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Save the Children

Disability-inclusive child safeguarding **toolkit**

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Contents

Tool 1 Disability-inclusive child safeguarding risk assessment

This tool is designed to help practitioners working with children with disabilities. Using participatory approaches[1], the tool helps to identify potential safeguarding risks and risk mitigation strategies to ensure all activities are safe and inclusive.

Safe programming is not about mitigating all risks, all actions have risks and attempting to mitigate all risks may mean the programme will not go ahead. This is particularly important when working with children with disabilities as there may be more risks and therefore, if we are attempting to mitigate all risks there is a greater chance that the activity will not go ahead resulting in even less provision for children with disabilities. However, it is essential we identify, monitor, and build into our programme design risks that children with disabilities may experience as a result of engaging in activities or programmes.

Who is this for what it will offer you?

This tool is for all organisations who work with children, it should complement existing risk assessments ensuring a disability lens is applied to all risk assessments. Even if your target audience is not be children with disabilities, all practitioners who work with children will come into contact with children with disabilities.

The tool contains; **a)** a short question and answer section, **b)** a disability-inclusive risk assessment template containing practical examples and **c)** guidance on risk ratings. This tool compliments chapter 7, page 85 of the disability-inclusive child safeguarding guidelines.

For the purpose of this tool we are looking at activity/project/programme risk assessments.

1. **Discuss & identify risks** - with children with disabilities, parents and caregivers and organisations of persons with disabilities

2. **Develop risk mitigation strategies** - with children with disabilities, parents and caregivers and organisations of persons with disabilities

3. **Implement risk mitigations** - with parents and caregivers and organisations of persons with disabilities

4. **Learning informs practice** - listening and learning from children with disabilities is the best way to safeguard them

1 A participatory approach is one in which everyone who has a stake in the intervention should be part of the process

Risk assessments: Questions & answers

Q1. What is a risk assessment?

A risk assessment is a systematic process of identifying and evaluating the potential risks that may be involved in a planned activity. A risk assessment defines which risks that are likely to cause harm to participants and equips individuals with the knowledge to make decisions on level of risk and define what mitigating actions can be put in place to reduce those risks.

Q2. Why are risk assessments important for child safeguarding?

Child safeguarding is about creating a safe and empowering environment which values and respects the human rights of all beings (especially the most at risk which might include children with disabilities). Risk assessments are a vital safeguarding tool enabling practitioners to carefully examine the ways in which their work can cause harm to children with disabilities and identify ways to reduce the risk of harm. A risk assessment itself is not sufficient will not safeguard children with disabilities, but it does set the framework for identifying where further action is needed to safeguard children including those with disabilities effectively.

Q3. What should be included in a risk assessment?

All risks that could potentially cause risk or harm to an individual participating in the activity including prior to the activity (considering for example transport needs) and following the activity. We know that we cannot foresee, mitigate, or respond to all safeguarding risks, therefore, risk assessments should also operate as a decision-making tool. What is the level of risk? Is the risk manageable? Is the risk too high for the activity to go ahead as designed? The risk assessment should also reference referral pathway for safeguarding concerns, which should be detailed in the referral mapping (see chapter 9.6, page 161 in the disability-inclusive child safeguarding guidelines for guidance on referrals and referral mapping tool).

Q4. How is a 'disability-inclusive' risk assessment different to regular risk assessments

A disability-inclusive lens should be applied to all risk assessments. This should prompt, identify, and mitigate risks that are specific and unique for children with disabilities. All programmes and activities should be inclusive in order to be fully safe for children with disabilities, and we should never make assumptions around disability as each individual's experience is different. Organisations should integrate risks for children with disabilities into existing risk assessment templates to foster a disability-inclusive child safeguarding culture, applying a disability-inclusive lens must not be seen as an add-on.

Q5. Who should carry out the risk assessment?

This will likely differ in each organisation. It might be the responsibility of the Programme Manager; or the Safeguarding Officer/ Focal Point or a disability expert. Most importantly, the risk assessment should be carried out by people who understand and are in contact with organisations of persons with disabilities or children with disabilities. Organisations should clearly identify who should own the process and provide oversight of implementation and follow up on the risks and mitigation measures identified.

Q6. Who should be involved in the disability-inclusive child safeguarding risk assessment process?

Risk assessments should be a collaborative process. Key project stakeholders should be involved in designing and implementing risk assessments to ensure they are context specific. Stakeholders should include children with disabilities, their parents or caregivers, and representative organisations of persons with disabilities. Power relations between these groups can result in additional risks which should be observed and mitigated, for example, if a child with disabilities has been invited to participate in a risk assessment with adults they do not know, they may not feel comfortable criticising plans or offering suggestions. This is especially relevant when staff travel internationally to conduct risk assessments. Care must be taken to enable and empower children with disabilities participate fully in the risk

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assessments together with peers or adults they know in an environment in which they are comfortable. Children with disabilities know and understand the risks better than anyone.

Q7. When should a disability-inclusive child safeguarding risk assessment be carried out?

Risk Assessments should be seen as live document, reviewed, and updated throughout the project cycle. An initial risk assessment should be conducted during project design, and then reviewed and updated before each activity. Risk management is an ongoing process; therefore, assessments need revisited throughout a project cycle to check that mitigation measures are in place and working and to ensure learning is captured. The initial risk assessment must be conducted well ahead of a planned activity to allow enough time to implement risk mitigation strategies, this may require more time for risks specific to children with disabilities due to the additional requirements relating to accessibility and inclusion.

Q8. How should a risk assessment be carried out?

Using a participatory approach; key stakeholders should be identified and brought together to discuss potential risks. Each risk should then be scored in terms of likelihood and potential impact. Then key stakeholders should discuss potential mitigations for each risk, after which the risk should be scored again (likelihood/ impact). Mitigations should be multifaceted; they should consider different disability types and be detailed in terms of what steps are to be taken and by whom. Mitigations should be linked to budgeting.

Q9. What are some of the risks we need to think about when applying a disability-inclusive lens to risk assessments?

Risk is often categorised in three areas: **1)** staff and personnel, **2)** programme and processes and **3)** physical space. However, when applying a disability-inclusive lens, we must also think about risk in terms of the barriers children with disabilities experience that put them at risk.

These can include:

Attitudinal Risk prevailing cultural and social norms around the perceptions of children with disabilities including lack of awareness around the range of disabilities and limited knowledge of intellectual disabilities or mental health disorders.

Institutional Risk there remains fundamental conscious and unconscious bias that limit individual's ability to see all people as equal human beings with unique perspectives and contributions to make this often results in the absence of support systems/ tools (interpreters, personal assistants or caregivers). This compromises how well persons with disabilities are safeguarded by organisation.

Communications Risk children with disabilities may need information or materials in different formats e.g. braille, sign language etc. Lack of accessible information or materials can leave individuals feeling excluded and disempowered. This can result in safeguarding risks such as lack of informed consent.

Medical Risk children with disabilities may have complex medical support needs requiring additional support in terms of caregivers in order for them to fully participate in the activity.

Financial Risk lack of awareness around the need for additional financial support (e.g. for caregivers or transport costs) can translate in exclusion or partial exclusion from an activity.

Environmental Risk the physical environment is vital for meaningful participation. Children with disabilities may face challenges that could negatively impact on their engagement e.g. accessibility of the building's facilities, noise levels in the venue etc.

Some examples have been provided in the risk assessment template (page 12-15).

Q10. How best to budget for this?

Conducting a through and inclusive risk assessment will take staff time and require budget to bring key stakeholders together, you will need to consider budget implications for support services such as sign-language interpreters etc. Risk mitigation activities may also have cost implications e.g. providing accessible communications material. Unless specific costs relating to risk mitigations for (particularly for children with disabilities) have been considered and budgeted for, projects will not be able effectively safeguard them. The earlier in the project cycle costs are identified - alongside costs for awareness-raising, reporting, and responding - the less expensive it will be, and the more likely risks will be mitigated. It is hard to know detailed costs before a full risk assessment is completed. However, as a guide, Mobility International recommend allowing 3%–5% of the total programmatic costs allocated to disability inclusion and 2%–3% of the total administrative costs (reasonable accommodation for staff and accessible communication, etc.).

Q11. How to use the Programme Risk Assessment

The programme risk assessment should be used during the design of a programme. This is a top-level risk assessment that looks at all risks associated with programme implementation in relation to safeguarding, including risks for children with disabilities. Practitioner can use standard internal project or programme risk register templates and simply add a column for disability-inclusive mitigating actions. This additional column will force practitioners to consider if identified mitigation strategies are fully inclusive and what additional steps will need to be taken to ensure children with disabilities are protected during project programme implementations. Example disability-inclusive mitigations have been provided in the template below.

Q12. How to use the Activity Risk Assessment

The template allows practitioners to systematically think through the environmental, attitudinal, communication and institutional barriers that exists for keeping children with disabilities safe during activity planning and implementation. This risk assessment should take place during activity planning during project implementation and ahead of any activities including all children. Multiple risks under each barrier can be identified depending on the nature of the activity. This risk assessment should be conducted separately or as an additional exercise alongside usual activity risk assessments conducted by practitioners. Example risks and mitigations have been provided in the template below.

