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Graded Care Profile 2

MEASURING CARE, HELPING FAMILIES

Handbook

Updated July 2018

NSPCC

EVERY CHILDHOOD IS WORTH FIGHTING FOR

Welcome

This handbook explains how to use the Graded Care Profile 2 – with guidance on scoring and interpreting results.

Instructions for scoring

The level of care is graded according to a descriptive scale. It ranges from 1 to 5, with 1 being the best and 5 being the worst.

1

Always met
All the child's needs are always met, and the parent goes the extra mile. The child is always first.

2

Met
All essential needs are always met. The child is priority

3

Met most of the time
Most of the time the essential needs of the child are met. The child and the carer are at par.

4

Not met most of the time
Most of the time the essential needs of the child are not met. Child is considered second.

5

Never met
The child's essential needs are not met. May be due to intentional disregard. The child is last or not considered.

Who
It's important to be clear about which carer and whose care you are measuring.

- The scoring is done in relation to one child where care is provided by a given carer, however other or all children within the family can be assessed simultaneously.
- If there's reason to believe that the care provided by one parent/carer is substantially different from the other parent/carer, then each should be scored individually.
- Where care is delivered jointly, the Graded Care Profile 2 (GCP2) scoring will represent the care of that child in that family. Minor variation in care by the other parent can be noted on the same form.
- If there are a number of children in the family, decide who should be the focus of the scoring. It can be done on one, some or all of the children in the family.
- If a child is of suitable age and understanding then they can grade themselves.
- Carers/parents can also grade themselves.
- It can be used on children with a physical or intellectual disability. You need to be fully aware of the care that the child should be receiving. Some disabled children may require intimate personal care, this element may need to be discussed or potentially assessed by a health professional who knows the child's needs in detail.

How
- Undertake the scoring between two identified dates. Don't take any observations into account outside of this timescale. This will allow you to mark the GCP2 at a particular point in time and reliably measure any change when it's repeated.
- Be objective and only score what you observe during home visits or have been reliably informed about.
- However, evidence could also be gathered from health records or professionals (non-attendance, immunisations, health surveillance, for example). Any other evidence should be credible and you should always note its source on the summary sheet or in the report.
- Don't interpret the grades based on context. For example, don't change the score because the mum or dad have learning difficulties. Score first, then explain.
- Make sure you carry out scoring in a **steady state (normal circumstances)** and not during a state of extreme transient upset such as recent bereavement.
- When scoring for Emotional Care, make sure observations are done in a state that's representative of daily life as far as possible.
- Take account of the effect of factors that the carer has not contributed themselves such has house repairs by an agency. Note what input the carer has made themselves.
- If the carer is trying to mislead you by deliberately giving a wrong impression or information, score as indicated in the manual.
- Constructs are not exhaustive and prescriptive – they're indicative. If there are areas that require a grading then

align or comment on it in relation to the nearest suitable item or sub-area. For example, routines are not mentioned independently but could be mentioned in organisation or development.

Interpretation of the GCP2

Analysis
All care should be graded according to the quality of the care you observe or are reliably informed about. However, you may draw different conclusions from understanding or making assumptions about the family context or other relevant information. Some of these could be:

False positives
You may suspect grooming for sexual abuse if the care between individual children is substantially different – for example, some children score 4s or 5s and one particular child scores 1s or 2s – or if you notice behaviour which may lead you to suspect that sexual grooming is happening. The GCP2 is not the main tool or route for this work, so alternate assessment and enquiries will be needed to substantiate any suspicions.

Behavioural issues
A small minority of children may have behavioural issues due to a diagnosed medical condition. The parent's behaviour or care delivered may seem necessary in the context of the child's needs, but the grading should always be scored as seen and then explained in the analysis. It's vital that the quality of care is not mitigated at the point of scoring.

Adult concerns – risk factors
Parental issues may impact on the quality of care. These are factors such as parental learning difficulties, domestic abuse, and parental mental health issues, which are not measured within the GCP2. You may become aware of these during home visits. It's very important to take note of these issues, as they will help you understand where to focus the work with the family. As always, the scoring should only be based on the quality of care delivered by the parent and then explained in the analysis in the report produced.

GCP2 and Adolescent neglect

The UN rights of the child defines adolescence as "a life stage characterised by growing opportunities, capacities, aspirations, energy and creativity, but also significant vulnerability"

It is still a contentious and undefined life stage – which remains a squeezed period of life; not child and not youth. The challenge is how do you empower adolescents to make independent choices, while simultaneously ensuring they benefit from the protections afforded to them by virtue of their young years?

