Needs Analysis 2010

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Introduction

The definition of safeguarding used in the Children Act 2004 and in the government guidance Working Together is:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the prohibition of safe and effective care
- undertaking that role so as to enable those children to have a optimum life chances and to enter adulthood successfully.

The aims of the Stay safe Outcome addressed by Bradford Safeguarding Children Board (BSCB) are that all children should:

- be safe from maltreatment, neglect, violence and sexual exploitation
- be safe from accidental injury and death
- be safe from bullying and discrimination
- have security, stability and be cared for

The 2010 Safeguarding Needs Assessment reflects the nature and extent of data on children subject of a Child Protection Plan. Bullying, Sexual Exploitation, Unintentional Injury and Children who go missing from home or care are dealt with separately below in parts 2-5 to reflect their status as BSCB, Children and Young People's Plan or Local Area Agreement priorities. A section on children who go missing from local authority care is included in the Looked After Children Needs Assessment.

The objectives of the Safeguarding Needs Assessment are to:

- explore data on the district's Child Protection population and to identify factors that increase the level of risk for already vulnerable children
- identify opportunities for improving and linking data
- summarise evidence of interventions with success in reducing known risk factors
- summarise evidence of successful ways of reducing negative outcomes for children who have been abused or neglected
- to inform the BCSB Strategic Plan (2007-2011)

For each issue where possible a 'what works?' section signals where there is evidence of effective interventions. This has been constrained by limited time and consists of messages collated from existing evidence reviews rather than a thorough review of the evidence on safeguarding vulnerable children.

The **Bradford District Children's Needs Analysis** was completed in November 2010 and is published and available on the Bradford Observatory website:

Further Needs Assessments on specific vulnerable groups of children in Bradford have been carried out such as **Bradford Looked After Children & Care Leavers** (link to Bradford Children's Integrated Service Improvement Framework website) and **Bradford Disabled Children and Young People** (link to Bradford Observatory website).

Population Demographics

Bradford has a significantly higher proportion of children and young people than the UK average. The total population of Bradford was estimated as 502,000 in 2008 and around 140,000 are children & young people aged 0-19. A large proportion of the Bradford population are from ethnic minority communities, which comprise nearly one quarter of the population total. Three quarters of the population describe themselves as White British; around 18% of the ethnic minority population described themselves as Pakistani (15%) or Indian (3%). The birth rate in Bradford district is continuing to grow and Bradford has a higher percentage of young people in all age groups than is the average for England. The population of children and young people is higher than the national average and projected to rise significantly over the next 20 years by nearly 30%.

Part 1 – Child Protection

1.1 Number of children subject of a Child Protection Plan

The number of children who were the subject of a child protection plan (CPP) as at 30th September 2010 was 378 (a decrease of 27 children since March 2010) and a decrease of 14 since September 09. The proportion of boys (55%) was higher than girls. Most children with a CPP were from young age groups; 44% of children were under 5.

Number of children and young people who were the subject of a Child Protection at 30th September 2010

	BOYS (by Age)						GIRLS (by Age)							
Category of Abuse	Under 1	1-4	5-9	10-15	16 +	TOTAL BOYS	Under 1	1-4	5-9	10-15	16 +	TOTAL GIRLS	Unborn Children	TOTAL CHILDREN
Neglect	16	35	25	22	0	98	10	33	24	23	1	91	2	191
Physical abuse	4	14	6	12	0	36	1	4	5	6	1	17	0	53
Sexual abuse	1	2	5	2	0	10	1	4	5	9	0	19	0	29
Emotional abuse	9	22	18	13	1	63	3	9	15	12	1	40	2	105
Totals	**30**	**73**	**54**	**49**	**1**	**207**	**15**	**50**	**49**	**50**	**3**	**167**	**4**	**378**

As at 31st March 2010, nationally the number of children subject of a plan was 39,100 (an increase of 5,000 compared to the previous year). This is a rate of 35.5 per 10,000 under 18 population; Bradford's rate of 31.5 was lower than the national rate and much lower than the statistical neighbour average of 40.01 per 10,000 child population.

	2010				2009		
	Children who were the subject of a child protection plan at 31 March 2010	Population 0-17 (mid 2009 Estimate)	Rate per 10,000 of children aged under 18 years		Children who were the subject of a plan at 31 March 2009	Rate per 10,000 at 31 March 2009	% change between 2009 and 2010
ENGLAND[4]	**39,100**	**1,101**	**35.50**		34,100	31	14.7%
Kirklees	274	9.40	29.10		230	24	19.1%
Peterborough	119	3.99	29.80		100	25	19.0%
Bradford	405	12.85	31.50		305	24	32.8%
Calderdale	154	4.56	33.80		160	35	-3.8%
Rochdale	190	4.93	38.60		140	29	35.7%
Derby	217	5.32	40.80		135	25	60.7%
Coventry	292	6.81	42.90		300	44	-2.7%
Walsall	277	6.05	45.80		195	33	42.1%
Blackburn with Darwen	180	3.84	46.90		135	35	33.3%
Oldham	304	5.48	55.50		235	43	29.4%
Bolton	367	6.24	58.80		250	41	46.8%
SN Group Average	**2,779**	**69**	**40.01**		2,185	31	27.2%

The number of children who newly became subject of a Child Protection Plan during the period of 1st October 2009 to 30th September 2010 was 404. This is an increase of 21 children compared to the 12 months earlier. 42 children (10.4%) became subject of a plan for a second or subsequent time (very similar to previous year), 9 of these children became subject of a plan within 1 year of cessation of last plan.

Number of children who became the subject of a Child Protection Plan (registrations) during the year ending 30-Sep-2010, by category

Category of abuse	Number of registrations
Neglect	196
Physical abuse	60
Sexual abuse	33
Emotional abuse	115
Multiple/not	0
Totals	**404**

Number of children who became the subject of a Child Protection Plan (registrations) during the year ending 30-Sep-2010, by age group

Age at start of plan/registration	Number of children who became the subject of a Child Protection Plan (registrations)			
	Boys	Girls	Unborn	TOTAL
Under 1	37	16	41	94
1 - 4	65	50	0	115
5 - 9	54	50	0	104
10 - 15	43	45	0	88
16 and over	2	1	0	3
Totals	**201**	**162**	**41**	**404**

In the period of 1st October 2009 to 30th September 2010 there were 408 children whose protection plans ended (an increase of 157 children compared to 12 months previously). Children on average stayed subject of a plan for 12 months. The number of children whose Child Protection Plans had lasted longer than two years was 25 (6.2%) similar to the national average (6%).

Number of children who were de-registered or whose Child Protection Plans were discontinued (ceased) during the year ending 30-Sep-2010, by length of time as the subject of a plan (registered)

Length of time with a Child Protection Plan (registered)	Number of plans discontinued			
	Boys	Girls	Unborn	Total
Under 3 months	21	29	0	50
3 months but under 6 months	15	16	0	31
6 months but under 1 year	96	99	0	195
1 year but under 2 years	62	45	0	107
2 years but under 3 years	16	5	0	21
3 years and over	2	2	0	4
Totals	**212**	**196**	**0**	**408**

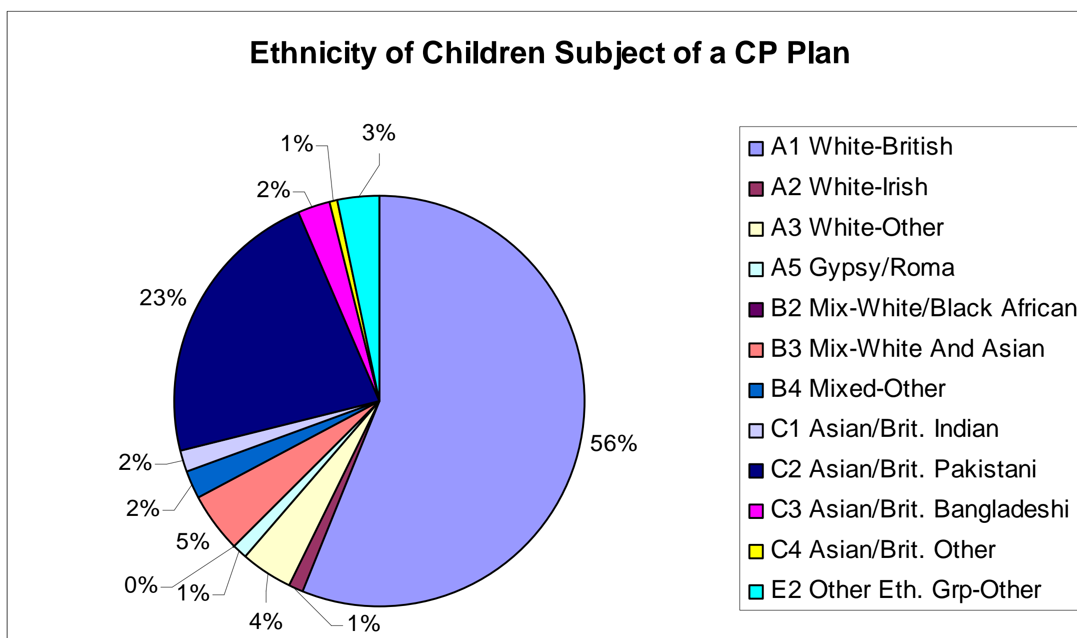
1.2 Ethnicity Profile

According to the 2001 Census 34% of children and young people under 19 in the District were from an ethnic minority background other than White British. 64% of under 19's in Bradford West were from non-White British backgrounds. 24% of dependent children in the District were of Asian or Asian British: Pakistani origin. 50% of children in Bradford West were of Asian or Asian British: Pakistani origin.

