closure date. Cases where the child turned 18 within one month of the closure date were also excluded due to the rounding of dates in the underlying data (day of birth was not available). Similar to the analysis for re-referrals City of London, Isles of Scilly, Dorset, Bournemouth, and Poole were excluded from the analysis, leaving 147 LAs in total.

The unit of analysis was CP plans where a social assessment was carried out. Children that did not have a repeat CP plan within the observation window were denoted as censored; their duration was calculated as being the amount of time from initial CP plan ending to the end of the study period (March 31st 2020). Children who reached the age of 18 were also denoted as censored; their duration was calculated as being the amount of time from initial CP plan ending to their 18th birthday (as they were no longer 'at risk' of a CP plan from this point forward). Kaplan-Meier curves and Cox proportional hazard models were fitted. The Cox regression models focused on repeat CP plans that occurred within one year of a CP plan closure, for similar reasons to that of re-referrals. Included in the models were age, gender, ethnicity, IMD, length of CP plan, CP plan category of abuse, and factors identified at assessment [LCA]. If a child had multiple assessments then the latest assessment immediately prior to the CP plan was included in the analysis.

2.5.3. Re-entries to care

A similar analysis was carried out to look at factors associated with re-entries to care. The analysis considered all periods of care that ended in reunification between 1st April 2014 and 31st March 2020 (cease codes E4A and E4B. The reunified cohort was chosen because return to birth family is the most common exit route from care, has a much higher rate of re-entry compared to other exit routes, and is the most suitable for comparing demand categories based on social work assessments carried out when the child was living with their parents/carers. Voluntary, short-term respite placements were excluded (legal status codes V3 and V4), as these children are looked-after under an agreed series of short-term placements which are planned, at regular intervals, and therefore different in nature to other reunions. Cases where the child turned 18 within one month of the closure date were also excluded due to the rounding of dates in the underlying data (day of birth was not available). Similar to the analysis for re-referrals and repeat CP plans, City of London, Isles of Scilly, Dorset, Bournemouth, and Poole were excluded from the analysis, leaving a total of 147 LAs.

The unit of analysis was periods of care where a social work assessment was carried out. Children that did not have a repeat period of care within the observation window were denoted as censored; their duration was calculated as being the amount of time from initial period of care ending to the end of the study period (March 31st 2020). Children who reached the age of 18 were also denoted as censored; their duration was calculated as being the amount of time from initial period of care ending to their 18th birthday (as they were no longer 'at risk' of care from this point forward). Kaplan-Meier curves and Cox proportional hazard models were fitted for the analysis. The Cox regression models focused on repeat periods of care that occurred within one year of reunification, for similar reasons to that of the re-referrals and repeat CP plans analysis. Included in the models were age, gender, ethnicity, IMD, length of period of care, whether the child was accommodated in care under Section 20, placement type, placement provider, distance placed from home, and factors identified at assessment [LCA]. If a child had multiple assessments the latest assessment prior to the period of care was included in the analysis. We investigated the effect of the care characteristics both at entry and at exit (e.g. placement type at entry and placement type at exit), which generally produced similar results. In the models we report on the care characteristics at exit.

2.5.4. Transitions between classes

The main objective of this analysis was to see whether children are more or less likely to transition from one LCA category into another by comparing proportions at two different time-points.

Transitions between demand categories were studied for children who experienced more than one episode of CSC provision between 2015 and 2020. Three age-specific cohorts were considered for the analysis:

1. Children assessed in 2015 aged under 1 and again in 2020 aged 5 (n=3,393)
2. Children assessed in 2015 aged 5 and again in 2020 aged 10 (n=3,497)
3. Children assessed in 2015 aged 10 and again in 2020 aged 15 (n=3,580)

Descriptive tables and Sankey plots were generated to show the number and proportion of episodes within each demand category for these groups. This provides an overview of how demand shifts or evolves as children get older (as measured by the multiple assessments completed at two different time points).

2.5.5. Educational outcomes at KS2 and KS4

This part of the analysis was carried out within the ONS SRS. PMR numbers were used to link CIN and CLA data with tables in the NPD, including the pupil, KS2, KS4, and exclusions tables. The analysis focused on two cohorts: children who sat KS2 exams in 2019 (n=649,250) and children who sat KS4 exams in 2019 (n=610,010). We looked at the previous 5 years of school census data, which identified whether the child was eligible for free school meals, their SEND status, and whether they received a fixed-term or permanent exclusion. We looked at the previous 5 years of CSC data to identify children who had any involvement with CSC services. Children in the KS2 and KS4 cohorts were broadly categorised into 5 hierarchical groups: 1) children not referred to CSC, 2) children referred and assessed but who received no CSC service 3) children who were in need 4) children who were in on CP plans 5) and children who experienced an episode of care.

The main objective of this analysis was to explore how different factors (including demographics, SEND provision, CIN and care characteristics) affected school attainment at KS2 (children aged 11) and KS4 (children aged 16). Using the social care data we were able to derive the total number of CSC episodes within the last 5 years, highest level of intervention within the last 5 years, total time receiving services within the last 5 years, whether the child was receiving services in the last year, factors recorded at latest CSC assessment (LCA), latest CP plan category of abuse (for those subject to a CP plan), and latest CLA placement (for those in care). The KS2 attainment outcome was measured by whether the child achieved the expected standard in reading test, writing TA and maths test (yes / no) (Department for Education, 2022b), and the KS4 attainment outcome was measured using each pupil's Attainment 8 scores, which is calculated by adding up the points for

their 8 subjects on a scale of 9 (highest) to 1 (lowest), with English and maths counted twice) (Department for Education, 2022c).

Descriptive tables showed the breakdown of characteristics of children who sat KS2 and KS4 exams in 2019, with stratification by level of contact with CSC within the last 5 years. Descriptive tables also show the mean attainment scores for each characteristic. Following this, Poisson regression models were carried out in order to obtain rate ratios (and 95% CIs). This shows the relative likelihood of obtaining higher (or lower) attainment scores associated with a particular variable (e.g. type of SEND) based on a reference category (e.g. children who had no SEND provision). For example, a rate ratio for children with SEND for learning disability of 0.5 would mean that their predicted attainment scores were 50% lower than children who had no SEND provision. In this analysis, each variable is adjusted for each other variable. The main purpose for the adjustments was to test the degree to which certain variables (such as Gender or SEND status) status might confound (i.e. attenuate or magnify) the effect of different needs and risks recorded at social work assessments on pupil attainment.

2.5.6. Exclusions at age 11 and age 16

Descriptive tables showed the exclusion rate (%) in year 7 (children aged 11, year of KS2) and year 11 (children aged 16, year of KS4) for each child and CIN / CLA characteristic. Following this, binary logistic regression models were carried out in order to obtain odds ratios (and 95% CIs). This shows the relative likelihood of being excluded associated with a particular variable. Similar to the analysis of KS2 and KS4 adjustments, each variable is adjusted for each other variable to test the degree to which certain variables (such as Gender or SEND status) status might confound (i.e. attenuate or magnify) the effect of different needs and risks recorded at social work assessments on rates of exclusions.

3. Findings

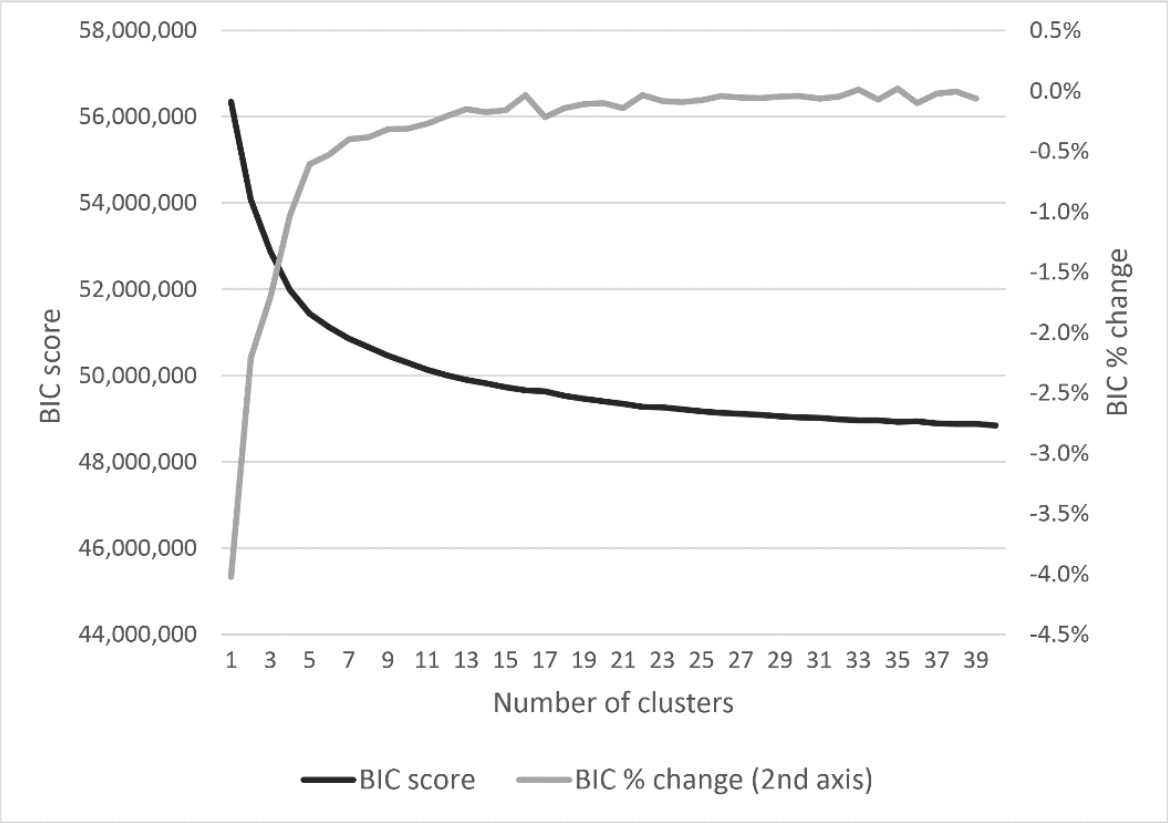
Findings are reported below for the latent class analysis of demand categories, followed by the intermediate outcomes of service provision, and education outcomes for children in each of the categories. Comparisons are made between different subgroups using regression analysis.

3.1. Types of demand for CSC services in England

3.1.1. Results of latent class analysis

Goodness of fit indices were not conclusive for determining a definitive number of classes. Increasing the number of classes continued to improve the model's fitness but at a diminishing rate of change. Figure 3.1 shows this pattern for the BIC score, often considered to be the most reliable fit statistic (Nylund). An 'elbow', or point of diminishing returns, is discernable at, or around, the 10-model solution. The decision was taken to report on the 11-class model. The rationale for choosing this model was that the plateauing of the BIC elbow occurred around this point (indicating a point of 'diminishing returns'), the entropy was comparatively high compared to models with 5 to 10 classes (which denotes better class separation), the model was robust in a range of sensitivity analyses (e.g. it was reproducible across different years), and the classes were qualitatively interpretable and could be characterised by the research team and by stakeholders. For example, by comparison, the 10-class model did not identify a class that could be characterised as child mental health, which was deemed to be informative in the 11-class model, whilst the 12-class model identified a relatively complex class that looked similar to another complex class and therefore deemed not to be informative. Results from the measurement invariance tests showed that the latent structure could be applied equally across different LAs and across different years (i.e. the homogeneity restrictions were supported by the data). These results were also supported by sub-group analysis; e.g. the classes were substantively similar in a model conducted on 2020/21 assessments (the years affected by the Covid-19 pandemic) compared with a model conducted on all other assessments, and substantively similar in randomly selected LAs. A table showing goodness of fit indices and results of invariance testing can be found in Appendices 6 and 7.

Figure 3.1 Goodness of fit statistics for latent class models (1-40)



3.1.2. Description of the classes

The latent classes – or demand categories – were initially described in terms of their frequency in the dataset and the conditional probabilities (the likelihood of factors occurring within each class). Conditional probability refers to the likelihood that a particular factor will have been recorded in an assessment assigned to the class in question. The classes were given provisional names based on the factors with the highest conditional probabilities of occurring, and these names were subsequently refined in a process of consultation with stakeholders (see Section 2.4).

Figure 3.2 shows the names of twelve demand categories and the frequency with which they are recorded in the sample of assessments (n=3.6m). They include the 11 latent classes along with a twelfth category comprising assessments in which only 'other' was recorded (included as a 'known' class). A heat-mapped summary of conditional probabilities estimated in the 11-class model is provided in Table 3.2.

Figure 3.2 Bar chart showing 12 demand categories and how often they were recorded in all assessments 2014-21 (n=3.6m)

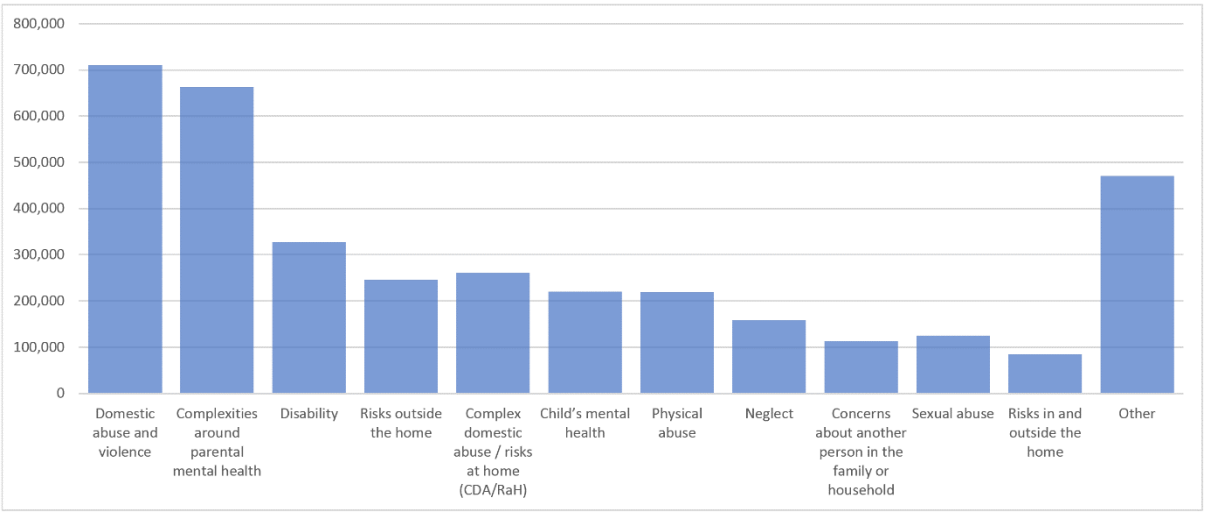


Table 3.1 Conditional probabilities of factors estimated in the 11 latent classes (plus 'other')

Indicators \ Latent Classes	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child's mental health	Physical abuse	Neglect	Sexual abuse	Concerns about another person in the family or household	Risks in and outside the home	Known class ('other')
Prevalence of categories	***20%***	***18%***	***9%***	***7%***	***7%***	***6%***	***6%***	***4%***	***3%***	***3%***	***2%***	***13%***
Child's alcohol misuse	1%	1%	0%	7%	2%	3%	0%	0%	0%	7%	39%	-
Parent's alcohol misuse	14%	32%	2%	2%	38%	5%	1%	1%	1%	37%	25%	-
Another's alcohol misuse	2%	1%	0%	0%	1%	0%	0%	0%	0%	45%	5%	-
Child's drug misuse	1%	1%	0%	22%	4%	7%	0%	0%	0%	10%	64%	-
Parent's drug misuse	6%	36%	2%	4%	38%	2%	1%	4%	0%	38%	26%	-
Another's drug misuse	1%	3%	1%	2%	2%	0%	0%	1%	0%	52%	9%	-
Domestic violence (child)	30%	2%	1%	4%	39%	8%	1%	0%	0%	40%	33%	-
Domestic violence (parent)	75%	39%	5%	3%	77%	9%	0%	0%	1%	74%	38%	-
Domestic violence (another)	11%	1%	2%	1%	8%	1%	0%	0%	0%	66%	10%	-
Child's mental health	2%	3%	10%	12%	24%	84%	2%	0%	1%	19%	63%	-
Parent's mental health	14%	57%	26%	4%	70%	36%	5%	7%	4%	55%	46%	-
Another's mental health	2%	2%	6%	1%	4%	5%	0%	0%	1%	46%	8%	-
Child's learning disability	2%	2%	49%	5%	12%	14%	2%	0%	2%	7%	18%	-
Parent's learning disability	0%	3%	9%	0%	10%	1%	1%	3%	1%	5%	5%	-
Another's learning disability	0%	0%	7%	0%	2%	1%	0%	0%	0%	6%	3%	-
Child's physical disability	1%	1%	30%	1%	7%	5%	1%	1%	0%	4%	7%	-
Parent's physical disability	1%	5%	16%	1%	11%	7%	1%	1%	1%	7%	12%	-

Indicators \ Latent Classes	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child's mental health	Physical abuse	Neglect	Sexual abuse	Concerns about another person in the family or household	Risks in and outside the home	Known class ('other')
Another's physical disability	0%	0%	5%	0%	2%	1%	0%	0%	0%	5%	3%	-
Young carer	0%	3%	8%	0%	13%	7%	0%	0%	0%	7%	12%	-
Privately Fostered	0%	0%	0%	2%	1%	0%	0%	0%	0%	1%	2%	-
UASC	0%	0%	0%	7%	0%	0%	0%	0%	0%	0%	1%	-
Going/being missing	0%	0%	0%	16%	2%	5%	0%	0%	0%	1%	49%	-
Child sexual exploitation	0%	0%	2%	20%	2%	8%	0%	0%	6%	2%	43%	-
Trafficking	0%	0%	0%	3%	0%	0%	0%	0%	0%	0%	5%	-
Gangs	0%	0%	0%	14%	1%	0%	0%	0%	0%	1%	25%	-
Soc. unacc. behaviour	2%	2%	7%	39%	9%	14%	2%	2%	2%	9%	61%	-
Self-harm	0%	0%	2%	4%	7%	36%	1%	0%	1%	4%	38%	-
Neglect	4%	23%	11%	6%	53%	9%	9%	100%	3%	38%	39%	-
Emotional abuse	25%	20%	5%	5%	81%	16%	20%	8%	6%	51%	44%	-
Physical abuse	10%	2%	3%	2%	44%	7%	100%	0%	0%	22%	23%	-
Sexual abuse	1%	1%	3%	3%	8%	7%	3%	2%	100%	4%	17%	-
FGM	0%	0%	0%	1%	0%	0%	0%	0%	0%	0%	0%	-
Faith / belief	0%	0%	0%	1%	1%	0%	0%	0%	0%	0%	0%	-
Other	-	-	-	-	-	-	-	-	-	-	-	100%

Domestic abuse and violence

Domestic abuse and violence made up a fifth of all cases (19.7%), making it the most common category of demand. This latent class was constituted from three factors at assessment used to record concerns about domestic violence (DV). The type that is recorded depends on who is being subjected to abuse and violence: the child, the parent/carer, or another person living in the household (see Appendix 1 for the statutory codes and descriptions). Concerns about the child's parent/carer being the subject of DV were the most likely to be recorded, having a conditional probability of 75% (see Table 3.2). Concerns about the child being subject to DV had a 30% probability of occurring. There was also a 25% probability that emotional abuse would be recorded alongside one of the DV factors. While the statutory labels for these factors refer to 'domestic violence' (DfE, 2020), consultation with stakeholders suggested that the term 'domestic abuse' was more suitable for conveying the range and complexity of behaviours and harms associated with abusive relationships. It was also noted that definitions of significant harm in statutory guidance

include harm that results from witnessing the ill-treatment of others (DfE, 2018). This category was therefore labelled 'domestic abuse and violence'.

Complexities around parental mental health

Complexities around parental health constituted just under a fifth of all cases (18%), making this the second most common category. The most likely factor to be assessed was concerns about the mental health of the parent/carer, which had a conditional probability of 57%, often co-occurring with other factors such as parental drug misuse (36%) and alcohol misuse (32%), or with concerns about domestic violence (39%). There was also a 23% probability of neglect and a 20% probability of emotional abuse being identified within this category. Given the likely co-occurrence of multiple needs within this category, it was initially labelled as 'complex parental mental health'. However, consultation with stakeholders showed that some people might understand this to mean that parents had been diagnosed with a complex mental health condition. The name was therefore changed to place more emphasis on the complexity of need surrounding the concerns about parental mental health.

Disability

Disability was a category that covered 9% of cases. It was mainly characterised by two factors relating to child disability, with conditional probabilities of 49% for concerns about a child's learning disability and 30% for concerns about a child's physical disability. There was also a 26% probability that cases in this category would include concerns about parental mental health. Stakeholders raised some queries about the extent to which children's disability was identified and recognized by CSC services. While all children with disabilities are defined as children in need under the 1989 Children Act, which is the main legislation underpinning CSC, not all children who receive support for their special educational needs and/or disability (SEND) will receive a social care assessment.

Risks outside the home

Risks outside the home made up 7% of cases and reflected a range of concerns about children's welfare, behaviour and vulnerability, including to criminal and sexual exploitation. The most commonly identified risks were socially unacceptable behaviour (39%), child's drug misuse (22%) and child sexual exploitation (20%). Other co-occurring factors included concerns about self-harm, going missing, and gang involvement. The initial name for this category was 'vulnerable young person', in order to highlight risks to children's welfare as opposed to concerns about their behaviour. However, stakeholders did not find this label to be particularly informative, since

arguably it could refer to children in any of the categories. Another term considered was 'extra-familial harm', which is often used by practitioners in England to refer to abuse and exploitation happening outside of the family system. Ultimately, it was decided to name this category 'risks outside the home', partly as a way of distinguishing it from another extra-familial harm category, which is described below.

Complex domestic abuse / risks at home

Complex domestic abuse/risks at home was characterised by multiple factors that in various combinations accounted for 7% of cases. The factor most likely to be assessed was emotional abuse, which had a conditional probability of 81% and was generally linked to concerns about the parent or child being subject to domestic violence (77% and 30% respectively) as well as concerns about parental mental health (70%). There was also a strong chance of assessments recording concerns about parental drug or alcohol misuse as well as neglect and/or physical abuse. The number of co-occurring factors made it difficult to interpret and label this category. While domestic abuse was a defining component, compared to the first DAV cluster there were stronger associations with concerns about other parental risk factors and various forms of child maltreatment. While some type of domestic abuse and violence was often identified in these cases, it was generally accompanied by other risk factors as well as a high risk of maltreatment. It was therefore decided to combine the term 'complex domestic abuse' with 'risks at home', pointing to contrasts and connections with other categories including those relating to extra-familial harm.

Child's mental health

Child's mental health accounted for 6% of cases. As its name suggests, this category was primarily to do with concerns about a child's mental health (conditional probability of 84%), alongside which there was also a strong likelihood of self-harm (36%) and concerns about parental mental health (36%) being recorded. Some assessments also identified concerns about emotional abuse or a child's learning disability. The naming of this category was considered unproblematic by stakeholders.

Physical abuse, neglect, and sexual abuse

Three categories were constituted by a single maltreatment factor. The most common was physical abuse, which made up 6% of cases[1]. In this category, physical abuse was recorded as a factor in 100% of assessments and there was also a 20% chance of emotional abuse being identified. The neglect category, again with 100% of assessments identifying neglect as a factor, made up 4% of assessments. Finally, the sexual abuse category, in which all assessments identified concerns about sexual abuse, constituted 3.5% of cases.

Concerns about another person in the family/household

Concerns about another person (i.e. someone other than the child or parent) accounted for 3.1% of cases. Such concerns included another person being subject to domestic violence (conditional probability of 66%), drug misuse by another person (52%), mental health of another person (46%) and alcohol misuse of another person (45%). However, these factors were not found on their own but generally co-occurred with risk factors concerning the parent/carer, particularly domestic violence (74%) but also parental mental health (55%), drug misuse (38%), and alcohol misuse (37%). There was a strong chance that emotional abuse or neglect would be identified in these assessments. Consultation with stakeholders indicated that the general rubric of 'another person' could cover a range of situations, including concerns about members of the child's immediate or extended family, parents' partners, lodgers, neighbours, or other people in the community. These were likely to be important distinctions when it came to assessing and managing risks to the child.

Risks in and outside the home

Risks in and outside the home was the smallest category in the LCA model, making up 2% of cases. It was characterised by many of the same concerns about extra-familial harm described in the 'risks outside the home' category (see above) but differed in that these often co-occurred with risks to the child within the family system. The most likely factors to be identified were child's drug misuse (conditional probability of 64%), child's mental health (63%) and socially unacceptable behaviour

[1] In this context, physical abuse refers to concerns about a child being subject to physical abuse, generally by their parent or carer. This is seen as different from concerns about child being subject to domestic abuse, e.g. harm inflicted by an older sibling, or suffered as a result of intervening in parental conflict.

(61%). There was also a strong chance that assessments would identify one or more concerns about parental mental health, domestic violence, child sexual exploitation, and the child going missing. Maltreatment factors were also commonly identified, particularly neglect and emotional abuse. The labelling of this category reflected the presence of problems inside the family home in many of these cases.

Other

The 'other' category consisted of assessments in which only 'other' was recorded and accounted for 13% of cases. These assessments were included in the LCA as a 'known' class. For obvious reasons, it is difficult to interpret this category because none of the listed factors have been used to describe the risks and needs identified in the assessment. Consultation with social workers suggested that the combination of high workloads and tight deadlines on assessment completion may sometimes lead to 'other' being ticked by default, particularly if it is a complex case with many different needs being identified. Organisational practices may also have a bearing, e.g. selection of 'other' to represent multiple needs may be more common in LAs where the convention is to report only one factor rather than several.

3.1.3. Child characteristics

A breakdown of each demand category by child characteristics is shown in Table 3.3. The results show that each category has a distinctive profile in terms of children's gender, age, and ethnicity, as well as local area deprivation.

Gender

There were differences in the gender profiles of the categories, although these should be seen in the context of male children being slightly more prevalent (51%) in the overall dataset. Taking account of this average imbalance, male children were still over-represented in the categories of disability (58%), risks outside the home (55%) and physical abuse (53%). In contrast, female children were over-represented in the categories of sexual abuse (57%) child's mental health (56%), and risks in and outside the home (53%).

Table 3.2 Breakdown of demand categories by child characteristics

	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child's mental health	Physical abuse	Neglect	Concerns about another person in the family or household	Sexual abuse	Risks in and outside the home	Other	No factors recorded	All classes
Gender[1]														
Male	50.9%	50.6%	58.2%	55.2%	51.4%	43.8%	52.8%	51.7%	50.8%	43.4%	47.4%	50.6%	50.3%	51.0%
Female	49.1%	49.4%	41.8%	44.8%	48.6%	56.2%	47.2%	48.3%	49.2%	56.6%	52.6%	49.4%	49.7%	49.0%
Total (column)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Age (start of episode)[1]														
Under 1	13.8%	17.5%	6.9%	3.5%	16.8%	3.1%	7.5%	14.6%	17.1%	6.8%	4.1%	10.8%	10.3%	11.3%
1-4 Years	28.4%	26.9%	18.1%	8.4%	22.7%	8.6%	21.5%	26.8%	23.3%	19.0%	7.5%	22.5%	23.7%	22.4%
5-9 Years	29.8%	28.2%	31.3%	15.4%	28.2%	19.1%	34.8%	28.9%	27.7%	28.4%	13.7%	28.5%	28.7%	27.8%
10-15 Years	23.2%	23.3%	35.7%	49.5%	27.3%	50.9%	31.0%	24.9%	26.2%	37.5%	52.8%	29.9%	29.3%	30.5%
16-17 Years	4.7%	4.1%	8.1%	23.2%	5.0%	18.3%	5.2%	4.8%	5.7%	8.3%	21.9%	8.2%	8.1%	8.0%
Total (column)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ethnicity[1]														
Asian	10.8%	5.1%	9.1%	7.7%	6.2%	5.7%	12.1%	5.2%	3.5%	5.9%	3.8%	9.4%	9.2%	8.2%
Black	7.4%	4.5%	9.0%	14.0%	4.4%	4.9%	16.5%	10.3%	2.5%	4.7%	5.4%	11.1%	8.7%	8.3%
Mixed	9.6%	9.0%	6.6%	7.7%	9.3%	6.9%	7.2%	7.1%	8.6%	5.2%	8.6%	7.6%	7.3%	8.0%
Other	2.7%	1.5%	2.3%	5.2%	1.6%	1.7%	3.6%	2.7%	1.1%	1.8%	1.6%	3.5%	2.9%	2.6%
White	69.6%	79.9%	73.0%	65.3%	78.5%	80.8%	60.5%	74.7%	84.2%	82.5%	80.6%	68.4%	72.0%	72.9%
Total (column)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
IMD[1,2]														
Missing	16.2%	13.6%	16.0%	20.5%	12.4%	16.8%	17.8%	17.0%	11.6%	15.7%	15.9%	20.2%	19.1%	16.9%
1 (least deprived)	6.5%	5.9%	7.2%	5.8%	5.5%	8.2%	6.8%	4.5%	5.2%	7.9%	5.8%	6.9%	6.2%	6.4%
2	8.8%	9.0%	9.6%	7.7%	8.8%	10.8%	8.9%	6.7%	9.6%	10.3%	8.5%	8.4%	8.6%	8.9%
3	13.6%	13.3%	13.5%	12.1%	13.2%	14.0%	13.2%	11.8%	14.0%	13.1%	12.9%	12.3%	12.5%	13.0%
4	20.3%	21.3%	21.1%	20.4%	21.2%	19.6%	19.9%	21.3%	22.0%	19.4%	20.1%	19.2%	19.5%	20.3%
5 (most deprived)	34.7%	36.9%	32.6%	33.4%	38.9%	30.5%	33.5%	38.8%	37.7%	33.6%	36.7%	32.9%	34.0%	34.5%
Total (column)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Notes

[1] Includes the first assessment following CSC referral. The results were similar when looking at the last assessment within each episode.

[2] Linked via the school's census, using PMR number, and therefore limited to children aged 5 to 15 only. This accounts for the high number of missing data (due to lack of data on under 5s).

Age

Overall, most assessments were carried out for children in the age band 10-15 (31%). There was a difference in the age profiles of categories when compared to the overall breakdown. Categories that were characterised by higher proportions of children in younger age groups (under 1s and 1-4s) were complexities around parental mental health, complex domestic abuse/risks at home, domestic abuse and violence, concerns about another person in the family/household, and neglect. Categories that were characterised by higher proportions of children in older age groups were disability, risks outside the home, child's mental health, and risks in and outside the home.

Ethnicity

Only very broad ethnic groupings were available in the data. Overall, the largest group was White (73%), followed by Black (8%), Mixed (8%), Asian (8%) and 'Other' (3%). Differences in terms of ethnicity were evident across the categories. Compared with the average, White children were more prevalent in the categories of concerns about another person, sexual abuse, child's mental health, risks in and outside the home, and complexities around parental mental health. Black children were more prevalent in the categories of physical abuse, risks outside the home, neglect and 'other'. Asian children were more prevalent in the categories of physical abuse, domestic abuse and violence, disability and 'other'. Children from Mixed backgrounds were more prevalent in the categories of domestic abuse and violence, complexities around parental mental health, and risks in and outside the home. Children from other ethnic backgrounds were more prevalent in the categories of risks outside the home and 'other'.

Deprivation

Deprivation data was only available for school-aged children. Overall, there was a steep social gradient across all classes, indicated by the progressive increase in prevalence from the least deprived quintile of neighbourhoods (6%) to the most deprived quintile (34%). Differences in this gradient were observed across the categories. The strongest social gradients were found in the categories of neglect, complex domestic abuse, risks in and outside the home, complexities around parental mental health, and domestic violence and abuse. The social gradient was weaker than average (but still noticeably present) in the categories of child's mental health and disability.

3.1.4. Intervention pathways

Intervention pathways mean the type of service provided for all episodes in a particular category, based on the threshold of intervention, how long the episode lasted, the type of abuse or neglect (CP plans only), and characteristics of care provision (CLA only).

Threshold of intervention

Table 3.4 provides a breakdown of categories by the highest level of intervention following assessment. Episodes were allocated to four mutually exclusive thresholds:

- *None* – episodes in which an assessment was carried out but the child was not found to be 'in need' and therefore did not receive a statutory CSC service. This constituted 40% of all episodes.
- *CIN only* – episodes in which children were assessed as being 'in need' and went on to receive statutory CSC services but were not subject to CP plans or have an episode of care. This was the most common type of provision, making up 45% of all episodes.
- *CP plan* – episodes in which children were made subject to a CP plan, amounting to 9% of all episodes.
- *CLA* – episodes in which children were accommodated in care. This was the least common type of provision, constituting just 5% of all episodes.

The crosstabulation in Table 3.4 shows the numbers of episodes within each category across the four thresholds of intervention, the percentage within each category, and the percentage within each level of intervention. Key findings from this analysis are:

- Three categories accounted for half of all episodes of care (CLA): complexities around parental mental health (20%), complex domestic abuse/risks at home (15%) and risks outside the home (14%) – see row percentages.
- Three categories accounted for the majority of all CP plans: domestic abuse and violence (22%), complexities around parental mental health (21%), and complex domestic abuse/risks outside the home (17%) – see row percentages.
- The three most likely categories to lead to a CP plan following assessment were complex domestic abuse/risks outside the home (32%), concerns about another person in the family/household (24%), and risks in and outside the home (20%) – see column percentages.

- The three most likely categories to lead to an episode of care were risks in and outside the home (16%), complex domestic abuse/risks inside the home (16%), and risks outside the home (11%) – see column percentages.

Child protection and care episodes are of particular interest because they are the most acute form of intervention in CSC. However, they made up only 14% of overall episodes. 45% were CIN only episodes, in which the most prevalent categories were domestic abuse and violence (20%), complexities around parental mental health (16%) and 'other' (18%). 40% were assessed as 'not CIN' and therefore received no statutory intervention. The categories most likely to result in an assessment of 'not-CIN' were domestic abuse and violence, complexities around parental mental health, child mental health, and disability. In all of the categories, a majority of episodes were either assessed not-CIN or proceeded to CIN-only provision. This was even true of the complex domestic abuse/risks at home category, in which 48% of assessments were followed by either a CP plan or CLA episode.

Table 3.3 Breakdown of categories by threshold of intervention

	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child's mental health	Physical abuse	Neglect	Concerns about another person in the family or household	Sexual abuse	Risks in and outside the home	Other	No factors recorded	All classes
Type of intervention following an assessment (counting the first assessment from each episode)[1,2]														
Count														
None	172,660	127,040	58,210	49,290	18,970	40,470	37,670	26,340	15,180	22,950	6,510	80,910	374,610	1,030,790
CINO[3]	214,340	172,490	99,500	78,480	43,940	65,990	90,210	45,880	22,120	49,380	17,690	193,390	67,910	1,161,310
CPP	49,330	47,600	10,020	6,750	38,380	7,680	12,870	13,910	14,120	7,100	7,470	11,800	3,880	230,890
CLA	11,720	25,260	6,140	16,890	18,950	6,000	8,150	7,510	6,440	1,880	5,980	9,420	3,520	127,870
Total	448,040	372,390	173,870	151,410	120,240	120,150	148,890	93,630	57,870	81,310	37,650	295,520	449,910	2,550,850
Row %														
None	26.3%	19.4%	8.9%	7.5%	2.9%	6.2%	5.7%	4.0%	2.3%	3.5%	1.0%	12.3%	-	100.0%
CINO	19.6%	15.8%	9.1%	7.2%	4.0%	6.0%	8.3%	4.2%	2.0%	4.5%	1.6%	17.7%	-	100.0%
CPP	21.7%	21.0%	4.4%	3.0%	16.9%	3.4%	5.7%	6.1%	6.2%	3.1%	3.3%	5.2%	-	100.0%
CLA	9.4%	20.3%	4.9%	13.6%	15.2%	4.8%	6.6%	6.0%	5.2%	1.5%	4.8%	7.6%	-	100.0%
Total	21.3%	17.7%	8.3%	7.2%	5.7%	5.7%	7.1%	4.5%	2.8%	3.9%	1.8%	14.1%	-	100.0%
Column %														
None	38.5%	34.1%	33.5%	32.6%	15.8%	33.7%	25.3%	28.1%	26.2%	28.2%	17.3%	27.4%	83.3%	40.4%
CINO	47.8%	46.3%	57.2%	51.8%	36.5%	54.9%	60.6%	49.0%	38.2%	60.7%	47.0%	65.4%	15.1%	45.5%
CPP	11.0%	12.8%	5.8%	4.5%	31.9%	6.4%	8.6%	14.9%	24.4%	8.7%	19.8%	4.0%	0.9%	9.1%
CLA	2.6%	6.8%	3.5%	11.2%	15.8%	5.0%	5.5%	8.0%	11.1%	2.3%	15.9%	3.2%	0.8%	5.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Notes

[1] Hierarchical categorisation of interventions i.e. highest level of intervention following assessment

[2] Including episodes with at least one year of follow-up after assessment

[3] CINO refers to 'CIN only' episodes that were not CPP or CL

Length of episode

Table 3.5 provides a breakdown of categories by the length of episode for assessments leading to an intervention, i.e. CIN, CP plans and CLA. Length of episode was classified as either below or above 12 months. Most CIN and CP episodes (74% and 73% respectively) lasted less than 12 months, compared to half of CLA episodes (50%). Demand categories with the highest proportion of CIN episodes lasting over 12 months were complex domestic abuse/risks at home, concerns about another person, risks in and outside the home. In contrast, demand categories with the highest proportion of CP plans lasting over 12 months were neglect, disability and risks in and outside the home. Categories with the highest proportion of CLA episodes lasting over a year were complex domestic abuse/risks at home, concerns about another person, and disability.

