



Queen's University
Belfast

SCHOOL OF
Sociology, Social Policy
and Social Work

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SBNI

**Safeguarding Board
for Northern Ireland**

**Safeguarding Disabled Children and Young People:
A Scoping Exercise of Statutory Child Protection
Services for Disabled Children and Young People in
Northern Ireland**

Dr Berni Kelly & Dr Sandra Dowling

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1. Introduction

The Safeguarding Board NI's (SBNI) Strategic Priorities 2013-2016 include the protection and safeguarding of children by responding to new and emerging concerns and driving improvements in the current child protection system. As limited attention has been given to safeguarding issues for disabled children in research and policy in NI, it is intended that this scoping exercise will assist SBNI in fulfilment of these priorities by contributing to our understanding of issues relating to the protection of disabled children within the current child protection system in the Northern Ireland context.

2. Background

Disabled children are known to be particularly vulnerable to all forms of abuse (Stalker et al., 2012). Contributory factors include physical vulnerability, communication difficulties, denial and lack of respect for their human rights. Research suggests that disabled children are more likely to be abused than non-disabled children and are three times more vulnerable to sexual abuse (CDSA, 2012; Taylor et al., 2014). The Ofsted (2012) thematic inspection on 'Protecting Disabled Children' highlighted that disabled children were less likely than other children to become the subject of child protection plans and suggested that either risks to disabled children were not well identified or that support effectively reduces risks and helps to keep them safe. The inspection found evidence that low level risks were managed effectively through multi-agency early support but that children who were in receipt of child in need services too often had child protection needs that went unidentified. However, when children were made subject to child protection plans good progress was usually made in reducing risks.

Where neglect was the key risk, children had previously received support as children in need for a long time and there were delays in recognising that the levels of neglect had met the thresholds for child protection. Inspectors also found a mixed picture on how well the views, wishes and feelings of disabled children were captured. There was also a lack of confidence in working with disabled children amongst practitioners, and a lack of relevant training coupled with variability in thresholds for action.

The review also highlighted that very few local Safeguarding Boards in England scrutinised the quality of work across agencies to ensure that thresholds for child protection for disabled children were fully understood and rigorously applied. The review recommended that Safeguarding Boards should ensure thresholds for child protection are well understood and rigorously applied at every stage in work with disabled children; and establish robust quality assurance case file audits and management information systems to assess and evaluate the quality and impact of work with disabled children.

Research for the Scottish Government by Taylor et al. (2014) highlighted that thresholds for action in the child protection system were higher for disabled children than for non-disabled children. The research emphasised the need to consider how best to adapt assessment and intervention for children with a range of impairments, and recommended that training on disability issues for child protection workers and more child protection training for those working in children's disability teams.

3. *Definitional parameters of the scoping exercise*

As an initial scoping exercise, it is important that the extent of its remit and definitional parameters are clearly defined to keep the project manageable.

Operational Definition of Disability

A definition of impairment is provided in the Disability Discrimination Act (1995) which promotes the protection of the rights of disabled people, providing a framework for promoting equality and challenging discrimination on the grounds of disability. This Act defines disability as:

“a physical or mental impairment that has substantial or long-term effect on a person's ability to carry out normal day-to-day activities” (p.8).

The Autism Act (2011) further amended this definition of disability to include social and communication impairments related to autistic spectrum conditions. This definition of disability will be used for the scoping exercise as it is the local definition used by the Health and Social Care Board (HSCB) and Health and Social Care Trusts (HSCTs) across Northern Ireland (NI).

Operational Definition of Safeguarding and Child Protection

It is also important that the term safeguarding is clearly defined for the purposes of this scoping exercise. Safeguarding is usually interpreted to include both preventive and protective activity. Whilst it is important to consider wider safeguarding activities in relation to disabled children, this is beyond the remit of this initial scoping exercise given the resources and time available. Therefore, the main focus of the scoping exercise is on child protection within the social work statutory sector. Key stakeholders in the voluntary sector were also consulted. It is hoped that this scoping exercise will inform a future research study on wider safeguarding issues for disabled children which could incorporate a broader range of perspectives and safeguarding roles across families, communities and service sectors.

4. Aims and objectives

This initial scoping exercise aimed to inform SBNI's ongoing work by exploring the issues in relation to safeguarding and disability within Northern Ireland to determine whether a similar pattern to the rest of the UK exists. The objectives of the scoping exercise were to examine:

- The organisational and policy context relating to protecting disabled children;
- The strengths and weaknesses of current approaches to protecting disabled children;
- Issues and challenges relating to thresholds of risk for disabled children; and
- Issues relating to training for social workers in child protection and children with disabilities teams.

5. Methodology

The scoping exercise began with a review of current policy in NI relevant to safeguarding disabled children to provide a context for data collection in each Trust. Given regional variation in organisational context and the limited time and resources available, this was followed by key informant meetings with senior staff responsible for child protection and/or children with disabilities services across NI (n=18) and representatives from key voluntary organisations (n=4).

In order to develop understanding of Trust policies and organisational processes, meetings were first held with Assistant Directors with responsibility for child protection services in each HSCT. In three Trusts, the senior manager for children’s disability services joined this meeting with Assistant Directors because of the key role children’s disability services played in relation to child protection services for disabled children in these areas. Following meetings at management level, individual meetings with Team Leaders in Family Intervention Teams (or equivalent)¹ and Children’s Disability Teams in each Trust were undertaken to develop an understanding of practice issues on the ground. Finally, based on feedback from the key informants and the Steering Group, representatives from four voluntary organisations (Mencap, NSPCC, Barnardo’s and National Deaf Children’s Society) were consulted.

Table 1: Number of Key Informants

Assistant Directors for Safeguarding	5
Managers of Children's Disability Services	3
Team Leaders in Family Intervention Teams	5
Team Leaders in Children's Disability Services	5
Representatives from Voluntary Sector	4
TOTAL	22

At meetings with key informants the focus of the discussion centred on five core themes: policy and organisational arrangements; child protection responses; thresholds of risk; participation; and training. Key questions asked under these topics are provided in Appendix one.

6. Policy Context

The scoping review considered the international and regional rights-based context for policy in NI followed by a short review of key law, policy and guidance relevant to

¹ For the purposes of brevity in this report, the term Family Intervention Team will be used to refer to these teams and their equivalent across Trusts (including Family Support and Intervention Teams).

statutory child protection processes in NI. In reviewing these documents, the aim was to outline the key policy underpinning social work child protection practice and to explore the extent to which existing child protection policy incorporates specific issues relevant to safeguarding disabled children.

The Rights-Based Policy Context

The United Nations Convention on the Rights of the Child (UNCRC) (1989) and the United Nations Convention on the Rights of Persons with Disabilities (UNCPRD) (2006), provide a foundational rights context for law and policy across the UK. The UNCRC addresses all children and makes special mention of disabled children. The UNCPRD (2006) applies to all disabled people (children and adults) and also makes specific mention of the human rights of disabled children (Article 7). The UNCRC is underpinned by four basic principles: that all children should be free from all forms of discrimination (Article 2); that the best interests of the child are central to all decisions affecting them (Article 3); that all children have the right to life, survival and development (Article 6); and that all children have the right to express their views and for those views to be taken seriously (Article 12). Article 23 makes specific reference to disabled children recognising their right to provision of services, access to information and to education, health, employment and social and cultural activities, recognising the fact that disabled children should enjoy a “full and decent life” (Article 23). The rights contained in the UNCRC are often grouped into four categories; survival rights, development rights, participation rights and protection rights. In relation to protection, Article 19 specifies that State Parties shall take:

"All appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child."

These protective measures include support for the child and their carers and 'identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment' (Article 19). In cases where children are removed from their birth family, Article 20 specifies the right of the child to 'special protection and

assistance' from the State, including alternative care through fostering, adoption or, if necessary, institutional care.

The UNCRC and UNCPRD are mutually reinforcing with both emphasizing that the best interests principle should apply to disabled children alongside consideration of a child's right to family life. Article 23 of the UNCPRD states that:

"In no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents."

In terms of protection, Article 16 stipulates that:

"State Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse..."

Under this Article, State Parties are also to take 'all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services'.

In its General Comment 13, on the rights of the child to freedom from all forms of violence, the UN Committee on the Rights of the Child (2011) noted the additional needs of disabled children:

"Particular vigilance is needed when it comes to marginalized groups of children who are rendered particularly vulnerable due to their alternative methods of communicating, their immobility and/or the perceived view that they are incompetent, such as children with disabilities. Reasonable accommodation should be provided to ensure that they are able to communicate and signal problems on an equal basis with others." (UN Committee, 2011: 19)

Building on the international human rights legislation, a number of important rights-based documents feature in the Northern Irish legislative landscape. For example, the Disability Discrimination Act (DDA) (1996) and Section 75 of the Northern Ireland Act (1998) aim to address discrimination and promote equality of opportunity

between disabled and non-disabled people. The Disability Discrimination Order (NI) (2006) provides amendments to the DDA to broaden the definition of disability, requiring public bodies to promote positive attitudes towards disabled people and to develop strategies to broaden the participation of disabled people in public life. While these rights-based Northern Irish laws are not specific to disabled children per se, they do form overarching mechanisms through which equal access to rights by all disabled people are enabled and supported.

