University of Salford MANCHESTER

Writing pre-adoption medical (PAMs) and initial health assessment (IHA) reports for “Our Children” [Looked After Children]: guidance and top tips

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[1] https://www.salford.ac.uk/library/open-research/usir-university-of-salford-institutional-repository

Clinical governance

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In this guidance, “Looked After Children” and “Our Children” are used synonymously. In this guidance, Looked After Children means:

> “*A child who has been in the care of their local authority for more than 24 hours… Looked after children are also often referred to as children in care, a term which many children and young people prefer*” [2] [3].

[2] https://learning.nspcc.org.uk/children-and-families-at-risk/looked-after-children

[3] https://www.gov.uk/topic/schools-colleges-childrens-services/looked-after-children

Each UK nation has a slightly different definition of a looked after child and follows its own legislation, policy and guidance. But, in general, looked after children are living [2]:

- with foster parents;
- in a residential children's home; or
- in residential settings like schools or secure units.

Scotland's definition also includes children under a supervision requirement order. This means that many of the looked after children in Scotland are still living at home, but with regular contact from social services [2].

There are a variety of reasons why children and young people enter care. The child's parents might have agreed to this – for example, if they are too unwell to look after their child or if their child has a disability and needs respite care. The child could be an unaccompanied asylum seeker, with no responsible adult to care for them. Children's services may have intervened because they felt the child was at significant risk of harm. If this is the case the child is usually the subject of a court-made legal order [2].

A child stops being looked after when they are adopted, return home or turn 18 years old. However local authorities in all the nations of the UK are required to support children leaving care at 18 years old until they are at least 21 years old. This may involve them continuing to live with their foster family [2].

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INTRODUCTION

4. Introduction

Children seen for pre-adoption medicals (PAMs) or Initial Health Assessments (IHAs) often have experiences in common. There may be features in the child's family history, intrauterine environment and experiences following birth which can have significant effects upon their development, learning, behaviour, and health.

With this in mind, we have produced some guidance around common themes, with suggestions about what to write in reports, so that these reports contain all the relevant information and implications for the child in a consistent coherent fashion.

When writing a pre-adoption medical report or initial health assessment report it is crucial to be mindful of the young person who is the subject of the report and it is vital that the report is written in a trauma-informed way so that the report itself, if/when read by the young person in the future, does not add to or exacerbate any difficulties already experienced.

The authors of this document are aware that, for this first edition, the document suffers from having *not* been co-produced by young people. In the next edition the authors intend to work out how children and young people could be involved in the revisions of the document.

The areas summarised in this document are shown in **Figure 1**.

1. **Antenatal substance misuse: introduction**
2. **Commonly used substances in pregnancy: smoking, alcohol, specific drugs**
3. **Parental mental health factors**
4. **Domestic abuse**
5. **Adverse Childhood Experiences**
6. **Children who have a parent in custody**
7. **Unaccompanied asylum-seeking children and refugees**
8. **Other circumstances: including limited information, limits to expertise**

Figure 1: Key issues reviewed in this document

This advice is a summary and does not cover every clinical situation. Specialty Registrars (StRs) should ask their supervising consultant for advice about children and young people seen in clinics. Please always ask colleagues if you want to discuss specific points or concerns about a child or young person seen for health assessment. Advice can be requested from the relevant (Adoption Medical Advisor) for pre-adoption medicals, and from the relevant Named Doctor for Our Children ("Looked after children") for IHAs.

Please bear in mind when producing an IHA report and plan that the IHA plan will usually be shared with the young person if they have the developmental ability to understand it (usually this means sharing plans with children who are developmentally over the age of 10 years old).

Even if the IHA report and/or IHA plan is/are not shared with the young person in real time, they are more likely than not to be able to access it in the future [4].

[4] https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/individual-rights/right-of-access/health-data/

ANTENATAL SUBSTANCE MISUSE

5. Antenatal Substance Misuse

Introduction to substance misuse in pregnancy

In this section, a brief overview of substance misuse in pregnancy will be provided followed by a short summary of some specific substances and their impacts or potential impacts.

Generally, most drugs of abuse (including alcohol) easily cross the placenta and can affect fetal brain development. In utero exposure to drugs and alcohol can have long-lasting implications for brain structure and function. These effects on the developing nervous system often differ from the effects on mature systems.

Antenatal/intrauterine substance exposure is, in general, associated with an increased risk of long-term effects such as developmental delay; learning difficulties; learning disabilities; difficulties with concentration; attention difficulties; and behavioural problems. These effects are permanent. Substance use can also be associated with lower birth weight and prematurity and their attendant difficulties/problems. There may be specific teratogenic effects associated with certain substances, such as alcohol.

Effects of substance misuse

The overall effects of maternal substance misuse on the child are likely to be dependent on

- **when** in the pregnancy the substance(s) was/were taken;
- **how often** the substance(s) was/were taken; and
- **how much** of the substance(s) was/were taken.

It is rare that only one substance is taken in isolation throughout the whole pregnancy. Mothers who take drugs may be drinking alcohol and/or smoking cigarettes. Even in the same family the effects of maternal substance use vary between each individual child. Many different factors come into play such as resilient factors in the foetus, maternal vulnerabilities such as mental health problems or poor physical health, and additional stressors such as domestic abuse (inter-partner violence (IPV)). Consequently, it is not possible to predict to what *extent* an individual child will or will not be affected, or at what *age* an individual child will or will not be affected. Sometimes difficulties may not become apparent until school age.

It is important that those involved with the child are mindful of the potential implications of antenatal substance exposure in utero. If concerns arise about the child's development, learning, or behaviour, there should be a low threshold for seeking further advice, so that appropriate assessments can be carried out and support provided to ensure optimal developmental potential for that child. A tendency to misuse substances can run in families [5], though social and environmental factors play a prominent part in the patterns of drug taking. It is

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[5] Latvala A, Kuja-Halkola R, D'Onofrio BM, Jayaram-Lindström N, Larsson H, Lichtenstein P. Association of parental substance misuse with offspring substance misuse and criminality: a genetically informed register-based study. *Psychological Medicine*. 2022 Feb;52(3):496-505. Available from: link

important for the child to have good role models in this respect to minimise the risk of being similarly affected. Many people who use illicit drugs and/or alcohol do so to help them to cope with the ups and downs of life and it may give you further insights to try to understand whether an individual is drinking excess alcohol or using illicit drugs in order to get *away* from somewhere or to get *to* somewhere (in an emotional or psychological sense, if not a physical sense).

A consistent and responsive home, where emotional issues are acknowledged and discussed, can reduce the risk of turning to substance misuse [6].

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[6] Velleman R, Templeton LJ. Impact of parents' substance misuse on children: An update. *BJPsych Advances*. 2016 Mar;22(2):108-17.
Available from: link

Alcohol is the commonest substance used by women whilst pregnant [7] [8], and often the one most overlooked [9] [10]. Social workers will often comment on maternal drug misuse but will not always comment on alcohol usage. Most women who misuse illicit drugs when they are pregnant, drink alcohol too. It is important to document whether this information is available when a PAM / IHA is being produced for a child.

Remember, it is very difficult to study the effects of maternal substance misuse because of sample recruitment, poly drug usage, and compounding maternal factors.

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[7] Lange S, Probst C, Gmel G, Rehm J, Burd L, Popova S. Global prevalence of fetal alcohol spectrum disorder among children and youth: a systematic review and meta-analysis. *Obstetrical & Gynecological Survey*. 2018 Apr 1;73(4):189-91.

[8] Lange S, Probst C, Gmel G, Rehm J, Burd L, Popova S. Global prevalence of fetal alcohol spectrum disorder among children and youth: a systematic review and meta-analysis. *JAMA pediatrics*. 2017 Oct 1;171(10):948-56.
Available from: link

[9] Popova S, Lange S, Probst C, Gmel G, Rehm J. Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis. *The Lancet Global Health*. 2017 Mar 1;5(3):e290-9.
Available from: link

[10] Tsang TW, Elliott EJ. High global prevalence of alcohol use during pregnancy and fetal alcohol syndrome indicates need for urgent action. *The Lancet Global Health*. 2017 Mar 1;5(3):e232-3.
Available from: link

When writing PAM or IHA reports you might like to consider using some of the suggested phraseology in **Figure 2**.

Intrauterine substance exposure to drugs and/or alcohol is, in general, associated with an increased risk of long-term effects such as developmental delay and learning difficulties; learning disabilities; difficulties with concentration and attention; and behavioural problems.

These effects are permanent. It is not possible to predict to what extent a child will or will not be affected. It is not possible to predict at what age the child will or will not be affected; sometimes these difficulties may not become apparent until school age.

It is important that those involved with the child are mindful of the implications of antenatal substance exposure in utero. Should concerns arise with the child's development, learning, or behaviour, there should be a low threshold for seeking appropriate assessments, advice and support to ensure optimal developmental potential.

A tendency to misuse substances can run in families, though social and environmental factors play a prominent part in the patterns of drug taking. It is important for the child to have good role models and to live in a consistent and responsive environment, where emotional issues are acknowledged and discussed.

Figure 2: Suggested "substance misuse" phraseology

For individual effects of maternal drug use, we recommend that you look up the BUMPS (best use of medicines in pregnancy) website [11]. This website includes effects of both illicit and prescribed drugs in pregnancy. You can print off information about effects of individual drugs and enclose this together with the IHA reports and pre-adoption medical reports to be sent to the child's social worker.

[11] https://www.medicinesinpregnancy.org/

COMMONLY USED SUBSTANCES IN PREGNANCY

6. Commonly used substances in pregnancy

Maternal cigarette smoking

Nicotine can cross the placenta and affect fetal growth, causing reduced birth weight and preterm birth. Maternal smoking can also affect brain size and function. This is associated with developmental or learning difficulties; and difficulties with attention, concentration, and behaviour. Children of mothers who smoked in pregnancy also have an increased incidence of obesity, diabetes, and heart disease in later life. Maternal smoking during pregnancy has been associated with increased risk of wheezing and asthma, especially in children under the age of two years. Exposure is also associated with increased risk of sudden and unexpected death in childhood (SUDC), sometimes known as 'cot death'. Suggested ways to incorporate the above into a medical report are shown in **Figure 3**.

*[Name of child]**'s mother smoked whilst she was pregnant with** [Name of child]**. Research suggests that exposed infants are at increased risk of sudden infant death syndrome (SIDS | cot death), difficulties with development, learning, behaviour, attention, and concentration. They are also at increased risk of having heart and respiratory (chest) problems, obesity, and diabetes as they get older. It is important for carers to be non-smokers and to minimise** [Name of child]**'s exposure to passive smoking.***

Figure 3: Suggested "smoking" phraseology

Maternal alcohol use

Mothers who drink alcohol when pregnant put their children at an increased risk of developing Fetal Alcohol Spectrum Disorder (FASD) [12] [13]. Alcohol inflicts permanent damage on the fetal brain even in the absence of recognisable physical abnormalities. This can include pre- and post-natal growth delay; microcephaly (small head and therefore small brain); neurodevelopmental delay, including developmental, learning and behaviour difficulties; and difficulties with memory, attention, language, sleep, social relationships, and/or processing skills [14] [15]. These features often may not appear or be noticed until the child is of school age and up until this point the child may have been described as having "*normal development*". Those with FASD are at increased risk of

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[12] British Medical Association (BMA) (2016) Alcohol and Pregnancy: Preventing and managing fetal alcohol spectrum disorders.
Available from: www.bma.org.uk/media/2082/fetal-alcohol-spectrum-dis orders-report-feb2016.pdf

[13] Hoyme HE, Kalberg WO, Elliott AJ, Blankenship J, Buckley D, Marais AS, Manning MA, Robinson LK, Adam MP, Abdul-Rahman O, Jewett T. Updated clinical guidelines for diagnosing fetal alcohol spectrum disorders. *Pediatrics*. 2016 Aug 1;138(2).

