Development and Piloting of a Children's Disability Toolkit

SCOTTISH CHILDREN'S REPORTER ADMINISTRATION

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Contents

1. Acknowledgements

This research is an exploratory piece of work that was undertaken through consultation with the Disabled Children Child Protection Network. The authors wish to thank the Network Chair, Robert Fraser, and the rest of the group for their guidance and support.

2. Author contributions

Catherine Nixon was involved in the design and conception of the disability toolkit, extracted the data used from SCRA casefiles, undertook the statistical analysis and helped to draft the report for publication.

Sarah McGarrol facilitated the initial consultation work with the Disabled Children Child Protection Network, was involved in the design and conception of the disability toolkit, extracted the data used from SCRA casefiles and helped draft the report for publication.

Gillian Henderson facilitated the initial consultation work with the Disabled Children Child Protection Network, was involved in the design and conception of the disability toolkit, extracted the data used from SCRA casefiles and provided feedback on the draft report.

Indiya Kurlus was involved in the design and conception of the disability toolkit and provided feedback on the draft report.

3. Executive Summary

The Scottish Children's Reporter Administration (SCRA) was approached by the Disabled Children Child Protection Network (DCCPN) to develop and pilot a toolkit that would: 1) allow for the identification of additional needs that could have substantial and long term impacts upon a child's ability to carry out normal day to day activities; 2) provide an indicator of wider vulnerability and contextual factors that were pertinent to understanding child protection risk.

The developed toolkit included measures of: adverse experiences in the perinatal period and early infancy; childhood trauma; socioeconomic circumstances; social isolation and victimisation; ability to participate in education and social activities; common childhood disabilities and illness; and functioning across a range of 'normal' activities such as emotional regulation, peer interactions and difficulties with routine day-to-day activities such as self-care. The toolkit is included for reference at the end of this summary, with more detailed instructions for completion included in Appendix 2.

To pilot the toolkit, we examined the case files of 40 children who had been subject to Compulsory Supervision Orders (CSOs) with residential care conditions when they were aged 5-12. Half of the sample (n=20) had been recorded as having a disability within casefiles, while the remainder were not identified as having a disability. Data was systematically collated from statutory documentation and reports (e.g. those from social work, police, education, health, Safeguarders etc.) held by SCRA. Data were collected from birth through to 24 months after entry into residential care.

Our analyses indicated that the toolkit could robustly identify children who had been previously identified as having a disability, as well as recognising children who may have an undiagnosed disability, or be experiencing difficulties across a number of functioning domains. For instance, the toolkit identified that 39 of the 40 children in our sample had at least two areas of functioning where they experienced difficulties, despite only 20 of the

children having previously been identified as disabled. The number of functioning domains where children experienced difficulties was greater for those previously identified as disabled (6.9 [range 3-10] deficits] than those who had not previously been identified as disabled (4.3 [range 0-7[deficits). Our analysis indicates that this difference is explained by those who were identified as disabled having received a diagnosis for their condition, in addition to experiencing the wider socioemotional, mental health and physical health difficulties observed for both groups.

Our data collection indicates that collecting information on the wider vulnerabilities and contextual factors of children's lives is useful in identifying potential child protection concerns, as well as understanding differences in the probable predictors of disability among children. For instance, our analysis indicated that there was no significant different in the number of ACES experienced both by young people who had, and who had not been identified as disabled. There was also no difference in any of the contextual factors measured for this group; reflecting perhaps the high levels of social exclusion in the children's family backgrounds.

The higher levels of sexual abuse, parental death and parental abandonment present within the histories of children not previously identified as disabled, raises the question as to what extent trauma was the driver underscoring the difficulties experienced. And, if that is the case, should trauma-induced changes in functioning be classified as a disability in order to promote greater recognition of rights among this group?

Although the toolkit has been demonstrated to robustly identify children experiencing difficulties with functioning across a range of domains, further work needs to be undertaken to test the effectiveness of the tool among children in less marginalised populations. Work is also required to assess whether it is possible to create normative scores to aide practitioners to quickly and accurately identify where children may require additional supports.

3.1 The Disability Toolkit

Contextual Factors	Scoring
Child has 1+ parent who has experienced homelessness or housing insecurity	1
Child has 1+ parent where concerns are regularly expressed about the cleanliness, suitability and/or safety of their home	1
Child experienced socioeconomic disadvantage	1
Child is a victim of bullying	1
Child does not have a trusted adult or other individual considered to be important to them	1
Child is not coping educationally	1
Chid has poor school attendance or regularly refuses to attend school	1
Child has been temporarily or permanently excluded from education	1
Child receives special educational provisions and/or has an individual learning plan or additional statement of needs	1
Child does not participate in extracurricular activities	1
Child has been a victim of and/or witnessed violence in the community	1
Total Score	**11**

Vulnerability Factors	Scoring
Evidence of withdrawal from alcohol or drugs at birth and/or suspected neonatal abstinence or foetal alcohol syndrome	1
Child born before 37 weeks gestation	1
Child weighed less that 2500g or 5lbs 8oz at birth	1
Child admitted to neonatal ICU at birth or during first year of life	1
Child experiencing growth retardation or failure to thrive	1
Child has a history of being either physically abused or neglected	1
Child has a history of being either emotionally abused or neglected	1
Child has a history of being sexually abused	1
Child is exposed or potentially exposed to interpersonal violence	1
Child has 1+ parents with a history of misusing drugs and/or alcohol	1
Child has 1+ parents with a history of mental health difficulties	1
Child has 1+ parents with a history of learning difficulties	1
Child has 1+ parents with a history of physical ill-health	1
Child has experienced their parents separating or divorcing	1
Child has experienced 1+ parent being imprisoned	1
Child has experienced a significant bereavement	1
Child has been abandoned or disowned by 1+ parents	1
Total Score	**17**

Functioning	Scoring
Child has an identified or suspected learning disability	5
Child has been identified as dyslexic or is being/has been referred for dyslexia assessment	5
Child has an identified or suspected visual impairment/delay	5
Child has an identified or suspected hearing impairment/delay	5
Child has an identified or suspected physical or motor impairment/delay	5
Child has an identified or suspected language or speech disorder/delay	5
Child has been identified or is suspected of being on the autistic spectrum	5
Child has been identified or is suspected of having ADD/ADHD	5
Child has been identified or is suspected of having socioemotional and behavioural difficulties	5
Child has an identified or suspected long-term/chronic/life-limiting physical health condition	5
Child has difficulty managing age-appropriate levels of self care	5
Child has difficulty concentrating on work, play and other activities	5
Child has difficulty making and sustaining friendships	5
Child experiences anxiety or social anxiety	5
Child experiences low mood	5
Child has self-harmed or expressed suicidal thoughts	5
Child has an identified or suspected mental health concern	5
Total Score	**85**

4. Project brief

The Scottish Children's Reporter Administration (SCRA) was approached by the Chair of the Disabled Children Child Protection Network (DCCPN) to explore how to collect data regarding safeguarding concerns for disabled children. The remit for this work was based upon acknowledgement by the DCCPN that current data published around child disability in Scotland is often inconsistent and reports lower levels of concern based upon practice knowledge. As such, the DCCPN requested the support of SCRA to explore whether a new or improved data collection model could provide more consistent and informative information about the functioning of children. In particular, the DCCPN noted the importance of developing a tool that would allow for the identification of additional needs that could have substantial and long term impacts upon a child's ability to carry out normal day to day activities, irrespective of whether or not that child had received a formal diagnosis. They also felt that it was important that the toolkit be capable of identifying additional safeguarding needs beyond the child's disability. As no funding existed for the project, SCRA agreed to undertake this piece of research on a pro bono basis, as the aims were complementary to our own organisational objective of: recording accurate and relevant information about the individual support needs of children in the Children's Hearings System in order to ensure we provide a sensitive-needs based service.[1]

This document describes the development of a toolkit by SCRA that can be used to assess both the adverse living circumstances of children (i.e. vulnerabilities such as adverse events across the perinatal, infancy and childhood period, and contextual factors such as social deprivation and wider social exclusion), and their functioning across a number of domains. It also describes how we tested the toolkit using statutory data on children held by SCRA, and presents results on the feasibility of the toolkit to: 1) accurately identify those children who

[1] Scottish Children's Reporter Administration (2021). Equality, Diversity and Inclusion Mainstreaming Report 2020/21, p12. Available at: SCRA-Equalities-and-Inclusion-Mainstreaming-Report-2020-21.pdf (last accessed 12/5/21).

have been previously identified within statutory held records as having a known disability; 2) identify children who have not been identified as disabled within statutory held records but have evidence of additional needs that could result in their meeting the criteria for having a disability, or being considered differently abled from other children.

5. Background

5.1 Definitions of disability and the importance of recording who has disabilities

The current UN Convention definition of people with disabilities states that "persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."[2]

There are multiple definitions of disability that have changed over time, reflecting both the dynamic nature of disability and its complexity, with dominant definitions being linked to changing 'models' of disability. In particular, the dominant models of disability include the medical model of disability, the social model of disability and more recently, the biopsychosocial model of disability.

The WHO has produced an International Classification of Functioning, Disability and Health (ICF)[3] considering and describing both functioning and disability "as the outcome of a complex, multidimensional interaction between a person's health condition(s) and context, environmental and personal factors" stating that positive or neutral aspects of those interactions are referred to as functioning; negative aspects as disability. Disability can be

[2] United Nations (2006), "United Nations Convention on the Rights of Persons with Disabilities". New York: United Nations General Assembly. Available at: https://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf Last accessed May 12th 2021.
[3] World Health Organization (2001), "ICF: International classification of functioning, disability and health". Geneva: World Health Organization.

described as arising out of limitations on activity and restrictions on participation that are determined by the interaction between bodily functioning, structural impairments, and an unhelpful context. Of note, the ICF does not describe disability exclusively from the viewpoint of health professionals, instead it adopts the 'biopsychosocial approach.' [4]

The United Nations Convention on the Rights of Persons with Disabilities (2006) sets out state responsibilities to "collect appropriate information, including statistical and research data, to enable them to formulate and implement policies." Despite revisions to definitions of functioning and disabilities, consistency in collecting disability data is persistently lacking.

Numerous countries collect data on disability at the population level, however, the methodology, data collection tools, reliability and comparability of data, particularly for children's disability, reveals inconsistencies both in the definitions, and measures of disability, that ultimately contribute to serious challenges for producing reliable and comparable statistics.[5] This is particularly important given the multifaceted and dynamic nature of disabilities that pose significant challenges for routine data collection. Researchers involved in the development of surveys for identifying children with disabilities have outlined the importance of having clear definitions of disability that can aid the production of relevant indicators of disability for use in data collection instruments.[6] Definitions have changed over time, as highlighted above, and researchers state that it is, in part, these definitional changes that have resulted in measures of disability being excluded from data collection, or have resulted in wide variations between and within countries using different instruments. These inconsistencies have undoubtedly impacted on the estimates of disability prevalence.

