**CALDERDALE SAFEGUARDING CHILDREN PARTNERSHIP**

**CHILD DEVELOPMENT TOOL**

**0 TO 16**

November 2022

**Text

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**Child Development Tool**

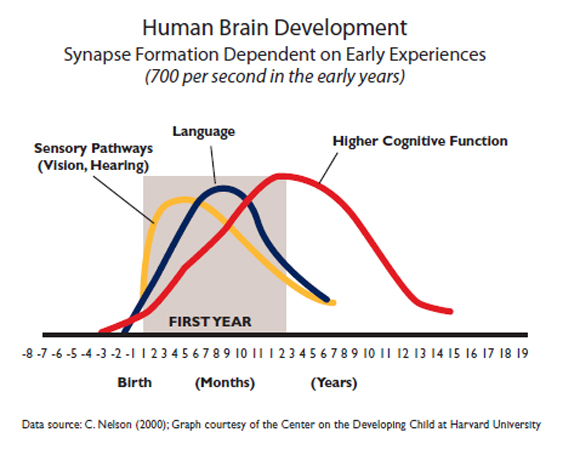
Knowledge of child development is essential for all workers who come into contact with children and for their managers. It is a crucial component in family support and child protection and in assessment and planning interventions.

The Children Act 1989 defines “development” as physical, intellectual, emotional, social or behavioural development and “health” as physical or mental health. In determining and defining which children are in need of services, the child’s development is compared with that which could reasonably be expected of a similar child. This comparison with a ‘similar child’ requires familiarity with the range of development any child might demonstrate. It also requires balancing the norms of development with the needs of the individual child (Daniel et al 2010). It is also important to remember that children develop at their own rates, and in their own ways.

Understanding the child’s development and making good use of that understanding in exercising judgements and making decisions, clearly requires good relationship skills. Developing good relationships and exercising judgements about child development require the kind of ‘containing’ practice conditions that encourage practitioners to be both thoughtful and confident (Ruch 2006). Practitioners need regular and challenging supervision, opportunities to enhance and extend their knowledge of child development and the time and opportunity to reflect on what they see and what they know. They also need the time and confidence to check out what they see and know with colleagues from other agencies.

Understanding the child’s development in the context of their environment includes issues such as good nutrition, maintaining good health, hygiene, physical and economic security, the physical environment, opportunities for social interaction and play, and aspects of parenting such as stability, availability, affection, and setting boundaries. Understanding attachment is the principal theoretical foundation for the analysis of the complex interaction of both parental and child vulnerability factors (Howe 2006). This includes exploring what does the child mean to the parent/caregiver, and what does the parent/caregiver mean to the child?

Some disabled children may be at higher risk of being neglected or abused. The prolonged and heightened dependence of disabled children on their parent/caregivers may make them more susceptible to neglect, and may also increase the stress on parent/caregivers as triggers for physical and emotional abuse. Because of their greater dependency, disabled children may be more vulnerable or less resistant to abuse and neglect; those with language disability may be less able to talk about their experiences. It is important, however, to recognise that disabled children do not form a heterogeneous group, either in severity or type of disability, so an understanding of the particular nature of any underlying disability and how it affects the child’s development is essential.

**What do we know?**

Babies are born with 25% of their brains developed

By age 2 this has rapidly increased to 75%

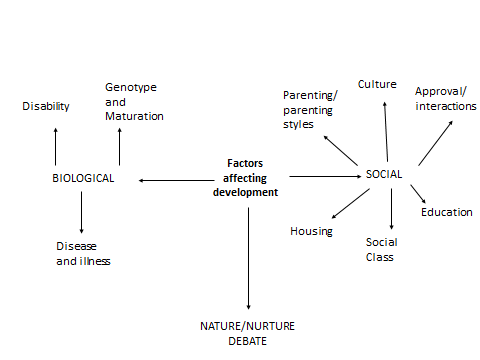
A child’s developmental score at 22 months can accurately predict educational outcome at age 26

This tool provides a guide to a child’s expected developmental progress and makes reference to the potential effects of poor care, abuse or neglect. Recognition of these different stages and of what constitutes normal development is crucial to understanding what is going on in the abused and neglected child’s life, the likely impact of any harm, and how it might manifest through disordered development or behaviour. The development statements and their order should not be taken as necessary steps for individual children and therefore should not be used as a ‘checklist’. Similarly, the age/stage bands overlap because these are not fixed age boundaries but suggest a typical range of development.

