

Responses to abuse, neglect, and trauma of children with intellectual disability: Experiences of social workers and health practitioners in Aotearoa New Zealand

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ABSTRACT

PURPOSE: Children with intellectual disabilities are three to four times more likely to be abused and neglected than their peers without intellectual disabilities. While the Children's Action Plan and Children's Act (2014) aim to keep children safe and ensure their needs are met, much of the focus still treats children as a homogenous group with limited reference to children with disability. The current research focused on exploring the experiences and perspectives of social workers and health practitioners to abuse, neglect, and trauma among children with intellectual disabilities.

METHODS: In 2020, eight participants were first involved in a focus group to provide a wider perspective of practice and policy issues of abuse, neglect, and trauma among children with intellectual disability. This was followed by a more in-depth exploration and investigation with four experienced social workers to understand the issues and challenges in supporting this cohort of children and to identify what best practices are needed to strengthen service provision.

FINDINGS: Results of the study indicated that, to ensure safety and implement support interventions, practitioners need to be equipped with knowledge about disability and its related needs. Furthermore, to influence positive and transformative change, a strong relational practice with children with intellectual disabilities, their whānau and family is paramount.

CONCLUSION: Practitioners are urged to draw on knowledge and skills, such as relational practice, socio-ecological frameworks, human rights and social justice, and advocacy to develop appropriate assessments and interventions to support children with intellectual disabilities and their wellbeing.

KEYWORDS: Children; intellectual disabilities; abuse; best practice; relational practice

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Child abuse and maltreatment is a substantial problem with wide-ranging negative impacts on health and wellbeing. In Aotearoa New Zealand the definition of child abuse is defined in the Oranga Tamariki Act (1989), Children's and

Young People's Well-being Act (1989): "*child abuse* means the harming (whether physically, emotionally, or sexually), ill-treatment, abuse, neglect, or deprivation of any child or young person" (New Zealand Government, 1989 Section 2). Research

has found that children with intellectual disabilities are three to four times more likely to be abused and neglected than their peers without intellectual disabilities (Jones et al., 2012; Sullivan & Knutson, 2000). Research conducted by Rouland and Vaithianatha (2018) reported that one in four children in Aotearoa New Zealand under the age of 17 years were likely to have had at least one “report of concern” relating to an alleged form of abuse to Oranga Tamariki, of which 10% were substantiated. With the additional estimate of one in 10 children with intellectual disability who have experienced substantiated abuse (Oranga Tamariki, 2020) and looking at data collected between 2015 and 2019 (92,114 tamariki/children), it would suggest that in each of these years there are, on average, 1,845 children with intellectual disabilities who have experienced abuse that come to the attention of child protection services in Aotearoa New Zealand. Given that it has already been noted that children with intellectual disabilities are three to four times more likely to be abused than their peers without intellectual disabilities, it would not be inconceivable to suggest that the prevalence of abuse is much higher for children with intellectual disabilities. Social workers and health practitioners have been criticised for their lack of understanding and ability to assess abuse when working with children with developmental disabilities (Algood et al., 2011). Disability status is often disregarded in the assessment of maltreatment despite it being a contributing factor for maltreatment (Brandon et al., 2011; Cook & Standen, 2002). In the past two decades, research has identified several gaps and inconsistencies in how social workers and health practitioners have responded to abuse, neglect, and trauma of children with intellectual disability (Brandon et al., 2011; Franklin & Smeaton, 2018; Jones et al., 2017). As children and people with disabilities now have longer life expectancy due to advances in medical treatment and better support services, the numbers of children with intellectual disabilities will continue to increase globally, indicating the importance

of enhancing knowledge and skills to support their needs. This article, derived from a Master’s of Social Work thesis, sought to bring an Aotearoa New Zealand perspective to the growing concerns and challenges faced by practitioners working with this cohort of children in response to abuse and trauma, and to establish a deeper understanding of the contributing factors that are needed to improve assessment, intervention, relationship building, and future support.

