

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 – October 2008
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The impact of integrated Children's Services on the scope, delivery and quality of social care services for deaf children¹ and families. Phase 1 executive summary.

Research commissioned and funded by: **The National Deaf Children's Society**
Research carried out by: **Alys Young, Ros Hunt, Carole Smith** (University of Manchester).

Research questions addressed:

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?

Data collection methods:

Five in depth case studies using documentary analysis, interviews and structured case response methods. 17 people were interviewed at varying levels of strategic, operational and fieldworker levels of responsibility. Case study sites were chosen to represent a diversity of local arrangements and stages of service delivery development. (i) one that has established a clearly differentiated deaf child and families social work service; (ii) one seeking to improve on clearly demarcated and good quality joint working between specialist deaf/sensory teams and children and families teams that may have no deaf child related experience; (iii) one with good integrated service planning and delivery structures prior to the Children's Services reforms but that is concerned about the potential negative effects of new service arrangements; (iv) one struggling to establish appropriate reforms in planning and delivery structures but is known to previously have had a reasonable service for deaf children and families; (v) one with little prior history of adequate provision and with current poorly planned and developing provision.

Principal findings:

Notwithstanding the good practice identified, there is clear cause to be concerned about the quality, availability, responsiveness and appropriateness of social care services for deaf children and families.

The separation of Adult and Children's Services strongly tends to work to the detriment of social care provision and practice for deaf children and their families, unless specific investment is made in a specialist team/team arrangements for social care with deaf children and families within Children's Services integrated structures.

¹ 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).

Without such specialist team/team arrangements being made, there is strong evidence that the new structures of children's social care services actually *militate against* (i) the identification of needs; (ii) the appropriate provision of services by suitably skilled and knowledgeable practitioners; (iii) effective joint working practices with deafness-related colleagues in education and health services.

In circumstances of little/no investment in specialist social care provision for deaf children and families a self fulfilling prophecy is created whereby little or no demand for social care services emerges from families/deaf young people, thus reinforcing the apparent lack of need and redundancy of role.

Deaf children are largely invisible on the social care radar (unless there have been significant individual champions in Authorities who have fought for their needs to be recognised and services to be maintained/developed). This invisibility is evident in local children's policy/planning documents and reinforced in the ways in which the structuring of services actually militates against needs being recognised. Where there is no specialist children's service/service arrangement, then being deaf is patently not sufficient to trigger any kind of social care response. Social care involvement is only triggered when the deaf child/young person/family has a problem that is identifiably complex or serious by *other* criteria, the seriousness of which is more readily identifiable (e.g. serious mental health difficulties, child protection).

Only in those situations where there had been positive investment in specialist deaf children and families social care services/service arrangements was it possible for the psychosocial, linguistic and cultural complexities of deaf children's developmental and social needs to be recognised and responded to in a proactive and preventative manner. This kind of response is entirely coherent with an understanding of safeguarding in the broadest sense of the promotion of wellbeing.

The invisibility of deaf children is further reinforced by the fact that in Local Authority terms they are relatively 'cheap' – that is to say they do not generally cause a significant strain on local financial resources that might bring their needs to attention in the way in which some disabled children might.

We found evidence of planning for social care children's services based firmly on assumptions of deafness as impairment i.e. a bio-physiological problem that can prevent optimal functioning but that can be adequately remediated through, for example, the provision of hearing aids. Thus resource allocation decisions were made in terms of severity of impairment in comparison with the full spectrum of disabled children. By this yardstick deaf children's needs were rarely regarded as a priority if the comparator was, for example, children with severe physical disabilities, or life-limiting conditions. A social and/or culturo-linguistic model of deafness that would identify the potential complexity of deaf children's linguistic, and social developmental challenges (and differences), including, for example, the considerable risk of mental ill health in childhood, was missing. Where it was missing, so was the basis for arguing for specialist social care deaf

children's services that could operate on a preventative basis and be available to all relevant families.

We are concerned that when the structural organisation of Children's Services has resulted in no specialist provision for deaf children and families and/or the location of specialist knowledge in Adult Services with little effective contact with Children's Services colleagues, then the viability of the service actually to *recognise* a presenting issue involving a deaf child as serious or warranting further assessment, is markedly compromised. In effect deaf children and families' needs have to escalate to acute proportions before need is recognised and action taken. Equally we found evidence that the involvement of a social worker/social care professional at a much earlier stage who has deaf-related expertise could more readily identify the complexity of a child/family situation, provide a comprehensive assessment of strengths and needs and intervene supportively to prevent escalation of seriousness.

In those Sites without a specialist deaf children and families social care service/service arrangement, we were seriously concerned by the lack of clarity about the relevant referral route(s) and subsequent pathways of provision for parents of deaf children (or other professionals) seeking social care involvement. We found examples of strategic managers whose remit theoretically included deaf children and families who were unaware of where any specialist expertise in their own Authority might reside; contact centres who did not know where to send us when we enquired about services for deaf children and families; teams who were unsure of whether their remit should or could include the provision of services to deaf children and families; representatives of services who were clear that their remit should or could include the provision of services to deaf children and their families but who could not provide us with examples of when it had; and local operational guidance that formally assumed that deaf children and families' social care needs would be met *in their entirety* by education/health services personnel, thus obviating the need for a social care response except in extreme cases such as child protection.

We encountered several situations in Authorities where the division of Adult and Children's Services had left social workers/social care staff with deaf relevant expertise without any remit, resource, authority, or practical means of working with deaf children and their families – even in situations where the equivalent expertise within Children's Services was not established. We would like to draw attention to those dedicated individuals who nonetheless sought all manner of ways and means to respond to deaf children and their families when they sought out a service and who were, in several cases, tirelessly seeking ways to formalise their involvement and the use of their expertise in cases involving deaf children and families.

Respondents who had deaf related service experience were quite clear about the case for distinctive social work practice with deaf children and families. Beyond the specification of particular duties, roles, responsibilities and tasks, arguments were made for: (i) the influence of social work values on how actions are undertaken and the prioritisation of particular processes and outcomes (that sister professionals would be less concerned

with); (ii) the significance of practice within an holistic family assessment context/orientation; (iii) the understanding of deafness from within a social model thus setting the agenda for the identification of need, assessment of strengths/resources, and the shape of appropriate provision. By contrast, respondents who had little or no direct experience of deaf children and families were concerned that any attempt to establish specialist social care provision would in fact be “anti-inclusionist”.

The existence of specialist deaf children and families social care children's services/service arrangements greatly assisted in the process of joint working with education and in pushing forward the integrated services agenda in this sector. There was still a long way to go in truly co-ordinated, well being promoting, holistic multi-professional services for families with deaf children that included a strong social care element. Nonetheless it was quite clear that the establishing of a specialist social care service/service arrangement greatly facilitated this process.

In conclusion:

- **we found clear evidence of good practice that was enabling pro-active social care involvement with deaf children and families that was thus extending the range of provision and resource for those families in such a way as to complement that provided by educational and health colleagues. However, these arrangements were exceptional.**
- **We also found clear evidence of the ways in which the structuring of Children's Services, when they have not paid specific attention to deaf children and families, results in poor recognition of need, little resource allocation, inability to work preventatively within a broad understanding of safeguarding, poor joint working with health and education colleagues, 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 and their optimum development.**
- **In these circumstances, and with specific reference to social care, we 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 families in those cases where there has been no investment in specialist deaf children and their families social care services within new Children's Services structures.**

Phase 2 of this research project, will involve the testing out of these conclusions with the 150 Local Authorities in England to establish whether the concerns we have identified and the markers of effective practice are recognisable and generalisable.

Introduction

This research study 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?**

As such, it is firmly focused on exploring the impact of the current radical restructuring of Children's Services and how the social care component of services for deaf children and families is defined and delivered. We did not set out to identify what the social care needs of deaf children might be, nor to assess with service users what would constitute an ideal or desired service². Rather, we were interested in understanding how the structure of a service (its strategic direction, operational constitution, and practice delivery) was shaping the nature of social care services for deaf children and families.

We took this firmly structural perspective because it was clear that Local Authorities, charged with implementing integrated Children's Services structures, were being faced with difficult decisions about: where to place responsibility for deaf children in new service structures; how to ensure the delivery of statutory duties and responsibilities to a population requiring specialist professional knowledge; and what it is that social work professionals can and should be doing within integrated approaches to service delivery with colleagues in education and health. These issues are further compounded by two factors: deafness, from a social care perspective, because of its fundamentally linguistic nature, does not easily fit under an umbrella of disability services; there is a key difference between education/health services constituting universal provision for all deaf children and families in a way in which social work and social care, historically, has not.

It was, therefore, crucial to understand the consequences of how these new structural-functional questions were being addressed, for the nature, quality, acceptability and effectiveness of social care services in relation to deaf children and families. We were of the view that to evaluate critically the effects of the processes of integration would give us a clear insight into whether, how and why integrated Children's Services were benefiting deaf children and families in respect of social care expertise and resources.

In what follows, therefore, we will be addressing 6 primary areas of interest:

² We firmly acknowledge that both of these issues are important, however, we took the view that to seek to define social care needs and explore user perspectives divorced from a clear understanding of the constraints and opportunities of service structure and delivery would not result in a clear assessment of strengths and weaknesses of social care services currently, nor provide a means to model how both good practice and difficulties might arise.

- (i) We will analyse in detail different approaches to the structural location of deaf children's social care services within new integrated Children's Services structures, including the underpinning rationale and service consequences of these models.
- (ii) We look in detail at some of the challenges of the process of integrating Children's Services, identifying it firmly as a work in progress with differing effects at different stages of implementation.
- (iii) We focus on one specific example in practice of how variations in service organisation within integrated structures constrain and enable particular kinds of social care response.
- (iv) We address in detail the recurring issue of eligibility criteria and thresholds for services as experienced as an intra-team issue as much as a service user/service provider problem.
- (v) We consider the nature of joint working within integrated Children's Services structures as experienced by social care professionals working with deaf children and families.
- (vi) Finally, we look at what it is that social care and social work with deaf children and families might actually be – in terms of approach and resource, as much as in terms of specific knowledge and action.

We begin, however, with a brief review of the policy background and relevant research literature that contextualize our study.

2. Background to the issues and a brief review of relevant literature

2.1 The Children Act 2004 and its consequences

The Children Act 2004 is a sea change in how services for all children should be organised and delivered within England. It has required, as of April 2005, that all Local Authorities appoint a Director of Children's Services, Schedule 2 of the Act removing the existing duty on Local Authorities in England to have separate Directors of Social Services and Chief Education Officers. In effect, social services for children and education services become one Children's Service Authority – an integration that is reinforced by pooled budgets, common governance, integrated strategic planning and new approaches to multi professional and multi agency front line delivery of services (DfES, 2005b). However the new arrangements extend beyond simply the merging of education and social services for children. Section 10 of the Act “places duty on Local Authorities in England to make arrangements to promote co-operation between the authority, the ‘relevant parties’ and other locally determined parties, to improve the wellbeing of children in the authority’s area” (DfES, 2005a, para 1.14). In other words, to establish Children's Trusts/Children's Trust Arrangements in which the main statutory services, as well as voluntary sector providers and indeed parents and young people themselves, work together in a strategically co-ordinated and jointly operationalised manner to deliver joined up and effective services for all children and families under a common framework of governance, strategic planning, operational processes and joint delivery. Furthermore, the ‘wellbeing’ of children that is sought through such arrangements has acquired from the Children Act 2004 a statutory definition that encompasses the 5 desired outcomes first defined through the Every Child Matters (ECM) consultation and subsequent statutory guidance ([www.http://everychildmatters.gov.uk](http://everychildmatters.gov.uk)) namely: be healthy; stay safe; enjoy and achieve; make a positive contribution; achieve economic well being.

These changes have spawned a whole host of government guidance to assist authorities and service providers in engaging with the changes to policy, planning and practice that will be required as the new legislation is played out in practice (DfES, 2005c). The implications of integrated Children's Services (social services and education) as well as the wider context of the implementation of Children's Trusts inevitably creates new challenges of interpretation and effects in practice for sector-specific services such as those working with disabled children, children with mental health problems, looked after children and so forth. In this respect, the planning, organisation and delivery of services is also increasingly influenced by a key philosophical and policy underpinning to much of the guidance associated with new Children's Services; namely an emphasis on the increase in availability and suitability of universal services for all children and thus a consequent reduction in the need for targeted services for children with some specific needs. Given the common universal outcomes for all children, the adaptation of universal services to meet a range of needs becomes an important principle and with that the notion that better access for all to children's services at an earlier stage should militate against the need for targeted services in response to acute need at a later stage. The investment in Sure Start, early years children's centres and extended school provision are

cases in point. That said, questions have been raised about the likely detrimental effects of pursuing this vision in relation to those children who do require specialist services, not all of which can be supplied by mainstream universal providers (Young et al, 2008).

2.2 Integrated Children's services and deaf children and families

The impact of these changes on the organisation and delivery of social care services for deaf children and their families was, at the start of this project, completely unknown and was one of the key drivers for the investigation. However, it was clear that there were three core issues that pointed in the direction of why such an investigation would be of significance.

i) Within the context of early identification of deafness and preschool provision, the national roll out of the Newborn Hearing Screening Programme (NHSP) has revealed gaps in the provision of social work services; and raised questions about the appropriateness and quality assurance of some social care components within multi disciplinary child and family support. The evaluation of phase 1 of the national roll out of the NHSP found, for example, significant difficulties in the then constituted social work services' ability to respond to referrals from other agencies; significant variation in quality of provision dependent on whether deaf children were considered the remit of specialist sensory teams or generic children's teams; poor engagement at a strategic level with the NHSP programme; enduring difficulties over the definition of 'social care needs' and whether deaf children met eligibility criteria for services (Young et al, 2004; Young et al, 2005). Four years on, although the policy and practice landscape has undergone radical reorganisation the issue of quality assuring the social care component of services for families with deaf children following early identification of deafness remains an enduring concern as all local authorities are now actively assessed for the quality of their services in relation to NHSP.³

ii) The introduction of the Common Assessment Framework (CAF) and Lead Professional Guidance within the context of Every Child Matters has refocused attention on the long standing tension between statutory responsibility towards deaf children as "children in need" and the impact of the heterogeneity of deafness and its implications for how services interpret and respond to such a status. Legislation and statutory guidance have firmly classified deaf children as "children in need" since the late 1980s (Young and Huntington, 2002). This status is reinforced by the recent guidance associated with the CAF in which children are deemed to have 'additional needs' if they are at risk of failure optimally to achieve the 5 outcomes defined in ECM; and to have 'complex needs' if they have a number of needs requiring support from more than one agency (DfES2006a, DfES 2006b). The implications for deaf children and their families are complex with, on the one hand, an argument that all deaf children meet these definitions and therefore holistic

³ Recently, the following quality standard in relation to social care services has been agreed by the NHSP Quality Assurance Team., but is yet to be ratified. "The social care needs of all families with a deaf child should be reviewed as part of an initial assessment by the Lead Professional. In all areas there should be available a member of Social Care staff with appropriate expertise in working with deaf children and their families to respond to the identified needs" We are grateful to the NHSP QA team for permission to reproduce it here.

assessment through the CAF framework is required and on the other that we need to differentiate different levels of risk of not meeting the five outcomes and therefore not all deaf children would be appropriate for a CAF response (e.g. children with mild or unilateral hearing losses; Deaf children in Deaf families). Whatever the arguments, the fact remains that Local Authorities using CAF within newly constituted integrated service provision are making choices about the characteristics and shape of service response to deaf children in light of CAF. We know practically nothing about the effects of those choices on the type and extent of services that are provided or the impact on children and families of having/not having provision assessed and planned within the CAF guidance. In cases where CAF is being used we do not know who is carrying out such an assessment with what training and its implications for the wider multidisciplinary team (for example, whilst social workers are generally familiar and routinely trained in CAF, teachers of the deaf generally are not despite being the most common lead professional in this context). More broadly, children's services reforms, in its emphases on universal, targeted and specialist services is equally asking the question who is best placed to meet deaf children's needs given they may not need any kind of specialist provision (universal services are sufficient and appropriate), as well as identifying whether they actually do. Both may be reasonable outcomes of an assessment through CAF, both may be considerably influenced by the deaf-related knowledge and experience of the practitioner involved.

iii) The organisation and delivery of social work services for deaf children and families have been notoriously variable in terms of service arrangements, resourcing and quality on a national basis. The creation of integrated (social work/education) Children's Services within Children's Trusts/Children's Trust arrangements more generally, potentially has great impact in creating the requirement to specify, resource and plan from an holistic health/education/social care perspective. Deafness in its medical, social and cultural manifestations is par excellence a test case for the extent to which a more truly multi dimensional policy, planning and delivery structure is able to respond effectively to diversity of need and potential. From professional networks we know that social work services and social care provision more generally is very differently arranged in different Local Authorities (few have specialist deaf child and family social work teams; some seek co-working between specialist sensory teams and specialist children's teams; some have very little provision at all). Integrated service provision is forcing a much more explicit focus on specifying what constitutes appropriate social care provision, how social care services should be provided and by whom, the effectiveness of social work arrangements for meeting statutory and non statutory duties towards deaf children and families and the relationship between different professionals working with the same families to define and meet social care needs. This latter issue is an additionally complex one given the long history of mistrust between social workers with deaf children and teachers of the deaf who have traditionally been identified with different approaches to communication (social workers as the 'signing lobby'). Even recent research has clearly demonstrated significant differences in professional culture between the groups (Young et al, 2004). In a broader context, some research studies are beginning to map and evaluate different models of Children's Trust arrangements and their effects on various desired outcomes such as meeting the needs of children at risk of social exclusion; and transitions across services (Bachmann et al, 2006; Frost et al, 2005).

This research study constitutes the first that has looked specifically at the impact of the introduction of Children's services Authorities on the delivery of social care services for deaf children and families.

3. Overview of research design and methods

3.1 Research 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?

3.2 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).

3.3 Research Design

The project was designed in two phases with Phase 1 consisting of five in depth case studies using documentary, interview and structured case response methods. Phase 2, a national survey guided by the findings of Phase 1, is not reported here.

3.4 Case Study Methodology

Integrated Children's Services is a new and changing phenomenon that both has shaped and is shaping the contemporary context of welfare services, be it at philosophical, policy or practice levels of activity and influence. As such any study of its effects needs firmly to be rooted in its operational context in which its consequences are being worked out in real life praxis. The specific domain of services for deaf children and families adds an additional layer of complexity to any potential study. The multi professional players (health, education and social care) each bring to the integrated context different perspectives on the very thing to which they respond – deafness (be it understood in medical, cultural linguistic and/or disability terms). A research approach was sought, therefore:

- that could describe, explore and to some extent explain an applied phenomenon (a new approach to the organisation of Children's Services and their delivery)
- whose application was likely to be different in a variety of contemporary contexts (teams, service structures and authorities)
- where a core feature of that which services were meeting (deafness as part of a complex of potential issues) was itself a contested phenomenon (impairment, disability and source of cultural-linguistic identity).

A case study methodology was chosen for its strengths in investigating “a contemporary phenomenon within its real life context especially where the boundaries between phenomenon and context are not clearly evident” (Yin, 2003, p.13). It is an approach well

suiting to studying a moving target such as a Local Authority designing and redesigning its Children's Services structures and where researchers have little hope of being able behaviourally to control in any way that which they are attempting to document and understand.

In the case of this project, we chose to study in depth what was happening to social care services for deaf children and families in five different Local Authorities who were implementing an integrated Children's Services approach (see below). Data from these case studies would then form the basis of expanding the research on a national basis to investigate the research questions previously identified. However, in using a case study methodology, we did not expect to be able to generalise to all Local Authorities in the sense of suggesting that these five case studies would represent what was happening nationally. There was no way of knowing what was the case based on the study of only 5 examples and given the notoriously typically atypical nature of Local Authorities. However, we were confident that we would be able to generalise at the level of theoretical propositions. That is to say, to identify from the case studies a series of propositions about:

- i) what it is that is shaping the nature of social care services for deaf children within the context of implementing integrated Children's Services;
- ii) what it is that is influencing the consequences deriving from those structures and practices; and
- iii) the key factors or dimensions that can be used to evaluate the impact and quality of the resulting social care services for deaf children and families.

It was these propositions that would then be tested out in the second phase of the research that would involve contact with Children's Services on a national basis (this phase of the project is not reported here).

3.5 Sampling of Participating Sites

Five teams with designated responsibility for the delivery of social care services to deaf children and families, within integrated Children's Services structures, were purposively sampled. Variation was sought with regard to:

- structural location of service within integrated structures (e.g. specialist deaf/sensory team or housed within a disability team)
- degree of integration with other professional groups also working with deaf children and families (e.g. teachers of the deaf)
- Extent of strategic implementation of integrated Children's Services within the local authority
- Model of service provision (e.g. stand alone specialist team or dispersed non deaf specialist responsibility)
- Previous history of social care service provision for deaf children and families

Five potential 'types' of service were thus identified which could form the basis of in depth case examination. These were characterised as:

- i) one that has established a clearly differentiated deaf child and families social work service;
- ii) one that is seeking to improve on clearly demarcated and good quality joint working between specialist deaf/sensory teams and children and families teams that may have no deaf child related experience;
- iii) one that had good integrated service planning and delivery structures prior to the Children's Services reforms but that is concerned about the potential negative effects of new service arrangements on what already was working well;
- iv) one that is struggling to establish appropriate reforms in planning and delivery structures but is known to previously have had a reasonable service for deaf children and families;
- v) one with little prior history of adequate provision and with current poorly planned and developing provision.

The previous and current professional networks of two of the research team enabled the swift identification of potential Sites offering the degree and type of diversity sought. Contacts at a senior level in each Site were approached informally and if initial interest was shown, they were formally approached following ethical permission being granted for the study (see below). (In reality all initial Sites approached consented to participation and as the study progressed a number of other Local Authorities approached the research team to volunteer to participate as well. These could not be included because of time and financial constraints).

