



Child Neglect: Practice Guidance incorporating the Graded Care Profile Tool

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1. Introduction

This guidance has been produced because it is recognised that neglect is a complex and multifaceted issue, which can be difficult for professionals to address effectively. In contrast to other forms of abuse, where specific and critical incidents can highlight 'Significant Harm', the less tangible indicators of neglect combined with its nebulous presentation, often make neglect cases more difficult to identify as a child protection concern.

Furthermore, differences in opinion about what constitutes 'persistent failure', 'serious impairment of health or development', and 'adequate' make this definition, as with others, more open to interpretation, resulting in confusion and lack of consensus amongst child care professionals about what neglect actually involves.

Poverty and other adverse social factors which often co-exist confound the issue even more. These may generate empathy for the carer and justification for their action or inaction which can be detrimental to a child. The continuing neglect can be overlooked and even despite the provision of services as a 'child in need', harm may still continue.

It is well known that some families continue to provide good care to their children, despite adverse conditions where as others do not. Therefore, a helpful way to view neglect is to consider what a carer could have done that s/he did not do or what they shouldn't be doing in terms of meeting a child's health and developmental needs. For example, poverty alone can not justify shouting at a child, denigrating a child or not praising when a child brings his/her drawing home to show it to his mother. This concept is at the core of this procedure facilitated by the use of a tool designed for this purpose, the Graded Care Profile Scale (GCP) (*Srivastava et al 2007*). The objective is to identify neglect early so that interventions, either in the community or through timely referral to statutory agencies can commence, preventing ongoing harm to children.

The Graded Care Profile (GCP) is a tool devised as a measure of quality of care on a continuum extending from most 'positive' to most 'negative' end. It is a five point scale where 'grade 1' is at the positive, 3 is intermediate, and 5 at the negative end. These grades are applied to all four main areas of a child's needs. Thus, when scored, each area will have its own individual grade of care. Some areas of care may show a positive while others may show a negative grade of care as the case may be. The scoring is done based on an observation of what a **carer is actually doing in respect of caring** and what **level of commitment s/he is showing** rather than whether s/he is rich or poor, young or mature or a mental health problem or learning disability problem is present. Explanatory notes to guide the scoring is available at www.lutonlscb.org/images/pdf_files/resources/GradedCareProfile.pdf

To complete the GCP tool, a grade (1-5) is assigned to each of four main areas of care – physical, safety, love (warmth & overtures), and esteem (learning & development).

Only Information gained from either observation or other reliable sources are used. At the time of scoring no allowances are made for any additional/extrinsic risk factors identified; this is to minimise the bias.

Adverse risk factors, where identified, need to be considered later alongside the complete GCP score to enable a fuller assessment and understanding of the neglect issues. This will support the development of an improvement or management plan.

It is important to note, a GCP score is always in the context of a specific carer in relation to a specific child. Thus, if a single mother has a learning disability and the concern is that she can not care for her child, a GCP scoring can be completed and if possible, the level of the mother's learning disability ascertained. Each (GCP & level of learning disability) need to be juxtaposed to obtain a full picture. If the GCP grades of care are on the positive side, there may still be a risk, particularly if the learning disability is severe, as the care provided maybe adversely affected in more demanding situations. Consequently, a decision needs to be made as to how long/ how much support is required.

Conversely, if the learning disability is mild to moderate, the parent may do well with some minimal support as and when needed. However, if the GCP scoring is on the 'negative' end in all areas, a referral to the Referral and Assessment Team may be appropriate.

Thus a number of different combinations can be found, each representing a different level of risk of harm to a child which can guide the management of a neglect concern before and after referral to Children's social care.

Even where a GCP cannot be scored at the outset by some one who is concerned about the care provided, similar guidance applies. Concerns and actual care given should be analysed separately and then combined to make sense of the whole situation. This is to discourage extrapolating care from prevailing adverse factors as this would blur the distinction between cases needing support only and cases needing a child protection plan.