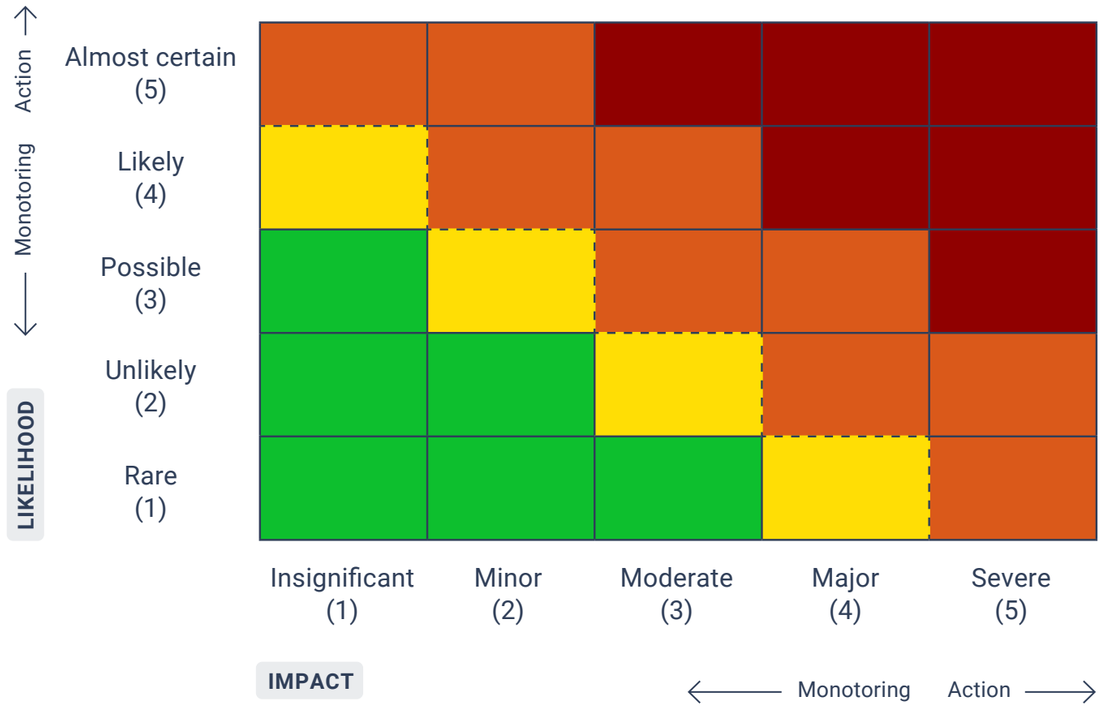
Simple risk categorisation guidance

Overall risk rating

Please identify the overall rating of an identified risk by finding the intersection of your probability and impact ratings in the matrix below and cross-referencing the colour of the cell with the four risk ratings to the right.

- **Minor**
- **Moderate**
- **Major**
- **Severe**

Likelihood vs. Impact Matrix



Disability-inclusive child safeguarding programme risk assessment

Description of Programme:

Location of the Programme:

Date(s) of the Programme:

Country Office Child Safeguarding Focal Person:

Risk (description)	Risk Rating			Mitigating Action	Disability-Inclusive Mitigation Required?	Risk Rating following mitigation			Responsible person
	Likelihood	Impact	Rating			Likelihood	Impact	Rating	
Activities do not have sufficient impact as children have not been consulted on project design.	4	4		Children are consulted during the design of the project.	Children with disabilities are consulted during the design of the project using accessible and appropriate consultation methodologies for various needs.	2	2		Project Manager
Inadequate vetting procedures and due diligence for staff adults working with children.	3	3		Vetting procedures and due diligence for staff adults working with children with disabilities.	There are enhanced due diligence and vetting criteria for staff working with children with disabilities.	2	2		HR Staff
Full consent from children is not obtained for their participation in activities or use of data and therefore their privacy, dignity and rights are not protected.	4	4		Staff are trained to understand how to collect full consent or assent from children and set up accountability systems to monitor that this onset has been obtained.	Staff are trained on how to collect informed full consent or assent from children and youth with disabilities and budget for sign interpreters or additional time needed to obtain consent from children and youth with disabilities is made available.	2	2		Project Manager

Disability-inclusive child safeguarding activity risk assessment

Description of Activity:
Key Event Contacts:
Location of the Activity:

Date(s) of the Activity:
Country Office Child Safeguarding Focal Person:

Risk Type	Risk (description)	Risk Rating			Mitigating Action	Risk Rating following mitigation			Responsible person
		Likelihood	Impact	Rating		Likelihood	Impact	Rating	
Environmental risks	Children with disabilities have not been consulted activity preparations encompasses.	4	4		Children with disabilities are consulted prior to the activity using accessible and appropriate consultation methodologies for various needs	2	2		Project Manager
	Training venues for children are inaccessible and unsafe for children with disabilities.	3	3		Disability-inclusive accessibility audits are conducted by staff on all spaces where activities take place.	2	2		Project Manager
					Environment walks are conducted with children with disabilities to assess safety and accessibility.				
					All children and youth with disabilities are familiarised with spaces where activities take place.				
Attitudinal risks	Stigma and cultural beliefs relating to disability mean staff abuse, bully or discriminate against children with disabilities during project activities, either intentionally or unintentionally.	4	4		The staff code of conduct explains that any form of discrimination, prejudice or exclusion of children with disabilities will be taken seriously, and disciplinary action will be taken.	1	1		Project Manager
					Safeguarding training includes discussion and advice on bias and stigma relating to disability.				Safeguarding Manager
Communication risks	Children with disabilities are not aware of safety procedures during activities (e.g., emergency exits) because safety information is not provided in accessible formats.	4	4		Staff review support needs of participants and provide them tailored safety information.	2	1		Project Manager
					Safety information is provided in formats suitable to the needs of the individuals and in multiple formats.				Project Manager
					Practitioners check Understanding of safety information.				Project Manager
Institutional risks	Internal policies and practices do not requite practitioners to assess specific risks children with disabilities experience before during or after activity implementation.	4	4		Train staff to understand that assessing, responding to and mitigating the specific risks children with disabilities is a pre-requisite to any activity delivery and an organisational expectation outlined in safeguarding procedures and quality standards.	2	2		Safeguarding Manager

Tool 2 Safeguarding referral mapping tool: Meeting the needs of children with disabilities

Questions & answers

Q1. What is this tool?

This tool compliments Chapter 9 (page 143) of the disability-inclusive child safeguarding guidelines. It is designed to help practitioners working with children with disabilities effectively map existing referral mechanisms so that when child safeguarding concerns they can respond quickly and appropriately. The tool consists of a short QA and a referral mapping template.

Q2. What is included in the mapping template?

The template is divided into six sections designed to explore all areas of referral mapping from an overview of existing projects to detailed mapping of statutory, non-statutory and community services-based systems and services. Understanding the cultural context is vital for decision making around referrals, therefore, the mapping template also includes a section on community attitudes, customs, and practices. There are complex challenges associated with referral services, particularly catering for children with disabilities and in countries where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services may be of poor or variable quality. We acknowledge that available services may not meet all of the child's urgent needs and that they may need additional support to access services, therefore this mapping includes directory of support services for children with disabilities e.g. sign language interpretation.

Q3. Why is it important?

Responding to concerns; when a child safeguarding incident is reported to an organisation it is important that organisations can act quickly and efficiently in order to; mitigate any immediate risk of harm, ensure that the survivor can access specialist support services and, to reduce future risk of harm. Ensuring safety is 'built in'; the process of including all stakeholders in the development of a referral map also ensures that organisations have full oversight of the context in which they work from a disability-inclusive perspective. This will help to identify who needs to be involved in other safeguarding processes such as the development of risk assessments and reporting mechanisms and the support needed to ensure people with disabilities are fully involved in these processes.

Q4. When should a referral mapping be completed?

The mapping is completed prior to any activity to ensure it is embedded in safeguarding practice and well understood. The mapping should be regularly reviewed and updated.

Q5. How it should be completed?

The organisation should nominate one person to lead the referral mapping process, ideally, this should be the Safeguarding Focal Point. It is important to include a range of people in the exercise including, children with disabilities, Organisations of people with disabilities, parents/caregivers and siblings, Disability Officers (also referred to as 'Disability Councillors' or 'Disability Representatives'), parent support groups, community-based rehabilitation groups (CBR). More detailed information on who to include is included on page 162 of the guidelines.

Q6. How does the mapping compliment other safeguarding tools?

Referral mapping should be an integral part of organisational safeguarding practice. It should be referenced in reporting and response systems and in programme or project risk assessments.

Q7. Additional considerations

Budget some support services e.g. sign language translators may need additional budget. Organisations should include a budget line for 'safeguarding case management support'.

Proportionate approach recognising that safeguarding capacity is sometimes limited, organisations should take a proportionate approach to completing the mapping exercise, for example, you may not be able to complete all sections or engage all stakeholders. The mapping should be seen as a live evolving document that draws information in from others working with children with disabilities in your area.

