Hampshire Safeguarding Children Board

Hampshire and Isle of Wight
Neglect Strategy
2016/18

A Partnership Approach

Contents

Foreword

Awareness of child neglect and its consequences on the future wellbeing and development of children has increased during the last two decades. Apart from being potentially fatal, neglect causes great distress to children and leads to poor health, educational and social outcomes in the short and long-term (NSPCC, 2014).

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 (Taylor and Bridge 2005), thereby repeating the cycle of neglect and consequential abuse.

The degree to which children are affected during their childhood and later in adulthood depends on the type, severity and frequency of the neglect and on what support mechanisms, resilience strategies and protective factors were available to the child.

Neglect has been identified as a priority for the Hampshire and Isle of Wight safeguarding children boards because of the serious impact it has on the long-term chances for children. Neglect in the first three years of life can seriously impact on brain development and have significant consequences through adolescence and into adulthood.

The purpose of this document is to establish strategic aims, objectives and priorities for Hampshire and the Isle of Wight's approach in tackling neglect. It was developed through the Local Safeguarding Children Boards and as such applies to all agencies across all sectors working on the Isle of Wight and in Hampshire.

This document identifies both the current statutory definition of neglect and other factors to consider in assisting and further supporting practitioners in early identification and intervention. This strategy is intended as a practical guide to identify a number of guiding principles under which all work around neglect should be undertaken. It also identifies four strategic priority areas in order to improve the quality, reach and scope of the response to neglect.

This strategy recognises the four types of neglect (Howe, D 2005) are a means by which better understanding will be gained of what causes neglect:

- Emotional neglect
- Disorganised neglect
- Depressed or passive neglect
- Severe deprivation.

1. Introduction

1.1 Definition

The NSPCC (2014) provides the following definition of child neglect:

> *"A persistent failure to meet a child's basic physical and/or developmental needs. Neglect includes failing to provide for a child's health, education, emotional development, nutrition, clothing, shelter, safety and safe living conditions, and includes exclusion of the child from the home and abandonment."*

According to the World Health Organisation (WHO) neglect is different from poverty[1] because it happens when there is a failure to provide the resources to meet a child's needs if those resources exist or should be available.

Working Together 2015 (HM Government)[2] describes neglect as including:

- a parent's or guardian's failure to provide adequate food, clothing and shelter, such as excluding a child from the home, abandoning them and leaving them alone

- failure to protect a child from physical or emotional harm, or danger

- failure to ensure that the child has adequate supervision (including the use of inadequate and inappropriate caregivers)

- failure to ensure the child has access to appropriate medical care and treatment when needed

- unresponsiveness to a child's basic emotional needs

Neglect is defined developmentally, so that a parent or guardian failing to do or to provide certain things will have a detrimental impact on the development or safety of a young child, but not necessarily on an older child. A child who is neglected will often suffer from other abuses as well. Neglect is dangerous and can cause serious, long-term damage - even death[3].

There is a considerable body of research which demonstrates the damage done to young children living in situations of neglect; this includes the impact of a lack of stimulation, resulting in delayed speech and language, and the development of insecure attachments[4].

There is a pervasive and long-term cumulative impact of neglect on the well-being of children of all ages including physical and cognitive development, emotional and social well-being and children's mental health and behaviour[56].

Action for Children (2012) presents neglect as differing from other forms of abuse because it is:

- Frequently passive
- Not always intentional
- More likely to be a chronic condition rather than crisis led and therefore impacts on how we respond as agencies
- Combined often with other forms of maltreatment
- Often a revolving door syndrome where families require long term support
- Often not clear-cut and may lack agreement between professionals on the threshold for intervention7

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1   For more information on the environment causes of neglect see section 3.3 of this strategy.
2   HM Government (2015) Working Together to Safeguard Children: a Guide to Inter Agency Working to Safeguard and Promote the Welfare of Children, London, Department For Education
3   NSPCC (2015) accessed on 17 September 2015 via: www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/neglect/what-is-neglect/
4   OFSTED (2014), In the child's time: professional responses to neglect, Accessed on 2 October 2015 via: www.ofsted.gov.uk/resources/140059
5   C Davies and H Ward, Safeguarding children across services: messages from research, Department for Education, 2011; www.gov.uk/government/publications/safeguarding-children-across-services-messages-from-research.
6   A Lazenbatt, The impact of abuse and neglect on the health and mental health of children and young people, NSPCC Research briefing, 2010; accessed on 02/10/15 via: www.nspcc.org.uk/Inform/research/briefings/impact_of_abuse_on_health_wda73372.html.
7   Action for Children (2012), Working with neglect: Practice toolkit, Action for Children 04/2012. 12/13 0020 accessed on 05/10/15 via: www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=12193&p=0

1.2 Why do we need a strategy?

The impact of neglect on children cannot be overestimated. Neglect causes great harm to children, leading to poor health, educational and social outcomes and is potentially fatal., Children's abilities to make secure attachments are affected and this impacts on their well-being in adulthood and their ability to parent in the future, and so the cycle continues[8]. For example, on the Isle of Wight (as at 31st March 2016) of the 213 children subject to a child protection plan 57.7% of these were under the category of Neglect.

Through this strategy local partners agree on the following principles:

- The safety and welfare of children is paramount
- Professionals and volunteers from all agencies have a statutory responsibility to safeguard children from neglect and its consequences.

As such the aim of this strategy is to tackle the causes and effects of neglect in Hampshire and on the Isle of Wight. In order to achieve this, the objectives of this strategy are:

- To strengthen local responses in line with current national and local guidance, policies and good practice
- To adapt, rather than duplicate, existing guidance, policies or procedures to tackle neglect.
- To raise awareness and improve the safeguarding duty of all relevant agencies with regards to neglect

1.3 Scope of the strategy

Neglect can affect everyone. The issue of neglect with regards to vulnerable adults is addressed by the Safeguarding Adult Boards (SAB)[9]. This strategy addresses neglect in relation to children from conception to the age of 18.

The organisations who are expected to understand, recognise and appropriately respond to the four types of neglect are:

- Adult Services
- Ambulance Service
- Animal Welfare Groups
- Children's Services
- Clinical Commissioning Groups
- Community CAMHS
- Community Rehabilitation Company
- Dentists
- District and Borough Councils
- Education – early years, primary, secondary, post-16, special schools, independent
- Environmental Health
- Faith Groups
- Fire Service
- General Practice
- Hampshire Constabulary
- Housing
- National Probation Service
- NHS England
- NHS Trust Providers
- Opticians
- Town and Parish Councils
- Youth Offending Teams
- Voluntary Groups

1.4 Purpose of the strategy

The purpose of the strategy is to set out Hampshire and the Isle of Wight's approach to tackling neglect. This strategy also identifies key principles and key priority areas of work in order to improve the local multi-agency response to neglect.

This document has been developed in conjunction with the partners represented on the Local Safeguarding Children Boards. This strategy should be considered alongside other key strategies, policies and procedures, such as the local Early Help Strategies, the Levels of Need framework[10], Female Genital Mutilation Strategy, Domestic Violence Strategy, Substance Misuse Strategy and guidance from professional bodies such as the Royal Pharmaceutical Society and the Optical Confederation (see 'Useful Resources' at the end of this strategy document).