**Things to consider when exploring child development**

* The development of children who attend any Early Years provision will be closely monitored to ensure progression and this information will be available if there are Safeguarding concerns.
* Curiosity about the meaning of the pregnancy to the mother and any ambivalence gives a helpful context to the developing relationship between the mother and her baby. ( Late ante‐natal booking and poor ante‐natal care provide an ambivalent backdrop to the mother–child relationship)
* Bruising of the child is not necessarily connected to complex health needs or disabilities
* Does the explanation for any bruising match the child’s developmental capability and likely behaviour? Is the child developmentally capable of causing injuries to him or herself? See <https://westyorkscb.proceduresonline.com/files/multi_age_bruises_scalds.pdf>
* The child’s development may be ‘as expected’ in some areas but not others. For it to count, achieving developmental milestones should be seen consistently in different contexts.
* Is there an understanding of the roles and responsibilities of each parent/caregiver? The person who may be perceived as a risk of harm to the child may be out of the picture but is not the perpetrator
* Parent/caregivers who are hostile or difficult may prevent the practitioner from seeing clearly what is happening.
* Is the parent/caregiver’s voice being allowed to dominate?
* Is there a full understanding of the caregiving the child receives?
* A child with a disability should be seen as a child first
* Are the same standards and expectations of parenting being applied for disabled and non-disabled children? (Would the same parenting practices be accepted for a non-disabled child?)
* What meaning does each child has for the parent/caregiver and how does each child make them feel? (Each child’s experience may be different even though children may seem to be treated in similar ways)
* Is the parent/caregiver’s ability to change linked with the child’s developmental needs and pace of development? Intensive work with parent/caregivers, specifically to increase parental sensitivity to their child’s needs, can lead to an improvement in the child’s emotional development but it must be in the child’s timescale.
* How is the parenting that is provided for the child (or any other factor e.g. extended family, environmental, community) affecting the child’s health and development in terms of resilience and protective factors and vulnerability and risk factors?

Failure to understand the impact of what’s happening from the child’s perspective means that the child’s development cannot be wholly understood. Gaining this understanding involves talking to the child, observing them and thinking about what is happening to them in the context of their particular family and environment. See [a-day-in-the-life-](https://safeguarding.calderdale.gov.uk/wp-content/uploads/2021/11/a-day-in-the-life-child-and-adult.pdf) tool.