3.6 Case Study Method One: documentary analysis

A search was carried out to identify a range of publicly available documents in each Site that were pertinent to an investigation of integrated children's service provision e.g. The Children's Plan⁴, Sub-strategy/plan for disabled children, Joint Area Reviews, Annual Performance Assessment (Children's Services). These were then searched for the terms "deaf" and "hearing impaired" using the appropriate 'find' facility. The website of each of the 5 Sites was also searched for these terms using the search facility provided.

Additionally individual Sites and interviewees supplied the research team with internal documents that they considered of particular relevance to our study and that they wanted included within our analysis, e.g. Joint working protocols; Information sharing protocols, Transition strategies; [A full list of all documents consulted at each Site is given in the Appendix]

The aims of the documentary analysis were:

1. To contribute information to assist in the understanding of the organisation and delivery of social care services for deaf children and families in each Site and in comparison between Sites

⁴ At the time of the research LAs who had achieved a 3 star rating with respect to Children's Services were not subject to the requirement to have a Children's Plan published on the web

2. To provide a point of comparison between formal expression of service structure/arrangements and in-practice evidence of service delivery arrangements derived from the interviews
3. To evaluate the extent to which deaf children and their families are visible within Authority planning, policy and practice guidance (with regard to Children's Services)
4. To identify trends and consequences for service provision in how the needs of deaf children and families are implied, made explicit, subsumed or specifically addressed within relevant documents

3.7 Case Study Method Two: individual interviews

Seventeen semi-structured interviews were carried out (16 face to face and 1 by telephone).

The interviews were designed to enable individualised and in depth exploration of range of issues pertinent to main concerns of the research in such a way as to be sufficiently contextualised within each Local Authority. This contextualisation was important because of the need to understand (not just document) the diversity of service arrangements for the delivery of social care for deaf children and their families, and to identify the forces that might sustain and challenge these arrangements within the shifting landscapes of the implementation of integrated provision. It was also considered vital that within any given Site data were gathered from a range of perspectives amongst participants likely to have different degrees and kinds of responsibility for service planning, delivery, evaluation and accountability.

3.7.1 Interview focus

Interviews focused on 6 main issues:

- Description of actual working arrangements and structures of service delivery as well as the rationale for these and how these have changed/are undergoing change in light of integrated provision.
- Description of actual service in terms of referral, assessment, working arrangements including identification of unmet need, service gaps, and trajectories for service growth and development.
- Resource related considerations whether economic, skills based or personnel based.
- Evaluation of likely or actual improvement in how the social care needs of deaf children and families are being met in comparison with previous service arrangements.
- Examples of good practice –in the spheres of governance, strategic planning, operational delivery and front line working.
- Risks and concerns.

Participants were sent the interview schedule in advance so they could consider what they would like to tell us about each issue and why. [Full interview schedules are available in the Appendix].

3.7.2 Interview participants by role:

Site A	
1	Team Manager Deaf Adult Services Authority wide
2	Service Manager, Disabled Children. Authority wide. Strategic.
3	Team Manager Multi Agency Community Support for Disabled Children. Authority wide
Site B	
4	Disabled Children Service Development Manager. Authority wide. Strategic
5	Area Manager, Children's Services. Strategic
6	Manager Adult Sensory services. Authority wide
Site C	
7	Manager Adult Service, Sensory Impairment & Physical Disabilities Authority wide. Strategic
8	Manager Deaf Services Adults. Authority wide
9	Service Manager, Children's Disability Team Strategic
10	Area Manager Children's Disability Services (Education background)
Site D	
11	Manager, Deaf Children and Families Team. Authority-wide
12	District Manager Disabled Children (line management responsibility for DCFT) Strategic
13	Head of Specialist Children's Services. Authority wide. Strategic.
Site E	
14	Team Manager Children with Disabilities Team (Authority wide)
15	Service Manager Children with Disabilities (Authority wide) Strategic
16	Team Manager Adult Deaf Services. Authority wide
17	Service Manager Adult Services (with line management responsibility for Deaf Services) Strategic

3.8 Case Study Method Three: structured case responses

Each interview also included a common, structured element. This consisted of two case examples, each consisting of two parts, where interviewees were invited to explain how this fictional case would be responded to in practice (not in ideal terms). In this way a point of comparison between Sites is established and specific illustrations of more general issues that might have been raised in the interviews themselves are made more concrete.⁵

⁵ We only report one of these case studies.

The research team drew on their own professional experiences to create the case studies, each of which are composites of a range of different situations, rather than fictionalised accounts of one particular situation. Nonetheless on numerous occasions, interviewers were asked whether the 'case' had been taken directly from one of the case files of the person being interviewed because the circumstances described were so recognisable to them. Unintentionally, therefore, these responses have provided a validation of the credibility and plausibility of the case studies used. [The full case studies are provided in the Appendix].

3.9 Data analysis

3.9.1 Documentary analysis

Documentary analysis was undertaken by searching the websites of the five Sites in two ways. Firstly the websites were searched for the terms 'deaf' and "hearing impaired". In addition, terms that LAs are usually expected to provide, such as a Children's Plan⁶ were specifically searched for these terms. Sites were also invited to contribute any internal documentation that they considered to be relevant to the research aims. [See Chapter 6 for the full documentary analysis].

3.9.2 Interview analysis

All interviews were audio recorded and transcribed in full. They were then read and re-read by members of the research team independently to derive a set of thematic codes that might form the framework for analysis. The three lists of potential codes were then considered alongside each other with common ones agreed where there was difference in emphasis or identification. A process of further discussion and refinement of what was exactly intended by each proposed code led to the final coding framework. The codes were then applied to the transcribed interviews with the assistance of the sort and retrieve programme NViVO. [The full analysis framework applied, consisting of 10 codes and their working definitions is available in the Appendix]. The thematic resulting groupings were then allocated between the research team members for analysis. At frequent stages through this process, team members came together to discuss how their analysis of different thematic groupings was developing in order to identify areas of overlap, challenge, confirmation and query. Each thematic code analysis was written out separately, before being combined in the final version.

3.9.3 Structured case response data analysis

Interviewee responses to the structured cases were also transcribed and entered into NViVO. In this way it was possible to make direct comparisons within and across Sites in response to the case studies. In analysing responses, attention was paid not only to the description of the likely actions given by interviewees, how these were explained and justified, but also interviewees attitudes to what they were telling us e.g. whether they themselves were satisfied or critical about how they knew their own team was likely to respond when faced with the case described.

⁶ At the time of the research, LAs who had previously received a 3 star rating with respect to Children's Services were not required to publish a Children's Plan on the web.

4. The structural location of deaf children's social care services within new integrated Children's Services structures

4.1 Crossing the divide: adults' sensory services and children's social care

When describing current structural arrangements for providing social care services for deaf children and their families, respondents traced their development back two or three years to decisions that were made in the context of Government pressure to integrate services for children. Thus, in all sample Authorities the previously generic organisation of services under a single Director of Social Services had become managerially, financially and structurally divided between services for adults and services for children and families. Social care/social work for children subsequently became integrated with education, although in the sample Authorities the relationship between social work and education was largely expressed through common managerial responsibility towards the top of the management hierarchy, rather than in terms of multi disciplinary responses to assessment and service provision.⁷

The immediate impact of these changes on services for deaf children and families was both to divide and shift responsibility for their provision in comparison with previous service arrangements. Previous arrangements had generally comprised generic sensory support teams or specialist deaf services teams that typically worked across the whole age spectrum, covering children and adults (although the extent of involvement with deaf children and families varied considerably). With the division of Adult and Children's Services, Authorities were faced with difficult decisions about how to use the specialist resource that had existed and teams and individual practitioners faced considerable reorganisation. The puzzle to be solved concerned the relationship between specialist deaf-related knowledge/skills in the social work/social care workforce that was pre-existing, locality based children and families teams, and disabled children's services. Furthermore, that pre-existing specialist deaf-related knowledge had not necessarily been predominantly concerned with deaf children and families if the specialist team had mostly worked with d/Deaf adults. Similarly, pre-existing disabled children's teams may have had little if any contact with deaf children and their families. With specialist deaf education teams having a long history of providing services to all deaf children and their families on a universal services basis, the relationship between that provision and social care provision for deaf children and their families specifically within Children's Services, raised new questions of service structure, remit and delivery.

In broad terms our 5 case study Sites fell into two categories of response to these new challenges. In Sites C and D specialist arrangements were created that specifically focused on deaf children and their families (be they with differing degrees of integration with education colleagues). In Sites A, B and E whilst specialist deaf services within Adult Services structures were retained, equivalent specialist services to support deaf children

⁷ How education and social care professionals worked together in practice is discussed in detail in Chapter 0.

and their families in parallel children's directorates were not established. However, service arrangements for responding to deaf children and families did exist, be they with differing degrees of clarity, opportunity and constraint.

Before discussing in detail the rationale and effects of these structures, we will describe how each Site's social care services for deaf children and families was constructed because the picture is a complicated one. As later discussion of such factors as eligibility criteria (See Chapter o) will show, the scope, quality and impact of social care services are inextricably bound up with the consequences of the structuring of the services.⁸

4.2 Description of service organisation in Site A

Site A is a city based team. Services for D/deaf adults are provided within a specialist sensory services team which is structurally located within physical disability services in the Adult Services Directorate. [Within the sensory services team, those working with d/Deaf people tend to be referred to as the Deaf Services Team]. Within this team there are deaf-specialist workers e.g. professionals who have a broad range of deaf related skills and knowledge, including sign language, and who work closely with the local Deaf community. Deaf children and their families are, in the organisational structure, the responsibility of the Children and Families Directorate within which there is a Children with Disabilities Team. They also fall within the remit of the Multi Agency Community Support Team for Disabled Children. This team is responsible for assessment and review panels on a pan-disability basis and act as a gateway to a range of provision including social care provision (e.g. family support at home; access to specialist play schemes). They have no statutory responsibilities but would be a pathway to formal referral to the Children with Disabilities Team who do. However, very few deaf children and families are actually known to the Multi Agency Community Support Team for Disabled Children or come before a multi agency assessment panel. It is more likely that the education wing of Children's Services are the ones routinely responsible for deaf children and their families and contact between that service and the Multi Agency Community Support Team for Disabled Children is poorly developed.

The Children with Disabilities Team has formal responsibility for social work (i.e. statutory assessment and other duties) with deaf children and their families. It has no specific deaf related expertise embedded within it through any kind of post with specialist remit, or worker with specialist skills. However, it is only if there is a complex issue over and above being deaf that potentially the Children with Disabilities Team might get involved e.g. if the child has multiple disabilities or if there were a child protection concern. [We return to the implications of such criteria and their underpinning assumptions and implications in Chapter o]. Therefore, in broad terms, the social care needs of deaf children and families would not be responded to by the social work teams within Children's Services. This situation in some respects is not unique or unusual to deaf children. Of the 3,000 children on the Children's Health and Disability Team's data base, only 600 meet the criteria for a social work service provided by the Children with Disabilities Team.

⁸ Setting out the description of each service structure in this way is also intended to enable readers to consider the arrangements in their own localities against these types and characteristics of service structures and arrangements.

However, a working practice has arisen whereby Deaf Services, although existing within Adult Social Care, can respond to some of the needs of deaf children and their families provided they are not ones that require (or are deemed only able to be met following) formal assessment e.g. under the NHS and Community Care Act 1990. So for example, 'link workers' (who are not necessarily qualified social workers but do have specialist deaf related knowledge, skills and experience) working in the Deaf Services Team would be able to advise on issues such as welfare rights, equipment provision, communication access and support into employment that parents of deaf children might bring to their attention. In this way they are responding to an adult referee (the parent) although the focus may well be the child and they are able to use this route to provide more general social care support to the family. They estimate that 10 to 15% of users of their service are in effect parents of deaf children and/or deaf young people with the majority being young people/families of young people aged 14 to 18. The Deaf Services team are also responsible for the provision of equipment to deaf children.

In terms of statutory assessment at point of transition, social work provision in relation to d/Deaf adults sits within the Physical Disabilities Team within Adult Services (again the distinction is made between social work provision such as that requiring statutory assessment that would not be done by the Deaf Services Team who provide more general social care provision). A 'Transition Officer' exists (created in the past 18 months) whose role it is to identify those children for whom there should be a 14+ assessment, including deaf children. The assumption is that if children are identified as receiving Children's Services (this includes education support) then they are picked up age 18 by Adult Services to receive a formal community care assessment. However if the child leaves school at age 16 then they fall through the gap often only reappearing in terms of service provision through for example a self referral to the Deaf Services team typically in their 20s. Additionally there have been real difficulties in locating some of the children for whom a 14+ assessment may apply because of being in mainstream schools. This problem is beginning to be addressed.

4.3 Description of service organisation in Site B

Site B is a large county and is somewhat distinctive insofar that at the time of the research, the transfer of responsibility for children's sensory support services from the Adult to the Children and Families Directorate of the Local Authority was in process. At the point then, arrangements about the structuring of social care services for deaf children and families were still in a state of flux. The manager of sensory services described an extended period of re-organisation for physical disability and sensory support services under the structural umbrella of Adult Services. This was attributed, at least in part, to senior managers focusing their attention on services for older people which eclipsed other service user groups in terms of level of need, an emphasis on the social care-health interface and budgetary and workforce considerations. This perception was confirmed by another manager responsible for strategic development in Children's Services, who suggested that during the disaggregation of Adults' and Children's Services little attention was paid to the structural positioning and resourcing of sensory services be they for adults or for children.

Ongoing deliberations about the provision of sensory services in Site B may account for some confusion about their organisation and the locus of responsibility for service delivery. The manager of sensory services, including services for d/Deaf adults and children, reported that the senior management team had recommended a transfer of responsibility for Children's Services to the Children and Young People's Directorate. Under this arrangement, sensory services located under the Adults' Directorate would only continue to provide services to children and families at transition and with regard to equipment. However, this recommendation had not been implemented at the time of our research. Current arrangements, as reported by an area manager for Children's Services, identified the Physical and Sensory Impairment Team in Adult Services as still holding responsibility for service provision from birth to old age. There was also a clear assumption that in effect Education would be the lead service for deaf children, which was taken as meaning that there will be little or no involvement of social care services on a routine basis. Whilst deaf children would fall within the remit of the Children with Disabilities Team, the threshold for service involvement was so high it was unlikely that this team would have much to do with deaf children and families. Area children's social care teams would pick up any referrals associated with child protection. It was envisaged that adult sensory services would have a severely prescribed role, focusing on equipment provision and transition review.

4.4 Description of service organisation in Site C

Site C is a county-wide service. Located within the Adult Services directorate, the Hearing Impairment Team does provide services across the whole age spectrum. Its remit to provide services to deaf children and their families is structurally enabled through a specific service level agreement. In addition, although all members of the team may work with children, there is a designated lead specialist children and families practitioner, although this post is currently vacant. This service level agreement with Children's Services transfers funding in respect of its work with children and young people. This arrangement was a conscious decision made at the time of reorganisation in line with integrated services because of a desire to preserve those aspects of the service that were already working well in respect of children and families. To disaggregate Children's Services and Adult Services, thus effectively splitting up a specialist team, was felt at the time to be counter productive.

In terms of organisational structure, the referrals with respect to the social care needs of deaf children and their families are filtered through the appropriate team in Children's Services before being referred to the Hearing Impairment Team in Adult Services. The Hearing Impairment Team commonly, therefore, negotiates referrals and co-working with a range of teams located in Children's Services. For example, the Hearing Impairment Team would not take the lead on child protection enquiries – that would be the responsibility of one of the three Children's Assessment Teams within the county. However, the team would expect to co-work in any case involving a d/Deaf child and/or a d/Deaf family. Similarly, d/Deaf children with a learning disability would be subject to negotiation about roles and services between learning disability services and the Hearing

Impairment Team; whilst a deaf child with multiple disabilities would fall under the remit of the Children with Disabilities Team.

Within the Special Educational Needs branch of Children and Families Services there is a strategic move towards locality working across the Children's Services Authority. Locality coordinators, including those from SEN support services, are responsible for overseeing the introduction of the CAF, promoting multi-disciplinary working and providing support and advice in relation to child protection issues.

4.5 Description of service organisation in Site D

Site D is a county wide specialist service dealing exclusively with Deaf Children and Families as a separate team (their remit also includes d/Deaf parents who have hearing children).

The team sits within Children, Families and Education Services within which there is a Children's Social Services division. That division in turn has four directorates, one of which is a Specialist Services Unit that encompasses for example, fostering and adoption, and disability. But the team does not sit within disability services; it is a specialist team within the Specialist Services Unit.

For line management purposes, the team leader of the Deaf Child and Family Team (DCFT) is managed by a district manager who heads up the Disabled Children's Team for part of the county. But the DCFT are a county wide, not a district or area service. The team consists of three social workers, three support workers, an administrative assistant and a team leader.

Social work and social care services for d/Deaf adults are the remit of a separate specialist service that sits within Adult Services within the county. At the time of reorganisation of services, some of the pre-existing specialist workers, therefore, chose either to work with children and families or to work with adults. The previous team was in this way split up.

One of the primary effects of becoming their own team is that the workers are no longer seen as providing specialist assessments that may be additional/ complementary to normal practice. Rather deaf children and families as a service user group are treated in exactly the same way as any other children and families referral i.e. within the Department of Health (DH) assessment framework. The team operates an open door open referral policy (no eligibility criteria apply). Referrals come through the central social care county gateway for all referrals and/or direct to the team (but are then processed back through the central system).

That said, there are separate county wide main referral points for children and families (social care) and for children and families (education). Consequently, it is not routinely the case that this social care team is likely to know about all deaf children and families in the county, or for those families to be aware of their potential entitlement to service. There should be cross referral between education (deaf children) and DCFT but in practice

this does not work particularly well. There is no neither a single, nor an integrated management structure for education and social care (and health) working with deaf children and families. The manager (social care) has a counterpart who is the manager (education) but there is little strategic or operational co-working between them at this stage. There is as yet no co-ordinated nor routine processes of joint planning and co-ordinated operational practices between deaf children's services (education) and deaf children's services (social care) although steps are being taken to understand why and to address this as a medium term goal. Co-ordinated processes with health services as might be expected within Children's Trust arrangements in relation to deaf children is barely off the ground.

Good transition processes are under review since the split between Adult and Children's Services. DCFT do get routinely invited by education colleagues to transition review meetings, but these are not perceived to be fully operational multi agency planning and review meetings. Some further work is being undertaken on a county wide and wider than deaf children basis to improve the operational procedures of this point of service transition and increase the involvement of young people and families in that process.

4.6 Description of service organisation in Site E

In Site E, a unitary authority, there is a specialist team providing services for d/Deaf adults. Equipment services for adults and children are also located with this team. Until about two years ago, the team also provided assessment, case management and social work services for deaf children and their families. In keeping with the policy and practice aspirations towards integrated services and the legal definition of deaf children as being children 'in need', responsibility for Children's Services was moved to the Children with Disabilities Team. Nobody from the specialist d/Deaf team was re-located into Children's Services.

The manager for the Children with Disabilities Team noted that her team's specialist knowledge and understanding relating to the needs of deaf children was limited. Of a consistent caseload of around 200 children, the Team are never working with more than two deaf children/families. They thus tend to depend on co-working with the team providing services for d/Deaf adults (although one of the Children with Disabilities Team social workers is currently learning BSL to facilitate her work with a particular child). However, because referrals concerning deaf children must always be routed to the Children with Disabilities Team, the adult /Deaf services team must wait to be approached for help and advice before they can intervene. There is a perception within the d/Deaf services team that they are sometimes not appropriately approached to co-work because the Children with Disabilities Team lacks the knowledge and expertise to recognise when some deaf children and their families need a social care service.

The team providing services to d/Deaf adults is managed, along with other services for physical and sensory disability, by a Service Manager and management responsibility extends upwards to the Director of Adult Services. Organisationally, the Children with Disabilities Team is embedded in services for children and young people where management is divided between a Director of Education and a Director for Children, both

of whom are responsible to an Executive Director. The organisation of services for children and young people thus demonstrates the structural and management integration of education and social services.

However, it also seems to be the case, as might be anticipated during the relatively early stages of this process, that multi-disciplinary work is limited on the ground and that even inter-disciplinary work remains problematic in some areas. For example, the manager for the Children with Disabilities Team's perception was that schools and other education services were not good at recognising where children and families needed a social care intervention and they often failed to refer appropriately. The perceived 'autonomy' of schools may, however, be a double edged sword insofar as the threshold for assessment and services from the Children with Disabilities team is very high – i.e. complex disabilities or significant learning/behavioural difficulties associated with less severe disability. There was an acceptance that for children who would not meet this threshold, including deaf children, education services provided some support (although there was also a view from adult d/Deaf services that an educational perspective, which, their view, had a tendency to neglect issues related to Deaf culture/communication can 'bury' problems until a child becomes older).

4.7 Identifying consequences of the structural organisation of services following the split of Adult and Children's Services.

The arrangements we have described thus far necessarily point to questions about how social work and social care services for deaf children and their families were managed and provided once they had transferred out of Adult Services. The majority of those we interviewed were alive to these concerns, although some respondents who had little direct contact with d/Deaf service user groups readily suggested they had not really considered some of the complexities of social care arrangements for deaf children and families until participating in the research⁹. Much of the rest of this report is concerned with outlining in detail the key issues identified, however we introduce them in general terms at this stage.

4.7.1 Limitations in scope of Children's Social Care Services

Where specialist knowledge and skills resided in teams that structurally were still located within Adult Services (without any formal service level agreements to work across Children's Services), there was concern that involvement with deaf children and their families had become highly restricted, for example to the level of advice giving, signposting or equipment provision. Whereas each such activity could potentially open the way to a relationship with particular children and families that could be more holistic in its scope, encompassing formal assessment of social care needs within the context of multiprofessional /multi agency arrangements, the Adult Services structural positioning offered little or no scope for such an approach. This double bind of having the

⁹ All study Sites have expressed the importance of the results of this work in assisting further their reviews of service arrangements. In some cases this research has acted as the catalyst for staff within the same authorities, who had differing roles that nonetheless encompassed services for deaf children, to talk with each other strategically for the first time.

appropriate knowledge but not the appropriate remit stands in sharp contrast to those Sites where there was a specialist deaf children and families social care service, with the power to assess in their own right, co-work as required and carry out the full range of statutory and non statutory roles and responsibilities. In those Sites where no parallel specialist deaf children and families arrangements were in place, concern was expressed about the impact on the well being of deaf children and their families. Although other professional groups were clearly involved (notably education and health) whether their roles truly encompassed the assessment and provision of social care remained a question for debate. In one Site the existence of other professionals' involvement with deaf children and families was used as a clear justification as to why specialist social care provision was not needed (although statutory social work intervention in a small number of cases might be).