The GCP2 can support this by looking at the care and support that parents/carers are providing during this transition time. It can be used as a medium for facilitating conversations between young people and their parents and help adolescents understand the support that they are receiving and where they aren't getting

1. DePanfilis D,(2006) Child Neglect: A Guide for Prevention, Assessment and Intervention

what they should. The GCP was tested on adolescents up to the age of 16 and the GCP2 reliability and validity research up to age 14.

So when undertaking a GCP2 assessment with adolescents the core issues remain the same:

- What is the care (or support) that is being offered?
- What effort are the parents/carers demonstrating?

There are, though, a number of issues which are particularly relevant to the adolescent period which can also be picked up in the GCP2.

- The balance between proactive parental care and the encouragement and enabling of safe, appropriate autonomy and independence can be picked up in the tool. As always you must score and then explain. For example, if there are a lot of scores of 1 and 2 then this could be seen as a parent who is not enabling their child to develop independently. Boundaries can be described in the development section under the discipline sub area.

Remember what the GCP2 does and doesn't do. It can help understand the quality of care and commitment a parent is providing. It helps understand how much commitment they are demonstrating to supporting the transition to adulthood. However:

- It does not assess the impact of the care or lack of it provided.
- It does not review the adolescent's own risk-taking behaviours.
- It does not focus on what type of skills and information the young person would need as they progress towards adulthood. E.g. budgeting or sexual health.

Using the GCP2 with other assessments

The GCP2 provides an excellent way to measure and scale the quality of care delivered whilst keeping the child at the centre, but it doesn't review or collate information on the causes that may have led to suboptimal parenting. It therefore works well alongside single assessment, Early Help Assessment, IA or S47 assessments and can be used at all levels of the spectrum of need.

Local Safeguarding Children Board (LSCB) guidance

For the purpose of clarity, each LSCB area needs to agree locally how to respond at each level identified by the GCP2. However, we know that some guidance would be useful. This is provided on the next page based on the work undertaken by Diane DePanfilis[1], and has been amended for the UK.


More detailed information is included in the individual sections further in this document.

GCP2 GRADE	DESCRIPTION	RESPONSE
1 2	**No neglectful parenting** Consistent good quality parenting where the child's needs are always paramount or a priority.	Normal universal access: further assessment as and when indicated.
3	**Mild neglect** Failure to provide care in one or two areas of basic needs, but most of the time a good quality of care is provided across the majority of the domains.	Usually does not warrant a report to the Local Authority, but might require a single agency targeted short-term intervention or potentially Early Help Assessment until resolved. May escalate if care deteriorates.
4	**Moderate neglect** Failure to provide good quality care across a number of the child's needs most of the time. Can occur when less intrusive measures such as community or single agency interventions have failed, or some moderate harm to the child has or is likely to occur (for example, the child is consistently inappropriately dressed for the weather — wearing shorts and sandals in the middle of winter).	This requires a multi-agency co-ordinated intervention, potentially with a Early Help Assessment or at CIN level (or similar) for further support where needed. All cases need formal monitoring for referral to children's services if they don't improve. If there's evidence of no improvement; if associated with substantial risk factors; or where care is grade 4 in most areas, a referral should be made from the outset. May also be managed at CP level when parents aren't engaging with work or there have been concerns for a substantial period of time.
5	**Severe neglect** Failure to provide good quality care acrossa number of the child's needs all of the time. Occurs when severe or long-term harm has been or is likely to be done to the child or the parents/ carers are unwilling or unable to engage in work.	Where care is grade 5 in more than one area, a consultation with children's social care should be made and a referral considered. If the child is subject to child protection arrangements then the GCP2 should be repeated for each review, or as agreed. If this persists across a period of time or care is grade 5 in all areas, then discussion about a legal option may be required. The GCP2 can be used as part of the evidence for legal planning.

Detailed construct guidance

In this section, we take a look at specific guidance for grading each area, and the sub-areas and items within it. This guidance supplements the descriptions in the tool itself.

AREA A:

Physical care

This area includes a number of sub-areas of physical care to give a rounded view of this aspect of parenting, which could be impacting on the welfare of the child.