**Factors Affecting Child Development**

**Typical Child Development and Impact of Abuse and Neglect**

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|  | **Expected Milestones** | **Impact of Abuse and Neglect** |
| **Birth to 2 months** | * Reflexes include grasping, rooting and sucking the breast. * Responds to stimulation that follows quickly from some action, e.g. when the baby’s arm movements cause a mobile to turn around. * Initially, baby orients towards the adult without discriminating between people. * Parent/caregivers play significant role in facilitating sensori-motor play - adjusting their actions to complement what the baby is doing. This is called co-regulation – a social process through which parent/caregiver and baby dynamically alter their actions in harmony with one another. * Engages in rhythmical and playful actions, often in partnership with caregiver. * Shows a preference for attending to people. * Indicates recognition of parent/caregiver’s voice. * Shows an intent regard for faces. * Parent/caregivers and babies can hold one another’s attention e.g. they engage in subtle, mutually regulated exchanges, i.e. forming a primary connection between the two. * Begins to smile. * Begins to imitate adult’s facial expression. * Enjoy songs and rhythmic games. | From birth, development is always sequential and progression is expected to occur at a steady rate (some fluctuation in progress is likely during the child’s lifetime.) Significant variation in progress may indicate abuse or neglect or other organic/medical issues.  Practitioners need to be aware of the parent/caregivers’ reactions to their child, and to specifically observe and reflect on the child’s responses to his or her caregivers. These are the foundations of emotional development and of attachment behaviour. What happens during feeding, for example, provides powerful clues to emotional development. What does each parent/caregiver or parent figure bring, psychologically, to the relationship with their child?  Injury In infancy affects emotional regulation, attachment, growth and developmental delay.  Babies and young infants exposed to abuse and neglect are more likely to experience [insecure or disorganised attachment](https://en.wikipedia.org/wiki/Attachment_theory) problems with their primary caregiver. For children with an insecure attachment, the parent/caregiver, who should be the primary source of safety, protection and comfort, becomes a source of danger or harm. Without the security and support from a primary caregiver, babies and infants may find it difficult to trust others when in distress, which may lead to persistent experiences of anxiety or anger.  Poor nutrition can lead to failure to thrive and brain damage. |
| **2 to 6 months** | * Shows preference for familiar people. * Smiling now co-ordinated with the parent/caregiver and can be comforted by them. * More responsive to familiar adults than to strangers. * Baby needs reassurance in the presence of unfamiliar adults. * Appears to expect parent/caregiver’s responses to be in tune with his/hers and may become upset if not, by frowning or looking away. * Can communicate emotions like sadness and joy. * By 4 months, can lift his/her head to 90 degrees from prone position * Baby’s gaze can follow an object from side to side. * By 4 months, baby has simple action schemes, such as grasping a rattle. * By 6 months, baby can keep head level when pulled into a sitting position and can communicate with sounds. * By 6 months, baby’s ability to see is around 20/60. * Shows growing interest in playful behaviour accompanied by babbling. * Enjoys imitating caregiver’s actions, e.g. clapping or opening the mouth. * Produces more vowels and some consonants rather than cooing. * *Echolalia* appears where baby frequently repeats sounds, such as “dadadadad” or “mummummum”. * Can shout for attention and scream with rage; sometimes refuses to look at parent/caregiver when annoyed or upset. | In infancy, the child is particularly vulnerable to the impact of both physical abuse and neglect because of rapidly developing skills in all areas, the formation of multiple neural connections in the brain, the importance of different types of stimulation and the development of attachment relationships. If this stimulation is lacking during a child’s early years, the weak neural connections that are developed in expectation of these experiences may wither and die, and the child may not achieve the usual developmental milestones. Consequently, a negative impact on early brain development can influence how a child reacts to stress and other stimulating situations in their early and later life.  Insecure attachments can severely affect a child's ability to communicate and interact with others and form healthy relationships throughout their life.  The abused or neglected child may present as listless, lack curiosity, be unresponsive to others, difficult to engage.  Physical abuse in babies, infants and young children can lead to brain dysfunction; however, a child does not need to be struck on the head to sustain brain injuries. Babies and infants who are shaken vigorously e.g. by holding the feet or shoulders may sustain internal bleeding with no sign of external head injury. |
| **6 to 9 months** | * Baby stays close to preferred adults; crawls after them when they leave room; shows wariness of strangers. * Demonstrates more intense [attachment behaviour](https://www.simplypsychology.org/bowlby.html). * Emergence of separation anxiety, by 8 months, baby needs reassurance after short separations. * Parent/caregiver and baby have well-established conversational routines and games with objects to sustain communication and interaction. * Each movement is adjusted to the next, providing an example of a communicative dance in which we co-ordinate our feelings, thoughts and intentions, often by way of non-verbal as well as verbal communication during the communication process. These shared experiences foster feelings of security in the baby. * The developing connection between parent/caregiver and child continues out of the many playful exchanges between them; these games and routines are a form of mutually enjoyable communication in which each gesture and expression is new and meaningful. * Baby can imitate social stimuli, clap and copy facial expressions. * Baby’s smiling is now co-ordinated with that of the parent/caregiver, can express positive and negative emotions. * Can stand up with support. | From birth, development is always sequential and progression is expected to occur at a steady rate (some fluctuation in progress is likely during the child’s lifetime.) Significant variation in progress may indicate abuse or neglect or other organic/medical issues.  The growth in each region of the brain largely depends on receiving stimulation, which spurs activity in that region. This stimulation provides the foundation for learning. A lack of, or inappropriate, stimulation during this phase lays patterns that may impact on achieving future developmental milestones. For example, if baby’ sounds are ignored repeatedly when they begin to babble at around 6 months, their language may be delayed. Failure to develop appropriate language skills due to neglect in this stage may lead on to wider cognitive and social impairments, whilst disorders of attachment can give rise to future emotional and social difficulties. |
| **9 to 12 months** | * Baby directs parent/caregiver’s attention to interesting objects. * Can clearly differentiate between familiar and strange adults. * Responds differently to male and female adults. * Can clearly ‘read’ parent/caregivers’ visual expression, uses as a cue for enjoying new experiences. * Baby’s ability to see clearly reaches adult level (20/20). * Shows differentiation of relationships between what he/she tastes, touches, hears and feels. * Is learning through play that objects have different properties and reactions. * Continues to experiment with familiar and unfamiliar objects. * Responds positively to a wide range of toys, textiles, wooden and plastic bricks, paper and cardboard, natural and everyday objects. * Responds positively to varied sensor-motor opportunities to explore, touch and feel. * Appears to understand that objects have a separate existence from self. * Moves around by crawling and can stand when supported. * By 12 months, some can walk by holding onto furniture. * Increased mobility increases independence as baby can now move away from annoying or unpleasant objects. * Shows capacity to entertain self with familiar objects, toys and people. * Shows intentionality by deliberately manipulating objects or using gestures to communicate needs. |
| **1 to 2 years** | * First words appear at around 12 months, followed by 2-3 word utterances. * Verbal age and gender labels, such as “mummy”, “daddy”, “baby”, “boy”, “girl” begin to be used correctly. * Reactions to social situations are strongly influenced by response of the parent/caregiver, i.e. social referencing – ability to ‘read’ emotional clues in the face of the other person*.* * Rewording child’s sentences in a conversational way is more effective than correcting them. * Can engage in teasing and anticipate parent/caregiver’s reactions to forbidden behaviour, e.g. saying playfully, “That’s naughty!” * Often children at this age engage in strong protests and even tantrums when they do not get their own way. | From birth, development is always sequential and progression is expected to occur at a steady rate (some fluctuation in progress is likely during the child’s lifetime.) Significant variation in progress may indicate abuse or neglect or other organic/medical issues.  If the parent/caregiver is uninvolved and unresponsive to their toddlers, showing little affection and tending to ignore their child’s cues for help, displaying very little social interaction and initiating few activities with their child, the toddlers become passive although they are likely to gradually become more angry, aggressive or hostile as they approach the age of two, particularly with other children. They may become angry when trying to solve puzzles or problems, and are noticeably angry or avoidant of their main carer, perceiving them as unavailable to meet their needs.  Inconsistent parenting (lack of rules, failure to monitor child, inconsistent punishment and reward) can impact on language and cognitive development.  The child may feel that they are "bad" affecting the development of self- esteem; become fearful and anxious; depressed and withdrawn; aggressive and physically hurt others. |

