**Research in Practice**

**Assessing risk of further child maltreatment: a research based approach in relation to [Insert the child’s name], DOB: [Insert the child’s date of birth] and [Insert the adult’s title, full name and relationship to the child]**

Factors in ***italics*** are more strongly associated with increased risk: *prior maltreatment, neglect, developmental delay, very young child, learning disabilities, parent- child difficulties, parental conflict, personality disorder, lack of social, family support networks and significant mental ill health.*

Remember that domestic abuse, mental health problems and substance misuse interact to escalate harm.

Assessment to be reviewed at least every six months as significant harm increases with length of exposure (particularly in relation to domestic abuse and neglect).

**(Important note: Delete any rows of the table that you have not filled in.)**

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| **Factors** | **Future significant harm more likely** | **Future Significant harm less likely** | **Relevant chronology entries/Sources of Information** |
|  |  |  |  |
| **Abuse** | **Severe physical abuse including burns/scalds**Severe injury caused to child to warrant hospital admission/medical treatment. Examples include: broken bones, head injury. The terminology of ‘rough handling’ may mask the risks of physical injury or death (Brandon et al, 2009).See also section on defining maltreatment below.  | **Less severe forms of abuse**Defined in terms of harm, duration and frequency.Physical abuse which does not warrant hospital admission/medical treatment. Note: If severe, yet parent shows compliance with child protection plan and does not deny abuse occurred or their part in it, success is still possible.  |  |
| ***Neglect****See section on defining maltreatment in the table below.*  |  |  |
| **Severe growth failure**Stunted growth and failure to thrive without evidence of a medical reason. Examples include parents forgetting to feed an infant and thus causing failure to thrive.  |  |  |
| **Multiple types of maltreatment**Evidence that more than one type of abuse is being experienced by child, including combinations of physical abuse, neglect and witnessing intimate partner violence. See also section on defining maltreatment below. |  |  |
| **More than one affected child in household** |  |  |
| ***Previous maltreatment****If either or both parents (if have some responsibility in caring for child) have previously had a child permanently removed, or a child who has been subject to a child protection plan.* |  |  |
| **Sexual abuse with penetration or a long duration**Sexual abuse or sexual grooming that the child’s primary caregiver(s) were responsible for or compliant with. See also section on defining maltreatment below. |  |  |
| **Fabricated/induced illness**Evidence from a medical practitioner that the child has been subject to a fabricated or induced illness and that their primary caregiver(s) had been responsible or compliant. |  |  |
| **Sadistic abuse**Child cruelty; child treated in an inhumane and degrading manner. |  |  |
| **Child** | ***Developmental delay with special needs****Both developmental delay caused by a disability/illness and/or development delay attributed to poor parenting should be included. There would need to be evidence from a medical/health/educational professional that developmental delay is an issue. Special needs attributed to a disability/illness and/or attributed to emotional and behavioural difficulties should be included.*  | **Healthy child**A healthy child who does not have any of the following: illness/disability, developmental delay, special needs, emotional or behavioural difficulties. Note: There may be difficulties with this category for very young children and babies as it may be too early to know whether there are any health or developmental problems. If there is no evidence, then this category should not be included. It should not be assumed that the child is healthy. |  |
|  | **Attributions (e.g. not blaming self in sexual abuse)**Not applicable for infants in first year of life.  |  |
| **Child’s mental health problems**Diagnosed mental illness for which medical/therapeutic intervention is necessary. For a baby or very young child this category should not be included.  |  |  |
| ***Very young child requiring rapid parental change.*** | **Later age of onset**Not applicable for infants in first year of life. |  |
|  | **One good corrective relationship**Not applicable for infants in first year of life. |  |
| **Parent** | ***Personality disorder (anti-social, sadistic, aggressive)****Diagnosed personality disorder for which medical/therapeutic treatment is necessary for primary carer(s) of child.****Paranoid psychosis****Diagnosed paranoid psychosis should be included. A parent stating that they sometimes feel paranoid, and without diagnosis should not.* ***Significant Parental Mental Health Problems*** | **Mental disorder responsive to treatment**The primary caregiver should be accessing and responding to the treatment being given for their mental disorder. |  |