The GCP is more likely to be used by practitioners working across universal services including healthcare staff, community and education settings: nurseries, sure start, schools and childcare settings.

A number of NHS, social care, school and nursery staff in Luton have been using the GCP tool since 1999. In addition, the GCP tool is now being used by several other local authority areas around the UK. The LSCB run training workshops on the GCP tool – see the www.lutonlscb.org for more information.

2. Defining Child Neglect

'Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of

maternal substance abuse. It may involve a parent or carer failing to:

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

'The Framework for the Assessment of Children in Need and their Families (2000, Chapter 2) identifies a 'Child's Developmental Needs', 'Parenting Capacity' and 'Family and Environmental Factors' are all intrinsically linked to the overall wellbeing and needs of children. Reference should always be made to these areas when considering the possibility of child neglect.

Where concerns are identified that a child's needs are being unmet, neglect can be considered as an hypothesis and tested in terms of significant harm and whether or not there exists a deficit in parenting capacity to cause the shortfall. It is important to remember that the recognition of unmet needs may not in itself indicate neglectful parenting unless it is shown that if parents had tried, these needs would have been met. A wide view of the child's circumstances and an effective assessment identifying why such needs remain unmet will always be required.

3. Impact on the Child/Young Person

Neglect can have damaging long-term effects on all aspects of a child's health and development. However, the degree of impact will differ in relation to individual children and the nature of the carer's neglectful parenting. The range of potential impact may lie on a continuum that starts with developmental delay and ends with significant long-term harm and in some cases death. (Howarth 2007)

4. Neglect and Brain development

The hardware for intellectual and other developmental potential of a child is the number of neurones in the brain at birth (no more are acquired after this). This is dependent on genetic influences but their connections (called 'synaptogenesis') are influenced by genetic as well as environmental factors and continue to develop after birth. Although the former (number of neurones) is capped at birth and can not be enhanced by careful nurturing, they can be affected adversely by events before birth, e.g. intrauterine malnutrition, maternal-foetal infections, maternal drugs, alcohol and substance use. The latter (neuronal connections), which continue to develop after birth, although influenced by genetic factors, can be very much influenced both positively and negatively by environmental factors. Positive environmental input results in richer connections and negative input results in poorer connections. Positive environmental factors include – physical (e.g. being touched & caressing, fed etc.), social (being responded to in time, opportunities for assuring social interaction), emotional (e.g. being comforted, encouraged, praised and appreciated).

It is a main body of knowledge in medical science that part of the brain called 'hypothalamus' has a specialised area which secretes hormones which control the 'anterior pituitary' gland. This in turn secretes hormones which control other glands at the end of this chain including thyroid, adrenals, and gonads (sex hormone secreting glands). Hormones from glands at the end of the chain control a number of vital functions in the body including the onset of puberty, growth and emotional state. The main controller, hypothalamus, is under the influence of higher parts of the brain which also regulates emotion. Hence a child with emotional neglect or abuse may have slow growth. There is some evidence that the precise calibration of this 'chain of command' in regulating hormonal functioning is done before birth under both genetic and environmental influences. This is where mother's emotional state and health during pregnancy are so important for the baby. Any event that disrupts this, like depression or domestic abuse, can affect the developing endocrinal biofeedback of the baby adversely.

In addition, softer elements which form the scaffolding for a child's development are very important. After all a baby's brain is a functioning brain from birth, though it has still to grow and differentiate (mature). It is capable of storing environmental inputs through its own experience in life which has a profound effect on how effectively a child uses his/her developmental potential.

Thus, the knowledge we now have of brain development, makes it clear - young babies require not only food, shelter and a physically safe environment - but also their cognitive, emotional and social needs met from birth and indeed considered, during pregnancy' (Perry 2004). Perry goes on to comment that the earlier the neglect occurs and the more extensive it is, the more likely the child will continue to suffer from its effects into adulthood.