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| **Age** | **Sensory and physical** | **Communication and interaction** | **Cognition and learning** | **Social, mental and emotional health** |
| **2 to 5 Years**  **For more detailed information about child development through the early years (birth to 5 years) see** [Development Matters - Non-statutory curriculum guidance for the early years foundation stage (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1007446/6.7534_DfE_Development_Matters_Report_and_illustrations_web__2_.pdf) | * More independent e.g. knows when they need to eat, drink, go to toilet. * Develops physical strength through active games, e.g. pushing and pulling toys, running around, kicking balls. * Cooperates in physical activities with other children – siblings or friends * Develops greater sensory awareness of colours, shapes, quantities and sizes through water and sand play. * Typically shows curiosity about own bodily functions; explores own body, including their own genitals. | * 24 to 27 months, 3 – 4 word utterances appear, followed by rapid increase in prepositions (“up”, “down”), irregular verb endings (“written”), questions (“why is doggy eating?) and negative (“I no want it”). * Rhyming and alliteration as evident in nursery rhymes and songs are very enjoyable at this stage. * 36 months - most children have a vocabulary of around 1,000 words. * Develops preference for particular companions. * Shows early signs of cooperative play, e.g in Home Corner. * Enjoys language play, e.g. telling jokes and riddles. * Can take different roles in play, e.g. doctor/ patient, mother/baby. * Friendship increasingly important; shows grief when separated. * Engages in play-fighting showing that it is fun - puts on a ‘play face’ smiles and laughs. | * Children learning language and able to symbolically represent things, places, and events through speech, art, physical objects but find it hard to grasp that objects retain qualities in different conditions. Can think about these things, but in very limited way. Thinking is self- centered. * Cannot yet achieve conservation. * Object play emerges, e.g. stacking bricks, doing simple jigsaws. Much is solitary play leading up to play with other children. * Fantasy play emerges involving toys and dolls as characters where stories are enacted with scripts and different characters. Children give these characters different voices to demonstrate individuality. * Play with dolls, etc facilitates conversational dialogues and develops capacity to take perspective of different characters in a situation. * 3 – 5 years, child can increasingly talk about inner states and show evolving understanding of relation between other people’s feelings and their actions. * Show growing understanding of the rules of their family and community. * Can differentiate photographs of adults and children into categories by age and gender. Curiosity is boundless - “why?” and “what?” questions. * Everyday interactions and imaginative play play an enormous part in developing the child’s theory of mind. Conflicts between siblings give opportunities to learn about sharing, cooperation, taking turns and learning about the social and moral rules of the family. | * Many children have an imaginary companion for up to 10 years -These “friends” offer help when child is troubled and take the blame when things go wrong. * Can both include and exclude other children, for example, “I’m not your friend today!” * Siblings and other children in the family and community network play important role in the child’s social and emotional development. Interactions help children to develop understanding of the perspective of others. * Daily negotiations with other children enhance child’s growing awareness of needs of others and nature of relationships with others. * Child begins to take into account how their understanding of the world influences and helps evaluate their contact and future interactions with others. * Tantrums, defiance and jealousy is typical. * Begins to use words depicting inner states, e.g. “I want”, “Look!”, “I see” “I taste”. |

