Solihull Local Safeguarding Children Board

Neglect Toolkit

Guidance for Practitioners

November 2014
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“Child neglect is the most pervasive form of child abuse in the UK today. It robs children of the childhood they deserve – that is their right – and leaves broken families, dashed aspirations and misery in its wake. And, while we know more about the causes and consequences of neglect than ever before, it remains the biggest reason for a child to need protection. As a society, it is in our power to change this”.

Action for Children, 2010

1. Introduction

Awareness of child neglect and its consequences on the future well-being and development of children has increased during the last two decades. It is notoriously difficult to define and varies by type, severity and chronicity. Research shows that it often co-exists with other forms of abuse and adversity. To make the management of neglect even more complex, numerous reviews have commented on the dynamics of professional uncertainty regarding thresholds and criteria and what constitutes significant harm. Thus neglect can lead to a difference of opinion and professional optimism in relation to ‘good enough care’.

Neglect is the most common reason for child protection plans in the United Kingdom. Analysis of Serious Case Reviews have made the link between neglect and childhood fatalities. Apart from being potentially fatal, neglect causes great distress to children and leads to poor outcomes in the short and long-term. Consequences can include an array of health and mental health problems, difficulties in forming attachment and relationships, lower educational achievements, an increased risk of substance misuse, higher risk of experiencing abuse as well as difficulties in assuming parenting responsibilities later on in life. The degree to which children are affected during their childhood and later in adulthood depends on the type, severity and frequency of the maltreatment and on what support mechanisms and coping strategies were available to the child.

Neglect is currently a priority for Solihull LSCB and a number of initiatives are underway to improve awareness, recognition and interventions for children and families affected.

This guidance is designed for multi-agency managers and practitioners working with children and their families, whether their principal focus is upon a child or an adult within the home. The guidance is applicable to managers and practitioners from all agencies: it is only by working together and co-ordinating our activities that we can be effective in addressing concerns about neglect.

This document has been produced to support professionals in their understanding, identification, assessment and interventions in childhood neglect. Thus this toolkit is intended to assist in decision making and planning so that children about whom there are concerns about neglect are effectively safeguarded.
2. Definitions and Types of Child Neglect

“Neglect is the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development.

Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- Protect a child from physical and emotional harm or danger
- Ensure adequate supervision (including the use of inadequate care-givers)
- Ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

HM Government ‘Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children’ 2013

This definition is the official Government definition of neglect and is important as it supports a consistent understanding of neglect amongst multi-agency professionals. It provides a guide and a threshold in the identification, assessment and decision making process of neglect and is the criteria for determining if a child’s name is to be placed on a child protection plan.

However the definition can only be useful if there is a clear and shared understanding of neglect – and its impact upon a child’s health and development - in its broadest sense.

Neglect, (in contrast to other forms of abuse where specific and critical incidents can highlight significant harm) often presents us with less tangible and more diverse indicators which makes it harder to identify. Further, differences of opinion about what constitutes “persistent failure”, “serious impairment of health or development” and “adequate” make this definition, as with others, more open to interpretation, resulting in confusion and lack of consensus amongst childcare professionals about what neglect actually involves.

An additional difficulty that professionals may have in identifying neglect relates to concerns about imposing their own standards and values on other people and a reluctance to be ‘judgemental’. Yet professionals are tasked to make professional judgements, based on the best evidence available and within a co-ordinated multi-agency response. The definitions of neglect, an understanding of the impact upon the child’s health and development and effective working together can help professionals to distinguish between being ‘judgemental’ and articulating a defensible ‘professional judgement’.
In seeking to clarify neglect further, some areas to consider are:

a. **Persistence:** Neglect is usually – but not always - something that is persistent, cumulative and occurs over time. It can continue without a critical event, or incidents may be widely spaced, but its effects are corrosive to children’s development. Its presentation as a “chronic condition” requires the collation and analysis of sometimes small and seemingly insignificant events that only when viewed together provide evidence that neglect is an issue of concern.

Gardener (2008) warns of the danger of viewing neglect as a chronic phenomenon as this involves waiting for a time when ‘chronic’ is deemed to be present – this delays professional response to children’s safeguarding needs.

Neglect can also occur as a one-off event e.g. where there is a family crisis or a parent is under the influence of drink/drugs. It is possible that one-off incidents are part of a wider background of the neglect of the child, thus any incident based reports need to be assessed to identify whether there are patterns, however widely spaced.

b. **Acts of Omission and Acts of Commission:** Neglect is often – but not always - a passive form of abuse and the definition from ‘Working Together, 2013, refers to ‘failures’ to undertake important parenting tasks, what is often referred to as ‘acts of omission’. It is not always easy to distinguish between acts of omission and acts of commission however and both can occur simultaneously. For example, a parent leaving a child in the supervision of an unsuitable person involves both an omission to provide appropriate supervision and intent in leaving the child with someone unsuitable. The issue for those identifying and assessing neglect is less about understanding intent and more about assessing the child’s needs not being met. Neglect may be passive, but it is nevertheless harmful.

c. **Neglect often co-exists with other forms of abuse:** Certainly emotional abuse is a fundamental aspect of children’s experiences of neglect. However other forms of harm such as physical abuse, sexual abuse, harm from exposure to domestic abuse, child sexual exploitation can and do co-exist with neglect. The existence of neglect should alert practitioners to exploring if children are being exposed to other forms of harm.

d. **Parents and carers with complex and multiple needs:** A wide range of circumstances and stressors exist for parents whose children are neglected including poor housing, poverty and lack of capacity or knowledge about children’s needs, disability, learning impairment, asylum or refugee status and other circumstances which might weaken parental capacity. Brandon (2012) in a review of serious cases involving child deaths collectively called parental substance and/or alcohol misuse, domestic abuse and mental health difficulties the ‘toxic trio’. There is a complex interaction between the three
areas which significantly increases risk for children. Parents do need support to address their complex circumstances and needs so that they can parent their children effectively. Professionals may feel great empathy for parents and develop a tolerance for actions or inactions which are detrimental to the child. This type of a parent-centred approach invokes a risk that the focus on the child, the actual or potential harm s/he experiences and the impact on the child’s development become marginalised. Keeping a focus on the child has to be a priority.

“Child neglect must be understood in its broadest sense – when a child is not having their needs met and when this is having – or is likely to have – a detrimental effect on their health, development and wellbeing”

*Action for Children, 2010*

**Types of Neglect**

Howarth (2007) identified five types of neglect and this breakdown is helpful for practitioners to begin considering where the child’s needs may be being neglected. A thorough and methodical way of addressing failure to meet need will assist in identifying and planning interventions in neglect.

**Medical** – minimising or denying illness or health needs of children; failure to seek medical attention or administer treatments.

**Nutritional** – not providing adequate calories for normal growth (possibly leading to failure to thrive); not providing sufficient food of reasonable quality; recently there have been discussions about obesity being considered a form of neglect.

**Emotional** – unresponsive to a child’s basic emotional needs; failure to interact or provide affection; failure to develop child’s self esteem or sense of identity.

**Educational** – failure to provide a stimulating environment; failure to show interest in education or support learning; failure to respond to any special needs related to learning; failure to comply with statutory requirements regarding attendance.

**Physical** – failure to provide appropriate clothing, food, cleanliness, living conditions.

**Lack of supervision and guidance** – failure to provide for a child’s safety, including leaving a child alone; leaving a child with inappropriate carers; failure to provide appropriate boundaries.
3. Recognising Signs and Indicators of Child Neglect

Neglect can impact on children in numerous ways and children can show signs of neglect in a variety of ways – dependent on their age, the severity, frequency and duration of the harm, their resilience, the availability of alternative sources of care and support. Children may exhibit many, some or none of these indicators of neglect.

By themselves, many these signs do not necessarily prove the existence of neglect but they do indicate that something for the child is not right and thus there is a need for further exploration and assessment into the child’s circumstances. Being inquisitive, talking with and listening to children, observing them and their interactions with their parents and seeking a multi-agency perspective are key to gaining a wider understanding of what may be happening in the child’s life. Recognition and a prompt response to indicators of neglect are crucial if the neglected child is to be safeguarded. The longer a child is exposed to neglect, the more difficult it will be to reverse the adverse effects of neglect.

It is important to recognise that neglected children are likely to also be exposed to other adversities such as the effects of poverty, poor housing, isolation from sources of support, parental mental ill-health etc. The interaction of multiple adversities, including abuse and neglect impact negatively overall on childhood development. When assessing neglect, the child’s age, stage of development and specific needs (e.g. those relating to disability) should be a focus.

The National Institute for Health and Care Excellence (NICE) has produced guidance ‘When to Suspect Child Maltreatment’ which has sections on ‘neglect’; ‘emotional, behavioural, interpersonal and social functioning’ and ‘parent - or carer - child interactions’, including indicators of harm. The link to this guidance can be found at http://nice.proceduresonline.com/index.html

Disabilities

Disabled children are at (about 3-4 times) higher risk of being abused and neglected (Sullivan & Knutson, 2000). Of course disabled children are not a homogenous group and careful assessment of their unique circumstances is required. However some of the increased risk factors for disabled children are:

- They have a prolonged and heightened dependence upon their carers which may make them more susceptible to neglect and for example may be isolated.
- The caring responsibilities for parents may increase stress levels and lower their capacity to parent effectively.
- Disabled children may be less likely to be able to protect themselves or be less able to speak out about their experience of being parented.
- Professionals relate the signs and indicators of distress or harm to the disability and not necessarily to the possibility of maltreatment.
• Professionals can accept a different or lower standard of parenting of a disabled child than of a non-disabled child (Brandon et al, 2012)

Culture

There are many differences in patterns and methods of parenting across cultures. However there isn’t any culture that accepts abuse and neglect of children.

Parents may explain their approach to parenting in terms of cultural factors and it is important to explore and seek to understand the perspective of parents. However caution is required in placing too much emphasis on cultural factors – the main focus has to be about the impact on the child’s health and development.
4. **Risk and Protective Factors Associated with Child Neglect**

Risk factors raise concern that the care given by parents and carers may be compromised. Risk factors do not inevitably mean that parenting capacity is reduced but do need to be assessed: if care given to the child is deemed to be good, than concerns about risk factors may be dispelled. However, some risk factors may still affect care adversely in the future if the severity worsens or if the care required becomes more demanding (e.g. child is unwell). Some risk factors (e.g. substance abuse, mental illness) may mean that the care the child receives is inconsistent or unpredictable, such as their health and development is affected. The priority and focus when assessing risk factors is that the safety and well-being needs of the child are ensured.

Factors which indicate strengths in parenting capacity are also important to address. As noted above when relating to risks however, strengths in parenting does not always relate to good care being provided to the child in a consistent a predictable way.

Research (from reviews into serious cases) suggests that certain family and environmental factors may be seen as predisposing risk factors in child neglect. These include:

**Factors in Parents/Carers**
- History of physical and/or sexual abuse or neglect in own childhood; history of care
- Multiple losses
- Multiple pregnancies, with many losses
- Economic disadvantage/long term unemployment
- Parents with a mental health difficulty, including (post natal) depression
- Parents with a learning difficulty/disability
- Parents with chronic ill health
- Domestic abuse in the household
- Parents with substance (drugs and alcohol) misuse
- Early parenthood
- Families headed by a lone mother or where there are transient male partners
- Father’s criminal convictions
- Strong ambivalence/hostility to helping organisations

**Factors in the child**
- Birth difficulties/prematurity
- Children with a disability/learning difficulty/complex needs
- Children living in large family with poor networks of support
- Children in larger families with siblings close in age

**Environmental Factors**
- Families experience of racism/discrimination
- Family isolated/in dispute with neighbours
- Social disadvantage
- Multiple house moves/homelessness

The assessment of risks and strengths in parenting requires a holistic, multi-agency assessment using professional judgement. The table below indicates some of the risk and protective factors to support such professional judgement. Where neglect is suspected the list can be used as a tool to help assess whether or not the child is exposed to an elevated level of risk. This list is not exhaustive nor listed in order of importance:

<table>
<thead>
<tr>
<th>Elevating Risk Factors</th>
<th>Strengths (protective factors)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Basic needs of the child are not adequately met</td>
<td>Support network / extended family meets child's needs; parent or carer works meaningfully and in partnership to address shortfalls in parenting capacity</td>
</tr>
<tr>
<td>2. Age of the child</td>
<td>Child is of age where risks are reduced</td>
</tr>
<tr>
<td>3. Substance misuse by parent or carer</td>
<td>Substance misuse is 'controlled'; presence of another 'good enough' carer</td>
</tr>
<tr>
<td>4. Dysfunctional parent-child relationship</td>
<td>Good attachment. Parent-child relationship is strong</td>
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<td>5. Lack of affection to child</td>
<td></td>
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<td>6. Lack of attention and stimulation to child</td>
<td></td>
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<tr>
<td>7. Mental health difficulties for parent/carer</td>
<td>Capacity and motivation for change; capacity to sustain change. Support available to minimise risks. Presence of another 'good enough' parent or carer</td>
</tr>
<tr>
<td>8. Parent/carer learning difficulties</td>
<td></td>
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<tr>
<td>9. Low maternal self esteem</td>
<td>Mother has positive view of self. Capacity and motivation for change</td>
</tr>
<tr>
<td>10. Existence of Domestic Abuse</td>
<td>Recognition and change in previous patterns of domestic abuse</td>
</tr>
<tr>
<td>11. Age of parent or carer</td>
<td>Support for parent/carer in parenting task. Parent/carer co-operation with provision of support services; maturity of parent/carer</td>
</tr>
<tr>
<td>12. Negative, adverse or abusive childhood experiences of parent/carer</td>
<td>Positive childhood. Understanding of own history of childhood adversity; motivation to parent more positively</td>
</tr>
<tr>
<td>13. History of abusive parenting</td>
<td>Abuse addressed in treatment</td>
</tr>
</tbody>
</table>
14. Dangerous/damaging expectations upon children | Appropriate awareness of a child's needs. Age appropriate activities and responsibilities provided.