5. Neglect and Socio-Emotional Development

A child who is able to feel confident in their carer's availability and who is able to predict their response with relative certainty, will feel safe enough to explore the world and, gradually, to become more autonomous. These children will also be supported to manage difficult feelings and emotions and this will help them to develop their own coping mechanisms over time. Thus a secure pattern of attachment is formed which will give the child the foundations for future resilience and the ability to manage other relationships. By comparison, a child who is neglected will not be able to rely upon their carer's availability or to feel the same level of confidence in the response they may receive from the carer. To cope with this, the child will develop strategies that will depend upon the way their carer relates to them. These fall into different patterns.

According to Erickson's theory of social development a child develops 'trust' in a care giver during early infancy and if maintained during subsequent stages of development, forms the basis for social behavioural regulation. In toddler years when a child is mobile, he/she needs external regulation to curtail and

modify his/her behaviour to acquire a pro-social norm. External direction works because the child has trust in his/her carer. In the absence of that trust, it will not work that well. This external regulation gradually becomes the internal reference so that by the time a child is ready for school, he/she would have developed set of core values for self regulation in a carer's absence.

Development of 'trust' early is pivotal in building this aspect of development. External direction works because of 'trust'. Another factor is the consistency of external direction. 'Trust' used in this context signifies 'attachment'.

Children who are securely attached to their care giver develop better social competence and are emotionally secure. They are better able to withstand adversities than children who grow up insecurely attached. Insecure attachment is caused by certain characteristics of parent/carer which includes neglectful behaviour. There are two types of insecure attachment – anxious and avoidant.

Insecure anxious or ambivalent attachment

Children who develop insecure attachment or ambivalent attachment feel insecure about their care giver. They may display a set of behaviours which reflects this: clinginess, attention seeking, approval seeking, lacking in confidence and anxious behaviour. Such children become overly anxious when the carer is not around.

Insecure avoidant attachment

Children who develop this type of attachment are avoidant of their own carer. It does not matter to them whether the carer is around or not. Some will go on to become more self-reliant where as other may become very vulnerable to exploitation by others.

6. Neglect and cognitive development

Cognitive development can be affected by neglect in a number of ways starting from the antenatal period through to school age. It can be affected antenatally in various ways described above (para 3) and by a lack of opportunity and experience of learning particularly in the early years.

However, it should be noted that actual learning ability or intellectual development is primarily genetically determined. However, if neglect is severe and prolonged, it can limit this development particularly in those under seven years of age.

In most cases however, it is the performance which is compromised through a lack of emotional motivational drive. If neglect is recognised in time and intervened, this can be reversed. Malnutrition associated with neglect can also have a negative effect on performance.

Other factors such as poor school attendance, poor self-esteem, emotional-social behavioural problems and school exclusion can all contribute to poor

school performance and in extreme cases social exclusion.

A lack of provision of a safe environment can result in a head injury or lack of immunisation can result in illnesses like meningitis which again can have detrimental effect on cognitive development.

7. Neglect and physical development

Growth is more readily affected in cases where there is emotional neglect or abuse, but can also be affected by significant under nutrition if it is prolonged (years). Under nutrition also affects bone development which reduces bone density. As food items containing carbohydrate are cheap and can be consumed in plenty even in neglectful conditions, obesity is becoming a feature of neglect. Obesity has a direct negative impact on physical well being including liver failure, heart failure and cardiovascular accidents. Providing and persuading a child to consume a balanced diet is required for optimum growth and physical wellbeing but this is also demanding of parents.

Although physical milestones are not affected by neglect in the long run, it may cause initial delay. Skills that need focused learning in the early formative years, like hand writing, can be adversely and irreversibly affected. There are rare examples of neglect where an infant had been left strapped to a pram over a long period. In such a situation, contracture had developed irreversibly affecting walking.

8. Child Neglect and Significant Harm

In order to evidence that concerns relating to child neglect require a safeguarding response, it is necessary for professionals to think of neglect in the context of 'actual or likelihood of Significant Harm'.

