

CRCF RESEARCH BRIEFING



Children and young people who go missing: pathways through education, social care, justice and health.

Scoping Report

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Introduction

This scoping project took place between November 2025 and March 2026 and was a collaboration between the Centre for Research on Children and Families (CRCF) based in the School of Social Work at the University of East Anglia and the Rees Centre at the Department of Education, University of Oxford.

Academics at the CRCF and the Rees Centre worked together to find out what professionals, parents and young adults had to say about young people who go missing and the statutory processes surrounding them.

This report summarises the main findings from our work. The findings will be used to apply for a National Institute of Health Research Social Care research grant to conduct a national study on young people who go missing from home or from care.

Aims

The scoping project had three aims:

- 1) To conduct a literature review on young people who go missing, with a focus on young people's pathways through, needs and experiences within social care, education, justice and health;
- 2) To speak with a range of professionals working with young people who go missing about what was and was not working with the protocols and multi-agency working established by the *2014 Statutory guidance on children who run away or go missing from home or care*;
- 3) To learn what parents and young adults with lived experience of missing episodes had to say about their experiences with missing episodes and professional systems.

Methods

We received ethical approval from the UEA School of Social Work to carry out this scoping project.

We conducted a **literature review** to establish what research had been done around young people who go missing from home and from care and their experiences with social care, education, justice and health.

We carried out 29 semi-structured **interviews and focus groups** with professionals, parents and young adults who had repeat missing episodes when they were younger. Interview schedules for parents and young adults covered experiences of going missing, support received and what was helpful and less helpful. They were also asked to reflect on support they felt the young person/parent needed and to provide recommendations on how to improve experiences for young people who go missing and their families. Focus group schedules for practitioners/policy leads covered current

practice and policy; factors they felt contributed to young people going missing; what they considered effective practice; main challenges or practice issues; how well agencies worked together and what got in the way of multi-agency working. Finally, they were asked what they felt the priorities in research should be. Interviews with data and information governance specialists covered what data (i.e. administrative records collected by agencies) on young people who go missing was collected; how consistently they felt data on young people who go missing was recorded; what data on young people who go missing were shared with other agencies; what worked well/less well in these data sharing arrangements; and what would be required to link administrative data records between multiple agencies involved with young people who go missing (i.e. social care, criminal justice, education, and/or health) for research purposes in order to understand young people's needs. Interview and focus group data was analysed thematically.

In total, we spoke to 23 professionals in 10 organisations, 4 parents and 2 young adults. The professionals worked for local authorities, the police and charities and held roles that covered data, policy, research and direct practice within care, justice, education and health.

Summary findings from the literature review

The literature review carried out as part of the scoping work is available in full as a separate document appended to this scoping report. The following is a summary of the literature on young people who go missing from home and from care with a focus on young people's experiences in social care, education, justice and health systems.

1. 25 years of research on young people who go missing from England, Wales, Scotland and the U.S. have examined children's characteristics, vulnerabilities, harms and safeguarding responses through a variety of quantitative and qualitative methods.
2. Age and ethnicity have emerged as important children's factors associated with missing episodes, with older young people (adolescents) and black and minoritised young people overrepresented in missing episodes.
3. Young people who go missing often have significant unmet needs. These include needs related to mental health, disability, and/or emotional and behavioural difficulties. Support for young neurodivergent young people is increasingly identified as an unmet need in the profiles of missing young people.
4. Young people who go missing also have significant needs identified within education, including absence from school, exclusion or having problems and difficulties at school.
5. Family and social relationships, including in care, have emerged as further challenges. Young people who go missing are often vulnerable to exploitative relationships, which take advantage of young people's unmet emotional needs and go on to expose them to harm.
6. Protective factors include positive relationships with caregivers and for young people in care, placement stability, allowing their attachments to grow. Professionals, through establishing trusted relationships, can support young

people's attachment and relational needs. Strong family relationships are also an important protective factor.

7. Immediate and short-term consequences of missing episodes may include victimisation, including sexual and criminal exploitation, abuse and neglect, and death. In other cases, missing episodes may not lead to harm yet may be indicative of unmet needs. Long-term outcomes related to health, education, victimisation and offending are less established and is thus a gap.
8. Statutory responses in England since 2014 include police Safe and Well Checks, Return Home Interviews (RHIs), and multi-agency safeguarding. There is little evidence on the effectiveness of police Safe and Well Checks. RHIs have been found to be effective in identifying concerns and facilitating safeguarding responses with relational continuity an important factor (e.g. involving the same professional conducting subsequent RHIs where the young person is missing repeatedly). RHIs only happen in half of missing incidents, however. Within these interviews there is often a focus on the missing incident, rather than its meaning and link to unmet needs. This presents challenges for supporting young people, developing effective safeguarding plans and identifying patterns to prevent future missing episodes.
9. Multi-agency safeguarding is variable and dependent on effective partnership working within the local area, information sharing, and tailored responses to young person's needs, including family relationships, educational and health needs. According to young people themselves, practice which includes the young person, parents and other agencies alongside project workers is most effective. There is little evidence on how and if long-term multi-agency working supports young people who go missing.