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8   Liverpool Council (2014) Neglect Strategy 2014-16, accessed on 18/09/15 via: www.liverpoolscb.org/user_controlled_lcms_area_home/uploaded_files/ Liverpool's%20Multi%20Agency%20Negelct%20Strategy%202014%20-%202016.pdf

9   For more information on the role of the SAB see: https://www.iwight.com/Residents/Care-and-Support/Adults-Services/Keeping-Adults-Safe/Safeguarding-Adults-Board and www.hampshiresab.org.uk

10   See appendix 1: Different forms of neglect and how they manifest.

Case Study

Reason for referral

Primary school raised concerns in relation to mother's mental health and that she had periods when she was hospitalised. There were financial issues due to mother's inability to work. Children's presentation was at times grubby and they appeared unkempt. There was a reliance on food parcels and the children's diet was not balanced. There were also concerns about school attendance.

Assessment

A home visit identified poor home conditions. The three year old wet the bed meaning the mattress was not suitable to sleep on. There was no bedding or mattresses for the older children. There were no carpets on the floor, the house was sparsely furnished and it was not being regularly cleaned.

The children were not registered with a dentist and it was not clear if their immunisations were up to date. Mother felt isolated due to where the family lived and not being near extended family and friends for support. Mother could not drive due to the medication she was taking. Neighbours were not willing to help as the relationship had broken down.

Mother was being supported by adult mental health services who felt she was making progress. Mother had low self-esteem and was struggling to manage the behaviour of the five year old. School's view was that the older children were negatively affected by mother's mental health.

Support provided

A family support worker engaged with mother and started to build a relationship. The home conditions were addressed and mother was supported to purchase new mattresses, protectors and bedding on the understanding the condition of the home improved.

Mother noted down her concerns and received regular monitoring through home visits. She was given advice on routines to help her to maintain the improved conditions of the home. A new sofa and carpets were sourced from a support group which mother used to attend.

The school nurse followed up outstanding health appointments and immunisations with the health visitor. Mother was encouraged to ensure the children registered with and visited a dentist.

Work was undertaken on a one to one basis with mother using the 'family links nurture model' alongside self-empowerment and self-esteem work. The work with mother ensured she was able and ready to make sustained changes.

Outcome

Mother was supported to be rehoused nearer family and friends which allowed the three year old to access a local nursery and mother to access a local support group. The family's finance stabilised with advice and guidance which allowed a balanced diet to be introduced. Mother has on-going mental health needs however she has a better understanding of how to manage these. As a result the children are more settled and happier.

2. Strategic Priorities

Partners agreed the following priorities to achieve the aims and objectives of this strategy:

PRIORITY 1: GOVERNANCE

To provide a robust strategic framework for the delivery of an effective range of interventions to tackle neglect in Hampshire and on the Isle of Wight.

- Outcome: The delivery of the strategy is effectively governed through the Isle of Wight and Hampshire LSCBs and their partners.

PRIORITY 2: PREVENTION

To improve awareness, understanding and recognition of neglect as maltreatment across Hampshire and the Isle of Wight.

- Outcome: There is a strong focus on addressing causes not symptoms.
- Outcome: Practitioners are confident enough to identify early where sustained change in families cannot be achieved.
- Outcome: Members of the community are better equipped to recognise neglect in all its forms and how to report it.

PRIORITY 3: INTERVENTIONS

To improve the effectiveness of interventions to tackle neglect

- Outcome: Proactive, multi-disciplinary assessment processes are in place and routinely used.
- Outcome: Interventions match the identified/assessed needs with clear achievable targets in realistic timescales.
- Outcome: Practitioners understand the importance of using family histories in identifying patterns of neglect.
- Outcome: Practitioners are confident in making judgments and decisions that they can share with other agencies.

PRIORITY 4: EVALUATION

To monitor progress in reducing the risk of neglect in the population

- Outcome: There is a robust, shared and jointly owned evaluation framework in place to measure success and impact of the four strategic priorities.

3. Tackling Neglect: A Strategic Framework

3.1 National principles in tackling neglect[11]

Neglect is a multi-faceted issue and demands a systematic response from government through to front line provision. NSPCC research indicates this should include:

- agreed information-sharing and recording of concerns about child neglect[12]
- greater precision in legal and procedural terms and thresholds
- each LSCB having an inclusive strategy for addressing neglect, including a crisis response
- good quality information for children, parents and concerned others, with identified contact points
- universal and targeted provision for children and parents (separately and together) that addresses specific components of neglect
- located responsibility for achieving best practice on child neglect, in all relevant services - including emergency, community and adult services
- staff development and training plans that address staff security, health and safety, knowledge base, supervision, audit and case work
- assessment and risk analysis specific to child neglect, linking identified problems to relevant services.

The challenges that face the children's workforce in all sectors can sometimes appear insurmountable when working with neglect. The reasons for this can include:

- loss of momentum and follow through of plans
- difficulty joining up adult and children's services
- desensitisation and demoralisation of practitioners
- failure to track referrals and collate data
- concern about blame where the parent is perceived as not intentionally abusive
- difficulty with legal thresholds
- lack of training and reflective practice.

It should be noted that the workforce extends to cover services that routinely or regularly come into contact with children and families but who might not obviously view themselves as being part of the children's workforce. This will include opticians, GPs, dentists, fire officers, volunteers in community groups and vets.

Neglect and emotional harm are some of the most highly stressful and demanding areas of work for individuals and groups of professionals.

(Gardner, 2008)[13] found that interviewees from all disciplines and levels of experience recommended the following as essential to effective work in this area as well as preventing burnout:

- leadership and support in sound planning and review of cases
- regular research and best practice updates
- single and joint agency training
- off-line consultation and reflection opportunities
- updates on best practice in neglect
- regular case audit

Locally the importance of tools for professionals to support, inform and evidence decision-making for universal services and early help are also recognised as necessary for effective work in measuring change in neglect cases. Alongside this is the need to make available support to raise awareness of neglect as a safeguarding issue for example through the provision of training and resources.

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11   The following section was extracted from: www.nspcc.org.uk/globalassets/documents/research-reports/developing-effective-response-neglect-emotional-harm-children.pdf
12   Information sharing, Advice for practitioners providing safeguarding services to children, young people, parents and carers: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf
13   Ruth Gardner (2008) Developing an effective response to neglect and emotional harm to children. University of East Anglia and The National Society for the Prevention of Cruelty to Children; accessed on 05/10/15 via: https://www.nspcc.org.uk/globalassets/documents/research-reports/developing-effective-response-neglect-emotional-harm-children.pdf

3.2 Role of the Local Safeguarding Children Board (LSCB)

There is heightened interest in learning about neglect and applying this knowledge to joint safeguarding practice. Both central government and local safeguarding children boards are challenging agencies to improve local early intervention responses to reduce the incidence and recurrence of neglect[14].

LSCB duties and responsibilities include promoting activity amongst local agencies and in the community to:

- Identify and prevent maltreatment[15] or impairment of health or development, and ensure children are growing up in circumstances consistent with safe and effective care
- Safeguard and promote the welfare of groups of children who are potentially more vulnerable than the general population
- Increase understanding of safeguarding children issues in the professional and wider community, promoting the message that safeguarding is everybody's responsibility

3.3 Common risk factors and indicators of neglect

It is important for practitioners to be able to distinguish between a risk of neglect occurring and indicators of *actual* neglect[16]. A number of factors increase the likelihood of neglect in some families. However, there are issues of interpretation to be aware of in relation to both risks and indicators.