Working Together to Safeguard Children 2010 is clear that there are no absolute criteria upon which professionals can rely when judging what constitute 'Significant Harm'. Therefore there are no specific criteria that will explain exactly where the threshold for child protection intervention will begin or end. The point at which this threshold is crossed depends upon a number of factors and will be largely reliant upon professional judgement and the completion of an accurate and effective assessment using the GCP tool. The GCP will show that neglect in certain area/s of care was identified and graded; a targeted intervention was tried for a mutually agreed period. If at the end of that period grade/s of care did not improve or deteriorated further, then the threshold for a child protection referral is deemed to have been reached.

Another scenario will be where grades of care is graded at the negative end in all areas from the outset.

9. Risk Factors Associated with Child Neglect

Additional risk factors (e.g. learning disability/substance misuse) may raise concerns that the care may be compromised (Para.1). However, where the

care itself is good, it may dispel this fear. Some risk factors may still affect the care provided adversely in the future, for example, where the severity of a risk factor worsens or care becomes more demanding (e.g. learning disability). Some risk factors may affect the care provided unpredictably (e.g. drug, alcohol, mental illness).

During any professional contact with a child, consideration should always be given to the presence of the following factors which may indicate neglect is an issue. This list is not exhaustive or listed in order of importance;

Poverty

Professionals must guard against the risk of 'excusing' neglect because a family is in poverty. Neglect is about a child's needs being unmet through a carers action or inaction to such a degree that impairment of health and development may occur and in serious cases can result in outright cruelty. This can occur in families who are considered to be 'in poverty' as well as those considered to be 'well-off'. Conversely, some parents are able to bring up their children happily and effectively in spite of their limited financial resources. However, poverty may not only affect the material aspect of care provided, like housing, clothing, hygiene etc but it can also affect the attitude and motivation of the carer.

It can be difficult sometimes to distinguish between indicators of early neglect and those of poverty and this can present dilemmas when considering whether a safeguarding response is required. The GCP score, based on parental commitment, would give a profile where care is of a poor grade (4 or 5) in the physical area of care, where material resources are required (housing, clothing etc.) However, it may still be positive in other areas where material resources are not required e.g. love (emotional warmth) and esteem (developmental support).

In some families there may be a sub-culture by parents of letting children fend for themselves, underestimating the need to ensure the child's safety. In these cases, the GCP area of 'safety' may also score 'poor' on the GCP. By working cooperatively with parents, such behaviour and attitude may change and thereby improve the care provided. Where it does not and the grades of care on the GCP do not improve, regardless of sympathy for the carer, protecting the child from neglect must be the priority.

Substance Misuse

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

Parental addiction can alter the capacity to prioritise their children's needs over their own and in some cases alters their behaviour so that they display outright hostility towards children.

The key messages contained in Hidden Harm - Responding to the Needs of

Children of problem Drug Users (2003) are:

- Parental problem drug use can and does cause serious harm to children of every age
- Reducing the harm to children should become the main objective of drug policy and practice
- Effective treatment of the parent can have major benefits to the child
- By working together, services can take practical steps to protect and improve the health and well-being of affected children.
- The number of affected children is only likely to decrease when the number of problem drug users decreases.

Whenever substance misuse is identified as a concern, a thorough assessment of the impact upon parenting and potential implications for the child must be completed.

Where the GCP shows positive care in all or some areas, it indicates there is potential to work with the carer supporting them and focusing on their addictive behaviour. If conversely, the GCP is uniformly poor in all areas and the addictive behaviour is deeply entrenched, a referral to the Referral and Assessment Team (Children's social care) should be made.

Mental Health Issues

It is recognised that mental health problems in carers can significantly impact upon parenting capacity, depending on the type of mental illness and individual circumstances. As such, parental mental ill health should be considered as a possible contributory risk factor to neglect when identified. For example:

- Severe depression or psychotic illness impacting upon the ability to interact with or stimulate a young child and/or provide consistency on parenting.
- Delusional beliefs about a child, or being shared with the child, to the extent that the child's development and/or health are compromised.
- Extreme anxiety states in an adult leading them to limit or curtail their child's developmentally appropriate activities.

