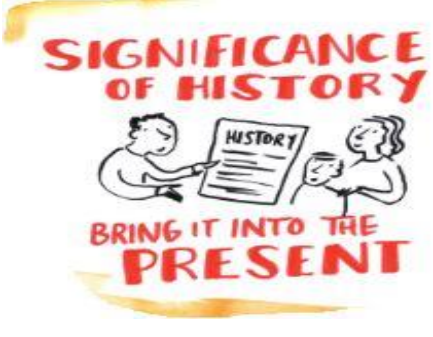
LONDON BOROUGH OF BEXLEY

Neglect Strategy and Toolkit

August 2016



Title: Neglect Strategy V3	
Date of publication: August 2016 ***Date for review: January 2018***	***Responsible Manager:*** ***Sara Taylor, Service Manager***
Electronic file location: N:\Directorate of Social & Community Services\Children & Families\Strategies Policies & Procedures\Strategies\Neglect Strategy and resources	
Associated statutory guidance and regulations: **Pan London Child Protection Protocols, available on the Bexley Local Safeguarding Children Board website at: http://www.bexleylscb.org.uk/page.php?section=section_5&id=311** **Working Together to Safeguard Children, a guide to inter-agency working to safeguard and promote the welfare of children, Department for Education Statutory Guidance March 2015: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2**	
Key Objectives (including Signs of Safety principles to apply) **1. To support practitioners to recognise and effectively work with neglect.** **2. To provide a practice resource for working with children and families.** **3. To use Signs of Safety principles to identify strengths in families wherever possible.**	

Introduction

This strategy has been developed in response during 2015 to audit and quality assurance reviews of neglect cases in the London Borough of Bexley and to incorporate the findings and recommendations from the Ofsted Thematic Inspection Report *In the Child's Time: Professional Responses to Neglect (2014)* into practice.

Neglect has far reaching and long term effects on children and young people. Children who are exposed to chronic neglect may suffer from a wide range of difficulties leading to poor physical health, underachievement in education and social and emotional difficulties. The effects can extend into adult life and lead to poor functioning and impact on an individual's own ability to parent. Neglect is often difficult to recognise as the impact is cumulative and the concerns may increase gradually over a long period of time.

Neglect is a complex area of practice, presenting particular challenges. It requires skilful use of assessment, professional authority and direct work with the child and parents to effect change. Professionals need to be alert to the complexity of practice in this area. *Working Together to Safeguard Children* (2015) highlights some of the challenges of working with neglect:

Neglect can fluctuate both in level and duration. A child's welfare can, for example, improve following input from services or a change in circumstances and review, but then deteriorate once support is removed. Professionals should be wary of being too optimistic. Timely and decisive action is critical to ensure that children are not left in neglectful homes (DfE, 2015).

Professionals must be able to balance the right to family life with the need to intervene to safeguard a child. Assessment of neglect must be rooted in evidence to clearly demonstrate the impact on the child and measures of parental capacity to change. The challenge of working effectively with neglect and the need for cogent evidence is no more clearly set out than in *A (a child) v Darlington Borough Council (2015) EWFC.* As Munby HHJ sets out in his judgment:

In the present case, as we shall see, an important element of the local authority's case was that the father "lacks honesty with professionals", "minimises matters of importance" and "is immature and lacks insight of issues of importance". May be. But how does this feed through into a conclusion that A is at risk of neglect? The conclusion does not follow naturally from the premise. The local authority's evidence and submissions must set out the argument and explain explicitly why it is said that, in the particular case, the conclusion indeed follows from the facts.

The complexity of working with neglect and being able to effect meaningful change with the family concerned cannot be underestimated. Recommendations for local authorities and LSCBs to effectively manage working with neglect are set out in Ofsted's thematic inspection report (2014). The report identifies a variable standard of practice amongst all professionals leading to inconsistent practice and safety planning which can result in children being left in neglectful situations for too long.

The report concludes that:

Those local authorities providing the strongest evidence of the most comprehensive action to tackle neglect were more likely to have a neglect strategy and/or a systematic improvement programme across policy and practice, involving the development of specific approaches to neglect (Ofsted, 2014).

This document sets out the London Borough of Bexley's aims and objectives to approach working with neglect. It highlights messages from research and identifies the key principles of good practice with

neglect. It provides a resource for assessment and a framework for practice, including learning and quality assurance.

Definition of Neglect

Neglect is defined as the persistent failure to meet a child's basic physical and / or psychological needs, such that it is likely to result in the serious impairment of the child's health or development.

Neglect may occur during pregnancy as a result of maternal substance misuse, maternal mental ill health or learning difficulties or a cluster of such issues. Where there is domestic abuse and violence towards the mother, the needs of the child may also be neglected.

Once a child is born, neglect may involve a parent or carer failing to:

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

It may also include neglect of, or unresponsiveness to, a child's basic emotional, social and educational needs.[1]

As well as the statutory definition, practitioners need to have regard for the specific needs of children and young people that are often subsumed under the term 'failure to meet basic needs'. (Howarth, 2007). These include:

- Medical neglect
- Nutritional neglect
- Emotional neglect
- Educational neglect
- Physical neglect
- Lack of supervision and guidance

It is important that practitioners recognise that children and young people who are being neglected may also be experiencing other forms of abuse and maltreatment. Practitioners need to have an understanding of the overlap between neglect and other types of abuse.

The Bexley Context

Neglect is a key factor for a number of children/young people open to Bexley Children's Social Care. During 2015, approximately 50% of children subject to child protection plans were as a result of neglect. Furthermore, there were approximately 600 children with a current child in need status open to the locality teams. The Liquid Logic system is currently unable to differentiate the reasons for cases being open, however we can reasonably surmise that the child in need population is similar to the child protection population. Therefore we are likely to be working with approximately 400 families at any one time (300 child in need & 100 child protection cases), where neglect is a factor.

In order to explore how neglect is managed within Bexley Children's Social Care, in October 2015 a series of case file audits were undertaken. Child Protection Chairs looked at 11 cases which had been subject to child protection for over a year and Team Managers in the Locality Service audited 22 child in need neglect cases that had been open for less than a year.

[1] *London Child Protection Procedures* (2017), 5th edition, London, online at http://www.londoncp.co.uk/index.html

The combined findings and learning were as follows.

	Good	Requires improvement	Inadequate
Standard of Practice	44%	44%	12%
Impact on Outcomes	44%	40%	16%

What is working well?

