GRADED CARE PROFILE (GCP) SCALE

A qualitative scale for measure of care of children

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Introduction

The Graded Care Profile (GCP) scale was developed as a practical tool to give an objective measure of the care of children across all areas of need. Other scales in this field at best indicate whether the care environment is neglectful or not by comparing a score in a case with a reference score worked on a sample. In a given case, care could be bad in one area, not so bad or even good in another. This scale was conceived to provide a profile of care on a direct categorical grade. It is important from the point of view of objectivity because the ill effect of bad care in one area may be offset by good care in another area.

Instead of compartmentalising care into neglectful and non-neglectful, this scale draws on the concept of continuum. It has long been recognised that mothers are naturally disposed to care for and nurture their children to adulthood (*Winnicott, 1957, Brimblecombe, 1979).* However, the net care delivered is the product of interaction of the carer's disposition to care (caring instinct) with socio-familial circumstances, carer's attributes other than caring disposition and child's attributes. It can be enhanced if interacting factors are positive or eroded if negative. Thus, in the same case, care can vary if circumstances change. Based on different combinations of this interaction Belsky (*Belsky, 1984)* proposed eight grades of care on a bipolar continuum, best when all factors are positive and worst when negative. This scale is based on actual care by giving a grade to what the carer is doing in the way of caring without taking separate account of other factors. If those factors actually influenced the care then they are reflected in the same. Belsky's eight grades seemed difficult to work in practice. A practical approach was found in a long term prospective cohort study of children and families (Miller et al, 1960 & 1974). Here, care was categorised in three grades. 'Satisfactory', if families provided everything that the child needed making extra effort if required, 'unsatisfactory', if there was clear disregard for the child mixed with cruelty; 'variable' if it was unpredictable.

In this scale there are five grades based on levels of commitment to care. Parallel with the level of commitment is the degree to which a child's needs are met and which also can be observed. The basis of separation of different grades is outlined in table 1 below.

Table 1.

	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 and belongingness and esteem. This model was adopted not so much for its hierarchical nature but for its comprehensiveness. Each area is broken down into sub-areas, and some sub-areas to items, for ease of observation. A record sheet shows all the areas and sub-areas with the five grades alongside.

To help obtain a score, a coding manual is prepared which gives brief examples (constructs) of care in all sub-areas/items for all the five grades. From these, score for the areas are worked as per instructions.

Items and sub-areas are based on factors, which have been shown to bear relation to child development. Care component relating to the items/sub-areas are based more on intuitive than learnt elements (skills) keeping the interest of child uppermost as some skills themselves could be controversial and ever changing (e.g. nursing babies on their backs). This should minimise scores being affected by culture, education, and poverty, except in extreme circumstances.

Following its design, a field trial was conducted to assess its user friendliness and inter-rater reliability. It was found to be workable, user friendly, and gave a high inter-rater agreement. The inter-rater agreement was a measure of its consistency in getting the similar grade by different independent raters on the same case. Almost perfect level of agreement was achieved in the area of physical care ($k = 0.899$, 95%CI = 0.850 – 0.948), safety ($k = 0.894$; 95% CI = 0.854 – 0.933), and esteem
($k = 0.877$; 95% CI = 0.808 – 0.946), and a substantial level in the area of love
($k = 0.785$; 95% CI = 0.720 – 0.849). The mean time taken for scoring was 20 minutes (range 10 – 30) (*Srivastava & Polnay, 1997).*

It is a descriptive scale. The grades are qualitative and on the same bipolar continuum in all areas. Instead of giving a diagnosis of neglect it defines the care showing both strengths or weaknesses as the case may be. It provides a unique reference point. Changes after intervention can demonstrably be monitored in both positive and negative directions.

In practice it can be used in a variety of situations where care for children is of interest. In child protection it can be used in conjunction with conventional methods in assessment of neglect and monitoring; in other forms of abuse it can be used as an adjunct in risk and need assessment. Where risk appears low but care profile is poor it will safeguard the child by flagging up the issues, if it is good it will relieve any anxiety that there might be. Where risk is high and care profile is also poor it will strengthen the case and care will not be a forgotten issue, but if it is good it should not be used to downgrade the risk on its own merit as yet. In the context of children in need, it can help identify appropriate resources (depending on area of deficit) and target them. In the context of child health it can be used to identify care deficit where there is concern about growth, development and care, post-natal depression, repeated accidents, or simply where care is the sole concern.

Uniform care profile (same grade of care in all areas) poses less of a problem in decision making than uneven care profiles. From an intervention point of view it gives a point of focus. More work and experience is needed to know the true significance of uneven profiles.

Finally it should be remembered that it provides a measure of care as it is actually delivered irrespective of other interacting factors. In some situations where conduct and personality of one of the parents is of grave concern, a good care profile on its own should not be used to dismiss that fact. At present it brings the issue of care to the fore for consideration in the context of overall assessment.