15. Child left home alone | Evidence of parent engaging positively with agency network (health) to meet the needs of the child.

**Poverty**

Professionals should guard against the risk of 'excusing' or minimising neglect because a family is in poverty. Neglect is about a child's needs being unmet through a parent or carers action or inaction to such a degree that there is impairment of a child’s health and development. This can occur in families that are in poverty or in those who could be considered as 'well-off'. It should be noted that many parents are able to bring up their children happily and effectively in spite of limited financial resources – the parenting task is invariably more difficult, but these parents are able to maintain a focus on meeting their child’s needs.

**Substance Misuse**

If parents or carers misuse either drugs or alcohol and this use is chaotic, there is a strong likelihood that the needs of the child will be compromised. Any concerns of substance misuse need to be assessed thoroughly and the household carefully checked for dangers and risk of immediate harm.

Parental addiction to substances including alcohol can alter capacity to prioritise the child’s needs over their own and in some cases alters parenting behaviour so that child experiences inconsistent care, hostility or has their needs ignored.

It is essential that there is a collaborative and joined up approach between those working with adults involved in substance misuse and the safeguarding children professionals so that there is a clear understanding between both sets of staff about:

- The level and type of substance misuse, prognosis for change, commitment to reduce or control substance use.
- Whether the findings of any assessments are based on self-reporting or have been verified. It is essential that self-reports of reduction or cessation of substance misuse is verified prior to significant reductions in safeguarding activities. It is not effective safeguarding practice to take self-reports about addictions to substances at face value.
- The implications for parenting capacity and good care being offered to the child consistently in relation to the misuse of substances.

The key message contained in Hidden Harm - Responding to the Needs of Children of Problem Drug Users (2003) was that parental problem drug use can and does cause serious harm to children of every age. The report states that reducing the harm to children should be the main objective of drug policy and practice and concludes that:

- Effective treatment of the parent can have major benefits to the child
• By working together, services can take practical steps to protect and improve the health and well-being of affected children.
• The number of affected children is only likely to decrease when the number of problem drug users decreases.
• Whenever substance misuse is identified as a concern, a thorough assessment of the impact upon parenting and potential implications for the child must be completed.
**Mental Health Difficulties**

It is known that mental health problems in parents and carers can significantly impact upon parenting capacity. Type of mental illness and individual circumstances are factors that need to be taken into account in any assessments. The following may be possible contributory factors when assessing neglect:

- Severe depression or psychotic illness impacting upon the ability to interact with or stimulate a young child and/or provide consistency on parenting.
- Delusional beliefs about a child, or being shared with the child, to the extent that the child’s development and/or health are compromised.

Specialist advice about the impact of mental health difficulties on parenting capacity must always be sought from an appropriate mental health practitioner in these cases. It is essential that there is a collaborative and joined up approach between those working with adults who have mental health difficulties and the safeguarding children professionals so that there is a clear understanding between both sets of staff about:

- The degree and manifestation of the mental health difficulty, treatment plan and prognosis.
- The implications for parenting capacity and good care being offered to the child consistently in relation to the mental health difficulty.

**Learning Disabilities**

Many parents and carers with a learning disability have an instinct to parent their child well, whilst others may not. However, even with a good caring instinct, a parent and carer with a learning disability may have difficulty with acquiring skills to care (e.g. feeding, bathing, cleaning and stimulating) or being able to adapt to their child’s developing needs. The degree of the learning disability as well as commitment and capacity to undertake the parenting task are key areas to assess.

It is a priority that the child’s health and development needs are met both now and – as those needs change - in the future and that the child is not exposed to harm or significant harm as a result of parenting which deprives them of having their physical and emotional needs met. Thus any interventions will also need to consider the level and length of time that support for parents will be required to assist them to parent adequately, and to ensure that plans made in this regard are viable and robust.

Specialist advice about the nature and severity of the learning difficulty is required as well as the impact of the difficulties on parenting capacity. It is essential that there is a collaborative and joined up approach between those working with adults who have learning difficulties and the safeguarding children professionals so that there is a clear understanding between both sets of staff about:
• The degree and manifestation of the learning difficulty, support and services available and prognosis.
• The implications for parenting capacity and good care being offered to the child consistently in relation to the learning difficulty.

**Domestic Abuse**

Growing up in a violent and threatening environment can significantly impair the health and development of children, as well as exposing them to an ongoing risk of physical harm. Chronic, unresolved disputes between adults, whether these involve violence or not, have an adverse impact on the child’s emotional wellbeing and hence emotional neglect is a relevant concern. Professionals need to remain alert to the indicators of neglect whenever domestic abuse is raised as an issue and equally consider whether the child is exposed to domestic abuse when working with cases of neglect.

**Age of the Child**

Babies and toddlers depend almost exclusively on their parents or carers to meet their basic physical and emotional needs. Babies who are not fed cannot compensate by eating at school and babies who are not cleaned do not have the capacity to do this themselves. Generally speaking, the younger the child, the greater the vulnerability and the more serious the potential risk in terms of either their immediate health or the longer-term emotional or physical consequences.

The neglect of adolescents is an area that has received less attention, both in practice and research terms, but it is essential that the health and development needs of adolescents are considered by professionals. Adolescence may well be a time when young people experience abandonment by their parents or carers or where they are forced to leave home (acts of commission). This is particularly worrying as it may be likely that those young people have experienced long term physical and emotional deprivation (persistent neglect) such that their resilience and ability to fend for themselves is impaired (although it may be over-estimated by young people themselves as well as their parents and professionals). It also leaves young people potentially exposed to harm such as sexual abuse, sexual exploitation and the risks to their health and development as a result of homelessness, lack of education etc.
5. **Neglect and Significant Harm**

‘Harm’ is defined in section 31(9) of the Children Act 1989 as the ill treatment or impairment of health and development. This definition was clarified in section 120 of the Adoption and Children Act 2002 (implemented on 31 January 2005) so that it also includes, “for example, impairment suffered from seeing or hearing the ill treatment of another”.

The definition of harm includes the following:

- Development means ‘physical, intellectual, emotional, social or behavioural development’
- Health means ‘physical or mental health’
- Ill-treatment includes sexual abuse and other forms of ill-treatment which are not physical, e.g. ‘emotional harm’.

The Children Act 1989 introduced the concept of ‘significant harm’ as the threshold that justifies compulsory intervention in family life in the best interests of children. The Review of Child Care Law (Department of Health and Social Security, 1985) which led up to the Children Act 1989, said “only where their children are put at unacceptable risk should it be possible compulsorily to intervene. Once such a risk of harm has been shown, however, [the child’s] interests must clearly predominate” (para 2.13).

Significant harm is harm which is considerable, noteworthy or important. There are no absolute criteria on which to rely when judging what constitutes significant harm. Sometimes a single incident (such as a sexual or physical assault) may constitute significant harm but more often it is an accumulation of events, both acute and long-standing, which interrupt, damage or change the child’s development. The harm has to be attributable to a lack, or likely lack, of reasonable parental care, so it is important to identify the respects in which parental care is falling, or is likely to fall, short of what it would be reasonable to expect.

The point at which the threshold of significant harm is crossed depends upon a number of factors and will be largely reliant upon professional judgement and the completion of accurate and effective assessments and multi-agency information sharing and work.

It is necessary for professionals to think of neglect in the context of actual significant harm being suffered now or the likelihood of significant harm being suffered in the future. It is more difficult to identify the likelihood of significant harm in the future where a child hasn’t yet suffered any kind of harm. The ‘likelihood’ of significant harm means that it is a real possibility that it will occur and such a conclusion must be based upon facts established on the balance of probabilities.
6. Effects of Neglect

Chronic and serious neglect can have damaging and disastrous effects on all aspects of childhood, a child’s health and development, life-chances and have catastrophic repercussions throughout the life of the child. The persistent nature of neglect is corrosive and cumulative and can result in irreversible harm.

The degree of impact will differ in relation to individual children and their circumstances, the nature of the neglectful parenting and the existence of resilience. The range of potential impact may lie on a continuum that starts with developmental delay / impairment and ends with significant long-term harm and in some cases death. Research by the University of East Anglia in 2013 which analysed 645 serious case reviews in England between 2005 and 2011, found that 59% of children who died or were seriously injured were on a child protection plan for neglect during or prior to the injury/death.

Neglected children have some of the poorest long term health and developmental outcomes and are:

- at high risk of accidents
- vulnerable to sexual abuse and sexual exploitation
- likely to have insecure attachment patterns
- less likely than other children to develop characteristics associated with resilience or have access to wider protective factors

**Neglect is bad for brain development**

Research has highlighted the impact of neglect on the baby’s developing brain, including insecure attachment and sensory deprivation. This is key to helping our understanding about how early neglect can have life-long consequences and the importance of early intervention. There is a need for optimism and indeed the brain does continue to have ‘plasticity’ but early intervention is crucial.

“Our brains are sculpted by our early experiences. Maltreatment is a chisel that shapes a brain to contend with strife, but at the cost of deep, enduring wounds.”

*Teicher, 2000*

Babies are born with neurons (brain cells), the number of which are capped at birth and by the age of 3 a baby’s brain has reached almost 80% of its adult size. From birth, connections are made between the neurons as a result of receiving stimulation and by environmental factors. Repeated positive stimulation such as physical affection, social interaction, being comforted results in richer and strengthened connections. Thus, growth in each region of the brain largely depends on receiving stimulation. This stimulation provides the foundation for learning so that brain development is ‘experience dependent’.

Where neural connections are not made (e.g. in the absence of stimulation or where hostile, neglectful or frightening care is experienced), neural connections are not made or are weakened (‘pruned’) and wither such that the child cannot achieve their
full potential. Through these critical early experiences, the structure of the brain becomes ‘hard wired’ and sets the foundation for later life. Over time, atrophy becomes increasingly harder to reverse. Although the brain retains ‘plasticity’ and change remains possible, progress is more challenging. Poor brain development can lead to difficulties in regulating emotion, lack of cause-effect thinking, inability to recognise emotions in others, memory, focus and lack of conscience. Secondary difficulties can thus emerge because neglect has cumulative effects, e.g. difficulties in learning, forming relationships etc.

**Neglect is bad for the child’s relationships and emotional development**

We can see that the early infant-parent relationship or ‘attachment’ is key to determining brain development. A secure attachment pattern, based on circumstances whereby a child feels confident in their carer’s availability and who can predict their care-giving response will feel safe enough to explore the world and, gradually, to become more autonomous. This child will also be supported to manage difficult feelings and emotions and this will help them to develop their resilience and coping mechanisms. Fundamentally, this sets the foundation for the child to successfully develop and manage other relationships throughout life.

In contrast, a neglected child cannot rely on their carer's availability and is likely to experience inconsistent, unpredictable or hostile care. Based on these insecure patterns of attachment, the child will develop strategies for survival that will depend upon the way their carer relates to them. These strategies are learned and replayed within other relationships:

- **Insecure anxious or ambivalent attachment**
  A child with this type of attachment pattern may feel insecure about their care giver and display behaviours such as clinginess, attention seeking, approval seeking, lacking in confidence and anxious behaviour. Such children become too anxious when the carer is not around.

- **Insecure avoidant attachment**
  A child with this type of attachment may display attachment-seeking behaviour towards others and are avoidant of their own carer. It does not matter to them whether the carer is around or not. Some will go on to become more self-reliant where as other may become very vulnerable to exploitation by others.