SUB-AREA A1:

Nutrition

A good balanced diet is especially important for children because it's directly linked to all aspects of their growth and development – impacting on their level of health as adults too. Children of different ages require different nutritional intake. If you're unsure whether the diet you are observing for the baby, toddler or child you are assessing is suitable, you can find detailed advice on the Food Standards Agency website.

Items

1.1 Quality

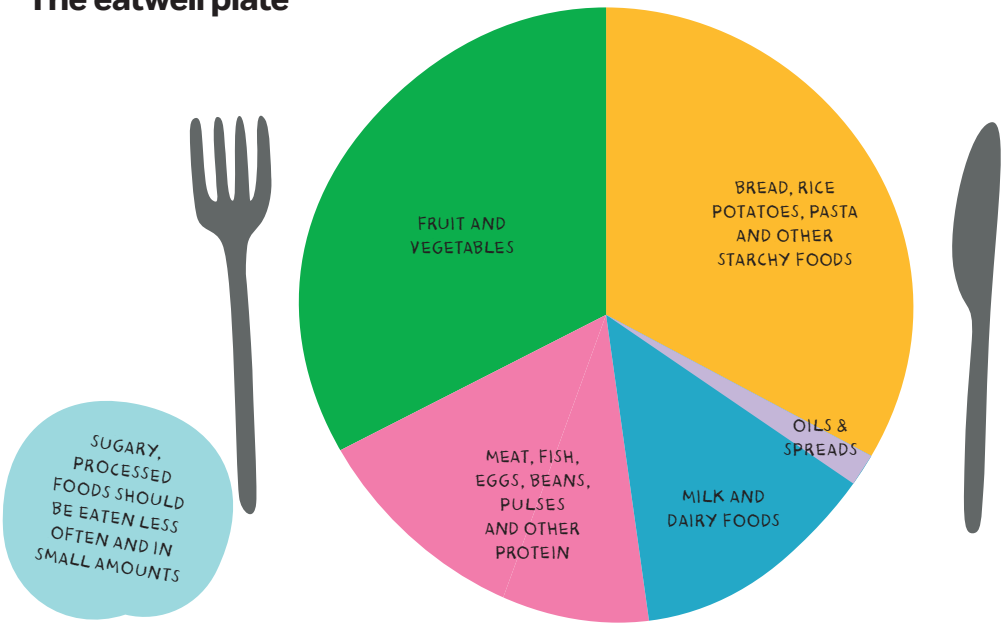
- This is about the quality of food that is offered to the child.
- Is the parent providing a good spread of nutrition? Are they having vegetables (either fresh or frozen), protein and carbohydrates, with not too much sugary or fatty food? See *The eatwell plate* on the following page.
- Takeaways, processed food and convenience food are all acceptable in moderation.

1.2 Quantity

- This covers not only underfeeding but overfeeding too. With the rise of obesity in children it's important that children are neither overfed or underfed.
- Marion Brandon's research Neglect and Serious Case Reviews[2] identified a small number of cases where children died of malnutrition. You should always be aware of the possibility that food is being purposefully withheld from children.
- The eatwell plate diagram gives good guidance on the general variety and proportion of food that should be eaten. It's a good idea to try to get this balance right every day, however, not necessarily at every meal. It might be easier to get the balance right over a longer period such as a week.[3]
- Further advice can be found on nhs.co.uk/livewell

2. Brandon M, Bailey S, Belderson P and Birgit Larsson: (2013) Neglect and serious case reviews Systematic analysis of neglect in serious case reviews in England NSPCC
3. Eatwell website

The eatwell plate[4]



1.3 Diet for children with specific dietary requirements

- This item refers to those children who have a diagnosed medical condition that requires a specific diet. This covers conditions such as diabetes, coeliac disease or for those children put on a specific diet for obesity by a paediatrician.
- It may be a good idea to speak to a health professional who knows the family to seek advice on a particular condition. They will help you understand whether the parents stick to the required diet or not.
- You may need to make a formal referral for a specialist assessment.

1.4 Preparation

- This item looks at preparation and, by proxy, indicates the level of commitment and effort the parent shows in relation to preparing adequate food for the child.

1.5 Organisation

- Research has shown that children whose families have organised meal times are less likely to be obese.[5]
- This is a good place to comment on general organisation and routines within the household, but this can also be discussed in developmental care.

