



Graded Care Profile A Reference Guide for Practitioners

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Introduction

When we are undertaking an assessment in a child welfare or child protection context, it is vital that we should be able to make a reliable judgment about the quality of the care being received by the children involved. However, the findings of serious case reviews at both local and national levels repeatedly suggest that this is something that we do not do very well. The judgments we make can be highly subjective; prone to bias and vary according to which agency is assessing the quality of care.

When we are faced with identifying neglect of children, the factors that we are trying to capture are notoriously intangible and hard to pin down. Most importantly, despite our increased recognition of neglect as a serious and widespread component of the harm that children suffer, we still seem to be applying alarmingly high thresholds for recognition and intervention. To tackle this challenge more effectively, Cambridgeshire and Peterborough Safeguarding Children Partnership Board has decided to adopt the Graded Care Profile, for Cambridgeshire, as a single and multi-agency assessment tool for use in situations where neglect of children is known or suspected.

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. 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.

It is a descriptive scale. The grades indicate quality of care and are recorded using the same 1 to 5 scale in all areas. Instead of giving a diagnosis of neglect it defines the care showing both strengths and 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.

It can be used to improve understanding about the level of concern and to target specific areas of work as it highlights areas of greater risk of poorer outcomes and should be used in all cases where neglect is suspected or identified. The GCP can be used with the family by individual workers, or groups of workers, to inform family action meetings and child protection Core Group meetings. It can also be used prior to adopting the Signs of Safety approach.

Hierarchy of needs

The Graded Care Profile is based on psychologist Abraham Maslow's hierarchy of needs. The tool allows practitioners to explore four areas, or "domains" of care – physical care, safety, love and esteem – and to judge the parenting, which they observe against simple predetermined criteria. The results of the assessment are entered on to a summary sheet, which pinpoints those areas of deficit, which require further attention.

For many users, the most important aspect of the tool's success has been the fact that it can be employed by practitioners from any agency involved in child welfare. In that regard, it pre-dated the common assessment framework by many years. The profile gives the agencies a common language, a common frame of reference."

In Cambridgeshire, Graded Care Profile assessments completed by any agency should be accepted by children's services as evidence of the need for intervention in cases that meet certain criteria. This will reduce the need for further assessment and minimise the potential for inter-agency misunderstanding.



Identifies Strengths and well as areas of Concern

The structure of the assessment process means that strengths are highlighted alongside weaknesses, and areas of concern are identified sufficiently precisely to allow intervention to be targeted specifically at areas of weakness, which can result in considerable resource savings. For example, family centres can stop receiving rather vague referrals asking for generalised “parenting training”. Instead, the Graded Care Profile provides them with a concise analysis of the care being given which allows them to devise shorter but more intensive programmes.

It is designed to be used by workers to make a baseline assessment at the beginning of intervention and then to be reapplied regularly to gauge progress. This is an aspect of the tool which families have found particularly helpful, as it has provided them with specific targets to aim for and a clear idea of what it is they are trying to achieve and how they will be judged.

It fits neatly into the wider framework of integrated assessment, making a useful contribution at pre-referral, and early help, initial and core assessment stages.

It involves grading care

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.

The four ‘areas’ – physical, safety, love and esteem 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, and d**. Thus the unit for scoring is an ‘item’ or a ‘sub-area’ where there are no items. 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.

Based on what we know about a child's need

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. placing babies to sleep on their backs). This should minimise scores being affected by culture, education, and poverty, except in extreme circumstances.

When should it be used?

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.

A 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.

Where a single agency has concerns about a child and neglect is thought to be a factor, the GCP will be used in partnership with the parents. Where the parents do not agree with its use or refuse to engage, then the tool may still be useful to assist individual practitioners decide where best to focus their intervention.

Where concerns about a child require multi-agency intervention, a decision may be made to complete a GCP. Decisions about who will engage the family and which professionals will gather which information will have to be made.

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 checklist of sub-areas and items to ensure that they are covered during the visit. Alternatively, carry the profile itself and if feasible, share it with the parent/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 them can simply go through the profile.

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, and 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 mealtime 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 welfare agencies or landlord does repair or decoration.

3. Clothing (a) *Insulation* (b) *Fitting* (c) *Look*

Observe. See if effort has been made towards restoration, cleaning, and 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 carer'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. Notes:

Use the column section and the notes section in each of the areas to add any comments in relation to the scoring. These 'spaces' 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) who's 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.

7. 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.



Example: Nutrition

| | | | | | |
|-----------|---------------------------|---------------------------------|--|--|---|
| Sub-areas | 1 All Needs Met | 2 Essential Needs Met | 3 Some Essential Needs Unmet | 4 Many Essential Needs Unmet | 5 Most/ all Essential Needs Unmet |
|-----------|---------------------------|---------------------------------|--|--|---|

| | | | | | |
|--------------|--|---|---|--|--|
| Quality | | | ✓ | | |
| Quantity | | ✓ | | | |
| Preparation | | ✓ | | | |
| Organisation | | ✓ | | | |

Score for Sub-Area Nutrition here would be 2

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

| | | | | | |
|-----------|---------------------------|---------------------------------|--|--|---|
| Sub-areas | 1 All Needs Met | 2 Essential Needs Met | 3 Some Essential Needs Unmet | 4 Many Essential Needs Unmet | 5 Most/ all Essential Needs Unmet |
|-----------|---------------------------|---------------------------------|--|--|---|

| | | | | | |
|--------------|--|---|---|--|--|
| Quality | | | ✓ | | |
| Quantity | | ✓ | | | |
| Preparation | | | ✓ | | |
| Organisation | | ✓ | | | |

Score for Sub Area Nutrition here would be 3

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

| | | | | | |
|-----------|---------------------------|---------------------------------|--|--|---|
| Sub-areas | 1 All Needs Met | 2 Essential Needs Met | 3 Some Essential Needs Unmet | 4 Many Essential Needs Unmet | 5 Most/ all Essential Needs Unmet |
|-----------|---------------------------|---------------------------------|--|--|---|

| | | | | | |
|--------------|--|---|---|---|--|
| Quality | | | | ✓ | |
| Quantity | | ✓ | | | |
| Preparation | | | ✓ | | |
| Organisation | | ✓ | | | |

Score for Sub Area Nutrition here would be 4



8. 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, for example calculating the mean, is 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.

9. Transferring the score from the Record sheet to the 'Summary sheet'.

Transfer all scores to the summary sheet and then identify the areas flagged for attention together with the action required within a given timescale.

10. Use '**Assessing Progress**' sheet to record the initial assessment followed by a differently coloured line with identifies target scores and /or which maps progress. 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.

11. Use the Summary sheet and Assessing progress sheet to discuss concerns with parents, in supervision and in multi-agency meetings.