[14] Jan JE, Asante KO, Conry JL, Fast DK, Bax MC, Ipsiroglu OS, Bredberg E, Loock CA, Wasdell MB. Sleep health issues for children with FASD: Clinical considerations. *International journal of pediatrics*. 2010 Jul 14;2010.

[15] Rasmussen C, Bisanz J. The relation between mathematics and working memory in young children with fetal alcohol spectrum disorders. *The Journal of Special Education*. 2011 Nov;45(3):184-91.

experiencing disrupted family lives, disengagement from school, mental ill health, and criminal justice system encounters [16] [17].

Many alcohol-affected children fit some or all of the criteria for ADHD and/or Autism Spectrum Condition [18] on standard screening tests, leading to multiple assessments and incorrect diagnoses which can be unhelpful for both children and carers. Around half of people with FASD fulfil the diagnostic criteria for making a diagnosis of ADHD. 62% of people with FASD have visual impairment (a rate more than 30 times higher than the general population), 58% have hearing problems (a rate more than 100 times higher than the general population), 83% have speech and language delay, and 91% suffer from impulsivity and inappropriate behaviour.

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[16] Popova S, Lange S, Bekmuradov D, Mihic A, Rehm J. Fetal alcohol spectrum disorder prevalence estimates in correctional systems: a systematic literature review. *Canadian Journal of Public Health*. 2011 Sep;102(5):336-40.

[17] Streissguth AP, Bookstein FL, Barr HM, Sampson PD, O'Malley K, Young JK. Risk factors for adverse life outcomes in fetal alcohol syndrome and fetal alcohol effects. *Journal of Developmental & Behavioral Pediatrics*. 2004 Aug 1;25(4):228-38.

[18] https://www.autism.org.uk/advice-and-guidance/what-is-autism

In research looking at 127 studies of FASD, 428 conditions were found to co-occur with FASD [19]. They can affect almost every system in the body, including:

- the central nervous system (brain)
- vision
- hearing
- cardiac
- circulation
- digestion
- musculoskeletal
- respiratory

If there are no signs in early life and alcohol exposure is known or is strongly suspected to have occurred, carers need to be aware that difficulties may develop in middle childhood or beyond. They should be directed to information available on the FASD website [20]. A Multidisciplinary team is required to diagnose Fetal Alcohol Spectrum Disorder as there has to be evidence of

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[19] Popova S, Lange S, Shield K, Mihic A, Chudley AE, Mukherjee RA, Bekmuradov D, Rehm J. Comorbidity of fetal alcohol spectrum disorder: a systematic review and meta-analysis. *The Lancet*. 2016 Mar 5;387(10022):978-87.
Available from: link

[20] https://nationalfasd.org.uk/

significant difficulties / severe impairment i.e. less than two standard deviations below the norm in at least three out of 10 areas of assessment. The areas of assessment are:

1. Brain structure/neurology
2. Motor skills
3. Cognition
4. Language (expressive and receptive)
5. Academic achievement
6. Memory
7. Attention
8. Executive function including impulse control and hyperactivity
9. Affect regulation
10. Adaptive behaviour and social skills or social communication

If alcohol was consumed in pregnancy at the time of the development of the face (between four to six weeks gestational age), specific facial features may be seen, including a smooth philtrum, thin upper lip, upturned nose, flat nasal bridge and midface, epicanthal folds, small palpebral fissures, and small head circumference (**Figure 4**) [21]. It is possible to have FASD with or without sentinel facial features [22]. The three sentinel facial features are:

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[21] https://www.aafp.org/afp/2005/0715/p279.html

[22] Popova S, Charness ME, Burd L, Crawford A, Hoyme HE, Mukherjee RA, Riley EP, Elliott EJ. Fetal alcohol spectrum disorders. *Nature Reviews Disease Primers*. 2023 Feb 23;9(1):11.

1. Short palpebral fissure length (ie more than or equal to two standard deviations below the mean)
2. Smooth philtrum (rank four or five on the lip philtrum guide)
3. Thin upper lip (rank four or five on the lip philtrum guide)

In February 2023 a study was published which aimed to validate the "FASD-Tree" as a screening tool for fetal alcohol spectrum disorders [23]. As many as 80% of individuals with FASD are misdiagnosed or not diagnosed. In this study, children with histories of antenatal alcohol exposure and controls were examined for physical signs of fetal alcohol spectrum disorder, and parents completed behavioural questionnaires. Data were entered into the FASD-Tree, a web-based decision tree application. The FASD-Tree was successful in accurately identifying young people with histories of antenatal exposure to alcohol and the subgroup of individuals with FASD, indicating its validity as an FASD screening tool. Overall accuracy rates for FASD-Tree components ranged from 75.0% to 84.1%, and both the decision tree outcome and risk score, and their combination, resulted in fair to good discrimination (area under the curve = 0.722 to 0.862) of young people with histories of antenatal alcohol exposure or FASD. While most participants were correctly classified, those who were misclassified differed in IQ and attention. Race, ethnicity, and sex did not affect the results. The FASD-Tree is not a biomarker of antenatal exposure to alcohol and does not provide definitive evidence of antenatal alcohol

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[23] Mattson SN, Jones KL, Chockalingam G, Wozniak JR, Hyland MT, Courchesne-Krak NS, Del Campo M, Riley EP, CIFASD. Validation of the FASD-Tree as a screening tool for fetal alcohol spectrum disorders. *Alcoholism: Clinical and Experimental Research*. 2023 Feb;47(2):263-72.

exposure. Rather it is an accurate and valid screening tool for FASD and can be used by clinicians who suspect that a patient has a history of antenatal alcohol exposure, even if the exposure is unknown.

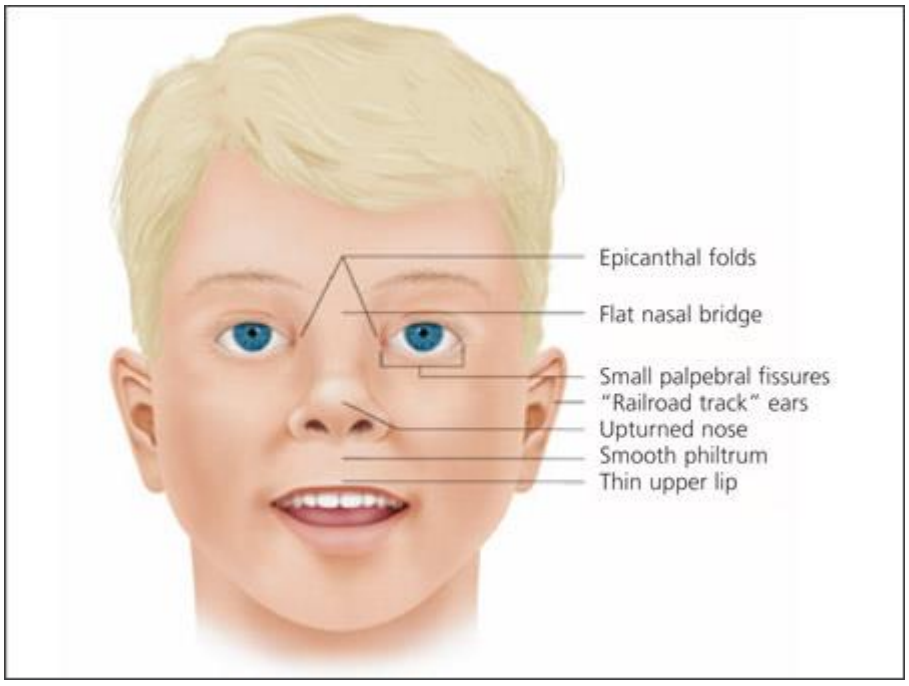

Figure 4: Characteristic facial features of antenatal exposure to alcohol

Remember that at this time the mother may not even be aware she is pregnant. The presence of facial features only accounts for 10% of the total number of children who have FASD and does not always mean that the child will be more severely affected than those children who do not have the facial features.

Vulnerabilities of individuals with FASD to, and within, criminal justice system encounters

Internationally, some studies have demonstrated the over representation of individuals with FASD in the criminal justice system (CJS) [24] [25]. Several vulnerabilities predispose individuals with FASD to CJS encounters and also, impact outcomes during these encounters. Some of the vulnerabilities of individuals with FASD to, and within, CJS encounters include:

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[24] Popova S, Lange S, Bekmuradov D, Mihic A, Rehm J. Fetal alcohol spectrum disorder prevalence estimates in correctional systems: a systematic literature review. *Canadian Journal of Public Health*. 2011 Sep;102(5):336-40.

[25] McLachlan K, McNeil A, Pei J, Brain U, Andrew G, Oberlander TF. Prevalence and characteristics of adults with fetal alcohol spectrum disorder in corrections: A Canadian case ascertainment study. *BMC Public Health*. 2019 Dec;19(1):1-0.

- **Interrogative suggestibility** (immediate and after time delay): Individuals with FASD are likely to admit to false suggestions / leading questions during police questioning [26] [27] [28] [29].

- **Compliance**: Individuals with FASD may easily say 'yes' to a suggestion for immediate instrumental gain but internally disagree with the suggestions from interviewers [29].

- **Confabulation**: replacement of memory gaps with imaginative stories is evidenced in individuals with FASD [29].

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[26] Allely CS, Mukherjee R. Suggestibility, false confessions and competency to stand trial in individuals with fetal alcohol spectrum disorders: Current concerns and recommendations. *Journal of Criminal Psychology*. 2019 Dec 2.

[27] Brown NN, Gudjonsson G, Connor P. Suggestibility and Fetal Alcohol Spectrum Disorders: I'll tell you anything you want to hear. *The Journal of Psychiatry & Law*. 2011 Mar;39(1):39-71.

[28] Gilbert DJ, Allely CS, Mukherjee RA, Cook PA. Foetal alcohol spectrum disorder and Investigative interviewing: A systematic review highlighting clinical and legal implications and recommendations. *Behavioral Sciences & the Law*. 2022 Feb;40(1):170-85.

[29] Gilbert, D. J., (2023). Exploring the vulnerabilities of individuals with Fetal Alcohol Spectrum Disorders to, and within, criminal justice system encounters. PhD thesis submitted to the University of Salford

- **Distortion and fabrication**: these are the individual components that add up to confabulation. Distortion is the misconstrue of facts while fabrication is addition of new ideas to existing facts. Distortion and fabrication is evidenced in individuals with FASD [29].

- **Frontal lobe paradox**: individuals with FASD can do well in psychology assessments but struggle with same tasks in real life [30].

- **Poor executive functioning**: these are impairments in executing goal-oriented behaviour [31] [32].

- **Poor memory**: including in an investigative interview context [29] [32].

- **High levels of impulsivity** [32].

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[30] George M, Gilbert S. Mental Capacity Act (2005) assessments: Why everyone needs to know about the frontal lobe paradox. *The neuropsychologist*. 2018;5(1):59-66.

[31] Connor PD, Sampson PD, Bookstein FL, Barr HM, Streissguth AP. Direct and indirect effects of prenatal alcohol damage on executive function. *Developmental neuropsychology*. 2000 Dec 1;18(3):331-54.

[32] Mattson SN, Bernes GA, Doyle LR. Fetal alcohol spectrum disorders: a review of the neurobehavioral deficits associated with prenatal alcohol exposure. *Alcoholism: Clinical and Experimental Research*. 2019 Jun;43(6):1046-62.

Referencing maternal alcohol use in reports

There are some ways in which you might like to consider describing the use of alcohol in pregnancy, and these are shown in **Figure 5** and **Figure 6**.

