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Disabled Children and Child Protection in Scotland: An investigation into the relationship between professional practice, child protection and disability

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Disabled Children and Child Protection in Scotland:

An investigation into the relationship between professional practice, child protection and disability

Scottish Government Social Research

Julie Taylor, Professor of Child Protection and Co-Director of the University of Edinburgh/NSPCC Child Protection Research Centre

Kirsten Stalker, Professor of Disability Studies, School of Social Work and Social Policy, University of Strathclyde

Deborah Fry, Lecturer in Child Protection at the University of Edinburgh/ NSPCC Child Protection Research Centre

Alasdair B R Stewart, Research Assistant at the University of Edinburgh/ NSPCC Child Protection Research Centre

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EXECUTIVE SUMMARY

Introduction

In March 2013 the Scottish Government appointed researchers from the University of Edinburgh/NSPCC Child Protection Research Centre and the University of Strathclyde, School of Social Work and Social Policy, to investigate the relationship between disabled children and child protection practice. Through interviews and focus groups, the researchers spoke with 61 professionals working on issues of disabled children and child protection in Scotland.

Background

Although most parents of disabled children provide safe and loving homes, there is a significant body of international research to show that disabled children are more likely to be abused than their non-disabled peers. They are more likely to experience both maltreatment and more than one form of maltreatment. Furthermore children with particular forms of impairment are more at risk than others. Those with communication impairments, behavioural disorders, learning disabilities and sensory impairments are those most vulnerable to maltreatment. A range of factors has been cited to explain this increased vulnerability to abuse, including child or impairment factors; parental factors; and service factors. Despite this heightened risk, there is evidence that the abuse of disabled children often goes undetected and, even when suspected, may be under-reported. This is given further credence by the low numbers of children on child protection registers recorded as having an impairment.

Little research in the UK has been conducted on child protection and disabled children. The evidence to date has shown few disabled children have protection plans in place or are placed on a child protection register and that a medicalised approach dominates. Communicating with children with communication impairments is seen as particularly challenging. In relation to thresholds, it has been reported that professionals may apply higher thresholds for disabled children for triggering a child protection response than they do with non-disabled children. In part this had been explained by a tendency of professionals to over-empathise with the parent and to be more tolerant of some behaviours than they would be of parents of non-disabled children.

Analysis of child protection policy across the UK has shown an invisibility of disabled children. The Scottish Government has taken steps to address this, with reference in the National Guidance to the increased vulnerability of and need for heightened protection of disabled children and establishment of a Ministerial Working Group on Child Protection and Disability.

The Study

The study used a qualitative approach to address four main questions:

1. What are the decision-making processes and 'triggers' for intervention used by professionals when determining the nature of interventions for disabled children at risk of significant harm?
2. What are specific issues faced by practitioners in Scotland in supporting children at risk of significant harm?
3. How do services coordinate to support disabled children at risk of significant harm?
4. What are practice examples in Scotland addressing these issues?

The study used four concurrent components to address the research questions including: Interviews with participants from six local authority areas and across five different services (n = 21); focus groups with Child Protection Committees (n = 5 with 40 participants); practice case studies; the development of systems and response models. Inductive analysis across interviews and focus groups resulted in findings within three main themes.

Theme One: The Child at the Centre?

There were positive messages about putting the child at the very heart of child protection assessment and intervention, regardless of any impairment a child may have and some practitioners had found creative ways to approach that. In other cases, though, tensions were evident between the desire to treat every child equally, and to individualise child protection successfully for disabled children. Understanding different types of impairment and associated support needs played a critical role in helping to assess the risk to the child and the possible forms of intervention. There were examples of interventions being adapted in order to support individual disabled children, for example the venue, pacing and materials used in joint interviews, but this was by no means universal.

The implications of communication impairments received prominent attention: these were said to prevent practitioners from being able to gain adequately the child's perspective and hinder accurate information gathering. Nonetheless there were examples of many successful adaptations, suggesting these difficulties may be perceived rather than real. Indeed, there were a number of cases of children making a direct disclosure, including children with communication impairments. However, the perception of impairments making children unreliable witnesses led to disclosures not always being treated the same as those made by a child without an impairment. Given the difficulties participants reported when working with disabled children, there was also concern that practice was at times parent-centred rather than child-centred.

Theme Two: Practice Issues (Muddling Through)

The issues arising from working with disabled children in the child protection system meant that some participants appeared to be 'muddling through[1]'. While all practitioners emphasised and valued the level of interagency working that takes place to protect children, the data revealed a lack of confidence among many participants when working with disabled children. While some social workers had received training in communication with disabled children, others reported a lack of relevant training available along with high staff workloads, perceiving work with disabled children as requiring specialist knowledge and much time. There was a debate about whether or not there should be separate children's disability teams or whether these should be integrated into generic children's teams. Perceived thresholds of significant risk and when to intervene varied, with different views among participants over whether thresholds were the same, lower, or higher for disabled children compared to other young people.

Theme Three: Interagency Working

All participants reported high levels of interagency working and saw this as inherently positive, bringing significant benefits, although they recognised some failings and tensions. Notably, participants talked about interagency working in general child protection terms and did not articulate well what this could do for disabled children. Communication and co-operation was one area in particular that was seen as having improved in recent years, with services more likely to talk to each other about concerns and to work together. This was tied to the improvements the majority also felt existed in relation to information sharing and the co-ordination of services to ensure adequate investigation of concerns and the best use of time and resources. Social Work was often seen by other agencies as having higher thresholds and concerns were expressed by some practitioners that particular children were left in neglectful or risky circumstances for too long. Although facilitating communication with disabled children was highlighted repeatedly as a positive of interagency working, this was not the case when it came to criminal prosecutions – health and social services were frustrated by the standard of evidence needed by police and courts.

Discussion

Several tensions were highlighted in relation to establishing and maintaining a child-centred approach for disabled children at risk of significant harm. Overall, there was a strong commitment by practitioners to the principles of *Getting it Right for Every Child*, yet significant barriers in practice were identified to ensuring disabled children were consulted, informed and had the opportunity to give their views about decisions

[1] Cited in interview

affecting them. The positive emphasis on child centredness potentially leads to an invisibility for disabled children. Efforts to treat every child the same may mean crucial contextual and vulnerability factors are missed. Troubling language arose from some practitioners, reflecting their adoption of an impairment-centred approach rather than a child-centred approach. Decisions and actions were often portrayed as being 'done to' the child. A depiction of disabled children lacking ability and agency often preceded discussions about the inability to gather children's views or involve them in discussions around child protection concerns, despite disclosures from children themselves being the top 'trigger' for an initial child protection concern. However, other practitioners recognised and respected disabled children's rights and abilities to express their views and contribute to decision-making, and had taken appropriate steps to facilitate this. Some practitioners expressed anxiety and low levels of confidence in working with disabled children, especially children with communication impairments. There was anxiety about 'getting it wrong'. for example, failing to recognise significant harm, fear of missing vital information or making an incorrect judgment and additional concerns that any failure by practitioners would contribute to or heighten the risk faced by the child. This was also cited as a reason why some practitioners failed to involve disabled children in the process.

Interagency working was identified as a potential enabler to overcoming lack of individual knowledge and confidence in working with disabled children. The current fiscal climate of fewer resources without diminishing demand was raised as a potential challenge, especially in relation to disabled children and their families who may require additional support. However, one local authority had committed to provide intensive domiciliary support over a ten year period to keep one family together, an arrangement which, two years on, had led to successful outcomes.

Data from this study suggests that thresholds for disabled children may be higher than for non-disabled children. A number of reasons are posited, including disabled children being more dependent on support from parents/carers; the increased vulnerability of disabled children and young people as a result; increased parental stress and complex family environments (including multiple disabled children); multiple carers and care in different settings; with subsequent consequences for assessment.

Implications and Recommendations

The National Child Protection Guidance (2010) on working with disabled children highlighted seven key messages for practice. This research shows these are still relevant. Many (but certainly not all) child protection professionals were aware of the increased vulnerability of disabled children, but there were views that disabled children without communication impairments were more 'protected' than other

children. The issue that child protection workers struggled with was how to work with and adapt current child protection processes for disabled children's needs. It is clear that more training and guidance in the area of chid protection and disability is needed, including disability training for child protection professionals, child protection training for children's disability teams and communication training for all staff whose job brings them into contact with children with communication impairments. In general, participants were engaged with short-term consequences and immediate actions and spoke less about longer-term planning and transitions to adult services. This study also identified additional recommendations for policy and practice.

- Assessments of child protection concerns should include and support the views of disabled children and young people where possible.
- Local services need to provide training for disability teams, speech and language therapists and others with specific disability expertise on child protection and the child protection process (including joint interviewing).
- The vulnerability of all disabled children, not just those with communication impairments, should be highlighted in practice guidance and supervision.
- Where concerns have been raised and addressed for a particular child experiencing maltreatment, detailed consideration of subsequent harm that may be posed to other children should be monitored.
- The availability and suitability of foster carers and other care arrangements for disabled children should be examined across Scotland. Where services do not exist, they should be created.
- Child protection case conferences should be made accessible for the involvement of disabled children.
- All sectors should review their support to disabled children in the area of child protection to ensure best practice.
- A stronger focus on prevention of child abuse and neglect against disabled children is needed.
- Safe interagency reflective spaces should be created for discussing and learning from examples of practice related to child protection and disability.

Conclusion

There is whole-hearted commitment across the child protection system for putting the child at the centre. However, getting it right for every child does not mean treating every child the same. Consideration needs to be given to how best to adapt practice, assessment and intervention for children with a range of impairments. A lack of confidence suggests that practitioners are often 'muddling through' when it comes to working with disabled children. Child protection workers require more training regarding disability, and children's disability teams need more training about child protection. Interagency working was regarded positively and was seen as an

enabler to good practice. However, thresholds for action in the child protection system are higher for disabled children than for non-disabled children. More needs to be done to ensure their voices are heard and included within formal systems. Whilst there are positive aspects, this research shows that the child protection system is a cause for concern in relation to disabled children.

1. INTRODUCTION

1.1 In March 2013 the Scottish Government appointed researchers from the University of Edinburgh/NSPCC Child Protection Research Centre and the University of Strathclyde, School of Social Work and Social Policy, to investigate the relationship between disabled children and child protection practice.

1.2 The report details the findings from interviews and focus groups with 61 professionals working in the area of child protection and disability in Scotland.

2. TERMINOLOGY AND DEFINITIONS

2.1 In this report we use the term ‘disabled children and young people’ rather than ‘children and young people with disabilities’. This is consistent with the social model of disability[2,3,] which distinguishes between ‘impairment’ and ‘disability.’ 'Impairment' refers to an individual's loss or limitation of bodily or cognitive functioning, such as visual impairment, hearing impairment or learning disability. ‘Disability’ refers to:

> *The disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical, [sensory or mental] impairments and thus excludes them from the mainstream of social activities*[4].

2.2 Thus, the social model locates disability in the social, cultural, material and attitudinal barriers, which exclude people with impairments from mainstream life, rather than in individual ‘deficit’. Drawing on the social model of disability, this study included children and young people with a wide range of impairments, all of whom are disabled by external barriers. This means we addressed research and policy relating to children and young people with physical, sensory, cognitive and communication impairments and those with mental distress, a group often neglected.

2.3 At the same time, the social model has been critiqued on a number of counts, including its limited acknowledgment of the day to day impact of living with impairment. Thomas refined the social model by developing a ‘social relational understanding of disability’; arguably a more rounded and nuanced

[2] Oliver, M. (1990) The individual and social models of disability. Workshop on the Living Options Group and the Research Unit of the Royal College of Physicians.
[3] Oliver, M. and Barnes, C. (2012) The New Politics of Disablement, Tavistock: Palgrave/Macmillan (in press).
[4] UPIAS (1976) *Fundamental Principles of Disability*. Union of the Physically Impaired Against Segregation.

explanation of the experiences of disabled people. As part of this, Thomas introduced the idea of 'impairment effects' to signify restrictions of activity which result from living with an impairment; such as the pain or lack of energy caused by certain conditions, or the inability to do certain things.[5,6]

2.4 For this study, children and young people were defined as children, adolescents and young adults between the ages of 0 and 21. The older cut-off point follows the 1995 Children (Scotland) Act's upper age range for the responsibility of local authorities for older looked after children. For brevity and readability we use the term 'children' to denote 'children and young people and young adults'.

3. THE RESEARCH CONTEXT

3.1 Disabled children and abuse

3.1.1 Research internationally has found that disabled children are more likely to be abused than their non-disabled peers. A meta-analysis of 17 studies of violence against disabled children and young people, representing over 18,000 individuals was published in *The Lancet* in 2012[7]. This is the first study to provide pooled estimates of the prevalence and risks of violence experienced by disabled children and young people. It found that this group are three to four times more likely to experience violence than non-disabled children and that 26.7% of disabled children and young people have experienced more than one type of violence in their lifetime. Over 20% experience physical violence, nearly 14% experience sexual violence while the incidence of emotional abuse is described as 'comparable' to that for physical violence. These findings broadly concur with those of Sullivan and Knutson[8], which hitherto had widely been viewed as the most authoritative prevalence study, involving examination of case records for 50,278 young people aged 0 – 21 in Nebraska. This study found that disabled children and young people were 3.4 times more likely to be abused than their non-disabled peers, the incidence rates being 9% and 31% respectively. Sullivan and Knutson found that neglect was the most common type of maltreatment experienced by disabled children although, again, most experienced multiple forms of abuse.

[5] Thomas, C. (1999) Female Forms: Experiencing and Understanding Disability, Buckingham: Open University Press.
[6] Thomas, C. (2007) Sociologies of Disability and Illness. Contested Ideas in Disability Studies and Medical Sociology. Basingstoke: Palgrave Macmillan.
[7] Jones, L., Bellis, M.A., Wood, S., Hughes, K., McCoy, E., Eckley, L., Bates, G., Mikton, C., Shakespeare, T. and Officer, A. (2012) Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies Lancet 380 (9845), 899-907.
[8] Sullivan P. M. & Knutson, J. F. (2000) Maltreatment and disabilities: a population-based epidemiological study. *Child Abuse and Neglect,* 24(10): 1257-1273.

3.1.2 Children with particular forms of impairment are more at risk than others. Although findings vary on this point, a literature review[9] found that those with communication impairments, behavioural disorders, learning disabilities and sensory impairments are likely to experience higher levels of violence and neglect. For example, Sullivan and Knutson[10] found that children with speech and language impairments faced three times the risk of abuse compared to non-disabled children, those with learning disabilities faced four times the risk while young people with 'behavioural disorders' were 5.5 times more likely to be abused. Not enough is known about the direction of causality, however, and the extent to which some of these impairments may have been caused by abuse[11].

3.1.3 Despite this heightened risk, there is evidence from a number of countries that the abuse of disabled children often goes undetected and, even when suspected, may be under-reported. To quote two international examples, Kvam[12] surveyed 302 deaf adults in Norway and found that 134 (44%) had been abused as children. Fifty had not reported this at the time; 11 who had were not believed. In Israel, Hershkowitz and colleagues[13] examined the forensic records of 40,430 victims of sexual abuse aged 3-14. They found that the disabled children in the sample failed to disclose abuse much more often than the non-disabled ones. In the UK, research by Morris (1999)[14], Cooke and Standen[15] and Stalker et al[16] evidences under reporting in the UK as well. This is given further credence by the low numbers of children on child protection registers recorded as having an impairment.

3.1.4 There is some evidence that the abuse of disabled children differs in certain respects from that directed at others. For children with particular impairments (identified by Sullivan and Knutson[10] as 'health/orthopaedic, communication, behavioural and intellectual disabilities'), abuse appears to start at an earlier age - pre-school as opposed to the more typical onset age of 6-9. Boys are disproportionately represented among abused disabled children compared with non-disabled children who have been abused[17]. The reasons for this are

[9] Stalker, K. and McArthur, K. (2010) Child abuse, child protection and disabled children: a review of recent research Child Abuse Review, 21, 1, 24-40. DOI: 10.1002/car.1154
[10] Sullivan P. M. & Knutson, J. F. (2000) *op. cit.*
[11] Spencer N, Devereux E, Wallace A, Sundrum R, Shenoy M, Bacchus C, Logan S. 2005. Disabling conditions and registration for child abuse and neglect: A population based study. Paediatrics 116: 609-613. DOI: 10.1542/peds.2004-1882.
[12] Kvam MH. 2004. Sexual abuse of deaf children. A retrospective analysis of the prevalence and characteristics of childhood sexual abuse among deaf adults in Norway. Child Abuse and Neglect 28: 241-251. DOI: 10.1016/j.chiabu.2003.09.017
[13] Hershkowitz I, Lamb ME, Horowitz D. 2007. Victimization of Children with Disabilities. American Journal of Orthopsychiatry 77: 629-635. DOI: 10.1037/0002-9432.77.4.629.
[14] Morris, J. (1998) Accessing human rights: disabled children and the Children Act. Ilford, Essex: Barnardos.
[15] Cooke, P. and Standen, P.J. (2002) Abuse and disabled children: hidden needs? DOI: 10.1002/car.710 Child Abuse Review, 11, 1-18.
[16] Stalker K, Green Lister P, Lerpiniere J, McArthur K. 2010. Child Protection and the Needs and Rights of Disabled Children: Abridged Report. University of Strathclyde Faculty of Education/ Sir Halley Stewart Trust: Glasgow, Scotland.
[17] Sobsey, D. , Randall, W., & Parrila, R.K. (1997). Gender differences in abused children with and without disabilities. Child Abuse & Neglect, 21 (8), 707-720.

not fully understood although can be partly explained by the fact that more males than females have impairments. Kvam[18] also found that the average age of disclosure of sexual abuse was two years older for boys than girls, suggesting either that males are older when first abused or else take longer to report it.

3.1.5 There is some evidence that disabled children experience more severe abuse than their non-disabled counterparts. A Turkish study compared two samples of children aged 7-16, one group having learning disabilities and one without, but all of whom had been sexually abused[19]. Significantly more of the learning disabled children had been exposed to vaginal penetration and they had been subject to more violent abuse.

3.1.6 A range of factors has been cited to explain disabled children's increased vulnerability to abuse, some child or impairment related, some parent related and others associated with shortcomings in service provision and professional response. In relation to the young person, she or he may be viewed by potential perpetrators as less aware and/or knowledgeable that a non-disabled child and thus, abusers perceive a better chance of 'getting away with it'; communication impairments may make it hard for some young people to report abuse; for others, mobility difficulties can make it hard to remove themselves from the abuser while personal care needs open up opportunities for abuse. Family related factors may centre on the stress of caring for a disabled child without adequate support (although it should be noted that the vast majority of parents provide loving and safe homes for their disabled children), as well as ambivalence about having a disabled child and disciplinary approaches[20]. Increased risk may arise in services if staff are not aware of disabled children's heightened vulnerability or may even think that no-one would abuse a disabled child[21]. Other risk factors may include staff not knowing how to communicate effectively with children who have communication impairments, within residential settings (where disabled children are disproportionately represented), and that signs of distress and abuse may go undetected, or perhaps attributed to the impairment.

[18] Kvam MH. 2004. Sexual abuse of deaf children. A retrospective analysis of the prevalence and characteristics of childhood sexual abuse among deaf adults in Norway. Child Abuse and Neglect 28: 241-251. DOI: 10.1016/j.chiabu.2003.09.017
[19] Akbas S, Turia A, Karabekirolgu K, Pazvantoglu O, Kekskin T, Boke O. 2009. Characteristics of sexual abuse in a sample of Turkish children with and without mental retardation, referred for legal appraisal of the psychological repercussions. Sexuality and Disability 27: 205-213. DOI: 10.1177/1079063208314817
[20] Stalker K, Green Lister P, Lerpiniere J, McArthur K. 2010. *op.cit*
[21] NSPCC (2003). *It doesn't happen to disabled children: Child protection and disabled children. Report of the National Working Group on Child Protection and Disability.*

3.2 Disabled Children and Child Protection Services

3.2.1 Very little research has been conducted on child protection and disabled children in Britain over the last decade. Cooke and Standen[22], in a survey of 73 Area Child Protection Committees in the UK, found that following case conferences, disabled children were 'significantly' less likely than non-disabled children to be placed on child protection registers or have protection plans put in place. They received much the same response as non disabled children in terms of legal interventions and more attention in terms of medical examinations and treatment, indicating a medical model of disability at work.