Research[17] regularly reveals that factors associated with an increased risk of neglect may also act as risks for a range of adverse outcomes and not just for neglect or maltreatment; this means that these risk factors are not predictors of neglect. In addition, prospective longitudinal studies reveal that the majority of families where risk factors are found will not go on to neglect or abuse children (Sidebotham et al 2001).

14 Ibid 12
15 "Child maltreatment, sometimes referred to as child abuse and neglect, includes all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child's health, development or dignity. Within this broad definition, five subtypes can be distinguished – physical abuse; sexual abuse; neglect and negligent treatment; emotional abuse; and exploitation". World Health Organisation (WHO), Child Maltreatment, Accessed on 18/09/15 via: http://www.who.int/topics/child_abuse/en/
16 M. Brandon, D. Glaser et. Al (2014), Missed opportunities: indicators of neglect – what is ignored, why, and what can be done? Research report – Childhood Wellbeing Research Centre, accessed on 01/10/2015 via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/379747/RR404_-_Indicators_of_neglect_missed_opportunities.pdf
17 Ibid 13

Risk factors do aid understanding of the child's experience, and help agencies determine priorities for offering support, however, they should be used and interpreted with care. Vulnerable families may have a combination of the following risk factors[18]:

- Family violence, modelling of inappropriate behaviour
- Multiple co-habitation and change of partner
- Alcohol and substance abuse
- Maternal low self-esteem and self-confidence
- Poor parental level of education and cognitive ability
- Parental personality characteristics inhibiting good parenting
- Social and emotional immaturity
- Poor experience of caring behaviour in parents own childhood
- Depriving physical and emotional environment in parents own childhood
- Experience of physical, sexual, emotional abuse in parents own childhood
- Health problems during pregnancy
- Pre-term or low birth weight baby
- Low family income
- Low employment status
- Single parenting
- Teenage pregnancy

Delayed development, emotional and behavioural problems and poor socialisation are also all well recognised as potential indicators of child neglect. Such indicators are particularly helpful and should be taken seriously since both the causes and consequences of such parent/child behaviour may have important implications for the child both now and in the future[19].

Environmental causes of neglect

In addition to the risks highlighted in the previous section, the LSCBs believe very strongly that the environmental factors of neglect are not always acknowledged. Many environmental indicators of neglect are not difficult to recognise. These factors relate to interactions between the family and their immediate environment and other significant factors in the immediate environment outside of the family (Glaser, 2011)[20]. Professionals (or lay significant others) will be concerned when children come to school dirty or hungry, or when visiting homes that are indisputably filthy or unsafe[21].

The Childhood Wellbeing Research Centre[22] (2014) describes the main environmental factors as follows:

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18 Action for Children (2012)
19 Ibid 13
20 Cited in NSPCC (2014)
21 Ibid 13
22 This section was extracted from : Childhood Wellbeing Research Centre (2014) see: footnote 15 accessed on 9 October 2015

Poverty

Research suggests that living in poverty damages physical and psychological health in children and their families and harms relationships. Poverty often brings social isolation, feelings of stigma, limited educational and employment prospects and high levels of stress which can in turn make coping with the psychological as well as the physical and material demands of parenting much harder.

Poor living conditions and unstable housing

Neglect is commonly recognised where there are poor or unsafe physical living conditions and living circumstances such as:

- An unsafe home, for example: home cluttered, dark, holes in the floor, broken windows, exposed wires and other electrical problems, leaky roof, infestation of rodents/insects, appliances such as the fridge not working, toilet broken, no available hot water.
- Overcrowding: a high ratio of people to bedrooms, the home appears crowded.
- Instability as indicated by frequent moves, homelessness, short stays with friends/family, stays in shelters, living in abandoned buildings, on the streets or in vehicles.

Social isolation and lack of community support

Parents who neglect their children have been found in systematic reviews and other studies either to have had fewer individuals in their social networks and to receive less support, or to perceive that they received less support from them, than did other parents.

Isolation and limited networks may mean that parents have little social interaction and by implication little help with the day to day responsibility of supervising small children. Alternatively, neglecting parents in low income neighbourhoods have been found to have had as many social contacts as their peers but not to have reciprocated social support instead making considerable demands on friends and family.

Violence in communities

For children living in dangerous neighbourhoods it has been found they are at higher risk of neglect, physical abuse and sexual victimisation. Furthermore, social attitudes and the promotion of violence in communities and the media have also been suggested as risk factors for physical abuse.

3.4   Good practice principles in tackling neglect

The NSPCC Research briefing (2010) provides examples of specific practices and policies that address neglect, emotional harm and associated professional challenges. These practices advocate the development of effective working policies and protocols between children's services and all emergency and adult services, to ensure:

- genuine efforts to engage both parents and other significant adults
- tracking of families
- clarity on confidentiality
- high quality information exchange
- access to vulnerable children
- challenging intimidation
- prompt and sensitive action to support and protect children in all situations posing a risk to their health, wellbeing or safety.

The NSPCC report also mentions the following good practice principles in tackling neglect:

- timely response to all expressions of concern about neglect
- an understanding of the child's day-to-day experiences
- adequacy of child care must be addressed as the priority
- engagement with mothers, fathers, male partners and extended family
- clarity on parental responsibility and expectations
- full assessment of the child's health and development
- monitoring for patterns of neglect and change over time
- avoiding assumptions and stereotypes
- tracking families whose details change (name, address, school, GP)

The following overarching principles[23] will be adopted in tackling neglect on the Isle of Wight and in Hampshire:

| A. | *Develop a whole family approach and ensure it is owned by all stakeholders.* |

This should ensure the approach is child focussed as the safety, well-being and development of children is the overriding priority.

The approach should be inclusive of children with additional needs such as disability or special educational needs as they are potentially more vulnerable.

All agencies need to consider historical information to inform the present position and identify families at risk of inter-generational neglect. This whole family approach will include absent and new partners.

Improved understanding of patterns of neglect through use of chronologies to identify and evidence patterns of neglect.

| B. | *Be outcome focussed* |

Work with children and young people needs to be measured by its impact on outcomes. This will require good quality assessments and plans as these are key to getting it right for children and young people.

| C. | *Develop a shared understanding* |

Significant regard needs to be given to the overlap between neglect and other forms of child maltreatment such as domestic abuse and substance misuse.

As such collaboration and partnership arrangements will be central to ensuring effective identification, assessment and support and promote consistency of practice where agencies need to challenge each other about improvement made by families and its sustainability. This will require effective information sharing to inform assessments and evaluations of risk.

| D. | *Building resilience* |

Help needs to be of a kind and duration that improves and sustains the safety of children and young people into the future. As such early help will play a key role in ensuring the early recognition and identification of the signs and symptoms of neglect and the importance of effective collaboration amongst agencies co-ordinated through early help assessments.

| E. | *Risk management* |

Suitable statutory action needs to be taken if insufficient progress is achieved and methods have been unsuccessful in addressing levels of risk present. Decisive action will be taken when improvements are not made.

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23   *Principles used in this section were inspired by Cheshire's Neglect Strategy available via: http://www.cheshireeastlscb.org.uk/pdf/cheshire-east-neglect-strategy-nov-2014.pdf*

3.5   Reviewing and auditing practice

The statutory guidance for Local Safeguarding Children Boards requires them to maintain a local learning and improvement framework. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result. The local frameworks on the Island and in Hampshire reference different types of reviews that the LSCB will undertake:

- Serious Case Review - where abuse or neglect is believed to be a factor (statutory requirement)
- Child death review - a review of all child deaths up to the age of 18 (statutory requirement)
- Review of a child protection incident which falls below the threshold for a serious case review;
- Review or audit of practice in one or more agencies.