Previous studies have estimated that children with intellectual disabilities have a significantly higher risk of being victims of abuse, neglect, and trauma. They are more likely to experience multiple incidents of abuse over extended periods of time due to lower socio-economic status and impoverished material circumstances which can exacerbate the stress levels of parents (Algood et al., 2011; De La Sablonniere-Grif et al., 2021; Sullivan & Knutson, 2000). Research has also shown that children with intellectual disability and their whānau and family are often unable to access the necessities of life such as food, heating, affordable/accessible housing, specialist appointments, and the ability to easily access financial entitlements (Wynd, 2015). Some children with intellectual disabilities have had more re-referrals into child protection services than other groups of children in the system due to the additional challenges of parents’ lack of knowledge of child development, lower socio-economic contexts and parents with drug and alcohol issues (Connell et al., 2007; Dakil et al., 2011; Perrigo et al., 2018). In addition, concerns were raised when care assessment was conducted informally based on observations rather than a confirmed diagnosis from a qualified professional; this further complicated reporting and the ability to provide appropriate interventions and support (Perrigo et al., 2018). Broadhurst et al. (2010) argued that some social workers and health practitioners chose to define child abuse from their own understanding, and this created adverse effects on how responses

were made to assessment and service delivery. This can be seen when practitioners see the disability as only a condition, which can prevent them from identifying potential abuse (Cooke & Standen, 2002). For example, some social workers and health practitioners may only connect a behaviour, such as self-soothing by rubbing their genitalia, as part of the condition of the disability instead of looking at underlying reasons for the redness or bruising. This could lead to social workers focusing only on intellectual disability to make a recommendation on “behaviour management” instead of following best practice guidelines to assess for abuse and neglect (Manders & Stoneman, 2009; Ofsted, 2012).

Another concerning assumption is that children with intellectual disabilities are less likely to report being abused (Briggs, 2006; Jones et al., 2017; Lightfoot, 2014). Successful interventions to address child abuse and harm reduction can only be achieved if assessments are conducted properly, systematically, and rigorously (Stalker et al., 2015). For children with intellectual disability, effective interventions create more positive outcomes developmentally, behaviourally, and socially to enhance the child’s wellbeing (National Academies of Sciences, Engineering and Medicine, 2016). Research has found that medical and healthcare professionals are more likely to be successful in identifying abuse when assessments are informed by a multi-disciplinary response and staff receive regular training in child maltreatment, assessment, and interventions (Schertz et al., 2018). Recognising the role of parents in the child’s development is also important and should be supported to enable them to advocate for their child to the best of their ability (The Royal Australasian College of Physicians, 2013). A clear understanding of the wider issues, such as care needs, grief and loss, isolation for parents/caregivers, and disability education for parents, are key practice components in carrying out effective assessments and interventions (Sen & Yurtsever, 2007; Stalker et al., 2015).

Social workers in child protection services, however, have been reported to be ill-equipped to support families and whānau with children with intellectual disabilities, and this is not surprising given that research has indicated that they tend to have limited exposure to knowledge about intellectual disability while in tertiary education (Jones et al., 2012; Manders & Stoneman, 2009; Mogro-Wilson et al., 2014). Despite a growing trend in the tertiary education sector to include disability studies in undergraduate studies (Meekosha & Dowse, 2007), some social work educators reported that specialised training was beyond the scope of what they could offer, and the responsibility should sit with the social workers’ employers (O’Reilly & Dolan, 2017). However, Kim and Sellmaier (2020) have argued that equity and inclusivity in society must be seen in social work education where social work students of all abilities are able to actively participate in programmes and contribute to the ongoing development of the curriculum and wider structures to reflect the diversity of students. Others have emphasised that, when social workers are resourced and have relevant hands-on disability knowledge and experience, they are generally more competent and confident in working with people with disabilities (Haney & Cullen, 2017). Prynallt-Jones et al. (2018) called for attention to the unavailability of disability specific education in the tertiary arena and ongoing professional development once social workers and health practitioners are in practice, instead of relying on parents/caregivers for developing their knowledge of intellectual disability.