Children's Law, Policy and Procedures

The Children (NI) Order 1995 provides the primary legislative framework for safeguarding children and young people in NI. Chapter 15 of the Children (NI) Order focuses on Child Protection and Court Orders and addresses breakdown of parental care and where the child is suffering or is likely to suffer significant harm. Responsibility for child protection is delegated to each of the five Health and Social Care Trusts in NI and each adheres to a single set of child protection procedures laid out in the Area Child Protection Committee's (ACPC) regional policy and procedures (DHSSPSNI, 2005), which draws on the changes in thinking and practice outlined in the document Co-operating to Safeguard Children (DHSSPSNI 2003). Co-operating to Safeguard Children provides a framework for ACPC to develop safeguarding strategies for children assessed to be at risk of significant harm. It defines child protection within the parameters outlined in the UNCRC (1989, Article 3) and unpacks the descriptors of the different categories of abuse.

The ACPC policy and procedures provide comprehensive and detailed guidance on the principles, policy and procedures which should underpin professional responses to safeguarding children. It acknowledges learning from the Victoria Climbié Inquiry Report (2003) and incorporates the DHSSPSNI multi-professional audit (2003). The guidance draws on a rights-based approach and underlines that the protection of children is a shared responsibility, both in professional and public domains. Whilst this document emphasises equality and states that "Safeguards for children with a disability should be the same as those for other children" (ACPC, 2005, p.20), in Chapter 9 it provides specific guidance for particular groups, including disabled children. This chapter highlights factors which may increase the risk of abuse of disabled children, such as dependence on others, lack of education or information to help disabled

children to recognise abusive behaviour, or communication challenges which make it difficult to disclose abuse. Societal attitudes, such as an unwillingness to accept the abuse of disabled children, and inaccessible reporting opportunities (such as, telephone helplines) are also identified as barriers to protection. The document states, “it is not the impairment itself that places these children at risk, but adult responses to that impairment” (Kennedy 1998, in ACPC, 2005, p. 157).

The ACPC guidance also outlines investigation processes, designated case responsibilities and the need for a multi-disciplinary child protection plan for children who have experienced abuse. It goes on to give specific guidance regarding the investigation procedure for disabled children detailed in a flow chart. This shows that a child protection referral for a disabled child should be followed up by notification in writing to the disability team in time for information sharing purposes. The child protection team is designated to take lead responsibility for child protection processes. Following a single or joint investigation, a best interests decision should be taken as to which team (child care or disability) should take the lead in completing the investigation. If responsibility lies with the child care social worker, then input can be expected from the disability social worker in relation to particular areas of expertise which can assist the investigation (the example of communication is given). If the disability social worker is designated to complete the investigation, the child care social worker will still take the professional lead with clear structured communication between team leaders for disability and child care. The guidance makes it clear that, whilst child protection issues are being investigated, the child care team will retain responsibility with the disability team continuing to provide support for the child’s disability related needs. It is intended that the child care team and disability team will continue to work together should the case progress to a child protection plan or care plan to meet the needs of the child.

The 2013 “Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse NI” provides an outline of roles and procedures to ensure that key partner agencies (including Trusts, the police service and NSPCC) work together in all aspects of child protection work and to ensure that the best interests principle is central. This document sets out the requirements for information gathering, initial assessment and joint investigation. The police take

responsibility for cases proceeding to criminal investigation following a Strategy Meeting, however, the social worker plays a key role in assisting with the evidential interview with a child, identifying potential witnesses and representing the child's welfare interests. There are two training courses that social workers must have completed to undertake interviews with the child Module 1 training on Initial Consultation and Interview Assessment and Module 2 training on Interview Assessment.

Prior to the criminal investigative interview, a pre-interview assessment should be conducted with the child to explore their ability to give evidence as a competent witness and consider their welfare needs. At this point, the impact of the child's impairment on their capacity to understand relevant concepts (such as, time, places and events) and ability to participate in a formal evidential interview is assessed. Any requirements the child may have in relation to communication as a result of impairment should also be considered, including the need for interpreters or facilitators in augmentative communication. The guidance clearly states that a reliable method of communication understood by the interviewer directly or through an interpreter must be established. If the child is progressing to an evidential interview, 'Achieving Best Evidence' guidance is followed. Section 5 of the Joint Protocol focuses on disabled children and states that: 'there is rarely any reason in principle why children with disabilities should not take part in a video recorded interview, provided the interview is carefully tailored to the particular needs and circumstances of the child' (HSCB, 2013:35). It is recommended that a specialist worker with expertise of working with disabled children should be consulted, including social workers, speech and language therapists, occupational therapists, psychologists and psychiatrists. The specialist worker can play a range of roles to assist with the investigative process and take account of the child's impairment including: providing appropriate information; contributing to the decision about whether or not a particular child should be interviewed and what type of interview is appropriate; advising on the level of disability; assessing indicators of abuse; and facilitating communication with the child and their carer. In exceptional circumstances a disabled child could be interviewed by someone who is not a member of the investigating team because the child knows them and has confidence in them (provided they are suitably qualified, impartial and prepared to cooperate with appropriately trained interviewers regarding the questioning approach).

Additional Guidance for Children's Services

Professionals working with children are also guided by the regional UNOCINI (DHSSPS, 2011) assessment framework guidance. It is intended that the UNOCINI framework is used by all professionals in the assessment of children's needs to ensure a child-centred and coordinated approach. UNOCINI provides a model for assessing need across four levels, with safeguarding and children with complex or enduring needs identified at the most acute (level 4). Section 3.5 of the UNOCINI guidance focuses on 'Assessing the Needs of Specific Groups of Children'. It highlights that obvious need presented through disability (as well as, for example, children who are seriously ill) may mask other needs, which may be considerable. The guidance underlines that services must be applied equally to children with and without specific needs and recommends a high degree of co-operation and co-ordination between professionals working with the child to ensure the child's needs remain central. Assessment should be informed by evidence from current research and professionals making assessments should access up to date literature with this aim. Section 4.6.2 of the guidance specifies that child protection referrals should be made to the local Gateway Service and a UNOCINI Preliminary Assessment or Agency Appraisal is required. The ACPC Regional Policies and Procedures are referenced for further guidance on the management of child protection cases. Section 4.9 details the Child Protection Pathway which should be used in cases where children are known or thought likely to suffer significant harm and are subject to a child protection case conference. The guidance underlines the need for robust assessment and thorough planning for children in need of protection. It draws attention to the need to consider both the potential for harm that has or is likely to occur through child abuse and the protective or resilience factors which exist and are likely to reduce the risk of harm. The guidance sets out reporting requirements and standards, specifically the Initial UNOCINI Child Protection Conference Report (sections 4.9.1 and 4.9.2) and UNOCINI Child Protection Pathway Assessments (sections 4.9.3 and 4.9.4).

In relation to looked after children, "Protecting Looked After Children" (DHSSPSNI, 2010) was produced through the collaboration of the five Trusts. It provides guidance on the protection of looked after children, although it makes no specific mention of disabled children. This document acknowledges that looked after processes

establish multi-agency protection and care plans focused on improving outcomes for looked after children and that good practice would indicate that looked after children should not be subject to separate child protection processes (dual process). Nevertheless, this document underlines the central importance of adherence to legislative requirements in relation to protecting children within the looked after child planning and review processes. It is acknowledged that there may be exceptional circumstances when 'dual process' (looked after and child protection case conference) may be required including: during an emergency admission to care when assessments of risk are not yet complete; and prior to a child being discharged from care to their birth family. In such circumstances, dual status arrangements should be agreed at the looked after child review so they are well coordinated and should ordinarily not exceed three months in duration.

Key Points:

1. Whilst specific guidance relating to disabled children is given, the overriding message is that all children, including disabled children, should be afforded an equal right to protection from harm, in line with equality policy. However, in treating all children as equal, it is important to consider how well the unique needs or additional risks for disabled children are addressed in current policy.
2. There is no specific separate policy on safeguarding disabled children, however, responding to the abuse of disabled children is addressed within the ACPC policy and procedures and UNOCINI guidance.
3. Policies are underpinned by a commitment to listening to children and young people and ensuring actions taken do not cause further unnecessary distress to the child. There is limited specific guidance around the communication needs of disabled children, apart from acknowledgement of the expertise of children's disability social work teams in this area.