Safeguarding:
Referral mapping template

Country:	
Scope of mapping e.g. whole country, region or community:	
Date of mapping:	
Updated:[1]	
Safeguarding Focal Point:[2]	
Contact Email:	
Country Lead:	
Authors/contributors:[3]	

Section 1:	Overview (write below italics)
Number and type of projects:	*Is this mapping for one programme or several programmes? Are the in the same locality or multiple localities?*
Partners:	*Include the names of all partners*
Names and contact emails of location/project-specific safeguarding focal points:	*All partners should have a named safeguarding focal point*
Funders and their safeguarding requirements:	*For example FCDO, USAID*

1 This form should be seen as a live document, reviewed and updated regularly - as a minimum, annually or if there is a significant change in the countries circumstance e.g. civil war, health pandemic
2 Safeguarding Focal Point should lead the referral mapping process
3 You should engage people with disabilities in completing this mapping - see guidance in question 4

Section 2:	Community attitudes, customs and practices - particularly those that affect people with disabilities (write below italics)
Identify any harmful practices such as early marriage or female genital mutilation, and details of any locations where this is known/believed to be particularly prevalent.	*(example from Kenya) Early marriages - The practice of giving away girls for marriage at the age of 11, 12 or 13, after which children are expected, is prevalent among the Maasai, Samburu and Turkanas.*
Any informal observations on attitudes or behaviours seen in country that may cause harm to children with disabilities (particularly around perceptions of people with disabilities).	*For example, the perception that a child's condition is a demon or curse caused by a family wrongdoing*
Details of any informal or community-based justice and safeguarding mechanisms and how they function (if known).	*Community Based Groups that have been trained on how to raise awareness about gender and child protection*
Details of any formal justice systems and how children with disabilities interact with them (if known).	*For example, are Chiefs or Village given legitimacy by local police officers to make and enforce decisions?*

Section 3:		Detailed Service Mapping			
Statutory Protection:					
List of ministries/ bodies/agencies with statutory authority for the protection of children *e.g. Child Protection Unit, Ministry for youth, Police gender desk*	**Type of agency/ service offered**	**Does this agency/ service have specific provision for children with disabilities or other groups e.g. young women (be as specific as possible)?**	**How effective is this agency/body?[4]**	**Can this agency be contacted in the event of an incident? If yes, please give contact details of the senior officer/s who may be contacted (name, position, telephone and email contact).**	**Comments** *e.g. do they have a positive reputation for working with children with disabilities?*

4 For example: Provision of protection services based on national/local legislation or regulation; adequately resourced; staff capacity; outreach/accessibility for children with disabilities.

NGOs (local and international), professional agency/body/network etc. for survivor response:[5]					
Name of agency/ service	**Type of agency/service (medical, health, safe housing, child centre, refugee centre, etc.)**	**Does this agency/ service have provision for children with disabilities or other groups e.g. young women (be as specific as possible)?**	**Location**	**Detail any local joint arrangements for dealing with child protection incidents**	**Can this agency be contacted in the event of an incident? If yes, please give contact details of the senior officer/s who can be contacted (name, position, telephone and email contact).**
Organisations of people with disabilities who could support survivor response:					

Section 4	Safeguarding organisations of persons with disabilities networks or alliances - Details of any professional networks/alliances involved in child safeguarding, disabilities and/or child protection.			
Network/ Alliance	**Is it national/ regional or international**	**Safeguarding or Child Protection Experience**	**Disability Focus (if applicable)**	**Comments**

5 For example if a child has been sexually abused, they will need both medical and emotional support that is disability-inclusive and accessible

Section 5	Specialist Support Services				
Type of disability /support needed	**Name of person/ agency/service**	**Specific services available**	**Location**	**Detail of point person (name, position, telephone and email contact)**	**Have you used this service? If yes, please give date and person who supported you.**
Hearing impairment/ can provide sign language interpretation for example					
Visual impairments/ can translate information provided in braille for example					
Intellectual disabilities or mental health disorders understand need and can provide support					
Psychosocial disabilities/ this could be a reputable counselling service					

Section 6[6]	Country legal framework and legislation
Details of any government bodies or organisations with statutory authority for the safeguarding of children	
Summary of legislation governing welfare/safeguarding/protection of children with disabilities.	
International conventions on welfare/ safeguarding/protection of children with disabilities, to which the country is a signatory or has ratified. (e.g. UN Convention on Rights of the Child.)	
Brief analysis of extent of implementation/enforcement of legislation, as far as this is known.	
Local police position on investigation of criminal assault against children with disabilities, the extent to which they are inclusive of people with disabilities and the likelihood of prosecution of such offences.	
Legal age of consent, and of marriage, in country and legislation covering this.	

6 Seek information from organisations of persons with disabilities networks or alliances where possible

Tool 3 Ensuring safeguarding reporting mechanisms work for children with disabilities

This tool is designed to help practitioners to ensure safeguarding reporting mechanisms work for children with disabilities. The tool contains;

a) a short Q&A section to explore why accessible reporting mechanisms are important, how, and when to develop them and who to engage in the process,

b) a reporting mechanisms checklist for organisations working with children with disabilities. This tool compliments section eight, of the disability-inclusive child safeguarding guidelines on reporting safeguarding concerns.

Q1. Why is it important?

Low reported numbers of child safeguarding incidents concerning children with disabilities do not mean they are not experiencing safeguarding violations, instead it indicates that we are simply not hearing about them. We know that children with disabilities are three to four times more likely to be victims of violence[1] than those without disabilities. We also know that girls with disabilities are at high risk of being sexually assaulted, an estimated 40%–70% of girls with disabilities have been sexually abused before they reach 18 years of age.[2] One of the key reasons that safeguarding reports from or regarding children with disabilities are rare is that reporting mechanisms are often inaccessible or inappropriate for children with disabilities and that staff and community members are not aware or incentivised to report concerns involving children with disabilities. Practitioners therefore must assess existing reporting mechanisms and adapt them to ensure they are appropriate and accessible for children with disabilities.

Q2. What are the specific considerations when setting up accessible reporting mechanisms for children with disabilities?

a) Children with disabilities face unique barriers to reporting safeguarding incidents

b) Others are less likely to report safeguarding incidents involving children with disabilities due to cultural norms or stereotypes about people with disabilities.

c) Children with disabilities are often not aware of their rights and do not understand when reports of safeguarding incidents should be made.

d) Children, including children with disabilities, rarely report sexual abuse immediately after the incident occurs.

e) Disclosures of child sexual abuse are primarily made by others who witness or suspect abuse.

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1 World Health Organization (webpage). Disabilities and Rehabilitation: Violence against adults and children with disabilities. https://www.who.int/disabilities/violence/en/ [Accessed: 5 March 2021
2 The Roeher Institute (2004). Violence against Women with Disabilities." Ottawa, Public Health Agency of Canada. at: https://www.un.org/womenwatch/daw/csw/csw57/ side_events/Fact%20sheet%20%20 VAWG%20with%20disabilities%20FINAL%20.pdf [Accessed via UN.org on 25 February 2021]

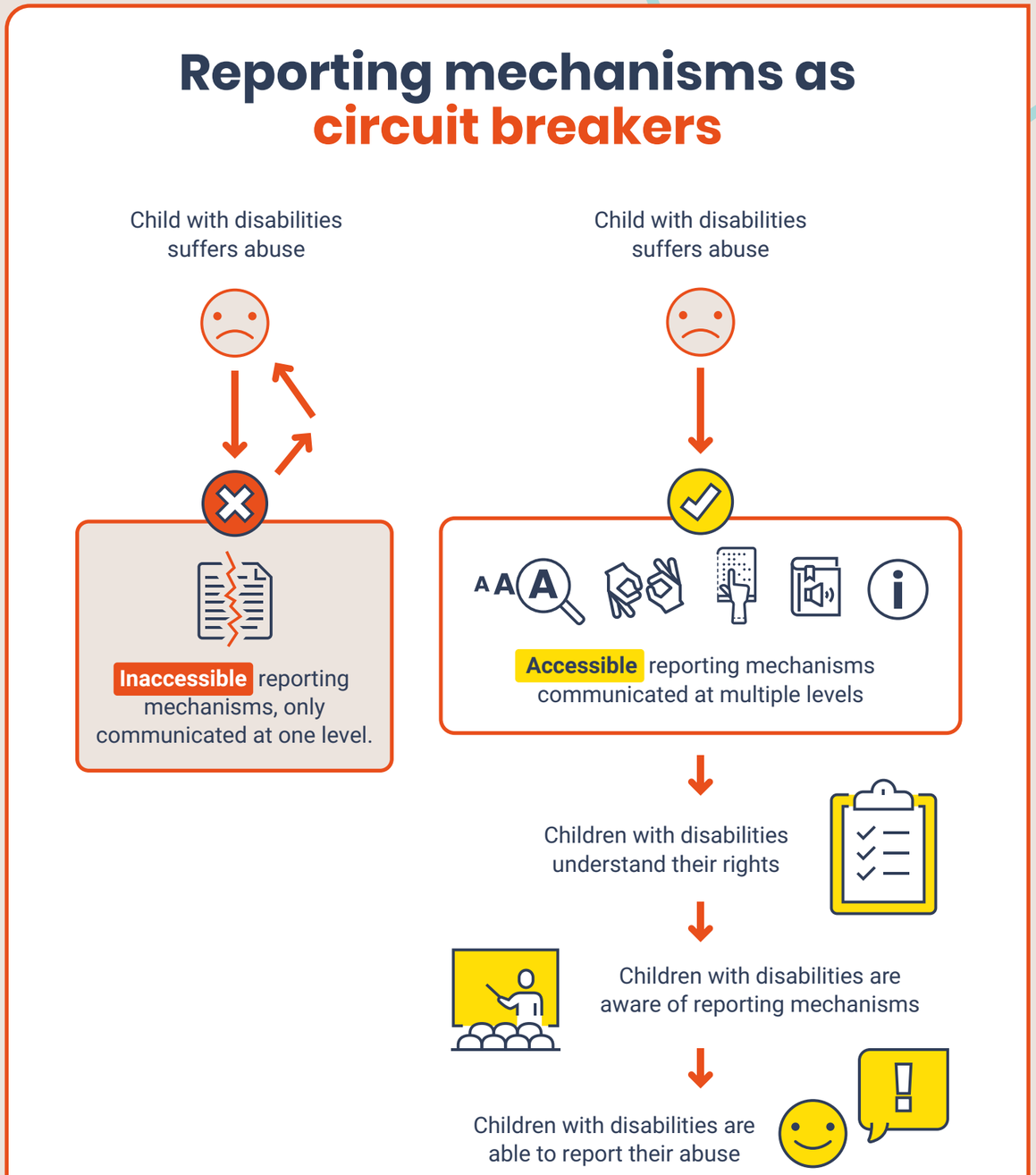

Figure 7

An effective reporting mechanism requires children with disabilities to recognise abuse and child safeguarding concerns, and needs well-functioning reporting channels they can access to make disclosures. However, if children with disabilities are not made aware of reporting channels available to them, they will be unable to report, and as a result, child safeguarding concerns and abuse may go undetected.

