East Sussex
County Council

Neglect toolkit
for practitioners

"Neglect can be life threatening and needs to be treated with as much urgency as other categories of maltreatment.

Neglect with the most serious of outcomes is not confined to the youngest children, and occurs across all ages."

Brandon 2012

Contents

1. How to use your toolkit

This toolkit should be read in conjunction with the ESCC Neglect Strategy 2017.

It is expected that the tools within this resource will support you in your assessment with an expectation that your focus will be on:

- A Day In the Life of a Child
- Chronology
- Observation of parent child interaction
- Assessment checklist.

If there are concerns about the child's emotional/ behavioural presentation then it is expected the following questionnaire will be used:

- Strengths and Difficulties Questionnaire

Then at the first review meeting agreement should be sought as to when the tools should be used again to measure progress (additional tools may be used as agreed with your manager e.g.... GAD7 and PHQ9 depending upon parental presentation). Note that these tools only form part of the assessment which is also based on observation, application of theory and research set within your own experience of safeguarding.

The assessment model we use in ESCC is the Assessment Framework and therefore the information you gather will be organised into:

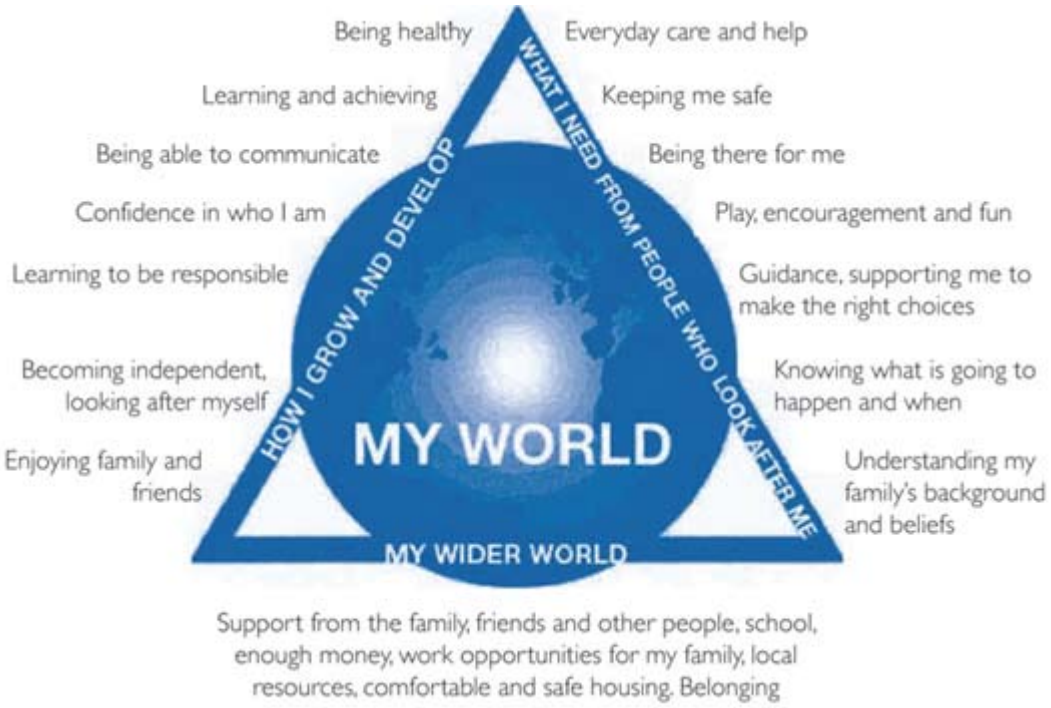
- Child development
- Parenting capacity
- Family and environmental factors.

The analysis of the information you gather will be underpinned with knowledge in the following areas:

- Child development
- Attachment and trauma
- Motivational Interviewing.

It is expected that the toolkit is used in every neglect case; in particular it should be used in the following situations:

- Re-referrals accepted into Social Care
- Third Review Child Protection Case Conference
- Second or more subject to Child Protection Case Conference
- Care Planning Agreement to Meeting Before Action.



The family doesn't understand / the family is hard to engage

The family don't accept concerns

2. Common issues

When working with neglect practitioners should be mindful of the following issues:

- The importance of observing and listening to children and seeing the world through their eyes
- Ensuring individual children's needs are taken into account and avoiding a collective view of children in the same family
- Being compromised by a fear of imposing professional and class values on others
- Making assumptions about race and culture that could under or overstate the risks
- Viewing neglect as inevitable as the parents are unable to change their lifestyle/behaviour
- Over identification with vulnerable parents, leading to denial of children's needs
- When professionals have fixed views about the family and child, and the 'rule of optimism' develops, it is then difficult for workers to change their views about the family. This may occur in spite of compelling evidence of neglect and significant harm
- Neglect is usually seen as the mother's failure to provide care whereas little is known about male figures and the impact they have upon the children within the family.

First of all develop a hypothesis as to why the family is not able to understand the concerns (e.g. fear of consequences, learning disability, depression). Consider what you can do to address this underlying reason (e.g. provide reassurances through actions and words that you are working to keep the family together, ensuring your communications are clear and to the point with visual aids, ensure the right mental health support is provided).

Be mindful that simply telling the family to change their behaviour will not work. You need to engage with the family by showing respect and empathy before getting them to accept your safeguarding concerns. Try using mentalization- based/ motivational interviewing questions such as:

"Could you tell me what it is like being a mum at the moment?"

"If your child could speak, what do you think she would be saying right now?"

"Is there anything that your child would want to change?"

"What worries do you have about your child's development?"

"What do you think I may be thinking when you say these things?"

(David Shemmings and Yvonne Shemmings 2014)

See what the family response is and use this as a springboard for further conversations. Sometimes families respond to visual representations - consider producing individual cards with concerns - on them and ask the family to prioritise them. Leave them with the family to think about (see exercise on page 48).

If you have been involved with the family for a long time and you feel that when you talk about issues you are no longer making an impact, try and visit with a colleague to produce a new way of talking about the same things.

Be mindful of the level of cognitive ability of the family and adjust your language accordingly (this is particularly relevant with families with significant learning disabilities).

How do I prevent drift?

Are the concerns broken down into specific components which set a baseline to measure progress?

Is this baseline/current concern understood by parents and all other professionals?

Have you been very explicit about what adequate day to day care looks like so that it is understood by the parents (and professionals)? Again this may mean visual representations of basic household management tasks.

Identify how you are going to measure current concern and future progress in your plan (see below tools). Ensure that you build in periods of observation and feedback with the family.

Guidance to writing a child's plan

View guidance to writing a child's plan which can help prevent drift and is the basis to working collaboratively with the family whilst maintaining your professional judgement regarding risk:

http://intranet.escc.gov.uk/sites/cs/single-source/Documents/Outcome%20focused%20plans%20guidance.pdf

Ensure the plan has clarity about what evidence is needed to show that the child's experience at home has improved – not simply a list of appointments the parents have to attend (e.g. in a physical neglect case attending lots of professional appointments does not mean that the child is now sleeping in clean bedding).

Bring your plan and chronology to supervision and group supervision, develop your hypotheses as to why the plan is not working and use this to inform next steps:

- Is the plan incremental, achievable and owned by the family?
- What worked, when and how?
- Can this be replicated and what can be put in place to sustain change?

Do a similar exercise as part of review/core group producing a multi-agency chronology – looking at periods when intervention worked and considering how this could be sustained.

Ensure your plan is built around what success looks like for the parents and the child.

Words and Pictures

This is a technique developed through Signs of Safety. In this approach you work with the family to help them design a story of what has happened and why children services are involved. Parents and the worker will write what happened to potentially share with the child. The headings are who's worried, what are they worried about, what happens because of the worries, and what are we doing about the worries (consistent with ESCC child's plan). This process often identifies what the barrier is to moving the case on – and helps a plan to be written that is more focused and achievable. See example at:

http://intranet.escc.gov.uk/sites/cs/single-source/Documents/Neglect%20Toolkit/safety%20plan%20sos.pdf

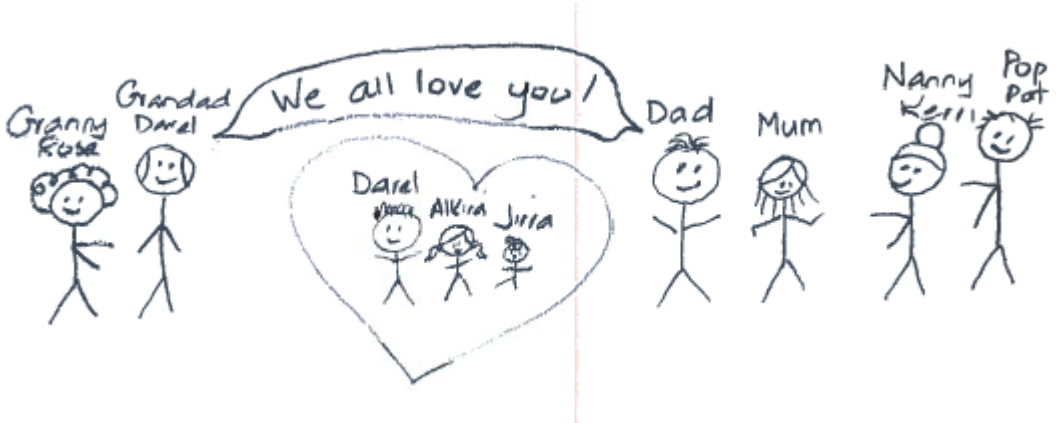
Example of part of the Signs of Safety - Safety Plan

The Words and Pictures Explanation

A story for Darel, Alkira and Jirra about why they are staying with Granny Rose and Granddad Darel.

Who's worried?

Mum, Dad, Granny Rose, Granddad Darel, Nanny Kerri, Pop Pat as well as Sally and Dianne who works at CPS, have been worried about Darel, Alkira and Jirra. There's been a lot going on in the family lately and the grown ups thought the kids might be wondering what was happening. Everyone got together and wrote this story to help the kids know what they are worried about, what has happened and what is going to be happening to make sure the kids are safe and happy. Most of all everyone wants the kids to know how much they all love them.



Have you involved the family/friends network

It's hard to work with issues of neglect within this family because sometimes parenting is safe and sometimes it isn't

There is strong evidence that long term sustained change is often contingent on family support as well as modelling of adequate parenting.

This highlights the need to share and review multi-agency chronologies working with the family to think what was happening when parenting was better and how can professionals and the family network sustain the change. What are the triggers for decline and how can they be addressed?

Is the plan incremental, achievable and owned by the family?

Avoid "start again syndrome" in which each period of decline is looked at in isolation and therefore the risk is downgraded. Accumulative neglect is as damaging as other forms of abuse but is difficult to evidence. This is why it is critically important to maintain a chronology and build a profile of the child by taking account of their history.

Having a good understanding of parental capacity to change is essential. Consideration has to be given to parental internal and external motivators, as well as environmental factors – see the following link for helpful resources in assessing parental capacity to change:

http://intranet.escc.gov.uk/sites/cs/single-source/Documents/ripfrontlineparentcapacityweb.pdf

Bear in mind that there has been a tendency to use a different criteria with regards to neglect for disabled children. The criteria should be the same. Disabled children are 3.4 times more likely to be abused and 3.8 times more likely to be neglected than non-disabled children (Sullivan and Knutson, 2000).

Consider involving individuals who can act as role models to parents, preferably in the home. There may be resources within the extended family.

Ideally you would identify someone who is able to spend significant periods of time in the home assisting and guiding parenting. It might mean helping a young mother or father to safely bath a baby, or helping a family to understand the necessity for good hygiene in the kitchen.