3.2.2 In a small scoping study of disabled children and child protection[23], key informants (senior managers in central government, the NHS, the inspectorates, the police and voluntary sector agencies, most of them in Scotland) were asked how child protection policies were implemented in respect of disabled children and young people. Joint working on child protection was said to be better for families with disabled children than for others because, typically, a range of services was already in touch with these families prior to child protection concerns arising. However, communicating with children with learning disabilities or communication impairments was identified as problematic for many participants, while communication and co-ordination between social workers in child protection teams and those in children's disability teams required improvement.

3.2.3 South of the border, Ofsted[24] conducted an inspection of the effectiveness of child protection services in safeguarding disabled children and young people. Where concerns were picked up at an early stage and dealt with through multi-agency working, these were generally handled well. Similarly, when issues were seen as clear-cut, prompt action usually ensued. Delays were more likely where there was less certainty about the child's situation. 'Markedly improved' outcomes for children were found when a child protection plan was put in place. Most staff involved in child protection work with disabled children were well trained and experienced although a minority was not. Local authorities were found to be generally 'poor' at monitoring child protection activities in relation to disabled children.

3.2.4 In relation to thresholds, a key part of the current research, it has been reported that, where disabled children are concerned, some participants may apply higher 'thresholds' for triggering a child protection response than are

[22] Cooke, P. and Standen, P.J. (2002) *op.cit.*
[23] Stalker K, Green Lister P, Lerpiniere J, McArthur K. 2010. *op. cit*.
[24] Ofsted (2012) *Protecting Disabled Children: Thematic Inspection*. Ofsted, London.

used with non disabled children[25]. Key informants in Stalker's study suggested that, in some cases, social workers develop close working relationships with parents over time, empathise with the levels of demand they face and consequently may be reluctant to make a formal child protection referral if they witness 'a wee bit of neglect or whatever'. It was also reported that some social workers appear to be more tolerant of parents smacking a disabled child than a non disabled child. If concerns did arise, it was not unusual for the agencies already in touch with the family to increase support to the parents rather than consider child protection measures. It was also suggested that different organisations may have differing understandings of acceptable 'thresholds', with schools sometimes raising early concerns which social workers may perceive as premature.

3.2.5 Similar concerns were reported by Ofsted[26]. Children using 'children in need' services 'too often' had undetected child protection needs as well. Not uncommonly, those at risk of neglect had been in receipt of other support services for a long time but there were delays in professional recognition that neglect had reached the threshold of child protection concerns. Because the focus tended to be on supporting parents, participants had taken their eyes 'off the ball' of the children themselves.

3.3 The Policy Context

3.3.1 Stalker et al's (2010)[27] study also involved analysis of child protection policies across the UK in order to examine how well they addressed the needs of disabled children. The authors concluded that disabled children were all but invisible in Scottish policies at that time. However, the National Guidance for Child Protection in Scotland[28] contained a section devoted to disabled children and made reference elsewhere in the document to the increased vulnerability, and need for heightened protection, of this group. This guidance is currently being revised, with ways of strengthening the messages about protecting disabled children under consideration.

3.3.2 The Report of the National Review of Services to Disabled Children[29] identified the need for improvements to the child protection system in respect of disabled children. In 2012, a Ministerial Working Group on Disabled Children was set up to take this work forward at research, policy and practice levels. Its work focuses on guidance, training and research, including the

[25] Stalker et al (2012) *op.cit.*
[26] Ofsted (2012) *op.cit*.
[27] Stalker K, Green Lister P, Lerpiniere J, McArthur K. 2010. *op. cit.*
[28] Scottish Government (2010). National Guidance for Child Protection in Scotland
[29] Report of the National review of Services to Disabled Children (2011)

commissioning of this study. The recently refreshed 'Pink Book'[30], the child protection guidance for health professionals in Scotland, also contains a short section on the specific factors relating to disabled children.

3.3.3 Finally, it is worth noting that the Munro report[31], reviewing the child protection system in England and Wales and making recommendations for change, made no reference to disabled children's increased vulnerability and need for heightened protection.

4. METHODS

This section outlines the research questions and the design that was used to address these, including the rationale for our research methods. The sampling frame for local authorities and participants is described. We outline in turn the four concurrent components of the research methods. We then turn to the coding and analysis of the data gathered through these methods. Finally, ethical issues that were deemed significant for the research and how they were dealt with are discussed.

4.1 Aims and Research Questions

4.1.1 The aim of this study was to assess how public services (including social work, health care, education, police and other related services) identify and support disabled children and young people at risk of significant harm, whether neglect or abuse.

The study addressed four main questions using a mixed-methods approach:

1. What are the decision-making processes and 'triggers' for intervention used by professionals when determining the nature of interventions for disabled children and young people at risk of significant harm?

2. What are specific issues faced by practitioners in Scotland in supporting children and young people at risk of significant harm?

3. How do services coordinate to support disabled children and young people at risk of significant harm?

4 What are practice examples in Scotland addressing these issues?

[30] Scottish Government (2012) Protecting Children: A Shared Responsibility. Guidance for Health Professionals in Scotland (the Pink Book).
[31] Munro, E. (2011) The *Munro Review* of Child Protection *Part 1*: A Systems Analysis.

4.1.2 The study involved four concurrent components to address the research questions. These were: interviews with participants from a range of organisations, focus groups with Child Protection Committees (CPCs), practice case studies and, lastly, the development of systems and response models. Combined, these four components provided in-depth data on the practice of identifying and responding to children at risk of significant harm. Whilst the original brief suggested *good* practice examples, it was later agreed that we would provide a range of practice examples and offer critical discussion and learning points from those. Our brief did not involve speaking to children or parents.

4.2 Sampling, Recruitment and Participants

4.2.1 A total of 21 participants were recruited from six local authority areas and across five different services. Furthermore, focus groups were conducted with five Child Protection Committees. Local authority areas were chosen using local authority and child protection register data. Local authority areas for inclusion were sampled on the basis of urban/rural, small/large, and diversity in the number of disabled children on their child protection registers.

4.2.2 For the interviews with professionals, potential participants were contacted by the research team and invited to participate. Each potential participant was provided with a consent form and information leaflet about the research. From each local authority area, potential participants were contacted from social work, education, police, voluntary organisations, and health with practice experience of responding to at least two child protection cases involving a disabled child.

4.2.3 As well as contacting services directly the research team drew upon existing networks to assist in the identification of potential participants. Specifically, the Child Protection Committee Coordinator at WithScotland was contacted to help identify practitioners in each of the selected local authority areas. In the education field, the researchers drew upon the expertise of colleagues including key Additional Support Needs researchers and practitioners in the Scottish Sensory Centre and CALL Scotland Centre. Furthermore, a member of staff from the Scottish Government aided the establishment of contact for relevant potential participants within education, health and the police.

4.2.4 Members of staff from the Scottish Government also aided in the contact of Child Protection Committees (CPC) for the focus groups in the sampled local authority areas. A letter to each CPC was sent out notifying them about the research and encouraging their engagement. Following this the Chair and

Lead Officer for each CPC was contacted to arrange a date and time suitable for holding a focus group.

4.2.5 Despite exhaustive efforts recruitment of participants took longer than originally envisaged. Although initial contacts at services forwarded information about the research to their team, it was not always relevant participants who replied and we were often passed from one administrator to another. Further contact revealed that potential participants had not felt they had enough experience with cases involving disabled children and/or had not been sure those with whom they had worked would classify as disabled. Additionally, there was a time delay between making initial contact and services locating the best person to deal with our research request. In one instance the email was forwarded through eight people before a return email came with a research approval form to be completed before the arrangement of interviews could begin. Similarly, clarification had to be given to initial contacts when they replied saying they were unable to help that we were looking to speak to any practitioner with some experience of child protection cases involving disabled children and not just those working specifically with disabled children.

4.2.6 While the research was commissioned to focus on child protection and disability, there were participants who were not comfortable with the term disability, preferring additional support needs or similar phrases. A small minority also felt that the focus on questions relating to disability avoided the wider child protection framework that would apply for any child, regardless of whether they were disabled or not (this is discussed further in section 5.1). Questions related to disability or disabled children therefore were at times met with strong reaction as some participants felt this missed the complexity of child protection in general[32]. Additionally, while questions were devised to probe on any considerations that might apply when working with disabled children, a few of the participants answered by clarifying how the system worked and in one local authority seemed to interpret the line of questioning as challenging current practice and reacted negatively.

4.3 In-Depth Interviews with Participants

4.3.1 In-depth telephone interviews lasting on average an hour were conducted with participants. While face-to-face interviews might be preferable, the limited

[32] This issue is picked up in the findings sections. Participants seemed to think that there was 'no issue' with disabled children and child protection.

budget and timescale of the study militated against this[33]. Interviews were thematic covering areas of practice highlighted as important by previous research.

4.3.2 In addition, participants were asked to recall two incidents from practice: 1) an example of good practice and 2) an example in which there were questions or issues involved in either identifying significant harm, provision or uptake of interventions and/or interagency working and how these questions or issues were resolved. This follows a Critical Incident Technique (CIT) methodology[34] [35]. CIT focus upon real events in order to explore how professionals make decisions, what the triggers for action are and how coordination and interagency working are reflected in practice.

4.4 Focus Groups

4.4.1 Since CPCs are locally-based and have interagency strategic partnerships to inform child protection policy and practice across the public, private and third sectors in their locality and in partnership across Scotland, their feedback into the research was considered very important. Focus groups were conducted with members of the CPCs in five of the six local authority areas sampled. They were asked to discuss key themes and issues they had identified in responding to and supporting disabled children who may be at risk of significant harm as well as questions focusing on interagency working. Focus groups, where possible, were conducted immediately after already scheduled CPC meetings or as an agenda item within a meeting to explore these topics. Two members of the research team were usually at each focus group to ensure effective facilitation and note-taking[36].

4.5 Case Studies

4.5.1 From the CIT questions asked in the 21 interviews with practitioners, eight incidents were chosen to develop further into case studies. CIT was developed from an aviation psychology programme for the US Air Force[1] and used to improve the outcome of flying missions. The hallmark of CIT is its focus on real life events rather than abstract concepts. It has since been used in numerous studies to effect in unearthing the different nuances of practice, including those undertaken by members of the team[37]. Practitioners were

[33] Bryman (2012) Social Research Methods, Oxford Press.
[34] Flanagan J (1954): The critical incident technique.Psychological Bulletin,51, 327-358.
[35] Bradbury-Jones C& Tranter S(2008): Inconsistent use of the Critical Incident Technique in nursing research. Journal of Advanced Nursing 64, 399-407.
[36] Webb C & Kevern J (2001): Focus groups as a research method: a critique of some aspects of their use in nursing research. Journal of Advanced Nursing 33, 798-805.
[37] Taylor, J; Bradbury-Jones, C.; Kroll, T.; Duncan, F. (2013) Health professionals' beliefs about domestic abuse and the issue of disclosure: A Critical Health Soc Care Community. 21(5):489-99. doi: 10.1111/hsc.12037. Epub 2013 May 3.

asked to recall events from practice that highlighted for them issues of exemplary or poor practice and to reflect on the issues involved. In total there were 34 practice examples and these were also interrogated for thematic groupings.

4.6 Modelling Complex Interventions

4.6.1 Following the Medical Research Council's Framework for Development and Evaluation of Complex Interventions, a series of modelling exercises was developed using the interview, focus group and case examples data to understand better the issues faced by practitioners in providing interventions and support for disabled children and young people. Modelling is concerned with unravelling and distinguishing the key components in a complex intervention[38]. This involved delineating issues identified in practice and how they interrelated and how active components of a complex intervention, such as responses to disabled children and young people at risk of significant harm, work in practice. These models were produced using diagrams and flowcharts and were useful in analysing the initial triggers for child protection concerns, the decision-making ecology, child protection thresholds for disabled children and young people and the barriers and enablers for professionals at each stage of the child protection process. The models build on the large body of decision-making theoretical frameworks in child protection including the Decision-Making Ecology Model for Child Welfare[39], the Systems Model[40], and the General Assessment and Decision-Making Model (GADM) first introduced by Dalgleish[41,42]. The models are forward looking by providing focal points in practice for improved response and provide a basis for making concrete recommendations.

4.7 Ethics

4.7.1 The research followed the Scottish Government's Social Research Ethical Sensitivity Checklist and a full ethical protocol was accepted by the University of Edinburgh Moray House School of Education Ethics Committee (9th May 2013).

4.7.2 Whilst the research asked participants about their professional practice on issues with which they were used to dealing, questions specifically about child protection issues risked making participants feel uncomfortable. Within the

[38] MRC (2000). A framework for development and evaluation of RCTs for complex interventions to improve health.
[39] Beaumman, D.J., Dalgleish, L, Fluke, J and Kern, H. (2011) The Decision-Making Ecology. American Human Association.
[40] Munro (2011) *op. cit.*
[41] Dalgleish, L .I . (1988) . Decision-making in child abuse cases: Applications of social judgment theory and signal detection theory . In B . Brehmer & C .R .B. Joyce (Eds) *Human Judgment: The SJT view* . North Holland Elsevier.
[42] Dalgleish, L .I . (2003). Risk, needs and consequences . In M .C . Calder (Ed.) *Assessments in child care: A comprehensive guide to frameworks and their use.* (pp . 86-99) . Dorset, UK: Russell House Publishing

informed consent forms and information leaflets provided to participants it was stated clearly that they could choose to omit answering any questions.

4.7.3 The 21 in-depth interviews with practitioners and the five focus groups with local CPCs were recorded digitally with the participants' consent. Consent was sought for the practitioner interviews through informed consent forms and, in addition, verbal consent was sought before the start of the interviews.

4.7.4 Incidents mentioned by practitioners during interviews were only developed into case studies in situations where appropriate. Situations where confidentiality could be challenged were not selected.

4.7.5 All names, locations and other identifying information was removed or anonymised to protect the participants and to ensure cases could not be identified. Only the research team had access to the raw data. Transcription services were used to transcribe the recordings and were subject to a confidentiality agreement. No other person or organisation was given access to the transcripts.

4.7.6 As interviews were conducted with practitioners involved with relevant services it was unlikely that there would be a disclosure of cases that were not already known to the relevant authorities or contained potentially harmful information. However, as a precaution the research team and the Scottish Government agreed upon a named person for disclosure of any information that could come out of the research. The named person was chosen for their competence to reach a decision on whether and how to act and was in a position to trigger action.

4.8 Findings

4.8.1 The following three sections present the analysis and findings from the research with 61 participants including the 21 individual interviews and five focus groups with Child Protection Committees (n = 40). They are grouped within three main themes: the child at the centre, muddling through, and interagency working.

4.8.2 The child at the centre theme covers the 'putting the child first' perspective which participants described as organising the child protection system, alongside the difficulties experienced in adapting this child centredness when working with disabled children.

4.8.3 The second theme encompasses the practice issues arising from working with children in the child protection system which meant that many participants

appeared to be ‘muddling through’. Included is the fact that participants often lacked confidence in their own knowledge of disability or perceived other workers as being afraid of working on child protection cases involving disabled children. Additionally, participants felt there was not always enough training provided.

4.8.4 Finally, the third them, interagency working, details the way services worked together and organised their roles and responsibilities. Furthermore, it examines the situation where criminal proceedings did not proceed for cases involving disabled children with communication impairments.

4.8.5 Case studies are interspersed through the findings sections. These provide a more detailed look at particular cases discussed with participants in the interviews that relate to theme. For each, details of the incident and the events that took place are described alongside commentary on the actions taken and learning points the case study has for future practice.

5. THEME ONE: THE CHILD AT THE CENTRE

> *[Higher prevalence of abuse and neglect among disabled children has] not really been the experience that [we’ve had], and I don’t know whether that is because we’ve managed to crack the thing about the child first and the disability. I think irrespective of a feature of the child it is Child First and I think by and large we are quite good at being focused on that* [Focus Group 3].

This section details the discussion with participants about putting the child at the centre of child protection. Particularly, the view that in all cases children should be treated first and foremost as a child. There was then a juxtaposition between the conviction of participants to treat every child the same regardless of any impairment(s), whilst at the same time acknowledging the influence impairments (both perceived and real) had for disabled children within the child protection system.

Although seeking to treat every child the same and recognising them as an individual there were sometimes difficulties in managing to individualise child protection successfully for disabled children. Impairments could not always be seen as secondary where they had a critical role in assessing the risk to the child and the possible forms of intervention to take. Similarly, services were not always adapted in order to support disabled children, which limited the options available.

Communication impairments received prominent attention in the interviews. These were seen as preventing practitioners from being able to gain the child’s perspective or to gain accurately the information they required. Despite this there were also

examples where successful adaptations were made in communications and within interview settings that question the extent these perceptions match with reality.

Indeed, there were a number of cases mentioned where children had been the one making a disclosure. This included children with communication impairments. However, the perception of their impairments making them unreliable witnesses led to their disclosures not always being treated on a par with those made by a non-disabled child.

Finally, given the challenges participants perceived when working with disabled children, there was also concern that practice was at times parent-centred rather than child-centred. Furthermore, the very systems in place to try and ensure the protection of disabled children were also seen as creating a risk that neglect and abuse were not always identified.

5.1 Child Centredness

5.1.1 Across interviews the majority of participants expressed that every child, whether disabled or not, should be seen first as a child, thereafter as a child with an impairment. Disability was a term which not all participants were comfortable with and many preferred the term 'additional support needs' which was also seen as more encompassing of other groups, such as children whose first language was not English. Participants felt that 'flagging' a child as disabled was the wrong approach to take, insisting that the signs and behaviours indicative of maltreatment would be the same as for non-disabled children. While there were participants who highlighted differences in signs and behaviours signalling concerns of significant harm in a disabled child, they meant where there were communication impairments. Where disabled children did not have communication impairments, there was an assumption that the child would make a disclosure of abuse. This suggests a misunderstanding of disability as a problem situated within the child rather than a source of discrimination that must be acknowledged and addressed.

> *Presumably [a deaf child] could tell somebody [if she was being abused]… I'd be looking for the same signs I would see in [a] child that wasn't deaf…because she's only deaf…just any changes in her general demeanour and behaviour…she's a 12 year old girl she just happens to be deaf* [Interview 2].

5.1.2 Participants viewed seeing every child as a child first as beneficial. This is to be commended but not if accompanied by inattention to specific needs

relating to impairment. This was because the approach was perceived as reflecting the perspectives and welfare of children, as opposed to the perspectives of parents which some participants felt was how the child protection system had operated previously. Overall participants hoped or emphasised that this contrasted with their own or current practice.

> *I'm working for the best interests of the child. I want the child to be safe and secure* [Interview 13].

5.1.3 Participants spoke of the importance of the inclusion of the child within the child protection system, especially when the child had an impairment. It was stressed that disability did not prevent child protection work from taking place and that there was a common framework to be followed in any case.

> *You'd be looking at the child first and I think… long gone are the days when we've seen disability as an absolute barrier for children to be protected and safeguarded and I think that whole agenda, about 'the child is a child irrespective' then within that there'll become professional judgements about what the protective factors are, what's the resilience, what's the environment around the child and what is the best place for that child now* [Focus Group 3].

5.1.4 When discussing how this would apply to considerations of impairments and how this approach might affect their work, participants highlighted the need to individualise their approach to the child. At the same time it was remarked that this individualising of child protection would also be done within the same framework for each child.

> *A child protection concern is a child protection concern at the end of the day, if a child is at risk of significant harm there's no tightening it up, but it also doesn't take away from the individualised needs of a child with disability* [Interview 8].

5.1.5 While examples were given for how this would relate to a disabled child, individualisation was seen as important for all children. Ensuring that this was the same for every child led a few participants to question the language of disability and impairment.

> *Communication impairment? I don't know what that is, don't recognise it. I think people have a difficulty with communicating within a bigger spectrum of something and I think yes you would have to absolutely individualise your approach to the needs of that youngster* [Focus Group 3].

5.1.6 Tailoring child protection to individual need was explained as a need to 'look beyond' and grasp the full picture. This led some participants to stress there being no set criteria that would trigger concern, with a change in a specific child's usual behaviour being the most important means to detect a risk of significant harm. In order to do this each child's behaviour had to be understood in relation to that child's situation.

> *It first came to our notice from school, school raised it that they noticed a huge change in [the child's] behaviour [displaying sexualised behaviour], this was after the child had been taken abroad and stayed with family for several months* [Interview 2].