Over the past two and a half years the ratio of children subject of a Child Protection Plan that were from minority ethnic groups compared to the proportion of children in the local population that were from minority ethnic groups has changed from 0.77 to 1.22 meaning children from ethnic minority background are over-represented. The increase has primarily been within the Asian British/Pakistani group.

Ethnicity of children subject of a CP plan

Ethnicity		**2006**	**2007**	**2008**	**Mar 2009**	**Sep 2009**	**Sep 2010**
White	White British	199	162	185	209	255	207
	White Irish	2	3	0	0	0	4
	Any other white background	2	0	4	2	8	15
Mixed	White and black Caribbean	5	1	0	9	9	0
	White and black African	2	1	1	5	6	1
	White and Asian	19	13	28	27	25	17
	Any other mixed background	6	0	1	1	1	8
Asian or Asian British	Indian	0	3	1	4	6	6
	Pakistani	31	11	27	38	66	85
	Bangladeshi	1	0	0	0	0	9
	Any other Asian background	1	2	1	1	1	2
Black or Black British	Caribbean	4	5	0	1	1	0
	African	0	1	1	3	0	0
	Any other black background	0	1	0	0	0	0
Other ethnic groups	Chinese	0	0	0	0	0	0
	Any other ethnic group	0	0	6	3	4	12
	Unborn children	4	2	1	2	2	4
	Info not yet obtained					14	8
Total children		**276**	**205**	**256**	**305**	**398**	**378**



1.4 Categories of Abuse

The category of abuse reasons for children subject of a CPP were:

- Neglect (50.5%)
- Emotional Abuse (27.8%)
- Physical Abuse (14%)
- Sexual Abuse (7.7%)

In previous years the rates had remained fairly stable over the last few years both locally and nationally:

Children who were the subject of a Child Protection Plan (CPP), by category of abuse in Bradford

Years ending 31 March 2006 to 2009

Category of abuse	Number				Percent			
	2006	2007	2008	2009	2006	2007	2008	2009
All children	276	205	256	305	*100*	*100*	*100*	*100*
Neglect	125	93	139	153	*45*	*45*	*54*	*50*
Physical abuse	21	34	25	53	*8*	*17*	*10*	*17*
Sexual abuse	27	13	34	21	*10*	*6*	*13*	*7*
Emotional abuse	34	45	54	73	*12*	*22*	*21*	*24*
Multiple / not recommended by 'Working Together'	69	20	4	5	*25*	*10*	*2*	*2*

Children who were the subject of a Child Protection Plan (CPP), by category of abuse (Coverage: England) [1, 2].

Years ending 31 March 2005 to 2009

Category of abuse	Number					Percentage				
	2005	2006	2007	2008	2009	2005	2006	2007	2008	2009
All children	25,900	26,400	27,900	29,200	34,100	*100*	*100*	*100*	*100*	*100*
Neglect	11,400	11,800	12,500	13,400	15,800	*44*	*45*	*45*	*46*	*46*
Physical abuse	3,900	3,600	3,500	3,400	4,400	*15*	*14*	*12*	*12*	*13*
Sexual abuse	2,400	2,300	2,000	2,000	2,000	*9*	*9*	*7*	*7*	*6*
Emotional abuse	5,200	6,000	7,100	7,900	9,100	*20*	*23*	*25*	*27*	*27*
Multiple / not recommended by 'Working Together' [3]	3,000	2,700	2,700	2,500	2,900	*12*	*10*	*10*	*9*	*8*

Source: CPR3

1. Figures may not add due to rounding.
2. This table includes unborn children.
3. 'Multiple' refers to instances where there is more than one main category of abuse. These children are not counted under the other abuse headings, so a child can appear only once in this table. 'Not recommended' refers to classificatory categories not recommended by 'Working Together' (1999).

Source: DCSF (September 2009)

Ethnicity and Categories of Abuse

Analysis shows that Asian children were more likely to become subject of a CP plan due to emotional abuse reasons rather than neglect.

Children subject of a CP plan by ethnicity and category of abuse

	Category of Abuse				
Ethnicity	**Emotional**	**Neglect**	**Physical**	**Sexual**	**Grand Total**
A1 White-British	50	120	17	17	207
A2 White-Irish		4			4
A3 White-Other	2	13			15
A5 Gypsy/Roma		4			4
B2 Mix-White/Black African			1		1
B3 Mix-White And Asian	7	9		1	17
B4 Mixed-Other	2	3	3		8
C1 Asian/Brit. Indian		2	4		6
C2 Asian/Brit. Pakistani	38	18	15	11	85
C3 Asian/Brit. Bangladeshi	1	4	4		9
C4 Asian/Brit. Other		2			2
E2 Other Eth. Grp-Other		5	7		12
F1 Info not yet obtained	5	7	2		8
Grand Total	**105**	**191**	**53**	**29**	**378**

1.4 Children subject of a CP plan by ward areas

Bradford is amongst the most deprived districts in the country; ranking 32 out of 354 local authorities in England and within the 10% most deprived authorities.

Analysis on looking at where children lived at the point of becoming subject of a child protection plan shows there is appears to be a link between a child becoming subject of a CP plan and living in the most deprived areas.

The area wards with the most children subject of CP plans are Little Horton (46 children = 12.2%), Tong (39 children = 10.3%), Bradford Moor (29 children = 7.7%), Clayton & Fairweather Green (6.6%) Manningham (6.35%) and Toller (6.35%). All these wards contain areas that are amongst the highest 1% of deprived areas nationally.

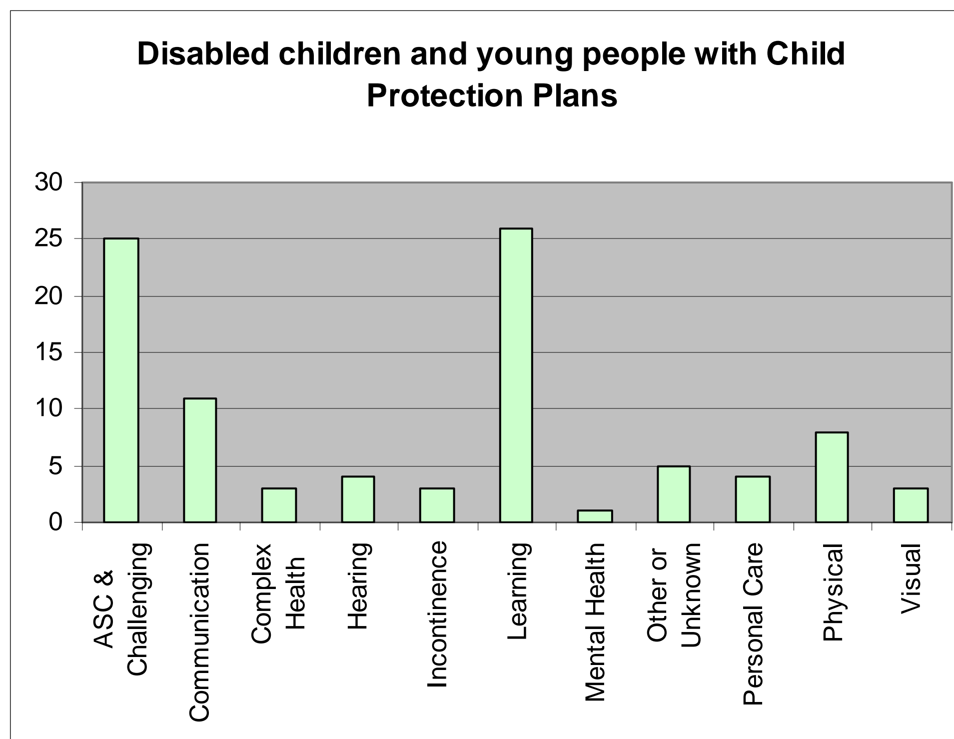
Table 7: Children subject of a CP Plan by ward area

Ward Name	Total
Little Horton	46
Tong	39
Bradford Moor	29
Clayton and Fairweather Green	25
Manningham	24
Toller	24
Bowling and Barkerend	19
Eccleshill	18
Royds	15
City	14
Wibsey	14
Out of Area	13
Keighley Central	12
Keighley East	12
Great Horton	11
Thornton and Allerton	11
Bolton and Undercliffe	10
Heaton	8
Keighley West	7
Windhill and Wrose	6
Craven	5
Wyke	5
Confidential	3
Baildon	2
Bingley	2
Bingley Rural	2
Wharfedale	1
Worth Valley	1
Grand Total	**378**

1.5 Disabled Children and Young People with Child Protection Plans

According to the Bradford Disabled Children and Young People's Needs Analysis 2010, "the numbers of disabled children are disproportionately high in Child Protection Plans. On 6th July 2010, 41 individuals with Child Protection Plans (CP Plans) were identified as being disabled. This represents approximately 10% of all children with CP Plans at that date. As disabled children represent 6.9% of all children in the district at this point in time numbers disabled children were disproportionately high.