Type of abuse or neglect

Table 3.6 provides a breakdown of demand categories by the type of abuse or neglect identified for children with a CP plan. In most cases, one of either emotional abuse, neglect, physical abuse, or sexual abuse is recorded but in a few cases more than one is recorded ('multiple abuse'). Overall, the most frequent type was neglect (46%), followed by emotional abuse (38%), physical abuse (8%) and sexual abuse (4%). Multiple types of abuse and neglect were identified in 4% of CP plans. Demand categories varied not only in the proportion of episodes that proceeded to a CP plan following an assessment (see above) but also in the type of abuse that was identified in these episodes. Categories in which the proportion of CP plans for neglect was particularly high were neglect, complexities around parental mental health, and disability. Categories in which the proportion of CP plans for emotional abuse was particularly high were domestic abuse and violence, child's mental health and complex domestic abuse/risks at home. Categories in which the proportion of CP plans for physical abuse was particularly high were physical abuse, domestic abuse and violence, and risks outside the home. Categories in which the proportion of CP plans for sexual abuse was particularly high were sexual abuse, risks outside the home and child's mental health. Finally, the proportion of CP plans for multiple abuse was particularly high in the 'other' category.

Table 3.4. Breakdown of categories by length of episode

	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child's mental health	Physical abuse	Neglect	Concerns about another person in the family or household	Sexual abuse	Risks in and outside the home	Other	All classes
Counts													
CIN [1]													
<12 months	217,670	170,600	75,910	75,190	50,180	59,960	93,800	46,770	23,750	49,010	17,270	189,480	1,069,0
1 year and over	57,510	74,510	39,630	26,280	50,990	19,560	17,340	20,430	18,890	9,340	13,740	24,860	373,650
Total	275,185	245,109	115,542	101,476	101,166	79,526	111,139	67,204	42,632	58,351	31,009	214,344	1,442,6
CPP [2]													
<12 months	39,650	43,370	8,170	6,110	34,560	6,190	12,370	12,330	12,750	5,790	6,750	10,800	198,830
1 year and over	14,380	17,260	3,630	1,970	13,840	2,520	3,000	5,530	4,910	1,980	2,810	3,550	75,400
Total	54,030	60,630	11,800	8,080	48,410	8,710	15,370	17,860	17,650	7,770	9,570	14,360	274,230
CLA [3]													
<12 months	5,310	10,330	2,280	8,110	7,110	2,790	4,640	3,100	2,470	790	2,900	4,760	54,600
1 year and over	4,670	11,070	2,830	7,940	9,300	2,430	3,010	3,550	3,030	890	2,350	4,020	55,100
Total	9,990	21,400	5,110	16,050	16,410	5,220	7,650	6,650	5,500	1,680	5,250	8,780	109,690
Percentage (column)													
CIN [1]													
<12 months	79%	70%	66%	74%	50%	75%	84%	70%	56%	84%	56%	88%	74%
1 year and over	21%	30%	34%	26%	50%	25%	16%	30%	44%	16%	44%	12%	26%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
CPP [2]													
<12 months	73%	72%	69%	75%	72%	71%	80%	69%	72%	75%	71%	75%	73%
1 year and over	27%	28%	31%	25%	29%	29%	20%	31%	28%	26%	30%	25%	28%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
CLA [3]													
<12 months	53%	48%	45%	51%	43%	54%	61%	47%	45%	47%	55%	54%	50%
1 year and over	47%	52%	55%	50%	57%	47%	39%	53%	55%	53%	45%	46%	50%

Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Notes

[1] Includes CIN episodes that started before 1st April 2019 (at least 12 months of follow up)

[2] Includes CP plans that started before 1st April 2019 (at least 12 months of follow up)

[3] Includes periods of care that started before 1st April 2019 (at least 12 months of follow up)

Table 3.5. Breakdown of categories by type of abuse or neglect (CP plans only)

	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child's mental health	Physical abuse	Neglect	Concerns about another person in the family or household	Sexual abuse	Risks in and outside the home	Other	All classes
Counts													
CPP category of abuse[1]													
Emotional abuse	38,430	26,260	3,220	2,780	24,940	4,770	4,890	2,980	9,040	1,400	3,680	5,530	128,230
Neglect	16,780	43,500	8,990	4,960	27,160	4,530	5,040	16,690	10,750	1,440	6,290	7,070	153,350
Physical abuse	6,350	2,480	840	980	4,390	630	6,950	630	1,140	110	640	1,470	26,450
Sexual abuse	780	980	910	1,100	900	860	290	400	240	5,840	850	970	14,060
Multiple abuse	2,460	1,960	480	360	2,640	430	1,020	400	840	430	540	1,310	12,720
Total	64,800	75,250	14,440	10,170	60,090	11,230	18,180	21,100	21,990	9,210	11,980	16,370	334,820
Percentage (column)													
CPP category of abuse													
Emotional abuse	59%	35%	22%	27%	42%	43%	27%	14%	41%	15%	31%	34%	38%
Neglect	26%	58%	62%	49%	45%	40%	28%	79%	49%	16%	53%	43%	46%
Physical abuse	10%	3%	6%	10%	7%	6%	38%	3%	5%	1%	5%	9%	8%
Sexual abuse	1%	1%	6%	11%	2%	8%	2%	2%	1%	63%	7%	6%	4%
Multiple abuse	4%	3%	3%	4%	4%	4%	6%	2%	4%	5%	5%	8%	4%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Notes

[1] Includes CP plans that started before 1st April 2020

3.1.5. Intersection of child characteristics and intervention pathways

In order to examine intervention pathways for children with different characteristics, episodes in each demand category were subdivided by the threshold of intervention (Section 3.1.5) and then again by gender, age, ethnicity, and deprivation (Section 3.1.4). The most noticeable differences were around age and deprivation, as illustrated in Figures 3.3(ii) and 3.4(ii). The general pattern for deprivation was for the social gradient to increase at higher thresholds of intervention. This can be seen in the 'stepped' sequence of proportions shown in the 'all classes' column in Figure 3.4(ii) . In other words, over-representation of children from more deprived backgrounds becomes progressively more pronounced at each statutory threshold following assessment and is highest among children in care. This pattern - the stepped social gradient – is present throughout all the demand categories. The only difference in some categories – disability, risks outside the home and child's mental health – the social gradient is steeper for CP plans than for CLA.

In relation to age, the pattern in many categories was for children in younger age groups to become more prevalent at higher thresholds of intervention. In Figure 3.3(ii), this can be seen as a stepped progression in the light blue shaded columns. The pattern was particularly noticeable in categories with a lower overall age profile (see Section 3.1.4): neglect, complex domestic abuse/risks at home, concerns about another person, complexities around parental mental health, and neglect. In categories with a higher age profile, such as risks outside the home, child's mental health and risks in and outside the home, there was a tendency for children in the older age group (10+) to be over-represented in CLA but under-represented in CP plans.

Intervention pathways for children did not show many differences when broken down by gender and ethnicity. The most noticeable findings were in the risks outside the home category, in which male children were much more likely to have an episode of care compared to female children, while children from Black, Asian and Mixed backgrounds were much more likely (3.5x, 3.5x and 1.5x respectively) to have an episode of care compared to White children. Similar differences were evident in the 'Other' category, in which male children and children from Black, Asian and Mixed backgrounds were more likely to have an episode of care, while White children were more likely to have a CP plan.

Figure 3.3 Thresholds of intervention for each category differentiated by i) gender and ii) age

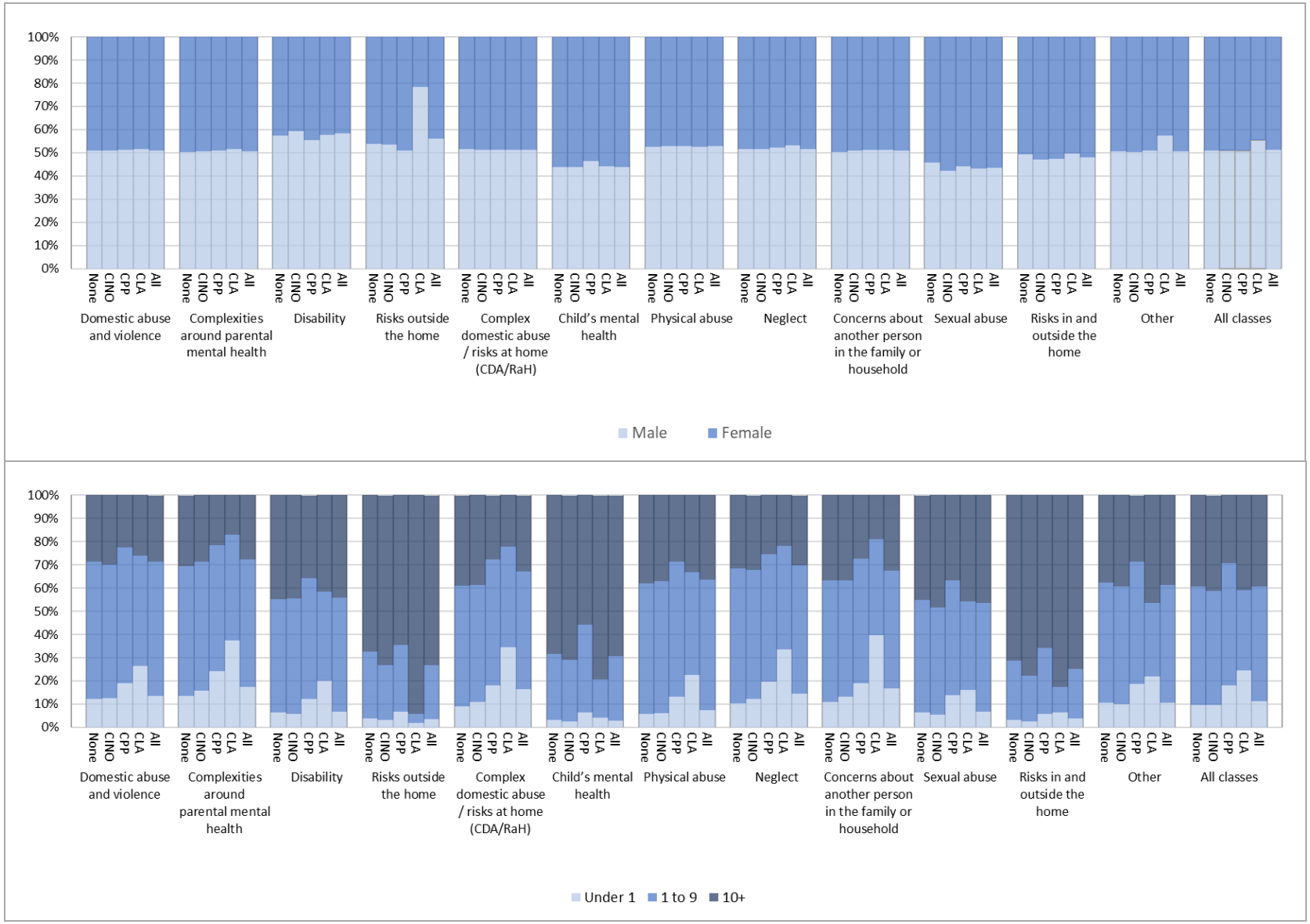
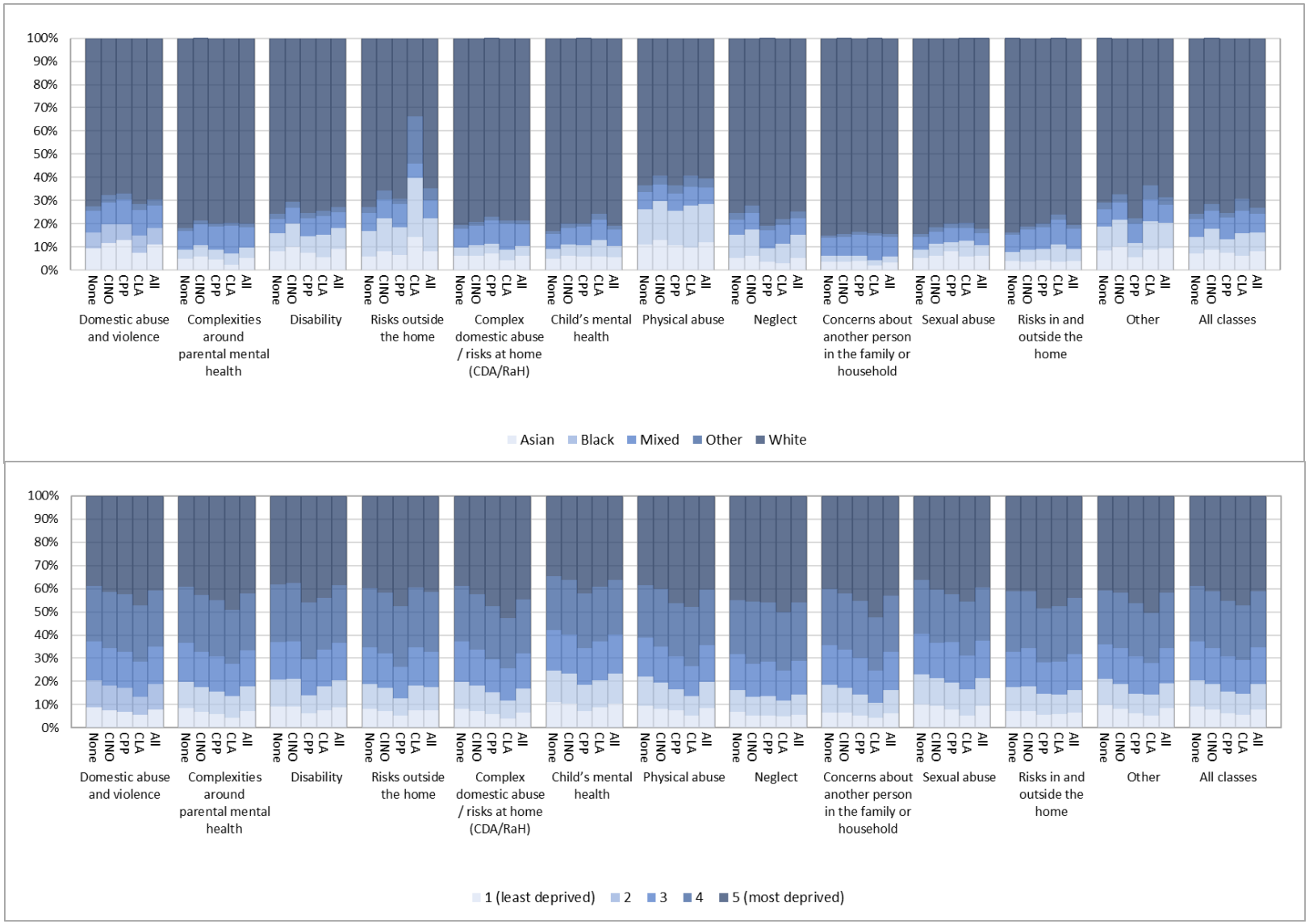


Figure 3.4 Thresholds of intervention for each category differentiated by i) ethnicity and ii) deprivation



3.1.6. Variation between LAs

The prevalence of demand categories as a proportion of total demand for CSC varied widely across LAs in England, as shown in Table 3.7. For example, the proportion of episodes covered by the domestic abuse and violence category, which was just over a fifth of all cases nationally, ranged from 31% to 9%. This is not to say that there is less domestic abuse and violence occurring in some LAs than in others; the finding refers only to differences based on the factors at assessment recorded by social workers. It is important to remember that domestic abuse also forms part of other categories in which it co-occurs with other needs and risks, while recording practices will also vary between LAs. Similar provisos apply to inter-LA differences in the other categories. Perhaps the most surprising range of variation was found in relation to disability, in which prevalence ranged from 63% in to 1% of cases. Again, the degree of disparity may reflect variable practices when it comes to the recording of children's disability as a factor at assessment. The reasons for such disparities are unclear and would merit further examination. A table showing the full breakdown of episodes in each category across 147 English LAs can be found in Appendix 16.

Table 3.6 Variation in demand categories across LAs

	Overall frequency (England)	**Range (Local authorities)**
Domestic abuse and violence	21%	30% to 9%
Complexities around parental mental health	18%	29% to 6%
Disability	13%	63% to 1%
Risks outside the home	11%	18% to 3%
Complex domestic abuse / risks at home	8%	15.5% to 3 %
Child's mental health	8%	20% to 0.4%
Physical abuse	4%	13% to 1%
Neglect	5%	19% to 0.2%
Concerns about another person in the family or household	5%	25% to 1%
Sexual abuse	1%	9% to 0.2%
Risks in and outside the home	4%	8% - 0.1%
Other	2%	7% - 0.1%

3.1.7. Trends in prevalence

Table 3.8 shows the numbers of assessments falling within the twelve CSC demand categories each year from 2014-21, as well as the proportion of all assessment accounted for by each category. Both measures suggest an increasing prevalence over time of multiple, complex needs and categories more likely to lead to a CP plan or episode of care. The quality of recording of factors at assessment noticeably improved after 2015, although this could not fully account for the trend in more complex cases. Key findings in this respect include:

- The number of assessments with factors recorded increased from 439,940 to 535,950 between 2014-21 (overall 22% rise).
- Over the same time period there was a 63% increase in 'complex DAV', 78% increase in 'risks in and outside the home', and 53% rise in 'concerns about another person'.
- This means very complex/high risk cases occupy a higher proportion of cases dealt with by CSC, e.g. 8% complex DAV in 2021 compared to 6% in 2014.
- Numbers of assessments focused on child mental health more than doubled (111%) - and this rise largely took place pre-Covid.

Table 3.7 Trends in annual prevalence of categories (2014-21)

	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child's mental health	Physical abuse	Neglect	Concerns about another person in the family or household	Sexual abuse	Risks in and outside the home	Other	All classes
% assessments completed													
2014/15	21.0%	17.1%	8.8%	5.7%	5.8%	4.6%	6.6%	4.9%	2.7%	3.5%	1.7%	17.6%	100.0%
2015/16	20.3%	17.7%	9.2%	6.6%	6.7%	5.2%	6.5%	5.0%	3.1%	3.7%	2.1%	13.8%	100.0%
2016/17	19.8%	17.9%	9.3%	6.8%	7.2%	5.4%	6.5%	4.6%	3.1%	3.7%	2.3%	13.5%	100.0%
2017/18	19.9%	18.3%	9.0%	7.1%	7.6%	5.9%	6.6%	4.5%	3.2%	3.6%	2.5%	11.7%	100.0%
2018/19	19.6%	18.2%	9.0%	7.2%	7.5%	6.3%	6.4%	4.4%	3.2%	3.5%	2.4%	12.4%	100.0%
2019/20	18.6%	19.0%	9.1%	7.5%	7.7%	7.2%	5.8%	3.8%	3.3%	3.2%	2.7%	12.1%	100.0%
2020/21	19.3%	20.5%	9.3%	6.8%	7.8%	7.9%	4.4%	3.7%	3.4%	3.2%	2.5%	11.1%	100.0%
Total (column)	19.7%	18.4%	9.1%	6.8%	7.2%	6.1%	6.1%	4.4%	3.1%	3.5%	2.4%	13.1%	100.0%
N assessments completed													
2014/15	92,310	75,200	38,780	24,860	25,730	20,060	29,160	21,520	11,940	15,210	7,600	77,570	439,940
2015/16	97,790	85,400	44,420	31,800	32,170	24,940	31,340	24,170	14,700	18,040	10,330	66,350	481,450
2016/17	101,170	91,300	47,610	34,770	36,700	27,510	33,110	23,620	15,830	18,740	11,620	69,100	511,080
2017/18	104,390	95,660	46,910	37,030	39,700	31,020	34,730	23,630	16,550	19,080	13,230	61,350	523,280
2018/19	105,640	97,880	48,310	38,830	40,300	33,720	34,420	23,770	17,170	18,940	13,120	67,080	539,180
2019/20	105,930	107,940	52,060	42,890	43,970	40,790	32,750	21,720	18,620	18,280	15,350	69,150	569,450
2020/21	103,610	109,900	49,730	36,400	42,020	42,380	23,820	19,590	18,120	17,270	13,530	59,560	535,950
Total (column)	710,840	663,280	327,810	246,580	260,590	220,420	219,340	158,020	112,940	125,560	84,790	470,170	3,600,320
% change from 2014-21	**+12%**	**+46%**	**+28%**	**+46%**	**+63%**	**+111%**	**-18%**	**-9%**	**+52%**	**+14%**	**+78%**	**-23%**	**+22%**

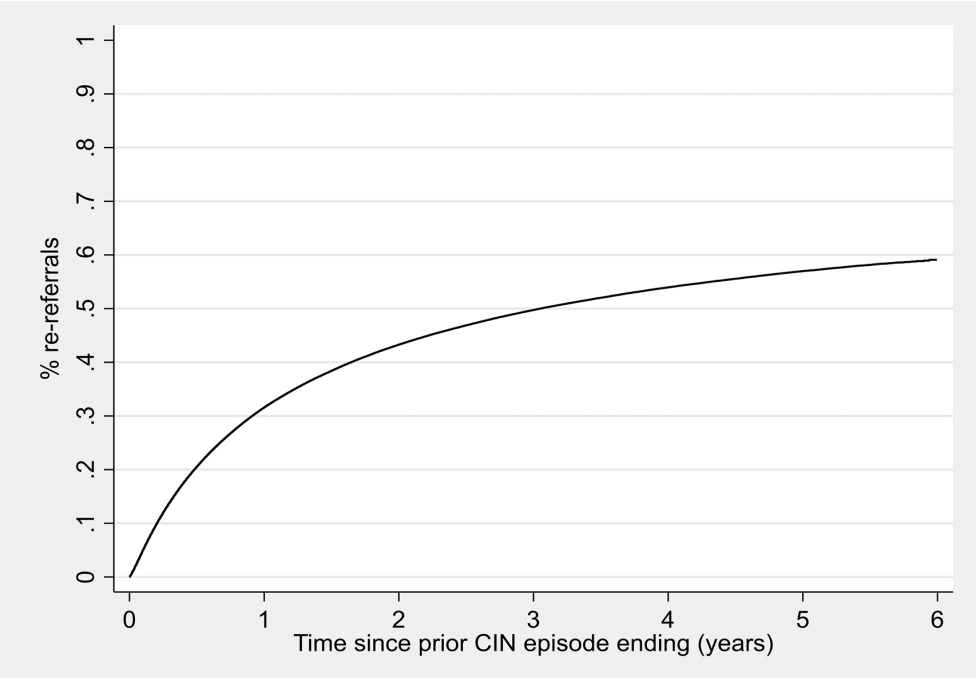
3.2. Outcomes of provision

In this section, the outcomes of provision are first explored through an analysis of re-referrals, repeat CP plans and re-entries to care. Transitions between demand categories for children who received multiple episodes of CSC involvement are also explored, as well as an analysis of educational attainment and exclusion.

3.2.1. Re-referral to CSC

2,169,220 CIN episodes (1,565,710 children) were closed between 2014 and 2021. Of those, 891,820 episodes (41%) resulted in a re-referral over that same period. For children who were re-referred, the next episode could occur any time between 1st April 2014 and 31st March 2020 of the last one ceasing. As described in Section 2.5.1, survival analysis techniques were used to accurately estimate the probability of re-referral, after accounting for varying lengths of follow-up during the study period. The Kaplan Meier plot in Figure 3.5 shows the rate of re-referrals over different follow-up periods from 2015-21. The graph shows the rate of re-referral over a six-year period was 59%, over three years was 50%, and over 12 months was 30%. The curve is steeper at the start, suggesting that a critical period for re-referrals is in the first 12 months after an episode ceases.

Figure 3.5 Kaplan Meier plot showing rates of re-referrals (2015-21)



Further analysis explored the extent to which different characteristics of the child and the type of provision affected the likelihood of a re-referral within 12 months of an episode ceasing. Table 3.9 and Figure 3.6 show findings from a Cox proportional hazard model, which was fitted for each child characteristic, including their demand category. The results are presented as hazard ratios (HRs) with accompanying confidence intervals (CIs). The HRs show how a particular factor (e.g. child's age on first referral) affected the relative likelihood of a re-referral based on a reference category (e.g. children under one year old). The HRs and CIs reported here are from the fully adjusted model, in which all factors were considered together. HRs from the univariate model, which considers the effect of each factor separately, can be found in Appendix 8 but are not shown here. Figure 3.6 shows the same results from the adjusted model but visualised as a forest plot. The dotted line in the middle represents the reference category; points to the left of this line indicate characteristics that reduced the likelihood of a re-referral, while points to the right indicate characteristics that increased the likelihood of a re-referral. Findings are summarised below:

- *Gender* – no significant differences were found in relation to gender, in that female children were not more likely to be re-referred than male children (information on other gender identities was not recorded in the data).
- *Age* – children aged under 1 were more likely to be re-referred than children in all other age groups and 16/17 years olds were the least likely to be re-referred. Although increasing age did seem to be associated with a lower likelihood of re-referral, children aged 10-15 were slightly more likely to be re-referred than children aged 5-9.
- *Ethnicity* – children from Asian backgrounds were much less likely to be re-referred than children from any other ethnic backgrounds. Black children were less likely to be re-referred than White children. However, children from Mixed backgrounds were more likely to be re-referred than White children. These results are likely to obscure differences within the broad ethnic groups described here.
- *Deprivation* – children in more deprived neighborhoods were more likely to be re-referred children in more affluent neighborhoods. The gradient was steeper in LAs that had lower levels of deprivation overall. This means that children living in high deprivation neighborhoods in low deprivation LAs are disproportionately more likely be re-referred compared with children living in (equivalently) high deprivation neighbourhoods in more affluent LAs.

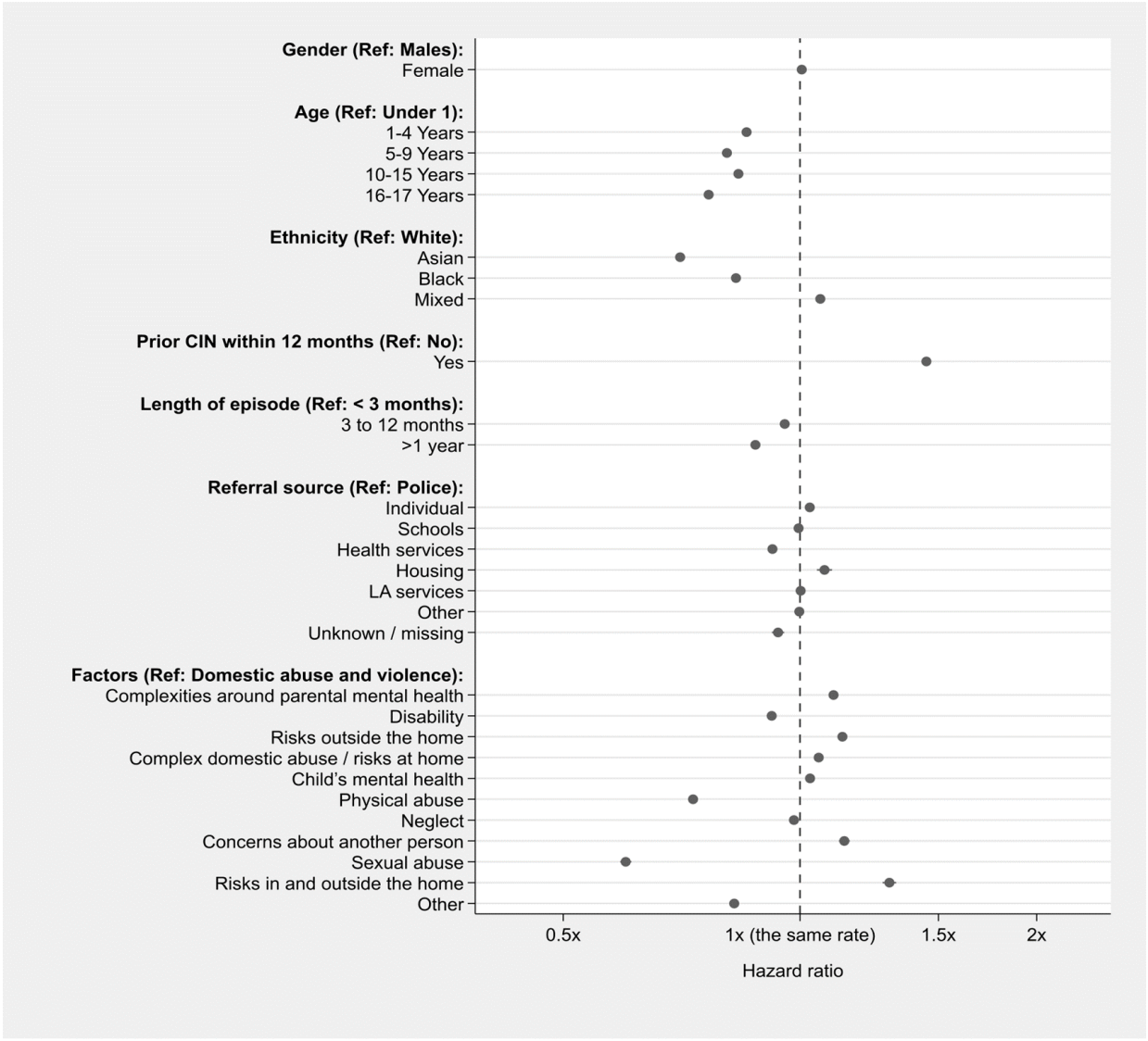
- *Referral* – re-referral was less likely if the source of referral was from health services, but more likely if the child had already had a previous CIN episode in the past 12 months.
- *Length of episode* – children were less likely to be re-referred if the episode lasted longer, with episodes lasting over a year having the lowest chance of a re-referral.
- *Demand categories* – after adjusting for all these characteristics, the categories of demand least likely to result in a re-referral were sexual abuse (HR_{adj} 0.60), physical abuse (HR_{adj} 0.73) and Other (HR_{adj} 0.82). Those most likely to result in a re-referral were risks in and outside the home (HR_{adj} 1.30), concerns about another person (HR_{adj} 1.14), risks outside the home (HR_{adj} 1.13), and complexities around parental mental health (HR_{adj} 1.10).

Table 3.8 Factors affecting likelihood of re-referral to CSC (within 12 months)

Characteristics	Category	Number of episodes ending (column %)	Number of re-referrals (% within stratum)	Fully adjusted model	
				HR	CI
Gender	Male	873,860 (50.7%)	272,080 (31.1%)	Ref	
	Female	850,260 (49.3%)	265,490 (31.2%)	1.01	1.00 to 1.01
Age	Under 1	139,630 (8.0%)	44,920 (32.2%)	Ref	
	1-4 Years	401,360 (23.1%)	129,720 (32.3%)	0.86	0.85 to 0.86
	5-9 Years	495,580 (28.5%)	152,160 (30.7%)	0.81	0.80 to 0.82
	10-15 Years	539,790 (31.0%)	171,520 (31.8%)	0.84	0.83 to 0.84
	16-17 Years	162,640 (9.4%)	40,030 (24.6%)	0.77	0.76 to 0.78
Ethnicity	Asian	134,920 (8.1%)	31,000 (23.0%)	0.70	0.70 to 0.71
	Black	135,230 (8.1%)	34,300 (25.4%)	0.83	0.82 to 0.84
	Mixed	133,050 (8.0%)	46,470 (34.9%)	1.06	1.05 to 1.07
	Other	40,990 (2.4%)	9,160 (22.3%)	0.69	0.68 to 0.70
	White	1,229,190 (73.5%)	409,780 (33.3%)	Ref	
Deprivation	Low dep. LA | Low dep. LSOA	24,120 (2.3%)	7,590 (31.5%)	0.94	0.87 to 1.02
	Low dep. LA | Mid dep. LSOA	160,110 (15.4%)	58,340 (36.4%)	1.10	1.02 to 1.19
	Low dep. LA | High dep. LSOA	17,580 (1.7%)	7,050 (40.1%)	1.22	1.12 to 1.32
	Mid dep. LA | Low dep. LSOA	14,700 (1.4%)	4,130 (28.1%)	0.82	0.80 to 0.85
	Mid dep. LA | Mid dep. LSOA	404,040 (39.0%)	133,490 (33.0%)	Ref	
	Mid dep. LA | High dep. LSOA	233,330 (22.5%)	88,980 (38.1%)	1.14	1.13 to 1.15
	High dep. LA | Low dep. LSOA	620 (0.1%)	180 (28.8%)	0.67	0.56 to 0.81
	High dep. LA | Mid dep. LSOA	65,720 (6.3%)	20,230 (30.8%)	0.91	0.84 to 0.99
	High dep. LA | High dep. LSOA	116,420 (11.2%)	42,620 (36.6%)	1.02	0.95 to 1.11
Prior CIN episode	No	1,343,490 (77.2%)	377,790 (28.1%)	Ref	
	Yes	395,910 (22.8%)	160,590 (40.6%)	1.45	1.44 to 1.46
Length of CIN	<3 months	1,015,940 (58.4%)	312,320 (30.7%)	Ref	
	3 to 12 months	540,980 (31.1%)	170,130 (31.4%)	0.96	0.95 to 0.96
	>1 year	182,470 (10.5%)	55,920 (30.6%)	0.88	0.87 to 0.89
Referral source	Individual	136,090 (7.8%)	44,470 (32.7%)	1.03	1.02 to 1.04

Characteristics	Category	Number of episodes ending (column %)	Number of re-referrals (% within stratum)	Fully adjusted model	
				HR	CI
	Schools	364,180 (20.9%)	108,510 (29.8%)	1.00	0.99 to 1.00
	Health services	254,720 (14.6%)	74,850 (29.4%)	0.92	0.91 to 0.93
	Housing	23,190 (1.3%)	7,500 (32.4%)	1.07	1.05 to 1.10
	LA services	217,380 (12.5%)	68,330 (31.4%)	1.00	0.99 to 1.01
	Police	509,380 (29.3%)	160,360 (31.5%)	Ref	
	Other	192,230 (11.1%)	61,320 (31.9%)	1.00	0.99 to 1.01
	Unknown / missing	42,240 (2.4%)	13,020 (30.8%)	0.94	0.92 to 0.95
Factors (LCA)	Domestic abuse and violence	389,440 (22.4%)	125,330 (32.2%)	Ref	
	Complexities around parental mental health	305,500 (17.6%)	108,080 (35.4%)	1.10	1.09 to 1.11
	Disability	135,900 (7.8%)	39,710 (29.2%)	0.92	0.91 to 0.93
	Risks outside the home	118,920 (6.8%)	40,350 (33.9%)	1.13	1.12 to 1.14
	Complex domestic abuse / risks at home (CDA/RaH)	80,450 (4.6%)	26,670 (33.1%)	1.06	1.04 to 1.07
	Child's mental health	96,500 (5.5%)	30,490 (31.6%)	1.03	1.02 to 1.04
	Physical abuse	131,630 (7.6%)	31,400 (23.9%)	0.73	0.72 to 0.74
	Neglect	76,830 (4.4%)	25,160 (32.7%)	0.98	0.97 to 1.00
	Concerns about another person in the family or household	42,580 (2.4%)	15,530 (36.5%)	1.14	1.12 to 1.16
	Sexual abuse	72,210 (4.2%)	14,870 (20.6%)	0.60	0.59 to 0.61
	Risks in and outside the home	24,710 (1.4%)	9,300 (37.6%)	1.30	1.27 to 1.33
	Other	264,730 (15.2%)	71,500 (27.0%)	0.82	0.82 to 0.83
LA-level indicators					
	CIN starting			1.11	1.08 to 1.15
	Spend safety			0.96	0.93 to 0.99
	CIN per SW			1.00	0.97 to 1.02

Figure 3.6 Forest plot showing factors associated with re-referral to CSC[1]



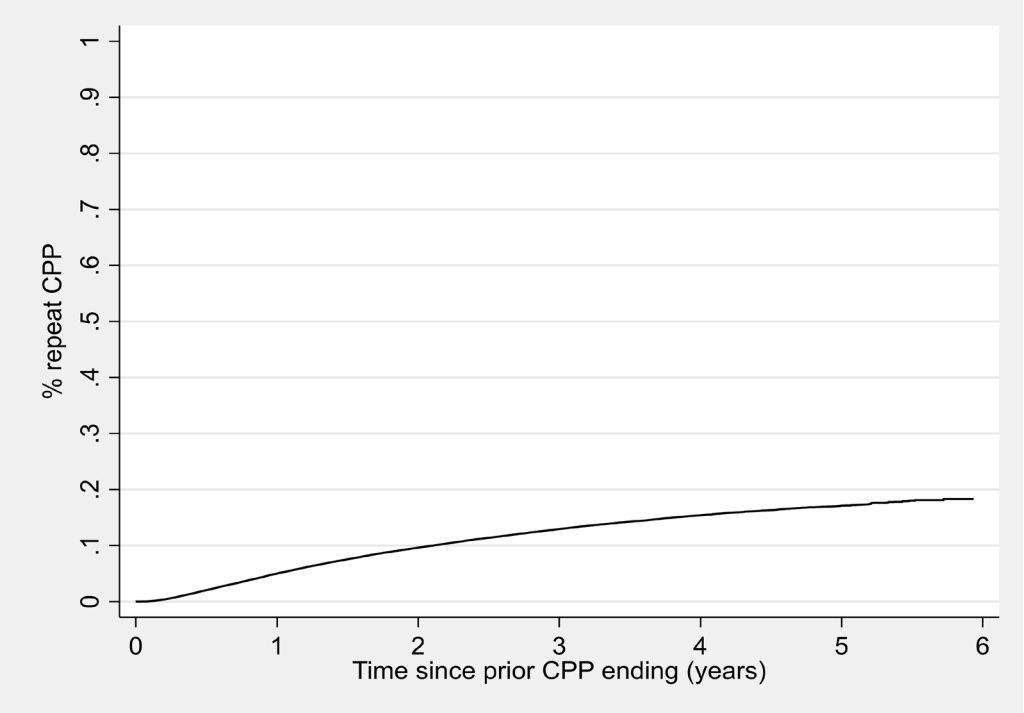
Note:
[1]Confidence intervals were calculated but are not visible on the plot due to their narrowness

3.2.2. Repeat CP plans

300,330 CP plans (280,040 children) ceased between 2014 and 2021. Of those, 27,770 (10%) were subsequently followed by another CP plan. For children who did receive a repeat CP plan, this could occur any time between 1st April 2014 and 31st March 2020 of the previous CP plan ceasing. As with re-referrals, survival analysis was used to estimate the probability of a repeat CP plan after

accounting for varying lengths of follow-up. The Kaplan Meier plot in Figure 3.7 shows the rate of repeat CP plans over time, which was 18% over 6 years and 10% over two years.

