

The impact of integrated Children's Services on the scope, delivery and quality of social care services for deaf children and their families.

Phase 2 Report – February 2010
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The views expressed in this report are, however, those of the authors and not necessarily those of NDCS.

Ethical Approval

This work was approved by the Association of Adult Social Services (ADASS), the Association of Children's Services (ADCS), The University of Manchester Research Ethics Committee and met the governance requirements in the one Local Authority who required it.

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Executive Summary

The impact of integrated Children's Services on the scope, delivery and quality of social care services for deaf children and families¹.

Fifty-seven Local Authorities in England have taken part in the largest ever study of the organisation and provision of social care services for deaf children and their families. Specifically, the two-part study focused on the impact of integrated Children's Services on how social care needs are identified, assessed and met for this specialist user group.

This question is important because deaf children are at particular risk of a range of less than optimum outcomes: they are 3.4 times more likely than hearing children to experience abuse; 40% will experience mental health problems in childhood; educational attainments lag significantly behind national averages. Deaf children, whether using spoken or signed language, face significant challenges in achieving normative linguistic, cognitive and psychosocial development. Over 90% are born into hearing families with usually no prior experience of raising a deaf child. Meeting the complexity of deaf children's needs within the diversity of their family contexts does not lie solely within the skills and responsibilities of audiology and deaf education services. Furthermore, some statutory duties lie specifically within the domain of social work services.

The research was funded by the National Deaf Children's Society, carried out as part of the Social Research with Deaf People programme at the University of Manchester² and was approved by ADASS and ADCS.

Service organisation effects

In the case of deaf children and their families, the main impact of the move to Children's Services Departments has not been the integration of education and social services, but rather the effects of the disaggregation of Adult and Children's Services. Previously social care services for d/Deaf people had commonly been organised by means of specialist teams providing 'cradle to grave' provision staffed by social workers/social care professionals with highly specific skills. The separation of Children's and Adult services has created a puzzle for Local Authorities about how best to meet the needs of deaf children and provide specialist services to d/Deaf adults when the available social care resource might be highly specialized and also quite small. We found in light of integrated Children's Services:

Only around a third of Local Authorities had specialist team/team arrangements with designated responsibility for deaf children and their families and containing social workers/social care personnel qualified and experienced in working with deaf children and their families.

Where broad based 'children's disability teams' had designated responsibility, they were unlikely to have any internal specialist expertise beyond an occasional worker with basic communication skills.

The lack of specialist knowledge and expertise was significant because it demonstrably hampered teams from being able appropriately to recognise the seriousness of a presenting problem when it concerned a deaf child.

¹ Young, A.M., Hunt, R., Smith, C. (2008). The impact of integrated Children's Services on the scope, delivery and quality of social care services for deaf children and families (Phase 1 report). London: NDCS. http://www.ndcs.org.uk/news/ndcs_news/social_care_radar.html

² <http://www.nursing.manchester.ac.uk/research/researchgroups/socialwork/sord/>

Within non-specialist service arrangements, being ‘deaf’ was rarely seen as encompassing complex developmental concerns or presenting particular safeguarding risks. A situation tended to have to escalate to a generically identifiable crisis before any response was possible.

Where teams had specialist knowledge and experience, deaf children and families’ needs were significantly more likely to be identified as meeting eligibility criteria for the provision of assessment/services and there were clear referral pathways for families and other professionals alike.

The retention of service responsibility for deaf children and their families within Adult Services structures only worked where arrangements occurred by design, rather than by default. Otherwise specialist social workers were left to find ‘ways round the system’ whilst their ‘manager turns a blind eye’.

We found 4 Authorities with no designated service arrangements at all in respect of deaf children and their families.

Specialist workforce

Over a quarter of the Local Authorities did not employ any qualified workers who were specialist working d/Deaf adults and/or deaf children. In no case can this result accounted for by the Authorities concerned having contracted out arrangements whereby a specialist voluntary organisation, for example, provides services.

In 46% of the Local Authorities there were no qualified social workers who worked with deaf children and their families either as part or whole of their job remit.

The median staff complement of qualified social workers working with deaf children and their families across all sampled Authorities was 0.25.

‘Children in need’

In only 40% of participating Authorities would a deaf child be regarded as a ‘child in need’ in line with the definition contained in the Children Act 1989. Of those who would recognise this status, only two thirds were of the view that such designation would lead to even an initial assessment.

Integrated working

In half of the Authorities, there were no systematic arrangements for ensuring that deaf children and their families receive a joint assessment involving health, education and social care, nor a defined multi-disciplinary ‘pathway’ for planning and service provision.

Over 50% of Authorities said they had no formal referral arrangements between social work and education professionals “where deaf children and their families may require assessment and/or service provision”.

Nearly 45% of Authorities said they had no formal referral arrangements between social work and health professionals “where deaf children and their families may require assessment and/or service provision”.

Statutory child protection

Only 37% of responding Local Authorities described co-working arrangements between child protection teams and specialist social workers.

18% described a situation in which there was no co-working at all, either because specialist social workers did not exist to co-work with anyway, or because specialists working in Adult services were not allowed to work cases involving children, or because the CDT did its own child protection work and did not involve outside deaf related specialists.

The remaining Local Authorities described various arrangements that involved getting 'help', of different varieties, from workers either within or outside of their Local Authority. In looking at the range of descriptions given to us of the external help sought, we were struck by three things: (i) how much the help took the form of information and advice in a general sense about deafness or sign language rather than specifically in relation to any particular case; (ii) how little awareness there was about the extent to which specialist knowledge might be required about cultural issues or deaf child development issues in a broad sense, rather than only about language and communication (several respondents described involving an interpreter as of itself solving the problem of specialist aspects of a case); (iii) how ad hoc the arrangements appeared to be.

Additionally, no respondent who was not themselves a deaf specialist seemed aware that there would be issues that needed to be taken into account or that would impact on the investigation if a child was deaf and not a BSL user.

Principal Conclusions

Whilst there is evidence of some good practice that enables pro-active social care involvement with deaf children and their families and thus extends the range of provision and resource for those families in such a way as to complement that provided by educational and health colleagues, such arrangements are exceptional. In only a minority of Local Authorities would there appear to be effective, skilled and specialised social care provision for deaf children and their families.

There is clear evidence, on a widespread basis, of poor integrated children's services arrangements in respect of deaf children and their families which results in a lack of specific attention to deaf children and families' social care rights and needs; poor recognition of need and provision of assessment; severely limited ability to work preventatively within a broad understanding of safeguarding; ambiguous pathways of service provision; responsiveness only in situations of acute need, (the escalation of which may have been preventable); and lack of focus on the psycho-social developmental, linguistic and cultural challenges and differences of the full diversity of deaf children. In these circumstances, and with specific reference to social care, there is strong evidence to suggest that the statutory duty on Local Authorities to co-operate within Children's Services to promote the well being of children is being significantly compromised in relation the well being of deaf children and their families.

1. Introduction and Research Aims

This report presents the findings from Phase 2 of a research project investigating the impact of integrated children's services on the provision of social care services for deaf children and their families.

The overall research project has sought to answer two questions:

1. What is the impact of the move towards integrated children's service arrangements on how social care services for deaf children and families are organised and delivered?

2. To what extent do new arrangements within integrated services frameworks create opportunities for and/or threats to identifying, assessing and meeting social care need effectively?

Phase 1 (published in October, 2008)³ sets these questions in their contemporary policy and research context. It was based on in-depth case studies, including documentary review and 17 interviews in five Local Authorities. These Local Authorities represented different types of service history and trajectories of development in line with the integration of Children's Services. The Executive Summary of the main findings of Phase One can be found in Appendix 1.

Phase 2 is national (England) in scope and set out to:

- Map the findings of Phase 1 of the research on a national (England) basis
- Obtain a more complete picture of service organisation and delivery in relation to this service user group
- Test out the extent to which the benefits and disadvantages of service delivery structures identified in Phase 1 are common across a wider range of contexts and service organisation structures
- Identify any potential challenges to Phase 1 findings

³ http://www.ndcs.org.uk/news/ndcs_news/social_care_radar.html

2. Research Methods and Sample

2.1. Project Parameters

The project was confined to England only. 'Deaf children' is used throughout to refer to deaf children and young people from birth to 19 years (the current remit of Children's Services departments). Data were collected between 1st January 2009 and 31st May 2009.

2.2. Data Collection Method

Data were collected by means of a structured questionnaire containing mostly scaled and multiple choice questions. The questions derived directly from the main findings of Phase 1. A copy of the questionnaire can be found in Appendix 2.

This questionnaire was sent out in advance for consideration by the participants (see below), but it was not filled in and returned as a written or on-line questionnaire. Rather, each respondent was phoned individually and the answers to each question gathered by means of direct interview, with the interviewer noting down the specific responses and all additional information provided in the course of answering the standard questions⁴. We adopted this dual layer approach because:

- The heterogeneity of local authority provision was likely to mean that there would be versions of service organisation and delivery that did not necessarily fit the structures we had derived from the phase 1 study. We wished to capture the full range of variation where local arrangements might differ from those we had previously identified. By offering the possibility of 'explaining' answers we would both be able to capture these variations and avoid errors deriving from respondents having to make their services fit our pre-determined categories.
- The method offered respondents flexibility in that it allowed careful consideration in advance but the actual process of data collection could be carried out swiftly at a time that suited their working schedule.
- The opportunity for respondents to 'answer back' and provide more details when they felt our categories or questions were not appropriate to their service served as both a validity check and an enrichment to the data. [At several points in the presentation of findings in Section 4.5, there are examples of how seemingly opposite answers given to scaled questions actually meant the same thing when the context from which respondents was replying was fully understood. Without an interview approach to the questionnaire then the seeming contradiction would not have been identified as a false one].

We received positive feedback from many respondents about how useful they had found this approach to data collection.

⁴ In the information supplied, we offered the possibility of doing this interview by video phone/skype for any professional who preferred to do the interview in BSL. Nobody requested this option.

2.3. Recruitment of the Sample

Following approval from ADASS and ADCS, all directors of Adult and Children's Services were contacted about participation in the research project (See Appendix 3). It was necessary to contact both Adult and Children's Services because phase 1 had demonstrated that specialist social care services for deaf children and their families may be located or managed from within Adult Services structures.

Designated participants were provided with an information sheet and a personal consent form. Even though the Authority might have consented to be involved in the project we wanted to ensure that personal consent was obtained from anyone who might be representing that Authority (See Appendix 3).

A mutually agreed time for the questionnaire-interview was negotiated by 'phone and email.

2.4. Description of participating Local Authorities

Number of participating Authorities

Of the 153 Local Authorities in England, we contacted 148 because we did not include those 5 Authorities who had participated in phase 1 of the research project.

Of the 148 Local Authorities contacted, 69 (46.6%) responded in some way. We received 53 consent forms, but one agreement to participate was received after the cut off date for the project, 3 LAs agreed to be involved but we were unable to locate an appropriate person to respond within the project timescales and 2 respondents failed to complete any identifying features on the consent form and so were untraceable. This resulted in 47 consent forms which proceeded to interview. In the course of completing the interviews, it became apparent that the participants were actually responding on behalf of 51 Local Authorities as 3 respondents were representing more than 1 LA. In addition, one anonymously completed questionnaire was received through the post and was included in the statistics.

Fifteen other communications were received. Six Local Authorities declined to participate for a variety of reasons. In eight instances we were in communication with the Local Authority but failed to receive consent within the data collection phase. In addition one telephone call enquiring about participation was received too late.

This resulted in 47 completed questionnaires on behalf of 52 Local Authorities on which this report is based. The final sample is thus made up of 35.1% of the 148 Local Authorities in England eligible to be included in this report (see Figure 1 following).