SUB-AREA A2:

Housing

Research has shown that the quality of housing has an impact on the long-term emotional and physical health of children.[6] This sub-area helps practitioners articulate exactly what the issues are, if any, in relation to the quality, and the parent's/carer's commitment to keeping a tidy and safe environment for the child. It must be noted in the report if the house is rented, if there are issues with any of the facilities/amenities or maintenance, and if repairs are the responsibility of the parent or the landlord. If there are problems that the landlord should have fixed, how proactive has the parent been in relation to chasing it up? This should be noted in the report.

4. *The eatwell plate* source: Public Health England in association with the Welsh government, the Scottish government and the Food Standards Agency in Northern Ireland
5. Fiese, Barbara H.; Schwartz, Marlene: Reclaiming the Family Table: Mealtimes and Child Health and Wellbeing. Social Policy Report. Volume 22, Number 4
6. Courtney M, Mcmurtry S: Housing Problems Experienced by recipients of Child Welfare Services https://secureweb.mcgill.ca/crcf/sites/mcgill.ca.crcf/files/Roundtable-for HousingProblemsExperiencedbyRecipientsofCWS.pdf
7. Lucini G, Monk I, Szlatenyi C: An Analysis of Fire Incidents involving Hoarding Households

Items

2.1 Facilities

- This item focuses on facilities/amenities that are actually present in the house.
- Again, you can use your discretion but a suggested minimum could be:
  - washing facilities for clothes and personal hygiene
  - heating
  - somewhere to sleep
  - somewhere to cook food
  - somewhere to keep food fresh
  - somewhere for the child to play and learn
  - weatherproof environment.

2.2 Maintenance

- This reviews how well maintained the facilities in the environment are – including the garden and any outside areas.
- By proxy, the commitment of the parent to ensure a safe, secure environment for the child.

2.3 Decor

- This covers the decor, state, and cleanliness of the house and how child-focussed the decoration is.
- It should be noted if the house is cluttered, as this could potentially be a fire hazard. Research has shown that houses with lots of clutter[7] can impede basic living activities and can increase the chance of death in the case of fire.
- The child's bedroom is of particular interest in this section, so it's important to see it during the assessment period.
- The overall aim is to ensure a hazard-free environment.

SUB-AREA A3:

Clothing

How children see themselves has been proven to have an impact on their long-term mental health. The clothes they wear can influence how people relate to them and in turn how they feel about themselves.[8] This sub-area covers weather-suitable clothes for hot as well as cold or stormy weather, fitting and look. It doesn't matter if the clothes are given from friends or family, the main thing is that the clothes are suitable for the weather, fit well and look clean.

A child who isn't suitably dressed for different weather conditions could potentially get badly sunburnt, end up with bad colds, or even have existing chronic conditions exacerbated, such as asthma.

As always, the age and understanding of the child needs to be taken into account as well as the commitment of the parent. Talk to the child or young person about their wishes and feelings wherever possible.

For example, if a teenager wants to wear oversized crumpled clothes, this is a choice of the child and not a parenting problem. Similarly, if the child refuses to wear weather-appropriate clothing, this should be noted but not made an issue for the parent. The issue is about asking whether the parent is trying to provide and encourage the child to wear adequate clothing. It's always an advantage to see the child on a couple of occasions to help you understand clothing in context, and ensure the parent isn't being graded on a one-off incident.

Items

3.1 Weather-appropriate clothing

- This covers all potentially harmful weather conditions – are children suitably dressed for when it's cold/wet/hot?
- Could also comment on whether the child has sun cream when weather is particularly hot.

3.2 Fitting

- This looks at whether clothes are too big or too small for the child.

3.3 Look

- This covers how the clothes actually look. Are they well cared for? Even if they aren't ironed, are they reasonably crease-free? If they are damaged and can't be replaced, has the parent made an effort to repair?

8. Heatehrton F, Assessing Self Esteem

SUB-AREA A4:

Hygiene

Often the first thing for teachers to notice about a child who's being neglected is that they are unkempt and smell badly.

The carer's involvement in the child's personal care is different depending on the age of the child, so this sub-area is divided into items according to age, to help with scoring.

Remember that children will get dirty when they're out playing, but – as with all things – it's the normal state that needs to be scored. What is the child's normal hygiene routine? Is their hair brushed, are their hands and face washed on a regular basis?

When it comes to babies, parents don't need to bathe their baby every day, but should wash their face, neck, hands and bottom carefully daily. This is often called "topping and tailing". More advice can be found on the NHS website.