Research indicates that children who have experienced neglect are likely to have greater difficulties in assuming parenting roles successfully in later life.

**Neglect is bad for the child’s learning**

Neglect can impair learning throughout a child’s life including from the ante-natal period in the ways described above. Poor nutrition, impoverished opportunities, unmet health and educational needs, poor routines, living in chaotic or frightening environments all contribute significantly to limiting learning, performance and educational outcomes.
Neglect is bad for the child’s physical development

Foetal neglect, foetal addition to substances, delayed growth within the womb, non-organic failure to thrive, faltering growth, vulnerability to illness/infections/accidents, poor access to medical care, not treating routine conditions, e.g. head lice, pain caused by untreated conditions, access to harmful substances, poor nutrition (resulting in poor growth, anaemia), poor sleep, are some of the ways in which children’s physical development is impaired by neglect. Research also indicates that there are poorer health outcomes for children who have experienced neglect in contrast to the non-neglected population.

7. Learning from Serious Case Reviews

A number of reviews and analyses of Serious Case Reviews have taken place seeking to summarise the learning from serious cases and below is a synthesis of these to help to consider practice issues when things have gone terribly wrong (the References section at the end offers suggestions for further reading).

a. A large percentage of children who were subject of Serious Case Reviews involving serious incidents and death were known to agencies in relation to long-term neglect. This indicates the severe extent of the harm that neglect can do. It should be mentioned that whilst there are particular characteristics of children that make them more vulnerable to harm, children of all ages and the spectrum of ability have been represented in serious case reviews.

b. Reviews found that there had been insufficient challenge by professionals to parents and carers whose comments or explanations for injuries being accepted at face value, even where those explanations seemed unrealistic. Often, there was a focus on the adult parent or carer in relation to their complex needs, allied with a desire to support them and be optimistic about their parenting of their child. Many reviews have described the ‘rule of optimism’ which is a tendency by professionals towards rationalisation and under-responsiveness in certain situations. In these conditions, workers focus on adults strengths, rationalise evidence to the contrary and interpret data in the light of this optimistic view. They confuse parental participation with meaningful engagement by parents.

c. This was at a cost to maintaining a focus on the child who risked becoming ‘invisible’ in their own safeguarding interventions. Reviews described professionals having a poor understanding of what life was like for the child now, or what life would be like for the child in the future if nothing changed. Steps were not taken to establish the wishes and feelings of children and young people or for their voice to be sufficiently heard.

d. Most of the serious case reviews identified sources of information that could have contributed to a better understanding of the child and their family. This included information about or from fathers and extended family, historical
knowledge, information from other agencies, the cultural background and research findings.

e. Many reviews commented on the issue of ‘hidden men’, i.e. fathers or father-figures who either absented themselves or were not known, but who had a significant influence in the family and on the welfare of the child. In a number of reviews, these male figures were not known or not engaged with by professionals and the risk they posed in the home was either not understood or misunderstood thus jeopardising the safeguarding activities.

f. Most of the reviews noted difficulties in inter-agency information sharing and multi-agency working together. Some reviews noted ‘silo’ working whereby professionals did not look at the needs of the child beyond their own specific brief. There were also concerns that poor co-operation and information sharing meant that professionals assumed – incorrectly – that someone else was undertaking an important aspect of information sharing such as reporting a concern.

g. A number of reviews explored concerns about the ‘start-again’ syndrome or ‘assessment paralysis’, whereby assessment was viewed as the child protection intervention rather than as a process which helped to identify the most appropriate intervention.

h. Recording – or rather the absence of clear records which are referred to and used to plan and make decisions – has regularly been a feature of learning from serious case reviews. This includes chronologies which help in the management of neglect which involves harm experienced by the child over a prolonged time. It is imperative that chronic harm is not viewed as a series of single incidents or episodes but that a longer-term developmental perspective is taken.

i. Many reviews have highlighted short-comings in supervision and the lack of opportunities for practitioners to participate in reflective supervision and critical thinking in child protection cases. Such supervision can provide opportunities to question underlying assumptions – or fixed ideas – about the circumstances in the family; support multi-agency working, guide the work with families presenting with complex difficulties, ensured holistic assessments and that the child’s views are both gained and influence decision making about children and their families.
8. Assessment of Child Neglect

An assessment must address the most important aspects of the child’s needs and the capacity of the parents or carers to respond to these needs within the wider family and community context. These are the three ‘domains’ of the Assessment Framework, shown below. An important principle of the Assessment Framework is that assessments are based on inter-agency collaboration and contribution and are not the sole responsibility of one agency. The assessment should be informed by a variety of relevant sources, develop a critique and an analysis, make conclusions about risks and protective factors and create plans for a way forward. These plans need to be implemented, monitored and reviewed.


Key areas to consider when undertaking an assessment

- **Understand the family’s circumstances**
  A clear understanding of the family’s background and previous involvement with services is required at the start of assessments and this can be gained by completing a Genogram (family tree), social history and starting a chronology.

- **Isolated incidents of neglect are rare**
  It is likely that there will be several, possibly fairly minor incidences of neglect, which over time begin to identify patterns of parenting and heighten concerns. It is important to identify and analyse any patterns of neglectful behaviour within
the family context and therefore the usefulness of compiling chronologies cannot be over stated.

- **Talking with parents about the neglect**
  It is often difficult to raise issues with parents about neglect because it requires practitioners to question their own value base and to communicate with parents on matters which are personal and difficult to raise, for example, smells, dirt or hazards in the house. As part of the assessment process practitioners need to ensure that their specific concerns are clearly and explicitly understood by parents who can then be informed about what needs to change in the care of their children, why and in what timescales. It is important to be honest, clear and sensitive, not to use jargon and check that parents have understood what has been said to them. The whole family is key to the process of assessment, they need to know what the assessment is going to involve, why it is happening, what their role is within it and possibilities in terms of outcomes.

- **Involve fathers, father-figures and the wider family**
  Fathers, father figures and the wider family need to be engaged in the assessment in order to understand the role they have in the child’s life. Care of children is likely to be more effective where there is positive support from fathers and most children want and benefit from this contact. Where fathers may pose a risk to the child, it is imperative that they are engaged with the assessment process so that risks are identified, understood and managed.

- **Parents are likely to have many needs of their own**
  Examples of these could include substance misuse, learning disability, mental health difficulties, domestic violence and abuse, all of these requiring high levels of support. It is important to offer support and services to parents and carers which will ultimately enhance their care of the children, however this must never be allowed to compromise keeping a clear focus on the needs of the child.

- **Avoid drift and lack of focus**
  It is important to plan the assessment and have clear time-scales for finalising written assessments. Remember that before, during and after undertaking formal assessments, the safeguarding interventions and service delivery still needs to be inputted as required to protect the child. These services and interventions can inform the assessment process.

- **Guard against becoming ‘immune’ to neglect**
  Professionals who work regularly with families where there is neglectful parenting can become de-sensitised and can tend to minimise or ‘normalise’ situations which in other contexts would be viewed as unacceptable. Sound supervision, which involves reflective discussion and evaluation, is vital to prevent workers becoming desensitised. It is also valuable for workers from different agencies to meet, e.g. in professionals meetings or Case Learning Meetings to discuss issues, share concerns and keep neglect issues in focus.
• **Use assessment tools as a means of focusing and reviewing**

Assessment tools can be used as a means of evidencing concerns and will give clarity and a transparent basis to any planning of interventions or legal proceedings if they become necessary. Assessment tools can highlight where more in-depth work needs to be undertaken or joint working with specialist services. It is important to remember that assessment tools should not be used in a ‘tick-box’ way but will require an application to the child and family’s unique circumstances and will always warrant use of professional judgement.

• **Consider at an early point the likelihood of the parents capacity for change**

Practitioners involved with child neglect should guard against being overly optimistic about the potential for parents to effect lasting change and provide consistently well enough parenting. Change is not always possible and even when positive change occurs, practitioners need to be mindful if it is so minor that it does not really improve the child’s experience of harm and practitioner also need to monitor that positive changes are sustained over time.

Families may co-operate with plans although their motivation in doing may be related to a wish to be seen to be compliant to remove the safeguarding work rather than any understanding or acceptance of the need for change to meet their child’s needs. Such motivation is less likely to lead to sustained change and therefore outcomes for the child remain unaltered.

The assessment of positive change needs to be made on the basis of timely outcomes for the child. The ‘rule of optimism’ can come into play, whereby practitioners are reluctant to consider possible signs of abuse or minimise the significance of what children say, because the parents are perceived to be making improvements. Practitioners should also be careful not to implement the ‘start again syndrome’ with families and (re)commence assessment work at points such as change in worker or an incident in the family, without taking into account previous understanding of the family dynamics. The ‘start again syndrome’ can cause delay and undermine the effectiveness of an assessment or plan.

Appendix 2 contains further information and tools to support practitioners to assess parental motivation to change.

• **Assess sources of resilience as well as risk**

Assessments should not overlook the importance of sources of resilience and opportunities for building upon areas of a child’s life that reduce the risk. Resilience has been described as “qualities which cushion a vulnerable child from the worst effects of adversity, in whatever form it takes, and which may help a child or young person to cope, survive and even thrive” (Gilligan, 1997). There are many aspects of resilience, the key area is secure attachment with one other person and other areas include a sense of self-esteem, a safe friendship group, problem solving skills, social skills, abilities, talents, or interests and hobbies. Assessing resilience in a child needs to be done with care as some children may present as being able to cope or minimise their sense of vulnerability.
• **Observe the parent-child interactions**
Observations can inform assessments of attachment and offer insight into the relationships between parents and child, and child and other siblings. Unrealistic expectations or skewed interpretations of a child’s behaviour are often a feature of neglectful parenting, for example, a child who cries a lot being described by the parents as ‘nasty’ – as though the child’s crying is a deliberate action designed to irritate the parent.

• **Address the child’s basic needs**
The assessment process should continue to consider the child’s basic needs and routinely check aspects of care e.g. food in the cupboards and fridge, sleeping arrangements, hazards in the home, toilet and bathing facilities. Practitioners will need to look into rooms and cupboards to observe these aspects rather than take what parents say at face value. Gaining agreement to do this is important and relates to discussions held with the parents at the engagement stage of the work.

• **Assess each child within the family unit as a unique individual**
Not all children in a family will be treated the same or have the same roles or significance within a family. For example there may be a child who is perceived to be different, perhaps due to an association by the parent/s with a difficult birth, the loss of a partner, the child’s age or needs, an unplanned child or a stepchild or a change in life circumstance. Negative feelings may be projected onto one child but not others in the family.

• **Maintain a focus on the child**
In complex situations such as working with neglect, it is easy to lose sight of the child whose needs can be over-shadowed by the needs of the parents or where parents are reluctant for professionals to have access to the child. The significance of seeing and observing the child cannot be overstated in such complex and chaotic circumstances. Guidelines for keeping the child in focus includes:

  o Children should be seen in their family unit and in other settings, i.e. school, nursery, respite care, to observe any differences in their demeanour and behaviour. They should be seen on their own. The child’s views should be sought in relation to where they would be comfortable to meet with you.
  o It is important to use age and interest appropriate tools, games and other methods to communicate with children. These are relevant to begin to engage with the child and get to know them as a person so that there is an understanding about what life is like for the child everyday in their home. Remember that neglect is less about an event or an incident but about the daily lived experience of a child who doesn’t get their needs met.
  o Speak with the child in their first language or using the communication methods with which they are comfortable. This may require you to use interpreters or to seek specialist advice.
Children value being treated with respect, honesty and care. This involves listening to them and showing that you have heard, remembered and have taken into account what they have expressed. It also involves making sure that they are not let down e.g. missing appointments with them or making last minute changes to plans that have been agreed with them. These behaviours can impair any relationship that they want to form with you and reinforce any negative feelings about themselves.

- Children should be spoken to and observed to determine the quality of attachment they have to their parents and siblings and other members of the family.
- Consideration should be given to each child within the family. How are they different or similar, e.g. in appearance and personality? Are any of the children in the family more resilient than others to the care they are receiving? What can be discovered about their health and development (using the dimensions of the Assessment Framework)? Theories of child development should be used as a benchmark by which to measure concerns about a child’s presentation and welfare.
- Give children age appropriate explanations about why you are involved and what information you will discuss with their parents.