4.7.2 The challenge of appropriate knowledge, skills and resources.

The lack of appropriate deaf children and family knowledge and skills was expressed as a recurring issue by all Sites, be it in different ways. For those services and individual practitioners who had made the transition to being workers with deaf children and families (whereas before they might have primarily carried out their specialist role in an adult context), there was a lot to learn. Some of this new knowledge concerned policies, procedures and practices of working within Children's Services. Some of it concerned the focus on deaf children and families, including issues of children's development, education and transition to adulthood. Whilst a great deal of prior knowledge in the field of deafness remained relevant, there were many new things to learn. For Sites who had chosen not to invest in specialist deaf children's service arrangements for social care, the lack of knowledge in this field was used as a key reason for largely deferring to other professionals, such as teachers of the deaf, as the lead professional and for a lack of resource allocation to social care provision. Across all Sites, although this was more acutely felt in those who had not invested in specialist provision within a Children's Services structure, concern was expressed whether other Children's Services teams who might encounter deaf children and families, would have enough knowledge and experience adequately to identify when an issue was serious, or see the true complexity behind whatever might be the presenting issue. [This particular point is picked up very clearly in the case study that follows in Chapter 6] The team manager for Children's Disability Services in Site E, for example, readily acknowledged that her staff had little experience of working with deaf children of whom there were consistently likely to be no more than two in a caseload of around 200 children. Deafness is relatively rare (DfES 2006b) in childhood population terms and highly heterogeneous in its implications, making the opportunities quite scarce for non-specialist workers within Children's Services team to build up their knowledge and experience. Creative solutions for closing the knowledge and expertise gap between Adults' and Children's (deaf) Services were being actively sought. One senior manager suggested this could be achieved by either importing staff from adult deaf services into Children's Services or arranging for a practitioner with a specialist role in Children's Services to be located with the deaf services team. However, she perceived the challenge of either arrangement to lie in enabling practitioners to maintain/develop their specialist knowledge and skills and to retain a sense of their own professional identity. Also for staff who might be Deaf

themselves and embedded within a non deaf specialist team, there was an additional issue of potential communication isolation in a context where other staff were not deaf aware and/or did not sign.

4.7.3 The dispersed social care response

The structural separation of Adult and Children's Services presented commonly experienced challenges in terms of providing a clear, seamless and readily accessible service for deaf children and families. Unlike education or health, there was not necessarily any easily identifiable specialist team who were responsible for deaf children. Even in cases where there might be, social work and social care responses were routinely dispersed across a wide range of teams within any one authority depending on the presenting issue. There also existed a bewildering number of permutations across Sites as to which part of Children's Services was likely to deal with what and in partnership with whom. In one sense atypical arrangements for service provision are not a problem, in that Children's Trust arrangements purposefully allow for a degree of flexibility in local service arrangements to meet the conditions of context most appropriately. However, it is a problem if: (i) it is not clear to potential service users where they may access social work and social care services for deaf children and families; (ii) if Authorities themselves are unclear who is responsible for the delivery of social care services for deaf children and families; (iii) if the structural location of the service (and/or uncertainty about service arrangements) in some way impedes the delivery of the service or reduces its effectiveness. In our small sample of 5 Sites we found evidence of all three problems as later Chapters will illustrate.

Also, as researchers with considerable experience of social work and social care with deaf children we would also like to note that in two Sites we experienced real difficulties in working out which parts of the service structure would be responsible for social care with deaf children and families and within those who to approach in connection with this research. In one particular example, the researcher was directed by the central contact centre to one team, then directed to another team, and then back to the contact centre. Each of the teams thought that the other was responsible for receiving non child protection referrals for d/Deaf children.

4.7.4 Thresholds for service provision

As will become apparent, thresholds for service provision and the operation of eligibility criteria was a crucial issue in defining the social care response to deaf children and families. In those Sites where there was not a specialist arrangement within the Children's Services structures, then operation of eligibility criteria within children and families teams and children's disabilities teams effectively excluded the majority of families from receiving a service except in the most extreme of circumstances. It also meant that it was unlikely that they would be picked up by any other team (e.g. deaf teams within Adult Services were unlikely to be aware of referrals and/or not able to become involved). In Sites where there were specialist structures within children's services, children and families were more likely to have contact with social care provision but eligibility criteria remained an issue where cross team involvement was required, for example with children and families teams on issues of preventative safeguarding work, or

with child and adolescent mental health teams. In Chapter 6 we look in detail at the operation of eligibility criteria not just in terms of resource management and the structure of service provision, but also in terms of the relevance of the assumptions underlying assessments of severity as applied to deaf children and family circumstances.

4.7.5 Working in an integrated way – a work in progress

What integrated working actually meant on the ground in relation to deaf children and their families was clearly influenced by the choices that had been made about how to structure social work and social care arrangements for this service user group. It was also, at the time of the research, strongly influenced by how developed more generally, integrated working practices were across the 5 sample Sites. In Chapter 6 we discuss integrated working with education and health in light of the shifting and developing picture of integrated provision as well as considering other influences, such as history and professional cultures. Finally in Chapter 6 we consider the case, if there is one, for the specialist social work role with deaf children and families in light of the broader integrated children's context and new joint working practices.

4.8 Summary of main points

- i) all 5 Sites had radically different arrangements for the provision of social care for deaf children and their families – illustrative of the likely heterogeneity on a broader scale
- ii) there was significant variation in the extent to which Sites had actively considered social care service arrangements for deaf children and their families following the division between Adults and Children's Services. This variation ranged from almost no consideration at all (yet) through to the creation of a new specialist team or specialist team arrangement.
- iii) 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.
- iv) 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.
- v) 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.
- vi) 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.

- vii) 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.

Many of these main points are elaborated further in subsequent chapters which provide greater detail.

5. Case Study

5.1 Introduction

To understand the implications for real life service planning, provision and response of the structural arrangements we have previously discussed, all respondents were asked to consider the same case study. This case study was designed to explore service responses at the direct interface with an educational issue (school exclusion); within an age range that would imply consideration of duties and arrangements in association with transition and transitional assessment (14+)¹⁰; that addressed problems that could be regarded as generic rather than deaf-specific (challenging teenage behaviour); and which nonetheless included a specialist concern that would require specific expertise to understand fully (language and communication). In the second part, Part B, the case study was designed to introduce an additional risk element that may or may not be regarded as indicating a statutory response (physical violence by the young person to family members including young children).

The actual case study that respondents received was as follows (with Part B only being shown once Part A had been discussed):

<p>Part A</p> <p>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.</p> <p>Please explain what action you and your service would take and give as much detail as possible. Focus on realistically what would happen and why, not ideally what you might wish to see happen,</p> <p>Part B</p> <p>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. How would your service respond and why?</p> <p>Please explain what action you and your service would take and give as much detail as possible. Focus on realistically what would happen and why, not ideally what you might wish to see happen.</p>

¹⁰See ADSS et al, 2002; DH et al, 2000

5.2 Dimensions shaping nature of response – Part A of the case study

Two of the five Sites (Sites C and D) were unequivocally clear that if this kind of referral came to their attention then it would fall within their remit to respond. By contrast Sites A, B and E were unclear whether a case such as this would be regarded as an appropriate referral to their service and/or even if it were, whether it would actually get a response from them. Individual practitioners in these Sites varied considerably in the extent to which they were of the view that the case “should” trigger a response and in the extent to which they were satisfied with how the structure of Children’s Services was likely to channel how the referral was dealt with. Across all Sites, the same dimensions could be identified as underpinning the discussion of practice shared with us. Where an individual respondent or a Site as a whole operated along these dimensions was a key determinant of the shape of response that was discussed in relation to the case study. These 4 dimensions are:

Clarity – Ambiguity over whether the case would fall within the remit of the service

Confidence – Unconfidence about joint working within different facets of integrated Children’s Services.

Centrality – Marginalization of the specifically ‘deaf’ related issues

Formality – Looseness about assessment as a response

These dimensions were not unconnected and will be treated with some fluidity in the following discussion to show their inter-relationships.

5.2.1 Characteristics of Sites where it was clear that the case would fall within the remit of the service and would trigger a social care response [Sites C and D]

Site D is the Site where a specialist Deaf Children and Families Social Care Team is firmly established as separate from a Children with Disabilities Team, although its relationships with education colleagues working with deaf children and families are not optimum. Site C is the Site where a strong service level agreements and written policies and protocols exist between education and social work in respect of service delivery to deaf children and families. These structurally embedded characteristics quite obviously gave confidence and clarity about the remit of the Sites to respond to the case described whether or not subsequently that initial response led to continued involvement by them, or appropriate involvement of other professionals/agencies initiated by them having grasped the case in the first place.

“...it would come through county duty or it would be put through county duty... we would accept it as a referral.”¹¹ [D:11]

¹¹ All quotations are referenced according to the table of participants at o

“I would definitely expect that this is an appropriate case to be involved in. Social workers themselves I would expect either to be the resource themselves to tackle some of this issue or actually be working with other people who have a specific role to work with young deaf people and can maybe do some individual work with this young man if he would engaged with that...” [D:12]

Respondents in both Sites talked about a usual response being to carry out an initial assessment in a formal way and if required, a core assessment. In one case a respondent (with an education background) discussed using the CAF to indicate the way forward and as a means of engaging her social work colleagues.

This notion of structurally embedded expectations of involvement is exemplified by two respondents in Site C and three in Site D, explaining that in circumstances such as those described in the case study, they were most likely already to know the family. For the social workers in our sample, this knowledge would have come from the routine involvement of social care professionals in interagency structures where the young person/family might already have come to attention e.g. in transition meetings; or multi agency meetings that might have been called as a result of the young person's school exclusion. The key point is that such involvement is both expected and routinely experienced as happening. The social care professional perspective is one that is already round the table, not one that is called in when or if deemed to be required by other professionals.

“Hopefully we would know him already...at fourteen plus we would normally have. There are two things that would happened, there's a transition team that's S's [the t?? itle??] but [we] would usually be involved, if he's profoundly deaf, we have a list coming through...And we would link, we would know at the fourteen point...” [C:7]

“I would have expected to be invited to the transition meeting. We would expect, because we are working closely with education at the moment, we are integrated services, we have this service level agreement. We... I would have expected we would have been invited.” [C:8]

In Site C where this routine expectation of involvement was better in relation to some schools than others, then steps were actively being taken to ensure that there was consistency. The one education professional in our sample in these two Sites made it clear that she would be involved already in a case such as this simply by dint of education services being involved de facto with all deaf children in mainstream education.

The clarity about expectation of involvement and response appropriate to remit, also derived from an emphasis on the specialist nature of knowledge and skills that the teams had to offer. It was, in this respect, striking how respondents in Sites C and D discussed part of the rationale for their involvement in terms of working out the extent to which deaf-specific issues were influencing the circumstances reported in the case. Interestingly, the consequence of the application of this specialist know-how was not to conclude that they should therefore be responsible for the case, but rather that the application of the

specialist knowledge could be important in working out how appropriately to work alongside other professionals within Children's Services more broadly to ensure a more comprehensive and appropriate response to the family. For example, one respondent speculates on the possibility of joint working with colleagues from a youth offending team; others on joint working with educational social workers, CAMHS professionals, or from an education perspective, with colleagues within social care.

“I would want...obviously [to] be clear which issues are deafness and which are little toe rag sitting out at night with alcohol and abusive and nothing whatsoever to do with the deafness bit and I suppose that's where we would aim to co-work with anyone else working, so if the child got referred, say to the Youth Offending Team ... to support them to understand how to actually still work with the child even if he does still use sign language, so that they can understand how to get a communication support worker...” [C:7]

“...you'd be looking at a plan that you could review realistically...is there like a peer, why he might not be going to the deaf club is because actually the transport down to the city has proved [difficult] and actually if we put in place funding for a taxi...which [the sensory social care team] could be involved with etc etc. So I think you know the mechanism is there...” [C:10]

Again, the key issue here is that structurally embedded confidence of remit, when combined with clarity about specialist contribution, contributed positively to strategies and practices of inter-professional working – including the initiation of new ones:

“Again, CAMHS is an issue that we struggle often to get involved with deaf children... but there are specific issues around deaf young people who might have emotional, mental health problems. There's a new CAMHS strategy manager just recently been appointed and actually said to [the team manager, deaf children and families team] you need to kind of be flagging up deaf children specifically, the group that they need to make is in their strategies.” D:12

Each of these elements (embedded confidence of remit, clarity of specialist contribution, strategies of interprofessional working) formed a virtuous circle that served to reinforce each other. Interestingly, in this respect, a discrepant response serves to demonstrate this connection further. A team manager of a Children's Disability Team in one of these Sites who was interviewed was very clear the case would not fall within the remit of her particular team but was confident that it would be picked up elsewhere. That said, she could also see how through, for example, the sensory team picking it up then that team might come back to the Children's Disability Team to discuss joint working if assessed as needing such. An approach she would not find inappropriate and that as a system worked for her.

“Again, this wouldn't be one that would come to us although it may well be that the Special Educational Needs Support Services team, particularly if they thought

there might be some safeguarding issues, might well just run it past me with a 'what would you do with this?'" [C:9]

5.2.1 Characteristics of Sites where it was unclear that the case would fall within the remit of the service and whether a social care response would be triggered [Sites A, B and E]

The overwhelming impression of responses from Sites A, B and E was not that respondents were sure that this case fell outside their remit, but that they were decidedly unclear whether it did, could or should. Respondents at all levels of responsibility recognised the uncertainty and we are grateful that they were prepared to discuss it with such frankness¹².

"...you could get a response that these are social care issues and it needs referring to the area social work team, so that's one [response]. The other is and I mean I've been honest, I think it is about who answers the phone for this group of children... and the other is that we would go out initially perhaps, offer information and advice to the parents, signpost them to other services, hopefully go on because of the problems, to do an assessment and a plan... [but] I think the threshold for this team is unclear. Especially for this group of children." [E:15].

Unlike in Sites C and D, specialist social care skills in deafness related matters were not structurally embedded within Children's Services. Across all three Sites, the 'Deaf Team' (meaning social work and social care team, rather than deaf education team) were located within Adult Services, not Children's Services. Thus their expertise¹³ was in part hidden, but more significantly, the structure presented real barriers to enabling any of that expertise actively to be involved in a response to a case such as the one presented. In the example above, the Service Unit Manager for Children with Disabilities did not consider contact with the Deaf Services Team within his county as one of the available options. When we interviewed the Assistant Team Manager for Deaf Services (located within Adult Services) he confirmed the likely lack of contact adding that he was not sure that Children's Services was likely to be involved anyway:

"Again... would we be becoming involved? If we became aware of it then we would get involved...I guess that Children's Services would be involved... see there's a chance that we would never even found out that this happening, although a profoundly deaf [young person]..." [E:16].

¹² It is also worth noting that subsequent to involvement with the research process, we received feedback from two of these Sites that the discussion they had had with us, which had highlighted the degree of uncertainty, had prompted some managers to make new connections with others in their areas working with deaf children and families and to begin to reconsider the service.

¹³ By 'expertise' we are referring to d/Deaf expertise in general as applied to social care. We acknowledge that there may be a lack of experience d/Deaf issues in relation to deaf children if workers have predominantly worked with adults.

A view further reinforced by the Business Unit manager, Adult Services, with responsibility for the Deaf Services Team:

“I’m not confident they [Children with Disabilities Team] would accept it as a referral and...even if they did, I’m not confident they would then refer it through to us or ask us to joint work in effect.” [E:17].

In other words, because Deaf team expertise exists within Adult Services, it is in effect decoupled from the structures of Children’s Services responses. Thus pathways of involvement of Deaf Team services are at best ambiguous, at worst structurally impeded. There is a lack of any embedded remit for deaf children amongst those with deafness related skills and experience within the structure of services. This in turn induces a lack of confidence in involvement even if the team and its management can see how such involvement might be helpful (even in terms of working out what might be an appropriate social care response).

This pattern is replicated across the other two Sites as well. For example, a Team leader of a Deaf Services Team described how it was likely that he would be asked for some advice and information, including signposting to possibly appropriate support via the Deaf Centre, but he would not formally be involved in any sort of case work. This was partly because he had no mandate to do so, (being part of Adult Services), whilst nonetheless being a gateway to specialist deaf related provision; and partly because the young person was unlikely to meet the threshold to trigger a formal social work response:

“...so although we would not be providing formal services I think we would be recognising that there was issues” [A:1]

Elsewhere, the Area Manager Children’s Services rehearsed a similar conundrum:

INTERVIEWER: “You would expect that child to be known to the Deaf Services Team presumably?”

RESPONDENT: “...We probably would, albeit if I’m honest with you, that wouldn’t be the forefront of people’s heads, I mean I would imagine the conversation would go something along...you’d talked to the school and Connexions...so you would pick it up through that. But the issue would be who would pick it up you see, so is it the Deaf Team’s responsibility or my team’s responsibility?” [B:5]

An additional issue in relation to remit and responsibility was also posed by a lack of clarity about who should be taking the lead in issues of transition for young deaf people such as the one in the case study:

INTERVIEWER: “But you would see...your team would be involved because it was at a transition stage [?]...”

RESPONDENT: “I think we’d be beginning to be ...it’s be up for debate should se say... and this is where it’s difficult to answer because I’m not... quite clear the things we’re not quite clear on yet, where it would be.” [B:6]

Implicit in this discussion about uncertainty about remit to provide a service, and how available expertise may be being structurally excluded from the equation, is an underlying issue of eligibility for service. For example, across all three Sites it was perfectly obvious that the issues raised by the case (in Part A) were unlikely to be regarded as serious enough to warrant any kind of formal social work response, including even the provision of an initial assessment. On the other hand, it was also perfectly clear to some of our respondents that social care involvement would be helpful. The question was how to achieve that.

Across all three Sites, respondents described solutions to this problem in terms of findings ways round the system, whilst acknowledging that these were essentially ad hoc and did not result in actions that were likely, in the longer term, actually to solve the problem of clarity about social care involvement. So for example, a service manager described strategies for trying to find a way to get social work invited to the required multi agency / multi professional meeting where the young person's situation was likely to be discussed. There was not an established mechanism for that routinely to occur. That said, she was also aware of the contribution that social work's own eligibility criteria makes to the history of lack of routine involvement:

“I know [it's] our duty to get involved in the meetings even though we've thought he's not necessarily our criteria, but it's just possible we could get the duty officer talking to the school and saying 'can we be invited to a meeting this? Can we make sure Connexions are there? And so on and so on. We might also ask [the Team Leader Deaf Services Team within the adult directorate] ...'can you send anyone to that meeting in case we're talking about communication issues here'? I dunno, all sort of things spring to mind don't they?” [A:2].

From the perspective of a Team Manager responsible for the Multi Agency Community Support Team for Disabled Children the issue was one of advocacy and negotiation to try to persuade the Disabled Children's Team that they should be offering a social work service:

“...that's [a] typical kind of ...complex case that we're flagging up recently and it's one where they might not get a service from the Disabled Children's Team...[but] when we're not sure, we put them through and we discuss and we negotiate, yeah?...each one is taking you a bit further towards opening that gate isn't it?” [A:3]

This issue of putting pressure on the responsible team when they are unlikely to take up the case because it does not meet their eligibility criteria was replicated at another Site where the respondent described strategies of both “badgering” and “manipulation” to which he was forced to resort, providing he was even aware in the first place that such a case, as the one described, existed:

INTERVIEWER: “If this came your way and somebody rang you up about it, you wouldn't dare just hang onto it? You would have to refer it to the Children with Disabilities Team?”

RESPONDENT: “I might start dabbling, but we would refer it on and we would hang on to it by you know, badgering Children's Services and saying ‘look this is what we need to do and ...let's joint work’ ...me as the manager...I might notice that there's something going on and I might know something that this social worker said to be about a concern and then I might notice that there's a meeting going that the social work's not been invited to. So you might try and manipulate your way into that one without giving too much away.” [E:16].

However, the issue of hitting the threshold for a service, was not just about eligibility criteria for social work provision (see Chapter 6 for more detailed discussion). It was also about the identification or not of deafness and deaf-consequential issues as being complex and potentially serious in cases such as the one the interviewees were responding to. As one respondent made clear, deafness as a trigger is invisible. If the case were picked up, it was more likely to be because of the school exclusion issue rather than anything to do with additional complexities that might be involved with the young person being deaf:

“But I guess what I'm saying is in terms of social care the badge, the child would get here by a circuitous route...interest to the mainstream would have been triggered” [B:4].

There was real concern across these three Sites that Deaf related issues might not be regarded as central to any potential assessment of the situation:

“Staying out late, use of alcohol, poor communication skills, how many other hundreds of children aged fourteen in our county drink alcohol and stay out late at night and are quite abusive to their parents? You and I know that this is to do with the fact that the child [in the case study] has very poor communication skills and is very isolated within a hearing household, but no, I'm not confident that this would get assessed.” [E:17].

This marginalisation of the potentially deafness related issues was partly because those doing an assessment (if one should take place) were not likely to be deaf specialists, nor routinely to work in collaborative practice with staff who were deaf specialists. It was also partly, as we have documented, that the structure of services in these Sites does not provide a clear pathway within which any concerns that may be associated with deaf children and families actually might be considered alongside any other presenting problems in a routine way.

5.3 Summary – part 1

- i) In Sites A, B and E the pathways whereby a young person and their family might receive a social care response were highly ambiguous.