[4] Federici, Bracalenti, Meloni and Luciano (2017). World Health Organization disability assessment schedule 2.0: An international systematic review. Disability and Rehabilitation, 39(23), pp. 2347-2380.
[5] Cappa, Petrowski and Njelesani (2015). Navigating the landscape of child disability measurement: A review of available data collection instruments. Alter, 9(4), pp.317-330.
[6] Loeb, Mont, Cappa et al (2018). The development and testing of a module on child functioning for identifying children with disabilities on surveys. I: Background. Disability and health journal, 11(4), pp. 495-501

Both the WHO [7] and UNICEF [8] have acknowledged a lack of data on disability in children and even where data collected on childhood disability has increased in recent years, these data are often inadequate in terms of the description of children with disabilities and how disabilities affect their lives. In countries where services are available e.g. in wealthier nations, children are often identified as having a disability in educational or medical settings, and then, frequently by diagnosis. Even in these wealthier countries, children with disabilities who lack access to services, or who do not fit into certain diagnostic categories, can often be missed. [9]

5.2 Existing disability toolkits

After reviewing the literature around toolkits and screening tools used to identify disability, it became apparent that the instruments commonly used tended to focus on self-reported assessment and/or screening tools for use by professionals. Most were for use with adults, excepting those developed by UNICEF/WG and specifically, the UNICEF/WG Child Functioning Module (CFM).[10]

The UNICEF/CFM has two components: a module for children 2-4 years of age comprised of 16 questions covering 8 core domains of functioning, and a module for children 5-17 years of age comprised of 24 questions covering 12 core domains of functioning. Domains were selected based on their universality and commonality across cultures and countries at various stages of economic development. These include: seeing, hearing, walking, communicating, learning, remembering (ages 5-17), self-care (ages 5-17), fine motor skills (ages 2-4), behaviour, emotions (ages 5-17), coping with change (ages 5-17), focusing

[7] World Health Organization and The World Bank (2011). World report on disability. Geneva: World Health Organisation.
[8] UNICEF (2013). The state of the world's children 2013: Children with disabilities. New York: UNICEF.
[9] Loeb, Mont, Cappa et al (2018). The development and testing of a module on child functioning for identifying children with disabilities on surveys. I: Background. Disability and health journal, 11(4), pp. 495-501
[10] Devandas (2018). The Development and Testing of a Module on Child Functioning for Identifying Children with Disabilities in Surveys. Disabil Health 11(4), pp. 493-494.

attention (ages 5-17), playing (ages 2-4) and relationships (ages 5-17). A copy of the UNICEF/CM is included in Appendix 1.

SCRA's research team identified that there are a lack of toolkits or screening tools that combine known childhood vulnerabilities, such as adverse childhood experiences[11] with child functioning. Although functioning was considered an important element of the development of the toolkit, being able to account for common vulnerabilities in children's lives by incorporating ACES to capture the child's lived experience and exposure to trauma, was considered a significant and important inclusion in any toolkit developed by SCRA.

Understanding the wider context of a child's life was also considered important, in order to give a fuller picture of a child's vulnerability and functioning, as well as to shift the focus of understanding of disability beyond the child's impairment. For example, DCCPN group members considered that it was important to know about wider contextual factors, such as poverty, housing, health etc., experienced by both the child and their family/carers. SCRA's research team also identified that understanding of the wider context and circumstances of children's lives is often overlooked and is rarely collected in toolkits or assessments.

These three factors - vulnerability, context and functioning - are inter-linked and interactive. By including multiple factors within the toolkit, the toolkit can help build a broader picture of whether or not a child is likely to have a disability, or difficulty affecting their functioning across their life-course. Collecting this type of information can also provide practitioners with a better understanding of the broader safeguarding needs of disabled children. To that end, SCRA explored how the UNICEF/CM could be adapted to include functioning measures and wider measures of childhood adversity, as well as pertinent contextual factors.

[11] Felitti, Anda, Nordenberg et al (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American journal of preventive medicine, 14(4), pp.245-258.

6. Developing a new disability toolkit

In order to develop the toolkit a facilitated discussion was held with members of the DCCPN in order to gain an insight into the range of vulnerability, contextual and functioning factors that could be used to: 1) identify children as potentially having an undiagnosed disability and/or not being able to fully participate or equally function within society due to physical, mental, cognitive, socioemotional or neurological differences; and 2) explore the potential safeguarding needs of those children. The following factors were identified as being potentially relevant for the toolkit design:

- adverse experiences in the perinatal period and early infancy;
- childhood trauma;
- socioeconomic circumstances;
- social isolation and victimisation;
- ability to participate in education and social activities;
- common childhood disabilities and illnesses; and,
- functioning across a range of 'normal' daily activities such as emotional regulation, interactions with peers and difficulties with routine day-to-day activities such as self-care.

To be included within the toolkit a measure had to be: 1) identified as relevant by either the facilitated discussion with practitioners or within the wider literature as being associated with the risk of childhood disability or dysfunction; and 2) likely to be mentioned within the case files of children known to the Children's Hearings System. The full toolkit, along with full descriptions of the measures that were collected can be found in Appendix 2.

6.1 Vulnerability factors

The vulnerability measures selected for the toolkit cover adversity in both the perinatal and wider childhood period. The perinatal factors included were all associated with increased risk

of disability or dysfunction during childhood within the literature, namely preterm birth, low birth weight, admission to a neonatal ICU, and a child having experienced or being at increased risk of experiencing neonatal abstinence or foetal alcohol syndromes (NAS/FAS).[12,13,14]

We also included failure to thrive as a global indicator of childhood vulnerability due to it being widely caused by inadequate nutrition and care during the early childhood period; although it should be noted that the relationship between failure to thrive and disability is complex, i.e. failure to thrive among children may result in long-term health deficits or disability, but could also be a symptom of a known or undiagnosed health deficit or disability.[15]

We also collected data on twelve ACES. Our ACE measures included modified versions of those used in the original CDC-Kaiser ACE study[16.] These included three measures of child maltreatment (sexual abuse; emotional abuse and/or neglect; physical abuse and/or neglect) and five measures of chronic household challenges (interpersonal violence witnessed within the home; having a parent with a substance misuse problem; having a parent who experiences mental ill-health; parental separation or divorce; and having a parent who has been incarcerated). All of these measures have well documented associations to poor physical and mental health outcomes[17].

12 Schieve, Tian, Rankin et al (2016). Population impact of preterm birth and low birth weight on developmental disabilities in US children. Annals of Epidemiology, 26(4), pp. 267-274.
13 Fill, Miller, Wilkinson et al (2018). Educatonal disabilities among children born with neonatal abstinence syndrome. Pediatrics 142(3) e20180562.
14 Allotey, Zamora, Cheong-See et al (2018). Cognitive, motor, behavioural and academic performances of children born preterm: a meta-analysis and systematic review involving 64 061 children. BJOG: An International Journal of Obstetrics & Gynaecology, 125(1), pp.16-25.
15 Perrin, Cole, Frank et al (2003) Criteria for determining disability in infants and children: failure to thrive. Evidence Report/technology Assessment (Summary) Mar(72):1-5.
16 CDC-Kaiser ACE Study. Available at: https://www.cdc.gov/violenceprevention/aces/about.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Facestudy%2Fabout.html. Last accessed May 12th 2021.
17 Allen and Donkin (2015). The impact of adverse experiences in the home on the health of children and young people, and inequalities in prevalence and effects. Available at: basw_13257-1_0.pdf. Last accessed 6th May 2021.

Four additional measures of adversity were added by the research team. Living with a parent who has learning difficulties or who has a long-term physical illness or disability were added due to the potential for genetic inheritance of certain conditions (i.e. speech and language disorders, ADHD and learning disabilities).[18,19] We also included two additional measures relating to the separation of parents and children, namely experiencing the death of a parent or a child being disowned by one or more parent. The collection of data on all ACEs was restricted to parents rather than households as SCRA case files do not consistently include information about other children or relatives living within the parental home.

6.2 Contextual factors

The contextual measures selected for the toolkit cover factors such as the socioeconomic and educational circumstances of children, as well as their exposure to victimisation and isolation. The socioeconomic measures chosen included:

- the experience of homelessness and housing instability;
- concerns about the condition and safety of the family home; and,
- whether the child resided in a socially deprived household.

The inclusion of socioeconomic measures was considered important as within the literature there are strong causative links between social inequality, poor physical/mental health and disability; although it should be noted that this association is likely to be bi-directional with the health and functioning of households members strongly associated with the experience of social inequality, and the experience of social inequality in turn promoting increased risk of ill-health and diminished functioning among household members.[20,21]

[18] Faraone, Ghirardi, Kuja-Halkola et al (2017). The familial co-aggregation of attention-deficit/hyperactivity disorder and intellectual disability: a register-based family study. Journal of the American Academy of Child and Adolescent Psychiatry 56(2), pp. 167.174
[19] Swagerman, van Bergen, Dolan et al (2017). Genetic transmission of reading ability. Brain and Language 172, pp. 3-8.
[20] Katikireddi, Skivington, Leyland et al (2017). The contribution of risk factors to socioeconomic inequalities in multimorbidity across the lifecourse: a longitudinal analysis of the Twenty-07 cohort. BMC Medicine 15(1), pp.1-10.
[21] Byrne, B (2018). *Dis-Equality*: exploring the juxtaposition of disability and equality. Social Inclusion 6(1), pp. 9-17.

The educational circumstances measured focussed upon identifying whether children were experiencing difficulties within the school environment, including;

- whether a child was perceived as not coping with education;
- had poor school attendance;
- had been temporarily or permanently excluded from school;
- received additional educational supports; and,
- whether there was evidence that they were engaging in extracurricular activities.

The inclusion of these variables was based upon existing evidence that children with disabilities or those who are identified as having additional support needs within the classroom are more likely to experience poorer educational outcomes. For instance, education statistics in Scotland identify that a child with a disability is over two times more likely than a child without a disability to be permanently excluded from education.[22]
Finally we included three measures of social isolation and victimisation within the toolkit. These were:

- whether children had been a victim of bullying;
- whether children had been a victim of violence in the community; and,
- children having no identified trusted adults or a person who was considered 'special' to them

These measures were included as children with disabilities are more likely to experience victimisation and isolation as a result of their disability.[23,24]

[22] School exclusions 2018-19. Available at: School exclusion statistics - gov.scot (www.gov.scot). Last accessed May 13th 2021
[23] Chatzitheochari, Parsons and Platt (2015). Doubly disadvantaged? Bullying experiences among disabled children and young people in England. Sociology 50(4), pp. 695-713.
[24] Clarke (2006). Preventing Social Exclusion of Disabled Children and their Families: Literature review paper produced for the National Evaluation of the Children's Fund. Available at: https://dera.ioe.ac.uk/6462/1/RR782.pdf. Last accessed: May 13th 2021

6.3 Functioning factors

Functioning factors were adapted from domains of functioning contained within the UNICEF/CFM screening tool.[25] The domains that we developed encapsulated all of the functioning measures included in the UNICEF/CFM, but were modified based upon our practical knowledge of how information was recorded within SCRA case files. For instance, the UNICEF/CFM uses multiple questions (e.g. “does x wear glasses?”, “when wearing their glasses does x have difficulty seeing?” and “does x have difficulty seeing?”) and graded scales to identify the degree to which children experience difficulty with specific areas of functioning (i.e. no difficulty, some difficulty, a lot of difficulty, cannot do at all). This level of information is not present within the case files of children and therefore all domains had to be simplified to record whether difficulty with functioning in that area was evident or not. To that end, we simplified items within the age 5-17 UNICEF/CFM to measure whether a child had:

- a hearing impairment;
- a visual impairment;
- a physical or motor impairment;
- difficulties with self-care;
- a language, communication or speech disorder;
- a learning difficulty;
- concentration and memory difficulties;
- indicators of autistic spectrum disorder or sensory processing disorders;
- difficulty making and maintaining friendships;
- feeling anxious, nervous or worried; and,
- feeling sad or depressed.

[25] Devandas (2018). The Development and Testing of a Module on Child Functioning for Identifying Children with Disabilities in Surveys. Disabil Health J. 11(4), pp. 493-494.