5.2 Impairment Effects

5.2.1 Many participants emphasised that following a child centred approach meant they would not approach child protection matters any differently for disabled children. There was a division therefore between participants who thought disabled children faced unique risks and those who thought it was a question of the level of vulnerability to risks that would be the same for any child. Despite this child-centred approach placing focus on also treating children as individuals, there were difficulties in individualising responses in relation to any impairments.

5.2.2 For example, participants discussed how the presence of impairments could lead to issues with recognising if there was a risk of serious harm to a child. While child protection was seen as having a unified approach, impairments were perceived as adding further complexity to an already difficult area. The level of people involved with a disabled child, the blurring of what was acceptable, and impairments effecting communication were highlighted.

> *I think our rate of detection is probably quite poor because I think of all the personal care and things that child have, I would suspect that the rate of sexual abuse and stuff is probably higher than we actually detect. It's hard enough in the average population without them being disabled where they can't talk and tell us* [Interview 3].

5.2.3 A few participants highlighted cases where the existence, or lack, of a formal diagnosis additionally effected the adaptation of interventions. Despite the view that any impairment should be seen as secondary there were cases mentioned where the lack of recognition of an impairment was seen as negatively impacting upon the ability to assess the specific risk for the child. This is also highlighted in a case study of practice where serious concern had

been raised initially about the well-being of a child with a rare genetic condition.

> *There's been a number of children where I've seen professionals having huge difficulty about deciding whether it might be a child protection issue or related to a diagnosis of autism...what is autism, what is child protection and what is both and what is neither, it is very, very confusing sometimes. Very hard for professional groups* [Focus Group 4].

Case Study A:

Child/young person at risk: Baby with a rare genetic condition

Critical incident: Child failing to thrive at home with decreasing weight, raising alarms with health visitors

Critical interactions:

1. **Child born with a rare genetic condition, affecting feeding and growth.**
2. **Health visitors making home visits to support the family were alarmed at the child's decrease in weight and failure to thrive. The house was described as 'very dirty'.**
3. **Mother had missed several health appointments as she had to attend up to 14 a week at some points. These were noted as failed 'appointments' and used as a trigger by the health visitors to instigate a referral to social services, at which point social work placed the child on the child protection register.**
4. **Young mother (first child) felt demoralized and hence did not know what to do and how to care for her baby, despite her commitment to do so.**
5. **Social worker was sent to assess the situation only to find committed parents who were out of their depths. The child wears an oxygen mask all the time, taking the bus was almost impossible for the mother and she had to take taxis to health appointments, which she could not afford, resulting in her missing several.**
6. **Social worker arranged for the child to attend an educational service, where it was noted that the child was still losing weight. Social worker also suggested coordinating appointments and making some**

of the appointments home visits rather than the family having to attend clinics. Social work assistant was appointed to the family and was responsible for taking them to their appointments.

7. **The social workers ensured that the mother started receiving a carer's allowance, as she could not return to work, and organized domestic support to give the house a thorough clean.**
8. **The child is now no longer on the child protection register and is thriving. Home care is minimal as the parents now have the capacity and know-how to cope with all the child's needs.**

Comment on Case Study A

Due to a lack of awareness of the child's condition among health visitors, the child was referred to social work and put on the child protection register on grounds of 'failing to thrive', although not at risk of significant harm. After a social worker reviewed the case and identified the health visitors' misreading of the situation, she was able to better inform them about the child's condition and empower the parents by arranging support to build their capacity to care for their child's specific needs. This case study highlights the pivotal role of a social worker in taking a holistic view, assessing the merits of a situation and identifying areas for improvement. The outcome was the best possible result for all concerned, as the child remains at home being cared for by parents who have an increased capacity to provide the right support for their child's needs.

Key Messages for Practice from the Case Study

Co-ordination between health and social care staff, and taking a rounded view of the family situation, can help ensure that a child is receiving the best care from fully supported parents.

5.2.4 Practitioners were divided in their responses regarding the system's collective ability to involve and respond to disabled children. Some practitioners felt confident in the system's ability to reach every child who was at risk of significant harm.

> *It does not appear I don't think, from what we see, that disability or additional support needs seem to come up as a major issue…. We are reasonably confident that we are not missing [anything], there's not loads of children out there who are in trouble that we don't know about.*

I mean we may be wrong about that of course but there's no evidence to support that [Focus Group 3].

5.2.5 Indeed, it was common across the focus groups to shift discussion to statistics when questioned on the prevalence of abuse and neglect amongst disabled children. While one focus group felt the few disabled children on the register meant they were doing things right, other focus groups highlighted the lack of statistics, or lack of analysis of them, but when probed felt there was a possibility of under-reporting. There remained, however, a sense that if there was anything seriously wrong it would become obvious to practitioners.

If that client group was problematic then presumably before now would've jumped up and hit us in the face and we'd of done something about it [Focus Group 1].

5.2.6 While participants were divided in their confidence about whether all cases of abuse and neglect of disabled children were being identified, there was more consensus of there being a lack of adaption of services for disabled children. This included a lack of available residential care units or placements where it could become difficult to find suitable accommodation for disabled children who were removed from the family home or foster care. In a few situations, there were concerns that children had remained at risk because of an inability to find suitable accommodation: this is clearly a worrying finding. Furthermore, one participant discussed the issue of a failure to make a building physically accessible as having been a barrier to effective child protection.

The video recorded interview unit in [the city] doesn't fit a powered wheelchair… we discovered that when we took somebody there in a wheelchair [they] couldn't get through the door! [Interview 2].

5.3 Communicating with Disabled Children

5.3.1. The extent to which the presence of impairments influenced the identification of child protection risks was perceived differently by participants. Impairments for many participants were not viewed as causing a problem as long as the child was able to make a disclosure. Waiting for a disclosure is a reactive stance to child protection. Disabled children with communication impairments, however, were perceived as not having the same ability to disclose any incidents of abuse and/or neglect. This was in direct contrast to the evidence from the 34 case examples given throughout the study (see paragraph 4.61 for a reminder of the source of these case examples). In the case examples, of the nine disclosures by children, six were made by disabled children with

communication impairments about the abuse they reported experiencing. Throughout the interviews, many participants focused upon communication impairments as being a barrier to child protection. A couple of participants apologised for 'sound[ing] like a broken record' (Interview 4) given how often they returned to this theme. It is possible they had little understanding beyond this of the needs of disabled children.

> *It is easier to abuse a child who has a disability. Who are they going to tell? What are they going to say? Can they say anything? How is that going to be brought to light and then when they play the poor parent card what action is going to be taken because what provision is there for children with disabilities? Especially complex disabilities* [Focus Group 5].

5.3.2 Participants felt that due to a lack of knowledge and training, or a perceived inability of children to communicate, there was a greater chance of missing signs of neglect and abuse that would be picked up more efficiently in non-disabled children. It is a matter of concern that this barrier was sometimes attributed to the child's lack of ability rather than that of the professional. Where there were communication impairments, participants stressed the importance of knowledge about the child's usual behaviour and looking for any change in it:

> *I think that's the difficulty with children who have a disability that certainly with children that don't have a disability they are telling us what their life experience is like through their behaviour, so that very much informs our assessment* [Interview 1].

5.3.3 Participants noted that adding to the difficulty of this was the uniqueness of each child's communication and interpreting their behaviour required spending a lot of time with the child. Being able to pick up signs from behaviour though was also viewed as not always possible based on the type and level of impairment. Additionally, participants mentioned again how the difficulty in knowing what was a result of an impairment and what was a result of the environment made it hard to discern if the child was at risk.

> *Most of the disabled children don't have enough language. Not just oral, verbal language, don't have enough body language, so they cannot really express. The only way probably they express is having some form of behaviour issues, but then again it's difficult to say why the child is behaving like that. Is that abuse or is that just their problem with behaviour* [Interview 13].

5.3.4 Communication impairments were often mentioned in relation to the increased vulnerability of disabled children.

> *I think their vulnerability largely comes in forms of their communication…* [which makes professionals] *unable to recognise what's acceptable and what isn't. If you can't open a dialogue with a child then you just kind of give up* [Interview 8].

5.3.5 Despite this there were a number of incidents mentioned in the interviews and focus groups of communication being adapted. This included involving speech and language specialists, particularly those from the child's school who were already known to the child, and communication aids such as Makaton. These were used as part of the holistic approach to investigate concerns with changes in behaviour.

> *If you identified that the child used to like swimming and all of a sudden they don't anymore, and you can ask the child by using photographs or symbols about it. [For a young women who stopped liking swimming] she was able to tell me through breaking it down that somebody was pinching her when she went swimming and that's why she didn't like it* [Interview 2].

5.3.6 Experience of adapting communication with disabled children varied across the interviews. One participant spoke of a joint interview with a child as a 'disaster' because the child was regularly distracted and it was difficult to achieve a chronology of events. The participant, however, was aware that the interview was not set-up correctly, including having interviewed the child after school when they were already tired, and was eager to know if there was any way the situation could have been handled differently.

> *[The child] was all over the place, although [the child's] got cerebral palsy, [the child] can walk…aided and with the aid of a frame, but [the child] wasn't at peace, and was in and out of the room. We couldn't focus on anything, it was just a disaster and I'm not sure how that could have been improved* [interview 15].

5.3.7. An example of how this could be done came from another participant. Working with a child with a similar impairment, they ensured that the speech and language therapist was a person already known to the child to minimise the number of new people he was introduced to and allowed him time to inspect the recording equipment before the interview started. Additionally, if he became distracted during the interview they allowed this before slowly

returning focus to the interview. Another participant who similarly felt an interview had been a success changed their opinion upon reviewing the recording of the interview. For, in doing so they were able to take the additional time necessary to tease out the chronology of events that had been difficult for the child to give.

> *In this case we had to review the video which led me to find everything [the child] said because he was very quick and very muddled in the way he was relaying information to us, so me sitting there listening to him at the time, I wasn't really able to comprehend what he was saying. It was only going back to looking at the video afterwards that you found that there was lots of things weaved in and out of what he was saying. …[It] made more sense looking at it for the second time, [than] listening to it live the first time* [Interview 14].

5.4 Child Agency

5.4.1 Although there were concerns from participants about the ability of children with communication impairments to make disclosures of abuse, there were also in the case studies, six examples where such children were the ones who made disclosures of neglect and/or abuse. In such cases, the adaptation of communication and ensuring there were workers involved whom the child trusted was important.

> *His stepfather had pushed him and he was noted to have an injury to his face....the disclosure was made to his pupil support assistant who was obviously was a trusted person to him. … she stayed with him while he was actually treated for the injury that he sustained... this child had had that trusted person right through the whole process for him, a very vulnerable child obviously cause there's a developmental delay, and his language difficulties [were not good]. And she knew him so well that she was able to understand the things that he was saying. Whereas for me because of his language difficulties he was quite difficult to understand and get his story from* [Interview 20].

5.4.2 Many incidents interviews were adapted to facilitate communication and to take the disclosures of abuse and neglect seriously. However, the extent to which this was done was not the same across all cases, including cases participants acknowledged were not best practice. Furthermore, in the case quoted where the participant made adaptations for communication, the abuse of the child was not picked up until after the fifth time he had been referred to

health services. The participant who recounted the case felt his communication impairment was the reason it had not been identified sooner.

> *I wonder… if that little boy who's been seen five times previously, I wonder whether because of his difficulties, his disclosures were being minimised because people really weren't understanding him* [Interview 20].

5.4.3 Participants throughout the study questioned whether the perceived limited agency of disabled children was due to communication or other impairments or to the failure to adapt communication to the needs of the child. Indeed, even where communication was adapted, the case did not always progress as it would for non-disabled children; an issue that will be returned to when discussing the criminal justice system.

5.5 Parents

5.5.1 Participants viewed the family situation as being important when making an assessment of a child protection risk and the type of intervention required. The presence of impairments, in particular, was seen as impacting upon decisions discerning whether there was a situation of general neglect or more an issue of parents' coping capacity where increased support was required. In addition, substance misuse, mental ill-health, and domestic abuse were present in many case examples though often not highlighted as significant concerns for children. Case study two explores an example of practice where these familial risk factors are taken into account.

Case Study B:

Child/young person at risk: Adolescent on the autistic spectrum

Critical incident: Effect of family situation on young person, specifically emotional impact as parents' needs are 'overpowering' those of the young person. The latter exhibited a lot of frustration by physically abusing the mother (hitting, kicking, punching, biting and also soiling at school).

Mother experiences mental health problems and father has addiction problems, mainly alcoholism. Father's drinking habits adversely affects the young person.

Critical interactions:

1. **Voluntary sector staff had raised on-going concerns with Social Work over a number of years about this child's risk of significant harm.**
2. **Good relations existed between staff in a voluntary sector agency and parents and child/ young person.**
3. **The child was exposed to emotional abuse, which is not always easy to identify; however, once identified (through signs of withdrawal), the support provided was increased.**
4. **Voluntary sector agency staff initiated the involvement of the local authority Children with Disabilities Team.**
5. **Once the Social Work Department were involved, progress moved on very quickly.**
6. **Mother admitted she was having trouble coping and agreed to have her child accommodated voluntarily. (It was reported that, otherwise, social workers would eventually have had to remove the child and accommodate her under a statutory order).**
7. **Ensuring consistency for the child/young person was essential. This was achieved by having a practitioner from the voluntary sector agency act as focal point for this case and maintain contact with the child/young person.**
8. **The child was made aware of her rights, presented in an accessible way taking her autism into account.**
9. **In order to be manageable to the child, the different stages of the process were introduced gradually. The child's opinions and wishes were taken into account, as the child expressed a desire to return home.**
10. **During the time the child was accommodated by the local authority, she was given driving lessons and went to Paris on a visit. The City Council expressed commitment to providing the child with on-going support and further opportunities.**

Discussion of Case Study B

This case illustrates good interagency collaboration to provide timely long-term support to a disabled child at risk of significant harm due to maternal mental health problems and paternal addiction problems. Partnership between a voluntary sector agency and the social work department worked particularly well with clear lines of communication. Mother was very cooperative and wanted to improve her parenting skills to be better prepared in dealing with her child's particular needs. Her willingness to help and openness to receive support added to the positive and beneficial outcome of this particular case. The critical

intervention allowed the relationship between child and parents to develop and reach a level whereby it was safe for the young person to return home to a healthy family life.

<u>Key Messages for Practice from the Case Study</u>

Support provided by a local authority for disabled children and young people can help alleviate pressures at home and provide opportunities that a child/young person would otherwise miss out on.

5.5.2 Participants stressed that parents were not always deliberate perpetrators of abuse and/or neglect and were acknowledged as experts on their child's impairment. It was felt though that their desire to protect their child could create its own limitations and potential situations of unintentional neglect where children were not given ample opportunity to take risks or engage in activities out with the home.

> *The problems about disabled children is people want to keep them at home, a lot of them, not all of them, they want to keep them at home, they're very overprotective, some of them have had very difficult times with deliveries with the children, you're trying to look at it from their point of view but actually on the other hand you're trying to say 'well actually this child needs to get out and go and mix and needs to go* [Interview 3].

5.5.3 Participants acknowledged that potential neglect of disabled children was not always intentional if the parents or carers lacked capacity. However, participants felt that when given the right support to build parental capacity, the outcome could be positive.

> *[Health] was saying this mum's never going to cope, this mum's never going to cope, she's not got the capacity to cope. She damn well does and she does cope superbly and the child is doing fine now but at the time they basically, mum was demoralised that she didn't know what to do. She was … 19, first child, not a great capacity but certainly not daft* [Interview 8].

5.5.4 Additionally, it was noted that not all parents and carers may require support initially, but when their situation changes it can be hard to admit they need help.

> *I think as children get older they become physically* [harder to care for]*, especially the ones with the more complex needs* [who] *need the kind*

of care and lifting and handling and things and the constant care. I think there comes a time when people actually struggle and it's that barrier of saying, 'Actually when is it okay to say I need some more assistance? [Interview 11].

5.5.5 Despite the level of support that some families require, participants also highlighted the negative perceptions people have of social services that discourages parents and carers from seeking support. This was usually raised in interviews by social workers themselves as a barrier to their own practice.

> *We want to be able to support people on a voluntary basis and for a large number of families that's what we do, but I still feel there's this perception, […] we'll send a letter out to parents and it's not unusual for parents to phone up really quite distressed thinking [because the letter is from social work] somebody must have said that they're doing something wrong, whereas that's not actually the case* [Interview 4].

5.5.6 Participants also spoke of cases where parents were resistant or reluctant to accept the involvement of services. In these cases the parents' knowledge of their children's disability again was acknowledged but as a reason for why they were resistant. Practitioners when dealing with such cases maintained a relationship with parents but a few also spoke of the importance of their relationship with the children themselves.

> *The parents were very resistant to social work, they come from quite a coastal community and they were really resistant, but actually the fact that I was able to speak to the girl and not to them or not over her was a real icebreaker and that's been a real benefit and, like I say, she was telling me to brush up [on my sign language] and it was really good* [Interview 11].

5.5.7 The view of the increased difficulty in discerning cases of abuse or neglect for disabled children was one of the areas highlighted where empathy with parents might intrude upon decisions. There was also though a concern that failing to take account of the effect of an impairment could lead to a misdiagnosis of what was causing a significant risk, which could result in parents receiving unwarranted blame.

> *I think in particular when it's clear that [the] parent is struggling to parent the assumption is that it's their failure. I think health quite often report factual kind of concerns that trigger the child protection about*

missed appointment or about injury; they don't always look beyond [Interview 8].

5.6 The Invisible Child

5.6.1 The child-centred operation of child protection was positively regarded as moving away from placing parents at the centre, and from prioritising parents' perspectives over children's. With disabled children however, this did not always happen. Concern was expressed by participants that within child protection practitioners may sometimes over-empathise with parents, and particularly parents of disabled children with potentially higher levels of stress and coping needs. Additionally, a few participants expressed concerns that they themselves had unwittingly been too sympathetic to the parent's situation and potentially underestimated the risk posed to the child.

> *It's back to this thing about parents being able to cope and what they cope with. If you've got a child who's not sleeping, you've got a lot of physical work to do with them, perhaps you've got difficult social circumstances, maybe we just allow a bit of neglect that we wouldn't tolerate elsewhere* [Interview 3].

5.6.2 A few participants discussed how they had been unsure whether restraint used to control a child's behaviour bordered onto abuse. More recalled having been involved in cases where they felt other workers were being tolerant of what they felt constituted abuse and/or neglect and overly empathetic with the parents.

> *I think we're maybe not always as critical as we should be. I mean, I can think of examples where a child repeatedly came in, it's chair was so filthy and it's feeding equipment was so filthy that the nurse refused to use it and we actually kept separate feeding equipment. I have to say we also felt that the social worker was in cahoots with the mother* [Interview 3].

5.6.3 The numbers of services that would potentially be involved with disabled children to provide general support was highlighted as a safety net for ensuring any cases of abuse and/or neglect were identified. However, some practitioners expressed a concern that this could also lead to situations of complacency where practitioners may mistakenly believe other services would act on any child protection risks.

…there is a tendency to think that if there's a child with additional needs or disabled then they have already got that extra support there… if there's anything that is not quite right that they might be concerned about with a normal child as such then there'd be less likely to be as concerned with that child because they have got this additional support and they would expect somebody else to pick it up [Focus Group 4]

5.6.4 This reliance on others for protecting disabled children could extend to relying upon parents or carers to understand what the child was communicating, or even using them as a proxy for the child's perspective is illustrated in the quote below and also in case study C.

We work with children who have behavioural problems that can't be put down as part of the condition they have, but equally it might be them trying to communicate that something else is going on. We rely on carers because, again just coming back to communication, if children don't have any [communication]... it's not even just verbal communication, but if their communication is limited then quite often you're talking to carers and, you know, if there are child protection concerns they're more likely to be around the people who are caring for the child. So I think definitely are under-represented in terms of formal child protection procedures [Interview 4].