*[Name of child]**'s mother drank alcohol during the pregnancy with** [Name of child]**. We cannot predict to what extent maternal alcohol use in pregnancy may have had effects upon** [Name of child]**.***

[Name of child] may look fine – 90% of affected children have no facial features [that is they do not have the characteristic sentinel facial features formerly known as Fetal Alcohol Syndrome] but there may still be problems with, for example, [Name of child]'s behaviour, attention, cognition, language, sleep, social relationships, or memory. This is called FASD (Fetal Alcohol Spectrum Disorder). We cannot predict at what age (if any) problems may arise.

Carers need to be aware that difficulties may develop at any stage in [Name of child]'s life and may only be apparent in middle childhood or beyond. They should read information from the FASD website https://nationalfasd.org.uk/

Should concerns arise with** [Name of child]**'s development, learning, or behaviour, appropriate assessments, advice and support should be sought to ensure** [Name of child]**'s optimal developmental potential is realised.

Figure 5: Suggested phraseology if there has been parental alcohol misuse

Some studies have demonstrated the over representation of individuals with FASD in the criminal justice system (CJS). Several vulnerabilities predispose individuals with FASD to CJS encounters and also, impact outcomes during these encounters. Some of the vulnerabilities of individuals with FASD to, and within, CJS encounters include:

***Interrogative suggestibility (immediate and after time delay)**: Individuals with FASD are likely to admit to false suggestions / leading questions during police questioning.*

***Compliance**: Individuals with FASD may easily say 'yes' to a suggestion for immediate instrumental gain but internally disagree with the suggestions from interviewers.*

***Confabulation**: replacement of memory gaps with imaginative stories is evidenced in individuals with FASD.*

***Distortion and fabrication**: these are the individual components that add up to confabulation. Distortion is the misconstrue of facts while fabrication is addition of new ideas to existing facts.*

***Frontal lobe paradox**: individuals with FASD can do well in psychology assessments but struggle with same tasks in real life.*

***Poor executive functioning**: these are impairments in executing goal-oriented behaviour.*

***Poor memory**: including in an investigative interview context.*

***High levels of impulsivity**.*

Figure 6: Suggested phraseology regarding potential vulnerabilities of individuals with FASD to, and within, Criminal Justice System encounters

Maternal cannabis use

The active chemical in cannabis can pass to the foetus via the placenta. This means that the growing foetus may be affected by any amount of cannabis taken by the pregnant woman. The effect of passive smoking of cannabis as a result of breathing in the smoke of others is not clear, and it should be avoided. Any form of smoking can reduce the supply of oxygen and nutrients to the baby, which can result in restrictions to the growth of the baby and possibly premature birth.

Cannabis use during pregnancy may have a modest effect on prenatal growth, but the results are inconsistent from study to study and other factors often co-exist making it difficult to separate the effects of cannabis from poor maternal health. These effects, if any, are not associated with later growth problems, although a few studies have suggested an impact on height as well as persistent negative effects on head circumference in the offspring of heavy cannabis users. A review of studies found no consistent link between prenatal cannabis use and other adverse pregnancy outcomes or birth defects.

Subtle effects of cannabis exposure on cognition have been observed in studies. Cannabis may have an impact on higher level executive function and performance. Specific links to inattention and/or impulsivity and subtle deficits in memory and learning have been observed.

Maternal cocaine use

There is conflicting evidence as to whether exposure to cocaine in utero causes congenital abnormality. This is because there are often confounding factors which could also affect the

risk, such as poor maternal health. There have been reports of microcephaly and heart defects, and cocaine may affect the developing foetus' circulation. There may be an increased risk of SIDS and a 'fetal cocaine syndrome' has been described. Issues with withdrawal are less prominent but there is evidence of a risk of neurodevelopmental/ behavioural difficulties in later childhood.

Maternal heroin or methadone use

Babies born to mothers who use heroin may be of low birthweight and there is a risk of prematurity. There is conflicting evidence regarding the risk of abnormal brain development in children exposed to heroin in utero. Some evidence suggests that children may have language delay. Babies exposed to heroin may show signs of withdrawal (breathing difficulties, seizures and 'jitteriness'). If there are concerns, then babies are kept in hospital for a period of observation. Treatment in the form of oral morphine solution is available if needed which would then be weaned and stopped. There is an increased risk of Sudden infant death syndrome (SIDS).

There are many advantages of being on a methadone programme compared to other opiates during pregnancy. Methadone is longer acting and non-injectable. Women will also have support, medical care and counselling. Babies exposed to methadone may show reduced fetal growth and/or low birth weight. Children born to women treated with methadone may demonstrate mild developmental or behavioural difficulties, although the risks are thought to be less than the risks with heroin use. Babies will still need to be monitored for signs of withdrawal.

Methadone treatment increases the risk of withdrawal symptoms if over 40mg/day.

Codeine

Codeine is sometimes prescribed for the management of severe pain in pregnant women. The data available indicates that the risk of teratogenicity is low; however, in some women there may be confounding factors and therefore it may be difficult to predict the effect of the individual drug. Withdrawal effects may occur if taken in the last trimester.

Diazepam

The evidence for effects on the developing fetus is conflicting however the risks overall are likely to be low for diazepam exposure. There is some evidence of withdrawal effects, but this would depend on the frequency and dose used of the drug.

Drug withdrawal / neonatal abstinence syndrome

Babies exposed to opiate drugs (heroin, methadone, morphine, codeine) in the last few weeks before delivery can show signs of withdrawal at birth. These are monitored and in severe cases require treatment with small doses of oral morphine. The degree of withdrawal is related to the timing of ingestion during pregnancy, i.e. in the latter stages rather than the amount ingested. Withdrawal symptoms do not predict the extent of long-term damage caused by drug use during pregnancy.

If there are concerns about ongoing withdrawal symptoms, it is imperative that professional advice is sought, whether from a midwife, health visitor, or General Practitioner (GP), so that appropriate advice can be provided. If a baby is thought to be withdrawing from maternal drug use, a neonatal discharge summary and treatment plan should be available.

If there are concerns about the withdrawal effect of other maternal drugs, advice should be sought from the neonatal unit for any specific monitoring plan, and can be supplemented using information from the BUMPS website [11].

PARENTAL HEALTH FACTORS

7. Parental health factors - mental health

Depression and anxiety

Depression and anxiety can run in families, but social and environmental factors play a very prominent part. Between 1 in 3 to 1 in 4 of us will have a mental health problem at some point in our lives. It would be in the best interest of any child to have plenty of opportunity to discuss feelings as they grow up and to learn by discussion and role model how to deal with difficult feelings safely. Ensuring the child / young person develops effective skills for managing life stresses can be critical to a healthy lifestyle in order to avoid things that can aggravate the illness (such as drugs and alcohol).

Schizophrenia

Schizophrenia tends to run in families, but no single gene is thought to be responsible. The background risk of someone in the general population developing schizophrenia in their lifetime is 1 in 100. This increases to 13 in 100 if one parent has schizophrenia and 45 in 100 if both parents have the condition. It is more likely that different combinations of genes make people more vulnerable to the condition however, having these genes doesn't necessarily mean an individual will develop schizophrenia. The exact causes of schizophrenia are unknown. Research suggests a combination of physical, genetic, psychological and environmental factors can make a person more likely to develop the condition. This means that someone might have inherited the genes that cause schizophrenia but these genes need to be “turned on” for the condition to manifest. Unfavourable environments, drug misuse, and/or emotional trauma can

“turn on” the schizophrenia genes and the condition then becomes manifest. Research suggests that children with a family history of schizophrenia who are brought up in favourable, loving, predictable, consistent, non-critical environments are much less likely to develop the condition compared to children with a family history who are brought up in non-favourable environments.

Bipolar affective disorder

The exact cause of bipolar disorder is unknown. Experts believe there are a number of factors that work together to make a person more likely to develop the condition. It is thought that bipolar disorder is linked to genetics, as the condition seems to run in families. Bipolar disorder is difficult to diagnose. The background risk in the general population is 2-3 in 100, this increases to 15 in 100 if one parent is affected and 50 in 100 if both parents have the condition. Other factors including stressful life events, abrupt changes in sleep patterns, and chronic medical illnesses can contribute to the development of the condition.

The family members of a person with bipolar affective disorder have an increased risk of developing it themselves although no single gene is responsible for bipolar disorder. Instead, a number of genetic and environmental factors are thought to act as triggers. A stressful circumstance or situation often is a trigger for the symptoms of bipolar disorder in a susceptible person. Further information is available in the section on **Schizophrenia** regarding the “turning on” of genes.

Emotionally unstable personality disorder

We all have personality traits. When these traits become maladaptive then these traits become a “disorder”. It is likely that a number of factors are involved in the development of personality disorder. Studies have shown that about 40% of the influence on the condition may be genetic and 60% due to environmental influences. Personality disorder is associated with experience of abuse and neglect in childhood and a history of childhood trauma. Genes are known to interact with the environment – this may play a part and could explain why some people develop the condition and others don’t.

Social factors implicated in the development of personality disorder include how people interact in their early development with their family, friends, and other children. Other factors include the individual's personality and temperament, and learned coping skills for dealing with stress. Multiple factors probably contribute to the disorder. There may also be protective factors that, if present, may prevent development of the condition. These are likely to include consistency, a secure attachment, warmth, and an open expressive environment to allow a child to develop emotional regulation.

Learning disability

The World Health Organization's "International Classification of Diseases" is now in its 11th edition ("ICD-11") [33]. ICD-11 now recognises both learning disability [34] and learning difficulty [35].

The term learning disability implies a reduced intellectual ability and difficulty with everyday activities. Learning disabilities are heterogeneous conditions, but are defined by three core criteria:

- lower intellectual ability (usually defined as an IQ of less than 70)
- reduced ability to cope independently (impaired social or adaptive functioning)
- onset in childhood.

Children and adults with learning disability may have problems with speech and language, memory, reasoning and concentration, reading and numeracy. In many cases the cause of the learning disability is not known. Brain development can be affected either during pregnancy, (poor maternal health, drugs, alcohol), or by problems during delivery. The unborn baby can develop certain genes associated with learning difficulties or can inherit these genes from one

[33] https://icd.who.int/browse11/l-m/en

[34] "6A03.Z Developmental learning disorder, unspecified"

[35] "QF20 Difficulty or need for assistance with learning"

or both parents. Effects on child heath in early life can also cause learning disability (environmental causes). Sometimes a combination of influences result in learning disability.

A learning disability can be mild, moderate, or severe and is sometimes classified in terms of IQ score. For example, a person with a mild learning disability may have an IQ of between 50 and 70.

The UK Office for Health Improvement and Disparities has published comprehensive data profiles about the health and care of people with learning disabilities [36]. These profiles provide a range of data about the health and care of people with learning disabilities. They can be used by commissioners and health and care professionals to help make decisions about how best to meet the health and care needs of people with learning disabilities [37].

Parent with intellectual disabilities

Statistics suggest that 10% of children who have one birth parent with an intellectual disability [38] (learning disability) may develop similar problems in later life, whereas this number rises to 50% or more if both parents are affected.

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[36] https://fingertips.phe.org.uk/profile/learning-disabilities

[37] https://www.gov.uk/government/publications/people-with-learning-disabilities-in-england

[38] "6A00 Disorders of intellectual development" / learning disabilities

National statistics (England)

Children with Moderate Learning Difficulties (MLD), Severe Learning Difficulties (SLD) and Profound and Multiple Learning Difficulties (PMLD) are more likely to be eligible for Free School Meals (an indicator of household poverty) than children without an identified special educational need (SEN).

In 2018, 26% of children with a statement or EHC plan and with a primary SEN associated with learning disabilities were being educated in mainstream schools, including:

- 44% of children with a primary SEN of MLD, down from 51% in 2010
- 12% of children with a primary SEN of SLD, down from 18% in 2010
- 15% of children with a primary SEN of PMLD, similar to 2010 (15%)

Children with a primary SEN of MLD were markedly more likely to be excluded (fixed-period exclusion 4.4%, permanent exclusion 0.2%) than children with no SEN (fixed-period exclusion 1.5%, permanent exclusion 0.05%).