- ii) The structural location of deafness-related expertise outside of Children's Services created real difficulties in the routine involvement of a specialist perspective and did not generate effective pathways of joint working within Children's Services.
- iii) 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.
- iv) By contrast, in Sites C and D social care expertise in deaf children and families was clearly embedded in the structuring of Children's Services.
- v) Social care workers in these circumstances were confident of their remit and specialist knowledge and were routinely engaged in the multi agency and cross-team service structures by which issues such as those in the case study, were likely to present.
- vi) The routine embedding in the structure of services, combined with confidence of remit and skills, positively led to effective partnership working.
- vii) 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).

5.4 What was the effect of Part B of the case study?

Part B of the case study was designed to introduce an additional element of risk that may or may not be regarded as indicating a statutory response (physical violence by the young person to family members including young children). We wanted to see how the patterns of response we had identified through part A of the case study, and the factors that underpinned them, were modified and/or influenced what would now happen. In charting these influences, we consider the five Sites once more in the two groups we have already established: Sites C and D and Sites A, B and E.

5.4.1 The response of Sites C and D to Part B

These are the Sites with clarity of remit, confidence in joint working, likely to do formal assessments and with identified relevant specialist expertise to contribute.

Responses from Sites C and D were founded on three basic assumptions: (i) confidence that they would already be involved with this young person and their family; (ii) clarity that they would have done at least an initial assessment as a matter of course already; (iii) that social care was likely to be part of the package of joint working that was already being planned or was being delivered to this young person/family. Consequently, some of the respondents' views were rather paradoxical, namely if they had already done an assessment and were already involved and had not picked up the potential risk of behaviour escalating, then one should question whether they had actually done their job well enough so far!

Or the same point, from a different perspective, as one respondent speculated, if they had already been as involved as she would have expected then she might be surprised to see this Part B because their initial involvement would perhaps have been preventative enough to avoid such escalation.

More generally, the view was that part B would imply an intensification of the involvement that already existed, rather than initiating involvement for the first time.

Furthermore, the nature of that involvement might change, in that the social care workers who already had contact might begin to involve for advice, or for joint working, colleagues in other parts of Children's Services – namely, Children and Families Team workers, who had responsibility for Section 47 referrals (under child protection procedures) rather than only Section 17 referrals (children in need). Here the point was not that issues of safeguarding belonged elsewhere (Deaf Services Teams would regard their remit to involve safeguarding also in the holistic sense¹⁴), but that the element of specific risk now introduced may require different approaches to assessment and child and family working.

“...when it gets to a level of child protection at this level, we would consult with them [the Children and Families Team] initially to say ‘this is the situation, this is what we’re doing’...and then they would say ‘right, we think this is eligible for a section 47’. The chances are I don’t think this one would meet their criteria because it wouldn’t be high enough risk on the agenda, however, we would consult with child protection just to clarify with them how they would like to do that, go forward.” [D:11].

Both Sites however, were confident that the mechanisms already existed for them to contact relevant colleagues, whether it be for advice, discussion or to initiate joint working. The pathways to do so were clear and experience existed of using them, although there was always some room for improvement:

“...suppose we hadn’t been involved and this was the first thing that we knew...if they did send it to duty, then this is where our protocol should kick in which is that if they’d got a child then who was disabled or deaf, they should be alerting the appropriate team and include them in strategy discussions so that they are part of the plan of what happens next. It doesn’t always happen, but that’s what should happen...” [D:12].

That said, one respondent from an Education background, also looked at the issue from the point of view of the family and speculated on the potential tensions that the involvement of additional professionals might bring, whilst acknowledging that in a situation such as that described in Part B, that additional involvement was necessary, both for her and for the family:

¹⁴ For further discussion of safeguarding issues see Chapter o

“Well, I think my suspicion is...’cos it’s certainly what we’ve experienced so far, is the family would want the teacher of the deaf to be the lead professional because that’s the person they’ve got the relationship with and that might not necessarily be the best person in place to facilitate the move forward...so that’s one of my potential tensions of families who’ve been very used to working with one agency and maybe helping them to recognise there are other people [and] that does not mean you are losing this persons, but you know because, as I’m sure you’re aware and as I’m certainly working out now, there’s a lot, there’s things out there I wasn't aware of and actually you know , as I said earlier, for me, this is a benefit...” [C:10]

Again, there was clear recognition of the appropriateness of the social care deafness related expertise in the assessment process, working alongside children and family specialists.

“Right, we’d probably at that stage start talking to our Children and Families colleagues and look at, there is a young abuser project so we would see whether it was appropriate to refer him to the young abuser project...I suppose back to the issue of communication as well, we’d perhaps be prepared to work with colleagues to see if communication was an issue around that, whether it was just somebody being violent in terms of learned behaviour or whether it was because of an inability to express themselves, again working closely, co-working I think would be our biggest input there.” [C:7]

“And of course, you know... when it works well because you actually bring together the expertise of both sides, the child protection expertise and the deafness or the disability expertise and they can look at that together and that’s the system we have in our county.” [D:12].

5.4.2 The response of Sites A, B and E to Part B

These are the three Sites we have shown through Part A are characterised by: uncertainty of remit, lack of formalised joint working arrangements, structural exclusion of deafness related expertise, unlikely to be carrying out assessments in response to original referral.

In light of the additional information provided in Part B all Sites were of the view that this case was now likely to generate a social work response, in a formal sense, in that it was a referral that was likely to be picked up by a Children and Families Team or an area/locality team.

“That would come to us for information only...It would go to the district social worker for the area which that family lives.” [A:3]

“...we’d want to tease that out a little bit but I think on the basis of those two bits of information that’s now gravitated more towards an initial assessment.” [B:5]

However, there still remained some uncertainty how that might in practice operate. The following Service Manager was very frank in pointing out the extent to which actual practice, if the case came to a duty team, might be worker dependent, and not necessarily ever get to the Disabled Children's Team, let alone to any team with any deafness related expertise:

"If social worker 'X' were on that case they wouldn't refer to a manager, they would arrange a meeting with the school and they'd go on their next duty and arrange their next duty to be there. If social worker 'Y' had that case they'd probably shut it and that is a danger... they might try to farm it off and in this case yes, they would probably take it to their manager and say 'I was on duty' and shove it in the manager's tray, hoping they'll avoid it. And the manager might send it back to them and say 'OK, will you arrange on your next duty to get a meeting for this sorted out'...there is still a bit of being worker dependent again." [A:2].

"I think they would probably tell her to phone Children's Services, I think then probably the escalation may well meet the criteria with Children's Services... whether, what team he would then be referred to within Children's Services is questionable. I wouldn't be confident they would actually get through to the Children with Disabilities Team." [E:17]

The reasons why it was likely to be picked up (and likely now to lead to at least an initial assessment) were because the situation had become identifiable as potentially complex or risky by criteria that were recognised by the mainstream i.e. not primarily because there were deafness related issues involved, or because the young man involved was deaf. So in one Site the identifiable issue was now that others were potentially at risk and would be recognised as such by formal structures of policy and practice that were relevant to the situation:

INTERVIEWER: "There's a Part B. Would that change anything?"

RESPONDENT: "Yes erm... probably not the way you'd want it to. It would generate a referral in regards to the mother and younger sisters under the protection of vulnerable adults and 'no secrets' which would then look at the safety of them and that would, should then hopefully initiate a response from Children's Services and I would say it definitely would then initiate it." [A:1].

Similarly in another Site the Team Manager saw how the mainstream recognition of risk could be used as a lever to get social work involvement, whereas the conditions described in Part A would not have done:

"... we would have to refer to Children's Services so they would be involved and you could say that he's then putting at risk other members of the family and you would need to be looking at ways of minimising that risk..." [E:16].

As some of the respondents pointed out, the fact that there were issues of language and communication associated with deafness and the young person's family circumstances,

were still not generally regarded as central to an understanding of the family situation and the young person's behaviour. Once again deaf-consequential issues were largely unseen contributors to a social care response. In the following, the respondent explains that they do not generally accept referrals involving deaf children but if disability is construed as impacting on issues that may generate a different threshold of risk then the referral becomes relevant.

“At that point it would be based on the level of risk he might pose to his younger siblings and go and do an initial assessment to look at what was going on and whether it was around parenting, you know more around the parenting and protection than support...it's not about the level of disability, it's how the disability is impacting on the parents, on the parenting capacity so the threshold is in a sense different...but with deaf children we wouldn't see it, you know, we don't take referrals on that sort of basis.” [E:14]

It is worth contrasting this view with that prevalent in Sites C and D (as previously discussed) where the complexities of how deafness might impact on family, relationships and language are regarded as central from first point of referral, not just when they trigger an event that is recognisably serious by generic criteria (such as risk to vulnerable others).

In one Site it was suggested that there simply was not the deaf children and family expertise existing to joint-work with colleagues in the team now likely to have picked up the referral. Furthermore, the lack of such expertise was seen as existing within a broader framework of the authority concerned not yet having adequately tackled the complexity of child protection in relation to disability, let alone in relation to the particular complexities of language and communication associated with deafness. This is a situation this respondent regarded as “fundamental” and “primitive” and needing to be tackled before anything more sophisticated should even get on the agenda:

INTERVIEWER: “And would routinely child protection teams in this authority have arrangements with specialist who knew something about deafness...?”

RESPONDENT: “No”

INTERVIEWER: “So there's no arrangements either informal or formal?”

RESPONDENT: “Not to bring in specialist colleagues, it might be interpreters”

INTERVIEWER: “But nothing in terms of co-working?”

RESPONDENT: “I'm not sure who they'd co-work with!”

INTERVIEWER: “...Do you think it's a concern that there isn't a specialist knowledge around child protection and deafness?”

RESPONDENT: “If you go back to the generic, the concern for me is that there isn't an understanding in child protection and disability...I think it's much more fundamental, primitive issues that we haven't resolved.” [B:4]

In the other Sites, respondents were doubtful whether local policy or practice would result in Deaf Team personnel being contacted at all to advise or joint work, even through a process of assessment. Yet, it was perfectly apparent to some respondents how this

might work well. Even if specialist deaf related workers within Adult Services did not themselves have the deaf child expertise to be able to co-work, they would know what the salient issues were to consider and where it was likely that relevant expertise could be found:

“I don't know, I would hope that they [Children's Services] would get somebody involved that was deaf specialist and we would know...from this team where to go for that. They're few and far between for children, but maybe get some assessment work done... properly, specialist assessment work done.” [E:16]

The underlying scepticism arose again from the lack of clear precedent of routine communication with Children's Services in cases involving deaf member families and a continued lack of formalised arrangements whereby joint working might take place

5.5 Summary – part 2

- viii) Those Sites with a specialist deaf children's services remit, clarity of response, and confidence in specialist skills 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.
- ix) Part of their preventative strategies would have included routine expectations of joint working as appropriate with other service providers e.g. CAMHS. 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.
- x) In assessing the original situation and its now more serious escalation, the specialist team would be concerned to be clear about which aspects of the 'problem' could be regarded as consequential to the child's deafness and which should be treated as not.
- xi) 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 now agreed that the escalation in the situation in Part B of the case study would trigger a social work response.
- xii) 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.
- xiii) 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. Some respondents also expressed doubt that in these circumstances their colleagues would know where to go within Children's Services to find that expertise and appropriately involve them, particularly as their expertise sat outside of Children's Services structures.

6. Eligibility Criteria and Thresholds for a Service

6.1 Introduction

In the course of the interviews it became clear that there were complex issues surrounding how and why deaf children and families might or might not become eligible for social care services. Some of these issues were to do with how severity/complexity of need was constructed in association with deafness; some were to do with more generic concerns about the designation of thresholds for services in light of resourcing constraints and the prioritisation of risk and need. However, it was actually the relationship between these two sets of issues (understanding of severity of need in association with deafness and operation of thresholds for services more generally) that was most telling in accounting for whether deaf children and their families might receive a service response. In what follows we will unpick this relationship and assess its variety of consequences for deaf children and families seeking a service.

For our purposes, we are using the term 'eligibility criteria' in a loose, rather than formalised way, to refer to the making of professional judgements about whether any particular presenting circumstance (involving a deaf child/their family) would be regarded as falling within the sphere of operation of a particular team to which they might refer/be referred and whether it would trigger a response from that team. In practice shorthand, 'is this a suitable referral and would we be likely to do anything?' Within that broad definition, some Sites did have formalised standard eligibility criteria, however, our discussion of eligibility is not confined just to those specific structures.

Whilst there is a history of eligibility issues receiving critical attention in the literature for the ways in which service imperatives (e.g. rationalisation of resources) may come to set the definition of need, the advent of integrated Children's Services has also raised new issues. Namely that judgements of eligibility are important in the diversion of service users away from specialist or targeted social work services (Thorpe et al, 2007; Young et al, 2008) and into more universal provision (e.g. children's centres; multi agency support services) in accordance with the principles of progressive universalism (HM Treasury, 2005; Cabinet Office, 2006) that underpin the Every Child Matters agenda and the Children Act 2004. In focusing on eligibility issues we were also interested in seeing, in the context of integrated provision and deaf children, whether diversion from specialist/targeted services was a central concern, or whether the complexity of the communication and developmental issues associated with the heterogeneity of deafness and its effects, meant that specialist social work provision remained an imperative.

6.2 The Site where eligibility criteria did not exist – why?

Only one of our five Sites was categorical that they did not operate any kind of eligibility criteria in association with referrals concerning deaf children and families. This was Site D where a specialist Deaf Children and Families Team had been established in its own right. They operated an open door policy whereby they would pick up any referral involving deaf children/ deaf member families (e.g. deaf parents with deaf or hearing children) and would expect to do an initial assessment on all. It was on the basis of this

assessment that decisions would be made about how to proceed and whether that would involve colleagues in other professional groups within Children's Services (e.g. teachers of the deaf) and/or colleagues in other teams within Children's Services such as Children and Families. Not surprisingly, actions could range from straightforward advice, information and signposting to more complex casework following a core assessment¹⁵. Whilst clearly the judgements made about suitable responses involved some degree of consideration of suitability, resources and appropriateness of skills to meet needs, the key point is that eligibility criteria did not operate in the sense of making decisions whether the referral met a threshold to trigger an assessment in the first place; nor in the sense of provoking a diversion away from formal social work assessment if it was clear that the problem may be relatively simple e.g. information only.

“We've got an open door policy at the moment. I say that because it's about demand and at the moment... we are able to consider anybody where deafness has an impact on an issues within the family or for the child.” [D:11]

“We do an initial assessment of all referrals and from that initial assessment there'll be a decision made whether we go ahead on the core assessment.” [D:13]

Underpinning this approach was sufficient resource, both in terms of money and in terms of professional skills.

“I think with the Deaf Services Team eligibility criteria doesn't seem to be a problem. It has sufficient resources to provide services to people who feel they require it and I'm not saying that perhaps you know sometimes [they] may have to wait a while to get a response, but I mean obviously with our timescales on an initial assessment, they will at least have that, even though there might be a bit of a delay on implementing assessments.” [D:13]

The rationale behind both not having a threshold and not operating a diversion policy was threefold. Firstly, it was a team priority that they recognised as fundamental the potential complexity of the language, communication and developmental issues associated with deafness. Therefore, even if the presenting issue might appear straightforward, it was important to see the impact of deafness in the family as holistically as possible, which could not easily be achieved without at least an initial assessment. This approach was underpinned by absolute clarity that deaf children were by definition “children in need” as defined by the Children Act 1989, and therefore should be considered under Section 17 assessment procedures. The establishing of a Deaf Child and Family Team in its own right, had provided the necessary structure to be able to act on this conviction.

“...when we came over [from Adult Services to Children's Services] we took on board the DoH framework for assessing children because prior that children, deaf children, sat outside of this.” [D:11].

¹⁵ See the case study in Chapter 5 for more detailed descriptions of professional practice.

Secondly, the team's work was founded strongly on a principle of preventative work. Whilst it could be argued in other sectors that preventative work was a key reason for a move to diversion towards universal provision (families could be supported in such a way to prevent escalation of any difficulties into matters requiring targeted intervention), in the case of deaf children and families, preventative work was seen as requiring specialist intervention at an early stage. Again, the argument here is founded on the need to understand the developmental, linguistic, social and cultural impacts of deafness in order to effectively practice preventatively. Universal sources of social care support were thought unlikely to have this specialist understanding.

“And the thing is, I really do want to run a preventative service here. I think that's the nature of the work that makes it so fantastic working, is that we can intervene and you know, do brief intervention at a very early stage and that can set parents up for a very positive attitude to deafness to enable them to bring their child up, you know, in the best possible environment. So the thing is...that would perhaps be screened out, [if] people aren't fully aware of the impact that it has for parents to get the right information at the right time so therefore, we don't have an eligibility to screen people out.” [D:11].

Thirdly, the open referral policy was important in the context of building better integrated working with colleagues in education and health. For these services, all deaf children de facto are clients/patients and so the open referral policy put social work on a similar footing. Once again, in this respect, it was ownership of the definition of children in need in the Children Act 1989, as applying to all deaf children, which was central:

“Well, they [deaf children and families] may not need services, but they are by definition a child in need and therefore would be entitled to ask for an assessment of that need and out of that might flow some services, but that's the same for other children in need, that they may not need specific service at any one point, but they're entitled to an assessment of that. And in a way it's an entitlement to have their needs considered.” [D:12]

Also this approach of universal entitlement at least to assessment was a way of ensuring that the social care aspects of deaf children and families needs were routinely considered and professional colleagues from other disciplines (e.g. teachers of the deaf) could be sure that if they referred the referral was appropriate and would get a response. [See chapter 0 on joint working with colleagues in Education for further details]

6.3 Deafness is not sufficient a condition

In three of the other four Sites (A,B,E)¹⁶ with varying degrees of frustration and dissatisfaction, eligibility criteria did exist that impacted strongly on how and why deaf

¹⁶ Site C was slightly different in that, although based within Adult Services, they had clearly established service level agreements, protocols and practices for working with deaf children and families. E.g. see Case Study, Chapter 5. But in this context they still did encounter issues of eligibility criteria because of needing to liaise with other teams with Children's Services, when they themselves were placed within an Adult Services structure.

children and families may receive a social care response. The issue was stark. A child being deaf was not of itself a reason for social work or social care resources to be involved with that child and family.

“They would make referrals, they would make referrals through to social work, children’s care, but the support, often they would not meet the criteria, the Children’s Team would have a very high critical criteria where being deaf or being deafness would not on its own [trigger a response]”. [A:1]

“Basically they have to have associate problems which are additional, which causes them to meet the criteria in order to get a service.” [A:3]

This bottom line is very different from that operated by colleagues from other professional backgrounds (e.g. education and health) where even if there is minimal active involvement, the fact of the child’s deafness would in a fundamental sense be sufficient a condition for professionals to regard it as a reason for involvement. As one education professional working with deaf children put it, by contrast:

“We are almost as cradle to the grave as you can be as long as you’re in education!...the fact that the child was severely deaf would automatically involve us as a service.” [C:10]

The central issue, therefore, in considering whether a referral met the threshold for a service, in any given team, was whether deafness in association with other issues was severe, risky or complex enough to warrant a response. It should be said, however, that deaf children were in no way unique in being unlikely to meet thresholds for social work from a Disabled Children’s Team. Site A for example reported to us that there were 3,000 children registered as disabled in their authority, of whom only 600 met the threshold criteria for involvement from the Disabled Children’s Team (although a substantial number may have some access to social care services by other routes through an authority wide Multi Agency Community Support Team for Disabled Children (see Site description, Chapter 4). However, as previously discussed this service had very little contact with deaf children and families.

One respondent at senior management level went so far as to describe this situation, whereby disabled and deaf children were routinely filtered out of provision by how high the thresholds for services were, as “an abuse of the children and the Children Act”. For her the essential issue was that the Authority had never fully owned the definition of deaf children being children in need as defined by the Children Act 1989 and therefore the considerable barriers faced in even getting an assessment were unacceptable. The situation was maintained both by the high thresholds for access to Children’s Services and by the fact there were no specialist deaf children and families social care professionals in the Authority, who through other routes, may have been able to support families.

6.4 Conceptualisations of severity and complexity in association with deafness

Given the emphasis on deafness generally not being enough to trigger a response and additional issues being required, what becomes interesting is the different ways in which severity and complexity were themselves conceptualised. For some individual respondents, and for some Sites as a whole (e.g. Site B), the issue of severity was firmly linked with degree of impairment in a medicalised sense. It was assumed that the greater degree of impairment then the greater the need. Consequently straightforward equations are created whereby problems for a moderately deaf child are regarded as unlikely to be as severe as those faced by a profoundly deaf child.

Analogies were drawn by one respondent in respect of Autism, where in his authority children with autism are likely to hit the threshold for a service from the Disabled Children's Teams but children with a diagnosis of Asperger Syndrome' are not. However he was concerned that the identification of severity of need based on such distinctions was hardly an exact art and one he worried about:

“More complex cases we feel that need specialism [get referred to the Disabled Children's Team] rather than locality, and of course that leads to the floodgates, so we have to hold that position as best we can. So it would be severe autisms such as child won't be functioning in society without intervention and care, so that would not be Aspergers, would not be ADHD...but it would be autism and learning disability such that at eighteen they will still need service, and how do you tell that at two?” [A:2]

Similarly in another Site, comparisons were drawn with severity of physical impairment as a likely basis for distinctions around who would get a service from a specialist disability team, the expectation being that children with mild or moderate support needs would be supported by the mainstream children's teams.

“...but again we wouldn't take a child with a mild cerebral palsy, perhaps who was unsteady or had you know a weakness in the hands, those would be the group that we'd see. We would see the ones that are wheelchair dependent and have that sort of level of support.” [C:9]

In one Site, this impairment based approach to understanding eligibility, had gone so far as the draft guidance for eligibility criteria for additional needs social care assessment thresholds, to specifically exclude those children where it was deemed a “technical solution” would obviate the need for involvement e.g. effective hearing aids would render the child “independent” and therefore would not meet the threshold for services:

“...we have a draft eligibility that's coming round at the moment for Children's Services...that almost specifically refers to children with sensory impairment as not needing support because to a degree technical inputs will resolve the problem...the criteria, it will not cover disability which can be described as

impairments, that is there are remedial actions that can be taken to significantly reduce the difficulty for the young person, for example hearing aids..." [B:4]

Complexity was also commonly associated with medical and impairment criteria e.g. whether the child had additional disabilities such as learning disabilities or physical care needs.