Case Study C:

Child/young person at risk: primary school aged child with communication impairments

Critical incident: Child communicated to a speech and language therapist that he had been physically assaulted by the mother

Critical interactions:

1. **Referral submitted by speech and language therapist worker to the Child Protection team in NHS, noting that the child had communicated to the speech and language therapist alleging physical assault by the mother.**
2. **After the initial referral, the child retracted the allegation in the presence of his mother.**
3. **On receipt of the referral, health worked in collaboration with social work to request an initial referral discussion. Each sector compiled any information they had on the family to discuss how to progress the case.**

4. **During the referral discussion it was agreed to have a joint interview with the child, health, police and social work and it was decided that the speech and language therapist should attend the interview to help the child communicate effectively, using visual aids as necessary.**
5. **As this is not part of the speech and language therapist's routine work, she was briefed on what was expected of her during the interview and given clear guidance and reassured that she was not expected to question the child herself but to act as an interpreter.**
6. **The speech and language therapist gave a briefing to the interagency team prior to the interview with the child, updating them on the child's communication difficulties.**
7. **The interview was held at a health facility. During the interview with the social worker and police, the child, with support from the speech and language therapist, repeated the allegations of physical assault by his mother.**

Comment on Case Study C

Interagency collaboration and effective mechanisms for joint working meant the child was able to express himself and be fully understood with the speech and language therapist's support. Preparation and cooperation from the four sectors involved meant the child was able to express and communicate his views and experiences in a safe environment. It is not usual for a speech and language therapist to attend such an interview as the usual role of the speech and language therapist would extend to offering advice on how to communicate with the child to those interviewing the child. The Child Protection team within NHS have provided support and built the capacity of the speech and language therapist in relation to joint interviewing including setting clear guidance on the role of the speech and language therapist in the interview process.

Key Messages for Practice from the Case Study

Involving speech and language therapists in an interview with a child or young person who has communication impairments can be, with appropriate guidance and training, a positive step to ensuring the child's view is taken into account. More formalised training on child protection for specific disability experts such as speech and language therapists is needed to ensure clear guidance and support is provided.

5.7 Summary of Theme

5.7.1 The interpretation of current policy on child protection in relation to disabled children as reflected by participants is to not to treat disabled children differently from other children. Child-first operated as an over-arching discourse drawn on repeatedly within the interviews and focus groups to explain the current operation of child protection, however this did not always translate into effective identification and intervention for child protection risks involving disabled children. This distinction made a separation between disabled children being a child first and any impairments being secondary. However, in practice it was not always possible to maintain this separation as knowledge about impairments could be vitally important for identifying if a child protection risk existed and for making assessment of that risk. Therefore, the discourse of treating every child the same and as an individual conflicted with the means through which to individualise the same protection standards for disabled children.

5.7.2 The language of treating every child the same and every child being an individual perhaps could be interpreted as somewhat rhetorical. Such vague terminology does not address a gap between the language of the child protection system and the issues faced in practice. While some participants spoke of communication impairments as potential barriers to child protection there were also incidences of adaptation to facilitate the inclusion of disabled children and hear their views. Cases where this did not happen meant that disclosures of abuse and neglect were not heard or not treated as reliable. Despite the language of being child centred there were cases where parents and carers were used as proxies for the child's view instead, including a case where the carer was the abuser – another cause for concern.

5.7.3 The adaptation of buildings and service provision to be accessible for children with impairments was important in removing barriers to protecting disabled children. The degree to which impairment effects were a result of the perception of participants or real may reflect on the ability of participants to be adaptive and draw on alternative techniques.

6. THEME TWO: PRACTICE ISSUES (MUDDLING THROUGH)

> *I think it was a huge learning curve for the speech and language therapist and I've supported her since that, because she had to get her head round a few things about understanding joint interview processes and the guidance and training that staff receive to do that. So, it was a good bit of learning for lots of people* [Interview 9].

This section details the information provided by participants on the practice issues they encountered whilst working with disabled children where there were child protection concerns. Whilst all practitioners emphasised the level of interagency working that takes place to protect children, there were themes that related to how each practitioner viewed their individual roles and how they might undertake child protection investigations and interventions.

There were four main elements within this theme. Firstly, building upon the issues raised in the previous section, there was a lack of confidence among many participants when working with disabled children. This included the fear of working with disabled children that participants perceived existed among other practitioners (but not themselves). In discussing why this was the case, participants focused on the lack of training available, heavy staff workloads, and not unreasonable perceptions of work with disabled children requiring specialist knowledge and higher time resource. Interagency working was seen as desirable in order to draw on the expertise of others and maximise available staff time. There was debate around whether there should be separate disability teams or whether these should be integrated into general children's teams. Children's disability teams suggested other staff are not adequately trained in disability and then offload work to them; but children protection teams felt that sometimes disability teams were not as adequately trained in child protection. Finally, thresholds of significant risk are discussed, including the differing opinions among participants over whether thresholds were the same, lower, or higher for disabled children.

6.1 Confidence and Fear Culture

6.1.1 Participants expressed a general lack of confidence in identifying significant risk for disabled children often citing the complex care environments, the specific impairment and a lack of experience as reasons for why this created uneasiness. The presence of communication impairments was again a source of anxiety. Not only was there concern expressed about missing vital information or in making an incorrect judgement, there was additional concern that any failure on these fronts by participants would contribute to or even heighten the risk faced by the child.

There was anxiety around that for me of what if I miss something, what if I get this wrong and what if I leave this child more vulnerable because I haven't picked upon something this child's trying to communicate to me [Interview 19].

6.1.2 Communication impairments were perceived repeatedly throughout interviews as one of the main barriers to working with disabled children and as an area in which participants lacked confidence. Members from disability teams cited communication impairments as a reason why other practitioners failed to engage with disabled children.

There's a fear within child protection circles of children with disabilities and how to communicate [Focus Group 5].

6.1.3 Participants mentioned how practitioners avoided cases involving disabled children and/or passed such cases on to specialist services or disability teams. Fear was further associated with a lack of understanding of impairments in general, arising from a lack of confidence in being able to recognise significant risk and or being able to see how the child's impairments could influence their situation. In this regard the fear associated with child protection and disability can be understood as a lack of confidence in being able to achieve a child centred approach through failings in recognition and being able to communicate adequately with the child.

There is a fear culture, there is a fear of the unknown going on with children with disabilities… I think if they don't know about the condition and they don't know about the implications of the condition then their confidence is undermined so they're going out with 'they've said x, y and z and this has happened here'. They're not appropriately handling the information that they require to be effective [Interview 8].

6.1.4 Where positive references were made in regards to confidence it was generally associated not with the individual practitioner's practice but with interagency working and being able to rely on the collective pool of skills and resources as well as the wider systems.

I think that I can say that there is an increased confidence specifically in the named person, so health and education workers are feeling more confident and understand the named person role I would say. That's becoming more obvious. They are arranging and organising the team around the child meetings, which are interagency meetings that are happening before child protection issues arise. [Interview 9].

6.2 Training, Experience and Workload

6.2.1 A lack of training for working with disabled children was reported throughout the interviews, including from a member of a children and disabilities team. Where training was provided it often took the form of short courses and/or was part of a larger course on child protection in general. There was a tension between the emphasis on child centeredness and participants having confidence that they had the necessary training to achieve this in practice for disabled children. It was felt therefore that training about impairments would help increase confidence.

> *You can never have enough training… there's immediately an anxiety for people of 'I don't know anything about that disability' and I consistently say 'look you're looking at that child first and then we need to look at what else is around', so there is an anxiety [where] post training should improve that and be available* [Interview 19].

6.2.2 The lack of available training was also discussed as preventing practitioners from being able to proceed with child protection investigations:

> *[Some training we did receive] was about an hour and a half and it was very, very general. [Training in communication would be useful] because we need to try and find out what's happened. We've got to investigate it. [Training] might lead to better joint interviews, better prepared joint interviews, the right people being in the right place for a joint interview* [Interview 15].

6.2.3 Given the lack of appropriate training, many practitioners spoke of 'learning on the job' and placed high value on experience for working with disabled children. This included situations where there were troubling aspects of a case, including cases that did not have as positive an outcome as practitioners had hoped: these were viewed as learning opportunities in order to improve practice in the future.

> *I'm not sure that there is actually [any training]. I think people just tend to gain things through experience of working over time, rather than actually having a set in place programme* [Interview 21].

6.2.4 In terms of communicating with children with communication impairments, except for the few practitioners who had received specific training, there was a reliance on other services to help with interviews and investigations. This was not perceived as a negative given the potential expertise required in, for

example, sign language and the need to ensure there was at least someone who could communicate with and understand the children and young people. Members of disability teams also expressed the view that it could not be expected of them to know all the different communication aids. A few participants felt they had learnt from the child how best to communicate with them and stressed the individual ways certain children would communicate with others. Communication was associated with a high level of anxiety and featured prominently in interviews due to a combination of underlying reasons including a lack of training in this area, a felt need for interagency working, and perceptions that this was an area where experience was not always seen as enough.

> *I work with disabled children all the time, but because I always have either the carer or the teacher or somebody, there's a specialist nurse there to help me to facilitate the medical really. I think I've gained more experience over the years with my own job so that I am experienced in working with disabled children, but I don't know about actual communication* [Interview 13].

6.2.5 Importantly a few participants expressed that adaption of communication with disabled children was an area requiring further development. While in a personal capacity they spoke of the training needs for themselves or their team, participants perceived communication as an area necessarily requiring interagency work. However, a few participants also felt that this was not effectively organised. This ranged from the availability of communication specialists and their training in child protection to effective interagency working between services.

> *I think there is [work being done on adapting communication with disabled children] but it takes time, it takes effort and it takes a multi-agency, a multi-disciplinary team to be aware of communication aids and how effective they are and how they're used and we're a long way off from multi-agency working in that level* [Interview 8].

6.2.6 Some participants also felt that there was a lack of formal guidance for working with disabled children.

> *I think quite often what we end up doing [when it comes to children on the autistic spectrum] is quite often there's not an equivalent tool to use with those children, so I know myself over doing years of different parenting programmes, you're constantly having to try and adapt what you're delivering to meet the needs of a specific child, which is what we*

should be doing, but I think there's not enough thinking round about having these things adapted [Interview 5].

6.2.7 An additional concern amongst practitioners was that there was 'not enough hours in the day' (Focus Group 4) in order to adequately assess and provide effective interventions for protecting disabled children. This was associated with the high workloads and pressures faced by practitioners within the child protection system in general. The time seen as necessary to establish working relationships with disabled children who had particular impairments only increased the pressure, particularly amongst social workers. It was not regarded as feasible to spend enough time with some children in order to establish a positive relationship. In turn, this increased the reliance placed on interagency working as a means to shore up protection efforts. Operating in this way though also had implications for how the participants perceived their relationship with the child.

> *It's unrealistic to think that social workers have a key relationship with children that have got profound disabilities… with children that have got really difficult verbal communication, you have to build up a relationship that's almost daily. I mean, it's not that I don't think social workers can make the effort to do it, to find out who the best person to communicate with on this but it very rarely is the social worker, it's just not realistic* [Interview 2].

6.2.8 Throughout the practice examples, issues arose around the behaviour of disabled children where the underlying concerns around the initial concerning behaviour were not fully addressed. Previous research highlights that challenging behaviours may be children's way of disclosing abuse or trying to be 'heard'. This was again highlighted as an area for additional training. One example is in case study D.

Case Study D:

Child/young person at risk: Child, 10 years of age with learning difficulties and communication impairment

Critical incident: Child in short breaks unit found to have bruises on their body

Critical interactions:

1. **Child stayed overnight in a short breaks unit.**

2. **Staff providing personal care found bruises on the child's body. This set off alarm bells because the child was known to the unit and there had been no previous evidence of bruising.**
3. **The bruises were recorded on a body map which was passed on to social work. Child Protection Policy was followed and information was passed on in a timely manner.**
4. **The research informant reported that discussion with the parents revealed that the child was going through a difficult period and had started 'nipping' or pinching himself.**
5. **Staff at school and in the short breaks centre, and parents, were encouraged to share information about the child, including any further incidents of bruising, so that all parties working with the child were aware of the current situation.**

Discussion of Case Study D

Short breaks staff acted promptly to investigate whether the child was being subjected to physical abuse at home or in school. This case study highlights the importance of communication and information sharing between parents and the services children use.

Key Messages for Practice from the Case Study

The reason for the child pinching himself was not investigated further, despite the fact that this can be a form of self-harming behaviour displayed by children experiencing abuse. The underlying cause of this child's nipping behaviour should have been thoroughly investigated to ensure whatever was distressing him was identified and removed. In addition, practitioners took the parents' account at face value. There appears to have been no attempt to seek the child's account, using non-verbal methods of communication.

6.2.9 The tensions arising within different stages of child protection proceedings where concerns were felt to be quickly identified and passed on, yet with less chance of being adequately followed through, meant that when participants discussed what they considered to be good practice the examples drawn upon could be from cases where there were also many elements of poor practice. Identification and passing on of concerns, adaptation of communication, and subsequent responsiveness were common areas highlighted as good practice. At the same time, however, there were reports of criminal proceedings not going ahead, difficulties in establishing what took place, and a lack of suitable services for disabled children and young people that prevented effective interventions after the identification and investigation

stages. Good practice therefore was often seen in terms of having managed to take what was felt to be the best possible course of action under complex circumstances, even if it meant deviating from standard child protection practice for non-disabled children and young people.

> *I suppose it's good practice he's come into care but there's elements of bad practice because we don't have, well we've got a carer that's trying to learn to sign so I suppose that's good, but we don't have hearing impaired or signing carers just sitting there […] So we're doing as well as we can, I mean, I think there's bits of good practice here obviously* [Interview 3]

6.3 Children's Disability Teams

6.3.1 The aspect of policy which practitioners commented on most frequently was Getting It Right for Every Child (GIRFEC). Participants spoke highly of GIRFEC's effectiveness in improving interagency working and facilitating greater levels of shared responsibility, even if they had doubted how effective it would be when first introduced. While GIRFEC was reported to have been successful in these areas, it became clear through the interviews that the phrase, 'getting it right for every child', may be being misinterpreted as 'treating every child the same' despite the difficulties that can arise in trying to individualise this to specific children such as those with impairments. In order to individualise responses for disabled children, it is beneficial to have practitioners with the relevant expertise were involved with the case.

6.3.2 The stated purpose of having specific children's disability teams differed between participants. While a few participants felt that cases involving disabled children were 'offloaded' onto disability teams, no participants reported doing this themselves. A primary viewpoint, however, was that a children's disability team with specialist knowledge and skills regarding children with particular impairments and which other services could draw upon when needed, was beneficial. A few additionally felt such a service could spread relevant knowledge among other professionals.

> *Well within children and families we have a specialist disabilities team and I'm sure if any practitioner from any of the other practices has concerns they will consult with them, so they themselves build up a specialist knowledge and expertise [Focus Group 1].*

6.3.3 As previously mentioned, a main area where disability teams were called upon for support was communication. It was generally felt, even among

members from children's disability teams, that it would be impossible for every practitioner to know every possible alternative form of communication. However, there was a tendency for some participants to refer to cases that they found difficult because the child was 'non-verbal'. This was a perception which one participant from a children's disability team strongly questioned.

> *I've read some reports, even I might have put it in reports that I did before I was involved in the children's disability team, that you know, statements like 'we can't communicate with this child because he or she doesn't speak'. You know so there's you know it's, I think there may be less rigour in communicating with these young people so therefore there must be things we miss and I would estimate that we must be missing some, some neglect or abuse* [Interview 7].

6.3.4 Another reason participants viewed it beneficial to have children's disability teams was that professionals would only rarely require knowledge of ways to adapt communication.

> *To be honest with you, officers would be called upon so infrequently to carry out such interviews that certainly the police really should be looking into professionals who are working with these sort of children on a daily basis, i.e. the disability team. I keep coming back to them. We're the jack-of-all-trades in the police and we do many many things, but I'm a believer in we should be asking the person who can do those things better* [Interview 12].

6.3.5 This perception differed among participants, however. While the majority felt that it was important to have other services available that could be called upon, many also thought that there was a need for improved training on disability and communication. Many of those who had received prior training reported that it lasted half a day to a few days and did not view it as providing them with enough information or skills.

> *We haven't had any particular training in relation to children with disabilities […] I think certainly to us and the family protection unit [training would be beneficial in terms of more] awareness raising, how to deal with children who've got specific disabilities. Some examples of what you can do to aid communication perhaps* [Interview 15].

6.3.6 A few participants raised the issue that while child protection teams might not have sufficient training and experience with disabled children, children's disability teams did not deal with many child protection cases and might not

be as suitable for handling such cases. Yet one participant raising this point also made an appeal to interagency working due to the lack of knowledge about disability amongst other services.

> *The number of cases that a children and disabilities social work team might have on a child protection register I think is minimal but I'd like to be confident that other agencies would do something about that* [Interview 9].

6.3.7 Another participant illustrated the difficulties children's disability teams might face when dealing with a potential child protection case.

> *I think in this particular example that we spoke about, I think that it should have been sitting with a different social work team. I think the disability team had not been..., you know, they're not trained to the same extent as far as children and families are in relation to child protection and I think that they were being visited and the place was an absolute tip, the house was a tip, the kids didn't have beds to sleep in, they had mattresses on the floor, there was hardly a light bulb in the flat, you could hardly see where you were going, the work surfaces in the kitchen were absolutely filthy and disgusting and just piling over. […] I think they were out of their depth with this one, but I think they should have been in there and okay the children were under supervision, but perhaps they should have been on the child protection register* [Interview 15].

6.3.8 Despite the differences in perception about training needs and areas of specialism, the discourse of placing the child first and treating every child the same still operated across services.

> *We're the children with disabilities team but we're in children's services so our view is very much that children with disabilities and their families should be treated in exactly the same way as everybody else* [Interview 4].

6.3.9 There were reports from a few areas that children's disability teams had been disbanded, with members returning to general area teams, or that this development was a possibility on the horizon within their local authority. For two participants who discussed this as a potential change, they saw it as negative and diluting the skill base they had. Another participant, in a local authority where the children's disability team had been disbanded, reported

other staff regularly approaching them with queries and a lack of knowledge about disabled children within the local area teams.

> *A complete lack of awareness [of disability is a challenge for the child protection system]. Overall, there is no protocol, there is no, they've disseminated the disability team so it's now come down to local area teams.[…] I certainly have queues and queues and queues of people at times saying I need to ask you about this, can I ask you about this, can I ask you about this […] I think they should have a formal duty system of identified workers who are suitably qualified in some way in disability […] any concerns it should be up to the team leader to default back to them to include them in the initial stages of investigation to provide advice and guidance as to how to pursue something* [Interview 8].

6.3.10 In contrast a participant from another local authority where a 'hub' had been set up after the dispersal of the children's disability team perceived this as being a positive development.

> *The children's disability team used to be a team that covered the [local authority] and they've been dispersed back into area teams to integrate and best meet need locally rather than being a separate entity […] We meet to say, 'Has anybody heard of this, what about training, what about this, what about that?' There's a lot of dialogue, but also a lot of physical face to face feedback and things, so there is that commitment particularly in relation to communication strategies* [Interview 11]

6.4 Thresholds

6.4.1 When it came to discussing thresholds for deciding if a disabled child or young person was at risk of significant harm, there were differences amongst interviewees as to whether thresholds were higher, lower, or the same for disabled children and young people as for others. Being 'child centred' meant that thresholds should be the same for all children regardless of any impairment. Although there might be greater complexity, but the underlying core principles and processes would apply across all cases.

> *I think it is about having the same sort of view that this is acceptable, whether a child has got an additional support need or not, what is acceptable, what is not, I don't think is different. I think you know children need to be cared for and protected and we need to look at the same sort of thresholds and have the same view of the world, it is not*

any more acceptable for a child with disabilities, you know to be shouted at than it is for a child who hasn't got, it is not different really but certainly how parents manage children, how children with complex needs are managed and as you say there's lot of different people interacting. It makes the process more complicated I am sure [… however] the core process would be the same [Focus Group 3].

6.4.2 Some practitioners, after stating that thresholds should be the same regardless of any impairment, then expressed concern that practitioners' 'sympathy' for parents and the blurring of what was acceptable may result in higher thresholds being applied. In the majority of cases where this was mentioned, practitioners were speaking of other practitioners and not themselves, although a few also worried that they might unintentionally have used higher thresholds through empathising with parents.

6.4.3 There were varying thresholds applied in practice and different perceptions of vulnerability existed based on type of impairments. Disabled children with communication impairments were perceived as more vulnerable and other disabled children were seen as more 'protected'. This arose from the perceived heightened vulnerability of those with communication impairments, even when the form of neglect or abuse was the same.