Research gaps in England include (but are not limited to) understanding the experiences of and best practices with certain groups of young people overrepresented in missing episodes (e.g. young people who are neurodivergent or disabled; who are of minority ethnicity; or who have repeat missing episodes); longitudinal pathways and outcomes of young people who have been missing (including experiences and outcomes in social care, education, health and justice); protective factors/effective practice that reduce missing episodes and harm; and the implementation and effectiveness of multi-agency safeguarding processes.

Findings from the interviews and focus groups

The findings from the interviews and focus groups with professionals, parents and young adults are divided into four sections: 1. risk factors; 2. policy and practice with missing young people and their families or carers; 3. data on young people who go missing from home or from care; and 4. recommendations to improve practice. Each section presents views of professionals, parents/carers and young adults with lived experience. The report concludes with recommendations on future directions for research.

1. Risk factors

Professionals identified two groups of missing young people they saw in practice: young people going missing from home and young people going missing from care. However, they emphasised that these groups of young people were not distinct, and there was movement between the groups. For example, if young people repeatedly went missing from home, being placed in care under a voluntary arrangement became an option, particularly when parents were viewed by professionals as unable to keep the young person safe. Other young people in care who went missing returned home to birth families during missing episodes.

Push and pull factors

Reasons for going missing are often described as being due to either 'push' factors away from home/care or 'pull' factors towards someone or something. The professionals interviewed, regardless of which agencies and systems they worked for, identified similar push and pull factors for young people who were going missing. 'Push factors' included young people leaving home due to challenging placements or home situations, including abuse or conflict with parents/carers. 'Pull factors' included the draw of peer groups, with social media raised as a factor that helped connect missing young people to others (both adults and other young people) they would otherwise not have any connections to through neighbourhood and school. Professionals described how relationships formed through social media meant young people travelled further to see 'friends' on trains and buses and thus went missing for longer periods of time. While away from protective adults and with peers, young people sometimes engaged in substance abuse and/or criminal activity, or came to harm, including through exploitation.

Exploitation was described as both a driver of missing episodes as well as an outcome. Exploitation could be sexual, with young people believing they were going to spend time with a partner, sometimes not recognising elements of grooming and control in the relationship. Exploitation could also be criminal including debt bondage and feeling they did not have a choice other than to engage in activities they were pressured into by another person or group. When exploitation was happening to young people, missing episodes were often the first indicator that a young person was being exploited.

For children in care professionals identified some additional push and pull factors. These included wanting to be normal by going out and staying out with friends. Professionals also described children in care as not being used to curfews or boundaries from parents and rebelling against these once in care. Others did not want to be in care and went missing to return home. Finally, unaccompanied asylum-seeking young people and young people aged 16 and over in unsuitable looked after accommodation were identified as particularly vulnerable to push and pull factors.

For children missing from home, professionals emphasised the presence of family conflict, including conflict emerging from blended families. Professionals suggested that children missing from home often only have one or two missing episodes, with the situation resolving itself, regardless of whether there was professional intervention. If the situation did not resolve, then the option of entering care would be raised. However, entering care did not always resolve missing episodes. Young people often continued to go missing. Moving children out of area, as an action to keep them safe, sometimes had

unintended consequences such as a reduction of protective factors and a lack of psychological safety.

Parents' perspectives

The parents interviewed also identified push/pull factors for their young people. One parent described going missing as an expression of their young person's personality (strong willed; adventurous) seen from the age of three, with a first missing episode at age 10. The young person, now an adult and no longer going missing, was described as still 'living on the edge', indicating some level of ongoing sensation seeking:

She's still very adventurous, you know, 'living on the edge', she said it's called. (Parent)

Another parent described going missing as a trauma response related to childhood exposure to domestic abuse and unmet support needs:

He was sort of like named as like a naughty child, but he never got the support that he needed because it just sort of got worse and worse, yeah (Parent)

A third parent identified bullying-related trauma as the main driver of first missing episodes:

She used to run away from school. And I mean, to the point that she crawled under railings. (Parent).

Similar to professionals, parents identified the pull of inappropriate peers and adults. For one young person, this included grooming from adults who deliberately enticed the younger person to go missing through gifts. For another young person, it was associations with young people involved in criminal activity.

Finally, parents described going missing as part of normal adolescent rebellion but linked this to their young person's social isolation, particularly where they felt they had no friends at school and did not fit in. For these young people, running towards friendship groups elsewhere appeared to meet an important need for belonging.

Young adults' perspectives

Of the two young adults interviewed, one had gone missing from home and the other from care. Both had experiences of multiple missing episodes, and one had a diagnosis of a type of neurodivergence. School challenges featured in both young adult's stories.

The young person who went missing from home identified bullying in school as the push factor that started difficulties:

I was really bullied at school and I hated it...school being this horrible place and I just don't want to go because everything, like I got jumped at school. (Young adult)

While the young person had repeat missing episodes from school and home, they did not consider themselves to be 'missing' and emphasised that the intention had never been to run away, but rather to see friends:

I was never running away. No. I just wanted to go out. (Young adult)

For the young adult who had spent time in care, entry into care was a push factor for further missing episodes:

I found a lot of control and barriers being put on myself, which led me to go more missing. (Young adult)

Individual risk factors

Age was a critical risk factor raised by professionals, with missing episodes mainly associated with adolescence. Young people who went missing under the age of 13, however, were considered to be at highest risk by professionals.