The two most represented categories within CP Plans were learning and ASC/challenging behaviour."



Data source: Demographic data July 2010, Social Care ICS data

1.6 Children affected by compromised parenting issues

Children subject to various parental risk factors are particularly at risk of abuse and neglect. The major themes of compromised parenting have been identified as: domestic violence; parental mental health problems; parental substance misuse and children affected by two or more of the three factors.

BSBC carried out a case audit in 2009 involving a sample of 100 children subject of a CP plan in order to identify how much of an issue compromised parenting was. The results were stark; in total, 80 out of the 100 children sampled were affected by one or more forms of compromised parenting. In almost half of the cases domestic violence was a primary issue. Parental mental health was seen as primary issue for 13 of the children whilst parental substance misuse was a primary issue for 19 children.

	Primary Issues						
CP Plan Category	Alcohol & Drug Abuse	Alcohol Abuse	Drug Abuse	Domestic Violence	Mental Health Issues	No Primary Issues	Grand Total
Emotional		4	2	15	4	1	**26**
Neglect	1	5	5	17	6	9	**43**
Physical	1	1		14	2	7	**25**
Physical, Emotional				1			**1**
Sexual					1	3	**4**
Sexual, Emotional				1			**1**
Grand Total	**2**	**10**	**7**	**48**	**13**	**20**	**100**

1.6.1 Domestic Violence

In 2009/10 there were 3,334 incidents of domestic violence reported to the police where children were present. This is a small reduction compared to 2008/09 (3,340 incidents). However, there was an increase of 194 incidents in Airedale / Bradford North division and a reduction of 191 incidents in Bradford South division.

In 2009/10 there were 6,177 children present at incidents reported to the Police. This was an increase of 87 children in comparison to 2008/09. It must be borne in mind that 46% of the incidents were repeat incidents therefore it is difficult to identify how many individual children this accounts for.

The above information ties in with findings from research; half of domestic violence cases between partners or ex-partners take place in households containing a child. In one study, 29% of children reported that they were aware of what was going on, 45% of abused women reported that children were aware of the last incident. (Mirlees-Black, 1999)

1.6.2 What Works? Domestic violence

A 2008 review of research on children and domestic violence established that children cannot be viewed as passive bystanders but are affected and may actively intervene in trying to prevent or reduce violence in the family, putting themselves at risk of violence. (Worrall et al, 2008)

"… children and young people need to understand what is happening to them, to be listened to and helped to develop coping strategies, as well as have their accounts inform the planning and delivery of services." (Worrall et al, 2008)

Increasing recognition of the emotional and psychological impact of domestic abuse on children has meant that the broader safeguarding approach, as opposed to child protection, is welcomed as it provides opportunities to involve all relevant agencies in recognising and reducing the varied impacts of domestic violence on children. However, the consistent identification of domestic violence as a factor in serious case reviews of child death and injury from 2001- 2007 highlights that is remains a significant child protection issue and one in which the literature implies practice has yet to be fully developed and where inter-agency working could be improved. One set of serious case

review authors identify safeguarding training priorities, policies about agency supervision and other aspects of agency management as in need of development:

- keeping a child or children in focus when there may be understandable attention being given to complex and pressing adult family members' needs;
- gathering knowledge about family history as an essential part of assessing and understanding what is happening and what may be family patterns of behaviour in stressful situations;
- ensuring that children are seen by practitioners, and that children are acknowledged as important contributors as part of safeguarding work with a family;
- recognising the emotional impact, and its consequences, of work with children and families experiencing severe difficulties, particularly where violence and conflict are inherent in family interactions;
- reinforcing the importance of all practitioners assessing a child within a developmental/ecological framework and ensuring appropriate training;
- addressing issues of risk of harm in the context of evidence from systematic reviews of risk factors, particularly for the recurrence of maltreatment (see Hindley et al 2006);
- giving careful attention to the processes of analysis of information, decision making and planning (see Jones et al 2006);
- addressing interagency communication and the factors which facilitate or inhibit effective interagency working (see Hudson et al 1999).

(Rose and Barnes, 2008)

1.6.3 What Works? Parental mental health issues

"(P)arenting interventions that improve maternal psychological wellbeing may therefore impact positively on child safety practices and childhood unintentional injury." (Kendrick et al, 2007a)

The Social Care Institute for Excellence has formalised the messages from 20 years of research and practice review into its 2009 guide to parental mental health and child welfare. It recommends:

Signposting and improving access to services
A multi-agency communications strategy to tackle stigma and fears that parents and children have about approaching and receiving services

Screening
Routinely and reliably identify and record information about which adults with mental health problems are parents, and which children have parents with mental health problems. Ensure the right questions are asked and data recorded for future use.

Assessment
Adapt existing assessment and recording processes to take account of the whole family using 'family' threshold criteria for access to services to take into account the individual **and** combined needs of parents, carers and children. Strategies for the management of joint cases should be recorded where the situation is complex or there is a high risk of poor outcomes for children and parents.

Planning care
Care planning needs to meet the needs of each individual family member as well as the family as a whole, and staff should aim to increase understanding and resilience in family members and reduce stressors as this can strengthen their ability to cope. Allocating an individual budget could provide this flexibility.

Providing care
Commission to meet the full spectrum of needs, including the practical priorities of parents with mental health problems and their children, using non-traditional and creative ways of delivering accessible services.
Reviewing care plans
Reviews should consider changes in family circumstances over time, include both individual and family goals, and involve children and carers in the process.
Strategic approach
Multi-agency, senior-level commitment is required and we recommend that a 'Think Family Strategy' is developed to implement this guidance. Involve parents, children and carers in all stages of development.
Workforce development
Invest in training and staff development for adult and children's front-line managers and practitioners to support the changes recommended in this guide about how to 'think child, think parent, think family' and work across service interfaces.
Generating more evidence about what works

1.6.4 What does national research tells us about parental substance misuse?

The 'Hidden Harm' Report (2003) from the Advisory Council on the Misuse of Drugs estimated the number of children affected by parental alcohol problems nationally was between 780,000 - 1.3 million.

It is estimated nationally that there is an average of one child for every problem drug user (Advisory Council on the Misuse of Drugs, 2003). In the UK it is estimated that 2–3% of all children under the age of 16 years have parents with drug problems (ACMD, 2003, cited in BPS/RCP, 2008:39). With one estimate giving a figure for Bradford District of 4,582 problem drug users (Hay *et al,* 2006) a potentially large group of children live with the safeguarding issues raised by problem drug use.

Children affected by adult substance misuse can face the following issues:

- **Increased levels of domestic violence**

One estimate is that around one-third of domestic violence incidents (360,000 per year) relate to alcohol misuse. (Strategy Unit: 2003).

- **Neglect**

Registration on UK child protection registers for neglect has been correlated strongly with parental heroin use, and parental problem drug use has been shown to be one of the commonest reasons for children being received into the care system (Barnard & McKeganey, 2004 cited in BPS/RCP, 2008:32)

- **Increased risk of child substance misuse**

Recent survey research of 8000 11-15 year olds reported that children are twice as likely to smoke if they live with a smoker and far more likely to drink alcohol if they live with a drinker or with parents who tolerate the child's drinking (NatCen/NFER, 2009).

- **Poor health outcomes pre-birth and from birth**

"Beyond the healthcare costs incurred directly by the users, the NHS costs relating to treatment of neonates affected by their mothers' drug misuse were calculated at £4.3 million per year (Godfrey *et al.*, 2002), with the annual cost of social services in caring for these children amounting to £63 million." (BPS/RCP, 2008:39)

- **Risk of accidental injury**

The Bradford alcohol harm reduction strategy outlines the link between alcohol misuse and safeguarding issues, for example, “25% of fires are known to be due to alcohol impairment”.