Well many of these children are (a) more vulnerable to abuse, and (b) can't speak for themselves. So, you know, for this wee boy, for example, his communication is impaired and he's not a normal 10 year old boy who's able to fight back, or say as easily as some other children. So I think that's why we need to have that threshold a bit lower [Interview 20].

6.4.4 Participants described a sense of venturing into the unknown at times, of going to 'places that we would not routinely go to in order to make sure it is child centred as possible' (Focus Group 3). While there may be lower thresholds, this did not always result in effective intervention. In particular, where children had communication impairments this was cited as a reason why creative means of working had to be devised but also a reason for why cases would not always have as positive an outcome as practitioners hoped for.

When it comes to investigation, I think it's usually maybe not followed through because of […] not [being] 100% sure of trying to get the feedback from young people and not complete clarity of what's went on, so I don't think it necessarily, you know, is followed through as

much, but I think that we probably raise more concerns because just what we know about the exposure of children with disabilities and how they can possibly be more at risk, so I think we tend to pass on more but it doesn't necessarily, after you've passed it on, get followed through just cause of the confusion of what's actually went on [Interview 6].

6.5 Summary of Theme

6.5.1 Participants' lack of confidence in working on child protection cases with disabled children appeared to be linked to a perceived lack of training. Not knowing the implications of a particular impairment, how to communicate with a disabled child, and the difficulties in individualising child protection for disabled children were also sources of anxiety. Participants also thought that it was impossible to be trained for every possible impairment a practitioner might encounter. Confidence instead lay in interagency work and the involved of specialist services. This was reinforced for some by their own work-loads where they felt it would not be feasible to dedicate the additional time they thought necessary to work with a disabled child.

6.5.2 Although participants thought it important when working with disabled children to ensure all the relevant services were involved, there was a division between the children's disability teams and child protection teams. Participants from children's disability teams spoke of cases being offloaded onto them by practitioners who were too anxious to handle them themselves. There was also a sense that they may not have the necessary disability training. Child protection teams conversely thought that children's disability teams may not be best placed for handling child protection concerns. From the participants who took part in the interviews there appeared to be a move towards dispersing members of children's disability teams in local area teams instead. This was met with mixed views with a fear that specialist knowledge was being diluted. A participant who was positive of the move was in a local authority where a hub had been set up to ensure the sharing of information and knowledge in relation to disability.

6.5.3 While participants stressed disabled children should be treated the same as non-disabled children, there were reported differences, or suspected differences, in the way thresholds of significant harm were being applied. A number of participants were concerned that empathy with parents meant that practitioners might not intervene in situations where they would when non-disabled children are involved. Other participants, however, spoke of having

lower thresholds for disabled children with communication impairments in recognition of their higher vulnerability.

7. THEME THREE: INTERAGENCY WORKING

> *You know, if they were thinking that one agency wasn't recognising concerns, I would hope that a child with a disability, you know, usually they have a multi-agency team around them and I think I would like to say I was confident that one or the other agencies might recognise that* [Interview 9].

This section presents the discussion with participants on interagency working. All participants reported high levels of interagency working and saw this as inherently positive, especially, for a few, when compared to times when less interagency working took place. Not all discussion of interagency working was positive, however: some failings and tensions were also reported. Overall though, interagency working was an area in which participants had confidence.

Communication and co-operation was one area in particular that was seen as having improved in recent years, with services more likely to talk to each other about concerns and to work together effectively. This was tied to the improvements the majority felt existed in relation to information sharing and also in the co-ordination of services that ensured both adequate investigation of concerns and the best use of time and resources.

Finally, although an area repeatedly highlighted positively about interagency working was facilitating communication with disabled children, no criminal prosecutions arose within any of the cases discussed by participants. Disabled children were seen as unreliable witnesses, as unable to disclose abuse, and/or unable to give accurate accounts of what had taken place.

7.1 Benefits of Interagency Working

7.1.1 There was a general positive consensus regarding the effectiveness of interagency working. Additionally, it was an area of practice highlighted as having undergone improvement within recent years.

> *I think multi-agency working, that's the biggest change I've seen in the last five years. We're speaking to partners, because we're doing that and because we're doing things generally, we understand what their strengths and weaknesses are and I think as long as we keep forging these good relationships… we can more easily highlight what needs to be done* [Interview 13].

Case Study E:

Child/young person at risk: Two children aged 6 and 8, one disabled; single mother has learning disabilities.

Critical incident: Mother unable to care adequately for her children, who are on the child protection register. Social Work has made a referral to the Reporter, recommending both children be accommodated. If this proceeds, they are unlikely to return home.

Critical interactions:

1. **Mum "really wants to do the right thing" but her parenting capacity is severely restricted by her learning disability.**
2. **Despite the referral being made to the Reporter, the social worker believed the children's interest would be better served in the long run if they could remain at home, provided sufficient support was available. However, a typical input of 3-6 months was not going to work in this case.**
3. **After "working hard" to bring other partners on board, social work committed to provide an intensive care package in the home to support mother and children until the latter reached adulthood – a 10 year commitment.**
4. **This package has now been in place for two years and outcomes are good. The children are no longer on the register or under supervision. They attend school regularly and are achieving well. There has also been a very positive response from senior management in social work.**

<u>Comment on Case Study E</u>

This case shows an unusual and imaginative use of resources in order to keep a family together. Offering support for a limited period would not have been effective but a longer term commitment has enabled the family to stay together and flourish.

<u>Key Messages for Practice from the Case Study</u>

This example illustrates the value and effectiveness of preventative work and long-term support. It also shows that, as the authority in this case argued, it is sometimes worth spending now to save later; ie: it is less expensive to provide intensive support to this family at home than to accommodate the children. This model could be applied more widely to support parents who need long term support to keep their children at

home. Finally, it should be noted that many parents with learning disabilities bring up their children with much less support than was available here: it should not be assumed that all people with learning disabilities are unable to look after their children.

7.1.2 Involving other services with particular cases and having knowledge of the work they did was seen as offering avenues for gathering information and improving decision making. Reference was often made to the 'team around the child' and being able to draw upon the various skillsets of the different services.

> *It is making best use of the people around the child, whether that be someone in health or someone in education or whatever it may be*

Case Study F:

Child/young person at risk: Two siblings under the age of five, both wheelchair users, with a serious medical condition.

Critical incident: During the process of working with the family through support services around the children's impairments, information came to light about previous allegations of father's alleged sexual abuse towards friends of his older children.

Critical interactions:

1. **Referral submitted by child development centre in local authority area to provide support to the family, given that two siblings have a genetic condition with significant health needs.**
2. **Social work carried out a needs assessment (under section 22 of the Children (Scotland) Act 1995) to determine what support the family required.**
3. **The father was described as very uncooperative. Whilst at the child development centre, one of the children choked on the food she was eating and subsequently the father did not allow her to attend again.**
4. **Social services were aware of previous sexual assault allegations against the father concerning friends of his older (adult) children. These were investigated by the police but insufficient evidence was found to charge him.**
5. **After an initial referral discussion, an investigation was undertaken and a police officer spoke to all the people who had alleged sexual assault at the time of this case and more witnesses came forward, including the father's two adult daughters. However, there still was not enough evidence to press charges.**

6. **The father was asked to leave the family home to ensure the children were safe. He refused to do so and the mother was adamant that he was not guilty of harming the children. Child protection orders were required to accommodate all four children as no other options remained.**
7. **The two younger children were placed on the child protection register due to their parents' non-compliance of medical instructions.**
8. **Social services were required to find appropriate accommodation for two severely disabled children.**
9. **The children started to go on short breaks. One child is now in permanent foster care and the other is waiting for kinship care with the grandmother and two older siblings.**

<u>Comment on Case Study F</u>

Good assessment skills and regular cross-sectoral network meetings between social work, education, police and the health sector meant the children were identified as being at risk of significant harm and removed from the family home. Continuous information sharing about the situation between the different parties ensured that all four children, including the younger disabled ones, were safeguarded and removed from direct risk of significant harm. Home care staff supporting the family were essential in relaying vital information about the domestic circumstances which social work would have struggled to witness if working alone. The non-compliance with the necessary overnight ventilation for one of the children could have potentially been fatal.

<u>Key Messages for Practice from the Case Study</u>

This case study highlights the importance of working with disabled children and young people in a holistic way, as children and as part of a family. The case offers an example of good practice in interagency collaboration across the various sectors involved.

7.1.3 Adaptation of communication with disabled children was commonly mentioned by participants as benefiting from interagency working. As mentioned in the previous sections, participants expressed a lack of confidence and training when communicating with a child with any communication impairments. Having other services available that could help facilitate interviews or provide practitioners with information on a child's specific impairments was seen as improving the ability to seek the child's view and make decisions in their interest.

Health and education are involved in that initial referral discussion, … what team from health, if any, are working with a child and that they might be a good person to speak to the policeman or social worker or both that are going to maybe speaking to the child to understand any disability that they might have. So, and again the school can come with a great wealth of information about what this child, his ability, how well they speak, how do they communicate in school [Interview 9].

7.2 Information sharing and Co-Ordination

7.2.1 Across interviews frequent reference was made by participants to Initial Referral Discussions (IRDs). IRDs were used for the sharing of information, discussing concerns about allegations of abuse and neglect and for making decisions about intervention. IRDs were additionally important for establishing agreement between services regarding whether or not there was a risk of significant harm to a child.

Sitting round the table and saying 'this is what we're worried about' and hearing what other people's experience of that child is. There's no easy answer, you know, other than if it's physical abuse or sexual abuse where there's clear physical demonstration… like there's a bruise or a cut or something like that, but beyond that it comes down to professional judgement, and sharing of information is absolutely critical [Interview 4].

7.2.2. The sharing of information between services was noted across interviews as being a reason why increased interagency working was beneficial. Participants from social work and police were able to gain details of a disabled child's health records and regularly through a child's school learn more about any adaptation to make for communication. Additionally, participants from education, health and the third sector noted they would regularly pass on any concerns to social work and any other services involved.

Our communication would be with the social work department, would be with the lead professional, in the first instance. You know, we would be raising our concerns and sharing them both with the parents and the wider multidisciplinary team that are involved […] with the family [Interview 1].

7.2.3 Participants also spoke of the necessity of sharing information: while failing to do so was often attributed to other services, it was never reported by a participant as a failing of their own.

One of my colleagues was on a phone call […] and she was talking to this other professional who had done a visit to the home and I'm not sure if it's a social worker or who it was but the person said now what I'm telling you now is private, it's to go no further and my colleague rightly said I'm very sorry but when you tell me something I can't keep it to myself, it's got to be discussed and… it's clear that some agencies think, you know, we can have this between you and me discussion and we can't [Interview 7].

7.2.4 Information sharing was crucial in avoiding multiple services repeating interviews with disabled children and for helping to co-ordinate services. This helped with making the best use of staff time and to prevent causing any unnecessary stress to children where sensitive issues were discussed with them.

The social worker with this child would spend individual time with the child building up a relationship with them and exploring his views of family life. So he was able to bring information back to the core group about some of the discussions that he had with the boy… that seemed to work very well. … So I think that was good practice that you didn't have several different adults trying to talk about sensitive information with this child [Interview 1].

7.2.5 Despite the sharing of information, a few participants had concerns that a lack of clarity or context could reduce the usefulness of shared information. In contrast to the comments that each service had a good understanding of what each other does, there was also concern from participants that information shared was not always appropriate.

Social workers don't know what they're asking for in health, health reports what they think social workers need to know, education also is the same and they'll just say they're fine here or they're not fine here, the environment is different in education… the environment's time limited, there's more staff, it's more regimented and education often very pass remark about what goes on at home but they're not good at articulating what the concern is [Interview 17].

7.2.6 The focus on what is best for the child also was mentioned as explaining the ability to keep working together even where relationships were not as strong.

It can leave a bit of a bitter taste in the mouth… if the relationships between the different agencies are not good. I think they need to be above that somehow though you know. I think if you've had a poor relationship with another agency you can't carry any grudges you know, you've got to keep working with them for the good of the child [Interview 7].

7.2.7 The majority of participants stressed the high-level of co-operation that took place when working with disabled children and their families, highlighting specifically working alongside communication specialists. This was also an area where many felt they lacked the necessary training or time to build relationships.

There is a local school where they […] have electronic boards, pads and boards and things where they use that to communicate with a child, so if we had any concerns about not being able to communicate we would seek support from the local school that does support children with a variety of communication needs. So it's not our skill but we do know where to go if it's required [Interview 18].

7.2.8 Participants spoke at length about the value of interagency working and how this was crucial within the child protection system. However, joined up working is good practice in child protection generally and not all participants emphasised how this might be even more important where a child had an impairment; or where failings in it might be especially difficult for disabled children.

Case Study G:

Child/young person at risk: Child, aged 11, on the autistic spectrum with learning difficulties, ADHD and dyslexia

Critical incident: Older sibling looked after and accommodated because of parenting capacity of mother.

Critical interactions:

1. **The child has an older sibling, housed on a voluntary basis (under section 22 of the Children (Scotland) Act 1995) as there were concerns around neglect and mother's parenting capacity.**
2. **The father came back into the picture and both children went to live with the father.**

3. **There were concerns around the disabled child's behaviour, particularly around impulse control and behaviour in the community and queries around an eating disorder and potential neglect**
4. **A case discussion took place about parental capacity to care for the disabled child. Practitioners found it hard to separate which aspects of the child's behaviour were due to impairments and which were due to neglect. There was accumulative neglect from when the child was living with the mother.**
5. **Identifying the additional parenting needs for this child was essential to assess whether the father had the capacity to provide the child with the appropriate level of care.**
6. **Father was very protective of his child and did not disclose his child's impairments easily because he did not want the child to be stigmatised. Members of the community and a housing officer were thus unaware of the child's impairments, the former complaining about his behaviours and about a 'noisy' bus that collected the child early in the morning.**
7. **A housing officer working with the family, due to complaints from neighbours, threatened to evict the family.**
8. **At this point, father gave his consent to a voluntary sector agency to disclose his child's impairments confidentially to relevant organisations.**
9. **A working group was set up by the voluntary sector agency, involving housing, social work and education, to develop a shared understanding of the child's difficulties and establish which factors related to the child's impairments and which to neglect. For example, it was determined that the child's failure to eat properly was a result of his medication regime, rather than neglect.**
10. **The child, older sibling and father all attended a working group meeting. The child was asked to tug on his brother's arms if he wanted to leave the room. He heard all that was being said and was included in the discussions taking place. The child attended for 45 minutes and stated that he did not want to have to move house.**
11. **The family remained in the house and the threats of eviction were lifted. Father accepted that the child should go to a special, rather than a mainstream, school. The child is no longer on the child protection register.**

<u>Comment on Case Study G</u>

Initially, there was a lack of communication between various sectors, coupled with a lack of awareness about the child's impairments on the part of housing officers who were threatening to evict the family. The

voluntary sector agency played a positive role in taking responsibility for setting-up a multi-sectorial working group to establish a shared understanding of the child's condition and help put a plan in place for child and father. The boy was actively involved in discussions to resolve the matter and his views taken into account. The family had a history of non-engagement with the authorities, which may have clouded practitioners' perceptions of the case.

Key Messages for Practice from the Case Study

This example of promising practice highlights the importance of understanding and respecting the family perspective (both parents' and child's) when dealing with sensitive issues. In addition, it illustrates the importance of interagency collaboration and information-sharing when necessary and how these can be used to better inform assessments and map out a way forward that ensure child is safe from significant harm.

7.2.9 Child protection case conferences were described as being extremely unwelcoming not just towards children in general, but especially disabled children. Several participants mentioned that case conferences were too distressing and complicated to involve children.

> *[What considerations do you think need to be taken into account if a disabled child is invited to a case conference?] I think you need to look at their level of understanding. I think you need to look at whether it's appropriate for the young person to be there or not and whether they understand anything that's going on, and albeit some young people might be twelve or thirteen, they may have the ability of a three year old and I think that needs to be taken into consideration. You wouldn't take a three year old and ask them loads of questions, because they just wouldn't be able to answer them* [Interview 10].

7.2.10 Although several participants reported disabled children did not attend case conferences, they saw these meetings as important for assessing children's needs.

> *My understanding of [case conferences] is that there's a lot of rich information about the child's needs and that's across a range of different issues for the child, whether it be arising from disability or. what does this child need to be safe or healthily nurtured* [Interview 20].

7.2.11 Most participants admitted that although case conferences are essential for child protection concerns, when it came to disabled children and young people the conferences were inadequate. Participants also reported that they had never seen a child present at a child protection case conference.

> *It's not good at all. Certainly of any of the ones I've been to in the six years I've been here, [children] certainly haven't attended a case conference. I've certainly been to case conferences. but not one where a child with disability has been represented* [Interview 4].

7.2.12 In such cases, social work or another service representative were seen as having enough knowledge of the child to present their views to the conference.

7.3 The Criminal Justice System

7.3.1 Discussion of children's communication impairments by participants often related to issues experienced with criminal proceedings. Participants often perceived it as impossible to interview a child with communication impairments; considered that the information from interviews did not provide enough evidence; or believed that the child would be an unreliable witness. Even those who took a critical view of this were doubtful of a case being followed up:

> *When it comes to investigation, I think that it's usually maybe not followed through… [there's not 100% clarity behind] trying to get the feedback from young people and [also] of what went on, so I don't think it necessarily… is followed through as much, but I think that we probably raise more concerns because… what we know about the exposure of children with disabilities and how they can possibly be more at risk…I think we tend to pass on more but… after you've passed it on, [it doesn't necessarily] get followed through… cause of the confusion of what's actually went on* [Interview 6].

7.3.2 There were various stages where a case could be stopped from proceeding. A few participants spoke of interviews not taking place with disabled children who were 'non-verbal', or believed that interviews would not be productive to the investigation.

> *Because of the young persons' needs… the police were basically saying, 'well we couldn't really interview them'. I think that's really been the most frustrating thing, that [the child] couldn't be used as evidence because of their disability* [Interview 6].

7.3.3 When interviews did take place, despite participants' perceptions of the value of the child's testimony, cases still did not progress to court.

> *There was a joint meeting held between police and social work… it was decided that they would do [the interview] just using verbal communication. We got some help from school to their advice but they weren't at the joint interview and the joint interview was done and it was quite sad in a way you know, this wee boy had said very clearly his foster carers son-in-law had punched him and hit him and was very specific about where on his body he got hit yet the police spoke to the foster carer and the son in law and would take no further action and it felt as though it was mainly due to the boy having complex needs* [Interview 7].

7.3.4 Whilst both the son-in-law and the foster carer were banned from speaking to the child, there was no further action clarified. This raised a concern as to whether other children may have been left at risk if then subsequently placed with this foster carer.

7.3.5 The regularly citied reason for legal proceedings being halted or not initiated was that even where adaptations were made to interviews and time spent with sequencing of events, disabled children were still not considered reliable witnesses.

> *Disabled children don't make good witnesses…they are not classed as reliable witnesses. I've got a 15 year old girl, you know who has no disability whatsoever, perfectly lucid, perfectly average IQ etc and she sits there and she tells the police that she's been raped. There's far more chance of there being a conviction in that case than of a 15 year old girl in a wheelchair who needs a speech and language therapist to help her to communicate to court, there's far more chance of the conviction going the other way, because it is a perception that, well they won't make a reliable witness. And that is scary because you know these children are at a huge amount of risk* [Focus Group 5].

7.3.6 The combined result of these various stages where investigations could stop meant that criminal investigations for all the specific cases mentioned in the interviews were collapsed at various stages and no prosecutions arose.

> *The police … come from a standpoint of, you know, can somebody give a statement and is their information credible? So if you're working with children where their language is limited or there's difficulties with their sequencing of events, they're unlikely to get the same outcomes*

in terms of someone being prosecuted than non-disabled children… but in terms of the police and their role [in this case], it was clear at all the IRDs that, from the point of view of a criminal prosecution, their view was that there was nowhere to go with it because [the child] wouldn't be reliable as a witness [Interview 4].

7.3.7 In cases mentioned by participants where police had been involved but no prosecution took place, the continued involvement of other services was highlighted regularly as evidence that the child was, nevertheless, adequately protected. Within this were assumptions that the police needed to take a rigidly defined 'for' or 'against' position, as opposed to social work who could intervene in situations if the perceived level of risk to the child warranted it.