| **Learning disabilities when *plus mental illness***Learning disability and mental illness together, and mental illness alone. Mental illness should be diagnosed by a mental health professional or GP. A parent or non-health professional stating that for instance, ‘they can feel depressed’ should not count. Note: Mental illness alone should be classified as a risk factor; however, learning disabilities alone should not be, unless it comes with a mental illness.  |  |  |
|  | **Non-abusive partner**A partner for whom there are no current concerns of abuse either to children or to their partner. This is especially relevant if one parent has a history of abuse, and the other does not, and can be either the father or mother, or stepfather or stepmother. This might also include a partner for whom there have been past concerns that have since been **entirely** overcome. |  |
| **Lack of compliance**Hostility towards professionals, deliberate deception, sporadic engagement, not giving professionals access to children, and numerous cancelled appointments with social workers without justified reason. False compliance should be included – i.e., telling social workers what parents think they want to hear, rather than working with social workers.  | **Willingness to engage with services**The primary caregiver(s) should be willing to accept social care and other service involvement with their family as a necessary measure to safeguard their children. Appointments should be kept and not cancelled without good reason. Primary caregivers should also be willing to participate with other relevant services. Children’s attendance at school/nursery should not be a cause for concern, and children should be taken to all their necessary health appointments which should not be cancelled without good reason. |  |
| **Denial of Problem**Parents’ inability to acknowledge their destructive behaviour, or deny the part their own actions have had in the abuse of this child or previous children. For example: can a parent understand why a child witnessing intimate partner violence is harmful, or how their own drug use might affect their ability to care for their child and meet their physical and emotional needs? | **Recognition of Problem**Parents should be able to acknowledge why their behaviour is affecting or has affected their ability to care for their child and meet their emotional and physical needs. |  |
|  | **Responsibility taken**Primary caregiver(s) should be making some steps in taking responsibility for their actions, i.e., they should not blame others for their own destructive behaviour.  |  |
| **Substance abuse**An addiction to substances such as class A drugs, class B drugs, alcohol or any other substance that impairs the child’s primary caregiver(s’) ability to make sound judgements and to meet their physical and emotional needs. A parent on a methadone, or other similar, programme should be included. Primary caregiver(s) who do not themselves take drugs, but allow the child’s home to be used for drug taking and/or who routinely leave children unsupervised with a non-primary caregiver who is under the influence of drugs and/or is drunk should also be included.  |  |  |
| **Abuse in childhood – not recognised as a problem**Any type of childhood abuse should be included. Evidence can be taken from case file papers, assessments and the parents’ own accounts. Note: Evidence that a parent does or does not view their own experiences of childhood abuse as a problem can be difficult to ascertain. If there is evidence that a parent experienced childhood abuse but not whether they recognise it as a problem it should be included.  | **Adaptation to childhood abuse**Primary caregivers who have received therapeutic intervention to help them come to terms with childhood abuse should be included, unless it is clear that the caregiver has not been able to adapt to their earlier experiences. Primary caregivers who experienced childhood abuse and can focus on the needs of their own children should be included.  |  |
| **History of Violence or Sexual Assault** |  |  |
| **Parenting & Parent/Child Interaction** | **Disorganised attachment; severe insecure patterns of attachment**Observed by a health/childcare professional. This information is difficult to ascertain from social care case files, as limited information on the child’s development and emotional and psychological needs is recorded and what there is may not be based on a clinical understanding of attachment disorders. | **Secure attachment; less insecure attachment patterns**Observed by a health/childcare professional. This information is difficult to ascertain from social care case files, as limited information on the child’s development and emotional and psychological needs is recorded and what there is may not be based on a clinical understanding of attachment. Note: If attachment is not observed/recorded to be either disordered or normal this category should not be included. It should not be assumed that there is a normal attachment, if an attachment disorder is not recorded/observed. |  |
| **Lack of empathy for child**The parent(s) do not show understanding of how the child might experience adverse situations, such as how a child might feel if their parents are fighting, or how a neglected child might feel if their needs are not being met. This would also include the child being treated in a degrading or inhumane way.  | **Empathy for child**Understanding of how the child might feel in adverse situations, and/or if their needs were not being met.  |  |