1.6.5 What works? Parental substance misuse

Barlow et al (2008) cite some evidence that brief, motivational interviewing can be effective in getting light to moderate drinkers to stop drinking alcohol during pregnancy and good evidence for adding a psycho-social component plus incentives to stop drinking during pregnancy for heavy drinkers and providing information to other family members.

***Family Intervention Projects**:*
Family Intervention Project pilots targeted parental drinking as a contributory factor to poor parenting, anti-social behaviour and child neglect. The pilot programmes worked with the most challenging families to tackle alcohol problems, particularly where these were affecting both parents and children in the same family. (DCSF/Home Office/DH, 2008) The interim evaluation of the impact on 90 families outlines evidence that they improve a wide range of outcomes for children (White et al, 2009).

1.6.6 Current Activity

Addressing parental substance misuse has been highlighted as a key priority for Bradford Safeguarding Children Board. A Serious Case Review was carried out by the Board in response to a child dying from swallowing his mother’s drugs. From the lessons learnt and recommendations a ‘Hidden Harm’ working group was established to include Drug Agencies, Health Agencies and Children’s Social Care in order to identify responses to the issues which come out the review. This includes reviewing current guidance and practice around situations where drugs are an issue, ensuring there is a shared understanding of the role of all the substance misuse services, and further consideration of the possible drug testing of young children.

1.7 Referrals to Children’s Social Care

In the twelve months up to 30th September 2010, approximately 7,000 referrals were made to social care agencies within the District, where the referring agency considered a child needed intervention from Social Care Services. This was a decrease of around 500 referrals compared to the previous 12 months.

In the period, just under 2,000 children & young people were referred again to Social Care Services within 12 months of their previous referral. This represents approximately a quarter of children whose needs may not have been satisfactorily met or their needs may potentially have changed.

Referrals by source

Referrals received in the period - by source	2007/8	2008/9	2009/10
Education	1026	1267	1475
Police	942	1280	1645
Health	1019	1117	1280
Parent/Carer/Family Member/ child or young person	586	794	780
All Other	1842	1965	2367
Total	**5415**	**6423**	**7547**

The number of children and young people being referred to social care agencies as at March 2010 (last available comparative data) was higher in comparison to rates nationally and with statistical neighbour activity rates (Bradford 587.3 per 10,000; Statistical Neighbours mean average 571.10 per 10,000; National average 548.2 per 10,000).

Referrals	Number	Population 0-17 (mid 2009 Estimate)	Rate per 10,000 of children aged under 18 years
England	**603,700**	**1101.24**	**548.2**
Blackburn with Darwen	3,101	3.84	808.1
Bolton	3,546	6.24	567.9
Bradford	7,547	12.85	587.3
Calderdale	1,649	4.56	361.8
Coventry	3,779	6.81	555.3
Derby	3,370	5.32	633.8
Kirklees	5,269	9.40	560.5
Oldham	2,827	5.48	515.9
Peterborough	2,357	3.99	590.0
Rochdale	3,185	4.93	646.4
Walsall	3,043	6.05	502.7
SN Group Average	**39,673**	**69.47**	**571.10**

1.8 Multi-Agency Public Protection Arrangements Data

According to the West Yorkshire Multi-Agency Public Protection Arrangements (MAPPA) annual report 2009/10, 333 people are currently required to sign the sex offenders' register in Bradford. The total number of Registered Sex Offenders in West Yorkshire was 1564, (75.64 per 100,000 head of population).

Location	RSO
Leeds North West	210
Leeds North East	191
City & Holbeck	164
Wakefield	220
Kirklees	306
Calderdale	140
Bradford South	176
Airedale & Bradford North	157

1.9 CAMHS Out of District Bed Statistics 2010

The CAMHS Service works with children and young people (from the pre-school years up until age 16 or older if still at school) as well as their parents and carers. The service provides a family centred approach, providing the highest level of mental health care for children and young people across the Bradford and Airedale District.

Whilst the service provides a range of therapeutic intervention and response some children / young people require more specialist treatment and care that is not available within the Bradford / Airedale District. For these young service users specialist treatment and care is provided out of the Bradford / Airedale area.

14 CAMHS service users receiving care outside of our district in 2010. 4 of these were young people with eating disorders, who between them had a total of 507 bed days to date, whilst placed at Lime Trees (York), Little Woodhouse (Leeds) and St Georges (London). The remaining 10 children received 434 bed days to date, spread at the same locations.

1.10 Can we identify the children most at risk of abuse and neglect?

Identifying children most at risk of abuse and neglect and trying to pin-point factors leading up to a child becoming subject to plan is complex. National clinical guidance for health staff on child maltreatment[1] cites the risk factors for child maltreatment that are so well recognised that they are taken as *a priori* risk factors and exempted from the guideline. These include:

– parental/carer drug or alcohol abuse;

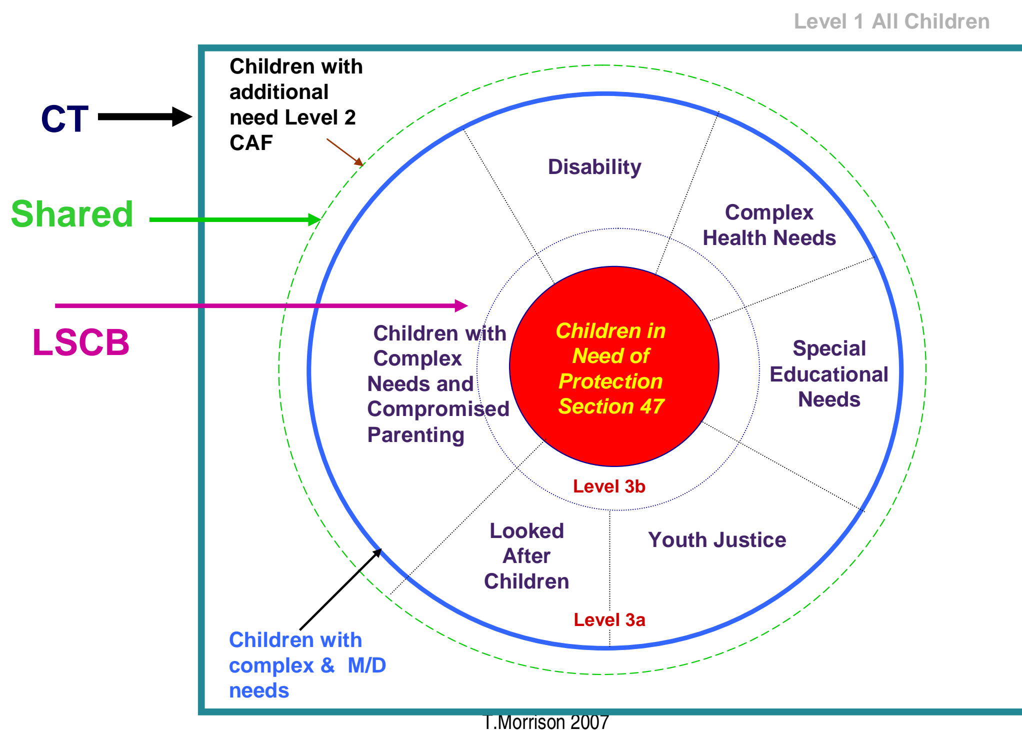
[1] The guidance describes when to *consider* child maltreatment as a possible explanation of symptoms and when to *suspe*ct that child maltreatment *has* taken place.

– poor parental/carer mental health;
– intra-familial violence or history of violent offending;
– previous child maltreatment in members of the family;
– known maltreatment of animals by the parent or carer;
– vulnerable and unsupported parents or carers;
– pre-existing disability in the child.
(NICE 2009:1)

Additional factors known to put children at increased risk of harm include:

- poorly *controlled* mental ill-health producing volatile behaviour;
- children with additional vulnerabilities: very young children; disabled children;
- some of the ways that older children behave or respond to problems or poor levels of parenting or care, for example going missing from home or care;
- being targeted by abusive adults e.g. for the purposes of sexual exploitation.

Morrison's (2007) diagrammatic representation of the link between the CP and CiN populations shows a permeable boundary between the population of children in need and the child population in receipt of child protection intervention (see diagram below). The view is that the children most vulnerable to abuse and neglect could be those children in need who hover just outside the child protection population (Level 3b). This potentially includes children who have been, but are no longer, subject to a child protection plan. ***Therefore more needs to be known about the outcomes of children once they cease being subject of a child protection plan. This is in order to understand why some children become subject of a plan for a second time.***



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Part 2 - Unintentional Injuries

Unintentional injury is a leading cause of death and illness among children, and causes more children to be admitted to hospital each year than any other reason. Unintentional injury occurring to children results in approximately two million accident and emergency (A&E) visits a year costing the NHS approximately £146 million (Audit and Healthcare Commission, 2007)

Children in the Bradford District are 20% more likely to be admitted to hospital due to unintentional injury than the national average according to the Child Injury Prevention Strategy 2008-2011 (p2). Many of these injuries are largely preventable.