"...what happens a lot of the time is that [deaf] children are screened out at that initial stage because they're not such a high threshold, so their needs aren't as massive in comparison with some of the children we're working with that have got multiple disabilities. In fact I think one of the criteria is that children have got two or three different aspects of disability so that they would then take co-ordination." [E:16].

Deafness on its own and its potentially serious psychosocial consequences for language, communication socialisation, mental health and family well being, was generally not regarded as an indicator of complexity. Even in those situations where it was recognised that the real issue was how the consequences of deafness may be impacting on other family related matters such as parenting capacity, respondents expressed extreme doubt whether if the child was 'only' deaf then such a referral would meet the threshold for a service.

"In terms of social work and ongoing care management, we work with children nought to 18 across all disabilities but the thresholds are high so it's more complex disability, physical learning, some autistic spectrum disorder and there are some anomalies where the children, the level of disability is lower, but we get involved because of the impact of that disability on family functioning. Broadly speaking we don't take a single disability so we, deaf children, wouldn't meet our criteria necessarily just because of the deafness, same as visually impaired children wouldn't." [C:9]

The association of complexity with degree of impairment, in a medical model sense, also meant in the wider scheme of things, when deaf children are considered alongside all disabled children then they are, on that scale, going to be seen to be amongst the least in need, in comparison for example with children with life limiting conditions, severe learning difficulties or technological dependence.

The fundamental question raised by this data is whether the scale by which severity/complexity of need is being assessed is calibrated correctly in the case of deaf children and families? Although deafness involves an impairment (to hearing) deafness is fundamentally a complex psycho-social, developmental phenomenon in terms of its potential impact, where the differentiation of the degree of severity of that impact bears no axiomatic association with degree of hearing impairment. Therefore if a system of thresholds for eligibility is fundamentally grounded in decision making that is strongly influenced by judgements of degrees of impairment then perhaps we should be asking whether the complexity of deaf children's and families needs can be appropriately

recognised, particularly if the child in the family is not routinely even qualifying for an assessment that would elaborate the nature of those needs; and if teams do not have specific expertise to understand the subtleties of how deafness can impact on development and family well being. This is the argument we saw as fundamental to approach of Site D. It also operated in Site C where although the sensory services team were based in Adult Services, effective service level agreements and operational arrangements meant that a team with deaf specialist knowledge would routinely pick up referrals involving deaf children and families in order to carry out an appropriate assessment of need before seeking referral, if required, to a Disabled Children, or Children and Families Team. Although that said, at that point of referral onwards, similar issues of high thresholds were encountered, although at least the referring team were in a better position to argue the case for severity and complexity based on a deafness perspective.

6.5 Resource allocation and deaf children

The operation of thresholds for Disabled Children's Teams was also an issue of resources. There was a finite budget that could be spent on the support of disabled children and families and difficult decisions had to be made which inevitably included the filtering out of some children. However, paradoxically in the case of deaf children, the fact that many are likely not to be resource intensive in terms of social care, can work against their eligibility for provision. As one respondent pointed out, the fact that some disabled children's needs are very expensive means that they are very visible and therefore more likely to get attended to, because the consequences for an authority of not doing so are likely to be more publicly visible and long term critical:

“...quite often statutory authorities have had to show interest because this group [children with particular disabilities] has gone and caused them difficulties through costs ...so things happen with these children that means we have to do something and it hurts us...they're expensive, so a child with severe learning difficulties – far more interesting for the authority because they might become a £4,000 a week placement...[a deaf child] they are not going to come and bite you. And in terms of their ongoing community care requirement, likely to be of minimal cost to the authority.” [B:4]

Additionally deafness is a low incidence condition in comparison with, for example, autistic spectrum disorders, therefore by that criteria also deaf children are not particularly visible in their demands on social care provision.

“...deaf children will be somewhat at the back of even that queue.” [B:4]

However, some respondents were at pains to point out to us that deaf children were in no way exceptional in generally being filtered out a system with finite resources and demands that exceed them:

“And the danger is you can be ruled by your available resources, so that you can say right, as I had done when I was team manager, I've only resources for 550

kinds, roughly and I'm not taking any more, but there happens to be 643 I think today." [A:2].

6.6 Prioritisation of risk and need in Children's Services

Thus far we have largely considered the issues of thresholds in terms of referrals to teams with specific responsibility and budget for disabled children. However, the question of eligibility criteria was also acute in relation to referrals to Children and Families teams where there might be more general concerns about family breakdown, risk and safeguarding. As several respondents pointed out to us, these teams were under immense pressure and the operation of their eligibility criteria was primarily designed to ensure that they were able to prioritise and respond to the most severe situations where the default positions were to prevent children going in to care and/or protect children who were at direct risk of harm. This was a general response issue, not an issue of thresholds that was specific to deaf children and families.

"...their priority levels are exceptionally high and the general comment from everybody, including their colleagues in other Children and Families teams are quite often that you just can't get in the front door... she [a colleague who did a placement in that team] was quite cynical before she went as to whether they really did apply such strict eligibility criteria or whether it was just we hadn't found the right key words to use as it were to get people in the door. But once she was in the system she said that she could fully understand why they've set such high thresholds, simply because the capacity wasn't there to deal with it any other way." [C:7]

Nonetheless, it meant in practice that even the most complex social care needs involving deaf member families are unlikely to hit this threshold, which was of considerable concern particularly to respondents who worked on a daily basis in the context of deafness and social care (be it largely from within an Adult Services structure). For example:

"Had a young deaf male, 16 years old, due to be leaving school at the end of the year...had been in trouble with the police, was due a court appearance, he had a disabled younger brother...had no equipment in the house, single parent family...lots of problems, troubles between mother and the boy and we put referrals in [the Children and Families Team and to the Disabled Children's Team], I was approached by the teacher like for support, said like, [we] need to put a referral in for social work interaction, was told it did not meet the criteria...it went back and forth, back and forth, the only intervention...we could do was through our team proving equipment, link worker support, help with him getting access to college...it wasn't really part our remit but we felt we needed to otherwise this boy would have gone further off the rails..."¹⁷ [A:1].

¹⁷ Details of this particular case have been changed to preserve anonymity. At no point was this young person formally identified as a 'child in need' and neither he nor his family received any formal assessment by Children's Services.

However, there was also recognised a tension between this prioritisation of children seen as being at immediate risk of harm or on the edge of care, and the lack of capacity in Disabled Children's Teams to respond to any but the referrals regarded as indicating most complex or severe need. As one respondent pointed out, if she could actually respond to the vast number of parents of disabled children who were requesting respite care (and the reality was she could not) then she would actually be significantly contributing to the priority agenda of keeping children away from care. But families at the end of their tether would fall between both the Disabled Children's Team and the Children and Families Team.

“...what we have is a meeting every month with the managers of the budgets to say no to an increasing number of children and families that come on wanting respite...that takes us back to what the criteria is about, it's a specialist services, what does specialist service do in terms of social work? It does other social work, what other social workers do, avoid kids coming into care. How does it do that? It provides services, so part of the teams providing services to avoid care but it's come out of a system that says 'you provide services because children need them'. So there is a, there's a tension here between those two...at one end, 'it's my right, it's my right'. At the other end, 'you can't have it, but you have it because it stops your child going into care'. So the tension tends to come round the table called the resource panel once a month. People don't look happy at the end the meeting.”
[A:2]

Whilst respondents could generally see the justification for this position, those who worked directly in specialist deaf services/sensory teams were most vocal in their frustrations. Some questioned whether, because the full complexity of deafness and its consequences for families may not be understood by the non specialist, then accurate judgements about the seriousness of a family situation might be impaired.

“I see it as being not just the intervention stage, but the prevention stage as well, is the biggest problem we often have is getting our Children's Assessment colleagues to take on board where we think there is a high risk and that we do want some prevention strategies in there quickly!” [C:7].

That said in Sites where there was an established procedure for consultation and joint working between deaf specialist and children and families team colleagues (e.g. Site D), such fears were more diminished.

6.7 Falling between the gaps – the lost deaf children

Also more generally, for those families with deaf children with serious and complex social needs, if they do not fall within the remit of disabled children's teams and do not meet the threshold for children and families teams, then as several respondents commented they effectively fall through the gaps. They are the 'lost children'. They are lost because they do not fit how the eligibility criteria are constructed even though there is an identifiable need and/or deafness is constructed in such a way as to not be visibly hitting those criteria.

“Children’s Services would only be brought in for a specific reason and that reason would have to be compatible with the existing threshold criteria.” [B:5]

There were respondents in Sites A, B and E who were quite clear that deaf children who did not meet thresholds for services, and where, in their Authorities, there was not a clearly developed deaf children’s social care pathway or team, then in effect these children would be “lost” in terms of their potential social care needs being assessed or met:

“...and it’s very difficult because they often don’t fulfil the eligibility criteria for the PSI [Physical and Sensory Impairment??] team and nobody really has any responsibility for them and they live in the rather grey area where essentially the lead is taken by the SENCO in school...” [B:5]

By contrast, other respondents pointed to the potential for deaf children and families to fall between the gaps not because eligibility criteria were so strict, but because they could be so inconsistent and so team or worker dependent:

“And for example deaf children, you know, they’ll go to the Sensory Support Service, they’ll come here, we may or may not offer them a service, we may or may not joint work with the Adult Deaf Team, so it’s just there’s no consistency in what parents can expect.” [E:15]

In Sites C and D where there was a specifically designated deaf children’s social work/social care service, the consequences of children and families falling between these gaps was not particularly regarded as a problem. These teams had a remit to respond regardless and whilst in the case of Site D problems of eligibility were still encountered in seeking the involvement of other teams/workers, there was nonetheless a backstop of a service that was still working with deaf children and families, regardless of securing that additional involvement.

6.8 Summary

- i) Only one Site did not operate eligibility criteria in relation to deaf children and family services. They carried out at least initial assessments as a matter of course on all referrals. The rationale for doing this was:
 - a. an unequivocal understanding that deaf children were by definition ‘children in need’ as defined by the Children Act, 1989;
 - b. deafness is a complex socio-linguistic developmental phenomenon therefore without specialist assessment of even the most seemingly straightforward presenting issue, the true complexity of need may not be recognised;
 - c. there was a clear commitment to providing a preventative service, which was in the context of deaf children and their families recognised as requiring specialist provision at an early stage of involvement rather than diversion to generic/universal provision;

- d. routine assessment in respect of all referrals built better relationships with sister professions within Children's Services whose involvement with deaf children is mandated on a universal provider basis (e.g. health and education).
- ii) In three Sites, it was evident that deafness of itself would not trigger eligibility for assessment, let alone service provision, unless there were an identifiable serious problem over and above the fact the child was deaf (e.g. child protection concerns). In other words, the complexity of consequences for child and family attendant on a child's deafness was not identified as potentially serious or requiring of itself social care expertise, resources or support. This situation was labelled by one senior manager as "an abuse of the children and of the Children Act".
- iii) In Sites where there was no specialist deaf children's social care service, there was also a clear tendency to use medical model understandings of impairment-based criteria to classify seriousness of need and complexity of problem. By this token, deaf children's needs were rarely regarded as serious or complex in comparison with, for example, children with severe physical impairments or life-limiting conditions. The application of this model of understanding complexity also meant that deaf children's needs could be regarded as solved or resolvable by technical solutions e.g. hearing aids that would mean they fell even further away from notions of eligibility for social care services.
- iv) There was a clear demarcation between respondents who worked/had worked closely with deaf children and families who firmly saw the complexity of deafness as psychosocial developmental phenomenon with a heterogeneity of potential consequences, and those who had not, and thus tended to regard deafness as a mild impairment that could be made better and which of itself would not be sufficient to warrant social care involvement. This latter group did not tend to recognise the significance of preventative involvement precisely because of the complexity of issues for deaf children and families over the course of childhood/young adulthood.
- v) Deaf children's needs were also written out of the consciousness of Local Authorities because they were in resource terms mostly invisible. Unlike children with some disabilities who require expensive placements or high expenditure for other reasons, deaf children are relatively cheap for Local Authorities and so not very visible by this criterion. In terms, therefore, of prioritisation of need, they were unlikely to be regarded as a high priority as judged by drain on local resources.

7. Documentary Analysis

As part of the case study design we analysed publicly available documents in each Site and additional internal documents that were supplied by respondents to the research. The aims of this analysis were:

- To contribute information that we anticipated would clarify and assist in our understanding of the organisation and delivery of social care services for deaf children and families in each Site and in comparison between Sites.
- To enable a comparison between the formal (documentary) expression of service structure/arrangements and practical/operational evidence derived from our interviews.
- To identify and evaluate the extent to which deaf children and families are visible within documentary references to Authority planning, policy and practice guidance in Children's Services.
- To identify, in conjunction with evidence from the analysis of interviews, trends and consequences for service provision relating to how the needs of deaf children and families are implied, explicitly addressed or subsumed within relevant documents.

The following analysis relates only to aims 3 and 4. Aim 1 is incorporated into a description of service arrangements within each Site and aim 2 is largely incorporated into the analysis of interview data.

7.1 Documents included in the analysis

Identified below are the documents that were analysed for each study Site

SITE A

Children and Young People's Plan (2006-2009)
 Safeguarding Children Procedures
 Disability Equality Action Plan
 Review of Children's and Young People's Plan
 Education Development plan (2002-2007)
 Annex A: Pupil Performance Set by Each Maintained School

SITE B

Children and Young people's Plan (2006-2009)
 LSCB Safeguarding Inter-Agency Procedures
 Disability Equality Scheme
 Procedures for the Initial Assessment of Children and Young People who Display Sexually Harmful Behaviour
 Protocol for the Provision of Therapy for Child Witnesses Prior to a Criminal Trial
 Protocol for Children who have a Mentally Ill Carer
 Protocol to Safeguard the Welfare of Children at Risk when Parents or Carers have a Learning Difficulty
 Guidance for Professionals Working with Sexually Active Young People under the Age of 18 in Site B

<p>Fabricated or Induced Illness in a Child Site B Common Referral Form Child Protection Advice and Guidance Pack Domestic Violence Policy and Guidance Unexplained Deaths in Children and Young Persons Information Sharing Guidance Mental Health and Child care Protocol Allegations Against Foster Carers</p>
<p>SITE C Children and Young People's Plan (2006-2009) Child Protection Procedures Children and Young people's Plan: Children and Young People with Special Educational Needs/Disabilities Youth Justice Plan (2002-2005) Guidance for Professionals Working with Sexually Active Young People Strategy for Special Educational Needs (2004-2007) Policy for Children with Special Educational Needs Private Fostering Services: Statement of Purpose, Policy and Procedures Indicators for Admission to Special Schools and Special Provision Early Years Development and Childcare Partnership Plan (2006-2008) Children's Disability Service and the Multi-Agency Priority Panel process (personal communication)</p>
<p>SITE D Children and Young People's Plan (2006-2009) Local Safeguarding Children Board: Child Protection Procedures (for consultation, June 2007) Child Protection Committee: Equality and Diversity Statement (December 2003) Policy and Procedure for Responding to Children in Need</p>
<p>SITE E Children and Young People Plan (2007-2010) Site E Safeguarding Framework Equal Opportunities Policy Children's Needs Framework Report of the NHSP Quality Assurance Support Visit 2007* Improvement Plan for Newborn Hearing Screening Programme in the Site E locality CAF Form</p>

Clearly, Authorities will have a range of documents for different purposes including statements of policy, procedural requirements, eligibility criteria, statements of values such as equality and diversity principles, practice guidance and detailed operational instructions. Such documents will also be particularly relevant at different levels of the organisation, from high-level policy statements and strategic plans to those that guide operational decision making and action on the ground. Given evident access and practical limitations we chose to analyse a selection of documents from each Site. However, we also ensured that we read documents that might be expected to yield information about

social care/social work policies and services for deaf children and families, namely each Authority's Children and Young People's Plan, Child Protection/Safeguarding Children Procedures and statements about equality and diversity policies. Thus, our intention was not to analyse every document relevant to children and families but to explore those documents that might be expected to include some reference to the needs of deaf children. We cannot, therefore, assert that our documentary coverage includes all possibilities for referring to deaf children's needs. However, we can identify the extent to which such needs are recognised and addressed in documents about existing services for children and families, plans for service development and safeguarding children arrangements.

In order to manage the documentary analysis we developed a matrix that identifies references to relevant subjects, the number of references in particular documents and themes under which the references can be appropriately organised. The matrix is summarised below (7.2).

7.2 Document Matrix

Reference to the following subjects in relevant documents	Themes according to which subject references are organised
Deafness/means of communication indicating a recognition of deafness (specific reference to signing) Disability as a general category Sensory impairment as a general category but excluding references to visual impairment Special needs and impairment as general categories Communication needs as a general category Provision of specific methods/services to assist communication (excluding a particular reference to signing) Learning disability as a general category	Equality/diversity statements Child protection/safeguarding arrangements/issues Working with children and parents Services/eligibility Referral/assessment Structure/organisation of services

7.2 Analysis

We found only one statement of an Authority's equality and diversity policy that explicitly recognises deafness as an issue by citing British Sign Language users as being included in the policy remit.¹⁸

Other Authorities' equality and diversity statements include disability as a recurring theme. They also mention service users with 'communication difficulties' but without any explicit reference to the needs of deaf children and their families.

¹⁸ We are unable to quote from the policy as that would allow the Site to be identified

In our matrix, Authorities' Children and Young People's Plans yield most entries in relation to the themes of service provision/eligibility and structure/organisation. However, these Plans are lacking in explicit references to deaf children and families although they identify existing services for children with disabilities and special educational needs and incorporate these children's needs into plans for service development. Children and Young People's Plans are generally alert to the needs of disabled children for play and leisure opportunities, access to Children's Centres, effective safeguarding arrangements, improved access to equipment, more effective support at transition to Adult Services, help in achieving continued education, training and employment and the needs of their parents for childcare facilities and early assessment, information and service provision. However, the specific needs of deaf children and families are rarely mentioned. This reflects information from interviews with operational and strategic managers that deaf children's needs are either presumed to be met within education services, or only become an issue for social care/social work services if deafness is accompanied by disabling conditions that meet an Authority's eligibility criteria.

Our conclusion must be that although the needs of disabled children and their families are well recognised in Authorities' Children and Young People's Plans, the needs of deaf children are only acknowledged insofar as they can be incorporated within the category of disability and/or special educational needs and the drive towards integrated services for disabled children.

The majority of entries in our matrix that relate to deaf children's needs are recorded under the theme of child protection. Here it is suggested that children with 'communication difficulties' may be more vulnerable to abuse, may find it problematic to tell someone what is happening and may need additional help to participate in safeguarding children arrangements. However, while two Authorities explicitly mention deaf children in this context, most of the matrix entries for child protection issues still fall under disability, sensory impairment, special needs and communication difficulties as general categories. Again we are unable to quote directly as this would make the Sites identifiable, but we have paraphrased some examples.

"the child should be enabled to communicate in the way that the child prefers and in language appropriate to her/his age"

"Allow children who have a mental health problem or a communication difficulty more time to develop trust."

"Social workers should ensure that appropriate interpreters or communication aids are available"

"Where a disabled child has communication difficulties or learning difficulties, special attention should be paid to communication needs, and to ascertain the child's perception of events, and his or her wishes and feelings. Social services and the police should access specialist help with non-verbal communication systems when they are necessary to communicate effectively with a disabled child."

This concern with 'communication difficulties', particularly in the context of safeguarding children from harm, is instrumental in nature. That is, it does not relate to social care/social work perspectives on the relationship between methods of communication, choice, empowerment, identity, social interaction and cultural affiliation but to the business of exchanging information for a particular purpose.

Overall, we found relatively few references in the documents that could be included under the matrix subject heading of 'deafness/means of communication indicating a recognition of deafness (specific reference to signing)', rather than under other headings incorporating general references to disability, impairment, special needs, communication difficulties or learning disability. Under the heading that explicitly recognises deafness and/or communication issues in relation to deafness, we found one Authority that referred to this under the theme of equality and diversity, two Authorities that referred to communication issues for deaf children under the theme of child protection and one Authority that explicitly considered this in relation to services/eligibility. This is not to suggest that Authorities are oblivious to the needs of deaf children but that, as is apparent under other themes included in our matrix, they tend to subsume children's protection/safeguarding needs and their need for social care/social work services under general categories relating to children with disabilities and special needs.

7.3 Summary

- i) The conclusions from our documentary analysis are consistent with data from interviews with operational and strategic managers.
- ii) Although the needs of disabled children and their families are well recognised in Authorities' Children and Young People's Plans, the needs of deaf children are only acknowledged insofar as they can be incorporated within the category of disability and/or special educational needs and the drive towards integrated services for disabled children.
- iii) Deaf children only become visible in Local Authority documents insofar as they are also disabled, vulnerable to abuse and/or identified as having 'communication difficulties' where effective communication is required to meet specified ends.
- iv) We could glean very little from the documents that indicated an awareness of deaf children's and families' needs or the possibility that they might benefit from social care/social work services.
- v) We accept that, given the low number of deaf children relative to children with disabilities and the constraints imposed by high eligibility thresholds, local authorities may not consider it practical to emphasise the social care needs of deaf children in their policy and practice documents. However, all of this conspires to render deaf children and families relatively invisible in the context of social care/social work services (with the exception of Site C and D) and documentary records.

8. Operational processes of joint working with education and health within integrated Children's Services

8.1 Introduction

Thus far we have considered a range of strategic issues linked to decisions about where social care services for deaf children and families may be positioned within the emerging new structures of Children's Services, and the consequences of those different kinds of structures. In this chapter, we turn to more operational issues about how in practice integrated Children's Services are working with respect to deaf children and families. The issue of eligibility for services has already been dealt with in its own chapter (Chapter 6) because it was such a dominant concern with far reaching effects. Here we additionally focus on: joint working with education including systems of cross-referral; and joint working with health. However, first it is important to spend some time considering two major issues of context in understanding some of the operational concerns. The first is the constantly evolving nature of integration in the Sites we studied; the second is the fact that deaf children and families are most likely to be invisible in this shifting picture.