Instructions

The Graded Care Profile (GCP) is a new design, which gives an objective measure of care of a child by a carer. It is a direct categorical scale, which gives a qualitative grading for actual care delivered to a child taking account of commitment and effort shown by the carer. Personal attributes of the carer, social environment or attributes of the child are not accounted for unless actual care is observed to be affected by them. Thus, if a child is provided with good food, good clothes and a safe house GCP will score better even if the carer happened to be poor. The grades are on a five point bipolar (extending from best to worst) continuum. Grade one is the best and five the worst. This grading is based on how carer(s) respond to the child's needs. This is applied in four areas of need – physical, safety, love and esteem. Each area is made up of different sub-areas and some sub-areas are further broken down into different items of care. The score for each area of made up of scores obtained for its items. A coding manual is prepared giving brief examples of constructs for the five grades against each item or sub-area of care. Scores are obtained by matching information elicited in a given case with those in the coding manual. There is a system of notation by which each item or sub-area can be represented. This is taken advantage of in designing the follow-up and targeting intervention. Methods are described below in detail. It can be scored by the carers/s themselves if need be or practicable.

How it is organised.

It has two main components, which are described below.

1. **The Record Sheet**

It is printed on an A4 sheet with 'areas' and 'sub-areas' in a column vertically on the left hand side and scores (1 to 5) in a row of boxes horizontally against each sub-area. Next to this is a rectangular box for noting the scores for the area, which is worked from the scores in sub-areas (described later). Adjacent to the area score, there is another box to accommodate any comments relating to that area. At the top there is room to make note of personal details, date and to note who the main carer is against which the scoring is done. At the bottom there is a separate table designed to target item(s) or sub-area(s) where care is particularly deficient and to follow them up. (See appendix 1).

On the reverse side of the record sheet there is a <u>full reference scheme</u>, which accommodates the entire system down to the items. It is for the reference and the record as it is not feasible to keep a coding manual with each case each time scoring is done.

The Reference System:- A capital letter denotes an 'area'. Numerals denote a 'sub-area' and a small letter denotes an 'item'. For example, A/1a = area of 'physical' care sub-area 'nutrition' for this area/item 'quality' for this sub-area; meaning quality of nutrition for physical care.

2 The Coding Manual

The coding manual, which is incorporated here next to the instructions, is laid out according to the reference system described above. There are four '**areas**' – physical, safety, love and esteem which are labelled as – **A, B, C** and **D** respectively. Each area has its own **'sub-areas',** which are labelled numerically – **1, 2, 3, 4** and **5**. Some of the '**sub-areas**' are made up of different '**items**' which are labelled as – **a, b, c, d.** Thus unit for scoring is an 'item' or a 'sub-area' where there are no items. For example, score for 'nutrition', one of the five sub-areas of the area of 'physical' care, is worked from scores obtained for four of its items – quality, quantity, preparation and organisation. For some of the sub-areas or items there are **age bands** written in bold italics. Apparently, only one will apply in any case. Stimulation, a sub-area of the area 'esteem', is made up of 'sub-items' for age bands 2 – 5 & above 5 years.

How to Use

1. Fill in the relevant details at the top of the record sheet.

2. **The Main Carer:** is whom these observations mainly relate to – one or both parents as the case may be, substitute carer or each parent separately if need be. Make note of it in the appropriate place at the top right corner of the record sheet.

3. **Methods**: For prescriptive scoring it is necessary to do a home visit to make observations. In that case carry a check list of sub-areas and items to ensure that they are covered during the visit. Alternatively, carry the coding manual itself and if feasible, share it with the carer. It can also be used retrospectively where already there is enough information on items or sub-areas to enable scoring. Carers using it for themselves can simply go through the manual.

4. **Situations**:

   a) So far as practicable use the ***steady state*** of an environment and discount any temporary insignificant upsets e.g. no sleep the night before.
   b) Discount effect of ***extraneous factors*** on the environment (e.g. house refurbished by welfare agency) unless carers have positively contributed in some way – keeping it clean, adding their own bits in the interest of the child like a safe garden, outdoor or indoor play equipment or safety features etc.
   c) Allowances should be made for ***background factors,*** which can affect interaction temporarily without necessarily upsetting steady state e.g. bereavement, recent loss of job, illness in parents. It may be necessary to revisit and score at another time.
   d) If carer is ***trying to mislead*** (deliberately giving wrong impression or information in order to make one believe otherwise) score as indicated in the manual (e.g. 'misleading explanation'- grade five for PHYSICAL Health/follow up or 'put an act showing care' – grade five for LOVE Carer reciprocation), otherwise score as if it is not true.

5. Obtaining Information on different items or sub-areas:

A) PHYSICAL

1. **Nutritional:** (a) *quality* (b) *quantity* (c) *preparation and* (d) *organisation*

Take a good and skilful history about the meals provided including nutritional contents (milk, fruits etc.), preparation, set meal times, routine and organisation. Also note carer's knowledge about nutrition, note carer's reaction to suggestions made regarding nutrition (whether keen and accepting or dismissive). Observe for evidence of provision, kitchen appliances and utensils, dining furniture and its use without being intrusive. It is important not to lead as far as possible but to observe the responses carefully for honesty. Observation at meal time in natural setting (without special preparation) is particularly useful. Score on amount offered and the carer's intention to feed younger children rather than actual amount consumed as some children may have eating/feeding problems.