Characteristics of participating Authorities

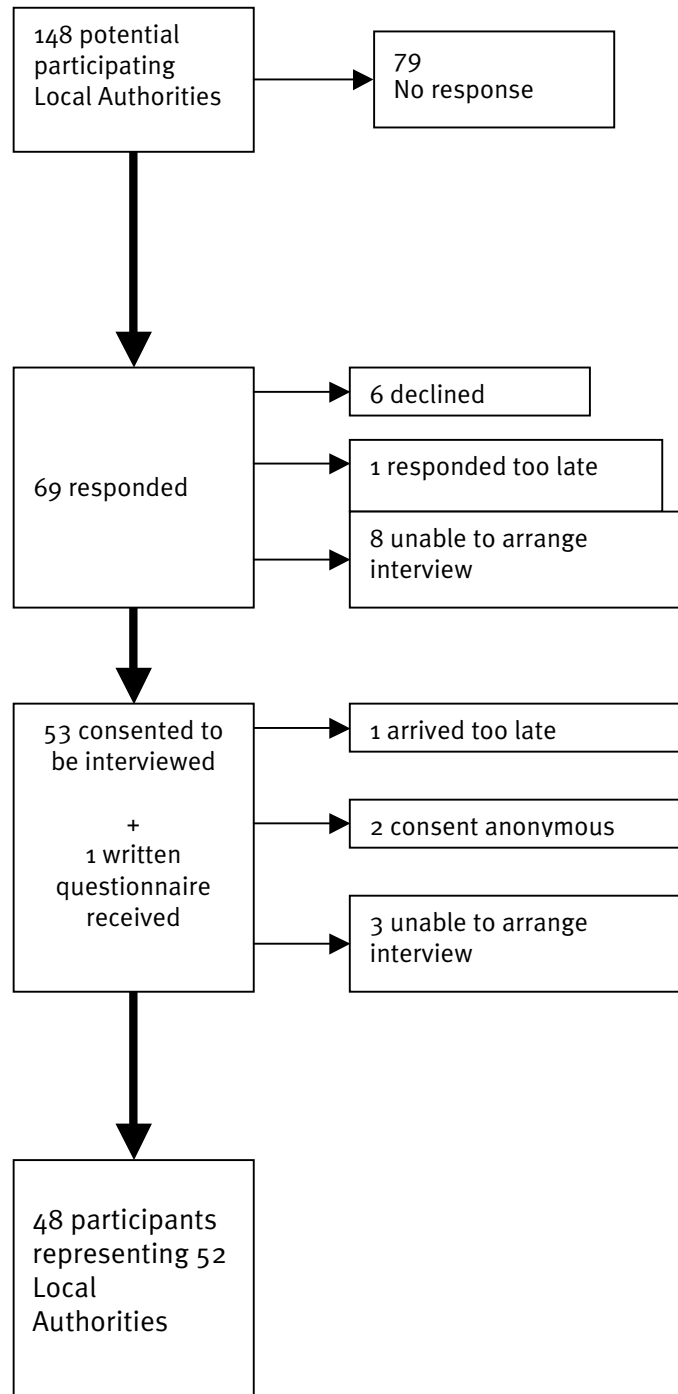
Of the 52 Authorities represented in this report, 9 are London boroughs, 19 are unitary authorities, 15 are large rural counties and the remaining 8 are mostly inner city areas. The one anonymous postal response clearly could not be

classified. Geographically, the 51 classifiable Authorities are fairly evenly spread throughout England although the North-East is under-represented.

Characteristics of participants (roles/job titles)

54 actual people participated in interviews (in some cases more than one person answered at the same time or for the same Authority). For example, a mainstream social worker within a Children and Families team chose to participate in tandem with a Community Care worker in a sensory team. On two occasions there were a social care and an education professional on the other end of the 'phone and on two occasions there were social care representatives both from the Local Authority and from the Voluntary Organisation to whom the service was contracted out. Overall, of the 54 participants: 4 were from an education background; 47 from a social care background; and 3 were of an unknown background. In addition, in 5 cases the respondent had discussed the questionnaire with someone from a different part of the Local Authority and provided agreed answers or in one case, two different sets of answers. The non-present respondents were in 2 cases from a different part of social care and in 3 cases from education

Figure 1
Summary flow diagram of number of returns and participating Authorities



3. Service Organisation

3.1. How are social services for deaf children and their families organised?

Results from Phase 1 of the research had shown considerable variations in the organisation of social care services for deaf children and their families. More significantly it had demonstrated how different decisions about the appropriate location of such services within new integrated structures within Local Authorities affected the scope, quality, accessibility and responsiveness of services for deaf children and their families. Specifically, the phase 1 results had highlighted:

- (i) Where there was no investment in specialist deaf Children's Services arrangements, specialist social workers/social care workers located in Adult Services experienced new constraints on their ability to become involved in deaf Children's Services without having confidence that any branch of Children's Services would in reality be 'picking up' deaf children and families needs except in cases of extreme seriousness.
- (ii) Those workers in Adult Services who had specialist skills and knowledge of deaf services nonetheless strove to find ways round a system to enable them to become involved with deaf children and their families.
- (iii) The dispersed social care response made it difficult to be clear, in some cases, about which branch(es) of Children's Services might be actually responsible for social care in the case of deaf children.
- (iv) Where investment had taken place in the establishment of specialist team/team arrangements that specifically had a remit for all aspects of social care in relation to deaf children, there was much greater clarity of remit.
- (v) The nature of the structure of social care services for deaf children and their families was confirmed as exerting a significant influence on what could be provided, was deemed appropriate to provide, by who and how.

[Phase 1 report, extract from summary section 4.8, p, 29]

Therefore, as a precursor to investigating further these conclusions on a wider scale, information was sought about how each Local Authority organised their social care services for deaf children and their families. As one respondent pointed out to us, that question was not necessarily easy to answer and the answer could change in light of experience:

"It's a changing process. A SW from Deaf adults moved to the CDC [Children's Disability Centre] 3 years ago. That wasn't right as no colleagues were familiar with the issues. So she moved to the sensory support team [education]. Now the post is moving back to adult services." (26)⁵

Through specialist deaf children and families teams

In only 11.5%⁶ of the responding Authorities [n=6] were services provided through a specialist deaf children and families team. In five instances education took the

⁵ The number in brackets that follows direct quotations refers to the code we have given to each responding Local Authority, it is not a numerical total of how many people answered in that way.

⁶ All percentages presented are a percentage of those who answered the question rather than a percentage of the participating Authorities

lead and managed the team, but in two of these teams there were no social work qualified staff. In the other instance, services to deaf children were provided by a children's sensory team which was part of a larger sensory and physical disability team.

Through the CDT (Children with Disabilities Team)

In 42.4% of cases [n= 22] social care services for deaf children and their families were the responsibility of the Children with Disabilities Team (CDT) but only 12 of these teams considered that there was specialist deaf child related expertise within the team. Furthermore, this defined 'expertise' encompassed any level of British Sign Language competence (including basic level). In other words, it is not possible to be confident that the expertise within even the minority of CDTs that claimed to include it was of a breadth and level appropriate to social work practice with deaf children and their families.

In the remaining 10 of the participating Authorities who designated responsibility to the CDT, the CDT sought specialist deaf knowledge either from the Deaf team located in Adult services [n=7], or from elsewhere [n=3]. However, collaboration with Deaf teams in Adult services could mean a range of differing levels of involvement. It could be confined simply to the provision of aids and equipment to deaf children and their families (where Adults services had retained responsibility for this aspect of work across the whole age range); or it could encompass other kinds of involvement (ranging from information and advice to potentially co-working). However, as data from the Phase I study demonstrated, without formal arrangements for the involvement of Adult Deaf services with the CDT (or other colleagues), co-working was unlikely.

Other sources of expertise drawn on by CDTs were usually considered to be the specialist (deaf) education service, or in one instance the RNID. However, as the results on integrated working practices later demonstrate (Section 3.3), joint working arrangements between social care and specialist education services are generally far from strong. The respondent who pointed to support from the RNID commented:

"We muddle through. If we get really stuck we contact the RNID interpreting service." (2)

This comment is particularly concerning as here expertise is defined in terms of a sign language interpreter if the child signed, rather than in terms of specialist social care related expertise concerning deaf children and their families. The respondent was, in this case, of the view that the primary reason a CDT would need to seek additional expertise would be because of communication barriers, rather than, for example, any additional issues that might be associated with deaf children's developmental differences.

Through specialist d/Deaf services within Adult Services

In 19.2% [n = 10] of cases, services for deaf children and their families were provided by specialist d/Deaf services within Adult Services. However of these 10 Authorities, only 6 did so by what they called formal arrangements such that their specialist remit continued to be 'cradle to grave' as had usually been the case before integrated Children's Services structures. As Phase I findings had shown,

the location of services for deaf children within d/Deaf Adult services could be effective in ensuring a clear point of contact for families, a depth of specialist knowledge, and a clear remit for involvement. Phase II findings additionally suggest that such an arrangement also appears to require a commitment to ongoing active negotiation between the parties involved and regular review of the systems.

"Children's services pay for a full time senior practitioner. There is a formal transfer of funds. The adult manager meets with children's services and education services. Pathways are jointly written. If the barrier is communication, it goes to this team. (8)"

However, "formal arrangements" within d/Deaf Adult Services did not always necessarily imply strategic thinking or active decision making about whether this was the most appropriate and effective way to meet the social care needs of deaf children and their families:

"When services split, adults kept the money. Never disaggregated" (36)

"But it's about to change - we're currently looking for a SW." (42)

In other cases so called formal arrangements were more akin to an informal agreement:

"There is no transfer of funds. A formal agreement is in process (currently it's a 'back of fag packet'). Not sure if there will be money attached or whether it will be on a good will basis." (49)

Additionally, 4 of the 10 Authorities where services were delivered through d/Deaf Adult Services could not be described as so doing through any kind of formal arrangement. Rather it was best described as occurring by default since no arrangement had actually been made for d/Deaf children and their families. The Deaf services team within Adult services simply continued to offer the service as they had done prior to the disaggregation of Children's Services to their best of their ability in the new structures.

These instances were of significant concern. In effect, in these Authorities deaf children and their families were invisible within the service organisational structure with no explicitly designated service arrangement. As Phase I findings have previously demonstrated, where such a lack of arrangement occurs, from a service user's point of view there is no transparent pathway of contact, from a joint working perspective with other services (e.g. health) there is no formal way to do this, and from a social care professional's point of view workers are left to find a way round a system that does not recognise a constituency of service user and need. As one respondent in Phase II commented:

"Services for deaf children and families were historically combined in a team which provided services with regard to deafness for children and adults. Moves to integrating children's services led to services for deaf children being removed from this

team but without the resources to ensure a service for deaf children/families. The LA is currently trying to secure funding for a specialist social worker with deaf children/families to be placed in children's services." (5)

Through contracted out arrangements

Six Authorities contracted out their services for d/Deaf children to a voluntary organisation. In all 6 cases services to Deaf adults were also contracted out to the voluntary organisation, effectively creating a 'cradle to grave' service located externally to the LA. In four instances a LA team would become involved in the event of a child protection issue arising, working in association with the voluntary organisation.

Other kinds of arrangements

Eight Authorities had arrangements which did not easily fit into any of the categories provided and were sufficiently different to be categorised as 'other'. In most instances (n=5), a specific 'cradle to grave' service had been specifically established. For 3 of these Authorities this was commissioned from a neighbouring Authority. One Authority shared a service for hearing impaired and visually impaired children with 2 other Authorities, but this service had no qualified SW within it and appeared to be education focused.

For one Authority the location of services depended on the age of the child, the level of complexity of the disability and the medically defined level of deafness. Thus a deaf child might receive social care services from the CDT, or mainstream children's social care, or the local voluntary organisation, or the education services.

Interestingly, one Authority had continued to provide a 'cradle to grave' service for Deaf adults and deaf children, but had located this within Children's services rather than within Adult Services. Adult services commissioned services for Deaf adults from Children's Services by means of a service level agreement. The rationale for this was that this created a 'safer' situation for everyone in terms of maintaining a high level of specialist expertise and identification of risk.

Finally, it is worth noting that no Authority used one of the predefined categories offered, that of a single specialist worker outposted to a team other than CDT.