Children with a primary SEN of PMLD were less likely to be excluded (fixed-term exclusion 0.3%, no permanent exclusions) than children with no SEN.

With regard to children's social care, in 2015/16 18,030 children with a primary SEN need of MLD were children in need or looked after children (LAC), compared to 9,650 children with a primary SEN need of SLD and 4,860 children with a primary need of PMLD.

Children with a primary need of MLD, SLD or PMLD represented 9.2% of all looked after children, 5.6% of all children with a Child Protection Plan, and 8.5% of all children with a Children in Need Plan.

DOMESTIC ABUSE

8. Domestic abuse

Domestic Abuse Statutory Guidance

Statutory guidance was published in July 2022 [39] to accompany the Domestic Abuse Act 2021. To deliver an effective response, professionals and agencies should be aware of the different types of domestic abuse.

Inter-partner abuse

Domestic abuse most commonly takes place in intimate partner relationships, including same-sex relationships [40]. Intimate relationships can take different forms, partners do not need to be married or in a civil partnership and abuse can occur between non-cohabiting intimate partners. As with all forms of abuse, abuse in intimate relationships can vary in severity and frequency, ranging from a one-off occurrence to a continued pattern of behaviour. Domestic abuse involves physical and non-physical forms **(Figure 7)**.

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1089015/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf

40

https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseprevalenceandvictimcharacteristicsappendixtables

[Name of child] ***has experienced, and/or been exposed to, non-physical forms of domestic abuse which also have the potential to have a significant adverse impact on*** *[Name of child]****'s wellbeing.*** *[Name of child]****'s relationship with a trusted adult who has capacity to support them, wider family networks, and friendship groups are important factors to help mitigate the adverse effects of the domestic abuse that*** *[Name of child]* ***has experienced.***

Figure 7: Experience of non-physical domestic abuse

Teenage relationship abuse

Young people can also experience domestic abuse within their relationships. Teenagers may not self-identify as victims. They may perceive their relationships to be 'casual', for example engaging in multiple romantic and sexual partners through dating applications. Abusive behaviours by one young person toward another, where each are aged between 16 and 18 years old could be both child abuse and domestic abuse as a matter of law. Abusive behaviours within relationships between young people can include similar incidents or patterns of behaviours as adult relationships. For teenagers in particular, abuse to harass or control victims can occur through using technology, this includes social media, or location-based tracking apps, such as *Find My Friends*.

Young people's lives are often heavily online-based, and perpetrators of abuse may exploit this, demanding access to passwords and monitoring online activity. Young people may also experience intimate image abuse within their relationships, including threats to expose intimate images.

Teenage relationship abuse often occurs outside of a domestic setting. Victims may feel that domestic abuse occurs only between adults who are cohabiting or married. Teenage victims may find it difficult to identify abusive behaviour, for instance, controlling or jealous behaviour may be misconstrued as love.

Domestic abuse in teenage relationships can be just as severe and has the potential to be as life threatening as abuse in adult relationships. Young people who experience domestic abuse do so at a particularly vulnerable point in their lives. They may experience a complex transition from childhood to adulthood which impacts on behaviour and decision making. It may impact on the way that they respond to abuse or if and how they engage with services.

LGBTQI+

Due to the stigma attached to LGBTQI-plus [41] (Lesbian, gay, bisexual, transgender, queer and intersex) identities, young people from the LGBTQI-plus [LGBTQI+] community may lack relevant and accurate information on healthy relationships, which may inform behaviour and decision making. LGBTQI+ young people may face unique obstacles [42] to seeking help, especially in a context of a first relationship or when first coming out as they may be unable to

[41] https://www.un.org/en/fight-racism/vulnerable-groups/lgbtqi-plus

[42] https://socialprotection-humanrights.org/key-issues/disadvantaged-and-vulnerable-groups/lgbtqi/

confide in their peers or family, owing to the reaction they might receive due to their sexuality or gender identity.

Abuse by family members

Domestic abuse may also be perpetrated by a family member including by parents, those with parental responsibility, siblings, or extended family members (including family members who are not biologically related to the person being abused. Abuse may be perpetrated towards a victim by more than one relative.

Abuse within a family set up can encompass a number of different harmful behaviours. Abuse may be perpetrated as a perceived means to protect or defend the 'honour' of an individual, family or community against alleged or perceived breaches of the family or community's code of behaviour. It can therefore include 'honour'-based abuse, forced marriage, female genital mutilation, and other harmful practices such as reproductive coercion (and as part of this, forced abortion).

Young people may be at an increased risk of abuse perpetrated by family members [43]. Young people may be inherently more vulnerable because it is harder for them to distinguish between normal and abusive behaviours, and this may especially be the case where the perpetrator is a

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https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseprevalenceandvictimcharacteristicsappendixtables

trusted family member. A young person may find it more difficult to report or disclose abuse by an adult. There may be no safe channel for disclosure, young people may fear the repercussions of disclosure or may not want other family members to get into trouble. There may be an increased risk of abuse by family members for young LGBTQI+ people.

Domestic violence in-utero

Mothers experiencing domestic abuse (also called domestic violence or inter-partner violence) while pregnant become stressed. This stress response can affect their unborn baby's stress response system, in that once the baby is born, they may react to stresses more readily. This difficulty with self-regulatory behaviours can impact on their ability to form secure attachments **(Figure 8)**.

[Name of child] **has been exposed to domestic violence in utero and/or in early life. This means** [Name of child] **is at increased risk of emotional health difficulties which may include anxiety and sleeping difficulties or may manifest as apparent behavioural difficulties.** [Name of child] **requires a nurturing, predictable, loving environment with carers who are attuned to their needs.**

Figure 8: In-utero and/or early life exposure to domestic abuse

Child victims of domestic abuse

Domestic abuse has a significant impact **(Figure 9)** on children and young people of all ages (up to 18 years old) **(Figure 10)**.

[Name of child] ***has experienced domestic abuse. Broadly, some of the impacts that domestic abuse can have on a child with experience of domestic abuse, include:***

1. Feeling anxious or depressed;

2. Low self-esteem and difficulties with forming healthy relationships;

3. Hypervigilance in reading body language or changes in mood and atmosphere;

4. Having difficulty sleeping, nightmares;

5. Physical symptoms such as stomach aches or bed wetting;

6. Delayed development or deterioration in speech, language and communication;

7. Reduction in school attainment, truancy, risk of exclusion from school;

8. Increased application to activities outside the home, including academia or sports, as a distraction;

9. Inconsistent regulation of emotions, including becoming distressed, upset or angry;

10. Becoming aggressive or internalising their distress and becoming withdrawn;

11. Managing their space within the home so they are not visible; and/or

12. Using alcohol or drugs, or self-harming.

It is therefore important that *[Name of child]* ***is placed in a supportive and stable environment. Carers, attuned to*** *[Name of child]****'s needs, will need to provide nurturing loving care with consistent responses.***

Figure 9: Impact of domestic abuse

A child is a victim of domestic abuse if the child sees, hears, or experiences the effects of the abuse, and is related to, or falls under “parental responsibility” of, the victim and/or perpetrator of the domestic abuse. A child might therefore be considered a victim of domestic abuse where one parent is abusing another parent, or where a parent is abusing, or being abused by, a partner or relative.

[Name of child] ***has experienced domestic abuse at a particularly vulnerable point in their life. They have experienced emotional trauma (given their likely exposure to frightening and confusing situations) the full extent of which are likely to be unknown. There is the potential for adverse impact on their future mental health, their ability to learn, their ability to socialise and the chances of them developing healthily if they are not supported by caregivers who can consistently, effectively, and appropriately respond to them.***

They may experience a complex transition from childhood to adulthood which may impact on behaviour and decision-making, including how they respond to abuse and/or engage with services. It is therefore important that *[Name of child]* ***is placed in a supportive and stable environment. Carers, attuned to*** *[Name of child]****’s needs, will need to provide nurturing loving care with consistent responses.*** *[Name of child]****’s relationship with a trusted adult who has capacity to support them, wider family networks, and friendship groups are important factors to help mitigate the adverse effects of the domestic abuse that*** *[Name of child]* ***has experienced.***

Figure 10: Experiencing domestic abuse at a particularly vulnerable point in the child's life

Estimates suggest that between March 2017 to 2019, 7% of children aged ten to 15 years old were living in households where an adult reported experiencing domestic abuse in the previous Year [44]. For the year ending March 2018, victims of partner abuse were asked whether any children in the house heard or saw what happened during the most recent victimisation. In 41% of cases where adults aged 16 to 59 reported having experienced partner abuse, there was at least one child under the age of 16 living in the household. Where children were living in the household, one in five were reported to have either seen or heard what had happened [45].

Domestic abuse as a risk factor for child physical abuse

The presence of domestic abuse has been identified as a risk factor for child physical abuse, with children who were exposed to domestic violence being more likely to be physically abused and neglected [46].

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[44] ONS. Childhood vulnerability to victimisation in England and Wales - Office for National Statistics: data year ending March 2017 to year ending March 2019.
Available from: link

[45] ONS. Partner abuse in detail, England and Wales - Office for National Statistics (ons.gov.uk): Data year ending March 2018.
Available from: link

[46] Holt S, Buckley H, Whelan S. The impact of exposure to domestic violence on children and young people: A review of the literature. *Child abuse & neglect*. 2008 Aug 1;32(8):797-810.
Available from: link

A review of 877 child abuse cases between February 2011 to September 2013 showed that the majority (97%) of children living with domestic abuse are exposed to that abuse. Of the children exposed to the abuse, two thirds were directly harmed, most often physically or emotionally abused, or neglected. When looking at all children that were exposed to domestic abuse, over half had behavioural problems, or felt responsible or to blame for negative events. Difficulties adjusting at school were found in over a third of cases [47].

Non-physical forms of domestic abuse like coercive control also have a significant impact on children [48] [49] and professionals focused on physical acts of violence may fail to understand the daily experience of victims and children, how it is affecting them, and the level of risk posed by perpetrators.

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[47] Coordinated Action Against Domestic Abuse (2014). In plain sight: the evidence from children exposed to domestic abuse.
Available from: link

[48]

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-_Pathways_to_harm_and_protection.pdf

[49]

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1062330/JTAI_domestic_abuse_18_Sept_2017.pdf

Experiencing domestic abuse perpetrated by or directed towards a relative can have devastating consequences for children. Experience of domestic abuse is recognised as an Adverse Childhood Experience (ACE), further examples of which are in a separate chapter **(below)** of this guidance document.

A child's relationship with a trusted adult who has capacity to support them, wider family networks, friendship groups, and the type and frequency of the abuse are important factors **(Figure 11)**.

[Name of child] ***has experienced domestic abuse and this has been shown to be a risk factor for child physical abuse. All agencies and professionals working with*** *[Name of child]* ***should be aware that a child exposed to domestic violence is also more likely to have been physically abused and neglected. When looking at all children that have been exposed to domestic abuse, over half have behavioural problems, or feel responsible or to blame for negative events. Difficulties adjusting at school have been found to occur in over a third of cases.*** *[Name of child]****'s relationship with a trusted adult who has capacity to support them, wider family networks, and friendship groups are important factors to help mitigate the adverse effects of the domestic abuse that*** *[Name of child]* ***has experienced.***

Figure 11: Risks of experiencing domestic abuse

Impact of domestic abuse on children

Broadly, some of the impacts that domestic abuse can have on children include [50]:

- Feeling anxious or depressed;
- Low self-esteem and difficulties with forming healthy relationships;
- Hypervigilance in reading body language or changes in mood and atmosphere;
- Having difficulty sleeping, nightmares;
- Physical symptoms such as stomach aches or bed wetting;
- Delayed development or deterioration in speech, language and communication;
- Reduction in school attainment, truancy, risk of exclusion from school;
- Increased application to activities outside the home, including academia or sports, as a distraction;
- Inconsistent regulation of emotions, including becoming distressed, upset or angry;
- Becoming aggressive or internalising their distress and becoming withdrawn;
- Managing their space within the home so they are not visible; and/or
- Using alcohol or drugs, or self-harming.