For adolescents it's important that parents are providing the correct products to help that young person take care of their hygiene needs.

SUB-AREA A5:

Health

If there are ongoing health issues, it's a good idea to speak to the health professional who knows the family during the assessment.

You need to always be mindful of induced or fabricated illness and will need to check the LSCB procedures in any such potential cases to find the best route for advice and support.

It's also important to remember that even one event of poor or non-attendance or compliance in health related issues could have serious consequences for the child.

Items

5.1 Seeking medical opinion

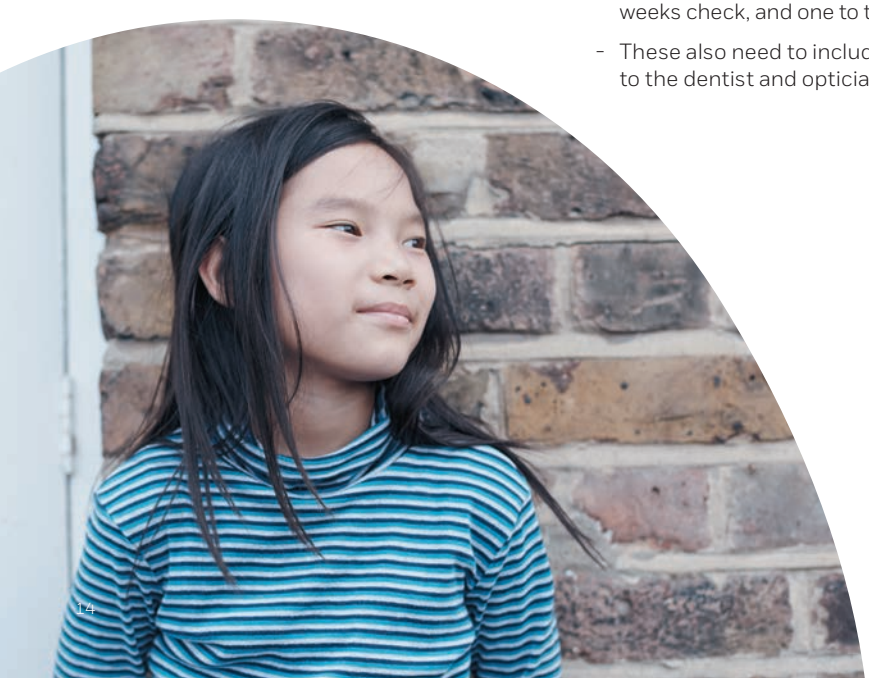
- Does the parent seek appropriate medical treatment when their child is ill or do they delay in taking the child to the GP?
- Do they make excessive use of emergency services rather than taking preventative action?

5.2 Follow up

- Not only should the child be taken to the doctor initially – any follow up appointments should be organised and kept.
- It's also worthwhile in this section to note if the parent is administering the prescribed treatment as directed.

5.3 Health and developmental checks

- These include antenatal, birth visit, neonatal hearing, blood spot, six to eight weeks check, and one to two years check.
- These also need to include visits to the dentist and optician.



- This is age-related. The relevant checks for children up five years old can be found at: nhs.uk/conditions/pregnancy-and-baby
- Information on vaccinations can be accessed here: nhs.uk/conditions/vaccinations
- Some parents have clear reservations based on their own research and beliefs that vaccinating their child would not be in their best interest. If the parent's rationale is sound and well-researched this should be noted and should not necessarily be seen as neglectful if it's in keeping with the rest of the child's care. Children should be taken to the dentist at least once per year – more if there are issues.
- Further information on dentistry can be accessed from NICE guidance: nhs.uk
- Children's eyes are checked by health visitors or GPs in the first two years of their life. After that they should go at least every two years. Further guidance can be found on the NHS website: nhs.uk/NHSEngland
- Adolescence - as the child matures are the parents/carers supporting or encouraging their child to attend dentist or opticians?

5.4 Disability or chronic illness

- Compliance with health related advice is even more important for those children who have long-term chronic health conditions. These conditions can range from asthma or eczema to life limiting or life affecting conditions.
- There is a time when parents are coming to terms with conditions that will affect the life of their child in a major way and what this means for the child and themselves. So it's good to note that this element should only be scored over 3 months after diagnosis – or make sure you note the timing and any possible relevance to the GCP2 review.