Poor mental health was described as a risk factor for missing episodes with young people sometimes going missing in order to self-harm. Professionals identified that anxiety and stress within a house where there was limited private space to retreat to (related to socioeconomic circumstances and crowded housing) sometimes further exacerbated young people's distress.

Professionals and parents felt that *neurodivergence* was an emerging and important child characteristic in missing episodes:

You know, with children that have neurodiverse conditions, they can't control some of their behaviour, you know. So, you know, we've got to learn how to manage that properly and make sure that we're not penalising children that need help. (Parent)

Professionals also felt they were increasingly working with neurodivergent parents whose children were going missing, adding complexities to how to support families:

It's the reporting of the missing that's a real challenge for parents. They really struggle with the response they get from the call handlers and because they have to tell their story every time. When you think they could be going missing every day, these children. Imagine having to repeat yourself that many times. And some of our parents a lot of our parents are neurodiverse so they struggle with that. (Professional)

Neurodivergent young people were identified as going missing due to feeling overwhelmed or overstimulated at home/placement, lacking strategies to manage these feelings (or lack of support to do so), being unable to express how they were doing, not having their boundaries respected at home/placement, and not understanding risks related to going missing. Several professionals suggested there was little understanding about the best ways of working with neurodivergent missing young people and their families:

There is nothing really available that's UK specific on neurodivergence and missing. (Professional)

A particularly important area of need identified by professionals was understanding how to work with missing young people who were neurodivergent and also had trauma histories and/or poor mental health.

According to professionals, neurodivergence was not currently captured in data or in the profiles agencies such as the police had on missing young people. This could have

implications for how young people were approached and viewed, as well as potential unintended consequences such as criminalisation/arrests during missing episodes. Professionals suggested that an Autism Passport might aid police in supporting young people and avoid criminalisation. However, it was noted that Autism Passports were not frequently shared or known about.

Special Educational Needs and Disabilities and unidentified educational needs. Young people who went missing were described by professionals and parents as often having significant but unidentified SEND, which impacted their pathways through education and related to missing episodes. Young people who go missing were identified as experiencing social exclusion and bullying in school. Professionals and parents suggested that educational or emotional needs were hidden or not sufficiently supported by schools. Professionals emphasised that it was critical to ensure that missing young people's needs were being correctly identified, particularly needs related to disability, and within education.

Their view aligned with parents, who felt their children's needs and/or distress first became evident within schools, where they were unable to cope with their educational setting. For some young people this was as early as primary school where they were labelled as 'naughty'. For others, it occurred around the transition to secondary school. One parent described that their adolescent's missing episodes started with absconding from school and then escalated to absconding from school and home.

For parents, tensions arose between parents and schools when young people did not want to attend or went missing from school because they did not feel safe. Parents described the threat of prosecution for their young person's non-attendance. For single-parent households this increased the family's socioeconomic vulnerability alongside the young person's missing episodes.

Professionals in the charity sector raised education as a key area for prevention of further missing episodes, with supporting and/or advocating for a child's needs in education an important step after a missing episode:

Often in terms of missing prevention, it's the wider thing about ensuring that children are having their needs met appropriately...that their special education needs, their disabilities are being recognised. (Professional)

2. Policy and practice with missing young people and their families

In England, practice on young people who are missing from home or from care is set out in the Department for Education's (2014) *Statutory guidance on children who run away or go missing from home or care*. It sets out a number of requirements for the local authority, the police and other agencies to work together. Professionals, parents and young adults reflected on their experiences of these practices and processes.

Professional perspectives

Professionals expressed frustration that the government had not updated the statutory guidance despite demand from the sector and particularly since agencies and charities had been actively involved in discussions with the Home Office, Department for

Education and the NSPCC on how the guidance was working. Professionals felt the guidance was now out-of-date and that feedback from a range of multi-agency partners needed to inform the update.

One issue raised was that a large number of frameworks and practices around the country had been developed, resulting in inconsistent practice:

Because statutory guidance hasn't been updated for twelve years we're seeing an increase rise of the development of non-statutory frameworks. So that's like basically different areas kind of taking it upon themselves to develop different practice frameworks, different methods.... and I think when you have good practice that's great because you can bring it back to the fore and kind of like help roll it out on a more national level but I do also think that sometimes it's risky and it means there can be inconsistent practice. And I think again that's just a kind of argument to refresh the 2014 guidance because otherwise it's just a lack of clarity for people. (Professional)

Professionals wanted a clear steer on what was considered best practice to inform the development of their local response:

Missing is replicated everywhere and everyone has the same problems but we're dealing with it independently as each independent police service...is that in 2026 the right thing to do? (Professional)

A further suggested area of need was to have more clarity on the different roles and responsibilities of the various agencies involved in missing young person cases, enabling local authority and police intervention to be supported as part of wider, multi-agency safeguarding response. Health and education involvement, for example, were frequently described as absent in cases where young people go missing.