Effect of the age of the child

Children and young people of different ages may respond in different ways to domestic abuse, depending on their stage of development. Babies and young children may be particularly vulnerable when living with domestic abuse, with protective factors

[50] https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/domestic-abuse/#signs

often minimal for this age group (unable to seek help or remove themselves from danger, often 'out of sight' of regular contact with professionals, dependent on others and may not be able to recognise abusive behaviour). Babies experiencing the effects of domestic abuse may be more likely to have difficulty sleeping, have higher levels of excessive crying and disrupted attachment **(Figure 12)**.

[Name of child] ***has experienced domestic abuse as a baby and/or young child. Babies and young children may be particularly vulnerable when living with domestic abuse, with protective factors often minimal for this age group (unable to seek help or remove themselves from danger, often 'out of sight' of regular contact with professionals, dependent on others and may not be able to recognise abusive behaviour). Babies experiencing the effects of domestic abuse may be more likely to have difficulty sleeping, have higher levels of excess crying and disrupted attachment.***

Figure 12: Exposure to domestic abuse as a baby

Children of pre-school **(Figure 13)** age tend to show the most behavioural disturbance such as bed wetting, sleep disturbances and eating difficulties and are particularly vulnerable to blaming themselves for the adult violence.

[Name of child] ***has experienced domestic abuse in the pre-school years. Children of pre-school age exposed to domestic abuse tend to show the most behavioural disturbance such as bed wetting, sleep disturbances and eating difficulties and are particularly vulnerable to blaming themselves for the adult violence.***

Figure 13: Exposure to domestic abuse in the pre-school years

Older children **(Figure 14)** may be more likely to show the effects of the disruption in their lives through under performance at school, poorly developed social networks, self-harm, running away and engagement in anti-social behaviour [51].

*[Name of child]**'s experiences of domestic abuse as an older child are more likely to mean that the effects will be shown through disruption in their lives through under performance at school, poorly developed social networks, self-harm, running away and engagement in anti-social behaviour.***

Figure 14: Exposure to domestic abuse as an older child

Children with SEND

Children with special educational needs and disabilities (SEND) may find it difficult to express their feelings or may express them in different ways particularly if the child has autism spectrum, a sensory impairment, a learning disability or complex or profound difficulties and is, for example, non-verbal. Distress can be presented in different ways, including through challenging behaviour, becoming more withdrawn, difficulties concentrating or other changes to their usual behaviours or ways of communicating **(Figure 15)**.

[51] https://gov.wales/sites/default/files/publications/2019-08/cafcass-cymru-impact-on%20children-experiencing-domestic-abuse.pdf

[Name of child] ***has special educational needs and/or disabilities (SEND). Children with SEND who have experienced domestic abuse may find it difficult to express their feelings or may express them in different ways particularly if the child has an autism spectrum disorder, a sensory impairment, a learning disability or complex or profound difficulties and are, for example, non-verbal. Distress can be presented in different ways, including through challenging behaviour, becoming more withdrawn, difficulties concentrating or other changes to their usual behaviours or ways of communicating.***

Figure 15: Children with SEND who are exposed to domestic abuse

Children of separated parents

For children of separated parents where domestic abuse is a factor, the impact of the abuse may intensify after separation. Therefore, providing support to both children and the non-abusive parent is essential and the child's voice, their safety and the safety of the non-abusive parent should always be considered. There should be a focus on the importance of joint and parallel work for victims, including children and a range of services to sensitively address and overcome the harm domestic abuse has caused to the non-abusive parent-child relationship. This should also include appropriate access to relevant services for the perpetrator alongside clear accountability that the perpetrator is responsible for the harm caused.

Experiencing abuse in their own intimate relationships can be hugely damaging for young people and abuse in teenage relationships should be taken just as seriously as in adult relationships.

Trauma-informed strategies of mitigating the effects of domestic abuse

England and Wales data from 2015 to 2018 suggests that 60% of the children accessing domestic abuse related services experienced behavioural problems and around half (52%) experienced problems with social development and relationships. Over a third were undertaking risk taking behaviour. The Children's Insights England and Wales report shows that a trauma-informed approach, including receiving help from specialist children's services reduces the impact of domestic abuse on these children and young people and improves their safety and health outcomes. A trauma-informed approach recognises that people who have survived significant childhood adversity may experience a triad of entwined social, physical, and psychological injuries. While these injuries are typically studied independently, they are better understood as interlocking and interdependent, shaping people's subjective experiences in complex ways across their lifespan. The result can be 'harm building upon harm', reducing the 'shock absorbers' available to cope at times of stress.

ADVERSE CHILDHOOD EXPERIENCES

9. Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences (ACEs)

The first 1000 days of a child's life are crucial in terms of developing healthy attachments and a positive sense of the world and themselves. Their early experiences of care, stability and consistency can be the blueprint for future relationships and where there are disruptions or adverse childhood experiences (ACEs), in these early years, children can experience difficulties in their later years [52] [53].

We know that exposure to adverse childhood experiences (ACEs) leaves children at an increased risk of negative health outcomes across the life course, and may affect other life outcomes such as contact with the criminal justice system.

Experience of domestic abuse is recognised as an Adverse Childhood Experience (ACE), Other ACEs include physical, psychological, and sexual abuse, or household dysfunction such as having incarcerated relatives or relatives experiencing substance abuse or mental illness. Research suggests that ACEs can often overlap, occurring in clusters [54].

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[52] http://longscan.research.unc.edu/pages/publist/index.htm

[53] https://www.cdc.gov/vitalsigns/aces/pdf/vs-1105-aces-H.pdf

[54] https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years). For example:

- experiencing violence, abuse, or neglect
- witnessing violence in the home or community
- having a family member attempt or die by suicide

Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with:

- substance use problems
- mental health problems
- instability due to parental separation or household members being in prison

ACEs are linked to chronic health problems, mental illness, and substance use problems in adulthood. ACEs can also negatively impact education, job opportunities, and earning potential. However, ACEs can be prevented. Please note the examples given are not meant to be a complete list of adverse experiences. There are many other traumatic experiences that could impact health and wellbeing.

It is not possible to predict the outcome for an individual child or young person. However, the risk of negative health and wellbeing outcomes increases with exposure to multiple ACEs. The type of ACE and the time for which it is experienced may also impact on the risk of negative outcomes. ACEs include child maltreatment and specific experiences affecting the household or family in which the child lives (see below for list). Most children entering care will have been exposed to ACEs.

There are some suggested ways that ACEs could be referenced in reports shown in **Figure 16** and **Figure 17**.

[Name of child] ***has been exposed to multiple adverse childhood experiences and is at an increased risk of physical health difficulties and poorer mental health outcomes. All professionals should be aware of the low threshold for seeking further advice and support if there are any concerns about*** *[Name of child]****'s emotional/mental health. In order to mitigate these risks, it is imperative for*** *[Name of child]* ***to have nurturing loving care in a stable environment, with carers who are attuned to*** *[Name of child]****'s needs and can respond consistently.***

Figure 16: Potential way to reference ACEs in a PAM or IHA report

[Name of child] ***has been exposed to multiple adverse childhood experiences and is at an increased risk of physical health difficulties and poorer mental health outcomes.*** *[Name of child]****'s emotional health and behaviour should be monitored, and can be discussed with relevant health and/or education professionals to decide if further assessment or support is warranted. In order to mitigate these risks, it is imperative for*** *[Name of child]* ***to have nurturing loving care in a stable environment, with carers who are attuned to*** *[Name of child]****'s needs and can respond consistently.***

Figure 17: Potential way to reference ACEs in a PAM or IHA report if it is not clear whether the child has any difficulties

What is an ACE?

Whilst there is no universally agreed definition for an ACE, studies addressing the issue have mostly converged on a similar set of experiences and listed the following:

- verbal abuse
- physical abuse
- sexual abuse
- physical neglect
- emotional neglect
- parental separation
- household mental illness
- household domestic violence

- household alcohol abuse
- household drug abuse
- incarceration of a household member

Further information is available from the Manchester Safeguarding Partnership [55].

[55] https://www.manchestersafeguardingpartnership.co.uk/resource/adverse-childhood-experiences-aces-resources-for-practitioners/

CHILDREN

WITH A

PARENT IN

CUSTODY

10. Children who have (a) parent or parents in custody

Children of prisoners [56] have been referred to as 'invisible' victims of punishment, as the challenges they experience are often not immediately recognised [57] [58].

They may experience a range of difficulties including behavioural problems, anxiety, anger, confusion and depression [58] [59] [60] and are disproportionally represented amongst children

[56] Lockwood K, Long T, Loucks N, Raikes B, Sharratt K. A double-edged sword: children's experiences of visiting a parent in prison in Scotland. *Probation Journal*. 2022 Jun;69(2):159-76.

[57] Perry S. Hidden sentences: supporting the children of prisoners. *Community Pract*. 2016;89(7):24-5.

[58] Scottish Centre for Crime and Justice Research (2019) Scotland's prison population. Available from: https://www.sccjr.ac.uk/

[59] Flynn C. Getting there and being there: Visits to prisons in Victoria– the experiences of women prisoners and their children. *Probation Journal*. 2014 Jun;61(2):176-91.

[60] Jones A, Gallagher B, Manby M, et al. (2013) Children of Prisoners: Interventions and Mitigations to Strengthen Mental Health. Huddersfield: University of Huddersfield.

accessing mental health services [61]. They are known to have higher emotional needs than their peers [62]; and can experience symptoms indicative of post-traumatic stress disorder [63] **(Figure 18)**.

[61] Phillips SD, Burns BJ, Wagner HR, Kramer TL, Robbins JM. Parental incarceration among adolescents receiving mental health services. Journal of Child and Family Studies. 2002 Dec;11:385-99.

[62] Woodall J, Kinsella K. Striving for a "good" family visit: The facilitative role of a prison visitors' centre. Journal of Criminal Psychology. 2018 Jan 4;8(1):33-43.

[63] Sharratt K. Children's experiences of contact with imprisoned parents: A comparison between four European countries. European Journal of Criminology. 2014 Nov;11(6):760-75.

[Name of child] ***has a parent /*** *[Name of child]* ***has parents in custody. Children of prisoners have been referred to as 'invisible' victims of punishment, as the challenges they experience are often not immediately recognised. They may experience a range of difficulties including behavioural problems, anxiety, anger, confusion and depression and are disproportionally represented amongst children accessing mental health services. They are known to have higher emotional needs than their peers; and can experience symptoms indicative of post-traumatic stress disorder. Having a parent in prison also exerts a significant impact on children's education; including poorer attainment and attendance and more behavioural issues compared to their counterparts. Parental imprisonment can also bring about stigma, bullying, victimisation, and social isolation. Children of prisoners are more likely to engage in anti-social or offending behaviour than other children. It is therefore essential that*** *[Name of child]* ***'s carers are aware of these possible effects and if they occur, support is requested without delay.***

Figure 18: Potential effects on children of having a parent in custody (detained)

Having a parent in prison also exerts a significant impact on children's education; including poorer attainment and attendance and more behavioural issues compared to their counterparts [63].

Parental imprisonment can also bring about stigma, bullying, victimisation and social isolation [64]. Children of prisoners are more likely to engage in anti-social or offending behaviour than other children [58].

Children visiting a parent in custody

Sometimes, children are able to visit their parent(s) in custody. Whether or not such a visit is permitted by the prison (or other) authorities depends on the reason(s) the parent is / parent(s) are detained. Exploring those reasons is beyond the scope of this guidance document.