Specialist advice as to the impact of mental health difficulties on parenting capacity must always be sought from an appropriate mental health practitioner in these cases.

In less severe cases, if the care GCP scores show good care in some areas and not so good in other areas, further support may be needed.

However, if the GCP scores shows uniformly poor care, whether linked to mental health or not, a referral to referral to the Referral and Assessment Team (Children's social care) should be made.

Learning Disabilities

Identified or suspected learning disabilities of parents or carers do not necessarily indicate that parenting capacity is affected to a degree that a child is neglected. However, even with a good caring instinct, a carer with a learning disability may be prone to some difficulty with acquiring skills to care, for example feeding, bathing, cleaning, and stimulating the child.

However, parents/carers with good caring instincts will also show a high level of commitment to improve. This is where the GCP will be valuable. It will capture the areas of deficient care which can be specifically targeted and rescored after a period of intervention. If it improves then more sustained work will be needed to ascertain the level and length of support needed. If it does not improve, the child will remain exposed to harm or potential harm. ***Priority should be to ensure the wellbeing of the child regardless of sympathy for the carer.*** Where there is a significant learning disability, an assessment by the Learning Disability Team should be sought in order to inform the management plan.

Please note, parental learning difficulties impacts upon the 'normal' parent-child interactions, which, if affected significantly, can lead towards emotional and/or physical neglect. Therefore, special attention needs to be paid to GCP score in the area of 'esteem' and 'love'.

Domestic Abuse and Chronic Unresolved Disputes between Adults

Growing up in a violent and threatening environment can significantly impair the health and development of children, as well as exposing them to an ongoing risk of indirect physical harm. Chronic, unresolved disputes between adults, whether these involve violence or not, would have an adverse impact on the child's emotional wellbeing and hence emotional neglect would remain an issue. Professionals need to remain alert to the indicators of neglect whenever domestic abuse is raised as an issue. Carefully explore and assess the circumstances and if violence is recurrent, think of the likely consequences for the child in terms of impact on his or her emotional and development and well being.

In this context, where the GCP scores are good against one or both parents, that can be used to motivate them to resolve their conflict. If domestic violence continues then regardless of the GCP, a referral should be considered.

10. The Graded Care Profile in context

As mentioned earlier, the GCP gives a measure of quality of care based on the carer's commitment at the time of scoring. It usually reflects a steady state of care in the prevailing family and environmental circumstances. As it has not been specifically studied, it is hypothesised on the basis of other indirect studies that it can potentially be affected by changes in the supportive environmental dynamics e.g. loss of job, divorce, illness etc. It can also be affected by factors which can override the parenting instinct e.g. drug-alcohol-

substance misuse, significant mental illness, certain personality disorders etc.

It has been observed anecdotally that these changes happen more if GCP care grades are clustered around 3 and less if around 1 or 2.

The scoring by grades is done on the basis of the level of the carer's commitment to care. Parallel with the level of commitment is the degree to which a child's needs are met and which can also be observed.

Table 1. Care grades.

	Grade 1.	Grade 2.	Grade 3.	Grade 4.	Grade 5.
1	All child's needs met	Essential needs fully met	Some essential needs unmet	Most essential needs unmet	Essential needs entirely unmet/hostile
2	Child first	Child priority	Child/carer at par	Child second	Child not considered
3	Best	Adequate	Equivocal	Poor	Worst

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

These grades are then applied to each of the four areas of need based on Maslow's model of human needs:

- Physical
- Safety
- love (warmth & overtures)
- Esteem (learning & development)

Each area is broken down into sub areas for ease of observation:

