**Neglect appraisal tool**

**Introduction**

It is estimated that 10% of all children in the UK are currently experiencing neglect[[1]](#endnote-1). It is the single most frequent reason for children being subject to a child protection plan or registration. Evidence from a range of sources has identified that although practitioners are good at gathering information about children and families, they find it challenging to analyse complex information in order to make judgments about whether a child is suffering, or is likely to suffer, significant harm[[2]](#endnote-2) .

This tool builds on the foundation of extensive experience and study by the NSPCC in the area of neglect assessment. It draws particularly on the research and update of the ‘Graded Care Profile’; the GCP2 and of the ‘NSPCC Neglect Bespoke Assessment Framework’.

Challenges with assessment of neglect include:

* no absolute threshold criteria for defining neglect, therefore difficulty with describing when the significant harm threshold has been met;
* difficulty with acknowledging when harm becomes apparent;
* issues with apportioning harm to the neglect ; and
* continuing undulation of the neglect, so short term improvement overrides long term history.

This is compounded by:

* issues with lack of clarity by professionals as neglect is seen as an homogenous issue where in reality it is complex and multi-faceted;
* lack of true understanding of how child development is impacted by neglect;
* lack of skill in articulating how the neglect is or can impact on current and future development;
* diffculty with the need to balance the risk and protective factors and make a sound judgment based on the evidence; and
* struggles with articulating ‘why now’.

Principles that underpin the tool are:

* This tool is to aid the Guardian’s thinking in reviewing the evidence presented and in undertaking a gaps analysis.
* It does not replace professional judgment, it is designed to support it.
* Not all areas need to be commented on and there are potentially issues which need to be taken into account which may not be included.
* The evidence presented should not reflect the chaos that is evident in a lot of families where neglect is an issue – ‘help the reader’ – think about the structure; have bullet points and headings been used where necessary to make it easier to read and understand.
* Any evidence presented needs to be succinct, evidence based and not repetitive.
* Please refer to the guidance when completing the tool.

**Guidance**

Does the evidence presented demonstrate the extent, type, impact, capacity, risk and protective factors?

Use the tool for each child in the family, so that the issues for each individual child can be articulated clearly.