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| **Impact of abuse and neglect** | From birth, development is always sequential and progression is expected to occur at a steady rate (some fluctuation in progress is likely during the child’s lifetime.) Significant variation in progress may indicate abuse or neglect or other organic/medical issues.  During the pre‐school years, there is a strong emphasis on social development. Early abuse and neglect may lead to difficulties in emotional regulation, initiating social interactions, and learning to respond appropriately to others. Poor nutrition can lead to failure to thrive, excess weight gain, mobility delay, dental decay and other health issues. Abuse or neglect can delay physical and cognitive development, speech and language, in particular a delay in both understanding and constructing sentences. Over use of artificial pacifiers (dummies) can specifically lead to speech delay and dental decay. Educational achievement is likely to be lower than other groups of children.  The child may present as excessively fearful, easily traumatized, have night terrors, and seem to expect danger; show signs of poor self-esteem and a lack of confidence. Their response to caregivers may be indiscriminate, superficial or clingy. They have learnt that their carers are unlikely to be a source of comfort or relieve their distress and overall these children have a negative view of the parent/caregiver.  They may present as bland, flat and be emotionally passive and detached.  They may show signs of emotional disturbance: anxiety, depression, emotional volatility, or exhibit self-stimulating behaviours such as rocking, or head banging, weeing or pooing in places other than the toilet. They may be sickly and susceptible to frequent illness; have poor muscle tone; delayed gross motor skills. |

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| **Age** | **Sensory and physical** | **Communication and interaction** | **Cognition and learning** | **Social, mental and emotional health** |
| **5 to 7 years**  **5 to 7 years** | * Play promotes healthy physical development - skipping, football, dancing, running. * Play fighting with friends is distinct from real fighting often accompanied by laughter and a ‘play face’. * Some children escalate play fighting into real fighting. * Games with rules (e.g. skipping, hide-and-seek, football) increasingly important - helps to develop sense of mastery and confidence in own skills. * Interest in body parts continues; some sexual play, may ask questions about sexual concepts and behaviour. * Thinking shifts from sensori-motor stage to the intuitive stage i.e. less reliant on the sensori-motor qualities of the environment and more on his/her own mental representations of the world. | * Engages with process of learning to read and write. * Child’s interpersonal communication shows some awareness of needs and wishes of peers; can bargain and compromise in social situations. * Becomes aware of how well liked they are within peer group. * Shows capacity to play cooperatively with others, e.g. sharing toys etc. * Can fit into small groups; shows understanding and awareness of other children’s viewpoints. | * Orders, classifies and quantifies in a more systematic way, though still unaware of the principles that underlie these operations. * Begins to understand how other people may be thinking and feeling. * Recognises that other people may have different views from their own - step towards logical reasoning * Can distinguish between their own cultural group and that of others. * Emergent sense of gender identity as expressed in describing a range of gender roles and relationships. * Shows growing understanding of the rules of their family and community. | * Able to deal with separation from parent/caregiver; typically is reunited in a cheerful, affectionate way. * Expresses awareness of different kinds of relationship through narrative play, (e.g. with dolls and figures), expressing contrasting qualities such as happiness/sadness, trust/mistrust, affection/dislike. * Demonstrates theory of mind by negotiating different characters and personalities in a range of settings. * The child shows the capacity to form new relationships with adults, and peers. * Keeps a balance between the secure base of familiar people and situations and the willingness to develop new relationships and explore new experiences. * Shows preferences for some peers over others; * Plays cooperatively, e.g. by sharing toys. |
| **Impact of abuse and neglect** | During the primary school years, the effects of early adversity may be seen in poorer academic achievement, difficulty in concentrating and inability to organise or structure their thoughts.  Early attachment disorders can result in persistent negative concepts of self and others. The child may experience anxiety disorders, mood disorders, poor impulse control, disruptive behaviour, and poor relationships with peers. The child may be suspicious and mistrusting of adults or over friendly, eager to please or attempt to manipulate others. Also at this time, the child may demonstrate ‘role reversal’ and assume a ‘parenting’ role with others. They are likely to exaggerate positive aspects of family life.  If punished for self-sufficient or independent behavior, they may learn that self-assertion is dangerous and then may present as more dependent, exhibit fewer opinions, show no strong likes or dislikes, not be engaged in productive, goal-directed activity; lack initiative, give up quickly, and withdraw from challenges.  Physical development is generally delayed. | | | |