Keep the needs of the children in central focus and strive to understand their world. If you do not have the child's voice you do not know whether or not the child is safe. You need to spend time developing a relationship with the child and the family in order for you to understand what the child is experiencing. See the communication toolkit for exercises and games to play with children and young people:

http://intranet.escc.gov.uk/sites/cs/single-source/Pages/Childrens-Participation-Toolkit.aspx

When you know that parents can care adequately some of the time it becomes harder to remain objective and there could be a tendency to err on the side of optimism. Record carefully when the dips in parenting occur and compile chronologies of accidents and issues around poor supervision and failure to attend to child's needs.

Common forms of neglect for disabled children

Neglect of severely disabled children is frequently through lack of engagement and stimulation e.g. that the disabled child is left in their chair unstimulated or not included in family activities. Lack of engagement can often be observed through poor interaction and rapport between parent and child. There may be no suitable toys and occasionally the parent has not learnt the child's communication system. Another example may be that the parent has not developed toileting for the child at home even when this has been successful at school.

Sometimes parents request increasing amounts of breaks from the child and the quality of care and interaction needs to be ensured so that the child returns to a consistent caregiver who meets their needs, including emotional needs. In some instances the care given to non-disabled children is significantly compromised by the demands of parents caring for a disabled sibling.

Observation and communication are more complex issues in disability and training must be accessed in communication methods for those working in the disability service.

This toolkit is applicable for parents and it is particularly useful for the parents to complete A day in the life of a child and parenting daily hassles.

Teenage neglect

Research shows that neglect at home during teenage years can be as damaging as neglect during early years. The Children's Society conducted research with 1000 adolescents in 2016 which found 8% of teenagers experienced some form of neglect, with lack of supervision being the most common (58%). More young people age 14 and 15 years (3 times as many) than 12 and 13 years reported that their parents hardly ever or never helped them if they had a problem or provided emotional support. This may indicate that as children get older parents think they need less of this kind of support. Research shows a strong correlation between young people's risk taking behaviour and their not being emotionally supported at home. There is also a very strong correlation between young people experiencing very poor health and being exposed to neglectful parenting.

Young people that experience neglect report low levels of general competence, feel that no one cares for them, are negative about their future, have difficulty in engaging in education and are generally unhappy with their lives overall. If the young person experienced different forms of neglect than their emotional wellbeing deteriorated with an increase in externalising behaviours e.g. drinking alcohol and truanting from school and internalising behaviours (depression, anxiety and post- traumatic stress disorder). Maltreatment that begins during adolescence is more damaging than neglect that starts and finishes during childhood as it causes problems during late adolescence and early adulthood including involvement in criminal behaviours, substance misuse, health-risking sexual behaviours and suicidal thoughts (Thornberry et al 2010).

http://www.childrenssociety.org.uk/what-we-do/research/troubled-teens-understanding-adolescent-neglect

Age of Concern Ofsted found that SCR of teenagers showed practice focused on a young person's challenging behaviour rather than the causes of this behaviour and that young people were being treated as adults rather than as children.

3. Assessment

A Day in the Life of a Child

What is the Child's Daily Routine?

Suggested questions for Assessment.

Waking

Do they use a clock to get up? Does someone get them up? Do they have to get anyone else up? Does anyone else get up with them? Does the same thing happen every day?

What time does this happen?

Breakfast

Do they have breakfast? What sort of food do they have? Do they have a choice? Who makes breakfast?

Dressing

Do they dress themselves? Do they help anyone else get dressed? Do they wash and clean their teeth before getting dressed? Who makes sure they are doing this? Is there hot water and clean clothes?

Getting to School

Does someone take them? Do they have to take anyone else? Do they cross busy roads? Who helps them do this? Do they get to school on time?

In School

What do they like about school? What don't they like about school? Who are their friends? What do they do with their friends? What do they like to do at break times? What do they eat at lunchtime? Do they have a favourite teacher or subject? Are they experiencing bullying?

After School

How do they get home from school? Does someone meet them at school? If so, who is this? If not, then is there anyone at home to meet them? What do they do after school? Do they look after anyone else? Do they have anything to eat? What do they have? Who makes it for them? Do they prepare food for anyone else? Do they go out and play? Do they do homework? Are there any issues around doing homework?

Evenings

Do they have an evening meal? What time is this? Who prepares the meal? What is their favourite food? Do they have this often? Do they eat with their parents/carers/other family members? If not, where do they eat? Who do they tell if they are hungry and what happens about this? Do they watch TV? If so, what do they watch? Do they use the internet/social networking sites? Is this supervised? Who do they communicate with online? What do they talk about? Do they go out? If so, who are they with and where do they go? Do they communicate this information to anyone? Do they have to be in at a particular time? Do they like toys and games? Do they have any? What do their parents/carers do in the evenings? Do they spend time with parents/carers in the evening? If so, what do they do?

Bedtime

Do they have a set time to go to bed? Who decides when it is time for bed? Where do they sleep? Do they like where they sleep? Do they wash and brush their teeth at bedtime? Do they change for bed? Who else is in the house at night? Are they put in charge of anyone else at bedtime?

School holidays/weekends

Do they look after anyone? Do they have chores/jobs to do? If so, what are they and who are they for? How else do they spend their time? Do they see friends? Who looks after them when they are not in school? Who supervises mealtimes?

An Assessment Checklist

At each section consider whether there is anything that seems likely to have an impact on the child.

Physical care and wellbeing - is there any reason to be concerned about the child's physical care and wellbeing in terms of?

A. Nutrition and Feeding

- Is the child regularly fed?
- Does the child eat enough food?
- Does the child eat appropriate food?
- Is the child patiently handled during feeding?
- Does the parent/carer seek help regarding nutrition/feeding problems?
- Is the child punished for not eating?
- Is the child encouraged to eat?
- Is the child encouraged to develop appropriate skills?
- Are there flexible routines?
- Is the parent/carer aware of the child being over or under weight?
- Is there evidence that the child is thriving?

B. Physical Warmth

- Is the child appropriately dressed for the weather?
- Is the bedroom appropriately heated?
- Is the house in general appropriately heated?

C. Physical Health (includes dental)

- Are physical health needs anticipated by parent?
- Do physical health needs get an appropriate and timely response from parents/carers?
- Is expert advice sought appropriately regarding non-emergencies?
- Is expert advice sought appropriately regarding emergencies?
- Is expert advice acted upon?
- Are any additional needs of the child understood and appropriately responded to?
- Does the parent/carer ignore or not recognise the need for diagnosis and/or treatment of physical health needs?
- Does the parent/carer act in a way that increases the likelihood of poor outcomes for physical health?
- Is there appropriate and active management of any head lice?

D. Mental and Emotional Health

- Does the parent/carer ignore or not recognise the need for diagnosis and/or treatment of mental and emotional health needs?
- Does the parent/carer refuse to allow or provide or facilitate diagnosis and/or treatment of mental and emotional health needs?
- Does the parent/carer act in a way that increases the likelihood of poor mental and emotional health? (This may include not taking known appropriate measures and/or not acting on advice in this respect).

E. Safety and Protection

- Is the child left alone inappropriately?
- Are all babysitters of an appropriate age and capability? And known to the child? And are adults or young people without obvious problems that may affect their ability to care for the child?
- Are there safe physical boundaries? For example, not allowed/able to wander from home; parents have clear ideas of limits of play areas
- Is there safety equipment, for example, stair-gates and fireguards? Is the equipment in use?
- Can the windows and doors be opened by a child if unsafe for them to do so?
- Are dangerous household substances (e.g. bleach and cleaners) kept safely?
- Are dangerous personal items (e.g. medication, needles and drugs) kept safely?
- Is dangerous household equipment (e.g. knives, lighters, electrical appliances) accessible to children?
- Is there effective supervision in potentially dangerous situations in and outside of the home?
- Is the child expected/allowed to do inappropriate dangerous tasks, e.g. cooking, lighting fires, supervising very young siblings etc.?

- Is there a history of fire setting, in or outside of the home, by any member of the family?
- Is the area immediately around the home safe? E.g. are there accessible dangerous objects, balconies, stairwells etc.?

F. Cleanliness

- Is general hygiene in the home reasonable?
- Is animal mess cleaned up promptly? Or is it left within reach of the child?
- Is old food cleared away?
- Is rubbish disposed of safely?
- Does the child have clean clothing available?
- Does the child smell? If they do, are they teased/rejected by peers?
- Is there bedding available? If so, is it clean and dry?
- Is food stored hygienically?
- Is the toilet cleaned on a regular basis?
- Are there facilities for washing and bathing? Are they used regularly?
- Does the house have an unclean smell?

G. Possessions and Personal Space

- Does the child have his/her own clothing?
- Does the child play with age appropriate toys?
- Does the child have toys of his/her own?
- Does the child have personal space (e.g. bedroom), including personal privacy?
- Does the child have appropriate personal possessions?

H. Animals and Pets

- Are the pets appropriately cared for?
- Are the needs of the pet(s) prioritised over those of the child?
- Are pets safe in terms of harm to the child?
- Do the parents/carers ensure the child learns to behave appropriately with pets, and take appropriate responsibility for them (if age appropriate)?
- Is a significant proportion of family income being spent on the pets(s)? To the detriment of the child?
- Is access to, or ill-treatment of a pet, being used to control or punish the child?
- Are animals harmed by any member of or visitors to the household?

I. Visitors to the Household

- Is the child's home often frequented by 'visitors', i.e. adults or young people who have no significant relationship with them?
- Is the child left in the care of 'visitors'?
- Does the presence of 'visitors' disrupt the child's normal routines or result in inappropriate routines?
- Do the needs of the 'visitors' take priority over those of the child?
- Do 'visitors' stay overnight?
- Are 'visitors' genuinely friends of a parent, or are they exploiting or abusing a parent?

J. Parent/carer's Emotional Involvement with the Child

- Is the child comforted when distressed?
- Does the parent expect comfort from the child when the parent is distressed?
- Is the child denigrated?
- Is the child praised/rewarded for achievements?
- Does the parent/carer emphasise or punish failure?
- Does the parent/carer have limited physical and emotional contact with the child?
- Is affection shown and expressed?
- Do the parents/carers have a negative attitude towards the child?
- Do the parents lack emotional maturity?
- Is there a sense of belonging and security in the family? i.e. a sense of the parents/carers commitment to the child and to protect the child?
- Is the child free to express themselves?

K. Routines

- Are routines regarding meals, bedtimes, access to television, school attendance, homework, age appropriate?
- Are routines consistent and consistently applied?

L. Controls

- Is the child locked or shut in rooms or a cupboard etc.?
- Is the child subject to punishment or sanctions that cause damage or pain?
- Is the parent able to instigate/ maintain appropriate controls and/or maintain structure/ routines and/or ensure safety and protection?

M. Parent's/Carer's Expectations of the Child

- Are the parent's/carer's expectations age appropriate?
- Are the parent's/carer's expectations of ability appropriate?
- Is there awareness of the child's needs?
- Is there awareness of the child's developmental progress?
- Are the parent's/carer's expectations realistic?
- Are the parent's/carer's expectations consistent?
- Is the child expected or allowed to act as a carer for the parent/carer or sibling?

N. Domestic Violence and Abuse

- Does the child experience domestic violence and abuse as a part of family life? ('Experience' means being aware of, not just being actually involved in it or seeing it)

O. Parent's/Carer's Behaviour

- Is the parent/carer able to instigate and maintain basic routines?
- Is the parent's/carer's behaviour chaotic and/ or unpredictable and/or inconsistent?
- Does the parent/carer allow multiple carers? Do they have a relationship with the child?
- Does the parent/carer allow age/gender appropriate carers?
- Does the parent/carer leave the child unattended?
- Does the parent/carer provide reactive rather than proactive care?
- Does the parent/carer treat animals better than the child?
- Does the parent/carer acquire possessions for themselves, but markedly less so for child?
- Does the parent/carer provide better living conditions for themselves than for the child? (For example, bedrooms).
- Does the parent/carer help the child to know right from wrong?
- Does the parent/carer involve the child in criminal/drug related/anti-social behaviour?
- Does the parent/carer attempt to address child's inappropriate behaviour? For example, committing offences, causing damage, being abusive and/or threatening, not attending school and so on.
- Does the parent/carer allow, encourage, or fail to prevent bullying by siblings?