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| **Area** | **Guidance** |
| **Extent and type of neglect [[3]](#endnote-3)** | This allows the LA SW to articulate the areas where care is lacking and to what level. Should cover some of the areas below. (tools such as GCP2 would articulate this clearly) |
| **Physical care** | |
| 1. Nutrition | Quality as well as quantity |
| 2. Housing | Cleanliness and appropriateness of home environment |
| 3. Clothing | Are the clothes adequate for the weather, do they fit |
| 4. Hygiene | Are the child hygiene needs taken care of |
| 5. Health | Is the child up to date with vaccinations, are they taken to the doctor appropriately, is medical advice followed |
| **Safety** | |
| 6. How safe is the child’s environment | Are there suitable safety measures in pace. Is the house unsafe for the age and development of the child |
| 7. What are the arrangements when the child is left | When the child is left with an adult – is that adult safe, family member or known to be unsafe |
| **Emotional care** | |
| 8. Responsiveness | Does the parent/s\*\* show adequate warmth, response and support. Has the relationship been observed and commented on  How does the child respond to the parent/s? Who initiates the relationship |
| 9. Mutual engagement | Does the child have to demand attention or is the child passive |
| **Developmental care** | |
| 10. Stimulation | Are the child’s education/stimulation needs taken into account? Are there age appropriate toys/support for school? |
| 11. Approval | Does the parent/s demonstrate adequate support for the child |
| 12. Disapproval | Are adequate and age appropriate discipline measures in place. Is the child supervised adequately? |
| 13. Acceptance | Does the parent accept and show appropriate support for the child regardless of the child’s needs or challenges |
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| **Level of neglect** | Has the scale of the neglect been described? The definitions below are a good guide. |
| 14. Does the reportmake it clear about the scale of neglect? Does it identify any single issue which may cause potential immediate harm? | **Mild neglect**  Failure to provide care in one or two areas of basic needs, but most of the time a good quality of care is provided across the majority of the domains.  **Moderate neglect**  Failure to provide good quality care across quite a number of the areas of the child’s needs some of the time. Can occur when less intrusive measures such as community or single agency interventions have failed, or some moderate harm to the child has or is likely to occur (for example, the child is consistently inappropriately dressed for the weather — wearing shorts and sandals in the middle of winter).  **Severe neglect**  Failure to provide good quality care across most of the child’s needs most of the time. Occurs when severe or long-term harm has been or is likely to be done to the child or the parents/ carers are unwilling or unable to engage in work.[[4]](#endnote-4) |
| 15. Chronic nature of the neglect | Does the statement state at what age the neglect started and the duration. Was this during a particularly vulnerable time for the child’s development? I.e. prior to 3. Are there any elements of acute neglectful behaviour which increase the immediate risk i.e. supervisory? |
| **Impact on the child** | The LA SW needs to be able to articulate the impact of the neglect on the child’s physical, social or emotional development |
| 16. Physical | Has the child’s physical development been measured – if under 5yrs (in England) an Ages and Stages assessment should have been undertaken by the HV? Is this included? Is it recent? |
| 17. Emotional | Has the emotional impact on the child been described? A Strength and Difficulties Questionnaire is one way of showing this. Has this been undertaken have the impact been articulated. |
| 18. Lived experience | Has the child’s day been described? Has the parent been asked for their view of their child’s day – are there discrepancies |
| **Parental issues[[5]](#endnote-5)[[6]](#endnote-6)**  **risk factors** | Neglect is often the outcome of parental issues. The impact of these on the parents’ ability to look after their child should be described. It’s not enough to say there is an issue, the impact on their ability to parent needs to be described. It should explain ‘the so what’ question. Have standardised measures been included to measure the level of the issue. It’s important to articulate any acute risk factors which could at any point increase the immediate risk to the child, alongside the enduring risk factors which may be longer term. |
| 19.Situational risk factors[[7]](#endnote-7) | * Acute life stress * Any underlying neglectful behaviour which may lead to immediate harm i.e. supervisory, co sleeping * Acute mental health & physical * health crises * Acute school problems * Acute family relationship conflict   *There are a number of standardised tools which may help articulate the scale of the above issue. Depression/ Anxiety and Stress Scale measures mental health issues (DoH Scales and Measures toolkit)* |
| 1. Enduring risk factors | * Child behaviour, mental health or physical * health problems * Caregiver mental health & physical health * problems, or substance abuse * Impaired caregiver-child relationship * Family conflict * Social isolation * Everyday stress   *The Alcohol or drug audit can be used to scale the alcohol issues. Daily Hassles Scale (DoH) can help describe the daily challenges this family could be facing. The GCP2 will help with describing the parent child relationship.* |
| 1. Underlying risk factors | * Poverty * Caregiver childhood adversity * Experiencing racism * Violence in the community   *Is there some evidence of a short biography for the parent(s)?* |
| 1. Areas particularly relevant in neglect | * Poverty * Domestic abuse * Social isolation/stress * Relocate frequently, distancing themselves both geographically and emotionally * Substance misuse * Mental illness * Learning difficulties * Poor attachment histories of parents * Poor psychological attitudes to children behaviour and quality or relationship * Evidence of apathetic and believe that their efforts are futile * Poor coping skills * Little social and emotional support * Interact with children infrequently   Context – own history, patterns of engagement |
| **Capacity/capability** | |
| 1. Current capacity | Has the current capacity to keep the child safe or free from neglect been described and refers to the question of ‘whether or not parents are capable of meeting their children’s needs. ‘ (DoH 1989) |
| 1. Has the parent’s readiness for change been described? | Has the parent’s readiness for change been described? ([[8]](#endnote-8)Prochaska and DiClemente’s 1984)   * Precontemplation – parents don’t perceive that there is a problem * Contemplation (getting ready) – parents are beginning to recognise that there is an issue, which is affecting their child that they can/should do something about * Preparation (ready) – starting to make small steps * Action – starting to modify behaviour, engage in assessment or the work * Maintenance – understood the assessment, made changes and sustaining them * Relapse – sliding back to previous state (this can happen at any time and for varying periods   Is there comment about how much insight the parent has to his/her behaviour and the impact it has on their child? Has the situation been clearly explained to the parents, is this evidenced – has the quality and relevance of support been described. |
| 1. Motivation to engage | Has the parent demonstrated any motivation to engage in assessments, interventions or change services? |
| 1. Capacity | Refers to the question of whether or not parents are capable of meeting their children’s needs. (DoH 1989) |
| 1. Capacity (capability) to change | Defined as ‘the parents willingness and ability to overcome risk factors’ [[9]](#endnote-9) (Ward et al 2014) Bentovim [[10]](#endnote-10)argues that parents’ failure to take responsibility for their children’s maltreatment, their dismissal of the need for treatment, their failure to recognise their children’s needs and the maintenance of insecure or ambivalent parent–child attachments are all key indicators of a poor prognosis.  Ward et all 2014 states that areas of concern are when:   * When parents do not acknowledge that a problem exists * In DA where there is a pervasive pattern of abuse * Where parents consciously systematically cover up maltreatment   Harnett[[11]](#endnote-11) in 2007 described a way to measure capacity to change – which was   * Complete a standardised tool * Agree SMART goals * Implement package of intervention * Repeat standardised tool |
| 1. Patterns | Does this section review   * Past history of involvement and engagement with services, what has been tried and what the outcome was? * Past history of relationships and putting the needs of the child first. |
| **Protective factors** | |
| 1. Resilience[[12]](#endnote-12)[[13]](#endnote-13) | Resilience has been described by [[14]](#endnote-14)Fonagy et al 1994 as normal development under difficult conditions but also as known as strength and adaptability in the face of adversity and is supported by:   * Good attachment between parent/carer and child * Good Self-esteem in the child * Positive parenting * If the child has a high IQ * If there is flexible parenting * If the child has good problems solving skills * Positive school experience * Supportive adult (apart from parent) * Emotional or behavioural support * Good community or social networks including leisure activities |
| 1. Other positive options | What other positive influences are evident in the life of this child that could be seen to balance out the risks/concerns and how influential are they. |
| **Summary** | |
| 31. Reflection | * Has the evidence demonstrated that the threshold been met?   If not:   * What more needs to be known and how do you get it? * What extra information is required? * Why Now – is it evident in the report why a decision has been made to make an application now? This could be issues such as:   + Despite suitable support there is no evidence of sustained parental change   + The child’s development is being or will be harmed – it would be best to reference this against the child’s age and developmental trajectory.   + The current behaviour puts the child at high risk of other forms of abuse or immediate risk of harm. * Does the structure help the reader? |