2. Housing (a) *Maintenance* (b) *Décor* (c) *Facilities*
Observe. If deficient ask to see if effort has been made to remedy, ask yourself if carer is capable of doing them him/herself. Discount if repair or decoration is done by welfare agencies or landlord.

3. Clothing (a) *Insulation* (b) *Fitting* (c) *Look*
Observe. See if effort has been made towards restoration, cleaning, ironing. Refer to the age band in the manual.

4. Hygiene
Child's appearance (hair, skin, behind ears and face, nails, rashes due to long term neglect of cleanliness, teeth). Ask about practice. Refer to age band in manual.

5. Health (a) *Opinion sought* (b) *follow-up* (c) *Surveillance* (d) *Disability*
See if professionals or some knowledgeable adults are consulted on matters of health, check about immunisation and surveillance uptake, reasons for non-attendance if any, see if reasons can be appreciated particularly if appointment does not offer a clear benefit. Corroborate with relevant professionals. Distinguish genuine difference of opinion between carer and professional from non-genuine misleading reasons. Beware of being over sympathetic with carer if the child has a disability or chronic illness. Remain objective.

B) SAFETY

1. In Presence (a) *Awareness* (b) *Practice* (c) *Traffic* (d) *Safety Features*

This Sub-Area covers how safely environment is organised. It includes safety features and career's behaviour regarding safety (e.g. lit cigarettes left lying in the vicinity of child) in every day activity. The awareness may be inferred from the presence and appropriate use of safety fixtures and equipment in and around the house or in the car (child safety seat etc.) by observing handling of young babies and supervision of toddlers. Also observe how carer instinctively reacts to the child being exposed to danger. If observation not possible, then ask about the awareness.

Observe or ask about child being allowed to cross the road, play outdoors etc. along the lines in the manual. If possible verify from other sources. Refer to the age band where indicated.

2. In Absence: This covers child care arrangements where the carer is away, taking account of reasons and period of absence and age of the minder. This itself could be a matter for investigation in some cases. Check from other sources.

C) LOVE

1. **Carer** (a) *Sensitivity* (b) *Response Synchronisation* (c) *Reciprocation*

This mainly relates to the carer. Sensitivity denotes where carer shows awareness of any signal from the child. Carer may become aware yet respond a little later in certain circumstances. Response synchronisation denotes the timing of carer's response in the form of appropriate action in relation to the signal from the child. Reciprocation represents the emotional quality of the response.

2. **Mutual Engagement** (a) *Overtures* (b) *Quality*

IT is a dyadic trait inferred from observing mutual interaction during feeding, playing, and other activities. Observe what happens when the carer and the child talk, touch, seek out for comfort, seek out for play, babies reaching out to touch while feeding or stop feeding to look and smile at the carer. Skip this part if child is known to have behavioural problems as it may become unreliable.

Spontaneous interaction is the best opportunity to observe these items. See if carer spontaneously talks and verbalises with the child or responds when the child makes overtures. Note if the pleasure is derived by both the carer and the child, either or neither. Note if it is leisure engagement or functional (e.g. feeding etc.).

D) ESTEEM

1. Stimulation: Observe or enquire how the child is encouraged to learn. Stimulating verbal interaction, interactive play, nursery rhymes or joint story reading, learning social rules, providing developmentally stimulating equipment are such examples with infants (0 – 2 years). If lacking, try to note if it was due to carer being occupied by other essential chores. Follow the constraints in the manual for appropriate age band. The four elements (i, ii, iii and iv) in age band 2-5 years and 5-years are complementary. Score in one of the items could suffice. If more items are scored, score for whichever column describes the case best. In the event of a tie choose the higher score (also described in the manual).

2. Approval: Find out how and how much child's achievement is rewarded or neglected. It can be assessed by asking how the child is doing or simply by praising the child and noting the carer's response (agrees with delight or neglects)

3. Disapproval: If opportunity presents, observe how the child is reprimanded for undesirable behaviour, otherwise enquire tactfully (does the she throw tantrums? How do you deal if it happens when you are tired yourself?) Beware of discrepancy

between what is said and what is done. Any observation is better in such situations e.g. child being ridiculed or shouted at. Try and probe if carer is consistent.

4. Acceptance: Observe or probe how carer generally feels after she has reprimanded the child or when the child has been reprimanded by others (e.g. teacher), when child is underachieving or feeling sad for various reasons. See if the child is rejected (denigrated) or accepted in such circumstances as shown by warm and supportive behaviour.