- Regular core group meetings take place for children subject to child protection plans.
- Collaborative practice amongst professionals to develop & work with child in need plans. Some child in need plans are of good quality and demonstrate collaboration with families.
- Chronologies are mostly present on case files.
- Signs of Safety is starting to be used (introduced in July 2015) in assessing risk and working in partnership with parents/cares to identify strengths and risks.

What we are worried about?

- The quality of plans remains variable and inconsistent across teams. In general, goals are set but safety measures and what we need to see change is absent, which contributes to drift.
- Plans are not always reviewed or updated with strengths and progress being recognised.
- Actions we need to take if things don't change is also not well expressed or set out for the families and children.
- Children/young people need to understand why they are receiving social work help and what is going to happen.
- Case recording requires improvement. This includes chronologies and case summaries being updated, case notes lacking analysis, limited evidence of collaborative work with families, S47 enquires lacking detail and analysis of what needs to happen and minutes from child in need meetings are not always evident.

Messages from Research - Common pitfalls of practice[2]

- Inadequate assessments that do not identify the seriousness, nature and cause of neglect. Insufficient consideration is given to the cumulative impact of chronic neglect because past history is not sufficiently considered.
- Over assessing in the search for certainty, at the expense of meaningful intervention.
- A lack of clear planning where there are not clear outcomes to measure change.
- Feeling hopeless and unable to effect change, which can lead to drift and delay, unnecessary referrals to other services, active looking away and/or cases being closed prematurely despite a lack of progress.
- Difficulties and confidence working with hostile, avoidant and resistant parents. This can lead to accepting unlikely explanations, being unable to distinguish behaviour that is complaint and/or disguised compliance from real engagement
- Being over-optimistic about capacity for change or the ability for change to be sustained.
- Becoming desensitised to the child's situation and acclimatised to poor standards of care which normalises the concerns.
- Over-identification with parents and the threshold for action can become too high.

[2] Adapted from Wilkins, D., (2015) *Which assessment tool? A comparison of neglect tools used nationally to identify and assess levels of child neglect,* online at http://ccinform.co.uk

- Lack of understanding about what constitutes neglect & threshold disputes, leading to splitting of professionals.
- Multiple professionals involved and difficulties in information sharing between them.
- Failure to revise initial judgements.
- Concentrating on the processes and procedural ritual tasks (e.g. meetings & visits) to diffuse and manage uncertainty and anxiety, losing focus on the child and the purpose of the intervention.

Messages from Research – What does good practice look like?

Early help is a key factor in working with child neglect. Munro (2011) recognises the need for early intervention to tackle child maltreatment and improve outcomes for children.

Recognition of the prevalence of neglect is important to help practitioners understand its impact on children and young people. Data gathered by the NSPCC confirms that 'neglect remains the most common form of child abuse across the UK, and is usually the most common cause for being subject to a child protection plan or on a child protection register across all UK nations' (Jutte et al, 2015).

Other risk factors in the family may increase the likelihood of child neglect. An NSPCC summary briefing of case reviews (2015) indicates these factors include domestic abuse, parental mental ill health difficulties, drug and alcohol misuse, poor housing, employment and poverty. Some groups of children and young people are also particularly at risk of being neglected. These include new born babies and babies with ongoing health needs. Teenagers in families where neglect is a concern can also be overlooked due to a focus on younger siblings.

Turney and Tanner (2005) identify a number of factors that help when working with neglect. These include:

- Proactive assessment of neglect as an issue in its own right. Don't wait for an incident to happen and consider quality of the overall care of the child.
- Addressing the underlying causes not the symptoms.
- Using an ecological framework to understand and the complexity of neglect and offer more effective help. Work with the whole family network wherever possible.
- Multidisciplinary assessment with effective sharing of information and a clear plan which the family and professionals understand
- Understanding family histories and patterns of interaction over time using chronologies, genograms and direct observation of family interactions.
- Matching interventions to identified needs by being flexible and creative about what can help individual families.
- Relationships based practice can build social support and networks to help families build resilience.
- Appropriate time scales and purposeful, focused help.
- Measurable goals for change and ways to evaluate progress. Practitioners and families need to be clear about what an acceptable outcome will be for the child/ren and how they will know this has been achieved.
- Work with parents by building and sustaining a relationship to help the family change.
- Work with children within a resilience framework. Find out what life is like for the child by working with them frequently and in a meaningful way. Help the child build resilience through relationship building, achievement at school or other interests.

The organisational context can also promote a more effective response to working with neglect.

Gardner (2008) identifies leadership and support in case planning and review, regular use of research, training and best practice updates, opportunities for case reflective and regular case audit as ways to promote effective working with neglect and prevent professional burnout and desensitisation.

The NSPCC (2015) highlights key learning for improved practice including:

- Be aware of children who are more vulnerable to neglect,
- Monitor missed appointments.
- Pay attention to accidents and injuries.
- Have confidence and knowledge to effectively assess parental capacity to change.
- See the bigger picture and understand the long-term impact of neglect.
- Support families through early evidence-based assessment and intervention.
- Work closely with other agencies to identify concerns and plan interventions.
- Undertake robust and comprehensive assessments.
- Keep focus on the need to improve outcomes for the child's daily lived experience.
- Use staff supervision to avoid case drift.

Signs of Safety

Signs of Safety provides a framework for practice focusing on strengths as well as risks. It enables practitioners to work collaboratively with families and children to develop safety plans using the strengths and resources of the family and wider network. The London Borough of Bexley uses Signs of Safety as its practice model. The NSPCC (2013) commissioned a report to review the research literature and the effectiveness of the model. Some of the key research messages were;

- Signs of Safety is described by practitioners as a useful framework for addressing danger and harm, particularly in complex cases.
- Signs of Safety helps identify risk.
- Practitioners felt more confident to describe behaviours and frequencies rather than generic terms such as the child is being neglected.
- Signs of Safety increases co-operation and engagement.
- There is a focus on individual families and their needs rather than a family having a certain type of problem.
- Parents liked focusing on strengths and not just problems.
- The approach helped parents to see things from the child's perspective.
- The tools gave younger children a voice and a say.
- Using Signs of Safety means that action and change was more likely to happen.