Updating the language used in the guidance was also regarded as important, reflecting the greater awareness of vulnerability, trauma and exploitation in the twelve years since publication.

Generally, protocols and multi-agency working around young people who went missing from care were experienced as welcome by professionals, but areas for improvement were identified. At the point of reporting a missing young person, for example, professionals suggested that appropriate and proportional information sharing about a young person's mental health and well-being; any significant, recent experiences at school; and social care record should take place. Sometimes this happened, and sometimes it did not. The Philomena protocol¹ was mentioned as a helpful information sharing tool when it was kept up-to-date and completed with the young person's input. However, use of the Philomena protocol was described as 'patchy.'

¹ A policing protocol intended for young people who have gone missing and are at risk of going missing again. It is a document which, when filled in, describes a young person's needs, circumstances, and habits, contacts (including parents/carers, professionals and peers) in order to aid the police in locating a missing young person.

Professionals also identified that there were significant knowledge, information and data gaps when working with young people who went missing from home. Young people might not be reported missing by parents and unless they also had a social work assessment and/or were a Child in Need, only the police would hold a record of the missing episode. This was an area of practice identified as needing improvement.

Finally, professionals were aware that young people who went missing were not a homogenous group and that responses to missing young people should be tailored to their individual needs. There was thus a tension with there being one statutory response for all missing young people, particularly when there was little evidence of how this response was working.

Professionals also shared their views on specific aspects of the current processes in place around missing episodes, including Safe and Well Checks and Return Home Interviews (RHIs).

Safe and Well Checks. According to the 2014 guidance, once a missing young person returns home, police should conduct a Safe and Well Check (sometimes also called a Prevention Interview or a Found Report) as soon as possible to confirm a safe return home and assess whether the young person has come to harm. Safe and Well Checks and RHIs should then be used to form case planning and be shared with professionals (pt 37 of the guidance).

Professionals identified a significant knowledge gap in how the Safe and Well Checks and RHIs should complement each other and be meaningful for young people and their parents/carers as well as for professionals. Some professionals, for example, suggested that information collected during the Safe and Well Check by the police should be shared with the RHI team to help inform the discussion with the young person. What information was currently shared between the police and RHI teams, however, was experienced as inconsistent.

Return home interviews (RHIs). The 2014 guidance sets out the requirement that young people who return home after a missing episode should be offered an independent RHI, in a neutral location, and that this should be carried out within 72 hours of a young person's return home to hear from the young person the reasons for the missing episodes and risks the young person may have encountered.

Professionals described variation across areas in terms of the RHI process. Generally, RHIs were offered to young people under the age of 18 who had gone missing from home or from care as per the guidance. In one area, RHIs were also offered to young people under the age of 25 if the young person was a care leaver.

Professionals raised concerns over the need for RHIs to take place within 72 hours, with this being part of Ofsted monitoring. The recommendation from professionals was that this was not always achievable or appropriate as more time was sometimes needed. In those instances, professionals questioned whether the rush to complete a RHI within 72 hours, in order to comply with the regulations and Ofsted monitoring, compromised the quality of the interview and the safeguarding response. Generally, professionals wanted more flexibility around the 72 hours.

RHIs were described by one professional as:

...feeding a mapping process as opposed to understanding a young person.

Professionals questioned to what extent they captured the voice of the child.

Information gathered during the RHI, like Safe and Well Checks, is, according to the 2014 guidance, meant to be recorded on case files and shared with relevant professionals. Professionals raised that there was no consensus on good practice regarding information sharing in this area. Non-policing professionals, for example, sometimes felt police solely relied on the RHIs for their information rather than the Safe and Well Checks:

I think sometimes our police colleagues see our role in Return Home Interviews especially since they get nothing out of anybody, because as you would expect, you know, no child is going to start telling the police. But they see our role as information collectors. (Professional)

Professionals who specialised in working with young people who went missing, felt sharing an intelligence briefing containing necessary information with the police, rather than full interview notes, was the most appropriate, giving young people a degree of confidentiality. They, however, reported that some RHI providers shared full notes with the police, with some police forces insisting on receiving full notes. As RHI were a publicly commissioned service, it was up to local authorities to establish the requirements, but professionals suggested this was problematic without a consensus on what good practice looked like.

Professionals working on behalf of charity or voluntary sectors where they were commissioned to provide RHIs emphasised that RHIs could facilitate relationship-based practice, particularly if the same person conducted each one with the same young person. This allowed for continuity of relationships and an opportunity for a professional to show commitment. They found that, with time, this increased the chance of disclosures from the young person, which then could lead to future preventative work.

Some professionals saw the RHIs as an opportunity to work with both the young person and their parent in the home. Other professionals preferred having a RHI at a young person's school in order for the young person to have a safe place in case challenges at home were the push factor for the missing episodes.

Effectiveness. Professionals were divided as to whether they saw RHIs as useful, with some identifying an evidence-gap in terms of whether they are effective in reducing missing episodes and whether they lead to increased support for young people:

I see insufficient evidence that return interviews have actually changed someone's circumstances. I see evidence that we collect information about some of the threats to them. I see evidence that we sometimes act upon that. But I don't see that we...often or often enough listen to what it is that they're actually trying to tell us and respond appropriately. (Professional)

For whom, how and why RHIs made a difference to young people and their families was identified as an evidence gap.