AREA B:

Safety

This section looks specifically at the carer's safety related practice when they are with the child and the arrangements made when they are away from the child.

SUB-AREA B1:

In parent's presence

You must take how independent the child or young person is into account in this section. This is particularly important for adolescents. You need to take note of the young person's independence whilst observing what measures are in place to ensure their safety.

You also need to make sure co-sleeping is discussed with parents. Be aware of the NICE recommendations, you can find them on the NICE website (to ensure parents aren't taking unacceptable risks with how or when they are sleeping with their child).

This section initially covers children in their home, then outside – for example, in the garden or equivalent safe space in the wider community as they grow.

Items

1.1 Awareness

- This covers the parent's awareness of safety issues and the risks their child is facing.

1.2 Practice

- This covers what measures the parent is taking to keep their child safe.
- This item is divided into three, depending on the child's age and mobility. Choose which applies to the child who is the focus of your assessment.

1.3 Online safety

- This covers all online devices, phones, computers and games.
- It's a developing area where parents are slowly catching up.
- It's important to gauge how much the parents actually know about online safety, and the fact that they may have little knowledge about what the risks are or how to protect their children online.
- Talk to the child or young person about their wishes and feelings wherever possible.

1.4 Safety in traffic

- Research from the Institute of Child Health, shows injuries account for 31 per cent of deaths in one to four year-olds and nearly half (48 per cent) of deaths in teenagers aged 15 to 18. The most common injury involves traffic accidents.[9] So, it's important that carer's traffic related safety is assessed.
- There are two ages covered in this item pre-school and primary school age.

9. Hardelid P, Duttani N: Child Health Review UK – Overview of child deaths in the four UK countries 2013 RCPCH,RCGP

1.5 Practical safety features in the home

- Again, due to the high incidence of child deaths from accidents, it's important that there are adequate safety features in the home. These need to be relevant to the child's age.
- Are there stair gates, covers for electrical sockets, working smoke detectors, and cupboard locks on accessible cupboards with cleaning products inside?
- Where are medications kept? Are they out of reach? Where is alcohol kept? Is it locked away? This should include any street drug, if relevant.
- Is the child at an age where choking may be a hazard? If so, small items such as batteries, small toys, staples, and dry pasta all need to be kept out of the child's reach.
- Are there any cords from blinds? If so, can they be reached by the child? Could they be a strangulation hazard?
- Is there any standing water in the garden? Is it covered? Can children access it?
- Do heating sources have appropriate covers? If there's an open fireplace, is there a fireguard?
- Are there any windows that the child can access? Do they have locks that the child can't open/are they restricted on how far they can open?
- Where are sharp items kept? If in the kitchen, do the drawers have locks or are they at a height that the child can't access?
- Are there any bookcases or units that a child may be able to pull over onto themselves? Have they been secured to the wall?

SUB-AREA B2:

When parent is absent

Neglect makes children more susceptible to other forms of abuse. In part this is due to parents not checking where their children are or leaving them with unsuitable adults. So, it's important that childcare arrangements are discussed with parents.

Adolescents: it is important that the parent is making an effort to understand where the young person is, who they are with and that arrangements are in place.

AREA C:

Emotional care (nature of attachment)

This area looks at the emotional care provided by the carer, and the relationship between them and their child.

Psychologists believe that the attachment we form with our primary carer (usually our mother) forms a template for all future relationships – with friends, teachers, and, in the future, with husbands, wives and our future children.

There isn't the expectation that anyone undertaking the GCP2 is an expert in attachment, but the items are graded to make it easier for practitioners to identify concerns through observations of the relationship with their parent.

SUB-AREA C1:

Responsiveness

Bowlby[10] said there is a 'sensitive' period from when the baby is born to around the age of 2, when the baby is programmed to form a special attachment. If something happens to damage or break this attachment, the child may form an insecure attachment and their development may be damaged.

For a secure attachment to take place, the child's main carer (usually the mother) needs to be attentive, sensitive and responsive to the child's needs during this sensitive period. Sensitive parenting is not only important for children up to the age of 2, it's important for all children, so this section covers all age groups.

Items

1.1 Sensitivity

1.2 Timing

1.3 Quality

The three items – sensitivity, timing and quality of responsiveness – allow a non-expert to identify areas of concern which can be easily explained to the parent. This is important for all age groups, including adolescents.