### Be confident about the assessment

A good assessment that practitioners can be confident in is one that includes:

- all relevant information (and comments on the unknowns).
- an evidence base, including tools, guidance, research.
- analysis and evaluation of the information. Analysis is key to any assessment and involves interpreting and attaching meaning and significance to the information that has been gained and to observations that have been made. If the information that has been gathered is a description of ‘what’ has happened, the analysis should reflect on ‘so what’ does that mean for the individual child now and in the future.
- reasoned conclusions and professional judgements.
- plans for the logical next steps and timeframes, i.e. the ‘now what’. It is imperative that those next steps are implemented and their effectiveness monitored and measured.
- update and revision (assessments have to be an ongoing process not a single event) in the light of new and emerging information

**Specialist assessments** can be useful but should only be commissioned in specific, agreed circumstances where there are additional complexities. Examples of such situations may include:

- Children born to parents with additional needs such as chronic mental ill-health difficulties, parents with a disability or long term illness who may face particular challenges which may impact on their parenting capacity. Joint working between professionals working with adults and children’s services should occur.
Children born to mothers who use drugs during pregnancy may suffer from withdrawal and exhibit distressed or restless behaviour which parents find difficult to manage. Parents may lack motivation because of drug use and may find meeting the needs of their children difficult. A pre–birth assessment may be required in these cases to inform planning. Joint working between professionals working with adults and children’s services should occur.

Babies born prematurely or with low birth weight may mean that parents find coping with the high dependency needs of the baby to be very stressful and this may have a negative effect on the ability of the carer to form attachments to the baby. These children are more likely to have feeding difficulties, chronic illness, and neurological, behavioural and cognitive disabilities than other children.

Children with disabilities are more vulnerable to abuse and neglect but are unrepresented in child protection figures. Research indicates that children with disabilities are 3.4 times more likely to be abused than non-disabled children and 3.8 times more likely to be neglected (Sullivan and Knutson, 2000). Reasons for this are varied and complex: they may be less able to communicate their needs and concerns, or to access help outside of their families; the stresses of caring for a disabled child may mean the child becomes the outlet for the parents frustration.
9. Graded Care Profile (GCP)

As we have seen, effective assessment of neglect is a key to improving outcomes for children. The Graded Care Profile (GCP), developed by Dr’s Srivastava and Polnay, is a practice tool which helps practitioners identify neglect and assess the care that is given to children.

It is a tool that gives an objective and graded measure of the quality of care provided to children across four areas of need: Physical, Safety, Love and Esteem. The GCP displays both the strengths and weaknesses in different grades (1-5, with 1 being the best care and 5 being the poorest care) so that it defines the quality of care giving. It helps to target areas of work and can support the understanding of changes after interventions have been made. It is important from the point of view of objectivity because the ill effect of bad care in one area may be offset by good care in another area. It can enable engagement with families because areas of strength and not only weaknesses are highlighted.

The benefits of using the Graded Care Profile are:

- The early recognition of neglect through the clear identification of environmental risk factors or concerns.

- The categorising of the level of neglect as severe, intermediate or low.

- The early referral of severe neglect and focused intervention in ‘intermediate’ cases to prevent deterioration.

- The SMART management of neglect.

- The timely referral to Children’s Social Work Services where early intervention has demonstrably failed.

- The immediate referral to Children’s Social Work Services where the GCP score grading is in the ‘severe’ category, thereby minimising length of exposure to the neglect.

- The post-referral use of the GCP scores to complement other statutory assessments.

- Assessing the impact of intervention in measurable steps and the timely initiation of legal proceedings where intervention has demonstrably failed.
The GCP is based on Maslow’s ‘hierarchy of needs’ represented below:

- **Physiological needs:** food, water, warmth, rest
- **Safety needs:** security, safety
- **Love and belonging needs:** intimate relationships, friends
- **Esteem needs:** stimulation, approval, disapproval, acceptance
- **Self-actualization:** achieving one’s full potential, including creative activities

The GCP develops the Maslow hierarchy by creating **sub-sections** for the first four levels, which in turn have been translated into a set of descriptive behaviours that can be measured as in the model below:

1: **Physical** - nutrition, housing, clothing, hygiene and health.
2: **Safety** - present and absent.
3: **Love** - sensitivity, responsivity, reciprocity, overtures.
4: **Esteem** - stimulation, approval, disapproval, acceptance.
This gives us 15 sub-sections. Underneath each subsection are a set of factors that need to be observed in terms of the parent-child interaction as follows:

<table>
<thead>
<tr>
<th>AREAS OF NEED</th>
<th>SUB-SECTIONS</th>
<th>DESCRIPTIVE FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Nutritional</td>
<td>Quality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quantity</td>
</tr>
<tr>
<td></td>
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<td>Preparation</td>
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<td></td>
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<td>Organisation</td>
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<td></td>
<td>Housing</td>
<td>Maintenance</td>
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<td>Décor</td>
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<tr>
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<td></td>
<td>Facilities</td>
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<tr>
<td></td>
<td>Clothing</td>
<td>Insulation</td>
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<tr>
<td></td>
<td></td>
<td>Fitting</td>
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<tr>
<td></td>
<td></td>
<td>Look</td>
</tr>
<tr>
<td>Hygiene</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td>Opinion sought</td>
<td>Follow-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surveillance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disability</td>
</tr>
<tr>
<td>Safety</td>
<td>In presence</td>
<td>Awareness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practice</td>
</tr>
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<td></td>
<td></td>
<td>Traffic</td>
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<tr>
<td></td>
<td></td>
<td>Safety Features</td>
</tr>
<tr>
<td></td>
<td>In absence</td>
<td></td>
</tr>
<tr>
<td>Love</td>
<td>Carer</td>
<td>Sensitivity</td>
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<tr>
<td></td>
<td></td>
<td>Response</td>
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<td></td>
<td></td>
<td>Synchronisation</td>
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<tr>
<td></td>
<td></td>
<td>Reciprocation</td>
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<tr>
<td></td>
<td>Mutual</td>
<td>Overtures</td>
</tr>
<tr>
<td></td>
<td>Engagement</td>
<td>Quality</td>
</tr>
<tr>
<td>Esteem</td>
<td>Stimulation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Approval</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disapproval</td>
<td></td>
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<tr>
<td></td>
<td>Acceptance</td>
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</table>

The grading table is below and helps to identify how well the child’s needs are met in relation to each of the descriptive factors noted above.

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<tr>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All child’s needs met</td>
<td>Essential needs fully met</td>
<td>Some essential needs unmet</td>
<td>Most essential needs unmet</td>
</tr>
<tr>
<td>2</td>
<td>Child first</td>
<td>Child priority</td>
<td>Child/carer at par</td>
<td>Child second</td>
</tr>
<tr>
<td>3</td>
<td>Best</td>
<td>Adequate</td>
<td>Equivocal</td>
<td>Poor</td>
</tr>
</tbody>
</table>

1. = level of care; 2 = commitment to care; 3 = quality of care

The GCP tool is at Appendix 2 of this guidance (with acknowledgments to Luton LSCB) and offers detailed instructions about completing the assessment and scoring the observations.
10. Chronologies

Chronologies are imperative for a true picture of family history. A chronology seeks to provide a clear account of all significant events in a child’s life to date. This brief and summarised account of events provides accumulative evidence of patterns of concerns as well as emerging need and risks and can be used to inform decisions on support and safeguarding services required to promote a child’s welfare.

Chronologies are particularly important when working with neglect where there may be fewer critical incidents but where children live in families where they are exposed to chronic and long term harm. Chronologies can help identify these patterns of harm.

Chronologies do not replace routine case recording, but offer a summary view of events and interventions in a child’s life in date order and over time. These could be, for example, changes in the family composition, address, educational establishment, in the child or young person’s legal status, any injuries, offences, periods of hospitalisation, changes to health, interventions by services. The changes that are noted could be positive or negative events in the child’s life.

The chronology should be used by practitioners as an analytical tool to help them to understand the impact, both immediate and cumulative, of events and changes on the child or young person's developmental progress.

**Chronologies are done for these reasons:**

- Done effectively it helps to place children at the centre of everything we do
- An effective chronology can help identify risks, patterns and issues in a child’s life. It can help in getting a better understanding of the immediate or cumulative impact of events
- It helps us to make links between the past and the present, helping to understand the importance of historic information upon what is happening in a child’s life now
- Good chronologies enable new workers to become familiar with the case
- Importantly, a good case chronology can, at a later stage, help children, young people and families make sense of their past
- A good chronology can draw attention to seemingly unrelated events or information
- Using chronologies in practice can promote better engagement from children and families
• Accurate chronologies can assist the process of assessment, care planning and review

• When carried out consistently across agencies, good chronologies can improve the sharing, and understanding of the impact, of information about a child’s life.

Compiling a chronology

How chronologies are compiled and how they are used and referred to in practice will make a significant difference to improving outcomes for children. In undertaking a chronology:

• Commence chronologies at the start of involvement in a case

• Enter relevant information as it occurs, including the date of the event and the source of the information

• Include only factual information – analysis and professional opinion on events should be recorded within the case records or assessment documentation

• Enter information throughout involvement in the case, an out of date chronology cannot provide full information for further analysis and planning

• Be brief in chronologies, normally one line

• Make reference to where in the case records more detailed information can be found.

If chronologies are to help with the ongoing analysis of the case, they must be reviewed and used as a ‘live’ document in these ways:

• When adding information to case chronologies consider its relationship and relevance to previous information. (E.g. numbers of missed appointments; A&E appointments; police call outs to a home; numbers of injuries over time etc). Ask yourself after making a new entry “what is the impact of the known information on this child and what else do I need to do?”

• Build in regular reviews of the chronology to assist in case planning and evaluating progress, for example, in preparation for reviews and discussion in supervision

• Share the information being placed in chronologies with children, young people and families as appropriate. This can be to a) check for accuracy of information b) check children and families’ views and perceptions of the information/ events
11. Working with Resistance

Resistance is used here as a catch all phrase to indicate a range of parental behaviours which serve to keep professionals at bay and from identifying, assessing and intervening in neglect. Working with resistant families is very challenging indeed, and good multi-agency working and effective supervision is essential to support practitioners and help maintain the focus on the needs of the child. The quality of supervision available is one of the most direct and significant determinants of the practitioners’ ability to develop and maintain a critical mindset and work in a reflective way and this is pivotal when practitioners are working with resistant families.

Resisting behaviours by family members can seriously hamper professional practice and leave already vulnerable children subject to significant harm. In terms of prevalence, a 2005-2007 analysis of Serious Case Reviews found that 75% of families were characterised as ‘uncooperative’ (Brandon 2008).

The existence of resistance may be identified when parents:
- Only consider low priority areas for discussion
- Miss appointments
- Are overly co-operative with professionals.
- Are aggressive or threatening
- Minimise or deny events or responsibility or the effects on the child

Parents and carers resist in numerous ways and their reasons for doing so vary. At one end of the continuum, parents may genuinely not understand the problem or the way it has been defined and feel they are unfairly caught up in a process which is not their responsibility. At the other end, some parents understand they are harming their children and wish to continue to behave in this way without interference. In the middle are parents who fear authorities, have had previously poor experiences of authority, lack confidence and feel anxious about change. They may struggle to work with individual practitioners. Research indicates that families want to be treated with respect and in a non-judgemental way, be kept fully involved in processes and receive services which meet their needs in a timely way.

When considering if resistance is a dynamic in the family, it is helpful to clarify the behaviours and reasons for these. This is because sometimes what appears to be resistance is in fact a family’s frustration regarding the type and quality of service they are receiving which is not meeting their need, rather than an attempt to divert attention from the safeguarding concerns in their family.

Resistance can be grouped into four types:
- Ambivalent
- Denial/Avoidance
- Violent/Aggressive/Intimidating
- Unresponsive to intervention/disguised compliance
**Ambivalent**
Parents may have mixed, conflicting feelings towards the agency the individual worker or the safeguarding issue. Most parents who are involved in safeguarding interventions will experience mixed feelings but some, in extreme situations may remain stuck in their ambivalence. Behaviours related to ambivalence include avoidance of people, meetings or of certain topics; procrastination, lateness for appointments or superficially undertaking the tasks required. Ambivalence occurs when families are not sure of the need to change or are ‘stuck’ at a certain point.

**Denial/Avoidance**
This could manifest as a result of feelings of passive hopelessness and involve tearfulness and despair about change. It may also be about parents wishing to hide something relevant or being resentful of outside interference. Indicators include an unwillingness to acknowledge the neglect; purposely avoiding practitioners; avoiding appointments or cutting visits short due to other apparently important activity.

**Violent/Aggressive/Intimidating**
Parents who actively display violence or anger or make threats which could either be obvious or be covert or implied (e.g. discussion of harming someone else); use threatening behaviour e.g. deliberate use of silence, bombarding professionals with e-mails and phone calls or entering personal space; use intimidating or derogatory language or swear, shout and throw.