Much of the existing research on child welfare and child abuse in Aotearoa New Zealand has reflected a generic focus on children with social and environmental vulnerabilities such as poverty and substance misuse, but with limited reference to children with intellectual disability and their experiences with abuse, neglect, and trauma. Within the neo-liberal political context, it has been argued that the focus is

on “troubled families” in child protection practice, which fails to engage meaningfully and purposefully with whānau and families who are in challenging and vulnerable situations (Hyslop, 2016). As such, the child requires *fixing* to ensure they go onto be a contributing member of society, and the parent is seen as solely responsible for the vulnerability of their child (Featherstone et al., 2014; Wacquant, 2014). Social work scholars have criticised the neo-liberal agenda for forcing social work practice to assume an interventionist approach, focusing on discipline, and punishing the poor, with little thought given to wider influential factors such as poverty (Hyslop, 2009; Keddell, 2017). Relational practice is a crucial social work response to the complex lives that whānau and family lead, in part due to the underlying psychological dynamics that can be present, such as stress, grief, anger, and trauma (Ruch et al., 2018). Kandel and Merrick (2007) have established that whānau and family and their children require consistent support throughout their child’s life by putting appropriate interventions in place, not only in their day-to-day lives but also interventions that are responsive to the changing needs and significant events in education, health, and family systems. When practitioners support parents with education about their child’s disabilities and how to support them, they are more likely to increase their resilience and capacity to bounce back from challenging times (Machalicek et al., 2015).

In Aotearoa New Zealand, a small number of research studies have called for addressing the relationship between child abuse and disability and other lived experiences (Peters & Besley, 2014; Wynd, 2013). There is also some evidence of preventative sexual violence initiatives, but these are at a foundational level and require significant expansion and revision to provide education to children and adults with intellectual disability if they are to be equipped with the knowledge and skills to safeguard themselves against sexual abuse (Moore et al., 2020). Given the limited local research

regarding violence against children with intellectual disability and the infamous position of being rated as having one of the highest rates of child abuse in the OECD, it is critical that further research on this subject be conducted to capture the prevalence in Aotearoa New Zealand and to identify the support and resources that would keep children with intellectual disability safe from harm. In examining how practitioners responded to abuse, neglect, and trauma among children with intellectual disabilities, the current research aimed to explore how they identified disabled children who are at risk of abuse, neglect and trauma, the kind of interventions and strategies used, strengths and challenges in service provision and professional development required to enable better support for this group and their family and whānau.

Methods

Study design

This research was undertaken using a qualitative research approach drawing on the interpretive underpinnings of this methodology (Holloway & Galvin, 2016), which captured the participants’ subjective experiences (Ryan et al., 2007) of responding to abuse, neglect, and trauma of children with intellectual disabilities. This method allowed movement from structured, open-ended questions to “unexpected data” (O’Leary, 2017, p. 240), providing opportunities for the participants to share information that has not been identified in similar research. A focus group was first used to draw on the experiences of participants who had similar professional backgrounds and significant knowledge of the research topic (Patton, 2015; Yin, 2016). The expert knowledge gathered in the focus group interviews was then examined to inform and validate the development of the semi-structured interview template for in-depth, individual interviews. The strength of using the semi-structured, individual interviews was the ability to capture the

participant's thoughts and experiences through a shared conversation between the interviewer and the participant (Hunter Revell, 2013; Ryan et al., 2007).

Study participants

A purposive sampling method was chosen with the intention to recruit participants, social workers, and health practitioners, who had professional experience of working with children with intellectual disabilities who had experienced abuse, neglect, and trauma (D'Cruz & Jones, 2004; O'Leary, 2017). For the focus group interviews, the eligibility criteria to participate involved qualified social workers or other health practitioners who held senior positions in management, policy, or practice leadership and had at least five years' relevant experience in working with children with intellectual disabilities and had supported them with abuse, neglect, and trauma experiences. Recruitment was conducted through emailing study invitations to non-government organisations (NGOs) across the Waikato and Hauraki regions and the first author's professional networks. Two focus groups were conducted. The first one with four participants (three in clinical psychology and one in social work) was conducted in mid-August 2019 while the second group with three participants in clinical psychology, physiotherapy and occupational therapy was organised in late August 2019. One participant, a senior social worker, who could not attend either of the focus groups was keen to be involved; hence, an individual interview was organised. Most of the participants had extensive experience (more than ten years) in the disability field and had worked in a variety of sectors including mental health, education, health, community, and justice. They were all considered to be senior practitioners, and some had their own private practices. All identified themselves as of New Zealand European descent and two were born abroad.

After the completion of the focus groups, individual interviews were commenced;

qualified social workers with at least 3 years' practice experience of supporting children with intellectual disabilities were recruited. The aim was to gain a wider understanding of issues and challenges from front-line social workers who have been supporting this cohort of children and to further investigate what best practices are needed to support and strengthen service provision. Participants were recruited through NGOs in the Waikato area and permission was also sought from Aotearoa New Zealand Association of Social Workers (ANZASW) to circulate an advertisement through their website to invite potential applicants. Four participants were successfully recruited for interviews between September and November 2019, with two of them with lived experience in having a family member with intellectual disability. Among the four participants, two participants were of New Zealand European descent while the other two identified as Māori and Pasifika, respectively.