P. Leisure Activity

- Does the child have access to age inappropriate video, DVD, computer games etc.?
- Does the child have access to adult pornography?
- Does the child have uncontrolled access to the internet?
- Does the child have unrestricted access to late-night television?
- Is the child supervised by a responsible person during potentially dangerous leisure activities?
- Is the child allowed to take part in age-inappropriate activities?

Q. Self-Harming

- Self-harming may include using drugs or alcohol or deliberate exposure to danger.
- Does the child experience self-harming, or threats of self-harming by a parent/carer or sibling as part of family life?
- Is the child self-harming, or threatening self-harm?

R. Educational Needs

- Does the parent/carer ensure the child receives an appropriate education?
- Does the parent/carer allow and/or recognise the need for treatment and/or services regarding serious educational problems or needs?

- Is the parent/carer involved in the child's education? (E.g. assisting with homework, ensuring child has equipment, engaging with teachers as appropriate, and so on)
- Is the child unable to access the curriculum or fully benefit from the educational experience? (E.g. because of their or others behaviour in class, relationships with peers and/or adults in school, ability to concentrate and/or learn, punctuality and/or attendance, social skills and/or acceptability and so on).

S. Parents/Carers Attitudes to Professionals

- Are parents/carers likely to refuse (actually or effectively) to be involved with professionals?
- Is there any history of disguised or non-compliance?
- Do parents/carers accept that professional involvement is appropriate?
- Do parents/carers accept that professional involvement is necessary?

T. History and Context

- Is there a history or context of current concerns in terms of?
- Abuse or neglect?
- Mental ill health?
- Learning disability?
- Drug or alcohol misuse?
- Poverty or financial problems?
- Homelessness?
- Frequent changes of home and/or school?
- Child going missing, with or without parents/carers?
- Addictive behaviour by parents/carers?

U. The Child

- Is the child seen as being 'difficult'? (Crying, refusing to engage with parents or in play and so on)
- Is the child 'passive'? (i.e. vacant facial expression, failing to respond to adults, reluctant to play)
- Is the child able to enjoy social intercourse, take turns, and respond to adult interest and so on?
- Does the child have a secure attachment to parent/carer?
- Does the child have strong feelings of self-worth and self-confidence?
- If there are concerns regarding the child's behaviour, demeanour, development and/or emotional well-being, consider the following in more detail. These checklists are intended for use by professionals who are involved in identifying possible issues for a child and parents/carers. An 'expert' opinion - for example from a psychiatrist - is not necessarily required in this context, but may be if issues appear to warrant exploration in more detail.

Attachment relationships

Persistent, severe neglect indicates a breakdown or a failure in the relationship between parent and child. This may be reflected in maladaptive attachment patterns; for example, neglected children are as likely as children maltreated in other ways to develop disorganised attachment styles. However, they differ from other maltreated children in that they show more evidence of delayed cognitive development, poor language skills, and poor social skills and coping abilities (Hildyard and Wolfe, 2002). They may also present as dependant and unhappy, and display a range of pathological behaviours (see Egeland et al, 1983; Ward, Brown and Westlake, 2012). Children who are neglected from early infancy may find that as their need for nurturing or responsive relationships goes ignored, they withdraw from relationships, feel a greater sense of failure and may even blame themselves for the neglect they experience (Manly et al, 2001).

Consider any concerns regarding the child in the following terms:

Type of attachment	Indicators
Secure attachment	• Child has strong feelings of self-confidence and self-worth
Avoidant attachment	• Child does not seek out physical contact • Child is generally wary • Child's play is inhibited • Child is indiscriminate regarding who they interact with • Parent/carer fails to recognise or are indifferent to child's signals and needs
Ambivalent attachment	• Child seeks contact, but does not settle when he/she receives it • Child resists attempts at pacification • Child demands parental attention, but angrily resists it • Child nervous of new situations • This behaviour often reflects parents/carers behaviour that is inconsistent and insensitive, rather than hostile and rejecting
Disorganised attachment	• Child is confused and has difficulty in controlling feelings of aggression. Child has no impulse control. • Child experiences parents/carers as frightening and/or frightened and not as a source of safety and comfort

Interaction observation chart

Parent/carer details: .....

Child's details: .....

Date and venue: .....

	Child	Parent	Reaction
Playing			
Talking			
Touch / Affection			
Reassurance			
Boundaries			
Guidance			
Praise			
Criticism / Negative comments			

An Accumulative Chronology of Neglect and its Impact

Accumulative risk level						
Analysis of impact accumulative						
Risk level for specific referral						
Outcome						
Action taken						
Reason for referral / issues						
Date of referral						

Strengths and Difficulties Questionnaires

Department of Health

Evaluation of children's emotional and behavioural development is central to understanding the impact of neglect. These questionnaires screen for child emotional and behavioural problems providing guidance as to whether the issue can be resolved through supporting parenting or requires specialist intervention.

Strengths and Difficulties Questionnaire: Age 3-4

TO BE COMPLETED BY A MAIN CARER OF A CHILD AGED BETWEEN 3 AND 4

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain, or the items seem daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name: ……..…….. Male/Female Date of Birth: ….. / ….. / ……..

	Not true	Somewhat true	Certainly true
Considerate of other people's feelings			
Restless, overactive, cannot stay still for long			
Often complains of headaches, stomach-aches or sickness			
Shares readily with other children (treats, toys, pencils etc.)			
Often has temper tantrums or hot tempers			
Rather solitary, tends to play alone			
Generally obedient, usually does what adults request			
Many worries, often seems worried			
Helpful if someone is hurt, upset or feeling ill			
Constantly fidgeting or squirming			
Has at least one good friend			
Often fights with other children or bullies them			
Often unhappy, downhearted or tearful			
Generally liked by other children			
Easily distracted, concentration wanders			
Nervous or clingy in new situations, easily loses confidence			
Kind to younger children			
Often argumentative with adults			
Picked on or bullied by other children			
Often volunteers to help others (parents, teachers, other children)			
Can stop and think things over before acting			
Can be spiteful to others			
Gets on better with adults than with other children			
Many fears, easily scared			
Sees tasks through to the end, good attention span			

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No difficulties	Yes – minor difficulties	Yes – more serious difficulties	Yes – severe difficulties
○	○	○	○

If you have answered **'Yes'**, please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	5-12 months	Over a year
○	○	○	○

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
○	○	○	○

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
Home life	○	○	○	○
Friendships	○	○	○	○
Learning	○	○	○	○
Leisure activities	○	○	○	○

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
○	○	○	○

Signature: ……..

Date: ….. / ….. / ……..

Mother / Father / Other (please specify)

Thank you very much for your help

Strengths and Difficulties Questionnaire: Age 4-16

Department of Health

TO BE COMPLETED BY A MAIN CARER OF A CHILD AGED BETWEEN 4 and 16

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain, or the items seem daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name: ……..…….. Male/Female Date of Birth: ….. / ….. / ……..

	Not true	Somewhat true	Certainly true
Considerate of other people's feelings			
Restless, overactive, cannot stay still for long			
Often complains of headaches, stomach-aches or sickness			
Shares readily with other children (treats, toys, pencils etc.)			
Often has temper tantrums or hot tempers			
Rather solitary, tends to play alone			
Generally obedient, usually does what adults request			
Many worries, often seems worried			
Helpful if someone is hurt, upset or feeling ill			
Constantly fidgeting or squirming			
Has at least one good friend			
Often fights with other children or bullies them			
Often unhappy, downhearted or tearful			
Generally liked by other children			
Easily distracted, concentration wanders			
Nervous or clingy in new situations, easily loses confidence			
Kind to younger children			
Often lies and cheats			
Picked on or bullied by other children			
Often volunteers to help others (parents, teachers, other children)			
Thinks things over before acting			
Steals from home, school or elsewhere			
Gets on better with adults than with other children			
Many fears, easily scared			
Sees tasks through to the end, good attention span			

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No difficulties	Yes – minor difficulties	Yes – more serious difficulties	Yes – severe difficulties
○	○	○	○

If you have answered **'Yes'**, please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	5-12 months	Over a year
○	○	○	○

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
○	○	○	○

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
Home life	○	○	○	○
Friendships	○	○	○	○
Learning	○	○	○	○
Leisure activities	○	○	○	○

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
○	○	○	○

Signature: ……..

Date: ….. / ….. / ……..

Mother / Father / Other (please specify)

Thank you very much for your help

Strengths and Difficulties Questionnaire: Age 11-16

Department of Health

TO BE COMPLETED BY A YOUNG PERSON BETWEEN 11 AND 16

Please read the questionnaire carefully. For each of the statements put a tick in the box that you think is most like you. It would help us if you put a tick for all the statements – even if it seems a bit daft! Please give answers on the basis of how you have been feeling over the last six months.

Child's Name: ……..…….. Male/Female Date of Birth: ….. / ….. / ……..

	Not true	Somewhat true	Certainly true
I try to be nice to people. I care about their feelings			
I get restless, I cannot sit still for ong			
I get a lot of headaches, stomach-aches or sickness			
I usually share with others (food, games, pens, etc.)			
I get very angry and often lose my temper			
I am usually on my own. I generallly play alone or keep to myself			
I usually do as I am told			
I worry a lot			
I am helpful if someone is hurt, upset or feeling ill			
I am constantly fidgeting or squirming			
I have one good friend or more			
I fight a lot. I can make other people do what I want			
I am often unhappy, downhearted or tearful			
Other children or young people pick on or bully me			
I often volunteer to help others (parents, teachers, children)			
I think before I do things			
I take things that are not mine from home, school or elsewhere			
I get on better with adults than with people my own age			
I have many fears, I am easily scared			
I finish the things I'm doing. My attention is good			
Thinks things over before acting			
Steals from home, school or elsewhere			
Gets on better with adults than with other children			
Many fears, easily scared			
Sees tasks through to the end, good attention span			

Overall, do you think that you have difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No difficulties	Yes – minor difficulties	Yes – more serious difficulties	Yes – severe difficulties
○	○	○	○

If you have answered **'Yes'**, please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	5-12 months	Over a year
○	○	○	○

- Do the difficulties upset or distress you?

Not at all	Only a little	Quite a lot	A great deal
○	○	○	○

- Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
Home life	○	○	○	○
Friendships	○	○	○	○
Learning	○	○	○	○
Leisure activities	○	○	○	○

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
○	○	○	○

Signature: ……..

Date: ….. / ….. / ……..

Thank you very much for your help

Guidance on using strengths and difficulties questionnaires

Background

1. Evaluation of children's emotional and behavioural development is a central component of social work assessment.
2. These questionnaires screen for child emotional and behavioural problems. These scales are similar to older scales such as Rutter A & B Scales developed for use by parents and teachers, but put a greater emphasis on strengths.