In addition to this, auditing is a key element of the LSCB quality and performance framework. Case and thematic audits are completed quarterly by a multi-agency group of practitioners. Findings from a multi-agency neglect audit in December 2014 on the Isle of Wight evidenced good practice around the proactive role of the lead professional in early help cases , and excellent examples of robust intervention plans clearly focused on the needs of the individual children with clear challenge to the parents/carers about what needs to change.

3.6   Workforce development

Professionals may individually have concerns about a neglected child but these concerns do not necessarily trigger effective action. Numerous factors have been identified as potential obstacles to effective action.

Firstly, professionals may have concerns about neglect, but they may lack the knowledge to be aware of the potential extent of its impact. Secondly, resource constraints influence professional behaviour and what practitioners perceive can be achieved when they have concerns about neglect (Brandon 2014)[24].

In terms of access to relevant knowledge, continuing professional development for all practitioners with safeguarding responsibilities may be a significant issue. Training for social workers and arguably other frontline practitioners, to ensure they are up to date with the major features that may be observed or assessed in a child experiencing neglect, is an important step towards ensuring appropriate and timely interventions[25].

The knowledge base is constantly changing in this area, and not all professionals may be sufficiently up to date with new research or best practice. One of the key underpinning principles of this strategy is to make the case for a well trained workforce able to identify and intervene in cases of neglect.

In addition supervision has a crucial role to play in ensuring that practitioners are supported not only to use their knowledge but also to withstand the emotional demands of the role.

The current economic climate of austerity is undoubtedly challenging for both families and professionals. Safeguarding services are under significant pressure and this is being felt by practitioners on the front line across the UK (Burgess et al, 2014; Harker et al., 2013).

Expenditure across the UK has not been able to keep pace with the increased demand for services to protect children; public expenditure peaked in 2009/10 and has been falling since this date (Jutte et al., 2014).

Data from the Institute for Fiscal Studies on the central funding allocation to local government in England show a 26.6% reduction in local authority budgets in the five years since 2010 (Ofsted 2014).

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24   M. Brandon (2014), Missed opportunities: indicators of neglect – what is ignored, why, and what can be done? Research report, DFE Accessed on 2 October 2015 via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/379747/RR404_-_Indicators_of_neglect_missed_opportunities.pdf
25   Ibid 13

4. Picture of neglect

4.1 What the national research tells us

A series of large scale research studies with adults have been undertaken to determine the prevalence of neglect in children in the UK and elsewhere. In 2005 May-Chahal and Cawson[26] found that children were most at risk in the home for physical and emotional abuse and neglect. They were at greater risk of sexual abuse outside the home, particularly in dating relationships.

In 2013 Radford et al[27] looked at a wide range of childhood victimisation experiences and measures of impact on mental health. The report identifies that 2.5% of children aged under 11 years and 6% of children aged 11–17 years had one or more experiences of physical, sexual, or emotional abuse or neglect by a parent or caregiver in the past year. This compares with 8.9% of children under 11 years, 21.9% aged 11–17 years, and 24.5% of young adults who had experienced this at least once during childhood.

Child neglect is the most prevalent form of child maltreatment in the UK, with an estimated one in 10 young adults having been severely neglected by parents or guardians during childhood (Radford et al, 2011). As at 31 March 2015 49,690 children were the subject of a child protection plan in England, compared with 39,100 six years ago (DfE child in need census, 2015). Most children's primary need identified through a social care assessment is due to abuse or neglect and the proportion is up on last year from 47.2% to 49.4% (Statistical First Release by DfE called Characteristics of children in need: 2014 to 2015, published 22 October 2015).

4.2 The four types of neglect and how they manifest

There is a gap between the substantiated cases of maltreatment that come to the attention of child protection agencies and the larger numbers of cases that are not detected, reported or recorded (NSPCC, 2014).

In order to detect and tackle neglect in Hampshire and on the Isle of Wight the LSCBs used the research of Howe (2005) which highlights four forms of neglect as the basis for their approach. Each form is associated with different effects on both parents and children, and implications for the type of intervention offered.

Emotional neglect	Depressed or passive neglect
Disorganised neglect	Severe deprivation neglect

Emotional neglect ranges from ignoring the child to complete rejection. Children suffer persistent emotional ill treatment, they feel worthless and inadequate. Their parent keeps them silent, scapegoats them and show them no affection or emotion.

Disorganised neglect ranges from inconsistent parenting to chaotic parenting. Practitioners will see their classic 'problem families'. The parents feelings dominate, children are demanding/action seeking and there is constant change and on-going disruption.

26   May-Chahal, C. and Cawson, P. (2005). Measuring child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect, Child Abuse & Neglect, 9 (29): 969 – 984

27   Radforda, L., Corralb, S., Bradleyc, C. and Fisherd, H., L. (2013). The prevalence and impact of child maltreatment and other types of victimization in the UK: Findings from a population survey of caregivers, children and young people and young adults, Child Abuse & Neglect, 37 (10): 801– 813

Depressed or passive neglect ranges from a parent being withdrawn or detached to suffering from severe mental illness. There will always be a greater focus on themselves than the children and they will be uninterested in and unresponsive to professionals. The parent does not understand the child's needs and believes nothing will change. They will fail to meet their child's emotional or physical needs and will appear passive and helpless.

Severe deprivation neglect ranges from a child being left to cry to a child being left to die. Both the home and the child will be dirty and smelly. Children will be deprived of love, stimulation and emotional warmth. The parent will completely ignore them. Often children become feral and roam the streets.

In developing this strategy the LSCBs consulted with practitioners about using these four forms of neglect. 87% of practitioners who responded agreed that these four types of neglect are a good basis for use in assessments. The general consensus was that it is useful to be able to recognise different causes of neglect and that there may be many different reasons for neglect occurring.

Similarly, the majority (87%) agreed that the different types of neglect form a sound basis for use in interventions and case management. They are seen as helpful to promote ideas around hypothesis and possible interventions. The approach allows evidence based practice and provide reminders about the signs of neglect and improve understanding about why children's basic developmental needs aren't being met.

Rather than re-developing the children and family assessment or creating a stand-alone assessment tool for neglect, practitioners responded that a toolkit or checklist for working with neglect cases would be the most effective way of implementing a new approach across all agencies. This would be particularly helpful for universal services to allow earlier intervention and prevent escalation to children's social care.

The development of the neglect indicators and guide to recognising neglect in children (see Appendix 1) are likely to increase the numbers of children formally identified across the LSCB threshold chart even further. Given the likely prevalence of as yet unidentified children who might be recognised as suffering from one of the four types of neglect, effective interventions will be developed and deployed that include addressing the underlying causes of neglect through prevention and early help.