It is useful to think of an effective, inclusive child safeguarding reporting mechanism like an electrical circuit. If any of the mechanism's components fails, the circuit breaks, the information will not flow, and the reporting mechanism itself will not work. The most important part of a functional circuit is that children with disabilities know their rights, have access to accessible reporting mechanisms and understand when, where and how to report (Figure 7).

Q3. What are the barriers to reporting for children with disabilities?

Children with disabilities may face a multitude of barriers to reporting safeguarding concerns. These include (but are not limited to): physical (for example, the high positioning of the phone/ feedback box), visual (for example, unable to read written information or fill in written reports), psychosocial (for example, find reporting frightening or distressing and might assume that their complaint would not be believed). Therefore, practitioners need to understand the barriers children with disabilities face and ensure that multiple reporting mechanisms are developed and respond to the type of barriers they experience. more information can be found in the disability-inclusive child safeguarding guidelines in Chapter 8, Tool 6 Examples of adjustments to overcome barriers to reporting.

Q4. How do I ensure reporting mechanisms are inclusive for children with disabilities?

The best way to ensure child safeguarding reporting systems and mechanisms are disability-inclusive is to include children with disabilities in thier design. Children with disabilities should be consulted on how they best receive important information (assessable formats), who they would feel comfortable reporting to and where they might go to make a report. This will ensure their experiences are considered and mechanisms can be tailored to meet their need.

Practitioners should consider the universal design of the mechanism and its accessibility for example, are children with disabilities able to reach places where reports can be made? Are they able to communicate effectively through the reporting formats? Practitioners should also consider reasonable accommodations[3] for example, are there supported decision-making alternatives for persons who require assistance in making decisions or communicating decisions to others? Has legal capacity been considered (the ability to hold rights and duties - legal standing - and to exercise those rights and duties - legal agency)?

Q5. Do we need accessible reporting mechanisms if children with disabilities are not our target group?

Yes. All programmes and activities should be inclusive in order to be fully safe for all children including children with disabilities. We should never make assumptions around disability as everyone's experience is different. Organisations should ensure that reporting mechanisms are accessible and inclusive for all, this will foster a disability-inclusive child safeguarding culture, applying a disability-inclusive lens must not be seen as an add-on.

3 See chapter 2.3 in the disability-inclusive child safeguarding guidelines for more information

Q6. What formats should I consider, that would ensure reporting mechanisms are accessible for children with disabilities?

Reporting formats must be relative to the type of barriers children with different disabilities experience. A reporting format well-suited to one child with disabilities may be entirely inaccessible to another. For example, reporting over the phone may be ideal for children with physical disabilities who are unable to travel to submit a report but inappropriate for nonverbal children. Practitioners will need to develop multiple formats to ensure all children can access at least one reporting channel these should include written, verbal, and visual.

Q7. Why is it important to raise awareness around human rights and reporting mechanisms?

Practitioners must ensure that children with disabilities are aware of their rights under international and domestic law(s). This foundation enables children with disabilities understand when they should report something that does not feel right. Unless specific efforts are made to ensure children with disabilities are aware of their rights and the reporting mechanisms, they will not know they exist e.g., a child with visual impairments would not be aware of mechanisms that are only publicised in visual formats, e.g. posters and leaflets. Or a child with disabilities who does not attend school will not be aware of reporting mechanisms only communicated at school. This will then lead to incidents going unreported and allow individuals to continue to cause are and abuse children with disabilities.

Q8. How do I know if my reporting systems are working for children with disabilities?

Organisations should ensure that reporting data is collected and disaggregated - adhering to strict confidentiality rules. They should also ensure that each reporting mechanism includes a space for user feedback. Data and user feedback should be analysed regularly to inform organisational understanding of remaining or continued access barriers for children with disabilities and to adapt reporting mechanisms them if they are not working effectively for children with disabilities.

Q9. What existing systems are available to support this process?

Many communities, schools, or children with disabilities themselves will have come up with creative ways of identifying or reporting abuse and child safeguarding concerns using community-based approaches that work for children with different disabilities. Organisations can learn from these reporting systems and incorporate them into their organisational child safeguarding reporting process. Organisations should recognise that in many contexts effective child protection systems are weak or are not suitable for children with disabilities, therefore organisations should carry out a referral mapping exercise prior to starting and activity or programme.

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Checklist:
Child friendly disability-inclusive safeguarding reporting mechanisms

How to use this checklist

This checklist should be used to support the development of safeguarding reporting mechanisms for children with disabilities at the planning stage of programme design. It should then be used to monitor reporting mechanisms throughout the programme cycle.

How should the level be decided?

Practitioners should indicate what systems are in place and to what level they are working.

Indicators should be rated as; Green - in Place, Amber - partly in Place, Red - needs Attention and Grey - Note Required (Sections graded as Grey must include a clear justification in comments box):

In place	We are confident that the right process is in place and are working well
Partly in place	Some process is in place, but we are not sure this is working everywhere
Needs attention	We do not have the right process in place and this requires more work
Not required	This is not currently required or relevant to our context

How will the checklist inform practice?

- Completion will aid organisational understanding of how accessible reporting mechanisms are and identify areas for improvement.
- Items rated as “Needs Attention (Red)” should be priority area for action.

Indicator					Comments/ Action Required
Consultation					
We have spoken to children with disabilities, and we understand:					
Thier potential barriers to reporting.					
Who they are most likely to confide in should they have a safeguarding concern.					
How (complaints box, telephone line etc.) they might make a report.					
Where they might feel safe to report concerns.					
Accessibility					
There are a variety (minimum of 3) of reporting mechanisms in place.					
There are multiple locations where reports can be made.					
The reporting mechanism information is written in accessible (simple) language.					
The reporting mechanism information is translated into local language.					

Indicator					Comments/ Action Required
Reporting mechanisms are available in a variety of formats:					
Written					
Verbal					
Visual					
Awareness Raising					
Participants (including children with disabilities) have recieved training and understand their rights and how to report a safeguarding concern.					
We have spoken to parents, caregivers and community members and they understand who, how and where they might report safeguarding concerns.					
The reporting and response system is clearly displayed in areas where children with disabilities are likely to be.					
Capacity					
We have allocated budget to ensure reporting mechanisms are designed to be inclusive for children with disabilities.					
Safeguarding training for staff (programme start-up, inductions and refreshers) includes a module on ‘child friendly inclusive safeguarding reporting mechanisms’ that explores barriers to reporting.					

Indicator					Comments/ Action Required
Capacity					
We have completed a referral mapping process and are confident we can respond to safeguarding concerns raised by children with disabilities effectively and appropriately.					
A referral mapping has been completed so that we can respond to concerns when they arise.					
Accountable					
Feedback mechanism (s) has been developed for each reporting process.					
Reporting mechanisms are reviewed and adapted based on feedback from users.					
All reporting mechanisms and feedback mechanisms are reviewed regularly (frequency is detailed on the programme/ activity risk assessment).					
Data on usage is collected, reviewed, and used to improve practice (data should be disaggregated to include: how many reports are made by children with disabilities? How many cases involve people boys, girls, men, and women etc.).					

Tool 4 Disability-inclusive child safegaurding policy audit

Q1. What is this tool?

This tool provides organisations with a checklist to assess the extent to which child safeguarding policies are disability-inclusive.

Q2. Why is it important?

Most child safeguarding policies and procedures fail to include children with disabilities and as a result contribute to the institutional barriers that put children with disabilities at increased risk of harm.

Policies and procedures tend to make generic statements around non-discrimination, inclusion or disability inclusion ad fail to outline the specific steps, advice and expectations for staff and personnel that keep children with disabilities safe.

In order to be fully inclusive child safeguarding policies, need to include specific commitments, responsibilities and approaches which should be clearly and explicitly expressed to ensure children with disabilities are included across child safeguarding systems.

Q3. How should it be used?

This tool can be used in a number of ways, including:

- As a checklist to guide policy development.
- As checklist during policy review and approval processes.
- As a tool for governance or oversight bodies to hold organisations to account of safe and inclusive policies and processes
- As a starting point for discussion on how to improve safeguarding systems for children with disabilities more generally.