However, if a child is able to visit a parent in custody the growing body of research exploring children's experiences of when they do visit a parent in custody highlights complex and nuanced responses [65] **(Figure 19)**. Although there are exceptions [56 59 60 63], the lived experience of prison visits, particularly, those of children visiting a parent in prison, is limited.

Children have been found to value visits with the opportunity for physical contact and interaction and to demonstrate ongoing support for their parent in prison [63]. Visits can also reassure

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[64] Murray J, Farrington DP, Sekol I. Children's antisocial behavior, mental health, drug use, and educational performance after parental incarceration: a systematic review and meta-analysis. *Psychological bulletin*. 2012 Mar;138(2):175.

[65] McGinley M, Jones C. Growing up with parental imprisonment: children's experiences of managing stigma, secrecy and shame. *Practice*. 2018 Oct 20;30(5):341-57.

children of their parents' well-being and alleviate concerns about their living conditions [60]. Maintaining regular contact can also facilitate more satisfying relationships both during and after prison [66]; and is associated with better emotional adjustment and more effective coping skills for children [67].

However, the prison environment can equally be unpleasant and intimidating for children [63]. Research has highlighted that despite good relationships with their parent in prison, some children found visits distressing, consequently visiting less frequently or not at all [60]. However, in contrast, it has also been noted that despite the largely negative visiting experience for adolescents with a mother in custody in Australia, most still wanted to visit more often [59].

Specific challenges exist for adolescents visiting a parent in custody [56]. Young people often have more negative visiting experiences – frequently owing to prison environmental factors leaving some young people feeling stigmatised; and surveillance strategies, limiting intimacy and privacy, especially where sensitive issues related to the transition to adulthood, needed to be discussed [56]. Further research is needed to explore and compare the potential variability of visiting experiences across the prison estate. Equally, further research is essential to understand the needs and experiences of children not visiting their parent in prison [56] **(Figure 20)**.

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[66] Poehlmann J. Incarcerated mothers' contact with children, perceived family relationships, and depressive symptoms. *Journal of family Psychology*. 2005 Sep;19(3):350.

[67] Murray J (2005) The effects of imprisonment on families of prisoners. In: Liebling AM and Maruna S (eds) The Effects of Imprisonment. Devon: Willan, pp. 442–462.

[Name of child] ***has a parent / has parents in custody. If*** *[Name of child]* ***is able to visit their parent(s) in custody the effect of that visit may involve complex, nuanced and potentially unpredictable responses. The lived experience of prison visits, particularly those of children visiting a parent in prison, is limited.***

Figure 19: Considerations if a child has (a) parent(s) in custody

Children have been found to value visits with the opportunity for physical contact and interaction and to demonstrate ongoing support for their parent in prison. Visits can also reassure children of their parents' well-being and alleviate concerns about their living conditions. Maintaining regular contact can also facilitate more satisfying relationships both during and after prison; and is associated with better emotional adjustment and more effective coping skills for children. However, the prison environment can equally be unpleasant and intimidating for children. Research has highlighted that despite good relationships with their parent in prison, some children found visits distressing. However, in contrast, research has noted that despite the largely negative visiting experience for some adolescents with a mother in custody, most still wanted to visit more often.

Young people often have more negative visiting experiences – frequently owing to prison environmental factors leaving some young people feeling stigmatised; and surveillance strategies, limiting intimacy and privacy, especially where sensitive issues related to the transition to adulthood, needed to be discussed. Further research is needed to explore and compare the potential variability of visiting experiences across the prison estate. Equally, further research is essential to understand the needs and experiences of children not visiting their parent in prison.

Figure 20: Potential effects of a child visiting their parent(s) in custody

UNACCOMPANIED ASYLUM-SEEKING CHILDREN

11. Unaccompanied asylum-seeking children and accompanied refugee children

The Royal College of Paediatrics and Child Health has produced extensive guidance to support paediatricians in the assessment and care of refugee and asylum-seeking children, both when accompanied by parents and carers and when unaccompanied. This guidance was updated in September 2022. This chapter is reproduced from the RCPCH guidance and colleagues undertaking assessments of children who are new to the UK and have arrived here unaccompanied or as accompanied refugees, should ensure they are familiar with the multitude of resources made available by the RCPCH to assist those undertaking assessments [68].

This guidance can also be used when caring for other displaced children, such as those coming from areas of conflict, failed asylum seekers, victims of modern slavery or human trafficking, and some undocumented families.

Migrant means a person staying outside their country of origin, who are not asylum seekers or refugees, and may have left because they want to work, study, or join family. Migration has been a feature of the history of the world that has enriched the culture and prosperity of the UK across its society throughout history.

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68 https://www.rcpch.ac.uk/resources/refugee-asylum-seeking-children-young-people-guidance-paediatricians#sb-site

Definitions

Asylum seeker - adult, child, or young person whose request for sanctuary has yet to be processed by the Government.

UASC (unaccompanied asylum seeking child) - young people who have journeyed to the UK unaccompanied by a parent or legal guardian. They are automatically a Looked After Child, under the care of the Local Authority. They have full entitlement to free NHS care and other public services. NHS charging regulations do not apply to them.

Refugee - adult, child, or young person whose application for asylum has been accepted by the UK government as meeting the definition of refugee in the Refugee Convention, resulting in refugee status documentation. In the UK, refugees are usually granted five years leave to remain as a refugee, after which they need to apply for further leave.

'Undocumented' migrant - a term often used to refer to people who do not have any formal immigration status/leave to remain. People without leave to remain also do not have recourse to public funds.

Limited leave to remain - legal terminology referring to temporary visas. People with limited leave to remain are permitted to stay for up to 10 years, depending on the type of visa, and are required to re-apply for another period of limited leave or for indefinite leave to remain (permanent residency rights) at the end of the time limit. These families have the No Recourse to Public Funds condition applied automatically to their visa in most cases.

Health assessment of refugee and asylum-seeking children and young people

The health assessment of refugee and asylum-seeking children and young people may occur in different settings with professionals who have different levels of experience. A formal health assessment is part of the statutory duties for looked after children, but less formalised health assessments may occur opportunistically in primary care, as part of a referral into developmental clinics, general paediatric clinics or acute settings. The general health assessment should be thorough, holistic and carefully documented (**Figure 21**).

This cohort of children may be particularly vulnerable and are likely to have complex physical and mental health, and social needs. They may have grown up in a low or middle income country, have been exposed to conflict and disruption of infrastructure, or experienced long, dangerous journeys and possible abuse, and often separation from family members.

On arrival to the UK, they may face barriers of language, culture, finance, stigma and limitations of access to healthcare and education. For refugee families, there is good evidence that

adverse physical and mental health of parents and grandparents impacts on the health of children [69] [70].

There are resources, research and textbooks available to support professionals in delivering good care to asylum seeking and refugee children and families [71].

Health concerns for Unaccompanied Asylum-seeking Children (UASC)

This section of this guidance document relates to some of the specific health needs of UASC. Whilst it is specific to UASC it is likely that information provided in this part of the document will be of use in the assessment of accompanied asylum-seeking children and refugees.

Unaccompanied asylum-seeking children are particularly vulnerable. They may have experiences of bereavement, loss or violence and these are often a reason to leave their birth country. They undertake perilous journeys in crowded conditions with limited access to food,

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[69] Barker DJ, Eriksson JG, Forsén T, Osmond C. Fetal origins of adult disease: strength of effects and biological basis. International journal of epidemiology. 2002 Dec 1;31(6):1235-9.

[70] Heindel JJ, Vandenberg LN. Developmental origins of health and disease: a paradigm for understanding disease etiology and prevention. Current opinion in pediatrics. 2015 Apr;27(2):248.

[71] https://www.rcpch.ac.uk/resources/refugee-asylum-seeking-children-young-people-guidance-paediatricians#sb-site

shelter and hygiene. They are known to endure physical violence and emotional abuse during their journey. UASC also come from different countries with different endemic diseases as well as have risks of exposure to diseases during their journey. A careful clinical assessment is therefore required.

National guidelines make recommendations for the assessment of “migrant health” and these are particularly useful to consider when assessing UASC [72].

Symptoms in migrant children should be assessed in the same way as you would for non-migrant patients; however, where infectious disease(s) is/are suspected the differential diagnosis should not only include infections commonly acquired in the UK, but also those that may occur in their country of origin or in countries transited enroute to the UK. It is not uncommon for those new to the UK (UASC, refugees, accompanied asylum seeking children) to present with infectious diseases on their first assessment in the UK. Healthcare practitioners should remain vigilant for this and investigate and manage appropriately.

UASC should all be offered routine screening in accordance with the rationale summarised in this document (with further detail available from the associated references). The following algorithms aim to assist the initial management of symptomatic migrant patients. They have been taken or adapted from those used in publications including those produced by the National

[72] https://www.gov.uk/guidance/childrens-health-migrant-health-guide

Travel Health Network and Centre (NaTHNaC) [73], Fit for Travel [74], the Migrant Health Guide [75], and the CDC Yellow Book [76].

Early referral to a specialist centre for advice and management is essential for those practitioners with little or no experience in managing infectious diseases acquired abroad.

A series of helpful algorithms exist, and these are linked to below.

Fever

A useful algorithm exists to assist with the assessment of a migrant patient with fever including consideration of sepsis, malaria, diarrhoeal illness, respiratory illness and other conditions [77].

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[73] https://travelhealthpro.org.uk/about

[74] https://www.fitfortravel.nhs.uk/home

[75] https://www.gov.uk/government/collections/migrant-health-guide

[76] https://wwwnc.cdc.gov/travel/page/yellowbook-home

[77] https://webarchive.nationalarchives.gov.uk/ukgwa/20140714100406mp_/http://www.hpa.org.uk/webc/MigrantHealthFile/MigrantHealth_C/1284474828327

Dermatology

Infection-related and non-infectious conditions may give rise to symptoms and signs in migrant patients [78].

Diarrhoea

When considering your assessment of a migrant patient with diarrhoea it is first essential that you assess whether the patient is febrile and has arrived from, or transited through, a malarious country in the last year. You will then need to consider whether the diarrhoea is acute or chronic and whether there is weight loss [79].

Respiratory illness in a migrant patient

Assessment of a migrant patient with respiratory illness includes consideration of their country of origin; the countries they have passed through on their journey to the UK; activities

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https://webarchive.nationalarchives.gov.uk/ukgwa/20140714100405mp_/http://www.hpa.org.uk/webc/MigrantHealthFile/MigrantHealth_C/1284474826929

79

https://webarchive.nationalarchives.gov.uk/ukgwa/20140714100405mp_/http://www.hpa.org.uk/webc/MigrantHealthFile/MigrantHealth_C/1284474792558

undertaken during that journey; and specific circumstances in which infection transmission may be more likely to occur [80].

Eosinophilia

Screening of a migrant patient with asymptomatic eosinophilia should include a detailed travel history and examination as well as haematological and microbiological investigations [81].

Schistosomiasis

It is not uncommon for migrant patients to have had freshwater contact in schistosomiasis endemic areas. If you have a febrile patient with a clinical picture of acute schistosomiasis, then you must refer to a specialist infectious diseases centre. If your patient is not febrile but has symptoms consistent with possible schistosomiasis or you have an asymptomatic patient who had their last freshwater contact in an endemic area more than three months ago, you should consider screening for schistosomiasis [82].

80

https://webarchive.nationalarchives.gov.uk/ukgwa/20140714100406mp_/http://www.hpa.org.uk/webc/MigrantHealthFile/MigrantHealth_C/1284474829786

81

https://webarchive.nationalarchives.gov.uk/ukgwa/20140714100405mp_/http://www.hpa.org.uk/webc/MigrantHealthFile/MigrantHealth_C/1284474829643

82

https://webarchive.nationalarchives.gov.uk/ukgwa/20140714100406mp_/http://www.hpa.org.uk/webc/MigrantHealthFile/MigrantHealth_C/1284474828745

Investigations

As a minimum UASC should have the following investigations performed:

- Full blood borne infection (BBI) screening to include:
    - Hepatitis B
    - Hepatitis C
    - HIV
    - Syphilis

- Haematological investigations:
    - Full blood count (FBC)
    - Ferritin
    - Kidney function (U&E)
    - Liver function (LFT)
    - Thyroid function (TFT)
    - Vitamin D

- Strongyloides serology as intestinal worms are very prevalent in many parts of the world.