In developing coding instructions for each of these items, the decision was taken to combine descriptions of some behaviours, particularly around children's social functioning and ability to form peer relationships, from the UNICEF/CFM for ages 2-4 and 5-17. This decision was based upon practice knowledge garnered through discussions with the DCCPN that indicated the potential for some children, particularly those with trauma histories, to show signs of developmental regression or have cognitive delays that meant they had disparities in their age and stage of behaviour.

In addition to the items that were identified from the UNICEF/CM we included some additional items that we knew were included within SCRA case files and were well suited to supporting the view of the DCCPN that "*a child may not always have a medical diagnosis to have additional needs that impact substantially on their functioning and contribute to risk of harm*". These items were whether a child was identified as having:

- dyslexia;
- attention deficit or hyperactivity disorder (ADHD);
- a socioemotional and behavioural difficulty (SEBD);
- self-harmed or attempted suicide;
- a long-term physical health problem or chronic illness;
- an identified mental health problem or receiving care from a mental health practitioner.

7. Testing the toolkit

7.1 Data collection

All data used in the testing of the disability toolkit was drawn from information held in SCRA's case files in its case management system (CSAS). These case files hold statutory documentations, reports (e.g. those from social work, police, education, health, safeguarders

etc.), correspondence, and records of decisions by Children's Reporters and Children's Hearings.

The vulnerability, contextual and functioning factors (i.e. research variables) were recorded as being present or absent, where absent meant that the information was either not specified within the case file or there was evidence that there were no concerns related to the variable in question. This approach was used for simplification; however it is important to note that this may mean that concerns could be underreported.

7.2 Sample

The case records of 40 children were sub-sampled from a larger study looking at the experiences of children who entered a residential care setting when they were aged 5-12 [26]. Sub-sampling from this study was undertaken as many of the variables included within the toolkit had already been collected, and minimal additional data collection to test the disability toolkit was required. Data were collected from birth through to 24 months after entry into residential care. The wider sample consisted of two gender-matched sub-groups: children who had been identified through case file analysis as having a known disability (n=20) and children who were not identified as having any known disability (n=20). The sub-sample of children with an identified disability was created by purposively sampling to ensure that a broad range of physical, cognitive and mental health disabilities were included within the dataset.

[26] SCRA are currently conducting a piece of research exploring the experiences of children under the age of twelve living in residential care settings. The study aims to address four questions: 1) what are the characteristics and family backgrounds of children placed into residential care before age 12? 2) How is placement into residential care before age 12 associated with health and social wellbeing, including education and offending outcomes? 3) What are the decision making processes and operational constraints that underscore the placement of children under the age of 12 into residential care? 4) Are there identifiable points for earlier intervention in the case histories of under 12s placed into residential care? And if so, what are these? Results from this study will be published in late 2021/early 2022.

Table 1: Disability characteristics of children identified in case files as disabled

Chronic illness	Physical disability	Neurological, cognitive or learning disorders	Mental health conditions	Autistic spectrum or neurodiverse	Genetic disorders
15% (3)	30% (6)	55% (11)	30% (6)	15% (3)	5% (1)

* Numbers do not sum to 20 due to children being classified as having more than one active condition

Table 1 provides an overview of the disability types captured within the sample. The sub-sample of children who had not been identified as disabled were selected at random. Although the sample was gender-matched, no matching occurred for age. This resulted in a disparity between the two groups with disabled children being slightly older than those who were not identified as disabled at the end of the data collection period (identified as disabled: mean age 12.8 years vs. not identified as disabled: mean age 11.9 years; t-test p=0.019).

7.3 Analysis of data

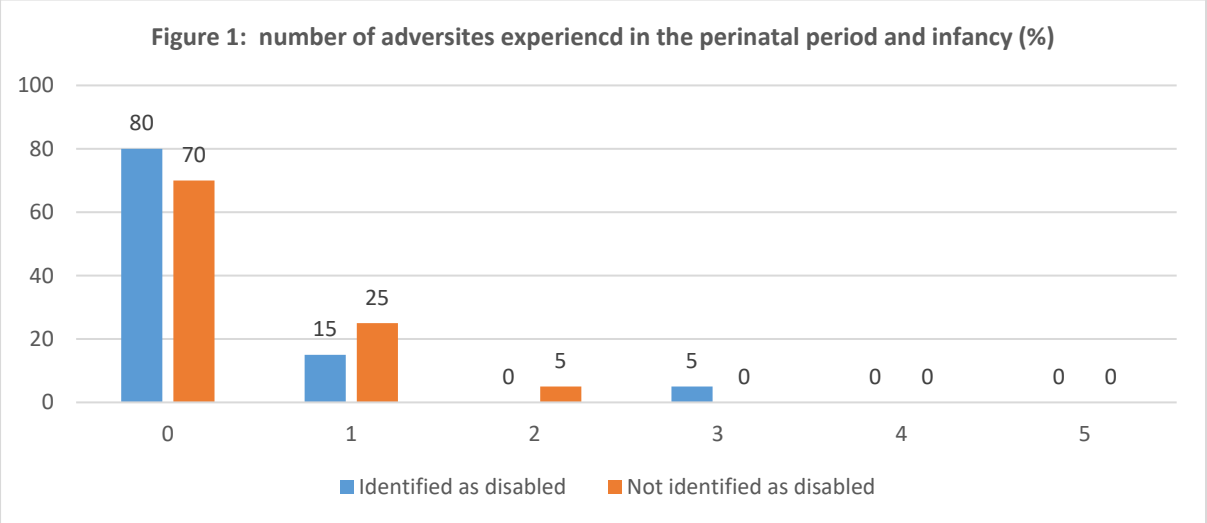
Descriptive statistics and associated charts were generated using the data analysis function of Microsoft Excel. Comparisons of means was undertaken using the independent samples t-test function after conducting one-way ANOVAs to test for homogeneity of variance within the samples. Chi-square tests were used to explore whether associations exist between vulnerability, contextual and functional measures and being identified as disabled within children's case files. All statistical tests were undertaken using the data analysis API in Microsoft Excel. Due to the small sample sizes involved in this pilot, statistical significance is indicated at $p<0.1$ rather than the more conventional $p<0.05$.

8. Results

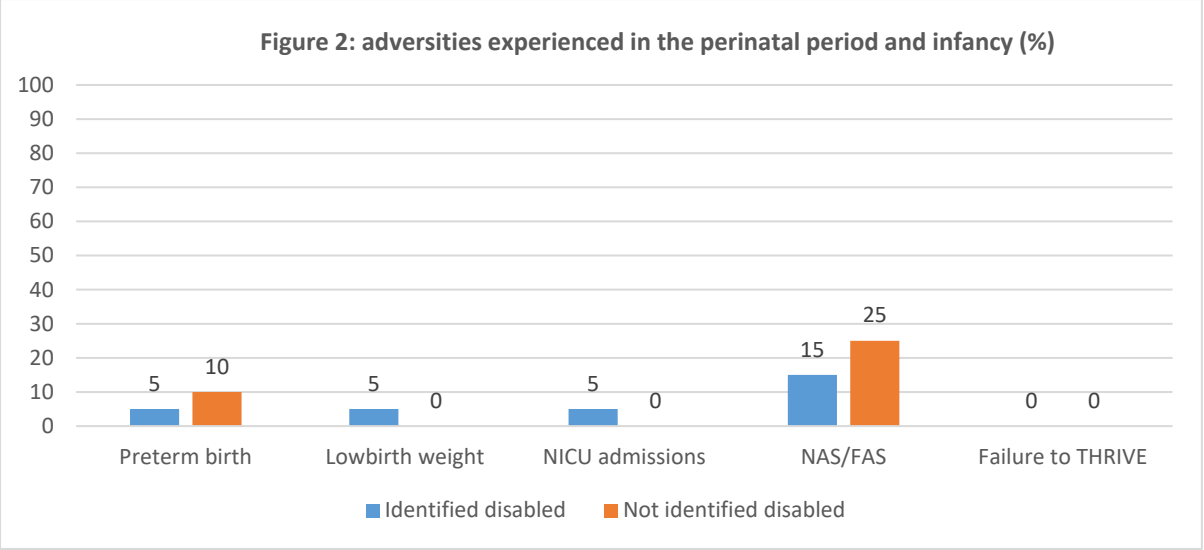
8.1 Vulnerability Factors: adversity during the perinatal period and infancy

The majority of children had no adverse events recorded in their file for the perinatal period or infancy (Figure 1: identified as disabled 80% vs. not identified as disabled 70%). The

mean number of adverse events recorded for the perinatal period and infancy was 0.33 (range 0-3). There was no significant difference in the mean number of events recorded for the two samples (identified as disabled 0.30 vs. not identified as disabled 0.35, t-test p=0.813).

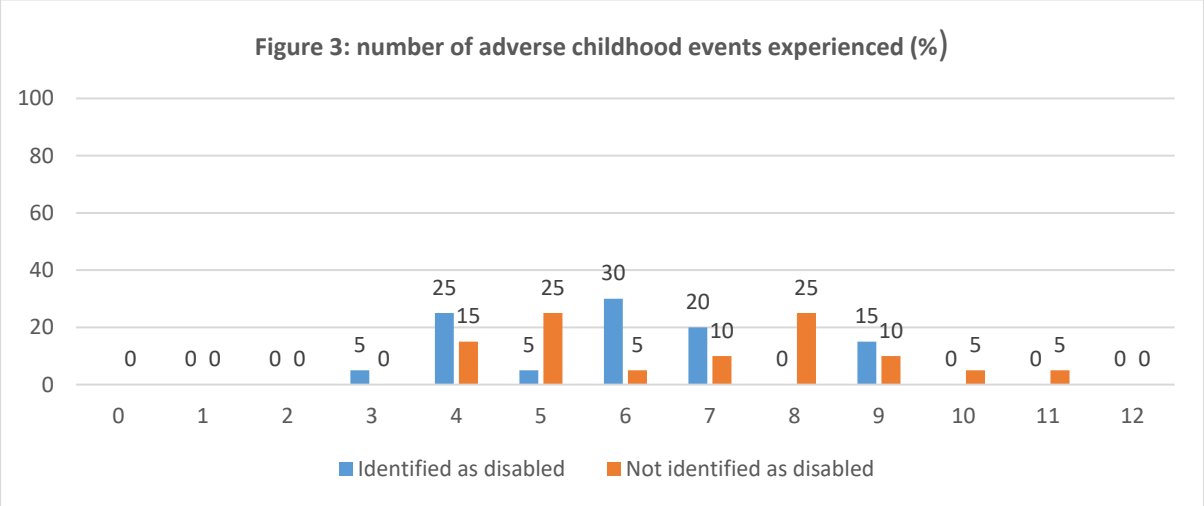


The most commonly recorded adverse events were children having confirmed or suspected neonatal abstinence syndrome (NAS) and/or foetal alcohol syndrome (FAS) (Figure 2: identified as disabled 15% vs. not identified as disabled 25%) and pre-term birth (Figure 2: identified as disabled 5% vs. not identified as disabled 10%). Chi-square tests for association indicate that there was no significant difference in the adversities experienced in the perinatal period and infancy by children who were and were not identified as disabled within case files (p>0.5 for all measures).