2.1 Hospital Admissions

Data on child hospital admissions due to accidental injuries (2007/08) shows a greater number of boys are admitted to hospital across all age groups. Children under the age of five had the highest number of admissions, mainly for injuries occurring in the home. The most common causes of child accidents are being crushed or caught between objects, falls, pedal cyclist injuries and foreign bodies.

Hospital admission rates for under 3 days per 10,000 population 0-18 years due to accidental injuries in Bradford District 2007-2008

Sex	Age	Apr to Jun	Jul to Sept	Oct to Dec	Jan to Mar
Female	**0 to 4**	43.7	32.5	26.1	35.2
	5 to 9	22.8	31.9	13.7	14.2
	10 to 14	13.2	13.2	11.5	9.8
	15 to 18	9.0	12.6	11.9	7.7
	Total	23.2	23.2	16.2	17.5
Male	**0 to 4**	46.0	47.0	31.3	37.4
	5 to 9	42.9	47.8	23.9	16.8
	10 to 14	46.4	38.1	28.2	29.26
	15 to 18	27.6	42.4	42.4	29.64
	Total	41.5	44.0	30.9	28.38
Both	**0 to 4**	44.9	39.9	28.8	19.19
	5 to 9	33.1	40.0	18.9	8.61
	10 to 14	30.2	25.9	20.0	14.93
	15 to 18	18.5	27.8	27.4	15.08
	Total	32.5	33.8	23.7	14.51

Source: Health Intelligence and Analysis Team, NHS Bradford and Airedale

2.2 Child (0-15 year old) killed or seriously (KSI) injured in Road Traffic Accidents

The child KSI rate for 2010 was 35 (1 child killed, 34 seriously injured). The majority of the children were pedestrian casualties.

In 2009, 3 children were killed and a further 38 were seriously injured in Bradford. This represents 19% of total KSI. In 2008, the number of children KSI was 50 compared to 58 in 2007. The reduction in 2009 was mainly due to the number of pedestrian casualties which decreased by 15%. The breakdown of the child age groups reveal that the reduction

is down to the 8-11 and 12-15 years old. The KSI for these groups decreased by 67% and 39% respectively.

Fatal & Serious Child casualties with Target for 2010

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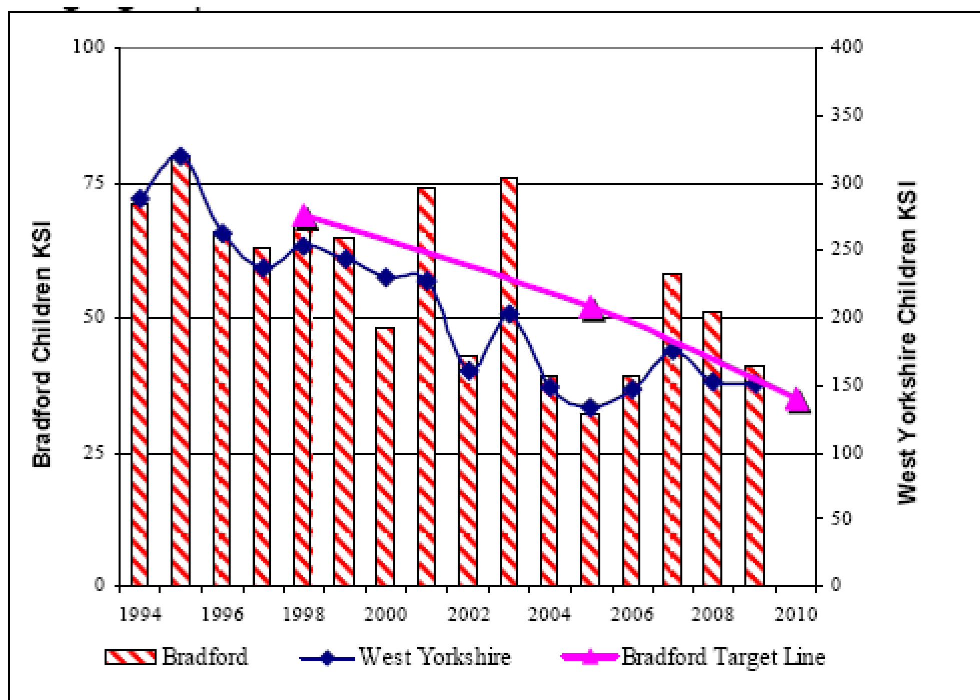

Source: City of Bradford Metropolitan District Road Casualties 2009

Child Pedestrian KSI

The largest proportion of child KSI casualties is associated with the pedestrian road user group, accounting for 80% of the total. The trend for this group has fluctuated in recent years.
The break down of child pedestrian KSI per age group reveal the following:

- The number of pedestrian casualties aged 12-15 years continued to fall for the third consecutive year.
- The pedestrian KSI casualties for the 8-11 age group has decreased significantly (92%) this year (1) against 2008 (12).
- The number of pedestrian KSI for the 0-4 and 5-7 years old is still relatively high. The figure for the 5-7 has jumped from 4 (2008) to 13 (2009).

Source: City of Bradford Metropolitan District Road Casualties 2009

The Bradford District has a worrying trend for pedestrian injuries occurring to very young children which goes against the national figures. This highlights a possible issue around parental/carer supervision.

The areas of Bradford with highest rate of child road casualties are City, Manningham, Heaton, Little Horton and Bowling and Barkerend, all areas with high levels of deprivation.

2.3 Fire related injuries

Statistics provided by West Yorkshire Fire and Rescue Service for 2006-10 show that children under the age of five are most commonly affected by fire related injuries.

Asphyxiation is the most common type of injury amongst children whilst the main cause of injury is chip pan fires.

2.4 Data development issues.

The quality of data around injuries is variable across agencies within the district. There exists high quality data on road traffic and fire related injuries achieved through national recording systems but lesser quality data from hospitals systems due to low levels of data coding. It is anticipated collection of accident and emergency department data may improve after recent hospital data system changes with the installation of new IT systems.

There is a requirement for improved data sharing; in particular more needs to be known about the reasons why children are involved in accidents. Also a greater focus should be directed at capturing data on injuries not leading to hospital admission and those occurring in the home environment.

Bradford Safeguarding Children Board provides regular updated lists of children subject of a child protection plan to the local hospital A&E departments. The A&E departments can record and flag those children on the new IT system and also monitor any admissions. ***It is anticipated this will process provide us with a better understanding of the reasons why children subject of CP plan are visiting A&E.***

2.5 Local Studies

In the Bradford district, a recent, unpublished, epidemiological study of accidental injury rates in children (aged 4-12) (Hardy et al, 2005) analysed all A & E attendances 2004-2005 at BRI and Airedale General Hospital. For the age group 4-12 10,140 were recorded. Of these, only 826 were for government priority areas (550 cycle injuries, 156 RTC pedestrian injuries and 120 fire/thermal injuries). 9,314 were therefore not related to government priority areas. The study found that:

- Children from minority ethnic communities were more likely to attend A & E following an accident as a vehicle occupant than white children. No evidence was found that this was the case for pedestrian injuries.
- 23% of A & E attendances were as a result of injury in the school environment.
- A greater proportion of children living in deprived areas attended A & E as a result of injury than those living in affluent areas.
- The home was the most common injury environment among 4-7 year olds. Injury rates were significantly associated with residential economic deprivation.
- Children residing in affluent areas were more likely to attend with a fracture (linked to sport related injuries) than those living in deprived areas.

In a study of patients presenting with burn injuries at Bradford Royal Infirmary Khan et al (2007) highlighted the high level of children with burn injuries as an issue of concern for the District.

At 36% of the total, children under 10 represented the largest age category of the 460 patients presenting with burns in a 12 month period. Children's average age was 5. Most were aged between 1 and 2 years of age. Children under 10 formed 48% of Asian burn patients compared to 28% of non-Asian patients. For Asian burn patients 87% of injuries happened in the home compared to 61% for non-Asian patients.

When discussing type of burns the study did not distinguish between adults and children but overall 52% of burn injuries were scalds with hot water or steam (around half of which related to preparing hot drinks), 23% were contact burns and 16% fire-related.

2.6 Story behind the figures

A range of factors influence the likelihood of an unintentional injury:

- age;
- behaviour (for example, smoking or use of safety equipment);
- environment (for example, degree of exposure to road traffic);
- socio-economic structure (for example, affordability of and access to safety equipment) (Millward et al. 2003);
- personal (for example, demographic);
- socioeconomic (for example, poor housing or unemployment);
- lifestyle factors (for example, unsafe driving, failure to use safety equipment, substance misuse).