3. Findings from Key Informants

From the findings of the scoping exercise, seven core themes relating to safeguarding disabled children have been identified. These are: organisational arrangements for managing child protection services for disabled children; roles of family intervention and children's disability teams; staff training; under-representation of disabled children in child protection statistics; vulnerability of disabled children to abuse; actions related to thresholds of risk; and participation.

7.1 Organisational arrangements for managing child protection services for disabled children

Respondents confirmed that the two main policies informing child protection social work practice are the Children (NI) Order (1995) (and associated guidance) and the ACPC Policies and Procedures (2005). There was clear agreement that these policies and procedures are equally applied to disabled and non-disabled children.

"We apply our child protection procedures to a disabled child as we would to any other child, as per the flow chart in the ACPC procedures... child protection is child protection and there should be one policy for all..."

Reference was also made to joint protocol and UNOCINI assessment guidance. Several respondents indicated that further guidance could be provided in relation to protecting disabled children and assessing parental capacity in the context of caring for a disabled child.

"I don't think there's enough thought in the UNOCINI guidance on parental capacity in relation to the disability issue. That's the debate we always have - is this compromised parenting because of the disability or because of the parents own capacity in general? It's very complex and when does that tip over and become a safeguarding issue?"

"ACPC could be clearer. Disabled children are almost an add on rather than child first... I'd like to see disabled children integrated more into the whole policy. I know that disabled children have very specific and sometimes complex needs but they are children first and foremost. It's about making sure nothing is missed because a child is disabled."

In all Trusts, following the ACPC guidance, a single point of entry team receives child protection referrals, usually the Gateway team. In all Trusts the initial assessment and investigation is undertaken by the Gateway team unless children's disability

services know the case and have made the referral directly to the family intervention team (apart from one Trust where the children's disability team continues to have responsibility for the child protection investigation). If appropriate, the Gateway team then refers disabled children's cases to either the children's disability team or family intervention team, or both. In cases where disabled children only require further family support, they may be referred to the children's disability team, particularly for children clearly identified as disabled (e.g. already known to children with disabilities service or diagnosed with a significant impairment). However, in other cases eligibility for access to children's disability services may not be straightforward and discussion between Gateway and children's disability teams is required, usually at Team Leader level, to make a decision about ownership of the case.

Social workers were also informed by Trust specific policies which provide further direction on local organisational arrangements and processes, often related to transfer of responsibility for cases. In relation to disabled children, some Trusts have operational policies outlining procedures for case transfer from Gateway teams to either children's disability or family intervention services. In other Trusts where no explicit written guidance was available, respondents indicated that it would be useful to have guidance on roles and responsibilities for disabled children.

"ACPC is clear but there is a grey area about whose role and responsibility is the disabled child. There seems to be a tension about who is going to provide this service. Is it child protection social workers who have the protection role or the disability social worker who is better placed to identify and resource need?"

"All those things need to be better structured and written down as policy on what exactly we do to address internal politics around that... It's not always clear as there is an element of discretion... "

"We work fairly well together but it's time to review the policies and procedures and when they're doing that to involve disability in drawing it up."

However, even when a transfer policy was available, there was still a need for discussion about ownership of cases.

"Even though we have a policy on who does what, roles and responsibilities still have to be agreed between the two team leaders and sometimes we have difficulties."

In this context, teams worked closely together to make decisions about the transfer of cases, usually at Team Leader level.

"It depends on the case. Gateway and disability services would have fairly frequent conversations about cases and if they're not sure they'll have further discussion and debate about which service it fits best under. We probably haven't got it fully resolved to where we need to but certainly people have a lot of conversations about that."

"A lot of it is about the networking with the other Team Leaders. You need to use a lot of negotiation skills and it helps to know them. You're balancing up the needs of my team with the needs of their team and the needs of the family come first."

In all but one Trust, it was clear that the lead responsibility for child protection services for disabled children lies with Family Intervention Teams (FIT) with children's disability services co-working the case if the child is known to them. Children's disability teams play a key role in the assessment of risk and need, and could lead on aspects of work with the family as part of the child protection plan, particularly if this involves additional support for the family.

"Sometimes it's a nominal following of policy and procedure but children's disability are still doing most of the work... I know some people get very frustrated about that because we know the family but if they want us to do it they need to re-write the policy and procedure."

Respondents acknowledged that it can sometimes be difficult to reach agreement about access to other services once a disabled child is known to one service. For example, some staff in children with disabilities teams indicated there may be barriers to having referrals accepted by family intervention teams or adult disability teams when they are already working with the child and family. The challenges of working across service structures and teams were highlighted and, in the context of high caseloads and reduced staffing and budgets, teams are reluctant to take ownership or co-work cases unless necessary. Some frustration was expressed about the challenges of communicating across teams and agreeing on ownership of cases.

"If disability is known, the Gateway team bat it off and... keep trying to send it to the disability team but it is a child protection issue not a disability issue... There is still a tendency to think in silos... All teams are under that much pressure that good co-working can be difficult."

"There are some tensions and there generally needs to be some discussion of roles around every case. The disability team would often feel we should be taking on a greater role in terms of the assessment and gathering all the information but our take would be that disability already have a lot of that information... "

"When we have non-disabled siblings we have more problems as children's disability are focused on the disabled children and don't often feel they have a role with the non-disabled children so there is some work to be done with that in terms of the child protection risks within all the family and how the roles overlap."

Given these challenges, respondents emphasised that the child protection plan must have clearly identified responsibilities and actions for the various professionals involved in the case.

In one Trust, the children's disability service undertakes the lead role in child protection proceedings for disabled children. In this Trust, children's disability teams work primarily with children with more severe or complex impairments and usually exclude those with mild to moderate levels of impairment. Staff in this Trust indicated that children's disability teams are best placed to undertake child protection work for disabled children.

"It lessens the burden on FIT and they have the specialist information about available services for children with particular disabilities or working more intensively with the family and having communication expertise e.g. sign language."

"There's no reason why children's disability teams could not hold the cases as they are qualified social workers working in the field, know the family and the issues."

These teams also took measures to avoid any undue influence of empathy with the parent including regular rotation of staff allocated to cases, particularly when there are concerns about parenting capacity. However, respondents in Trusts where family intervention teams led on child protection work had concerns about children's disability teams taking full responsibility for child protection cases.

"That could be worrying in terms of expertise and experience of risk assessment, being tuned into child protection issues and safety planning. You can know how to follow procedures but in terms of the risk assessment and safety planning I would be concerned if it wasn't their day-to-day work."

"There needs to be an objective social worker looking at the child protection issue because the disability social worker is conditioned to be supporting the family..."

Trusts adopted varying criteria for access to children's disability services, some focusing mainly on level/type of impairment and others moving towards a needs-based approach. In all Trusts, regardless of entry criteria to children's disability services, there are disabled children who do not access disability services due to their lower level or type of impairment. When child protection referrals are made for these children, Family Intervention Teams hold all responsibility for the case. However, they may not have experience of working with disabled children or knowledge of/access to the range of specialist services these children need.

"Social services see it that if they can go to mainstream schooling they're not that severe but those children are still vulnerable and in need of a specialist service and quite often child protection teams haven't got those resources to meet that immediate need which might relate to their over-representation in care."

"Children with autism and borderline children fall within the family intervention service not the children with disabilities team... yet children with disabilities would have greater expertise to handle those cases or access to resources for those children whereas we struggle to get services to meet their needs... For a while we were inundated with referrals about ASD and we couldn't access anything for them other than send out a family support worker or put in afterschool activities which don't work so well for a child with ASD."

"We are frustrated when a disabled child doesn't have a disability social worker because we can't access those resources for disabled children. I understand we are in our world and disability is in their world but sometimes we need more flexibility around the child. Children are more than just their disability and it's about their assessed need rather than 'oh she doesn't have a disability social worker so she can't access that respite facility'. It should be the understanding that children at risk should be safeguarded and that might mean accessing a specialist respite placement."

The lack of access to disability services for some children also impacted on the implementation of the child protection plan as family intervention teams had no control over decisions about the availability of necessary supports.

"We had a case where respite was cancelled at the last minute which is really frustrating for us because the respite was part of our safety plan for a full weekend and we have nothing else. We were told the day before that the respite had been pulled based on risks for other children in the same respite setting. That was very frustrating from our point of view because we weren't involved in that decision but it is our responsibility. We were left at the last minute to try and build a safety plan for that weekend so that is disjointed, difficult and frustrating... and ultimately the children were let down because they were prepared to go and didn't get to go to respite. Their parents were also frustrated that they had agreed a plan they signed up to in court that wasn't being stood over and we were having to introduce people into their lives that they didn't know which was inconsistent and had a huge impact on the situation."