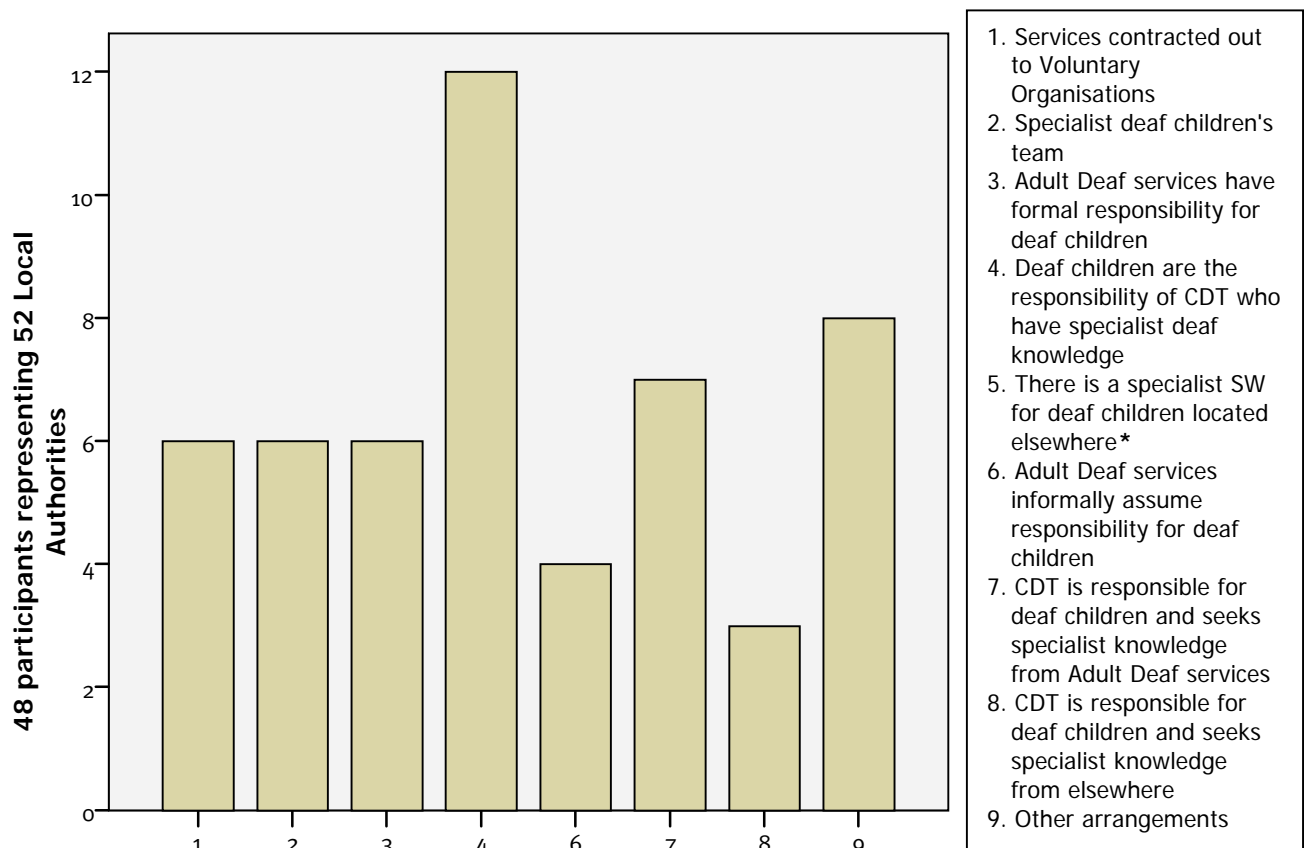


Fig 2. Delivery of Services for deaf children

*not illustrated as there were no responses in this category

A comparison of services for d/Deaf adults and deaf children

In contrast to what we have previously termed the “dispersed social care response” in relation to children’s services, the organisation of social services for d/Deaf adults was more straightforward. In around two thirds of Authorities (68.6%, n=35) a dedicated specialist team provided services either as their own team or as a specialist team within a larger sensory or physical disabilities team. A contracted out service arrangement accounted for a further 17.6% of cases [n=9] with contracted organisations being either a specialist deaf related organisations in the voluntary sector, or a specialist team in a neighbouring Authority.

However, it was of considerable concern that in 3 Local Authorities there was no specialist Adult Deaf Services workers at all. (This finding is not accounted for by those Authorities who might have contracted out their service to a neighbouring Authority or to an external agency).

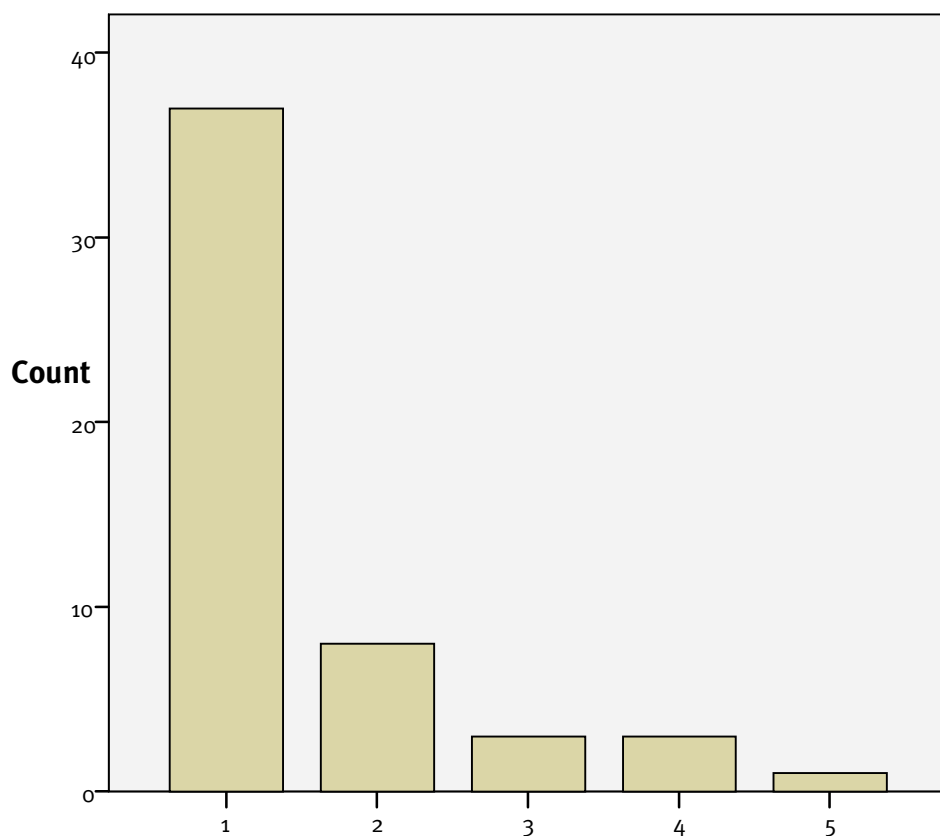


Fig 3 Delivery of services for d/Deaf adults

Part A

A 14 year old profoundly deaf boy in mainstream school is currently excluded. A recent transition meeting reached no firm conclusion about his future. Questions have been raised about his use of alcohol, staying out very late at night and being abusive to his mother. His oral communication skills are very limited. He uses sign language but it is not thought to be age-appropriate

3.2. In Summary

- There were many and varied service organisation arrangements in place for meeting the social care needs of deaf children and their families.
- Although a minority consisted of the establishment of specialist deaf children’s teams these did not necessarily include any qualified social workers.
- It is of considerable concern that 4 out of the participating 52 Authorities had no officially designated service arrangements at all in respect of deaf children and their families.
- Although a fifth of Authorities had cradle to grave specialist teams within Adult services whose remit also included deaf children and their families, this arrangement was not necessarily by design. Some existed by default as decisions were yet to be made about appropriate structures within an integrated children’s services approach.
- Only just over half of the Children with Disabilities teams who had responsibility for deaf children and their families actually had any workers within the teams with any deaf child related expertise.
- Within those CDTs who identified that they did have deaf child related expertise this was, in some cases, defined only in terms of a worker having some level of British Sign Language (that could be basic level), rather than in terms of deaf child related knowledge and experience.

- Although we found evidence of CDTs being prepared to seek expertise as and when required from outside of their team, we were concerned that this expertise was frequently being defined in terms of the provision of equipment or interpreting services, rather than social work expertise concerning deaf children and their families.
- We found one example of an unusual approach to service arrangement whereby a specialist cradle to grave service was located within children's services (with Adult services buying in provision through a service level agreement). The rationale for this arrangement was that it was that this created a 'safer' situation for everyone in terms of maintaining a high level of specialist expertise and identification of risk.
- By contrast, service organisation arrangements for d/Deaf adults were far more consistent with over two thirds of Authorities having retained a dedicated specialist team in its own right or as part of a wider sensory service and another 15% contracting out services to a local voluntary organisation. Thus over 86% of services to d/Deaf adults were provided by specialist teams.
- However, it is of significant concern that in 3 Authorities there were no specialist Adult deaf services workers at all – a finding not accounted for by the contracting out of services.

3.3. Integrated services and deaf children and their families

One of the key aims of this research project as a whole is to understand how organisational changes that were taking place in light of the move to integrated children's services, were affecting the scope and delivery of social care services for deaf children and their families. Phase I findings had demonstrated both that there was a significant variation in the structural organisation and service arrangements in response to integrated provision and that different Authorities were at different stages within the same direction of travel. Therefore, any description of social care services for deaf children and their families had to be appreciated within this changing context. In terms of how far integrated processes between education and health colleagues were taking shape, Phase I findings had concluded:

- (i) that within operational planning for integrated social care/education joint working, deaf children and families are usually invisible as a service user group requiring specialist consideration
- (ii) in those circumstances where strategically specialist consideration has been given in the organisation of children's social care services for deaf children and families, this strategic endorsement does not translate easily into effective joint working between social work and education personnel. Indeed integrated systems (be they IT or referral systems) might still both symbolically and practically reinforce the separation of otherwise apparently integrated structures in the case of deaf children and families.
- (iii) The dispersal of many Children's Services down to locality teams presents a further challenge in those cases where it has been possible to establish specialist deaf teams within integrated service structures. Locality teams will not automatically relate to the specialist provision, however much that provision has been able successfully to meld differing professionals into one specialist team.
- (iv) There is still a long way to travel in fully integrated services with health colleagues in respect of deaf children and families. Whilst developments in multidisciplinary service structures of referral, assessment and care pathways for disabled children in general were in most Sites underway, these did not automatically in practice impact on deaf children and families unless distinct consideration was given to particular needs and strengths associated with deaf children. In places, the assumption that disabled children's strategies would work for deaf children had been accepted without specific consideration of deaf children and their families.

[From Phase I report, section 8.6, pp. 86-87]

In Phase II we sought to look in a structured way at markers of integrated service arrangements for this service user group and to test out the extent to which our findings (above) were common across a much larger sample [Section 6 of the survey].

We first looked at whether education or health teams who provided services for deaf children and their families might include social workers who shared the same premises. In only 13.5% of Authorities (n=7) did teams include both education and social work sharing the same premises and in only 7.7% (n=4) of cases did health teams include social workers sharing the same premises.

Regardless of co-location, it might be the case that education and social work teams providing services to deaf children and their families, or health and social work teams, might be jointly managed at team level. We found this not to be case:

- 91.8% of Local Authorities (n=45) had no joint management arrangements at team level between education and social care for this user group;
- 94.1% (n=48) had no joint management arrangements between health and social care.

However, if joint management arrangements are looked at one tier above, i.e. at service manager or equivalent level the picture changes slightly in respect of Education services but not of Health.

- Just over a quarter of Local Authorities (28.8%, n=15) had joint management arrangements at service manager or equivalent level between education and social care in respect of deaf children's services.
- The picture of few joint management arrangements in respect of health remained largely consistent with 88.5% (n=46) saying 'no', even at service manager or equivalent level of management.

Regardless of co-location or joint management, it might be the case that there are effective joint working arrangements across disciplinary areas of responsibility and activity. We therefore asked respondents to say 'yes' or 'no' to the following:

Whether or not social workers, health and education workers are co-located and/or jointly managed, there are systematic arrangements for ensuring that deaf children and their families receive a joint assessment and a defined multi-disciplinary 'pathway' for planning and service provision.

It is of concern that 46% of respondents said 'no' or 'don't know'. In other words, in half of the Authorities asked there are no clear process of joint assessment, planning or co-working between staff from health, education and social care in respect of deaf children and their families.

Even amongst those who answered 'yes' to this question, the nature of the multi disciplinary pathway was not necessarily universal and could be significantly constrained. For example:

“YES: But only if they meet eligibility criteria for DCT. If there are SEN issues they will receive a service from the sensory team (education)” (4)

“YES: In our area the senior audiologist talks to parents at diagnosis and information about social care is sent, even if we don't meet the child. They need someone who understands deafness” (7)

“YES: Primarily for under 5s. For transition answer is 'yes', for older children, 'no'.” (22)

“In principle, 'yes', in practice 'no!'” (35)

This finding is reinforced by responses to questions where we asked about “regular meetings” with colleagues from health or education about “the needs of deaf children and their families through a deaf child’s childhood” [Qu.6.2]. 46.2% of respondents [n=24] said they did not have such meetings with health colleagues, and 32.7% [n=17] said they did not have such meetings with education colleagues.