**Unresponsive to intervention/disguised compliance**
Disguised compliance is identified by Fauth et al (2010) as “families where interventions are not providing timely, improved outcomes for children”. Reder et al (1993) state that it is where a parent gives the appearance of co-operation to avoid raising suspicions, allay professional concerns and diffuse professional intervention.

Indicators of disguised compliance include:

- No significant change at reviews despite significant input
- Parents agreeing about the change needed but making little effort
- Change occurring but only as a result of external agencies’ efforts
- Change in one area of functioning not matching change in other areas
- Parents engaging with certain, preferred, aspects of a plan, and aligning themselves with certain professionals
- A child’s report of matters conflicting with that of the parents

This can be classified as ‘passive-aggressive’ resistance because co-operation is noticeable but is superficial and the compliance covers up hostility, antagonism and anger. Disguised compliance occurs when parents want to draw the professional’s attention away from allegations of harm and by giving the appearance of co-operating to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention.

It is a significant concern because the apparent compliance can affect the professional’s engagement with families and children and can prevent or delay understanding of the severity of harm to the child. Examples of disguised compliance include a sudden increase in school attendance, attending a run of...
appointments, engaging with professionals such as health workers for a limited period of time, or cleaning the house before a visit from a professional.

Disguised compliance has been reported to be a dynamic in many Serious Case Reviews and the learning from these indicates that the following practice is helpful:

- Focus on the child: see and speak to the child, listen and take account of what they say
- Cross check what parents say, question the accounts they give, get additional opinions and remain curious. Above all, don’t take at face value explanations that parents give for significant events or incidents.
- Address the safeguarding aspects for children who are living in chronic neglect
- Don’t be overly optimistic without good enough evidence. Be curious about what is happening to the child.
- Consider in supervision and with the multi-agency network what strategies to employ when families are hostile and able to keep professionals at arm’s length
- Share information with other professionals and other agencies, check your assumptions with your colleagues, explore with each other the parents accounts of events.

Appendix 2 discusses further assessment of parental motivation to change and shows a model to help with the identification of compliance and whether it is genuine commitment, tokenism, avoidance or externally motivated compliance which seeks approval from others. Practitioners are referred to Appendix 2 for further details, and the model (with additional detail) is here:

<table>
<thead>
<tr>
<th>GENUINE COMMITMENT</th>
<th>TOKENISM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Talk the talk &amp; walk the walk</strong></td>
<td><strong>Talk the talk</strong></td>
</tr>
<tr>
<td>Parent recognises the need to change and makes real efforts to bring about these changes</td>
<td>Parent will agree with the professionals regarding the required changes but will put little effort into making change work</td>
</tr>
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<table>
<thead>
<tr>
<th>COMPLIANCE/APPROVAL SEEKING</th>
<th>DISSENT/AVOIDANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Walk the walk: disguised compliance</strong></td>
<td><strong>Walk away</strong></td>
</tr>
<tr>
<td>Parents will do what is expected of them because they have been told to “do it”</td>
<td>Dissent can range from proactively sabotaging efforts to bring about change to passively disengaging from the process</td>
</tr>
<tr>
<td>Change may occur but has not been internalised because the parents are doing it without having gone through the process of thinking and responding emotionally to the need for change</td>
<td>The most difficult parents are those who do not admit their lack of commitment to change but work subversively to undermine the process (i.e. perpetrators of sexual abuse or fictitious illness)</td>
</tr>
</tbody>
</table>

Taken from Horwath and Morrison (1999).
12. Supervision

“The risks of recurring maltreatment are higher with neglect than other types of abuse. Practitioners need support to prevent them becoming overwhelmed and to help them to think and act systematically in cases of neglect and to avoid the “start again” syndrome.”

Analysing child deaths and serious injury through abuse and neglect: what can we learn? (DCSF, 2008)

Safeguarding supervision of staff is a key element of a robust and effective safeguarding system and it has a clear link to the protection of children. All agencies should have a mechanism for ensuring that cases of neglect are regularly reviewed in supervision.

The complexity of a family’s situation can be overwhelming for practitioners in many ways and it is important to bear in mind the following aspects for workers who may:

- become desensitised to the effects of neglect, especially if working in this area comprises a large part of their work or if they have become acclimatised to an individual neglectful family.

- get so drawn into working with the complexities that parents face that they lose focus on the child.

- find it hard to make objective assessments and struggle to identify what is good enough parenting in a particular family or resolve any differences between their own views and those of others in the professional network.

- be unsure of when thresholds for escalating safeguarding actions have been met.

- mirror the chaos and helplessness within a family and therefore not take action in a timely or effective way.

- be anxious to challenge parents through a lack of confidence or fear of an aggressive response.

- be drawn into the dynamics of disguised compliance such that they do not challenge parents and accept what they say at face value.

- focus on specific issues and ignore others.

- need support to participate fully in the multi-agency work in a particular family.
Supervision needs to acknowledge these feelings and aspects and look at ways of minimising the effects.

Regular appraisal of the nature of the engagement between the family and practitioner should take place to ensure the balance between support and challenge to families is maintained. Without this balance, there is a risk that the family and practitioner relationship becomes collusive or loses focus.

Lack of direction and drift has been characteristic of a number of cases where neglect has resulted in tragic deaths. Effective supervision gives focus and purpose to the work and allows practitioners to ‘step back’ from cases and reflect on the family’s situation as well as on their own judgements and interventions. Supervision should be used to clarify and focus on:

- exploring the case, assumptions and hypotheses held – to promote objectivity, evidence based analysis and sound professional judgement.
- clarifying roles and responsibilities of the practitioner and those involved in the multi-agency response; support for practitioner in managing stress to ensure that they can carry out their responsibility
- the intended and desired outcomes for the child
- the needs of the child and developmental progress and their presentation
- assessment of parenting capacity, and parents motivation and capacity to change
- identification of clear targets and timescales and methods of monitoring these
- ensuring that the work is undertaken within the framework of legislation, policy, procedures and agency objectives in safeguarding children
- reviewing the plan and ensuring there is no drift

Supervision should also address any process whereby there is selection of information which points to reducing interventions or closing cases where there is serious neglect. This is likely to be unrealistic and can result in a ‘revolving door’ syndrome because the chronicity of neglect means that services will become involved in families again in the future.

Regular reviews undertaken in this way in supervision can help to identify ways forward in the management of cases, e.g. calling a professional’s meeting, arranging co-working in a complex case or joint visits being established. Supervision should also consider the practitioner’s learning and development needs.
13. References, Further Reading and Resources


Brandon, M et al (2013) *Neglect in Serious Case Reviews (2012-2013)*, UEA


Department for Education (2013), *Working Together to Safeguard Children* A guide to inter-agency working to safeguard and promote the welfare of children, London

Department for Education (2010), *Learning Lessons from Serious Case Reviews : Ofsted’s evaluations of serious case reviews 1 April 2009 to 31 March 2010*, Ofsted DfE


**Resources**

**Cardiff Child Protection Systematic Reviews – CORE INFO**
CORE is the Welsh systematic review group collating all research evidence on aspects of abuse and neglect and then summarising the evidence base in recommendations written jointly as usable leaflets with the NSPCC. It is a multiagency group and is an essential tool for evidence based information and advice on aspects of abuse and neglect.
www.core-info.cardiff.ac.uk

**Department for Education**
This link takes you to the safeguarding children pages of the website where there are numerous articles, reviews and research papers related to child neglect as well as wider safeguarding concerns.
https://www.gov.uk/childrens-services/safeguarding-children

**NSPCC**
The website provides access to an Information Service to help to locate practice, policy and research on particular topics, CASPER which provides free email updates about safeguarding matters and Inform which includes full and summary research documents.
http://www.nspcc.org.uk/

**Ofsted**
This site contains several publications including findings from Serious Case Reviews and good practice guides.
http://www.ofsted.gov.uk

**Research in Practice (RIP)**
RIP supports practitioners and agencies to ensure evidence informed practice to achieve the vest outcomes for children. The site contains a wide range of resources and research and policy updates as well as access to learning events.
https://www.rip.org.uk/

**Solihull Local Safeguarding Children Board**
Our Board’s website has the link to the multi-agency procedures for identifying and responding to safeguarding concerns. The website also contains numerous articles, links and resources that can support practitioners and managers.
www.solihull.gov.uk/stay safe

Specifically, our procedures have these chapters on ‘working with uncooperative families’ and ‘chronologies’ which are available at these links:
http://solihulllscb.proceduresonline.com/chapters/p_working_fam.html
http://solihulllscb.proceduresonline.com/chapters/g_ma_chron.html
Appendix 1

Assessment of parental motivation to change


The assessment framework guides professionals to assess the child’s developmental needs, as well as the parent’s capacity to meet these needs. If an assessment suggests that a child’s health and development are impaired or likely to be impaired, the assessment needs to identify the changes needed, both in terms of parenting and support services. If the change needed is change in the parenting, then this should lead to an assessment of the parents capacity to change. This is in order to assess their willingness to work to achieve and sustain the changes required of them. Change must be assessed over time.

Capacity to change is made up of motivation and ability, and the authors suggest that if either of these is missing, the parent in question will lack the ability to change. They suggest that the use of DiClementi’s model of change (1991) might be helpful:
Assessments often focus on information gathering but often fail to consider and understand motivation and change and to engage parents in that process. This model can be used with parents, especially when their engagement with professionals is involuntary.

The basis premises are:-

- Change is a matter of balance. If the motivational forces are greater than the status quo forces, change will be likely to happen.
- For the process to work, professionals need to assess and work with parents in terms of their readiness to accept or deny the need for change.

The blocks to change in terms of the model above are pre-contemplation and relapse.

**Pre-contemplation**
Most families are at this stage at the start of contact with the agencies. They may have a vague notion of wanting change, but not that they need to change. Parents at this stage are unable to make a full psychological commitment, as they have not yet come to terms with the need to change. The implications for this are that early contracts need to be reviewed as (if) the parents move into the change cycle.

**Contemplation**
At this stage, the parents consider that there is a problem, and can explore how to tackle it. Effective intervention will depend on whether external motivation can be transformed into internal motivation. This means that workers need to be able to combine external sanctions with engagement with parents in order to effect change.

Parents may need time to:

- Look at themselves and come to terms with what they see.
- Appreciate the child’s needs.
- Count the cost of change.
- Identify the benefit of change.
- Identify goals which are meaningful to them

The professional task is to assess sources of motivation and:

- Recognise the parents’ ambivalence, compliance, genuine commitment and capacity to change.
- Recognise that each parent may be at a different stage of the change process.
- Those different changes may be required from each parent.
- Assess the motivational/status quo sources in the extended family.
The authors identify seven stages of contemplation as follows:

i. Accept that there is a problem

ii. Accept some responsibility for the problem

iii. Have some discomfort about the problem

iv. Believe things must change

v. See yourself as part of the problem

vi. Make a choice to change

vii. See the next steps towards change

**Determination**

At this stage, parents should be able to express:

- Real problems and their effect on the child
- Changes they wish/should make
- Specific goals to achieve
- How parents and professionals will co-operate to achieve the goals
- The rewards of meeting the goals
- Consequences if change is not achieved.

Professionals need to be clear about agreed plans, and plans should be detailed and specific. Plans should be for incremental change, as motivation to change is more likely if there is early support and clear expectations.

**Action**

This is the point of change, where parents use themselves and services. There can be a danger of confusion and parents feeling overwhelmed (and consequently disengaging) at this stage, so clarity of aims and objectives is essential. Any agreement which was made at the pre-contemplation stage needs to be reviewed to see if it is still valid.

**Maintenance**

This stage is about consolidating changes made, rehearsal and testing of new skills and coping strategies over time and indifferent conditions.

Professionals need to pay attention to relapse prevention, essentially work to anticipating stresses and triggers which might arise.

This can be the stage where one parent is able to change, and the other not thus causing stress in the relationship. If this is due to professionals concentrating their efforts on one parent, this sets up failure, so including both parents is important. The assessment task is to ascertain if parents are able to internalise changes if external motivators are relaxed.
Lapse and relapse
Change is cyclical, and most of us do not succeed first time. Change comes from repeated efforts, re-evaluation, renewal of commitments and incremental successes. A lapse can usually be dealt with, but a relapse, such as a return of their abusive behaviour is not so easy to deal with.

Overall, the task for professionals is to increase the weight of the factors which promote change, whilst decreasing the forces for the status quo. Motivation is interactional, so look to the wider network (partners/professionals/family/friends and community) for sources of motivation, stresses and weaknesses.