At the time of the scoping exercise, a number of Trusts were reviewing their eligibility criteria for access to children's disability services, some moving away from a medicalised focus on impairment levels to a more holistic consideration of level of need. Such developments in Trust specific policy will impact on future access to disability services for all disabled children, including those in contact with the child protection system.

Key Points:

1. Regionally agreed criteria for access to disability services are required to ensure equality of access to services.
2. Written Trust policy on handling the transfer of cases between gateway/family intervention services and children's disability services is helpful and should be available in all Trusts.
3. A formal evaluation comparing approaches to managing child protection cases led by children with disabilities teams or family intervention teams would inform decisions about a regionally agreed approach.

7.2 Roles of family intervention and children's disability teams

When there are child protection concerns for a disabled child, or they are named on the child protection register, respondents indicated that there is no ambiguity about the roles of professionals or actions required as these are clearly stipulated in the child protection plan.

"As long as it's clearly drawn out within the child protection plan - that the family intervention worker is the driver of the child protection plan and then the disability worker is much more around supports and ensuring mechanisms of the plan are in place to ensure safeguarding... "

As most Trusts adopted a dual working approach, disabled children and their families had two social workers involved in their case (from children's disability and family intervention services). Respondents suggested that this approach provided additional support for families and opportunity for a more holistic assessment of risk/need from the perspectives of both disability and child care social workers. It was noted that social workers from each team bring a different set of specialist skills, knowledge and experience. Given their knowledge of the child and family, the children's disability social worker plays a key role in assessment and understanding the individual needs of the child, including their preferred communication style.

"Quite often children with disabilities know the family so we're not starting from scratch. We have an understanding of the complexity of the family and where the strengths and needs lie. And any cases we have co-worked have been positive "

"If you have a social worker that is familiar with the family and their history and the young person, particularly if they don't deal with change very well it's a good starting point that a lot of the assessment of needs of the child has been done."

"There needs to be co-working because the communication issues for disabled children are so varied and if we already know the child we have an insight into how they communicate. That would be very difficult for the child care team to pick up. When there's no verbal communication it's very easy to think they can't communicate."

Whilst the children's disability social worker focuses on supporting the family, the family intervention social worker drives the child protection plan. However, with two social workers on the case, there is potential for duplication of roles, reduced involvement from one worker and confusion for the family.

"It's weighing up do you just have one worker and that person be a master of all trades or do you have child protection expertise? We choose the road of expertise but making sure there's close collaboration so the family don't suffer with having two workers. The family's usually very clear about the role of the worker but I wouldn't say it's not without its tensions at times. It requires people working closely together and putting the child at the centre."

Respondents also emphasised the importance of both social workers clearly addressing the child protection concerns with the family and presenting an agreed and consistent approach to the child protection plan.

"Even if it's child care taking the lead the disability social worker needs to be saying the same things to the family so it's not 'I don't believe this is child protection but child care think that'. It needs to be a consensus for it to be effective."

It was acknowledged that this may be more difficult for social workers in children's disability teams who may have years of experience of supporting the family, a close working relationship with the family and unique insight into the stress and strain of their caring role over time. In this context, respondents emphasised the importance of keeping a focus on the best interests of the child and communication between teams. Indeed, the relationship a children's disability social worker has with a family may form the basis of working in partnership as child protection concerns are addressed.

"Nobody wants to see us at their door so the children with disabilities teams might be able to get further with the family and have a more cooperative partnership at the beginning."

"It's about the way you engage transparently with a family and... because of that relationship they may continue to cooperate to turn around the situation... So a disability social worker saying there's concerns here - I feel I can work with these but if there's not going to be a change or there's a deterioration I need to be making a referral under child protection. If you have that openness it's helpful."

Respondents repeatedly emphasised the importance of close supervision of staff working on child protection cases.

"You need to keep the focus on the risks in supervision... what's attributable to the disability and what's not.. Everything is coloured by how we approach our assessment, our mindset and that's the supervisory role."

"Supervision is critical. I have formal monthly supervision and an open door policy as some staff with complex cases need more supervision and need time to reflect on practice and access guidance on child protection cases."

For those in children's disability services, Team Leaders with previous experience of child protection work found their prior knowledge of the child protection system and relationships with staff in the family intervention service to be very useful. Team Leaders in these services emphasised that a key theme in staff supervision is recognition of when parenting is not good enough (particularly cases of neglect) and when thresholds of risk of significant harm are met.

"There is an acceptance that it can be difficult to care for a disabled child and parents should be given a bit of extra understanding... a bit of leeway and I understand that but it's important to keep the balance between that and dangerous practice. That's the key role of the supervisor and that can be difficult when you're managing a lot of staff."

"What I try to say to staff is take the focus off the parent and focus on the child. Be the child and think 'is this good enough? Is it meeting my needs?'"

For those in family intervention services, Team Leaders often acknowledged the lack of knowledge of impairment-related needs and disability services, and emphasised the importance of consultation with colleagues in disability services and other professionals involved in the case. In some areas, close working relationships and informal consultations between colleagues (sometimes facilitated by the location of teams in the same building) helped to promote a shared approach to safeguarding disabled children.

"We learn from each other and communicate quite well with each other and sometimes jointly work on a case and it's very helpful especially where family intervention lack knowledge of disability and children's disability may be lacking knowledge of child protection so we put it together."

"If we had a child protection issue for a child with a disability I would be automatically phoning the team leader in the children's disability team and we would work hand in hand asking for their direction and guidance... if they are involved before they have better knowledge of the child and how to communicate and a better working relationship so their input is invaluable."

"Location of teams is important. We are all in the same building and it's all about communication and networking and an attitude that we run ideas past each other. We discuss cases we are concerned about and check it out with each other."

It was also noted that voluntary organisations who work closely with disabled children play a very important role, not only in terms of intensive support for families of disabled children deemed to be at risk, but also in the identification and referral of child protection concerns, and implementation of child protection plans.

In child protection cases involving disabled children and their non-disabled siblings, involvement from both disability and family intervention teams is required and sometimes different thresholds for action are evident in court proceedings.

"There can be a bit of a tussle about who takes the lead if we're going to court. It's in care proceedings that we begin to see different thresholds for action... sometimes a disabled child will need to be removed from the home but a non-disabled child won't... perhaps linked with the child's vulnerability versus resilience and capacity to protect themselves."

"We have a few cases where we have reached the threshold for removal from the home for the disabled child but the court will not agree we've met the threshold for other children in the family so we remove the disabled child just because of their particular vulnerabilities putting them so much at risk."

Respondents were not sure how families of disabled children perceived having two social workers from different teams involved in assessing risk and implementing the child protection plan. However, they suggested that one of the main advantages of their dual role is the likelihood of accessing additional support services.

"It helps that the children's disability social worker who knows the family isn't leading on the child protection investigation. If they were, there would be a danger that the family would disengage and the child would lose out on services."

In addition, some respondents felt that the continued involvement of the children's disability social worker provided continuity of services during and after child protection processes.

"It's an easier transition back. The role of the disability social worker remains very, very supportive and very much about facilitating communication with both parents and the disabled child. That allows a better transition whenever the gateway process or family intervention piece comes to an end."

A final theme in the discussion of the roles of social workers was the potential to develop the role of the children's disability social worker in these co-worked cases. In many instances, the children's disability social worker played a major part in the implementation of child protection plans but had limited involvement at earlier stages of the child protection investigation. Some respondents felt that they could play a greater preventive role in child protection and joint protocol processes.

"The involvement of children's disability social workers in ABE would be brilliant even in terms of what they know about the child's disability and the best approach based on their working relationship and expertise... rather than sending a stranger to tell their story to."

Whilst the children's disability social worker may be consulted and accompany the child to investigative interviews, child protection professionals lead on joint protocol processes. Some respondents indicated that social workers in children's disability teams could undertake joint protocol training and engage more in these investigative processes for disabled children.

"There's huge issues around communication. We would never go out to interview a foreign national child in child protection without an interpreter and yet people go out who have no specialist skills in communication with non-verbal children to do joint protocol interviews. We need very specialist training tied onto joint protocol for a few people covering a wide area so they are using their skills more frequently."

This is particularly important in the Trust where children's disability teams lead on child protection work, but also relevant to the other Trusts where children's disability social workers have developed relationships and skills to support and communicate with disabled children undergoing a child protection investigation.