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| **Age** | **Sensory and physical** | **Communication and interaction** | **Cognition and learning** | **Social, mental and emotional health** |
| **7 to 11 years** | * Can accommodate needs of others, e.g. during team sports. * Continuing interest in sexual play, like kissing and flirting. * Some girls start menstruating by nine years. * Receptive to discussing physical changes that will take place during puberty and in understanding messages about sexuality from the media or from own social networks. * Continues to demonstrate pro-social behaviour through cooperative group work. * Shows ability to play fairly and cooperatively in team sports, informal games and online gaming. * Self-esteem can be specific to one domain, such as skill at sport, or global, by referring to the whole person. | * Friendship is increasingly reciprocal so can deal with everyday conflicts and begin to understand different ways of looking at a disagreement. * Very aware of gender-appropriate behavior * Self-regulatory behaviour appears; * Tends to identify with same-sex peers. * Mediates in conflict situations, e.g. intervenes to protect more vulnerable peers who are being bullied. * Increasingly able to deal with social relationships online, including cyberbullying and of the risks in cyberspace while still being increasingly involved in friendship groups online. * Able to take on responsibilities in school, e.g. school council. * Likely to need support and guidance in understanding costs and benefits of relationships formed online or on social networking sites. * Can work cooperatively outside immediate friendship group. * Shows more advanced capacity to reflect on relationships, e.g. can explain why people fall out and suggest how they might resolve interpersonal difficulties. | * Considers several aspects of a task simultaneously; e.g. understands objects retain same properties even when shape is changed. * Conservation of number appears at five to six years; conservation of weight at seven to eight years and conservation of volume at ten to 11 years. * Becomes more skilled at classifying and ordering. * Developing a theory of mind. E.g is able to reflect on ups and downs of relationships; can describe relationship difficulties like rejection, neglect, exclusion; shows some empathy for those who have such experiences; can give examples of qualities such as ‘being fair’ and ‘being someone I can trust’. * Can describe in more complex detail than at earlier stages the complexities of friendships and relationships; begins to articulate more abstract qualities such as trust and intimacy; begins to be very selective about friends on basis of shared interests and values. | * Can increasingly communicate inner feelings and emotional states; can also communicate judgements of self by others; sometimes indirectly through drama and play. * Continues to learn about managing difficult emotions; can learn more sophisticated ways of reading social cues in others. * Shows capacity to deal with conflicts in relationships and to resolve them in a range of ways; can mediate in disputes. * Can join in group discussions: take turns, listen respectfully, behave confidently * Demonstrates growing capacity for empathy towards peers in distress; able to show kindness and concern for peers in distress. * Learns about bullying and strategies for addressing it * Able to use more complex language to express emotions and describe what other children might be feeling. * Self-esteem strongly influenced by child’s perceived competence in a variety of domains and their experiences of social support from adults and other children. |
| **Impact of abuse and neglect** | The impact of abuse and neglect on children in this age group is as described above. As they get older, the effect of their traumatic experiences may become more noticeable in their general physical development, academic achievements, social relationships, self-concept and behaviours (see below). | | | |

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| **Age** | **Sensory and physical** | **Communication and interaction** | **Cognition and learning** | **Social, mental and emotional health** |
| **11 to 14 years** | * Onset of puberty - physical and hormonal changes continue * Outward signs of puberty appear with onset of menstruation (girls) and pubic hair (boys), and other changes in the body. * Growing interest in sexual activity. Solo sex/masturbation is common, some experimentation with different partners. * Shows awareness of romantic/sexual relationships - often swayed by peer group attitudes but shows emergent understanding that romance and intimacy integrate with sexual feelings and emotions. * Some awareness of risks from partner violence, especially in context of pressure to be sexually active. * Aware of emerging sexual orientation and risks and benefits of ‘coming out’ as gay, lesbian or bisexual. * Some knowledge of health risks involved in excessive use of alcohol or drugs, or ‘initiation’ practices such as body-piercing and tattoos. | * Growing awareness that friendship involves mutual concern and shared values; can describe ability to resolve conflicts within relationships e.g. via peer support action. * May engage in anti-social activities and risky behavior - seek out cliques and gangs that reinforce this behaviour. * Some show capacity to deal with peer pressure, e.g. refuse to engage in unwanted sexual activity or strategies to deal with online harassment, sexting etc. * Emerging capacity to develop responsibility and autonomy in social networks, online and offline. Aware of boundaries between private and public spaces. * Emerging awareness of conflict between pressure to conform to the opinions of peers and the need to form one’s own independent views. | * Shifting from concrete to formal operational thinking. * Can use hypothesis with scientific problem * Recognises the process of dealing with peer pressure to experiment and take risks. * Recognises tension between logical thinking about risks and experimenting with new experiences. | * Dramatic changes in self-concept. * Many experience anxiety about friendships and body image e.g. boys often anxious about penis size with unrealistic views on what is typical * A period of storm and stress for some, but for many the transition to adolescence is relatively smooth. * Identity formation is a key task. * Some engage in anti-social activities and risky behavior - seek out cliques and gangs that reinforce this behaviour. * Able to discuss conflicting feelings, such as anger, shame and guilt in context of relationships. |
| **Impact of abuse and neglect** | With age, the effect of abuse and neglect may become more noticeable in the young person’s general physical development, academic achievements, social relationships, self-concept and behaviours (see below). | | | |