[No criminal proceedings took place, however the child was placed by social work in permanent care] because they don't have to prove beyond reasonable doubt, like what we have [to], but because the children are at risk of sexual and emotional harm. […] Social work is very much in the interests of the children and don't get me wrong, we're certainly in the interests of the children as well, but we want to lock up these bad people. At the end of the day that's perhaps not the best thing for the children, perhaps it's maybe just to make them safe [Interview 15].

7.3.8 Such a risk-based approach also attracted critical comments from other services. While participants defended the lack of prosecutions by the Procurator Fiscal due to their need for solid evidence whereas social workers working through civil procedures such as the Children's Hearing System could afford a more nuanced understanding of the situation, other participants expressed dissatisfaction with social work for failing to intervene sooner or more often.

I think sometimes, and I'm not being critical, 'cause one of the social workers is a very good social worker, but I do think that there's sometimes, the kind of priorities can be different, I think, […] I've spoken to colleagues within schools as well, sometimes our reaction to things tends to be maybe a wee bit more black and white, you know, and thinking, given the age of the child, that you know the child very well, you know where the dangers potentially lie for them. And sometimes I feel that there's more of a grey area with social work, and maybe given less of a priority, or they don't seem to have as strong a reaction to things as we do [Interview21].

7.4 Summary of Theme

7.4.1 High levels of interagency working were reported and this was seen as inherently positive. Communication and co-operation in particular were seen to have improved over recent years, with subsequent improvements in information-sharing and in the co-ordination of services. However, generally participants did not emphasise how this might be even more important where a child had an impairment; or where failings in it might be especially difficult for disabled children.

7.4.2 From the interviews it appeared criminal process was less likely to be followed in respect of abusive treatment of disabled children. Despite the successful adaptations of interviews for children with communication impairments participants reported they were still being viewed as unreliable witnesses or unable to provide the standard of evidence required by the criminal justice system. In this respect, there appeared to be a difference in the treatment of disabled children compared to non-disabled children and the effects of child protection procedure in practice. While social workers may have remained involved and children removed from harmful situations, there was less done to address the risk the adults who had avoided prosecution still posed to other children. Best practice guidance is available[43] and could usefully inform practice in this area.

8. DISCUSSION

This chapter brings together the main findings into an analysis and discusses the implications for practice. Specifically, in light of the findings this chapter discusses the place of the disabled child in the child protection system, thresholds for intervention, factors identified as important for decision-making, barriers and enablers at each stage of the child protection process, and examples of practice. The chapter concludes with a review of the National Child Protection Guidance for Scotland and recommendations for practice and policy.

8.1 Where is the Child in Child Protection

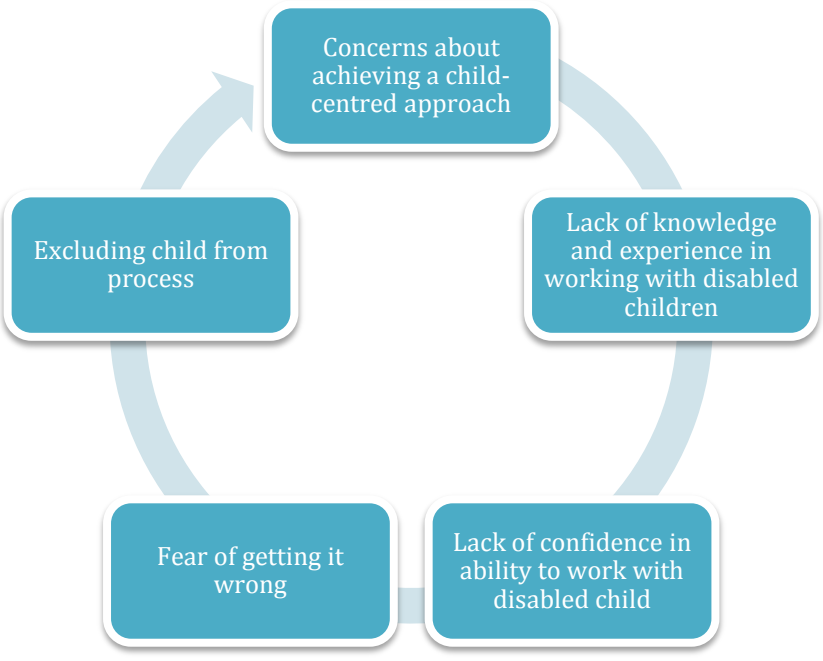
8.1.1 Throughout this research study, several tensions were highlighted in relation to establishing and maintaining a child-centred approach for disabled children at risk of significant harm. Overall, there was a strong commitment by practitioners to the principles of GIRFEC, yet significant barriers were identified in practice to ensuring disabled children were consulted, informed and had the opportunity to give their views about decisions affecting them.

[43] NSPCC (2011) Safeguarding Deaf and Disabled Children (Training DVD). NSPCC: London

8.1.2 Throughout the research, troubling language arose from some practitioners. When disabled children were compared to non-disabled children, barriers to effective working were often attributed to children's impairments rather than inadequate service responses. Decisions and actions were often portrayed as being 'done to' or 'done on' the child and non-disabled children were often called 'normal' or 'mainstream' children compared with their disabled peers. This description of disabled children as lacking agency often preceded discussions about the inability to gather children's views or involve them in discussions around child protection concerns, despite disclosures from children themselves being the top 'trigger' for an initial child protection concern in the cases mentioned.

8.1.3 When this impairment-centred focus was dismantled, it identified that many practitioners feel anxiety and low levels of confidence in working with disabled children, especially children with communication impairments. There was a desire to utilise a child-centred approach and anxiety about 'getting it wrong'. There are multiple sources to this anxiety, including failing to recognise significant harm, fear of missing vital information or in making the correct judgment and additional concerns that any failure by practitioners would contribute to or heighten the risk faced by the child. This was also cited as a reason for why many practitioners failed to involve disabled children in the process. In this regard, the initial fear of not being able to utilise a child-centred approach is realised.

Figure 1: Cycle of Anxiety on 'Getting it Right' for Disabled Children



8.1.4 While anxiety was at the centre of practitioners' reflections on practice, interagency working was identified as a potential enabler to overcoming lack of individual knowledge and confidence in working with disabled children.

8.1.5 The emphasis on child centredness is commendable, but potentially leads to an invisibility for disabled children. Efforts to treat every child the same may mean crucial contextual and vulnerability factors are missed. The most recent report from the Care Inspectorate on Child Protection Services offers no analysis and makes no comment at all on disabled children.[44] Responses from over 60 participants in this research suggest there is cause for concern.

8.2 Thresholds for Disabled Children: Higher, Lower or the Same?

8.2.1 A child protection threshold is the point at which action is taken - where something goes from being a concern to entering the child protection system. In order to understand child protection thresholds, we have to first understand initial 'triggers' of child protection concerns and the overall decision-making ecology.

8.2.2 Overall, this research highlighted a collective sense of the additional complexity that child protection concerns involving disabled children posed. Across the 21 interviews conducted for this study, 34 examples of practice were collected highlighting a range of cases in Scotland. These examples provide a cross-sectional 'snapshot' of practice. Overall, the initial trigger or child protection concern could be identified from 33 of the case examples. Initial child protection concerns were for risk of neglect, physical abuse, sexual abuse and harm from witnessing domestic abuse in the home.

8.2.3 Within these case examples, most initial concerns came to light in regards to risk for neglect or physical abuse. This echoes previous research that shows that often the more 'visible' indicators of potential child maltreatment such as bruising or unsafe home environments are more likely to lead to a child protection concern being raised.[45,46] Figure 2 highlights the range of triggers that were present in the case examples highlighted by practitioners. It is interesting to note that in 15 of the cases the initial concerns were raised by school staff and an additional seven concerns were raised by health

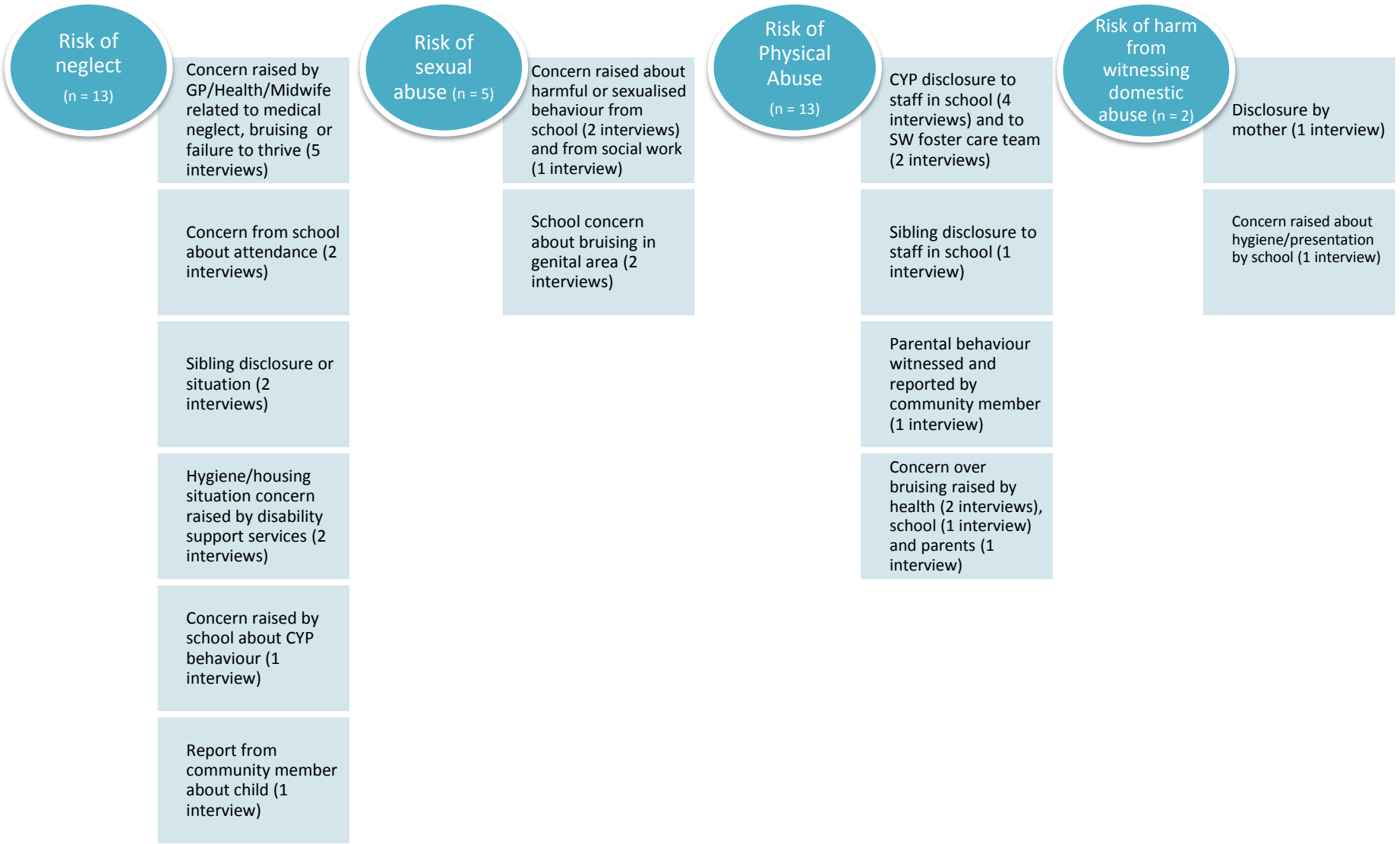
[44] Care Inspectorate (2013) *Child Protection Services. Findings of Joint Inspections 2009-2012*. Care Inspectorate, Dundee.
[45] Munro, E.; Taylor, J.; Bradbury-Jones, C. Understanding the causal pathways to child maltreatment *Child Abuse Review* DOI: 10.1002/car.2266
[46] Ofsted (2012) *Protecting Disabled Children: Thematic Inspection*. Ofsted, London.

professionals. Community members and parents also expressed initial child protection concerns for four of the cases (two each respectively).

8.2.4 For nine cases, the initial trigger was a child or young person disclosure about abuse they experienced or as experienced by a sibling. Of these, six cases were disclosures by a child with communication impairments of abuse they reported experiencing. A recent study conducted by the NSPCC on disclosure found that 80% of their sample of young adults who experienced child abuse attempted either through verbal communication or actions to disclose that they were experiencing abuse during childhood[47]. However, not all of these disclosures were heard or acted upon[1]. Research has highlighted that children with disabilities may not disclose abuse as frequently as their peers due to a number of barriers[48].

[47] Alnock amd Miller (2013). No one noticed, no one heard: A study of disclosures of childhood abuse. London: NSPCC.
[48] Stalker, K. and McArthur, K. (2012) Disabled children and child protection: a literature review . Child Abuse Review, 21, 1, 24-40.

Figure 2: 'Triggers' for Sharing Child Protection Concerns from Critical Incident Data (n = 33 case examples)



8.2.5 Once an initial concern is raised, there are a myriad of factors that can impact upon or influence decision-making. Figure 3 highlights the key factors arising out of the case examples from this study using a decision-making ecology model adapted from Baumann and colleagues[49].

8.2.6 Case factors are the individual or family-level characteristics that can impact on decision-making. From the 34 case examples given, nine included either parental substance misuse, mental ill-health or domestic abuse. Previous reviews of serious case reviews in the UK highlight that these three factors were present in a high percentage of child death cases[50]. Other research on adverse childhood experiences highlights that children living with these co-occurring familial factors are at an increased risk of child abuse, neglect and peer victimisation.[51] There is also a growing body of research highlighting that it is harmful for children to live with domestic abuse even if they are not directly harmed physically (Buckley et al 2007[52]; Holt et al 2008[53]; Stanley 2011[54]). For practitioners, the chaos within some of these family environments often made it difficult to both identify and diagnose impairment or to pick up child protection concerns for disabled children.

8.2.7 Additional support needs for parents or other children were also highlighted in the case examples. For four cases, additional parental support needs were present including learning difficulties, sensory impairments and serious health needs. In five cases, there were multiple disabled children in the family. In addition, the presence of child communication impairments was one factor that was seen by practitioners as significantly impacting on decision-making processes and timeframes. Nine case examples included children with complex communication impairments.

8.2.8 Seven case examples highlighted the difficulties surrounding challenging behaviour as displayed by disabled children. Often the challenging behaviour was the trigger for an initial child protection concern being raised such as displaying sexually harmful behaviours or aggressive behaviours towards parents/carers, adults or peers. Practitioners highlighted the difficulties this raised for decision-making processes related to child protection and especially when they were combined with complex communication impairments. Previous research highlights that challenging behaviours may be children's

[49] Brandon M, Sidebotham P, Bailey S, Belderson P, Hawley C, Ellis C & Megson M (2012) *New learning from serious case reviews. Research Report DFE-RR226*. Department for Education, London.
[50] NSPCC (2011). An analysis of serious case reviews concerning children under one. London: NSPCC.
[51] Devaney J (2009): Chronic child abuse and domestic violence: The characteristics and careers of children caught in the child protection system. *British Journal of Social Work* **39**, 24-45.
[52] Buckley, H., Holt, S., & Whelan, S. (2007). Listen to me! Children's experiences of domestic violence. *Child Abuse Review, 16*, 296-310.
[53] Holt et al (2008) Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse & Neglect 32*, 797-810.
[54] Stanley (2011) Stanley, N. (2011). *Children Experiencing Domestic Violence: A Research Review*. Dartington: Research in Practice.

way of disclosing abuse or trying to be heard.[55] Challenging behaviours can also result from the impact of the trauma experienced and the consequences of child abuse and neglect can result in challenging or risky behaviours in children, adolescents and adults.[56] In addition, specific impairments may have associated behaviours that are seen as challenging at the individual, relationship and societal levels. Previous research has tended to focus on challenging behaviours among teenagers and the impact on outcomes, particularly disengagement, within the child protection system, yet very little research to date has examined the impact disabled children and young people's perceived challenging behaviour may have on child protection decision-making.

8.2.9 Organisational factors highlighted from the research include staff expertise in working with disabled children around child protection concerns and the policies, procedures and organisational flexibility to bring in external expertise in these cases. The organisational climate of high caseloads, staff turnover and the subsequent challenges were cited as important for understanding decision-making factors. In addition, interagency working and the various thresholds that exist from different disciplinary perspectives (e.g. police, social work, education) arose as several of the key organisational factors.

8.2.10 In addition to organisational factors, several external factors were highlighted that impacted on the child protection decision-making ecology. These included the difficulty in securing additional support and specialist advice when needed and the lack of accessible care arrangements for disabled children. Interagency working and particularly information sharing were highlighted as key external factors.

8.2.11 Decision-maker factors are also a key piece of the decision-making environment. This study found that empathy with parents was one of the factors highlighted by practitioners that may increase the difficulty in both discerning cases of abuse or neglect for disabled children but also impact decisions around any concerns that may be identified. This resonates with previous findings from a scoping study on disabled children and child protection[57] which found professionals may over-empathise with the level of demands parents face and may be reluctant to make a formal child protection referral especially for neglect and physical abuse concerns. Professional knowledge, attitudes and confidence were also key components of decision making as highlighted throughout the report.

[55] Buckley, Holt and Whelan (2007) *op.cit.*
[56] Daniel B, Taylor J & Scott J (2011) *Recognizing and Helping the Neglected Child: Evidence Based Practice for Assessment and Intervention*. Jessica Kingsley, London.
[57] Stalker K, Green Lister P, Lerpiniere J and McArthur K (2010) *op.cit.*

8.2.12 When practitioners were asked about thresholds, there were mixed opinions about whether they were higher or lower for disabled children than for non-disabled children. Data emerging from this study suggests that professionals may view disabled children with communication impairments as the most vulnerable, whereas disabled children without communication impairments may be more protected and less vulnerable than their peers. This conflicting view on the perceived vulnerability of disabled children resulted in the mixed opinions about whether thresholds were higher or lower. More training is needed to highlight that all disabled children, regardless of the presence of communication impairments, are more vulnerable to child maltreatment. Figure 3 shows how this continuum of vulnerability may act to mask the risks faced by disabled children who do not have communication impairments. The +/- signs in the figure relate to practitioner's views of whether they were aware (positive) or not (negative) of the increased vulnerability of the specific group and whether they felt able to recognise significant harm (positive) or not (negative) and lastly their confidence (if they were confident or not) in working with the specific group of children.

8.2.13 Despite the mixed professional views on threshold levels, the case example data suggests that thresholds for disabled children may be higher than for non-disabled children with the various factors cited throughout this report indicating why this may be the case. Some practitioners conflated raising initial concerns with thresholds for action once concerns were known. For the purposes of this discussion, we now explore the thresholds for taking action on concerns already raised.

8.2.14 While this study has focused mainly on response (e.g. interventions after child protection concerns have been raised), it is crucial to highlight the important role that prevention can play in raising awareness about child maltreatment against disabled children and also stopping abuse and neglect before it ever begins. Primary prevention initiatives would seek to address some of the risk factors identified within the study which participants highlighted lead to perpetration of abuse and neglect against disabled children and the potential impunity that many abusers have which allows child abuse and neglect against disabled children to continue.