Finally, the term RHI was not seen by all as appropriate or child-sensitive, particularly for young people who would also be experiencing police interviews.

Multi-agency working.

The 2014 guidance sets out the requirement that the local authority, police and other partners agree a Runaway and Missing from Home and Care Protocol (RMHCP), which lays out the responsibilities for various agencies involved. The guidance names the voluntary sector, Jobcentre Plus, and education and health throughout as having an interest and stake in the guidance.

Professionals interviewed described multi-agency working as:

...very variable, not just by local authority but it's variable by workers and teams working together.

Professionals perceived that multi-agency working was most effective when different agencies and systems were in a shared building or co-located within a multi-agency safeguarding hub (MASH). A specific point of contact with responsibility for missing young people was identified as particularly positive. Multi-agency working within a shared space meant professionals could walk over in person to ask questions and gather further information on missing young people. Good professional relationships and effective information-sharing were facilitated through regular contact and informal discussion, rather than as a formal process. One benefit to multi-agency working was that when a variety of professionals were co-located it was easier to identify a range of support options for young people. However, a commonly mentioned occurrence was that not all agencies took part regularly in this type of work. Professionals from health and education were identified as most frequently absent from these shared discussions:

Health and education...are harder to get around the table. (Professional)

Some professionals described using multi-agency 'panels' to discuss young people who had gone missing in their areas. Panels were held once a week and were composed of representatives from children's services, the police, health, education and the voluntary sector, with one area also including professionals from housing and specialist teams such as exploitation. One professional in an area using multi-agency young people panels found them to be helpful but as panel meetings were set on the same day each week, this meant panel meetings were not always aligned with statutory requirements of RHIs taking place within 72 hrs. A RHI may have taken place before the weekly, scheduled panel where the young person was to be discussed. The professional described that this led to missed opportunities for information-gathering and sharing between a wider group of professionals.

Police. Police were recognised by professional as vital when it came to work with missing young people as they often held the greatest amount of information on the missing episode. Professionals noted that the current expectation was that the police take the lead on safeguarding missing young people. However, they observed that an effective response relied on all relevant agencies working together. Professionals noted that prevention and supportive work were areas that other agencies may be better-placed to lead, since a police-led approach meant that protocols and guidance around

young people going missing were orientated towards criminal justice, and sometimes experienced as 'heavy-handed.' However, professionals also described pockets of innovative police practice, particularly cases where youth workers were embedded in police missing persons teams. In larger metropolitan areas, professionals described how the responsibility for missing young people could be passed between agencies resulting in professional conflicts.

Professionals noted that police attitudes toward missing young people could be problematic when a young person went frequently missing. Locating missing young people was labour-intensive and was sometimes seen as a waste of police time. However, professionals also recognised police colleagues were under intense pressure due to the complexity of their work and lack of support, which could lead to compassion fatigue. This could be exacerbated in cases where police faced challenging and abusive behaviour from young people. A range of professionals described wellbeing and morale among police colleagues as low, noting that police received little support in relation to the vicarious trauma caused by their role.

Professionals identified that the specific role of the police officer attending a missing young person's meeting or panel was vital. When the police employee in attendance worked in the exploitation team or was the officer who had had contact with the missing young person their contribution was regarded by professionals as important. Sometimes, however, when a sergeant or patrol officer with no knowledge of a young person attended, their contribution tended to be regarded as less useful.

Education. Where present at missing young people's meetings or panels, education professionals could provide vital information about a young person's experiences in education and, where appropriate, could support RHIs taking place in school. However, professionals representing education were described as not always present at these meetings.

Health. Professionals from health were mentioned infrequently in participants' discussions of multi-agency working for missing young people. They were described as adopting a more peripheral role compared to the main agencies, identified as the local authority and the police. There was also confusion among professionals about whether health had a statutory role within missing episodes.

As professionals in one organisation noted,

Health can be quite difficult because we don't have anyone who is actually in a health role attached to our service...so we don't always see that there's any health updates. (Professional)

This led to consistent evidence gaps on the health needs of young people who go missing. While professionals emphasised that sharing a young person's full health records with the police was inappropriate, information directly relevant to a missing episode such as recent suicide attempt, medication they may not be taking, neurodivergence and any sensitivities or reactions they might have to being approached by a uniformed officer was identified as vital.

Quality control. Professionals noted that there was very little quality control around multi-agency working and currently no efforts to seek the views of young people and families about their experiences. Professionals asked:

How do we know if a multi-agency partnership are doing a good job? It tends to be quite self-reported and it feels like there's not great metrics. There's no kind of consistent multi-agency inspections....it would be good to have a bit more clarity around what good looks like and how we assess that. (Professional)

Finally, professionals described their work with parents of young people who go missing.

Parents. Working with the parents of missing young people was identified as complex. Professionals described how parents had to be investigated to see whether or not the family home itself posed a risk, as this was an established push factor. They also felt this was, at times, unfair and risked inappropriately holding parents accountable for their young person's missing episode. Best practice with missing young people was thought to involve working with both the young person and the parent(s), holistically. However, participants observed that this did not happen routinely. Professionals were aware that missing episodes had significant impacts on parents, including shame, fear, embarrassment and isolation. Professionals' views were that, as a minimum, there needed to be additional support for both parents and young people in navigating the statutory responses to missing episodes.