Figure 3.7 Kaplan Maier plot showing the rate of repeat CP plans (2014-20)



Further analysis explored the extent to which different factors affected the likelihood of a child being subject to another CP plan within 12 months of their previous CP plan ceasing. Table 3.10 and Figure 3.8 present the results of a Cox proportional hazard model, showing hazard ratios (HRs) from the adjusted model with accompanying confidence intervals (CIs). The model tracked the time lapse between the end of one CP plan and start of the next, adjusting for the length of the initial CP plan as one of the control variables. HRs from the univariate model, which considers the effect of each factor separately, are reported in Appendix 4 but are not shown here. Figure 3.8 shows the same results from the adjusted model but visualised as a forest plot. Key findings were:

- *Gender* – no significant differences were found in relation to gender, in that female children were not more likely to have a repeat CP plan than male children (information on other gender identities was not recorded in the data).
- *Age* – children aged under five were more likely to be re-referred than children in older age groups and 16/17 years olds were the least likely to be re-referred. Although increasing age was generally associated with a lower chance of a repeat CP plan, children aged 1-4 were slightly more likely to have a repeat CP plan than children aged under 1.

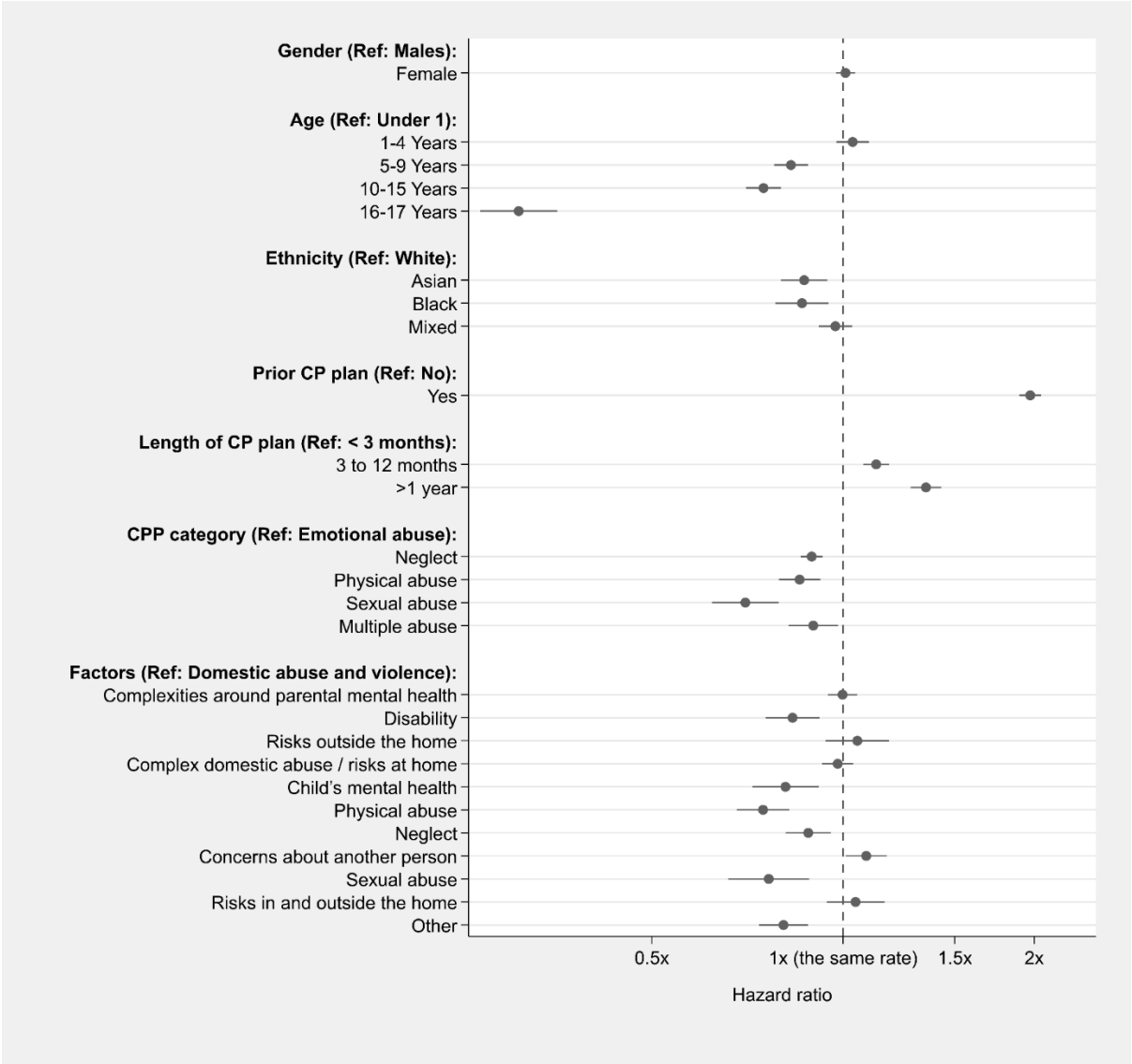
- *Ethnicity* – children from Asian and Black backgrounds were both significantly less likely to have a repeat CP plan than children from White backgrounds. Children from Mixed backgrounds were slightly less likely to be have a repeat CP plan than White children but not significantly so. These results are likely to obscure differences within the broad ethnic groups described here.
- *Deprivation* – no discernible patterns were found in relation to neighborhood deprivation. There was an excess of repeat CP plans in the LAs with lower overall levels of deprivation i.e. the more affluent LAs had proportionately higher caseloads of children that had already been previously subject to a CP plan.
- *CP plan* – a repeat CP plan was significantly more likely if the existing CP plan category was for neglect , if the CP plan lasted more than a year, or if the child had already had a CP plan in the past. Conversely, a repeat CP plan was significantly less likely if the existing CP plan category was for sexual abuse or if the CP plan lasted less than a year.
- *Demand category* – after adjusting for all these factors, the demand categories least likely to result in a repeat CP plan were physical abuse, other, sexual abuse, and child mental health. The categories most likely to result in a repeat CP plan were concerns about another person in the family/household, risks in and outside the home, domestic abuse and violence, and risks outside the home.

Table 3.9 Factors affecting the chances of a repeat CP plan (within 12 months of a CP plan ceasing)

Characteristics	Category	Number of CPP ending (column %)	Number of repeat CPP (% within stratum)	Fully adjusted model	
				HR	CI
Gender	Male	121,740 (50.9%)	6,040 (5.0%)	Ref	
	Female	117,620 (49.1%)	5,820 (4.9%)	1.01	0.97 to 1.04
Age	Under 1	34,290 (14.3%)	1,570 (4.6%)	Ref	
	1-4 Years	61,510 (25.6%)	3,650 (5.9%)	1.04	0.98 to 1.10
	5-9 Years	66,730 (27.8%)	3,390 (5.1%)	0.83	0.78 to 0.88
	10-15 Years	65,010 (27.1%)	3,060 (4.7%)	0.75	0.70 to 0.80
	16-17 Years	12,340 (5.1%)	200 (1.6%)	0.31	0.27 to 0.35
Ethnicity	Asian	15,090 (6.4%)	550 (3.6%)	0.87	0.80 to 0.95
	Black	13,630 (5.7%)	450 (3.3%)	0.86	0.78 to 0.95
	Mixed	22,800 (9.6%)	1,140 (5.0%)	0.97	0.92 to 1.03
	Other	3,840 (1.6%)	150 (4.0%)	0.92	0.79 to 1.07
	White	181,920 (76.7%)	9,530 (5.2%)	Ref	
Deprivation	Low dep. LA | Low dep. LSOA	2,810 (1.9%)	180 (6.3%)	1.50	1.18 to 1.91
	Low dep. LA | Mid dep. LSOA	23,490 (15.5%)	1,520 (6.5%)	1.43	1.19 to 1.73
	Low dep. LA | High dep. LSOA	3,000 (2.0%)	210 (7.0%)	1.46	1.15 to 1.86
	Mid dep. LA | Low dep. LSOA	1,680 (1.1%)	70 (4.1%)	0.72	0.54 to 0.96
	Mid dep. LA | Mid dep. LSOA	55,740 (36.7%)	2,950 (5.3%)	Ref	
	Mid dep. LA | High dep. LSOA	36,070 (23.8%)	2,110 (5.9%)	1.09	1.01 to 1.16
	High dep. LA | Low dep. LSOA	140 (0.1%)	10 (6.5%)	0.96	0.42 to 2.18
	High dep. LA | Mid dep. LSOA	9,890 (6.5%)	490 (5.0%)	0.90	0.73 to 1.11
	High dep. LA | High dep. LSOA	18,930 (12.5%)	1,140 (6.0%)	0.91	0.75 to 1.11
Prior CPP	No	194,530 (81.1%)	8,470 (4.4%)	Ref	
	Yes	45,360 (18.9%)	3,390 (7.5%)	1.70	1.62 to 1.79
Length of CPP	<3 months	51,450 (21.4%)	2,180 (4.2%)	Ref	
	3 to 12 months	141,230 (58.9%)	6,950 (4.9%)	1.04	0.97 to 1.11
	>1 year	47,210 (19.7%)	2,730 (5.8%)	1.18	1.09 to 1.27
CPP category	Emotional abuse	90,450 (37.7%)	4,860 (5.4%)	Ref	

Characteristics	Category	Number of CPP ending (column %)	Number of repeat CPP (% within stratum)	Fully adjusted model	
				HR	CI
	Neglect	107,470 (44.8%)	5,330 (5.0%)	0.95	0.90 to 1.01
	Physical abuse	19,660 (8.2%)	760 (3.9%)	0.85	0.76 to 0.96
	Sexual abuse	10,410 (4.3%)	330 (3.2%)	0.72	0.61 to 0.84
	Multiple abuse	11,900 (5.0%)	580 (4.8%)	0.89	0.79 to 1.01
Factors (LCA)	Domestic abuse and violence	46,570 (19.4%)	2,440 (5.2%)	Ref	
	Complexities around parental mental health	52,500 (21.9%)	2,820 (5.4%)	0.99	0.91 to 1.06
	Disability	10,880 (4.5%)	430 (3.9%)	0.85	0.75 to 0.97
	Risks outside the home	6,920 (2.9%)	310 (4.4%)	0.95	0.81 to 1.11
	Complex domestic abuse / risks at home (CDA/RaH)	42,060 (17.5%)	2,230 (5.3%)	0.98	0.90 to 1.06
	Child's mental health	7,210 (3.0%)	270 (3.7%)	0.82	0.71 to 0.95
	Physical abuse	13,780 (5.7%)	490 (3.5%)	0.77	0.68 to 0.88
	Neglect	15,920 (6.6%)	770 (4.8%)	0.84	0.75 to 0.95
	Concerns about another person in the family or household	15,340 (6.4%)	870 (5.7%)	1.16	1.05 to 1.29
	Sexual abuse	6,750 (2.8%)	220 (3.2%)	0.80	0.66 to 0.96
	Risks in and outside the home	8,150 (3.4%)	390 (4.8%)	1.02	0.89 to 1.17
	Other	13,810 (5.8%)	640 (4.6%)	0.76	0.67 to 0.87
LA-level variables					
	CIN starting			1.22	1.12 to 1.33
	Spend safety			0.93	0.86 to 1.01
	CIN per SW			1.08	1.00 to 1.15

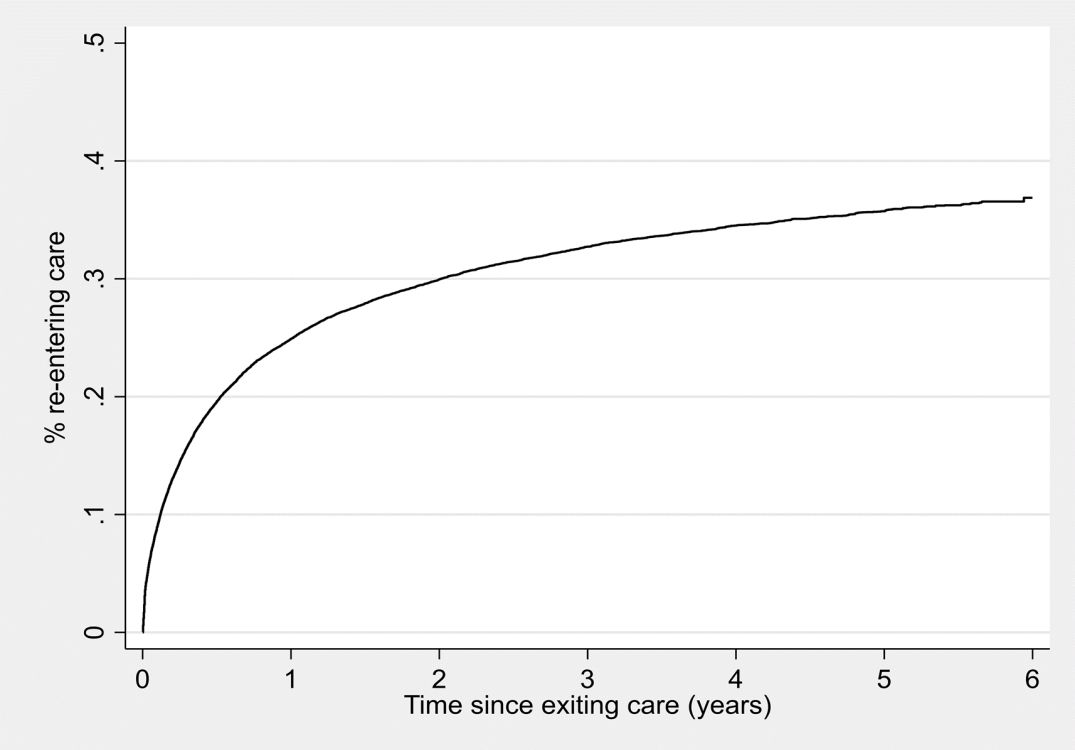
Figure 3.8 Forest plot showing factors associated with repeat CP plans



3.2.3. Re-entries to care

36,350 periods of care (32,620 children) ended in reunification between 2014 and 2020. Of those, 9,960 periods of care (27%) resulted in a re-entry to care over that same period. For children whose episode of care ended, re-entry could occur any time between 1st April 2014 and 31st March 2020 after the previous period of care ceased. Survival analysis was used to estimate the probability of re-entering care after accounting for varying lengths of follow-up. The Kaplan Meier plot in Figure 3.9 shows the rate of re-entry, which was 37% over six years, 30% over two years, and 25% over 12 months.

Figure 3.9 Kaplan Meier plot showing rates of re-entry to care (2014-20)



Further analysis explored the extent to which different factors affected the likelihood of a child re-entering care within 12 months of their previous care episode ceasing. Table 3.11 and Figure 3.10 present the results of a Cox proportional hazard model, showing hazard ratios (HRs) from the adjusted model with accompanying confidence intervals (CIs). HRs from the univariate model, which considers the effect of each factor separately, are reported in Appendix 10 but are not shown here. Figure 3.10 shows the same results from the adjusted model but visualised as a forest plot. Key findings were:

- *Gender* – no significant differences were found in relation to gender, although female children were slightly more likely to re-enter than male children (information on other gender identities was not recorded in the data).
- *Age* – under ones were the least likely to re-enter care and 10-15 year olds were the most likely. The effect of age on the likelihood of re-entry to care was in the opposite direction to re-referrals and repeat CP plans, with increasing age generally associated with a lower likelihood of re-entry to care. However, children aged 16-17 year olds were less likely to be re-referred than children aged under 1.

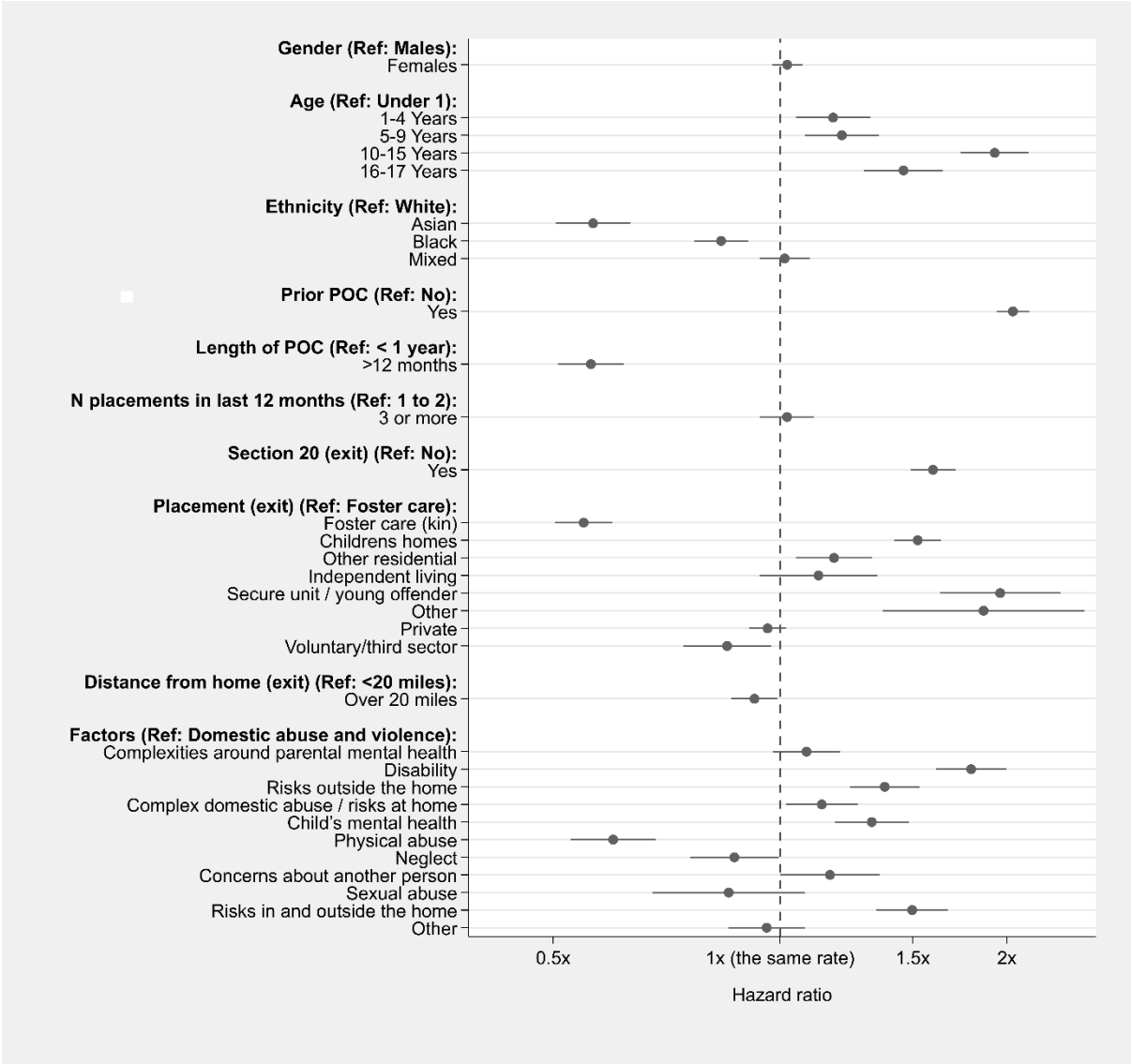
- *Ethnicity* – children from Asian and Black backgrounds were significantly less likely to have a re-enter care than children from White backgrounds. However, the likelihood of re-entry for children from Mixed backgrounds were not significantly different from White children. These results are likely to obscure differences within the broad ethnic groups described here.
- *Deprivation* – deprivation was not included in this analysis as the scores would have reflected levels of neighborhood deprivation for the care placement (i.e. the location of children's homes or foster homes), rather than the child's home prior to entering care.
- *Care provision* – re-entry to care was significantly more likely if the child had previously been in care, if the episode of care lasted less than a year, or if the child had been accommodated under Section 20. Compared to children placed in local authority foster care, children placed with kinship foster carers and were less likely to re-enter care, but children in residential care and secure units were more likely to re-enter care. Children over 20 miles away from their home were slightly less likely to re-enter care than those placed less than 20 miles away.
- *Demand categories* – after adjusting for all these factors, the demand categories least likely to result in children re-entering care were physical abuse, other, sexual abuse, and neglect. The categories most likely to result in re-entry to care were disability, risks in and outside the home, risks outside the home, and child mental health.

Table 3.10 Factors affecting the likelihood of re-entering care (within 12 months of a care episode ceasing)

Characteristics	Category	Number of children reunified (column %)	Number of re-entries to care (% within stratum)	Fully adjusted model	
				HR	CI
Gender	Male	14,040 (50.0%)	3,520 (25.1%)		
	Female	14,030 (50.0%)	3,580 (25.5%)	1.02	0.98 to 1.07
Age	Under 1	3,700 (13.2%)	510 (13.7%)		
	1-4 Years	5,200 (18.5%)	830 (15.9%)	1.18	1.05 to 1.32
	5-9 Years	5,390 (19.2%)	970 (18.0%)	1.21	1.08 to 1.35
	10-15 Years	11,260 (40.1%)	4,060 (36.1%)	1.93	1.74 to 2.14
	16-17 Years	2,520 (9.0%)	730 (29.0%)	1.46	1.29 to 1.65
Ethnicity	Asian	2,110 (7.6%)	310 (14.8%)	0.56	0.50 to 0.63
	Black	3,680 (13.3%)	730 (19.9%)	0.84	0.77 to 0.91
	Mixed	2,730 (9.8%)	740 (27.2%)	1.01	0.94 to 1.10
	Other	930 (3.4%)	160 (17.2%)	0.79	0.68 to 0.92
	White	18,270 (65.9%)	5,130 (28.1%)		
Prior POC	No	23,210 (82.7%)	4,760 (20.5%)		
	Yes	4,850 (17.3%)	2,340 (48.3%)	2.04	1.94 to 2.14
POC length	<12 months	25,930 (92.4%)	6,700 (25.8%)		
	12+ months	2,140 (7.6%)	400 (18.7%)	0.56	0.51 to 0.62
Placements within last 12 months	1 to 2	26,040 (92.8%)	6,500 (25.0%)		
	3+	2,030 (7.2%)	600 (29.6%)	1.02	0.94 to 1.11
Section 20	No	6,640 (23.7%)	980 (14.8%)		
	Yes	21,420 (76.3%)	6,120 (28.5%)	1.60	1.49 to 1.71
Placement (exit)	Foster care	19,530 (69.6%)	4,760 (24.4%)		
	Foster care (kin)	4,280 (15.2%)	570 (13.3%)	0.55	0.50 to 0.60
	Childrens homes	2,280 (8.1%)	1,160 (50.9%)	1.52	1.42 to 1.64
	Other residential	1,130 (4.0%)	320 (27.9%)	1.18	1.05 to 1.33
	Independent living	440 (1.6%)	130 (29.6%)	1.12	0.94 to 1.35
	Secure unit / young offender	320 (1.2%)	130 (40.9%)	1.96	1.63 to 2.35

Characteristics	Category	Number of children reunified (column %)	Number of re-entries to care (% within stratum)	Fully adjusted model	
				HR	CI
	Other	90 (0.3%)	30 (35.6%)	1.86	1.37 to 2.54
Placement provider (exit)	Local authority / public provision	20,030 (71.4%)	4,810 (24.0%)		
	Private	7,120 (25.4%)	2,080 (29.1%)	0.96	0.91 to 1.02
	Voluntary/third sector	920 (3.3%)	210 (23.3%)	0.85	0.74 to 0.97
Distance from home (exit)	Under 20 miles	24,240 (87.5%)	6,030 (24.9%)		
	Over 20 miles	3,460 (12.5%)	1,000 (28.8%)	0.92	0.86 to 0.99
Factors (LCA)	Domestic abuse and violence	2,850 (10.1%)	550 (19.1%)		
	Complexities around parental mental health	4,560 (16.2%)	930 (20.5%)	1.08	0.98 to 1.20
	Disability	2,080 (7.4%)	860 (41.4%)	1.79	1.61 to 2.00
	Risks outside the home	2,630 (9.4%)	960 (36.7%)	1.38	1.24 to 1.53
	Complex domestic abuse / risks at home (CDA/RaH)	3,130 (11.2%)	680 (21.6%)	1.14	1.02 to 1.27
	Child's mental health	1,860 (6.6%)	660 (35.6%)	1.32	1.18 to 1.48
	Physical abuse	3,110 (11.1%)	360 (11.5%)	0.60	0.53 to 0.68
	Neglect	1,760 (6.3%)	310 (17.8%)	0.87	0.76 to 1.00
	Concerns about another person in the family or household	960 (3.4%)	220 (22.8%)	1.16	1.00 to 1.36
	Sexual abuse	410 (1.5%)	80 (18.9%)	0.85	0.68 to 1.08
	Risks in and outside the home	2,020 (7.2%)	900 (44.5%)	1.50	1.34 to 1.67
	Other	2,700 (9.6%)	590 (21.9%)	0.96	0.85 to 1.08
LA-level indicators					
	LA IMD			1.03	0.96 to 1.11
	CLA starting			1.06	0.98 to 1.14
	Spend CLA			0.95	0.90 to 1.02
	CIN per SW			1.00	0.95 to 1.06

Figure 3.10 Forest plot showing factors affecting the chances of re-entry to care



3.2.4. Transitions and multiple episodes

Transitions between demand categories were studied for children who experienced more than one episode of CSC provision between 2015 and 2020. Three age-based cohorts were considered:

1. Children assessed in 2015 aged under 1 and again in 2020 aged 5 (n=3,390)
2. Children assessed in 2015 aged 5 and again in 2020 aged 10 (n=3,500)
3. Children assessed in 2015 aged 10 and again in 2020 aged 15 (n=3,580)

Table 3.12 shows the number and proportion of episodes within each demand category for these groups. Domestic abuse and violence (DAV) and neglect were the only categories that became less common among re-referrals of children in all age groups. For example, among children who were

assessed when they were babies and again at age 5, the proportion of cases in the DAV category went from 29% to 21%. Among children assessed when they were 5 and again at age 10, the equivalent figure dropped from 21% to 16%; the proportion of DAV then fell again to 10% for children assessed at age 15 who were previously assessed at age 10. Some categories – namely complexities around parental mental health, physical abuse, and 'other' – maintained a similar proportion among re-referrals in the younger age groups (under 1s to age 5) but became less common when older children were re-referred. In contrast, sexual abuse was less common among re-referrals for younger children but not for older children. Other categories were more frequently identified when children were re-referred, namely disability, risks outside the home, complex domestic abuse, child's mental health, concerns about another person, and risks in and outside the home.

Table 3.11 Breakdown by demand category for three cohorts of children experiencing multiple episodes of CSC involvement (2015-20)

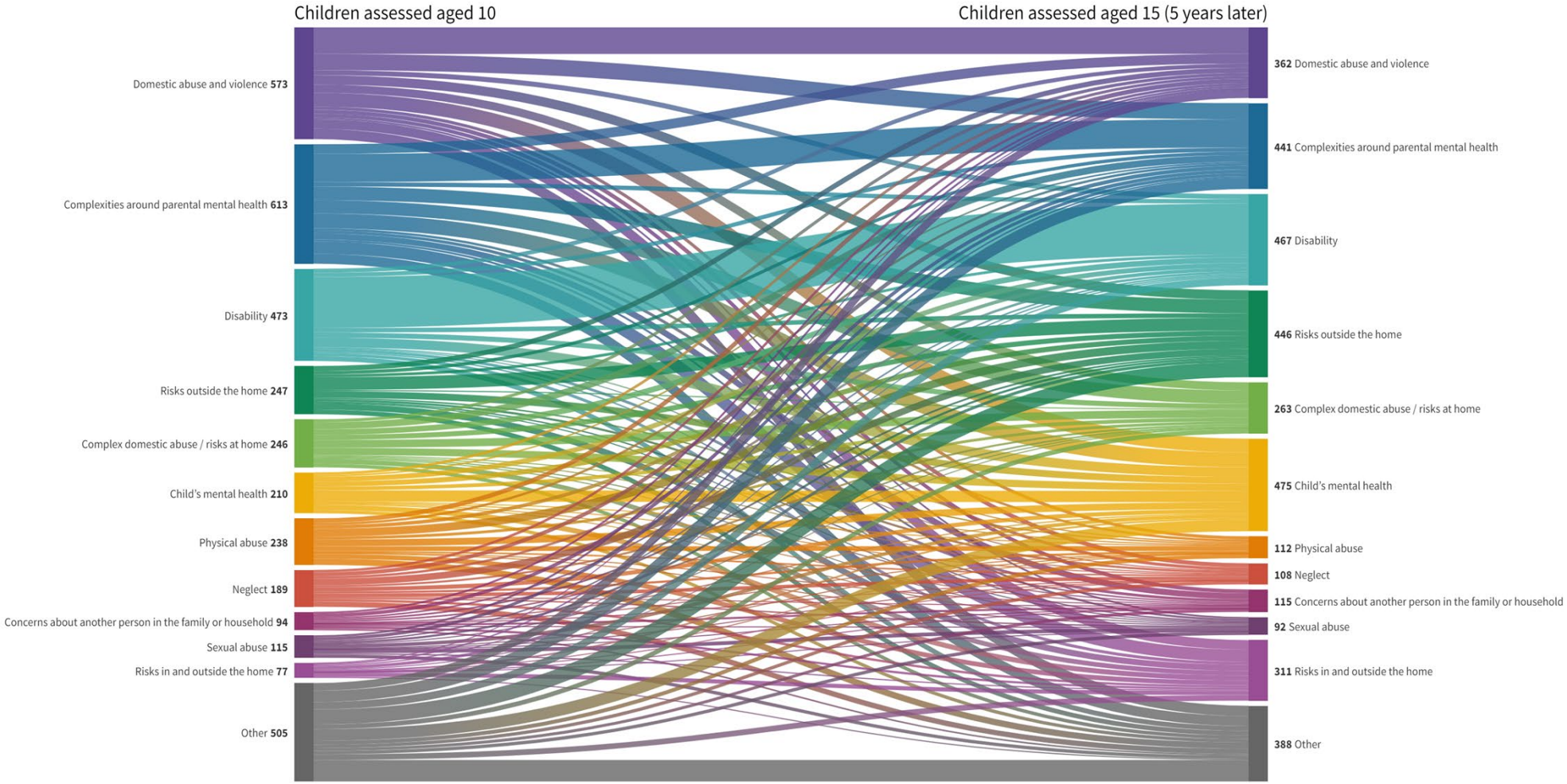
	Transition 1		Transition 2		Transition 3	
	Children assessed under 1 (and again at age 5)	**Children assessed age 5 (and previously under 1)**	**Children assessed age 5 (and again age 10)**	**Children assessed aged 10 (and previously at age 5)**	**Children assessed aged 10 (and again at age 15)**	**Children assessed aged 15 (previously assessed age 10)**
Domestic abuse and violence	990 (29%)	720 (21%)	730 (21%)	560 (16%)	570 (16%)	360 (10%)
Complexities around parental mental health	840 (25%)	860 (25%)	690 (20%)	680 (19%)	610 (17%)	440 (12%)
Disability	180 (5%)	270 (8%)	440 (12%)	500 (14%)	470 (13%)	470 (13%)
Risks outside the home	80 (2%)	80 (2%)	100 (3%)	140 (4%)	250 (7%)	450 (12%)
Complex domestic abuse / risks at home	230 (7%)	370 (11%)	260 (8%)	340 (10%)	250 (7%)	260 (7%)
Child's mental health	60 (2%)	120 (4%)	120 (3%)	250 (7%)	210 (6%)	480 (13%)
Physical abuse	160 (5%)	170 (5%)	260 (7%)	160 (4%)	240 (7%)	110 (3%)
Neglect	200 (6%)	140 (4%)	230 (7%)	150 (4%)	190 (5%)	110 (3%)
Concerns about another person	120 (3%)	140 (4%)	100 (3%)	140 (4%)	90 (3%)	120 (3%)
Sexual abuse	90 (3%)	70 (2%)	100 (3%)	90 (2%)	120 (3%)	90 (3%)
Risks in and outside the home	10 (0%)	40 (1%)	30 (1%)	70 (2%)	80 (2%)	310 (9%)
Other	420 (12%)	410 (12%)	450 (13%)	430 (12%)	510 (14%)	390 (11%)
All classes[1]	**3390 (100%)**	**3390 (100%)**	**3500 (100%)**	**3500 (100%)**	**3580 (100%)**	**3580 (100%)**

Note:
[1]Totals may not add exactly due to rounding

Changes in the type of needs identified in assessments over time can be visualised using a sankey diagram. An example is shown in Figure 3.11, which shows the transition between demand categories for children assessed at age 10 and then again at age 15. The diagram illustrates not just the varying proportions of demand when children are re-referred but also the extent to which children's needs are assessed differently when they come back into the system. Although the demand category assessed at age 10 was still the most commonly identified at age 15, this mostly constituted a minority of cases. The only exception was disability, in which 56% of assessments were assigned to the same category at both time points. Concerns about another person in the family/household (9%) and risks in and outside the home (7%) were the categories least frequently identified at both time points. Among cases re-referred at aged 15 and then assigned to one of the highest risk categories (complex domestic abuse, concerns about another person, and risks in and outside the home), the most common category identified at age 10 was complexities around parental mental health. Among cases re-referred and assessed as sexual abuse at age 15, the second most common category assessed at age 10 (after sexual abuse) was 'other'. Similar patterns were observed in the other two transition groups, results for which can be found in Appendix 11.

Overall, it was found that higher risk categories became more frequently assessed in children who are re-referred and single factor categories became less frequently assessed. In other words, not only are complex needs more likely to be re-referred (see Section 3.2.1) but re-referred cases are more likely to have become complex (or be assessed as such).

Figure 3.11 Transition between demand categories for child assessed aged 10 and then again aged 15



Longitudinal outcomes were analysed using three measures: educational attainment at KS2 (end of primary school), educational attainment at KS4 (end of secondary school), and exclusion from school.

3.2.5. Educational attainment at KS2

The characteristics of this cohort, along with the mean KS2 scores for each characteristic, are shown in Appendix 12. The results of a fully adjusted regression model are summarised in Table 3.13, which shows the extent to which different factors affected the outcome of average scores at KS2. The results are additionally stratified within the five main tiers of service provision: not referred to CSC, assessed but no service provided, child in need, child protection plan, and child in care. Average KS2 scores vary across these thresholds of provision, ranging from 0.68 for children not referred to CSC to 0.38 for children in care, with a pattern of decreasing attainment for children at each successive threshold. The stratification also allowed the analysis to consider aspects of provision that were specific to some forms of provision but not others, such as category of CP plans or type of care placements. As with the findings on intermediate outcomes (Section 3.2), rate ratios are relative to a reference category, marked 'Ref' in Table 3.13 under each characteristic.

Gender

Within the non-referred cohort, female children on average achieved 7% higher KS2 scores than male children. This effect was sustained for children referred to CSC, CIN, or on CP plans, but slightly lower for children in care (4% higher for females).

Ethnicity

Within the non-referred cohort, White children generally achieved lower KS2 scores than children from Asian, Black and Mixed backgrounds. The attainment gap between White children and children from other ethnic groups was wider among those with CSC involvement, particularly for those on CP plans (i.e. White children had lower attainment scores than other ethnic groups). These findings relate to broad ethnic categories, and so are likely to obscure differences between different groups.

Deprivation and free school meals

There was a social gradient in educational attainment at KS2 among all groups, including the non-referred cohort. The highest scores were obtained by children who were not on free school meals and lived in the least deprived quintile of neighbourhoods (as measured by average IMD). Among children who did not have free school meals, those from more deprived neighbourhoods tended to

have lower attainment. Among children who did have school meals, the level of neighbourhood deprivation did not make as much difference, but their attainment scores were lower overall. When comparing children who were never referred with children who were referred or received services, it is noticeable that the social gradient was less steep for the latter cohorts. For example, among children never referred to CSC, those in receipt of free school meals who lived in the most deprived IMD quintile had average KS2 scores that were 0.77 times lower than children who did not receive free school meals and were living in the least deprived IMD quintile; the equivalent attainment gap among children on CP plans was 0.84. Whilst deprivation and receipt of free school meals is a weaker determinant for (lower) attainment for these cohorts, the attenuation should be seen in the broader context that children involved with CSC are over-represented in the more deprived quintiles (see descriptive statistics in Appendix 12), and that attainment was substantially lower for children who had any involvement with CSC services (as shown in Table 3.13). Fundamentally, the central finding is that higher deprivation is associated with lower KS2 attainment, across all tiers of CSC provision.

Special educational needs and disabilities (SEND)

Children with any type of SEND had lower average KS2 scores compared with children with no SEND. Children with learning difficulties and speech, language and communication difficulties had the lowest attainment. For all SEND types the attainment gap widened for children who had any involvement with CSC services. For example, children with learning difficulties who were on CP plans had average KS2 scores that were 0.11 times lower than children with no learning difficulties, whereas child with learning difficulties with no CSC involvement had 0.22 times lower KS2 scores. This magnification effect is seen across all SEND types. This shows that disability is a strong determinant of poor educational attainment particularly for children are in receipt of CSC services. This should also be seen in the broader context that children with disabilities are overrepresented in the cohorts of children who had any involvement with CSC (see descriptive statistics in Appendix 12).

Demand categories

Findings on demand categories only exist for children who have received a social work assessment, so the non-referred cohort could not be included in this part of the analysis. At a given level of provision, such as CIN or CP, the demand category made a relatively small difference to educational attainment at KS2. However, it is worth noting that children in some categories were much more likely to proceed to CP or accommodation in care (see Section 3.1.5), which means that those children would also tend to have lower scores than CIN or children not receiving services. Compared

to the reference category, which was single factor DAV, children in the disability group had the lowest average attainment scores at each level of provision. Children in the neglect category also had lower KS2 attainment scores, particularly for those receiving services as CIN or on CP plans (0.88 times lower than the reference category). Other differences between the categories were found to be relatively small and/or non-significant.

Characteristics of provision

Characteristics of provision relevant to attainment at KS2 included the total number of episodes (i.e. repeat involvement), total time receiving services, the CP plan category of abuse (for children on CP plans only) and the type of care placement (for children in care only).

Children with two or more episodes of involvement with CSC generally had lower KS2 scores than children with only one episode of involvement. Children who received services for over a year had lower attainment than those who received services for less than a year. Among children on CP plans, the lowest KS2 scores were achieved by children whose CP plan was for neglect, compared to physical, sexual or emotional abuse; specifically the average KS2 score for children on a CP plan for neglect was 0.84 times lower than the reference category (emotional abuse). Among children in care, children in children's homes tended to have the lowest attainment scores; specifically the average KS2 score for children in children's homes was 0.34 times lower than the reference category (children in foster homes).