This checklist is not exhaustive and consultation with organisations of persons with disabilities and children with disabilities themselves may lead to additional considerations that will need to be included in policies.

Q4. Who should it be used with?

This audit should be conducted by organisational leadership, governance bodies and those responsible for organisational safeguarding. Where disability inclusion is the responsibility of individuals not listed these internal experts should be included also.

Children with disabilities and organisations of persons with disabilities should be listened to and consulted in this review and in the development of child safeguarding policies and procedures to ensure it responds to the risks they experience.

Q5. When should it be used?

This tool should be used during any policy development or review exercise.

It is advised that all organisations should conduct a review of its Child Safeguarding.

Disability-inclusive Child Safeguarding Policy audit

Frameworks and definitions	Does your Child Safeguarding Policy reflect the principles of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and the United National Convention of the Rights of the Child (UNCRC)? (i.e. Equality, Non-discrimination, Best Interests of the Child, etc.)	Y / N
	Does your Child Safeguarding Policy consider the following descriptions and definitions? **a.** Child/children with disabilities **b.** Universal Design **c.** Accessibility **d.** Reasonable accommodation	Y / N
	Does your policy explicitly recognise the increased risk for children with disabilities, specifically the increased risk of sexual exploitation, abuse and sexual harassment (SEAH)?	Y / N
Roles and responsibilities	Do you have a named/assigned representative on your Board of Trustees for child safeguarding who is also aware of and responsible for disability-inclusive child safeguarding?	Y / N
	Does your Child Safeguarding Policy outline an expectation for all staff working or communicating about children with disabilities to have completed disability awareness training and disability-inclusive child safeguarding training?	Y / N
	Do those with specific child safeguarding roles also oversee the safeguarding of children with disabilities (including reviewing and evaluating adherence)?	Y / N
	Does your Child Safeguarding Policy specifically outline an expectation for volunteers, consultants and donors working or visiting children to be trained on disability rights and disability-inclusive aspects of safeguarding?	Y / N

Communication and confidentiality	Does your organisation's Child Safeguarding Policy or Behavioural Code of Conduct consider confidentiality implications when using personal assistants or communications support, such as sign language interpreters?	Y / N
	Does your organisation share its Child Safeguarding Policy with children with disabilities and their families?	Y / N
	Does your organisation have child-friendly disability-accessible versions of your Child Safeguarding Policy?	Y / N
	Does the Code of Conduct recognise the possibility that children with disabilities sometimes require: ● Physical touch for personal assistance or support? ● Additional time spent with practitioners or professionals (such as rehabilitation or counselling)? ● Some time alone with a practitioner to preserve their dignity (e.g. for personal care or to be taken care of after a seizure)?	Y / N
Behavioural Code of Conduct	Does your Code of Conduct address how a 'two-adult rule' will be implemented when working with children who have personal care requirements?[1] **For example,** practitioners should work with the child with disabilities and their parents to discuss how the two-adult rule will work, document this consultation process and collect informed consent/ assent.	Y / N
	Does your Code of Conduct proactively challenge the stigma and discrimination that children with disabilities often face? Is it empowering rather than a potential opportunity to perpetuate stereotypes and stigma against children with disabilities?	Y / N
	Was your Code of Conduct designed in collaboration with any children with disabilities, or has it been shared with them for their input?	Y / N
Risk assessment[2]	Does your Child Safeguarding Policy require children with disabilities to be involved in risk assessments?	Y / N
	Does your Child Safeguarding Policy require specific risks for children with disabilities to be identified and mitigated?	Y / N

1 For an in-depth detailed explanation of how to create and review a disability-inclusive code of conduct, see RSH Inclusive Safeguarding Code of Conduct in appendix 3: Disability-inclusive tools
2 For an in-depth detailed explanation of how to assess child-safeguarding risks see chapter 7.1 of the disability-inclusive child safeguarding guidelines

Tool 5 Disability-inclusive code of conduct

Questions & answers

Q1. What is this tool?

This tool provides a list of the additional considerations that must be included in any standard code of conduct to ensure it is disability inclusive and underpinned by the United Nations Convention on the Rights of People with Disabilities' (UNCRPD) general principles. This tool does not provide an exhaustive list of all rules, principles, values, and behaviours an organisation expects, but instead focuses on the dos and don'ts relevant to ensuring the safety of children with disabilities in the work an organisation delivers.

Q2. Who is a disability-inclusive code of conduct for?

The code of conduct is for everyone associated with an organisation and its work. It should be known and understood at all levels including project implementors, service users, caregivers, senior management and Board members so that staff members and project implementors can be held accountable to it.

Q3. Why is it important?

All organisations should have a code of conduct which is disability inclusive. Having a written set of principles, values and behaviours that considers specific behaviours that will protect children with disabilities will ultimately ensure children with disabilities are kept safe during the work an organisation delivers.

We know that children with disabilities can face stigma and discrimination and that they are at a higher risk of abuse and harm. We also know that a standard code of conduct may not be appropriate for some children with disabilities who may, for example, need to spend time alone with a staff member in order to meet their care needs with dignity. Therefore, assuming that a standard safeguarding code of conduct will protect all children is not enough. Organisations must recognise that additional considerations or adaptations may be required to an organisation's code of conduct to ensure that it is disability inclusive and appropriate for safeguarding the needs of children with disabilities.

Q4. How should a disability-inclusive code of conduct be developed?

Wherever possible, a draft of the code of conduct should be shared with the individuals the organisation aims to serve for review and input. This includes children with disabilities. Organisations should hold consultations with children with disabilities and organisations of persons with disabilities (OPDs) to ascertain what they need to feel safe and identify behaviours which can cause harm. A disability-inclusive approach for developing the code of conduct will ensure its appropriateness for children with disabilities whilst increasing children with disabilities' awareness of their rights and what they can expect from the organisation working with them. The code of conduct should be reviewed every 2-3 years and all reviews should include consultations with children with disabilities and organisations of persons with disabilities (OPDs).

Q5. How should the code of conduct be implemented?

The code of conduct should underpin all other organisational polices and guidelines. All individuals who work with or represent the organisation should be provided with annual training on the disability-inclusive code of conduct alongside disability rights awareness raising training and disability-inclusive safeguarding training. A disability-inclusive code of conduct should be included in the terms of employment for all employees, whatever their role.

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Q6. What is the ‘two-adult rule’ and how does it differ for children with disabilities?

Standard behavioural code of conducts usually includes something called the ‘two-adult rule.’ The ‘two-adult rule’ usually means that when interacting with children in a work context, staff members are required to ensure another adult is always present or within easy reach.

However, when working with children with disabilities a proportionate approach to this rule should be taken, particularly when working with children with personal care needs, such as support when changing or going to the toilet. In these instances, the dignity of the child must also be considered, as failing to protect the dignity and privacy of a child with personal care needs is also a form of harm. To ensure the safety and dignity of a child with personal care needs, staff and volunteers should work with service users and caregivers to agree clear processes around the two-adult rule, based on what is necessary and appropriate to safeguard them and uphold their dignity. For example, if a staff member needs to assist a child with toileting or take a child or at-risk adult to a quiet room during or after a seizure s/he should leave the door ajar and be regularly checked by another staff member or volunteer. This process should be documented, and consent gained and stored prior to commencing any programme.

As always, the safety of each individual child remains paramount, and organisations should only consider variations on the principles of the ‘two-adult rule’ where it is absolutely necessary and well documented.

Please note this tool has been adapted from the Code of Conduct Template originally developed by Jo Dempster in partnership with the FCDO Safeguarding Resource and Support Hub (RSH). To access the original document including the code of conduct in different languages, please use this link: https://safeguardingsupporthub.org/documents/rsh-inclusive-safeguarding

Template:

This code of conduct applies to all staff, volunteers, and associates, international and local, employed or contracted by the organisation.

I will

- Be sensitive to different cultures, beliefs, and points of view, and treat differences of physical or intellectual ability, race, gender, sexuality, and social background with respect and dignity.
- Ensure physical contact is always appropriate and not an invasion of the individual’s privacy, where physical contact is necessary in order to provide care for some individuals with disabilities, I will ensure there is agreement and consent from individuals themselves.
- Use positive, non-violent methods to manage behaviour, even if that behaviour is linked to a disability.
- Ensure the proportionate use of the ‘Two-Adult Rule’. This means, when interacting with children in a work context, I will ensure that another adult is always present or within reach. If the two-adult rule is not possible, for example when working with children with personal care needs, such as support when changing or going to the toilet, the safety and dignity of the child or at-risk adult will remain paramount. I will work with other staff and the service user and care giver to agree clear processes around the two-adult rule based on what is necessary and appropriate to safeguard them and uphold their dignity, this process will be documented, and consent gained and stored.
- Always respect an individual’s dignity and their need to be safeguarded when taking photographs, filming, or writing reports.
- Always refer to a child with disabilities using their preferred or given name as opposed to their disability type.
- Be mindful and proactively seek to challenge the specific discrimination and stigma some children with disabilities may face.
- Ensure that when including individuals in your work, that fully informed consent/assent has been obtained in a way that is disability-inclusive and accessible.