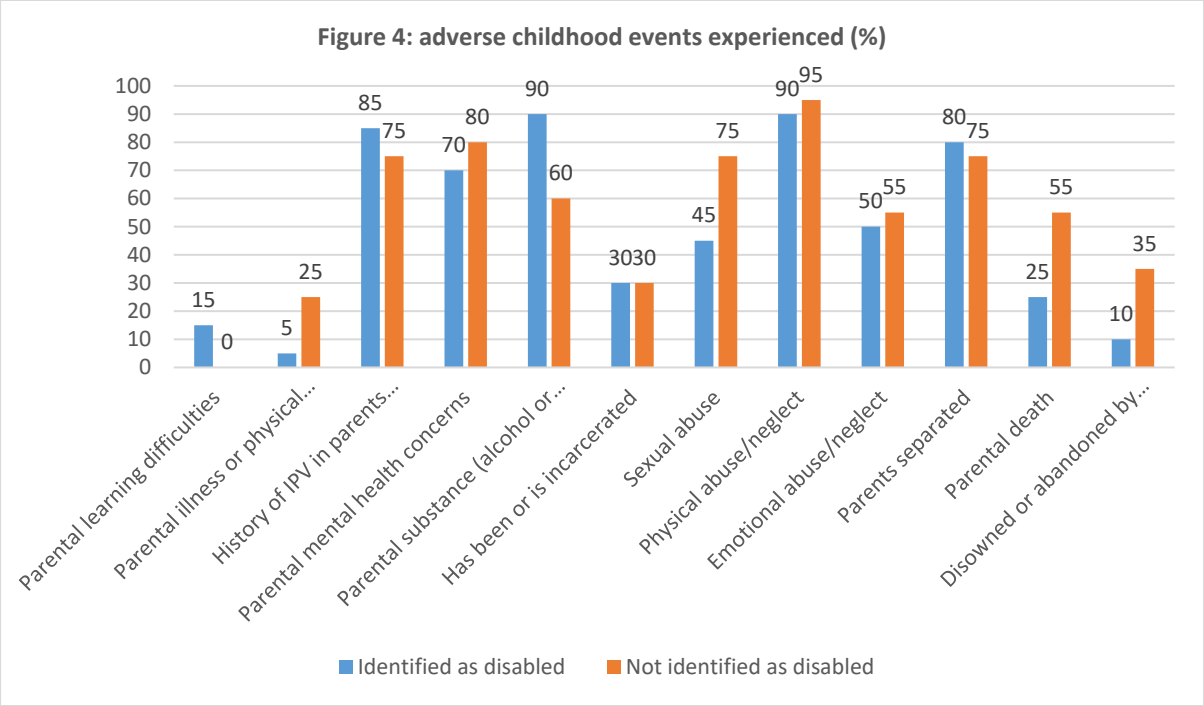
8.2 Vulnerability Factors: adverse childhood events

Figure 3 shows that all of the children had at least three adverse childhood events (ACEs) recorded in their files. The mean number of ACEs experienced was 6.38 (range: 3-11). There was no significant difference in the mean number of ACEs recorded for the two samples (identified as disabled 5.95 vs. not identified as disabled 6.80, t-test p=0.179).



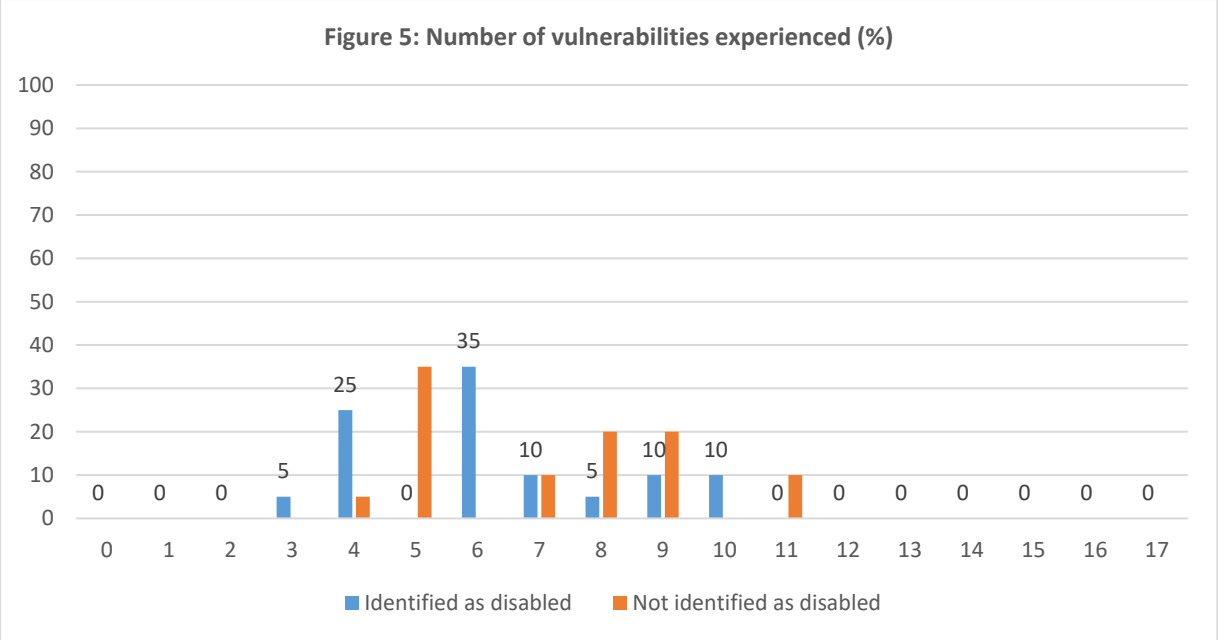
Although there was no overall difference in ACEs scores between the groups, our analysis indicates that children who were identified as being disabled were more likely than those

who were not identified as being disabled to have references to parental substance misuse (Figure 4: 90% vs. 60%, chi-square p=0.029) and parental learning difficulties (Figure 4: 15% vs. 0%, chi-square p=0.072) within their files. Children who were not identified as being disabled were more likely than those who had been identified as disabled to have references to parental illness/disability (Figure 4: 25% vs. 5%, chi-square p=0.077), sexual abuse (Figure 4: 75% vs 45%, chi-square p=0.053), parental death (55% vs. 25%, chi-square p=0.053) and parental abandonment (Figure 4: 35% vs. 10%, chi-square p=0.058) within their case files.



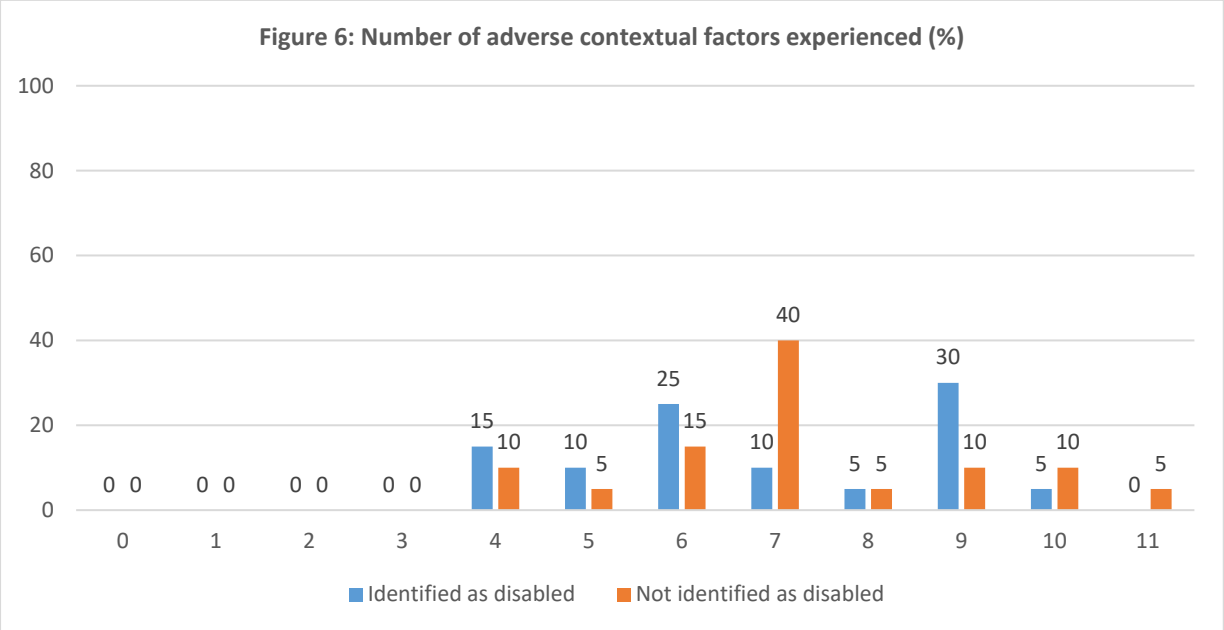
8.3 Vulnerability Score

Figure 5 shows that all of the children had at least three vulnerabilities recorded within their case files. The mean vulnerability score was 6.7 (range: 3-11). There was no significant difference in the mean number of vulnerabilities recorded for the two samples (identified as disabled 6.25 vs. not identified as disabled 7.15, t-test p=0.189).

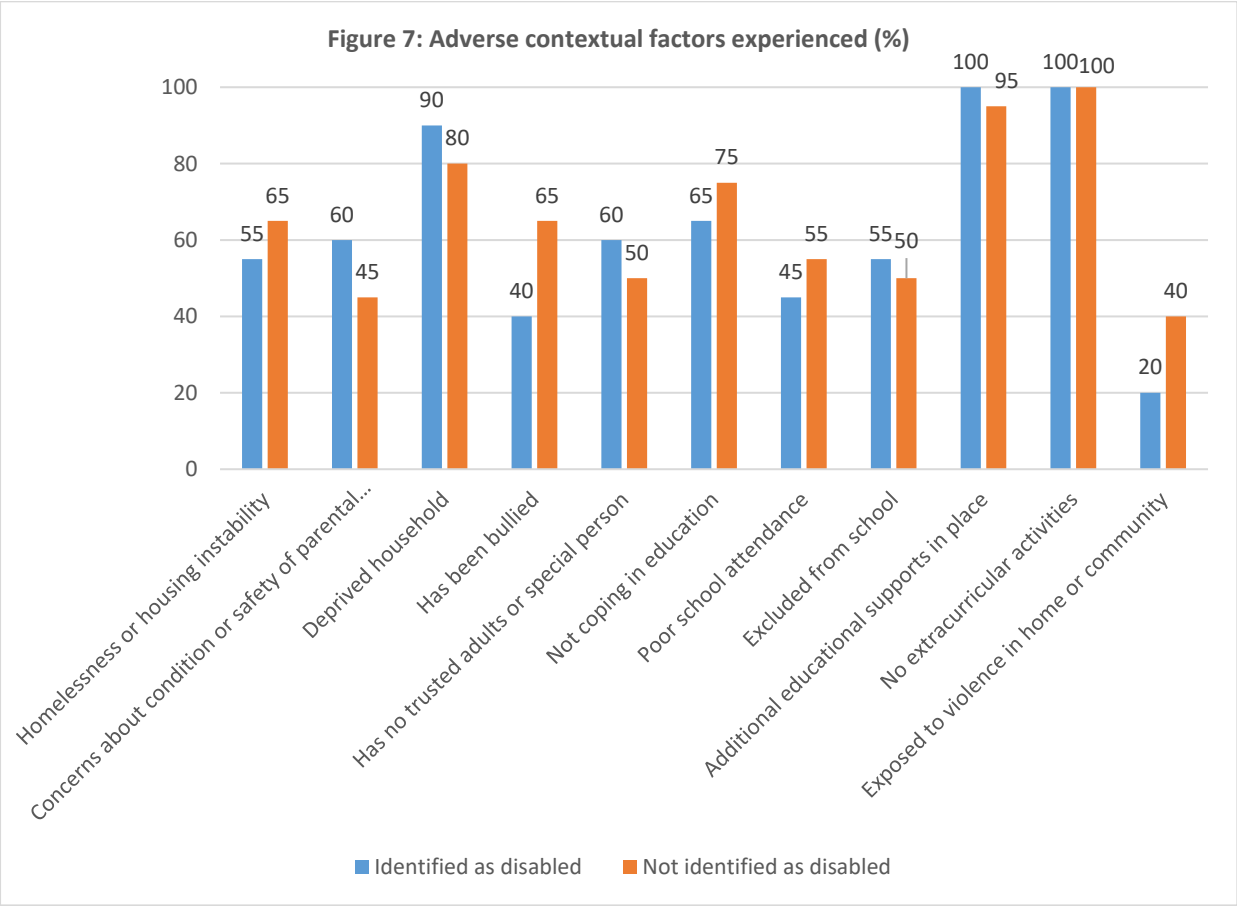


8.4 Adverse contextual factors

Figure 6 shows that all of the children had at least four adverse contextual factors recorded within their case files. The mean score for adverse contextual factors was 7.05 (range: 4-11). There was no significant difference in the mean number of adverse contextual factors recorded for the two samples (identified as disabled 6.90 vs. not identified as disabled 7.20, t-test p=0.625).