This research was approved by the Massey University Humans Ethics Committee (SOA 19/18). Before conducting the focus groups or individual interviews, participants were provided with information about the research, the process, and given the assurance of confidentiality over their data. Informed consent, voluntary participation, minimising any potential conflict of interest and secure data storage, were adhered to in the guidelines set by the institution where ethics was approved. Participants were assigned pseudonyms to protect their identity. They all signed the consent forms.

Data collection

The first author facilitated the two face-to-face focus group interviews in neutral spaces in the community and each lasted between 60 and 90 minutes. A focus group schedule was used to ensure transparency of process and the wellbeing of the participants (Barbour, 2007). The protocols included: a welcome, introduction of the facilitator, consent form, a review of the subject and

the valuable role the participants would play in sharing their stories for this study, and what the expectations were of the day, housekeeping—toilets, emergency, and refreshments. The individual interview that was supposed to be part of the focus group was conducted in a mutually agreed venue for 40 minutes. All the interviews were digitally recorded. The individual interview was transcribed verbatim while a summary of key points was written from the two focus groups.

Following a preliminary analysis of the focus groups, a series of four in-depth interviews was conducted. Two participants were interviewed face to face in a mutually agreed place and time while two other participants were interviewed via Skype in the privacy of their own offices. All interviews were digitally recorded and lasted for approximately 90 minutes. All interview transcripts were sent back to the participants for member checking and approval.

Data analysis

The focus group data were initially analysed prior to conducting the individual interviews to ensure the semi-structured interview covered essential aspects to address the research topic. After consulting with the second and third authors, it was deemed appropriate to analyse both the focus group and individual interviews to provide a comprehensive perspective. Thematic analysis was used to generate the key themes (Bryman, 2016). Inductive logic was used to ensure authenticity and ethical practice was maintained throughout the data analysis process (Elliot & Timulak, 2005; O'Leary, 2017). Integration of multi-methods in research has become more prevalent and important to produce better understanding of the experiences of an issue investigated (Moran-Ellis et al., 2006). In the current research, initial quotes and themes from the focus group were placed alongside the individual interviews, followed by a summary of how the two sets of data were connected, converged,

diverged and/or complemented. The first author then assessed all elements of the data from both focus groups and individual interviews (Silverman, 2011). Thus, upon finding a new theme in a transcript, all prior transcripts were re-examined to ensure relevance and consistency. Once the initial inductive process was completed, the data were analysed from a deductive perspective to see if there was any validation of previous research and knowledge. The use of focus groups and individual interviews contributed to triangulation to add "breadth or depth to our analysis" (Fielding & Fielding, 1986, p. 33) to enhance the topic (Fenech Adami & Kiger, 2005). The qualitative research approach provided a framework which captured the subjective experiences of Aotearoa New Zealand social workers and other health practitioners and laid the foundation for the discussion of themes identified.

The motivation for this research came from the first author's professional practice and experience in the disability sector and it was important to acknowledge the first author's background as part of the research instrument and the bias that may affect the study as a result (Morrow, 2005). During the research process, the first author also learnt to be mindful of (and at times suspended) her own insider's view to allow more flexible and fluid development in the research process and analyses to focus on the participants' narratives to speak for the research. To address trustworthiness, the first author engaged in reflective field notes and memo writing after each interview and data analysis was discussed with the second and third authors.

While the use of integration of two sets of data was a strength in the current research to enhance the richness of the issue concerned, this research was limited by the small sample size. Therefore, caution must be applied, as these findings may not be transferable to all other social workers and health practitioners with different social and cultural backgrounds and/or working with Māori,

Pasifika, or other ethnicities. Although the focus of the research was not purposely on Māori, it is important to acknowledge that Māori children (0–14 years) have higher disability rates than other ethnic groups according to the Disability Survey 2013 (Statistics NZ). In addition, Māori /Pasifika children known to Oranga Tamariki are 1.6 times more likely to have an intellectual impairment than other ethnicities known to Oranga Tamariki (Oranga Tamariki–Ministry for Children, 2020). Despite the limitations, this study adds to our understanding of Aotearoa New Zealand social workers and other health practitioners' responses to abuse, neglect, and trauma of children with intellectual disability.