2.7 Current Activity

Nationally, public health guidelines for preventing unintentional injury in under 15s are in preparation by the National Institute for Health and Clinical Excellence (NICE). These will cover:

- overall strategy on preventing unintentional injury (due October 2010);
- road design (due April 2010);
- preventing road injury (due date tbc);
- preventing injury in the home (due April 2010); and
- preventing injury in external environments (due October 2010).

Locally, the District's Child Accident Prevention Strategy is based on national recommendations from the Audit and Health Commissions (2007). A sub-group of the Bradford Safeguarding Children Board focuses on Accident Prevention and is responsible for implementing the Accident Prevention Strategy for Bradford. A Child Accident Prevention Co-ordinator is in post as recommended in the priority review by DCSF/DH/DoT (2009) and works with colleagues in health, transport and social care.

2.8 Key Stakeholder views

2.8.1 Views from children and young people

In autumn 2007 Bradford Safeguarding Children Board used an educational consultant to gather views on accidental injury risk from children and young people in two classes in Bradford District schools. Concerns included

- Road Traffic Collisions (RTCs), dog bites and breaking bones (the three most common concerns);
- being in hospital for lengthy periods of time;
- serious injuries occurring to them and their friends;
- being able to play out safely without fear of RTC's and or dog bites;
- that their parents felt unable to let them play out due to these concerns;
- risks associated with trampolines and hair straighteners.

2.8.2. Practitioner feedback at the November 2008, Children's Area Conference

2.8.2.1. Practitioner views of causal and contributory factors

- In deprived areas and families, less use of home safety equipment;
- Unable to afford or know how to fit equipment – lack of Home Safety scheme in some areas;
- Lack of parental knowledge of risks and how to minimise them;
- In middle-class areas, sporting injuries such as fractures;
- Older boys engaging in risky behaviour;
- Drug and alcohol use lowers inhibitions re. risk-taking;
- Poor driving in the District;
- Lack of safe play areas;
- Lack of parental supervision;
- Densely populated areas with no safely-accessible play areas leaves children playing in street at risk from traffic;
- Lack of opportunity to take risks in relatively safe environment, so that children learn to judge risk;

2.8.2.2. Practitioners' ideas for strategy/practice

- Recognise the very strong association between child injury rates and poverty/deprivation rates;
- Develop a Home Safety Scheme targeted on children most vulnerable to health inequalities, provide **and fit** equipment;
- Develop safety education including peer led and child-adult;
- Deliver home, play and road safety content through existing agencies and workers;
- Strategic planning of data collection and feedback to HIS;
- Limit traffic speed to 20mph in all residential areas.

2.9 What Works?

2.9.1 What Works? Messages from research

Nationally, the reason for the overall fall in mortality from injury in children is probably due to the declining exposure of children to risk of injury, particularly as pedestrians. This has further widened the gap between children in the top social or economic groups and those at the bottom of the scale (Edwards et al, 2006).

2.9.2 What Works: Messages from practice

A priority review identified messages for strategy and practice.

"Focus group work carried out within the DCSF shows that low income/non working parents are receptive to messages on how to keep their children safe, but often accidents happen because a parent has not realised that they or their home is presenting a risk to the child. This can be done through practitioners and communications work. There is clearly scope for more to be done in this area and **deprived areas with high accidents rates in under 5s should particularly be targeted through practitioners and communications**." (DCSF/DH/DfT, 2009:40, emphasis in the original)

Look for local opportunities to reduce accident rates by linking to other local agenda that have the potential to contribute and from where useful lessons about behaviour change could be learned:

- Sustainable development
- Obesity and healthy living
- Alcohol reduction
- London 2012 preparation
- PE and sport strategy
- Play

(DCSF/DH/DfT, 2009:20)

The role of early years, fire safety and outreach staff is particularly valuable and has the potential to reach more parents if staff understand how many children are injured, where they are most likely to be injured and in what way or by what. For example early years workers could highlight to parents both that children are at particular risk of hot water scalds and how to minimise the damage caused by running under cold water before seeking treatment. The review highlighted the potential to include safety messages in the initial training of more practitioners.

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Part 3 – Children being bullied or at risk of being bullied

3.1 Size and distribution

Bullying has been highlighted, through consultation as a very important issue for many children & young people in Bradford District. Reducing bullying has also been included as a 'Staying Safe' priority in the district's Children and Young People plan. However, information on prevalence and distribution of the issue is difficult to ascertain. The lack of quantitative data is recognised by the Safeguarding Board as a deficit which needs to be addressed. In the short term a number of national studies and some older consultation exercises provide a basis for more work to understand the prevalence of bullying within Bradford.

Approximately 10,500 pupils in Bradford took part in the Health and Lifestyle Survey (2009/10), from which the main findings are:

- 35% of Year 4 pupils say they have been bullied at school in the last 12 months; this figure falls to 26% in Year 7 and 17% in Year 10
- The most common sorts of bullying or aggressive behaviours reported were teasing and name-calling, with being pushed or hit for no reason a clear third
- The most common reasons perceived for being picked on or bullied were size/weight and appearance.

There are a number of indicators of the effectiveness of schools in developing effective anti-bullying policy and practice including; the number of pupils formally excluded from school for bullying; the number of schools awarded the Healthy Schools and the judgement made and grade awarded to schools by Ofsted when undertaking an inspection of schools under section 5 of the Education Act 2005. These indicators provide a bench mark for evaluating future progress by mainstream schools in Bradford. 98% of schools in Bradford had fulfilled the rigorous requirements of the Healthy School Award by July 2010.

Number of pupils excluded from school for bullying 2007/08 – 2009/10

Year	No of primary pupils : Fixed term exclusions	No of secondary pupils : Fixed term exclusions
2007/08	7	73
2008/09	8	71
2009/10	3*	27*

* Provisional figures

There have been no permanent exclusions for bullying over the past three years. Considering the data received from schools (up to 14th September 2010) there was a reduction at both primary and secondary phases of at least 50% between 2008/09 and 2009/10.

Ofsted Inspection Reports. Grade awarded for 2the extent to which pupils feel safe".

	Grade				
	1 Outstanding	2 Good	3 Satisfactory	4 Inadequate	Total number of schools
Primary	32	59	43	4	138
	23%	43%	31%	3%	100%
Secondary	1	10	9	3	23
	4%	46%	37%	13%	100%

66% of the 138 primary schools inspected were judged to be "good or better" in relation to pupils feeling safe. 43 primary schools were satisfactory and 4 inadequate.

11 secondary schools inspected were judged to be "good or better" with 9 awarded a satisfactory grade and 3 considered inadequate.

Those schools judged inadequate have received targeted support from Education Bradford to improve their effectiveness.

3.2 Story behind the figures

A report for Ofsted (2008) by the Children's Rights Director for England - Children on bullying provides a recent national context. The study interviewed 319 young people about where bullying happens: "Bullying often happens at school, but those living in children's homes or residential schools also get bullied where they live". The study found young people were most likely to be bullied at school (55%); at home (24%) around where children live (18%); around where children go to school (12%); travelling from one place to another (11%).

In 2009 the DCSF published a series of guidance documents 'Safe from Bullying' each focused on one of the areas of vulnerability: during journeys; in children's homes; in extended services in and around schools. This builds on guidance on dealing with and preventing bullying in schools (DCSF, 2007).

Children's Society research (2007) indicated higher than average rates of running away for several groups of young people who also report higher than average rates of bullying:

- young people who define themselves as being disabled; or
- young people having difficulties with learning; and
- young people who define themselves as gay, lesbian or bisexual.

The additional vulnerability of these groups of young people to bullying was confirmed in DCSF consultation on bullying with young people (DCSF, 2009b) which also highlighted:

- those with health or visible medical conditions, such as eczema, may be more likely than their peers to become targets for bullying behaviour;
- children who are smaller;
- children who show signs of being affluent or poor.

Children identified those likely to be bullied as someone:

- who is different to the majority (53%)
- who doesn't stand up for themselves (17%)
- who annoys a bully (17%)
- who shows off (15%)
- who is quiet (14%)
- who is good at school or wants to learn (13%)
- who is alone or without a group to be with (7%)
- who talks a lot (7%)

(Ofsted, 2008)

Types of bullying identified include cyber-bullying, sexual bullying homophobic and racist bullying (DCSF, 2007)

As a safeguarding issue, the experience of bullying for young people adds to the level of distress experienced by young people who are already vulnerable by way of disability, ethnicity, learning difficulty, sexual orientation and underlines the specific nature and content of racist or homophobic bullying.

3.3 Current Activity

Action to address bullying within the District is co-ordinated through the Anti-bullying Strategy for Bradford District 2008-2011***.***

The strategy defines bullying as physical, verbal or emotional:

- Deliberate hurtful behaviour
- Repeated over time, where
- There is an imbalance of power which makes it hard for the bullied person to defend themselves.