| **Poor parenting competence**Lack of competence in everyday tasks needed for childrearing. This might include some of the following: establishing routines, feeding, bathing and clothing a child, upkeep of a household, paying bills, and going shopping. Inability to help with homework, or to get the child to and from school on time (or at all). This can also include: **not** showing emotional warmth and affection, and **not** providing the child with a nurturing environment. | **Parenting competence in some areas** |  |
| **Own needs before child’s**The parent(s) prioritising their own needs. For example, a parent remaining in an abusive relationship to the detriment of the child; a parent appearing more attached to drugs or alcohol than to the child. |  |  |
| ***Parent-child relationship difficulties*** |  |  |
| **Family** | ***Inter-parental conflict and violence****Physical and emotional violence between the child’s caregivers, or one caregiver and another adult taking place within the child’s home.* | **Absence of domestic abuse**This would include both families where domestic violence has been a concern in the past but it is not a current concern, and families where it has never been a concern. |  |
|  | **Non-abusive partner** |  |
| ***High stress****Examples of family stress include: housing problems, including homelessness and inadequate housing, financial difficulties, conflict within the extended family, conflict within the neighbourhood, family crisis such as bereavement or relationship breakdown.* | **Supportive extended family**Extended family able to provide emotional and practical support for the caregivers and children. It is important that the caregivers view this as beneficial. |  |
| **Power problems: poor negotiation, autonomy and affect expression**Poor self regulation, lack of congruence, unable to manage emotions pertinent to the situation. | **Capacity to change**This should be demonstrated with evidence. A parent stating their desire to change is not sufficient. For example, there should be clear evidence that substance misuse has stopped, or clear evidence that an abusive partner has left the household and has no further contact. |  |
| **Children not visible to the outside world and continuing perpetrator access** |  |  |
| **Professional**  | **Lack of resources**Resources not available, resources not offered when available, resources available but not accessible. No professional or therapeutic relationships with child or family. | **Resources available**Resources available, appropriate and accessible. Good professional relationships with family, therapeutic relationship with child. |  |
| **Poorly skilled professionals**Definition: child not seen, multiple changes of worker, cases unallocated, lack of professional boundaries, poor practice, professionals do not share information/lack transparency with child or family, over-optimism. | **Partnership with parents**Definition: effective working relationship between parents and social workers based on honesty and trust.  |  |
|  | **Outreach to family** |  |
|  | **Therapeutic relationship with child** |  |
| **Social Setting** | **Social isolation**Parents who have little or no contact with others on a social basis. They may stay home most days with little or no contact with their community. | **Social support**Parents are able to access community resources and support on a voluntary basis. |  |
| ***Lack of social and family support networks* and lone parenthood**Parents who have little positive contact within their community, and no access to (or no engagement with) community resources.  | **More local child care facilities**Preponderance of facilities in their area such as children’s centres and community groups etc. Parents should be engaging with these services to be included in this category.  |  |
| **Violent, unsupportive neighbourhood**These neighbourhoods include those where drug taking and crime are rife.  | **Volunteer network**Positive community resources and environment. |  |
|  | **Involvement of legal or medical services** |  |

Source: Jones et al. (2006) adapted by Rebeca Brown and Ward (2012), further adapted by NSPCC in 2015 to reflect White et al. (2015).

**Risk Assessment completed by: Date:**

**ADDENDUM 1 – GUIDANCE NOTES:**

**Defining Maltreatment**

The following definitions of maltreatment have been taken from *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote welfare for children* (HM Government, 2015).

**Abuse:** A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by other (e.g. via the internet). They may be abused by an adult or adults, or another child or children.

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| **Physical abuse** | A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child. |
| **Emotional abuse** | The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or ‘making fun’ of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, through it may occur alone. |
| **Sexual abuse** | Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children. |
| **Neglect** | 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. Once a child is born, neglect 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.
* It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.
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