Table 3.12. KS2 fully adjusted regression models showing RR and 95% CI for each characteristic

	Not referred to CSC		Referred no service		Child in need		CP plan		Child in care	
N cases	**541,700**		**15,760**		**38,280**		**12,120**		**5,290**	
Average KS2 score	**0.68**		**0.51**		**0.45**		**0.39**		**0.38**	
Rate ratio and 95% CI	**RR**	**95% CI**	**RR**	**95% CI**	**RR**	**95% CI**	**RR**	**95% CI**	**RR**	**95% CI**
Gender										
Male	Ref		Ref		Ref		Ref		Ref	
Female	1.07	1.06 to 1.08	1.07	1.02 to 1.12	1.08	1.05 to 1.11	1.08	1.02 to 1.15	1.04	0.95 to 1.14
Ethnicity										
Asian	1.05	1.04 to 1.06	1.11	1.03 to 1.20	1.13	1.08 to 1.19	1.18	1.07 to 1.31	1.23	1.01 to 1.49
Black	1.06	1.04 to 1.08	1.15	1.06 to 1.25	1.13	1.08 to 1.19	1.23	1.09 to 1.38	1.13	0.96 to 1.33
Mixed	1.06	1.04 to 1.07	1.12	1.03 to 1.22	1.12	1.06 to 1.18	1.07	0.97 to 1.18	1.13	0.98 to 1.31
Other	1.00	0.98 to 1.02	1.09	0.92 to 1.29	1.10	1.00 to 1.21	1.10	0.87 to 1.40	1.08	0.77 to 1.50
White	Ref		Ref		Ref		Ref		Ref	
IMD / FSM[1]										
IMD 1 (least dep) / No FSM	Ref		Ref		Ref		Ref			
IMD 2 / No FSM	0.96	0.95 to 0.97	0.97	0.87 to 1.09	0.97	0.89 to 1.06	1.06	0.83 to 1.35		
IMD 3 / No FSM	0.93	0.92 to 0.94	0.93	0.83 to 1.04	0.92	0.84 to 1.00	0.97	0.77 to 1.23		
IMD 4 / No FSM	0.90	0.89 to 0.91	0.90	0.81 to 1.01	0.94	0.87 to 1.02	0.95	0.77 to 1.19		
IMD 5 (most dep) / No FSM	0.85	0.84 to 0.86	0.89	0.80 to 0.99	0.94	0.87 to 1.02	0.90	0.72 to 1.12		
IMD 1 (least dep) / FSM	0.82	0.79 to 0.84	0.88	0.77 to 1.02	0.85	0.76 to 0.94	0.87	0.69 to 1.10		
IMD 2 / FSM	0.79	0.77 to 0.81	0.81	0.71 to 0.92	0.82	0.75 to 0.90	0.82	0.66 to 1.01		
IMD 3 / FSM	0.78	0.77 to 0.80	0.75	0.67 to 0.84	0.83	0.76 to 0.90	0.86	0.70 to 1.05		
IMD 4 / FSM	0.79	0.77 to 0.80	0.84	0.76 to 0.92	0.84	0.78 to 0.91	0.86	0.71 to 1.04		
IMD 5 (most dep) / FSM	0.77	0.76 to 0.78	0.80	0.73 to 0.88	0.82	0.76 to 0.88	0.84	0.70 to 1.01		
Primary SEND										
None	Ref		Ref		Ref		Ref		Ref	
Learning	0.22	0.21 to 0.22	0.14	0.12 to 0.16	0.11	0.10 to 0.13	0.11	0.09 to 0.13	0.15	0.12 to 0.19
Behavioural, emotional & social	0.59	0.57 to 0.60	0.56	0.50 to 0.63	0.51	0.48 to 0.55	0.51	0.46 to 0.58	0.54	0.47 to 0.61
Speech, language & communication	0.29	0.28 to 0.30	0.20	0.16 to 0.25	0.23	0.21 to 0.27	0.19	0.15 to 0.25	0.33	0.25 to 0.44
Autistic spectrum disorder	0.46	0.44 to 0.48	0.39	0.32 to 0.48	0.26	0.23 to 0.30	0.36	0.26 to 0.49	0.38	0.24 to 0.60
Physical disability / sensory	0.62	0.59 to 0.65	0.55	0.43 to 0.69	0.45	0.39 to 0.52	0.42	0.30 to 0.59	0.35	0.20 to 0.61

Other disability	0.38	0.36 to 0.39	0.33	0.26 to 0.43	0.31	0.27 to 0.37	0.22	0.16 to 0.31	0.26	0.17 to 0.42
Exclusions (last 5y)										
Not excluded	Ref		Ref		Ref		Ref		Ref	
Fixed-term / permanently excluded	0.72	0.69 to 0.75	0.71	0.62 to 0.81	0.66	0.60 to 0.72	0.62	0.54 to 0.71	0.68	0.56 to 0.82
Factors recorded at latest assessment										
Domestic abuse and violence			Ref		Ref		Ref		Ref	
Complexities around parental MH			1.02	0.95 to 1.09	0.99	0.95 to 1.05	1.02	0.93 to 1.12	1.15	0.98 to 1.35
Disability			0.85	0.77 to 0.94	0.78	0.72 to 0.84	0.88	0.74 to 1.03	0.61	0.47 to 0.81
Risks outside the home			0.90	0.82 to 1.00	0.95	0.88 to 1.02	0.90	0.75 to 1.09	1.08	0.79 to 1.46
Complex domestic abuse / risks at home			0.93	0.80 to 1.07	0.97	0.89 to 1.05	1.00	0.91 to 1.10	1.09	0.92 to 1.29
Childs mental health			0.99	0.89 to 1.10	1.01	0.94 to 1.08	0.91	0.78 to 1.07	0.99	0.76 to 1.30
Physical abuse			1.00	0.93 to 1.09	0.97	0.91 to 1.02	1.01	0.89 to 1.15	0.92	0.74 to 1.13
Neglect			0.90	0.79 to 1.02	0.88	0.81 to 0.96	0.88	0.75 to 1.04	1.18	0.95 to 1.46
Concerns about another person			0.92	0.78 to 1.08	0.95	0.85 to 1.06	0.97	0.84 to 1.11	0.96	0.75 to 1.21
Sexual abuse			0.96	0.86 to 1.07	0.98	0.91 to 1.05	0.99	0.82 to 1.18	1.11	0.82 to 1.51
Risks in and outside the home			1.03	0.79 to 1.35	0.98	0.84 to 1.14	1.05	0.86 to 1.29	1.11	0.79 to 1.57
Other			0.95	0.88 to 1.02	0.98	0.93 to 1.03	0.90	0.79 to 1.02	1.04	0.87 to 1.25
Total number of CSC episodes (last 5y)										
1					Ref		Ref		Ref	
2					0.95	0.91 to 0.98	0.96	0.89 to 1.04	0.97	0.87 to 1.09
3+					0.92	0.88 to 0.96	0.93	0.87 to 1.01	0.97	0.87 to 1.08
Child received a CSC service in year 11										
No					Ref		Ref		Ref	
Yes					0.95	0.92 to 0.98	0.93	0.87 to 0.98	1.00	0.89 to 1.11
Total time receiving CSC services (last 5y)										
Less than 1 year					Ref		Ref		Ref	
More than 1 year					0.94	0.89 to 0.98	0.96	0.90 to 1.03	0.98	0.84 to 1.14
Latest CP plan category of abuse										
Emotional abuse							Ref			
Neglect							0.84	0.79 to 0.90		
Physical abuse							1.03	0.93 to 1.16		
Sexual abuse							1.00	0.86 to 1.17		
Multiple abuse							1.07	0.92 to 1.23		

CLA placement (last placement)										
Foster care									Ref	
Foster care (kin)									1.02	0.92 to 1.14
Children's homes									0.34	0.18 to 0.62
Other residential									0.63	0.20 to 1.97
Placed with parents									1.01	0.88 to 1.17
Independent living[2]									c	c
Secure unit / young offender[2]									c	c
Other									1.09	0.84 to 1.41

Notes:

[1]deprivation data for CLA not included as the NPD records placement address rather than birth family address for children in care

[2]'c' in this table indicates the figures have been suppressed in order to protect confidentiality

3.2.6. Educational attainment at KS4

The characteristics of this cohort, along with the mean KS4 scores for each characteristic, are shown in Appendix 13. The results of a fully adjusted regression model are summarised in Table 3.14, which shows the extent to which different factors affected the outcome of average scores at KS4. The results are again stratified within the five main tiers of service provision: not referred to CSC, assessed but no service provided, child in need, child protection plan, and child in care. Average KS4 scores varied across these thresholds of provision, ranging from 47 for children not referred to CSC to 19 for children in care, with a pattern of decreasing attainment for children at each successive threshold.

Gender

Within the non-referred cohort, female children on average achieved 3% higher KS4 scores than male children. This effect was sustained amongst children referred to CSC, CIN, or on CP plans, but slightly higher for children in care (12% higher for females).

Ethnicity

Similar to the findings for KS2, White children generally achieved lower KS4 scores than children from Asian, Black and Mixed backgrounds. The attainment gap between White children and children from other ethnic groups was wider among those with CSC involvement, particularly for those on CP plans (i.e. White children had lower attainment scores than other ethnic groups). For example, children from Black and Asian backgrounds subject to CP plans had 1.24 times higher KS4 scores than White children.

Deprivation and free school meals

The highest KS4 scores were obtained by children who were not on free school meals and lived in the least deprived quintile of neighbourhoods (as measured by average IMD). As with KS2, there was a social gradient in educational attainment at KS4 among all groups, including the non-referred cohort, while the social gradient was somewhat less steep among children receiving CSC services. However, this finding should be seen in the context of children from deprived backgrounds being over-represented among children receiving services (see descriptive statistics in Appendix 13). Fundamentally, the central finding is that higher deprivation is associated with lower KS4 attainment, across all tiers of CSC provision. Again, the results for children in care are not shown because IMD scores for this cohort are based on placement address rather than birth family home address and so are not comparable to the rest of the analysis.

Special educational needs and disabilities (SEND)

Children with any type of SEND had lower average KS4 scores compared with children with no SEND. Children with learning difficulties and speech, language and communication difficulties had the lowest attainment. However, for most types of SEND, the attainment gap widened for children who had any involvement with CSC services. For example, children with learning difficulties who received services as CIN had average KS4 scores that were 0.42 times lower than children with no learning difficulties, whereas child with learning difficulties with no CSC involvement had 0.62 times lower KS2 scores. This magnification effect is seen across most SEND types. Similar to the findings on KS2 attainment, the results show that disability is a strong determinant of poor KS4 attainment, particularly for children are in receipt of CSC services. It should also be seen in the broader context that children with disabilities are overrepresented in the cohorts of children who had any involvement with CSC (see descriptive statistics in Appendix 12).

Demand categories

Compared to the reference category, which was single factor DAV, children assessed in the categories of disability, risks outside the home, and risks in and outside the home had the lowest attainment scores. For example, for children receiving services as CIN the KS4 scores were 0.78 times lower for disability, 0.86 times lower for 'risks outside the home', and 0.78 times lower for 'risks in and outside the home'. Children in the 'risks outside the home' category had progressively lower KS4 attainment at each tier of CSC provision; 0.86 times lower for those receiving services as CIN, 0.77 times lower for those who were subject to a CP plan, and 0.61 times lower for those in care. A similar pattern is seen in the 'risks in and outside the home' category. This magnification effect is shows that these two categories are particularly strong determinants of poor educational attainment, and that the effect is much greater for children who meet the threshold for CP and care.

Characteristics of provision

Characteristics of provision relevant to attainment at KS4 included the total number of episodes (i.e. repeat involvement), total time receiving services, receiving a CSC service in Year 11 (when KS4 exams are sat), the CP plan category of abuse (for children on CP plans only) and the type of care placement (for children in care only).

Children with three or more episodes of involvement with CSC had lower KS4 scores than children with one episode of involvement, which was consistent across all levels of provision. Children who

received services for over a year had lower attainment than those who received services for less than a year. Children who received CSC services in Year 11 had lower attainment than those who did not. Among children on CP plans, the lowest KS4 scores were achieved by children whose CP plan was for neglect, compared to physical, sexual or emotional abuse; specifically, the average KS4 score for children on a CP plan for neglect was 0.88 times lower than the reference category (emotional abuse). Among children in care, children in children's homes, children in other residential care settings, and children in a secure unit had substantially lower KS4 scores than children in foster homes; 0.57, 0.31, and 0.27 times lower respectively.

Table 3.13. KS4 fully adjusted regression models showing RR and 95% CI for each characteristic

	Not referred to CSC		Referred no service		Child in need		CP plan		Child in care	
N cases	**458,410**		**13,310**		**33,900**		**8,290**		**5,740**	
Average KS4 score	**47**		**35**		**29**		**25**		**19**	
Rate ratio and 95% CI	**RR**	**95% CI**	**RR**	**95% CI**	**RR**	**95% CI**	**RR**	**95% CI**	**RR**	**95% CI**
Gender										
Male	Ref		Ref		Ref		Ref		Ref	
Female	1.07	1.07 to 1.07	1.07	1.05 to 1.09	1.07	1.06 to 1.08	1.06	1.04 to 1.09	1.12	1.08 to 1.16
Ethnicity										
Asian	1.14	1.13 to 1.14	1.20	1.17 to 1.22	1.20	1.18 to 1.22	1.24	1.19 to 1.28	1.17	1.11 to 1.24
Black	1.08	1.07 to 1.08	1.17	1.14 to 1.21	1.19	1.17 to 1.22	1.24	1.19 to 1.30	1.15	1.08 to 1.21
Mixed	1.08	1.08 to 1.09	1.12	1.08 to 1.15	1.14	1.12 to 1.16	1.09	1.04 to 1.14	1.12	1.06 to 1.19
Other	1.12	1.12 to 1.13	1.22	1.16 to 1.29	1.19	1.16 to 1.23	1.25	1.17 to 1.34	1.12	1.03 to 1.23
White	Ref		Ref		Ref		Ref		Ref	
IMD / FSM[1]										
IMD 1 (least dep) / No FSM	Ref		Ref		Ref		Ref			
IMD 2 / No FSM	0.95	0.95 to 0.95	0.96	0.93 to 1.00	0.97	0.95 to 0.99	0.98	0.91 to 1.05		
IMD 3 / No FSM	0.91	0.91 to 0.91	0.91	0.89 to 0.94	0.92	0.90 to 0.94	0.94	0.88 to 1.01		
IMD 4 / No FSM	0.86	0.86 to 0.86	0.87	0.84 to 0.90	0.88	0.86 to 0.90	0.93	0.87 to 0.99		
IMD 5 (most dep) / No FSM	0.80	0.80 to 0.81	0.81	0.78 to 0.84	0.85	0.83 to 0.87	0.84	0.79 to 0.90		
IMD 1 (least dep) / FSM	0.83	0.82 to 0.84	0.86	0.82 to 0.91	0.87	0.84 to 0.90	0.89	0.82 to 0.96		
IMD 2 / FSM	0.79	0.78 to 0.80	0.81	0.78 to 0.85	0.85	0.82 to 0.87	0.86	0.81 to 0.93		
IMD 3 / FSM	0.77	0.76 to 0.78	0.80	0.77 to 0.83	0.84	0.81 to 0.86	0.85	0.80 to 0.91		
IMD 4 / FSM	0.76	0.76 to 0.76	0.77	0.75 to 0.79	0.81	0.80 to 0.83	0.83	0.79 to 0.88		
IMD 5 (most dep) / FSM	0.72	0.72 to 0.72	0.73	0.71 to 0.75	0.76	0.75 to 0.78	0.79	0.75 to 0.84		
Primary SEND										
None	Ref		Ref		Ref		Ref		Ref	
Learning	0.62	0.62 to 0.62	0.52	0.50 to 0.54	0.42	0.40 to 0.44	0.48	0.45 to 0.51	0.45	0.41 to 0.49
Behavioural, emotional & social	0.68	0.67 to 0.68	0.57	0.54 to 0.60	0.57	0.55 to 0.59	0.53	0.50 to 0.57	0.64	0.60 to 0.68
Speech, language & communication	0.57	0.56 to 0.58	0.53	0.49 to 0.59	0.51	0.48 to 0.55	0.57	0.50 to 0.64	0.52	0.43 to 0.62
Autistic spectrum disorder	0.70	0.69 to 0.70	0.63	0.59 to 0.68	0.50	0.48 to 0.53	0.48	0.42 to 0.55	0.40	0.32 to 0.50
Physical disability / sensory	0.80	0.79 to 0.81	0.74	0.68 to 0.80	0.64	0.60 to 0.68	0.65	0.56 to 0.75	0.59	0.48 to 0.72

Other disability	0.72	0.71 to 0.73	0.67	0.61 to 0.73	0.67	0.64 to 0.71	0.69	0.61 to 0.78	0.64	0.55 to 0.73
Exclusions (last 5y)										
Not excluded	Ref		Ref		Ref		Ref		Ref	
Fixed-term / permanently excluded	0.72	0.72 to 0.72	0.68	0.66 to 0.69	0.69	0.68 to 0.70	0.65	0.63 to 0.67	0.65	0.62 to 0.68
Factors recorded at latest assessment										
Domestic abuse and violence			Ref		Ref		Ref		Ref	
Complexities around parental MH			1.00	0.97 to 1.02	1.03	1.01 to 1.05	1.01	0.97 to 1.05	1.01	0.95 to 1.08
Disability			0.92	0.89 to 0.96	0.78	0.76 to 0.81	0.78	0.73 to 0.84	0.77	0.70 to 0.85
Risks outside the home			0.90	0.88 to 0.93	0.86	0.84 to 0.88	0.77	0.72 to 0.82	0.61	0.56 to 0.66
Complex domestic abuse / risks at home			1.01	0.97 to 1.06	1.00	0.97 to 1.03	0.97	0.93 to 1.01	0.96	0.90 to 1.03
Childs mental health			0.96	0.94 to 0.99	0.95	0.94 to 0.97	0.93	0.89 to 0.98	0.99	0.92 to 1.06
Physical abuse			0.98	0.95 to 1.01	1.00	0.98 to 1.03	0.96	0.91 to 1.01	0.96	0.89 to 1.04
Neglect			0.99	0.94 to 1.04	0.94	0.90 to 0.97	0.88	0.82 to 0.95	0.89	0.80 to 0.98
Concerns about another person			0.97	0.91 to 1.03	0.97	0.93 to 1.01	0.95	0.89 to 1.01	0.93	0.83 to 1.04
Sexual abuse			1.01	0.97 to 1.04	1.01	0.98 to 1.03	1.00	0.94 to 1.06	1.04	0.94 to 1.15
Risks in and outside the home			0.84	0.78 to 0.92	0.78	0.75 to 0.82	0.70	0.64 to 0.76	0.73	0.65 to 0.81
Other			0.97	0.94 to 0.99	0.97	0.96 to 0.99	0.99	0.94 to 1.04	0.95	0.89 to 1.02
Total number of CSC episodes (last 5y)										
1					Ref		Ref		Ref	
2					0.97	0.96 to 0.98	0.96	0.93 to 0.99	0.99	0.95 to 1.03
3+					0.92	0.90 to 0.93	0.93	0.91 to 0.96	0.92	0.88 to 0.96
Child received a CSC service in year 11										
No					Ref		Ref		Ref	
Yes					0.89	0.88 to 0.90	0.89	0.86 to 0.91	0.89	0.85 to 0.92
Total time receiving CSC services (last 5y)										
Less than 1 year					Ref		Ref		Ref	
More than 1 year					0.91	0.89 to 0.92	0.95	0.92 to 0.98	0.92	0.87 to 0.97
Latest CP plan category of abuse										
Emotional abuse							Ref			
Neglect							0.88	0.86 to 0.91		
Physical abuse							0.97	0.93 to 1.01		
Sexual abuse							0.99	0.94 to 1.05		
Multiple abuse							0.98	0.93 to 1.04		

CLA placement (last placement)										
Foster care									Ref	
Foster care (kin)									1.03	0.98 to 1.07
Children's homes									0.51	0.45 to 0.57
Other residential									0.35	0.20 to 0.61
Placed with parents									0.97	0.91 to 1.03
Independent living									0.66	0.55 to 0.79
Secure unit / young offender									0.27	0.12 to 0.60
Other									0.79	0.63 to 0.99

Note:

[1]deprivation data for CLA not included as the NPD records placement address rather than birth family address for children in care

3.2.7. Exclusions aged 11

The characteristics of this cohort, along with the exclusion rate (%) for each characteristic, are shown in Appendices 12 and 14. Table 3.15 summarises the results of a fully adjusted regression model, showing the extent to which different factors affected the outcome of exclusion from school for children aged 11. As with educational attainment, the results are stratified within the five main tiers of service provision: not referred to CSC, assessed but no service provided, child in need, child protection plan, and child in care. The proportion of children excluded from school varied across these thresholds of provision, ranging from 0.7% of children not referred to CSC to 6.2% of children on CP plans and 5.1% of children in care.

Gender

Female children were much less likely to be excluded than male children. Among children not referred to CSC, girls were 0.19 times less likely to be excluded than boys. The gap was slightly less among children assessed as not in need of services (0.23) and reduced a bit further for children on CP plans (0.27) and children in care (0.37).

Ethnicity

Children's ethnicity made a difference to the likelihood of exclusion. Overall, children from Asian backgrounds and 'Other' ethnical groups were much less likely to be excluded than children from Black, White or Mixed backgrounds. The gap was slightly reduced among children referred or receiving services. For example, among the non-referred cohort, children from Asian backgrounds were 0.5 times less likely to be excluded than children from White backgrounds, while the equivalent odds ratio for CIN and children on CP plans was 0.45. Conversely, children from Mixed heritage backgrounds were more likely to be excluded than White children if they had never been referred to CSC. Again, the gap was slightly reduced among children referred or receiving services.

Deprivation

There was a steep social gradient in rates of exclusion, particularly among children never referred to CSC. As with attainment scores, this social gradient was less steep among children receiving CSC services. For example, among children not referred to CSC, those in receipt of free school meals who lived in the most deprived IMD quintile had average KS4 scores that were 5.8 times more likely to be excluded than children who did not receive free school meals and were living in the least deprived IMD quintile; the equivalent odds ratio among CIN was 2.2 and among children on CP plans it was

1.7. Again, this finding should be seen in the context of children from deprived backgrounds being over-represented among children receiving services.

Special educational needs and disabilities (SEND)

Children with most types of SEND were more likely to be excluded than children with no SEND. Those least likely to be excluded were children with a physical or sensory disability or speech, language and communication disability. Children with behavioural, social and emotional difficulties were much more likely to be excluded than any other type of SEND. This gap was much lower for children with some form of CSC involvement. For example, children with behavioural, social and emotional disorders who were on CP plans were 7.5 times more likely to be excluded than children with no SEND, whereas children with behavioural, social and emotional disorders but no CSC involvement were 13 times more likely to be excluded.

Demand categories

There were some differences between demand categories when it came to the likelihood of exclusion. Compared to the reference category, which was single factor DAV, children assessed in the category of child mental health were significantly more likely to be excluded from school, with a larger gap for children in care. For example, children in the 'child mental health' category who received services as CIN were 1.3 times more likely to be excluded than those in the DAV category, whereas the equivalent odds ratio for children in care was 2.8. Wide confidence intervals for other categories meant that other differences were not significant.

Characteristics of provision

Characteristics of provision relevant to exclusion from school included the total number of episodes, total time receiving services, the CP plan category of abuse, and the type of care placement.

Children with three or more episodes of involvement with CSC were significantly more likely to be excluded than children with one episode of involvement, which was consistent across all levels of provision. Children who received services for over a year were *less* likely to be excluded than those who received services for less than a year, although this was only significant for children in care. Among children on CP plans, the highest chance of exclusion was among children whose CP plan was for neglect and the lowest chance of exclusion was among CP plans for sexual abuse or multiple forms of abuse. However, wide confidence intervals meant these differences were not significant. Among children in care, children in children's homes had a higher chance of being excluded than

children in other types of placement, although the difference was only significant in comparison with foster care.

Table 3.14 Exclusions aged 11 fully adjusted regression models showing odds ratios and 95% CI for each characteristic

	Not referred to CSC		Referred no service		Child in need		CP plan		Child in care	
N cases	**541,700**		**15,760**		**38,280**		**12,120**		**5,290**	
Average exclusion %	**0.7%**		**3.0%**		**3.8%**		**6.2%**		**5.1%**	
Odds ratio and 95% CI	**OR**	**95% CI**	**RR**	**95% CI**	**RR**	**95% CI**	**RR**	**95% CI**	**RR**	**95% CI**
Gender										
Male	Ref		Ref		Ref		Ref		Ref	
Female	0.19	0.17 to 0.21	0.23	0.18 to 0.30	0.25	0.21 to 0.28	0.27	0.22 to 0.33	0.37	0.27 to 0.49
Ethnicity										
Asian	0.52	0.46 to 0.60	0.28	0.16 to 0.51	0.45	0.34 to 0.59	0.45	0.27 to 0.74	0.59	0.21 to 1.65
Black	1.03	0.91 to 1.16	0.59	0.39 to 0.90	0.68	0.54 to 0.84	0.88	0.60 to 1.29	1.22	0.75 to 1.97
Mixed	1.17	1.04 to 1.33	0.92	0.66 to 1.27	1.04	0.87 to 1.26	1.25	0.97 to 1.61	0.90	0.58 to 1.39
Other	0.65	0.51 to 0.83	0.38	0.12 to 1.22	0.52	0.31 to 0.86	0.66	0.28 to 1.54	0.69	0.16 to 3.01
White	Ref		Ref		Ref		Ref		Ref	
IMD / FSM[1]										
IMD 1 (least dep) / No FSM	Ref		Ref		Ref		Ref			
IMD 2 / No FSM	1.30	1.09 to 1.55	1.55	0.83 to 2.90	1.17	0.77 to 1.79	1.00	0.37 to 2.69		
IMD 3 / No FSM	1.78	1.51 to 2.10	1.23	0.65 to 2.32	1.12	0.74 to 1.69	0.74	0.27 to 2.01		
IMD 4 / No FSM	2.15	1.83 to 2.52	1.13	0.60 to 2.13	1.31	0.89 to 1.93	1.16	0.49 to 2.76		
IMD 5 (most dep) / No FSM	2.93	2.51 to 3.43	1.48	0.81 to 2.70	1.52	1.04 to 2.22	0.66	0.26 to 1.70		
IMD 1 (least dep) / FSM	3.06	2.36 to 3.98	1.14	0.56 to 2.35	1.43	0.93 to 2.21	0.94	0.40 to 2.21		
IMD 2 / FSM	3.69	3.00 to 4.55	1.34	0.71 to 2.51	1.47	1.00 to 2.15	1.01	0.45 to 2.25		
IMD 3 / FSM	4.13	3.45 to 4.94	1.94	1.10 to 3.44	1.68	1.18 to 2.40	1.07	0.50 to 2.33		
IMD 4 / FSM	4.52	3.85 to 5.30	2.33	1.37 to 3.98	1.82	1.30 to 2.55	1.26	0.59 to 2.69		
IMD 5 (most dep) / FSM	5.84	5.05 to 6.75	2.55	1.53 to 4.27	2.18	1.57 to 3.02	1.74	0.82 to 3.65		
Primary SEND										
None	Ref		Ref		Ref		Ref		Ref	
Learning	2.14	1.92 to 2.39	1.51	1.11 to 2.05	1.77	1.49 to 2.09	1.46	1.12 to 1.90	1.93	1.24 to 3.01
Behavoural, emotional & social	13.04	12.01 to 14.15	7.64	6.15 to 9.49	7.25	6.37 to 8.26	6.83	5.66 to 8.22	7.52	5.40 to 10.46
Speech, language & communication	2.06	1.75 to 2.41	2.06	1.37 to 3.10	2.02	1.59 to 2.55	1.64	1.13 to 2.38	1.75	0.93 to 3.32
Autistic spectrum disorder	3.83	3.29 to 4.47	2.33	1.50 to 3.62	1.75	1.33 to 2.31	1.82	1.08 to 3.08	0.51	0.12 to 2.19
Physical disability / sensory	1.49	1.05 to 2.10	0.64	0.20 to 2.05	0.98	0.58 to 1.66	2.02	1.03 to 3.94	2.77	0.95 to 8.09
Other disability	3.06	2.53 to 3.72	2.50	1.47 to 4.26	1.85	1.29 to 2.65	2.21	1.38 to 3.56	3.29	1.55 to 7.00

	Not referred to CSC		Referred no service		Child in need		CP plan		Child in care	
N cases	**541,700**		**15,760**		**38,280**		**12,120**		**5,290**	
Average exclusion %	**0.7%**		**3.0%**		**3.8%**		**6.2%**		**5.1%**	
Odds ratio and 95% CI	**OR**	**95% CI**	**RR**	**95% CI**	**RR**	**95% CI**	**RR**	**95% CI**	**RR**	**95% CI**
Factors recorded at latest assessment										
Domestic abuse and violence			Ref		Ref		Ref		Ref	
Complexities around parental MH			1.00	0.74 to 1.34	0.84	0.69 to 1.03	1.04	0.80 to 1.35	1.02	0.61 to 1.70
Disability			0.99	0.71 to 1.39	0.79	0.64 to 0.97	0.85	0.59 to 1.22	0.95	0.51 to 1.76
Risks outside the home			1.43	0.99 to 2.07	1.83	1.46 to 2.30	1.55	1.04 to 2.32	2.71	1.31 to 5.59
Complex domestic abuse / risks at home			1.01	0.60 to 1.72	1.16	0.89 to 1.51	1.05	0.79 to 1.37	1.56	0.95 to 2.58
Childs mental health			1.48	1.01 to 2.15	1.34	1.08 to 1.68	1.25	0.87 to 1.80	2.78	1.50 to 5.17
Physical abuse			1.25	0.89 to 1.75	1.16	0.94 to 1.44	0.91	0.62 to 1.35	1.64	0.89 to 3.01
Neglect			0.92	0.53 to 1.60	1.18	0.89 to 1.57	0.99	0.67 to 1.46	1.07	0.52 to 2.20
Concerns about another person			1.09	0.61 to 1.95	1.38	0.99 to 1.93	1.17	0.81 to 1.69	1.10	0.54 to 2.22
Sexual abuse			0.50	0.27 to 0.93	0.99	0.73 to 1.34	0.83	0.47 to 1.47	2.07	0.91 to 4.69
Risks in and outside the home			1.10	0.41 to 2.94	2.12	1.42 to 3.15	1.11	0.68 to 1.79	1.92	0.85 to 4.35
Other			0.85	0.60 to 1.20	0.96	0.79 to 1.16	0.88	0.61 to 1.27	1.26	0.72 to 2.20
Total number of CSC episodes (last 5y)										
1					Ref		Ref		Ref	
2					1.25	1.10 to 1.43	1.05	0.83 to 1.33	1.04	0.75 to 1.44
3+					1.44	1.26 to 1.65	1.37	1.11 to 1.70	1.48	1.10 to 1.99
Child received a CSC service in year 11										
No					Ref		Ref		Ref	
Yes					1.38	1.23 to 1.54	1.24	1.05 to 1.47	0.96	0.67 to 1.37
Total time receiving CSC services (last 5y)										
Less than 1 year					Ref		Ref		Ref	
More than 1 year					0.91	0.80 to 1.04	1.27	0.38 to 1.41	2.35	1.12 to 4.96
Latest CP plan category of abuse										
Emotional abuse							Ref			
Neglect							1.20	1.01 to 1.43		
Physical abuse							1.19	0.86 to 1.66		
Sexual abuse							0.89	0.54 to 1.46		
Multiple abuse							0.80	0.52 to 1.24		

	Not referred to CSC		Referred no service		Child in need		CP plan		Child in care	
N cases	**541,700**		**15,760**		**38,280**		**12,120**		**5,290**	
Average exclusion %	**0.7%**		**3.0%**		**3.8%**		**6.2%**		**5.1%**	
Odds ratio and 95% CI	**OR**	**95% CI**	**RR**	**95% CI**	**RR**	**95% CI**	**RR**	**95% CI**	**RR**	**95% CI**
CLA placement (last placement)										
Foster care									Ref	
Foster care (kin)									0.73	0.52 to 1.02
Children's homes									1.71	1.02 to 2.86
Other residential									1.88	0.51 to 6.95
Placed with parents[2]									1.07	0.71 to 1.61
Independent living[2]									c	c
Secure unit / young offender									c	c
Other									1.04	0.51 to 2.15

Notes:

[1]deprivation data for CLA not included as the NPD records placement address rather than birth family address for children in care

[2]'c' in this table indicates the figures have been suppressed in order to protect confidentiality

3.2.8. Exclusions aged 16

The characteristics of this cohort, along with the exclusion rate (%) for each characteristic, are shown in Appendices 13 and 15. Table 3.16 summarises the results of a fully adjusted regression model, showing the extent to which different factors affected the outcome of exclusion from school for children aged 16. As with educational attainment, the results are stratified within the five main tiers of service provision: not referred to CSC, assessed but no service provided, child in need, child protection plan, and child in care. The proportion of children excluded from school varied across these thresholds of provision, ranging from 3.7% of children not referred to CSC to 16.5% of children on CP plans and 15% of children in care.

Gender

Female children were much less likely to be excluded than male children. The discrepancy was particularly large for children not referred to CSC, among whom girls were 0.35 times less likely to be excluded than boys. Although still substantial, the gap was lower among children referred but assessed as not in need of services (0.5) and reduced further for children on CP plans (0.7) and children in care (0.8).

Ethnicity

Children's ethnicity made a difference to the likelihood of exclusion. Overall, children from Asian backgrounds and 'Other' ethnical groups were much less likely to be excluded than children from Black, White or Mixed backgrounds, and this gap was higher among children referred or receiving services. For example, among the non-referred cohort, children from Asian backgrounds were 0.7 times less likely to be excluded than children from White backgrounds; the equivalent figure for CIN was 0.6 and for children in care was 0.5. Conversely, children from Black and Mixed backgrounds were more likely to be excluded than White children if they had never been referred to CSC but this was not the case for Black children who had been referred or received services from CSC.

Deprivation

There was a steep social gradient in rates of exclusion, particularly among children never referred to CSC. As with attainment scores, this social gradient was less steep among children receiving CSC services. For example, among children not referred to CSC, those in receipt of free school meals who lived in the most deprived IMD quintile were 3.7 times more likely to be excluded than children who did not receive free school meals and were living in the least deprived IMD quintile; the equivalent gap among CIN was 1.4 and among children on CP plans was 1.3. Again, this finding should be seen

in the context of children from deprived backgrounds being over-represented among children receiving services.

Special educational needs and disabilities (SEND)

Children with most types of SEND were more likely to be excluded than children with no SEND. The exceptions were children with autistic spectrum disorder or those with a physical or sensory disability, who were less likely to be excluded. Children with behavioural, emotional and social difficulties were much more likely to be excluded than any other type of SEND, although the gap was substantially less than for children aged 11. This gap was also lower for children with some form of CSC involvement. For example, children with behavioural, social and emotional disorders who were on CP plans were 1.7 times more likely to be excluded lower than children with no SEND, whereas child with behavioural, social and emotional disorders difficulties with no CSC involvement were 4.3 times more likely to be excluded.

Demand categories

There were differences between demand categories when it came to the likelihood of exclusion. Compared to the reference category, which was single factor DAV, children assessed in the categories of risks outside the home and risks in and outside the home were much more likely to be excluded from school. However, this gap reduced at higher thresholds of provision. For example, children in the 'risks outside the home' category who were CIN were 2.3 times more likely to be excluded than children in the DAV category who were CIN, whereas the equivalent odds ratio for children on CP plans was 1.85 and for children in care was 1.30. In comparison, children assessed in the categories of sexual abuse, disability and neglect were relatively less likely to be excluded unless they were on CP plans. For example, children in the 'sexual abuse' category who were CIN were 0.62 times less likely to be excluded than children in the DAV category who were CIN, whereas the equivalent odds ratio for children on CP plans was 1.2 and for children in care was 0.6.

Characteristics of provision

Characteristics of provision relevant to exclusion from school included the total number of episodes, total time receiving services, receiving a CSC service in Year 11, the CP plan category of abuse, and the type of care placement.

Children with two or more episodes of involvement with CSC were more likely to be excluded than children with one episode of involvement, which was consistent across all levels of provision. Children who received services for over a year were *less* likely to be excluded than those who

received services for less than a year. Children who received CSC services in Year 11 were more likely to be excluded than those who did not. Among children on CP plans, the highest chance of exclusion was among children whose CP plan was for neglect and the lowest chance of exclusion was among CP plans for sexual abuse. However, wide confidence intervals meant these differences were not significant. Among children in care, children in children's homes had a higher chance of being excluded than children in other types of placement, although the difference was only significant in comparison with foster care.