1. **Physical** includes the sub areas of nutrition, housing, clothing, hygiene and health
2. **Safety** sub areas include how safely the environment is organised. It covers safety features such as the use of stair gates and the carer's attitude to child safety, i.e. not leaving lit cigarettes in the vicinity of a child. This sub area also includes the child care arrangements when the parent/carer is away from the home, for example, the age of the minder used.
3. **Love** sub areas includes the carer's sensitivity, response synchronisation, reciprocity and quality of mutual engagement with the child
4. **Esteem** includes stimulation, approval, disapproval and acceptance

A completed score displayed on a 'Record Sheet' shows the grade of care in each of four main areas – physical, safety, love (emotional warmth), and esteem (development) on one side and their constituent items or sub-areas on the other side.

Example (Actual Record Sheet)

Areas	Grade of Care
Physical	4
Safety	5
Love	2
Esteem	2

In the example above the profile is uneven, scoring is negative in two areas physical and safety and positive in Love and esteem. Clearly, a number of variables can be identified which denote different levels of care neglect.

1. **Uniformly positive:** Positive (1 or 2) in all areas – currently no concern, child well cared for.
2. **Uneven:** Positive in some and negative in others – it can be worked on, using positive care identified in some of the areas as the motivator.
3. **Uniformly negative** (4 or 5) in all areas – this signifies significant neglect.

The GCP captures the care of a particular child against a specified carer. Thus, if there are neglect concerns about other children or there is need to know about care provided by another carer these should be scored separately.

11. Recognition:

Indicators of Child Neglect

The recognition and prompt response to indicators of neglect is crucial if the neglected child is to be protected. The longer a child is exposed to neglect, the more difficult it will be to reverse the adverse effects of it. Signs and symptoms of abuse and neglect must always be viewed in context and conclusions must not be made without a thorough assessment of the child's individual circumstances.

Physical Indicators

The following physical indicators of neglect are examples that primarily relate to the basic physical care that is afforded to a child, although it must be remembered that physical symptoms can also result from emotional neglect. Paediatric opinion will always be required to confirm the presence of such indicators and their relevance and relationship to neglectful parenting.

Inadequate warmth/shelter	Inadequate food/rest/inappropriate diet	Inadequate hygiene/physical care
<ul style="list-style-type: none"> ➤ Cold injury ➤ Hypothermia ➤ Red, swollen cold hands and feet 	<ul style="list-style-type: none"> ➤ Abnormally large appetite (at school or nursery) ➤ General physical immobility of lethargy ➤ Failure to Thrive (Faltering Growth) ➤ Lack of response to stimuli or contact ➤ Malnutrition ➤ Poor skin condition, particularly nappy rash in younger children ➤ Rickets ➤ Stunted growth ➤ Vitamin deficiencies 	<ul style="list-style-type: none"> ➤ Clothing inappropriate for the time of year/ inadequate/ dirty ➤ Dirty/smelly ➤ Poor oral hygiene & teeth decay ➤ Nappy rash ➤ Repeated episodes of gastro-enteritis ➤ Skin infections

Emotional, Social, Intellectual and Behavioural Indicators

Professionals should be alert to any of the following developmental and behavioural indicators of neglect. Any observations concerning a child's development or behaviour must be accurately recorded and justified in terms of evidence (i.e. what makes you believe the child has low self esteem or what behaviours suggest the child is anxious or withdrawn?)

- Low self esteem and poor confidence
- Anxiety
- Ostracised at school
- Child is withdrawn
- Child is distressed in the parent's presence
- 'Frozen watchfulness'
- Rocking
- Child moves away from parent/carer when under stress
- Little or no distress when child is separated from their main carer
Guard against this indicator when considering cultures and individual families that do not rely solely on the parents(s) as the main carer.
- Child is clearly avoiding contact with parent or carer
- Child's emotional responses are inappropriate to the situation
- Unpredictable and unprovoked attacks by the child on the parent/carer
- Eating disorder, including stealing and hoarding of food
- Language delay
- Cognitive and socio-emotional delays - school related difficulties

Faltering Growth or Failure to Thrive

These terms apply when a baby or a child is not gaining weight or growing as expected. Failure to thrive can result from illness or genetic or metabolic disorders and are termed 'organic failure to thrive'. Where there is no underlying medical reason explaining a child's lack of growth and development, this is termed 'non organic failure to thrive'.