Findings

Two themes that emerged from the data analysis are presented in this article: (1) the intersection of disability knowledge and competence to practise, and (2) the relevance of relational practice.

The intersection of disability knowledge and competence to practise

Identifying children with intellectual disabilities who have experienced trauma, abuse, and neglect is a challenging task. It requires social workers and other professionals to respond to abuse appropriately by drawing on their professional practice, underpinned by knowledge, skills, and bi-cultural Te Tiriti o Waitangi practice. While most participants reported that they learnt from working with this group of children to develop their skills, knowledge, and practice, navigating the nuances of disability and abuse was complex. Jill (a social worker) stated that “we must be willing to engage with people around them who know the child better than we do, and who might be able to provide good information about any changes in the child’s behaviour.” Colleen and Rose (both social workers) identified that communication and child-focused assessment tools were critical for best practice.

Complications can occur when the social worker or health practitioner has limited knowledge of disability, and this was apparent in the accounts of most of the participants. Sarah (a social worker) identified several crucial factors that impeded responsiveness to reports of concern by child protection services. Firstly, she talked about the lack of disability knowledge among social workers, such as limited understanding of intellectual disability to enable them to skilfully write good quality reports that reflected the requirements of support for children with special needs. Secondly, other issues such as lack of support for whānau and family, gaps in service delivery (e.g., respite) and the inability to identify and analyse care and protection concerns clearly and concisely to engage care and protection services have also impacted on timely service provision. Given the lack of knowledge about disability, professionals often had to rely on parents or caregivers to interpret what the child was saying. This meant more time was required to build a relationship with a child with intellectual disability than a neuro-typical child. When the child lacked communication skills or had alternative communication requirements, this made it more difficult to understand and identify potential indicators to assess abuse and its impact on their health and wellbeing.

Many of the participants also indicated that identifying and reporting abuse was not always easy, and it could become very problematic, particularly when there was tension between child protection and community agencies as to whether there was a care and protection issue or a disability issue. Rachel (a social worker) said “I have to work really hard to convince them [statutory care and protection organisation] to take on these cases. They show a lack of understanding and there needs to be an awful lot more education.” Jill (a social worker) shared, “I do know that children with intellectual and physical disabilities are more vulnerable to abuse because they are less likely to have the ability to identify that

they have been abused,” making disclosure and support planning challenging. Even when the incident was proven to be a care and protection issue, some of the participants reported that children with intellectual disability were not removed from the home because their care needs were too high and a suitable placement could not be found despite all their siblings being removed, leaving the most vulnerable child behind. Jane (a clinical psychologist) expressed her frustration and a sense of powerlessness about the lack of clear guidelines to initiate a clear response,

[T]here have been so many times where I have felt that the child has been let down by care and protection, at what stage do I write a more general letter about this child, what can I do as a professional, to elevate or escalate.

Their perceptions of children with intellectual disabilities being vulnerable to abuse, resulting in severe negative impacts, were supported by Jones et al. (2012) who found that abuse, neglect, and trauma did not exclude children with intellectual disability, but that these situations were often not rigorously investigated, disclosed, or discussed. Such inconsistent responses were highlighted by participants as at times their concerns were brushed off because of the problematic nature of having a clear and confirmed identification of abuse among children with intellectual disability (Algood et al., 2011; Ofsted, 2012; Taylor et al., 2015).

Despite the ongoing frustrations reported by many participants due to the lack of clear and consistent responses to address abuse, neglect and trauma experienced by children with intellectual disabilities, participants like Alice and Joanne (both clinical psychologists) expressed a strong sense of duty and responsibility to continue advocating for the rights of these children. Without doing this, they felt that there would be no hope of change at a systemic level locally and/or nationally. Three social work participants, Colleen, Jackie, and Rachel, expressed

strongly that a solid knowledge base and placement opportunities in disability should be included and taught in social work undergraduate studies, moving away from “the medical model to a social model of disability.” Rose (a social worker), however, acknowledged that it was not always possible to cover all fields of practice within the social work curriculum, but social workers should be supported by their employers to attend workshops on disability as part of their professional development. Rose also said that utilising supervision to engage in critical reflection and discussion on how to improve practice when supporting children with intellectual disabilities was paramount “to make it safe for the family, for the person, for the individual”, stating “it comes down to good quality supervision, your training, ongoing development, and you as a person.” It is imperative that social workers and health practitioners do not respond to disclosures of abuse, neglect and trauma with disbelief or inaction to ensure that children with intellectual disabilities are not left in environments which are harmful (Franklin & Smeaton, 2018; Jones et al., 2017; Robinson & Graham, 2019).