Table 3.15. Exclusions aged 16 fully adjusted regression models showing odds ratios and 95% CI for each characteristic

	Not referred to CSC		Referred no service		Child in need		CP plan		Child in care	
N cases	**458,410**		**13,310**		**33,900**		**8,290**		**5,740**	
Average exclusion %	**3.7%**		**11.4%**		**13.3%**		**16.5%**		**15.1%**	
Odds ratio and 95% CI	**OR**	**95% CI**	**OR**	**95% CI**	**OR**	**95% CI**	**OR**	**95% CI**	**OR**	**95% CI**
Gender										
Male	Ref		Ref		Ref		Ref		Ref	
Female	0.35	0.34 to 0.37	0.54	0.48 to 0.60	0.59	0.55 to 0.63	0.71	0.63 to 0.79	0.78	0.68 to 0.90
Ethnicity										
Asian	0.66	0.63 to 0.70	0.61	0.49 to 0.76	0.59	0.51 to 0.67	0.60	0.46 to 0.78	0.49	0.35 to 0.69
Black	1.06	1.00 to 1.13	0.89	0.71 to 1.11	0.82	0.73 to 0.93	1.05	0.82 to 1.34	0.90	0.70 to 1.17
Mixed	1.16	1.09 to 1.23	0.99	0.80 to 1.22	1.02	0.91 to 1.15	1.09	0.88 to 1.35	1.00	0.78 to 1.28
Other	0.70	0.63 to 0.79	0.58	0.35 to 0.97	0.81	0.63 to 1.03	0.62	0.35 to 1.09	0.42	0.24 to 0.72
White	Ref		Ref		Ref		Ref		Ref	
IMD / FSM[1]										
IMD 1 (least dep) / No FSM	Ref		Ref		Ref		Ref			
IMD 2 / No FSM	1.24	1.16 to 1.32	1.18	0.88 to 1.58	1.02	0.85 to 1.23	1.21	0.76 to 1.91		
IMD 3 / No FSM	1.45	1.36 to 1.54	1.46	1.11 to 1.92	0.97	0.81 to 1.16	0.92	0.57 to 1.49		
IMD 4 / No FSM	1.70	1.60 to 1.81	1.20	0.91 to 1.59	1.07	0.90 to 1.27	1.03	0.66 to 1.61		
IMD 5 (most dep) / No FSM	2.23	2.10 to 2.37	1.43	1.09 to 1.88	1.18	1.00 to 1.40	1.07	0.70 to 1.66		
IMD 1 (least dep) / FSM	2.39	2.11 to 2.71	2.06	1.46 to 2.92	1.19	0.95 to 1.49	1.10	0.69 to 1.75		
IMD 2 / FSM	2.57	2.33 to 2.85	1.32	0.96 to 1.84	1.31	1.09 to 1.59	1.14	0.75 to 1.72		
IMD 3 / FSM	2.97	2.74 to 3.22	1.58	1.20 to 2.09	1.35	1.14 to 1.60	0.97	0.66 to 1.45		
IMD 4 / FSM	3.19	2.98 to 3.42	1.63	1.26 to 2.11	1.36	1.16 to 1.58	1.23	0.85 to 1.79		
IMD 5 (most dep) / FSM	3.69	3.48 to 3.92	1.92	1.51 to 2.43	1.37	1.19 to 1.59	1.32	0.92 to 1.90		
Primary SEND										
None	Ref		Ref		Ref		Ref		Ref	
Learning	1.59	1.51 to 1.68	1.23	1.03 to 1.47	0.98	0.88 to 1.09	0.85	0.70 to 1.04	0.93	0.74 to 1.18
Behavoural, emotional & social	4.26	4.02 to 4.51	2.48	2.14 to 2.89	2.08	1.91 to 2.27	1.67	1.45 to 1.93	1.76	1.49 to 2.07
Speech, language & communication	1.23	1.10 to 1.38	1.04	0.72 to 1.50	1.08	0.87 to 1.34	1.04	0.71 to 1.54	1.14	0.70 to 1.86
Autistic spectrum disorder	0.88	0.78 to 1.00	0.83	0.60 to 1.16	0.64	0.53 to 0.78	0.66	0.42 to 1.03	0.90	0.59 to 1.36

	Not referred to CSC		Referred no service		Child in need		CP plan		Child in care	
N cases	**458,410**		**13,310**		**33,900**		**8,290**		**5,740**	
Average exclusion %	**3.7%**		**11.4%**		**13.3%**		**16.5%**		**15.1%**	
Odds ratio and 95% CI	**OR**	**95% CI**	**OR**	**95% CI**	**OR**	**95% CI**	**OR**	**95% CI**	**OR**	**95% CI**
Physical disability / sensory	0.88	0.73 to 1.05	0.78	0.46 to 1.35	0.67	0.49 to 0.92	0.50	0.25 to 1.01	0.39	0.16 to 0.98
Other disability	1.79	1.59 to 2.01	1.52	1.03 to 2.25	1.49	1.22 to 1.82	1.75	1.21 to 2.54	1.51	1.02 to 2.24
Factors recorded at latest assessment										
Domestic abuse and violence			Ref		Ref		Ref		Ref	
Complexities around parental MH			0.97	0.80 to 1.18	1.07	0.94 to 1.22	1.04	0.84 to 1.30	0.81	0.59 to 1.11
Disability			0.76	0.60 to 0.96	0.63	0.54 to 0.73	0.69	0.51 to 0.95	0.43	0.30 to 0.62
Risks outside the home			2.40	2.02 to 2.86	2.34	2.08 to 2.62	1.85	1.47 to 2.34	1.30	0.97 to 1.74
Complex domestic abuse / risks at home			0.99	0.70 to 1.41	0.97	0.80 to 1.19	0.97	0.76 to 1.22	0.79	0.57 to 1.09
Childs mental health			1.23	1.00 to 1.50	1.15	1.01 to 1.31	1.10	0.85 to 1.41	0.85	0.62 to 1.18
Physical abuse			1.03	0.80 to 1.33	1.03	0.88 to 1.21	0.88	0.63 to 1.23	0.81	0.54 to 1.20
Neglect			0.81	0.55 to 1.19	0.96	0.78 to 1.20	1.05	0.76 to 1.44	0.81	0.53 to 1.24
Concerns about another person			1.25	0.84 to 1.85	1.21	0.96 to 1.54	1.51	1.13 to 2.01	0.89	0.57 to 1.40
Sexual abuse			0.62	0.46 to 0.84	0.86	0.73 to 1.03	1.18	0.84 to 1.67	0.61	0.34 to 1.09
Risks in and outside the home			2.71	1.92 to 3.81	2.02	1.71 to 2.39	1.56	1.22 to 2.01	1.26	0.92 to 1.73
Other			1.04	0.85 to 1.28	1.12	0.99 to 1.26	1.24	0.95 to 1.62	0.85	0.62 to 1.17
Total number of CSC episodes (last 5y)										
1					Ref		Ref		Ref	
2					1.24	1.15 to 1.34	1.19	1.01 to 1.41	1.49	1.25 to 1.77
3+					1.55	1.43 to 1.68	1.26	1.08 to 1.47	1.68	1.42 to 1.99
Child received a CSC service in year 11										
No					Ref		Ref		Ref	
Yes					1.44	1.35 to 1.53	1.32	1.16 to 1.49	1.58	1.24 to 2.01
Total time receiving CSC services (last 5y)										
Less than 1 year					Ref		Ref		Ref	
More than 1 year					0.79	0.73 to 0.86	0.92	0.80 to 1.07	0.67	0.53 to 0.84
Latest CP plan category of abuse										
Emotional abuse							Ref			

	Not referred to CSC		Referred no service		Child in need		CP plan		Child in care	
N cases	**458,410**		**13,310**		**33,900**		**8,290**		**5,740**	
Average exclusion %	**3.7%**		**11.4%**		**13.3%**		**16.5%**		**15.1%**	
Odds ratio and 95% CI	**OR**	**95% CI**	**OR**	**95% CI**	**OR**	**95% CI**	**OR**	**95% CI**	**OR**	**95% CI**
Neglect							1.04	0.91 to 1.18		
Physical abuse							1.03	0.81 to 1.31		
Sexual abuse							0.91	0.71 to 1.18		
Multiple abuse							0.77	0.57 to 1.03		
CLA placement (last placement)										
Foster care									Ref	
Foster care (kin)									0.98	0.79 to 1.21
Children's homes									1.21	0.98 to 1.49
Other residential									1.72	1.02 to 2.92
Placed with parents									1.17	0.91 to 1.51
Independent living									1.34	0.92 to 1.97
Secure unit / young offender									0.73	0.45 to 1.18
Other									0.47	0.19 to 1.13

Notes:

[1]deprivation data for CLA not included as the NPD records placement address rather than birth family address for children in care

4. Discussion and implications

The findings provide evidence of consistent categories of demand for CSC based on factors at assessment, as well as evidence that children's intermediate and longitudinal outcomes differ between the categories. In what follows, the implications of these findings are discussed in relation to five key areas of policy and practice: 1) the value of demand analysis; 2) services for older children and adolescents; 3) child protection and neglect; 4) the problem of re-referrals; and 5) approaches to domestic abuse and violence. However, before addressing these points we point to some limitations of the study.

4.1. Limitations

The demand analysis was based on a large national dataset of social work assessments covering a seven-year period. In this sense, the findings on categories of demand are generalisable because they are based on the whole population of LAs and children receiving services. However, there are contextual differences between LAs, which affects both the profile of cases and presumably also the response to different types of demand (see Section 3.1.7). There are other ways to classify and describe demand, not least by asking children and families what matters to them and what they want from services. Recording practices, e.g. in relation to how many risk factors are checked, will vary between practitioners and LAs, while the checklist itself will not cover all aspects of the qualitative information contained in the written report. In terms of the analysis, there were some limitations to the LCA model, which was cross-sectional and so could not account for changes in children's needs over time. Extensions of the LCA, such as latent Markov modelling, might provide a more robust evidence base for transitions between classes (see Section 3.2.4). There was an unavoidable element of interpretation involved in choosing the optimum number of latent classes, so that different conclusions might be drawn had the findings been based on a smaller or larger number of classes. The results of the LCA are therefore best viewed as a summary tool, rather than a definitive segmentation of demand. There is also the possibility of measurement error, inherent to any LCA modal, when carrying out the modal assignment of cases, i.e. categorising them based on the highest probability of belonging to a latent class. This method facilitates interpretation and practical application of the model, including use of the categories as variables in subsequent analysis. However, slightly different results could be obtained from different methods of assignment. This might include setting thresholds (e.g. excluding assessments with less than a 50% probability of belonging to a single class) or using the 3-step maximum-likelihood method to account for

proportional assignment. However, the differences in results were marginal when these restrictions were imposed, in part due to the large sample size.

4.2. Complex needs and demand for CSC

Notwithstanding the limitations described above, the findings point to the value of undertaking analysis of demand for CSC services. As recommended in the concluding section of this report, the categories may serve a practical purpose for LAs wanting to understand more about the complexity of need their services are dealing with. There are a number of reasons for this. First, as noted in Section 1.2, complex needs cannot adequately be summarised in terms of single factors, such as domestic abuse or parental substance misuse, nor through heuristics such as the so-called 'toxic trio' (Hood et al., 2021; Skinner et al., 2020). The tendency to describe demand in terms of professional activity, such as numbers or rates of CIN and CP plans, can also be misleading; such aggregates are sensitive to the fiscal and workload pressures on LAs, the screen-and-intervene operational model, and the impact of rationing mechanisms on thresholds (Hood *et al.*, 2019). Trends in activity must therefore be seen in the context of children's needs, or at least those needs that services are able to identify and willing to assess. Government figures for England show that levels of all forms of CSC activity rose from 2013-2017 and then either plateaued or decreased – other than Section 47 inquiries and children in care, which continued to rise (Fitzsimons *et al.*, 2022). Does this suggest that levels of need in the child population are also plateauing or decreasing, that LAs have developed ways to keep children out of the statutory system, or that thresholds have risen to try and manage demand and control cost, or some other explanation? This question is difficult to explore without an analysis of changes in demand and the associated outcomes of provision.

Levels of notional (i.e. professionally unsubstantiated) need in the population are difficult to ascertain but it seems reasonable to assume, given the impact of austerity measures on welfare provision (Cummins, 2018), economic difficulties in the wake of Brexit (Portes, 2022), the impact of Covid-19 on inequalities (Blundell *et al.*, 2022), and the continuing high prevalence of child poverty (Stone, 2022), that they have not decreased over the past decade. At the same time, LAs have been encouraged by government to compensate for huge cuts to their funding through a programme of innovation, which has included CP practice models (Isokuortti *et al.*, 2020), family safeguarding approaches (Forrester *et al.*, 2017), Signs of Safety (Baginsky *et al.*, 2017), restorative practice (Harris *et al.*, 2020), and many others (Department for Education, 2022d). If such initiatives were to succeed in refining the screen-and-intervene system so that less complex needs could be addressed without the need for statutory intervention, the overall profile of cases receiving attention might be

expected to become more complex and higher risk. The findings in Section 3.18 suggest that this has indeed happened. Yet such changes are also congruent with LAs seeking to manage escalating demand through stricter gatekeeping of eligibility for services, while still fulfilling their statutory duties. One question this raises is whether LAs have enough resources to provide effective support to children and families who need help but do not meet the threshold for CIN. Judging by a series of annual reports on safeguarding pressures by senior leaders (ADCS, 2022), as well as a recent national review of the sector (MacAlister, 2022), the answer to this question appears to be 'no', i.e. there is a consensus that funding of CSC is inadequate and that substantial investment is required to underpin wide-ranging reform.

Evidence to support greater funding of preventative services has been accumulating in recent years, with statistical models showing the time-lagged effect on statutory CSC provision of increasing Early Help expenditure (Bennett *et al.*, 2021; Webb *et al.*, 2022) The breakdown and profile of demand categories (Section 3.1) might also contribute something to this type of analysis, for example by pointing to the types of need that might be affected – or indeed targeted – by social investment strategies. For example, the picture of demand in this study arguably points to the consequences of the shift to late intervention under the fiscal constraints of austerity, a period when services were having to come to terms with rising numbers of adolescents with mental health problems, complex safeguarding needs, and exposure to extra familial harm. Similarly, government figures for children in care over this period show a fall in numbers of children leaving care, a rise in the length of time that children stay in care, and a rise in the average age of the looked after population (Fitzsimons *et al.*, 2022). It cannot be overstated how challenging this profile of need is for LAs – the difficulty and cost of providing suitable out-of-home care for adolescents with complex needs (Ofsted, 2022), exacerbated by a dysfunctional placements market (Competition and Markets Authority (CMA), 2022), can threaten the financial stability of local councils (Butler, 2018). In such circumstances, it is unsurprising that LAs should seek to reduce numbers of children entering care, while trying to find ways to deal with cases of complex needs elsewhere in the system. In the absence of sufficient resources to address the variety of demand, however, the concern is that too many children will not receive the right kind of help early enough and will return into the system when they are older and their problems are more entrenched.

MacAlister's (2022) review argued that a significant increase in spending on family help could be justified on economic as well as ethical grounds since the cost would be recouped through a subsequent fall in demand for CLA placements. In response to review's recommendations, the

government has set about restructuring children's services but without offering significant additional investment (Department for Education, 2023) – in principle accepting the argument that services should be refocused on prevention but without committing to any substantial increase in funding. In effect, the strategy aims to encourage a cycle of enhancing family help, reducing rates of care provision and reinvesting the savings in more family help. The expense of CLA placements means that LAs already have an fiscal incentive to reduce rates of care, to which could now be added a policy (and perhaps regulatory) expectation to focus on such reductions. A potential problem is that a central objective to reduce numbers of CLA, whether by fewer entries to care, shorter periods of care, or more exits from care, might distort the overall purpose of the system (see Section 1.3.3). For example, shorter periods of care are a risk factor for subsequent re-entry to care (see Section 3.2.3) so an effort to reduce the CLA cohort purely through more timely exits from care might prove counter-productive. There could also be repercussions elsewhere in the CSC system, as services struggle to cope with an accumulation of complex child welfare cases at lower thresholds of intervention. Rather than a virtuous cycle of investment in prevention and cost savings from reductions in care placements, there would be a vicious cycle of tighter gatekeeping of statutory provision and escalating costs of placements for adolescents with complex needs. The implication is that policymakers should pay close attention to the profile and needs of older children in the higher risk categories. As reported in Sections 3.2 and 3.3, and discussed below, there are good reasons to worry about outcomes for these children.

4.3. Services for older children and adolescents

The findings raise concerns about outcomes for certain groups of older children and adolescents receiving services. Those whose needs were categorised as 'risks in and outside the home' and 'risks outside the home' consistently fared worse on almost every outcome in this study, whether this was measured as repeated involvement with services, educational attainment at KS2 and KS4, or exclusion from school. Age on its own does not explain these effects – older children were generally less likely to be re-referred or to have repeat CP plans, for example, although they were more likely to re-enter care. Instead, these cases were typified by a combination of complex needs associated with extra-familial harm, as well as a distinctive profile of child characteristics. Although similar in respect to age and some types of need, the categories had a different profile in terms of demographics and intervention pathways. Children assessed with 'Risks outside the home' were disproportionately male, Black, less likely to proceed to CP, but more likely to result in an episode of

care. Children assessed with 'Risks in and outside the home' were more likely to be female, White, and to result in either a CP plan or episode of care (Sections 3.1.4 and 3.1.5).

Over the past decade, extra-familial harm has become an important issue for CSC services in England (Wroe and Lloyd, 2020). A series of scandals about institutional failings in relation to child sexual exploitation (CSE), following an independent inquiry in Rotherham (Jay, 2014) and a serious case review in Oxfordshire (Leivers, 2015), has combined with greater awareness of vulnerable young people's involvement in 'county lines' drug dealing and other forms of child criminal exploitation (Robinson *et al.*, 2019). The high cost of residential care placements, particularly for adolescents with complex needs, has focused attention on addressing risks to older children that are mainly to do with their activities and relationships outside the family home. The sector has increasingly recognised that standard CP processes, which tend to focus on parenting capacity and problems within the family home, need to be adapted if they are to address a broader range of factors relevant to the developmental needs and harms experienced by older children. The 'contextual safeguarding' approach developed by Firmin (2020) and others has been influential in this respect, building on the insight that safety and harm are experienced differently by different children in different contexts; efforts to change young people's choices and behaviour means paying attention to the contexts in which harm occurs. The findings from this study suggest that assessments in relation to extra-familial harm tend to fall into two categories – one in which the context is considered to be entirely outside the home and another (less prevalent) group in which there is an interaction between these risks and problems within the family.

One problem with this kind of contrast is that services may be more inclined to view some children and young people through the lens of anti-social activity and gang involvement, while others receive a more holistic needs assessment that includes vulnerabilities to do with their family life. Firmin and Lloyd (2020) reported significant variation in how LAs applied thresholds in cases of extra familial harm, with CP plans used principally when there were parenting concerns in addition to risks outside the home. The findings in this study suggests that some of this differentiation may also be linked to gendered and racial biases, as has been suggested by research into adultification in child safeguarding (Davis and Marsh, 2020). For example, the disproportionate numbers of Black boys assessed in the 'risks outside the home' category, who were also unusually likely to be admitted to care, may be compared with their over-representation in the 'Other' category, which had comparatively low levels of CP and care but was also one of the main sources of re-referrals into the 'risks outside the home' category for older children (see Section 3.2.4). Research into educational,

health and welfare inequalities suggests that services providing assistance and support to be under-resourced in disadvantaged areas, communities and groups, whereas services involving surveillance, compliance and coercion are disproportionately targeted at disadvantaged areas, communities and groups (Hood, 2023). A related issue is the potential for children's need for help and support to be minimised and overlooked when the effects of traumatic or adverse childhood experiences are expressed as 'externalising', 'aggressive' or 'anti-social' behaviour. Such inequalities point to additional layers of contextual analysis within the case-based and place-based approaches outlined by Firmin and Lloyd (2020).

From a trauma-informed perspective, it could be argued that many of the children assessed in relation to risks outside the home are likely to be experiencing emotional and psychological difficulties, even if this is not disclosed or identified as a safeguarding concern. Child mental health itself was the fastest growing category, with the number of assessments more than doubling from 2014-21 (see Section 3.1.8, Figure 3.6). The proportion of cases of children with mental health problems is likely to have grown further since 2021 – government figures for 2021-22 show that child mental health was the fifth most common factor at assessment (Department for Education, 2022a). There have been longstanding concerns about the insufficiency of mental health provision for children and young people in England (Callaghan *et al.*, 2017; Dubicka and Bullock, 2017; Deighton *et al.*, 2019). NHS mental health trusts have been forced to raise the threshold at which they are able to provide support (Hall, 2023). The shortfall in provision has been exacerbated by the deleterious effects of lockdowns and other consequences of the Covid-19 pandemic (Cowie and Myers, 2021; Iacobucci, 2022; Samji *et al.*, 2022), but also by a growing range of problems, such as cyber bullying, eating disorders, social media and body image, digital misogyny and racism, which mainstream services such as schools and GP surgeries are ill-equipped to understand and address. Youth services have been among the hardest hit by government cuts from 2010-15, with an estimated one billion pound cut to annual expenditure during the last decade (YMCA, 2020). The decimation in provision for young people, combined with the acute shortage of specialist mental health care, means that CSC has effectively become the provider of last resort for children whose mental health problems can be categorised as a safeguarding concern. The evidence from this study is that CSC services are struggling to cope – for example, children assessed under 'child mental health' had relatively poor outcomes in terms of re-entry to care (Section 3.2.3) and exclusion from school (Section 3.2.7).

4.4. Child protection and neglect

The findings break down the ways in which neglect (or the assessment of neglect) constitutes various types of demand. There was evidence of a single factor category, i.e. cases where neglect was the only factor recorded by social workers, as well as other categories in which neglect was identified alongside multiple factors (see Section 3.1.3). Four categories were particularly likely to include concerns about neglect: complexities around parental mental health, complex domestic abuse/risks inside the home, concerns about another person, and risks in and outside the home. With the exception of complexities around parental mental health, children assessed within these categories were more likely to proceed to child protection or an episode of care than were children assessed within single factor neglect – and indeed they were the most likely to receive this kind of intervention. What is more, many children subject to a CP plan did not have assessments that identified neglect as a factor (at least in the checklist) but had nonetheless been categorised under 'neglect' as a CP plan category. For example, 62% of children assessed in the 'disability' category who proceeded to a CP plan did so under the (CP) category of neglect, and 28% of those assessed in relation to physical abuse (Section 3.3.1).

The findings highlight the centrality of neglect in the CP system but also the challenge of its operationalisation in assessment and decision-making. Although it is by definition a type of maltreatment, analysis of intervention pathways showed that not all safeguarding concerns about neglect lead to a statutory service being provided (Section 3.1.5). Neglect on its own tended to be treated as less risky (in the sense of likelihood of progression to CP or care) than neglect in combination with other risk factors, There are parallels here with domestic abuse, as discussed below (Section 4.6), which might also be seen as a form of de-facto abuse but in practice meets with a differentiated response. At the same time, neglect has particular significance for the threshold to child protection, making it the most common category of CP plan. In other words, neglect seems to present definitional problems when it comes to risk assessment but also provides an overarching rationale for CP interventions.

Neglect poses a number of challenges for professionals making operational judgements about harm. Its effects are global and cumulative in their implications for child development; unlike physical or sexual abuse, there may not be a single incident or disclosure that provides sufficient evidence that significant harm has occurred or is likely to occur, which puts the onus on critical analysis in assessment (Stevenson, 2008; Horwath, 2013). There are troubling overlaps between neglect and poverty – the social gradient of intervention is particularly steep for neglect cases (Goldacre and

Hood, 2022) – which can be difficult for professionals to disentangle. Analysis of serious case reviews have often highlighted neglect as a consistent feature in cases of child death and serious harm (Brandon *et al.*, 2014; Sidebotham *et al.*, 2016; Brandon *et al.*, 2020). Dickens *et al.* (2022) explore the notion that there has been a 'normalisation of neglect' in safeguarding services, due to professionals becoming accustomed to working with families in conditions of poverty and therefore being more likely to miss the 'warning signs' of neglect. Ofsted (2018) highlighted concerns about multi-agency responses to older children suffering long-term neglect, who were often referred to safeguarding services because of problems such as offending behaviour, mental health difficulties or substance misuse. Such concerns have led to a greater emphasis on trauma-informed practice and on obtaining a holistic picture of the child's needs, including their home circumstances. However, as discussed above in relation to the 'risks in and outside the home' category, more holistic assessments of extra-familial might be more likely for some types of children than for others.

The findings suggest that outcomes for neglect cases, especially for older children about whom there were child protection concerns, tended to be worse than for other types of demand. This is particularly noticeable for complex domestic abuse/risks inside the home, concerns about another person, and risks in and outside the home. They were the most likely categories to proceed to a CP plan, which in turn was more likely to be attributed to neglect than to any other type of maltreatment (see Section 3.1.5). Children in these categories were relatively more likely to result in a re-referral or repeat CP plan and to have lower educational attainment at KS2 and KS4. Children assessed in relation to single factor neglect, who tended to be younger, had relatively poor outcomes for KS2 (although not for KS4). They were also significantly more likely to have a re-referral or repeat CP plan than children assessed in the other two single factor abuse categories, i.e. physical abuse or sexual abuse.

4.5. Physical abuse and sexual abuse

One of the problems with considering the 'effectiveness' of child welfare services lies in the distinction between the records held by professional agencies about the children referred to them, and safety and wellbeing as it is experienced by children in the community (see Section 1.2). In other words, since services cannot identify all the maltreatment that happens, nor can be offered to every family that might want help and support, their activity is only a subset of actual demand. The challenge of identifying physical and sexual abuse in particular has been a key driver of policy and practice, as seen with the clinical diagnosis of 'battered child syndrome' in the 1960s (Kempe *et al.*, 1962), or controversies about sexual abuse in the 1980s (Department of Health and Social Security,

1987). Although it is not possible to obtain definitive figures, representative surveys give a sense of the prevalence of these types of maltreatment (Radford *et al.*, 2013). For example, it is estimated that around 1 in 14 children in the UK have experienced physical abuse and around 1 in 20 children have been sexually abused (NSPCC, 2021a, b). It is difficult to compare such estimates with the number of children subject to protective interventions, partly because the latter is generally reported as incidence (e.g. children on CP plans at a particular point or during a given year) but also because abuse that has been identified and assessed by children's services is unlikely to align straightforwardly with self-reported experience. Moreover, as our analysis of assessments goes to show, describing and labelling risks to children's welfare is far from straightforward. Claims about effectiveness in this ambiguous terrain are therefore best framed with caution.

While the points made above apply to any category of demand, in this study they are certainly germane to the findings on outcomes for 'single factor' categories of physical abuse and sexual abuse, i.e. cases where physical or sexual abuse was the sole concern recorded after assessment. This is because the findings suggest that CSC services were at their most effective when dealing with such cases. This was particularly noticeable for intermediate outcomes, i.e. re-referral, repeat CP plans and re-entry to care. In other words, CSC services were relatively successful at avoiding repeat involvement with children assessed with sole concerns about physical abuse or sexual abuse. These types of concern were also much less likely to be identified in cases of multiple needs than were concerns about neglect and emotional abuse. The main exceptions were complex domestic abuse/risks inside the home, in which there was a 44% likelihood that physical abuse would be recorded (see Section 3.1.3), and risks in and outside the home, in which there was a 17% likelihood that sexual abuse would be recorded. It is also important to note that other demand categories include cases of child sexual exploitation (CSE), which is a type of sexual abuse, as well as concerns about a child being the subject of domestic violence, which may overlap with physical abuse. The results for educational outcomes showed a similar pattern, although there few large differences between categories after adjustment. Nonetheless, children who had been assessed in relation to physical abuse or sexual abuse were among those with the lowest attainment gaps relative to others at the same threshold of intervention.

A comparison with neglect is perhaps instructive for considering these results. Like neglect, physical abuse and sexual abuse are complex phenomena with a long-lasting impact on a child's development. However, from a decision-making perspective a single incident or disclosure may be sufficient to establish that the threshold for statutory intervention has been reached. While

assessments of neglect had the highest social gradient of any type of child welfare service, assessments of physical abuse and sexual abuse were among the lowest (see Section 3.1.3). In other words, although all types of child welfare concerns are disproportionately assessed in more deprived families, social workers may be better able to disentangle difficulties relating to poverty and deprivation from physical and sexually abusive behaviour towards children, at least in comparison to neglect and emotional abuse. A combination of timely decision-making, clear communication of concerns, and a solution-focused approach to safety has long been understood as being crucial for effective CP work (Turnell and Edwards, 1999; Baginsky *et al.*, 2017; Munro and Turnell, 2020). It is possible that this type of practice lends itself more readily to physical abuse and sexual abuse cases than for complex cases of multiple needs and long-term neglect. However, given the problems around identifying and responding to indicators of physical and sexual abuse, this would require careful investigation.

4.6. Disability

The 'disability' category described by the LCA refers to a combination of issues, primarily concerns about the child's disability but sometimes also concerns relating to a parent's disability or mental health. As these are social work assessments, mostly in relation to safeguarding concerns, there is not a straightforward relationship between children presenting with these issues and those who have been through the formal process of diagnosing a disability or identifying the need for additional educational support. While all children with disabilities are defined as children in need under the 1989 Children Act, not all children who receive support for their special educational needs and/or disability (SEND) will receive a social care assessment. Moreover, care must be taken in interpreting results on educational attainment and school exclusions in relation to a category that is likely to include unusually high numbers of children with learning disabilities and/or behavioural, emotional and social difficulties.

Compared to most other types of demand, children in the 'disability' category were relatively less likely to be re-referred and to have a repeat CP plan (see Sections 3.2.1 and 3.2.2). The differences were not substantial and should be seen in the context of a 58% likelihood of referral to CSC within six years (and 10% likelihood of a repeat CP plan within two years). In comparison, Troncoso (2017) found that children with disabilities were more likely to be re-referred, although their analysis was based only on the primary need at assessment, which is a single factor recorded before a social work assessment is carried out. Repeat CP plans were not studied by Troncoso (2017) and we are not aware of any comparable figures to those provided in this study. Nonetheless, research in this area

has established that children with disabilities are more likely to experience all forms of maltreatment, particularly neglect (Stalker and McArthur, 2012; Miller and Brown, 2014; Barron *et al.*, 2019; Flynn, 2020). In this respect, it was somewhat surprising to find that children in the disability category were among the least likely to be subject to a CP plan or an episode of care (see Section 3.15). One reason for this could be that children with disabilities who were at risk of harm were being assessed primarily in relation to other risk factors, such as domestic abuse or risks outside the home, although if this were the case one might have expected a higher probability of child's physical or learning disability being recorded in these categories. The discrepancy may also point to barriers to professional assessment in this area, such as those identified by Flynn (2021), including resource constraints and the lack of disability-specific assessment tools. On the other hand, the findings on re-referrals and repeat CP plans did not suggest that these barriers were resulting in higher repeat involvement of children – provided they did not enter the care system.

In contrast to re-referrals and repeat CP plans, the results showed that children assessed in relation to disability were significantly more likely to have multiple episodes of care. This remained the case even after adjusting for other characteristics also associated with higher rates of re-entry to care, such as shorter periods in care and 'voluntary' (rather than court-ordered) accommodation. The results tally with other studies, which have also shown that children who enter care because of their disability are more likely to re-enter care (McGrath-Lone *et al.*, 2017; Goldacre *et al.*, 2022). For example, Goldacre et al. (2022) reported that children who entered care because of their disability and subsequently returned home to live with their parents were two and half times more likely to re-enter care than children whose reason for entering care was recorded as abuse and neglect. This is despite disabled children being less likely than other children in care to return home and spending longer in care before returning home (Baker, 2007; Thoburn *et al.*, 2012; Carlson *et al.*, 2020). These findings reinforce national and international research suggesting that permanency planning for disabled children continues to be a problematic area for child welfare services (Welch *et al.*, 2015).

As noted above, the findings on educational outcomes should be treated with caution, particularly when it comes to relative differences in attainment for this group. There were some conflicting patterns when it came to the gap between school-age children with or without recorded SEND. In relation to exclusion, there was some evidence that the gap in exclusions became narrower for children who were receiving services from CSC (Sections 3.2.7 and 3.2.8). This was particularly noticeable for children recorded with behavioural, emotional and social (BES) disorders, who were by far the most likely group of children to be excluded. For example, the exclusion gap at KS4 for

children on CP plans with BES was around a third of the exclusion gap for children with no CSC involvement (see Section 3.3.4). Also worth noting is that the tendency for Black pupils to be excluded more than White pupils also seemed to diminish among those receiving CSC services (see Section 3.3.4), as did the social gradient of exclusion. There has been increasing concern about the continued disproportionate exclusion of certain groups of children (Graham *et al.*, 2019; Timpson, 2019), including children with SEND, children receiving free school meals, and children from Black Caribbean and Mixed White and Black Caribbean backgrounds. Timpson (2019) found that 'children who have several of these characteristics have a multiplied risk of exclusion', suggesting that intersecting inequalities are important in this context. Given the contested role of exclusions in the educational system, it may be that social work involvement can sometimes serve as a protective factor for children with behavioural difficulties, and for other children disproportionately exposed to school exclusion, perhaps because additional resources and interventions are made available, or due to the benefits of professional advocacy and multi-agency collaboration.

In relation to attainment, however, the equivalent gap (between children receiving CSC services and those never referred) became wider for children with most type of SEND at each successive threshold of intervention (Sections 3.2.5 and 3.2.6). In other words, children with disabilities who were receiving CSC interventions experienced greater difficulties at school, despite the involvement of social workers and a narrowing of the gap in exclusion rates. There are two implications to this finding. The first is about the sufficiency of support for children with disabilities in receipt of safeguarding interventions, given research that suggests current statutory assessment processes for children with SEND are highly variable in terms of their quality and outcomes (Castro *et al.*, 2019; Cochrane and Soni, 2020), and that parents of children with psychosocial difficulties, behavioural problems and neurodevelopmental disorders are often dissatisfied with their experience of educational provision (Parsons *et al.*, 2009; Van Herwegen *et al.*, 2018). In other words, it seems likely that services to support a highly vulnerable cohort of disabled children are inadequate given that resources for disabled children as a whole are patchy and overstretched.

The findings on disability also reflect a more general pattern, which is for attainment outcomes for children receiving CSC services, whether or not they have a record of SEND, to get progressively worse at each successive threshold of intervention. In one respect, this shows that services are appropriately targeting children with more substantial needs in the higher tiers of provision. On the other hand, it also shows that the interventions being provided are no match for the level of need that services have themselves assessed. That is not to say that children would be better off without

the intervention, or that an equalisation of attainment rates is possible or even desirable, but that the stated purpose of services, i.e. to enable children grow up and thrive with safety, stability and love (see Section 1.3.1), appears very far from being achieved.

4.7. Domestic abuse and violence

Domestic abuse and violence (DAV) is a significant driver of demand for child welfare services and is the most common single factor identified in social work assessments (see Section 3.1.1). Its importance can be seen in the results of the latent class analysis (Section 3.1.2), which identified single-factor DAV as the most prevalent category, accounting for a fifth of all cases, but also identified DAV as a co-occurring factor in four other categories defined by complex needs and risks. Three of these categories, complex DAV/risks inside the home, concerns about another person, and risks in and outside the home, were the most likely type of case to proceed to a CP plan or episode of care. In a similar way to neglect, the categorisation of DAV is indicative of the sheer variety of problems encountered by CSC services, which do not lend themselves to universalising frameworks or standardised forms of provision. Moreover, the profile of DAV categories, or categories in which DAV is a major contributing factor, was suggestive of differences in how risk is assessed in relation to different groups of children. For example, single factor DAV was characterised by disproportionate numbers of children from Asian and Mixed ethnic backgrounds and a relatively low proportion of White children. In contrast, the complex DAV, risks in and outside the home, and concerns about another person categories were characterised by a relatively high proportion of White children. As with extra-familial harm, discussed in Section 4.3, this might reflect a tendency for some children to receive a holistic assessment of children's needs and family vulnerabilities, whereas others receive a more standardised, incident-driven response.

The number and variety of DAV cases create a problem for professionals seeking to operationalise thresholds around risk and harm. In the UK, the statutory definition of harm under the 1989 Children Act was amended in 2002 to include 'impairment suffered from seeing or hearing the ill-treatment of another', effectively highlighting child protection concerns where children are exposed to DAV at home. However, the change also highlighted – arguably exacerbated – the incident-driven nature of professional responses to DAV. CSC referral and assessment teams have struggled to deal with the large volume of DAV notifications shared with them, often by the police, making it harder for practitioners to identify those children most at risk (Peckover, 2014; Stanley and Humphreys, 2014; Hood *et al.*, 2020a). Such notifications often lack sufficient information, including about the seriousness of the incident, while police and CSC may interpret levels of risk differently or make

erroneous assumptions about what is already known by another agency (Cleaver *et al.*, 2019). Schools experience similar problems, grappling with an increased mandate to deal with concerns in relation to DAV, including information shared directly by the police[2], while experiencing acute shortages in appropriately qualified and experienced staff and therefore the time, resources and expertise to make informed judgements about risk (Baginsky *et al.*, 2022). Such issues have contributed to a narrow and undifferentiated approach to provision, focused mainly on the responsibilisation of mothers who are often multiply disadvantaged, while also failing to provide (mainly male) perpetrators with appropriate challenge and support (Featherstone and Peckover, 2007; Humphreys and Absler, 2011; Stewart and Arnull, 2022).

The outcomes of provision for DAV cases were shaped largely by the complexity of needs assessed and the threshold of intervention. Children assessed in the large, single factor DAV category were less likely to experience re-referral or a repeat CP plan than children assessed with DAV in combination with multiple other factors, but more likely to be re-referred than children assessed in relation to other categories of single factor abuse, such as physical or sexual abuse (see Section 3.2). The exception was the neglect category, which was often associated with worse outcomes than the single-factor DAV category. The same largely applied to the results around educational attainment and exclusion. DAV in combination with neglect was a feature of the categories most likely to proceed to CP and care, as well as those categories presenting with relatively poor outcomes. Because it was the largest category in terms of numbers, single factor DAV was likely to be the initial category of assessment for children who received multiple episodes of CSC involvement; however, the majority of these children were subsequently assessed in other categories, including those with more complex needs.

4.8. Parental mental health and substance misuse

A combination of concerns about parental mental health and concerns about either alcohol or drug misuse was a defining characteristic of 'complexities around parental mental health', which accounted for 18% of cases and was the second most prevalent category. These factors also commonly occurred in other complex needs categories, including those with the highest likelihood

[2] https://www.operationencompass.org/

of progressing to CP or care, and those with relatively poor outcomes in terms of repeat involvement and educational attainment. There were also intersections with DAV in many of these categories, although the probability means (see Section 3.1.3) suggest that a combination of all three major risk factors (DAV, substance misuse, and mental health problems) was much less likely than a combination of two. The literature on child protection has long recognised the significance of parental substance misuse (Forrester and Harwin, 2011; De Bortoli *et al.*, 2014; O'Connor *et al.*, 2014) and mental illness (Sheehan, 2004; Clark *et al.*, 2009). Recent years have seen more interest in their co-occurrence as a cumulative driver of concerns about child welfare (Reupert *et al.*, 2012; Coates, 2017; Roscoe *et al.*, 2018), although the specificity of this phenomenon has arguably been somewhat obscured by association with the 'toxic trio' discourse in child protection (Hood *et al.*, 2021) and increasing attention being paid to 'adverse childhood experiences' (Spratt and Kennedy, 2021). Problematic treatment trajectories and outcomes for adults with a 'dual diagnosis' have consistently been a prominent topic in mental health (Murthy and Chand, 2012; Tsantefski *et al.*, 2015; Iudici *et al.*, 2020). The findings from this study suggest that the intersection between substance misuse and mental health should also be regarded as a core issue for child welfare agencies.