Key Points:

1. Written policies on the referral process for disabled children to family intervention and/or children's disability services should be provided. This guidance should stipulate criteria for access to children's disability services and provide a flow chart of actions in cases where disabled children are not yet known to disability services.
2. Agreed protocols on co-working arrangements with clear roles and responsibilities would support dual team working and ensure clarity for families and professionals.
3. In co-worked cases, a consistent message about agreed child protection concerns should be given to families and the nature and extent of the dual roles of each social worker should be clearly explained to the family.
4. Supervision of staff in children with disabilities teams who have limited experience of child protection issues and those in child protection teams who have limited experience of disability is critical. Consultation between social workers in both teams also supports sharing of expertise and decision-making.
5. Potential for further involvement of children's disability social worker at earlier stages of child protection processes and in joint protocol processes should be further explored.

7.3 Staff Training

All Trusts offer annual training courses on working with disabled children and their families, however, this tended to be at a very basic level and respondents were also unsure about the uptake of disability training for those working in gateway or family intervention teams.

"There would be disability awareness training but in all honestly disability training is very limited... generally we have to generate information on issues we haven't dealt with before and link in with special schools or the disability team."

"Our staff are not trained in disability issues. I would like training on the complexities of a family who are trying to manage and care for a child with a disability. Assessment of parenting skills and family dynamics is very different for a family with a disabled child and they need to think of the family differently - how the disability can affect the dynamics within the family."

Similarly, whilst all staff attend basic child protection training, the extent to which this training considers disabled children is limited.

"A lot of the training we would go to doesn't actually include disabled children. It's never recognised, it's more generic.."

"I don't know if there's enough specifics on disabled children and child protection. We all know they are more vulnerable and that is part of the training but there isn't anything more specific."

In addition, staff in children's disability teams felt they needed to be kept up-to-date more regularly on developments in child protection policies, procedures and processes.

"We notice when we do go into case conferences there are changes we're not always aware of. One of the problems is that sometimes there's not enough communication across to us about new policies and procedures or changes."

Including consideration of disabled children in generic child protection training could extend the audience reach as more social workers will access such training and, thus, the opportunity to raise awareness of their specific vulnerability could be increased. However, for those working closely with disabled children and holding primary responsibility for their protection, the need for more specific training on safeguarding disabled children was identified. In one Trust, a training course had been developed in-house that specifically focused on safeguarding disabled children. It was also suggested that joint training may help to facilitate the sharing of

knowledge about safeguarding issues for disabled children and the roles of child protection and children's disability teams.

A second area of training highlighted was that of communication with disabled children. The extent of training on alternative ways to communicate and engage with disabled children is variable and respondents emphasised the need for more specialist training is required.

"There's a course on communicating with disabled children and most of the team have done that now and it's all very basic level stuff like demonstrating communication boards. I think we should have more specialist training."

Particular concern was raised in relation to children with limited or no verbal language. There was general agreement that staff could benefit from training on the social work role in relation to communicating with disabled children, including general training on alternative communication systems and specific training on communicating with disabled children with regard to safeguarding.

Key Points:

1. An audit of the content and uptake of training already available related to working with disabled children and their families would help to identify gaps in staff training in this area.
2. Existing mandatory child protection training should give greater consideration to safeguarding disabled children.
3. Joint protocol training could be made more available for social workers in children's disability services.
4. Core specialist training courses should be developed for those working in child protection and children's disability teams: (a) communicating with disabled children and their families and (b) safeguarding disabled children. Supervision and staff appraisal processes could help to identify training needs in these areas to ensure continued professional development for staff working with disabled children.

7.4 Vulnerability of disabled children to abuse

Whilst respondents suggested disabled children were referred to child protection services for the same reasons as non-disabled children, some indicated that there may be trends in sources of referrals as more professionals are involved in the lives of disabled children (e.g. professionals working in child development clinics) and schools play a key role in their health and social development. Some respondents noted that special schools worked closely with parents of disabled children and there may be a slower rate of referral from this source.

"For non-disabled children we tend to get a faster response from schools... if it is a disabled child they tend to allow a bit more leeway to parents before they make a referral to us... referrals from special schools would usually be at a very high level and even then they would be quite reluctant because they tend to have a very close working relationship with parents so they feel making a referral to social services will jeopardise their relationship and that slows down referral rate or raises the threshold."

"Special schools work quite differently to mainstream schools in that they are quite protective of families too particularly around the areas of physical neglect. For example, children coming into school dirty or with recurring head lice, they try to manage that with showering programmes."

Respondents acknowledged the increased vulnerabilities of disabled children to abuse or neglect, including barriers to disclosure of abuse or neglect if they have a sensory or communication impairment. It was also recognised that there can be child protection concerns unique to disabled children that require multi-disciplinary decision-making. For example, misuse of/refusal to give medication, feeding regimes followed against medical advice, repeated missing medical appointments, unexplained bruising or concern about inappropriate restraint.

"One of the big challenges is cases where parents are deciding on treatment or a specific level of care and social workers and a multi-disciplinary team saying if the family are not providing that care in a certain way or not providing medication could that meet the significant harm threshold?"

There was concern about the danger of mistakenly interpreting behaviour or other signs and symptoms of abuse as being associated with the child's impairment.

"Risk is heightened if a child is unable to say what is happening to them... sometimes children's behaviour is misinterpreted... sexualised or challenging behaviour is put down to their disability and hormones so a lot of it is explained away whereas for a non-disabled child you would note that's out of character... so you need to keep people's antennae up, is there abuse? Being aware and asking that question - not assuming oh it's because of their disability and they're highly sexualised... that's why we need a group of professionals with different expertise."

Some respondents recalled cases when it was very difficult to judge if presenting behaviours or injuries were signs of abuse/neglect or were linked to the plausible explanations offered by parents that they were related to the child's impairment.

"For a child with a bruise with ADHD who is usually running around wrecking the room or jumping off things, there's probably a plausible explanation other than abuse and if the child is non-verbal and unable to tell you it's trying to get an understanding from all the facts available rather than getting it from the child."

Social workers were also presented with challenging cases where parents took action to protect/restrain their disabled child that could be deemed inappropriate or abusive.

"Say you have an anonymous referral that the parent handled their disabled child inappropriately the parent may explain the child has challenging behaviour and was going to run out onto the road so I grabbed them or restrained them so Gateway may be giving the parents the benefit of the doubt and it's a difficult one to call because within that context there is a plausible explanation."

"We had a parent who was locking their child with autism in their room because of their behaviours... so is that abuse or a form of restraint with the parents doing the best they can because the child is challenging and is wrecking the place? Or are they trying to get the child to sleep and by letting him know he can't open the door they are trying to settle him? 'Is that appropriate?' And that's where Gateway would look to the children's disability team."

The necessary involvement of more professionals in disabled children's cases could result in some delay in safeguarding decisions due to the time required to gather in-depth information from the range of professionals working with the child to inform assessments of risk. The range of professionals involved could also add to the numbers of health care professionals attending case conferences for disabled children.

"Sometimes the child protection response for a disabled child needs more time to consult people who have knowledge about the child and to communicate with the child... But that would still have to be reported to the Board as a breach of the usual 24 hr timeframe for responding to a child protection referral."

"In a case of unexplained non-accidental injury we need to wait for forensic medical reports, police investigation and joint protocol procedure to inform our assessment. In the meantime, we need to have enough safety wrapped around the child with intensive support going in and maybe people who are medically trained and consistent... If it was a non-disabled child the same processes would be in place but the assessment might be complete quicker as we would have less information to gather from doctors and paediatricians... so it's not that we delay because the child is disabled, it's because we need so much more information to gather, process and analyse that takes a bit longer and needs safety measures in place in the meantime."

In these cases, family intervention teams worked closely with disability teams to ensure a robust assessment.

"Assessments could be very in-depth and take a long time. We need to factor in the school, medical professionals and caregivers and the disability team. We could have lots of observations within the family home and a plan of 24 hour care within the family home to keep the child safe at home whilst the assessment was ongoing so disability take a role in that too although ultimately we were taking it into court the assessment was co-written with them and they attended all of the core group meetings so it was a very joined up process of working and we needed them in terms of preparing the children for the possibility of alternative placements, drawing up a profile for foster carers and the training they would need."

Key Points:

1. An audit of sources of referral for disabled children would identify trends.
2. Reviewing the mechanisms for disclosure for children with sensory or communication impairments (e.g. use of text or IT) would indicate areas for improvement.
3. Training is required to raise staff awareness of: signs and symptoms of abuse in the context of a range of impairment types; and their responsibility to use alternative communication styles to engage with disabled children and increase their opportunity to disclose.
4. Comparison of child protection cases for disabled and non-disabled children would help to evaluate the impact of multi-professional involvement in child protection processes (including delay and medical model perspectives).

7.5 Under-representation of disabled children in child protection statistics

One of the concerning issues for SBNI is the very low number of disabled children recorded as being on the child protection register in child protection statistics in NI. All respondents were asked to comment on potential reasons for this low number and most agreed that disabled children's engagement with the child protection system is under-reported mainly due to issues relating to definition, identification (e.g. children not yet diagnosed as having an impairment or not receiving disability services) and inadequate recording systems (e.g. questions about disability not included on forms or electronic systems).