- Ensure that when photographing, filming or interviewing children with disabilities consent/assent has been obtained, individuals are properly dressed and are not depicted in a way that promotes a narrative of victimhood, overwhelming suffering, or exaggerated praise of children with disabilities that could demean them, or in a way that characterises them as being reliant on the viewer.
- Ensure that any media protects the privacy of the individual and that no personally identifiable information (PII) is shared, this includes PII related to children's disability type.
- Ensure my conduct is underpinned by the guiding principles of the Convention on the Rights of Persons with Disabilities (CRPD).

I will never

- Physically assault an individual including using excessive force or corporal punishment as a means to move, communicate or control a child with disabilities.
- Never wave in the face of a child with disabilities or pull and grab them to get their attention unless this was agreed with them as a way of communicating and consent has been obtained prior to delivery.
- Never emotionally or psychologically abuse a child with disabilities, including acting in ways intended to shame, humiliate, belittle, or degrade others.
- Never refer to or single out children with disabilities as examples of vulnerability.
- Refer to a child with disabilities by their disability type or any other derogatory term relating to their disability.
- Help at-risk children with disabilities with acts of an intimate or private nature, which they can do for themselves.
- Spend excessive time alone with a child with disabilities, away from others, behind closed doors or in a secluded area (in line with the 'two-adult rule') unless a child has personal care needs and a clear process has been agreed around the two-adult rule principle based on what is necessary and appropriate to safeguard them.

Tool 6 Myth busting cheat sheet

Disability myth-busting exercise

This is a myth-busting exercise that can be conducted with staff, partners, consultants and communities you work with.

It can be handed out as a worksheet for people to complete (with the implications removed) before being discussed in a group or one-on-one.

It is important when conducting myth-based exercises that practitioners ask individuals to identify their own assumptions and beliefs around persons and in particular children with disabilities.

This will allow a more open discussion around harmful myths and practices that can lead to child safeguarding risks.

Where possible, myth-based exercises are best conducted together with representative organisations of persons with disabilities who know the context, culture and personal impact of such beliefs.

On the right are some examples of myths and how to address them in awareness-raising activities.

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Myth-busting cheat sheet

Common myths	T / F	Implication on child safeguarding	Reality
Children with disabilities cannot communicate abuse that happens to them, so it will be impossible to identify or charge a perpetrator.		This can mean that when a child with disabilities is harmed or abused, there is no investigation.	*Most children with disabilities are able to communicate in some way, and it is the responsibility of practitioners to find a way to help them communicate.*
Disability is contagious, or that touching a person with disabilities brings bad luck.		This can mean children with disabilities do not receive support, medical attention, get to play and are neglected or treated differently in some way.	*Disability is not contagious. Some diseases that can cause disabilities are contagious, but persons with disabilities are not contagious just because they have a disability. If a child with disabilities requires support or medical attention, they have the same right to this as any other child.*
A child with disabilities (or their condition) is a demon/ curse caused by family wrongdoing.		This can lead to the child being shunned, abandoned or harmed.	*Disability can be genetic or a result of illness, accidents, or complications at birth. Children with disabilities deserve the same love and care as children without disabilities. Mothers who give birth to children with disabilities are not being punished but instead require support from their communities to ensure they can care for their child.*
Having unprotected sex with a person with albinism or a girl with disabilities will cure HIV.		This can lead to high incidents of sexual abuse, violence and exploitation, and underage pregnancy of girls with disabilities.	*Sex with a girl with disabilities will not cure HIV. It is illegal to have sexual intercourse without consent. Sexual activity with children (individuals under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief regarding the age of a child is not a defence. (IASC Principles 2019).*

Common myths	T / F	Implication on child safeguarding	Reality
Sexual abuse of children with intellectual disabilities is not as harmful as they are not aware of what is happening to them.		This can lead to high incidents of sexual abuse, violence and exploitation, and underage pregnancy of girls with disabilities.	*Children with intellectual disabilities can experience harm and abuse as acutely as children without disabilities. The psychological harm may even be more severe if they cannot express or make sense of what they have experienced. It is illegal to have sexual intercourse with anyone without consent. Sexual activity with children (individuals under the age of 18) is prohibited regardless of the age of majority or age of consent locally.*[1] *Mistaken belief regarding the age of a child is not a defence. (IASC Principles 2019).*[2]
Girls and boys with disabilities are at little risk of abuse from caregivers/ support workers who are good people.		This heroism of caregivers and support workers can embolden and protect perpetrators of abuse, who work closely with a child with disabilities.	*Girls and boys with disabilities are most likely to be abused by someone they know or by someone who cares for them.*
Children with disabilities are more likely to get confused or make false allegations of abuse.		This can mean that when a child with disabilities is harmed or abused, or there is suspicion of such harm, there is no investigation.	*Children with disabilities are not more likely to make false accusations than children without disabilities. Any safeguarding concern or abuse claim reported by any child should be taken seriously, investigated and responded to.*

Common myths	T / F	Implication on child safeguarding	Reality
Most children with disabilities who beg are part of a wider organised network of beggars and should be ignored as it is only perpetuating this practice.		This can mean children with disabilities who are being exploited and who are at risk are ignored.	*Many children with disabilities are being exploited, forced and also abused by adults or older children to beg. Some are doing it to support their families as their parents or caregivers have no other means to survive. They are also highly dependent on adults allowing begging and therefore at high risk of harm and abuse. Children with disabilities who are begging deserve to be protected by adults.*
Children with disabilities are not as competent as children without disabilities and can only do menial tasks.		This can lead to child labour, early child marriage, serfdom or other forms of exploitation. It can also lead to children not receiving an education.	*Children with disabilities, including children with intellectual disabilities, have as much potential as any other child. They can learn new skills and have regular jobs. All children with disabilities have the right to education, employment support and skills development.*
The body parts of persons with albinism have magical powers and can bring fortune and luck.		This can lead to the abduction, mutilation and murder of children with albinism.	*There are no magical attributes to persons with albinism. They are just as human as anyone else, and the reason their skin is lighter is because they are missing the skin pigment called melanin, which protects the skin. This does not make them different in any other way than the colour of their skin. Since melanin is needed for the eye to work fully, some persons with albinism can also have reduced vision.*

1 *UN Convention on the Rights of the Child* (Part 1, Article 1) (1989). https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

2 Inter-Agency Standing Committee (2019) *IASC Six Core Principles Relating to Sexual Exploitation and Abuse.* https://interagencystandingcommittee.org/inter-agency-standing-committee/iasc-six-core-principles-relating-sexual-exploitation-and-abuse

Tool 7 Environment walk: Children and youth with disabilities identifying safe spaces

Q1. What is this tool?

This tool provides guidance for practitioners to conduct an environment walk with children and youth with disabilities to assess how safe physical environments are for them.

Q2. Why is it important?

Children with disabilities have the right to access safe physical environments on an equal basis with others. Practitioners should ensure that appropriate measures are taken both to identify and eliminate environmental risks in the physical space.

There are many reasons that an inaccessible environment can be unsafe for children and youth with disabilities. There could be trip hazards, including uneven floors or steps, which make it difficult for children with disabilities to move around safely. There could be no accessible toilet facilities, or accessible toilets far away and unsafe for children to access. The venue could be poorly lit, limiting the ability of children with visual impairments to see their surroundings.

The best way to ascertain if a physical space is safe for children and youth with disabilities is **to ask them directly**. Environment walks use a child-centred approach to identify the existing and possible environmental barriers based on individual accessibility needs and give children and youth with disabilities an opportunity to identify solutions to unsafe physical environments.

Identifying and auditing how physical environments make children and youth with disabilities feel safe or unsafe will give practitioners the tools they need to and modify environments to be barrier free, accessible, and safe for all children.

Q3. When should this tool be used?

Identifying and eliminating environmental barriers should be a continuous process, recognising that new or unforeseen barriers may be uncovered at any time. However, risks deriving from physical space are best mitigated during the planning phase on a project and activity.

Environment walks should take place well before a project activity is planned. This will give practitioners enough time to change locations or amend project plans based on environmental safety.

Practitioners can either conduct environment walks before each activity or conduct them at the beginning of the project to identify appropriate and safe locations for the duration of project delivery.

This tool can be used following standard accessibility audits.

Q4. Who should it be used with?

This is usually conducted with adults, guides or older children who act as facilitators and consists of a child or youth with disabilities with disabilities moving around an environment individually or in a group identifying hazards.

The environment walk could also involve parents/ caregivers or teacher depending on the age of the child, their accessibility needs and what location is being assessed for accessibility and safety.

Practitioners will need to ensure a range of different impairments and experiences are included and that any children with disabilities already identified who are attending the activity take part.

Q5. How to deliver this activity

- Children and youth should be put into pairs or groups and pa rtnered with an adult or facilitator who is going to conduct the environment walk with them.
- Facilitators should be able to communicate effectively with the children, e.g. able to use sign language.
- Facilitators should inform participants that they are now going to be asked to be surveyors and complete an environment audit of this venue.
- Each group should be given a clipboard with the environment audit checklist on it and if possible, each child should be given a ‘surveyor’ badge.
- Any pair who needs help writing on the audit should have a facilitator acting as a scribe and recording their responses on the worksheet for them (see below).
- The facilitator will ask the participants to move around the room identifying things on the audit checklist that make the venue:
  - Less safe for them
  - Harder to move around easily
  - Made make them feel uncomfortable
  - Make them unable to fully participate
- Participants should also be asked to identify things that make them feel:
  - Safe
  - Included
  - Comfortable
- Facilitators should move around the group and ensure participants include of the ‘why?’ aspect to understand what different aspects of the physical space makes them feel and why.
- The facilitator will then ask the YwD to repeat the exercise outside but in within the safety of the grounds.
- Participants should then be asked to come back in a group and the facilitator should ask the group to feedback.