5. Scoring on the manual: Make sure your information is factual as far as possible. Go through the constructs in the order – (Sub-Areas and Items) as in the manual. Find the construct which matches best, read one grade on either side to make sure, then place a tick on that construct (use pencil which can be erased and manual reused). The number at the top of the column will be the score for that item or sub-area. Where more than one item represents a sub-area , use the method described below to obtain the score for the sub-area.

6. Obtaining a score for a sub-area from score in its items:
a) Read the score for all ticks for different items of a particular sub-area: if there is a clear mode but none of the ticks are beyond three (3) score the mode for that particular sub-area. To score on the record sheet encircle the appropriate score box against the sub-area. Example:

Nutrition		**1**	**2**	**3**	**4**	**5**
Score for **NUTRITION** would be **3**	Quality			✓		
	Quantity		✓			
	Preparation		✓			
	Organisation		✓			

b) If there is no clear mode (scores evenly or unevenly spilt) **but** no tick is above point three (3), use the higher score.

c) If there is even a single score **above** point 3, score that point regardless of mode.

7. Obtaining a score for an 'area' from score in its constituent sub-areas: -
Same as above (6)
This method helps identify the problem even if it is one sub-area or item. Its primary aim is to safeguard child's welfare while being objective. Besides, if mathematical computation like calculating the mean are done to obtain a common score it will not be possible to refer to an item or sub-areas which gave a poor score in order to target it which is an advantage with this scale. This is why it has been left as a categorical scale.

8. Transferring the score on the 'Record Sheet': Transfer all scores down to the items from the coding manual to the reverse side of the record sheet, which is titled 'Full Reference Scheme'. Having worked on the score for the sub-areas which have items, transfer the scores for all sub-areas on record sheet in the front by encircling the appropriate corresponding score box. Then is the time to work the score out for the areas and note it down in corresponding boxes.

9. Comments: This column in the record sheet can be used for flagging up issues, which are not detected by the scale but may be relevant in a particular case. For example, a child who is temperamentally difficult to engage with (in the 'manual

engagement' a sub-area of 'love') or a parent(s) whose over protectiveness gave rise to concern (may score better in the sub-area of 'disapproval' in 'area' of esteem). These may need separate expert evaluation.

10. Targeting: If the care is of poor grade in an item or sub-area, it can be picked up for targeting by noting it in the table at the bottom of the record sheet by using the reference system. A better score can be aimed at after a period of intervention. By aiming for one grade better will place less demand on the carer than by aiming for ideal in one leap.

A AREA OF PHYSICAL CARE

Sub-areas	1	2	3	4	5
1. Nutrition					
A. Quality	Aware and proactive; provides excellent quality food and drink.	Aware and manages to provide reasonable quality food and drink.	Provision of reasonable quality food, inconsistent through lack of awareness or effort.	Provision of poor quality food through lack of effort; only occasionally of reasonable quality if pressurised.	Quality not a consideration at all or lies about quality.
B. Quantity	Ample.	Adequate.	Adequate to Variable.	Variable to Low.	Mostly low or starved.
C. Preparation	Painstakingly cooked/prepared for the child.	Well prepared for the family always accommodating child's need, sometimes for the child.	Preparation infrequent and mainly for the adults, child sometimes accommodated.	More often no preparation. If there is, child's need or taste not accommodated.	Hardly ever any preparation. Child lives on snacks/cereals.
D. Organisation	Meals elaborately organised – seating, timing, manners.	Well organised- often seating, regular timing.	Poorly organised- irregular timing, improper seating.	Ill organised- no clear meal time.	Chaotic – eat when and what one can.

AREA OF PHYSICAL CARE Continued …

Sub-areas	1	2	3	4	5
2. Housing					
A. Maintenance	Additional features benefiting child- double glazing, child safety etc. (also referred to B/1/d)	No additional features but well maintained.	State of repair adequate.	In disrepair- amenable to self repair.	Dangerous disrepair- amenable to self repair (exposed nails, live wires).
B. Décor	Excellent, child's taste specially catered for.	Good, child's taste accommodated (practical constraints).	In need of decoration but reasonably clean.	Dirty.	Dirty and filthy (bad odour).
C. Facilities	Essential and additional amenities- central heating, shower and bath, play and learning facilities.	All essential amenities; effort to maximise benefit for the child if lacking due to practical constraints (child first).	Essential to bare- no effort to maximise benefit to the child who shares equally.	Essential to bare- adult first and child if any left e.g. Blanket.	Child dangerously exposed or unprovided for.

NOTE: Discount any direct external influences like repair done by other agency but count if the carer has spent a loan or a grant on the house or had made any other personal effort towards house improvement.