"Part of this issue is reporting and the soscare system only has certain criteria that allows you to record who is a disabled child... so you have to be known to be learning disabled, physically disabled or sensory impaired and open to the disability team... The categories need refined in line with legislative definitions."

"The only disabled children on the child protection register we can identify are those known to specialist services... we know that is a huge underestimate because we don't have a system for identifying the children who are known to FIT because of moderate autism or learning disability or ADHD or mental health issues..."

"Based on our own figures, we are over-represented with disabled children in the child protection register although it doesn't look like that regionally in any Trust because of soscare... We really need to re-define that definition regionally so we can issue guidance to staff on how to interpret the question about disability e.g. does the child have a diagnosed or assessed disability as under the disability legislation?"

There may also be a reluctance by staff and families to identify a child as disabled.

"The other thing to bear in mind is the mindset of staff and the families who are involved who may not see the child as disabled."

Given variance in criteria for access to children's disability services across the region, most respondents emphasised that a regionally agreed definition of disability would help to improve staff confidence and consistency in recording disability. Following the establishment of an agreed definition, training could be provided to further develop social workers' understanding of disability and raise awareness of the importance of recording information about disability for the purposes of assessment and monitoring of the population of disabled children in contact with the child protection system. Alongside such efforts to clarify definitions and raise awareness, it was suggested that the identification and recording of disabled children may improve as electronic systems are developed regionally.

"We know there are disabled children in our system that do not feature in our stats and that's because our current soscare system doesn't allow us to capture that... but the new web based UNOCINI platform being developed will allow us to extract that data in the future because it allows you to list a profile of the child e.g. autism."

There was also some discussion of the possibility that some disabled children removed from home due to safeguarding concerns may not be subject to child protection proceedings as they may be voluntarily accommodated or relinquished into care by their parents.

"Sometimes children are moved quicker to keep them safe and the danger is removed. We have several cases in last couple of years where children were immediately removed because of concerns under an EPO. That would be followed by an assessment and could include a CP case conference but the child may not be registered because they are out of the risk environment."

Key Points:

1. A regionally agreed definition of disability would help to improve staff confidence and consistency in recording disability for children in contact with the child protection system.
2. Electronic and hard copy recording systems should be improved to include a mandatory question on whether or not a child subject to child protection proceedings has a diagnosed impairment or there are disability-related concerns.
3. Guidance on these systems and awareness raising for social workers in child care and disability teams would improve the recording of disabled children in the child protection system.

7.6 Thresholds of risk

There was a consensus across respondents in both disability and family intervention services that the threshold of risk of significant harm is clear and applied to all children, including disabled children.

"There aren't issues with differing thresholds for child protection - cases children's disability teams refer are highly appropriate and service managers all talk to each other to discuss concerns."

"Supporting families shouldn't get in the way of challenging risk and addressing child protection concerns and moving cases into the child protection system when required... if you've met a threshold of significant harm then it needs to be dealt with in child protection."

However, there was some variance in interpretation of levels of significant harm between teams with some issues being perceived as family support rather than child protection concerns.

"Sometimes the lines are very blurred in relation to safeguarding versus support and it is more blurred when the children are disabled... because it's a parent not being able to cope with the difficulties of disability."

Respondents recalled cases where there was a clear divergence of opinion between children's disability and family intervention social workers on whether or not presenting issues constituted child protection concerns. Some respondents argued that family intervention social workers may have higher thresholds of risk.

"The thresholds for family intervention staff on what would warrant child protection would be higher because they're comparing it with other cases they have... Children with disabilities teams would sometimes genuinely think something is a child protection emergency when we wouldn't. Their tariff would be lower because disability services are not involved in the day to day child protection stuff."

However, others noted that the divergence of opinion reflected the expertise of the children's disability staff who were less surprised by the circumstances of families of disabled children.

"We work with families in terrible situations who manage that really well and you have another family that have nowhere near the same level of problems and yet they fall to pieces at the first crisis. So we're used to that and see that every day. But there are a lot of other people who aren't so at case conference when they hear the story they think 'Oh that's terrible and how does that poor mother cope?' But then that poor mother still drinks and it's still a risky situation so you need to keep your focus very well."

This finding raises concerns about the subjectivity of interpretations of risk of significant harm for children's disability cases and emphasises the importance of co-working cases across disability and child care teams. It also highlights the danger of scapegoating the disabled child.

"The grey area is when the label of the disabled child is used... people have been drawn to say mum's capacity is reduced because of the disabled child and their behaviours but when you actually drill down into it it's not the disabled child because usually we have high levels of support going in... I am constantly talking to staff and seniors about making sure that our children don't get scapegoated."

"There is a danger of losing sight of the vulnerability of the children and putting behaviours down to being because of their disability. We did have a case where when I looked at the file we could have acted sooner... but every time we went out the mum would say 'I'm stressed. I have two children with disabilities whose behaviour can't be managed and they're climbing the walls' so the social worker was taking that one hypothesis and running with that rather than looking at other reasons or the chronology of referrals."

Concern was also expressed in relation to misinterpreting risk for children who were undiagnosed, particularly younger children with emerging disability-related needs.

"There is a reluctance to diagnose learning disability or ASD in young children so they are assessed as having traits of autism but with the result that professionals stop looking at the child's behaviour and start looking at the parents and how they are failing to parent effectively/cope so it becomes conceptualised as a risk or compromised parenting issue rather than a behavioural issue resulting from the child's impairment."

Staff in family intervention teams were particularly concerned about their skills for working with disabled children who are non-verbal.

"For children who can't verbalise it is difficult..... children whose voice you can't get at all frightens me and worries me. I can't communicate with them the way my colleagues in disability can and they know how to get that from children who can't talk and then there's a part of me that thinks I would like to do it better."

"When you dealing with a non-verbal child and parents giving you different explanations it's very difficult to know - when being upset at school is questioned mum could say it was because of a different bus driver whereas if you have a child without a disability arriving to school upset and telling you what was going on it's much clearer.

"My big concern is that I think they children we are missing are non-verbal and we are very much relying on people who know them very well to tell us what they are thinking and feelings and those are the people who could be abusing them. I don't know how people then would find out unless there is physical evidence."

Respondents also recalled cases where, due to communication challenges or capacity issues alongside lack of clear physical evidence, cases did not progress to court or prosecution.

"If you have a child who is borderline and with speech it would be a typical child protection case with a joint protocol interview... For children with no speech, those cases tend to go nowhere. Even if we get them to joint protocol, there tends to be a response that the DPP won't take this forward because it's not a credible witness."

"In joint protocol, impairment can prevent disabled children progressing beyond pre-interview stage because to get to the next stage the child needs to understand the process and the difference between truth and lies... for a disabled child, their impairment may mean they are not be able to reach that next stage which could lead to court and a possible conviction."

"We had a case of a young person allegedly raped by a relative and it didn't go to court so in his eyes he's innocent because there was no physical evidence. Everyone believed it had happened but because she had down's syndrome it didn't go anywhere because there is a view that this will not stand up in court but she was verbal and it was a case that could have gone to court."

Chronic neglect was the most difficult safeguarding issue for staff working with disabled children and their families.

"In cases of neglect over a long period of time, it can be very difficult for any professional to see a trigger that warrants a referral and the neglect can become very normalised as a feature of a family.

"It's hard when it's neglect because mum can say they're exhausted and the children don't sleep so my head is all over the place and I missed the appointment today but again it's about the pattern and if that keeps repeatedly happening and you put supports in place and there's no change you have to decide what is best for this child but maybe that is difficult for some people who may think 'I couldn't cope with caring for children like that' and maybe the school is also having difficulties and can't manage and the parents have it 24/7 so you can see why they are getting stressed out."

Whilst it was recognised that the rights and needs of the disabled child is paramount, the needs of parents of disabled children were also highlighted, particularly the effect of the caring role on parenting capacity. Social workers in disability services were acutely aware of the unmet support needs of parents of disabled children. These social workers worked with parents over time and witnessed the stress of their caring role and the deterioration in their parenting capacity over the years eventually leading to child neglect.

“We have had parents with years sleepless nights, no respite, struggling financially, all of that, because they have poured every physical and emotional resource they have into their child. The difficulty for us is if a child is injured when a parent lashes out and there would be a lot of empathy for parents in that situation.”

Empathy with parental experience raises questions for practitioners about the appropriateness or effectiveness of bringing a family to case conference when better access to family support resources could more effectively respond to the presenting concerns and prevent the need for a child protection investigation. It was acknowledged that more preventive efforts may be made to support parents of disabled children who are struggling with their caring role, with an emphasis on using family support resources to respond to concerns rather than proceeding to case conference and child protection registration.