Safety Planning and Working with Neglect

Turnell (2013) sets out the key question in safety planning as '*What do you think needs to be in place to show everybody (including the child protection professionals) that the children will be safe and well looked after when they are (back) with you?*' (Turnell, 2013:22). Professionals need to help families think about the issues they are facing and how they might be able to address them to promote the child's safety. The following elements are suggested as typically needing to be addressed when working with a safety plan in a neglect case:

Neglect:

- *Careful exploration of typical times, events and triggers (for example mental illness, grief, developmental delay, alcohol/drug use) that have typically led to previous neglect, then explore specific rules that detail how the parents will deal with and respond to these circumstances in the future to ensure the children get 'good enough' care in these circumstances.*

- *Specific parenting routines and responses that need to be in place for the child to receive 'good enough' care, emotional security and stimulation.*

- *People in the safety network who will provide care, emotional security and stimulation if the parent(s) are unable to do.*

- *Signs for others that problems are building and they need to step or act to make sure the children are okay and the problems don't become worse.* (Turnell, 2013:23).

Neglect Resources

You can use Signs of Safety case mapping and group supervision to review your work with neglect cases. You can find Signs of Safety resources here.

Tools for direct work with children and young people and Signs of Safety direct work resources can be found here.

Neglect Toolkit

Bexley has developed a tool to help practitioners assess and work with neglect. It is designed to assist you in identifying and assessing children who are at risk of or who are being neglected. It is to be used when you are concerned that the quality of care of a child you are working with suggests that their needs are being neglected. It will help you to reflect on the child's circumstances and will help you put your concerns into context and identify strengths and resources.

It can be used to inform decision-making, assessments and planning. It can also be used in individual or 'Signs of Safety' group supervision or as part of case mapping discussions. Signs of Safety case mapping guidance and other resources can be found here. It can be used with families and does not replace other assessments such as children's social care assessments carried out in accordance with section 17 or 47 of the Children Act 1989.

Acknowledgements

London Borough of Bexley has adapted this work which was initially developed by Jane Wiffin on behalf of Hounslow LSCB, being further refined by Brent and Islington LSCB. The original concept came from work undertaken by Dr Leon Polnay and Dr O P Srivastava at Bedfordshire and Luton Community NHS Trust and Luton Borough Council (1997)[3].

[3] Srivastava, O.P., Polnay, L. (1997) *Field trial of graded care profile (GCP) scale: a new measure of care* in Archives of Disease in Childhood (1997) 76, 337–340

Introduction

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Using the tool

It should be used when there are concerns about whether the child's physical and emotional needs are being neglected. It will assist with the early identification of neglect and in coordinating support for families in need of additional help. The checklist can also be used to track improvements, deterioration or 'drift'.

This procedure should not be considered as a set of prescriptive rules, but advice that should be used to support and enhance your professional judgement, discussions and decisions. Neglect is persistent and its impact is complex to judge. Make sure you liaise closely with your service managers in the decisions you make. Keep solid evidential records, using photographs where possible to support and monitor change.

The advice focuses on five key areas of need and considers the extent to which children's needs are being neglected and/or the needs of their parents/carers are taking precedence. The toolkit details indicators and the possible impact on the child with four specific ratings where 1 is child focused care giving and 4 describes the child's needs not being considered.

The five key areas of need are:

1. Physical care
2. Health
3. Safety and supervision
4. Love and care
5. Stimulation and education.

Area 6 focuses on parental motivation and capacity to change.

By working through the process and scoring individual sections you will be able to identify strengths as well as areas of concern. Scores of 3 and 4 are cause for concern and should prompt further urgent discussion with your manager.

[4] *London Child Protection Procedures* (2017), 5th edition, London, online at http://www.londoncp.co.uk/index.html

Using the Process with Parents and Carers

The work can be useful tool to use with parents to facilitate discussions about their child's welfare and their hopes and ability to change.

Thinking about Neglect

Practice Guidance:

Use this guide when you are working with a family or children where neglect is a worry. You can complete it with the parent/s and children depending on their age and you can use it to measure progress and change. When completed, it should be uploaded onto the child's electronic file.

Child's name: _____ DOB: _____

Practitioner: _____ Date:_____

Agency:_____

Development Need	Score				Examples/evidence of impact child/young person
AREA 1: PHYSICAL CARE	1	2	3	4	
Food					
Quality of housing					
Stability of housing					
Child's clothing					
Animals					
Hygiene					
AREA 2: HEALTH and MEDICAL					
Safe sleeping arrangements and co-sleeping for babies					
Seeking advice and intervention					
Disability and illness, including regular					

appointments and checks					
AREA 3: SAFETY and SUPERVISION					
Safety awareness and features					
Supervision of the child					
Handling of baby/response to baby					
Care by other adults					
Responding to adolescents					
Traffic awareness and in car safety					
AREA 4: LOVE and CARE					
Parent/carer's attitude to child, warmth and care					
Boundaries					
Adult arguments and violence					
Young caring					
Positive values					
Adult behaviour					
Substance misuse					
AREA 5: STIMULATION, PLAY and EDUCATION					
Unborn					
0-2 years					
2-5 years					
School					
Sport and Leisure					
Friendships					
Addressing bullying					
PARENTAL CAPACITY FOR CHANGE					

Total in each area					

Strengths - what is going well?

Worries - what is not going well?

Complicating Factors - what don't we know?

Danger Statements - what are we worried will happen if nothing changes?

Safety Goals – what will life be like for the children if there have been changes which increase safety?

Safety Scale 0 ---------- 10		
You and other people in the child's network are so worried about the child that you don't think it is safe for the child to be looked after in this family at the moment.		You and other people in the child's network are not worried about the child at all. The family do not need help from a social worker.

What are the next steps to move up the scale even by 0.5?