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Q6. How to adapt the tool for different needs

A checklist can be provided, or it can be an open-ended conversation with the facilitator leading the check. This might be more suitable for younger children or children who find it difficult to write.

An environment drawing exercise that may be more appropriate for children with difficulties moving around. Individually or in groups, children with disabilities can draw an environment and identify hazards, places that make them feel safe/unsafe or aspects of the environment that exclude them.

Children with visual impairments can take part with a facilitator describing surrounding or with a facilitator helping them move around the environment.

Parents can also be asked to conduct an environment walk identifying hazards and potential dangers for their children in a physical space. Facilitators will need to ensure that sessions to collect feedback from parents /caregivers and children are conducted separately to ensure parents/ caregivers do not speak on behalf of their child.

Q7. Before the activity takes place

Organisers should include an activity at the start of any training where children and youth with disabilities (and others) are shown or walked around the environment. Potential hazards should be identified; participants should be taken to the accessible toilets, breakout rooms or places where they will eat or get water. Children with visual impairments or deafblindness should be helped to move around the room's layout or have it described to orient themselves.

Environment walk worksheet

Inside the room

Things that make me feel **SAFE**	Where was this?	Why did it make you feel that way?
The large windows in the training room	*Along one wall in the training room*	*The windows let a lot of light in which means I can see better and feel safer moving around and avoiding hazards.*
Things that make me feel UNSAFE	**Where was this?**	**Why did it make you feel that way?**
The steps in the dining room	*At the entrance to the dining room*	*There are no banisters and I feel unsafe using my crutches going up these stairs.*

Outside the room

Things that make me feel **SAFE**	Where was this?	Why did it make you feel that way?
That the accessible toilets are close by	*Next to the main conference room*	*I didn't need to travel far from the activity in order to use an accessible toilet.*
Things that make me feel UNSAFE	**Where was this?**	**Why did it make you feel that way?**
The courtyard	*At the entrance to the venue*	*The ground is uneven which makes it difficult for me to move around in my wheelchair indecently.*

Tool 8 Accessibility audit: Identifying safe and inclusive spaces

Q1. What is this tool?

This tool provides guidance for practitioners or other project stakeholders to conduct an accessibility audit on venues and locations where project activities take place to assess how safe physical environments are for children and youth with disabilities.

Q2. Why is it important?

Children with disabilities have the right to access safe physical environments on an equal basis with others. Practitioners should ensure that appropriate measures are taken both to identify and eliminate environmental risks in the physical space.

There are many reasons that an inaccessible environment can be unsafe for children and youth with disabilities. There could be trip hazards, including uneven floors or steps, which make it difficult for children with disabilities to move around safely. There could be no accessible toilet facilities, or accessible toilets far away and unsafe for children to access. The venue could be poorly lit, limiting the ability of children with visual impairments to see their surroundings.

This audit will enable practitioners to identify the existing and possible environmental barriers of any given space for children and youth with disabilities. It will provide them with the information needed to decide whether an alternative venue is needed or if there are possible solutions to existing hazards.

Identifying and auditing how physical environments make children and youth with disabilities feel safe or unsafe will give practitioners the tools they need to and modify environments to be barrier free, accessible, and safe for all children.

Q3. When should the audit be used?

Accessibility audits should take place well before a project activity is planned. This will give practitioners enough time to change locations or amend project plans based on environmental safety.

It is preferable that practitioners conduct accessibility audits on all potential project locations at the beginning of the project to identify appropriate and safe locations for children and youth with disabilities for the duration of project delivery. This should then be followed up with environment walks with children and youth with disabilities to get their direct feedback on the accessibility and safety of places where activities will take place.

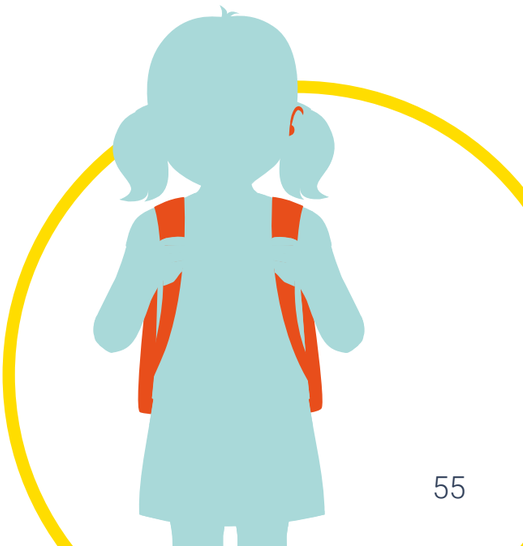
Q4. Who should conduct the audit?

A range of individuals can use this accessibility audit depending on the project.

Organisation practitioners will need to oversee the implementation of the audit, but the exercise would benefit from the involvement of other key stakeholders.

Ideally individuals from local organisations of persons with disabilities or persons with disabilities themselves should be asked to take part in the audit or at a minimum review the audit for any advice on aspects of accessibility that have been overlooked. Similarly, local Disability Officers, CBR Officers or the equivalent can assist practitioners. Parents/ caregivers of children with disabilities or teachers can also take part.

Results of audits should be shared with venues and appropriate stakeholders and practitioners should encourage modifications which will improve accessibility long-term.

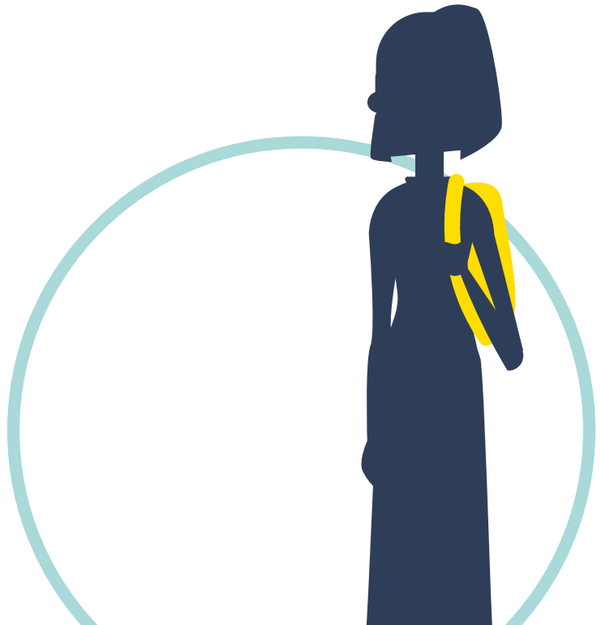


Accessibility checklist

Mitigating risks for children with physical disabilities	× / ✓
Is the building or space accessible for children who use any mobility equipment? This includes ensuring venues have ramps (minimising the presence of steps), widened doorways (enabling mobility equipment such as wheelchairs to pass), safety bars/railings and handles on both sides, and non-slippery floors.	
Will children require assistive technology to access the building or space? This includes verifying with the child or their parents or caregivers if they have the assistive devices necessary to access the space, enabling them to bring these devices (such as wheelchairs, crutches, prosthetics) as required.	
Is the internal set-up of the building/space inclusive for children who use any mobility equipment? This includes ensuring there are wide enough spaces between furniture (desks, chairs) to enable children with physical disabilities to move as freely around the room as others.	
Is the building or space free from hazards that may lead to accidents? This includes potholes, uneven floors and slippery floors that cause instability for children using crutches or wheelchairs.	
Will the building or space uphold the dignity of children with physical disabilities? Are the toilets accessible, with ramps, handrails and enough room for a wheelchair?	
If using a building with stairs, can a child with difficulties moving access all floors and levels with lifts or elevators?	
Are the lifts or elevators operating without disruptions?	
Is there a safe way to evacuate children with physical disabilities from a building if there is a fire and the lifts or elevators stop working (for example, evacuation wheelchairs)?	
Mitigating risks for children with visual impairments	**× / ✓**
Is printed safety information and messages, such as posters on walls, available in alternative formats such as texts in braille, large print or audio and provided before the event or activity?	
Does the space have plenty of natural light to increase visibility?	
If using an indoor space, are there curtains or blinds to control the level of illumination at different times of the day and avoid glare?	
Does the space contain non-reflective surfaces to avoid any glare from overhead lighting?	

Mitigating risks for children with visual impairments (continued)	× / ✓
Is it possible for furniture, electrical cables and other items to be arranged so that they do not become a trip hazard?	
Is it possible to adapt the space to include visual and tactile symbols or signs that will provide cues for a child's orientation and mobility? Once a child is oriented, is it possible for the environment to remain the same throughout?	
Do emergency exit or escape routes have edges on steps marked in a different colour and texture? Are there handrails on the escape routes and stairs? And does a child have an appointed buddy in case of an emergency?	
Does the space have limited visual clutter that could create visual distractions?	
Mitigating risks for children with hearing impairments	**× / ✓**
Does the building or space have adequate lighting to enable children to follow conversations as clearly as possible, such as seeing lip patterns, facial expressions, hand gestures and sign language?	
Does the room have soft furnishings that will absorb sound to dampen echoes and reverberations?	
Have chairs and tables been assembled in a way that will ensure people in a room or space can easily face each other, such as in a circle or semicircle (to avoid a person speaking with their back to a child with a hearing impairment)?	
Is the room or space set up in a way that will ensure speakers are not standing in front of a window (since it is not possible to see a person's face clearly if the light source is directly behind them)?	
Is the room equipped with a hearing loop for children using a hearing aid and, if so, has it been confirmed to work and made clear to organisers how to operate it and avoid auditory disturbances?	
Does the environment have limited visual and auditory distractions, such as colourful displays, people frequently walking in and out of the room, doors opening and closing, excessive background noise, road traffic?	
Is the building or space away from loud noises that would prevent children dependent on a quiet environment from hearing?	
A child with a hearing impairment may not be aware of a fire alarm if they are in a room on their own (such as the toilets or a bedroom). Has an appropriate system been installed to alert the child in an emergency, such as a flashing light, vibrating equipment or an appointed buddy?	