Relational practice

To provide effective support to children with intellectual disability who have experienced abuse, neglect, and trauma, it is crucial for social workers and health practitioners to build trusting and respectful relationships with whānau and families. Relational practice was strongly emphasised among participants as one of the major practice approaches to ensure support and interventions are delivered adequately and sensitively to children with intellectual disabilities and their whānau and families. Vital to building successful relationships is the notion of being empathetic and non-judgemental. Pam (a physiotherapist) said, “respecting and hearing both the families and the child’s voice as best you can, and then really hearing what it is they really need from me that is what makes it so successful.” Participants understood the significance of this practice, where

drawing from a participatory, therapeutic, and strengths-based position could not only contribute to trustful and meaningful relationships but also transform practice holistically (Teater, 2014).

Relational practice positioned the social workers and health practitioners in a space where they were able to draw on their disability knowledge and understanding of the wider societal challenges and capture, not only the explicit, but also the implicit experiences of the whānau and families. There was a collective agreement in the first focus group about the value of working with a child and their family from a young age until their teens, giving them an in-depth life-course of knowledge that enabled them to make good decisions. Sarah (a social worker) said, “if a crisis happens you can put it in the context of the family, this is not a crisis for them, this is something they go through regularly.” These parents often struggled with grief and loss that was associated with not having a “normal” child which led them to feel angry, despair, and doubtful of the future for the care of their children. Findings from the study recognised that children with intellectual disability and their whānau and families were more likely to be isolated, marginalised, and discriminated against, making them more vulnerable than other whānau (and family). To minimise this vulnerability, focus should be on how to develop a relational, humanistic, client-centred way of practising where professionals can build connections based on trust and established relationships to support good quality assessments and interventions. Jackie (a social worker) felt that parents did not need to be experts but “if the parent feels more confident in their parenting or has a greater awareness of their child’s needs and understanding of behaviours that are happening, I also see that as a success.” The need for parents to receive education about their child’s intellectual disability was often mentioned. Most participants verbalised the difference it made in the lives of children with intellectual

disability if their parents were proactive and “willing to learn about their children and be realistic” about their child’s abilities and needs, as reported by John (a clinical psychologist).

Relational practice is informed by the context of whānau and family life; therefore, it is critical that social workers and health professionals understand the additional challenges and difficulties experienced by parents/primary caregivers in raising a child with disabilities. Participants acknowledged the challenges and issues in raising a child with intellectual disability, but when combined with financial hardship, inadequate housing, gaps in service delivery, isolation, stigma, and social exclusion, these became more overwhelming for the whole whānau to manage. These additional pressures can also have a negative impact on the parents’ emotional resilience, potentially causing an increase in stress and anxiety and impacting on their ability to meet the needs of their child with intellectual disability (Murray, 2018; Sen & Yurtsever, 2007; Wynd, 2015).

Discussion

The social workers and health professionals who contributed to this research provided rich insights into the responsiveness to abuse, neglect, and trauma of children with intellectual disability in Aotearoa New Zealand. Those insights were supported by a growing body of research focusing on the lack of knowledge, competence, and confidence among social workers in the area of disability and its connection with child maltreatment. Differences in dealing with suspected child abuse and neglect may be due to different cohorts (Maclean et al., 2017; Sullivan & Knutson, 2000), identification approaches (Ben-Arieh & Haj-Yahia, 2006) and organisational settings (Louwers et al., 2012). To ensure that children with intellectual disability receive reliable assessments, collaborative, exemplary, and evidence-based practice in a multi-disciplinary team using a comprehensive “medical interview”, “child interview”,

and “anogenital and sexually transmitted infection tests” to form a pathway to develop a report about alleged abuse, are required (Vrolijk-Bosschaart et al., 2018).