"It can seem very punitive to parents who have struggled through the years but ultimately our concern and role is to protect that child and they have met the threshold for child protection registration. The disability social worker finds that harder but they know risk is risk."

"We're almost in a protective mode about the family and that's an area that needs to be looked at - the familiarity and sense of protection that grows when you're working long term with a family and you see the very clear struggles they are having - you would not want to walk a mile in the shoes of some of them - there's an element of understanding why if they're being slapped in the face by an older child they retaliate but it's still child protection... while we may have a level of 'I don't know how they are doing what they're doing' , it's still not acceptable and that's what child protection case conferences are for."

The impact of carer stress is clearly evident in cases of relinquishment when, in the context of child protection concerns, parents decide they can no longer care for their disabled child.

“We had a case of relinquishment in care where a non-verbal child with challenging behaviours presented with significant injuries and mum was telling us they were doing it to themselves... and mum with no tears just said 'I can't do this. I just can't do this'... we are looking for a specialist placement for that child. She was at that point before and worked through it but she's not prepared to do it again.”

Respondents were aware of cases where parenting became compromised due to lack of support for families in the form of practical and emotional support and substantial breaks from the caring role. Services were often provided as part of the child protection plan following child protection investigation, case conference or registration but could have had a greater preventive impact on safeguarding the

disabled child if they had been made available earlier to prevent escalation of neglect or breakdown in parenting capacity. Expanding on the provision of earlier intervention to prevent deterioration in parenting capacity was emphasised. Some respondents emphasised that much effort is made to support parents with intensive support within and outside the home to enable them to bolster parenting capacity and prevent cases from meeting the threshold for instigating child protection proceedings.

"If there is a safeguarding issue for the child you are in there and addressing it but maybe as you go along and you're putting supports in there's less chance of a breakdown so it is about supporting them prior to a crisis occurring."

"I think we manage things in a different way because of the child's disability and because we would be putting in a lot of practical hands on support which wouldn't necessarily be available from a FIT team."

"We have had parents under pressure where we are on the verge of child protection but a support package has gone in and has been sufficient to alleviate the pressure."

The importance of intensive family support was also emphasised for children who presented with complex needs or very challenging behaviours which also posed risks for siblings in the home.

"The challenges presented by the child with very challenging or aggressive behaviour is a bigger risk. A lot of that families would manage and siblings could be in the home and we are trying to manage the risk for them and family intervention wouldn't be involved in those cases. They would see that as a risk we need to manage because we could be providing support to the family to manage that risk."

For very complex and challenging cases, respondents indicated that shared care arrangements were often required to offer adequate respite and support for parents.

"Some children are in care because of the complexities of their disability the family cannot cope. A lot of them would still have a lot of contact with home but it hasn't been a child protection route into care. It's been because parents are saying 'it's too hard' and we've accepted that. It's about people needing a longer stay shared care residential option that RQIA will approve. That's what families with very complex children are asking for. They're not wanting to relinquish care. They're wanting to care as much as they are able to care for very complex children."

In many cases, actions specified in the child protection plan include the provision of intensive and scaffolded services to support parents in their caring role and enable them to safely care for their disabled child at home.

"We have some situations where the child protection plan builds in safety mapping and out of hours visiting with daily visits and increased support packages to enable children to have remained within the family home in an effort to support the family and the risk is being managed tightly within the family home."

Many respondents highlighted the extent of support provided to support families to continue caring for their disabled child whilst ongoing risk was being monitored.

"We put in heavy support packages of short breaks and a range of different services to try to support families with supervision... and without that the risks would be higher... and it's that balance of working out how much do you put in?"

"For many parents of disabled children the source of stress is very clear e.g. the child's behaviour or 24/7 level of care need... and it's not beyond their ability to care it's just beyond their energy levels... and those families need breaks so the small number of families of disabled children on the child protection register receive a significant level of resource because they require it."

Whilst this may provide an advantage for disabled children who may be able to access a range of supports and remain with their birth family during and following a child protection investigation, it is critical that the protection rights and best interests of the child are foregrounded. Respondents noted that staff in children's disability services are 'holding' high levels of risk to children remaining at home with following child protection investigation.

"The issue for children's disability teams is the management of risk. There are some situations where we know we are surrounding the family with scaffolding support services before it gets to a child protection investigation so there's a proactive arrangement surrounding the child... we are managing a high level of risk in respect of the maintenance and sustainability of families"

"There are families where you are very worried and have a high level of concern but we would struggle to get family intervention involved so we would manage a lot of risk... if we're already involved the message is that we manage it... and the stress of that is huge for staff. It's like a military operation keeping those children at home and it's very staff and resource intensive."

"For the disabled child who may have very specialised needs the parents know it would tend to raise the threshold of us removing that child from those parents to a carer who doesn't know their specific needs which could be more detrimental to that child so we tend to work to a higher level of risk management and would be more likely to keep them at home with their parents but with a much higher level of monitoring or support going in there from a range of professionals. So on a positive they are more likely to be maintained at home but on the negative they are possibly more likely to continue to be exposed to the harm."

It was also indicated that the judiciary were often in favour of trying all sources of support to maintain disabled children in the family home:

"The courts are very much of the view of 'What are you going to be offering that's going to be any better?' Yes you've got your thresholds and you are concerned but can you say you can do it any better? And that's about the impact on the kids if you bring them into care, separating them from their parents and siblings... and it's very difficult if you have other professionals involved with the family like a GP saying 'Give this family a break'. But it's also about what resources do we have for a young person with profound learning disability and autism?"

The importance of close supervision and support for these staff is critical to ensure that disabled children are safeguarded and, if required, to avoid delay in instigating child protection referral or removal of the child from the birth family home.

"We had a case where family intervention and children's disability did a whole chronology... and when we actually looked at as a collective it was horrific. So everybody had all these wee bits of information but when we pulled it together the amount of allegations and visits out to the children, the amount of appointments missed and phoning to say they're not coping - when we put all this together and then we had children who were so vulnerable and couldn't even verbalise then the risks went through the roof. That's the same in any case but what makes it different in a situation of disabled children is that you have more people involved and more chance of losing that information."

"It's for the social work manager in supervision to direct the social worker to look at it and see if there are any patterns in the behaviour... you need to do social histories to see the chronology of a case, especially in cases of neglect if change does not happen when supports are put in place action is needed."

One of the factors influencing a decision to maintain a disabled child at home following child protection investigation is the lack of alternative accommodation where the child could access specialist care (e.g. carers trained in specialist feeding techniques). Whilst staff in all Trusts emphasised that, if it was necessary to remove a disabled child from the family home to keep them safe, they would be removed, they also highlighted the impact of a severe shortage of available alternative care placements.

"Sometimes there is no alternative for a disabled child. We have a case of a single parent of two disabled children and mum is totally at her wits end but we don't have a facility they could go into so we have to maintain them at home with a very high package of care with as much safeguarding and respite as we can but if we had a facility I have no doubt those children would be in it. If you have a parent who is consistently saying they can't cope and you're putting things in place to try to manage it you are concerned about where the balance is. You could have a tragedy on your hands where someone decides they can't go on."

Given the lack of available placements, respondents were very concerned about the need to secure placements out of jurisdiction and, in some cases, outside Northern Ireland.

"There is a real shortage of placements for disabled children... We really struggle especially for children with additional needs and severe challenges. We have a few children placed in foster care and if those placements were to break down it wouldn't bear thinking about... There is no residential provision for disabled children and a lack of specialist foster placements as well. We only have respite care or out of jurisdiction in England. It's just a disgrace that children are taken to England and remain there because we have no provision in NI."

"We have had a number of child we just couldn't place... some children can't go into families due to their extreme challenging and destructive behaviours... We have placed children in Scotland because we have no options in NI."

"It's terrible. We have two very challenging children in independent service provider placements because the Trust can't provide a placement and we have to pay to keep them outside of the Trust services. They're very expensive but they're great placements for the children but it is ridiculous that we can't get a placement for a disabled child in the Trust."

Children who have complex physical and health care needs were often cited as being most difficult to place in alternative care arrangements as foster carers often did not have the specialist skills or experience required to meet their particular care needs. Many respondents recalled cases where they found it difficult to find a suitable care placement for a disabled child. Regionally, there is a limited number of foster carers who are trained or willing to care for a disabled child (particularly those with high level care needs or complex health needs). There is also a lack of suitable residential care options. As a result there can be a reliance on placements with short break carers who have prior experience of caring for a disabled child, in hospital settings or in residential short break facilities.

"When we are going to court we have to have a placement for the child and batter down doors right up the line... we have no residential options."