Furthermore, 53.8% [n=28] of respondents said that they had no formal referral arrangements between social work and education professionals “where deaf children and their families may require assessment and/or service provision”, with 44.2% [n=23] responding likewise in relation to formal referral arrangements with health professionals.

The lack of joint working arrangements and a multi disciplinary perspective is further reinforced by the assumption that social care might have little if any responsibility for the needs of deaf children and their families if another professional/service is involved. Over half (54.8%, n=28) responded ‘yes’ to the description that:

Referrals from education to social care occur at particular points in time, for example at the time of children’s transition from education and until then education professionals are presumed to take responsibility for the needs of deaf children and their families.

Amongst the half of Authorities who did respond positively to questions about cross disciplinary referral, joint assessment or joint working with colleagues in health and education, there were two recurring issues mentioned as evidence of and drivers for such collaboration. The first was the neonatal pathway/services from birth to 5 years. There was in this respect good evidence that for these Authorities the drive for service improvement in the wake of universal newborn hearing screening and the Early Support initiative was making a difference to multi disciplinary working arrangements. However several respondents pointed out that whilst they may be answering affirmatively because of these developments, they were less confident of joint working arrangements for older deaf children or throughout childhood. [This finding is echoed in the results on the provision of preventative services (See section 5.7 in this report)].

The second recurring explanation for being able to answer ‘yes’ to joint working arrangements, was the operation of CHSWGs [Children’s Hearing Services Working Groups] where social care was regularly represented. Whilst these were not a forum for joint referral and assessment involving individual deaf children and their families in any formal sense, they were a forum for joint planning and the sharing of multi disciplinary perspectives in a more general sense. They potentially were also the means to the agreement of joint protocols and more coherent procedures.

“CHSWG. Deaf Focus group city wide chaired by Deaf person. meets quarterly. Looks at QA and service improvement. Even Fire Service involved... CHSWG. Also specific equipment meeting with health. Have separate equipment assessment form.” (7)

“For early years and transitions, yeh. Attend CHSWG” (22)

That said, several respondents also pointed out that whilst they might attend on behalf of social care, they did wonder why they were there as they had such little influence.

“CHSWG. But no idea why we are there!! No sharing by health”
(42)

The existence of these forums did not necessarily imply the effective involvement of social care concerns but in other instances they clearly did operate well.

In Summary:

- Few responding Authorities had joint management arrangements in place between social care and education services in respect of deaf children and their families.
 - Only 6% had joint management arrangements between social care and education at team level
 - Just under a third had joint management arrangements between social care and education at the level of service manager or equivalent.
- 90% had no joint management arrangements with health at either team or service manager level.
- In half of the Authorities, there were no systematic arrangements for ensuring that deaf children and their families receive a joint assessment involving health, education and social care, nor a defined multi-disciplinary ‘pathway’ for planning and service provision.
- Over 50% of Authorities said that they had no formal referral arrangements between social work and education professionals “where deaf children and their families may require assessment and/or service provision”
- Nearly 45% of Authorities said that they had no formal referral arrangements between social work and health professionals “where deaf children and their families may require assessment and/or service provision”
- Just over a third of Authorities were of the view that education colleagues were responsible for the needs of deaf children and their families (including social care needs) unless referral was appropriate at particular points in time (e.g. transition), or some exceptional circumstance occurred. i.e. in these Authorities there was no assumption of routine involvement in the social care needs of deaf children and their families either in terms of assessment or provision [a finding reinforced and discussed further in Chapter 4]
- For the half of Authorities who could cite examples of joint or integrated working practices, there were two principal drivers: the development of the neonatal pathway for early identified deaf children in the wake of universal newborn hearing screening; the existence of CHSWGs as multi professional forums. However, experiences of integrated working practice did not necessarily extend beyond the 0 to 5 age range and experiences varied of the

usefulness of CHSWG involvement in promoting better joint working/
integrated working plans and practices.

3.4. The specialist workforce

In Phase I of this research project, we had explored in depth the role and functions of specialist social workers with deaf children and their families within integrated children's services structures [See Section 9, Phase I report for full conclusions]. Amongst the primary conclusions were:

- (i) Respondents with direct experience of deaf children and families/work with adult d/Deaf people/communities, were readily able to distinguish key features of social work perspective and practice that both set them apart and made their contribution complementary to that of other professionals.
- (ii) Respondents without such direct experience were more likely to doubt the validity of any arguments for specialist social work with this service user group seeing it as potentially counter-productive to the inclusion agenda and not regarding deaf children and families' needs as in any way distinct from that of disabled children.
- (iii) A key argument for the distinctiveness of social work with deaf children was
 - a. the fundamental focus on the family not the child per se
 - b. the familial, social, community, economic and cultural context in which the deaf child is developing as the starting point for one's professional activity.
 - c. a concern with the child's social development in its broadest sense, rather than a concern with particular developmental features that may be a consequence of deafness
- (iv) However without a specialist understanding of deafness, deaf children and families, such as specialist social workers possessed, there was real concern that two types of error would occur. Firstly that deafness would be seen as the main problem/root cause of whatever was the presenting issue, which in fact might not be the case; secondly that the implications of deafness in the family would not be recognised in an assessment of any presenting problem. An holistic focus on the child, in the family, and in the community was not regarded as effective unless the social worker involved had specialist skills, knowledge and experience of deafness.
- (v) Recurring bedrock principles for practice in the context of deaf children and families included: the promotion of autonomy; the nurturing of independence; the facilitation of choice within decision making processes (and allied to that how to challenge in situations where it might appear a service user was not aware of a range of potential choices); and the fostering of social inclusion.
- (vi) Whilst practitioners from other professional groups may also be interested in such values, they were not regarded as having the same primacy in setting the framework, priorities, modus operandi and desired outcomes sought in social care work with deaf children and their families.
- (vii) Practice within a social model, community orientated, autonomy enhancing, psychosocial developmental framework, was only really enabled in those situations where there had been investment in specialist social care Children's Services/service arrangements for deaf children and families. Furthermore a more community work model promoted flexibility of contact for families and pro-active engagement in initiating new resources, whereas a case management approach could easily restrain families' abilities to be aware of and make use of social care services in the first place.

[From Phase I report, pp.96-98]

In Phase II of the project, therefore, we sought to find out the extent of the specialist workforce; the kinds of teams in which they were working; and their likely involvement and influence in particular features of social work practice such as child protection.

Bearing in mind that all 52 responding Local Authorities were specifically responding in the context of the person/team/section with responsibility for social care of deaf children and their families we found:

- Over a quarter (28.3%, n=13) of the Local Authorities did not employ any qualified workers who were specialist working d/Deaf adults and/or deaf children. In no case can this result accounted for by the Authorities concerned having contracted out arrangements whereby a specialist voluntary organisation for example, provides services.
- In 46% (n=23) of the Local Authorities there were no qualified social workers who worked with deaf children and their families either as officially part of or as the whole of their job remit.
- The median staff complement of qualified social workers working with deaf children and their families was 0.25
- However, of those respondents who answered positively that there was a social worker who worked with deaf children and their families, some pointed out to us that this was not actually an official part of their role but, for example, “Manager turns a blind eye” (34).
- Of those who responded positively that there were specialist social workers experienced with deaf children and families working in their Authorities, the extent of the specialist knowledge/experience varied. Whilst some were clearly workers with many years professional experience, it was of concern that other respondents included workers for example who were newly qualified but had “Stage II” (i.e. the national recognised sign language qualification equivalent to approximately GCSE level). The learning of BSL in no way includes such issues as learning about the effects of deafness on child development, nor does the qualifying curriculum for professional social workers contain any specialist focus on deaf children.

3.5. Service organisation arrangements in cases of statutory child protection

Phase I findings had shown the significance of specialist deaf child knowledge and experience in:

- understanding risk;
- a broad appreciation of safeguarding (given the range of psycho social as well as linguistic developmental effects of deafness);
- assessment from a social model perspective with the full range of understanding of how deafness might impact on family, community, identity and inclusion;
- having appropriate communication skills and cultural knowledge to engage directly deaf children and their families.

It had also highlighted the new challenges faced by specialist social workers in working within Children’s Services with its own procedures and protocols.

More broadly, how to respond effectively to child protection concerns and investigations involving deaf children has been a longstanding area of concern. Deaf children are 3.4 times more likely to experience abuse than their hearing peers.⁷ As far back as 1990, Margaret Kennedy⁸ called for the provision of dual specialist social workers (experienced in both deaf children and in child protection) to avoid the problem of failing to understand the significance of particular evidence or behaviours if too readily written off as ‘because the child is deaf’ rather than being appreciated as signs of abuse. The Department of Health’s 2005 report *Mental Health and Deafness: Towards Equity and Access*⁹ recognised the particular vulnerability of deaf children to abuse and recommended that Area Child Protection Committees (now Local Authority Safeguarding Boards) should review their child protection arrangements for deaf children - a recommendation still to be implemented¹⁰.

In this study, we therefore were keen to understand the arrangements in Local Authorities should a child protection investigation arise that involved a deaf child. We asked about who would ‘hold’ the case and what the arrangements might be for co-working with specialist social workers.

We found that:

- Only 36.8% (n= 18) of responding Local Authorities described co-working arrangements between child protection teams and specialist social workers.
- 18.4% (n=9) described a situation in which there was no co-working at all, either because specialist social workers did not exist to co-work with anyway, or because specialists working in Adult services were not allowed to work cases involving children, or because the CDT did its own child protection work and did not involve outside deaf related specialists.
- The remaining Local Authorities (40.8%, n=20) described various arrangements that involved getting ‘help’, of different varieties, from workers either within or outside of their Local Authority. In no cases were these descriptions of co-working in a formal sense and in the majority of cases the help described was not from a social worker. For example, respondents described involving a BSL interpreter if the child was a sign language user; or advice might be sought

⁷ Sullivan P.M., Brookhouser P., Scanlan J. (2000) Maltreatment of deaf and hard of hearing children in: P. Hindley, N. Kitson (Eds) *Mental Health and Deafness* (pp. 149-184), London: Whurr).

⁸ Kennedy M. (1990) The deaf child who is sexually abused: is there a need for a dual specialist? *Child Abuse Review* 4, 3 - 6

⁹

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103995 (accessed, 01-09-09)

¹⁰ Department for Children, Schools and Families: 2020 children’s and young people’s workforce strategy – a response by the National Deaf Children’s Society, March, 2009. http://www.ndcs.org.uk/search_clicks.rm?id=3894&destinationtype=2&instanceid=127985 (accessed, 01-09-09).

from an external agency such as RNID or Sense, or a teacher of the deaf might be asked for an opinion.

- In looking at the range of descriptions given to us of the external help sought, we were struck by three things:
 - Firstly how much the help took the form of information and advice in a general sense about deafness or sign language rather than specifically in relation to any particular case;
 - how little awareness there was about the extent to which specialist knowledge might be required about cultural issues or deaf child development issues in a broad sense, rather than only about language and communication (several respondents described involving an interpreter as of itself solving the problem of specialist aspects of a case);
 - and how ad hoc the arrangements appeared to be.
- Additionally, no respondent who was not themselves a deaf specialist seemed aware that there would be issues that needed to be taken into account or that would impact on the investigation if a child was deaf and not a BSL user.

4. Assessment of need and service provision

4.1. Eligibility Criteria

Phase I research findings had raised significant concerns about the operation of eligibility criteria and thresholds for services in relation to the provision of social care for deaf children and their families (see Section 6 of Phase I report). From that study, we had drawn 6 main conclusions about the operation of eligibility criteria. We found:

- (i) Unless a service operated on the assumption that all deaf children were 'children in need' and therefore eligible for at least an initial assessment, eligibility criteria were used.
- (ii) In these cases, a critical or substantial problem needed to exist over and above a child's deafness to trigger any kind of social care response (e.g. mental health issue; child protection concern). The potential complexity for a child and family of the developmental, social and linguistic consequences of childhood deafness was not of itself a gateway to social care services. This meant in practical terms, that a problem in effect needed to escalate to a crisis before a social care response could occur.
- (iii) The extent to which a deaf child's need could be recognised as substantial or critical was also of itself called into question in those teams with little deafness related expertise or experience.
- (iv) We found evidence of rather crude medical model based criteria being used to decide the allocation of scarce resources (e.g. was the child profoundly deaf?) divorced from an holistic view of the impact of deafness of child and family that may have little to do with how deaf in audiological terms a child might be.
- (v) Opportunities for preventative work with deaf children and families tended only to occur in those services where either eligibility criteria were not operating and/or there was a specialist service with a clear remit for meeting the social care needs of deaf children and their families.
- (vi) Nonetheless we found examples of dedicated specialist social workers who were 'trying to get round the system' to work with deaf children and their families in those cases where either they lay outside of their team's remit, or the operation of eligibility criteria prevented access to services in ways they did not view as equitable or appropriate.