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| **Age** | **Sensory and physical** | **Communication and interaction** | **Cognition and learning** | **Social, mental and emotional health** |
| **14 to 16 years** | * Onset of puberty is marked by profound physical and hormonal changes in the body. * Early or late maturation can have psychological consequences, e.g. in earlier or later sexual activity; adolescents need reassurance that long-term this will not affect their sexuality or emotional health. * Some young people, especially early-maturers, are more vulnerable in their social and emotional development. * Growing capacity to be more confident in resisting peer pressure to engage in practices unwillingly, such as early sexual activity, excessive use of alcohol and drugs. * Within romantic/sexual relationships young people begin to value genuine affection and intimacy over status in the eyes of others. * Growing awareness of own sexual orientation; also aware of difficulties in self-labelling and ‘coming out’ as gay or lesbian from around 15 years. | * Increasingly demonstrates ability to navigate a wider circle of friends, including online relationships. More aware of the values and interests they are looking for in friendships. * More aware of cultural and ethnic identity; can describe in some detail attributes that distinguish different cultures and ethnicities. * Can articulate importance of becoming independent from parents/caregivers. E.g. can describe greater reliance on peer group. * Secure relationships contribute to a stronger sense of self and identity. * More advanced capacity to develop responsibility and autonomy in social networks, online and offline - have clearer boundaries between private and public spaces. * Demonstrate more advanced awareness of conflict between pressure to conform to the opinions of peers and the need to form one’s own independent views. | * Shift from the more concrete thinking of younger children to abstract reasoning. * Growing capacity for logical reasoning and a greater ability to apply logic to decision-making and negotiation. * Increasingly open to dialogues and debates on moral, religious and political issues. * Show capacity to reflect on own thinking processes. * Demonstrate more sophisticated thinking in understanding the complexity of relationships. * Show advanced empathy for vulnerable peers - more reflective in dealing with relationship difficulties; can discuss abstract qualities such as intimacy and values in relationships. * Increasingly influenced by peer group. | * Self-concept evolves; adolescents typically pass through certain stages in identity formation. * Cultural and ethnic identity is strongly influenced by the social context in which the young person is developing. * Increasingly value intimate relationships - can be very intense and break-ups are felt keenly. When friendship is betrayed in close relationships the effects on self-esteem can be very powerful. * Developing capacity to be realistic about the quality of friendship and demonstrate awareness of the emotional impact of separation and loss. * Self-awareness becomes more complex and reflective (e.g. ‘I try not to be selfish but I find it hard sometimes’. * Social anxiety that is typical at 11 to 14 tends to be reduced as young person develops greater independence and autonomy from family and peers. * Some evidence that mental health difficulties increase during adolescence. |
| **Impact of abuse and neglect** | The effects of abuse and neglect can continue to influence brain development and activity into adolescence and adulthood. These may be caused by the cumulative effects of abuse or neglect throughout their lives or by abuse and neglect newly experienced as an adolescent. Adolescents with a history of childhood abuse and neglect can have decreased levels of growth in the hippocampus and amygdala compared to adolescents that have not experienced such trauma. Often, the young people have developed brains that focus on survival at the expense of the more advanced thinking that happens in the brain’s cortex. An underdeveloped cortex can lead to increased impulsive behaviour, as well as difficulties with tasks that require higher-level thinking and feeling. Young people may show delays in school and in social skills. They may be more drawn to taking risks, engage in alcohol and drug abuse, develop eating disorders, engage in other risk taking behaviours and have unhealthy relationships which lead to recurrent victimisation. Thinking processes may be typical of much younger children and they may have difficulty solving problems, lack insight and empathy; they may find it difficult to keep up with the demands of school. They may not be able to think ahead, having no trust in the future and may fail to plan; or express grandiose and unrealistic goals, but without identifying the steps necessary to achieve goals; consequently, often expect failure.  In adolescence the likely effects of abuse and neglect include persistent illnesses, poor coordination.  The impact of early traumatic experiences on brain function means that some young people develop conduct disorders. They may have difficulty conforming to social rules and maintaining friendships with peers – withdrawing or easily succumbing to peer pressure in order to be accepted. They are likely to mistrust adults.  Negative self‐concepts that originate from childhood can lead to personality disorders, anxiety, depression, and problem behaviours. Abuse and neglect significantly increases the risk of suicidal thoughts and attempted suicide for young people, the risks increase for those with a history of sexual abuse.  Professionals need to get a sense of the young person’s developmental pathway over time. Children/young people who feel that their needs are repeatedly unrecognised, ignored or misunderstood are likely to become distressed, angry and desperate. | | | |