AREA OF PHYSICAL CARE Continued …

Sub-areas	1	2	3	4	5
3. Clothing					
A. Insulation	Well protected with high quality material garments.	Well protected, even if with cheaper material garments.	Adequate to variable weather protection.	Inadequate weather protection.	Dangerously exposed.
B. Fitting	Excellent fitting and design.	Proper fitting even if handed down.	Fitting somewhat improper.	Clearly improper fitting.	Grossly improper fitting.
C. Look- age 0 to 5	Newish, clean, ironed.	Effort to restore any wear, clean, ironed.	Repair lacking, usually not quite clean or ironed.	Worn, somewhat dirty and crumpled.	Dirty, badly worn and crumpled, odour.
Look- age 5+	As above	As above, odour if bed wetter, not otherwise.	Worse than above unless self-helped. If younger (under 7) gets relatively better clothes.	Same as above unless self helped. Even under 7 same as above.	Same as above, no means even of self help by the child.
4. Hygiene					
Age 0 to 4	Cleaned, bathed and groomed regularly daily.	Regular, almost daily.	Irregular but often, less so with older toddlers.	Occasionally bathed but seldom groomed.	Seldom bathed or clean.
Age 5 to 7	Some independence at above tasks but always helped and supervised.	Reminded and provided for regularly, followed and helped if need perceived.	Irregularly reminded and provided but not followed.	Reminded only now and then, minimum supervision.	Not bothered.
Age 7+	Reminded, followed, helped regularly.	Reminded regularly and followed if lapses.	Irregularly reminded, even provision not consistent.	Left to their own initiatives. Provision minimum and inconsistent.	No concern.

AREA OF PHYSICAL CARE Continued …

Sub-areas	1	2	3	4	5
5. Health					
A. Opinion sought	Not only on illnesses but also other genuine health matters proactively and with sincerity. Preventative.	From professionals/ experienced adults on matters of genuine and immediate concern about child health.	On illness or any severity / or frequent disgenuine consultation and/ or medication.	When illness becomes moderately severe (delayed).	When illness becomes critical (emergencies) or even that ignored.
B. Follow up	All appointments kept. Rearranges if problems.	Fails one in two appointments due to doubt about their usefulness or due to pressing practical constraints.	Fails one in two appointments even if of clear benefit for reasons of personal inconvenience.	Attends third time after reminder. Contests its usefulness even if it is of clear benefit to the child.	Fails a needed follow up a third time despite reminders. Misleading explanations.
C. Surveillance	Visits in addition to the scheduled surveillance, up to date with immunisation unless genuine reservations.	Up to date with scheduled surveillance and immunisation unless exceptional or practical problems.	Omission for reasons of personal inconvenience, takes up if persuaded.	Omissions because of carelessness, accepts if accessed at home.	Clear disregard of child's welfare, frustrates home visits.
D. Disability/chronic illness (3 months after diagnosis)/ illness	Compliance excellent, (any lack is due to difference of opinion).	Any lack of compliance is due to pressing practical reason.	Compliance is lacking from time to time for no pressing reason (excuses).	Compliance frequently lacking for trivial reasons, very little affection, if at all.	Serious compliance failure (medication not given for no reason), can lie, (inexplicable deterioration), any affection is put on.
Compliance = Availing professional advice at any venue and carrying out advice given.					

B AREA OF CARE OF SAFETY

Sub-areas	1	2	3	4	5
1. In Presence					
A. Awareness	Good awareness of safety issues how ever remote.	Aware of important safety issues.	Poor awareness and perception except for immediate danger.	Oblivious.	Not bothered.
NOTE: Please refer to the item 'd (Safety Features)' and the note below that					
B. **Practice**					
Pre-mobility age	Very cautious with handling and laying, seldom unattended.	Cautious whilst handling and laying, frequent checks if unattended.	A bit precarious handling, frequently unattended when laid within the house.	Handling precarious unattended even during care chores (bottle left in the mouth).	Dangerous handling, left dangerously unattended during care chores like bath.
Acquisition of mobility	Constant vigilance and effective measures against any perceived dangers when up and about.	Effective measures against any imminent danger.	Measures taken against imminent danger of doubtful efficacy.	Ineffective measures if at all, improvement from mishaps soon lapses.	Inadvertently exposes to dangers (dangerously hot iron near by).
Nursery school to 8 years	Close supervision indoor and outdoor.	Supervision indoors, no direct supervision outdoors if known to be at a safe place.	Little supervision indoors or outdoors, intervenes if in appreciable danger.	No supervision, intervenes after mishaps which soon lapses again.	Minor mishaps ignored or the child is blamed; intervenes casually after major mishaps.
Primary & secondary School 8+	Allows out in known safe surroundings within appointed time checks if goes beyond.	Can allow out in unfamiliar surroundings if thought to be safe and in knowledge. Reasonable time limit. Checks if suspicious.	Not always aware of whereabouts outdoors believing it is safe as long as returns in time.	Not bothered about daytime outings, concerned about late nights in case of child younger than 13.	Not bothered despite knowledge of dangers outdoors-railway lines, ponds, unsafe building, or staying away until late evening/nights.