These conclusions had been reached through in-depth study of 5 teams chosen for their diversity of service arrangements. In Phase II we were keen to test out the extent to which, on a much larger sample, our conclusions would be substantiated and/or further layers of complexity might be introduced. The survey asked respondents 8 questions (Section 3 of the Questionnaire) requiring fixed choice responses, but with the opportunity to explain to the researcher the reason for choosing as they did.

Does a problem have to reach a critical level to trigger a service?

We asked respondents the extent to which they agreed/disagreed that their Local Authority was only able to respond/provide a service to children and families whose need met criteria defined as 'substantial' or 'critical'¹¹. We asked this both in relation to children and families in general and specifically in relation to deaf children and their families. The percentage who strongly agreed/agreed dropped from about a half (45.1%, n=23) in relation to all children, to around a third

¹¹ In discussion with respondents we acknowledged that there were many different terms in current use in Children's Services to classify formally levels of need such as 'significant', 'profound', 'permanent', 'severe', or the use of a tier system

(33.3%, n=17) in relation to deaf children. Similarly the percentage who strongly disagreed/disagreed rose from just under a third (31.4%, n=16) for all children, to around a half who strongly disagreed/disagreed (58.9%, n=30) in relation to deaf children.

On the face of it, these would seem to be encouraging trends, indicating that in the case of deaf children and their families, high thresholds for service provision were either less of a barrier, or of less relevance in comparison with the situation for 'all' children and families. However, participants' commentaries on their own responses revealed the complexity underlying this seeming trend.

For example, we had several instances of respondents who had **disagreed** with the statement that their Local Authority could only provide a service for deaf children and families who met the highest thresholds of need, but only because they told us that they found a way round those criteria that otherwise would have excluded deaf children and families:

"'Disagree'. We reinterpret 'substantial' to mean ANY communication barrier" (8)

Whilst at the same time, we had instances of respondents who had ticked **agree**, but again, only because they found a way to re-interpret the criteria to meet the needs of deaf children and their families:

"'Strongly Agree' But we define 'critical and substantial' as preventative e.g. flashing light doorbells from a young age." (49)

Others just offered us two answers at the same time to reflect the dilemma they found themselves in:

"Answer 'strongly agree' refers to the LA's position and 'strongly disagree' refers to the Deaf Association's position¹²" (4)

Many of those who strongly disagreed/disagreed, did so because they operated in a service that was either able to provide preventative services specifically for deaf children and their families or had an agreement to contract out services to a specialist voluntary organisation.

"Disagree. Local Authority would refer deaf children/families to voluntary organisation for social work support/initial assessment" (43)

However, commentaries on responses again reveal that there might be more complex concerns lying behind the seeming lack of eligibility barriers. For example, a respondent within Adult Deaf Services had ticked 'disagree', because their service did act as a specialist point of contact for deaf children and their families. However, beyond that involvement if a more substantial problem were to occur, then those children and families would not necessarily receive a service from them and at that point may encounter problems of access to provision:

¹² In this Authority, services were contracted out to the regional Deaf Association

“Disagree. Lots of preventative services – particularly information and signposting. But Deaf service know that there are deaf children on waiting lists who need more than Deaf adults services can offer” (3)

There were also a large number of Authorities who ‘disagreed’ that eligibility criteria might be a problem because generic disability related systems for the assessment and provision of social care services were seen to be appropriate for deaf children and their families. For example:

“Disagree. Because use CAF to provide support services within the community” (53)

However, as Phase I findings had previously demonstrated, the validity of such a conclusion is questionable if in fact an Authority has contact with very few deaf children within its wider disability social care provisions, or few deaf children come to the attention of the Local Authority social care services in the first place. Without demand, it has little reason to question the adequacy of its provision. We cannot tell from the survey results alone, how many of those Authorities who were pointing to the inclusive nature of their disability service provision had indeed forged a deaf child appropriate service within it, able to identify the complexity of a presenting problem in light of the complexity of childhood deafness. However, the evidence from those specialist workers who told us about how they found a way round the system to enable deaf children and their families’ needs to be recognised despite the operation of eligibility criteria, would seem to suggest that many Authorities who perceived there not be a problem, may be ones who simply did not know.

In Summary:

- The operation of eligibility criteria appear not to be a bar to social care service provision for deaf children and their families, but only if one of two specific conditions exist:
 - A deaf specialist service arrangement exists (e.g. through specific team/expertise; contracted out service; or single specialist worker)
 - AND
 - They are able to re-interpret deaf service users needs in such a way as to define them as critical/substantial so they fit the official Authority response
 - OR
 - They are able to operate independently of the Authority’s substantial/critical thresholds (as in the case of voluntary organisations)
-
- There was a strong awareness amongst many of our respondents who identified themselves as specialist workers, of needing to operate a parallel kind of thinking to that of children’s services more generally, to enable deaf children and their families to meet thresholds for service provision.
 - Amongst Authorities eligibility criteria were not considered a bar to service provision because generic disability services were thought to meet the needs of

deaf children and their families too. However, the confidence of this position needs to be tempered by the extent to which an Authority actually had experience of providing a social care service to deaf children and their families.

- In many circumstances, deaf children and their families were in receipt of services despite the operation of eligibility criteria, not because of them.

‘Seeing’ need

The strategies we have described above, whereby deaf children and their families’ needs are re-packaged to meet substantial/critical thresholds are dependent on a broad based and specialist understanding of how deafness might seriously affect a child and family’s optimal functioning. In the Phase I conclusions, we had raised the issue that a lack of recognition of the potential complexity of deafness in terms of its developmental, psycho-social and family impacts contributed to difficulties encountered in accessing social care provision. We therefore asked respondents the extent to which deafness of itself was regarded by their Local Authority as weak or strong indicator of substantial or critical need (Qu. 3.4). On a five point scale where 1 represented ‘weak’ and 5 ‘strong’, 31.4% (n=16) regarded it as a strong indicator (scoring 4 or 5) with 43.1% (n=22) regarding it as a weak indicator (scoring 1 or 2).

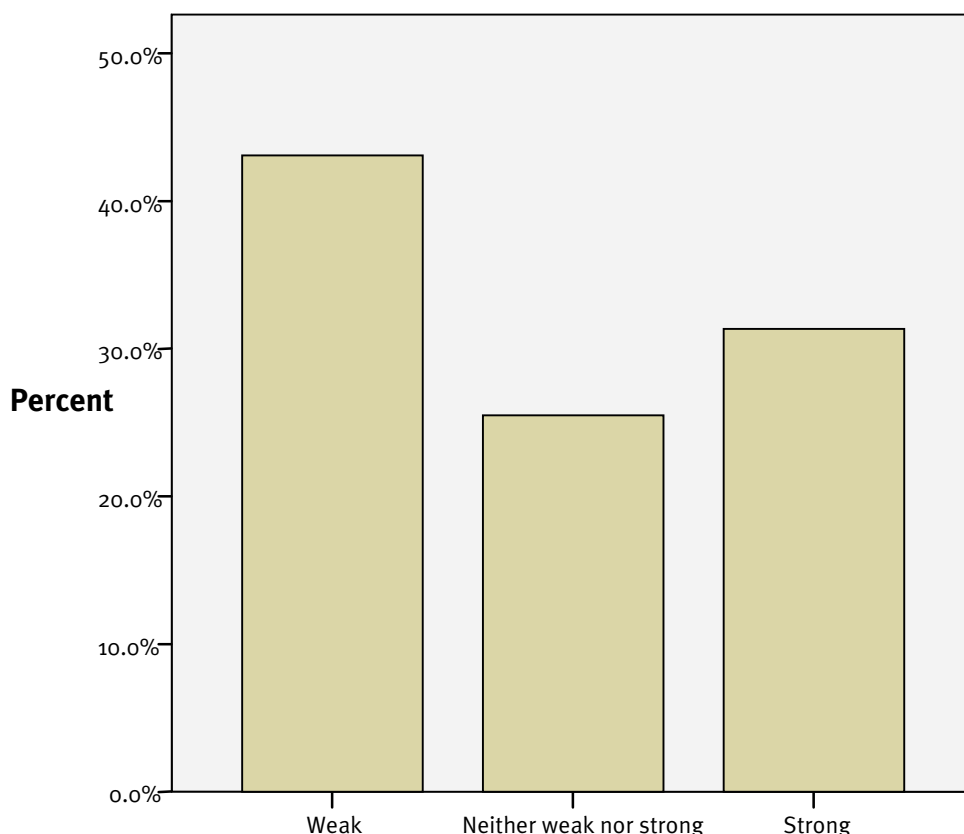


Fig 4 Deafness as indicator of need

However, some respondents once again pointed out to us that their position was not necessarily that of the Local Authority as a whole, as non-specialists were unlikely to understand, in an holistic sense, the potential effects of deafness for a child and family and therefore why it might be a strong indicator of need.

“2, Weak indicator: This is what my LA would say. Only a specialist would understand” (8)

“5, Strong indicator: Local Authority doesn’t understand. For the Voluntary Organisations, deafness is automatically ‘substantial/critical’” (31)

“5, Strong indicator: Deafness meets our criteria” (52)

At the other end of the spectrum, those for whom it was a weak indicator pointed out to us, for example, that the issue was ‘need’ not deafness; or that individual circumstances would be a far greater indicator than the fact the child was deaf.

“1, Weak indicator: Need, not deafness” (30)

“1, Weak indicator: Not deafness alone” (34)

“1, Weak indicator: Doesn’t tell you anything. Is there a need as a result of deafness?” (67)

These two contrasting positions are interesting in representing very different approaches to the interaction of childhood deafness with potential service provision.

One begins from an assumption of deafness as a risk factor (whether or not those risks materialise) and therefore a strong indicator of the need to provide a service response (whether an assessment or something more). This approach is not necessarily deterministic, in saying that all deaf children and their families are at risk and require social care services, but is clear that they are more likely to have needs that it is appropriate for social care services to meet. Furthermore, it assumed that the impact of deafness, properly understood, is central to the recognition of those needs. It takes an anticipatory perspective in assuming that there is likely to be a role for social care provision and that services should be equipped to recognise and meet potential need.

The other position sees deafness as one potential factor amongst many that may trigger the need for a service response. However it is uncomfortable about its identification as being of primary significance, seeing such a stance as deterministic. Need is seen as a potential result of a nexus of issues, rather than consequential of deafness in the family. This approach does not fundamentally identify deafness as a risk factor but takes a reactive approach, dependent on circumstances. Some respondents indicated it could be discriminatory or indeed oppressive to do otherwise.

“Deafness, ‘of itself’ is not recognised as indicating substantial/critical need – this would depend on other factors such as family functioning/difficulties and some families might not want a social work referral/services” (43)

These very different standpoints on the significance of childhood deafness as an indicator for service provision were also present in the variations we found when we investigated Authorities' responses to deaf children as 'children in need' and when we investigated preventative service provision.

4.2. Are deaf children “Children in Need”?

Within a broader consideration of eligibility criteria, Phase I results had highlighted variable practice in the designation of deaf children as 'Children in Need' under the provisions of Section 17 of the Children Act, 1989. This Section of the Act, whilst offering no specific guidance on the kind or extent of services to be offered, nor the specific mechanisms for so doing, nonetheless requires Local Authorities:

(a) to safeguard and promote the welfare of children within their area who are in need; and

(b) so far as is consistent with that duty, to promote the upbringing of such children by their families,

by providing a range and level of services appropriate to those children's needs. [Section 17, (1)]

It goes on to define:

For the purposes of this Part a child shall be taken to be in need if—

(a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part;

(b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or

(c) he is disabled, [Section 17, (10)]

In the Phase I research we found only one of the five Local Authorities studied regarded this definition as de facto encompassing all deaf children. They therefore provided a service which undertook to offer all deaf children (and their families) who came to their attention at least an initial assessment of need by way of response [See Chapter 6, Phase I report].