The summary below from a recent serious case review on the Isle of Wight (Child D, August 2015) highlights how the longer term consequences for the children in the family as well as the immediate risks associated with neglect were not sufficiently recognised by all agencies involved:

"...There was no shortage of well-intentioned plans. There was though, perhaps through excessive familiarity, optimism and normalising of the abnormal, a failure to evaluate in terms of probable long-term damage:

- *The impact on all family members of being able to use only a proportion of what is anyway a modest-sized house.*
- *The impact of mother's chronic ill-health (depression and anxiety rendered more complex by her autistic spectrum disorder) on both children, perhaps more obviously the older son.*
- *The inability of mother to ensure that her very intelligent elder son received the life-long benefit of education and with it the social opportunities and opportunity to observe and interact with others.*
- *The risk (with life-long consequences) of the older son absorbing his mother's anxieties and obsessions prompting school refusal and a premature sense of responsibility for his parent.*
- *The idiosyncratic diet and sleep patterns to which records allude..."*

Key Indicators - Emotional Neglect

	Universal/early intervention	Early help	Targeted early help	Children's social care
Characteristics of carers	• Cannot cope with children's demands • Parents may feel awkward/tense when alone with their children • Inconsistent responses to child	• Failure to connect emotionally with child • Lots of rules • Lack of attachment to child • Unrealistic expectations in line with child's development	• Dismissive/punitive response to child's needs • Poor attachment to child	• Parental responses lack empathy • Not emotionally available to child • No attachment to child
Characteristics of children	• Over friendly with strangers • Over reliance on social media to interact • No risk CSE	• Frightened/ unhappy/anxious/ low self-esteem • Know their role in family • Attention seeking • Mild risk CSE	• Withdrawn/isolated • Fear intimacy and dependency • Self-reliant • Difficulties in regulating emotions • Very poor self esteem • Moderate risk CSE	• Precocious • Unresponsive/no crying • Oversexualised behaviour • Self-harm • Significant risk CSE
What professionals notice	• Ignore advice • Children spend a lot of time on-line • Lack of engagement with universal services • Materially advantaged • Child not included • Child always immaculately clean • Child and family isolated in community • Pattern of re-referrals to HantsDirect • Poor dental hygiene	• Avoid contact • Missed appointments • Child learns to block expressions • Child 'shut down' • Risky behaviour on-line • Material advantages can mask the lack of emotional warmth and connection • Pattern of re-referrals to HantsDirect	• Deride professionals • Children unavailable • Children appear overly resilient • Poor social relationships due to isolation • Scapegoated child • Regression in child's behaviour • Pattern of step ups to social care • Severe dental disease	• May seek help with a child who needs to be 'cured' • Fabricated illness • Parents seeking a diagnosis/label for child • Pattern of step downs to early help

	Universal/early intervention	Early help	Targeted early help	Children's social care
Characteristics of carers	• Demanding and dependant • Cope with babies (babies need them) but then struggle • Flustered presentation • Late • Low mood • Unstructured • Problem driven • Revert back to own needs • Everything 'big drama'	• Feelings of being undervalued or emotionally deprived as a child-so need to be centre of attention/affection • Lack of 'attunement' • Crisis response • Avoidance of contact • Poor attachment • Poor parenting • Not engaging with health	• Disguised compliance • Putting own needs before child • Drug/alcohol misuse • Depression • Not getting children to school • Escalation of mental health	• High criticism/low warmth • Continuous use of medical issues to cover up/disguise • Chaotic family • Escalation of depression
Characteristics of children	• Anxious and demanding • Infants-fractious/clinging-difficult to soothe • Lateness at school/nursery • Overactive at school • No school equipment • Not able to sit still • Snatching • Struggle with quiet time • Vulnerable to unhealthy relationships • No boundaries or routines • Not at risk CSE	• Young children-attention seeking, exaggerated affect, poor confidence and concentration, jealous, show off, go too far • Fear intimacy • Missing school/nursery • Disruptive at school • Fretful • Crying • Angry • Afraid • Mild risk CSE	• Roaming late at night • Trouble during unsupervised times • Engaging in risky behaviours • Bullying • Aggressive • Jealous • Depressed • Poor school attendance • Speech and language delays • Moderate risk CSE	• Self-harm • Causing harm to others • Substance/alcohol use • Offending • Left at home alone • Anti-social behaviour • Able to do what they want • Feral • Ignored • Danger to self/others • Head lice infestation • Significant risk CSE
What professionals notice	• Classic 'problem families' • Numerous pregnancies • Missed appointments • Messy house • Erratic changes in mood • Unable to acknowledge problems • Not reporting absences • Disruptive behaviour • Poor hygiene • Poor dental hygiene	• Annoy and frustrate but also endear and amuse • Chaos and disruption • Avoidance of home visits • Lots of contact • Regular lateness and absences • Family identify own need • No improvement • Persistent lateness • Children visibly tired	• Thick case files • Feelings drive behaviour/social interaction • Dependency on services to provide support • Lack understanding/acceptance of issues • Exclusion from school • Severe dental disease	• Anti-social behaviour • Parents create new crises • Difficult to work with • Frequent exclusions • Non-engagement with education

	Universal/early intervention	Early help	Targeted early help	Children's social care
Characteristics of carers	• Contact with GP for depression • History of chronic mental health • Long term unemployed • Low cognitive functioning • Poor physical presentation • Socially isolated	• Contact with specialist agency for depression, mental health – in treatment • Postnatal depression • Poor attachment with children	• Carers with serious issues of depression, learning disabilities, substance misuse • Homeless • Not in treatment	• Institutional neglect • Suicidal thoughts
Characteristics of children	• Arrive late at school • Poor presentation • Hungry • Tired • Miss initial health checks • Lack confidence • Poor attachment with parents • Anxiety and low self esteem • Minor accidents at home • Poor dental hygiene • Poor school attendance • Not at risk CSE	• Inhibited, withdrawn, passive, rarely smile, autistic type behaviour and self-soothing • Relationships shallow, lack reciprocity • Disinhibited: attention-seeking, clingy, very friendly • Not accessing early years • High absence from school • Mild risk CSE	• Infants- poor pre attachment behaviours of smiling, crying, eye contact • Children-impulsive, hyperactive, attention deficit, cognitive impairment and developmental delay, eating problems, poor relationships • School exclusion • Moderate risk CSE	• Self-harm • Mental ill health • Sexualised behaviour • Failure to thrive • Recurrent illnesses • Going missing • Out of education • Significant risk CSE
What professionals notice	• Clutter • Disorganised home • Hoarding • Not enough furniture • Lots of animals • Not attending appointments • Poor dental hygiene	• Dirty home and children • Poor physical and mental health • Poor hygiene • Regularly attending A&E	• Material and emotional poverty • Head lice • Homes and children dirty • and smelly	• Urine soaked mattresses, dog faeces, filthy plates, rags at the window • Children left in cot or serial care giving • Child essentially alone-severe neglect, absence of selective attachment. • Unable to get into house • Severe dental disease