"It's absolutely awful and you're sitting thinking right up to the end of the day 'Am I going to have somewhere for the child to go tomorrow?' Especially a young child who has experienced trauma or separation or a child with autism who needs planning, preparation and routine to maintain positive behaviours."

"If they have or are likely to suffer significant harm they need to be removed and we need to find a placement. We can't compromise on risk because there's no availability of placements. We have situations where they have had to be admitted to respite units or social placement in hospital. And we have had children in those settings on a long-term basis because they had to be safeguarded which breached their statement of purpose."

It should also be noted that reliance on short break provision has a direct impact on the availability of those services for other families of disabled children. Indeed, in one Trust the placement of a disabled child removed from home due to child protection concerns into a residential short break facility resulted in the closure of that facility for all other disabled children who were due to have planned short break stays there.

Lack of available alternative care placements did result in some disabled children being supported intensively at home under close monitoring until an appropriate placement was secured.

“We know from regional meetings that all Trusts have cases of disabled children remaining in a placement that ideally you would like to move them on from. We have cases where we put a very expensive high intensive 24 hr plan in place to keep children safe at home until we found an appropriate placement... the compromised parenting is so great that the children need to come into care... It isn't an ideal situation but we make sure they are safe in the meantime. It would have done the children more damage to move them to an inappropriate placement resulting in two or three more placements...”

There is a need to develop the range of specialist foster carers who can offer a placement to disabled children with a range of needs. In some cases where parents can no longer continue with their caring role on a full-time basis, a shared care approach is the best option for disabled children. In some Trusts, this was effectively being provided through provision of intensive support within the home or a range of short break placements in place that result in the disabled child being away from the family home for significant periods of time each week. Therefore, respondents indicated that more formal shared care arrangements (requiring more specialist foster and residential care facilities) could best support families and safeguard disabled children, whilst also avoiding a reliance on shorter-term family support services which reduces their availability for other families with disabled children.

Whilst there are some services tailored to the specific needs of disabled young people (for example, NSPCC's programme on harmful sexual behaviour and school counselling service and Barnardo's Safer Choices project), respondents indicated that therapeutic support for disabled children who have experienced separation from family, trauma, neglect or abuse is also limited. Counselling and therapeutic support for children can be accessed via therapeutic services for looked after children,

mental health or learning disability services. However, the availability and suitability of such services for disabled children across the region is limited and some groups of disabled children may fall through service gaps.

"There is a particular gap for those who don't meet the criteria for specialist learning disability psychologists and at the same time present challenges to staff in generic CAMHS services who don't have the skills for working with children and young people with borderline learning disability."

"We could use the services child care use and CAMHS but if you have a child with a significant learning disabilities those kinds of services tend to feel they can't offer the specialism and there isn't really anything out there."

Key Points:

1. Early intervention with provision of a range of supports for parents of disabled children would help to prevent breakdown of their parenting capacity.
2. Developing the availability of trained, specialist foster carers would increase alternative care options for disabled children requiring emergency or longer-term care placements.
3. The development of more shared care options would help to safeguard disabled children whose parents require more intensive support and longer breaks from their caring role.
4. An audit of the availability of therapeutic support services for disabled children regionally would help to identify gaps in provision and areas for service development.

7.7 Participation of disabled children

Respondents recognised the importance of listening to children and involving them in decisions affecting their lives. However, there was concern about the extent to which this happens for disabled children, particularly those who do not use verbal communication or have communication impairments.

"If you have a child from an ethnic minority background the first thing you do is seek an interpreter but we don't do the same for disabled children with alternative communication or sign."

"There's a gap about consulting and involving the disabled child no matter how minimal that appears to be. We rely so heavily on parents for our assessments."

"We would use a range of engagement tools e.g. pictorial booklets... We link with speech and language therapists and occupational therapists but we've not got to where we need to get to... we've one member of staff trained in sign language - apart from that it's down to the skill of the worker but we could develop that further... we do see a gap in our skills and our knowledge bank."

In family support cases, practitioners often rely on parents of disabled children to assist with communication or represent their views and best interests. When there are child protection concerns related to compromised parenting, it is often not possible or appropriate to rely on parents to fulfil this role. However, it was acknowledged that there are significant challenges to hearing the voice of children who are non-verbal or have significant cognitive impairments. Implementation of the child protection plan can involve observations of disabled children and consultation with a range of professionals in contact with them regarding an assessment of their wellbeing, however, more efforts could be made to facilitate the direct participation of the disabled child. Respondents also noted that the availability of advocacy services tailored to the needs of disabled children is limited regionally. Developing these services would help to promote the involvement of disabled children in the child protection process and ensure their views and rights are considered.

Key Points:

1. Training on alternative communication approaches would help to promote staff efforts to communication with disabled children, including those who rely on non-verbal communication.
2. Further consideration should be given to the range of methods for involving for disabled children in child protection processes and decisions taken to keep them safe.
3. Social work staff should be encouraged to work closely with a range of professionals involved in the lives of disabled children on how best to facilitate the direct participation of the disabled child.
4. Development of advocacy services tailored to the needs of disabled children would help to ensure their views and rights are prioritised.

4. Conclusion

This scoping exercise has usefully identified the key policy and organisational arrangements impacting on child protection work with disabled children and the issues and challenges for social workers responsible for safeguarding disabled children. The findings emphasise the importance of: clear policies on the responsibilities of children with disabilities and family intervention teams; communication between both teams; willingness to accept referrals for disabled children already known to one service; and recording procedures that allow for the identification and reporting of disabled children in contact with child protection services.

The scoping review also indicates areas for further training and service development. In relation to training, the findings indicate that: the vulnerability of disabled children to abuse or neglect should be incorporated into generic courses for staff in disability and child care teams; specific courses on safeguarding disabled children could be developed for those working on child protection cases; and training on approaches to communicating with disabled children would be relevant to social work staff in both disability and child care sectors. In particular, training on understanding disability and communicating with disabled children for social workers in family intervention teams who are working with a range of disabled children (including those with autism and significant cognitive impairments) who are not eligible for children with disabilities services in some areas.

Areas for service development include the need for earlier intervention, shared care options and more specialist foster and residential care placements for disabled children, particularly for children presenting with complex needs or very challenging behaviours. Advocacy services would help to promote the participation of disabled children in child protection processes and represent their views and rights. Finally, therapeutic services for disabled children who have experienced abuse or neglect could also be further developed.

As this was a small-scale scoping review, it also highlights the following areas for further service evaluation/audit and future research:

- Comparison of the child protection cases involving disabled children who have and have not had involvement from children with disabilities services across Trusts;
- Exploration of disabled children and their parents' views and experiences of child protection processes;
- Examination of the extent of roles of social workers in both children with disabilities and family intervention teams when child protection cases are co-worked;
- Investigation of child protection processes for children on the autistic spectrum as a different range of services may or may not be available to these children;
- Examination of the care placements provided for disabled children who are removed from the family home due to child protection issues and comparison of cases who are returned/maintained at home and those who are not;
- A case file audit of the time between initial child protection concerns and actual processing of referrals from children with disabilities teams to gateway or family intervention teams, especially for cases of neglect; and
- A larger-scale study of safeguarding issues for disabled children across service domains, incorporating the views of a broader range of professionals (including school staff, health professionals and police).

Finally, as many Trusts are in the process of revising policies and criteria for access to disability services and as core policies and procedures are revised (including Cooperating to Safeguard Children and ACPC procedures), it is important that the particular safeguarding needs of disabled children are fully considered and integrated into updated policy and guidance documents. This requires inclusion of guidance on communicating and working with disabled children, and clarification of key roles and responsibilities for those working across service areas when disabled children are engaged with the child protection process.

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Appendix 1: Topic Guide for Key Informants

- a) What are the guiding policies followed by staff in relation to safeguarding disabled children?
- b) Why do you think we have very small numbers of disabled children in our regional child protection figures?
- c) What are the usual sources of, and reasons for, child protection referrals for disabled children?
- d) What is the child protection response for a disabled child in your Trust?
- e) What works well and what could be improved?
- f) In what circumstances would the children with disabilities team refer to the gateway team and vice versa?
- g) Who holds responsibility for cases when there is a child protection investigation relating to a disabled child who is known/not known to disability services?
- h) What thresholds of risk are applied for disabled children? Does level or type/complexity of impairment impact on the child protection response?
- i) What issues would be considered at child protection case conferences for disabled children?
- j) What alternative care options are available for disabled children during child abuse investigations? How do these influence the child protection plan?
- k) What processes are in place to ensure the views of disabled children are considered?
- l) What follow up therapeutic services are available for disabled children who have experience abuse or neglect?
- m) What training is available to child protection and children with disability teams regarding safeguarding? Are there any training needs in this area for staff?