If the FBC shows eosinophilia, then an empirical course of Mebendazole 100mg twice a day for three is the first line treatment – unless there is significant history of atopy. If eosinophilia persists, then further advice must be sought from a haematologist.

If freshwater contact has occurred in central Africa and possibly Southeast Asia, then a schistosomiasis screen is also required (Schistosomiasis).

Locally specific guidelines, for the follow-up of any positive results, should be put in place [83].

Notes

If your patient has a fever and has been in a malarious area in the last 12 months, you must discuss urgently with the regional infectious diseases team so that testing for malaria and blood cultures can be arranged. The infectious diseases team should also be contacted if there are any other concerns about an infectious disease, or any unexplained physical findings (for example enlarged liver, persistent cough, unusual neurology, lymphoedema, eye signs such as corneal scarring without history of trauma)

Positive results and informing carers

The young person has a right to decide about, with whom, and when information regarding BBI status is shared. Follow up for any positive BBI results needs to be arranged urgently.

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[83] In Manchester this is to refer the patient to the on-call infectious diseases consultant at North Manchester General Hospital via 0161 2761234 or 0161 7954567. Paediatric infectious diseases advice is also available when required.

It is recommended that positive results are discussed with the relevant service and the relevant named doctor for Our Children (Looked After Children) prior to a results-sharing meeting so that comprehensive support and advice can be provided. It is really helpful if a copy of the results is sent by GP to the community record holder (this can be via the named doctor or the looked after children administration team).

Carers can react adversely to learning that a young person in their care has a BBI- therefore any plans to share information with the carer need to be discussed with the named doctor or named nurse, who will then discuss with social worker once clear actions agreed. This is particularly important if there are other Looked After Children in the same placement.

We do not have access to comprehensive health and care records for *[Name of child].* ***As an unaccompanied asylum-seeking child (UASC) it is more likely than not that*** *[Name of child]* ***has been exposed to multiple adverse childhood experiences and is at an increased risk of physical health difficulties and poorer mental health outcomes.*** *[Name of child]****'s emotional health and behaviour should be monitored, and can be discussed with relevant health and/or education professionals to decide if further assessment or support is warranted. In order to mitigate these risks, it is imperative for*** *[Name of child]* ***to have nurturing loving care in a stable environment, with carers who are attuned to*** *[Name of child]****'s needs and can respond consistently.***

This cohort of children may be particularly vulnerable and are likely to have complex physical and mental health, and social needs. They may have grown up in a low or middle income country, have been exposed to conflict and disruption of infrastructure, or experienced long, dangerous journeys and possible abuse, and often separation from family members. On arrival to the UK, they may face barriers of language, culture, finance, stigma and limitations of access to healthcare and education. For refugee families, there is good evidence that adverse physical and mental health of parents and grandparents impacts on the health of children. The Action Plan that I have produced following my assessment of *[Name of child]* ***should be read and followed by all professionals providing health and care input for*** *[Name of child]* ***and there should be a low threshold for the escalation of any health concerns that practitioners may have, given the limited background information available.***

Figure 21: Potential way to reference the long-term health needs of an unaccompanied asylum-seeking child

OTHER CIRCUMSTANCES

12. Other circumstances

When you have limited or no information about birth parents

If there is a lack of documented information, you may consider adding some or all of the caveats shown in **Figure 22**.

There is a paucity of information about** [Name of child]**'s parents, therefore it is difficult to specify any risks for hereditary conditions for [Name of child].

We [also] do not have information about lifestyle for either parent, so it is possible that a parent may have misused drugs or alcohol.

It is in** [Name of child]**'s best interests for further information to be provided from the Social Worker about parental health and lifestyle, so that any potential risks can be determined and any further tests arranged if necessary (e.g. blood tests for bloodborne infections).

Figure 22: Suggested phraseology if there is limited information about birth parents

When assessing impact of previous experiences needs further advice

There may be specific clinical situations where you do not feel you have the required expertise to give informed advice. Children and young people may have complex presentations and histories, for which you require advice beyond the scope of these guidelines.

We would encourage you to discuss queries with consultant colleagues. If definitive advice cannot be provided, **Figure 23** shows a way in which this could be identified in your report.

I do not have the expertise to comment on the long-term wellbeing outlook for children exposed to [INSERT DETAILS]. If information about this is required, enquiries should be directed to a professional with expertise in the field

Figure 23: Suggested way of indicating further advice is required

CHILDREN'S RIGHTS

13. Children's rights

The final chapter in this guidance document is designed to introduce the concept of children's rights-based decisions, rights-based communications, and rights-based considerations. This optional chapter – which is not essential reading in preparation for every pre-adoption medical report or initial health assessment report – will help to provide context in complex cases, especially if there is a lack of consensus in the approach that should be adopted or concerns are raised about whether children's rights have been or are being protected.

The history of children's rights matters today

Human rights in the United Kingdom (UK) developed over the centuries. In 1215 the Magna Carta was sealed [84] and was the first document to put into writing the principle that the King and his government were not above the law. It sought to prevent the King from exploiting his power, and placed limits of Royal authority, by establishing law as a power in and of itself. Clauses 39 and 40 – and their talk of free men, lawful judgment and justice – are themes that can be traced through subsequent legislation [85] and the protection of human rights, albeit all human rights and not just those enjoyed by males.

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[84] https://www.parliament.uk/magnacarta

[85] https://www.bl.uk/magna-carta/articles/magna-carta-and-human-rights

Habeas Corpus Act 1679

In 1679 the Habeas Corpus Act was introduced which prohibits unlawful imprisonment. In effect it means 'you may have the body (if legal procedures are satisfied)' – a medieval phrase used to bring a prisoner to a Court, and later used to fight against arbitrary detention of people by the authorities [86].

Universal Declaration of Human Rights

By 1948 the Universal Declaration of Human Rights set out the fundamental human rights to be universally protected. This was a milestone document in the history of human rights. The Declaration was proclaimed by the United Nations General Assembly in Paris on 10 December 1948 as a common standard of achievements for all peoples and all nations. It set out, for the first time, fundamental human rights to be universally protected and it has since been translated into over 500 different languages [87].

These rights, in so far as they specifically mention children, include the right to a standard of living adequate to protect the health and wellbeing of the individual and their family, including food, clothing, housing, medical care, necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in

[86] https://www.legislation.gov.uk/aep/Cha2/31/2

[87] https://www.un.org/en/about-us/universal-declaration-of-human-rights

circumstances beyond his control. Specific rights are also included for children (for example, Article 25), all of whom are entitled to enjoy the same protection (**Table 1**).

Table 1: Universal human rights

Article	Summary of Human Right
1	All human beings are born free and equal in dignity and rights and should act towards each other with a common interest.
2	Prohibition of discrimination.
3	Right to life, liberty and security.
4	Prohibition of slavery.
5	Prohibition of torture.
6	Right to be recognised as a person wherever in the world the human being resides.
7	All human beings are entitled equally to the protection of the law and are equally required to abide by the law.
8	The right to have alleged violations of rights remedied by a Court.
9	Prohibition of arbitrary arrest, detention or exile.
10	The right to a fair trial.
11	The right to be innocent until proved guilty and the right to be judged by the law in place at the time a crime was committed.

12	The right to privacy, family life and home life and the right to be protected from defamation.
13	The right to freedom of movement and residence.
14	The qualified right to seek and enjoy asylum.
15	The right to a nationality, including to change nationality, and to be protected from arbitrary deprivation of nationality.
16	The right to marry and found a family and the introduction of equal rights between men and women as to marriage, during marriage and at its dissolution.
17	The right to own property alone as well as in association with others and to not be arbitrarily deprived of property.
18	The right to freedom of thought, conscience and religion.
19	The right to freedom of opinion and expression (free speech).
20	The right to freedom of peaceful assembly and association and the prohibition of being compelled to belong to an association.
21	The right to vote in free elections and to be governed by the will of the people.
22	The right to social security and to have realised the necessary economic, social and cultural rights indispensable for the maintenance of dignity and the free development of personality.
23	The right to paid free choice of employment with just and favourable conditions, including just and favourable remuneration, and protection from unemployment.

	The right to equal pay for equal work and the right to form and join trade unions.
24	The right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.
25	The right to a standard of living adequate to protect the health and well-being of the individual and their family, including food, clothing, housing, medical care, necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Specific rights to protect mothers and children, and for all children to enjoy the same social protection.
26	The right to education and the qualified right to free education. The direction that education shall promote understanding, tolerance and friendship. The parental right to choose the kind of education that shall be given to their children.
27	The right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits. The right to protection of the moral and material interests resulting from any scientific, literary or artistic production authored by the individual.
28	The entitlement to a social and international order in which the rights and freedoms in the Universal Declaration of Human Rights can be fully realized.

29	The declaration that everyone has duties to the community in which alone the free and full development of the individual's personality is possible. The declaration that in the exercise of rights and freedoms, the only permissible limitations are those determined by law as being necessary to respect the rights and freedoms of others and to ensure public order, general welfare and morality in a democratic society.
30	The direction that nothing in the Universal Declaration of Human Rights can be used to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set out within it.

European Convention on Human Rights

In 1950 the European Convention on Human Rights (ECHR) was introduced which specifies the agreed rights and freedoms that should be guaranteed to all people [88] of the States which are party to it. Some rights are absolute and cannot be limited or restricted at all; some are limited (so a person may be deprived of this right in certain circumstances, for example when it is necessary to deprive someone of their liberty for the protection of others); and some are qualified and may be interfered with in order to achieve another aim specified in the ECHR (**Table 2**).

[88] https://www.equalityhumanrights.com/en/what-european-convention-human-rights

Table 2: The Articles of Section 1 of the European Convention on Human Rights

Article	Right or freedom
1	Obligation to respect Human Rights
2	Right to life
3	Prohibition of torture
4	Prohibition of slavery and forced labour
5	Right to liberty and security
6	Right to a fair trial
7	No punishment without law
8	Right to respect for private and family life
9	Freedom of thought, conscience and religion
10	Freedom of expression
11	Freedom of assembly and association
12	Right to marry
13	Right to an effective remedy
14	Prohibition of discrimination
15	Derogation in time of emergency
16	Restrictions on political activities of certain people
17	Prohibition of abuse of rights
18	Limitation on use of restrictions on rights

Human Rights Act 1998

Consideration of how the European Convention on Human Rights (adopted in the UK as the Human Rights Act 1998) [89] apply to an individual child's case is not just an academic or theoretical exercise. Many of these rights are very much actively engaged when considering the needs of children who are involved in an adoption process or who are looked after by the State as a corporate parent.

United Nations Convention on the Rights of the Child

A major breakthrough specifically for the protection of the rights of children was the United Nations Convention on the Rights of the Child (UNCRC) 1989. The UK signed the convention on 19 April 1990, ratified it on 16 December 1991 and it came into force on 15 January 1992 [90] [91]. The UNCRC introduced the definition of a child as anyone who has not yet reached their 18th birthday. The UNCRC has 54 articles in total. Articles one to 42 are the rights of children in specific circumstances and generally (**Table 3**). Articles 43 to 54 are about how adults and governments must work together to make sure all children can enjoy all of their rights that they are entitled to [90].