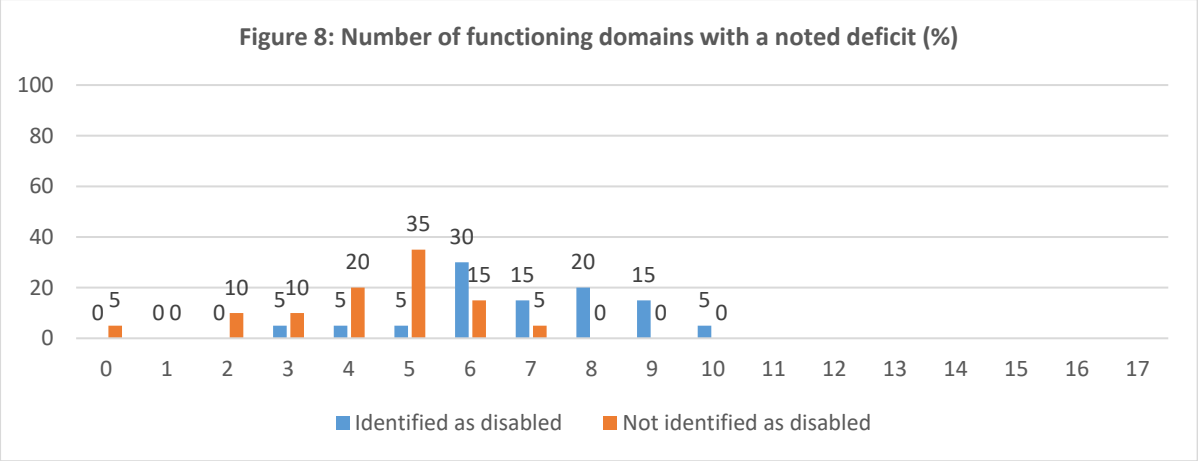
Although our descriptive statistics indicated that children who were identified as disabled were more likely to have had concerns raised about the condition or safety of their home (Figure 7: 60% vs. 45%), this difference was not statistically significant (chi-square p=0.342). Similarly, although descriptive analysis suggests that children who were not identified as disabled were more likely than those who were identified as disabled to have references to having been bullied (Figure 7: 65% vs. 40%) and exposed to violence in the home or community (Figure 7: 40% vs. 20%), these differences were not statistically significant (bullied chi-square p=0.113; violence in the community chi-square p=0.168).



8.5 Functioning

Figure 8 shows that within their case files, all bar one child had at least two areas of functioning where they were recorded as having a known deficit. To create a mean score for functioning, each functioning domain was given a score of 5 if a deficit was recorded. As we

measured eleven areas of functioning, the maximum achievable functioning score was 85. The mean functioning score was 28 (range 0-50) which is equivalent to an average of 5.6 recorded deficits across the sample. Children who were identified as having a disability had significantly higher mean scores than those who were not identified as disabled (34.5 {range: 15-50} vs 21.5 {range: 0-35}, t-test p=0.0002; this is equivalent to 6.90 vs. 4.30 deficits respectively).



Children who were identified as being disabled were more likely than those who were not identified as being disabled to have information present within their files that indicated that they had received a diagnosis for a known cognitive, physiological or mental health condition. Figure 9 highlights that this pattern can be seen for recorded references to: learning difficulties (90% vs. 0%; chi-square p<0.001); physical/motor impairments (35% vs 0%; chi-square p=0.004); speech and language disorders (40% vs. 10%; chi-square p=0.028); attention deficit disorder (25% vs. 5%; chi-square p=0.077); socioemotional and behavioural difficulties (15% vs 0%; chi-square p=0.072); physical illness and chronic conditions (60% vs. 25%; chi-square p=0.025); and mental health conditions (65% vs. 20%; p=0.004). There were six areas of functioning where children who had, and who had not been identified as having a disability, exhibited similar levels of dysfunction (chi-square p>0.10). These were: difficulties with self-care (55% vs. 45%), difficulties forming friendships

(70% vs 65%), feeling anxious, nervous or worried (85% vs. 90%); having suicidal thoughts and/or self-harming (55% vs. 60%), feeling sad and depressed (40% vs. 65%); and having difficulty remembering or concentrating on things (45% vs. 25%).

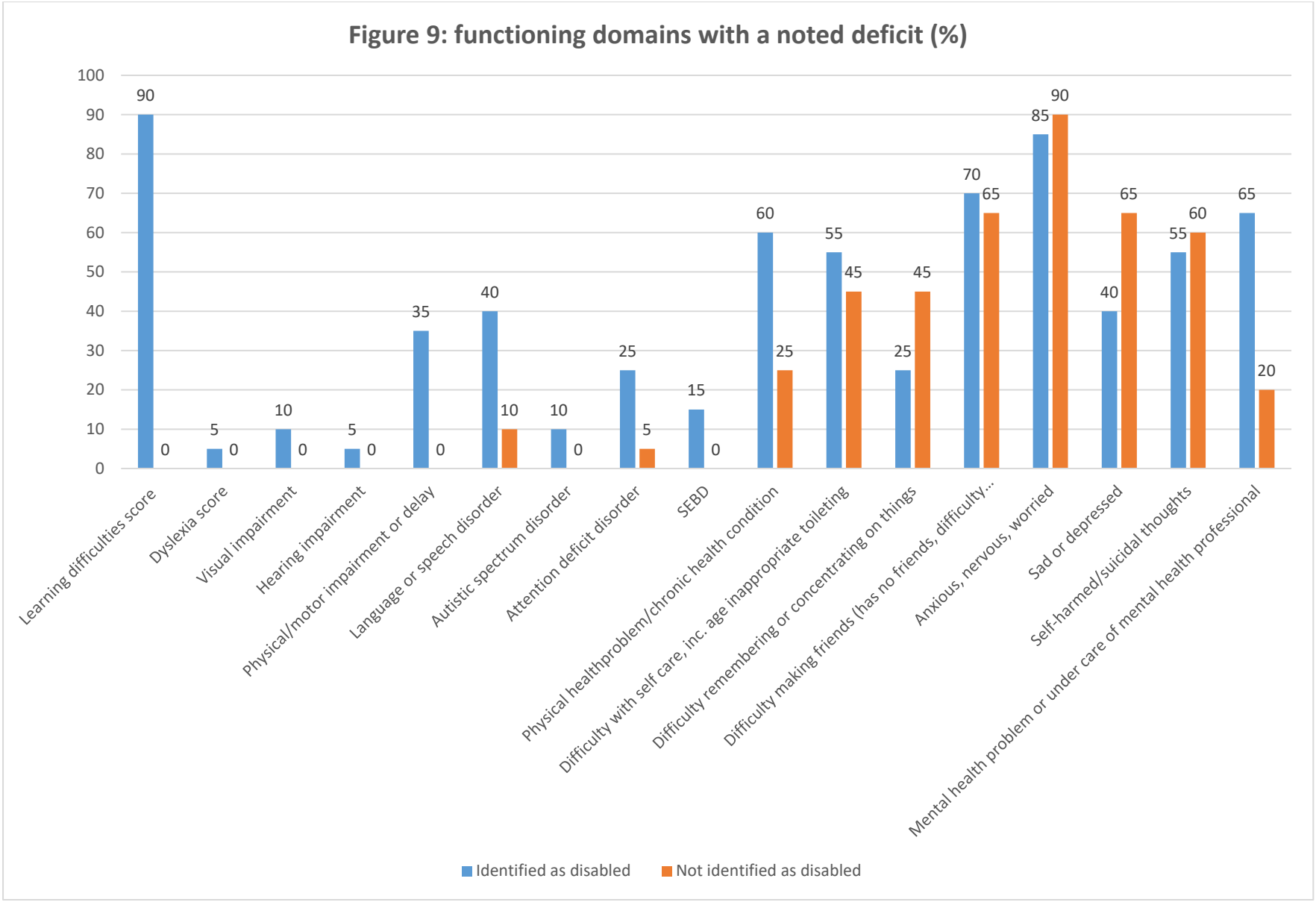


Figure 9: functioning domains with a noted deficit (%)
100
90
80
70
60
50
40
30
20
10
0
90
0
5
0
10
0
5
0
35
0
40
10
10
0
25
5
15
0
60
25
55
45
25
45
70
65
85
90
40
65
55
60
65
20
Learning difficulties score
Dyslexia score
Visual impairment
Hearing impairment
Physical/motor impairment or delay
Language or speech disorder
Autistic spectrum disorder
Attention deficit disorder
SEBD
Physical healthproblem/chronic health condition
Difficulty with self care, inc. age inappropriate toileting
Difficulty remembering or concentrating on things
Difficulty making friends (has no friends, difficulty...
Anxious, nervous, worried
Sad or depressed
Self-harmed/suicidal thoughts
Mental health problem or under care of mental health professional
Identified as disabled
Not identified as disabled

9. Discussion

Our results indicate that the toolkit developed by SCRA appears to robustly identify children who have been previously recorded as having a disability, as well as recognising children who may have undiagnosed disability or are experiencing difficulties across a number of functioning domains. In testing the toolkit, we identified that children who had previously been identified as disabled had 6.9 functioning domains where they were experiencing difficulties compared to 4.3 functioning domains among children who had not been identified as disabled. This difference in functioning scores appears to be largely driven by diagnosis, with those children identified as disabled in SCRA's case files having a confirmed diagnosis recorded in their case files in addition to the more generalised discussions of socioemotional and mental health difficulties that were present in 39 out of 40 of the case files we sampled.

One possible explanation for this difference is that the children who were identified as disabled were, on average, nine months older than those who had not been identified as being disabled, and had thus had more time to be evaluated for, and receive, a diagnosis. Another possible explanation could be that the care histories of these children, which we did not measure for the purpose of testing the toolkit, differ in some way, acting as a potential barrier or facilitator of diagnosis. For instance, it has been well documented that children who do not present as stable, either behaviourally or in their living arrangements, are less likely to be evaluated by child and adolescent mental health services (CAMHS) for mental health conditions, including neurodiverse conditions such as autism.[27]

[27] Wray (2018), Audit of rejected referrals to Child and Adolescent Mental Health Services in Scotland, Barnardo's Scotland. Available at: report-rejected-referrals-camhs-services-scotland.pdf (barnardos.org.uk). Last accessed: May 13th 2021.

As the data used to test the toolkit is drawn from a wider study currently being undertaken by SCRA exploring the experiences of children under the age of 12 in residential care, it is our intention to explore these issues in more depth with a larger sample (c. 130) of these children.