In Phase II of the research we investigated the extent to which Local Authorities “formally recognise” deaf children as 'children in need' as defined by the Children Act 1989, before considering the implications of such designation for assessment.

Just over half of participating Authorities (58.8%, n=30) formally recognised **all** deaf children as children in need. However, 3 Authorities (5.9%) were of the view that “very few” deaf children would be children in need as defined by the Act with the rest (35.3%, n=18) defining 'some' deaf children as children in need.

Those who responded 'very few' or 'some' tended to be those who emphasised that circumstances were paramount in whether a child was a 'child in need'; and those circumstances were more complex than whether a child was deaf or not.

The same kind of thinking was expressed in terms of deaf children meeting the criteria of being 'disabled children' and therefore de facto children in need within the terms of the Act. Several respondents regarded whether a child was disabled or not as being contingent on context. Depending on degree of deafness in an audiological sense and particular family circumstances, they would argue a child might not be disabled.

"Sometimes there is a family with a child with a complex need and the family are coping well. Other times there is a child with a moderate disability and the family are falling apart, so it depends on the overall situation. Circumstances, not disability" (64)

"Deaf children will only be recognised as being 'in need' if they have a severe hearing impairment AND additional difficulties relating to family breakdown, learning difficulties etc". (5)

Once again, in these responses we find evidence of an approach that was concerned to avoid seeing childhood deafness as deterministic of need and resistant to the offer of, or provision of, services on the basis of childhood deafness. However, the designation of child in need exists to entitle children and families to an assessment of their needs and to charge Local Authorities with the provision of services to meet needs. Therefore a reluctance to see deaf children as children in need might actually work to impede Authorities from being able to recognise and respond to the complexity of a situation that might indeed meet their own criteria of need resulting from circumstances, rather than from being deaf.

Regardless of the extent to which an Authority would designate deaf children as children in need, we were interested to know of those who were so designated, what the implications might be. Results revealed a considerable gap between the recognition of likely need and the provision of assessment. In only two thirds (62.7%, n=32) of the Authorities who participated would a deaf child who was formally recognised as a child in need, be offered at least an initial assessment. Interestingly, over a third of those responses are accounted for by those Authorities we have designated 'deaf friendly'. In other words, when one takes away the responses from deaf-specific service arrangements, the percentage of Authorities in which a designation of 'child in need' would lead to at least an initial assessment drops even further.

In practice, respondents pointed to a distinction between the formal recognition of the status of child in need and the operation of eligibility criteria within the Authority:

"Technically, disabled children are a priority group to be dealt with, but services often won't follow through 'cos of eligibility" (23)

"That is the formal response [recognition of child in need status], but in reality very few deaf children would be worked with." (34)

Furthermore, amongst those who did respond that ‘all’ deaf children recognised as children in need would be offered at least an initial assessment, there were important caveats. Respondents pointed out to us that their response of ‘all’ could be misleading because they in fact meant only all who were known to them, rather than all deaf children per se. Additionally, those known to them were most likely to be those service users who happened to have found them. Thus the practice that ‘all’ might be offered at least an initial assessment could in reality mean the few that had come to the Local Authority’s attention through their own endeavours. The following comments were all made by participants who responded that “all” deaf children recognised as children in need would be offered at least an initial assessment:

"If they approach us". (47)

"Services wouldn't offer but would respond to a request." (18)

"But only if they wanted it. On the whole, contact is initiated by the Service User - we're not going out looking!" (20)

"We assess those who are known to the service and want an assessment." (23)

Although theoretically, social care services might know about deaf children and their families because of specific referrals from colleagues in health or education services, or through joint systems of working together, as results concerning integrated working reveal (See Section 3.3), routine systems of joint working and formal systems of cross referral were the exception rather than the norm.

Furthermore, 10% (n=5) of participating Authorities were of the view that “very few” deaf children recognised as children in need would be offered at least an initial assessment. The remainder (29.4%, n=15) said that children and families would “sometimes” be offered at least an initial assessment.

In Summary:

- The formal recognition of deaf children as children in need as defined by the Children Act 1989 is far from universal amongst Local Authorities.
- In around 40% of responding Authorities, such a formal identification was felt to be unhelpful, or unnecessary, or entirely contingent on specific circumstances, rather than consequential of a child’s deafness.
- Even in those circumstances where this status is clearly acknowledged it does not guarantee in practice an assessment of need.
- Results revealed a considerable gap between the recognition of likely need and the provision of assessment. In only two thirds (62.7%, n=32) of the Authorities who participated would a deaf child who was formally recognised as a child in need, be offered at least an initial assessment.
- Amongst those Authorities without a deaf specialist team/team arrangement this figure drops to fewer than half.

- Even where it is common practice that recognition does lead to assessment, the extent to which this practice applies to the total population of deaf children and their families is severely constrained. In reality, assessment consequent on child in need status is more usually confined to those families whom might independently find the service, or those children known to the service for other reasons.
- It would be highly unusual for the total population of those with a potential right to an assessment under the Children Act, 1989 to be made aware of their entitlement and potential social care provision to be offered.

4.3. Hearing children in deaf families – children in need?

For sake of completeness, participants were also asked about children in need in so far as the provisions of the Act might relate also to hearing children from d/Deaf families. In these cases there might be an argument that on grounds of seeking to support appropriate spoken language development, for example, a hearing child in a d/Deaf family might be a child in need. Perhaps surprisingly around a fifth of respondents (20.8%, n=10) said they would “always” recognise a hearing child from a d/Deaf families as a child in need.

45.8% (n=22) said they “sometimes” would, dependent on circumstances in particular families. Being a hearing child of d/Deaf parents of itself was not enough to justify the designation of child in need:

"Depends on the circumstances- if they were a child in need under another category. Not simply because they were a hearing child in a Deaf family" (2)

"Thresholds would operate. There would need to be an additional focus (other than deaf parents) to get any sort of assessment." (18)

"Not a child in need because Deaf parents, but would assess a child to determine whether a child in need taking into consideration all the family circumstances." (21)

Also some respondents considered the potential status of hearing children in d/Deaf families as ‘young carers’ possibly making them children in need:

But not dealt with by us - probably the young carers team." (32)

"Only on a safeguarding basis or as a young carer which equals rarely" (33)

"Support for hearing children comes from classing them as carers." (34)

However, 29.8% (n=14) replied they would “rarely” and 1 Authority that they “never” would regard a hearing child from a d/Deaf family as a child in need. However, 2 of these responses (representing 5 Authorities) are accounted for by

specialist deaf child and family teams who said it was unlikely they would ever regard a hearing child of deaf parents as a child in need separate from the fact that they would more likely than not already be working with the family as a whole.

The provision of preventative services

We looked further into the extent to which services might understand the potentially far reaching complexities of childhood deafness through asking them about preventative services. In the Phase I work, we had found that:

- (i) Specialist teams/services were both able and prioritised the need to offer preventative services to deaf children and their families. This was usually in order to offset potential psychosocial developmental risks (such as poor mental health), to provide another variety of family support (beyond that available through health or education practitioners) and to enhance further language development and family communication.
- (ii) We also found practitioners who would have wanted to provide such preventative services but were unable to do so because of the remit of the team within which they were working.
- (iii) And thirdly, we identified examples of a significant lack of preventative work because either teams were only able to respond to substantial/ critical need on a crisis intervention basis; or there was no specialist deaf children and families expertise within teams; or there was little recognition of the significance of preventative social care work for deaf children and their families.

In the Phase II study we asked respondents to choose one four options that best described the extent to which their Local Authority was able to offer preventative social care services for deaf children and their families (Qu. 3.7). The four options were:

Routinely	i.e. social care services for deaf children and their families have a strongly preventative focus and there is routine investment in this aspect of work within Children’s Services.
Occasionally	i.e. there have been specific projects developed that work in a preventative fashion with deaf children and/or their families, but these tend to be in response to a specific need or be time limited. It is not a routine focus of everyday role and responsibility but the scope exists for such work to be initiated.
Rarely	i.e. historically there have been examples of preventative-orientated pieces of work but these are exceptional.
Never	i.e. there is not the scope, resources or priority to invest in preventative social care work with deaf children and their families (although this may be perceived to be the remit of other organisations/ voluntary sector).

Just over a third (36%, n=18) responded ‘routinely’ however 9 of these 18 responses are accounted for by Local Authorities where there is evidence of a specialist deaf child and family service/service arrangement. The majority of Local Authorities responded ‘occasionally’ (38%, n=19). However a quarter (26%, n=13) said they ‘rarely’ or ‘never’ were able to provide preventative social care services.

At first glance, these figures seem encouraging with over 70% of the Local Authorities who responded ‘routinely’ or ‘occasionally’ engaged with preventative social care provision for deaf children and their families. However respondents’ comments reveal that these headline figures are not synonymous with preventative social care services that are specifically targeted at deaf children and their families using specialist expertise encompassing the impact and potential consequences of childhood deafness.

Participants also responded ‘routinely’/’occasionally’ if they meant that deaf children and their families had access to social care services for all disabled children; or for all disabled children provided through education; or through mixed sensory and disability provision. In other words, generic disability services, rather than ones that might address deafness specific needs or be particularly appropriate for deaf children and their families.

“Occasionally: Via education. Reactive to family. preventing escalation. Parent forum for all disabled children. Holiday clubs for all disabled children. Not enough number to do more.” (13)

This point is important, for two reasons. As the Phase I findings demonstrated, social care services for disabled children are not necessarily accessed by deaf children and their families who might not find them relevant. Given the centrality of language development to understanding the needs and strengths of deaf children, social care services for disabled children are not necessarily targeted appropriately for this group of service users, without specialist input. One respondent in replying ‘never’ was also making the same point. Their Local Authority never provided preventative services for deaf children and their families because deaf children are seen to fall within the remit of disability provision:

“Never: But same as any other child - through Aiming High can access short breaks etc.” (36)

Also, responses of ‘routinely’/’occasionally’ were given because of the involvement of the teacher of the deaf service, which was perceived to provide family support and, therefore, preventative social care services.

“Routinely: Teacher of the Deaf works with mixed sensory group. Provide support and equipment.” (19)

However, as we highlighted in the Phase I findings, specialist education professionals may indeed work with families with deaf children in aspects that are beyond a purely pedagogic remit, but this is not the same as social care provision as specialist social workers with deaf children would understand it (See Phase I report, Section 6). Teacher of the Deaf involvement also lies outside a range of statutory and non-statutory powers and duties that fall within the remit of social care professionals.

More positively, some respondents also pointed out that they were able to reply ‘routinely’ because of the greater involvement of social care professionals within the service matrix for deaf children under 5 as a result of universal newborn hearing screening. Early involvement of itself was seen as preventative. However,

this involvement did not necessarily extend beyond early years service arrangements:

“Routinely: Our system is ‘put the service in early, or it comes back to haunt you’. Tier 3 and 4 merit response in mainstream. In CDT respond to 1 and 2.” (52)

“Routinely: Most only on an individual basis. Service offered from NHSP [Newborn Hearing Screening Programme]” (53)

Amongst those who replied ‘rarely’ or ‘never’, explanations included the impact of eligibility criteria, the very small numbers of deaf children known to social care preventing any substantial development and the lack of resources, whether in terms of money or workers. As we have already commented, the small number of children and families known to social care services is itself linked to the varying approach to deafness as developmental risk evident between Authorities and the extent to which severity or complexity of need can be recognised by workers/teams without specific deafness related expertise/knowledge.