CONTENT

PHYSICAL CARE

Food

Quality of housing

Stability of housing

Child's clothing

Animals

Hygiene

HEALTH and MEDICAL

Safe sleeping arrangements and co-sleeping for babies

Seeking advice and intervention

Disability and illness, including regular appointments and checks

SAFETY and SUPERVISION

Safety awareness and features

Supervision of the child

Handling of baby/response to baby

Care by other adults

Responding to adolescents

Traffic awareness and in car safety

LOVE and CARE

Parent/carer's attitude to child, warmth and care

Boundaries

Adult arguments and violence

Young caring

Positive values

Adult behaviour

Substance misuse

STIMULATION, PLAY and EDUCATION

Unborn

0-2 years

2-5 years

School

Sport and Leisure

Friendships

Addressing bullying

PARENTAL CAPACITY FOR CHANGE

PHYSICAL CARE: Food

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Child is provided with appropriate quality of food and drink, which is appropriate to their age and stage of development. Meals are organised and there is a routine which includes the family sometimes eating together Children's special dietary requirements are always met Carer understands importance of foods	Child is provided with reasonable quality of food and drink and seems to receive an adequate quantity for their needs, but there is a lack of consistency in preparation and routine. Children's special dietary requirements are inconsistently met. Carer understands the importance of appropriate food and routine but sometimes their personal circumstances impact on ability to provide.	Child receives low quality food and drink, which is often not appropriate to their age and stage of development and there is a lack of preparation or routine. Child appears hungry Children's special dietary requirements are rarely met. The carer is indifferent to the importance of appropriate food for the child.	Child does not receive an adequate quantity of food and is observed to be hungry. The food provided is of a consistently low quality with a predominance of sugar, sweets, crisps and chips etc. Children's special dietary requirements are never met and there is a lack of routine in preparation and times when food is available. Carer hostile to advice about appropriate food and drink and the need for a routine.

PHYSICAL CARE: Quality of Housing

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
The accommodation has all essential amenities such as heating, shower, cooking facilities, adequate beds and bedding and a toilet and is in a reasonable state of repair and decoration. Carer understands the importance of the home conditions to child's well-being.	The accommodation has some essential amenities, but is in need of decoration and requires repair. Carers are aware of this, and have taken steps to address these issues. The accommodation is reasonably clean, but may be damp, but the carer addresses this. Carer recognises the importance of the home conditions to the child's sense of well-being, but is hampered by personal circumstances.	The accommodation is in a state of disrepair, carers are unmotivated to address this and the child has suffered accidents and potentially poor health as a result. The look is bare and possibly dirty/smelly and there are inadequate amenities such as beds and bedding, a dirty toilet, lack of clean washing facilities and the whole environment is dirty and chaotic. The accommodation smells of damp and there is evidence of mould.	The accommodation is in a dangerous state of disrepair and this has caused a number of accidental injuries and poor health for the child. The look is dirty and squalid and there is a lack of essential amenities such as a working toilet, showering/bathing facilities, inappropriate and dirty bed and bedding and poor facilities for the preparation of food. Faeces or other harmful substances are visible, and house smells. The accommodation smells strongly of damp and there is extensive mould which is untreated and the carer is hostile to advice about the impact of the home circumstances on child's well being.

PHYSICAL CARE: Stability of Housing

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Child has stable home environment without too many moves (unless necessary). Carer understands the importance of stability for child.	Child has a reasonably stable home environment, but has experienced house moves/ new adults in the family home. Carer recognises that this could impact on child, but the carer's personal circumstances occasionally impact on this.	Child does not have a stable home environment, and has either experienced lots of moves and/or lots of adults coming in and out of the home for periods of time. Carer does not accept the importance of stability for child.	Child experiences lots of moves, staying with relatives or friends at short notice (often in circumstances of overcrowding leading to children sleeping in unsuitable circumstances). The home has a number of adults coming and going. Child does not always know these adults who stay over. Carer is hostile about being told about the impact on child of instability.

PHYSICAL CARE: Child's clothing

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Child has clothing which is clean and fits appropriately. Child is dressed appropriately for the weather and carers are aware of the importance of appropriate clothes for the child in an age appropriate way.	Child has clothes which are appropriate, but are sometimes poorly fitting, unclean and crumpled. The carer gives consideration to the appropriateness of clothes to meet the needs of the child in an age appropriate way, but their own personal circumstances can get in the way.	Child has clothing which is dirty and crumpled, in a poor state of repair and not well fitting. The child lacks appropriate clothes for the weather and does not have sufficient clothing to allow for regular washing. Carer(s) are indifferent to the importance of appropriate clothes for the child in an age appropriate way.	Child has clothes which are filthy, ill fitting and smelly. The clothes are usually unsuitable for the weather. Child may sleep in day clothes and is not provided with clean clothes when they are soiled. The carer is hostile to advice about the need for appropriate clothes for the well being of the child.

PHYSICAL CARE: Animals

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Animals are well cared for and do not present a danger to children or adults. Children are encouraged to behave appropriately towards animals.	Animals look reasonably well cared for, but contribute to a sense of chaos in the house. Animals present no dangers to children or adults and any mistreating of animals is addressed.	Animals not always well cared for or ailments treated. Presence of faeces or urine from animals not treated appropriately and animals not well trained. The mistreatment of animals by adults or children is not addressed.	Animals not well cared for and presence of faeces and urine in living areas. Animals dangerous and chaotically looked after. Carers do not address the ill treatment of animals by adults or children.

PHYSICAL CARE: Hygiene

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
The child is clean and is either given a bath/washed daily or encouraged to do so in an age appropriate way. The child is encouraged to brush their teeth and head lice, skin complaints etc are treated appropriately. Nappy rash is treated appropriately. Carers take an interest in the child's appearance	The child is reasonably clean, but the carer does not bath/wash the child regularly and/or the child is not consistently encouraged to do so in an age appropriate way. The child does not always clean their teeth, and head lice and skin conditions etc are treated in an inconsistent way. Nappy rash is a problem, but parent treats if given encouragement and advice.	The child looks unclean and is only occasionally bathed/ washed or encouraged to do so in an age appropriate way. There is evidence that the child does not brush their teeth, and that head lice and skin conditions etc are not treated appropriately. Carer does not address concerns about nappy rash and is indifferent to concerns expressed by others. Carers do not take an interest in child's appearance and do not acknowledge the importance of hygiene to the child's wellbeing	The child looks dirty, and is not bathed or washed or encouraged to do so. The child does not brush teeth. Head lice and skin conditions are not treated and become chronic. Carer does not address concerns about nappy rash and is hostile to concerns expressed by others. The carer is hostile to concerns expressed by others about the child's lack of hygiene.