To the best of our knowledge there are no toolkits that include a wider assessment of vulnerability and contextual factors within the assessment of children's disability or functioning. In testing the toolkit we identified high and statistically comparable levels of ACEs between looked after children who had and had not previously been identified as disabled. Given that the sample for testing was drawn from children who were subject to statutory requirements to reside in residential care prior to their 12th birthday, and thus were likely to have substantial maltreatment histories or evidence of poor family functioning, this finding was not unexpected. However, in a less vulnerable population it is likely that collecting information on childhood adversity could provide practitioners with a more nuanced and holistic assessment of the additional support needs of children, as well as providing an insight into potential safeguarding needs.

Although the number of ACEs observed were comparable among children who had and had not been previously identified as disabled, we noted statistically significant differences in some of the ACEs collected. Our testing indicates that children who had been previously identified as being disabled were significantly more likely to have parents who had known substance misuse histories or learning disabilities; both of which could, in theory, be related to the acquisition of disability in the child either through exposure to substances in utero, or through genetic transmission of learning

difficulties.[28, 29, 30] Unfortunately, data relating to perinatal adversity, including likelihood of children having NAS and FAS, was poorly recorded in case files so we were unable to test for associations between these and subsequent disability.

Children who were not identified as disabled were more likely than those who had been identified as disabled to have references to parental illness/disability, sexual abuse, parental death and parental abandonment within their case files. These differences, along with the fact that this group had on average four functioning domains where they were experiencing difficulties (mainly focussed on socioemotional relationships and mental health difficulties) could indicate that trauma histories rather than an underlying biological condition were a driver of the difficulties observed. Unfortunately without knowing more about the children's wider health we are unable to draw more definitive conclusions as to the role that trauma histories may play in children's support needs. This is an area where further work ought to be focussed.

Overall, we found no differences in the wider contextual backgrounds of children who had, and had not been identified as disabled, with high levels of contextual adversity observed for both groups. The lack of variation in contextual experiences is likely to reflect the fact that the majority of children known to the Children's Hearings System come from socially disadvantaged communities[31]. Although we found little difference in the contextual experiences of children in this sample, we believe that it is important to retain these variables in the toolkit going forward, as the effects of these contextual

[28] Faraone, Ghirardi, Kuja-Halkola et al (2017). The familial co-aggregation of attention-deficit/hyperactivity disorder and intellectual disability: a register-based family study. Journal of the American Academy of Child and Adolescent Psychiatry 56(2), pp. 167.174
[29] Swagerman, van Bergen, Dolan et al (2017). Genetic transmission of reading ability. Brain and Language 172, pp. 3-8.
[30] Fill, Miller, Wilkinson et al (2018). Educatonal disabilities among children born with neonatal abstinence syndrome. Pediatrics 142(3) e20180562
[31] Scottish Children's Reporter Administration (2020). Deprivation and Referrals to the Reporter. Available at: 07-Child-Deprivation.pdf (scra.gov.uk). Last accessed: May 13th 2021

circumstances, as well as changes in these circumstances over time, can have significant impact on the social conditions of children's lives and on children's level of functioning. Having access to information on wider contextual factors would be of use in helping practitioners ascertain how children's wider context and social circumstances influence support needs required.

Strengths, limitations and recommendations for further development

To the best of our knowledge this is the first toolkit developed and piloted that assesses functioning in the wider context of vulnerabilities and contextual factors, and as such it has the potential to provide practitioners with a valuable and robust tool for quickly assessing childrens' safeguarding and support needs. The strength and novel contribution of this toolkit, is to identify difficulties in functioning which can impact a child's life, beyond diagnosed disability. It includes domains that align with the WHO's definition of disability as "the outcome of a complex, multidimensional interaction between a person's health condition(s) and context, environmental and personal factors" through a focus on the wider context and circumstances influencing functioning.

At present there are some limitations to the approach that we have adopted for design and testing. The first is that the sample we used for piloting the toolkit with is not representative of children across Scotland; accounting for around just 1% of the 2% of children who are looked after by local authorities each year. While it is heartening that the toolkit is identifying difficulties in functioning among some of the most vulnerable children in Scotland, the level of vulnerability seen in this population makes it difficult to identify scores that could be used to indicate children at risk of having unmet additional needs because of the fact that nearly all of the children in this sample had high levels of adversity and high levels of dysfunction across multiple

domains. Thus, if the development of a scoring system was seen by practitioners as being something that would be advantageous for the quick identification of unmet needs, then further testing with a more representative sample of children would be required in order to develop cut offs for functioning and safeguarding concerns.

Another potential option for refining the toolkit would be to incorporate a scoring system that would provide a measure of the degree of dysfunction that children experience. For example, the UNICEF/CFM, from which we developed our functioning measures, utilises a scoring system that allows for the extent to which children experience difficulty in an area of functioning to be captured. This is not something that we were able to incorporate into this piece of work due to the way data is recorded within the SCRA case files of children. At present we only know that a difficulty with functioning exists and not the extent to which it impedes the child's life or what the level of additional support needed would be. Refining the scoring system in this way would increase the utility of the toolkit as a practice tool. Assessing the degree of functioning should not be additionally burdensome for practitioners to complete as they could either complete these items based upon their own knowledge of the child, or in conjunction with children and/or their caregivers; however, piloting of this method of scoring in practice should be undertaken.

While testing the toolkit, we identified that information about adverse perinatal factors was poorly recorded in the case files of children in the chosen sample. Although this evidence was absent in SCRA records, if the toolkit is adopted as a practice tool, this information would be much more accessible to practitioners, and could help provide additional background to the support needs of children who appear differently abled. Given the increased risk of disability among children with adverse experiences in the

perinatal period [32, 33, 34, 35] we feel that these variables are important to capture and should be retained. Future piloting work should explore how accessible information about perinatal adversity is to practitioners.

The question as to whether variables with poor completion in testing should be retained also raises the question of whether the measurement of any variables within the toolkit could be changed to provide a more meaningful understanding of childrens' functioning. One variable that could be altered is the measurement of homelessness and housing instability. When we designed the toolkit we decided to record whether a parent had ever been homeless or experienced housing instability as within case files these factors are often discussed more frequently in relation to parental living circumstances. However, in retrospect a better measure to include, and one that would be more meaningful for understanding the wider context of childrens' functioning, would have been whether the child had ever experienced homelessness or housing/placement instability. This information would also be useful to collect in order to understand whether crisis in housing/placements act as a barrier to diagnosis and support. We would therefore recommend that any future refinement and testing of the toolkit include a child-centred variable rather than the parent-centred variable that we used.

[32] Schieve,Tian,Rankin et al (2016). Population impact of preterm birth and low birth weight on developmental disabilities in US children. Annals of Epidemiology, 26(4), pp. 267-274.
[33] Fill, Miller, Wilkinson et al (2018). Educatonal disabilities among children born with neonatal abstinence syndrome. Pediatrics 142(3) e20180562.
[34] Allotey, Zamora, Cheong-See et al (2018). Cognitive, motor, behavioural and academic performances of children born preterm: a meta-analysis and systematic review involving 64 061 children. BJOG: An International Journal of Obstetrics & Gynaecology, 125(1), pp.16-25.
[35] Perrin, Cole, Frank et al. Criteria for determining disability in infants and children: failure to thrive. Evidence Report/technology Assessment (Summary). 2003 Mar(72):1-5.
35 CDC-Kaiser ACE Study. Available at: https://www.cdc.gov/violenceprevention/aces/about.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Facestudy%2Fabout.html. Last accessed May 12th 2021.

It may also be worth considering for future iterations and testing whether there are any additional factors that the toolkit is not measuring that it should be. For instance, one variable that is not included in the vulnerability factors that we have tested, but may be of interest, is whether or not a child has ever received a head injury. Head injuries are one of the most common childhood injuries, with 488 children (aged 0-14 years) per 100,000 population admitted to hospital each year. [36] Although the majority (>90%) experience mild injury and are discharged home with ill effect, the remaining children can experience long-term effects, including a diagnosis of acquired brain injury (ABI); an umbrella term used for describing an injury to the brain that happens "after birth and is not related to a congenital or degenerative disease".[37]

Children with an ABI can experience a wide constellation of potential deficits depending upon the severity and location of the injury, including physical and motor deficits, mental health issues and developmental delays. Furthermore, behavioural problems can emerge as a direct result of injury to the brain, or indirectly as a result of the child being unable to cope with their physical, cognitive, social and emotional problems.[38] Given that the World Health Organisation estimated that traumatic brain injuries would be the leading cause of disability in children by the year 2020[39] it would seem prudent to include this measure as a vulnerability factor going forward; however as with the information on perinatal factors, additional piloting would need to be done to ascertain how easy it would be for practitioners to access this information.

[36] NHS Scotland (2018). Paediatric ABI Standards. Available at: https://www.sabin.scot.nhs.uk/wp-content/uploads/2018/06/Paediatric-ABI-Standards-April-2018.pdf Last accessed May 13th 2021.
[37] Powell River Brain Injury Society (no date). What is acquired brain injury? Available at: https://braininjurysociety.com/information/acquired-brain-injury/what-is-abi/#:~:text=Definition%20of%20Acquired%20Brain%20Injury.%20An%20acquired%20brain,cause%20partial%20or%20functional%20disability%20or%20psychosocial%20maladjustment Last accessed May 13th 2021.
[38] Child Brain Injury Trust (2018), Childhood Acquired Brain Injury: The hidden disability. Staffordshire, UK: Nasen. Available at: https://childbraininjurytrust.org.uk/wp-content/uploads/2018/11/ABI-Mini-Guide.pdf Last accessed May 13th 2021
[39] Hyder, Wunderlich, Puvanachandra and Gururaj (2007). The impact of traumatic brain injuries: a global perspective. Neurorehabilitation 22(5), pp. 341-353.

10. Conclusions

In this piece of research, we have demonstrated that it is feasible to develop a toolkit that can reliably assess children's functioning and identify children who are likely to have additional support needs as a result of a known or potential disability. We have also demonstrated that it is possible to collect and incorporate data on wider vulnerabilities and contextual factors that may play a role in the development of disability, and can be used by practitioners to assess the safeguarding and support needs of children. To the best of our knowledge this is the first toolkit developed and piloted in Scotland that measures functioning. It is also the first in the world that combines measurements of functioning, vulnerability and contextual factors in order to identify safeguarding and support needs.

The developed toolkit is intended for use by practitioners, and we believe that it can be used to provide an assessment of need for children. It is not a diagnostic tool, but could be used to provide justification for requesting additional assessments and supports for children; particularly if normative scoring values were to be established through future refinement and testing. Identifying normative values is something that we consider to be essential going forward as the toolkit testing so far has been conducted with a very small sample of children who have all experienced high levels of adversity and all have some degree of additional support needs. We recommend that further testing of the toolkit should be undertaken across a range of settings and with different groups of children. This could be done by practitioners (teachers, social workers etc.) completing the measures for children they work with. Testing in this way would also be useful for determining any barriers that might exist to collecting certain variables, i.e. information on perinatal factors. Further testing should also explore how data collated from practice could be used to develop aggregated data about the functioning, safeguarding and support needs of children in Scotland.