Non organic failure to thrive has been linked to poverty, limited parenting skills and abuse and neglect. It is important for professionals to recognise that failure to thrive may result from both physical and emotional factors.

Whenever failure to thrive is identified, a paediatric assessment will be required to fully determine the extent of the poor growth and development and to determine if there is evidence of organic or non-organic factors causing the failure itself.

Whenever a child is identified as suffering from non-organic failure to thrive, consideration must be given to the possibility that this directly results from neglectful parenting.

Some features in children and young people which are indicative of neglect:

Physical	Developmental	Behavioural
<ul style="list-style-type: none"> ➤ Faltering growth/weight/h eight/ head circumference ➤ Late presentation with physical symptoms, e.g. impetigo, nappy rash ➤ Unkempt and dirty/poor hygiene ➤ Repeated accidents at home ➤ Obesity ➤ Delayed puberty 	<ul style="list-style-type: none"> ➤ Late attainment of developmental milestone ➤ Language delay, attention span limited ➤ Socio-emotional immaturity ➤ Poor performance in relation to potential ➤ Low self esteem ➤ Poor coping skills 	<ul style="list-style-type: none"> ➤ Attachment disorders, overfriendliness to strangers ➤ Lack of social responsiveness ➤ Disordered or few relationships ➤ Self-stimulating or self injurious behaviour or both ➤ Soiling/wetting ➤ Hyperphagia – over eating ➤ Conduct disorders, aggressive, destructive, withdrawn ➤ Poor/erratic attendance in school

		➤ Runaways, delinquent behaviour
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12. Action in the community (pre-referral)

If you are a professional working with children & families and can score a GCP.

Step 1. Record

- Record your concerns
- Gather information from available sources to build a full picture
- Record remedial measures you may have taken i.e. discussion with carer/s, referral to support services
- Identify any progress made – this will constitute the ‘Chronology’.

Step 2. Score a GCP

- If your concerns remain or increase, score a GCP in agreement with the carer/s.

Step 3. Analyse

- Analyse the GCP scores including any ‘additional’ risk factors that are known

If the GCP grades are positive, this signifies good care in spite of the identified ‘additional’ risk factors. Some ‘additional’ risk factors can be addressed using the GCP. For example, if the perceived risk is because the mother is young, single and a first time mother, but the GCP shows ‘good’ care across all areas, then the ‘additional’ risk factor/s identified has been addressed.

However, if the ‘additional’ risk factors include a mental health problem, drug/alcohol abuse, or severe learning disability in the carer, then these need to be assessed in their own right to identify the degree of severity and compliance with treatment or management of the condition.

If the ‘additional’ risk factor includes **domestic abuse**, this will have a degree of negative emotional impact on the child intentionally or unintentionally, regardless of an otherwise good GCP. If however, the GCP scores negatively against one or the other care areas, then the negative impact of domestic abuse will worsen the situatio and more urgent action is required.

Step 4. Draw up an Improvement Plan

If the GCP score is uneven (good care in some and poor care in other areas), there is scope for improvement. Good care can be used to motivate and engage with the carer. Seek agreement about the areas where the care needs to improve to a positive score (1 or 2). Then draw up an Improvement Plan identifying the changes required, i.e. set the target grade from 4 to 3 or from 5 to 3 etc to be achieved by the next monitoring stage. Re-score at the next monitoring stage and if this target has been achieved then agree the next target score until all care concerns are resolved.