In addition to inconsistent responses and lack of resources to aid diagnoses and assessment, participants also identified a sense of ambivalence among practitioners towards the context of abuse among children with intellectual disability. Social workers and other health practitioners are often seen as performing a delicate balancing act by juggling the demands of the law, upholding the established social relations within the family and whānau, the cultural contexts of the whānau (and family) and the child, and moral responsibility to their professions. The current research has highlighted that identification of abuse and neglect rests upon social workers’ own values and beliefs, and concerns about the potential outcome for the child if reported (e.g., family breakdown) and the persistent assumptions that children with disability do not get abused (Franklin et al., 2015; Kelly & Dowling, 2015; Palusci et al., 2015). Other research has also indicated that professionals such as teachers felt conflicted and lacked confidence to report abuse due to their loyalty to the families they have worked with, supported, and built trusting relationships with (Schols et al., 2013). These studies demonstrated that the process of reporting abuse among children with intellectual disability is not straightforward because of practitioners’ behaviours and assumptions hindering reporting and perpetuating the under-reporting of these situations. As more evidence appears in the literature to indicate that disabled children are more likely to be at risk for child abuse than neurotypical children (Heinonen & Ellonen, 2013), it is vital that practitioners do not respond to disclosures of abuse, neglect and trauma with disbelief or inaction to ensure children with intellectual disabilities are not left in environments that are harmful (Franklin & Smeaton, 2018; Jones et al., 2017; Robinson, 2015; Robinson & Graham, 2019).

Furthermore, the accumulative experience of life events such as family violence and poverty may erode the resilience of a person with intellectual disability more than peers without intellectual disabilities, making it more critical for social workers and health practitioners to understand the impact on wellbeing across their lifespan (Wigham & Emerson, 2015). Participants in the current study highlighted that, when social workers and health practitioners neglect the wider systemic influences, including inaccessibility to social and material resources and poverty (Jones et al., 2017), the trauma experienced by the child is exacerbated (Thomas-Skaf & Jenny, 2020). Kam (2020) has further emphasised that skills such as relational, advocacy, dedication, empowerment, and seeing their role as “not just a job” (p. 781) are crucial in supporting disabled people.

Most of the participants reported that they developed their knowledge and competence in working with children with intellectual disabilities and their whānau and this “learn on the job” experience was consistent with existing literature (Jones et al., 2012; Manders & Stoneman, 2009). The consequences of a lack of disability knowledge can impact on social workers and health practitioners’ abilities to provide adequate or even optimal care for this cohort of vulnerable children. Participants in the current research expressed concerns of some practitioners’ inability to recognise the results of abuse from behavioural changes over disability and have prompted the call for including disability as one of the main fields of practice in their profession’s qualification and training. This was observed in the growing body of literature, which showed positive outcomes for social workers who felt more confidence in working with the disability community when they acquired disability knowledge in their undergraduate study (Meekosha & Dowse, 2007; Mogro-Wilson et al., 2014). Although there has been progress in developing and including disability in the teaching curriculum, John and Schrandt (2019) identified that some social work

students struggled to identify the difference between intellectual disability and mental health. As such, there is a significant way to go in equipping new graduate social workers to work competently and confidently with children who have an intellectual disability.

What has been identified in the literature is that social workers and health practitioners could inadvertently or intentionally perpetuate the societal perceptions of what disability means due to the generationally and historically entrenched medical model of benevolence, treatment, and management (Geoffrey, 2014; Meekosha & Dowse, 2007). The social model of disability provides an opportunity for social workers and health practitioners to, not only challenge their own perceptions and prejudices about disability (Flynn, 2020), but to also move beyond individual and victim blaming models to develop new and transformative ways of practice (Munford & Bennie, 2015). These practices should focus on enabling more time to build relationships, develop purposeful assessment tools and enhance social workers and health practitioners as champions for equity and equality to address deficits and barriers in the social and physical environment and in social policy. Supporting children with intellectual disability to live in a safe and nurturing environment and recognised as valued members of society are all important elements to ensure that their citizenship and rights are respected. In doing so, when a child with intellectual disability requires therapeutic interventions—just like their peers without intellectual disabilities—in response to abuse, neglect, and trauma, there should be no societal and structural barrier of prejudice impeding them from accessing a counsellor or psychologist (Adams & Leshone, 2016; Bigby & Frawley, 2010).