HEALTH: Safe sleeping arrangements and co-sleeping for babies

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Carer has information on safe sleeping and follows the guidelines. There is suitable bedding and carers having an awareness of the importance of the room temperature, sleeping position of the baby and carer does not smoke in household. Carer aware of guidance around safe co-sleeping and recognises the importance of the impact of alcohol and drugs on safe co-sleeping. There are appropriate sleeping arrangements for children.	Carer has information on safe sleeping, but does not always follow guidelines, so bedding, temperature or smoking may be a little chaotic and carer may not be aware of sleeping position of the baby. (Be aware this raises risk of cot death). Carer aware of the dangers of co-sleeping and recognises the dangers of drugs and alcohol by the carer on safe co-sleeping, but this is sometimes inconsistently observed. Sleeping arrangements for children can be a little chaotic.	Carer unaware of safe sleeping guidelines, even if they have been provided. Carer ignores advice about beds and bedding, room temperature, sleeping position of the baby and smoking. (Be aware this raises risk of cot death). Carer does not recognise the importance of safe co-sleeping or the impact of carer's alcohol /drug use on safety. Sleeping arrangements for children are not suitable and carer is indifferent to advice regarding this. Carer not concerned about impact on child.	Carer indifferent or hostile about safe sleeping guidance. Sees it as interference and does not take account of beds and bedding, room temperature, sleeping position of the baby and adults smoke in the household. (Be aware this raises risk of cot death). Carer hostile to advice about safe sleeping and the impact of carer 's drug and alcohol on safe co-sleeping for the baby. Sleeping arrangements for children are not suitable and carer is hostile to advice regarding this. Carer not concerned about impact on child or risks associated with this, such as witnessing adult sexual behaviour.

HEALTH: Seeking advice and intervention

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Advice sought from professionals/ experienced adults on matters of concern about child's health. Appointments are made and consistently attended. Preventative care is carried out such as dental/optical and all immunisations are up to date. Carer ensures child completes any agreed programme of medication or treatment.	Advice is sought about illnesses, but this is occasionally delayed or poorly managed as a result of carer difficulties. Carer understands the importance of routine care such as optical/dental but is not always consistent in keeping routine appointments. Immunisations are delayed, but eventually completed. Carer is inconsistent about ensuring that the child completes any agreed programme of medication or treatment, but does recognise the importance to the child, but personal circumstances can get in the way.	The carer does not routinely seek advice about childhood illnesses but does when concerns are serious or when prompted by others. Dental care and optical care are not routinely attended to. Immunisations are not up to date, but carer will allow access to children if home visits are carried out. Carer does not ensure the child completes any agreed programme of medication or treatment and is indifferent to the impact on child's wellbeing.	Carer does not attend to childhood illnesses, unless severe or in an emergency. Childhood illnesses allowed to deteriorate before advice/care is sought. Carer hostile to advice from others (professionals and family members) to seek medical advice. Routine appointments such as dental and optical not attended to, immunisations not up to date, even if a home appointment is offered. Carer does not ensure that the child completes any agreed programme of medication or treatment and is hostile to advice about this from others, and does not recognise likely impact on child.

HEALTH: Disability and illness

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Carer positive about child's identity and values him/her. Carer complies with needs relating to child's disability. Carer is proactive in seeking appointments and advice and advocating for the child's well-being.	Carer does not always value child and allows issues of disability to impact on feelings towards the child. Carer is inconsistent in their compliance with needs relating to child's disability, but does recognise the importance to the child, but personal circumstances get in the way. Caregiver accepts advice and support but is not proactive in seeking advice and support around the child's needs.	Carer shows anger and frustration at child's disability. Often blaming the child and not recognising identity. Carer does not ensure compliance with needs relating to child's disability, and there is significant minimisation of child's health needs. The carer does not seek or accept advice and support around the child's needs, and is indifferent to the impact on the child.	Carer does not recognise child's identity and is negative about child as a result of the disability. Carer does not ensure compliance with needs relating to child's disability, which leads to deterioration of the child's well-being. Carer hostile when instructed to seek help for the child, and is actively hostile to any advice or support around child's disability

SAFETY & SUPERVISION: Safety awareness and features

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Carer aware of safety issues and there is evidence of safety equipment use and maintenance	Carer is aware of safety issues, but is inconsistent in use and maintenance of safety equipment, and allows personal circumstances to get in the way of consistency.	The carer does not recognise dangers to child and there is a lack of safety equipment, and evidence of daily dangers to the child. Carer indifferent to advice about this and does not recognise or acknowledge the impact on the child.	Carer does not recognise dangers to the child's safety and hostile to advice regarding this, does not recognise the importance to the child, and can hold child responsible for accidents and injuries.

SAFETY & SUPERVISION: Supervision of the child

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Appropriate supervision is provided in line with age and stage of development. Carer recognises the importance of appropriate supervision to child's well-being.	Variable supervision is provided both indoors and outdoors, but carer does intervene where there is imminent danger. Carer does not always know where child is and inconsistent awareness of safety issues when child away from home. Shows concern about when child should be home. Carer aware of the importance of supervision, but does allow personal circumstances too impact on consistency.	There is very little supervision indoors or outdoors and carer does not always respond after accidents. There is a lack of concern about where child is or who they are with and the carer is inconsistently concerned about lack of return home or late nights. Carer indifferent to importance of supervision and to advice regarding this from others.	Complete lack of supervision. Young children contained in car seats/pushchairs for long periods of time. The carers are indifferent to whereabouts of child, and often do not know where child is or who they are with, and are oblivious to any dangers. There are no boundaries about when to come home or late nights. Carer hostile about advice from others regarding appropriate supervision and does not recognise the potential impact on children's wellbeing.

SAFETY & SUPERVISION: Handling of baby / response to baby

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Carer responds appropriately to the baby's needs and is careful whilst handling and laying the baby down, frequently checks if unattended. Carer spends time with baby, cooing and smiling, holding and behaving warmly.	The carer is not always consistent in their responses to the baby's needs, because their own circumstances get in the way. Carer is a bit precarious in handling and is inconsistent in supervision. Carer spends some time with the baby, cooing and smiling, but is led by baby's moods, and so responds negatively if baby unresponsive.	Carer does not recognise the importance of responding consistently to the needs of the baby. Handling is precarious and baby is left unattended (bottle left in the mouth). Carer does not spend time with baby, cooing or smiling, and does not recognise importance of comforting baby when distressed.	Carer does not respond to the needs of the baby and only addresses issues when carer chooses to do so. There is dangerous handling and the baby is left dangerously unattended. The baby is strapped into a car seat or some other piece of equipment for long periods and lacks adult attention and contact. Carer hostile to advice to pick baby up, and provide comfort and attention. Carer does not recognise importance to baby.