Appendix 1: UNICEF/CFM

CHILD FUNCTIONING (AGE 2-4)		CF
CF1. I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT DIFFICULTIES YOUR CHILD MAY HAVE. DOES (*name*) WEAR GLASSES?	Yes ..... 1 No 2	 2⇨CF3
CF2. WHEN WEARING HIS/HER GLASSES, DOES (*name*) HAVE DIFFICULTY SEEING? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	 No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	 1⇨CF4 2⇨CF4 3⇨CF4 4⇨CF4
CF3. DOES (*name*) HAVE DIFFICULTY SEEING? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	 No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF4. DOES (*name*) USE A HEARING AID?	Yes ..... 1 No 2	 2⇨CF6
CF5. WHEN USING HIS/HER HEARING AID, DOES (*name*) HAVE DIFFICULTY HEARING SOUNDS LIKE PEOPLES' VOICES OR MUSIC? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	 No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	 1⇨CF7 2⇨CF7 3⇨CF7 4⇨CF7
CF6. DOES (*name*) HAVE DIFFICULTY HEARING SOUNDS LIKE PEOPLES' VOICES OR MUSIC? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	 No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF7. DOES (*name*) USE ANY EQUIPMENT OR RECEIVE ASSISTANCE FOR WALKING?	Yes ..... 1 No 2	 2⇨CF10
CF8. WITHOUT HIS/HER EQUIPMENT OR ASSISTANCE, DOES (*name*) HAVE DIFFICULTY WALKING? WOULD YOU SAY (*name*) HAS: SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF9. WITH HIS/HER EQUIPMENT OR ASSISTANCE, DOES (*name*) HAVE DIFFICULTY WALKING? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	 No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	 1⇨CF11 2⇨CF11 3⇨CF11 4⇨CF11
CF10. COMPARED WITH CHILDREN OF THE SAME AGE, DOES (*name*) HAVE DIFFICULTY WALKING? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	 No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	

CHILD FUNCTIONING (AGE 2-4)		CF
CF11. COMPARED WITH CHILDREN OF THE SAME AGE, DOES (*name*) HAVE DIFFICULTY PICKING UP SMALL OBJECTS WITH HIS/HER HAND? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF12. DOES (*name*) HAVE DIFFICULTY UNDERSTANDING YOU? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF13. WHEN (*name*) SPEAKS, DO YOU HAVE DIFFICULTY UNDERSTANDING HIM/HER? WOULD YOU SAY YOU HAVE: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF14. COMPARED WITH CHILDREN OF THE SAME AGE, DOES (*name*) HAVE DIFFICULTY LEARNING THINGS? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF15. COMPARED WITH CHILDREN OF THE SAME AGE, DOES (*name*) HAVE DIFFICULTY PLAYING? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF16. COMPARED WITH CHILDREN OF THE SAME AGE, HOW MUCH DOES (*name*) KICK, BITE OR HIT OTHER CHILDREN OR ADULTS? WOULD YOU SAY: NOT AT ALL, THE SAME OR LESS, MORE OR A LOT MORE?	Not at all ..... 1 The same or less ..... 2 More ..... 3 A lot more 4	

CHILD FUNCTIONING (AGE 5-17)		CF
CF1. I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT DIFFICULTIES YOUR CHILD MAY HAVE. DOES (*name*) WEAR GLASSES OR CONTACT LENSES?	Yes ..... 1 No 2	 2⇨CF3
CF2. WHEN WEARING HIS/HER GLASSES OR CONTACT LENSES, DOES (*name*) HAVE DIFFICULTY SEEING? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	1⇨CF4 2⇨CF4 3⇨CF4 4⇨CF4

CHILD FUNCTIONING (AGE 5-17)		CF
CF3. DOES (*name*) HAVE DIFFICULTY SEEING? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF4. DOES (*name*) USE A HEARING AID?	Yes ..... 1 No 2	2⇨CF6
CF5. WHEN USING HIS/HER HEARING AID, DOES (*name*) HAVE DIFFICULTY HEARING SOUNDS LIKE PEOPLES' VOICES OR MUSIC? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	1⇨CF7 2⇨CF7 3⇨CF7 4⇨CF7
CF6. DOES (*name*) HAVE DIFFICULTY HEARING SOUNDS LIKE PEOPLES' VOICES OR MUSIC? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF7. DOES (*name*) USE ANY EQUIPMENT OR RECEIVE ASSISTANCE FOR WALKING?	Yes ..... 1 No 2	2⇨CF12
CF8. WITHOUT HIS/HER EQUIPMENT OR ASSISTANCE, DOES (*name*) HAVE DIFFICULTY WALKING 100 YARDS/METERS ON LEVEL GROUND? THAT WOULD BE ABOUT THE LENGTH OF 1 FOOTBALL FIELD. [OR INSERT COUNTRY SPECIFIC EXAMPLE]. WOULD YOU SAY (*name*) HAS: SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	3⇨CF10 4⇨CF10
CF9. WITHOUT HIS/HER EQUIPMENT OR ASSISTANCE, DOES (*name*) HAVE DIFFICULTY WALKING 500 YARDS/METERS ON LEVEL GROUND? THAT WOULD BE ABOUT THE LENGTH OF 5 FOOTBALL FIELDS. [OR INSERT COUNTRY SPECIFIC EXAMPLE]. WOULD YOU SAY (*name*) HAS: SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF10. WITH HIS/HER EQUIPMENT OR ASSISTANCE, DOES (*name*) HAVE DIFFICULTY WALKING 100 YARDS/METERS ON LEVEL GROUND? THAT WOULD BE ABOUT THE LENGTH OF 1 FOOTBALL FIELD. [OR INSERT COUNTRY SPECIFIC EXAMPLE]. WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	3⇨CF14 4⇨CF14

CHILD FUNCTIONING (AGE 5-17)		CF
CF11. WITH HIS/HER EQUIPMENT OR ASSISTANCE, DOES (*name*) HAVE DIFFICULTY WALKING 500 YARDS/METERS ON LEVEL GROUND? THAT WOULD BE ABOUT THE LENGTH OF 5 FOOTBALL FIELDS. [OR INSERT COUNTRY SPECIFIC EXAMPLE]. WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	1⇨CF14 2⇨CF14 3⇨CF14 4⇨CF14
CF12. COMPARED WITH CHILDREN OF THE SAME AGE, DOES (*name*) HAVE DIFFICULTY WALKING 100 YARDS/METERS ON LEVEL GROUND? THAT WOULD BE ABOUT THE LENGTH OF 1 FOOTBALL FIELD. [OR INSERT COUNTRY SPECIFIC EXAMPLE]. WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	 3⇨CF14 4⇨CF14
CF13. COMPARED WITH CHILDREN OF THE SAME AGE, DOES (*name*) HAVE DIFFICULTY WALKING 500 YARDS/METERS ON LEVEL GROUND? THAT WOULD BE ABOUT THE LENGTH OF 5 FOOTBALL FIELDS. [OR INSERT COUNTRY SPECIFIC EXAMPLE]. WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF14. DOES (*name*) HAVE DIFFICULTY WITH SELF-CARE SUCH AS FEEDING OR DRESSING HIM/HERSELF? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF15. WHEN (*name*) SPEAKS, DOES HE/SHE HAVE DIFFICULTY BEING UNDERSTOOD BY PEOPLE INSIDE OF THIS HOUSEHOLD? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF16. WHEN (*name*) SPEAKS, DOES HE/SHE HAVE DIFFICULTY BEING UNDERSTOOD BY PEOPLE OUTSIDE OF THIS HOUSEHOLD? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	

CHILD FUNCTIONING (AGE 5-17)		CF
CF17. COMPARED WITH CHILDREN OF THE SAME AGE, DOES (*name*) HAVE DIFFICULTY LEARNING THINGS? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF18. COMPARED WITH CHILDREN OF THE SAME AGE, DOES (*name*) HAVE DIFFICULTY REMEMBERING THINGS? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF19. DOES (*name*) HAVE DIFFICULTY CONCENTRATING ON AN ACTIVITY THAT HE/SHE ENJOYS DOING? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF20. DOES (*name*) HAVE DIFFICULTY ACCEPTING CHANGES IN HIS/HER ROUTINE? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF21. COMPARED WITH CHILDREN OF THE SAME AGE, DOES (*name*) HAVE DIFFICULTY CONTROLLING HIS/HER BEHAVIOUR? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF22. DOES (*name*) HAVE DIFFICULTY MAKING FRIENDS? WOULD YOU SAY (*name*) HAS: NO DIFFICULTY, SOME DIFFICULTY, A LOT OF DIFFICULTY OR CANNOT DO AT ALL?	No difficulty ..... 1 Some difficulty ..... 2 A lot of difficulty ..... 3 Cannot do at all 4	
CF23. HOW OFTEN DOES (*name*) SEEM VERY ANXIOUS, NERVOUS OR WORRIED? WOULD YOU SAY: DAILY, WEEKLY, MONTHLY, A FEW TIMES A YEAR OR NEVER?	Daily ..... 1 Weekly ..... 2 Monthly ..... 3 A few times a year ..... 4 Never 5	
CF24. HOW OFTEN DOES (*name*) SEEM VERY SAD OR DEPRESSED? WOULD YOU SAY: DAILY, WEEKLY, MONTHLY, A FEW TIMES A YEAR OR NEVER?	Daily ..... 1 Weekly ..... 2 Monthly ..... 3 A few times a year ..... 4 Never 5	

Appendix 2: Developed disability toolkit and coding instructions

Vulnerability factors (ACEs) original	Vulnerability factors (ACEs) new	Score	Coding notes
Adverse perinatal factors	• Evidence of withdrawal at birth AND/OR suspected NAS/FAS	1	=1 if case notes record child has confirmed NAS/FAS OR there is evidence or maternal drug/alcohol use during pregnancy OR if there is reference to child needing additional medical support for withdrawal post birth
	• Preterm labour	1	=1 if case notes mention child as having been born prematurely or states child was born <37 weeks gestation
	• Low birth weight	1	=1 if case notes refer to low birth weight or state that birth weight was <2500g
	• NICU admission	1	=1 if case notes refer to neonatal ICU stay either directly after birth or in the first month of life
	• Failure to thrive	1	=1 if failure to thrive or concerns about growth are mentioned in case file
Physical abuse/neglect by parent/carer/family member	• Physical abuse AND/OR • Physical neglect	1	=1 if case file refers to experience of physical abuse and/or neglect
Emotional abuse/neglect/lack of love/support/protection by parent/carer/family member	• Emotional abuse AND/OR • Emotional neglect	1	=1 if case file refers to experience of emotional abuse and/or neglect

Vulnerability factors (ACEs) original	Vulnerability factors (ACEs) new	Score	Coding notes
Family history of domestic abuse	• Parental history of domestic abuse AND/OR • Child witnessed violence in the home	1	=1 if evidence of interpersonal violence or coercive control within the parental relationship AND/OR the child has witnessed violence or coercive control within the home
Family history of substance abuse	• Parental substance misuse	1	=1 if there is evidence of parental alcohol or drug misuse, including the use of opiate replacement therapy within case files, and social work concluding that drug use is problematic
Family history of mental health difficulties	• Parental mental health difficulties	1	=1 if there is evidence of parental mental health difficulties, including references to persistent low mood, diagnosed or suspected mental health conditions, referral/use of mental health services and/or references to self-harm, suicidal ideation and suicide attempts/completion
Family history of physical ill health/long-term condition	• Parental learning difficulties • Parental physical ill-health	1 1	=1 if there is evidence of parental learning difficulties =1 if there is evidence of parent(s) having long-term, chronic illness OR parents experiencing acute illness that interferes with care of child OR evidence of parent(s) having physical disabilities or impairments
Breakdown of family relationships	• Breakdown of family relationships	1	=1 if parents have separated at any point AND/OR there is evidence of frequent separation in parents relationship