Managing ambivalence
Ambivalence is an ordinary response to change, so the assessment of parent’s real commitment is important. The response to change model is useful. It identifies four possible types of response to change, depending on effort and commitment to change:

- Dissent and/or avoidance
- Tokenism
- Genuine commitment
- Compliance

<table>
<thead>
<tr>
<th>Effort</th>
<th>Commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>high</td>
<td>high</td>
</tr>
<tr>
<td></td>
<td>Genuine commitment</td>
</tr>
<tr>
<td>low</td>
<td>low</td>
</tr>
<tr>
<td></td>
<td>Tokenism</td>
</tr>
<tr>
<td></td>
<td>Compliance; Imitation; Approval seeking</td>
</tr>
<tr>
<td></td>
<td>Dissent; Avoidance</td>
</tr>
</tbody>
</table>

The professional task is to be aware of ambivalence, and assess how parents manage ambivalence.

Main messages
- Assess both parents.
- Be child centred, especially on the timing of change, can children wait?
- Being forced to engage heightens parents’ sense of failure and uncertainty.
- If parents are unsure, they are likely to respond negatively.
Appendix 2

The Salford Graded Care Profile

Adapted by Salford LSCB from
The Graded Care Profile
designed by
Dr Leon Polnay and Dr O P Srivastava,
(Bedfordshire and Luton Community NHS Trust
and Luton Borough Council).

With Acknowledgements to Salford LSCB
Introduction

The Graded Care Profile (GCP) was developed as a practical tool to give an objective measure of the care of children across all areas of need by Drs. Polnay and Srivastava. The profile was developed to provide an indication of care on a graded scale. It is important from the point of view of objectivity because the ill effect of bad care in one area may be offset by good care in another area. This Profile was adapted by Salford LSCB.

It is a descriptive scale. The grades indicate quality of care and are recorded using the same 1 – 5 scale in all areas. Instead of giving a diagnosis of neglect it defines the care showing both strengths and weaknesses as the case may be. It provides a unique reference point. Changes after intervention can demonstrably be monitored in both positive and negative directions.

It can be used to improve understanding about the level of concern and to target areas for work as it highlights areas of greater risk of poorer outcomes. It should be used in all cases where neglect is identified as an issue. The Profile can be used with the family by individual workers, or groups of workers, to inform Family Action meetings and child protection Core Group meetings.

Finally it should be remembered that it provides a measure of care as it is actually delivered irrespective of other interacting factors. In some situations where conduct and personality of one of the parents is of grave concern, a good care profile on its own should not be used to dismiss that fact. At present it brings the issue of care to the fore for consideration in the context of overall assessment.
Grades

In this scale there are five grades based on levels of commitment to care. Parallel with the level of commitment is the degree to which a child’s needs are met and which also can be observed. The basis of separation of different grades is outlined in table 1 below.

Table 1.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All child’s needs met</td>
<td>Essential needs fully met</td>
<td>Some essential needs unmet</td>
<td>Most essential needs unmet</td>
</tr>
<tr>
<td>2</td>
<td>Child first</td>
<td>Child first, most of the time.</td>
<td>Child/carer at par</td>
<td>Child second</td>
</tr>
<tr>
<td>3</td>
<td>Best</td>
<td>Adequate</td>
<td>Borderline</td>
<td>Poor</td>
</tr>
</tbody>
</table>

1. = level of care; 2 = commitment to care; 3 = quality of care

These grades are then applied to each of the four areas of need based on Maslow’s hierarchy of needs – physiological, safety, love and belongingness and esteem. This model was adopted not so much for its hierarchical nature but for its comprehensiveness. Each area is broken down into sub-areas, and some sub-areas to items, for ease of observation. An explanatory table shows all the areas and sub-areas with the five grades alongside.

To obtain a score, follow the instructions in this manual. The explanatory table gives brief examples of care in all sub-areas/items for all the five grades. From these, scores for the areas are decided.
Instructions

The Graded Care Profile (GCP) gives an objective measure of care of a child by a carer. It gives a qualitative grading for actual care delivered to a child taking account of commitment and effort shown by the carer. Personal attributes of the carer, social environment or attributes of the child are not accounted for unless actual care is observed to be affected by them. Thus, if a child is provided with good food, good clothes and a safe house the GCP will score better irrespective of the financial situation. The grades are on a 1 – 5 scale (see table 1). Grade one is the best and five the worst. This grading is based on how carer(s) respond to the child’s needs. This is applied in four areas of need – physical, safety, love and esteem. Each area is made up of different sub-areas and some sub-areas are further broken down into different items of care. The score for each area is made up of scores obtained for its items. An explanatory table is prepared giving brief examples of levels of care for the five grades against each item or sub-area of care. Scores are obtained by matching information elicited in a given case with those in the explanatory table. This is taken advantage of in designing the follow-up and targeting intervention. Methods are described below in detail. It can be scored by the carers/s themselves if need be or practicable.

Areas of Care

Sensitivity
Responsivity
Reciprocity
Overtures

Stimulation
Approval
Disapproval
Acceptance

In Presence
& Absence

Nutrition, Housing, Clothing, Hygiene & Health

Maslow, A. 1954
How it is Organised

It has three main components, which are described below.

1. The explanatory table

The explanatory table, which starts at page 13, is laid out in areas, sub areas and items. There are four ‘areas’ – physical, safety, love and esteem which are labelled as – A, B, C and D respectively. Each area has its own ‘sub-areas’, which are labelled numerically – 1, 2, 3, 4 and 5. Some of the ‘sub-areas’ are made up of different ‘items’ which are labelled as – a, b, c, d. Thus the unit for scoring is an ‘item’ (or a ‘sub-area’ where there are no items). See table 2 which shows Area A (physical), sub-area 1 (nutrition) and item a (quality).

Table 2

<table>
<thead>
<tr>
<th>Sub-areas</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aware and thinks ahead; provides excellent quality food and drink.</td>
<td>Aware and manages to provide reasonable quality food and drink.</td>
<td>Provision of reasonable quality food, inconsistent through lack of awareness or effort.</td>
<td>Provision of poor quality food through lack of effort; only occasionally of reasonable quality if pressurised.</td>
<td>Quality not a consideration at all or lies about quality.</td>
</tr>
</tbody>
</table>

For some of the sub-areas or items there are age bands written in bold italics. Stimulation, a sub-area of the area ‘esteem’, is made up of ‘sub-items’ for age bands 0 – 2, 2 – 5 & above 5 years. Clearly, only one will apply in any case.

2. The scoring sheet

There is a scoring sheet, which accommodates the entire system down to the items. It gives an overview of all scores and should be completed as the scores are decided from the explanatory table. See table 3.

Table 3
3. The summary sheet

It is printed on an A4 sheet. At the top there is room to make note of personal details, date and to note who the main carer about whom the scoring is done. ‘Areas’ and ‘sub-areas’ are in a column vertically on the left hand side and scores (1 to 5) in a row of boxes horizontally against each sub-area. Next to this is a rectangular box for noting the overall score for the area, which is worked from the scores in sub-areas (described later). Next to the area score, there is another box to accommodate any comments relating to that area. See table 4. At the bottom there is a separate table designed to target sub-area(s) or item(s) where care is particularly deficient and to follow them up.

Table 4

<table>
<thead>
<tr>
<th>Area</th>
<th>Sub-Area</th>
<th>Scores</th>
<th>Area Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>1. NUTRITION</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. HOUSING</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. CLOTHING</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. HYGIENE</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. HEALTH</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Workers who have used this say that although it looks complicated at first, it gets easier once familiar with the tool.
How to Use

1. Discuss with the parent or carer your wish to complete a GCP with them. Once you are sure they have understood, ask them to sign the consent form on the summary sheet. Fill in the relevant details at the top of the record sheet. Keep the form for your records and note that consent has been given in your case recording system.

2. The Main Carer: is the main carer present when you do the graded care profile. It can be either or both parents, or another main carer. Note who is involved in the top right corner of the record sheet.

3. Methods: It is necessary to do a home visit to make observations. You need to be familiar with the area headings to be sure everything is covered during one or more visits. This document can be shared with the family during the visit, or you can fill it in afterwards. Carers using it themselves can simply go through the explanatory table.

4. Situations:
   a) As far as possible, use the usual state of the home environment and don’t worry about any short term, smaller upsets e.g. no sleep the night before.
   b) Don’t take into account any external factors on the environment (e.g. house refurbished by welfare agency) unless carers have positively contributed in some way by keeping it clean, adding their own bits in the interest of the child like a safe garden, outdoor or indoor play equipment or safety features etc.
   c) Allowances should be made for background factors, e.g. bereavement, recent loss of job, illness in parents. It may be necessary to revisit and score at another time.
   d) If the carer is trying to mislead deliberately by giving the wrong impression or information in order to make one believe otherwise-score as indicated in the explanatory table. (e.g. ‘misleading explanations’- for PHYSICAL Health/follow up would score 5 and ‘any warmth/guilt not genuine’ for LOVE Carer/reciprocation would score 5).

5. Once completed, share a copy with the parents with whom you have completed it and ask them to sign to say they have seen the completed profile. Send them a copy as soon as possible.
**Obtaining Information on Different Items or Sub-Areas:**

A) PHYSICAL

1. Nutritional: (a) Quality  (b) Quantity  (c) Preparation and (d) Organisation

   Take a history about the meals provided including nutritional contents (milk, fruits etc.), preparation, set meal times, routine and organisation. Also note carer’s knowledge about nutrition, note carer’s reaction to suggestions made regarding nutrition (whether keen and accepting or dismissive). Observe for evidence of provision, kitchen appliances and utensils, dining furniture and its use without being intrusive. It is important not to lead as far as possible but to observe the responses carefully for honesty. Observation at a meal time in the natural setting (without special preparation) is particularly useful. Score on amount offered and the carer’s intention to feed younger children rather than actual amount consumed as some children may have eating/feeding problems.

2. Housing (a) Maintenance  (b) Décor  (c) Facilities

   Observe. If lacking, ask to see if effort has been made to improve, ask yourself if carer is capable of doing them him/herself. It is not counted if repair or decoration is done by welfare agencies or landlord.

3. Clothing (a) Insulation (b) Fitting  (c) Look

   Observe. See if effort has been made towards repairing, cleaning and ironing. Refer to the age band in the explanatory table.

4. Hygiene

   Child’s appearance (hair, skin, behind ears and face, nails, rashes due to long term neglect of cleanliness, teeth). Ask about daily routines. Refer to age band in explanatory table.

5. Health  (a) Opinion sought  (b) Follow-up  (c) Health checks and immunisation  (d) Disability/Chronic illness

   Ask who is consulted on matters of health, and who decides when health care is needed. Check about immunisation uptake, reasons for non-attendance if any, see if reasons are valid. Check with relevant professionals. Distinguish genuine difference of opinion between carer and professional from non-genuine misleading reasons. Beware of being over sympathetic with carer if the child has a disability or chronic illness. Remain objective.
B) SAFETY

1. In Presence   (a) Awareness (b) Practice (c) Traffic  (d) Safety features

   This means how safely the home environment is organised. It includes safety features and carer’s behaviour regarding safety (e.g. lit cigarettes, drugs or medication left lying in the vicinity of child) in every day activity. Awareness may be assumed from the presence and appropriate use of safety fixtures and equipment in and around the house or in the car (child safety seat etc.) by observing carers handling of young babies and supervision of toddlers. Also observe how carer instinctively reacts to the child being exposed to danger. If observation not possible, then ask about the awareness. Observe or ask about child being allowed to cross the road, play outdoors etc. along the lines in this manual. If possible check answers out with other sources. Refer to the age band where indicated.

2. In Absence: This covers child care arrangements where the carer is away, taking account of reasons and period of absence and age of the minder. This itself could be a matter for concern in some cases. Check answers out with other sources.

C) LOVE

1. Carer  (a) Sensitivity  (b) Timing of response  (c) Reciprocation (quality of response)

   This mainly relates to the carer’s relationship with the child. Sensitivity means where carer shows awareness of any signal from the child. Carer may become aware yet respond a little later in certain circumstances. Note the timing of the carer’s response in the form of appropriate action in relation to the signal from the child. Reciprocation means the emotional quality of the response.

2. Mutual Engagement  (a) Beginning interactions (b) Quality

   Observing what goes on between the carer and child during feeding, playing and other activities gives you a sense of whether both are actively engaged. Observe what happens when the carer and the child talk, touch, seek each other out for comfort and play, babies reaching out to touch while feeding or stop feeding to look and smile at the carer. Skip this part if child is known to have behavioural problems as it may become unreliable.