SAFETY & SUPERVISION: Care by other adults

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Child is left in care of a vetted adult. Never in sole care of an under 16. Parent/child always aware of each other's whereabouts. Out of necessity a child aged 1-12 is left with a young person under 14 who is familiar and has no significant problem for no longer than necessary as an isolated incident.	Child 0-9 year old is sometimes left with a child age 10-13 or a person known to be unsuitable. Parents unsure of child's whereabouts. Carer inconsistent in raising the importance of a child keeping themselves safe from others and provides some advice and support. Carer aware of the importance of safe care, but sometimes is inconsistent because of own personal circumstances.	Child 0-7 year old is left with an 8-10 year old or an unsuitable person. Child found wandering and/or locked out. Carer does not raise awareness of the importance of child keeping themselves safe from others and provides no advice and support. Carer is indifferent to the importance of safe care of the child and leaves the child with unsuitable or potentially harmful adults and does not recognise the potential risks to the child.	Child 0-7 year old is left alone or in the company young child or an unsuitable person. Child often found wandering and/or locked out. Carer does not provide any advice about keeping safe, and may put adult dangers in the way of the child. Carer hostile to advice or professional challenge about giving safe care and impact of children being left with unsuitable and/or unsuitable or dangerous adults.

SAFETY & SUPERVISION: Responding to adolescents

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
The adolescent's needs are fully considered with appropriate adult care. Where risky behaviour occurs it is identified and responded to appropriately by the carer.	The carer is aware of the adolescent's needs but is inconsistent in responding to them. The carer is aware that the adolescent needs appropriate care but is inconsistent in providing it. Where risky behaviour occurs the carer responds inconsistently to it.	The carer does not consistently respond to the adolescent's needs and recognises risky behaviour but does not always respond appropriately.	The adolescent's needs are not considered and there is not enough appropriate adult care. The carer does not recognise that the adolescent is still in need of guidance with protection from risky behaviour i.e. lack of awareness of the adolescent's whereabouts for long periods of time or seeking to address either directly or by seeking support of risky and challenging behaviour. The carer does not have the capacity to be alert to and monitor the adolescent moods for example recognising depression which could lead to self harm.

SAFETY & SUPERVISION: Traffic awareness & in-car safety

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Baby/Infant is well secured in pram/pushchair. Where a toddler is walking their hand is held safely. 3 – 5 yrs old are allowed to walk without holding hands, but are close and in vision. 5- 8 yr olds are allowed to cross with 13+ year old. Child taught traffic skills as per developmental needs.	Baby/infant not always secured in pushchair and 3- 5 yr old not fully supervised. 7yrs onwards are allowed to cross with another young child alone and 8 yrs old crosses regardless of suitability. Child given some guidance about traffic skills.	Baby/infant not secured in pushchair and 3- 5 yr old dragged along with annoyance or left to follow behind alone, with supervision. Under 7s onwards are allowed to cross road alone. Child not taught traffic skills.	Babies/infants are unsecured in pram/pushchair and carer is careless with pram. There is a lack of supervision around traffic and an unconcerned attitude. Lacks understanding of why teaching traffic skills might be important for the child.

LOVE AND CARE: Parent/carer's attitude to child, warmth and care

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Carer talks warmly about the child and is able to praise and give appropriate emotional reward. The carer values the child's cultural identity and seeks to ensure child develops a positive sense of self. Carer responds appropriately to child's needs for physical care and positive interaction. The emotional response of the carer is one of warmth. Child is listened to and carer responds appropriately. Child is happy to seek physical contact and care. Carer responds appropriately if child distressed or hurt. Carer understands the importance of consistent	Carer talks kindly about the child and is positive about achievements most of the time but allows their own difficulties to impact. Carer recognises that praise and reward are important but is inconsistent in this. Carer recognises child's cultural identity and is aware of the importance of ensuring child develops a positive sense of self, but sometimes allows personal circumstances to impact on this. Child is main initiator of physical interaction with carer who responds inconsistently or passively to these overtures. Child not always listened to and carer angry if child seeks comfort through negative emotions	Carer does not speak warmly about the child and is indifferent to the child's achievements. Carer does not provide praise or reward and is dismissive of praise from others. Carer does not recognise the child's cultural identity and is indifferent to the importance of ensuring that the child develops a positive sense of self Carer seldom initiates interactions with the child and carer is indifferent if child attempts to engage for pleasure, or seek physical closeness. Emotional response is sometimes brisk or flat and lacks warmth. Can respond aggressively or dismissively if child distressed or hurt.	Carer speaks coldly and harshly about child and does not provide any reward or praise and is ridiculing of the child when others praise. Carer is hostile to advice about the importance of praise and reward to the child. Carer hostile to the child's cultural identity and to the importance of ensuring that the child develops a positive sense of self. Carer does not show any warmth or physical affection to the child and responds negatively to overtures for warmth and care. Responds aggressively or dismissively if child distressed or hurt. Carers will respond to incidents of harm if they consider themselves to be at risk of involvement with the

demonstrations of love and care.	such as crying. Does not always respond appropriately if child distressed or hurt. Carer understands the importance of demonstrations of love and care, but own circumstances and difficulties sometimes get in the way.	Carer indifferent to advice about the importance of love and care to the child.	authorities. The emotional response of carers is harsh, critical and lacking in any warmth. Carer hostile to advice about the importance of responding appropriately to the child.

LOVE AND CARE: Boundaries

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Carer provides consistent boundaries and ensures child understands how to behave and to understand the importance of set limits. Child is disciplined appropriately with the intention of teaching proactively.	Carer provides inconsistent boundaries and uses mild physical and moderate other sanctions. The carer recognises the importance of setting boundaries for the child, but is inconsistent because of own personal circumstances or difficulties.	Carer provides few boundaries, and is harsh and critical when responding to the child's behaviour and uses physical sanctions and severe other sanctions. Carer can hold child responsible for their behaviour. Carer indifferent to advice about the need for more appropriate methods of disciplining.	Carer provides no boundaries for the child and treats the child harshly and cruelly, when responding to their behaviour. Carer uses physical chastisement and harsh other methods of discipline. Carer hostile to advice about appropriate methods of disciplining