8.2 The evolving nature of integration

The fieldwork for this research was carried out in winter 2007/spring 2008. The Children Act (2004) required all LAs to have a Director of Children's Services in place by January 2008, although there was flexibility below this as to how services were to be organised in order to meet local circumstances and challenges. Only one of our Sites, Site B, had been one of the pilot authorities for the establishment of Children's Trusts (UEA/NCB, 2007) the other four Sites, therefore, had not been early starters in the process of integrating children's services. All were in, what the senior managers we interviewed readily acknowledged, the relatively early days of integration. There was a tangible feel that in the different Authorities both new configurations and new working practices were being 'tried out' with a sense that they may well change as experience shows what works and what might be done better. As one respondent put it, integration had eased people out of their disciplinary, structural and managerial silos but only to the point where there were now emerging networks of "semi-permeable membrane silos" [C:7]. Practitioners too had a sense of feeling their way through the new arrangements – with attendant losses and gains in comparison with previous practice. When communicating across Adult and Children's Services boundaries, the relatively recent division into Children's and Adult's Services meant that staff were still communicating with those with whom they used to work and thus knew personally. The pace of this change should also not be underestimated. In the 6 months between ending our data collection and writing up the results, our respondents have informally told us of many further changes that have occurred, some of which are highlighted later in this chapter.

8.3 The relative invisibility of deaf children and families in this shifting picture

The other major issue in considering the context of evolving integrated service provision is the invisibility of deaf children and families. In that respect, this study is apt to give a false impression. We have focused attention specifically on deaf children within the

integrated Children's Services context, directly confronted managers to consider this service user group, deliberately interviewed practitioners who have contact with this group. Consequently we have rich data and complex findings about the impact of integration for this user group – as if these issues were at the forefront everybody's minds. For many, they were not (until we asked) and thus in some respects the results of this study are a distortion because the reality for these Local Authorities in terms of strategic and operational planning decisions is that deaf children do not ordinarily feature as a distinct consideration.

“In amongst all that [re-organisation], deaf children's needs haven't figured at all...in the sense... I mean my hunch is that the numbers are very small and nobody had really expressed any interest whatsoever in looking out for those needs are met.” [B:5]

“I honestly don't know for deaf children...until you guys made contact with us, it wasn't something at the top of anyone's agenda” [A:3]

As our documentary analysis of Children's Services planning and guidance documents revealed (See Chapter 6 and Appendix), deaf children were rarely if ever mentioned – presumably assumed to be covered under references to 'disabled children', although some impairment-specific groups were commonly singled out such as children with autism and children with learning difficulties. Indeed in much of our probing about the impact of integrated services on deaf children and families, we received a large amount of data from senior and strategic managers in respect of multi disciplinary teams for disabled children, using developments in service provision for children with physical and learning disabilities as key examples of good practice. For these respondents who had little (if any) contact with provision for deaf children (despite having strategic responsibilities that included these children) deaf children's needs were not recognised as distinct in any way from how one might be planning for disabled children. (In Chapter 6 on eligibility criteria and Chapter 7 on social workers with deaf children, we have illustrated why this elision of disabled children and deaf children may not be tenable in terms of recognising and meeting needs).

The notable exceptions to this picture were in Sites C and D where there have been individual champions for this user group in Local Authorities and a tailored specialist service has resulted¹⁹. It is also of note that in these two Authorities senior strategic managers we interviewed were well briefed on deaf children and families and were well aware of how the issues for social care may be for this group both similar to and different from those of disabled children more generally.

In considering, therefore, the nuts and bolts of integrating Children's Services, we have made a decision not to report the data we were given about the integration of disability services in general and/or improvements in multi disciplinary working for disabled children's families, where there was no evidence that this included in practice deaf

¹⁹ Sites A, B and E also had champions, but their support has not resulted in specialist services/ specialist arrangements for deaf children.

children and families. We say in practice, because we have no reason to believe that respondents were anything but sincere in assuming that these developments would apply to deaf children too (either in the present or the future), or that the same systems of service planning and delivery theoretically could be used. It is just that in three of our Sites (A, B and E) it was clear that these developments were not bringing tangible benefits for the delivery of social care for deaf children and their families as the previous analysis of service structures, the illustrative case study and the analysis of eligibility criteria have demonstrated in detail (Chapter o, Chapter o and Chapter o)²⁰. There was no automatic fit of the theory into practice of the Disabled Children's Services structures with the realities for deaf children and their families. The problem was, this potential lack of fit was not necessarily recognised or acknowledged.

In what follows, therefore, we will focus on operational issues of service integration specifically in respect of services for deaf children and their families whilst acknowledging the two important caveats we have discussed: this is a rapidly changing landscape; the specific nature of integrated Children's Services concerns in respect of deaf children is not one that is universally shared, nor necessarily considered of importance separately from the concerns of integrated services for disabled children.

8.4 Joint working with colleagues in education

A common issue in any study of multi professional/multi disciplinary working is the impact of mixing practitioners and managers with disparate values and professional expectations (Young et al 2006). In this context of social care and educational professionals forming an integrated provision for deaf children and families, the significance of historically embedded assumptions about each other's aims and practice was a recurring concern (amongst those we interviewed who had direct working experience of deafness and service provision)²¹.

The relationship between education services for deaf children and social work/social care services has historically been fraught. Even if relationships now have apparently improved with staff consulting one another, the history still exerts a powerful influence on the present. Traditionally Teachers of the Deaf have used a medical model of deafness and espoused an oral/aural approach to child language development, whilst social workers have used a social model of deafness and have been able to sign. This has inevitably led to conflict and has left parents confused when two different sets of apparently passionate and knowledgeable professionals have offered conflicting advice (for example, Fletcher, 1987). In Site D, for example, it would appear that the philosophical divide was still present, even if there were good working relationships:

²⁰ It should also be noted that one respondent in Site B at a strategic level of responsibility was also quite clear that the Authority's developments in integrated services for disabled children in general were not working well, it was not just a problem in respect of deaf children.

²¹ We choose to re-emphasise this distinction between the perspectives of those with direct deafness-related experience and those without because many of the subtle issues of historical effects, disparate models of deafness and deafness-related practice were unknown to the managers we interviewed who, although having structural responsibility for services to deaf children and families, would not have considered these issues through lack of contact/knowledge of them.

“I think I’ve understood more the issues around which educational path to go down and the fact that you know, there’s a lot of dogma around all of this in terms of signing or not signing, oral, not oral... whether you get any choice in that matter...some people in education obviously have very strong views about wanting to go down one path only rather than enabling choice to happen.” [D:12]

A similar perception existed in Site E:

“I think pre-integration, it’s my experience that...they would have been loathe to refer it to Social Services, yeah I think there was a feeling that they could deal with it. They had the skills to deal with it themselves. I mean there is still, you know, an ongoing tension between social care, looking at issues for deaf people, especially around the use of language and communication and Education where the belief is till very much that if you can get them to talk, that’s what you do.” [E:17]

However, integration was resulting in previous working practices with education colleagues having to be rethought. For example, where in the past a deaf services team might have not hesitated to challenge an educational placement on grounds of a child’s social well being, now that they were one and the same service the challenge needed to become a negotiation with more need to compromise:

“so we do have erm, a statutory duty to support other teams rather than to criticise other teams” [C:7]

Indeed in three of our Sites (C, D, E) there was clear evidence of growing together of social care and education and therefore a greater tolerance of what might have previously seemed to be opposing positions. [As we have already documented, in Site A there was no significant contact between education and social care personnel working with deaf children and families; in Site B there was a strong assumption that education would be the lead on all matters pertaining to deaf children including social care needs and therefore the notion of integrated professional groupings was not on the agenda]. This growing together was still, however, very much in its infancy and we saw examples of what we might consider different stages in the evolution of integrated working.

In Site E, where deafness expertise in social care resided in Adult Services, there was nonetheless evidence of a greater willingness on the part of education personnel to pick up the phone and ask for advice from a colleague in social care.

“A lot of things like that come to us through education because we have a good relationship with the special needs education team. So they would...if they were a but unsure about somebody and there was a child they were abut concerned about... their team leader would perhaps give me a ring directly and say ‘do you know about such a body and we’ve got this situation and what do you think we should do?’” [E:16]

However, such willingness to have joint discussions was, in this Site, largely predicated on personal relationships (relevant people had known each other for 20 years); there was no structural mandate for its occurrence. Opportunities for reciprocal communication initiated by social care professionals were somewhat restricted as the Adult Services location of deafness related social care expertise meant that inevitably they rarely were made aware of or had any contact with deaf children and families (see Chapter 6 for further discussion of these structurally imposed constraints and evidence from the Case Study in Chapter 6). This situation contrasts sharply with that of Site C, for example, where although located within Adult Services, clear formal agreements ensured that their legitimate responsibility for specialist work with deaf children and families would cross those structural barriers. In Site E also, the separation between deafness related expertise and Children's Services was further reinforced by the fact that the IT systems in Children's Services were not, at that time, compatible with the IT systems in Adult Services²². This lack of fit made it considerably more difficult to share information and knowledge, or to request a case (involving a child) to be open to the Deaf team as well as whichever branch of Children's Services may be involved. By comparison, in Site C, although there were two incompatible IT systems for Children's and Adults Services, the team had access to both.

In Site D there was evidence of cross-referral between education and social care, although one of those we interviewed in Site D was still convinced that education did not really understand what social care did. Also any cross referral, in her view, was still at education's discretion rather than being routinely considered from the perspective of what social care might be able to contribute.

“...we don't need to see all deaf children. However, sometimes I feel that their [education colleagues'] judgement of when we see children...I still think they find it quite challenging to understand what we do and I think that's because they think they know what we do. So when we we've actually given presentation to say what we do, I don't know it's like an elastic band, we tell then what we do and then all of a sudden they'll go back to their old way of thinking... So it's quite challenging in that respect, however, we do get a lot of referrals from education.” [D:11]

In other words, systems of routine consultation or joint working were not in place. There were still very much two teams (education and social work), but with some new bridges between them.

This separation was further reinforced by the referral system that existed in this Local Authority. Within an integrated Children's Services structure there still remained separate

²² With the migration to a national system for Children's Services, we do not think that this lack of compatibility between IT systems across Adults and Children's services is a rare occurrence. Also even when they may technologically be compatible it does not necessarily follow that personnel are trained to use both (as they may have different interfaces). In the case of deaf children, where expertise may be located in Adult Services, this can be a real problem as evidenced in Site E. In the second study in this project we will be asking all Local Authorities about these issues in order to gauge whether there is a disproportionately negative effect of the lack of IT migration on how services for deaf children and families are executed.

referral routes to Children's Services (education) and Children's Services (social care). This separation had several effects. Firstly there was no automatic way in which education colleagues and social care colleagues both working with deaf children and families would as one team actually all know about the same children and families. Indeed the debate remained whether in fact it was desirable for social care to be made aware of deaf children and families unless there was a specific reason that was identified by a teacher of the deaf, (other professional) or a parent themselves. Secondly, for the specialist deaf children and families social work team to be made aware of a service user, a formal internal referral was required from the education team. This new situation that had arisen as a result of integration had, in the view of the deaf children and families social work team actually resulted in a drop in referrals from their education colleagues who were reluctant to fill out the required form, when in the past they might simply have let social services know informally about a child/family then social services would have then decided what action to take (if any).

“However, they [education] were extremely challenged by the new referral process. The reason they were challenged by it was previously they would stop you in the corridor and it was quite a dangerous place to take referrals! Or you would get an email and you'd think, 'are they just informing us about this or is this [a referral]?' And so...when they do a referral now, they're expected to fill out a form, it's not a lengthy form, but it's an internal referral form, an internal assessment form, very brief, but just them owning really the referral and they found that quite challenging. So our referrals did go down because of this.” [D:11]

Thirdly, this internal referral system within integrated services also meant that, from the perspective of the deaf child and family social work team, what was often happening was that education colleagues were asking parents to refer themselves. This meant that the professionals did not have to complete the referral, but parents had to go back through the same system just via a different entry door. Asking a service user to go back into the same organisation through a different route to get a different facet of what should be the same service would seem to fly in the face of the aims of integrated provision and challenge a core principle that a referral to one is referral to all.

It is worth reflecting at this point, that the dislocated nature of social care/education joint working and the systems that support it that we are reporting is occurring in one of only two Sites where specialist social care practice with deaf children and families is actually facilitated by children's services structures. In other words, even where specialist social care practice has been recognised as a priority and structures support its existence these do not necessarily ensure well integrated working practices with other facets of Children's Services who also work with deaf children and families.

In Site C there was evidence of significant and ongoing consultation between education and social care professionals that was reinforced by members of the 'team' being from education as well as social care backgrounds and who were co-located in some instances²³.

²³ This circumstance is reflected in our sample from this Site.

“Certainly the cases I’m thinking of currently...there’s no doubt that the conversations I’ve had or that I’ve directed my teachers of the deaf to have...proved very, very helpful, not least in taking the pressure off the individual teacher feeling ‘I’ve got to do it all’, that actually there are other people out there who are better placed perhaps or who can point you in the right direction” [C:10]

These circumstances were ripe for cross professional consultation leading to active joint practice initiatives, although such joint initiatives were not perceived to take away any of the disciplinary disagreements of perspective.

“...if we had everyone, all in the same room, I think my stronger feeling would be around the teaching side, where you’ve got educationalists coming in with what they see as a social model, but what social workers wouldn’t necessarily see as a social model. I think everyone sees education as being key whereas social workers very often will see the abilities to communicate, get on with peers, make their way in life etc etc as being, not necessarily driven by education, but driven by social skills development...appropriate developmental milestones, targets, that sort of thing. And I think education, it can...particularly if someone is statemented, I think very...it can lead on an education model, what I would call an education model rather than a social model.” [C:7]

In many ways active joint developments just showcased the differences in professional values, priorities and expectations even more – the residual challenge thus became how to turn these into a better, more holistic service for families:

“The strategic manager of education for deaf children and I had quite different views on it [Deaf Role Models] to begin with. We didn’t come to blows, but we do have some quite different views...She was very, very adamant that she didn’t want children under seven into that system, whereas I felt that actually that’s a really good age to get them... but I think that our fear from the social and community services side that that is being influenced by the teachers and that is the concern and we keep thinking, how can we do this in a way that’s not going to alienate the teachers, that’s going to benefit the children and that’s going to benefit the parents?” [C:7]

In this Site, there was an additional challenge of the expertise of the integrated social care/education team working effectively with the new Children's Services locality teams. Just because there was a specialist service, did not actually mean that Children's Services in a more general sense would be aware of when it might be helpful to refer to them or involve them whether in a process of assessment or in terms of ongoing service delivery. As we have commented elsewhere a crucial issue was that of non-specialists actually being able to spot when a presenting issue was of significance, which could in some cases involve seeing past the deafness, in others firmly focussing on the deafness (See Chapter 6). These loose connections between locality based Children's Services and specialist deaf related services, was causing Site C to consider the possibility locating a

specialist deaf worker within the authority wide Children's Disability Team to ensure more embedded expertise, maintenance of up to date legislative and procedural knowledge and better joint working across the whole of children's services. Such a strategy carried the inevitable risks of the watering down of expertise and the potential isolation of workers, particularly of workers who were deaf sign language users in otherwise 'hearing' teams as had been experienced when similar worker allocation have been tried in Site D.

“Our experience is that it's extremely difficult to retain staff in those situation and they do then start getting absorbed by other issues within the team because either's so much pressure in terms of resources and you know, trying to ensure that you've got sufficient staff to provide that services...they can easily become involved in all of that rather than maintaining their specialism” [D:13]

Finally, it should be remembered that of our five Sites, only two were actively pursuing integrated education and social care Children's Services for deaf children within a framework of specialist team/team arrangement²⁴. In the other three Sites the move towards integrated Children's Services had not resulted in the recognition of any kind of joint specialist provision. Indeed, as we have previously argued, it has in fact enabled a far looser, and in many respects obscure relationship to exist between education working with deaf children and social care provision/response. In focusing as we have on those two Sites who were actively engaged in the struggle for better integrated working between education and social care for deaf children and their families, it is important not to lose sight of this bigger picture that effectively is bypassing most of these issues.

8.5 A note on integrated working with health

Integrated Children's Services is fundamentally about the ending of structural separation between education and social services. However, it exists also in the wider context of the establishment of Children's Trusts/Children's Trust arrangements (see Chapter o). Children's Trusts in the round require ultimately the co-ordinated strategic planning of all services for children including those provided by health and the voluntary sector within one approach in each local authority who have an appointed Children's Services director. In general, in all of our Sites, progress had been made in regarding health services as part of a co-ordinated children's service although many respondents identified that there was a long way to go. Sites provided us with evidence of how multi-professional service planning and delivery was developing with regard to disabled children and families. For example, in Site A there was an Authority-wide Multi Agency Community Support for Disabled Children Team which was responsible for the co-ordination and review of services with families with disabled children. The team sat outside formal referrals for social work intervention but was a system for ensuring families with disabled children had a point of co-ordination of services. However, it was clear that whilst this service would apply to deaf children and families, it had not (yet) being able to reach effectively this sector.

²⁴ We use the phrase 'team arrangement' as shorthand for the structure in Site C where although the 'deaf team' remained within the Adult Services structure, there were formal working agreements that mandated them to provide specialist services within children's services structures in the case of deaf children and families (including Deaf parents with either deaf or hearing children).

In Site B, there were different views on effective multi-disciplinary working for disabled children. From the children's team perspective it was considered to work adequately, with health and education colleagues taking the lead and making judgements as to whether or when it was appropriate to involve social care services. From a disabled children's perspective it was considered to fall short in that access for disabled children to what should be universal services was not achieved. In neither instance was it evidenced that deaf children would receive a service unless there was a crisis that made them eligible.

In Site D, the development of multi-disciplinary teams for deaf children and families (which would de facto include health) was described as "a bit further down the line" (D:12). However CHISWIGs (Children's Hearing Services Working Groups) were in operation and representatives of the social care workforce did regularly attend. There was, however, a parallel professionals meeting without parent representatives, that was seen as necessary by education and superfluous from a strategic social care perspective. Thus, it was perceived that there was a journey yet to travel in the strategic planning and operational resource for effective integrated working between health, education and social care. That said, the potential for better integrated working with health was seen as a real opportunity.

"I think there are opportunities to look at how we can work more effectively with teachers for the deaf and also with health colleagues, particularly with the newborn hearing screening programme... and Early Support. So we've got to look at how we join all of these things up" [D:12]

In relation to transition reviews in this Authority, members of the Deaf Children and Families Team were routinely invited "to raise any social issue concerns that we can take forward" (D:11) and to talk with parents and young people about social care services. However, these transition reviews were not seen currently to take a multi agency approach that truly integrated responsibility, decision making and resource allocation between health, education and social care. They were perceived rather to be "run by the schools" (D:11).

In Sites C and E, however, we did find some examples of more advanced joint initiatives with health colleagues that directly impacted on provision of services for deaf children and families (rather than disabled children in general). In Site C, the manager of the Children's Disability Team told us about joint protocols that have been developed between Children's Services and health, which are "about how social care staff can be supported to get involved in quite high level health care tasks and how they can be trained appropriately to do so" (C:9). The protocols give a sense of security to all involved such that both social care and health staff feel confident to act outside their normal roles, parents also feel safe and children with complex needs receive a more holistic and flexible service.

In Site E, education, social care and the PCT jointly funded a part-time worker to investigate/identify gaps in service provision for deaf children. This latter initiative in Site

E exists in the context of a PCT having contributed to the jointly funded appointment of a Service Manager with responsibility for developing integrated services for children with disabilities. She in turn manages the Children with Disabilities Team and her line management rests under the Director of Education. The ultimate plan is that she should assume management responsibility for PCT staff who are responsible for delivering services to children with disabilities so that children's social and health care needs are integrated under "one multi-agency manager". In this respect significant progress had been made in developing a single referral process, multi-disciplinary assessments, care pathways and jointly funded care packages for disabled children. However, these single processes were largely being conceived of in disability defined terms e.g. a pathway for autistic children; a pathway for children with Down's Syndrome and so forth. Whilst in one sense such divisions by disability could ultimately benefit deaf children and their families in making sure their distinct needs and strengths were recognised, some respondents also pointed out the dangers of a medical model of service provision that might privilege health defined components over social care related issues in how it conceived of need in the first place:

"The managers in the PCT want a pathway for autistic children, a pathway for complex health needs children, a pathway for developmental delay, a pathway for Downs Syndrome children... but from a social care perspective we...the issues we deal with are pan all of that because it's about the emotional and supporting the parenting function irrespective of the disability. I'm just a bit cautious about the medical model taking over really." [E: 14]

8.6 Summary

We have already discussed at some length in previous chapters three of the fundamental issues pertaining to social care involvement with deaf children and their families. These are:

- i) how the configuration of services following the division between Adult and Children's Services enables or constrains both referral pathways and social care practice involvement in respect of deaf children and their families;
- ii) how the operation of eligibility criteria and high thresholds for services effectively disallow a whole range of referrals in situations where there is no dedicated Children's Services provision for deaf children and their families;
- iii) how difficulties exist in the actual recognition that an issue might be complex/serious enough to prompt a response in situations where the social care professional does not have deafness-related knowledge, skills and experience and therefore does not identify the significance of a particular behaviour/ problem/ circumstance from a broadly preventative and safeguarding perspective.

In addition, this analysis of the processes of joint working with education and health has further highlighted:

- iv) 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
- v) 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.
- vi) 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.
- vii) 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.
- viii) There was an underlying concern amongst some of our respondents who worked directly with deaf children and families, that approaches to integrated services with health might privilege medical models of need to the detriment of social care considerations and by extension those aspects of deafness related needs that are essentially about language, social development and, in some cases, culture.