The scales

3. The questionnaires consist of 25 items that refer to different emotions or behaviours.
4. For each item the respondent marks in one of three boxes to indicate whether the item is **not** true, **somewhat** true or **certainly** true for the child in question.
5. On the back of each questionnaire are questions that aim to address severity by scoring duration of the difficulties and their impact on the child, themselves or others.
6. Children's emotional and behavioural problems are not always evident in all situations. When they are, the problem is usually more severe. As with the Rutter scales, the Strengths and Difficulties Questionnaires have both parent and teacher versions.
7. In young children, parents' reports of their emotions and behaviour are usually more reliable than those of the children themselves, but in adolescence, parents are often unaware of their children's emotional state. There is therefore a Strengths and Difficulties questionnaire for young people aged 11–16.
8. The Rutter scales were originally devised for children aged 9–10, and have been shown to be valid for those aged 6–16. The Strengths and Difficulties Scale covers ages 4–16, and there is an additional scale for children aged 3–4.
9. The scales can be scored to produce an overall score that indicates whether the child/young person is likely to have a significant problem. Selected items can also be used to form subscales for Pro-social Behaviour, Hyperactivity, Emotional Symptoms, Conduct and Peer problems.

Use

10. The questionnaires are of value in both assessments and for evaluating progress.
11. They can give an indication of whether a child/young person is likely to have a significant emotional or behavioural problem/disorder, and what type of disorder it is.
12. During piloting, over half the children assessed scored above the cut-off scores indicating a probable disorder.
13. The most common problems were Hyperactivity, Peer and Conduct problems. These were identified in over half the children.
14. One social worker commented that the questionnaire 'gave a more in-depth look at the young person'. Another said that with the individual child/young person it could be a springboard for therapeutic action, and that it would be helpful, alongside work with the family, to monitor progress.

Administration

15. The respondent – whether parent, child or teacher – needs to understand where the use of the questionnaire fits into the overall assessment.
16. It is usually best if the respondent completes the questionnaire in the presence of the social worker. Sometimes it will be necessary for the worker to administer the scale verbally.
17. The scale takes about 10 minutes to complete.
18. It is preferable if full discussion is kept to the end, but there will be occasions when what the respondent says while completing the scale should be acknowledged immediately.
19. Fuller discussion is vital for several reasons. Firstly, it is important to establish level and nature of any difficulties more clearly. Information from other sources is also relevant for this purpose. Secondly, the overall score may be below the cutoff point indicative of disorder, but there may still be issues that are important to the respondent. The response to a single item might provide the cue. Thirdly, it is crucial to understand how the child, parent and other family members are responding to how the child is, or what the child is doing/saying.

Scoring

20. This is explained on the sheet that accompanies the questionnaires.
21. Each item is scored 0, 1 or 2. Somewhat true is always scored 1, but whether Not true and Certainly true are scored 0 or 2 depends on whether the item is framed as a strength or difficulty.
22. The scoring sheet explains which item contributes to which subscales. The Pro-social scale is scored so that an absence of pro-social behaviour scores low. A child may have difficulties but if they have a high Pro-social score the outlook for intervention is better.
23. The scoring sheet has a chart, which indicates which total scores are low, average or high in the general population. High scores overall or for any subscale point to the likelihood of a significant disorder, and/or a disorder of a particular type. They do not guarantee that there will be found to be a disorder when a more thorough assessment is conducted. Neither does a low score guarantee the absence of a problem, but the instrument is useful for screening.

References

Goodman R (1997). The Strengths and Difficulties Questionnaire: A research note. Journal of Child Psychology and Psychiatry. 38: 581–586.

Goodman R, Meltzer H and Bailey V (1998) The strengths and difficulties questionnaire: A pilot study on the validity of the self-report version. European Child & Adolescent Psychiatry. 7: 125–130.

Scoring the self-report strengths and difficulties questionnaire

The 25 items in the SDQ comprise 5 scales of 5 items each. The first stage of scoring the questionnaire is generally to score each of the 5 scales. Somewhat true is always scored as 1, but the scoring of Not True and Certainly True varies with each item. The score for each response category is given below scale by scale.

Pro-social Scale

	NOT TRUE	SOMEWHAT TRUE	CERTAINLY TRUE
I am considerate of others	0	1	2
I usually share	0	1	2
I am helpful if	0	1	2
I am kinder to younger	0	1	2
I often volunteer	0	1	2

Hyperactivity Scale

	NOT TRUE	SOMEWHAT TRUE	CERTAINLY TRUE
I am restless	0	1	2
I am constantly fidgeting	0	1	2
I am easily distracted	0	1	2
Thinks things out	0	1	2
I see tasks through	0	1	2

Emotional Symptoms Scale

	NOT TRUE	SOMEWHAT TRUE	CERTAINLY TRUE
I get a lot of headaches	0	1	2
I worry a lot	0	1	2
I am often unhappy	0	1	2
I am nervous in	0	1	2
I have many fears	0	1	2

Conduct Problems Scale

	NOT TRUE	SOMEWHAT TRUE	CERTAINLY TRUE
I get very angry	0	1	2
I usually do as I am told	0	1	2
I fight a lot	0	1	2
I am often accused of lying	0	1	2
I take things	0	1	2

Peer Problems Scale

	NOT TRUE	SOMEWHAT TRUE	CERTAINLY TRUE
I am rather solitary	0	1	2
I have at least one good friend	0	1	2
Other people...like me	0	1	2
Other...people pick on me...	0	1	2
I get on better with adults	0	1	2

For each of the 5 scales the score can range from 0 to 10 provided all five items have been completed. You can prorate the scores if there are only one or two missing items.

To generate a total difficulties score, sum the four scales dealing with problems but do not include the pro-social scale. The resultant score can range from 0 to 40. Provided at least 12 of the relevant 20 items are completed, you can prorate the total if necessary.

Interpreting scores and identifying need

The provisional bandings shown below have been selected so that roughly 80% of children in the community do not have needs in these areas, 10% have some needs, and 10% have high need.

Self-completed

	LOW NEED	SOME NEED	HIGH NEED
Total difficulties score	0-15	16-19	20-40
Conduct problems score	0-3	4	5-10
Hyperactivity score	0-5	6	7-10
Emotional symptoms score	0-5	6	7-10
Peer problem score	0-3	4-5	6-10
Pro-social behaviour score	6-10	5	0-4

Child development chart 0-11 years

Child development chart 0-11 years

http://intranet.escc.gov.uk/sites/cs/single-source/Documents/Neglect%20Toolkit/chart.pdf

theory / stage	0-6 months	1 year	2 years	3 years
developmental theory: Sequential stages, defined by physical, cognitive and emotional milestones **theorists:** Sheridan M, 1997 Fahlberg V, 1994	Lifts leg; grasps foot. Lifts head. Rolls over front to back. Eyes move in unison. Turns to carer's voice. Vocalises, laughs. Puts everything to mouth.	Sits and crawls. May stand alone. Picks up small objects. Uses both hands. Knows and turns to own name. Babbles. Drinks from cup. Stranger anxiety - likes to be within sight and hearing of familiar adult/ caregiver.	Runs and climbs on furniture. Can walk backwards. Walks down stairs. Builds tower of six bricks. Uses 50 words. Uses own name – not 'I'. Dry during day. Demands attention. Cannot share.	Walks up stairs. Turns while running and pulling toys. Walks on tip toe. Draws person with head. Cuts with scissors. Knows full name and uses 'I'. Asks what, where and who questions. Uses fork and spoon. Dry at night. Can share.
cognitive theory: Ways of thinking about interactions with the surrounding world **theorist:** Piaget J, 1896-1990	**sensory-motor stage**	Although language development and thought begins, the major developmental tasks in this stage relate to experiencing the world through the five senses (sensory): learns to crawl and walk (gross motor) and to grasp and manipulate small objects and simple 'tools' (fine motor). Learns how to learn through exploration and manipulation of surroundings, linking cause and effect: for instance, understands that shaking a rattle produces noise or that sucking produces milk. Understands that objects are permanent and exist even when not visible. Beginnings of self-identity.		**pre-operational stage**
psychosocial theory: Specific developmental stages or social 'crises' which need to be resolved in a pre-determined sequence although uncompleted stages can be resolved at any time **theorist:** Erickson E, 1902-1994	**trust vs mistrust** First feelings form about the world and whether or not it is a safe place, based on the level of familiarity, consistency and continuity of carers and care-giving. Positive experiences lead to a belief that people are reliable and loving. Trust, security and hope or the strong belief that the world is a good place develop. Unreliable or inadequate care leads to fear and inner mistrust of the world. May be apprehensive, insecure and mistrustful.		**autonomy vs shame and doubt** Increasing self-awareness and desire to do things themselves. Will power develops; defiance, tantrums and stubbornness may appear. Needs safe space for experimenting without shame or ridicule as new skills are tried out (eg, food choices, toy preferences, clothing selection). Displays pride in assertion of choice and autonomy. Failure to manage transitions lead to feelings of worthlessness and inadequacy, doubting own ability to act autonomously. Low self-esteem and a tendency to be overly dependent on others can develop.	

www.rip.org.uk/frontline

4 years	5 years	6 years	7 years	8 years	9-11 years
Turns sharp corners, running, pushing and pulling. Hops and climbs. Draws person with head, trunk, legs and often arms. Speech intelligible – 1500 words. Gives name and address. Appreciates past, present and future. Helps with dressing.	Skips, dances and hops. Copies square and triangle. Writes a few letters. Draws a house. Counts fingers on one hand. Gives name, age, address and birthday. Dresses/ undresses alone.	Very active physically. Developing concentration. Wants to take on more than can manage. Often regresses to an earlier stage under pressure. Responds to praise. Co-operative but needs help.	Concentration much improved and gets very absorbed. More likely to sulk and be withdrawn when in difficulties. Easily frustrated by own failures. Learning about 'fairness' and 'luck'.	Eager but impatient with self and others. Better at group games and at losing. Has more developed sense of time. Interested in own past. Developing sense of humour and interest in jokes and riddles.	Quick and extreme emotional shifts. Increasingly independent and cooperative but can be critical. Integrates learning from multiple sources. Outside home and peer friendships important. Worried by mistakes and school failure.

Capable of symbolic representations of the world in play and language.

Uses toys to represent something else.

Not yet capable of sustained systematic thought.

Develops language and drawing to express self and experiences.

Becoming less egocentric.

concrete operational stage

Able to think logically to solve problems and organise information learned.

Able to:

- understand that some things remain unchanged despite changes in appearance: eg, liquid in different shaped cups
- mentally reverse a process or action
- concentrate on more than one aspect of a situation at a time
- deduce new relationships from earlier ones: eg, if pencil A is longer than B and B is longer than C, then A must be longer than C
- order things in sequence
- group objects on the basis of common features

Begins to think logically about concrete events but difficulty understanding abstract concepts or general principles applied to specific events.

initiative vs guilt

Conscience and imagination develops. Understanding of what people expect of them and with some responsibility for own actions. Begins to assert power and control over the world through directing play of all sorts, including fantasy. Learns to cooperate with others and to lead as well as to follow.

Initiative grows when encouraged to make plans and express fantasies safely, developing new skills and abilities to learn, enjoy, and achieve mastery. Has sense of purpose and feels capable.

Attempts to exert too much power lead to experiences of disapproval, and feelings of guilt develop. Can become fearful, hang on the fringes of groups, continue to depend unduly on adults. Displays limited play skills and imagination.

Initiative is squashed where carers interfere with, interrupt or control free play, create too many strict boundaries or force too much responsibility.

industry vs inferiority

Wants to learn, stick to tasks, do things well and learn from others.

Possibly competitive.

Consciously putting problem-solving and language skills to work.

Through social interactions, begins to develop pride in accomplishments and abilities. Encouraged and commended by parents, teachers and peers, a sense of competence and belief in skills develops. Prior mastery of trust, autonomy and initiative provides the basis for increasing self-discipline, application and industry .

Repeated failure and criticism leads to frustration and inadequacy. The mistrusting child will doubt the future; the shame-and-guilt filled child will experience defeat and inferiority which can be exacerbated by racism and sexism.