LOVE AND CARE: Adult arguments and violence

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Carers do not argue aggressively and are not physically abusive in front of the children. Carer has a good understanding of the impact of arguments and anger on children and is sensitive to this.	Carers sometimes argue aggressively in front of children, but there is no physical abuse of either party. Carer recognises the impact of severe arguments on the child's wellbeing but personal circumstances sometimes get in the way.	Carers frequently argue aggressively in front of children and this leads to violence. There is a lack of awareness and understanding of the impact of the violence on children and carers are indifferent to advice regarding this.	Carers argue aggressively frequently in front of the children and this leads to frequent physical violence. There is indifference to the impact of the violence on children and carers are hostile to advice about the impact on children

LOVE AND CARE: Young caring

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Child contributes to households tasks as would be expected for age and stage of development. Does not take on additional caring responsibilities. Carer recognises the importance of appropriateness regarding caring responsibilities.	Child has some additional responsibilities within household, but these are manageable for age and stage of development and do not interfere with child's education and interfere minimally with leisure/sporting activities. Carer recognises that the child should not be engaged in inappropriate caring responsibilities but is inconsistent in their response.	Child has onerous caring responsibilities that interfere with education and leisure activities. Carer indifferent to impact on child.	Child has caring responsibilities which are inappropriate and interfere directly with child's education/leisure opportunities. This may include age inappropriate tasks, and /or intimate care. The impact on the child's well being is not understood or acknowledged. Carer is hostile to advice about the inappropriateness of caring responsibilities.

LOVE AND CARE: Positive values

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Carer encourages child to have positive values, to understand right from wrong, be respectful to others and show kindness and helpfulness. Carer understands importance to child's development. This includes an awareness of smoking, underage drinking and drug misuse as well as early sexual relationships. Carer gives clear advice and support. Carer ensures child does not watch inappropriate films/TV or play with computer games which are inappropriate for child's age and stage of development.	Carer inconsistent in helping child to have positive values, to understand right from wrong, be respectful to others and show kindness and helpfulness. Carer aware of importance to child's development, but not always able to impose framework. Carer has variable awareness of smoking, underage drinking and drug misuse as well as early sexual relationships. Carer gives some advice and support. Carer aware of need to monitor child watching inappropriate material and playing inappropriate computer games , but is inconsistent in monitoring because of own personal difficulties and circumstances.	Carer does not teach child positive values. Is indifferent to issues of right and wrong, kindness and respect to others. Carer does not understand importance to child's development. Carer gives little advice about smoking, underage drinking and drug misuse as well as early sexual relationships. Carer does not monitor the watching of inappropriate materials or playing inappropriate games and is indifferent about the impact on the child.	Carer actively encourages negative values in child and has at times condoned anti-social behaviour. Carer indifferent to the impact on child's development. Carer indifferent to smoking, underage drinking and drug misuse, and early sexual relationships. No advice given, and may, at times, have encouraged some of these activities. Carer(s) allows child(ren) to watch inappropriate TV /film material and inappropriate computer games. Is hostile to advice about inappropriateness and to the impact on child (s) wellbeing.

LOVE AND CARE: Adult behaviour

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Carer does not talk about feelings of depression /low mood in front of the children and is aware of potential impact. Carer does not misuse drugs or alcohol.	Carer does discuss feelings of depression and low mood, but does not discuss suicide and is aware of the impact of parental mood on children, but their own mood or circumstances means there is inconsistency in awareness of this. Carer uses drugs and alcohol, but ensures that this does not impact on child.	Carer talks about depression and suicide in front of child and is unaware of potential impact on child. Carer indifferent to advice about the importance of not talking about this issue. Carer misuses drugs and/or alcohol, and is not aware of impact on child.	Caregiver has attempted suicide in front of child. Carer can hold the child responsible for feelings of depression and is open with the child and/or others about this. Carer is hostile to advice focussed on stopping this behaviour and carer does not recognise the impact on the child. Carer misuses drugs and alcohol and does not ensure that this does not impact on the child and this impacts on safety and wellbeing. Carer hostile to advice about this.

LOVE AND CARE: Substance misuse

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Alcohol and drugs are stored safely, if in the home. The carer models low consumption or does not drink or use in front of the child. The carer's use does not impact on the child in terms of carer's emotional availability and provides consistency of care or they have physical ability to care or respond to the child. The carer is able to respond to emergency situations should they arise appropriately. The carer talks appropriately about substances to the child, being aware of the child's development, age and understanding. The carer is aware of the impacts of substances on an unborn child and follows recommendations regarding the child's	The carer believes it is normal for children to be exposed to regular alcohol and substance use. The carer maintains boundaries and routines but these are changed and/or adapted to accommodate use at times. The carer understands the importance of hygiene, emotional and physical care of their child and arranges for additional support when unable to fully provide for the child. Finances are affected but the child's needs are generally met. The mood of the carer can be irritable or distant at times. The carer is aware of the impact of substances on an unborn child but inconsistently follows recommendations regarding the child's	The carer lacks awareness of the impact their substance use has on their child and is inconsistent in their engagement with specialist agencies. The carer's use leads to an inconsistency in caring and the child takes on inappropriate responsibilities at home. The carer needs support in order to manage their use during pregnancy and lacks awareness on the impact this may have on their baby in terms of immediate and medium to long term future. Substances can be accessed by the child. The child's access to appropriate medical or dental care is delayed and education is	The carer holds the child responsible for their use & blames their continual use on the child. The carer significantly minimises and is hostile to advice around their use or refuses to acknowledge concerns. The carer involves the child in their using behaviour (i.e. asking the child to get the substances or prepare the substances). The carer refuses antenatal care or does not attend care offered. The carer cannot respond to the child's needs or shows little awareness of the child's wellbeing (i.e. attending school) There is an absence of supportive family members or a social network. The child is exposed to abusive or frightening behaviour of either the carer or other adults (i.e. delusions/hallucinations). Education is frequently disrupted.

wellbeing. Appropriate antenatal care is sought. Alcohol and substances do not impact on the family finances. The child's needs are fully met and a wide network of family and supportive others are involved.	wellbeing.	disrupted. The finances are affected and the carer's mood is unpredictable.	The carer does not recognise and respond to the child's concerns and worries about the carer's circumstances.