One-off incidents are excluded from the definition although should be dealt with. Young people defined bullying as:

"Bullying can be mental, physical or verbal abuse. It happens over a period of time. It causes the victim to have little confidence and feel unhappy. It can lead to depression or suicide. Even though bullying is awful it makes the bully feel powerful. It needs to STOP."

Bradford has an IText texting signposting service for children and young people to use if they have any bullying issues, managed by the Youth Service and Youth Offending Team. A Bullying Strategy is in place across Schools in Bradford.

3.4 What works? Messages from research and practice (DCSF, 2009b)

3.4.1 Responding to bullying

When bullying does occur, **a clear consistent response is essential**. There are many different ways in which staff can respond to bullying. However, the goals of any intervention should always be the same:

- To make the victim safe.
- To stop the bullying and change the bully's behaviour.
- To make clear to every other child that bullying is unacceptable.

- To learn lessons from the experience that can be applied in future.

Recent guidance adapted for a range of settings emphasises work with both the bully and the bullied person, using principles of conflict resolution and restorative justice - avoiding reinforcing images of the bullied as weak and the bully as strong, building on positive behaviour and engaging both in suggesting ways forward.

3.4.2 Support the child who is bullied

- Make time to listen to the victim calmly, using effective listening techniques.
- Take bullying seriously and avoid telling young people to 'just ignore it'.
- Agree an action plan with his or her consent.
- Avoid humiliating the victim by taking actions which make them seem weaker, powerless or a 'grass'.
- Help the victim become more resilient, for example by building up their self-confidence, emphasising their strengths and helping them to develop protective friendships.
- Cyber bullying can be traced and tracked to find proof of the bullying, so it becomes less of a question about one person's word over another.

3.4.3 Work with the bullying child

- Make it clear that it is the behaviour that is 'bad', not the child.
- How does bullying make them feel? Why do they need to do this?
- Help children to find other ways than bullying to feel recognised and ways to manage their emotions.
- When a good relationship is established, try to elicit some understanding of the feelings of the victim, and challenge prejudice such as racism.
- How can this person make amends or compensate the victim for the distress caused? Can the child offer some ideas?
- Be aware that many people who bully others have been victims at some point themselves and may still be one. These cases might be more complex and 'bully victims' as they are known may need professional help and counselling.
- Avoid granting the bully hero status or marginalising them so that you have no influence.

3.5.4. Monitor and record

Bullies will often appear to comply – but may bully someone else, or bully more secretively so that they do not get caught. They can appear to comply because of strong controls strictly enforced, but it is unclear whether or not their behaviour and prejudices have really changed. So consider whether your intervention has secured lasting change and check from time to time. Encourage and praise any positive behaviour by the bullying child.

- Monitor the situation.
- Record any bullying incidents and action taken.
- Report back to the victim.
- Follow up, discreetly, with the victim to make certain the bullying has actually stopped and that they feel safe.
- Do nothing to perpetuate the image of a child as a permanently weak victim, but try to put across a positive strong image of them instead.
- Help the victim to come to believe in themselves starting with small steps.
- Use an incident as a learning opportunity for everyone.

3.5.5. Guidance for schools based on effective practice covers:

- Effective leadership, securing whole-school support for anti-bullying work and setting an example by positive staff behaviour.
- Using partnership and local authority links and resources to prioritise anti-bullying and safeguarding.
- Staff awareness of various types of bullying and vulnerable groups.
- Staff understanding of legal requirements and responsibilities including in relation to vulnerable pupils.
- Data-gathering, monitoring and evaluation.
- Reviewing staff supervision or pupils, activities and buildings, building design for blind-spots and hot-spots.
- Using regular curriculum opportunities and special events such as Anti-Bullying week, use of SEAL, creative learning opportunities and pupil voice activities.
- Ensure varied and confidential ways of reporting bullying, effective investigation and listening.
- Use of sanctions and learning opportunities.
- Positive support for bullied pupils including exclusion, investigating seemingly unprovoked violence for the possibility that it is retaliation to long-term bullying.
- Use of reward and celebration including developing the role of pupils as befrienders, peer mentors, leading diversionary activities.
- Developing the role of adult mediation.

(DCSF, 2007).

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Part 4 – Children who go missing

4.1 Size and distribution

Between January and September 2009, 50 children aged 16 or under were reported to have gone missing. Analysis of this group, including information provided by those children who consented to a "return Interview" tells us that 26 of the children had gone missing previously and the majority were female (41).

A high proportion of the children were of white ethnicity as shown below:

Ethnicity	
White British	37
Mix White/Asian	5
Mix White/Afro Caribbean	3
Asian	4
Other	1
Total	**50**

Their age breakdown was: (Please note that these ages are current and not taken from point of referral)

Age	Number
9	1
10	1
11	2
12	6
13	15
14	13*
15	9
16	3
Total	**50**

*13 of these were age 13 at point of referral

The length of time the children were missing was:

Under 24 hours	19
1 – 2 days	17
3 – 5 days	8
5 – 10 days	6

Their reasons for going missing were:

Reason	
Domestic incident	0
Peer Pressure	12
Child Sexual Exploitation	11
Offending Behaviour	6
Conflict with parent/carer	13
Runaway from LAC	4
Other	4
Total	50

4.2 Story behind the figures

The Children Society (2007) estimate that 100,000 children nationally run away each year all of whom are, in varying degrees, in need of support and services. This would equate to more than 1,000 young people running away from home or care in Bradford each year.

Evidence on the characteristics of runaways from self-reported surveys quoted in Stepping Up (Safe on the Streets Research Team, 1999; Rees & Lee, 2005) indicates that:

- More runaways are female than male.
- Most running away occurs from the age of 13 onwards.
- There are some differences in running away rates according to ethnicity, with young people of Indian, Pakistani and Bangladeshi origin being less likely than average to run away.

- There are higher than average running away rates for young people
    - who define themselves as being disabled; or
    - as having difficulties with learning; and
    - for those who define themselves as gay or lesbian
    - These are all groups of young people who report higher than average rates of bullying.

4.2.1. Going missing from home

Rates of running away are higher for young people currently living in a step family (18%) and in a lone parent family (13%) than with both birth parents (8%) (Rees & Lee, 2005).

DCSF guidance also warns that the prospect of forced marriage leads some young women to run away from home (DCSF, 2009)

Young people may run away or go missing from home (or from care) following grooming by adults who seek to exploit them sexually. Evidence suggests that 90 per cent of children subjected to sexual grooming go missing at some point. (DCSF, 2009: 7) Going missing for other reasons also puts young people at risk of being identified by risky adults looking for vulnerable young people (Scott and Skidmore, 2006)

Most of the risk factors found in studies reviewed by Thomas et al (2008) also related to family life. They separate risk factors into four domains:

Risk factors for running away (Thomas et al, 2008)

Family risk factors	*School risk factors*
Poor parental supervision and discipline Family conflict Parental involvement/attitudes condoning problem behaviour (e.g. drink/drug use) Family history of problem behaviour including poor mental health Low income and poor housing Overcrowding Experience of authority care	School exclusion
Community risk factors	*Individual risk factors*
None given	Experience of abuse Gender (female) Transition from local authority care

As well as the above factors in young people's home environment, there is a strong association between running away and a range of other problems and issues in young people's lives including truancy, offending, substance use and personal well-being (Rees & Lee, 2005).

4.2.2. Going missing from care

Children going missing from care is covered in the Looked After Children Needs Analysis

4.3. Current Activity

The Multi Agency Protocol for Children Missing from Home was revised and agreed in October 2008. There is a Designated Manager for LAC going missing and a Multi Agency Protocol for Children Missing from care which was produced and revised in Oct 07. Children under 13 are referred on their return to Barnardo's Turnaround Service. Children aged 13 plus are referred to Connexions on their return. Care leavers who run away from placements or accommodation are supported by the Seen and Heard Service.

4.4. Views from key stakeholders

"No-one runs away for no reason." Amie, 13, Surrey, (DCSF, 2009)

Nationally, young people's accounts of reasons for running away focus primarily on problems they are experiencing at home, including poor family relationships, conflict and maltreatment (Rees & Lee, 2005). Some young people also identify personal problems (e.g. depression and pressure) and school problems as triggers for running away. A significant proportion (around a quarter) of 'runaways' define themselves as having been forced to leave home. (Rees & Lee, 2005)

4.5. What works?

4.5.1. Messages from research

4.5.1.1. What works to prevent children going missing from home?

There has been very little high-quality or systematic reviewing of research specifically on this issue to date. However, research messages on reducing the risk factors outlined above are relevant - for example:

- reducing family conflict, improving communication and positive behaviour management;
- improving housing conditions and overcrowding;
- improving parental ability to set and enforce appropriate boundaries;
- reducing parental substance misuse.