	Universal/early intervention	Early help	Targeted early help	Children's social care
Characteristics of carers	• Often severely abused/neglected by own parents • Given up thinking and feeling • Withdrawn • Lack of meaningful engagement • Forgetting appointments • Can't impose boundaries • Focused on own needs • Not seen in school • Blame others for children's behaviour	• May seem unmotivated/mild learning disability • Learned helplessness • No structure/poor supervision • Stubborn negativism-passive aggressive • Missing appointments • Disorganised • Seeking services to solve problems (but not changing) • Emerging criticisms • One or two elements of toxic trio emerging • Change schools	• No smacks/ no shouting/no deliberate harm BUT no hugs, warmth emotional involvement either. • Unresponsive to children's needs- limited interaction • Avoiding appointments • Struggling to engage • Blaming services for lack of progress • Refuse to engage with early help	• Obstructing appointments • Blaming others • Combination of toxic trio reaching crisis • No ability to change • No boundaries
Characteristics of children	• Lack of interaction with carers • Presents as hungry • Lack of progression • Tired, withdrawn, isolated • Poor diet • Lateness at school • Dirty clothes • Developmental milestones not met • Attendance at A&E • Not at risk of CSE	• Infant-not curious, unresponsive, moans and whimpers but does not cry or laugh • Tend not to say much • Unwashed, ill-fitting clothes • Missing school • Repeated attendance at A&E • Unmet health needs • Obese • Mild risk CSE	• At school - isolated, aimless, lacking in concentration, drive, confidence and self esteem • Anxious • Goes missing • Poor school attendance • Self-harm • Self-isolating • Unresponsive • Moderate risk CSE	• Developmental delay • Absent from school • Regularly goes missing • Not accessing health services • Inappropriate behaviour for age • Morbidly obese • Significant risk CSE
What professionals notice	• Shut down and block out all information. • Absence from school/nursery • Children appear hungry • Inconsistent engagement • Turn up late at school • Poor dental hygiene	• Parents do not believe they can change so do not even try • A sense of hopelessness and despair-which can be reflected in the workers too • Poor dental hygiene • Stealing food	• Material and emotional poverty • Homes and children dirty and smelly • Chaotic, dirty households • Children not saying anything or making excuses for their parents • Children attending appointments on their own • Repeated concerns reported by neighbours • Severe dental disease	• Urine soaked mattresses, dog faeces, filthy plates, rags at the window • Children parenting their parents • Offending behaviour • Difficult to work with • Not in for visits

6. Governance and accountability

Governance will be provided to the LSCBs by the performance and quality assurance subgroup. This subgroup will monitor progress against the strategic objectives on a quarterly basis and challenge multi agency partners where appropriate.

The following outcome indicators are examples of how the effectiveness of the strategy and its implementation will be measured. These will be further developed over the first year of the strategy.

- Reduction in the incidents of neglect while acknowledging that figures may initially rise (due to better recognition and awareness) particularly at early help levels where neglect is a feature.
- Reduction over time in the number of children subject to a child protection plan due to neglect/incidents of neglect in comparison to our statistical neighbours.
- Reduction in the number of repeat referrals to children's services post child and family assessment where neglect is a feature.
- Improvement in school attendance.
- Percentage of early help assessments where neglect has been identified as a factor.
- Percentage of referrals to children's services for reasons of neglect.
- Percentage of children subject of a child protection plan for reasons of neglect.
- Number of children not brought (<16 years) or not attending (16-17 years) medical, including dental, appointments.
- Average length of child protection plan for neglect at point of closure (in months).
- Number of crimes recorded for neglect.

Note

It has to be acknowledged that the impact of effective recognition and intervention in respect of neglect is long term, sometimes spanning generations rather than short term or immediate.

Review

This strategy will be reviewed on a two-yearly basis by the LSCBs. Delivery plans and performance frameworks will be reviewed annually and monitored through the performance and quality assurance subgroups.

7. Useful Resources

Action for Children

Review of Child Neglect in Scotland (2012)
*www.actionforchildren.org.uk/media/4042383/
action_for_children_review_of_child_neglect_final_report.pdf*

Evaluation of the Action for Children UK Neglect Project (January 2012)
*www.actionforchildren.org.uk/media/3970224/
university_of_salford_evaluation_of_the_action_for_children_uk_neglect_project_final_report_2012.pdf*

Child Neglect review 2011
www.actionforchildren.org.uk/policy-research/research/child-neglect-review-2011

Effective relationships with vulnerable parents to improve outcomes for children and young people: final study report (2011)
www.actionforchildren.org.uk/policy-research/research/effective-relationships-with-vulnerableparents-to-improve-outcomes-for-children-and-young-people-report

Seen and Now Heard – Child Neglect Report (2010)
www.actionforchildren.org.uk/media/52188/seen_and_now_heard_child_neglect_report.pdf

Child neglect frontline report (2010)
www.actionforchildren.org.uk/media/145063/child_neglect.pdf

Deprivation and risk: the case for early intervention (2010)
www.actionforchildren.org.uk/media/139941/deprivation_and_risk_the_case_for_early_intervention.pdf

Evaluation of the Action for Children UK Neglect Project (July 2009)
*www.actionforchildren.org.uk/media/143099/
evaluation_of_the_action_for_children_neglect_project_year_2_interim_report.pdf*

Neglect: research evidence to inform practice (2009)
www.actionforchildren.org.uk/media/143188/neglectc_research_evidence_to_inform_practice.pdf

NSPCC

Spotlight on preventing child neglect' (October 2015)
www.nspcc.org.uk/globalassets/documents/research-reports/spotlight-preventing-child-neglect-report.pdf

Optical Confederation, Guidance on Safeguarding Children and Vulnerable Adults (January 2012)
*www.opticalconfederation.org.uk/downloads/guidance/Optical%20Confederation%20-%20Guidance%20
on%20Safeguarding%20Children%20and%20Vulnerable%20Adults.pdf*

Royal Pharmaceutical Society, Protecting Children and Young People (September 2011)
www.safechildren-cios.co.uk/media/11150192/RPS-protecting-children-and-young-people.pdf

Child Protection and the Dental Team, Department of Health (November 2009)
www.cpdt.org.uk/data/files/Resources/Childprotectionandthedentalteam_v1_4_Nov09.pdf

8. Appendix 1:
A guide to recognising neglect in children

Development and Education

	Universal Level 1	Early Help Level 2	Targeted Early Help Level 3	Children's Social Care Level 4
Pre-school specific check-list (aged 0-5 years)	Child well stimulated, carer aware of importance of this	Carer is aware of importance of stimulating child however sometimes inconsistent interaction due to personal circumstances	Carer provides inconsistent or limited stimulation, child is sometimes left alone unless making noisy demands	• Carer provides limited or no stimulation • Carer gets angry at demands made by child • Carer is hostile to professional advice • Child is restrained for the carer's convenience, such as in a pram
School aged child specific check-list (aged 5-16 years)	• Child receives good level stimulation- carer talks to child in interactive way, reads stories, plays with child • Child has age-appropriate toys	• Carer provides appropriate level of stimulation • Child has toys/games to support their development	• Carer provides inconsistent stimulation, does not • appear to understand the importance for the child. • Child lacks age appropriate toys/ games (not due • to finances)	• Little or no stimulation provided. • Carer provides few toys/games - usually from • other sources - not well kept.
	Carer takes child out to local parks/activities regularly	Carer takes child out to parks/activities - although sometimes struggles	• Child has limited opportunities for activities/outings	• Few if any activities/ outings for the child • Child prevented from going on outings/trips (e.g. • with schools or friends).
	• Carer takes active interest in child's schooling, attendance good, encourages child to see education as important. • Interested in school and homework.	• Carer understands importance of school • Provides appropriate level of support - although sometimes personal circumstances lead to inconsistency • Attendance generally good - can sometimes sanction days off where not necessary	• Carer makes limited effort to maintain schooling, • lacks consistent engagement. • Carer does not actively support homework/ • attendance	• Carer makes little or no effort to support • education/schooling. • Lack of engagement, no support for homework. • Does not regard attendance as a concern. • Does not encourage child to see any area of • education as positive.
Friendships	Carer supports friendship and understands importance to child	Carer supports friendship, but does not always promote	Child mainly finds own friendships, carer does not understand importance of friendships	Carer hostile to friendships and shows no interest/support
Bullying	Carer alert to child being bullied/bullying behaviour and addresses issues	Carer aware of bullying and intervenes when child asks	Carer has limited understanding of child being bullied/ bullying behaviour and does not intervene or appropriately support child	Carer indifferent to child bullying or being bullied