As always in safeguarding contexts, there is a tension between individual and structural explanations for the problems experienced by children and families (Hood, 2023). Both substance misuse and mental illness are more prevalent in more deprived areas (Marmot *et al.*, 2010) as well as in more unequal societies (Wilkinson and Pickett, 2010). Although social work assessments ostensibly take an ecological approach, which acknowledges the role of social and environmental factors in shaping parents' capacity to meet their children's needs (Department of Health *et al.*, 2000), the reality of child protection practice tends to revolve around parents' decisions, attitudes and behaviour, particularly when it comes to younger children. Indeed, the checklist of factors at assessment itself reinforces this emphasis on individual risks and needs, with no mention of socio-economic factors such as income, employment, and housing. As Featherstone *et al.* (2018) point out, the increasing focus on risk in individual cases and on shorter time scales for parents to demonstrate their capacity to change have had serious consequences for families, whose lives have become much harder as a result of political decisions about austerity, combined in recent years with the Covid-19 pandemic and cost-of-living crisis. It is therefore important to remember that the 'clustering' of substance misuse and parental mental health, and their increasing co-occurrence in families assessed by child welfare agencies (see Section 3.1.8), has its roots in social inequality as much as the characteristics of families needing help and support.

5. Conclusion and recommendations

This report has presented the methods and findings from a two-year study of CSC, which set out to identify categories of demand based on the factors identified in social work assessments and to compare the outcomes of provision for children in different categories. The first part of the research identified twelve different categories of demand, derived from a statistical summary of common combinations of needs and risks. These categories were consistently found in all LAs over the seven-year period covered by the data, although they varied considerably in their prevalence between LAs and over time. Each category had a distinctive profile, not only in terms of the needs that were assessed but also in relation to child characteristics, such as age, gender and ethnicity, and intervention pathways, such as the proportion of cases that proceeded to CP plans or an episode of care. The profiles shed light on the operational judgements and definitions employed by social workers and are informative about the typical kinds of problems that child welfare agencies seek to address. This potentially makes the categories useful for planning and designing services, as they are directly aligned with institutional goals and priorities. By the same token, they are limited by their derivation from a checklist of professional terms that may not correspond to what matters to families, nor indeed to the more nuanced understanding of need held by the practitioner. Nonetheless, there is merit in a concise and evidence-based typology of complex needs, which is able to account for various combinations of multiple safeguarding concerns.

In the second part of the research, the outcomes of CSC provision for children in different categories of demand for CSC were explored using a range of measures. Intermediate outcomes were defined on the basis of repeat involvement with services, such as re-referral or re-entry to care. Longitudinal outcomes were defined on the basis of educational attainment and exclusion from school. Overall, there was some consistency between intermediate and longitudinal outcomes, in that children who did relatively less well tended to be those assessed in relation to complex needs, extra-familial harm, and/or children on CP plans for neglect. On the other hand, children who were relatively less likely to experience repeat involvement, namely children assessed in relation to physical abuse or sexual abuse, did not have significantly better educational outcomes than others. Educational outcomes were substantially stratified by the threshold of CSC involvement, with the largest gaps in attainment and exclusion experienced by children on CP plans and in care. There was some evidence that social work involvement slightly narrowed the gap in school exclusions for children with SEND, particularly children with behavioural difficulties. In general, although there were differences in outcomes across

categories of demand, the threshold at which intervention was provided was a much more important causal factor. This raises questions about the extent to which CSC services can achieve their ostensible purpose of enabling children who have experienced adversity to thrive, especially given rising levels of financial hardship and inequality.

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

1. *Policy and reform of CSC*
    a. The need to refocus services on prevention and family help is a core theme in the recent independent review of CSC and in the current government consultation (DfE, 2023a). Key strategic concerns for preventative support are highlighted by the demand categories, which may help to inform the design of locality-based family services.
    b. To support the sector's efforts to understand demand and improve outcomes for children, official statistics on CSC should reflect the significance of multiple, complex needs for statutory services. For example, experimental statistics based on the kind of analysis set out in this report could complement the current reporting of demand based on single risk factors.
    c. Policy and guidance need to distinguish more clearly between demand indicators and outcome indicators, which tend to be combined in current frameworks (DfE, 2023b). The use of aggregate measures of provision, such as rates of CP plans or children in care, for performance and evaluation purposes is problematic and should be treated with caution.
    d. A comprehensive and differentiated analysis of demand could be used to underpin social investment decisions. For example, the need to re-invest in youth services over the next decade is evidenced by a rising proportion of complex needs in relation to older children and adolescents, which tend to be associated with a higher risk of entry to care.
    e. The steep social gradient associated with all types of demand, and particularly with child protection cases in relation to neglect, continues to highlight the need for policies that improve the financial circumstances of families – particularly in view of the current cost-of-living crisis.
    f. Reducing the pressure on CSC services will require a sustained policy focus on child and adolescent mental health, not only in relation to the higher threshold CAMHS services

but also provision for children suffering anxiety and depression as well as behavioural problems that often reflect an underlying mental health need.

2. *Design and management of services*
    a. Local authorities in England can straightforwardly apply the analysis set out in this study to their own assessments data, using the template and analysis code available on the project website. The potential benefits of doing so include:
        i. An evidence-based summary of complex needs being addressed by the service, which is comparable with all-England statistics and with nearest statistical neighbours (e.g. based on figures in this report).
        ii. Indication of the level of complexity and risk being managed at different thresholds (e.g. CIN or CP), as well as tracking changes and trends over time.
        iii. Identification of key problem areas and strategic concerns to inform decisions about resources, contribute to commissioning and planning, and design new specialist roles and functions.
        iv. Flagging types of needs that are more likely to lead to repeated involvement with services, which may be important for planning and design purposes, e.g. for specialist teams supporting reunification from care, and to inform training and professional development.
        v. Providing more specific information about the nature of complex needs when commissioning specialist services, e.g. placements for children in care.
    b. Bearing in mind the limitations of administrative data, LAs should seek to combine the type of detailed demand analysis set out here with the substantial qualitative knowledge about local safeguarding pressures held by managers and practitioners – not only in CSC but also in the voluntary and community sector. There is also the need to engage local communities in co-producing any responses to key strategic concerns that are identified.
3. *Practice*
    a. The sector as a whole, including academics and policymakers, should avoid use of the 'toxic trio' term as a shorthand for multiple risk factors in CP cases. It is stigmatising to families and does not reflect the evidence from social work assessments. The detailed demand analysis in this report does offer an alternative approach to describing complex needs in child safeguarding work (although it is by no means the only alternative).
    b. Knowing more about the types of needs that are more likely to lead to repeated involvement with services might help practitioners with threshold decisions and justify

additional resources to sustain positive change, e.g. when stepping down from CP to CIN or arranging a support package for a child leaving care.

c. The development of poverty-aware and anti-racist practice, which is an increasingly important part of training and professional development in social work, might be able to draw on the type of data reported here, e.g. which types of demand have the steepest social gradient, or the biggest differences in how children from minoritised groups are treated.

d. There needs to be a more nuanced understanding of domestic abuse and violence in child protection cases, which is sensitive to social inequality as well as the combination of needs and risks experienced by the child and family. This is a complex phenomenon that does not lend itself to universalising frameworks and requires new thinking to develop effective responses.

e. Similarly, the findings add to the evidence base on extra-familial harm, for example highlighting the complex links with early childhood adversity as well as the interdependence of risks in and outside the home. Understanding such associations may help with risk assessment and care planning in particular cases, as well as with a more general understanding of the field.

4. Service improvement and evaluation

a. Services should consider carefully the implications of using a demand indicator, such as rates of CP plans or children in care, to measure quality or effectiveness. While it may be desirable, all things being equal, to reduce the number of children receiving statutory services, focusing on this as an outcome may have unintended consequences due to interconnections between different parts of the system. For example, the aim of reducing rates of children entering care might be accomplished in a number of ways including increased use of CP plans to manage risk. An understanding of demand is necessary to understand pressures on the front door and subsequent thresholds of provision, and analysis of longitudinal outcomes is necessary to verify whether children benefit from any changes to the way services are delivered.

b. It would be easier to investigate the outcomes of CSC services if evaluators and researchers had access to longitudinal datasets tailored precisely for this purpose, as is the case in countries with similar child welfare systems such as Canada, Australia and the United States. Such datasets would ideally provide a picture of 1) drivers of demand including socio-economic factors such as household income; 2) characteristics of

demand and provision, including workforce indicators and expenditure; and 3) longitudinal outcomes in childhood and later life, including health, education, employment and wellbeing.

c. While the gap in longitudinal outcomes between children who receive services and those in the general population is the ultimate measure of whether services are effective, the sheer (average) size of that gap for children on CP plans and in care is further evidence, if any was needed, that substantial investment in preventative services is sorely needed

Further information

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

Professor Rick Hood, Department of Social Work and Social Care, Kingston University,

rick.hood@kingston.ac.uk

6. References

Action for Children, National Children's Bureau and The Children's Society (2017) *Turning the Tide*, Available online: https://www.childrenssociety.org.uk/what-we-do/resources-and-publications/turning-the-tide, Last Accessed: Last accessed 26 July 2018.

Allnatt, G., Elliott, M., Scourfield, J., Lee, A. and Griffiths, L. (2022) 'Use of linked administrative children's social care data for research: a scoping review of existing UK studies', *British Journal of Social Work*, **52**(7), pp. 3923-3944.

Association of Directors of Children's Services (ADCS) (2021) 'Research Report: Safeguarding Pressures Phase 7', Manchester, Association of Directors of Children's Services.

Association of Directors of Children's Services (ADCS) (2022) 'Research Report: Safeguarding Pressures Phase 8', Manchester, Association of Directors of Children's Services.

Baginsky, M., Driscoll, J., Purcell, C., Manthorpe, J. and Hickman, B. (2022) *Protecting and Safeguarding Children in Schools: A Multi-agency Approach*, Bristol, Policy Press.

Baginsky, M., Moriarty, J., Manthorpe, J., Beecham, J. and Hickman, B. (2017) 'Evaluation of signs of safety in 10 pilots', London, Department for Education.

Baker, C. (2007) 'Disabled children's experience of permanency in the looked after system', *British Journal of Social Work*, **37**(7), pp. 1173-1188.

Barnow, B.S., Buck, A., O'Brien, K., Pecora, P., Ellis, M.L. and Steiner, E. (2015) 'Effective services for improving education and employment outcomes for children and alumni of foster care service: Correlates and educational and employment outcomes', *Child & Family Social Work*, **20**(2), pp. 159-170.

Barron, I., Allardyce, S., Young, H. and Levit, R. (2019) 'Exploration of the relationship between severe and complex disabilities and child sexual abuse: A call for relevant research', *Journal of child sexual abuse*, **28**(7), pp. 759-780.

Barth, R.P. and Jonson-Reid, M. (2000) 'Outcomes after child welfare services: Implications for the design of performance measures', *Children and Youth Services Review*, **22**(9-10), pp. 763-787.

Bennett, D.L., Webb, C.J.R., Mason, K.E., Schlüter, D.K., Fahy, K., Alexiou, A., Wickham, S., Barr, B. and Taylor-Robinson, D. (2021) 'Funding for preventative Children's Services and rates of children becoming looked after: A natural experiment using longitudinal area-level data in England', *Children and Youth Services Review*, **131**, p. 106289.

Bilson, A., Featherstone, B. and Martin, K. (2017) 'How child protection's "investigative turn" impacts on poor and deprived communities'', *Family Law Journal*, **47**(4), pp. 416-419.

Bilson, A. and Martin, K. (2017) 'Referrals and Child Protection in England: One in Five Children Referred to Children's Services and One in Nineteen Investigated before the Age of Five', *The British Journal of Social Work*, **47**(3), pp. 793-811.

Blundell, R., Costa Dias, M., Cribb, J., Joyce, R., Waters, T., Wernham, T. and Xu, X. (2022) 'Inequality and the COVID-19 Crisis in the United Kingdom', *Annual Review of Economics*, **14**, pp. 607-636.

Boullier, M. and Blair, M. (2018) 'Adverse childhood experiences', *Paediatrics and Child Health*, **28**(3), pp. 132-137.

Bradbury-Jones, C. and Isham, L. (2020) 'The pandemic paradox: The consequences of COVID-19 on domestic violence', *Journal of Clinical Nursing*, **29**(13-14), pp. 2047-2049.

Brandon, M. (2009) 'Child fatality or serious injury through maltreatment: Making sense of outcomes', *Children and Youth Services Review*, **31**(10), pp. 1107-1112.

Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C. and Black, J. (2008) 'Understanding Serious Case Reviews and Their Impact: A Biennial Analysis of Serious Case Reviews 2005-07', London, Department of Children, Schools and Families.

Brandon, M., Bailey, S., Belderson, P. and Larsson, B. (2014) 'The role of neglect in child fatality and serious injury', *Child Abuse Review*, **23**(4), pp. 235-245.

Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C. and Megson, M. (2012) 'New learning from serious case reviews: a two year report for 2009-2011', London, Department for Education.
Brandon, M., Sidebotham, P., Belderson, P., Cleaver, H., Dickens, J., Garstang, J., Harris, J.P., Sorensen, P. and Wate, R. (2020) 'Complexity and challenge: a triennial analysis of SCRs 2014-2017', London, Department for Education.
Butler, P. (2018) *Child protection costs 'threaten local councils' financial stability*, Available online: https://www.theguardian.com/society/2018/jun/13/child-protection-costs-threaten-local-councils-financial-stability, Last Accessed: 25 February 2023.
Callaghan, J.E., Fellin, L.C. and Warner-Gale, F. (2017) 'A critical analysis of Child and Adolescent Mental Health Services policy in England', *Clinical Child Psychology and Psychiatry*, **22**(1), pp. 109-127.
Carlson, L., Hutton, S., Priest, H. and Melia, Y. (2020) 'Reunification of looked-after children with their birth parents in the United Kingdom: A literature review and thematic synthesis', *Child & Family Social Work*, **25**(1), pp. 192-205.
Castro, S., Grande, C. and Palikara, O. (2019) 'Evaluating the quality of outcomes defined for children with Education Health and Care plans in England: A local picture with global implications', *Research in Developmental Disabilities*, **86**, pp. 41-52.
Chikwava, F., Cordier, R., Ferrante, A., O'Donnell, M., Speyer, R. and Parsons, L. (2021) 'Research using population-based administration data integrated with longitudinal data in child protection settings: A systematic review', *PLOS ONE*, **16**(3), p. e0249088.
Clark, C.A., Smith, P.R. and Smith, P. (2009) 'Promoting collaborative practice for children of parents with mental illness and their families', *Psychiatric Rehabilitation Journal*, **33**(2), pp. 95-97.
Clark, T.G., Bradburn, M.J., Love, S.B. and Altman, D.G. (2003) 'Survival analysis part I: basic concepts and first analyses', *British journal of cancer*, **89**(2), pp. 232-238.
Cleaver, K., Maras, P., Oram, C. and McCallum, K. (2019) 'A review of UK based multi-agency approaches to early intervention in domestic abuse: Lessons to be learnt from existing evaluation studies', *Aggression and violent behavior*, **46**, pp. 140-155.
Coates, D. (2017) 'Working with families with parental mental health and/or drug and alcohol issues where there are child protection concerns: Inter-agency collaboration', *Child & Family Social Work*, **22**, pp. 1-10.
Cochrane, H. and Soni, A. (2020) 'Education, health and care plans: What do we know so far?', *Support for Learning*, **35**(3), pp. 372-388.
Competition and Markets Authority (CMA) (2022) *Children's social care market study: final report*, Available online: https://www.gov.uk/cma-cases/childrens-social-care-study, Last Accessed: 28 July 2022.
Cowie, H. and Myers, C.-A. (2021) 'The impact of the COVID-19 pandemic on the mental health and well-being of children and young people', *Children & Society*, **35**(1), pp. 62-74.
Cummins, I. (2018) *Poverty, inequality and social work: The impact of neo-liberalism and austerity politics on welfare provision*, Policy Press.
Davis, J. and Marsh, N. (2020) 'Boys to men: the cost of 'adultification'in safeguarding responses to Black boys', *Critical and Radical Social Work*, **8**(2), pp. 255-259.
De Bortoli, L., Coles, J. and Dolan, M. (2014) 'Linking illicit substance misuse during pregnancy and child abuse: what is the quality of the evidence?', *Child & Family Social Work*, **19**(2), pp. 136-148.
Deighton, J., Lereya, S.T., Casey, P., Patalay, P., Humphrey, N. and Wolpert, M. (2019) 'Prevalence of mental health problems in schools: poverty and other risk factors among 28 000 adolescents in England', *British Journal of Psychiatry*, **215**(3), pp. 565-567.
Department for Education (2018a) 'Children in need census 2019 to 2020: Guide for local authorities ', London, TSO.

Department for Education (2018b) 'Children in Need of help and protection: Preliminary longitudinal analysis', London, TSO.
Department for Education (2019) 'Help, protection, education: concluding the Children in Need review', London, TSO.
Department for Education (2022a) *Characteristics of children in need: 2021-2022 (England)*, Available online: https://explore-education-statistics.service.gov.uk/find-statistics/characteristics-of-children-in-need, Last Accessed: Last accessed: 5 February 2023.
Department for Education (2022b) *Key Stage 2 Attainment*, Available online: https://explore-education-statistics.service.gov.uk/find-statistics/key-stage-2-attainment, Last Accessed: 05 06 23.
Department for Education (2022c) *Key Stage 4 Performance*, Available online: https://explore-education-statistics.service.gov.uk/find-statistics/key-stage-4-performance-revised#dataDownloads-1, Last Accessed: 05 06 23.
Department for Education (2022d) 'Seven features of practice and seven outcomes', London, DfE.
Department for Education (2023) 'Stable Homes, Built on Love: Implementation Strategy and Consultation', London, DfE.
Department of Health, Department for Education and Employment and Home Office (2000) 'Framework for the Assessment of Children in Need and their Families', London, TSO.
Department of Health and Social Security (1987) 'Report of the Inquiry into Child Abuse in Cleveland', London, HMSO.
Dickens, J., Taylor, J., Cook, L., Cossar, J., Garstang, J. and Rimmer, J. (2022) 'Serious case reviews 1998 to 2019: continuities, changes and challenges', London, Department for Education.
Donabedian, A. (1966) 'Evaluating the quality of medical care', *The Milbank memorial fund quarterly*, **44**(3), pp. 166-206.
Dubicka, B. and Bullock, T. (2017) 'Mental health services for children fail to meet soaring demand', *British Medical Journal*, Available online, https://doi.org/10.1136/bmj.j4254
Dubowitz, H., Kim, J., Black, M.M., Weisbart, C., Semiatin, J. and Magder, L.S. (2011) 'Identifying children at high risk for a child maltreatment report', *Child Abuse & Neglect*, **35**(2), pp. 96-104.
Egelund, T. and Lausten, M. (2009) 'Prevalence of mental health problems among children placed in out-of-home care in Denmark', *Child & Family Social Work*, **14**(2), pp. 156-165.
Featherstone, B., Gupta, A., Morris, K. and White, S. (2018) *Protecting children: A social model*, Bristol, Policy Press.
Featherstone, B. and Peckover, S. (2007) 'Letting them get away with it: Fathers, domestic violence and child welfare', *Critical Social Policy*, **27**(2), pp. 181-202.
Firmin, C. (2020) *Contextual Safeguarding and Child Protection: Rewriting the Rules*, Abingdon, Routledge.
Firmin, C. and Lloyd, J. (2020) 'Contextual safeguarding: a 2020 update on the operational, strategic and conceptual framework', Luton, University of Bedfordshire.
Fitzsimons, P., James, D., Shaw, S. and Newcombe, B. (2022) 'Drivers of activity in children's social care', London, Department for Education.
Fluke, J.D., Harlaar, N., Brown, B., Heisler, K., Merkel-Holguin, L. and Darnell, A. (2019) 'Differential Response and Children Re-Reported to Child Protective Services: County Data From the National Child Abuse and Neglect Data System (NCANDS)', *Child Maltreatment*, **24**(2), pp. 127-136.
Flynn, S. (2020) 'Theorizing disability in child protection: Applying critical disability studies to the elevated risk of abuse for disabled children', *Disability & society*, **35**(6), pp. 949-971.
Flynn, S. (2021) 'Towards parity in protection: Barriers to effective child protection and welfare assessment with disabled children in the Republic of Ireland', *Child Care in Practice*, **27**(4), pp. 333-351.
Forrester, D. and Harwin, J. (2011) *Parents Who Misuse Drugs and Alcohol: Effective Interventions in Social Work and Child Protection*, Chichester, Wiley-Blackwell.

Forrester, D., Lynch, A., Bostock, L., Newlands, F., Preston, B. and Cary, A. (2017) 'Family safeguarding Hertfordshire: evaluation report', London, Department for Education.
Frederico, M., Jackson, A. and Dwyer, J. (2014) 'Child Protection and Cross-Sector Practice: An Analysis of Child Death Reviews to Inform Practice When Multiple Parental Risk Factors Are Present', *Child Abuse Review*, **23**(2), pp. 104-115.
Friedman, M. (2001) *The results and performance accountability implementation guide*, Available online: www.raguide.org, Last Accessed.
Goldacre, A. and Hood, R. (2022) 'Factors affecting the social gradient in children's social care', *The British Journal of Social Work*, Available online, https://doi.org/10.1093/bjsw/bcab255
Goldacre, A., Hood, R., Jones, E., King, A. and Wang, C. (2022) 'Reunification and re-entry to care: an analysis of the national datasets for children looked after in England', *The British Journal of Social Work*, **52**(8), pp. 4756-4777.
Graham, B., White, C., Edwards, A., Potter, S. and Street, C. (2019) 'School exclusion: a literature review on the continued disproportionate exclusion of certain', *Retrieved from the Department for Education Website: https://assets. publishing. service. gov. uk/government/uploads/system/uploads/attachment_data/file/800028/Timpson_review_of_school_exclusion_literature_review. pdf*.
Green, B.L., Rockhill, A. and Furrer, C. (2007) 'Does substance abuse treatment make a difference for child welfare case outcomes? A statewide longitudinal analysis', *Children and Youth Services Review*, **29**(4), pp. 460-473.
Hall, R. (2023) *'Buckling' NHS fails to treat 250,000 children with mental health problems*, Available online: https://www.theguardian.com/education/2023/apr/16/buckling-nhs-fails-to-treat-250000-children-with-mental-health-problems?trk=public_post_comment-text, Last Accessed: 25 February 2019.
Harris, J.P., Tinarwo, M. and Ramanathan, R. (2020) 'Leeds Partners in Practice: reimagining child welfare services for the 21st century: final evaluation report', London, Department for Education.
Hindley, N., Ramchandani, P.G. and Jones, D.P.H. (2006) 'Risk factors for recurrence of maltreatment: a systematic review', *Archives of Disease in Childhood*, **91**(9), pp. 744-752.
Hood, R. (2019) 'What to Measure in Child Protection?', *The British Journal of Social Work*, **49**(2), pp. 466-484.
Hood, R. (2023) *Inequality and Social Work*, London, Sage.
Hood, R. and Goldacre, A. (2021) 'Exploring the impact of Ofsted inspections on performance in children's social care', *Children and Youth Services Review*, **129**, p. 106188.
Hood, R., Goldacre, A., Gorin, S. and Bywaters, P. (2019) 'Screen, Ration and Churn: Demand Management and the Crisis in Children's Social Care', *The British Journal of Social Work*, **50**(3), pp. 868-889.
Hood, R., Goldacre, A., Gorin, S., Bywaters, P. and Webb, C. (2020a) 'Identifying and understanding the link between system conditions and welfare inequalities in children's social care services', Kingston Upon Thames, Kingston University and St Georges, University of London.
Hood, R., Goldacre, A., Grant, R. and Jones, R. (2016) 'Exploring Demand and Provision in English Child Protection Services', *British Journal of Social Work*, **46**(4), pp. 923-941.
Hood, R., Goldacre, A., Webb, C., Bywaters, P., Gorin, S. and Clements, K. (2021) 'Beyond the Toxic Trio: Exploring Demand Typologies in Children's Social Care', *The British Journal of Social Work*, **51**(6), pp. 1942-1962.
Hood, R., O'Donovan, B., Gibson, J. and Brady, D. (2020b) 'New development: Using the Vanguard Method to explore demand and performance in people-centred services', *Public Money & Management*, pp. 1-4.
Horwath, J. (2013) *Child neglect: planning and intervention*, Basingstoke, Palgrave Macmillan.

Humphreys, C. and Absler, D. (2011) 'History repeating: Child protection responses to domestic violence', *Child & Family Social Work*, **16**(4), pp. 464-473.
Iacobucci, G. (2022) 'Covid-19: Pandemic has disproportionately harmed children's mental health, report finds', *BMJ*, **376**, p. o430.
Isokuortti, N., Aaltio, E., Laajasalo, T. and Barlow, J. (2020) 'Effectiveness of child protection practice models: a systematic review', *Child Abuse & Neglect*, **108**, p. 104632.
Iudici, A., Girolimetto, R., Volponi, G. and Eletto, A. (2020) 'Dual diagnosis and application problems in the use of the construct: a review of literature', *The Journal of Nervous and Mental Disease*, **208**(3), pp. 181-189.
Jack, G. and Gill, O. (2003) *The missing side of the triangle: assessing the importance of family and environmental factors in the lives of children*, Barkingside, Barnardo's.
Jay, A. (2014) 'Independent Inquiry into Child Sexual Exploitation in Rotherham ', Rotherham, Rotherham Metropolitan Borough Council.
Kempe, C.H., Silverman, F.N., Steele, B.F., Droegemueller, W. and Silver, H.K. (1962) 'The battered-child syndrome', *Jama*, **181**(1), pp. 17-24.
La Valle, I., Hart, D. and Holmes, L. (2019) 'How do we know if children's social care services make a difference? Development of an outcomes framework', London, Nuffield Foundation and Rees Centre, University of Oxford.
Lee, A., Elliott, M., Scourfield, J., Bedston, S., Broadhust, K., Ford, D.V. and Griffiths, L.J. (2022) 'Data resource: Children receiving care and support and children in need, administrative records in Wales', *International Journal of Population Data Science*, **7**(1).
Leivers, J. (2015) 'Action taken in response to Child Sexual Exploitation and issues identified in the Serious Case Review of Children A-F', Oxfordshire, Oxfordshire Safeguarding Children's Board.
Lucas, S. and Archard, P.J. (2021) 'Early help and children's services: exploring provision and practice across English local authorities', *Journal of Children's Services*, Available online, https://www.emerald.com/insight/publication/issn/1746-6660#earlycite
MacAlister, J. (2022) 'Independent Review of Children's Social Care: Final Report', London, Independent Review of Children's Social Care.
Maclean, M.J., Taylor, C.L. and O'Donnell, M. (2018) 'Out-of-home care and the educational achievement, attendance, and suspensions of maltreated children: A propensity-matched study', *The Journal of pediatrics*, **198**, pp. 287-293. e282.
Maclean, M.J., Taylor, C.L. and O'Donnell, M. (2016) 'Pre-existing adversity, level of child protection involvement, and school attendance predict educational outcomes in a longitudinal study', *Child Abuse & Neglect*, **51**, pp. 120-131.
Malvaso, C.G., Delfabbro, P.H. and Day, A. (2017) 'The child protection and juvenile justice nexus in Australia: A longitudinal examination of the relationship between maltreatment and offending', *Child Abuse & Neglect*, **64**, pp. 32-46.
Marmot, M.G., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M. and Geddes, I. (2010) *Fair society, healthy lives: Strategic review of health inequalities in England post-2010*, Available online: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review, Last Accessed.
Mason, W., Morris, K., Featherstone, B., Bunting, L., Davidson, G., McCartan, C., Bywaters, P. and Webb, C. (2020) 'Understanding out of Home Care Rates in Northern Ireland: A Thematic Analysis of Mixed Methods Case Studies', *The British Journal of Social Work*.
Mc Grath-Lone, L., Libuy, N., Harron, K., Jay, M.A., Wijlaars, L., Etoori, D., Lilliman, M., Gilbert, R. and Blackburn, R. (2022) 'Data resource profile: the education and child health insights from linked data (ECHILD) database', *International journal of epidemiology*, **51**(1), pp. 17-17f.
McGrath-Lone, L., Dearden, L., Harron, K., Nasim, B. and Gilbert, R. (2017) 'Factors associated with re-entry to out-of-home care among children in England', *Child Abuse & Neglect*, **63**, pp. 73-83.

Miller, D. and Brown, J. (2014) ''We have the right to be safe'. Protecting disabled children from abuse', London, NSPCC.
Mills, R., Kisely, S., Alati, R., Strathearn, L. and Najman, J.M. (2017) 'Child maltreatment and cannabis use in young adulthood: a birth cohort study', *Addiction*, **112**(3), pp. 494-501.
Munro, E. and Turnell, A. (2020) *'You Can't Grow Roses in Concrete' Part 2. Action Research Final Report: Signs of Safety English Innovations Project*, East Perth: WA, Elia International Ltd.
Murthy, P. and Chand, P. (2012) 'Treatment of dual diagnosis disorders', *Current Opinion in Psychiatry*, **25**(3), pp. 194-200.
NSPCC (2021a) 'Statistics briefing: child sexual abuse', London, NSPCC Learning.
NSPCC (2021b) 'Statistics briefing: physical abuse', London, NSPCC Learning.
O'Connor, L., Forrester, D., Holland, S. and Williams, A. (2014) 'Perspectives on children's experiences in families with parental substance misuse and child protection interventions', *Children and Youth Services Review*, **38**, pp. 66-74.
Ofsted (2018) *Growing up neglected: a multi-agency response to older children*, Available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722740/Older_children_neglect_FINAL_060718.pdf, Last Accessed: 22 04 23.
Ofsted (2022) *Why do children go into children's homes?*, Available online: https://www.gov.uk/government/publications/why-do-children-go-into-childrens-homes, Last Accessed: 28 July 2022.
Parsons, S., Lewis, A., Davison, I., Ellins, J. and Robertson, C. (2009) 'Satisfaction with educational provision for children with SEN or disabilities: a national postal survey of the views of parents in Great Britain', *Educational Review*, **61**(1), pp. 19-47.
Peckover, S. (2014) 'Domestic abuse, safeguarding children and public health: Towards an analysis of discursive forms and surveillant techniques in contemporary UK policy and practice', *British Journal of Social Work*, **44**(7), pp. 1770-1787.
Portes, J. (2022) *The economics of Brexit: what have we learned*, London, CEPR Press.
Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N. and Collishaw, S. (2011) 'Child abuse and neglect in the UK today', London, National Society for the Prevention of Cruelty to Children (NSPCC).
Radford, L., Corral, S., Bradley, C. and Fisher, H.L. (2013) 'The prevalence and impact of child maltreatment and other types of victimization in the UK: Findings from a population survey of caregivers, children and young people and young adults', *Child Abuse & Neglect*, **37**(10), pp. 801-813.
Reupert, A., Goodyear, M. and Maybery, D. (2012) 'Engaging with, and understanding children whose parents have a dual diagnosis', *Child and Adolescent Mental Health*, **17**(3), pp. 153-160.
Reynolds, A.J. and Ou, S.-R. (2004) 'Alterable predictors of child well-being in the Chicago longitudinal study', *Children and Youth Services Review*, **26**(1), pp. 1-14.
Robinson, G., McLean, R. and Densley, J. (2019) 'Working county lines: child criminal exploitation and illicit drug dealing in Glasgow and Merseyside', *International Journal of Offender Therapy and Comparative Criminology*, **63**(5), pp. 694-711.
Robson, K. and Pevalin, D. (2015) *Multilevel modeling in plain language*, London, Sage.
Roscoe, J.N., Lery, B. and Chambers, J.E. (2018) 'Understanding child protection decisions involving parents with mental illness and substance abuse', *Child Abuse Negl*, **81**, pp. 235-248.
Rothstein, H., Huber, M. and Gaskell, G. (2006) 'A theory of risk colonization: The spiralling regulatory logics of societal and institutional risk', *Economy and Society*, **35**(1), pp. 91-112.
Sacker, A., Murray, E., Lacey, R. and Maughan, B. (2021) 'The lifelong health and wellbeing trajectories of people who have been in care', London, Nuffield Foundation.
Sakai, C., Lin, H. and Flores, G. (2011) 'Health outcomes and family services in kinship care: Analysis of a national sample of children in the child welfare system', *Archives of Pediatrics & Adolescent Medicine*, **165**(2), pp. 159-165.

Samji, H., Wu, J., Ladak, A., Vossen, C., Stewart, E., Dove, N., Long, D. and Snell, G. (2022) 'Mental health impacts of the COVID-19 pandemic on children and youth–a systematic review', *Child and Adolescent Mental Health*, **27**(2), pp. 173-189.
Sheehan, R. (2004) 'Partnership in mental health and child welfare: Social work responses to children living with parental mental illness', *Social Work in Health Care*, **39**(3-4), pp. 309-324.
Sidebotham, P. (2019) *Toxic Terminology*, Available online: https://www.childprotectionprofessionals.org.uk/blog/toxic-terminology, Last Accessed: 28/01/2020.
Sidebotham, P., Brandon, M., Bailey, S., Belderson, P., Dodsworth, J., Garstang, J., Harrison, E., Retzer, A. and Sorensen, P. (2016) *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014*, London, Department for Education.
Sidebotham, P., Golding, J. and Team, A.S. (2001) 'Child maltreatment in the "Children of the Nineties": A longitudinal study of parental risk factors', *Child Abuse & Neglect*, **25**(9), pp. 1177-1200.
Skinner, G., Bywaters, P., Bilson, A., Duschinsky, R., Clements, K. and Hutchinson, D. (2020) 'The 'Toxic Trio'(domestic violence, substance misuse and mental ill-health): how good is the evidence base?', *Children and Youth Services Review*, Available online, https://doi.org/10.1016/j.childyouth.2020.105678
Smith, P.C. (2009) *Performance measurement for health system improvement: experiences, challenges and prospects*, Cambridge, Cambridge University Press.
Sparrow, M. (2008) *The Character of Harms: Operational Challenges in Control*, Cambridge, Cambridge University Press.
Spratt, T., Devaney, J. and Frederick, J. (2019) 'Adverse childhood experiences: Beyond signs of safety; reimagining the organisation and practice of social work with children and families', *The British Journal of Social Work*, **49**(8), pp. 2042-2058.
Spratt, T. and Kennedy, M. (2021) 'Adverse childhood experiences: Developments in trauma and resilience aware services', *The British Journal of Social Work*, **51**(3), pp. 999-1017.
Stalker, K. and McArthur, K. (2012) 'Child abuse, child protection and disabled children: A review of recent research', *Child Abuse Review*, **21**(1), pp. 24-40.
Stanley, N. and Humphreys, C. (2014) 'Multi-agency risk assessment and management for children and families experiencing domestic violence', *Children and Youth Services Review*, **47**, pp. 78-85.
Stevenson, O. (2008) *Neglected children and their families (2nd Edition)*, Oxford, Blackwell.
Stewart, S. and Arnull, E. (2022) 'Mothers, domestic violence, and child protection: the UK response', *Violence against women*, Available online, https://doi.org/10.1177/10778012221097141
Stone, J. (2022) 'Local indicators of child poverty after housing costs, 2020/21', Loughborough, Centre for Research in Social Policy.
Teo, S. and Griffiths, G. (2020) 'Child protection in the time of COVID-19', *Journal of Paediatrics and Child Health*, **56**(6), pp. 838-840.
Teyhan, A., Boyd, A., Wijedasa, D. and Macleod, J. (2019) 'Early life adversity, contact with children's social care services and educational outcomes at age 16 years: UK birth cohort study with linkage to national administrative records', *BMJ open*, **9**(10), p. e030213.
Thoburn, J., Robinson, J. and Anderson, B. (2012) 'Returning children from public care', London, SCIE.
Timpson, E. (2019) 'Timpson Review of School Exclusion', London, HMSO.
Tregeagle, S., Moggach, L., Trivedi, H. and Ward, H. (2019) 'Previous life experiences and the vulnerability of children adopted from out-of-home care: The impact of Adverse Childhood Experiences and child welfare decision making', *Children and Youth Services Review*, **96**, pp. 55-63.
Trocmé, N.M., Tourigny, M., MacLaurin, B. and Fallon, B. (2003) 'Major findings from the Canadian incidence study of reported child abuse and neglect', *Child Abuse & Neglect*, **27**(12), pp. 1427-1439.
Troncoso, P. (2017) 'Analysing repeated referrals to children's services in England', London, Department for Education.

Tsantefski, M., Jackson, A.C. and Humphreys, C. (2015) 'A delicate balance: Intervention with mothers with dual diagnosis and their infants', *Advances in Dual Diagnosis*, **8**(2), pp. 78-89.
Turnell, A. and Edwards, S. (1999) *Signs of safety: A solution oriented approach to child protection casework*, London, WW Norton.
Van Herwegen, J., Ashworth, M. and Palikara, O. (2018) 'Parental views on special educational needs provision: Cross-syndrome comparisons in Williams Syndrome, Down Syndrome, and Autism Spectrum Disorders', *Research in Developmental Disabilities*, **80**, pp. 102-111.
Vial, A., van der Put, C., Stams, G.J.J., Kossakowski, J. and Assink, M. (2020) 'Exploring the interrelatedness of risk factors for child maltreatment: A network approach', *Child Abuse & Neglect*, **107**, p. 104622.
Vinnerljung, B., Hjern, A. and Lindblad, F. (2006) 'Suicide attempts and severe psychiatric morbidity among former child welfare clients–a national cohort study', *Journal of Child Psychology and Psychiatry*, **47**(7), pp. 723-733.
Webb, C., Bennett, D., Bywaters, P. and Hood, R. (2022) 'Impact of investing in prevention on demand for statutory children's social care', London, NCB.
Welch, V., Jones, C., Stalker, K. and Stewart, A. (2015) 'Permanence for disabled children and young people through foster care and adoption: A selective review of international literature', *Children and Youth Services Review*, **53**, pp. 137-146.
Wilkinson, R. and Pickett, K. (2010) *The spirit level: why equality is better for everyone*.
Williams, A.G. and Finlay, F. (2018) 'County lines: how gang crime is affecting our young people', *Archives of Disease in Childhood*, pp. archdischild-2018-315909.
Wroe, L.E. and Lloyd, J. (2020) 'Watching over or working with? Understanding social work innovation in response to extra-familial harm', *Social Sciences*, **9**(4), p. 37.
YMCA (2020) 'Out of Service: a report examining local authority expenditure on youth services in England and Wales', London, YMCA.