Preventive interventions that look likely to address some of the causal factors for running away from home include those focused on improving parenting such as :

- the Strengthening Families Programme 10-14 in terms of increasing positive parental control and reducing parent-child conflict (Coombes et al, 2003), and
- programmes showing evidence of improving parental care of children where there has been previous physical abuse such as Webster-Stratton and Parent-Child Interaction Therapy (Montgomery et al, 2009).
- 'skills-based programmes for adolescents and their parents that build on protective factors, for example, 'Preparing for the Drug Free Years' (Moran et al, 2004)

4.5.2. What works? Messages from practice?

Practical guidance for implementing parenting interventions has been produced by the Youth Justice Board (2008) for YOT staff to address risk of offending, but is relevant to staff working with parents and children to address other risk factors such as running away.

The Strengthening Families Programme 10-14 has an emerging evidence-base for successfully reducing conflict and increasing parenting skills in families experiencing conflict, including families of at-risk teenagers and where both parents and children have substance-misuse issues. An evaluation of a UK version of the programme reports feedback that the SFP 10-14 contributed to changes in the behaviour of the young people and improved parental management of the children in terms of:

- knowing and learning the rules of behaviour,
- setting the boundaries of behaviour,
- parents using effective questioning techniques to monitor the young person's whereabouts,
- using a points chart to manage behaviour,
- helping young people to resist peer pressure
- learning how to keep out of trouble

Parents/caregivers and young people reported that the SFP10-14 had played a part in improving family functioning through:

- strengthening the family unit,
- improving parent/caregiver communication,
- parents using a more consistent approach,
- increasing strategies for dealing with difficulties,
- developing better positive and negative feedback,
- working more together as a team,
- identifying family strengths,
- strengthening family bonds,

- receiving group support,
- working more closely with mum and dad,
- learning to listen more,
- learning to get along with each other better,
- helping parents/caregivers more,
- better understanding of what parents/caregivers/young people are saying, changing the code of behaviour and developing more interaction in famil(ies). (Coombes et al, 2006:5)

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Part 5 – Child Sexual Exploitation

5.1. Size and distribution

Since July 2008, 75 young people have had support from the Hand in Hand Project in Bradford.

As at December 09 there were 29 open cases, 27 girls and 2 boys of which nearly all have/are involved with social care and have an allocated social worker. 6 of these children have been/are looked after within the last 3-6months, 1 is currently in a secure unit.

A significant number of the young people have/do use alcohol and drugs, including cannabis, ecstasy, pills, crack, coke and heroin. The majority of the service users identify as white British, the project have/are supporting 2 Asian and 1 duel heritage young person.

As identified earlier in section 4 – Missing Children section of the Needs Analysis, 11 out of the 50 children that went missing in 2009 were due to CSE reasons.

5.2. Story behind the figures deduced from key national studies

Common background factors in the lives of young people supported by sexual exploitation services during a two year evaluation by Barnardo's were:

- Going missing: many young people had a history of going missing from home, during which they became increasingly involved with other vulnerable young people and exploitative adults through a need for somewhere to hang out and to receive acceptance. (This is described as the principal factor that puts children and young people at risk of being identified and targeted as vulnerable by sexually exploitative adults or may indicate that a child is already being groomed either by an exploitative adult or through an intermediary, sometimes another young person who is already being exploited.)
- Disrupted family life: only five young people were living in 'intact' families with both birth parents; 19 of the 42 had spent some part of their childhood in the looked-after system.
- A history of abuse and disadvantage: the majority (28) had suffered sexual abuse in the family, with physical abuse and neglect also common experiences: in only 4 case studies was there *no* apparent history of abuse or neglect. Domestic violence was a feature in 13 cases, with parental alcohol/drug misuse in 14.
- Problematic parenting: there was a clear deficit in the parenting capacities of many young people's parents, although many remained loyal and protective of their mothers. Relationships with fathers were frequently poor or non-existent and although some young people had support from other relatives, many were reliant for adult support entirely on professionals. In the absence of support in their teenage years, many young people had made a premature move into adult lifestyles where they became easy prey for 'risky' adults.
- Disengagement from education: almost all the young people in the study had disengaged from school in their early teens, compounding the disconnection from peers, regular routines and the prospect of college or employment, and increasing the likelihood of attachment to older people involved in drugs, crime and prostitution.

- Exploitative relationships: already vulnerable because of a combination of the above factors, the majority of the young people became involved in exploitative relationships.
- Drug and alcohol misuse: substance misuse was a concern to workers in 30 out of 35 case studies. In only four cases did the substance misuse evidently develop independently of the sexual exploitation.
- Poor health and well-being: the physical and mental health of the young people was severely compromised both by their family histories and current lifestyles. (Scott and Skidmore, 2006)
- Young men involved in or at risk of sexual exploitation tended to have a history of sexual abuse, family conflict or domestic violence. As described above, accommodation problems increased their vulnerability to exchanging sex for shelter (Harris and Robinson, 2007) with, as for young women, considerable denial of an element of exchange in relationships with older men (Scott and Skidmore, 2006)

Signs of exploitation reported by practitioners include:

- Sudden changes in attitude or behaviour;
- The appearance of new clothes, mobile phones, jewellery and other items clearly beyond the financial means of the young person;
- Inappropriate age gaps in relationships;
- High levels of drug and alcohol use;
- Repeated missing incidents;
- Chaotic behaviour.

(Harris and Robinson, 2007)

Children who are trafficked into the UK specifically for the purpose of sexual exploitation are unlikely to come to the attention of social care agencies by way of the risk factors outlined above, or at the early stages at a time when there is still a chance to take preventive action. Effectively the grooming stage is highly foreshortened, bypassed altogether or takes place before the transfer to the UK, often disguised as a financial transaction in exchange for a job that will not materialise. Where young people arrive unaccompanied and present to authorities at airports and ports there remains an opportunity to identify them and intervene. (Harris and Robinson, 2007).

5.3. Current Activity

Bradford Safeguarding Children Board oversees inter-agency arrangements to safeguard children identified as being at risk of significant harm through sexual exploitation. The work of statutory and voluntary agencies in the field of CSE is coordinated through a dedicated sub-group of the Bradford Safeguarding Children's Board. Sub regional inter-agency protocols and information sharing arrangements are in place.

5.4. What works to reduce sexual exploitation?

5.4.1. What Works? Messages from research

Factors that help to combat child sexual exploitation are:

- recognition of the issue as one of child abuse not juvenile prostitution and therefore a policing and child protection not youth justice issue;

- commitment to enact child protection procedures even where young people are at the upper age limits for child protection;
- established multi-agency procedures;
- Commitment of resources to maintain an expert post or service to co-ordinate service provision.

Two-year follow-up of the implementation of pan-London protocols on sexual exploitation found that these were being implemented only where there was a specialist service or post in place.

- Prevention and early intervention are vital when indications of risk are first identified;
- Many young people at risk of exploitation have been failed by services at an early stage in their lives;
- A pro active approach to identify sexual exploitation and the development of detailed protocols are essential to effective intervention;
- Specialist services play a key role in engaging with this hard to reach and vulnerable group;
- Continuity of care is essential;
- Responses to young people at risk of sexual exploitation are undermined by resource constraints.

Harris and Robinson (2007) identify that there are common "factors that combine to create invisibility." Therefore, it is particularly important to

- pay attention to classic signs of exploitation that can be missed unless practitioners know what to look for, particularly in vulnerable young people;

  "*Issues around age inappropriate relationships.*"
  "Manipulation"
  "Some kind of monetary involvement"
  "Exchange of sex for accommodation, gifts, drugs, etc"
  "A massive element of deception on exploiter's behalf"

- look for patterns of omission – a child who is not where they ought to be (at home, in their placement, in school) and who is raising concern by being found or reported to be in places and in the company of adults known to pose risks to children.

Consequently, sharing of information on risk factors and known sightings/contacts with young people suspected to be at-risk of sexual exploitation is particularly vital. Using procedures such as the Common Assessment Framework to pool the information held by the relevant agencies: health; education; children's social care; safeguarding board; policing, YOT, drug action teams; youth service and teenage pregnancy, key staff should co-ordinate assessment under child protection procedures to examine and interrogate the evidence of sexual exploitation.

5.4.2. What works? Messages from practice

Barnardo's (2008) nationally evaluated practice around sexual exploitation is based on four principles of:

Access: attractive, accessible services with facilities for basic care and positive activities;

Attention: positive attention to replace the exploitative attention given by abusive adults and to compensate for chaotic family lives and the lack of positive attention from non-exploitative adults.
Assertive outreach: to establish a consistent presence in the young person's life and counteract resistance from abusive adults.
Advocacy: to build a young person's resilience, understanding of their rights, and ability to access other services independently.

Given the close links between the two issues, where possible sexual exploitation and missing services are linked.

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