This chart should help you to understand the development stage of children you are working with and whether there are grounds for concern and further investigation. It shows the stages of typical development. You will of course need to consider it alongside the specific circumstances of each child, and will want to consider abilities as well as needs. It is important to note that the sequence of attaining development milestones is important as well as the age.

Impact of substance misuse on child development

	Pre-birth	0-2 years	3-4 years
Health	• Mother's exposure to drugs/alcohol • Isolation • Combination and type of substances • Mother exposed to multiple risk factors/ other risks – 'toxic trio'? • Where mothers are young, exposed to multiple risk factors • Level of engagement with ante-natal care • Hepatitis/HIV risk•Level of engagement with ante-natal care • Hepatitis/HIV risk	• Withdrawal syndromes and impact • Low parental self-esteem • Heightened feelings of shame/rejection in parents • Foetal alcohol spectrum disorder (FASD, alcohol) • Neonatal abstinence syndrome (NAS, drugs) • Safe/unsafe environment • Child's access /exposure to substances • Level of supervision/attentiveness • Unsuitable carers/visitors to home • Parents' self-care and impact on parenting • Diet/hygiene	• As 0-2 • Physical risks and dangers to child (lack of vigilance or environments) • Increased risk of physical violence • Neglect • Parents' health • Engagement with child's medical and other appointments
Education and cognitive ability		• Lack of stimulation due to parental distraction/ preoccupation • Impact of chaotic lifestyle/withdrawal on parenting • Capacity to engage in 'meaningful play' • Impact of structural pressures on parental energy • Possible impact of in utero exposure	• Lack of stimulation due to parental distraction/ preoccupation • Impact of chaotic lifestyle/withdrawal on parenting • Capacity to engage in 'meaningful play' • Impact of structural pressures on parental energy • Lack of attendance/engagement with pre-school (irregular attendance) • Impact of parental stigma with pre-school professionals and other parents • Possible impact of in utero exposure
Emotional and behavioural development		• Impact of PSM on bonding and attachment • Reduced emotional/psychological availability of parent • Inconsistent behaviour and routines/ parental distraction • Impact of parental histories - loss and separation	• Impact of PSM on bonding and attachment • Reduced emotional/psychological availability of parent • Inconsistent behaviour and routines/ parental distraction • Impact of parental histories - loss and separation • Impact of encountering disturbing or contradictory behaviour • Worry, anxiety, fears, separation anxiety • Attempts to cope and make sense of world • Emergence of internalising
Family, social relationships and identity		• Impact of inconsistent parenting on child's internal working model • Impact of demands of obtaining the substance on family • Routines and rhythms of family life	• Impact of 'family script' - what is normal? • Impact of lack of family routines and relationships with others (including professionals) • Impact of 'demands of supply' and family secrets • May start to take on inappropriate roles or feelings of responsibility, or blame themselves • Visibility and stigma; embarrassment and shame
Protective factors	• Enabling maternal contact with sustained ante-natal care • Encouraging supportive partner in the process • Encouraging other supports in network • Professionals acknowledging feelings of stigma and lack of self-worth • Focusing on mother's health	• Prompt treatment of illnesses or medical conditions • Child's secure attachment to at least one caregiver • Presence of person(s) to whom child is attached • Low levels of family conflict • Consistency of routines in everyday life • Protection from high-risk substance misusing situations • Lack of family disruption and conflict • Ensuring the child is not present when drugs or alcohol are taken • Ensuring equipment is out of reach and children are not exposed to a drug-taking environment • Mother's health • Adequate finances • Engagement in treatment	• Parent(s)/caregiver(s) able to be consistently warm and supportive • Limited impact of one partner's use on non-using partner's parenting • Child's regular attendance at pre-school • by age four • Child engaged and supported in pretend play and language skills • Child is helped with understanding confusing environment/inconsistency • Relationships with other children • Prompt treatment of illnesses or medical conditions • Regular medical check-ups

http://intranet.escc.gov.uk/sites/cs/single-source/Documents/Neglect%20Toolkit/chart%20dvp%20impact%20on%20substance%20misuse.pdf

5-9 years	10-14 years	15+ years
• Children may exhibit a range of psychosomatic responses as a result of anxiety • School medicals or health checks may be missed/ inconsistent • Parental fear of professionals may make it hard for them to identify health impacts on children	• Children may struggle with gaining a balanced view of alcohol or drug use and their use of it • May lack support to deal with physical and emotional challenges of puberty • Ongoing medical appointments may be missed	• Increased risk of problem alcohol or drug use • Physical risk of violence in the home may increase • Risk of pregnancy, sexually transmitted diseases and other health problems
• Impact of home circumstances on concentration, motivation, preparation • Impact of stigma/bullying at school, or fear of this and being 'different' • May lack appropriate assertive parent in school environment • Poor/infrequent attendance or missing significant school events • Disruption caused by moves/disruptions at home • Possible impact of in utero exposure	• Impact of combination of pressures at home and growing up on academic performance • Higher risk of exclusion • Increasing responsibility as carer resulting in lost learning	• Stigmatisation, bullying or aggression may impede development • Protection of parents or siblings may affect educational opportunities • School disruptions or exclusions may impact at time of transition • Children may lack assertive champion at this critical time • Lack of educational qualifications may impact on long term outcomes
• Reduced emotional/psychological availability of parent • Inconsistent behaviour and routines/ parental distraction • Impact of parental histories - loss and separation • Impact of encountering disturbing or contradictory behaviour • Worry, anxiety, fears, separation anxiety • Attempts to cope and make sense of world • Increased emergence of internalising or externalising behaviours • Children may have to care for others (parent or sibling) • Coping mechanisms may include trying to please or change parental drug/alcohol use	• Children may struggle with reconciling feelings of anger/guilt in response to parents' inability to stop using (emotion-focused coping replacing problem-focused) • Conflictual feelings and home circumstances may impact on developing relationships • Impact on self-esteem may result • Feelings of powerlessness and despair may lead to conduct disorders, risky behaviour or self-harm in some cases • Higher risks of offending	• Lack of suitable role models for problem-solving • Feelings of self-esteem and isolation may be intensified • Teenagers may become distrustful of relationships with 'unreliable adults' • Greater potential risk of self-blame, destructive behaviours
• Changing perceptions of parental behaviour • Impact of parents' continuing use or lack of change • Impact of ambivalent feelings about parental substance use • Friendships may be restricted • Impact of stigma, isolation or fear of difference on friendship development • Relationships with, and responsibility for, siblings	• Dangers of copying parental substance misusing behaviour • Strained relationships in home may result from challenging family norms • May be more at risk of becoming part of involvement in parental substance using culture • Challenges to developing their identity due to parental role model	• Fear of stigmatisation may have implications for friends not being brought home • Young people may leave home early to escape from stressful environments • Young people may struggle with their own identity • Teenagers may show more extreme forms of behaviour - anti-social, risk-taking or criminal
• Attending school regularly • Prompt treatment of illnesses or medical conditions • Parents understand children's worries • Parents or 'supportive other' able to help child live with lack of change/progress with PSM • Family manage to resolve or contain 'persistent stressors' • Home school link is maintained despite parental stress • Takes strength from family values • Child shielded from taking on 'parental role'	• Supportive peers or adults help child make sense of PSM behaviour • Child encouraged in self-belief and skills of planning, goal-setting, individuality • Continuing medical checks • Regular attendance at school • Parental support for schoolwork within the home environment • Valued outside activities • Managing the balance between	• Young person given support with impact of PSM over years • Parents or others provide supportive boundaries • Support with school exams, transitions, planning and past problems • Young person develops trustworthy and reliable friendships • Positive role models for own experimental behaviour

4. Tools to establish baseline (identify current concerns) and measure progress

- Parenting Daily Hassles Scale (Department of Health)
- Home Conditions Assessment (Department of Health)
- Adolescent Wellbeing Scale (Department of Health)
- Mental Health Screening Tools – PHQ9 and GAD 7
- Goal Attainment Scaling (GAS)

Parenting Daily Hassles - Scales

Department of Health

The statements below describe a lot of events that routinely occur in families with young children. These events sometimes make life difficult. Please read each item and circle how often it happens to you (rarely, sometimes, a lot, or constantly) and then circle how much of a 'hassle' you feel that it has been for you FOR THE PAST 6 MONTHS. If you have more than one child, these events can include any or all of your children.

Event	How often it happens	Hassle (low to high)
1. Continually cleaning up messes of toys or food	Rarely Sometimes A lot Constantly	1 2 3 4 5
2. Being nagged, whined at, complained to	Being nagged, whined at, complained to	1 2 3 4 5
3. Meal-time difficulties with picky eaters, complaining, etc.	Rarely Sometimes A lot Constantly	1 2 3 4 5
4. The kids won't listen or do what they are asked without being nagged	Rarely Sometimes A lot Constantly	1 2 3 4 5
5. Baby-sitters are hard to find	Rarely Sometimes A lot Constantly	1 2 3 4 5
6. The kids schedules (like pre-school or other activities) interfere with meeting your own	Rarely Sometimes A lot Constantly	1 2 3 4 5
7. Sibling arguments or fights require a 'referee'	Rarely Sometimes A lot Constantly	1 2 3 4 5
8. The kids demand that you entertain them or play with them	Rarely Sometimes A lot Constantly	1 2 3 4 5
9. The kids resist or struggle with you over bed-time	Rarely Sometimes A lot Constantly	1 2 3 4 5
10. The kids are constantly underfoot, interfering with each other	Rarely Sometimes A lot Constantly	1 2 3 4 5
11. The need to keep a constant eye on where the kids are and what they are doing	Rarely Sometimes A lot Constantly	1 2 3 4 5
12. The kids interrupted adult conversations or interactions	Rarely Sometimes A lot Constantly	1 2 3 4 5
13. Having to change your plan because of unprecedented child needs	Rarely Sometimes A lot Constantly	1 2 3 4 5
14. The kids get dirty several times a day requiring changes of clothes	Rarely Sometimes A lot Constantly	1 2 3 4 5
15. Difficulties in getting kids ready for outings and leaving	Rarely Sometimes A lot Constantly	1 2 3 4 5
16. Difficulties in leaving kids for a night out or at school or day care	Rarely Sometimes A lot Constantly	1 2 3 4 5
17. The kids have difficulties with friends (e.g. fighting, trouble, getting along, or no friends available)	Rarely Sometimes A lot Constantly	1 2 3 4 5
18. Having to run extra errands to meet the kids needs	Rarely Sometimes A lot Constantly	1 2 3 4 5

Questionnaire completed by *mother* / *father* / *adoptive parent* / *foster carer* (please specify)

Guidance on using parenting daily hassles scale

Background

1. This scale aims to assess the frequency and intensity/impact of 20 experiences that can be a 'hassle' to parents.
2. It has been used in a wide variety of research concerned with children and families. The research in which it has been used includes a parenting programme with families who had major difficulties in raising young children.
3. Parents/Caregivers enjoy completing the scale, because it touches on aspects of being a parent that are very familiar. It helps them express what it feels like to be a parent.
4. During piloting, social workers reported that it depicted concisely areas of pressure felt by the carer. This helped identify areas where assistance could be provided either by the social services department or other agencies.
5. It is seen by parents as a way for them to express their needs for help with parenting.

The Scale

6. The caregiver is asked to score each of the 20 potential Hassles in two different ways for frequency and intensity.
7. The frequency of each type of happening provides an 'objective' marker of how often it occurs.
8. The intensity or impact score indicates the caregiver's 'subjective' appraisal of how much those events affect or 'hassle' them.
9. The time frame for this scale can be varied according to the focus of the assessment. For example, if a family is thought to have been under particular pressure in the last 2 months the parent can be asked to consider how matters have been during that period. However, if it is intended to assess progress, the same time frame should be used on each occasion. Periods of less than one month are probably too short to give a useful picture.