Parents' perspectives

Parents interviewed all had young people with repeat missing episodes. They recalled it as a painful time:

Completely traumatising. I've actually, yeah, I have PTSD from quite a lot of the [missing episodes]... it went on for a long time. (Parent)

Some parents' distress was compounded by awareness of the harms that their children had experienced while being missing (which included sexual assault and being stabbed). For others it was also the duration of the missing episode, as well as the negative impact of professional involvement on their relationship with their child:

The pressure that I was put under as a parent was so horrific and so damaging that it did more damage to our relationship than anything else. (Parent)

Alongside the worry for their children, parents recalled shame and embarrassment at having the police repeatedly come to their doors in sight of their neighbours. Some parents were referred to professionals whom they had worked with, affecting their sense of both parental and professional identity.

Parents described contact with children's services, the police and the voluntary sector. Since all parents had children with repeat missing episodes, they had experienced many police Safe and Well Checks and RHIs. Some young people went missing numerous times per night, requiring a repeat of all statutory processes to the point parents felt the processes lost meaning:

So every time she returned home, and obviously I have to call the police to let them know, and they would do a debrief, and she started to learn that there's a pattern. (Parent)

Parents felt Safe and Well Checks and RHIs had not reduced missing episodes. There was a sense that these procedures intended to meet targets, rather than provide meaningful support:

And when you have the police debrief, they come, they say, where have you been? She says, you know, or she doesn't answer and they go away. And they didn't really, I felt they could have done more. They say, you know, young lady, do you realise the seriousness of what you're doing? You're putting yourself at risk. And I felt that oftentimes they just kind of just let her, you know, say whatever she needed to say to write the report and then left, you know. So I thought I could have had more support there. (Parent)

These processes often created additional challenges in already difficult family circumstances. Safe and Well Checks after a young person returned home, for example, required parents to stay awake and a RHI within 72 hours interfered with parental employment. When young people had multiple missing episodes per night, parents were faced with the dilemma that failing to report a missing episode to the police might lead services to view their parenting negatively and might possibly invoke child protection procedures. Yet, reporting their young person missing meant being caught up in a cycle of reporting and surveillance that neither reduced missing episodes nor facilitated change:

We have to wait for a welfare check and I'd be going, what time will that be? And they'd be saying, we'll try and get somebody out to you in the next two to three hours. And I'm going, well, that means I have to stay up. Yeah. ... So then the police would turn up at half four or five. ...And my biggest, and then so then the next day I get a phone call from the [RHI team] and they'd say, right, we need to come and see you. I say, that's great, I'm at work. And they say, well, you need to be at home, we need to come and see you. And I'd say, but I'm at work, I can't just leave work to, you know, and they'd be saying, well, we've got to see you, we've got to see you within 24 hours. ...So from a parent's point of view. But if you were then to just stop ringing them, then get in trouble. ...so it was just this awful situation because I was told that if I didn't report her, then they look at doing child protection because I was failing to protect her. (Parent)

Parents described positive interactions with some police officers, particularly when they had a single, established point of contact. For instance, one parent described how a detective supported the family through a number of challenging years with their young person. Another parent described feeling unclear about the remit of police powers and role when their young person was missing, causing frustration and fear.

Parents discussed feeling judged by social workers particularly if they themselves had a history of previous vulnerability (mental health, domestic abuse experiences, becoming a parent at a young age). Two parents felt pressured to put their child into care (under a

Section 20² arrangement). One parent in the sample signed a Section 20 agreement to try to prevent their young person from going missing as a last resort, only to find that the young person still went missing from care.

During missing episodes, social work intervention was generally described by parents as ineffective and unwelcome. However, one parent identified that a referral to a relationship-based therapeutic programme was useful. This programme provided the parent with tools on how to de-escalate conflicts with their young person when they returned home from a missing episode.

Some parents felt that the processes and procedures in place pitted parent against young person rather than helping them reconnect. They felt that professionals and services actively chose to privilege the views and experiences of the child over theirs. They linked this to what they regarded as common professional view: that parents must be the ones causing their children's missing episodes. Parents were concerned that professionals sometimes focused on challenging behaviour without sufficiently recognising the difficulties they faced in managing it, particularly where behaviour was related to neurodivergence or trauma (e.g. trauma arising from domestic abuse where the mother had also been a victim). One parent felt that both parents and the young person needed to be assessed holistically in order to understand what support services were needed.

3. Data on young people missing from home or care

The 2014 guidance sets out a requirement to 'collect, share and analyse' data on young people who go missing (pt. 48). Professionals raised several issues with current data collection processes. One professional summarised:

There are lots of issues with how and when information is shared in relation to missing and then there's also this kind of permanent problem of a lack of centralised data collection. So at an operational level, there's problems with what information is shared back and forth but also kind of strategic level...we have no real handle nationally on missing as an issue. The data tends to be...at least one year, if not two years, in retrospect...things like county lines, which we know are related to missing is probably quite a lot of context about where children are going missing from and turning up and whether they were found with drugs and where there's indicators of abuse or whether they were perpetrators. All that stuff gets logged operationally in a local area but it doesn't get used to inform national pictures of what's happening. So, yeah, it's very patchy.
(Professional)

Professionals suggested that the data collected on young people who go missing should be used more strategically in order to inform practice and policy. They raised the following issues and potential uses of existing data sources.