   Contact between carer and child that is unplanned is the best opportunity to observe these items. See if carer spontaneously talks to the child or responds when the child talks or makes noises. Note who gets pleasure from this, the carer and the child, either or neither. Note if it is play or functional (e.g. feeding etc.).
D) ESTEEM

1. Stimulation

Observe or enquire how the child is encouraged to learn. Talking and making noises, interactive play, nursery rhymes or joint story reading, learning social rules, providing fun play equipment are such examples with infants (0 – 2 years). If lacking, try to note if it was due to carer being occupied by other essential chores. Follow the explanatory table for appropriate age band. The four elements (i, ii, iii and iv) in age band 2-5 years and 5- years provide a comprehensive picture. Score in one of the items is enough. If more items are scored, score for which ever column describes the case best. In the event of a tie choose the higher score (also described in the explanatory table).

2. Approval

Find out how child’s achievement is rewarded or neglected. It can be assessed by asking how the child is doing or simply by praising the child and noting the carer’s response (agrees with delight or child’s successes rejected or put down).

3. Disapproval

If opportunity presents, observe how the child is told off, otherwise enquire carefully (Does the child throw tantrums? How do you deal with it if it happens when you are tired yourself?) Beware of any difference between what is said and what is done. Any observation is better in such situations than the carer’s description e.g. child being ridiculed or shouted at. Try and ask more if carer is consistent.

4. Acceptance

Observe or ask how carer generally feels after she/he has told the child off, or when the child has been told off by others (e.g. teacher), when child is not doing well, or feeling sad for various reasons. See if the child is rejected (put down) or accepted at these times with warm and supportive behaviour.
SCORING ON THE EXPLANATORY TABLE

Make sure your information is factual as far as possible. Go through explanatory table – (Sub-Areas and Items). Find the description which matches best, read one grade on either side to make sure, then place a tick on that description (photocopy the score sheet to use each time). The number at the top of the column will be the score for that item or sub-area. Where more than one item represents a sub-area, use the method described below to obtain the score for the sub-area.

Obtaining a score for a sub-area from its items’ scores.
Transfer the scores from the explanatory table to the scoring sheet for the items (and sub areas without items i.e. hygiene). Read the score for all the items of a particular sub-area: if there is a clearly repeated number but none of the ticks are beyond 3, score that number for that particular sub-area. To record it on the scoring sheet enter the number in the box for that sub-area. Example: the scores for the items average 2 so the sub area score is 2.
If there is even a single score of 4 or 5, score that point regardless of other scores. *
Example: the scores for the items average 3, but there is a score of 4, so the sub area score is 4.

**Obtaining a score for an ‘area’**

*Follow the same principle for getting an overall score for an area by taking an average of the sub-area scores. Again, if there is even a single score of 4 or 5, score that point regardless of other scores. *

*This method helps identify the problem even if it is one sub-area or item. Its primary aim is to safeguard child’s welfare while being objective. The average score is not used as it will not show up the high scores which are the areas of concern.*

**Transferring the scores to the summary sheet**:  
Transfer all scores in double boxes from the scoring sheet to the summary sheet. This will be the sub area and area scores.

Comments:

This column in the summary sheet can be used for flagging up issues, which are not detected by the profile but may be relevant in a particular case. For example, a child whose behaviour is difficult or a parent whose over protectiveness gives rise to concern. Comments noted may then lead to additional support.

Targeting:
If a particular sub-area scores highly, it can be noted in the table at the bottom of the summary sheet. A better score can be aimed at after a period of work. Aiming for one grade better will place less demand on the carer than by aiming for the ideal in one leap.
### Explanatory table

**A AREA OF PHYSICAL CARE**

<table>
<thead>
<tr>
<th>Sub-areas</th>
<th>1 child first</th>
<th>2 child a priority</th>
<th>3 child and carer equal</th>
<th>4 child second</th>
<th>5 child not considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nutrition</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>a. Quality</td>
<td>Aware and thinks ahead; provides excellent quality food and drink.</td>
<td>Aware and manages to provide reasonable quality food and drink.</td>
<td>Provision of reasonable quality food, inconsistent through lack of awareness or effort.</td>
<td>Provision of poor quality food through lack of effort; only occasionally of reasonable quality if pressurised.</td>
<td>Quality not a consideration at all or lies about quality.</td>
</tr>
<tr>
<td>c. Preparation</td>
<td>Painstakingly cooked/prepared for the child.</td>
<td>Well prepared for the family always thinking of the child’s needs.</td>
<td>Preparation infrequent and mainly for the adults, child sometimes thought about.</td>
<td>More often no preparation. If there is, child’s need or taste not thought about.</td>
<td>Hardly ever any preparation. Child lives on snacks, cereals or takeaways.</td>
</tr>
</tbody>
</table>
### Explanatory table

#### AREA OF PHYSICAL CARE Continued ...

<table>
<thead>
<tr>
<th>Sub-areas</th>
<th>1: child first</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>2. Housing</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>a. Maintenance</td>
<td>Additional features benefiting child- safe, warm and clean (also referred to B-safety area/1/d)</td>
<td>No additional features but well maintained.</td>
<td>State of repair adequate.</td>
<td>In disrepair- but could be repaired easily</td>
<td>Dangerous disrepair- but could be repaired easily (exposed nails, live wires).</td>
</tr>
<tr>
<td>b. Décor</td>
<td>Excellent, child’s taste specially considered.</td>
<td>Good, child’s taste considered (practical constraints prevent a score of 1).</td>
<td>In need of decoration but reasonably clean.</td>
<td>Dirty.</td>
<td>Long term engrained dirt. (Bad odour).</td>
</tr>
<tr>
<td>c. Facilities</td>
<td>Essential and additional fixtures and fittings- good heating, shower and bath, play and learning facilities.</td>
<td>All essential fixtures and fittings; effort to consider the child. If lacking, due to practical constraints (child comes first).</td>
<td>Essential to bare- no effort consider the child.</td>
<td>Adults needs for safety, warmth and entertainment come first</td>
<td>Child dangerously exposed or not provided for.</td>
</tr>
</tbody>
</table>

**NOTE:** Discount any direct external influences like repair done by other agency but count if the carer has spent a loan or a grant on the house or had made any other personal effort towards house improvement.
<table>
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<tr>
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</tr>
<tr>
<td><strong>3. Clothing</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>b. Fitting</td>
<td>Excellent fitting and design.</td>
<td>Proper fitting even if handed down.</td>
<td>Clothes a little too large or too small.</td>
<td>Clothes clearly too large or too small.</td>
<td>Grossly improper fitting.</td>
</tr>
<tr>
<td>c. Look- age 0-5</td>
<td>Newish, clean, ironed.</td>
<td>Effort to restore any wear. Clean and ironed.</td>
<td>Repair lacking, usually not quite clean or ironed.</td>
<td>Worn, somewhat dirty and crumpled.</td>
<td>Dirty, badly worn and crumpled, odour.</td>
</tr>
<tr>
<td>c. Look- age 5+</td>
<td>As above</td>
<td>As above, odour if bed wetter, not otherwise.</td>
<td>Worse than above unless child does own washing. If younger (under 7) gets relatively better clothes.</td>
<td>Same as above unless child does own washing. Even under 7 same as above.</td>
<td>Child unable to help him/herself therefore same as above.</td>
</tr>
</tbody>
</table>
4. Hygiene

<table>
<thead>
<tr>
<th>Age 0 to 4</th>
<th>Cleaned, bathed and hair brushed more than once a day</th>
<th>Regular, almost daily.</th>
<th>No routine. Sometimes bathed and hair brushed.</th>
<th>Occasionally bathed but seldom hair brushed.</th>
<th>Seldom bathed or clean. Hair never brushed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 5 to 7</td>
<td>Some independence at above tasks but always helped and supervised.</td>
<td>Reminded and products provided for regularly. Watched and helped if needed.</td>
<td>Irregularly reminded and products provided. Sometimes watched.</td>
<td>Reminded only now and then, minimum supervision.</td>
<td>Not bothered.</td>
</tr>
<tr>
<td>Age 7+</td>
<td>Reminded, followed, helped regularly.</td>
<td>Reminded regularly and encouraged if lapses.</td>
<td>Irregularly reminded, Products not provided consistently.</td>
<td>Left to their own initiatives. Provision minimum and inconsistent.</td>
<td>Not bothered</td>
</tr>
</tbody>
</table>
### Explanatory table  AREA OF PHYSICAL CARE Continued ...

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<td>5. Health</td>
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<tr>
<td>a. Opinion sought</td>
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<tr>
<td>Not only on illnesses but also other genuine health matters thought about in advance and with sincerity.</td>
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<tr>
<td>From professionals/ experienced adults on matters of genuine and immediate concern about child health.</td>
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<tr>
<td>On illness of any severity. Or frequent unnecessary consultation and/or medication.</td>
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<tr>
<td>Only when illness becomes moderately severe (delayed consultation).</td>
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<tr>
<td>When illness becomes critical (emergencies) or even that ignored.</td>
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<tr>
<td>b. Follow up</td>
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<tr>
<td>All appointments kept. Rearranges if problems.</td>
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<tr>
<td>Fails one in two appointments due to doubt about their usefulness or due to pressing practical constraints.</td>
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<tr>
<td>Fails one in two appointments even if of clear benefit for reasons of personal inconvenience.</td>
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<tr>
<td>Attends third time after reminder. Doubts its usefulness even if it is of clear benefit to the child.</td>
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<tr>
<td>Fails a needed follow up a third time despite reminders. Misleading explanations for not attending.</td>
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<tr>
<td>c. Health checks and immunisation</td>
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<tr>
<td>Visits in addition to the scheduled health checks, up to date with immunisation unless genuine reservations.</td>
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<tr>
<td>Up to date with scheduled health checks and immunisation unless exceptional or practical problems. Plans in place to address this.</td>
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<tr>
<td>Omission for reasons of personal inconvenience, takes up if persuaded.</td>
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<tr>
<td>Omissions because of carelessness, accepts if accessed at home.</td>
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<tr>
<td>Clear disregard of child’s welfare. Blocks home visits.</td>
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<tr>
<td>d. Disability/chronic illness (3 months after diagnosis)/illness</td>
<td>Compliance excellent, (any lack is due to difference of opinion). Compassion for child’s needs.</td>
<td>Any lack of compliance is due to pressing practical reason. Compassion for child’s needs.</td>
<td>Compliance is lacking from time to time for no pressing reason (excuses). Shows some compassion for child’s needs.</td>
<td>Compliance frequently lacking for trivial reasons, very little affection, if at all. Shows little compassion for child’s needs.</td>
<td>Serious compliance failure (medication not given for no reason), can lie, (inexplicable deterioration). Shows no compassion for child’s needs.</td>
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</tbody>
</table>

Compliance = accepting professional advice at any venue and carrying out advice given.
##AREA OF CARE OF SAFETY

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<tr>
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1. **In Presence**

a. **Awareness**

<p>| | | | | | |</p>
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</thead>
<tbody>
<tr>
<td></td>
<td>Good awareness of safety issues however remote the risk.</td>
<td>Aware of important safety issues.</td>
<td>Poor awareness and perception except for immediate danger.</td>
<td>Oblivious to safety risks.</td>
<td>Not bothered.</td>
</tr>
</tbody>
</table>

b. **Practice**

| Acquisition of mobility | Constant attention to safety and effective measures against any perceived dangers when up and about. | Effective measures against any danger about to happen. | Measures taken against danger about to happen of doubtful use. | Ineffective measures if at all. Improvement from mishaps soon lapses. | Inadvertently exposes to dangers (dangerously hot iron near by). |
| Infant school | Close supervision indoors and outdoors. | Supervision indoors. No direct supervision outdoors if known to be at a safe place. | Little supervision indoors or outdoors. Acts if in noticeable danger. | No supervision, Intervenes after mishaps which soon lapses again. | Minor mishaps ignored or the child is blamed; intervenes casually after major mishaps. |
| Junior and Senior School | Allows out in known safe surroundings within appointed time. Checks if goes beyond set boundaries. | Can allow out in unfamiliar surroundings if thought to be safe and in knowledge. Reasonable time limit. Checks if worried. | Not always aware of whereabouts outdoors believing it is safe as long as returns in time. | Not bothered about daytime outings, concerned about late nights in case of child younger than 13. | Not bothered despite knowledge of dangers outdoors- railway lines, ponds, unsafe building, or staying away until late evening/ nights. |

NOTE: Please refer to the item ‘d (Safety Features)’ and the note below it.
Explanatory table  AREA OF CARE OF SAFETY  Continued …