9. Social workers with deaf children and families – a necessary specialism within an integrated services framework?

9.1 Introduction

Thus far we have tracked the differing approaches to structuring a social work and social care service for deaf children and families and some of their consequences for practice. One of the variables underlying different service structures and a recurring issue in all of our Sites, regardless of structure, was whether and why specialist social workers with deaf children and families might be needed anyway. Within an integrated services approach, other professional groups are perceived to have a universal service remit for deaf children – such as teachers of the deaf and audiology personnel – in a way that social work does not. Therefore are other professionals simply better placed to be specialists in this field? If there are very few deaf children overall, few families who would have reason to call on a social work service and very few likely to meet eligibility criteria for service provision, why would one invest in the specialist provision from a children's social care perspective anyway? What is it that social workers might do that other professionals could not do in respect of deaf children and families? Questions such as these occupied the minds of many of our respondents, whether from a strategic resource, operational management or fieldworker perspective. In what follows we will explore the key dimensions of the debate about whether and how social workers with deaf children and families may be necessary and how is social work and social care for deaf children and families perceived (regardless of whether a specialist social worker is involved)

It is not the primary purpose of this piece of research to define the social care needs of deaf children and families, nor to define a social worker's role in meeting those needs²⁵. Nonetheless, if we are to analyse the impact of integrated services on how the social care needs of deaf children and families are met then we do need to analyse how the debate about whether specialist social workers should exist is being played out in light of structural reorganisation within integrated service frameworks.

9.2 The distinctiveness of social work perspective and practice

Amongst the practitioners we interviewed (including those team managers of specialist deaf children and families services) the overriding issue in explaining social work distinctiveness and in arguing for the specialism, was that of perspective and practice. More correctly one might consider this 'praxis' - that is to say the coherence of practice with its underlying values and theoretical orientation resulting in distinct ways of thinking and doing. The claim was that social work praxis was distinctly different from that of other professional groups involved with deaf children and families and so without that social work involvement then important elements of resource and response for families

²⁵ The document "Deaf Children: Positive Practice Standards" (2002) attempted to define the roles and responsibilities of social work in respect of deaf children and families is currently undergoing revision by the national group of social workers with deaf children and their families, supported by the NDCS and NSPCC. It is expected to be published in 2009.

with deaf children would be overlooked. The argument was not that social work input would be better or superior to any other professional input, but rather that without it some things would be missing for families. Their lack consequently was an issue of rights and duties as much as an issue of better practice. These claims to distinctive perspective and practice took a number of forms.

9.2.1 The family, not the child's deafness

Several respondents discussed how a key distinction for them about social work practice in this context, was that social work practitioners fundamentally began with the family, rather than the child's deafness per se as the focus of their work. There was no suggestion that other professionals did not think about the family, but there was a difference drawn between concerning oneself with the consequences of a child's deafness (e.g. language development, audiological care, educational progress) as the starting point of one's professional activity and concerning oneself with the familial, social, community, economic and cultural context in which the deaf child is developing as the starting point for one's professional activity. As one team manager replied in response to a question about how she saw the social care role:

“It's empowering at different life stages for the child, informing, supporting the family when you're thinking of the whole family.” [C:7]

Whilst another pointed out that whilst it may be the child who is the apparent focus of attention, more often than not most of the work is done with the family, not the child:

“I think often the child will be at the centre of our assessment, however, it's not about the child being fixed, whereas a lot of people come from that perspective. For us, it will be looking at the family or the community or the society around that child and often the work we do is not with the child. Although the perception is we will go in and we will 'fix' the child (and we will do work with child), often the work we do is with the family.” [D:11]

The social work role with the family was perceived by this team manager as a broad one, where social work typically intervened in helping to change the family context in which the deaf child was developing thus indirectly working with the child's longer term needs (in this case in promoting independence):

“...some of the deaf children, you almost have two camps. You have families who just allow them to go out and may not think about those hazards and equally you can have families who because of the deafness see the hazards...as the child is developing their independence and don't let them experiences those things. I think it's a broader social work/social care role that. Sort of working with general risks but also being promoting in how those risks can be managed and supporting families within that.” [E:14]

This strong focus on family and wider socio-cultural context is most readily seen in practices of assessment. Social work has a long tradition of holistic assessment of family

strengths and needs as a means to understanding the nature of any difficulty they may be experiencing as well as in respect of decision making about appropriate responses and required resources.²⁶ This is a fundamentally different kind of assessment from one that is focused on an aspect of the child themselves (such as phonological development) or an aspect of family needs in respect of a child's deafness (e.g. needs for information). In those Sites where it was possible for social workers routinely to respond to referrals with an initial and/or core assessment, the benefits to the families were clear, from respondents' perspective. Families could be signposted to resources and services about which they may previously have been unaware and/or become engaged further with social work professionals if required. Furthermore, this was a routinely available right for the family not something that might happen if they were fortunate to get to the correct branch of Children's Services.

“I think for us, we very much look at the community...because we work with a lot of children with behavioural issues, so we may have a family where a young child is kicking off and we may go in and try to unpick the reasons for that...we would go in and try to understand what those behaviours were and in doing so try to put in various services...because we are looking at the social aspect. What is socially happening for that family?...how is community impacting on that family?...the families themselves, how do their cultures impact on that? And how is the individual child? So we are coming from that perspective and then we would look to actually meet that need perhaps in a variety of ways, not just one. Were not there to fix it, we're there to change.” [D:11]

Also from social work's perspective it could equally be the adult(s) in the family who trigger a referral rather than the child. Although somewhat obvious to state, this is a clear difference in comparison with colleagues in health – an audiologist would not routinely be referred a mother of a deaf child, they would be referred the child, and then subsequently may or may not become engaged to differing degrees with parents and siblings²⁷. Similarly, colleagues in education (teachers of the deaf) are referred the deaf child and then engage with the child in the family, particularly in the early years when much work is done in supporting parents. In the case of social work, the parent may be referred independently of the fact they may have a deaf child and for reasons that on first consideration may not fundamentally concern their deaf child. However, it is through working within a strongly family assessment orientated model of understanding a service user's needs, strengths and difficulties, that the issues of how the deaf child in the family contributes to those and is affected by those that the child too may become part of the social work intervention.

²⁶ Department of Health, 2000.

²⁷ In this respect, it is worth noting the current trend in the US for audiology personnel to take on the role as family counsellor in respect of early identification of deafness. This is a key philosophical shift that is not without its controversy. The recommendation is formally made in the 2007 Joint Committee on Infant Hearing position statement: Principles and guidelines for early hearing detection and intervention. (available: <http://www.asha.org/policy>)

“...the referral had originally been for the parent who was profoundly deaf then two out of the four children were also deaf...so it was buy one get the family free sort of thing. And so that was obviously about meeting the parent’s needs and meeting the family’s needs... It was about providing, looking at the family needs as a whole.” [B:6].

These differences between professionals in respect of family inclusion in professional practice may seem rather subtle – after all, all professionals will be concerned to some extent with the family as well as the child – but they point to a distinctive social work emphasis about how a situation should be understood and therefore the basis on which a range of resources, responses and interventions may be considered appropriate.

More generally, there was a concern that without appropriate knowledge and skills in deafness and/or without an orientation to holistic assessment then two types of error commonly occurred. Firstly the deafness was ‘seen’ as the presenting problem and explanation for other issues and secondly, significant difficulties that might need social work intervention were ‘not seen’ because people were too focused on the child’s deafness as the main problem. These errors were recognised as potentially occurring both amongst other professional groups working with deaf children and families and amongst social workers who did not have deaf related skills/experience.

“Someone’s got to see it haven’t they? It might be a health visitor, it might be someone at school, someone got to see it, recognise it, then they’ve got to have the knowledge and ability and desire to actually refer it...when they’ve referred, who gets it, they’ve got to pick it up, see it for what it is and then assess it and send it through the system... And could it be masked? ‘Oh they’re deaf, therefore, I’m going to see the deafness and not the behaviour or that other need...’. I don’t know, I don’t think so, but maybe I’m being blinkered.” [A:2].

As several respondents were at pains to point out, being able to assess a situation and being alert to family strengths and needs was also about looking beyond the deafness; not just looking at the deafness in the family but that family with a deaf child within the wider contexts of social communities:

“...what I would hope that our staff would be doing would be looking to any areas where the child or the family could not either take part or access... because of the deafness or that deafness was impairing their function within one those areas and that they would then need to analyse where it really was the deafness because that’s a key question, but people often make that assumption and we quite often get people referred for issues because the child is deaf and it actually just happens that they’re deaf...” [C:7]

For this respondent, integrated service structures opened up the opportunity for all professionals, from whatever background, to contribute to such an assessment and begin to think this way. It was not exclusively the province of social workers, although it was

social workers who more commonly trained to take this approach and more usually had practised in this way.

Similarly another senior manager in emphasising the significance of assessing key child-related concerns and not just assessing deafness-related concerns, saw the benefits of working in an integrated services environment for keeping that perspective in focus:

“...they are children and we have to remember that all of those issues around child development, attachment, family issues, not just focus on the deafness or the disability, you know, or whatever the big issue is. I think that’s really important and that’s a huge benefit of having come into Children's Services.” [D:12]

Specialist social workers, trained and experienced in deafness as well as trained in social work were suggested by some respondents as the obvious solution for avoiding both sorts of error and for being able appropriately to evaluate referrals and carry out assessments.

In those Sites where routine assessment responses to referrals concerning deaf children did not exist, or assessments with families were not carried out by social work staff who had knowledge and experience of deafness, then the potential that families were missing out on was acutely felt.

“...at one point I was sat the table with like six parents of deaf children. I was dumbstruck by the hurt that they felt. They felt they just didn’t get anything, they got left, you know, they had to fight for everything themselves, do you know I mean?” [A:1]

In another Site, a senior manager suggested that because there had been no investment in social care services for deaf children and families within the new Children’s Services configuration, then the task was falling to teachers of the deaf who although trying their best, were neither resourced nor trained to take on this role:

“At the moment in terms of looking at social care issues for deaf children, you’ll probably find the educational hearing impairment serve has been thinking much more about that than anybody badged with social are... I [have] picked up that probably the HI teachers are having conversations with families and trying to sort of help out” [B:4]

At the time of the research the Common Assessment Framework (CAF) was only just beginning to be implemented and our study Sites varied in the extent to which they were using it. It will be interesting to track over time whether and how other professionals who may take the lead with CAF in respect of deaf children and families respond to its holistic, family orientated assessment approach, when this may not be one they have been routinely familiar with. However, CAF is only a new gateway, and the issue of skilled family-orientated assessment will remain. Of all the professional groups involved with deaf children and families, social workers are the only ones specifically trained within

such an orientation and who are most likely routinely to practice within such a framework. However, as many of our respondents also discussed, if social workers are carrying out assessments, be it at the most basic level of assessing referrals to decide on whether action should be taken, or more detailed structured assessments, then without specific specialist knowledge of deaf children's development, including key risks to optimal development, then there is a concern that much might be missed [we return to this point when considering the ideally preventative orientations of social work practice].

9.2.2 Social work values in practice

In defining social work as a profession, the new national statement of social work roles and tasks for the 21st Century (GSCC, 2008) makes it clear that one of its defining features is its fundamental concern with particular values and principles that underpin the profession's approach to working with people and problems. The prioritisation of particular value positions actively shape what the profession is, what it does and how it does it. In other words, to define social work in a functional way according to roles and tasks is to fail to define it, unless the realisation of these is understood according to the values framework in which the profession operates. The "Statement of social work roles and tasks for the 21st Century" define this aspect as:

"Social work embodies a set of core values and principles. It is committed to the rights of the child; respects the equality, worth and human rights of all people, and their individuality, privacy and dignity; and challenges discrimination and prejudice. Its knowledge base, drawn from relevant academic disciplines, is informed by the experience and expertise of people using services, developed through research and tested in practice." (GSCC, 2008:4)

Its significance for practice is summarised by:

"People value a social work approach based on challenging the broader barriers they face. They place a particular value on social work's social approach, the social work relationship, and the positive personal qualities they associate with social workers. These include warmth, respect, being non-judgemental, listening, treating people with equality, being trustworthy, open, honest and reliable, and communicating well. People value the support that social workers offer as well as their ability to help them access and deal with other services and agencies." (The Changing Roles and Tasks Of Social Work From Service Users' Perspectives. Shaping Our Lives, 2007 in GSCC, 2008:2).

We have stated this perspective at some length above, because it is one of the core features of what distinguished social work/social workers from other professional groups working with children. We are not suggesting teachers of the deaf or audiologists are not seriously concerned with ethics and values. However what we are saying is that underpinning values are not given the same priority in determining the definition of the profession and setting the parameters of its *modus operandi*. Social work essentially claims to be distinguished by how it does things and the particular outcomes it seeks, not

just by what it does. Social workers are from the very first trained within an overarching concern with the value base of all action and decision making.

It is therefore unsurprising perhaps, that an appeal to social work values and the definition of particular values as priority determinants of how social workers operated with deaf children and families, was a recurring issue in defining what they did. That said, this approach did not always necessarily result in a conclusion that specialist social work practitioners with deaf children and families were actually desirable or required.

When respondents were questioned about how they saw 'social care' with deaf children and families, in addition to a range of tasks and functions there was commonly an appeal to core values that shaped the operation of social work and social care. The most common were: 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.

“...providing information, providing support and enabling a person to maintain their independence by being able to make choices...working with them to develop enabled choice, enabled independence. So do you see what I mean?” [A:1]

INTERVIEWER: “what would you see as social care needs? How would you understand that?”

RESPONDENT: “I think probably the biggest thing would be to do with social inclusion and so sitting here you could see the chances of a deaf child being socially excluded as being actually very high so a lot of the mainstream you know, universal services that other young people of that age would be able to access, they probably wouldn't be able to do it just through issues to do with communication...” [B:5]²⁸

“It's about giving families informed choice. It's about making them aware and going back to the preventative model. This is the bit about empowering families because they are quite able to do for themselves.” [D:11]

“I see the role of the social worker... as supporting, empowering, informing, helping them make choices, being alert to any safety issues and that can be in its widest possible sense from say traditional safeguarding and child abuse issues right the way through to life stage work so if you know that a child is just moving from primary to secondary school, are they Ok with road safety, when they are moving up to teenage stage, are they ok about the community, do they know that

²⁸ Having recognised this risk of social exclusion as a result of issues of communication, it is important to note, however, that this respondent doubted his Local Authority actually provided services that met those needs. He went on to say: “Now I mean I have no understanding of how the county council meet those unique needs. And my hunch is it's probably through grants to voluntary sector organisation and probably there's a lot going on which parents are actually doing themselves. And that would be my hunch that if you scratch the surface, it's probably not very good” [B:5]

they themselves can get to their GP, can they use interpreters, that sort of thing. So it's empowering at different life stages for the child, informing, supporting the family when you're thinking of the whole family." [C:7].

Approaching working with deaf children and families from an independence enhancing choice-promoting perspective was presented by largely practitioner- respondents as something which, in terms of practice, distinguished a social work approach and distinguished social workers from other professionals who might be involved with families. Again the issue here was not so much that other professionals were not concerned with these features (although we were given examples where that was the case), but rather that practitioners from other professional backgrounds did not give the same primacy to these features as bedrock principles to guide how one might understand, assess, provide for and promote the needs of deaf children and families.

"And I think because there's controversy within the deaf world about deaf children, about communication, about audiology, I think people are frightened to actually let parents know what that controversy is and I think they've got a right to know the controversy that's about. And to let them know in a positive way that there are the choices and they may like explore these and find out more information." [D:11]

This issue of promotion of needs was particularly strong amongst social workers and team managers who worked directly with deaf children and families and who found that part of their role inevitably involved advocating for deaf children's abilities and needs to be seen amongst mainstream services (or other non specialist social work teams) who could not distinguish where potential and needs may be differently defined from those of 'disabled' children generally. (See Chapter 0 for fuller discussion of such effects).

Several respondents, however, who occupied strategic and senior management roles at one remove from direct contact and practice with deaf children and families presented the significance of core social work values and principles rather differently. This difference was most evident in discussions of how inclusion and the avoidance of social exclusion shaped social care provision. In two of the three Sites where no specific social care service for deaf children and families had been built into the structure of new Children's Services, the appeal to social inclusion as a guiding principle in shaping services was actively used to explain why no such specialist provision was actually required. In Site A for example, senior managers saw no reason why deaf children's needs should be distinguished or differently provided for than all disabled children's needs. They regarded deaf children as disabled children and indeed to do otherwise would in fact work against core principles of inclusion.

"Well it's interesting that you're focusing on deaf children, but we're talking about services which we feel applicable to all children. The majority of all services that I'm going to describe are applicable to all children with additional needs and difficulties for whatever reason..." [A:3]

Site B took a similar view, although one senior level respondent expressed considerable concern about this position. To her, the appeal to the avoidance of social exclusion could too easily become a means of actually ignoring the extent and complexity of what it would mean to promote inclusion – not just for deaf children but in fact for all disabled children. It was, in her view, too easy to limit what inclusion actually meant and so when there was a seemingly obvious example of its promotion the limitations of what was in fact being achieved were not questioned. In effect the inclusion agenda box had been ticked but not fulfilled.

“To give an example. I did an inclusion audit at N School. Now by most standards N School would be scoring very high, with lots of facilities taking place... out of school hours, high range of additional needs within the building. But if you actually, as an example, look at the hearing impaired bit of the school, one of the striking things was at 3.15 when the taxis come to take the young people back to their homes some distance away, the extended service off of XX School is not available for that group of children. So one level, you're sitting in somewhere that scores incredibly highly but actually we haven't thought through how is that young person going to have a life when the school door shuts?” [B:4]

She went so far as to suggest that the appeal to social work values as guiding and distinguishing what social care provision did could actually cover up a great deal of what it does not do. Transmuted into organisational terms, she went on to respond to our question about what social care for deaf children and families might be by reframing the question as:

“...what should be our organisational understanding of social care rather than what does a bit of our organisation which we call Social Care see as the task.” [B:4]

In addition to what one might term generic social work values and principles, there were particular ones associated with working with deafness that were also expressed as distinguishing features of social work perspective and practice. These are discussed separately in the section below.

9.2.3 A social model perspective and working with deaf children and families

All of our respondents who had a direct role in working with deaf children and families and/or d/Deaf adults, talked about the significance of a social model approach in their work. The use of 'social model' had different connotations. To some it meant the holistic family/ community/ society framework that was routinely used to assess and understand the needs and strengths of children, young people and families [as discussed above]. For others it implied seeing deaf young people's development and needs within a social framework – both in terms of their socio-developmental needs and challenges, and the way in which social structures might impede these and their successful achievement. This perspective was contrasted with that of other professionals who might be concerned

with, for example, deaf children's linguistic and educational progress or health (audiology) needs.

"...we're coming from the social model and I think people forget that, we are social workers and we come from that social model perspective and it's not denying the medical model because the medical model is of value because parents want to be able to maximise a deaf child's chances of developing speech or developing hearing that is usable and effective for them. But there's this social part that people often don't value and it is so important for a deaf child's self-esteem and long-term wellbeing [to] become you know, a good, healthy, functional adult"
[D:11]

"...a deaf child has been identified through the Newborn Hearing Screen... and they automatically get referred to a teacher of the deaf, they automatically get referred obviously to audiology, the medics are involved. But there isn't that emphasis on giving advice and information at that point from a social care point of view and the impact that that might have on that child's life, socially as it grows up. And I'd like to see some opportunity early on for that intervention, even if it is just a case of saying 'this is available;' giving information at that level and not on a medical level...because it seems to be a very medical focus." [E:16]

The social model approach was expressed both in terms of a focus/way of thinking and in terms of actual interventions that were appropriate to social care that arose from this kind of emphasis. As one respondent pointed out, from her perspective she may be more likely to focus on milestones in the development of social skills, than milestones in language development (not that these were unrelated).

"...you've got educationalists coming in with what they see as a social model, but what social workers wouldn't necessarily see as a social model. I think everyone sees education as being key whereas social workers very often will see the abilities to communicate, get on with peers, make their way in life etc etc as being, not necessarily driven by education, but driven by social skills development, appropriate developmental milestones, targets, that sort of things. And I think education, can particularly if someone is statemented, I think... it can lead on an education model, what I would call education model rather than a social model."
[C:7]

For others, focusing on the social needs and social development of deaf children and young people led to an emphasis on the provision of opportunities to foster such development (e.g. access to leisure, access to a peer group). The significance of addressing the social worlds and communities of young deaf people was regarded very much from a preventative perspective. It also encompassed social workers developing community based initiatives that they themselves may not actually deliver but that they supported and that families could access without necessarily becoming recorded clients of social care services. The following team manager linked this kind of broader activity with making social care services more accessible as well:

“[parent to parent support] – we’re looking at identifying parents that are willing to do this. And working in conjunction to give them training...and funding that service...The other thing is a family signing group where they’re run at weekends for families to drop in and it’s appropriate signing for the appropriate need an development of their child. So it’s not structured learning, it’s about looking at what parents want...I’m looking to recruit some Deaf role models so that we have a work force, qualified social workers and underneath we have a group of workers who would work outside core hours, so I want this group of workers to be working evening, weekends, so can include families, which includes fathers, grandparents and trying to turn our service into one that is accessible.” [D:11]

The consequences in practice of taking this social model approach were part of what distinguished the social work perspective and role in working with deaf children and their families. However, as we have previously discussed such work is only possible in those circumstances where the structure of the service is able to respond to needs at that kind of level of involvement – preventative family and community based interventions. As we have demonstrated, the operation of eligibility criteria, the assumption that deaf children’s social care needs can be subsumed under generic disability services, or addressed by the involvement of other professionals, all militate against this kind of involvement in socio-developmental interventions by social work practitioners. Allied, therefore, with discussion of social model approaches came discussions of what kind of social care structures (within Children’s Services) would best enable involvement with families and deaf young people themselves in psychosocial, developmental concerns. In this respect, three respondents in particular highlighted the difference between what might be seen as old fashioned, community orientated social work, with the procedural approaches of care and case management that were prevalent today.

Compare for example, discussions about the benefits of a social work approach where in effect the ‘case’ always remains open because the family/young person knows there is someone to go to as and when needed, having had previous experience of social care services; with the approach where social work operates in part as a diversion from involvement strategy where contact with the social care branch of Children’s Services is most likely to result in signposting to other agencies who might meet needs (e.g. for information, or for equipment).