Use

10. The caregiver should understand the aim of filling out the questionnaire, and how it will contribute to the overall assessment.
11. The scale is probably most useful with families that are not well-known. In piloting it was found to highlight areas for future discussion, and help prioritise which parenting issues should be addressed first.
12. It can also be used to monitor change.

Administration

13. It should be given to the parent/caregiver to fill out themselves.
14. It can be read out if necessary.
15. It takes about 10 minutes to complete.
16. The scale should always be used as a basis for discussion. In general this is best kept until the parent has finished, but there will be occasions when it is vital to acknowledge, or immediately follow up comments made while it is being filled out.

Scoring

17. The scale can be used in two distinct ways: (a) the totals of the frequency and intensity scales can be obtained, or (b) scores for challenging behaviour and parenting tasks can be derived from the intensity scale.
18. To obtain frequency and intensity total scores:

    (a) The frequency scale is scored: rarely = 1, sometimes = 2, a lot = 3, and constantly = 4. If the parent says that an event never occurs, never = 0.

    The range for this scale is 0–80. A score of 3 or 4 for any one event indicates that it occurs with above average frequency.

    (b) The intensity scale is scored by adding the parents rating of 1–5 for each item. If a 0 has been scored for frequency on an item then it should be scored 0 for intensity. The range for this scale is 0–100. A score of 4 or 5 for any one event indicates that it is at least some problem to the parent.

19. (a) The challenging behaviour total score is obtained by adding the intensity scale scores for items: 2, 4, 8, 9, 11, 12, 16. Range: 0–35.

    (b) The parenting tasks total score is obtained by adding the intensity scale scores for items: 1, 6, 7, 10, 13, 14, 17, 20. Range: 0–40.

20. There is no cut off for any of the scales but total scores above 50 on the frequency scale or above 70 on the intensity scale indicate on the one hand a high frequency of potentially hassling happenings, and on the other that the parent is experiencing significant pressure over parenting.

21. Events occurring with frequency 3 or 4, or intensity 4 or 5, particularly those where the parent rates high intensity or impact, should be discussed to clarify the extent of need.

22. The total score on the challenging behaviour and parenting tasks scales may be useful in indicating how the parent/caregiver sees the situation, whether difficulties lie in the troublesome behaviour of the children, or the burden of meeting the 'expected' or 'legitimate' needs of the children. The sub scores may also be useful in monitoring change.

References

Crnic KA & Greenberg MT (1990) Minor parenting stresses with young children. Child Development. 61: 1628–1637

Crnic KA & Booth CL (1991) Mothers' and fathers' perceptions of daily hassles of parenting across early childhood. Journal of Marriage and the Family. 53: 1043–1050.

Home conditions assessment

Department of Health

Guidance on using home conditions assessment

Background

1. Social workers assess physical aspects of the home environment.
2. This scale may appear judgmental, but workers necessarily make judgements about the safety, order and cleanliness of the place in which the child lives. The use of a list helps the objectivity of observation.
3. The total score has been found to correlate highly with children's abilities, so that children from homes with low scores usually have better language and intellectual development. This does not mean that all children from high scoring homes will have poor intellectual progress.
4. Like all methods of assessment it should not be used in isolation – other sources of information, including the quality of the parent-child relationship will contribute to the overall assessment.

The Scale

5. The assessment is identical to the Family Cleanliness Scale devised by Davie and others (1984).
6. This is a list of 11 items to be observed during home visits.
7. Social presentation, namely the cleanliness of the children is included.

Use

8. The scale is best used as a mental checklist to provide a framework for observation.
9. It is particularly appropriate to use during initial assessment. Once used it is a method of keeping track of progress or deterioration.
10. In order to be able to complete the scale it is necessary to look over the home. The caregiver can be asked whether they have any problems with their housing, or whether the nature of their accommodation causes difficulties from the point of view of bringing up the children. This can lead naturally to a request to look round.
11. It will usually be unhelpful to share all that has been observed with the caregiver. This could upset the establishment of partnership – a good working relationship is of overriding importance. However the worker needs to have a clear picture of the environment from the child's point of view.
12. Individual items can be a focus for a piece of work. This might be to encourage the parent to attend to something that could pose a health risk to the children, or to bring in additional support where the parent is unlikely to be able to improve matters unassisted.

Scoring

13. The scoring is binary 0 if the condition is not present, and 1 if it is.
14. Items are scored on the basis of what is observed. Why the conditions are as they are is not taken into account. Of course the worker needs to understand why matters are as they are to take appropriate action. The scale charts the child environment as it is.
15. The scale has no cut off. Depending on the age of the children different items may give more or less concern, but in general the higher the score the greater the concern.
16. Individual items may require action whatever the total score.

Reference

Davie CE, Hutt SJ, Vincent E & Mason M (1984) The young child at home. NFER-Nelson, Windsor

The scale

Smell (e.g. stale cigarette smoke, rotting food)	0	1
Kitchen floor soiled, covered in bits, crumbs etc.	0	1
Floor covering in any other room soiled as above.	0	1
General decorative order poor – obviously in need of attention (e.g. badly stained wall paper, broken windows)	0	1
Kitchen sink, draining board, work surfaces or cupboard door have not been washed for a considerable period of time	0	1
Other surfaces in the house have not been dusted for a considerable period of time	0	1
Cooking implements, cutlery or crockery showing ingrained dirt and or these items remain unwashed until they are needed again	0	1
Lavatory, bath or basin showing ingrained dirt	0	1
Furnishings or furniture soiled	0	1
Informant's or children's, clothing clearly unwashed, or hair matted and unbrushed	0	1
Garden or yard uncared for and strewn with rubbish	0	1
Total Score		

Adolescent wellbeing scale

Department of Health

Scale for young people aged 11 - 16.

Name of young person: ……..……..

Date: ….. / ….. / ……..

Please tick as appropriate

Event	Most of the time	Some-times	Never
1. I look forward to things as much as I used to			
2. I sleep very well			
3. I feel like crying			
4. I like going out			
5. I feel like leaving home			
6. I get stomach-aches/cramps			
7. I have lots of energy			
8. I enjoy my food			
9. I can stick up for myself			
10. I think life isn't worth living			
11. I am good at things I do			
12. I enjoy the things I do as much as I used to			
13. I like talking to my friends and family			
14. I have horrible dreams			
15. I feel very lonely			
16. I am easily cheered up			
17. I feel so sad I can hardly bear it			
18. I feel very bored			

Guidance on using the adolescent wellbeing scale

Background

1. How young people feel in themselves is a vital part of any assessment.
2. It is important to understand their worries and concerns, and whether they are depressed or even suicidal.
3. There is good evidence that the way a young person is feeling is often not recognised by their parents or caregivers. This makes it particularly important to have a way of helping them to express directly how they are feeling.
4. With very young children their reporting can fluctuate from day to day, or even hour to hour – they do not necessarily give a stable view of their situation. Evaluation of their perspective requires particular care, so questionnaires are not usually a good starting point
5. Older children and adolescents can give a more reliable report, which means that a questionnaire may be more helpful. As with some adults they often find it easier to respond to a questionnaire about feelings than face-to-face interviewing.

The Scale

6. The Adolescent Wellbeing Scale was devised by Birleson to pick up possible depression in older children and adolescents. It has been shown to be effective for this purpose.
7. The scale has 18 questions – each relating to different aspects of an adolescent's life, and how they feel about them. They are asked to indicate whether the statement applies to them most of the time, sometimes or never.
8. The scale can be used by children as young a 7 or 8, but as indicated above, responses are more reliable for those aged 11 or more.

Use

9. In piloting social workers found young people were pleased to have the opportunity to contribute to the assessment.
10. The questionnaire often helped them express their feelings. It gave 'an overall insight in a short time'. It presented a 'truer picture of the adolescent's state of mind'. 'It gave me insight into how sad and overwhelmed the young person felt'.
11. On occasions use of the scale pointed to particular issues that could be a focus for further work. It gave an opportunity for 'the young person to look at themselves'.
12. The scale has proved useful with adolescents at initial assessment, but also to monitor progress. For example it helped 'clarify a young person's feeling about placement with their mother'.
13. During piloting over half the young people who filled out the questionnaire were above the cut-off score of 13 indicating a probable depressive disorder.

Administration

14. The young person needs to understand the aim of the questionnaire, and how it fits into any wider assessment.
15. Ideally it is completed by the adolescent themselves, but, if necessary, it can be administered verbally.
16. Discussion is usually best at the end, but there may be important areas that need to be picked up as the result of comments made while the questionnaire is being filled out. A number of adolescents talk as they are completing the scale, and this may provide a good opportunity to promote conversation, or establish rapport.
17. During piloting the scale took about 15 minutes to complete, ensuing discussion took longer.

Scoring

18. The responses to each question are scored 0, 1 or 2. How the responses are scored depends on the nature of the statement that is being responded to as well as the response. 0 means that the response indicates no concern, 1 possible concern and 2 that the young person is indicating unhappiness or low self-esteem with regard to that item.
19. For example for question 8 – I enjoy my food – if no/never is ticked the score is 2. For question 17 – I feel so sad I can hardly bear it – a score of 2 would be obtained for most of the time.
20. A score of 13 or more has been found to indicate the likelihood of a depressive disorder. Discussion with the young person and information from other sources will be necessary to make a definite diagnosis. There will be some who score high, but who on careful consideration are not judged to have a depressive disorder, and others who score low who do have one.
21. In most instances the way a young person responds to the different questions will be as important and as valuable as any score, because they can give an insight into that particular young person's needs. The reply to only one question may give the opportunity to understand their point of view.

Reference

Birleson P (1980) The validity of Depressive Disorder in Childhood and the Development of a Self-Rating Scale; a Research Report. Journal of Child Psychology and Psychiatry. 22: 73–88.

Mental health screening tools PHQ9 and GAD 7

The GAD7 and the PHQ9 are screening tools used to assess the degree of depression and anxiety that a person may be suffering from.

The questionnaires need to be parent/caregiver and are based on how they have been feeling over the previous two weeks. These tools can be used at any time to talk about their emotional wellbeing and can provide help in determining whether specialist help i.e. SWIFT is required.

The GAD 7 is the tool used for generalised anxiety disorder and when screening for anxiety the cut off point for evaluation is a score of 10 or higher.

Scores represent:

- 0-5 mild
- 6-10 moderate
- 11-15 moderately severe
- 15 to 21 severe.

The PHQ 9 physical health questionnaire is used to screen for depression and a cut off point for evaluation is 10.

Scores represent:

- 0-4 minimal
- 5-9 mild
- 10 to 14 moderate
- 15 to 19 moderately to severe
- 20 to 27 severe

Name:

Date Completed:

SWIFT MH OUTCOME MEASURES

PHQ- 9

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
		PHQ9 total score			

GAD-7

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
		GAD7 total score			

Name:

Date Completed:

swift
specialist family service

SWIFT MH OUTCOME MEASURES

Work and Social Adjustment

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity.