Step 5. Interventions

Levels of **interventions in the community** (pre-referral to Children's Social Care) –

- Do what you can to support in your professional capacity and monitor.
- Refer to a colleague for additional support under the **existing pathways** (HV to the GP, or to a Community Paediatrician; School or Nursery to a School Nurse or HV respectively or to a Community Paediatrician; GP & Paediatrician to CAMHS or Drug & Alcohol team).
- Call a professionals meeting to pool knowledge and resources.
- Complete a CAF form to access specialised support through MAFSP e.g. parenting courses.
- Refer as 'Child in Need' if additional services are needed e.g. in case of a child with a disability.

Refer as 'Child Protection'.

After a period of community intervention, continue to monitor care by re-scoring of the GCP until either the care concerns are resolved or a child protection referral is made or Child in Need assessment is escalated by the Children Social Care (CSC) to a child protection level.

If you are a professional who does not have access to the GCP or are a member of the public and

You are concerned that a child may be neglected, but are not sure what to do;

- Contact the Referral and Assessment Team (CSC) on 01582 547653 to discuss your concerns and seek advice
- If you are a professional, discuss your concerns with a senior colleague or your manager/ contact the Referral and Assessment Team (CSC) on 01582 547653 to discuss your concerns and seek advice

13. Referral as 'child protection'

- If there is concern that a child has been abandoned, is treated with cruelty, or is starved make an immediate referral to the IAT or Bedfordshire Police.
- Where the GCP scores are at the negative end (4 &5) in all areas (uniformly negative) the child may be severely neglected. Therefore, a referral to the IAT is essential to minimise the length of exposure to harm.
- If the GCP scores are uneven and there is significant risk from GCP extrinsic risk factors (mental health problems, drug and substance misuse, or severe learning disability), make referral to the IAT using the GCP scoring to support your referral.
- If during monitoring at the community action stage, the GCP grades are not improving or further deteriorating, make a referral including all GCP scores completed at various stages.

14. Post-referral

- All referrals to the IAT or Bedfordshire Police concerning neglect will be responded to as per LSCB Interagency Safeguarding Procedures
- The Strategy meeting should include a discussion as to how a GCP scoring can be completed, if not previously submitted with the referral
- Any risk assessment/analysis should include the GCP scores as a measure of quality of care and prevailing risk factors at the time of the referral and the likelihood of neglect continuing
- The GCP scores can be included as an appendix in the core assessment while each element is analysed at length in the main report.
- The GCP can be used as part of the Child Protection Plan and Core Group for monitoring progress and accumulating evidence.

15. Risk Factors versus Protective Factors

The factors stated below are not exhaustive and other areas of risk or protective factors may be equally relevant. The areas of risk primarily relate to the adequacy of parental care.

Elevating Risk Factors	Strengths (protective factors)
1. Basic needs of the child are not adequately met	Support network/extended family meets child's needs/parent or carer works in partnership to address shortfalls in parenting capacity
2. Age of the child	Child is of age where risks are reduced
3. Substance misuse	Substance misuse is 'controlled'/presence of another 'good enough' carer

4. Dysfunctional parent-child relationship 5. Lack of affection 6. Lack of attention and stimulation	Good attachment/parent-child relationship is strong
7. Mental health difficulties 8. Learning difficulties	Capacity for change/support to minimise risks/ presence of another 'good enough' carer
9. Low maternal self esteem	Mother has positive view of self - capacity for change
10. Domestic Abuse	Recognition and change in previous violent pattern
11. Age of parent or carer	Support for parent/carer - co-operation with provision of support/services/maturity
12. Negative childhood experiences	Positive childhood or understanding of own history of abuse
13. History of abusive parenting	Abuse addressed in treatment
14. Dangerous/damaging expectations upon children 15. Home alone	Appropriate awareness of a child's needs and age appropriate activities/responsibilities
16. Failure to seek appropriate medical attention	Evidence of parent engaging positively with agency network (health) to meet the needs of the child

Useful Telephone Numbers:

Referral and Assessment Team – 01582 547816 Office hours

Emergency Duty Team - 0300 300 8123 Out of office hours

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