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[89] https://www.legislation.gov.uk/ukpga/1998/42/contents

[90] https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

[91] https://www.gov.uk/government/publications/united-nations-convention-on-the-rights-of-the-child-uncrc-how-legislation-underpins-implementation-in-england

Table 3: Articles of the United Nations Convention on the Rights of the Child

Article	Area covered by the right
1	Definition of a child
2	Non-discrimination
3	Best interests of the child
4	Implementation of the Convention
5	Parental guidance and a child's evolving capacities
6	Life, survival and development
7	Birth registration, name, nationality, care
8	Protection and preservation of identity
9	Protection from separation from parents
10	Family reunification
11	Protection from abduction and non-return of children
12	Respect for the views of the child
13	Freedom of expression
14	Freedom of thought, belief and religion

15	Freedom of association
16	Right to privacy
17	Access to information from the media
18	Parental responsibilities and state assistance
19	Protection from violence, abuse and neglect
20	Children unable to live with their family
21	Adoption
22	Refugee children
23	Children with a disability
24	Health and health services
25	Review of treatment in care
26	Social security
27	Adequate standard of living
28	Right to education
29	Goals of education
30	Children from minority or indigenous groups

31	Leisure play and culture
32	Child labour
33	Drug abuse
34	Sexual exploitation
35	Abduction, sale and trafficking
36	Other forms of exploitation
37	Inhumane treatment and detention
38	War and armed conflicts
39	Recovery from trauma and reintegration
40	Juvenile justice
41	Respect for higher national standards
42	Knowledge of rights

The UNCRC defines prerequisites for the optimal survival and development of children and the obligations of others, including individuals, parents, communities and States, to fulfil this right [92]. It provides strategies for rights-based approaches to clinical practise and health systems and there is a clear intersection between child rights and paediatric bioethics [92].

It is common ground that not listening to children's views on matters that affect them is wrong and is a breach of their human rights. However, whilst seeking children's views in a tokenistic fashion is wrong, it has been argued that not seeking their input on the basis that it would also be tokenistic is also wrong but arguably not as wrong as not seeking their views at all [93].

In the UK further rights-based legislation followed the introduction of the UNCRC, including the Human Rights Act (1998) [89] and the Equality Act (2010) [94].

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[92] Lansdown G, Lundy L, Goldhagen J. The UN convention on the rights of the child: relevance and application to pediatric clinical bioethics. *Perspectives in biology and medicine*. 2015;58(3):252-66.

[93] Lundy L. In defence of tokenism? Implementing children's right to participate in collective decision-making. *Childhood*. 2018 Aug;25(3):340-54.

[94] https://www.gov.uk/guidance/equality-act-2010-guidance

Ratification of the UNCRC into domestic legislation

Following ratification of the UNCRC in the UK in 1991 it was not until two decades later that Wales became the first country in the world to incorporate UNCRC into domestic legislation (as a result of the Child Rights Measure 2011) [95]. The UNCRC (Incorporation) (Scotland) Bill was introduced to the Scottish Parliament on 1st September 2020 and was passed unanimously on 16th March 2021. The main purpose of the Bill was to bring the UNCRC into Scottish law. The Bill is a milestone on Scotland's journey towards making rights real for every child. However, prior to this Bill becoming law in Scotland, the UK Government challenged specific areas of the Bill in the UK Supreme Court [96]. As a result of that challenge, the Supreme Court rules that four sections of the Bill went beyond the powers of the Scottish Parliament. Until changes are made to those sections, the Bill cannot become law in Scotland. In 2023 the Scottish Alliance for Children's Rights published an update report for the UN Committee on the Rights of the Child about the state of children's rights in Scotland. This report was intended to help the UN committee as it got ready to review the UK and Scottish Government's children's rights records in May 2023 [97].

Despite the lack of incorporation of the UNCRC into domestic law across the UK, following ratification of the UNCRC by the UK in 1991 governments and services have a duty to take the

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[95] http://www.legislation.gov.uk/mwa/2011/2/contents

[96] https://www.cypcs.org.uk/incorporationuncrc/

[97] https://www.togetherscotland.org.uk/

UNCRC into consideration in all activity that directly or indirectly affects the welfare of children. Despite this, the UK was criticised severely by the UN Committee on the Rights of the Child in 2016 [98], in respect of the rights violations of vulnerable populations of children in the UK. Over 150 recommendations were made for the UK including:

- Improving access to mental health services
- Banning placements in temporary accommodation for longer than six weeks
- Reducing the number of children in custody and improve their treatment whilst in custody
- Providing stability for children in care
- Reviewing the policy on unaccompanied asylum-seeking children
- Improving support services for children and young people with disabilities
- Improving access to health services and increase health outcomes for vulnerable children.

In January 2023 the Equality and Human Rights Commission (EHRC) presented evidence to the UN Committee on the Rights of the Child setting out implementations of recommendations since the UK's last review by the UNCRC in 2016 [99]. Priority areas for the UNCRC to review were highlighted as:

[98] from http://www.crae.org.uk/media/93148/UK-concluding-observations-2016.pdf

[99] https://www.equalityhumanrights.com/en/publication-download/children%E2%80%99s-rights-great-britain-submission-un-2023

- Violence against children (including harmful practices and online safety)
- Health and health services (including outcomes, access to treatment, and detention)
- Standard of living (including child poverty, the cost of living, and social security)
- The right to education (including loss of learning and educational attainment)
- Administration of child justice (including virtual justice and the Police, Crime, Sentencing and Courts Act 2022)

It is clear from the EHRC's review of the state of children's rights in the UK at the end of 2022 that there is much still to be done in the UK to improve compliance with human rights obligations as they apply to children. The Executive Summary accompanying the EHRC's full report is only 20 pages long and provides an excellent summary – much of which is relevant to the interaction between children's rights and assessment of a child for possible maltreatment – and professionals working in the fields of child protection, safeguarding are likely to find the recommendations interesting and useful when considering the reality of children's lives, including their, often unseen, lives behind closed doors [100].

All 54 articles of the UNCRC that set out the provision of services, protection, and participation of children have safeguarding relevance, and hence relevance to those children undergoing possible adoption procedures and/or who are cared for by the State as their corporate parent.

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https://www.equalityhumanrights.com/sites/default/files/11706_ehrc_executive_summary_report_english_accessi_1.2.pdf

The UNCRC confers over 40 substantive rights. Those which are most applicable to safeguarding include:

Article 4 (protection of rights)

Governments have a responsibility to take all available measures to make sure children's rights are respected, protected and fulfilled.

Article 6 (survival and development)

Children have the right to live. Governments should ensure that children survive and develop healthily.

Article 12 (respect for the views of the child)

When adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account. This is clearly of crucial importance when preparing initial health assessment reports and pre-adoption medical reports.

Article 13 (right to information)

Children have the right to get and share information, as long as information is not damaging to them or others.

Article 19 (protection from harm)

Article 19 states that all children have a right to be protected from '*all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation*

including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.'

Article 24 (health and health services)

Children have the right to good quality health care – the best health care possible.

Article 31 (play and rest)

Article 31 states that children have the right to play and rest and that all parties shall respect and promote the provision of appropriate and equal opportunities for recreational and leisure activities and that these rights are not neglected from the management of the child's condition

Article 34 (sexual exploitation)

Governments should protect children from all forms of sexual exploitation and abuse

Article 36 (other forms of exploitation)

Children should be protected from any activity that takes advantage of them or could harm their welfare and development.

Article 37 (detention and punishment)

No one is allowed to punish children in a cruel or harmful way.

Rights of participation and provision for children are as important as rights of protection, with protection, provision and participation being indivisible. Complaints procedures should be

provided in ways accessible to children to ensure complaints are heard, listened to and responded to. Involving service users (or future service users) in the design of services must ensure that participation is meaningful when scoping services, and that proposals for change and other best practice is followed using legislative guidance [101].

Child maltreatment is increasingly being seen as a violation of children's human rights, given that it results in rights violations of the profoundest kind; including the right to survival. The UNCRC provides a framework for understanding child maltreatment as part of a range of violations of the rights of children including violence, harm, exploitation, discrimination, marginalisation and exclusion at individual, institutional, and societal levels.

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https://webarchive.nationalarchives.gov.uk/ukgwa/+/www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/DH_4093411

A Children's Rights Based Approach

The children's rights movement seeks to challenge discrimination against children. Indirect discrimination often compounds direct discrimination; for example, a child may be disabled, belong to an ethnic minority community, be living in poverty, and have a parent/carer with mental health problems.

Multiple disadvantages may not be simply additive, but act in synergy to paralyse services and leave children in danger. Almost all the high-profile national reviews of child deaths involve this multiple jeopardy. Complex cases present practitioners with a range of conflicts of rights and values, in which they have to make judgements and risk assessments informed by their own personal class and cultural perspectives, and those of the child and family.

The UNCRC provides a framework by which to analyse value conflicts and resolve them in line with Article 3 – the best interests of the child. Rights based approaches can provide new ways to tackle old problems. UNICEF UK has developed seven principles to form the foundation of a guiding framework for putting rights into practice within public services [102]. The greatest strength of this approach is that UNICEF provides a framework to ensure that services are truly child-centred, leading to better outcomes for children across all dimensions of their lives. Those principles include dignity; interdependence and indivisibility; best interest; participation; non-discrimination; transparency and accountability; and life, survival and development.

[102] https://www.unicef.org.uk/child-friendly-cities/crba/

Whilst the rights of refugee children and unaccompanied migrant children are included within the UNCRC, child health professionals are still not included in the assessment process to determine whether the child is a victim of modern slavery and human trafficking. The health assessment of refugee children and young people, whether undertaken as part of a statutory Initial Health Assessment for looked-after children or as part of an initial general health assessment, should be a thorough and rounded one [103].

Children have the right to be involved in decisions that affect them in an appropriate way and health professionals must ensure their views are included in decisions about their care (by following the principles of Article 13). Improving communication between health professionals and children, and including their rights to information, healthcare and involvement in decision-making are key to improving the wellbeing of children overall [104].

Advocates of Children's Rights

The United Nations Convention on the Rights of the Child guides the work of children's commissioners in England, Scotland, Wales and Northern Ireland to safeguard and promote the rights and best interests of children. Each commissioner is responsible for advising government on legislation, policies and services and for helping to protect and promote the rights of children.

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103 https://www.rcpch.ac.uk/resources/refugee-unaccompanied-asylum-seeking-children-young-people-guidance-paediatricians

104 https://stateofchildhealth.rcpch.ac.uk/

The 'Voice of the Child ' is an increasingly important concept and local authorities and health organisations have engagement strategies, children's rights officers and consultation groups to capture children's views to influence both policy and operational initiatives.

Many organisations advocate and campaign for the rights of children both at national and local levels. The voluntary sector plays an important role in this regard. It is not possible to comprehensively list all of these groups.

Pressure groups/initiatives campaign on specific issues. An example of such a group is the 'Children Are Unbeatable! Alliance' [105] which campaigns against the corporal punishment of children and in particular the 'reasonable chastisement' defence.

In the future this work needs to be built upon to achieve a society which considers children's rights and views in all of the decisions that we take that affect the lives of children, our most vulnerable but arguably most important asset. The children of today are the adults of tomorrow, and we do a great disservice to children (individually and collectively) as well as to society in general, if we fail to fully protect and enhance their rights and to do everything we can to build child safe communities with happy, healthy, and safe children and young people at their hearts [106].

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[105] https://www.childrenareunbeatable.org.uk/

[106] Rowland AG. Building child safe communities with children and young people at their hearts (PhD thesis). The University of Salford (UK) 2020.

Available from: link

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We are grateful, and express thanks, to the authors of the Royal College of Paediatrics and Child Health Child Protection Companion (specifically the chapter on children's rights) for the material replicated in this chapter on children's rights in this IHA and PAM guidance. A summary of some further background reading materials, for those with additional interest in children's rights, is below.

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NHS Involvement Hub

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Royal College of Paediatrics and Child Health: how to guides and resources for participation: http://www.rcpch.ac.uk/and-us-resources

United Nations Convention on the Rights of the Child:

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