Building relationships with children with intellectual disabilities is key to safeguarding them from abuse, neglect, and trauma. It was identified by several of the participants that there have been limited therapeutic

interventions for these children due to the misconception of their cognitive inability to experience trauma and to actively participate in the therapeutic process. Findings in recent research evidence have challenged this notion by showing that indicators of post-traumatic stress disorder were no different in children with intellectual disability or without (Mevisen et al., 2016). Results have shown that therapeutic interventions using different methods of engagement such as eye movement desensitisation and reprocessing and play therapy, can have positive results in supporting children with disabilities, enabling them to strengthen their coping skills and resilience (Mevisen et al., 2016; Mora et al., 2018). To work successfully and supportively with children with disability and their whānau and family, findings in the current study have confirmed that it requires social workers and health practitioners to draw on their widely used professional skills and professional principles. These include anti-oppressive and rights-based approaches, adherence to ethical and moral obligations, advocacy and working in partnership to build trustful and respectful relationships as reflected in social work and health practitioners' professional codes of ethics (ANZASW, 2013; Occupational Therapy Board of New Zealand, 2015; Physiotherapy Board of New Zealand, n.d; Psychologists Board, 2012).

One of the major key concerns expressed by the participants was the lack of consistency in recognising, assessing, and responding to the initial allegation of abuse of children with intellectual disability within the community and within the child protection triaging system. This requires practitioners to practise confidently and competently. A possible solution could be the introduction of multi-disciplinary approaches with comprehensive and wide-ranging professional knowledge of children with intellectual disability and their experiences of abuse, neglect, and trauma (Vrolijk-Bosschaert et al., 2018). To do this well, this may also require social work education to focus on learning the

importance of applying a social model of disability across the life span to reduce the discrepancy of seeing disability as separate from human development and to promote inclusivity and relational practice.

Services and support to children and young people with intellectual disability are increasingly being impacted by neo-liberal agendas of cost-cutting, high turnover of social workers and health practitioners and support workers, individual contracts, and individual responsibility, which has made services and support more precarious (Carey et al., 2018). Participants in the current study recognised that, to mitigate risks and abuse among children with intellectual disability and their whānau and families, social and transformative changes are also required at a macro level. A recent report published by Waikato District Health Board (WDHB, 2019) in the New Zealand “Disability Responsive Plan” developed in partnership with people with disabilities highlighted the need to address accessibility barriers such as transportation, diagnostic assessments and interventions occurring in a timely manner and the removal of financial obstacles for those under 15 with disabilities. Social change requires collective responsibility to be responsive to the specific needs of children with disability and to maintain their dignity (Munford & Bennie, 2015; Thomas-Skaf & Jenny, 2020).

This research argued for the integration of trauma-informed frameworks into social services in relation to organisations’ policies, procedures, and vision statements, and regular trauma training with the intent of providing therapeutic support and minimising re-traumatisation (Fuld, 2018; Harvey, 2012; Munford & Bennie, 2015; Thomas-Skaf & Jenny, 2020). It has also been identified in the New Zealand Disability Strategy 2016-2026 (Office for Disability Issues, 2016) that one of the eight outcomes is specifically related to health and wellbeing, recognising that there is much work to be done to bridge the gap between policy

and practice to address inclusive service delivery and outcomes for people with disabilities. The importance of social workers having the knowledge and understanding of intellectual disability and its related discourses will enable them to practise from a social, relational, rights-based model by developing better socio-political and cultural understandings of childhood disability, mental health, and illness (Munford & Bennie, 2015).

Conclusion

Overall, this research has provided an opportunity to gain a better understanding of social workers and health practitioners’ experiences in supporting children with intellectual disability and their whānau and families. Their dedication and desire to make a difference in practice is admirable and provides important insights into moving forward to address abuse, neglect, and trauma of children with intellectual disability. The disability field is a unique field of practice that requires practitioners to be equipped with disability knowledge, competent practice skills and the ability to build respectful and sustainable relationships with children with intellectual disability and their whānau and families. To achieve this, social workers and health practitioners need to engage in critically reflective practice that enables them to establish trusting relationships and provide meaningful support to children and their whānau and families. This relational practice will be supported by an inclusive community, which values the experiences and contribution of children with intellectual disability and their whānau and families. Success will be evidenced when this group of children’s wellbeing is treated with the same respect and dignity as their peers without intellectual disabilities, enabling them to live in safe and nurturing environments where they are free from abuse, neglect, and trauma.

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