“...we look at the disability as the impact on the family and how we can support families in that and obviously some families just want that point of contact with us as and when they need it and they beg us not to close the case even though we’re not providing anything, they just like that security blanket of knowing that they don’t have to fight to get in anywhere, they can just ring.” [E:14]

INTERVIEWER: “How [do] you understand social care for deaf children and their families?”

RESPONDENT: “I think the way we’ve done it has been through care management which is quite different from I think the way that historically Sensory Services have

handled social care for children and families. So we would see it much more as being focused on particular tasks rather than necessarily being there throughout and we've ended up being much more looking at, I suppose, applying eligibility criteria. Is this a task this person should be doing or should it be, like if it was benefits for the family, should it be passed on to an agency that deals with benefits? So there has been those changes as well, just to enable overall waiting lists etc to be dealt with." [B:6]

One senior manager developed the issue further by suggesting that social work that was worked with deaf children and families from a strictly case management perspective could also have the effect of preventing families from accessing social care services when they did require them. Firstly, it was because there was no long term relationship established with social care that would enable families to be knowledgeable about what social care could offer that would encourage confident contact with them; and secondly because the means of contact (referral for a specific issue at a specific time through a central contact centre) could prove in itself a considerable barrier²⁹:

"For me, our failure to work well with disabled children and their families has part of its root in our obsession about caseload management and a complete misunderstanding for the community development perspective...[my first job] came with a clear understanding that everybody's who's in the filing cabinet in the corner was my responsibility. Whether they were open, closed or open to review. If the phone rang and somebody said there's a problem, you'd say, oh I'll pop on the way home, put the kettle on. Our social work culture has become rather divorced from a responsive position...structurally we now have Contact Centres, so once you become a 'closed person', to get back in you're gonna have to climb the wall again. We haven't provided you a door and we most certainly haven't provided you with a key." [B:4]

In a sense this is an old argument that is not particular to social work with deaf children and families. On the one hand a community work approach where intermittent contact and open accessibility are the norm is able to be reactive and pro-active in anticipating and meeting a vast range of needs because there does not have to be a defined problem or issue to trigger a referral. Social workers and social care are simply part of the landscape of Children's Services whether they are at any point active or not. On the other hand, an approach that diverts from long term social work involvement is seen to be less stigmatising; children and families do not need to become social work clients in order to access services; social work is not, nor should be the sole provider of the full range of services that might be required; in a system of limited resources, diversion away from social work provision enables a transparent rationalisation of priority areas of activity.

In the case of our subject matter, these arguments are played out in the differing emphases given to whether social model approaches are or should be distinguishing features of social work activity with deaf children and families. In rather stark terms, what we found was that in those Sites where a working specialist deaf children and families

²⁹ Issues concerning processes of referral for families are discussed in greater depth in Chapter 8

team (or specialist team arrangement) had been established then a social model informed approach to support and intervention over the varying stages of childhood was given a priority. This was most evident in the preventative kind of initiatives that were being developed from within a community base that could be accessed by children and families (in contrast and in addition to a more individual orientated approach to support and intervention).

In those Sites where no such specialist structures existed, then there was considerably less scope for social work activities that promoted the social development and social well being of deaf children and their families in a general sense, outside of case management structures where, as we have recorded, the criteria for becoming a 'case' was set so high that few families with deaf children would meet it. We should say, however, that one respondent in Site A would certainly disagree with this analysis in that from his perspective the city-wide multidisciplinary Child Health and Disability Service was specifically set up to plug this kind of gap. However, the extent to which this service was, at that time, actually engaging deaf children and families was very limited.

9.2.4 The preventative perspective

In considering what might constitute a distinguishing praxis amongst specialist social workers with deaf children and families, the preventative orientation was a key feature. As previously illustrated an emphasis on preventative work featured strongly among respondents who worked directly with deaf children and families. It was less a feature of those senior managers we interviewed who had little or no contact with deaf services (rather than disability services, or children and families services more generically). We suggest this dichotomy might arise as a result of the extent to which those we interviewed understood deafness as a developmental issue rather than as impairment. Seen from a developmental perspective, deafness is readily understood as either potential interference in usually expected trajectories of development; and/or as constituting a different kind of trajectory of development. As such anticipating needs from a psychosocial developmental perspective and the avoidance of the consequences of not meeting those appropriately becomes a crucial issue.

Many of the practitioners we interviewed who had direct experience of working with deaf children and young people, firmly linked a preventative orientation in their work, with issues of communication – particularly in the family. They spoke at length about the importance of anticipating, recognising and intervening in situations where communication in the family was not optimal for deaf children. They did this both as a means of support to parents and parenting but also firmly as a means of helping avoid later behavioural and more serious mental health difficulties that deaf young adults may experience.

“the signing project came through the Carers Grant. [it] provides communication support within the family home...if we go out an assess families and then we realise there's perhaps a need here for communication support...we match families to a tutor, a trained BSL, Sign Supported English or Makaton tutor and we match the tutor with the family, provide additional resources such as DVDs, BSL books,

toys ...then what the tutor does is give the family two hours a week all at the family's pace of communication sessions and that then supports within the family unit...I think it's brilliant. It's lovely to know there is a service out there and it's also preventative because the preventative areas is to support for them not to go into disruptive behaviour to understand that communication difficulties can lead to disruptive behaviours, frustration, lashing out just because you're not getting yourself heard. And this way its' child focused as well and family focused at the same time" [C:8]

Also preventative intervention was identified as being required to assist deaf children to develop a range of psychosocial skills that were more difficult to achieve in contexts of reduced communicative input (whether in the family or outside of it).

"if you get the early intervention right and deaf children learning social skills, coping strategies...emotional maturity, then you may in the long terms start reducing some of the issues where there are parenting issues...I'm still convinced that if people would give them strategies and support techniques at an earlier stage, there could be less need for crisis intervention in mental health work. It wouldn't necessarily stop all, it wouldn't stop all need for mental health intervention, but I'm still convinced that there needs to be more careful input an and earlier stage" [C:7]

The link between preventative work to promote better intra familial communication and better psychosocial development for deaf children, and thus avoid later mental health difficulties, was firmly placed within a safeguarding agenda.

"But there is a much broader picture also around safeguarding, so for example, deaf children who haven't been helped to communicate, who become very frustrated because they can't communicate, whose behaviour therefore becomes challenging and because of their challenging behaviour they many need people to intervene with them in some way. That can be a very frightening experience...there is that broader sense of safeguarding about how you can proactively and preventatively prevent children getting into those difficulties." [C:9]

In this respect, the new emphases of Every Child Matters (2003a) were useful (<http://www.everychildmatters.gov.uk>). Wellbeing throughout childhood and the achievement of the 5³⁰ universal outcomes could be firmly linked to supporting optimal communication within the context of the family (and other socio-developmental contexts) – thus safeguarding in the sense not only of preventing current distress and avoiding future harm, but also in the sense of intervening and supporting to ensure the normal range of child outcomes that are applicable to every child³¹. In Site D, where a specialist

³⁰ The 5 universal outcomes are defined as: stay safe; be healthy, enjoy and achieve, make a positive contribution and achieve economic well being.

³¹ As we have argued elsewhere (Young et al, 2008), one of the key strengths of the Every Child Matters Agenda is that it conceptualises desirable outcomes for deaf children (and disabled children) within universal, normative expectations rather than such outcomes as being conceptualised in separate terms

deaf child and family team had been created, this strong association of safeguarding with optimal communication development for deaf children and families was being further reinforced by the intended future structural positioning of the service within Children's Trusts:

“...we've got Children's Trusts somewhere out there forming, but as I understand it as this time, we're going to be part of the safeguarding social care part. So therefore, you know, for me safeguarding is a very wide agenda, so it can be crisis intervention, working with children protection, but it's also about that preventative thing because it's about Every Child Matters and that agenda is actually supporting us quite nicely in the fact that we can implement safeguarding so that things do not develop in the future.” [D:11]

However, as we emphasised at the beginning of this section, this preventative orientation being linked firmly with a safeguarding agenda in the context of deaf children tended only to be self evident to those we interviewed with direct experience of deafness/deaf children and families. Those strategic and indeed operational level managers whose experience was more generic or disability focused, did not make the link in the same way. For example:

INTERVIEWER: “...would safeguarding to you include mental health issues, preventative stuff around mental health issues...?”

RESPONDENT: “Personally, I wouldn't put that under the safeguarding umbrella, neither would I put it under at social care umbrella, but I would argue that would come under a health umbrella...through their GP or through health services that are inside the school.” [B:5]

Also, there is a strongly paradoxical element to the 'preventative orientation-communication enhancing-safeguarding agenda' we have identified. As the previous discussion on eligibility criteria [Chapter 0] has demonstrated, the prevention of children being received into care is a fundamental driver in the identification of those children most at risk and the appropriate allocation of support and preventative services. Yet as many of our respondents pointed out, the identification of risk to well being (or more serious indicators of potential harm) was not easily recognised by those teams without any specialist deaf-related knowledge. Therefore preventative safeguarding work with deaf children and families was not generally a priority in those Sites where there was no dedicated deaf children and families team/service arrangement, because the structure of the system of service delivery had no way to recognise it as an element of safeguarding. It was only in those Sites where Children's Services arrangements had enabled a specialist team/service arrangement to exist that it was possible for true preventative work to occur and thus to contribute ultimately to the avoidance of the more serious aspects of child protection and mental ill health. This paradox was not lost on those of our respondents who were specialist deaf-related social workers, but who found

(notwithstanding the fact that the pathways to such common outcomes may rightly be different for deaf children).

themselves in Adult Services with but tenuous and by no means routine involvement with deaf children and families.

“I think if the issue is deafness and the family is having problems, the young person is having difficulties. I think in the longer term, for us to get involved early, pick thing up early, work jointly together, in the longer term it would reduce the amount of resource s we might have to put into place for when family get into crisis and young people get into crisis.” [E:16]

9.2.5 Something missing?

Finally, in research terms, it is always difficult to report on something that is not positively evidenced in the data but the fact that it is missing is worth remarking upon. We do so here drawing on the knowledge of two of the researchers who have both been practising social workers in the field of deafness and who have been involved in previous research associated with social work in the context of deafness. From our perspectives there was one notably missing element that we might have expected to see in any discussion of what distinguishes social work perspective and practice in the field of deaf children and family. That element is the assertion that social workers are the ones who are most likely to bring knowledge of sign language and the Deaf community to the families they work with. The tradition of social work in deafness grew strongly out of working with the Deaf community. There are many qualified social workers who are Deaf themselves and this has been the case for many years, unlike in other sister professions. Social workers, in previous research have been identified by other professionals as the ‘signing lobby’ with concerns frequently raised by other professionals that social workers are likely to emphasise sign language with families thus fuelling controversy and potential distress – (not an interpretation the social workers in the research themselves necessarily agree with) (Young et al, 2004; Young et al, 2005).

In our data it is not that the practitioner-respondents did not talk about Deafness in a cultural sense, nor that they did not routinely refer to Sign Language based activities or interventions as part of their work. What was of note was that they did not lay claim to this knowledge and skill base as a distinguishing feature of them as specialist social workers; nor as distinguishing themselves and their contribution from other practitioners with differing professional backgrounds. We suggest there are several reasons for this.

Firstly, from the point of view of those respondents who worked directly with deaf children and families the fact they signed or Sign Language related services fell within the repertoire of what they could offer, was just taken as read. It is part of who they were and what they did. In other words there was no self perception of it as being special or exceptional. However, for those respondents we interviewed who were at one remove from direct practice, signing and Deafness in a cultural sense was largely not on their radar (with two notable exceptions).

Secondly, this research project has focused on social work practitioners and managers within Children’s Services. It has not focused on practitioners within Children's Services who have other professional backgrounds and who may be involved in the planning and

delivery of services to deaf children³². Therefore not only do we not have contrasting data from differing professional perspectives, the social workers who were our respondents knew they were talking to other social workers (as researchers). Both conditions make it less likely for respondents or researchers to identify what is regarded as a 'normal' feature of practice as a distinguishing feature of difference (if indeed it is).

Thirdly, it may be the case that Children's Services teams are so integrated from a multi professional point of view that differences in emphases between professional groups is not a matter of interest because they are legitimate and taken as whole it is these distinguishing differences that make up a full package for service users. However, given what we have evidenced about the stage of integration these Sites were at (Chapter 8) we do not think this is likely, with the possible exception of Site C where there was strong team working at a practice level between education and social work personnel.

9.3 Summary

- 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) The second key distinguishing feature was a concern with particular values and principles that guided assessment, intervention and the definition of desirable outcomes. Social work with deaf children and their families could not be

³² With the exception of one teacher of the deaf who was interviewed at one Site and one team manager who has considerable experience within social work but was originally trained within a different professional discipline.

- described in terms of roles and tasks without a clear understanding of how these were influenced and enacted within the social work values framework.
- vi) 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.
 - vii) 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.
 - viii) For respondents who had no direct experience of working with deaf children and their families (largely in strategic management roles) the influence of core social work values and principles was differently interpreted in relation to this service user group. Namely, the promotion of inclusion was largely understood to mean the inclusion of deaf children and families' needs in mainstream disability service provision, rather than seeking any kind of distinguishing practice/service. However, one senior management respondent did express concerns that policies and practices that actively sought the avoidance of social exclusion could too easily become a means of actually ignoring the extent and complexity of what it would mean truly to promote inclusion for disabled and deaf children.
 - ix) The social model as a fundamental approach to working with deaf children and their families was also identified as a core distinguishing feature. It was a focus/way of thinking about needs that generated a different core emphasis in comparison with other professionals involved and led to a range of service development and provisions for deaf children/young people/families that promoted in broad terms their psychosocial development. It also underpinned the holistic approach to family assessment and definitions of needs and strengths.
 - x) 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.
 - xi) A strongly preventative perspective was also fundamentally distinguishing of specialist social work practice with deaf children and their families. It was firmly linked with promoting optimal communication for deaf children within their families and the provision of experiences to enable social development and enhance well being through childhood. As such, this preventative perspective linked with language and social experience was strongly associated with a safeguarding agenda for deaf children – both in terms of enabling optimal development through childhood and in terms of the avoidance of behavioural and mental health problems later.

- xii) However, the clear safeguarding role identified by practitioners with experience of deaf children and families was somewhat paradoxical. In those Sites where there had been no strategic investment in specialist social care services for this user group, high thresholds for service involvement and the lack of specialist practitioners effectively denied the identification of need and provision of preventative support. At the same time in these Authorities, the prioritisation of resources (linked to eligibility criteria) was firmly argued in terms of pursuing a safeguarding agenda that sought to divert children from the necessity of reception into care.

10. Conclusions

From our in-depth structured case studies of 5 Local Authority 'Sites' in England, chosen for their likely diversity in service arrangements, our detailed research has enabled us to draw the following overall conclusions. [These in turn will be further tested for their applicability on a national basis in phase 2 of this research.]

Notwithstanding the good practice that we did find, there is clear cause to be concerned about the quality, availability, responsiveness and appropriateness of social care services for deaf children and families.

The separation of Adult and Children's Services strongly tends to work to the detriment of social care provision and practice for deaf children and their families, unless specific investment is made in a specialist team/team arrangements for social care with deaf children and families within Children's Services integrated structures.

Without such specialist team/team arrangements being made, then there is strong evidence that the new structures of children's social care services actually militate against the identification of needs, the appropriate provision of services by suitably skilled and knowledgeable practitioners and effective joint working practices with deafness-related colleagues in education and health services.

Eligibility criteria, high thresholds for service provision, the location of deaf-specialist skilled social care workers only within Adult Services structures, assumptions that other professional groups can/should be responsible for the social care elements of a deaf child/family's needs, the subsuming of deaf children's needs totally under the local policies and provisions for disabled children, all work in effect to divert families with deaf children away from social care services.

In circumstances of little/no investment in specialist social care provision for deaf children and families a self fulfilling prophecy is created whereby little or no demand for social care services emerges from families/deaf young people, thus reinforcing the apparent lack of need and redundancy of role.

Deaf children are largely invisible on the social care radar (unless there have been significant individual champions in Authorities who have fought for their needs to be recognised and services to be maintained/developed). This invisibility is evident in local children's policy/planning documents and reinforced in the ways in which the structuring of services actually militates against needs being recognised. Where there is no specialist children's service/service arrangement, then being deaf is patently not sufficient to trigger any kind of social care response. Social care involvement is only triggered when the deaf child/young person/family has a problem that is identifiably complex or serious by other criteria, the seriousness of which is more readily identifiable (e.g. serious mental health difficulties, child protection).

Only in those situations where there had been positive investment in specialist deaf children and families social care services/service arrangements was it possible for the

psychosocial, linguistic and cultural complexities of deaf children's developmental and social needs to be recognised and responded to in a proactive and preventative manner that was entirely coherent with an understanding of safeguarding in its broadest sense and in a manner consistent with the promotion of deaf children's wellbeing, in the now legal definition of that wellbeing.

The invisibility of deaf children is further reinforced by the fact that in Local Authority terms they are relatively 'cheap' – that is to say they do not generally cause a significant strain on local financial resources that might bring their needs to attention in the way in which some disabled children might.

We found evidence of planning for social care children's services based firmly on assumptions of deafness as impairment i.e. a bio-physiological problem that can prevent optimal functioning but that can be adequately remediated through, for example, the provision of hearing aids. Thus resource allocation decisions were made in terms of severity of impairment in comparison with the full spectrum of disabled children. By this yardstick deaf children's needs were rarely regarded as a priority if the comparator was, for example, children with severe physical disabilities, complex learning needs, or life-limiting conditions. A social and/or culturo-linguistic model of deafness that would identify the potential complexity of deaf children's linguistic, and social developmental challenges (and differences), including, for example, the considerable risk of mental ill health in childhood, was in effect missing. Where it was missing, so was the basis for arguing for specialist social care deaf children's services that could operate on a preventative basis and be available to all relevant families. [It was noticeable in those Sites who did have a specialist service/service arrangement that the social model understanding of deafness was one shared by senior strategic managers as much as by front line practitioners].

We are concerned that when the structural organisation of Children's Services has resulted in no specialist provision for deaf children and families and/or the location of specialist knowledge in Adult Services with little effective contact with Children's Services colleagues, then the viability of the service actually to recognise a presenting issue involving a deaf child as serious or warranting further assessment, is markedly compromised. In effect deaf children and families' needs have to escalate to acute proportions before need is recognised and action taken. Equally we found evidence that the involvement of a social worker/social care professional at a much earlier stage who has deaf-related expertise could more readily identify the complexity of a child/family situation, provide a comprehensive assessment of strengths and needs and intervene preventatively, supportively and pro-actively to prevent escalation of seriousness.

In those Sites without a specialist deaf children and families social care service/service arrangement, we were seriously concerned by the lack of clarity about the relevant referral route(s) and subsequent pathways of provision for parents of deaf children (or other professionals) seeking social care involvement. We found examples of strategic managers whose remit theoretically included deaf children and families who were unaware of where any specialist expertise in their own Authority might reside; contact

centres who did not know where to send us when we enquired about services for deaf children and families; teams who were unsure of whether their remit should or could include the provision of services to deaf children and families; representatives of services who were clear that their remit should or could include the provision of services to deaf children and their families but who could not provide us with examples of when it had; and local operational guidance that formally assumed that deaf children and families' social care needs would be met in their entirety by education/health services personnel, thus obviating the need for a social care response except in extreme cases such as child protection. Indeed one of the by products of this research, as some respondents told us, was they had actually thought for the first time about pathways of provision for this service user group. We were also able to introduce relevant personnel within some Authorities to each other for the first time to discuss deaf children and families' social care services.

We encountered several situations in Authorities where the division of Adult and Children's Services had left social workers/social care staff with deaf relevant expertise without any remit, resource, authority, or practical means of working with deaf children and their families – even in situations where the equivalent expertise within Children's Services was not established. We would like to draw attention to these dedicated individuals who nonetheless sought all manner of ways and means to respond to deaf children and their families when they sought out a service and who were, in several cases, tirelessly seeking ways to formalise their involvement and the use of their expertise in cases involving deaf children and families within the structuring of Children's Services within their Authorities.

Respondents who had deaf related service experience were quite clear about the case for distinctive social work practice with deaf children and families and the arguments for specialist deaf children and families social workers/social care staff. Beyond the specification of particular duties, roles, responsibilities and tasks, arguments were made for the influence of social work values on how actions are undertaken and the prioritisation of particular processes and outcomes (that sister professionals would be less concerned with); the significance of practice within an holistic family assessment context/orientation; the understanding of deafness from within a social model thus setting the agenda for the identification of need, assessment of strengths/resources, and the shape of appropriate provision. By contrast, respondents who had little or no direct experience of deaf children and families were concerned that any attempt to establish specialist social care provision would in fact be anti-inclusionist.

The existence of specialist deaf children and families social care children's services/service arrangements greatly assisted in the process of joint working with education and in pushing forward the integrated services agenda in this sector. There was still a long way to go in truly co-ordinated, well being promoting, holistic multi-professional services for families with deaf children that included a strong social care element. Nonetheless it was quite clear that the establishing of a specialist social care service/service arrangement greatly facilitated this process. We found no evidence that the reforms in multi agency disabled children's co-ordinated service provision evident in

some of our Sites were actually having a tangible benefit for deaf children and families, or promoting effective joint working with education and health personnel who were specialists in deafness where there was no social care worker within the disabled children's service arrangements who had any deafness related expertise.

In conclusion, we found clear evidence of good practice that was enabling pro-active social care involvement with deaf children and families that was thus extending the range of provision and resource for those families in such a way as to complement that provided by educational and health colleagues. However, these arrangements were exceptional.

We also found clear evidence of the ways in which the structuring of Children's Services, when they have not paid specific attention to deaf children and families, results in poor recognition of need, little resource allocation, inability to work preventatively within a broad understanding of safeguarding, poor joint working with health and education colleagues, 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 and their optimum development.

In these circumstances, and with specific reference to social care, we 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 families in those cases where there has been no investment in specialist deaf children and their families social care services within new Children's Services structures.

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