1. **WORK** - if you are retired or choose not to have a job for reasons unrelated to your problem, please tick N/A (not applicable)

0	1	2	3	4	5	6	7	8	N/A
Not at all		Slightly		Definitely		Markedly	Very severely, I cannot work		☐

2. **HOME MANAGEMENT** – Cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

3. **SOCIAL LEISURE ACTIVITIES** - With other people, e.g. parties, pubs, outings, entertaining etc.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

4. **PRIVATE LEISURE ACTIVITIES –** Done alone, e.g. reading, gardening, sewing, hobbies, walking etc.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

5. **FAMILY AND RELATIONSHIPS –** Form and maintain close relationships with others including the people that I live with

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly	Very severely	

W&SAS total score ☐

Goal Attainment Scaling (GAS)

This approach allows you to set clearly specified targets for change with the family. These should relate directly to the problems the family is facing and be agreed to be meaningful both by the family and the practitioners working with the family (Harnett and Dawe (2008). This can provide the framework and the above tools measure progress. Worked example:

Level of expected outcome	**Goal one: The sitting room is clean and safe**	**Goal two: Tom reduces his drinking and gets more involved in basic care**	**Goal three: Zara accepts help with the morning routine and her depression that underlies the difficulties**
Review date			
Much more than expected	The room is cosy and has been re-painted. The furniture is clean. The floor is clear. There are toys and books. The clean washing is put away regularly. There is no smell.	Tom does not drink alcohol and goes to all his appointments. He begins to spend more time with the children and take more responsibility for their care in the mornings. He is able to give the children money for the tuck shop at least twice a week.	Zara takes increasing responsibility for getting the children up. They arrive at school on time most days. Zara works with her counsellor to address her depression and takes her medication regularly.
More than expected	There is no smoking in the room, there are some toys available, all the surfaces are clear and clean.	Tom is sober most of the time. He goes to his appointments regularly. He finds other ways to relax. Tom starts to get more involved with the morning routine and puts the clothes out the night before.	Zara makes good use of her counselling sessions and continues with her medication. She gets out of bed and takes the children to school most mornings and has them ready for the parent support advisor on all other days.
Most likely outcome	The floor is clear, the furniture is clean, the dog is kept out of the room, there are no smoking materials within the children's reach.	Tom is sober around the children and goes to his Mum's if he gets drunk. He turns up to most of his appointments at the alcohol service. He spends less than £5 per week on alcohol. He does not shout from his bed in the mornings when the children are messing about and sometimes gets the breakfast.	Zara takes her medication regularly and attends an assessment appointment with the counsellor. She accepts help from the parent support advisor to get the children to school.
Less than expected	Some of the clutter has been cleared, any dog faeces are cleared up immediately.	Tom sometimes drinks around the children. He misses some of his appointments. He spends the family money on drink. He is not involved in the morning routine and is sometimes grumpy and hungover.	Zara does not attend her first appointment and does not always remember her medication. She stays in bed most of the day. The children's school attendance is below 80%.
Much less than expected	The floor is cluttered, there is stale food on the furniture, dog faeces are left on carpet, ashtrays and lighters are left in children's reach.	Tom is drunk whilst caring for the children. He misses most of his appointments. The family runs out of money because it has been spent on alcohol. He gets angry in the mornings because he is hungover and does not provide any care.	Zara does not take her medication or go for counselling. She spends most of the day in bed and the children continue to attend school late or not at all most days. They are not ready when the parent support advisor calls.

Adapted from work by Harnett and Dawe (2008) as presented in Jane Barlow's conference keynote. Home or Away: Making difficult decisions in the child protection system. Research in practice Partnership Conference 22 February 2011.

Level of expected outcome	**Goal one:**	**Goal two:**	**Goal three:**
Review date			
Much more than expected			
More than expected			
Most likely outcome			
Less than expected			
Much less than expected			

5. Cultural competence

Cultural competence practice puts children's wellbeing and protection within the cultural context…. cultural competence helps sort out which aspects of the family's difficulties are 'cultural', which are neglectful, and which are a combination of factors.

Children and families from diverse ethnic backgrounds are more susceptible to the following vulnerabilities. It is sometime easy to overlook these significant issues when focusing on a specific incident of maltreatment:

- Poverty
- Highly mobile families / insecure accommodation
- Being newly arrived in this country
- Language barrier
- Family structure and position in the family
- Private fostering
- Spirit possession and witchcraft
- Traumatic recent history
- Forced marriage
- Female genital mutilation
- Honour based violence
- Trafficked children

Your first task in working with a family from diverse backgrounds is to ask what their understanding of their religion/faith/culture is and what impact does it have on their parenting of their child? However throughout you should remain focused on needs of the child.

Within your assessment ask yourself the following questions and this will inform your intervention:

If this parent…

1. Cannot speak, read or write English, will s/he be able to e.g. get a job, arrange suitable childcare, register with a GP, pursue a legitimate asylum claim, understand the law etc.?
2. Fears that the 'State' is authoritarian, will s/he be able to register with a GP, engage with the local children's centre, talk to the school about their child's progress/difficulties, call social services or the police if necessary e.g. for help with domestic abuse?
3. Lacks strong social networks, will s/he be able to cope with the stresses of child rearing?
4. Lives in temporary housing, e.g. B&B, will s/he be unsettled, moving at [irregular] intervals to new and unfamiliar areas, not able to begin building a supportive social network?
5. Is living below the poverty line, will s/he have the added burden of not being able to buy enough food and clothing, keep warm enough, travel as needed or give things to their child as they would like?
6. Is living in a close-knit community, will s/he be too scared or ashamed to engage with services for herself for domestic violence, sexual abuse/rape, female genital mutilation, or honour based violence?
7. Has a perspective on parenting practices underpinned by culture or faith which are not in line with UK law and cultural norms, will s/he put their child at risk of harm through e.g. leaving young children at home alone, exercising robust physical punishment, forcing a child into marriage etc.?

and, if this young person…

8. Is compromised through being 'westernised' e.g. having a girl/boyfriend not from the same community; or by having a stigmatising experience e.g. sexual abuse, mental ill health or a disability, will s/he be able to seek help to keep safe from the community or statutory and other services?
9. Has strong allegiance to a group or gang, e.g. radicalised, will this stop him/her from seeking help from the community or statutory and other services, to stay safe?
10. Children from diverse backgrounds have specific needs related to knowledge and understanding of self, culture and religion, and identity which needs to be attended to systematically. If this is not tended to through the family and others then the child can be disadvantaged emotionally as the mature and make sense of their place in the world.

6. Planning and intervention

Identifying concerns

Overview:

The starting point of any assessment is to get the parents to understand and acknowledge concerns about the care of their children. They will have possibly been involved in Child in Need / Early Help meetings or some kind of multi-agency meeting, but what understanding do they have of what was discussed and what the priorities are? The aim of this activity is to make sure the parents/carers understand what the concerns are and to determine the potential for change.

Tools: make some cards labelled with identified concerns relating to the case, or points from the action plan – example below:

Method: Read through the action plan going over each point with the parent(s)/carer(s), then using the cards, ask the parent(s)/carer(s) to place the cards into two piles – "High Concern" and "Low Concern". Encourage them to say why they feel this way. Create any additional cards generated by this discussion.

It would also be useful to do this activity separately with the child/young person (if appropriate) to establish whether there are any differences of opinion as to what the priorities are, or whether there is agreement within the family. This information can then be used to further the assessment/action plan.

You will often find that what concerns professionals is not shared by the young person. For example social workers may be worried about domestic abuse in the family but the priority for the young person is having a clean bed with a mattress to sleep on every night (young person ESCC focus group 2015).

Susan's mental health	**Ben's non-attendance at school**	**Jamie needs a new coat**

Identifying Parenting Tasks, Knowledge, Skills and Attributes

The table below might provide a focus for discussions with parents about what is expected from them and could then inform the child's plan.

Parenting tasks	**Knowledge, skills and attributes**
Basic care • Meeting child's physical needs • Providing appropriate health care and medical attention • Ensuring child has nutritious diet, warmth, shelter • Giving clean and appropriate clothing and ensuring adequate personal hygiene	**Knowledge of:** • Healthy diet and the food and drink requirements of a child at different ages • A comfortable temperature for a baby and small child • Toileting requirements of baby or child • How to bath a baby and hygiene requirements of child • Common ailments and how to cope with accidents • How to access GP, dentist, optician etc. • Particular medical requirements of the child **Skill in being able to:** • Cook food that enables child to thrive • Recognise if a pre-verbal child is sick (pallor, appetite, toileting, temperature) • Keep a young child clean and teach an older child to take increasing responsibility for their own hygiene • Identify and respond to child's health care needs; know how to contact GP • Meet the particular needs of the child related to their disability
Ensuring safety • Ensuring child is adequately protected from harm and danger • Avoiding contact with unsafe adults/children • Protecting children from self-harm • Recognising hazards and dangers both at home and elsewhere	**Knowledge of:** • Sources of potential harm such as hazards in home, need for supervision, risk posed by unsafe adults and other children • Ways in which child can become involved in anti-social behaviours and indicators of this involvement • Particular vulnerabilities of a disabled child

	Skill in being able to: • Provide a safe home and age appropriate levels of supervision physically and online • Identify the signs and indicators that the child is at possible risk of harm including sexual exploitation and gang infiltration (not letting others know of whereabouts, unaccounted for gifts, lifts to a from school from unknown people, access to weapons) • Awareness of support available and how to access support
Stimulation • Promoting the child's learning and intellectual development • Encouraging, stimulating cognitive development • Providing social opportunities • Talking and responding to the child • Encouraging and joining in play • Enabling the child to experience success • Ensuring school/nursery attendance • Facilitating the child to meet the challenges of life	**Knowledge of:** • The education system and resources available to promote child's intellectual development within the community • The way in which a child develops cognitive and language skills • Impact of child's disability on their cognitive development **Skill in being able to:** • Engage with the child in play activities • Stimulate the child through verbal communication or child's particular communication method, reading, play materials etc. • Access and use educational resources in the community • Prepare child for preschool and school activities and support child enabling them to maximise the opportunities provided by these activities • Have appropriate expectations of child when encouraging them to take on the challenges of life

Emotional warmth • Ensuring the child's emotional needs are met • Giving the child a sense of being valued and a positive sense of own race and cultural identity • Ensuring the child has secure, stable and affectionate relationships with significant others • Demonstrating sensitivity and responsiveness to the child's emotional needs • Providing appropriate physical contact, comfort and cuddling sufficient to demonstrate warm regard, praise and encouragement	**Knowledge of:** • The child's cultural background • The emotional needs of children **Skill in being able to:** • Offer child love and acceptance (and being clear as to what that looks like) and being able to respond sensitively to their needs • Foster a sense of identity • Have confidence in the child's worth and abilities • Provide appropriate physical contact in light of age and ability • Demonstrating consistency, reliability and dependability, providing a stable environment
Guidance and boundaries • Enabling the child to regulate their own emotions and behaviours • Demonstrating and modelling appropriate behaviour and control of emotions and interactions with others • Providing guidance involving the setting of boundaries enabling child to develop values, a conscience and appropriate social behaviours • Enabling the child to grow into an autonomous adult acting appropriately with others • Allowing child to explore and learn • Enabling child to manage anger, consider others • Use effective methods of discipline to shape behaviour	**Knowledge of:** • Appropriate behaviour for age and ability • Effective methods for disciplining child **Skill in being able to:** • Understanding how their values and attitudes impact upon others • Be authoritative, rather than over protective, permissive or authoritarian • Offer a secure environment where rules are clear and consistent • Set appropriate boundaries, providing adequate supervision and encouraging children to set their own boundaries • Avoid harsh punishments but reinforce good behaviour • Model effective methods of dealing with conflict, demonstration of emotions and interactions with others • Have confidence in child • Have appropriate expectations of child

Stability • Provide a sufficiently stable family environment to enable the child to develop and maintain a secure attachment to the primary care-giver • Ensure secure attachments are not disrupted • Provide consistent emotional warmth • Respond in a similar way to the same behaviour • Recognise and respond to the child's changing needs • Ensure child keeps in contact with family members and significant others	**Knowledge of:** • What a child needs to develop a secure relationship with a care giver • Their own upbringing and its effect on their ability to parent **Skill in being able to:** • Maintain relationships with significant people in the child's life • Recognise the changing needs of the child as they mature and develop • Create a stable home environment