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<td><strong>1. In Presence cont.</strong></td>
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</tr>
<tr>
<td><strong>c. Traffic</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Age 0 – 4</strong></td>
<td>Well secured in the pram, harnesses, or when walking, hand clutched. Walks at child’s pace.</td>
<td>3-4 year old allowed to walk but close by, always in vision, hand clutched if necessary i.e. crowd.</td>
<td>Infants not secured in pram. 3-4 year old expected to catch up with adult when walking, glances back now and then if left behind.</td>
<td>Babies not secured, 3-4 year olds left far behind when walking or dragged with irritation.</td>
<td>Babies unsecured, careless with pram, 3-4 year old left to wander and dragged along in frustration when found.</td>
</tr>
<tr>
<td><strong>5 and above</strong></td>
<td>5-10 year old escorted by adult crossing a busy road, walking close together.</td>
<td>5-8 year old allowed to cross road with a 13+ child: 8-9 allowed to cross alone if they reliably can.</td>
<td>5-7 year olds allowed to cross with an older child, (but below 13) and simply watched: 8-9 crosses alone.</td>
<td>5-7 year old allowed to cross a busy road alone in belief that they can.</td>
<td>A child, 7, crosses a busy road alone without any concern or thought.</td>
</tr>
<tr>
<td><strong>d. Safety Features</strong></td>
<td>Abundant features- gate, guards, drug lockers, electrical safety devices, intercom to listen to the baby, safety with garden pond and pool etc.</td>
<td>Essential features- secure doors, windows and any heavy furniture item. Safe gas and electrical appliances, drugs and toxic chemicals out of reach, smoke alarm. Improvisation and DIY if can’t afford.</td>
<td>Lacking in essential features, very little improvisation or DIY (done too causally to be effective).</td>
<td>No safety features. Some possible hazard due to disrepair (tripping hazard due to uneven floor, unsteady heavy fixtures, unsafe appliances).</td>
<td>Definite hazard for disrepair- exposed electric wires and sockets, unsafe windows (broken glass), dangerous chemicals carelessly lying around.</td>
</tr>
</tbody>
</table>

Note: This item along with other safety provisions which are not a fixture like a bicycle helmet, safety car seats, sports safety wear etc. can be used to score for item ‘a’ (Awareness of safety).
### Explanatory table

**AREA OF CARE OF SAFETY  Continued ...**

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<tr>
<td><strong>2. Safety in Absence</strong></td>
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</tr>
<tr>
<td>Child is left in care of a vetted adult. Never in sole care of an under 16.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Out of necessity a child aged 1-12 is left with a young person over 13 who is familiar and has no significant problem, for no longer than necessary. Above arrangement applies to a baby only in an urgent situation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>For recreational reason leaves a 0-9 year old with a child aged 10-13 or a person known to be unsuitable.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>For recreational reason a 0-7 year old is left with an 8-10 year old or an unsuitable person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>For recreational reason a 0-7 year old is left alone or in the company of a relatively older but less than 8 year old child or an unsuitable person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
### Explanatory table

**C  AREA OF CARE OF LOVE**

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<tbody>
<tr>
<td>1. Carer</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>a Sensitivity</td>
<td>Looks for or picks up very subtle signals-verbal or nonverbal expression or mood.</td>
<td>Understands clear signals – distinct verbal or clear nonverbal expression.</td>
<td>Not sensitive enough – messages and signals have to be intense to make an impact e.g. crying.</td>
<td>Quite insensitive – needs repeated or prolonged intense signals.</td>
<td>Insensitive to even sustained intense signals or dislikes child.</td>
</tr>
<tr>
<td>b Timing of response</td>
<td>Responds at time of signals or even before in anticipation</td>
<td>Responds mostly at time of signals except when occupied by essential chores.</td>
<td>Does not respond at time of signals if during own leisure activity. Responds at time of signals if fully unoccupied or child in distress.</td>
<td>Even when child in distress responses delayed.</td>
<td>No responses unless a clear mishap for fear of being accused.</td>
</tr>
<tr>
<td>c Reciprocation (quality)</td>
<td>Responses fit with the signal from the child, both emotionally (warmth) and materially (food, nappy change). Can get over stressed by distress signals from child. Warm.</td>
<td>Material responses (treats etc.) lacking, but emotional responses warm and reassuring.</td>
<td>Emotions warm towards child if in good mood (not burdened by strictly personal problem), otherwise flat.</td>
<td>Emotional response brisk and flat. Annoyance if child in moderate distress but attentive if in severe distress.</td>
<td>Disliking and blaming even if child in distress, acts after a serious mishap mainly to avoid being accused, any warmth/guilt not genuine.</td>
</tr>
</tbody>
</table>
**Explanatory table**

AREA OF CARE OF LOVE  continued …..

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<tr>
<td><strong>2. Mutual Engagement</strong></td>
<td></td>
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</tr>
<tr>
<td>a, Beginning interactions</td>
<td>Carer starts interactions with child. Child starts interactions with carer. Carer does this more often.</td>
<td>Carer starts interactions with child. Child starts interactions with carer. Carer does this more often.</td>
<td>Child mainly starts interactions. Sometimes the carer. Carer negative if child’s behaviour is defiant.</td>
<td>Child mainly starts interactions. Not very often the carer.</td>
<td>Child does not attempt to start interaction with carer. Carer does not start interactions with child. Child appears resigned or apprehensive.</td>
</tr>
<tr>
<td>b, Quality</td>
<td>Frequent pleasure of engagement, both enjoy it, carer may seem to enjoy a bit more.</td>
<td>Quite often and both enjoy equally.</td>
<td>Less often engaged for pleasure, child enjoys more. Carer passively joins in getting some enjoyment at times.</td>
<td>Engagement mainly for a practical purpose. Indifferent when child attempts to engage for pleasure. Child can get some pleasure (attempts to sits on knees, tries to show a toy).</td>
<td>Dislikes it when child tries to enjoy interactions, if any. Child resigned or plays on own. Carer’s engagement for practical reasons only (dressing, feeding).</td>
</tr>
</tbody>
</table>

**CAUTION:** If child has temperamental/behavioural problems, scoring in this sub-area (mainly quality item) can be affected unjustifiably. Scoring should be done on the basis of score in area of ‘carer’ (C/1) alone and problem noted as comments.
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<tr>
<td><strong>Age 0-2 years</strong></td>
<td>Plenty of appropriate stimulation (talking, touching, looking). Plenty of equipment</td>
<td>Enough and appropriate intuitive stimulation (See below), less showy toys, gadgets, outings and celebrations</td>
<td>Inadequate and inappropriate- baby left alone while carer pursues own amusements; sometimes interacts with baby.</td>
<td>Baby left alone while adult gets on with pursuing own amusements unless strongly sought out by the baby.</td>
<td>Absent- even mobility restricted (confined in chair/pram) for carer’s convenience. Cross if baby demands attention.</td>
</tr>
<tr>
<td><strong>Age 2-5 years</strong></td>
<td>i Interactive stimulation (talking to, playing with, reading stories and topics) plenty and good quality. ii Toys and gadgets (items of uniform, sports equipment, books etc.) – Plenty and good quality iii Outings (taking the child out for recreational purposes) – frequent visits to child centred places locally and away. iv Celebrations – both seasonal and personal, child made to feel special</td>
<td>i Sufficient and of satisfactory quality. ii Provides all that is necessary and tries for more, make do if unaffordable. iii Enough visits to child centred places locally (e.g. parks) occasionally away (e.g. Legoland, zoos). iv Equally keen and eager but less showy.</td>
<td>i Variable- adequate if usually doing own thing. ii Essentials only. No effort to make do if unaffordable. iii Child accompanies carer wherever carer decides, usually child friendly places. iv Mainly seasonal (Christmas) low key personal (birthdays).</td>
<td>i Scarce- even if doing nothing else. ii Lacking on essentials. iii Child simply accompanies – holidays or locally (e.g. shopping), plays out doors in neighbourhood. iv Only seasonal- low key to keep up with the rest.</td>
<td>i Nil. ii Nil, unless provided by other sources- gifts or grants. iii No outings for the child, may play in the street but carer goes out locally e.g. to pub with friends. iv Even seasonal festivities absent or dampened.</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>1. Stimulation cont.</strong></td>
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</tr>
<tr>
<td><strong>Age 5+ years</strong></td>
<td>i Education – active interest in schooling and support at home.</td>
<td>i Active interest in schooling, support at home when can.</td>
<td>i Maintains schooling but little support at home even if has spare time.</td>
<td>i Little effort to maintain schooling or mainly for other reasons like free meals etc.</td>
<td>i Not bothered or can even be discouraging.</td>
</tr>
<tr>
<td></td>
<td>ii Sports and leisure – well organised outside school hours e.g. swimming, clubs etc.</td>
<td>ii All affordable support.</td>
<td>ii little effort in finding out but takes up opportunities at doorstep.</td>
<td>ii Child makes all the effort, carer not bothered.</td>
<td>ii Not bothered even if child is doing unsafe/unhealthy activity.</td>
</tr>
<tr>
<td></td>
<td>iii Friendships – encouraged and checked out</td>
<td>iii Carer offers some help.</td>
<td>iii Accepts if a friend is from a supportive family with carer.</td>
<td>iii Child finds own friends, no help from carer unless reported to be bullied.</td>
<td>iii Not bothered.</td>
</tr>
<tr>
<td></td>
<td>iv Provision – stylish e.g. sports gear, computers.</td>
<td>iv Well provided and tries to provide more if could.</td>
<td>iv Poorly provided.</td>
<td>iv Under provided.</td>
<td>iv No provision.</td>
</tr>
</tbody>
</table>

**NOTE:** Whichever describes the case best should be ticked as the score; in the event of a tie choose the higher score.

| 2. Approval | | | | | |
| | Talks about the child with delight/praise without being asked; material and generous emotional reward for any achievement. | Talks fondly about the child when asked, generous praise and emotional reward, less of material reward. | Agrees with other’s praise of the child, low key praise and damp emotional reward. | Indifferent if child praised by others, indifferent to child’s achievement, which is quietly acknowledged. | If the child is praised by someone else, successes rejected. Achievements not acknowledged, lack of reprimand or ridicule is the only reward if at all. |
### Explanatory table

**AREA OF CARE OF ESTEEM Continued**

<table>
<thead>
<tr>
<th>Sub-areas</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Disapproval</td>
<td>Mild verbal and consistent disapproval if any set limit is crossed.</td>
<td>Consistent terse verbal, mild physical, mild sanctions if any set limits are crossed.</td>
<td>Inconsistent boundaries or methods terse/shouts or ignores for own convenience, mild physical and moderate other sanctions.</td>
<td>Inconsistent, shouts/harsh verbal, moderate physical, or severe other sanctions.</td>
<td>Terrorised. Ridicule, severe physical or cruel other sanctions.</td>
</tr>
<tr>
<td>4. Acceptance</td>
<td>Unconditional acceptance. Always warm and supportive even if child is failing.</td>
<td>Unconditional acceptance, even if temporarily upset by child’s behavioural demand but always warm and supportive.</td>
<td>Annoyance at child’s failure, behavioural demands less well tolerated.</td>
<td>Unsupportive to rejecting if child is failing or if behavioural demands are high. Accepts if child is not failing.</td>
<td>Indifferent if child is achieving but rejects if makes mistakes or fails. Exaggerates child’s mistakes</td>
</tr>
</tbody>
</table>

**NOTE:** If the style of parenting (over protective, permissive to foster independence, authoritarian) or type of values instilled is of concern, please make a note in the corresponding comment box on the record sheet.
This is the scheme representing all 'items' (represented by small letters); 'sub areas' (represented by numbers), and 'areas' (represented by capital letters) these are printed in circles. Scores are to be noted in boxes adjacent to corresponding 'items', 'sub areas' and 'areas'. This represents the entire record as in the explanatory table for full reference.
Summary sheet

Name (Child)___________________________     Date of Birth _______________
Main Carer/s _______________________________________________________
Carer/s signature/s of consent to complete a GCP __________________________
Scorer’s Name                             Scorer’s Signature                                            Date

<table>
<thead>
<tr>
<th>Area</th>
<th>Sub-Area</th>
<th>Scores</th>
<th>Area Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Physical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. NUTRITION</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. HOUSING</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. CLOTHING</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. HYGIENE</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. HEALTH</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. IN CARER’S PRESENCE</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. IN CARER’S ABSENCE</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Love</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. CARER</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. MUTUAL ENGAGEMENT</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Esteem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. STIMULATION</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. APPROVAL</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. DISAPPROVAL</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. ACCEPTANCE</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Targeting Particular Item of Care:**
Any item with disproportionately high score can be identified by reference to the explanatory table by writing the area, sub area and item i.e. physical/nutrition/quality in the table below.

<table>
<thead>
<tr>
<th>Targeted items (area/sub area/item)</th>
<th>Current Score</th>
<th>Period for change</th>
<th>Target Score</th>
<th>Actual Score after first review</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have seen the completed GCP scores for my child.

Parent/ carer comments

Signed

Date