Local authority data. Data on missing young people who go missing from care is collected by local authorities in three ways: young people missing from placement;

² A Section 20 arrangement is a voluntary arrangement between children's services and parents where parents agree to their child entering care temporarily while maintaining parental responsibility.

young people missing due to unauthorised absences (away); and as part of the social work assessment as a risk factor. Young people who go missing from home do not appear in local authority datasets unless they have a social work assessment.

Missing due to unauthorised absence (away) can involve young people whose whereabouts are known but they are not where they are expected to be such as late returning home/ to placement or having missed curfew (sometimes by a few minutes). Professionals reported numbers of missing young people within a local authority increasing dramatically, only to see that this was due to a new provider reporting differently or having a different threshold for reporting missed curfews.

Another identified issue with local authority data collection was how a young person who was recorded as being missing due to unauthorised absence (away), but who then became missing, would have their original 'away' episode recorded as having ended and have a new 'missing' episode recorded as beginning. The number of 'missing' and 'away' episodes would then appear to be greater than the actual number of missing events and the number of RHIs with that young person would also appear to be fewer than the recorded episodes. Professionals also suggested there were missed opportunities within Children Looked After data (SSDA903) to capture data on RHIs, given that this was a suggestion within the guidance. Professionals suggested these issues, alongside great variation between local authorities in collecting and recording missing episodes, meant that it was impossible to capture an accurate national picture of missing young people.

Return Home Interview data: Professionals suggested RHIs could be a potential rich source of data to understand young people's needs and plan support. RHIs, for example, may contain disclosures about exploitation, serious harms, locations young people went missing to alongside a range of other risk factors. As RHIs are offered to young people missing from home and missing from care, data from RHIs could improve understanding of a wider group of young people than from local authority data.

As local authorities had different processes in place around RHIs, however, there were a number of issues professionals described which prevented the use and analysis of RHI data. RHI data is held on local authority databases, but differences in how RHI records were shared from providers to local authorities and the police affected how easily the information could be accessed, used and analysed. Professionals reported that some areas shared RHIs via PDF, preventing easy extraction of information. They raised anecdotal evidence that in some cases information in RHIs was not being used at all because of the lack of time professionals felt they had to go through the contents of a PDF.

Professionals described that despite the requirement that RHIs be offered to young people who go missing, none of the information from RHIs is published as part of annual returns and neither were the rates at which RHIs were completed. There is no benchmarking set for local authorities in terms of expected rates of RHI completion and while professionals highlighted that there is some good research on RHIs, there is no national reporting or monitoring, including demographic data on who receives RHIs and who does not. The latter was seen as particularly important due to knowledge of

disproportional risks to some young people who go missing such as young people from a minoritised background or young people with disabilities or neurodivergence.

Police data: Professionals indicated that police hold the most robust data on missing young people, whether they go missing from home or from care because locating missing young people is a costly and time-intensive non-crime. While police data about young people who go missing and potentially their families was considered rich, use and analysis of the data, however, is hampered by some police forces recording much of this data in open text fields or in systems that do not allow for basic level data to be exported. Professionals felt this resulted in missed opportunities to better understand missing episodes and how to respond to them.

Due to police forces using a variety of databases to record missing persons, there is also currently no national police data share on young people who go missing. Professionals suggested that police forces do not share data on missing persons with each other unless a missing appeal is live. As young people who go missing may go missing from one local authority into another, this represents a significant barrier to sharing pertinent information on vulnerable young people.

Professionals were aware that the National Crime Agency conducts an annual data report on missing people, retrieving data from police forces. As there is a delay between receiving this data, analysing and publishing it, professionals felt that by the time it was published it was 'at least two years out of date' and lacking in-depth information. Professionals felt hopeful, however, that the introduction of the Law Enforcement Data System (LEDS) would be positive step forward as it is supposed to include a missing persons function.

Policing professionals described good use and analysis of their missing persons data in order to identify local patterns. For example, they discussed using frequency and timing of missing episodes as a key flag of concern as they knew that a high number of missing episodes close together tended to increase the harm the young person was exposed to. Policing professionals were also able to describe that missing episodes for young people within their area tended to peak on weekends, holidays and summer months with fewer missing episodes in colder weather. Mondays also stood out as a day of the week when missing episodes coincided with school avoidance.

Education data: Professionals identified data and information gaps with the education system in that young people sometimes went missing from school but were not reported as missing to the police all day, regardless of the young person's whereabouts being unknown. Although unmet educational needs and absences from education were known to potentially be factors in missing episodes, professionals, including data analysts, were not analysing educational National Pupil Database (NPD) data alongside missing data. To what extent young people who were going missing were also missing from education was unknown. Data analysts suggested linking NPD and children's social care data to understand profiles and needs of missing young people in social care and education would be possible, but it would be limited by a lack of robustness of the children's social care missing variables and would not include all missing young people (such as those missing from home).