Healthcare

	Universal Level 1	Early Help Level 2	Targeted Early Help Level 3	Children's Social Care Level 4
Safe infant care and health care for unborn baby	• Carers make infant focused care decisions. • Carers follow safe sleep guidance for infants and recognise impact of alcohol or drugs on safe sleeping. • Avoids smoking in the household.	• Carer less infant focused, aware of safe sleep advice but follows advice chaotically. • Aware of impact of alcohol, drugs and smoking on safe sleeping but follows inconsistently.	• Infants needs secondary to carers needs. Carers unaware of safe sleep guidance even when provided. • Ignores or is resistant to advice on sleep position. • Carer does not recognise impact of alcohol, drugs and smoking on safe sleeping of infant.	• Infants needs not considered. • Carer indifferent or hostile to safe sleep advice, views advice as interference. • Carer hostile to advice about impact of drugs, alcohol and smoking on safe sleeping.
Advice and intervention	Advice sought from health professionals and/or experienced friends and family.	Advice is sought, but inconsistently followed because of carers own needs.	Carer does not routinely seek health advice, but will when there are serious health concerns for the child or when prompted by others.	• Carer only seeks health advice in an emergency. • Allows child's health to deteriorate before seeking help. • Hostile to advice to seek medical help.
	Health appointments attended, preventative health care accessed (immunisations, dental care).	Understands the need for preventative health care but is inconsistent in taking child to dental and immunisation appointments.	Does not routinely attend preventative care appointments but does allow access to home visits.	Preventative health appointments not attended, even if home appointment arranged.
	Prescribed medication or agreed treatment plan for illness completed.	• Carer recognises the importance of the child of completing prescribed medication or agreed treatment plans, but is inconsistently completed. • Carer's needs and/or circumstances can get in the way.	Carer does not ensure completion of prescribed medication or agreed treatment plan, and is indifferent to or denies the impact on the child's health.	• Carer does not ensure completion of prescribed medication or treatment plan and is hostile to advice on this. • Carer does not recognise the impact on the child.
Disability, chronic health conditions and illness	Carer is positive about child with disability or health condition.	Child and issues of disability and health need impact on the carers feelings for the child.	Carer shows anger or frustration at child's disability or health condition.	Carer does not recognise the identity of a child with a disability or chronic health condition, and as a result is negative about child.
	Carer consistently meets the child's increased health needs.	Carers personal needs/circumstances impact on meeting the child's health needs arising from their disability or health condition.	Carer does not ensure compliance with health needs relating to the disability or health condition and minimises the needs.	• Carer does not ensure health needs relating to disability or health condition are met and leads to a deterioration in the child's condition. • Parents' own issues impact on their ability to respond to urgent health needs of a disabled child, or child with a chronic health condition.
	Carer is active in seeking advice, accessing appointments and advocating for the child's wellbeing.	Carer is not pro-active in seeking advice and support on child's health needs but accepts it when offered.	Carer does not accept advice and support on the child's health needs and is indifferent to the impact on the child's disability or health condition.	Carer is hostile when asked to seek help for the child and is hostile to any advice or support around the child's disability or health condition.

Appearance

	Universal Level 1	Early Help Level 2	Targeted Early Help Level 3	Children's Social Care Level 4
Clothing	• Child has clean clothes that fit. • Dressed for weather and carers aware of the need for age appropriate clothes	• Clothes sometimes unclean, crumpled, poorly fitted. • Carer considers clothing to meet needs of child but personal circumstances can get in the way.	• Clothes dirty, poor state of repair and not fitted. • Not appropriate for weather, and insufficient items to allow for washing. • Carer indifferent to importance of clothing.	• Clothes filthy, ill-fitting and smell. Unsuitable for weather. • Child may sleep in day clothes, not replaced with clean clothes even when soiled. • Carer hostile to advice about need for appropriate clothing for child.
Hygiene	Child is cleaned, washed daily and encouraged to do so age appropriately.	Child reasonably clean, but carer does not regularly wash or encourage the child to wash.	Child unclean, only occasionally bathed or encouraged to.	• Child looks dirty, and is not bathed. • Teeth not brushed and lice and skin conditions become chronic.
	Child encouraged to brush teeth. Lice and skin conditions treated. Nappy rash treated. Carer takes an interest in child's appearance	• Teeth inconsistently cleaned and lice and skin conditions inconsistently treated. • Nappy rash a problem, but carer treats following advice.	• Teeth not brushed, lice and skin ailments not treated. • Carer indifferent to nappy rash despite advice. • Carer does not take interest in child's appearance and does not acknowledge importance of hygiene.	• Carer hostile to nappy rash advice and does not treat. • Carer hostile to concerns raised about child's lack of hygiene.

Feeding and Eating

	Universal Level 1	Early Help Level 2	Targeted Early Help Level 3	Children's Social Care Level 4
Food	• Appropriate quality food and drink for age/development of child. • Meal routines include family eating together. • Special dietary requirements always met and carer understands the importance of food.	• Reasonable quality of food and drink in adequate quantity, lack of consistency in preparation and routines. • Special dietary requirements inconsistently met. • Carer understands importance of food but sometimes circumstances impacts on ability to provide.	• Low quality food, often inappropriate for age/development, lack of preparation and routine. • Child hungry. • Special dietary requirements rarely met. • Carer indifferent to importance of food for the child.	• Child receives inadequate quantity of food and observed to be hungry. • Low quality of food, predominance of sweets or 'junk' food. • Special dietary requirements never met. • Carer hostile to advice about food

Attachment and Emotional Care

	Universal Level 1	Early Help Level 2	Targeted Early Help Level 3	Children's Social Care Level 4
Parental motivation for change	Carer is determined to act in child's best interests	Carer seems concerned with child's welfare and wants to meet their needs but has problems with their own pressing needs.	Carer is not concerned enough about child to address competing needs and this leads to some of child's needs not being met	Carer rejects the parenting role and takes a hostile attitude to child care responsibilities
	Carer is concerned about child's welfare and wants to meet the child's physical, social and emotional needs to the extent they understand them	• Professed concerns are often not translated into actions, and carer regrets their own difficulties are dominating. • Would like to change but finds it hard.	Carer does not have the right priorities and may take an indifferent attitude	Carer does not see that they have a responsibility to the child and believe the child is totally responsible for themselves, or the child deserves hostile parenting
	Carer is realistic and confident about the problems to overcome and is willing to make sacrifices for the child.	Disorganised, pays insufficient time to children or misreads signals.	Lack of interest in the child's welfare and development	May seek to give up responsibility for the child

Environmental Factors

	Universal Level 1	Early Help Level 2	Targeted Early Help Level 3	Children's Social Care Level 4
Housing	• Accommodation has all essentials for cooking, heating, bathroom and all in reasonable repair. • Stable home without unnecessary moves. • Carer understands the importance of stability and home conditions for the child. • Animals are appropriately cared for and do not present a risk to the child.	• Accommodation has some essentials but requires repair/ decoration. Reasonably clean, may be damp. • Carer taking steps to address this. • Reasonably stable, but child has experience some moves/new adults in home. • Carer recognises importance of stability and home conditions but personal circumstances hamper this. • Concern about welfare of animals in the home	• Accommodation in disrepair, carers unmotivated to address resulting in accidents and potentially poor health for child. • Home looks bare, possibly smelly, lack of clean washing facilities whole environment chaotic. • Child has experienced lots of moves and lots of adults coming in and out of home for periods. • Carer does not accept importance of home conditions and stability for child. • Issues of hygiene an safety due to animals in the home	• Accommodation in dangerous disrepair and has caused number of accidents and poor health for child. • Home squalid, lacks essentials of working toilet, bath facilities, bedding, food preparation facilities. • Smells. • Faeces or harmful substances visible. • Child has experienced numerous moves often at short notice, overcrowding. • Animals pose a risk to children in the home.