10. Bowlby J (1979). The Making and Breaking of Affectional Bonds. London: Tavistock Publications

SUB-AREA 2:

Mutual engagement

Bowlby[11] said the child develops a model or template from the attachment with its mother that influences all future relationships and their future parenting style. It is a prototype of all future relationships. He called this the child's 'internal working model'.

So it's important to review not only how sensitive the parent is but also the relationship between them and their child.

Items

2.1 Initiation of interaction

- This can be measured by observing who initiates the interaction. Parents/carers can tell you how they think something is going but it's vitally important to observe this.

2.2 Quality of relationship between parent and child

- Make sure you note on the recording sheet if the child appears to have some form of behavioural issues that may affect the scoring for either of these items. The effort and warmth the parent/carer exhibits can be picked up in the carer's responsiveness sub-area (C1).
- A separate specialist assessment may be required.
- If you have concerns about the relationship that you can't define easily, it's very important to discuss these in supervision or seek specialist advice.

2.3 Adolescence

- Adolescence is a time of transition to adulthood. It can also be a time of conflict between the young person and their parents. Reviewing the quality of the relationship between the parent/carer and young person can give an opportunity to open up discussions. As the professional undertaking the GCP2 assessment you should ensure you support the young person if they want to have these conversations with their parent/carer.

11. Bowlby J (1953). Child Care and the Growth of Love. London: Penguin Books.

AREA D:

Developmental care

This section examines the interactive stimulation, approval, disapproval, and acceptance given to a child and contributing to their development.

Child development is defined as the logical, systematic and enduring changes over time in physical and neurological structures, through processes and behaviour. In the first 20 years of life these changes usually result in new, improved ways of reacting, and in behaviour that's healthier, better organised, more complex, more stable, more competent and more efficient.

Going from crawling to walking, from babbling to talking or from concrete to abstract thinking are examples of development. In each instance we judge the latter appearing state to be the more adequate way of functioning than the former.[12]

SUB-AREA D1:

Interactive stimulation

The definition of developmental care implies several things – there are defined dimensions of development and development is orderly. The results of different stages of development lead to a more efficient way of functioning and, importantly for this sub-area, there are interactions between children and the context in which they grow up which will influence their development.[13]

Extensive biological and developmental research over the past 30 years has generated substantial evidence that young children who experience severe deprivation or significant neglect — defined broadly as the ongoing disruption or significant absence of caregiver responsiveness — bear the burdens of a range of adverse consequences. Indeed, deprivation or neglect can cause more harm to a young child's development than overt physical abuse, including subsequent cognitive delays, impairments in executive functioning, and disruptions of the body's stress response.[14]

Beginning immediately after birth, a strong foundation for human wellbeing requires responsive environments and supportive relationships to build sturdy brain circuits, facilitate emerging capabilities, and strengthen

12. Mussen et al (1990) p4.
13. Jones,D (2006) Developing World of the Child p220
14. Center on the Developing Child at Harvard University. (2012). The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain: Working Paper 12. www.developingchild.harvard.edu
15. Center on the Developing Child at Harvard University. (2012). The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain: Working Paper 12. www.developingchild.harvard.edu

the roots of physical and mental health. Through mutually rewarding, "serve and return" interactions with the adults who care for them, young children are both initiators and respondents in this ongoing process. These reciprocal and dynamic interactions are essential for healthy development and literally shape the architecture of the developing brain.[15]

This sub-area looks across ages and types of stimulation to quantify the type of interaction, so you can identify any areas where stimulation is lacking. So, you need to first identify the age of the child, and the relevant items that will be completed for that age group, as follows.

The age demarcation is only a guide and if there are particular items outside of the age indicated which is relevant for a particular child then it is acceptable to use any, all or some of the sections.

Items

Part 1 (Age 0-2)

1.1 Interactive

Part 2 (Age 2+)

1.1 Interactive

1.2 Toys

1.3 Outings

1.4 Celebration

Part 2 (Age 5+)

1.1 Education

1.2 Sport

1.3 Peer group

SUB-AREA D2:

Approval

A child's relative understanding of world and society come from the parents and their interaction with the child. A child's first trust is always with the parent or caregiver. If the parents expose the child to warmth, regularity, and dependable affection, the infant's view of the world will be one of trust. Should the parents fail to provide a secure environment and to meet the child's basic needs, a sense of mistrust will result. Development of mistrust can lead to feelings of frustration, suspicion, withdrawal, and a lack of confidence.