Health data: While professionals mentioned that they were increasingly seeing that missing young people had a variety of health needs, including disability, neurodiversity, and poor mental health, analysing health data of missing young people was not being done.

Charity data: Professionals representing charities described their own data collection on work with young people who went missing. For one charity this included demographic data, including age, gender and ethnicity; vulnerability and risk factors, home context, reasons for going missing and actions taken by the charity, including signposting or referrals to other agencies such as the police.

Data linkage: Linking local children's social care, education, health and police data for missing young people was not happening, neither was longitudinal analysis on child-level data over time. Policing professionals described that this was due to agencies using data analysis to intervene quickly to keep young people safe. This will also be due to resourcing issues, with statutory agencies lacking the time to link and analyse data.

Professionals suggested that while national data analysis was not available, in-depth analysis of multi-agency data on young people with missing episodes would be welcome as it would result in new information about networks of exploitation as well as other types of harm.

Outcome data: Professionals discussed that it was unclear what outcome was most meaningful when it came to young people who went missing. While reducing missing episodes and the amount of time young people were missing might be crucial to police priorities and might safeguard young people from harms and exploitation, it was unclear what outcomes were meaningful to young people themselves, parents/carers, and other professionals.

4. Recommendations

Going missing was described by participants in this scoping study as an issue that cut across a number of groups of young people, professional practice and systems but was rarely a focus of practice or research on its own.

Overall professionals felt that going missing was labelled as problematic behaviour or only of interest if linked to exploitation rather than important information that something was going on in a young person's life:

I don't think there's always been a recognition of the importance of missing episodes as...a barometer of the weather for a child...just understanding how things are. (Professional)

Professionals wanted to see missing recognised as a harm in its own right:

What happens is missing often shows up as a reference point within a larger, like, you know, we're talking about child criminal exploitation and missing will be there as an indicator. So you're leading with the exploitation and then missing is part of that but what we don't really tend to see is leading with missing and

talking about the intersecting harms of missing and talking about missing as a harm in and of itself. (Professional)

As missing episodes were a potentially useful indicator of unmet need, even where there was no significant harm, participants who took part in the scoping study highlighted the importance of considering needs of young people who went missing not only within their families but also within education and health.

The following recommendations *to improve practice* with young people who go missing emerge from analysis of the lived and professional experiences within this report.

1. **Earlier intervention and support** involving relational continuity, time and flexibility for young people who go missing. Current professional practice in response to missing episodes is reactive rather than preventative. Preventing young people from going missing, particularly when missing episodes are repeated, is an urgent priority to reduce harm.
2. **Involving all relevant agencies in multi-agency work** with missing young people. Some statutory agencies such as health and education appear to be missing or have a more limited role within multi-agency work. Given the health and education needs of this cohort, greater input from health and education is needed around prevention and return home support in particular, alongside voluntary sector partners. There may also be scope for including more of a voice and role of people with lived experience (young adults and parents) on how multi-agency work is experienced or as peer support.
3. **Parity in support and processes for young people who go missing.** There appear to be differences in which young people are given support, including RHIs, with some young people, particularly those of minority ethnicity or those considered 'street wise' possibly receiving less. There is, in addition, a lack of appropriate support for neurodivergent young people who go missing.
4. **Improved practice with parents or carers** of young people who go missing. For some families this may be clear information and signposting on the agencies that will be involved with the young person and family as well as roles and responsibilities. Other families may need ongoing family support while the missing episodes are happening and sometimes until the young person stops going missing. This is an area where voluntary support services offering one-to-one support or peer support may be particularly beneficial, as suggested by the 2014 guidance.
5. **Improved data collection** on missing young people. This scoping report highlights a number of issues with current data collection by local authorities and the police. Improving data collection and recording will allow for increased local and national understanding of young people who go missing, improving strategy and practice.

Future research

The scoping project has led to three recommendations as to what the research priorities in this area should be. The list reflects key issues identified as important research gaps in the literature but also offers additional ideas and emphasis from the powerful personal experiences of young adults, parents/carers and professionals.

1. Analysis of linked data (social care, education, justice and health) on cohorts of young people who have gone missing, including longitudinally to understand the profiles, pathways, needs and outcomes of young people who go missing.
2. Evidence as to what is best practice in terms of multi-agency working nationally for young people who repeatedly go missing and their parents/carers, including developing a consensus on what 'good' practice and 'good' outcomes are, for whom, why and how outcomes should be assessed.
3. Further qualitative research on the experiences of young people who have repeatedly gone missing, including neurodivergent missing young people, and their parents/carers. There is a particular need to learn about what the protective factors are and who was involved when young people with repeat missing episodes stop going missing.

Implications and next steps

We will continue to consult with people with lived experience and professionals, including participants in this scoping project, when finalising the research questions and design for the bid, including the role of both groups in the proposed project.

We will submit an outline bid to the National Institute of Health Research (NIHR) Social Care funding scheme.

The findings from the literature review and scoping report will be made available online from the Centre for Research on Children and Families at the University of East Anglia and the Rees Centre at the University of Oxford.