**Neglect appraisal tool**

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| **Child’s name:** |  |
| **ECMS number:** |  |
| **Court reference** |  |
| **Guardian’s name:** |  |
| **Local authority:** |  |
| **Date of completion:** |  |

|  |  |
| --- | --- |
| **Area** | **Comments** |
| **Extent type** |  |
| **Level** |  |
| **Impact** |  |
| **Parental risk factors** |  |
| **Capacity** |  |
| **Protective factors** |  |
| **Reflection** |  |
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Don’t forget to save in the Risk and Harm section of ECMS. An additional copy of the tool can be opened here:



1. Cawson, P. (2002) Child maltreatment in the family: the experience of a national sample of young people. London: NSPCC [↑](#endnote-ref-1)
2. Barlow, Fisher, Jones [↑](#endnote-ref-2)
3. Maslow,A.H. (1954) Motivation and Personality. Harper and Row; New York [↑](#endnote-ref-3)
4. Adapted from DePanfellis D (2006) Child Neglect: A Guide for Prevention Assessment and Intervention [↑](#endnote-ref-4)
5. Macdonald G: Effective Interventions for Child Abuse and Neglect: An Evidence-Based Approach to Planning and Evaluating Interventions [↑](#endnote-ref-5)
6. Gruendel et al when Brain Science Meets Public Policy: In brief 2015 [↑](#endnote-ref-6)
7. Gruendel et al when Brain Science Meets Public Policy: In brief 2015 [↑](#endnote-ref-7)
8. Prochaska, JO; Butterworth, S; Redding, CA; Burden, V; Perrin, N; Leo, M; Flaherty-Robb, M; Prochaska, JM. [Initial efficacy of MI, TTM tailoring and HRI's with multiple behaviors for employee health promotion.](http://dx.doi.org/10.1016/j.ypmed.2007.11.007) Prev Med 2008 Mar;46(3):226–31. Accessed 2009 Mar 21 [↑](#endnote-ref-8)
9. Ward et all Assessing Parental Capacity to Change when Children are on the Edge of Care: an overview of current research evidence Research report

   June 2014 , Centre for Child and Family Research, Loughborough University [↑](#endnote-ref-9)
10. (Bentovim *et al* 1987; Bentovim 2004) [↑](#endnote-ref-10)
11. Harnett. P.H. (2007) A procedure for assessing parents’ capacity to change in child protection cases. Children and Youth Services Review 29,9,1179-1188 [↑](#endnote-ref-11)
12. Adapted from Daniel and Wassell, (2002) Assessing and Promoting Resilience in Vulnerable Children Vols. 1,2,3, London and Philadelphia, Jessica Kingsley Publishers [↑](#endnote-ref-12)
13. Adapted from The Child’s World: Assessing Children in Need, Training and Development Pack(Departmetn of Health, NSPCC and Unversity of Sheffield 2000 [↑](#endnote-ref-13)
14. Fonagy, P., Steele H. Higgitt, A. and Target M (1994)The Emmanuel Miller Memorial Lecture1992. @The Theory of practice of resilience’, Journal of Child Psychology and Psychiatry, 35,2,231-257 [↑](#endnote-ref-14)