**Making Sense of the Information**

This tool should help practitioners to determine if the child is reaching typical milestones and what is either contributing to or hindering healthy development in relation to Parenting Capacity, Family and Environmental Factors (the domains of the Assessment Triangle). The information gathered can be better understood by transferring into the Strengthening Families Approach framework – see below.

**Strengths and Protective Factors**

Here we are seeking to identify the strengths and protective factors that exist within the family, including extended family and significant others who are able to positively support the family.

Strengths and Protective Factors are things parents/carers do on a regular basis which keep their children well cared for and safe.

**Harm or Danger**

Here we are seeking to understand what is the risk, actual harm or danger and what this “looks like”, in relation to:

* Physical abuse
* Emotional abuse
* Sexual abuse
* Neglect

and the impact on the well-being and welfare of the child

**Child or Young Person’s views, feelings, observations**

What is life like for them through their eyes?

What are they saying about their experience of parenting and care?

What do they say needs to happen to make things better for them?

**Complicating Factors**

Here we consider factors that may impact on the welfare of the child or young person and parents or carers ability to provide good enough parenting, stability or meet the emotional and physical needs of the child or young person.

These are things which make it harder for everyone to focus on harm and/or more difficult to bring about change.

**Grey Areas**

Here we are seeking to clarify things we need more information about or to further assess specific issues. We may have been given information but we are unclear if it is factually correct or concerns that require further assessment

**What are the desired outcomes for the Child or Young Person?**

**How will these be achieved?**

**How will change be measured?**

**Are the expected changes in the child’s timescales?**

**Selecting an Intervention**

This tool, used in conjunction with other relevant tools ([for example, see CSCB Practitioners Tools, Assessment Frameworks and Intervention Resources](http://www.calderdale-scb.org.uk/professionals/learning-and-development/practitioners-tools/)), should assist practitioners to gain a better understanding of a child’s development and identify some of the factors that may be impacting on their healthy and safe development. This information will enable practitioners to complete the single assessment and in turn inform a robust decision and plan.

Practitioners can be hugely influential in educating caregivers about the possible effects of child abuse and neglect on brain development, and the resulting symptoms, helping them to better understand and support the children in their care. Exploring any past abuse or trauma experienced by parent/caregivers/carers that may influence their parenting skills and behaviours will also help to promote an effective response.

When considering interventions with children, it is important to note that children who have been abused or neglected need nurturance, stability, predictability, understanding, and support. They need this from their caregivers but also from professionals who should be persistent and reliable. Some children will need frequent, repeated positive experiences to begin altering their view of the world from one that is uncaring or hostile to one that is caring and supportive. Until that view begins to take hold in a child’s mind, the child may not be able to engage in a truly positive relationship, and the longer a child lives in an abusive or neglectful environment, the harder it will be to convince the child’s brain that the world can change.

Healing a damaged or altered brain involves targeting those portions of the brain that have been altered. Because brain functioning is altered by repeated experiences that strengthen and sensitise neural connections, interventions should address the totality of the child’s life, providing frequent, consistent replacement experiences so that the child’s brain can begin to incorporate a new environment - one that is safe, predictable, and nurturing. Consistent nurturing from caregivers who focus the sequence of the interventions on the deficits in the lower brain first (those that control basic survival functions such as, sleeping, eating, warmth) and progressing to the higher brain functions (the conscious control of behaviour, thinking, perceiving, planning, and understanding language) may offer the best hope for the children who need it most.

Six “protective factors” have been identified that can strengthen families, help prevent abuse and neglect, and promote healthy brain development i.e.

|  |  |
| --- | --- |
| * Nurturing and attachment | * Social connections and support networks |
| * Knowledge of parenting and of child development | * Practical support for parent/caregivers[[1]](#footnote-1) |
| * Parental resilience | * Social, emotional competence and resilience for children |

1. The [HEY website](http://www.healthyearlyyears.co.uk/contacts.html) provides useful information for parents of 0 to 5 year olds [↑](#footnote-ref-1)