In summary:

- Over a quarter of all Local Authorities sampled said they ‘rarely’ or ‘never’ provided preventative social care services for deaf children and their families.
- Reasons for replying ‘rarely’ or ‘never’ to the provision of preventative social care services included: the impact of eligibility criteria, the small number of deaf children known to social care services and the lack of resources
- Amongst the 74% who responded that they ‘routinely’ or ‘occasionally’ did so, these responses were not necessarily indicative of services targeted specifically to meet the particular needs of deaf children. Rather they were inclusive of provision that might be available to all disabled children; or provision provided by Education that was considered to encompass social care issues.
- There was evidence of routine provision of preventative services targeted at deaf children and their families being strengthened as a consequence of multi professional service developments in the wake of universal newborn hearing screening. However there was no evidence that these ever translated into routine preventative services for older deaf children

4.4 A Case Example

In the Phase I research project, we had used a case example for discussion with interviewees. We were interested in comparing responses across different kinds of service organisation; exploring the influence of eligibility criteria; and understanding how the existence of a specialist social work role with deaf children and families might influence responses to referral. In Phase II we used the same case example with all participating Authorities but alongside structured responses, based on the findings from Phase I (Section 5 of the questionnaire). The delivery of the questionnaire in person by telephone allowed for Authorities to elaborate on their responses. The Case Example was in two parts, reflecting an escalation in the potential complexity and seriousness of the situation:

Part A

A 14 year old profoundly deaf boy in mainstream school is currently excluded. A recent transition meeting reached no firm conclusion about his future. Questions have been raised about his use of alcohol, staying out very late at night and being abusive to his mother. His oral communication skills are very limited. He uses sign language but it is not thought to be age-appropriate. He lives with his mother, step-father and younger half-sisters, all of whom are hearing.

Part B

A few weeks later, the mother self refers saying that her son has now begun to be physically violent towards her and his younger sisters.

Our principal findings in Phase I were:

- (i) The pathways whereby a young person and their family might receive a social care response were highly ambiguous in those service structures where there was no specific deaf child and family social work team/specialist service arrangement.
- (ii) Eligibility criteria within Children with Disabilities Teams militated against a likely formal social work response in the case described. However, committed professionals did consistently attempt to find ways around the system and thus enable social care involvement. Nonetheless, without case responsibility or a clear remit to become involved, the inclusion of deafness-related expertise tended to occur outside of structures of formal assessment of child and family needs.
- (iii) Where social care expertise in deaf children and families was clearly embedded in the structuring of Children's Services, Social care workers were confident of their remit and specialist knowledge and were routinely engaged in the multi agency and cross-team service structures through which issues such as those in the case study, were likely to present.
- (iv) The designation of specialist team status and/or service level agreements between professional groups gave clarity to the appropriateness of referrals habitually triggering formal assessment processes (whether alone or in collaboration with other colleagues/teams within Children's Services).
- (v) Those Sites with a specialist deaf children's services remit who would have responded to the referral in Part A of the case study with a routine assessment, found Part B of the case study puzzling. Namely because they would have normally expected to be already involved with the family, they would be concerned if the situation had escalated in the way described, because they would have already carried out assessments and put in appropriate support from a preventative perspective. Mechanisms for doing so were clear and well established and would not have had to be tried out in response to a crisis involving a particular case.
- (vi) In those Sites where initial uncertainty of remit and ambiguity over responsibility had been expressed in response to Part A of the case study, all agreed that the escalation in the situation in Part B of the case study would trigger a social work response.
- (vii) However, the trigger was not because of the child's deafness and associated needs, but because the behaviour the child was exhibiting could be classified under a different heading that would be recognised as appropriate for social work involvement.
- (viii) Even now that a recognisable trigger had been established, the pathways to a social care response were not necessarily clear to respondents and there was some lack of

confidence that if the case were picked up by a Children's Services team there would be expertise in that team to form an appropriate assessment/response.

[from: Phase I report, section 5.3 pp 39-40 and section 5.5, pp 45-46]

With a larger and more diverse sample of Authorities, we were keen to see the extent to which these initial findings were supported.

In respect of part A of the Case Example, 5 Authorities (9.6%) said that it was extremely likely or probable that they would not respond at all. This may seem a small number and therefore easily dismissible as of little significance. However, our definition of 'response' for purpose of this question meant taking less action than offering advice over the telephone or signposting to another agency/professional as these possible responses constituted the next two questions. It is, therefore, of considerable concern that nearly 10% of the sampled Authorities would not/would not be able to respond in the case of a profoundly deaf minor, who was school excluded, with poor language skills and exhibiting "abusive" behaviour.

Over one third (38.5%, n=20) said that it was extremely likely or probable that they would signpost/refer to a more appropriate agency/team in response to part A of the case example. This kind of response hardly changed in light of the escalation of circumstances in part B (35.3%, n=18), perhaps indicating that signposting on to a more appropriate team was a consistent response regardless of the gravity of a situation. For 14 of the Authorities this signposting/referral was in addition to their own continued involvement; these teams saw the additional support of professionals with expertise in, for example, anger management, young people's use of drugs and alcohol, or adolescent mental health as appropriate to the young man's welfare.

However, in terms of doing an 'initial assessment', three quarters (75%, n=39), said that it was extremely likely or probable that they would do an initial assessment in response to Part A of the case study. This figure includes all of those teams/services we have designated 'deaf-specialist'. Therefore, in only half of those Authorities who did not have a specialist service/service arrangement would an initial assessment be actually carried out.

In response to part A over half (57.7%, n=30) also said that it was 'extremely likely' or 'probable' that they would allocate the case and expect to do a full ('core') assessment in person. Once again this figure included nearly 90% of those teams we have designated as 'deaf-specialist'. If their response is removed we find that only 43% of Local Authorities without deaf specialist service arrangements would have done a full assessment in response to the conditions presented in part A of the case study.

With the introduction of the additional information in part B of the case example, there was no Authority who said they would not respond.

Again in Part B, when asked about the likelihood of working the case jointly with another team, over half (58.8%, n=30) were of the view that it was 'extremely

likely' or 'probable' that this would be the outcome. There were different reasons however for this response and different varieties of co-working:

- for some, the escalation in Part B indicated the need for a multi agency response (whether referral, assessment or co-working) in those areas with multi agency organisational structures for disabled children;
- in those cases where services to deaf children were contracted out to voluntary organisations, when safeguarding was an issue, the case would either be returned to the Local Authority or be co-worked by the Voluntary Organisation and the Local Authority
- for others, if the case were initially held by a specialist deaf team, the more complex issues of safeguarding involving siblings could mean that a children and families team would become more involved as well;
- for a CDT the escalation might mean seeking the involvement of a deaf services related team or worker (in some cases from adult services).

We asked Authorities how influential a range of factors were on how they said they would respond to the initial referral in part A of the case study [Qu. 5.2]. Respondents replied on a four point scale from 0 (= of no influence) to 3 (= highly influential). The three factors rated as the most influential were:

- "the eligibility criteria by which we operate" with 50% (n= 26) rating this as '3'
- "our team has the specialist knowledge needed to respond" with 46.2% (n=24) rating this as '3'
- " we need to be involved in preventative work at an early stage" with 38.5% (n=20) rating this as '3'

However interpreting the significance of these results is not straightforward. In terms of eligibility criteria, its substantial influence was understood from two very different points of view, both influencing respondents to rate it highly. Some were of the view that eligibility criteria were highly influential because they prevented them from dealing with potential service users. Others rated eligibility criteria highly because all deaf children were automatically 'eligible' either because of their recognition as children in need or because of how the specialist deaf child and family team/service might operate:

"we see every deaf child" (31)

"They are eligible by dint of being a deaf child" (50)

"all deaf are eligible" (52)

Between these two polar opposite underlying influences, there was once again evidence of the kind of doublethink that some respondents said they were engaged with in order to make deaf children and their families fit eligibility criteria that otherwise did not recognize the seriousness of need or complexity of situation. For example:

"I have to say this, but we have to tweak them. We don't fit - this doesn't work for our service users - senior management just don't get it... A team manager who does not understand the

situation of isolated Deaf youngsters would just refer it on and say 'oh, it's an ordinary teenager'. We would say 'loads of underlying issues'. He would meet the eligibility criteria for us" (7)

"We would do it regardless of the eligibility criteria" (1).

Respondent (3) marked '3', but said: "But Deaf services would say so".

In relation to preventative work, we had initially included this factor because Phase I findings had indicated that preventative work with this service user group was highly unlikely to occur outside of specialist teams/service arrangements. Only 39% regarded preventative work at an early stage as highly influential on their response. However this included 73% of those teams we have designated deaf-specialist. Others who did not see a preventative focus as influential in their response, pointed to the fact that it was probably too late anyway:

"This speaks of stable doors and horses. We would provide strategies to manage" (3)

"Not a preventative situation! I would like to have had a Deaf role model or link worker earlier." (7)

"Beyond preventative work already - quite concerned" (21)

In summary:

- Results from this case example, demonstrate again how precarious the pathway is from presenting problem to service response in the case of deaf children and their families
- Results reinforce the previous findings that the nature of the response is highly contingent on whether those with deaf-specialist expertise are involved. Where they were not, Authorities were less likely to respond with either an initial assessment or a core assessment.
- It is of grave concern that almost 10% of the sampled Authorities would have not responded/not been able to respond at all in the case of a profoundly deaf minor, who was school excluded, with poor language skills and exhibiting "abusive" behaviour.
- Yet all Authorities would offer a response in the face of escalating circumstances involving other members of the family, rather than only the deaf child.
- There was no single or predictable pathway of response. Authorities described varied service arrangements dependent on which part of the structure was initially seen to be responsible for deaf children and their families.

5. Conclusions

The following provides both a summary of the main conclusions from Phase II of the research project and discusses how they relate to the initial conclusions of Phase I. The sample in Phase II on which these findings is based represents over a third of all Local Authorities in England.

5.1. Service organisation and structures

It is both unlikely and undesirable that there would be one preferred way to organise the delivery of social care services for deaf children and their families. Local Authorities are highly variable with many context specific factors exerting influences on the organisation of children's services more generally. However, regardless of the variety of service arrangement, to be effective there are likely to be some specific factors that need to be in place. Phase I of this research project had indicated that optimal provision was enabled by: (i) an Authority having a specific plan for where responsibility for the social care needs of deaf children and their families should lie rather than by default a team/part of the structure being presumed to include that service user group also; (ii) there had to be workers with specific expertise in relation to deaf children and their families in relation to social care/social work; (iii) that where deafness specific expertise existed those workers had a clear remit to use it in relation to deaf children (not just in relation to d/Deaf adults); (iv) that the system's structures enabled social care provision with deaf children and their families, rather than individual workers having to find ways round a system to ensure this user group was included; (v) that there was a clearly identifiable pathway for service users to be able to know who was responsible for social care provision and how to access it.

The picture that has emerged from the Phase II results continues to suggest that these conditions for optimal service structures/arrangements remain rare.

Specifically we found:

- There were many and varied service organisation arrangements in place for meeting the social care needs of deaf children and their families.
- Although a minority consisted of the establishment of specialist deaf children's teams these did not necessarily include any qualified social workers.
- It is of considerable concern that 4 out of the participating 52 Authorities had no designated service arrangements at all in respect of deaf children and their families.
- Although a fifth of Authorities had cradle to grave specialist teams within Adult services whose remit also included deaf children and their families, this arrangement was not necessarily by design, but rather by default as decisions were yet to be made about appropriate structures within an integrated children's services approach.
- Only a half of the Children with Disabilities teams who had responsibility for deaf children and their families actually had any workers within the teams with any deaf child related expertise.

- Within those CDTs who identified that they did have deaf child related expertise this was, in some cases, defined only in terms of a worker having some level of British Sign Language (that could be basic level), rather than in terms of deaf child related knowledge and experience. Of concern here is whether the level of knowledge and expertise within the team is sufficient to identify when more specialised knowledge and expertise is needed.
- Although we found evidence of CDTs being prepared to seek expertise as and when required from outside of their team, we were concerned that this expertise was frequently being defined in terms of the provision of equipment or interpreting services, rather than social work expertise concerning deaf children and their families.
- We found one example of an unusual approach to service arrangement whereby a specialist cradle to grave approach was located within children's services (with Adult services buying in provision through a service level agreement). The rationale for this arrangement was that it was that this created a 'safer' situation for everyone in terms of maintaining a high level of specialist expertise and identification of risk.

5.2. Integrated children's services and deaf children and their families

Phase I findings had demonstrated just how challenging many Authorities were finding it to establish integrated provision for deaf children and their families. We expressed particular concern that some Authorities were in effect not providing specialist social care aspects of such integrated provision because either Education services were being seen as the default or mainstream disability service provision was regarded as entirely appropriate (regardless of the few deaf children and their families who might access it). Phase I findings had concluded that strongly integrated provision tended to be predicated on: (i) the clear acknowledgment by Authorities of the specialist nature of social care expertise in relation to deaf children and their families (rather than disabled children more generally); (ii) expressed through service arrangements that enabled social care workers with deaf children and their families to act with confidence of their remit and to be routinely (rather than exceptionally) involved within the disciplinary matrix of service provision.