AREA OF CARE OF SAFETY (Continued) …

Sub-areas	1	2	3	4	5
1. In Presence cont.					
C. Traffic					
Age 0 – 4	Well secured in the pram, harnesses, or walking hand clutched with child's pace.	3-4 year old allowed to walk but close by, always in vision, hand clutched if necessary i.e. crowd.	Infants not secured in pram. 3-4 year old expected to catch up with adult when walking, intermittent glance back if left behind.	Babies not secured, 3-4 year olds left far behind when walking or dragged with irritation.	Babies unsecured, careless with pram, 3-4 year old left to wander and dragged along in frustration when found.
5 and above	5-10 year old escorted by adult crossing a busy road walking close together.	5-8 year old allowed to cross road with a 13+ child: 8-9 allowed to cross alone if they reliably can.	5-7 year olds allowed to cross with an older child, but below 13 simply watched: 8-9 crosses alone.	5-7 year old allowed to cross a busy road alone in belief that they can.	A child 7 crosses a busy road alone without any concern or thought.
D. Safety Features	Abundant features- gate, guards, drug lockers, electrical safety devices, intercom to listen to the baby, safety with garden pond and pool etc.	Essential features- secure doors, windows and any heavy furniture item, safe gas and electrical appliances, drugs and toxic chemicals out of reach, smoke alarm. Improvisation and DIY if cannot afford.	Lacking in essential features, very little improvisation or DIY (done too causally to be effective).	No safety features. Some possible hazard due to disrepair (tripping hazard due to uneven floor, unsteady heavy fixtures, unsafe appliances).	Definite hazard for disrepair- exposed electric wires and sockets, unsafe windows (broken glass), dangerous chemicals carelessly lying around.
Note: This item along with other safety provisions which are not a fixture like a bicycle helmet, safety car seats, sports safety wear etc. can be used to score for item 'a' (Awareness of safety).					

AREA OF CARE OF SAFETY Continued …

Sub-areas	1	2	3	4	5
2. Safety in Absence	Child is left in care of a vetted adult, never in sole care of an under 16.	Out of necessity a child aged 1-12 is left with a young person over 13 who is familiar and has no significant problem, for no longer than necessary. Above arrangement applies to a baby only in an urgent situation.	For recreational reason leaves a 0-9 year old with a child aged 10-13 or a person known to be unsuitable.	For recreational reason a 0-7 year old is left with an 8-10 year old or an unsuitable person.	For recreational reason a 0-7 year old is left alone or in a company of a relatively older but less than 8 year old child or an unsuitable person.

C AREA OF CARE OF LOVE

Sub-areas	1	2	3	4	5
1. Carer					
A Sensitivity	Anticipates or picks up very subtle signals- verbal or nonverbal expression or mood.	Comprehends clear signals – distinct verbal or clear nonverbal expression.	Not sensitive enough – stimuli and signals have to be intense to make an impact e.g. cry.	Quite insensitive – needs repeated or prolonged intense signals.	Insensitive to even sustained intense signals or aversive.
B Response Synchronisation Timing	Responses well synchronised with signals or even before in anticipation	Responses mostly synchronised except when occupied by essential chores.	Not synchronised for own recreational engagement; synchronised if fully unoccupied or child in distress.	Even when child in distress responses delayed.	No responses unless a clear mishap for fear of incrimination.
C Reciprocation (quality)	Responses complementary to the signal. Both emotionally and materially, can get over stressed by distress signals from child. Warm.	Material responses (treats etc.) lacking, but emotional responses warm and reassuring.	Emotional reciprocation warm if in good mood (not burdened by strictly personal problem), otherwise flat.	Emotional reciprocation brisk, flat and functional, annoyance if child in moderate distress but attentive if in severe distress.	Aversive/punitive even if child in distress, acts after a serious mishap mainly to avoid incrimination, any warmth/remorse deceptive.

AREA OF CARE OF LOVE continued …..

Sub-areas	1	2	3	4	5
2. Mutual Engagement					
A. Overtures	Bilateral but overtures more by carer.	Bilateral- equally by both. Positive overture even if child is defiant.	Overtures mainly by child, sometimes by carer, negative if child's behaviour is defiant.	Mainly unilateral overture by the child, seldom by the carer.	Child appears resigned or apprehensive and does not make overtures.
B. Quality	Frequent pleasure engagement, mutual enjoyment, carer may seen to enjoy a bit more.	Quite often and both enjoy equally.	Less often engaged for pleasure, child enjoys more, carer passively participates getting some enjoyment at times.	Engagement mainly functional, indifferent when child attempts to engage for pleasure, child can derive some pleasure (attempts to sits on knees, tries to show a toy).	Aversive to pleasure overtures if any, child resigned or plays on own, carer directed engagement only.
CAUTION: If child has temperamental/behavioural problems, scoring in this sub-area (mainly quality item) can be affected unjustifiably. Scoring should be done on the basis of score in area of 'carer' (C/1) alone and problem noted as comments.					