Vulnerability factors (ACEs) original	Vulnerability factors (ACEs) new	Score	Coding notes
Sexual abuse	• Sexual abuse	1	=1 if case file states that child has been sexually abused OR there is evidence within the case file of childhood sexual exploitation and/or pre-13 sexual activity and/or exposure to age-inappropriate sexual behaviour AND/OR viewing of/exposure to age-inappropriate sexual material via internet or other media AND/OR child is displaying concerning and age-inappropriate sexualised behaviours
Family member incarcerated	• Family member incarcerated (mum and/or dad)	1	=1 if mum and/or dad has been imprisoned
Bereavement	• Bereavement – child lost parent and/or significant person	1	=1 if either or both parents have died OR if the child is recorded as having suffered another significant bereavement, i.e. death of parental figure, sibling or trusted/important adult
Parental abandonment	• Child abandoned/disowned by parents	1	=1 if child has been abandoned/disowned by one or both parents, including revocation or lack of recognition of parental rights
VULNERABILITY FACTORS (TOTAL SCORE)		**17**	

Contextual factors (broad)	Contextual factors (specific)	Score	Coding notes
Homelessness/housing instability	• Homeless (ever) • Housing instability (ever)	1	=1 if either parent has a history of experiencing homelessness or housing instability
Housing conditions	• Cleanliness of household AND/OR • Lack of essential household goods AND/OR • Overcrowding AND/OR • Safety of home	1	=1 if case file records concerns about the cleanliness or furnishing of household (including not having essential white goods, appropriate number of beds for household occupants etc) AND/OR states that the household is overcrowded AND/OR discusses concerns about the safety of the home (i.e. unsafe electrical wiring, access to alcohol/drugs paraphernalia by child, access to weapons by child or generally unsafe living conditions for children).
Socioeconomic deprivation	• Household in receipt of/reliant on benefits AND/OR • Household debt/problem debt	1	=1 if case file identifies child is from a non-workless household and/or a household reliant upon benefits and/or experiencing difficulties paying bills or with the accumulation of debts and/or child resides in 40% most deprived areas (SIMD via postcode) at time of referral to the reporter.
Social isolation	• Victim of bullying • Does not have a trusted adult AND/OR does not have someone identified as being important to the child	1 1	=1 if child is considered to be a victim of bullying =1 if child is **not** considered to have a trusted adult or does **not** have someone who is considered to be important to them

Contextual factors (broad)	Contextual factors (specific)	Score	Coding notes
Educational issues	• Coping with education	1	=1 if child is **not** coping in education at any time point
	• Poor attendance and/or Refusal to attend	1	=1 if child has poor school attendance or has refused to attend school at any time point
	• Exclusions	1	=1 if child has been temporarily or permanently excluded from education
	• Special educational provisions and/or individual plan, statement of needs	1	=1 if child has special educational provisions, receives additional supports within school, has an individual plan and/or a statement of educational need
	• Does not participate in extracurricular activities	1	=1 if child does **not** participate in extracurricular activities
Exposure to community violence/abuse	• Victim of community violence AND/OR • Witnessed community violence	1	=1 if child has been a victim of and/or witnessed violence in the community
CONTEXTUAL FACTORS (TOTAL SCORE)		11	

Functioning (broad)	Functioning (specific)	Score	Coding notes
Identified learning disability	• Has identified learning disability OR • Evidence of suspected learning disability (using case files information highlighted in red)	5	=5 if a child has a diagnosed learning difficulty or is perceived to have a learning difficulty. Case files might mention the following issues rather than directly specifying a learning difficulty: child has difficulty learning things, memory impairments, cognitive impairments affecting learning, global deficit disorder affecting learning, child has failed to meet developmental milestones for learning and play, child has difficulty playing, child does not play in an age appropriate way, i.e. engages in parallel play but not younger toddler, and problems with number/memory recognition and recall (or dyscalculia)
Identified dyslexia	• Has identified dyslexia OR • Evidence of suspected dyslexia and/or assessment referral	5	=5 if child has diagnosed dyslexia or is suspected of being dyslexic or has been referred for assessment for dyslexia.
Identified visual impairment	• Has identified visual impairment or delay OR • Evidence of suspected visual impairment or delay	5	=5 if child is recorded as being blind or having a visual impairment, i.e. difficulty seeing or can't see at all or has a record of having a developmental delay for vision

Functioning (broad)	Functioning (specific)	Score	Coding notes
Identified hearing impairment	• Has identified hearing impairment OR • Evidence of suspected hearing impairment	5	=5 if child is identified as being deaf or having a hearing impairment, including references to the child wearing hearing aids, having a cochlear implant or communicating through sign language. Case files might reference child having a suspected hearing impairment, i.e. difficulty hearing sounds like voices and/or music.
Identified physical or motor impairment	• Has identified physical or motor impairment or delay OR • Evidence of suspected physical or motor impairment or delay	5	=5 if child has an identified physical or motor impairment, or a developmental delay in their motor skills. Case files may discuss the child not having age appropriate fine motor skills, experiencing difficulty picking up objects with their hands (i.e. cannot hold a pen or use eating instruments), poor or delayed development of hand-eye coordination and appropriate mark making and writing skills, dyspraxia or general problems in motor coordination, the child requiring equipment/assistance for walking, having difficulty walking or climbing steps, and relying upon a wheelchair.
Identified language or speech disorder	• Has identified language or speech disorder, delay or difficulties OR • Evidence of suspected language or speech disorder, delay or difficulties	5	=5 if child has an identified language or speech disorder, delay or difficulties. Case files may record that the child has difficulty understanding and processing language, or that they are difficult to understand when they are speaking. Attendance or referral to speech and language therapy (SAL/SALT) may also be noted.

Functioning (broad)	Functioning (specific)	Score	Coding notes
Identified autistic spectrum disorder	• Has identified autistic spectrum disorder OR • Evidence of suspected ASD and/or assessment referral	5	=5 if child has a diagnosed autistic spectrum disorder (autism, aspergers, pervasive developmental disorder) or is suspected of having autistic spectrum disorder/traits or has been referred for an ASD assessment. For suspected disorders case files may not mention autism directly but mention concerns about cluster of behaviours relating to: not responding to their name, avoiding eye contact, not smiling when you smile at them, getting very upset if they do not like a certain taste, smell or sound, sensory processing issues, repetitive movements, such as flapping their hands, flicking their fingers or rocking their body, not talking as much as other children, repeating the same phrases, not seeming to understand what others are thinking or feeling, finding it hard to say how they feel, liking a strict daily routine and getting very upset if it changes, having a very keen interest in certain subjects or activities, getting very upset if you ask them to do something, finding it hard to make friends or preferring to be on their own, taking things very literally – for example, they may not understand phrases like "break a leg")
Identified attention deficit disorder	• Has identified attention deficit disorder OR • Evidence of suspected attention deficit disorder and/or assessment referral	5	=5 if child has diagnosed attention deficit disorder or is suspected of having attention deficit disorder or has been referred for an ADD assessment. Case files may not mention ADD directly but might mention concerns about cluster of behaviours relating to: having a short attention span and being easily distracted, making careless mistakes – for example, in schoolwork, appearing forgetful or losing things. being unable to stick to tasks that are tedious or time-consuming, appearing to be unable to listen to or carry out instructions, constantly changing activity or task, having difficulty organising tasks, being unable to sit still, especially in calm or quiet surroundings, constantly fidgeting, being unable to concentrate on tasks, excessive physical movement, excessive talking, being unable to wait their turn, acting without thinking, interrupting conversations, little or no sense of danger)

Functioning (broad)	Functioning (specific)	Score	Coding notes
Identified social, emotional and behavioural difficulty from early age	• Has identified social, emotional and behavioural difficulty **from an early age** AND/OR • Has identified ongoing difficulties in controlling and/or managing their emotions and behaviour AND/OR • Evidence of suspected social, emotional and behavioural difficulties and/or assessment referral	5	=5 if child has diagnosed social, emotional and behavioural difficultly or is suspected of having social, emotional and behavioural difficulties. Case files may not directly identify SEBD but instead mention concerns about a cluster of behaviours relating to: disruptive, antisocial and uncooperative behaviour, temper tantrums, frustration, anger and verbal and physical threats / aggression, withdrawn and depressed attitudes, anxiety and self-harm, stealing, truancy, vandalism, drug abuse, setting fires.

Functioning (broad)	Functioning (specific)	Score	Coding notes
Identified physical health problem/chronic health condition	• Has identified physical health condition (chronic or long-term) with evidence of medical/specialist care OR • Evidence of suspected long term or chronic physical health condition and/or assessment referral	5	=5 if child has diagnosed or suspected long term health condition, including references to receiving medical care or being referred to specialists for that condition
Difficulty with self-care such as feeding, washing, dressing him/herself, not age appropriate toilet training?	• Has identified difficulties (age inappropriate) with self- care, including feeding, washing, dressing, age appropriate toilet training OR • Evidence of suspected difficulties with self-care, including feeding, washing, dressing, not age appropriate toilet training	5	=5 if child has (age inappropriate or medically caused) difficulties with self-care such as feeding, washing and dressing. Include lack of age-appropriate toilet training and issues such as soiling and smearing. Do not code if due to control issues or if soiling is age appropriate or due to an identified stressor like fear.

Functioning (broad)	Functioning (specific)	Score	Coding notes
Difficulty remembering or concentrating on things?	• Identified difficulties concentrating on work, play or activities?	5	=5 if reports indicate that child frequently experiences difficulty concentrating on work, play or activities or if the reports mention that child appears to have difficulty with their memory, including long-term, short-term or working memory.
Difficulty making friends?	• Identified as having no friends and/or difficulty making or maintaining friend/ships AND/OR • Shunned or other children afraid of child OR • Demonstrates bullying/aggressive behaviour towards siblings/other children	5	=5 if the case file indicates that a child has no friends or has difficulty making and maintaining friendships. The case file may mention: concerns about controlling, aggressive or bullying behaviour towards children that they want to be friends with (or their siblings/cousins or other children residing in placement with them); intimidation and scaring children that they want to be friends with; being unable to name friend; being socially isolated; and not having skills needed to make and maintain friendships.

Functioning (broad)	Functioning (specific)	Score	Coding notes
Is child anxious, nervous or worried?	• Identified as anxious or having social anxiety OR • Evidence of suspected anxiety/social anxiety AND/OR • Identified as nervous and/or worried OR • Evidence of suspected nervousness/worrying	5	=5 if child is identified as being anxious, nervous or worried over an extended period of time, or is recorded as having or being suspected of suffering from anxiety or social anxiety. Code as 5 if the anxiety, nervousness or worrying is a cause for concern rather than general childhood worries.
Is child sad or depressed?	• Identified as having low mood, feeling sad OR • Evidence of suspected low mood, feeling sad	5	=5 if child is identified as experiencing low mood and/or feeling sad over an extended period of time, or is recorded as having or being suspected of having depression or another mood disorder.

Functioning (broad)	Functioning (specific)	Score	Coding notes
Has child self-harmed or had suicidal thoughts?	• Evidence of self-harming and/or suicidal thoughts AND/OR • Making threats of suicide	5	=5 if child has self-harmed, attempted suicide or is actively voicing threats of suicide. Suicidal ideation should be coded if the child is having abstract thoughts about ending their life or feeling that people would be better off without them, along with thinking about (and/or voicing) methods of suicide and/or making clear plans to take their own life.
Does child have an identified or suspected mental health condition?	• Evidence of having been diagnosed with a mental health disorder or being referred to and treated by mental health professionals AND/OR • Evidence of suspected mental health condition and referral for diagnostics and treatment	5	=5 if child has diagnosed or suspected mental health condition, including references to receiving medical care or being referred to specialists for that condition
FUNCTIONING RISK FACTORS (TOTAL SCORE)		**85**	

OVERALL SCORE	**108**

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