As the child grows, parents still provide a strong base of security from which the child can venture out to assert their will. The parents' patience and encouragement helps foster autonomy in the child. Children at this age (two to four years) like to explore the world around them and are constantly learning about their environment.

If caregivers encourage self-sufficient behaviour, toddlers develop a sense of autonomy — a sense of being able to handle many problems on their own. But if caregivers

demand too much too soon, refuse to let children perform tasks of which they are capable, or ridicule early attempts at self-sufficiency, children may instead develop shame and doubt about their ability to handle problems.

The development of courage and independence are what set preschoolers, ages three to six years, apart from other age groups. Within instances requiring initiative, the child may also develop negative behaviours. These behaviours are a result of the child developing a sense of frustration for not being able to achieve a goal as planned and may engage in behaviours that seem aggressive, ruthless, and overly assertive to parents. Aggressive behaviours, such as throwing objects, hitting, or yelling, are examples of observable behaviours during this stage.

If parents encourage and support children's efforts, while also helping them make realistic and appropriate choices, children develop initiative independence in planning and undertaking activities. But if, instead, adults discourage the pursuit of independent activities or dismiss them as silly and bothersome, children develop guilt about their needs and desires.[16]

Ages 5-12 years are critical for the development of self-confidence. If children are encouraged to make and do things and are then praised for their accomplishments, they begin to demonstrate industry by being diligent, persevering at tasks until completed, and putting work before pleasure. If children are instead ridiculed or punished for their efforts or if they find they are incapable of meeting parents' expectations, they develop feelings of inferiority about their capabilities.[17]

During adolescence (age 12 to 18 yrs), the transition from childhood to adulthood, children are becoming more independent and begin to look at the future in terms of career, relationships, families, housing, etc. The individual wants to belong to a society and fit in. This is a major stage in development where the child has to learn the role he will occupy as an adult. It is during this stage that the adolescent will re-examine his identity and try to find out exactly who he or she is.

Parents/carers have a role to support their child's maturation across all of their developmental domains. Whether its providing them with the practical tools, ensuring they have the opportunity to gain new experiences, supporting their education or getting to know their freinds and supporting their social life.

Items

2.1 Approval

- Grade 5 talks about a parent being aversive to their child. This is a very strong emotion where a parent finds their child repellent, repulsive or revolting – causing them to avoid or physically react to their own child in a negative way.

Remember

You can use any age related items. (Interactive, toys, outings, celebrations, education, sport and peer group) If you think its relevant for the child/young person you are working with.

SUB-AREA D3:

Disapproval

Discipline and boundaries are not only good for children – it's necessary for their happiness and wellbeing. It's as vital for healthy child development as nutritious food, physical and cognitive exercises, love, and other basic needs. Without discipline, children lack the tools they need to navigate relationships and challenges in life such as self-discipline, respect for others, and the ability to cooperate with peers.

Items

3.1 Disapproval

- Boundaries are particularly important in relation to adolescents. Parents need to ensure that they are clear about expectations. For example: who they are with, what they are doing etc. As the young person grows this is also a negotiation between the parent/carer and young person. Its also closely linked with the section of safety.

SUB-AREA D4:

Acceptance

Part of being nurturing as a parent is being accepting of your child's feelings, thoughts, and experiences. This is called 'parental acceptance' and goes a long way towards healthy interactions between parent and child.

Acceptance is not the same as agreement or discipline. Acceptance means acknowledgment and understanding of someone's experience. You can accept what a child is feeling, but not accept the behaviour the child is showing.

Items

4.1 Acceptance

- Grade 5 states that the parent belittles or denigrates the child – this specifically means that the parents/carers 'rubbish' or 'degrade' their child. As already stated, many young people examine who they are during their adolescent years. It's a time when there may be conflict about who they see themselves to be against who or what their parents perceive they should be. This domain will help you identify if this is an issue for the young person and also their parent.

16. Stevens, Richard (1983) Erik Erikson: An Introduction. New York: St. Martin's
17. Crain, William (2011). Theories of Development: Concepts and Applications (6th ed.). Upper Saddle River, NJ: Pearson Education.

The GCP2 is the only authorised and fully tested update of the original GCP. It is a more user-friendly and comprehensive tool that helps professionals with their assessment and subsequent work with families. But it keeps the original principles and values — ensuring that it retains its integrity in the way it scales and supports work with families.