D AREA OF CARE OF ESTEEM

Sub-areas	1	2	3	4	5
1. Stimulation					
Age 0-2 years	Ample and appropriate stimulation (talking, touching, looking). Equipments plenty.	Enough and appropriate intuitive stimulation but less of commercial equipments.	Inadequate and inappropriate- baby left alone while carer pursues own recreation; sometimes interacts with baby.	Baby left alone while pursuing own pleasure unless sought badly by the baby.	Absent- even mobility restricted (confined in chair/pram) for carer's convenience. Irate if sought by the baby.
Age 2-5 years	i *Interactive stimulation* (talking to, playing with, reading stories and topics) plenty and good quality. ii *Toys and gadgets* (items of uniform, sports equipment, books etc.) – elaborate provision. iii *Outings* (taking the child out for recreational purposes) – frequent visits to child centred places locally and away. iv *Celebrations* – both seasonal and personal, with pomp and zeal.	i Sufficient and of satisfactory quality. ii Provides all that is necessary and tries for more, improvises if unaffordable. iii Enough visits to child centred places locally (e.g. parks) occasionally away (e.g. Legoland, zoos). iv Equally zealous but less pompous.	i Variable- adequate if totally otherwise occupied. ii Essentials only. No effort to improvise if unaffordable. iii Child accompanies carer wherever carer decides, usually child friendly places. iv Mainly seasonal (Christmas) low key personal (birthdays).	i Deficient- even if totally unoccupied. ii Lacking on essentials. iii Child simply accompanies – holidays or locally (e.g. shopping), plays out doors in neighbourhood. iv Only seasonal- low key to keep up with the rest.	i Nil. ii Nil, unless provided by other sources- gifts or grants. iii No outings for the child, may play in the street but carer goes out locally e.g. to pub with friends. iv Even seasonal festivities absent or dampened.

AREA OF CARE OF ESTEEM (Continued)

Sub-areas	1	2	3	4	5
1. Stimulation cont.					
Age 5+ years	i *Education* – active interest in schooling and support at home.	i Active interest in schooling, support at home when free of essential chores.	i Maintains schooling but little support at home even if has spare time.	i Little effort to maintain schooling or mainly for other reasons like free meals etc.	i Not bothered or can even be discouraging for other gains.
	ii *Sports and leisure* – well organised outside school hours e.g. swimming, scouts, etc.	ii All affordable support.	ii Not proactive in finding out but avails opportunities at doorsteps.	ii Child avails by self effort, carer not bothered.	ii Not bothered even if child is unsafe/unhealthy pursuit.
	iii *Peer interaction* – facilitated and vetted.	iii Facilities.	iii Supports if a peer is from a friendly family with carer.	iii Child finds own peer, no help from carer unless reported to be bullied.	iii Not bothered.
	iv *Provision* – elaborate e.g. sports gear, computers.	iv Well provided and tries to provide more if could.	iv Under provided.	iv Ill provided.	iv No provision.
NOTE: Whichever describes the case best should be ticked as the score; in the event of a tie choose the higher score.					
2. Approval	Talks about the child with delight/praise without being asked; generous emotional and material reward for any achievement.	Talks fondly about the child when asked, generous praise and emotional reward, less of material reward.	Agrees with others praise of the child, low key praise and damp emotional reward.	Indifferent if child praised by others, indifferent to child's achievement, which is quietly acknowledged.	Negates if the child is praised, achievements not acknowledged, lack of reprimand or ridicule is the only reward if at all.

AREA OF CARE OF ESTEEM (Continued)

Sub-areas	1	2	3	4	5
3. Disapproval	Mild verbal and consistent disapproval if any set limit is crossed.	Consistent terse verbal, mild physical, mild sanctions if any set limits are crossed.	Inconsistent boundaries or methods terse/shouts or ignores for own convenience, mild physical and moderate other sanctions.	Inconsistent, shouts/harsh verbal, moderate physical, or severe other sanctions.	Terrorised. Ridicule, severe physical or cruel other sanctions.
4. Acceptance	Unconditional acceptance. Always warm and supportive even if child is failing.	Unconditional acceptance, even if temporarily upset by child's behavioural demand but always warm and supportive.	Annoyance at child's failure, behavioural demands less well tolerated.	Unsupportive to rejecting if child is failing or if behavioural demands are high. Accepts if child is not failing.	Indifferent if child is achieving but rejects or denigrates if makes mistakes or fails.
NOTE: If the style of parenting (over protective, permissive to foster independence, authoritarian) or type of values instilled is of concern, please make a note in the corresponding comment box on the record sheet.					

Record Sheet

GRADED CARE PROFILE (GCP) SCALE

Name (child)……..
Date of birth…….
Carefirst ID……
Date of scoring……..
Other identification date……..

Main carer/s…….
Rater's name……..
Rater's signature……...