7. Appendices

Appendix 1. Outcome frameworks in children's social care

Outcome frameworks set out how to measure the effect (or effectiveness) of providing a service. Often they are concerned with effects for which a service can reasonably be held responsible. Performance-based accountability (PBA) frameworks have therefore influenced the use of measures for performance management in health and social care (Friedman, 2001; Smith, 2009). PBA (also known as results-based or outcomes-based accountability) follows the healthcare literature in distinguishing between processes and outcomes when it comes to measuring quality of services (Donabedian, 1966). Friedman (2001) adds a further distinction, between quantity and quality, in order to produce a typology of measures. Table 1.1 adapts Friedman's typology to categorise some of the indicators commonly reported for CSC services (Hood, 2019). It shows how quantity measures, such as numbers of referrals and assessments, relate to levels of activity in different parts of the system, whereas quality measures say something about the standard of delivery. Demand analysis, as discussed above, would generally focus on the top-left quadrant of Appendix table 1.1, i.e. the quantity of work that is handled at the front door and processed at various thresholds of intervention. This leaves the other three quadrants as possible indicators of outcomes.

Appendix table 1.1. Performance-based accountability measures in CSC based on Friedman (2001)

	Quantity	**Quality**
Process	• Number of referrals • Number of assessments • Number of CP plans • Number of CLA	• Compliance with timescales (e.g. for assessment completion) • Length of CP plans (e.g. under/over one year)
Result	• Number of cases closed • Number of CP plans ceased • Number of children exiting care	• Percentage of re-referrals • Percentage of repeat CP plans • Percentage of children re-entering care

Measures of the quantity of result, such as numbers of case closures or CP plans ceasing, are sometimes referred to as 'outputs' because they refer to the amount of work that is completed. Measures of the quality of process, such as timely assessment completion or avoiding drift in CP

plans, are sometimes referred to as 'leading' measures because they are considered to lead to better outcomes for the child. Finally, measures of the 'quality of result', such as re-referrals, are sometimes called 'lagging' measures because they look in hindsight at effectiveness over time. Hood (2019) notes that CSC services report relatively few of the latter type of measure and they are mostly 'negative' in that it is usually assumed that repeated involvement with child welfare services is undesirable.

PBA indicators tend to rely on routine administrative data that are used for audit and quality assurance – and in some cases reported annually to the government. Indeed, for Friedman (2001) this is part of the point – services should not be held accountable for longer-term indicators of health and wellbeing because such outcomes are also shaped by factors outside of the agency's control. However, it could be argued that accountability processes, including the role of inspection but also the political sensitivity of child protection, are more of an issue here than the principle of tracking longitudinal outcomes (Rothstein *et al.*, 2006; Hood and Goldacre, 2021). Although they sidestep the politics of performance management, La Valle *et al.* (2019) set out a more holistic approach to outcome measurement in CSC. They distinguish between child outcomes, which represent the ultimate goals of providing a service, and what they call 'intermediate outcomes', which are aspects of provision considered necessary to achieve those goals. Intermediate outcomes are divided into three categories:

- The right conditions and culture to support good practice, e.g. effective leadership, or stable workforce.
- Reaching children who need help, e.g. effective identification of children at risk of harm, or providing support that is appropriate to meet a child's needs.
- Children and families are valued and involved, e.g. involvement of children and parents/carers in identifying their needs and planning their support.

For La Valle et al. (2019), child outcomes are defined largely as meeting children's needs for safety, stability and good health, as well as engaging with, and making progress in, their education. The groups covered by these outcomes are usually limited to those receiving relevant services within the past year. For example, the outcome of 'children are safe where they live' would apply to 'children in need of help or protection or looked after in the past year', using measures such as the 'percentage of children affected by domestic violence', or parental mental ill health, or parental substance misuse, 'over the previous six months'. Alternatively, the outcome of 'children make progress in their education' would be measured through evidence of improved attainment in children's school

exam results, or more tailored measures such as the percentage of care leavers in education, employment or training. As the authors acknowledge, the problem with most of the measures in their outcome framework is that they are not routinely collected by services and so would require bespoke surveys.

In 2023, the (UK) government declared its intention to establish a national outcomes framework for CSC, reinforced by a 'dashboard' of LA-level indicators that was expressly 'not intended to measure the performance of local authorities and does not set performance targets' (DfE, 2023: 21). At the time of writing, the proposed framework included four types of 'outcomes', with indicative measures taken from administrative data largely collected already by CSC services, along with some suggestions for long-term outcomes in areas such as health, education and employment. Appendix table 1.2 summarises these proposed outcomes and indicators.

Appendix table 1.2 Outcomes and indicators for CSC (DfE, 2023)

Outcomes	**Suggested indicators**
Outcome 1 Children, young people and families stay together and get the help they need	• % of referrals which are repeat referrals • school attendance of children in need • rate of new entrants to care • rate of assessments completed • rate of children in care
Outcome 2 Children and young people are supported by their family network	• % of section 31 proceedings that end with the child living with parents, and the age of the children in the proceedings • % of children in care living with their family networks
Outcome 3 Children and young people are safe in and outside their homes	• rate and number of section 47 investigations • rate of section 47 investigations which result in an initial CP conference • rate of new CP plans • % of children whose CP plans were de-escalated and did not present again with unmet needs in 2 years
Outcome 4 Children in care and care leavers have stable, loving homes	• % of children in care living in foster care • % of children in care living in residential care • distance of placements from home • stability of placements of children in care
Long term outcomes	• Good child development • Good education, attendance, attainment, training and progress • Good physical and mental health • Family stability, including housing and financial stability

	• Family functioning, including strong family relationships and support networks • Preventing and tackling crime

The DfE framework illustrates some of the problems with trying to use administrative data as a proxy for outcomes for the child. The validity of many of the proposed indicators can be questioned, i.e. it is not clear how much they correspond to the outcome with which they are linked. For example, how can services know if conducting more or less investigations is conducive to keeping children safe, or whether a higher proportion of children living with parents after care proceedings means that children are being supported by their family network? The framework does not distinguish between measures of quantity and quality, nor between the inputs and outputs of provision – instead these are combined under each outcome (or statement of purpose). Also noticeable, as with other frameworks discussed here, is the distinction made between the short-term (or intermediate) outcomes of service provision and longer term outcomes of children's health and wellbeing.

Appendix 2: Longitudinal outcomes of CSC

In their discussion of performance measures in US child welfare services, Barth and Jonson-Reid (2000) made a case for tracking the longitudinal impact of services. They argued that it was necessary to go beyond the immediate goals of provision in order to understand 'the potential long range impact of child welfare intervention' (2000: 766). The corresponding focus of their study was children's long-term physical health (i.e. safety), which they defined as the avoidance of criminal behaviour, incarceration, or ongoing maltreatment. Subsequent research in the US and Canada has made use of tailored datasets, such as the Canadian Incidence Study of Reported Child Abuse and Neglect (Trocmé *et al.*, 2003) and the National Child Abuse and Neglect Data System in the United States (Fluke *et al.*, 2019). Studies have used these or similar datasets to examine various outcomes of provision, including indicators of health (Sakai *et al.*, 2011), substance misuse (Green *et al.*, 2007), educational achievement (Maclean *et al.*, 2016), youth justice involvement (Reynolds and Ou, 2004), and employment (Barnow *et al.*, 2015). Similar studies have been carried out in countries like Australia (Malvaso *et al.*, 2017; Mills *et al.*, 2017; Maclean *et al.*, 2018), Sweden (Vinnerljung *et al.*, 2006), Denmark (Egelund and Lausten, 2009) and Norway, leveraging the potential of linked administrative data to examine longitudinal outcomes for children subject to protective interventions and/or out-of-home care (see Chikwava *et al.*, 2021, for a methodological review). In the UK, resources for this type of research include the Secure Anonymised Information Linkage (SAIL) Databank in Wales (Lee *et al.*, 2022), the Education and Child Health Insights from Linked Data (ECHILD) Database in England (Mc Grath-Lone *et al.*, 2022), the ONS Longitudinal Study (Sacker *et al.*, 2021) and the Avon Longitudinal Study of Parents and Children (ALSPAC) (Teyhan *et al.*, 2019). The National Pupil Database (NPD) for England also offers the facility to link CSC administrative records to data from the schools census, including educational attainment (for a review, see Allnatt *et al.*, 2022).

Evidence on the longitudinal outcomes of CSC provision often relates to children in care. Recently, Sacker *et al.* (2021) used data from the ONS Longitudinal Study to investigate the lifelong health and wellbeing trajectories of people in care, using census and life events data for a 1 per cent sample of the population of England and Wales between 1971 and 2001. Data was available for adult outcomes across four domains of wellbeing: health, education and work, living arrangements, and family formation and relationships. Their findings highlighted the scale of inequalities experienced by children in care and care leavers, the significance of structural inequalities linked to gender, race

and ethnicity, as well as the potential difference that can be made by the type of provision received by the child. Keys findings were that:

- Inequalities within the cared-for population were as great as the inequalities between the cared-for population and the population in parental care.
- Care leavers experienced higher rates of premature mortality than the general population and this gap appeared to be widening over time.
- Kinship care was associated with better adult outcomes than foster care, which in turn was related to better outcomes than foster care.
- Inequalities in employment and consequential social class widened between 1981 and 2001 and then narrowed between 2001 and 2011, possibly indicating that inequalities widen during periods of economic growth and narrow during recessions.
- Outcomes differed significantly between different groups of ethnically minoritised children in care, e.g. among adults born outside the UK, those previously in care were predicted to be in more advantaged social positions than their peers, even though they had a lower probability of reaching the managerial and professional social classes.
- Birth children of kinship and foster parents often made the transition to adulthood sooner than their peers and generally experienced poorer outcomes in terms of health, qualifications, employment, housing and family relationships.

Children with any kind of involvement with CSC services are a much larger group than children in care – one English study found that one in five children were referred to CSC services before the age of five and one in nineteen were subject to a CP investigation (Bilson and Martin, 2017). Also relevant but often forgotten (because little data is collected about them) are children whose needs do not reach the threshold for statutory services but are referred to Early Help and family support (Lucas and Archard, 2021). There is comparatively little evidence about longitudinal outcomes for children who received services as CIN or CP, but who were not in care, and what does exist has mainly focused on educational outcomes (Department for Education, 2018b, 2019). In England, the Department for Education began reporting educational outcomes for all children in need in 2020, following a review of children in need of help and protection that identified significant disparities in the CIN population as whole (Department for Education, 2019). Some of the main points highlighted by the review were:

- Children who have needed a social worker had lower educational attainment at every stage of their schooling than those who did not, even after controlling for other factors associated with attainment.
- Children receiving CSC services were 50% less likely to achieve a strong pass in English and Maths at Key Stage 4 (KS4 – end of school exams taken at age 16), with the likelihood for those on a CIN plan or a CP plan almost as low as children in care.
- Pupils who were in need at the end of their KS4 year were around three times less likely to go on to study A levels (advanced qualifications) at age 16 and almost five times less likely to enter higher education at age 18.

Berridge et al. (2020) used administrative data from the NPD to carry out a prospective longitudinal analysis of the educational attainments of CIN and children in care in England. They found substantial gaps in attainment at all stages of children's education between those who had any social work intervention compared to those who had no intervention. This gap 'increased with the severity of the intervention', i.e. children on CP plans tended to score lower in key stage exams than children on CIN plans, while children in care had the lowest scores. Much of this relatively poor attainment was due to variables such as gender, ethnicity, socio-economic status, special educational needs, and disabilities. At KS4, after taking all other variables into account, 'the only substantial attainment gaps that remained were for those who had spent time in Care and those who were receiving social work interventions in Year 11' (Berridge et al., 2020: 8). In contrast, some children who had received social work interventions at an early age were able to succeed at 16, and this was particularly the case for those who were not receiving social work services during the year of their KS4 exams, had fewer than four episodes of CSC involvement, and who had experienced a longer term stay in care.

Appendix 3: Factors at assessment (Department for Education, 2018a: 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.

Code	Description
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 4: The number of assessments with factors information recorded, by year:

Year	Number of assessments completed	Number of assessments with factors recorded	Percentage of assessment with factors recorded
2014/15	548,340	439,940	80.2%
2015/16	569,990	481,450	84.5%
2016/17	605,750	511,080	84.4%
2017/18	629,450	523,280	83.1%
2018/19	643,660	539,180	83.8%
2019/20	664,900	569,450	85.6%
2020/21	620,960	535,950	86.3%
Total	4,283,050	3,600,320	*84.1%*

Appendix 5: The average number of factors recorded at assessments, by year:

Year	Mean number of factors recorded
2014/15	2.5
2015/16	2.5
2016/17	2.6
2017/18	2.6
2018/19	2.6
2019/20	2.7
2020/21	2.8
Total	*2.6*

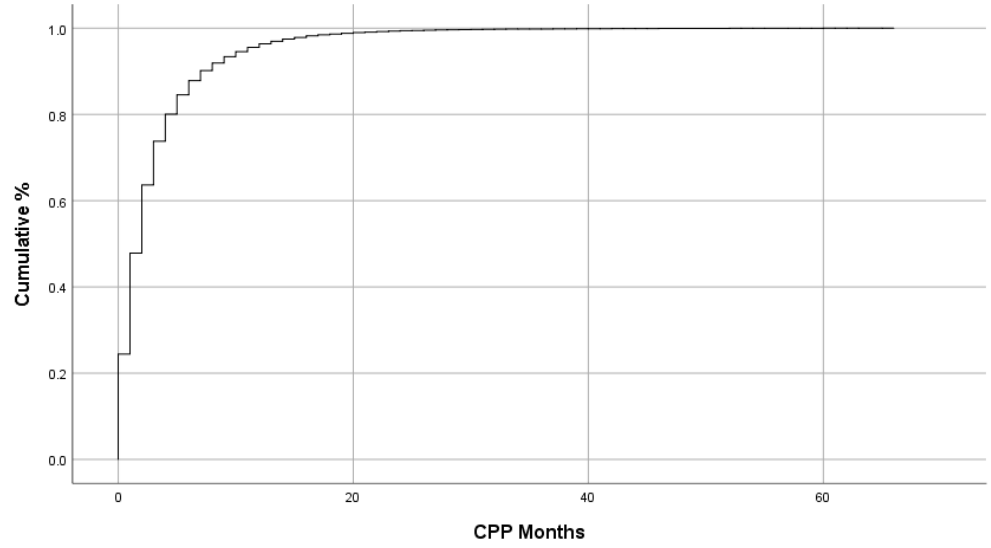
Appendix 6: Overview of data available on the factors recorded at social work assessments, by financial year (shaded area indicates code sets that were not collected)

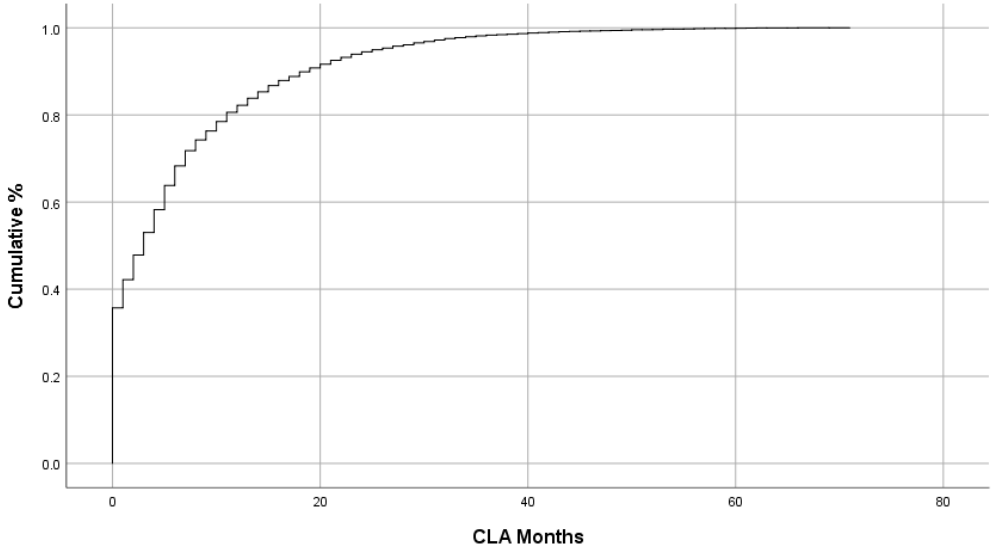
Code	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
1A							
1B							
1C							
2A							
2B							
2C							
3A							
3B							
3C							
4A							
4B							
4C							
5A							
5B							
5C							
6A							
6B							
6C							
7A							
8A							
8B							
8C							
8D							
8E							
8F							
9A							
10A							
11A							
12A							
13A							
14A							
15A							
16A							
17A							
18A							
18B							
18C							
19A							
19B							
19C							
20							
21							
22A							
23A							

Appendix 7: Invariance and sensitivity checks

The output from the LCA included class membership probabilities (the probabilities of individuals belonging to a particular latent class), and conditional item probabilities (the probabilities of factors occurring within a cluster). Measurement invariance tests were carried out to test whether the latent structure could be applied equally across different LAs and across different years. This involved running competing multi-group latent class models to examine the degree of homogeneity between groups. In the configural models the latent class model is freely estimated across all groups (the latent structure is assumed to be different between groups). In the invariant multi-group models the latent class loadings are restricted to be equal across all groups (the latent structure is assumed to be the same between groups). If the BIC and AIC values are lower in the invariant model then the data supports the homogeneity restrictions (i.e. the data is structurally equivalent across groups), which implies that the latent structure can be applied equally in the same way across all groups. Further sensitivity checks involved running models with equal sample weighting across LAs (e.g. 1,000 assessments from each LA). This did not substantially alter the conditional probabilities or change the interpretation of the latent classes. It is generally recommended to use the unweighted solution when parameter estimates are substantively similar because sampling weighting tends to increase standard errors (Vermunt, 2007). Further sensitivity checks involved running multi-level latent class models which adjusts for LA-membership and account for clustering within LAs (Finch, 2013). Similarly, this did not substantively change the interpretation of the latent classes. One of the downsides to reporting the findings from the multi-level models is that the estimates cannot be saved to score future data or samples of the data (e.g. classifying observations would be dependent on the availability of data from other LAs). Therefore, the decision was taken to report the models without group-level random effects.

Appendix 8: Cumulative frequency of i) CP plans and ii) care episodes.





Appendix 9: Goodness of fit statistics for latent class models examining the factors identified at CSC assessments

Class size	LL	AIC	BIC	SABIC	Npar	Avg. posterior	Entropy R^2
1	-28,170,543	56,341,153	56,341,598	56,341,490	34	-	-
2	-27,037,049	54,074,237	54,075,140	54,074,921	69	0.9007	0.6164
3	-26,438,963	52,878,135	52,879,497	52,879,166	104	0.8744	0.6756
4	-25,987,413	51,975,103	51,976,924	51,976,482	139	0.8640	0.7307
5	-25,719,067	51,438,482	51,440,761	51,440,208	174	0.8494	0.7269
6	-25,562,398	51,125,215	51,127,952	51,127,288	209	0.8278	0.7135
7	-25,427,095	50,854,679	50,857,874	50,857,099	244	0.7910	0.6931
8	-25,324,729	50,650,016	50,653,670	50,652,783	279	0.7905	0.7014
9	-25,227,448	50,455,524	50,459,636	50,458,638	314	0.7779	0.6982
10	-25,146,757	50,294,213	50,298,783	50,297,674	349	0.7826	0.7176
11	-25,067,423	50,135,613	50,140,642	50,139,422	384	0.7950	0.7420
12	-24,998,607	49,998,052	50,003,540	50,002,208	419	0.7983	0.7479
13	-24,945,541	49,891,991	49,897,937	49,896,494	454	0.7966	0.7490
14	-24,907,424	49,815,826	49,822,231	49,820,677	489	0.7908	0.7453
15	-24,862,683	49,726,413	49,733,276	49,731,611	524	0.7760	0.7470
16	-24,822,360	49,645,837	49,653,158	49,651,382	559	0.7915	0.7506
17	-24,813,157	49,627,501	49,635,280	49,633,393	594	0.7631	0.7337
18	-24,758,864	49,518,987	49,527,225	49,525,226	629	0.7896	0.7600
19	-24,723,491	49,448,310	49,457,006	49,454,896	664	0.8033	0.7921
20	-24,695,563	49,392,523	49,401,678	49,399,456	699	0.8015	0.7864
21	-24,669,729	49,340,926	49,350,539	49,348,207	734	0.8006	0.7910
22	-24,634,369	49,270,275	49,280,347	49,277,903	769	0.8299	0.8332
23	-24,625,817	49,253,242	49,263,771	49,261,216	804	0.8184	0.8179
24	-24,604,996	49,211,670	49,222,658	49,219,991	839	0.8206	0.8262
25	-24,581,355	49,164,458	49,175,905	49,173,127	874	0.7972	0.8031
26	-24,562,582	49,126,982	49,138,887	49,135,998	909	0.8147	0.8213
27	-24,551,164	49,104,216	49,116,579	49,113,579	944	0.8142	0.8221
28	-24,537,012	49,075,981	49,088,803	49,085,691	979	0.7936	0.8071
29	-24,521,981	49,045,991	49,059,271	49,056,048	1014	0.8081	0.8222
30	-24,510,413	49,022,925	49,036,663	49,033,329	1049	0.8018	0.8158

Notes:
ll=log likelihood; AIC= Akaike information criterion; BIC= Bayesian information criterion, SABIC=sample-size adjusted Bayesian information criterion; Npar=number of parameters; Avg. posterior=average latent class posterior probability.

Appendix 10: Multi-group invariance tests

	BIC	AIC
Multi-group models for year of assessment (7 groups)		
Unrestricted model, heterogeneity between years assumed	49,734,646	49,701,814
Restricted model, homogeneity between years assumed	**45,466,630**	**45,461,020**
Multi-group models for LA membership (147 groups)		
Unrestricted model, heterogeneity between LAs assumed	48,935,657	48,213,353
Restricted model, homogeneity between LAs assumed	**44,980,199**	**44,955,543**

BIC= Bayesian information criterion; AIC= Akaike information criterion

Appendix 11: Factors affecting re-referrals (univariate models):

Characteristics	Category	Univariate model	
		HR	CI
Gender	Male	Ref	
	Female	1.01	1.00 to 1.01
Age	Under 1	Ref	
	1-4 Years	1.00	0.99 to 1.01
	5-9 Years	0.94	0.93 to 0.95
	10-15 Years	0.98	0.97 to 0.99
	16-17 Years	0.92	0.91 to 0.93
Ethnicity	Asian	0.64	0.64 to 0.65
	Black	0.72	0.71 to 0.73
	Mixed	1.05	1.04 to 1.06
	Other	0.63	0.62 to 0.64
	White	Ref	
Deprivation	Low dep. LA | Low dep. LSOA	0.95	0.93 to 0.98
	Low dep. LA | Mid dep. LSOA	1.13	1.12 to 1.14
	Low dep. LA | High dep. LSOA	1.28	1.25 to 1.31
	Mid dep. LA | Low dep. LSOA	0.82	0.80 to 0.85
	Mid dep. LA | Mid dep. LSOA	Ref	
	Mid dep. LA | High dep. LSOA	1.19	1.18 to 1.21
	High dep. LA | Low dep. LSOA	0.85	0.74 to 0.99
	High dep. LA | Mid dep. LSOA	0.92	0.91 to 0.93
	High dep. LA | High dep. LSOA	1.13	1.12 to 1.15
Prior CIN episode	No	Ref	
	Yes	1.59	1.58 to 1.60
Length of CIN	<3 months	Ref	
	3 to 12 months	1.02	1.01 to 1.03
	>1 year	0.98	0.97 to 0.99
Referral source	Individual	1.06	1.04 to 1.07
	Schools	0.93	0.92 to 0.93

Characteristics	Category	Univariate model	
		HR	CI
	Health services	0.92	0.91 to 0.92
	Housing	1.09	1.06 to 1.11
	LA services	1.00	0.99 to 1.01
	Police	Ref	
	Other	1.02	1.01 to 1.02
	Unknown / missing	0.97	0.95 to 0.98
Factors (LCA)	Domestic abuse and violence	Ref	
	Complexities around parental mental health	1.12	1.11 to 1.13
	Disability	0.89	0.88 to 0.90
	Risks outside the home	1.12	1.10 to 1.13
	Complex domestic abuse / risks at home (CDA/RaH)	1.04	1.02 to 1.05
	Child's mental health	1.01	1.00 to 1.03
	Physical abuse	0.70	0.69 to 0.71
	Neglect	1.01	1.00 to 1.03
	Concerns about another person in the family or household	1.17	1.15 to 1.19
	Sexual abuse	0.60	0.59 to 0.61
	Risks in and outside the home	1.30	1.27 to 1.32
	Other	0.82	0.81 to 0.82

Appendix 12: Factors affecting repeat CP plans (univariate models):

Characteristics	Category	Univariate model	
		HR	CI
Gender	Male	Ref	
	Female	1.00	0.97 to 1.04
Age	Under 1	Ref	
	1-4 Years	1.31	1.23 to 1.39
	5-9 Years	1.11	1.05 to 1.18
	10-15 Years	1.03	0.97 to 1.09
	16-17 Years	0.42	0.36 to 0.48
Ethnicity	Asian	0.69	0.64 to 0.76
	Black	0.63	0.57 to 0.69
	Mixed	0.95	0.90 to 1.01
	Other	0.77	0.65 to 0.90
	White	Ref	
Deprivation	Low dep. LA | Low dep. LSOA	1.19	1.02 to 1.39
	Low dep. LA | Mid dep. LSOA	1.23	1.15 to 1.30
	Low dep. LA | High dep. LSOA	1.33	1.16 to 1.53
	Mid dep. LA | Low dep. LSOA	0.77	0.61 to 0.98
	Mid dep. LA | Mid dep. LSOA	Ref	
	Mid dep. LA | High dep. LSOA	1.11	1.05 to 1.17
	High dep. LA | Low dep. LSOA	1.25	0.65 to 2.40
	High dep. LA | Mid dep. LSOA	0.93	0.85 to 1.03
	High dep. LA | High dep. LSOA	1.14	1.07 to 1.22
Prior CPP	No	Ref	
	Yes	1.75	1.69 to 1.82
Length of CPP	<3 months	Ref	
	3 to 12 months	1.16	1.11 to 1.22
	>1 year	1.37	1.30 to 1.45
CPP category	Emotional abuse	Ref	
	Neglect	0.92	0.88 to 0.96
	Physical abuse	0.72	0.67 to 0.78
	Sexual abuse	0.59	0.53 to 0.66
	Multiple abuse	0.90	0.83 to 0.98
Factors (LCA)	Domestic abuse and violence	Ref	
	Complexities around parental mental health	1.03	0.97 to 1.08
	Disability	0.75	0.68 to 0.83
	Risks outside the home	0.86	0.76 to 0.97
	Complex domestic abuse / risks at home (CDA/RaH)	1.01	0.96 to 1.07
	Child's mental health	0.72	0.64 to 0.82
	Physical abuse	0.67	0.60 to 0.74
	Neglect	0.92	0.84 to 0.99
	Concerns about another person in the family or household	1.09	1.01 to 1.18
	Sexual abuse	0.61	0.53 to 0.70
	Risks in and outside the home	0.93	0.84 to 1.04
	Other	0.88	0.81 to 0.96

Appendix 13: Factors affecting repeat periods of care (univariate models):

Characteristics	Category	Univariate model	
		HR	CI
Gender	Male		
	Female	1.03	0.98 to 1.07
Age	Under 1		
	1-4 Years	1.17	1.05 to 1.31
	5-9 Years	1.36	1.22 to 1.51
	10-15 Years	3.06	2.79 to 3.35
	16-17 Years	2.75	2.45 to 3.08
Ethnicity	Asian	0.49	0.44 to 0.55
	Black	0.67	0.62 to 0.73
	Mixed	0.95	0.88 to 1.03
	Other	0.57	0.49 to 0.67
	White		
Prior POC	No		
	Yes	3.06	2.91 to 3.22
POC length	<12 months		
	12+ months	0.70	0.63 to 0.77
Placements within last 12 months	1 to 2		
	3+	1.23	1.13 to 1.34
Section 20	No		
	Yes	2.12	1.98 to 2.27
Placement (exit)	Foster care		
	Foster care (kin)	0.51	0.46 to 0.55
	Childrens homes	2.70	2.53 to 2.88
	Other residential	1.28	1.14 to 1.43
	Independent living	1.57	1.32 to 1.86
	Secure unit / young offender	2.04	1.71 to 2.42
	Other	1.60	1.12 to 2.28
Placement provider (exit)	Local authority / public provision		
	Private	1.28	1.21 to 1.34
	Voluntary/third sector	0.99	0.86 to 1.14
Distance from home (exit)	Under 20 miles		
	Over 20 miles	1.19	1.11 to 1.27
Factors (LCA)	Domestic abuse and violence		
	Complexities around parental mental health	1.07	0.96 to 1.19
	Disability	2.79	2.50 to 3.10
	Risks outside the home	2.22	2.00 to 2.46
	Complex domestic abuse / risks at home (CDA/RaH)	1.14	1.02 to 1.28
	Child's mental health	2.13	1.91 to 2.39
	Physical abuse	0.58	0.50 to 0.66
	Neglect	0.93	0.81 to 1.06

Characteristics	Category	Univariate model	
		HR	CI
	Concerns about another person in the family or household	1.21	1.04 to 1.42
	Sexual abuse	1.00	0.79 to 1.27
	Risks in and outside the home	2.79	2.50 to 3.10
	Other	1.20	1.06 to 1.34

Appendix 14: Transition between demand categories for children re-referred in different age groups.

Children assessed under 1 \ Children assessed aged 5	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child's mental health	Physical abuse	Neglect	Concerns about another person	Sexual abuse	Risks in and outside the home	Other	All classes
Domestic abuse and violence	44.6%	26.2%	17.7%	26.2%	30.5%	21.1%	25.4%	20.4%	20.3%	21.6%	32.5%	27.1%	29.3%
Complexities around parental mental health	19.9%	36.4%	15.9%	14.3%	29.4%	18.7%	19.5%	19.7%	34.8%	16.2%	12.5%	18.4%	24.8%
Disability	1.7%	2.4%	26.6%	3.6%	5.4%	5.7%	3.6%	4.4%	3.6%	8.1%	7.5%	4.8%	5.3%
Risks outside the home	1.7%	1.7%	1.1%	9.5%	1.6%	5.7%	2.4%	5.1%	5.8%	4.1%	2.5%	1.7%	2.4%
Complex domestic abuse / risks at home	5.4%	7.8%	5.9%	6.0%	8.2%	11.4%	3.6%	6.6%	11.6%	6.8%	2.5%	6.0%	6.9%
Child's mental health	1.1%	1.7%	1.8%	2.4%	1.9%	8.9%	1.8%	0.0%	2.9%	0.0%	5.0%	1.7%	1.9%
Physical abuse	4.7%	1.6%	5.5%	10.7%	3.3%	4.9%	17.2%	7.3%	0.0%	6.8%	0.0%	6.8%	4.8%
Neglect	3.1%	4.3%	8.1%	7.1%	3.3%	4.9%	12.4%	16.8%	2.9%	8.1%	10.0%	9.7%	6.0%
Concerns about another person	3.8%	4.2%	3.3%	2.4%	2.5%	1.6%	3.0%	1.5%	10.1%	1.4%	2.5%	1.9%	3.4%
Sexual abuse	1.8%	2.8%	2.2%	3.6%	1.4%	2.4%	1.2%	2.9%	1.4%	16.2%	2.5%	3.9%	2.7%
Risks in and outside the home	0.3%	0.0%	0.4%	1.2%	0.3%	0.0%	0.0%	0.0%	1.4%	1.4%	2.5%	0.2%	0.3%
Other	12.0%	10.7%	11.4%	13.1%	12.3%	14.6%	10.1%	15.3%	5.1%	9.5%	20.0%	17.9%	12.3%
All classes	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Children assessed aged 5 \ Children assessed aged 10	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child's mental health	Physical abuse	Neglect	Concerns about another person	Sexual abuse	Risks in and outside the home	Other	All classes
Domestic abuse and violence	40.9%	22.4%	8.8%	19.4%	22.8%	13.9%	18.5%	13.0%	16.8%	12.9%	16.2%	16.2%	20.8%
Complexities around parental mental health	17.2%	31.1%	10.2%	14.6%	24.0%	20.4%	11.5%	14.3%	25.5%	12.9%	14.9%	19.4%	19.7%
Disability	3.4%	4.3%	51.7%	5.6%	6.5%	10.6%	6.4%	8.4%	5.1%	8.2%	9.5%	6.8%	12.4%
Risks outside the home	2.7%	1.9%	1.0%	11.1%	0.9%	3.7%	2.5%	4.5%	2.9%	2.4%	6.8%	3.0%	2.7%
Complex domestic abuse / risks at home	5.7%	6.9%	5.8%	4.9%	16.3%	6.9%	5.7%	5.8%	13.9%	7.1%	9.5%	6.3%	7.5%
Child's mental health	1.4%	2.8%	3.2%	2.1%	3.0%	11.0%	1.9%	3.2%	4.4%	7.1%	2.7%	3.0%	3.4%
Physical abuse	6.8%	5.7%	4.4%	10.4%	5.9%	8.6%	21.0%	7.1%	1.5%	7.1%	4.1%	10.8%	7.3%
Neglect	5.4%	6.0%	4.6%	10.4%	5.0%	4.5%	8.3%	18.8%	3.6%	9.4%	8.1%	7.7%	6.6%
Concerns about another person	2.2%	3.7%	0.8%	3.5%	3.8%	2.9%	2.5%	0.6%	8.0%	2.4%	5.4%	2.3%	2.8%
Sexual abuse	2.2%	2.4%	1.8%	4.2%	0.6%	5.3%	2.5%	4.5%	2.2%	15.3%	1.4%	2.6%	2.8%
Risks in and outside the home	0.5%	0.9%	0.4%	0.0%	0.6%	2.0%	0.0%	0.6%	2.2%	0.0%	9.5%	0.5%	0.9%
Other	11.6%	11.9%	7.2%	13.9%	10.7%	10.2%	19.1%	18.8%	13.9%	15.3%	12.2%	21.3%	13.0%
All classes	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Children assessed aged 10 \ Children assessed aged 15	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child's mental health	Physical abuse	Neglect	Concerns about another person	Sexual abuse	Risks in and outside the home	Other	All classes
Domestic abuse and violence	37.6%	18.8%	5.6%	10.8%	16.0%	14.9%	14.3%	19.4%	16.5%	9.8%	15.8%	13.7%	16.0%
Complexities around parental mental health	13.8%	32.9%	4.7%	15.7%	25.9%	16.0%	10.7%	13.9%	27.0%	10.9%	20.3%	13.1%	17.1%
Disability	5.8%	4.8%	56.1%	5.2%	9.9%	10.3%	5.4%	3.7%	12.2%	7.6%	4.8%	6.4%	13.2%
Risks outside the home	7.2%	3.9%	3.0%	14.8%	1.9%	7.4%	6.3%	10.2%	6.1%	4.3%	10.0%	6.2%	6.9%
Complex domestic abuse / risks at home	4.4%	7.9%	6.2%	5.8%	15.2%	7.8%	4.5%	4.6%	5.2%	5.4%	7.7%	4.6%	6.9%
Child's mental health	3.9%	1.8%	5.4%	5.8%	7.2%	12.2%	3.6%	2.8%	4.3%	5.4%	8.4%	4.4%	5.9%
Physical abuse	6.4%	2.7%	3.9%	9.2%	5.3%	7.4%	21.4%	7.4%	1.7%	5.4%	7.7%	8.2%	6.6%
Neglect	3.6%	4.5%	2.6%	7.6%	3.8%	4.4%	9.8%	16.7%	3.5%	7.6%	3.9%	7.0%	5.3%
Concerns about another person	2.8%	4.1%	1.7%	2.0%	3.0%	1.3%	0.9%	1.9%	8.7%	3.3%	3.5%	2.1%	2.6%
Sexual abuse	2.8%	3.6%	1.5%	2.5%	1.1%	3.8%	3.6%	2.8%	0.9%	20.7%	1.9%	4.4%	3.2%
Risks in and outside the home	0.8%	1.8%	1.3%	3.4%	1.5%	1.9%	1.8%	0.9%	0.9%	1.1%	6.8%	1.5%	2.2%
Other	11.0%	13.2%	8.1%	17.3%	9.1%	12.6%	17.9%	15.7%	13.0%	18.5%	9.3%	28.4%	14.1%
All classes	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Appendix 15: Characteristics of children who sat KS2 exams in 2019 (n=643,330), along with the mean KS2 scores for each characteristic:

Characteristics	Count	Column %	Avg KS2 score
Gender			
Male	328,430	*51.1*	60.2
Female	314,900	*48.9*	69.8
Ethnicity			
Asian	71,540	*11.2*	68.9
Black	38,610	*6.0*	64.0
Mixed	38,410	*6.0*	66.3
Other	15,540	*2.4*	64.6
White	474,710	*74.3*	64.3
IMD quintiles			
1 (least deprived)	114,990	*17.9*	74.5
2	111,090	*17.3*	69.7
3	117,900	*18.4*	65.6
4	133,650	*20.8*	62.2
5 (most deprived)	164,390	*25.6*	56.7
FSM eligibility (last 5y)			
No	449,640	*69.9*	70.8
Yes	193,690	*30.1*	51.4
SEN provision			
None	527,340	*82.0*	74.3
SEN support	94,170	*14.6*	25.2
EHC plan	21,830	*3.4*	9.0
SEN provision			
None	527,340	*82.0*	74.3
Learning	48,680	*7.6*	13.6
Behavoural, emotional & social	22,770	*3.5*	34.0
Speech, language & communication	18,040	*2.8*	19.1
Autistic spectrum disorder	11,000	*1.7*	28.0
Physical disability / sensory	6,280	*1.0*	40.5
Other disability	9,220	*1.4*	24.9
Exclusions(last 5y)			
Not excluded	627,970	*97.6*	65.8
Fixed-term / permanently excluded	15,370	*2.4*	27.9
Total number of CSC episodes (last 5y)			
None	546,490	*84.9*	68.4
1	56,160	*8.7*	48.8
2	22,150	*3.4*	42.3
3+	18,540	*2.9*	38.0
Highest level of intervention (last 5y)			
Not referred to CSC	546,430	*84.9*	68.4
Referred no service	28,880	*4.5*	50.7
Child in need	47,430	*7.4*	44.7
Child protection plan	13,380	*2.1*	39.0