Resilience framework

Many of you will be familiar with the concept of resilience. Dr Angie Hart and Dr Derek Blinkow have further developed this thinking and have created a "Resilience Framework" – see the Boing Boing website for more information **http://www.boingboing.org.uk/index.php/resilience-in-practice/getting-to-grips-with-rt**

The resilience framework has 5 compartments – Basics, Belonging, Learning, Coping and Core Self – to help you think practically about doing things resiliently. Within each of these compartments is a selection of evidenced based ideas to draw on when trying to make a resilient move with a child or young person. In a nutshell, they include:

- **Basics** - Attending to the Basics is seriously important. So the ideas in this section are all about sorting out seemingly simple things. And for some people, it's no good going on about other things in their life, like careers or school work for example, unless you get some of these basics sorted first like a roof over your head and food to eat.
- **Belonging** - This puts good relationships at the heart of things. It focuses on reminding us to have and look after healthy relationships and to tap into good influences instead of bad ones. It recommends concentrating on the good times and places, find people our children can count on and remain hopeful about building new contacts.
- **Learning** – The importance of finding out about and discovering new things. So it's not just about sorting a child's schooling, although this is really important, it's also about less formal ways of learning, like making sure we develop interests, talents and life skills. It reminds us of the value of getting organized, noticing our achievements and developing new skills.
- **Coping** - This is all about those things we and our children do to help us get by in everyday ways. Like those times when we need to be brave, solve problems and stand up for our own views and beliefs. It's about putting on rose-tinted glasses when we need to, looking after our talents, finding ways to stay calm, remembering that tomorrow's a new day and leaning on others when it's necessary.
- **Core Self** - This puts the focus on our inner worlds – those thoughts and beliefs we have about ourselves that build our characters. It encourages us to take responsibility for ourselves, face problems and seek help when it makes sense to do so.

This approach also has a group of four 'noble truths' that underpin these 5 headings and their remedies. They include: acceptance, conservation, commitment; and enlisting.

With the young person and or family you can use the chart below and shade the areas where the gaps are to help you prioritise your interventions.

8 steps to applying the resilience framework

1. Get familiar with the framework
2. Have it to hand
3. Remember the noble truths
4. Use the framework to map out where the young person is at
5. Pick your priorities to make the most resilient moves (what's most urgent, what's most doable, quick wins, what you're up for, what the child/family wants, what the child/family can most easily manage, time available)
6. Make your resilient moves
7. Check out with them, and yourself. How well did it go?
8. What have I learnt for another time?

Resilience Framework (Children and Young People)

Visit the following link for the full interactive framework with linked interventions:
http://intranet.escc.gov.uk/sites/cs/single-source/Documents/Neglect%20Toolkit/resilience%20framework%20-%20interactive.pdf

<table>
<tr><th></th><th>BASICS</th><th>BELONGING</th><th>LEARNING</th><th>COPING</th><th>CORE SELF</th></tr>
<tr><td rowspan="15">SPECIFIC APPROACHES</td><td rowspan="2">Good enough housing</td><td>Find somewhere for the child/YP to belong</td><td rowspan="2">Make school/college life work as well as possible</td><td>Understanding boundaries and keeping within them</td><td rowspan="2">Instill a sense of hope</td></tr>
<tr><td>Help child/YP understand their place in the world</td><td rowspan="2">Being brave</td></tr>
<tr><td rowspan="2">Enough money to live</td><td rowspan="2">Tap into good influences</td><td rowspan="2">Engage mentors for children/YP</td><td rowspan="3">Support the child/YP to understand other people's feelings</td></tr>
<tr><td rowspan="2">Solving problems</td></tr>
<tr><td rowspan="2">Being safe</td><td>Keep relationships going</td></tr>
<tr><td rowspan="3">Access and transport</td><td>The more healthy relationships the better</td><td rowspan="4">Map out career or life plan</td><td rowspan="2">Putting on rose-tinted glasses</td><td rowspan="2">Help the child/YP to know her/himself</td></tr>
<tr><td rowspan="2">Take what you can from relationships where there is some hope</td></tr>
<tr><td rowspan="2">Fostering their interests</td></tr>
<tr><td rowspan="2">Healthy diet</td><td rowspan="2">Get together people the child/YP can count on</td><td rowspan="3">Help the child/YP take responsibility for her/himself</td></tr>
<tr><td rowspan="2">Help the child/YP to organize her/himself</td><td>Calming down and self-soothing</td></tr>
<tr><td rowspan="2">Exercise and fresh air</td><td>Responsibilities and obligations</td><td rowspan="3">Remember tomorrow is another day</td></tr>
<tr><td rowspan="2">Focus on good times and places</td><td rowspan="3">Highlight achievements</td><td rowspan="2">Foster their talents</td></tr>
<tr><td rowspan="2">Enough sleep</td><td rowspan="2">Make sense of where the child/YP has come from</td><td rowspan="3">Lean on others when necessary</td></tr>
<tr><td rowspan="2">Play and leisure</td><td rowspan="2">Predict a good experience of someone or something new</td><td rowspan="3">There are tried and tested treatments for specific problems, use them</td></tr>
<tr><td rowspan="2">Develop life skills</td></tr>
<tr><td>Being free from prejudice and discrimination</td><td>Make friends and mix with other children/YP</td><td>Have a laugh</td></tr>
<tr><td colspan="6">NOBLE TRUTHS</td></tr>
<tr><td colspan="2">ACCEPTING</td><td colspan="2">CONSERVING</td><td>COMMITMENT</td><td>ENLISTING</td></tr>
</table>

Different ways of working for different forms of neglect

The following provides information on direct intervention and when specialist intervention from SWIFT/ Adult Services may be required.

Highlighted in the section below are some of the effective or promising methods of working for different categories of neglect (for a full description of interventions see Barlow and Schrader-MacMillan, 2010).

1. **Emotional unavailability, unresponsiveness and neglect of the child that results from caregivers' absorption in their own needs and desires:**

   The recommendation here is for direct work that focuses on caregiver-child interaction. Evidence-based models include Parent infant psychotherapy (Toth, 2002, 2006). Other methods of working to improve parent-child interaction where abuse is of concern include video feedback delivered as part of a home visiting programme (Moss et al, 2011) or Video Interactive Guidance (VIG) which is delivered through SWIFT.

   A parent's capacity for mentalization – the capacity to perceive a child as an intentional being with a mind of their own – is linked to improved outcomes for children (Meins et al, 2002). View the link for further information on mentalization:

   http://intranet.escc.gov.uk/sites/cs/single-source/Documents/Neglect%20Toolkit/Intervention%20strategies.docx

   It is often necessary to attend first to parental risk factors that stand in the way of enhancing the parent-child interaction. For example, some parents who are absorbed with their own needs and desires may be dependent on substances and this may require specialist intervention.

2. **Negative attributions and misattributions:**

   Requires skillful work, which should involve exploring with caregiver(s) what a child's view of him/herself might be and how this might be altered by more positive interactions.

   The questions framed on page on page 5 help you to determine the level of concern in this area and again a mentalization approach may help. Using mental health screening to determine if specialist help is required via a SWIFT consultation is essential.

3. **Inappropriate developmental expectations, inconsistent and/or harsh parenting:**

   This is a broad category and treatment and response will vary according to the intensity, severity and chronicity of the situation. At the lower end of the spectrum caregivers who are inconsistent or have unrealistic expectations of their children may benefit from behavioural parent training such as the 'Advanced' form of the Incredible Years programme (Webster-Stratton, 1997; Hurlburt, 2008).

   Approaches that teach the parents about the child's need for a parent who can act as a 'safe base' (i.e. to help them to explore the world) in addition to being a 'safe haven' such as the 'Circle of Security' may also be helpful (Hoffman et al, 2006).

4. **Failure to recognise the child's individuality and emotional boundaries (caregivers using the child primarily to fulfil their own material and/or emotional needs):**

   Work with these troubled caregivers requires considerable skill and sensitivity (Glaser, 2011) and should include helping caregivers understand when and how interactions serve the caregivers' needs, helping the caregiver understand how the child might perceive these interactions and helping the caregiver change them (Glaser, 2011). This may be done individually or through family therapy (Carr, 2009). Again use of the mental health screening tools may assist in determining whether specialist intervention is required.

5. **Failure to promote the child's social development:**

   Caregivers include those who isolate children and discourage participation in peer groups and the educational environment. Cultural factors may play a part and it may therefore be valuable to work on the relationship between

parents and their wider social environment.

Where a child or young person remains at home in a potentially neglectful environment, direct work must be offered to the child to enable him or her to cope. This includes recognising the child's situation without denigrating caregivers, helping the child understand the caregiver's problems, taking a problem-solving approach to helping the child deal with the situation, addressing a child's self-blame and low self-esteem, helping the child develop a relationship with at least one caring and reliable adult, and helping the child to make gains in other areas of life including education, in order to enhance self-worth and resilience (Glaser, 2011).

Parenting worksheets

These parenting worksheets can help you to support parents to address concerns around communication, emotional development, play and stimulation and behaviour. They can form the direction of work during your home visits and have a particular focus on the quality of the relationship with the child and young person.

http://intranet.escc.gov.uk/sites/cs/single-source/Documents/Neglect%20Toolkit/Parenting%20Worksheets.pdf

7. Review

It is essential that we set realistic timescales for progress for children and families and that the tools identified in this resource are used to inform our thinking regarding whether the child's experience has improved.

The timescales to review this progress should fit within case review (CIN/Family Support Review, Core Group, Child Protection Conferences, and Early Help Review).

The areas of risk (identified through assessment/tools) should be the central focus when reviewing progress.

The progress needs to be articulated through the Signs of Safety approach adopted within Children Services Child Plan – please see our guide to writing a child's plan:

http://intranet.escc.gov.uk/sites/cs/single-source/Documents/Outcome%20focused%20plans%20guidance.pdf

What is going well?	What are we worried about?	How will we know when things improve?	Who does what by when?

8. Overview of current research

- **Child Neglect is Everyone's Business**, Research in Practice, April 2015
- **In the child's time: professional responses to neglect**, (Ofsted, March 2014)
- **Missed Opportunities: indicators of neglect – what is ignored, why, and what can be done** (DfE Research report November 2014)
- **Neglect and Serious Case Reviews, Executive Summary**, (Brandon et al, January 2013)
- **Evaluation of the Action for Children UK Neglect Project**, (Long et al, January 2012)
- **Making a difference to the Neglected Child's experience in 2013** (Jan Horwath)
- **A guide to Recognising Neglect and using the Graded Care Profile**: a tool for Herefordshire Council & partners of Herefordshire Safeguarding Children Board, (July 2014)
- **Really useful guide to recognising NEGLECT**: failure of provision, failure of supervision), Southampton LSCB
- **Child Neglect Toolkit for Practitioners**, (South Gloucestershire Safeguarding Children Board, May 2013)
- **Why have we made neglect so complicated? Implications for Early Years**, Brigid Daniel, University of Stirling
- **Working Effectively with Neglected Children and their Families – What Needs to Change?**, Farmer & Lutman, Child Abuse Review Vol 23, (2014)
- **Intervening with Severely and Chronically Neglected Children and Their Families: The Contribution of Trauma-Informed Approaches**, Milot, St-Laurent & Ethier, Child Abuse Review, 2015
- **Grading the Graded Care Profile**, Sen, Green Lister, Ridby & Kendrick, Child Abuse Review, 2014, Vol 23)
- **Reconstruct: Neglected adolescents: recognition and interventions**
- **Community Care webinar: Child Neglect: How to gather and present your evidence**, (Joanna Nicolas, April 28, 2015)

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