Figure 3: Continuum of Vulnerability

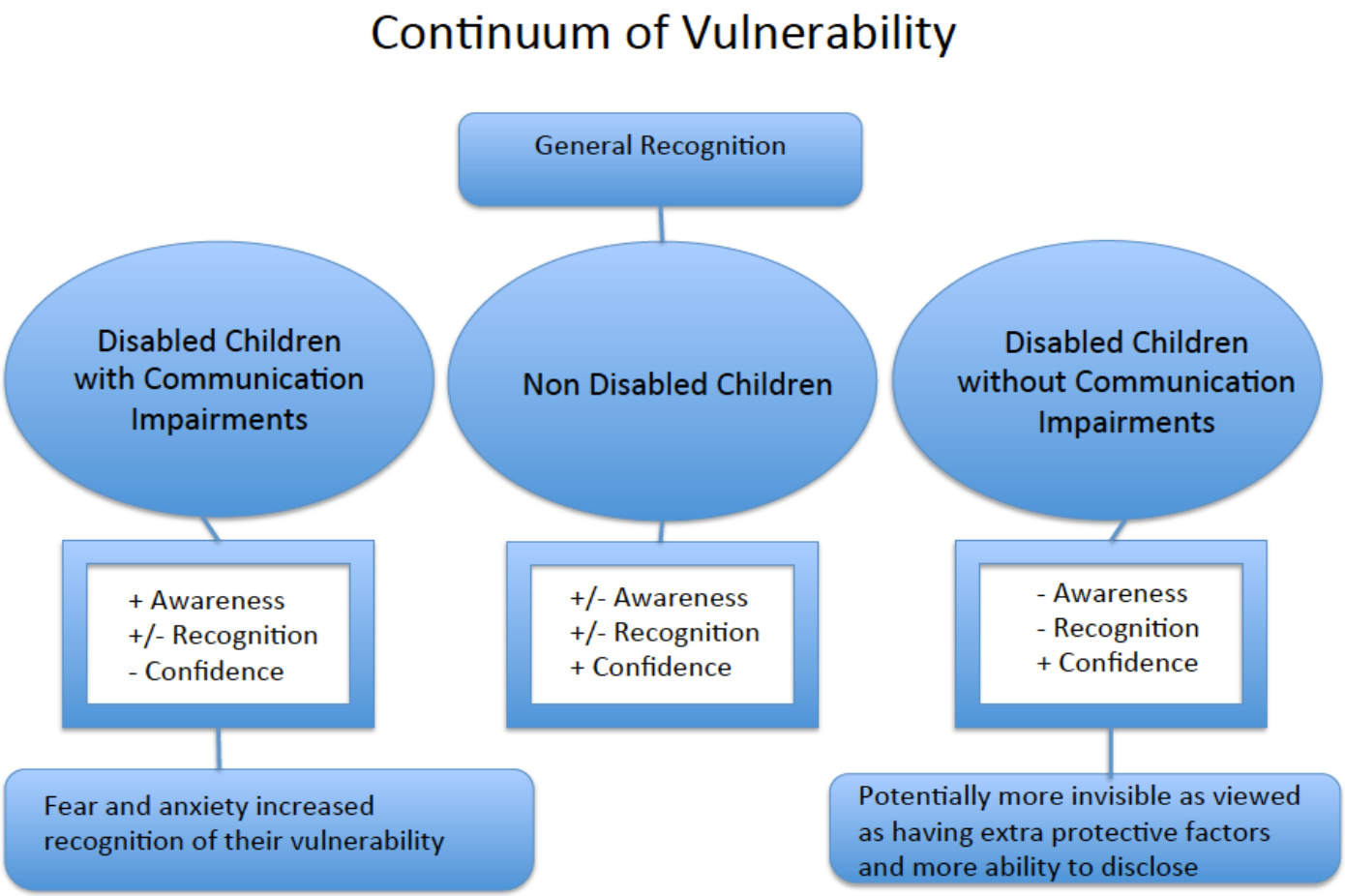
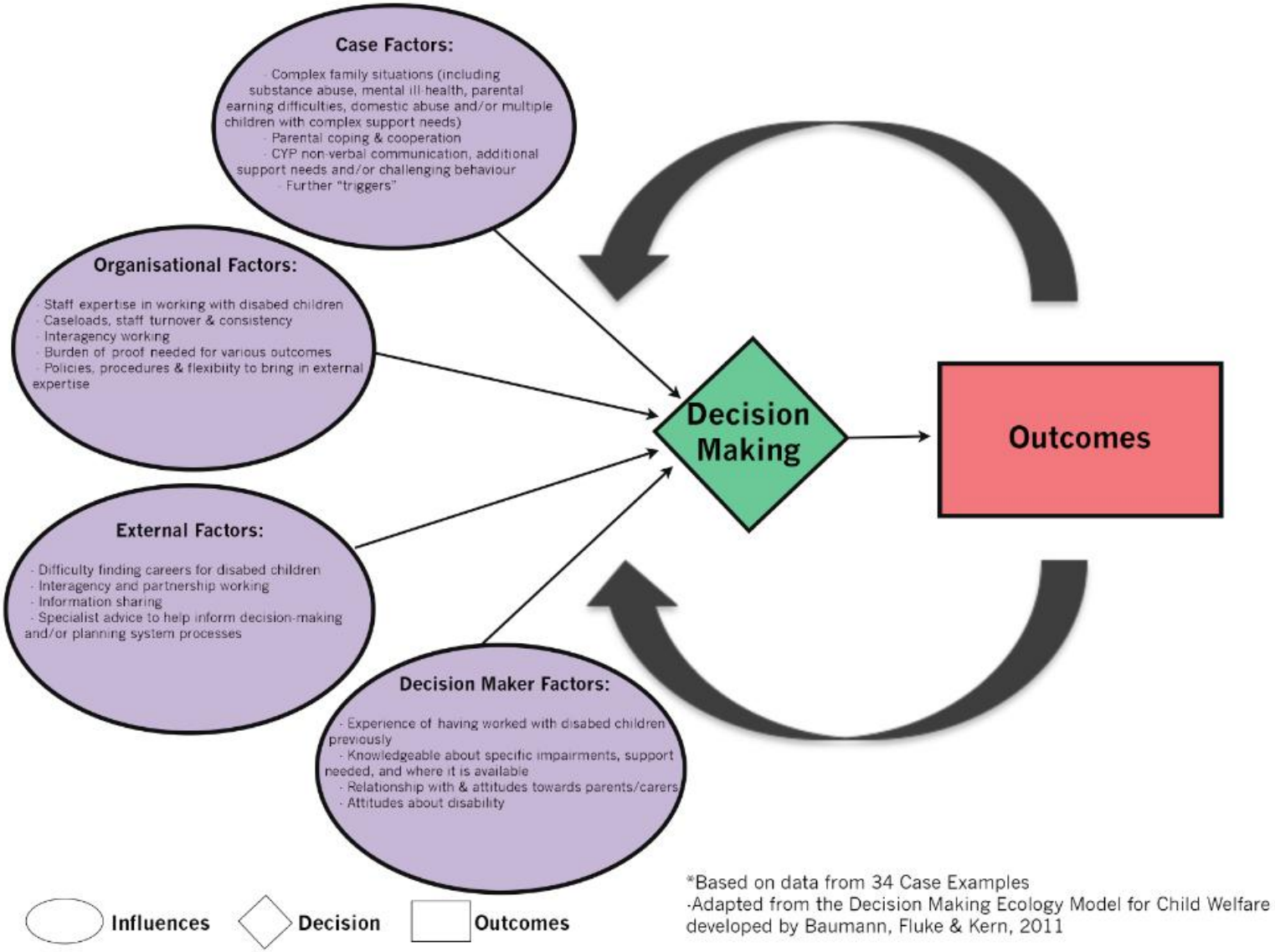


Figure 4: Decision-Making Ecology of Child Protection for Disabled Children*

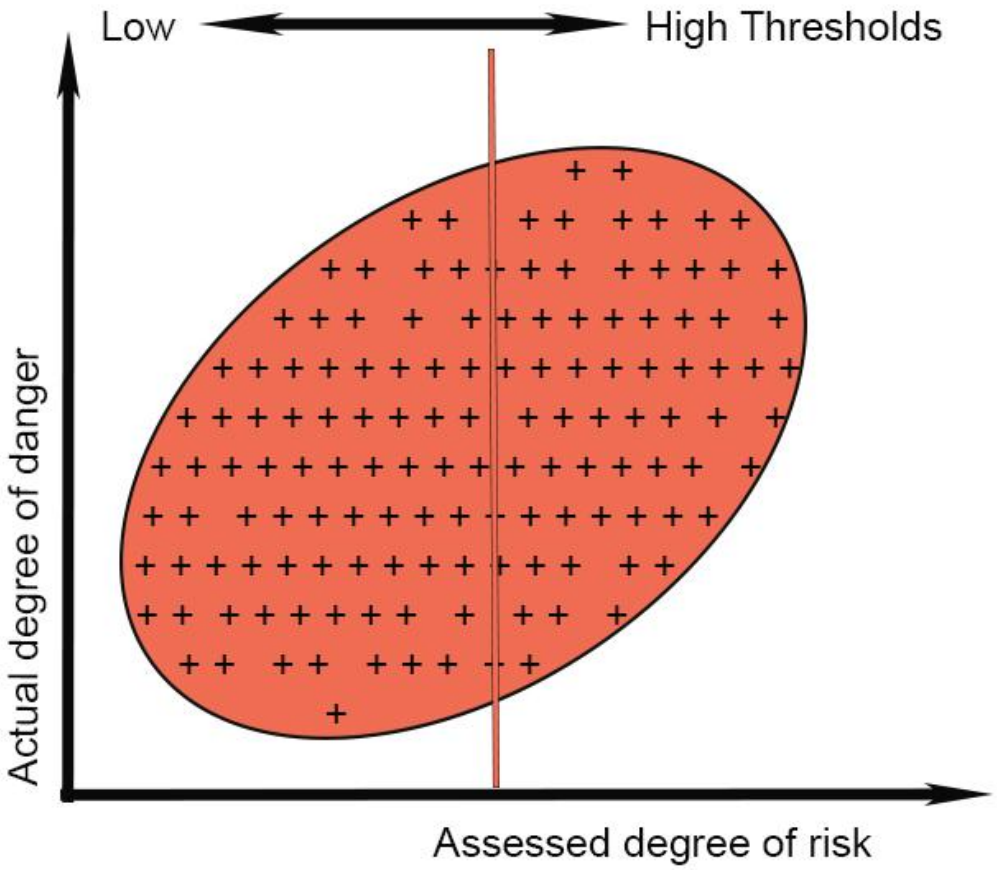


*Based on data from 34 Case Examples
-Adapted from the Decision Making Ecology Model for Child Welfare developed by Baumann, Fluke & Kern, 2011

8.2.15 Several threshold models exist which explore the 'tipping point' where cases or concerns go forward within the child protection system. Most of these models distinguish between the assessment or diagnostic system and action being taken. If we explore the systems approach model used by Munro[58] with the data collected from this study, we would hypothesise threshold models as displayed in Figures 5-7.

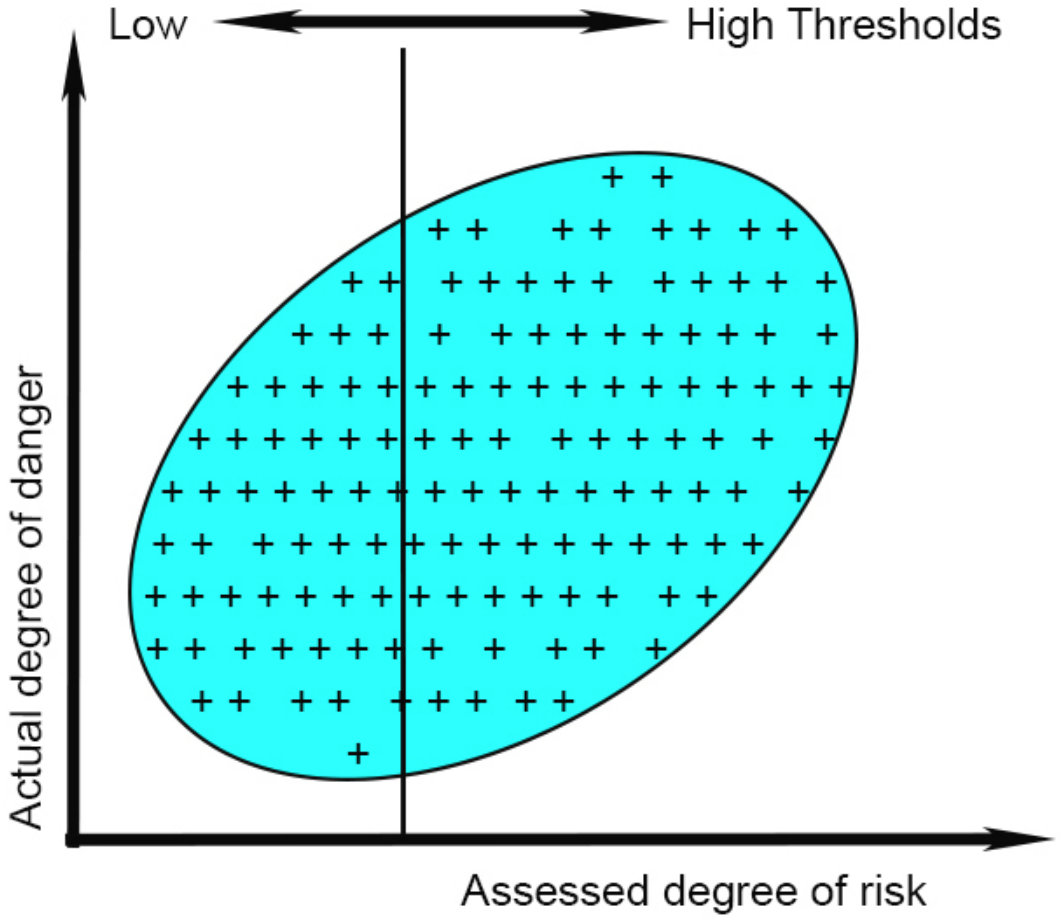
8.2.16 According to Munro, if we had a perfect way of identifying high-risk situations we would expect cases to follow a straight diagonal line where real and assessed risk would be the same. According to this model, the less accurate the diagnostic system for significant risk is, the larger the area of potential cases. In Figures 5 and 6, we present the hypothesised threshold model for disabled children (Figure 5) in comparison to non-disabled children (Figure 6).

Figure 5: Child Protection Threshold Model for Disabled Children



[58] Munro (2010) *op.cit.*

Figure 6: Child Protection Threshold Model for Non-Disabled Children



This study has highlighted that the system for assessing significant risk is broader for disabled children. This is due to disabled children being more dependent on support from parents/carers, the increased vulnerability of disabled children and young people as a result, increased parental stress and complex family environments (including multiple disabled children), multiple carers and care in different settings among the many additional factors highlighted. From this study, practitioners highlighted the difficulties in assessment that these factors presented. For this reason, the thresholds model for disabled children has a much broader and less accurate diagnostic system as identified by the red area. We have hypothesised that this is uniformly larger—though future research may need to disentangle and explore this concept further.

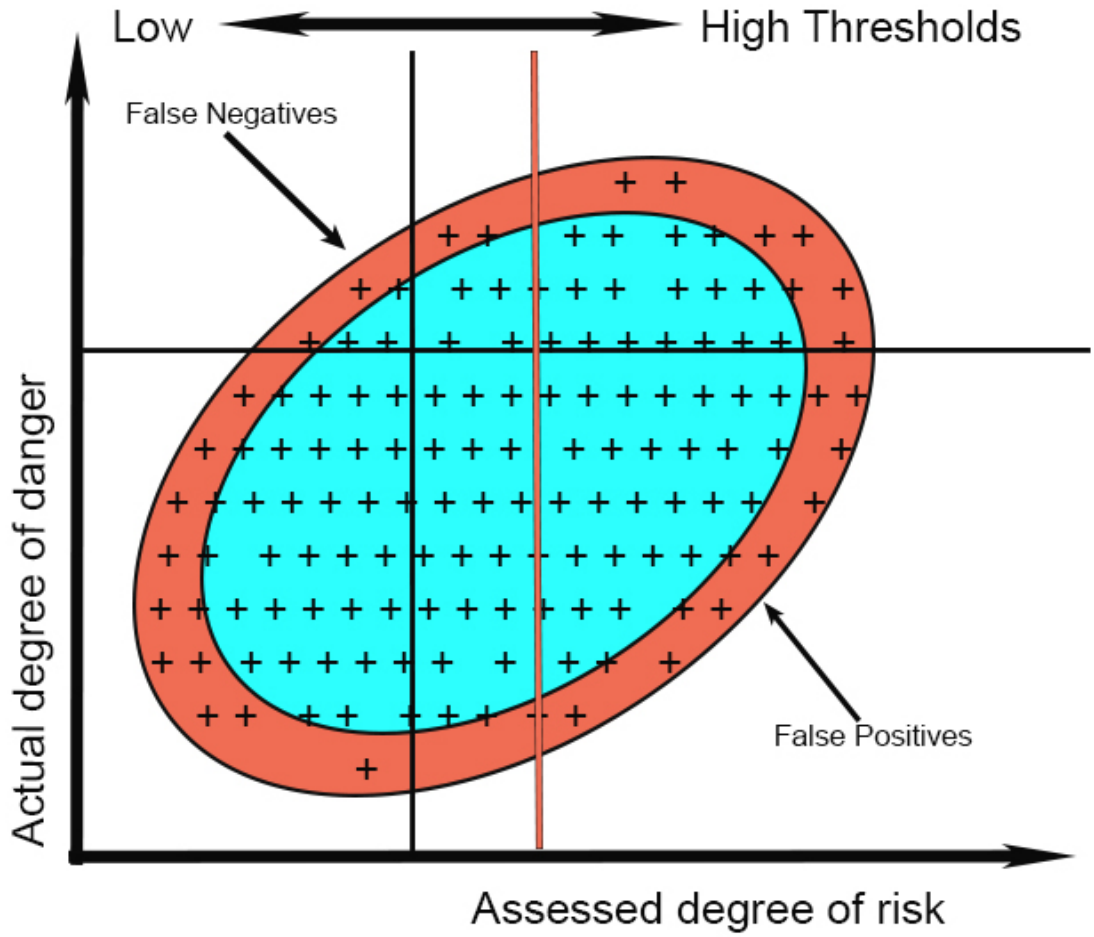
8.2.17 Within this thresholds model, we see the level of threshold ranging from low to high. Based on our findings, we hypothesise that the threshold for disabled children is higher than for non-disabled children based on practitioners' explanations of 34 case examples. In order to fully understand thresholds, there are two missing pieces of data. One is the actual number of disabled

children within the child protection system in Scotland and the outcomes of these cases. This information is not systematically collected across all local authority areas and our research shows that the data that is collected is underreporting the number of disabled children already in the system. The second crucial piece of information is the view and experiences of disabled children and young people - a vastly under-researched area of inquiry. However, a UK-wide study on this topic is now under way.[59]

8.2.18 If the field of cases is larger and the thresholds are higher for disabled children, compared to their non-disabled peers, how does this affect false positives (over-estimating risk) and false negatives (under-estimating risk)? Figure 7 maps the two threshold models together and as this diagram illustrates, moving the threshold to reduce one type of risk automatically increases the other type of risk. By raising thresholds, false negatives increase and the false positives decrease. Yet, because the diagnostic system for assessing risk for disabled children is larger, a move in thresholds does not significantly reduce either field. Therefore, in comparison to non-disabled children there is an increased risk of both false positives and false negatives. Despite this, the potential for underestimating risk and missing cases of serious abuse for disabled children is potentially the higher of the two (as illustrated by the red line marking the hypothesised threshold level).

[59] Taylor J, Stalker K, Franklin A, Fry D and Cameron A (in progress*) Researching the views and experiences of maltreated disabled children and young people about the child protection system.* University of Edinburgh (funded by NSPCC)

Figure 7: Child Protection Threshold Model for Disabled Children Compared to Non-Disabled Children



8.2.19 While research can help make more accurate identifications of high-risk situations, it cannot determine the point or threshold at which professionals should act—this is a value and professional judgement influenced by a range of individual, case, organisational and external factors[60] [61]. What is clear from this research is that professionals desire to minimise both overestimations and underestimations of risk but often feel as if they are 'muddling through' with these decisions and that more guidance and professional learning in relation to child protection and disability is warranted.

8.3 Enablers and Barriers: Are we Getting it Right for Every Child?

8.3.1 While a wide range of factors influence intervention decisions, there are also enablers and barriers at each step of the child protection process. Enablers are factors, systems and processes that enable decision-makers to intervene effectively in child protection cases. Barriers are factors that may inhibit or

[60] Munro (2010) *op.cit.*
[61] Baumman et al. (2011) *op.cit.*

delay effective intervention. The goal of any effective system is to enhance enablers and diminish barriers in relation to agreed upon processes as set out in child protection guidance documents and frameworks such as GIRFEC. Highlighting the contradictions arising within different stages of the child protection process, for example where concerns were felt to be quickly identified and passed on yet with less chance of being adequately followed through, allows for more detailed and action-oriented recommendations to be made.

8.3.2 Figure 6 highlights the key barriers and enablers at each stage of the child protection process based on the qualitative findings emerging from this study. Within the different phases of the child protection process, we see similar barriers and enablers emerging. Interagency working is seen as an enabler along every step of the process as highlighted by participants. Across the system, participants cited the most enablers at the first stage of raising initial concerns with the most barriers arising during the initial information-gathering phase.