Characteristics	Count	Column %	Avg KS2 score
Child in care	7,220	*1.1*	38.5
Child recieved a CSC service in year 11			
No	615,220	*95.6*	66.2
Yes	28,120	*4.4*	38.0
Total time receiving CSC services (last 5y)			
Not CIN	575,720	*89.5*	67.5
Less than 1 year	41,110	*6.4*	47.8
More than 1 year	26,510	*4.1*	35.4
Factors recorded at latest CSC assessment			
No CSC assessment	567,310	*88.2*	67.7
Domestic abuse and violence	15,410	*2.4*	50.6
Complexities around parental mental health	12,460	*1.9*	47.0
Disability	8,120	*1.3*	23.1
Risks outside the home	3,530	*0.5*	43.4
Complex domestic abuse / risks at home	4,990	*0.8*	41.0
Childs mental health	4,150	*0.6*	42.8
Physical abuse	7,060	*1.1*	49.8
Neglect	3,050	*0.5*	39.5
Concerns about another person in the family or household	2,210	*0.3*	40.6
Sexual abuse	3,510	*0.5*	48.5
Risks in and outside the home	950	*0.1*	41.5
Other	10,580	*1.6*	48.1
Latest CP plan category of abuse			
No CPP	626,480	*97.4*	65.6
Emotional abuse	7,210	*1.1*	43.0
Neglect	6,880	*1.1*	32.6
Physical abuse	1,200	*0.2*	44.8
Sexual abuse	700	*0.1*	43.5
Multiple abuse	860	*0.1*	40.1
CLA placement (last placement)			
Not in care	636,120	*98.9*	65.2
Foster care	4,050	*0.6*	37.7
Foster care (kin)	1,640	*0.3*	42.5
Children's homes	220	*k*	6.3
Other residential	30	*k*	9.1
Placed with parents	720	*0.1*	42.5
Other	550	*0.1*	42.2

Notes:
'c' in this table indicates the figures have been suppressed in order to protect confidentiality
'k' is used when a result that is not zero would appear as zero due to rounding

Appendix 16: Characteristics of children who sat KS4 exams in 2019 (n=548,720), along with the mean KS4 scores for each characteristic:

Characteristics	Count	%	Avg KS4 score
Gender			
Male	281,020	*51.2*	43.4
Female	267,700	*48.8*	49.2
Ethnicity			
Asian	58,430	*10.8*	51.0
Black	31,630	*5.8*	44.3
Mixed	27,590	*5.1*	46.8
Other	11,720	*2.2*	49.9
White	412,280	*76.1*	45.6
IMD quintiles			
1 (least deprived)	103,450	*18.9*	53.9
2	98,550	*18.0*	50.0
3	102,200	*18.7*	47.0
4	111,980	*20.4*	43.5
5 (most deprived)	131,630	*24.0*	39.2
FSM eligibility (last 5y)			
No	404,430	*73.7*	49.9
Yes	144,290	*26.3*	35.9
SEN provision			
None	465,810	*84.9*	49.8
SEN support	61,520	*11.2*	30.5
EHC plan	21,390	*3.9*	13.3
SEN provision			
None	465,810	*84.9*	49.8
Learning	34,720	*6.3*	25.8
Behavoural, emotional & social	19,590	*3.6*	21.8
Speech, language & communication	7,430	*1.4*	25.3
Autistic spectrum disorder	9,780	*1.8*	27.9
Physical disability / sensory	5,330	*1.0*	35.3
Other disability	6,060	*1.1*	31.5
Exclusions(last 5y)			
Not excluded	471,550	*85.9*	49.2
Fixed-term / permanently excluded	77,180	*14.1*	28.3
Total number of CSC episodes (last 5y)			
None	464,950	*84.7*	49.0
1	49,360	*9.0*	33.8
2	19,140	*3.5*	28.6
3+	15,270	*2.8*	23.9
Highest level of intervention (last 5y)			
Not referred to CSC	464,920	*84.7*	49.0
Referred no service	24,490	*4.5*	35.9
Child in need	42,260	*7.7*	30.5

Characteristics	Count	%	Avg KS4 score
Child protection plan	9,190	*1.7*	26.3
Child in care	7,870	*1.4*	22.1
Child recieved a CSC service in year 11			
No	521,990	*95.1*	47.4
Yes	26,740	*4.9*	23.3
Total time receiving CSC services (last 5y)			
Not CIN	489,720	*89.2*	48.3
Less than 1 year	35,650	*6.5*	32.9
More than 1 year	23,350	*4.3*	22.3
Factors recorded at latest CSC assessment			
No CSC assessment	483,710	*88.2*	48.4
Domestic abuse and violence	9,290	*1.7*	35.8
Complexities around parental mental health	7,790	*1.4*	33.1
Disability	7,240	*1.3*	18.2
Risks outside the home	8,230	*1.5*	23.9
Complex domestic abuse / risks at home	3,250	*0.6*	29.1
Childs mental health	7,120	*1.3*	29.9
Physical abuse	4,000	*0.7*	36.2
Neglect	1,940	*0.4*	28.5
Concerns about another person in the family or household	1,480	*0.3*	27.6
Sexual abuse	3,560	*0.6*	36.4
Risks in and outside the home	2,460	*0.4*	17.2
Other	8,660	*1.6*	33.8
Latest CP plan category of abuse			
No CPP	536,970	*97.9*	46.7
Emotional abuse	4,660	*0.8*	29.0
Neglect	4,750	*0.9*	20.4
Physical abuse	840	*0.2*	27.6
Sexual abuse	830	*0.2*	27.2
Multiple abuse	670	*0.1*	25.5
CLA placement (last placement)			
Not in care	541,090	*98.6*	46.6
Foster care	4,470	*0.8*	25.7
Foster care (kin)	1,110	*0.2*	27.1
Childrens homes	980	*0.2*	7.7
Other residential	100	*k*	4.2
Placed with parents	620	*0.1*	22.6
Independent living	180	*k*	11.3
Secure unit / young offender	110	*k*	3.3
Other	70	*k*	20.8

Notes:
'c' in this table indicates the figures have been suppressed in order to protect confidentiality
'k' is used when a result that is not zero would appear as zero due to rounding

Appendix 17: Exclusion rate (%) for children in year 7 (KS2) (n=643,330)

Characteristics	%
Gender	
Male	2.0%
Female	0.3%
Ethnicity	
Asian	0.5%
Black	1.4%
Mixed	1.7%
Other	0.6%
White	1.2%
IMD quintiles	
1 (least deprived)	0.5%
2	0.7%
3	1.0%
4	1.3%
5 (most deprived)	2.0%
FSM eligibility (last 5y)	
No	0.6%
Yes	2.6%
SEN provision	
None	0.6%
SEN support	3.7%
EHC plan	5.3%
SEN provision	
None	0.6%
Learning	1.9%
Behavoural, emotional & social	12.2%
Speech, language & communication	2.1%
Autistic spectrum disorder	3.1%
Physical disability / sensory	1.1%
Other disability	2.3%
Total number of CSC episodes (last 5y)	
None	0.7%
1	2.9%
2	4.5%
3+	6.6%
Highest level of intervention (last 5y)	
Not referred to CSC	0.7%
Referred no service	3.0%
Child in need	3.8%
Child protection plan	6.2%
Child in care	5.1%
Child recieved a CSC service in year 11	
No	1.0%
Yes	5.7%
Total time receiving CSC services (last 5y)	
Not CIN	0.8%
Less than 1 year	3.6%

Characteristics	%
More than 1 year	5.6%
Factors recorded at latest CSC assessment	
No CSC assessment	0.8%
Domestic abuse and violence	3.5%
Complexities around parental mental health	3.9%
Disability	4.1%
Risks outside the home	7.2%
Complex domestic abuse / risks at home	6.0%
Childs mental health	7.1%
Physical abuse	4.2%
Neglect	4.8%
Concerns about another person in the family or household	5.9%
Sexual abuse	3.0%
Risks in and outside the home	8.1%
Other	3.5%
Latest CP plan category of abuse	
No CPP	1.1%
Emotional abuse	5.7%
Neglect	7.1%
Physical abuse	6.3%
Sexual abuse	4.1%
Multiple abuse	5.5%
CLA placement (last placement)	
Not in care	1.1%
Foster care	5.4%
Foster care (kin)	3.8%
Childrens homes	12.1%
Other residential	c
Placed with parents	6.2%
Independent living	c
Secure unit / young offender	c
Other	2.7%

Notes:
'c' in this table indicates the figures have been suppressed in order to protect confidentiality
'k' is used when a result that is not zero would appear as zero due to rounding

Appendix 18: Exclusion rate (%) for children in year 11 (KS4) (n=548,720)

Characteristics	%
Gender	
Male	7.6%
Female	3.5%
Ethnicity	
Asian	3.8%
Black	7.3%
Mixed	7.5%
Other	4.3%
White	5.6%
IMD quintiles	
1 (least deprived)	3.2%
2	4.1%
3	5.1%
4	6.3%
5 (most deprived)	8.3%
FSM eligibility (last 5y)	
No	3.9%
Yes	10.2%
SEN provision	
None	4.5%
SEN support	12.5%
EHC plan	8.3%
SEN provision	
None	4.5%
Learning	8.3%
Behavioural, emotional & social	23.4%
Speech, language & communication	7.6%
Autistic spectrum disorder	5.9%
Physical disability / sensory	4.1%
Other disability	10.2%
Total number of CSC episodes (last 5y)	
None	4.0%
1	11.4%
2	15.9%
3+	20.4%
Highest level of intervention (last 5y)	
Not referred to CSC	4.0%
Referred no service	11.8%
Child in need	13.9%
Child protection plan	17.6%
Child in care	17.7%
Child recieved a CSC service in year 11	
No	4.9%
Yes	18.2%
Total time receiving CSC services (last 5y)	
Not CIN	4.4%
Less than 1 year	14.5%

Characteristics	%
More than 1 year	15.8%
Factors recorded at latest CSC assessment	
No CSC assessment	4.3%
Domestic abuse and violence	12.4%
Complexities around parental mental health	14.2%
Disability	8.6%
Risks outside the home	27.1%
Complex domestic abuse / risks at home	14.5%
Childs mental health	15.0%
Physical abuse	11.8%
Neglect	13.8%
Concerns about another person in the family or household	18.6%
Sexual abuse	9.8%
Risks in and outside the home	27.6%
Other	13.6%
Latest CP plan category of abuse	
No CPP	5.3%
Emotional abuse	17.4%
Neglect	20.0%
Physical abuse	16.4%
Sexual abuse	17.3%
Multiple abuse	15.9%
CLA placement (last placement)	
Not in care	5%
Foster care	15%
Foster care (kin)	17%
Childrens homes	21%
Other residential	22%
Placed with parents	20%
Independent living	28%
Secure unit / young offender	29%
Other	13%

Notes:
'c' in this table indicates the figures have been suppressed in order to protect confidentiality
'k' is used when a result that is not zero would appear as zero due to rounding

Appendix 19: Proportion of episodes in each demand category by local authority (England)

	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child' s mental health	Physical abuse	Neglect	Concerns about another person in the family or household	Sexual abuse	Risks in and outside the home	Other	All classes
Hartlepool	18.5%	29.0%	8.6%	8.2%	5.5%	6.0%	6.4%	5.3%	3.5%	2.7%	4.3%	1.9%	100.0%
Middlesbrough	16.0%	23.0%	19.4%	7.9%	5.1%	8.7%	6.3%	3.6%	3.8%	2.0%	2.1%	2.2%	100.0%
Redcar and Cleveland	13.5%	24.8%	6.9%	8.7%	4.5%	11.8%	7.0%	6.7%	3.5%	4.5%	5.3%	2.9%	100.0%
Stockton-on-Tees	20.6%	21.3%	9.5%	6.3%	4.9%	6.1%	3.6%	11.2%	5.3%	1.6%	8.0%	1.4%	100.0%
Darlington	17.5%	18.4%	9.5%	7.2%	5.6%	8.7%	5.3%	5.2%	13.0%	2.0%	5.4%	2.1%	100.0%
Halton	18.5%	21.4%	8.7%	10.0%	3.6%	10.4%	4.3%	4.8%	3.8%	6.4%	4.9%	3.2%	100.0%
Warrington	19.1%	20.3%	4.0%	9.3%	6.4%	10.4%	6.3%	5.8%	3.4%	6.4%	5.2%	3.5%	100.0%
Blackburn with Darwen	22.3%	25.9%	6.1%	9.0%	6.6%	7.6%	6.1%	5.3%	2.6%	2.4%	3.9%	2.2%	100.0%
Blackpool	21.8%	21.2%	10.3%	11.8%	6.9%	6.5%	4.5%	2.7%	3.0%	5.5%	3.9%	2.0%	100.0%
Kingston upon Hull, City of	16.9%	14.7%	23.5%	8.3%	4.3%	9.0%	4.1%	4.1%	7.3%	2.7%	3.0%	2.1%	100.0%
East Riding of Yorkshire	25.5%	16.1%	9.8%	4.7%	5.4%	1.0%	2.4%	19.2%	7.9%	0.3%	7.7%	0.1%	100.0%
North East Lincolnshire	22.2%	17.8%	7.9%	5.1%	4.8%	8.9%	4.1%	9.3%	8.8%	2.2%	6.1%	2.8%	100.0%
North Lincolnshire	19.9%	13.9%	3.1%	7.1%	6.3%	20.1%	4.6%	8.9%	2.5%	2.9%	6.5%	4.2%	100.0%
York	11.1%	13.6%	48.0%	5.9%	3.4%	3.0%	3.2%	2.0%	3.3%	3.9%	1.8%	0.7%	100.0%
Derby	19.5%	17.8%	5.1%	7.7%	6.6%	11.8%	6.8%	7.7%	4.6%	3.5%	5.2%	3.6%	100.0%
Leicester	19.4%	18.0%	11.6%	7.0%	6.7%	10.8%	4.9%	7.3%	2.9%	4.0%	4.6%	2.8%	100.0%
Rutland	16.1%	20.7%	12.0%	18.3%	5.4%	9.3%	9.4%	0.8%	1.2%	2.9%	1.5%	2.4%	100.0%
Nottingham	16.4%	17.3%	14.5%	9.5%	8.4%	11.0%	7.6%	4.7%	2.4%	2.2%	2.2%	3.7%	100.0%
Herefordshire, County of	19.4%	15.6%	22.8%	6.9%	7.7%	4.3%	4.4%	6.0%	5.3%	2.3%	4.2%	1.1%	100.0%
Telford and Wrekin	15.6%	21.9%	8.8%	12.3%	4.8%	8.2%	5.4%	8.3%	3.4%	3.8%	5.4%	2.0%	100.0%
Stoke-on-Trent	17.1%	21.4%	14.8%	8.8%	6.0%	10.3%	6.4%	3.0%	2.0%	4.6%	2.5%	3.1%	100.0%
Bath and North East Somerset	11.1%	16.6%	30.9%	9.1%	6.5%	7.9%	6.0%	2.1%	2.2%	2.5%	1.3%	3.9%	100.0%
Bristol, City of	17.9%	24.6%	1.1%	11.7%	5.8%	14.1%	6.7%	4.3%	2.4%	5.6%	1.9%	4.0%	100.0%
North Somerset	15.8%	20.4%	10.3%	11.7%	5.2%	12.5%	8.8%	4.3%	1.7%	2.9%	2.1%	4.2%	100.0%

	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child' s mental health	Physical abuse	Neglect	Concerns about another person in the family or household	Sexual abuse	Risks in and outside the home	Other	All classes
South Gloucestershire	20.3%	17.5%	13.6%	10.6%	7.9%	5.6%	5.7%	4.9%	5.6%	2.4%	4.1%	1.9%	100.0%
Plymouth	16.3%	17.7%	2.8%	6.0%	4.2%	9.4%	5.3%	15.2%	5.5%	6.7%	8.0%	2.9%	100.0%
Torbay	9.0%	13.5%	43.8%	6.8%	3.9%	7.9%	4.3%	1.4%	1.0%	3.5%	1.5%	3.6%	100.0%
Swindon	15.3%	12.9%	30.7%	8.7%	6.6%	4.3%	6.1%	5.0%	4.0%	1.7%	2.8%	2.1%	100.0%
Peterborough	14.6%	18.8%	23.1%	10.1%	6.1%	9.5%	4.7%	3.3%	2.3%	2.3%	2.3%	2.8%	100.0%
Luton	18.0%	12.2%	30.1%	8.1%	6.8%	6.2%	4.3%	4.6%	3.2%	2.1%	1.9%	2.4%	100.0%
Southend-on-Sea	18.9%	18.7%	8.0%	10.8%	6.6%	7.7%	6.4%	5.8%	5.4%	3.9%	3.6%	4.2%	100.0%
Thurrock	18.7%	17.5%	9.7%	11.5%	9.2%	9.7%	6.1%	6.1%	3.0%	3.0%	2.6%	2.8%	100.0%
Medway	22.8%	14.5%	13.9%	9.8%	6.6%	5.8%	4.6%	7.7%	3.5%	4.9%	3.9%	2.1%	100.0%
Bracknell Forest	18.6%	17.3%	13.5%	7.0%	9.8%	2.8%	4.2%	11.8%	5.7%	2.4%	5.9%	1.1%	100.0%
West Berkshire	22.6%	22.6%	15.6%	9.1%	6.8%	0.8%	4.4%	4.9%	9.2%	0.2%	3.6%	0.1%	100.0%
Reading	23.6%	14.3%	15.1%	7.2%	9.2%	4.6%	4.9%	7.0%	3.7%	4.7%	3.4%	2.2%	100.0%
Slough	25.1%	19.0%	5.0%	9.9%	9.0%	7.0%	6.4%	7.0%	3.7%	3.2%	2.3%	2.3%	100.0%
Windsor and Maidenhead	21.9%	20.3%	9.4%	5.6%	7.8%	3.1%	6.4%	11.7%	6.2%	0.8%	6.2%	0.6%	100.0%
Wokingham	24.3%	19.6%	6.1%	10.6%	8.9%	4.6%	5.9%	6.7%	3.0%	3.3%	5.1%	1.8%	100.0%
Milton Keynes	13.9%	20.0%	10.6%	12.3%	9.6%	7.2%	9.3%	5.3%	3.0%	2.0%	3.0%	3.8%	100.0%
Brighton and Hove	9.6%	25.9%	1.9%	14.2%	7.4%	13.2%	9.9%	2.7%	2.0%	6.1%	2.6%	4.6%	100.0%
Portsmouth	27.4%	13.0%	7.2%	6.0%	6.9%	0.8%	1.3%	7.6%	24.9%	0.6%	4.1%	0.2%	100.0%
Southampton	15.1%	17.9%	21.6%	9.6%	3.8%	11.5%	4.6%	4.2%	2.8%	4.2%	2.1%	2.5%	100.0%
Isle of Wight	15.7%	21.5%	16.6%	9.6%	5.3%	3.9%	3.7%	6.4%	11.9%	0.9%	3.7%	0.8%	100.0%
County Durham	20.9%	25.4%	13.2%	4.9%	6.6%	4.6%	4.7%	5.3%	6.3%	1.7%	5.4%	1.1%	100.0%
Cheshire East	19.0%	20.1%	12.0%	10.0%	6.2%	9.0%	7.4%	4.0%	3.6%	2.1%	3.2%	3.4%	100.0%
Cheshire West and Chester	20.3%	24.4%	4.9%	11.1%	5.1%	10.8%	7.6%	4.5%	1.4%	4.0%	2.9%	3.1%	100.0%
Shropshire	12.1%	22.4%	5.2%	9.5%	6.1%	15.2%	7.2%	4.7%	3.5%	6.2%	2.8%	5.0%	100.0%
Cornwall	16.4%	24.9%	16.7%	11.1%	5.3%	4.7%	5.7%	3.6%	4.7%	1.6%	4.2%	1.0%	100.0%
Wiltshire	15.7%	19.7%	9.3%	11.4%	5.3%	12.1%	8.0%	3.4%	2.4%	4.9%	3.5%	4.2%	100.0%

	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child' s mental health	Physical abuse	Neglect	Concerns about another person in the family or household	Sexual abuse	Risks in and outside the home	Other	All classes
Bedford	21.3%	17.7%	12.7%	11.4%	7.9%	8.2%	3.5%	5.1%	4.9%	1.0%	4.4%	1.7%	100.0%
Central Bedfordshire	20.9%	20.1%	10.0%	9.1%	8.1%	6.2%	5.3%	4.9%	3.4%	3.9%	5.3%	2.7%	100.0%
Northumberland	14.5%	24.5%	8.5%	11.1%	5.8%	9.6%	12.5%	2.8%	1.7%	3.1%	2.8%	3.1%	100.0%
Bolton	19.9%	20.0%	8.4%	8.6%	6.0%	10.7%	4.6%	7.4%	3.7%	2.8%	4.8%	3.1%	100.0%
Bury	18.7%	24.5%	4.4%	12.5%	6.6%	9.6%	9.2%	2.5%	2.2%	3.9%	1.7%	4.2%	100.0%
Manchester	17.2%	11.3%	32.2%	5.5%	7.0%	4.5%	4.2%	7.8%	4.1%	2.3%	2.4%	1.6%	100.0%
Oldham	26.4%	15.7%	10.2%	7.6%	9.2%	4.5%	4.0%	9.1%	4.2%	3.5%	4.1%	1.4%	100.0%
Rochdale	21.9%	22.9%	7.6%	9.0%	7.1%	9.8%	6.4%	2.9%	3.2%	2.9%	2.8%	3.5%	100.0%
Salford	24.1%	21.9%	2.6%	9.9%	4.8%	10.8%	6.2%	4.7%	2.3%	5.4%	4.0%	3.2%	100.0%
Stockport	26.9%	21.1%	14.3%	7.1%	5.8%	2.8%	4.9%	6.2%	5.8%	1.1%	2.8%	1.2%	100.0%
Tameside	19.5%	22.1%	6.8%	6.9%	7.1%	12.1%	7.6%	4.3%	2.2%	3.6%	3.8%	4.2%	100.0%
Trafford	13.7%	18.2%	23.1%	8.1%	5.9%	10.7%	6.0%	3.5%	2.1%	2.8%	2.3%	3.7%	100.0%
Wigan	17.4%	24.2%	14.1%	9.9%	5.6%	7.6%	5.7%	3.7%	2.1%	2.2%	5.2%	2.3%	100.0%
Knowsley	17.5%	23.8%	11.7%	10.2%	8.4%	7.9%	5.0%	4.4%	2.5%	1.9%	2.7%	4.1%	100.0%
Liverpool	16.8%	13.8%	42.1%	3.1%	5.8%	3.5%	2.9%	5.0%	2.9%	1.0%	2.0%	1.1%	100.0%
St. Helens	13.6%	25.2%	14.4%	11.3%	5.5%	9.2%	7.6%	2.3%	1.1%	3.7%	2.5%	3.5%	100.0%
Sefton	21.1%	23.1%	9.8%	7.2%	6.6%	9.8%	8.2%	2.9%	1.8%	3.4%	2.8%	3.3%	100.0%
Wirral	18.1%	19.6%	4.3%	10.7%	5.8%	10.2%	6.5%	8.3%	3.9%	3.5%	5.6%	3.6%	100.0%
Barnsley	20.7%	19.9%	18.8%	8.5%	5.6%	3.3%	3.7%	4.6%	9.0%	0.7%	4.7%	0.6%	100.0%
Doncaster	18.0%	26.1%	12.6%	8.0%	6.3%	6.3%	5.4%	6.3%	3.0%	1.9%	4.4%	1.7%	100.0%
Rotherham	14.4%	17.5%	26.7%	4.3%	6.1%	10.6%	5.3%	3.6%	3.1%	2.2%	4.0%	2.2%	100.0%
Sheffield	19.6%	21.2%	12.3%	12.3%	6.7%	5.9%	6.7%	4.2%	3.0%	3.4%	2.8%	2.1%	100.0%
Newcastle upon Tyne	16.0%	17.0%	15.7%	7.9%	4.4%	12.2%	5.4%	4.9%	2.9%	7.0%	2.8%	3.8%	100.0%
North Tyneside	22.0%	23.1%	16.5%	5.4%	4.6%	3.1%	4.3%	8.0%	7.6%	1.0%	3.5%	0.9%	100.0%
South Tyneside	18.0%	25.3%	6.5%	11.0%	5.1%	9.5%	8.5%	3.7%	3.6%	4.0%	1.4%	3.2%	100.0%
Sunderland	21.2%	20.9%	3.8%	7.4%	11.4%	5.6%	5.6%	6.1%	8.6%	2.0%	5.4%	2.2%	100.0%

	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child' s mental health	Physical abuse	Neglect	Concerns about another person in the family or household	Sexual abuse	Risks in and outside the home	Other	All classes
Birmingham	24.4%	18.6%	2.8%	9.1%	6.3%	11.9%	5.8%	6.3%	2.9%	5.4%	2.7%	3.9%	100.0%
Coventry	24.4%	20.6%	2.8%	7.6%	6.7%	8.7%	5.9%	9.3%	3.8%	3.3%	3.9%	3.0%	100.0%
Dudley	24.0%	11.8%	22.0%	6.7%	5.7%	0.7%	2.7%	11.7%	7.8%	0.2%	6.4%	0.2%	100.0%
Sandwell	28.5%	19.2%	9.6%	4.9%	7.3%	8.0%	5.4%	6.8%	3.5%	2.4%	2.6%	1.9%	100.0%
Solihull	18.5%	21.9%	16.9%	8.0%	5.4%	10.2%	7.2%	3.0%	1.3%	3.6%	1.3%	2.8%	100.0%
Walsall	26.0%	13.6%	21.7%	5.7%	5.7%	3.1%	2.3%	7.7%	8.7%	2.1%	2.5%	0.8%	100.0%
Wolverhampton	26.0%	22.0%	18.5%	7.9%	6.9%	2.3%	2.4%	3.6%	7.6%	0.4%	1.8%	0.6%	100.0%
Bradford	12.9%	10.8%	48.5%	4.4%	3.9%	6.5%	3.6%	2.4%	1.3%	1.7%	1.8%	2.0%	100.0%
Calderdale	26.0%	22.8%	9.0%	4.8%	4.6%	6.5%	3.3%	8.4%	6.1%	0.7%	6.4%	1.4%	100.0%
Kirklees	15.7%	16.1%	25.9%	10.1%	6.3%	6.9%	5.1%	3.0%	2.0%	2.7%	3.3%	2.9%	100.0%
Leeds	30.8%	5.9%	9.3%	3.1%	8.8%	3.5%	3.1%	17.3%	8.6%	2.0%	6.7%	0.8%	100.0%
Wakefield	19.3%	11.3%	28.6%	5.4%	5.3%	1.1%	2.3%	6.0%	12.9%	0.8%	6.8%	0.3%	100.0%
Gateshead	15.2%	18.2%	10.8%	14.1%	6.6%	12.9%	4.6%	3.4%	2.1%	3.9%	3.2%	5.0%	100.0%
Barking and Dagenham	21.6%	14.0%	15.6%	8.7%	9.8%	3.4%	4.6%	8.7%	8.3%	1.4%	2.6%	1.3%	100.0%
Barnet	22.0%	16.7%	14.3%	8.9%	9.5%	6.8%	7.2%	5.9%	2.0%	2.2%	1.7%	2.7%	100.0%
Bexley	17.1%	16.9%	10.3%	13.7%	9.4%	6.7%	8.9%	6.8%	2.1%	2.4%	2.7%	2.8%	100.0%
Brent	26.3%	11.9%	18.8%	9.8%	7.3%	1.6%	3.0%	10.5%	6.7%	1.0%	2.6%	0.5%	100.0%
Bromley	21.1%	17.4%	6.1%	10.0%	7.3%	8.9%	9.0%	6.2%	2.6%	5.0%	2.7%	3.7%	100.0%
Camden	20.7%	21.7%	10.3%	11.9%	10.5%	4.6%	6.0%	7.6%	2.4%	1.0%	2.0%	1.4%	100.0%
Croydon	15.9%	13.8%	16.7%	11.0%	11.2%	6.4%	4.4%	9.6%	5.8%	0.8%	2.0%	2.4%	100.0%
Ealing	25.3%	16.2%	18.3%	8.0%	12.4%	1.4%	4.3%	7.5%	4.2%	0.3%	1.8%	0.4%	100.0%
Enfield	20.6%	16.1%	16.2%	10.9%	8.1%	6.4%	5.6%	5.3%	4.0%	2.9%	1.2%	2.6%	100.0%
Greenwich	21.3%	15.5%	6.5%	13.3%	9.7%	5.2%	5.9%	8.9%	3.4%	5.6%	2.4%	2.2%	100.0%
Hackney	16.8%	16.8%	13.1%	7.2%	8.1%	3.8%	4.6%	10.8%	14.1%	1.6%	2.0%	1.1%	100.0%
Hammersmith and Fulham	21.6%	18.1%	22.2%	7.1%	9.9%	2.6%	6.2%	6.6%	2.7%	0.5%	1.1%	1.3%	100.0%
Haringey	22.9%	10.5%	21.7%	10.0%	10.2%	1.7%	3.5%	9.6%	5.4%	1.4%	2.4%	0.7%	100.0%

	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child' s mental health	Physical abuse	Neglect	Concerns about another person in the family or household	Sexual abuse	Risks in and outside the home	Other	All classes
Harrow	25.0%	16.6%	12.6%	10.0%	8.2%	2.1%	5.1%	13.3%	3.7%	0.7%	2.3%	0.5%	100.0%
Havering	20.8%	14.7%	16.2%	6.3%	11.1%	2.2%	4.5%	10.8%	7.8%	1.0%	3.6%	0.9%	100.0%
Hillingdon	20.5%	16.1%	14.0%	10.2%	11.8%	6.1%	6.1%	5.5%	3.4%	2.0%	2.0%	2.3%	100.0%
Hounslow	20.9%	18.7%	22.0%	8.4%	6.8%	5.1%	5.4%	5.1%	3.6%	0.8%	1.6%	1.6%	100.0%
Islington	21.1%	18.0%	9.1%	10.2%	10.4%	8.1%	7.4%	5.5%	1.9%	3.2%	1.6%	3.5%	100.0%
Kensington and Chelsea	11.5%	5.5%	63.4%	5.4%	6.5%	0.4%	5.6%	0.2%	0.0%	0.8%	0.1%	0.7%	100.0%
Kingston upon Thames	18.0%	19.4%	8.3%	12.8%	8.2%	10.5%	8.4%	4.8%	1.8%	2.5%	1.5%	3.8%	100.0%
Lambeth	18.2%	9.6%	27.6%	10.5%	11.6%	2.3%	3.9%	6.5%	4.3%	2.2%	2.1%	1.4%	100.0%
Lewisham	17.0%	16.0%	17.0%	12.3%	8.2%	8.2%	5.3%	6.9%	2.5%	2.4%	1.8%	2.4%	100.0%
Merton	22.5%	14.5%	6.9%	11.8%	9.3%	7.0%	7.6%	8.1%	2.5%	4.1%	2.6%	3.0%	100.0%
Newham	25.5%	16.0%	9.0%	10.2%	9.1%	6.0%	4.9%	8.5%	3.2%	2.0%	3.0%	2.5%	100.0%
Redbridge	24.7%	14.6%	20.8%	8.4%	9.3%	3.7%	5.0%	6.9%	2.9%	1.1%	1.3%	1.2%	100.0%
Richmond upon Thames	15.0%	19.6%	5.6%	14.7%	10.1%	11.6%	9.5%	3.3%	1.2%	2.7%	1.4%	5.2%	100.0%
Southwark	20.3%	11.2%	12.8%	11.8%	11.0%	6.0%	5.8%	8.1%	3.2%	4.2%	3.1%	2.4%	100.0%
Sutton	23.1%	19.4%	6.2%	6.8%	6.8%	6.2%	12.9%	10.8%	3.3%	0.4%	2.7%	1.5%	100.0%
Tower Hamlets	21.1%	14.7%	15.4%	9.4%	12.9%	2.7%	4.8%	9.4%	5.2%	0.7%	2.4%	1.3%	100.0%
Waltham Forest	22.6%	10.1%	17.9%	7.5%	12.8%	3.0%	4.1%	9.2%	4.8%	4.2%	2.5%	1.3%	100.0%
Wandsworth	22.1%	14.4%	15.5%	7.1%	15.5%	1.1%	5.3%	5.8%	10.8%	0.4%	1.6%	0.5%	100.0%
Westminster	21.5%	14.0%	26.1%	8.7%	10.5%	1.8%	5.3%	5.1%	4.1%	0.5%	1.3%	1.0%	100.0%
Buckinghamshire	21.5%	20.7%	5.0%	13.2%	5.2%	10.6%	7.4%	3.2%	2.4%	5.9%	1.8%	3.1%	100.0%
Cambridgeshire	15.2%	20.6%	7.5%	13.2%	4.7%	11.8%	7.7%	4.9%	2.6%	5.6%	2.7%	3.4%	100.0%
Cumbria	16.4%	24.5%	12.0%	10.1%	5.5%	9.9%	7.8%	2.8%	1.8%	3.7%	2.7%	2.9%	100.0%
Derbyshire	16.0%	13.8%	14.0%	7.3%	4.6%	9.3%	11.7%	9.6%	4.3%	1.5%	6.8%	1.2%	100.0%
Devon	14.0%	18.7%	12.8%	13.5%	4.0%	11.3%	6.4%	2.8%	3.7%	6.3%	2.5%	4.2%	100.0%
East Sussex	11.7%	17.5%	6.1%	9.1%	6.5%	19.0%	8.7%	2.2%	1.8%	5.8%	4.6%	7.1%	100.0%
Essex	21.7%	23.8%	5.8%	12.2%	4.7%	8.4%	4.7%	4.6%	3.4%	5.4%	3.3%	1.9%	100.0%

	Domestic abuse and violence	Complexities around parental mental health	Disability	Risks outside the home	Complex domestic abuse / risks at home	Child' s mental health	Physical abuse	Neglect	Concerns about another person in the family or household	Sexual abuse	Risks in and outside the home	Other	All classes
Gloucestershire	14.8%	21.2%	12.4%	5.8%	5.6%	15.8%	8.9%	2.8%	1.6%	4.4%	1.6%	5.1%	100.0%
Hampshire	14.1%	11.6%	31.2%	7.2%	4.1%	1.5%	2.4%	7.5%	16.4%	0.2%	3.5%	0.3%	100.0%
Hertfordshire	16.2%	22.7%	15.1%	8.9%	3.7%	11.0%	6.0%	4.6%	2.8%	3.1%	3.0%	2.7%	100.0%
Kent	21.6%	10.3%	7.1%	14.0%	8.2%	6.4%	9.9%	4.7%	2.3%	8.7%	3.1%	3.7%	100.0%
Lancashire	13.4%	19.0%	22.2%	8.6%	5.4%	12.1%	6.7%	2.3%	1.4%	3.0%	2.6%	3.4%	100.0%
Leicestershire	24.2%	23.5%	10.4%	11.2%	7.3%	3.9%	7.9%	3.9%	2.3%	1.0%	3.2%	1.2%	100.0%
Lincolnshire	24.5%	20.9%	5.7%	7.7%	3.7%	6.6%	3.3%	10.1%	5.4%	3.0%	8.0%	1.2%	100.0%
Norfolk	15.1%	18.6%	6.9%	11.3%	5.7%	10.7%	10.4%	5.4%	3.5%	5.2%	3.4%	3.8%	100.0%
Northamptonshire	18.9%	19.6%	3.6%	7.3%	6.6%	13.0%	6.8%	5.1%	4.5%	6.2%	3.8%	4.6%	100.0%
North Yorkshire	17.3%	20.4%	21.0%	6.4%	6.4%	5.7%	6.3%	5.7%	2.4%	2.3%	4.1%	2.0%	100.0%
Nottinghamshire	24.3%	19.6%	7.0%	10.3%	10.8%	2.8%	4.6%	6.5%	3.4%	4.9%	4.9%	0.9%	100.0%
Oxfordshire	19.2%	19.8%	10.2%	9.4%	7.8%	6.1%	6.7%	7.9%	3.1%	3.1%	3.9%	2.7%	100.0%
Somerset	15.8%	21.5%	19.6%	10.6%	4.0%	8.5%	7.4%	2.0%	1.8%	3.3%	2.6%	2.8%	100.0%
Staffordshire	20.8%	24.9%	6.8%	7.9%	6.1%	7.4%	5.7%	3.5%	3.9%	7.1%	3.3%	2.6%	100.0%
Suffolk	17.0%	20.5%	7.8%	9.2%	5.5%	12.0%	7.8%	4.2%	4.6%	4.7%	2.8%	3.8%	100.0%
Surrey	19.3%	19.4%	13.5%	10.7%	7.2%	6.8%	9.4%	3.9%	2.5%	2.3%	2.6%	2.3%	100.0%
Warwickshire	19.6%	15.2%	22.4%	6.8%	7.5%	5.5%	6.4%	5.8%	2.5%	3.4%	3.2%	1.8%	100.0%
West Sussex	24.5%	19.5%	4.6%	8.9%	7.9%	5.5%	5.3%	6.7%	3.9%	5.3%	6.1%	1.8%	100.0%
Worcestershire	18.0%	16.5%	23.4%	6.9%	4.4%	6.6%	4.6%	5.4%	3.2%	4.7%	4.6%	1.7%	100.0%
_All	19.4%	17.8%	14.6%	8.9%	6.8%	7.2%	5.9%	6.1%	4.4%	3.2%	3.5%	2.3%	100.0%