Against this backdrop, Phase II findings paint a very stark picture of just how poor integrated children's services arrangements are between social care and education in respect of deaf children. In the majority of cases the social care elements of an integrated service are just absent for deaf children and their families. However the picture was somewhat better in relation to the under 5s, but there was little evidence of those more integrated ways of working being developed across the whole age range. (A similar picture was present vis a vis social care and health provision, although such developments sit slightly outside of integrated Children's Services, but within the wider Children's Trust arrangements). Specifically we found:

- Few responding Authorities had joint management arrangements in place between social care and education services in respect of deaf children and their families.

- Only 11% had joint management arrangements between social care and education at team level
 - Just under a third had joint management arrangements between social care and education at the level of service manager or equivalent.
- Nearly 90% had no joint management arrangements with health at either team of service manager level.
 - In 46% of the Authorities, there were no systematic arrangements for ensuring that deaf children and their families receive a joint assessment involving health, education and social care, nor a defined multi-disciplinary ‘pathway’ for planning and service provision.
 - Nearly 54% of Authorities said that they had no formal referral arrangements between social work and education professionals “where deaf children and their families may require assessment and/or service provision”
 - Nearly 45% of Authorities said that they had no formal referral arrangements between social work and health professionals “where deaf children and their families may require assessment and/or service provision”
 - Over a third of Authorities were of the view that education colleagues were responsible for the needs of deaf children and their families (including social care needs) unless referral was appropriate at particular points in time (e.g. transition), or some exceptional circumstance occurred). i.e. in these Authorities there was no assumption of routine involvement in the social care needs of deaf children and their families either in terms of assessment or provision [a finding reinforced and discussed further in section 2]
 - For the half of Authorities who could cite examples of joint or integrated working practices, there were two principal drivers: the development of the neonatal pathway for early identified deaf children in the wake of universal newborn hearing screening; the existence of CHSWGs as multi professional forums. However, experiences of integrated working practice did not necessarily extend beyond the 0 to 5 age range and experiences varied of the usefulness of CHSWG involvement in promoting better joint working/ integrated working plans and practices.

5.3. The specialist workforce

In terms of social care assessment, service delivery and effective cross disciplinary working, Phase I findings had shown the significance of: (i) social workers who were knowledgeable about the complex consequences of childhood deafness: linguistically, developmentally and psychosocially; (ii) had experience working with deaf children and their families (rather than only d/Deaf adults); (iii) used a strongly social model focus as the bedrock of their practice; and (iv) who were skilled communicators. Phase I findings also raised concerns that social workers without specialist understanding and experience were unlikely to be able to recognise the complexity or seriousness of presenting problems from deaf children and their families, or to act pro-actively and preventatively to support deaf children’s optimal development. It is therefore, of considerable concern, that

we found in Phase II an extreme lack of specialist social workers with deaf children and their families employed in many Local Authorities¹³:

- Over a quarter (27.3%, n=12) of the Local Authorities did not employ any qualified workers who were specialist working d/Deaf adults and/or deaf children. In no case can this result be accounted for by the Authorities concerned having contracted out arrangements whereby a specialist voluntary organisation for example, provides services.
- In 46% (n=19) of the Local Authorities there were no qualified social workers who worked with deaf children and their families officially either as part of a whole of their job remit.
- The median staff complement of qualified social workers working with deaf children and their families was 0.25.
- However, of those respondents who answered positively that there was a social worker who worked with deaf children and their families, some pointed out to us that this was not actually an official part of their role but, for example, “Manager turns a blind eye” (34).
- Of those who responded positively that there were specialist social workers experienced with deaf children and families working in their Authorities, the extent of the specialist knowledge/experience varied. Whilst some were clearly workers with many years professional experience, it was of concern that other respondents included workers for example who were newly qualified but had “Stage II” (i.e. the national recognised sign language qualification equivalent to approximately GCSE level). The learning of BSL in no way includes such issues as learning about the effects of deafness on child development, nor does the qualifying curriculum for professional social workers contain any specialist focus on deaf children.

5.4. Child Protection

Specifically in relation to child protection (rather than safeguarding more generally) we found that in the majority of Authorities there were no arrangements that effectively involved specialist social workers with deafness related expertise in cases of child protection. Specifically:

- Only 36.8% (n= 18) of responding Local Authorities described co-working arrangements between child protection teams and specialist social workers.
- 18.4% (n=9) described a situation in which there was no co-working at all, either because specialist social workers did not exist to co-work with anyway, or because specialists working in Adult services were not allowed to work cases

¹³ Although this study was concerned only with England, recently similar concerns have been raised concerning the deaf-specialist workforce in Scotland where there are thought to be no deaf specialist social workers in any children’s services department in Scotland (Macfayden, W. 2009, “A voice that needs to be heard”, *Rostrum* (97), pp. 14-15.)

involving children, or because the CDT did its own child protection work and did not involve outside deaf related specialists.

- The remaining Local Authorities (40.8%, n=20) described various arrangements that involved getting ‘help’, of different varieties, from workers either within or outside of their Local Authority. In no cases were these descriptions of co-working in a formal sense and in the majority of cases the help described was not from a social worker. For example, respondents described involving a BSL interpreter if the child was a sign language user; or advice might be sought from an external agency such as RNID or Sense, or a teacher of the deaf might be asked for an opinion.
- In looking at the range of descriptions given to us of the external help sought, we were struck by three things:
 - Firstly how much the help took the form of information and advice in a general sense about deafness or sign language rather than specifically in relation to any particular case;
 - how little awareness there was about the extent to which specialist knowledge might be required about cultural issues or deaf child development issues in a broad sense, rather than only about language and communication (several respondents described involving an interpreter as of itself solving the problem of specialist aspects of a case);
 - and how ad hoc the arrangements appeared to be.
- Additionally, no respondent who was not themselves a deaf specialist seemed aware that there would be issues that needed to be taken into account or that would impact on the investigation if a child was deaf and not a BSL user.

5.5. Eligibility Criteria

Phase I findings had raised significant concerns about the operation of eligibility criteria in relation to deaf children and their families. Specifically it had concluded that being deaf of itself was unlikely to be regarded sufficient for the provision of social care services (including even an initial assessment) unless there were a problem which was regarded as substantial or critical over and above a child being deaf. Furthermore, non specialist social workers were unlikely to be able to recognise the significance of some presenting problems as substantial or critical because of a lack of understanding of the complexity of being deaf in linguistic, developmental and/or cultural terms. These findings were largely substantiated in the larger sample of Authorities in Phase II. Specifically we found:

- The operation of eligibility criteria appear not to be a bar to social care service provision for deaf children and their families, but only if one of two specific conditions exist:
 - A deaf specialist service arrangement exists (e.g. through specific team/expertise; contracted out service; or single specialist worker)AND
 - They are able to re-interpret deaf service users needs in such a way as to define them as critical/substantial so they fit the official Authority response

OR

- They are able to operate independently of the Authority's substantial/critical thresholds (as in the case of voluntary organisations)
- There was a strong awareness amongst many of our respondents who identified themselves as specialist workers, of needing to operate a parallel kind of thinking to that of children's services more generally, to enable deaf children and their families to meet thresholds for service provision.
- Amongst Authorities eligibility criteria were not considered a bar to service provision because generic disability services were thought to meet the needs of deaf children and their families too. However, the confidence of this position needs to be tempered by the extent to which an Authority actually had experience of providing a social care service to deaf children and their families.
- In many circumstances, deaf children and their families were in receipt of services despite the operation of eligibility criteria, not because of them.

Additionally, in response to a standard case study provided to all participants:

- It is of grave concern that 10% of the sampled Authorities would have not responded/not being able to respond at all in the case of a profoundly deaf minor, who was school excluded, with poor language skills and exhibiting "abusive" behaviour.
- Yet all Authorities would offer a response in the face of escalating circumstances involving other members of the family, rather than only the deaf child.

5.6. Deaf children as 'children in need'

In phase II we took the opportunity to investigate the recognition of deaf children as children in need in terms of the Children Act 1989, Section 17 provisions; and to explore the consequences for assessment and service provision of how Authorities interpreted this part of the Act. Results demonstrated a reluctance amongst many Authorities to regard deaf children as children in need, or to provide an assessment of need even if they were formally recognised as such. There was also considerable evidence of many Authorities being unaware of the majority of deaf children and their families in their locality and consequently of those families being unaware of their potential rights to an assessment of need (and subsequent provision of services). Specifically we found:

- The formal recognition of deaf children as children in need as defined by the Children Act 1989 is far from universal amongst Local Authorities.
- In around 40% of responding Authorities, such a formal identification was felt to be unhelpful, or unnecessary, or entirely contingent on specific circumstances, rather than consequential of a child's deafness.
- Even in those circumstances where this status is clearly acknowledged it does not guarantee in practice an assessment of need.

- Results revealed a considerable gap between the recognition of likely need and the provision of assessment. In only two thirds (62.7%, n=32) of the Authorities who participated would a deaf child who was formally recognised as a child in need, be offered at least an initial assessment.
- Amongst those Authorities without a deaf specialist team/team arrangement this figure drops to less than half.
- Even where it is common practice that recognition does lead to assessment, the extent to which this practice applies to the total population of deaf children and their families is severely constrained. In reality, assessment consequent on child in need status is more usually confined to those families whom might independently find the service, or those children known to the service for other reasons.
- It would be highly unusual for the total population of those with a potential right to an assessment under the Children Act, 1989 to be made aware of their entitlement and potential social care provision to be offered.

5.7. The provision of preventative services

In Phase I we had shown how specialist social workers with deaf children and their families were acutely aware of the significance of providing preventative social care services: (i) to support the linguistic and social development of deaf children; (ii) to offset the greater likelihood of mental health difficulties experienced by this population of children; (iii) to provide support to the whole family (which may not mean direct support to the deaf child as such); (iv) to complement education and health provisions. However, only in those situations where specific deaf child service arrangements were in place could social workers develop such services. Otherwise, the picture was more one of working on a crisis intervention basis once a problem had escalated and a referral come to light. Phase II findings reinforced these conclusions and demonstrated a worrying lack of preventative social care provision for deaf children and their families, with the exception of under 5s provision where there was evidence of some positive developments. Specifically we found:

- Over a quarter of all Local Authorities sampled said they ‘rarely’ or ‘never’ provided preventative social care services for deaf children and their families.
- Reasons for replying ‘rarely’ or ‘never’ to the provision of preventative social care services included: the impact of eligibility criteria, the small number of deaf children known to social care services and the lack of resources
- Amongst the 74% who responded that they ‘routinely’ or ‘occasionally’ did so, these responses were not necessarily indicative of services targeted specifically to meet the specific needs of deaf children. Rather they were inclusive of provision that might be available to all disabled children; or provision provided by Education that was considered to encompass social care issues.
- There was evidence of routine provision of preventative services targeted at deaf children and their families being strengthened as a consequence of multi

professional service developments in the wake of universal newborn hearing screening. However there was no evidence that these ever translated into routine preventative services for older deaf children.

5.8. In conclusion

Phase I of this research project, reached three overriding and stark conclusions. In light of testing out its findings on a national basis we have no reason to alter them. We therefore restate, with modifications reflecting the substantiation provided by the larger sample:

Whist there is evidence of some good practice that enables pro-active social care involvement with deaf children and their families and thus extends the range of provision and resource for those families in such a way as to complement that provided by educational and health colleagues, such arrangements are exceptional. In only a minority of Local Authorities would there appear to be effective, skilled and specialised social care provision for deaf children and their families.

There is clear evidence, on a widespread basis, of poor integrated children's services arrangements in respect of deaf children and their families which results in a lack of specific attention to deaf children and families' social care rights and needs; poor recognition of need and provision of assessment; severely limited ability to work preventatively within a broad understanding of safeguarding; ambiguous pathways of service provision; responsiveness only in situations of acute need, (the escalation of which may have been preventable); and lack of focus on the psycho-social developmental, linguistic and cultural challenges and differences of the full diversity of deaf children.

In these circumstances, and with specific reference to social care, there is strong evidence to suggest that the statutory duty on Local Authorities to co-operate within Children's Services to promote the well being of children is being significantly compromised in relation the well being of deaf children and their families.

NDCS is the national charity dedicated to creating a world without barriers for deaf children and young people.

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