STIMULATION & EDUCATION:

	1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Unborn	The mother acknowledges the pregnancy and seeks care as soon as the pregnancy is confirmed. The mother attends all her antenatal appointments and seeks medical advice if there is a perceived problem. She prepares for the birth of the baby and has the appropriate clothing, equipment and cot in time.	The mother attends antenatal clinic and prepares for the birth of her baby, but she is acutely aware of her mental health or substance misuse problems which could negatively impact on her unborn baby.	The mother is unaware of the impact her mental health and/or substance misuse problems on the unborn child.	The mother does not attend any antenatal clinic appointments; she ignores medical advice during the pregnancy. She has nothing prepared for the birth of her baby. She engages in activities that could hinder the development, safety and welfare of the unborn.
0-2 Years	The child is well stimulated and the carer is aware of the importance of this.	There is inadequate stimulation and the baby is left alone at times because of carer's personal circumstances and this leads to inconsistent interaction. Carer is aware of the importance of stimulation, but is inconsistent in response.	The carer provides the baby with little stimulation and the baby is left alone unless making serious and noisy demands.	The carer does not provide stimulation and the baby's mobility is restricted (confined in chair/pram). Carer gets angry at the demands made by the baby. Carer hostile to advice about the importance of stimulation and paying attention to the baby's needs for

				attention and physical care.

STIMULATION & EDUCATION: 2-5 years

	1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
2-5 years	The child receives appropriate stimulation such as carer talking to the child in an interactive way, as well as reading stories and the carer playing with the child. Carer provides all toys that are necessary. Finds a way even if things are unaffordable (uniform, sports equipment, books etc). Outings: Carer takes child to child centred places locally such as park, or encourages child in an age appropriate way to make use of local resources.	The carer provides adequate stimulation. Carer's own circumstances sometimes get in the way because there are many other demands made on the carer's time and there is a struggle to prioritise. However, the carer does understand the importance of stimulation for the child's well-being. The child has essential toys and the carer makes an effort to ensure appropriate access to toys even if things are unaffordable, but sometimes struggles. Outings: Child accompanies carer	The carer provides little stimulation and does not see the importance of this for the child. The child lacks essential toys, and this is not because of financial issues, but a lack of interest or recognition of the need. Carer allows presents for the child but the child is not encouraged to care for toys. Child may go on adult oriented trips, but these are not child centred or child left to make their own arrangements to plays outdoors in neighbourhood. Child has responsibilities in the house that prevents opportunities for outings.	No stimulation is provided and carer hostile to child's needs or advice from others about the importance of stimulation. The child has no toys and carer may believe that child does not deserve presents. No toys, unless provided by other sources, gifts or grants and these are not well kept. No outings for the child, may play in the street but carer goes out locally e.g. to pub with friends. Child prevented from going on outings with friends or school.

		wherever carer decides, usually child friendly places, but sometimes child time taken up with adult outings because of carers needs.		

STIMULATION & EDUCATION: School

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Carer takes an active interest in schooling and support at home, attendance is regular. Carer engages well with school or nursery and does not sanction missed days unless necessary. Carer encourages child to see school as important. Interested in school and support for homework.	Carer maintains schooling but there is not always support at home. Carer struggles to link with school, and their own difficulties and circumstances can get in the way. Can sanction days off where not necessary. Carer understands the importance of school, but is inconsistent with this and there is also inconsistency in support for homework.	Carer makes little effort to maintain schooling. There is a lack of engagement with school. No interest in school or homework. Carer does not recognise child's need for education and is collusive about child not seeing it as important.	Carer hostile about education, and provides no support and does not encourage child to see any aspect positively. Total lack of engagement and no support for any aspect of school such as homework, outings etc.

STIMULATION & EDUCATION: Sport and leisure

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Carer encourages child to engage in sports and leisure, if affordable. Equipment provided where affordable, or negotiated with agencies/school on behalf of child. Carer understands the importance of this for child's wellbeing. Recognises when child good at something and ensures they are able to pursue it.	Carer understands that after school activities and engaging in sports or child's interests is important, but is inconsistent in supporting this, because own circumstances get in the way. Does recognise what child is good at, but is inconsistent in promoting a positive approach.	Child makes use of sport through own effort, carer not motivated and not interested in ensuring child has equipment where affordable. Does not recognise the value of this to the child and is indifferent to wishes of child or advice from others about the importance of sports/leisure activities, even if child is good at it.	Carer does not encourage child to take part in activities, and may be active in preventing this. Does not prevent child from being engaged in unsafe/unhealthy pursuits. Carer hostile to child's desire to take part or advice from others about the importance of sports/leisure activities, even if child is good at it.

STIMULATION & EDUCATION: Friendships

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
This is supported and carer is aware of who child is friends with. Aware of safety issues and concerns. Fully aware of the importance of friendships for the child.	Carer aware of need for friends, does not always promote, but ensures friends are maintained and supported through opportunities for play etc. Aware of importance to child.	Child finds own friendships, no help from carer unless reported to be bullied. Does not understand importance of friendships.	Carer hostile to friendships and shows no interest or support. Does not understand importance to child.

STIMULATION & EDUCATION: Addressing bullying

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Carer alert to child being bullied and addresses immediately.	Carer aware of likelihood of bullying and does intervene when child asks.	Carer unaware of child being bullied and does not intervene.	Carer indifferent to child being bullied.

PARENTAL MOTIVATION FOR CHANGE:

1) Child focused care giving.	2) Adult focused care giving.	3) Child's needs are secondary to adults.	4) Child's needs are not considered.
Carer is concerned about children's welfare; wants to meet their physical, social, and emotional needs to the extent he/she understands them. Carer is determined to act in best interests of children. Has realistic confidence that he/she can overcome problems and is willing to ask for help when needed. Is prepared to make sacrifices for children.	Carer seems concerned about children's welfare and claims he/she wants to meet their needs, but has problems with own pressing circumstances and needs. Professed concern is often not translated into effective action, but carer expresses regrets about own difficulties dominating. Would like to change, but finds it hard. May be disorganised, does not take enough time, or pays insufficient attention; may misread 'signals' from children; may exercise poor judgement.	Carer is not concerned enough about children's needs to change or address competing demands on their time and money. This leads to some of the children's needs not being met. Carer does not have the right 'priorities' when it comes to child care; may take an indifferent attitude. There is lack of interest in the children and in their welfare and development.	Carer rejects the parental role and takes a hostile attitude toward child care responsibilities. Carer does not see that they have a responsibility to the child, and can often see the child as totally responsible for themselves or believe that any harm that befalls the child is the child's own fault and that there is something about the child that deserves ill treatment and hostile parenting. May seek to give up the responsibility for children.

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