Emotion and Behaviour

	Universal Level 1	Early Help Level 2	Targeted Early Help Level 3	Children's Social Care Level 4
Warmth and Care	• Carer provides emotional warmth, responds appropriately to physical needs. • Carer understands importance of consistent demonstration of love and care.	• Carer mostly provides emotional warmth, talks kindly about child and is positive about their achievements. • Sometimes carers own circumstances get in the way of demonstrating love and care.	• Carer inconsistent in providing emotional warmth, does not praise or reward. • Carer can sometimes respond aggressively if child distressed or hurt. • Carers can be indifferent to advice about importance of love and care to their child.	• Carer does not show emotional warmth to child, emotional response tends to be harsh/critical. • Hostility to advice and support. • Carers do not provide any reward or praise and can ridicule child if others praise.
Young caring	Child contributes appropriately to household tasks.	Child has some additional responsibilities within the home but these are age and stage appropriate, carer recognises that child should not be engaged in inappropriate caring/responsibilities however sometimes personal circumstances get in the way.	Child has some caring responsibilities that are having an impact on education and leisure activities.	• Child has caring responsibilities which are inappropriate and impact on their educational and leisure opportunities. • Impact is not well understood by carer. • Carer hostile to advice and support.
Boundaries	Carer provides consistent boundaries, provides appropriate discipline.	Carer recognises importance of boundaries and appropriate discipline but sometimes struggles to implement.	Carer provides inconsistent boundaries, sometimes uses inappropriate sanctions, can hold child entirely responsible for their behaviour.	• Carer provides few or no boundaries, treats child harshly when responding to their behaviour. • Physical chastisement used and other harsh methods of discipline. • Carer hostile to advice about appropriate boundaries/methods of discipline.
Adult arguments	Carers do not argue aggressively in front of the children - sensitive to impact on children.	• Carers sometimes argue in front of the children, no domestic abuse between parents. • Carers recognise impact of their behaviour on child.	• Carers frequently argue aggressively in front of the children, sometimes this leads to domestic abuse. • Lack of understanding of impact on child.	• Carers frequently argue in front of children and there is domestic abuse. • Indifference to the impact on child, inability to put their needs first.
Values	Carers encourages child to have positive values and understands importance of child's development.	Carer sometimes encourages child to have positive values.	Carer inconsistent in providing child to have positive values.	• Carer actively encourages negative attitudes in child, at times condones anti-social behaviour.
	Carers provides advice and support.	Awareness of importance of child development but not always able to support and advise child.	Provides little advice or guidance and does not monitor child's use of inappropriate materials/playing inappropriate games.	• Indifferent to smoking/under-age drinking, no advice provided. • Allows child to watch/play inappropriate material/games.
	Carer does not talk about feelings of depression/low mood in front of the children - aware of impact on child.	Carer does discuss some feelings of low mood in front of child - aware of the impact on the child.	Carer talks about depression in front of the child, limited insight into impact on child.	• Carer frequently talks about depression/suicide in front of the child - may have attempted suicide in front of child. Carer can hold child responsible for feelings/depression. • Carer will not engage in support and can be hostile to advice.
	• Carer does not misuse alcohol or drugs. • Carer able to respond if emergency situation occurs.	• Minimal use of substances - not in front of child. Understanding of impact of substance misuse on child. • Arranges additional support when unable to provide fully for child.	• Misuse of drugs and alcohol sometimes in front of child. Lack of awareness of impact of substance use on child. • Use leads to inconsistent parenting. • Finances are affected.	• Significant misuse of substances. Carer significantly minimises use and is hostile to advice, support - refuses to engage. • Carer cannot respond to child's needs. Absence of supportive network. • Child exposed to abusive/frightening behaviour of carer or other adults.

Safety and Supervision

	Universal Level 1	Early Help Level 2	Targeted Early Help Level 3	Children's Social Care Level 4
Safety awareness	• Carer aware of safety issues uses safety equipment. • Child taught traffic skills.	• Carer aware of safety issues but inconsistent in use and maintenance of safety equipment. • Child given some guidance about traffic skills.	• Carer does not recognise dangers to child, lack of safety equipment-carer indifferent to advice. • Child given insufficient guidance about traffic skills.	• Carer does not recognise dangers to child's safety, can be hostile to advice • Lack of supervision around traffic and an unconcerned attitude.
Supervision	Appropriate supervision provided in line with age/level of development.	• Variable supervision provided, but carer does intervene where there is imminent danger. • Carer does not always know were child is.	Little supervision, carer does not always respond after accidents, lack of concern about where child is, inconsistency in concern about lack of return home/late nights.	• Lack of supervision, child contained in car seats/ pushchairs for long periods of time. • Carers indifferent to whereabouts of child, no boundaries, carer hostile to advice, lacks recognition of impact on child's well being.
Handling of baby	Carer responds appropriately to needs of baby.	Carer not always consistent in responses to baby's needs-can be precarious in handling and inconsistent in supervision.	• Carer does not recognise importance of responding consistently to baby's needs. • Handling precarious and baby left unattended at times. • Carers does not spend time with baby - cooing/smiling - lacks recognition of importance of comforting baby when distressed.	• Carer does not respond to the needs of the baby, dangerous handling / baby left unattended. • Baby lacks adult attention and contact. • Carers hostile to advice and lacks insight to impact of their behaviours on the child.
Care by other adults	• Child is left in care of trusted/vetted adult. • Carer/child always know each other's whereabouts.	• Child (0-9yrs) sometimes left with a child (10-13yrs) or a person who may be unsuitable. • Carer/child sometimes unaware of each other's whereabouts. • Carer aware of importance of safe care but sometimes inconsistent due to own circumstances.	• Child (0-7yrs) left with child (8-10yrs) or an unsuitable person. • Carer/child often unaware of each other's whereabouts. • Child sometimes found wandering/locked out • Carer does not raise importance of child keeping themselves safe, no advice/support.	• Child (0-7yrs) left alone, in company of young child or unsuitable person. • Child often found wandering/ locked out. • Carer hostile/unable to talk on board advice and guidance about giving safe care. • Child exposed to multiple carers.
Responding to Adolescents	• The child's needs are fully considered with appropriate adult care. • Parent responds appropriately to risky behaviour.	Carer aware of child's needs but inconsistent in providing for them, responds inconsistently to risky behaviour.	Carer does not consistently respond to child's needs, recognises risky behaviour but does not always respond appropriately.	• Career indifferent to whereabouts of child and child's whereabouts often unknown. Child frequently going missing. No appropriate supervision of child's access to social media. • No guidance or boundaries about safe relationships including appropriate friendships and sexual relationships. Relationships are not age appropriate. • Child's needs are not met, lack of recognition by carer that child requires guidance and protection, does not recognise or address risky behaviour.

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