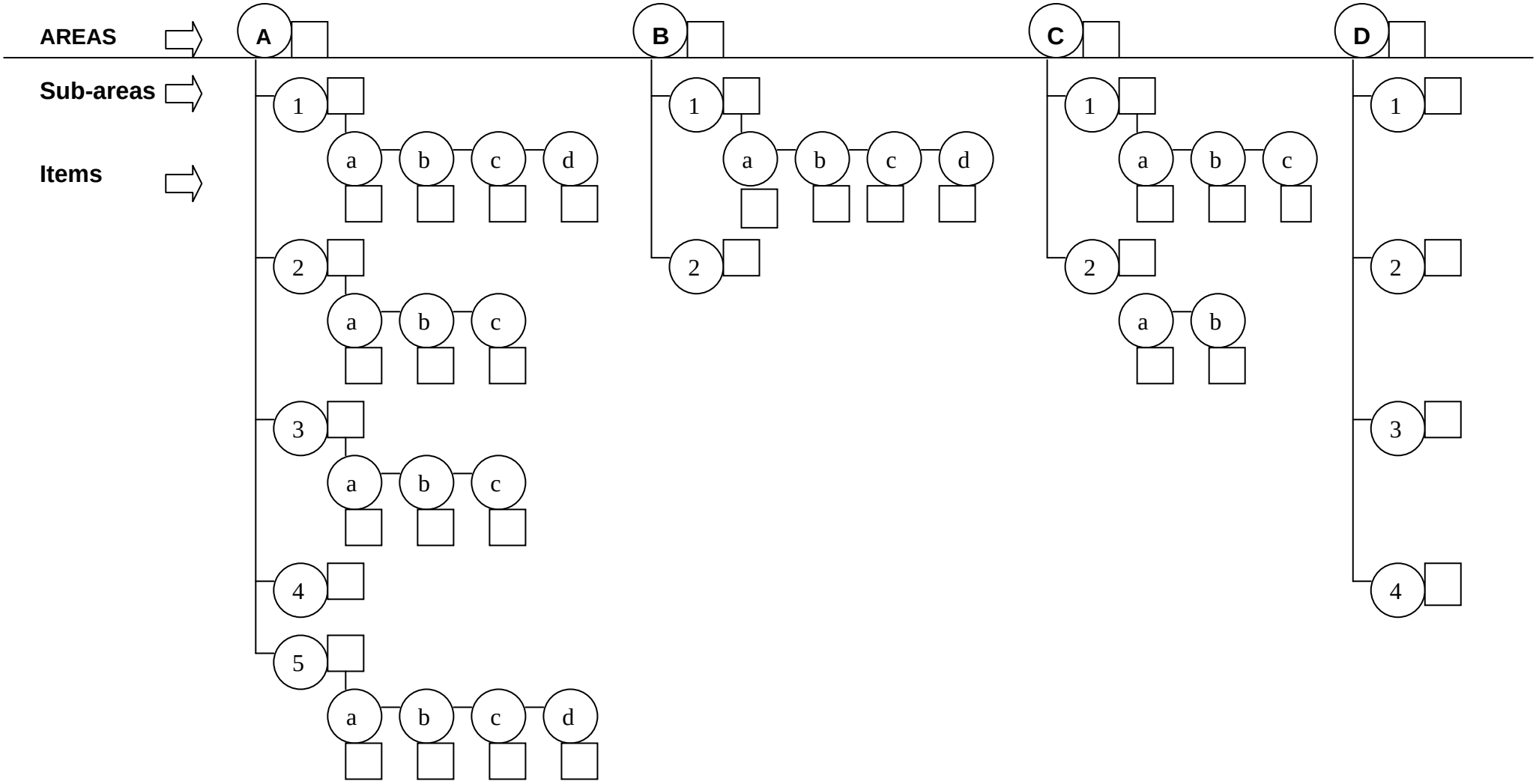
AREA	Sub-area	SCORES					Area score	Comments
(A) PHYSICAL	1. NUTRITION	1	2	3	4	5		
	2. HOUSING	1	2	3	4	5		
	3. CLOTHING	1	2	3	4	5		
	4. HYGIENE	1	2	3	4	5		
	5. HEALTH	1	2	3	4	5		
(B) SAFETY	1. IN CARER'S PRESENCE	1	2	3	4	5		
	2. IN CARER'S ABSENCE	1	2	3	4	5		
(C) LOVE	1. CARER	1	2	3	4	5		
	2. MUTUAL AGREEMENT	1	2	3	4	5		
(D) ESTEEM	1. STIMULATION	1	2	3	4	5		
	2. APPROVAL	1	2	3	4	5		
	3. DISAPPROVAL	1	2	3	4	5		
	4. ACCEPTANCE	1	2	3	4	5		

TARGETING PARTICULAR AREAS OF CARE

Any item with a disproportionately high score can be identified by reference to the manual as: capital letter for an 'area', numericals for a 'sub-area' and small letter for an 'item'
(A/1/b = physical – nutrition – quantity)

	Targeted item	Current score	Period	Target score	Actual score
1					
2					
3					
4					
5					

FULL REFERENCE SCHEME:



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This is the scheme representing all 'items' (represented by small letters); 'sub areas' (represented by numericals), and 'areas' (represented by capital letters). These are printed in circles.
Scores are to be noted in boxes adjacent to corresponding 'items', 'sub areas' and 'areas'. This represents the entire record as in the manual for full reference.

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