8.3.3 In terms of raising initial concerns, strong enablers included interagency working and passing on of concerns in timely manner across services. Mention of emergency social work teams and strong relationships with schools were mentioned as key interagency relationships at this stage. Barriers existed in terms of actually assessing and identifying concerns and understanding the parent/carer support role around a particular disabled child. The presence of communication impairments was mentioned as a significant barrier to identifying and raising concerns, which linked into professional knowledge, confidence and experience. This finding is in agreement with a previous scoping study conducted in the UK, which found that communication impairments were seen as significant challenges by participants working with disabled children and their families[62].

8.3.4 Within the initial information-gathering stage, again interagency working and specifically the IRD process were seen as enablers to effective intervention and useful for information sharing around specific concerns. Having access to and working with specialists, including speech and language therapists, interpreters, educational staff, etc., were mentioned as enabling the information-gathering process. Likewise, the absence of these specialist participants was seen as a barrier to moving forward effectively during this phase. Child communication impairments arose again as a barrier to

[62] Stalker et al 2010 *op. cit*.

information-gathering citing a potential over-reliance on third party and parent/carer information being used as the main source of information. The lack of interagency collaboration was cited as a barrier, specifically in terms of information being held in different areas by different services. This was linked to the number of services likely to be involved as participants mentioned assumptions held that someone else was already acting on a concern. Individual worker knowledge and confidence emerged as a barrier again in the information-gathering phase but specifically around fear of misrecognition.

8.3.5 Barriers to launching investigations included the standard of evidence needed for criminal prosecutions and the lack of clarity gathered during the previous stage. The burden of evidence discussion often centred around children being perceived as unreliable witnesses and the extent to which various outcomes could be achieved given the amount and quality of information gathered.

8.3.6 In the planning phase, barriers emerged around the lack of accessible support for children and families, the general sense of lack of clarity - initially arising in the information-gathering stage - and not getting any closure or clarity despite moving further along in the child protection process. There was again the potential barrier of assuming other services were taking the lead or addressing specific concerns in relation to planning.

8.3.7 Within child protection case conferences, there were concerns over support for disabled children's involvement, the use of inaccessible venues for case conferences, and the lack of worker and case conference team knowledge about specific impairments. The focus on interagency working was again highlighted in this area, as in all the others, as an enabler for practice.

8.3.8 During the Child Protection Plan stage, examples of child protection concerns for other children and young people not being addressed, difficulties in establishing what took place and the burden of evidence needed for various actions, and a lack of suitable services for disabled children that prevented effective interventions after the identification and investigation stages.

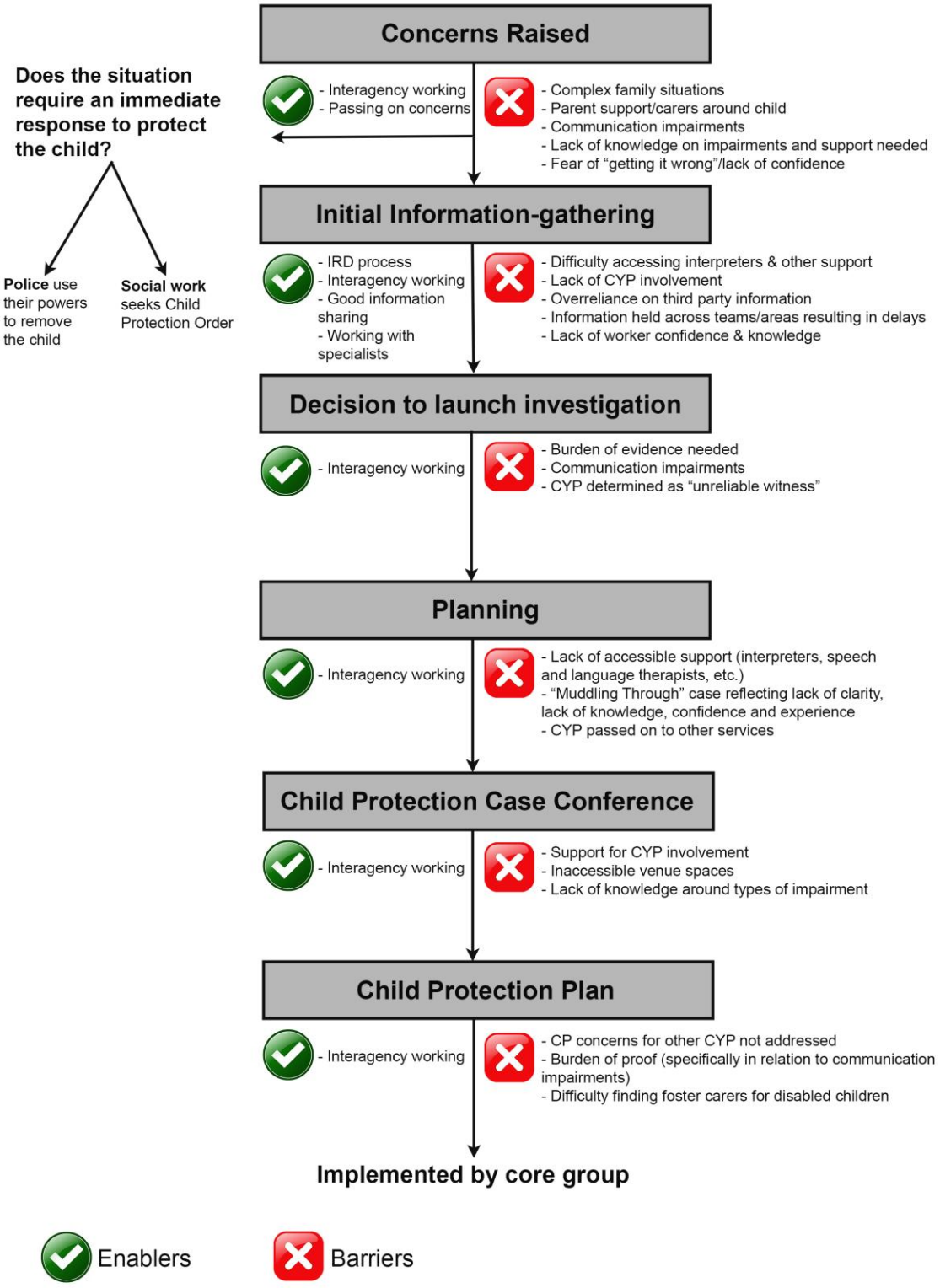
8.3.9 Looking across the system, it becomes evident that interagency working is a strong enabler for participants and the question becomes if there are ways to enhance this further to address some of the barriers felt in each level of the system. Some barriers are clearly individual, such as knowledge, confidence and experience. The difficulties with individual level barriers are if they occur frequently enough (as our research suggests they do), they can translate into interagency and even system level barriers.

8.3.10 Interagency enablers and barriers exist at every level of the system but particularly in the initial phases of raising concerns and gathering information. A much more diverse team of interagency professionals are often present around the lives of disabled children and their families and our research suggests that participants are seeking to transfer current interagency working to these extended networks but that more systematic and routine interagency working would be beneficial particularly with disability teams. Some participants mentioned good relationships with specialists and others mentioned a lack of available support suggesting that areas across Scotland may differ in this regard.

8.3.11 Very few system-wide (i.e. outside the control of individuals, teams or areas) barriers emerged. One potential system barrier exists with the repeated mention of the lack of care settings, especially foster carers, for disabled children.

8.3.12 Under Scottish legislation, disabled children are automatically classified as children in need, yet in every day practice the teams are smaller, the resources are limited and still do not have the priority that is needed. This study highlighted that more barriers than enablers exist for participants working in child protection and around child protection concerns and that more work is needed to capitalise on the good interagency working relationships that already exist in child protection.

Figure 6: Barriers and Enablers throughout the Child Protection Process



8.4 Reflecting on Practice and Learning from Case Examples: A Cause for Concern

8.4.1 A particular strength of this qualitative study lies in the detailed contextual information that was able to emerge about child protection in practice for disabled children. Participants are working within complex situations, under tight resources, heavy caseloads and short timeframes. There was a general reluctance and difficulty among participants in identifying good practice in relation to disabled children. Situations of good practice highlighted by participants took place alongside other aspects that would make it difficult to consider the case as wholly good practice. Some participants were also unable to identify any cases they would identify as good practice, which is a cause for concern.

8.4.2 The child protection pendulum often swings between 'tick-box' mandated responses to enhanced professional autonomy. What is clear is that an emerging feature of current thinking around child protection systems is a focus on the importance of reflective practice for professional learning. One key finding from this study is that this reflective practice is in large part missing in the area of child protection and disability. This is not necessarily surprising given the barriers and tensions that many practitioners mentioned in feeling confident about talking about disability. Due to the relatively smaller number of disabled children in the child protection system, the lack of experience of some participants and the sense of 'muddling through' for some interagency teams, it is clear that participants are lacking the spaces and support for reflective learning to happen. Many participants commented that their participation in this research allowed them the space to really think back on and process learning from particular cases. The question becomes whether safe, self-reflective and practice-oriented spaces need to be created and fostered in order to generate system-wide learning practices.

8.4.3 From the examples of practice included in this study, it is clear that more training in the area of chid protection and disability is needed including disability training for child protection professionals and child protection training for disability specialists. There was a tension between the emphasis on child centredness and practitioners having the confidence that they had the necessary training to achieve this in practice for disabled children. Training is also needed in communicating with young people with communication impairments.

8.4.4 From the case examples that practitioners highlighted, there remains some doubt as to whether people always looked beyond the immediate case. Whilst it was reassuring to see that children were removed from areas of risk, e.g. to different foster care settings or to live away from their families, it was not always clear that the case beyond that child was considered. Foster carers may have continued to work with other children; siblings may have been left at home facing the same risks as the index child; or children within schools or residential settings may have continued exposure to dangerous individuals. Furthermore, practitioners did not always recognise the risk that living with domestic abuse in particular, but also substance misuse or parental mental ill health may have had on disabled children.

Case Study G:

Child/young person at risk: Two siblings on the severe end of the autism spectrum with associated learning difficulties.

Critical incident: Disclosure by mother of experiences of domestic abuse and children witnessing domestic violence at home.

Critical interactions:

1. **Mother disclosed domestic abuse to voluntary sector worker after being admitted to a mental hospital.**
2. **Voluntary sector shared concerns about the children's situation with social work team. Mother advised to contact and seek refuge with Women's Aid to secure her safety.**
3. **Initial referral discussion between social work, police and voluntary organisation.**
4. **Social work became involved with family and the situation seemed to improve.**
5. **School raises concerns about older sibling displaying violent behaviours in school and that he is witnessing domestic abuse at home**
6. **Voluntary organisation shares this information with social work.**
7. **The following day the older sibling physically assaults the mother.**
8. **Voluntary organisation passes on these concerns and another interagency child protection meeting is held.**
9. **Child protection investigation didn't take place initially as the mother's partner (alleged abuser/father) would need to have been notified which could potentially put the mother's life at further risk which in turn would have further worsened the children's risk of significant harm.**

10. **Mother reported to school and social work but did not want to formally report to the police and did not want the children involved in the process.**
11. **After consultation with the school, due to the children's impairments, policed decide not to interview them about the domestic abuse perpetrated by the father.**
12. **Mother wanted to seek refuge through Women's Aid but had initial difficulty finding a special school in another area for the children.**
13. **Mother found a special school for the children to attend and was able to seek refuge in another area.**
14. **Father informed of child protection investigation after the mother and children were removed from the direct harm in the home environment. The child protection investigation was undertaken to assess the risk to the children of witnessing domestic abuse over a prolonged period of time.**

Comment on Case Study G

This case study highlights the challenge of balancing the safety of the mother against the risk of significant harm from witnessing abuse on the children. This example shows good interagency working and information sharing between a range of sectors. There was an understanding by everyone involved about the need to maintain as much safety in the home environment as possible and part of this was by waiting to do a full-scale child protection investigation, about which the father would have been informed, until the mother was in a safe space. The participants involved in this case highlighted the good interagency working but expressed frustration at how long the process took for the mother to be safe. Part of the difficulty came in arranging the children's transfer to a new special school in an area that also provided a refuge for the mother and children.

Key Messages for Practice from the Case Study

Witnessing domestic abuse poses significant risks to children and creates an unsafe home environment. In addition, the most dangerous time for a woman experiencing domestic abuse is when she tries to leave the relationship. The interagency communication and working in this case carefully monitored the situation and also ensured that their actions did not further endanger the mother or children. This case example also highlights the importance of ensuring refuges can accommodate disabled children but also making sure mothers with disabled children are given timely support for transitioning the

additional support services such as speech and language therapists, health services and school attendance for their children when seeking refuge.

8.4.5 Overall, within the practice examples interagency working was seen as very positive for professionals. There is a danger, however, for 'group think', where individuals may feel that they do not have the authority, experience or confidence to challenge group decisions or ways of responding. While this did not arise as a particular issue in our study, more research is needed to explore this aspect of interagency working and how teams can avoid this mentality, especially in areas where they may have less experience.

8.4.6 The current fiscal climate of fewer resources without diminishing demand was identified throughout this research as a potential barrier especially in relation to disabled children and their families who may require additional support. In terms of working with children and young people with communication impairments, except for the few who had received specific training, there was a reliance on other services to help with interviews and investigations. This was often done through the initiative of one worker and was not identified as a systemic or automatic response. Funding cuts have further exacerbated the availability of these resources and this was mentioned as a barrier throughout the child protection process. However, innovative practice in one authority involved a commitment to provide intensive long-term support, based on a belief in 'spend now to save later', which had proved effective in improving outcomes for children and parent.

8.5 Revisiting the National Child Protection Guidance for Scotland in Light of Findings from this Study: Where do we go next?

8.5.1 Revisiting the National Child Protection Guidance for Scotland (2010) on working with disabled children in light of our findings highlights some areas that have progressed and others that still need attention. The Guidance highlighted seven key messages for practice. Each of these messages is examined in this section with recommendations for further messages based on the findings from this study.

8.5.2 **Key message 1:** Local services need to ensure that systems for collecting information about disabled children are sufficiently robust. **Findings from this study:** This is still a key message for practice as national statistics of disabled children on the child protection register are still patchy and not

adequately collected. This study, with 34 recent case examples including in some areas that had not identified any child protection cases in national statistics, clearly demonstrates that much more work is needed in collecting information and statistics on the number of disabled children within the child protection system. In order to effectively understand and evaluate the system-wide response, this crucial information is needed. The Ministerial Working group on Child Protection and Disability is currently seeking to address this issue by providing concrete guidance for local authority areas on what types of data they could be collecting and how they can collect, manage and share that information.

8.5.3 **Key message 2:** Assessments for disabled children need to include the ability and capacity of parents/carers to cope with their demands. **Findings from this study:** Professionals feel confident and able to assess parental coping and several good examples were given of how this is done in practice. This study highlighted the key message for practice in terms of assessment now is that the views of disabled children and young people should be included where possible and that support should be given to children and young people to give their views. Worryingly, recent research in Scotland found that, due to financial cutbacks and tightened eligibility criteria, local authorities do not always carry out assessments of disabled children when asked to so by parents and disabled children are little consulted about which services to use[63].

8.5.4 **Key message 3:** When responding to concerns about a disabled child, expertise in child protection and disability should be brought together. **Findings from this study:** The case studies that were most often cited as examples of good practice were ones in which child protection professionals worked alongside experts in disability, speech and language therapy and support services. Yet barriers emerged in terms of the logistics and timeliness of expertise available. Additionally, disability teams often did not have the necessary training in child protection (including in joint interviewing procedures) and child protection experts mention that they needed more training in disability and working with children with a variety of impairments.

8.5.5 **Key message 4:** Local guidance should set out processes and available support and be sensitive to the particular needs of disabled children during the conduct of child protection investigations. **Findings from this study:** Professionals, from a range of local authority areas, often did not either know how to access additional support or the additional support was not available.

[63] Stalker K, MacDonald C, King C, McFaul F, Young C, Hawthorn M, Patrizio (2013) *"It always comes down to money": recent changes in service provision to disabled children, young people and their families in Scotland.* Scotland's Commissioner for Children and Young People.

Where additional support was available and used, it was often as a result of the proactive initiative of one individual worker and not as a result of an area-wide or system-level process. More work and training is needed in this area.

8.5.6 **Key message 5:** Local services need to provide training for those involved in child protection work on the particular vulnerability of disabled children. **Findings from this study:** There was variable knowledge on the part of child protection professionals about the increased vulnerability of disabled children with communication impairments to maltreatment. There were conflicting views and practice suggesting that professionals may view disabled children without communication impairments as more protected and thus less vulnerable than perhaps their non-disabled peers. In addition, child protection workers struggled with how to adapt current child protection processes for disabled children's needs. Another emerging finding was that disability teams and support services need much more training on child protection.

8.5.7 **Key message 6:** Specialist advice should be sought at an early stage to help inform decision-making. **Findings from this study:** Based on the cross-sectional findings of 34 case examples, specialist advice was often sought but usually much later in the child protection process. Specialist advice was usually incorporated in the 'planning' phase and less so in the information-gathering stage where it would be particularly useful.

8.5.8 **Key message 7:** Local services should consider the development of transition plans that reflect the complexity of transition from child to adult services. **Findings from this study:** Young disabled plans already have to have transition plans but no professional mentioned how child protection is reflected in these plans. In general, participants were engaged with the short-term consequences and immediate actions and spoke less about longer-term planning and transitions. This may link back to the lack of reflective space to think more broadly about children and young people and the extended support they may need.

9. ADDITIONAL RECOMMENDATIONS

9.1 In addition to the existing messages for practice from the National Child Protection Guidance for Scotland, this study identified additional recommendations for system-wide Scottish Government policy as well as for local practice.

9.2 **New Recommendation for Practice 1:** Assessments of child protection concerns should include the views of disabled children and young people

where possible and support should be given to children and young people to express their views in the way that is most comfortable to them.

9.3 **New Recommendation for Practice 2:** Where concerns have been raised and addressed for a particular child experiencing maltreatment, detailed consideration of subsequent harm that may be posed to other children (siblings, subsequent foster children, etc) should be monitored.

9.4 **New Recommendation for Practice 3:** The vulnerability of all disabled children, not just those with communication impairments, should be highlighted in practice guidance and supervision.

9.5 **New Recommendation for Practice 4:** Local services need to provide training for disability teams, speech and language therapists and others with specific disability expertise on child protection and the child protection process (including joint interviewing). The local services should also keep a roster of trained experts that can be consulted throughout the child protection process. Likewise, training should be provided for child protection workers on working with children with a range of support needs.

9.6 **New Recommendation for Practice 5:** Safe interagency reflective spaces should be created for discussing and learning from examples of practice related to child protection and disability.

9.9 **New Recommendation for Policy 1:** The availability and suitability of foster carers and other care arrangements for disabled children should be examined across Scotland. Where services do not exist, they should be created.

9.10 **New Recommendation for Policy 2:** Child protection case conferences should be made accessible for the involvement of disabled children.

9.11 **New Recommendation for Policy 3:** Sectors including criminal justice, police, health, social work and education should review their support to disabled children in the area of child protection to ensure best practice.

9.12 **New Recommendation for Policy 4:** Provide a stronger focus on the prevention of child abuse and neglect against disabled children in Scotland within policy by exploring research on promising interventions and providing guidance and support to professionals and organisations in the area of prevention.

10. CONCLUSION

There is whole-hearted commitment across the child protection system for putting the child at the centre of practice. However, getting it right for every child does not mean treating every child the same. Consideration needs to be given to how best to adapt practice, assessment and intervention for children with a range of impairments. A lack of confidence and fear about getting it wrong , especially when children have communication impairments, suggests that practitioners are often ‘muddling through’ when it comes to working with disabled children and some children in the system remain invisible. Troubling language that reflects a medical model approach continues to be used with regards to disabled children. Child protection workers require more training about disabled children, and children’s disability teams need more training about child protection. Interagency working was regarded positively and was seen as an enabler to good practice. However, thresholds for action in the child protection system are higher for disabled children than for others. Attention should be paid to ensure that disability is not conflated with communication impairments and that all disabled children are given the attention and support they need within the child protection system. More needs to be done to ensure disabled children’s voices are heard and included within formal systems. Whilst there are positive aspects, this research shows that the child protection system is a cause for concern in relation to disabled children

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