Mitigating risks for children with intellectual or neurological disabilities	✕ / ✓
Is it possible to minimise distractions that may overwhelm a child's senses and cause them to lose focus? Examples include smells, uncomfortable furniture, noises from mobile phones, people frequently walking in and out of the room, room temperature (particularly if the room is too hot), bright colours and excessive patterns.	
Can less obvious noise distractions such as lights buzzing and humming sounds from extractor fans be avoided?	
Does the room have soft furnishings that could absorb sound to dampen echoes and reverberations that may disturb some children?	
Is it possible to provide alternative lighting to different individuals, such as table lamps in addition to or instead of overhead lights, depending on individuals' differing sensitivities to light?	
Have checks been made to ensure there are no flashing or flickering lights?	
Could colour coding be used to mark out hazards and escape routes as colour is usually more easily recognised as a sign of danger?	
Mitigating risks for children with psychosocial disabilities	**✕ / ✓**
Is there a 'breakout' area or a place where children can relax if feeling overwhelmed?	
Is the venue easy to travel to, avoiding stressful commutes for children who feel anxious when travelling?	
Can efforts be made to avoid strangers or adults unknown to the children in the environment that may make a child feel nervous or anxious?	



Tool 9 Communication map activity

Communication maps

Communication maps allow children to make connections between different people they come into contact with and explain what type of relationship they have with them. It is an exercise to support children in demonstrating who they feel comfortable communicating child safeguarding concerns to. Children with disabilities may feel more comfortable confiding in people near them rather than formally designated representatives of an organisation.

How to conduct communication mapping

Start by helping the child draw a picture or representation of themselves in the centre of a piece of paper (support them to do so if requested).

Then ask the child who the main people in their life are. Try to get the child to think about different groups of people like friends, teachers, organisational staff, project volunteers, and other service providers such as healthcare workers, not just their family members. Use pre-prepared pictures or symbols if possible.

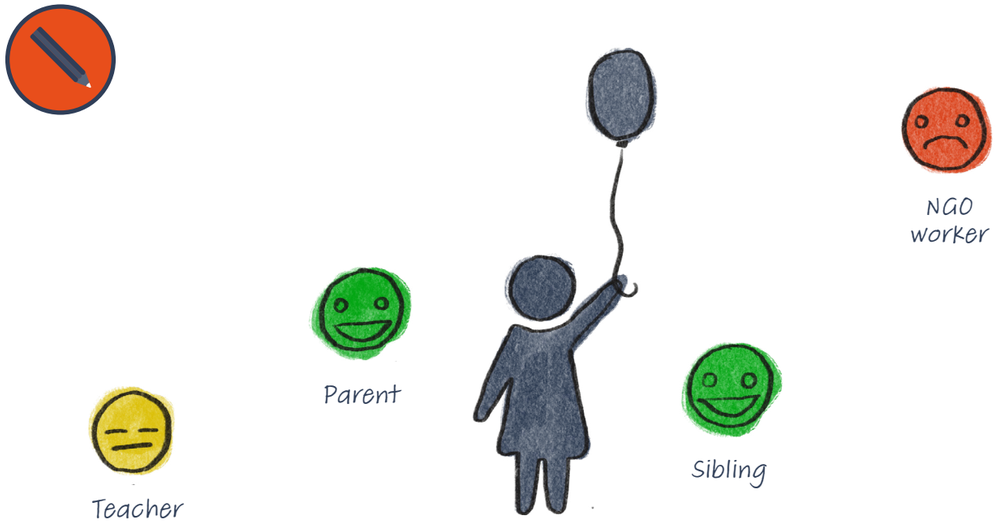


Figure 8: *Example communication map showing both how often the child sees the person (shown by proximity to the child figure) and how comfortable they are with the person (shown by the red, amber and green faces or happy, sad or neutral faces). This is just a guide and different drawing tools can be used.*

For every person the child identifies in their life, the facilitator should ask these questions:

1. How often do you see this person?
2. How comfortable are you with this person? (For younger children: How happy are you with this person?)
3. Is there anything that makes you uncomfortable with this person?
4. What things can you share with this person?

The facilitator can then help the child by placing the different people in relation to the child on the piece of paper based on the reaction the child has. The closer to the child, the more often the child interacts with them. Smileys represent the level of comfort the child indicates with the person in question.

When working with children with visual impairments, facilitators can describe the activity, asking the children to imagine the people they come into contact with, or they can use tactile communication maps attached to bulletin boards. For children with hearing impairments, images, symbols and colours can be used to indicate people and comfort levels.

When working with younger children with disabilities, one idea is to use a matching exercise with picture cards to get feedback on organisational staff or representatives. For example, children could be asked to select pictures of people they recognise or feel comfortable with.

It is useful to conduct this exercise together with a community mapping exercise (see Tool 5 in the disability-inclusive child safeguarding guidelines).

Tool 10 Community map activity

Community maps

Community maps are a useful tool to help children with disabilities explain where they want to report. Community maps involve children identifying places they frequently access and feel comfortable or safe in.

How to conduct community mapping

Start by helping the child draw a picture or representation of themselves (or support them to do so if requested) in the centre of a piece of paper.

Then ask the child about the places or environments they visit or have access to. Try to get them to think about their day and where they spend most of their time, not just places they know or would like to visit. Use pre-prepared pictures or symbols if possible (e.g., home, school, church).
For every place the child with disabilities identifies, the facilitator should ask four key questions:

1. How much time do you spend in this place?
2. How far is this place from your home?
3. Who else is usually in this place?
4. How safe do you feel in this place?

The facilitator can then help the child by plotting the different places on the piece of paper based on the reaction the child has. The closer to the child the more safe the child feels at the place and the colours shown indicate the frequency of visits.

This exercise can be conducted alongside the communications map activity (see Tool 8).

When working with children with visual impairments, facilitators can describe the activity, asking the child to imagine the places they visit or use tactile materials on a bulletin board. For children with hearing impairments, images, symbols and colours can represent places, frequency of visits and distances.

When working with younger children with disabilities, one idea is to use a matching exercise with picture cards to get feedback on environments children know and recognise. For example, children could be asked to select pictures of places they recognise, or they feel safe in.

Figure 9: *Example community map showing the places the child has access to, places the child feels safe in, how far the places are (shown by proximity to the child figure) and how regularly the child visits the place (shown by the red, amber and green colours). This is just a suggestion and different drawing tools can be used.*

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Tool 11 Safe data collection checklist: Case studies and consultations with children with disabilities

Q1. What is this tool?

This tool provides guidance for practitioners on how to safely collect data or case studies and how to safely consult with children and youth with disabilities.

Q2. Why is it important?

Children with disabilities have the right to have their voices and stories heard. All children, including children with disabilities, also have the right to decide, what, how and when to participate, share information and/or have their information shared in relation to any aspect of an organisation's work.

Crucially, children with disabilities have a right to decide that they do or do not want to participate in activities or share information and practitioners should seek to understand their preference and respect their decisions.

As outlined in Article 12 of the CRPD a child with disabilities' perceived or actual mental capacity must not be used as justification for denying their legal capacity or their right to decide how and when to participate or how and when information that concerns them is shared.

However, obtaining informed consent or assent is often overlooked or poorly executed when it comes to children with disabilities. Failing to provide children with disabilities with an opportunity to make decisions regarding their participation or how their information is used is a denial of their rights, can put a child at increased risk and can cause distress, which is a form of emotional abuse. It is therefore important that practitioners consult children with disabilities in a way which empowers them and which does not put them at risk of any harm.


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Q3. When should this tool be used?

This tool should be used any time that a practitioner is planning to interact with a child with disabilities to collect data, case studies, photos, or any other form of consultation.

This can include, but is not limited to:

- Conducting interviews
- Conducting consultations or focus groups
- Taking images or videos
- Collecting the story of a child with disabilities to be used as a case study
- Collecting a child with disabilities' name, age, location and/or other information.

This tool should be used well before any such activity takes place, allowing the child with disabilities the time to fully understand what is being asked of them, and most importantly giving them the opportunity to say no. The child with disabilities should not feel rushed or pressured into making a decision, nor should a practitioner fail to use this tool fully because of a lack of time.

Identifying and addressing potential risks should be a continual process. Remember that consent can be withdrawn at any time, and a child with disabilities should be asked throughout the activity if they are comfortable and want to continue. After the information has been collected, the child with disabilities should be shown what has been collected and asked if they are comfortable with it being shared.

Q4. Who should use this tool?

This tool is suitable for all practitioners working with children with disabilities but may be of particular relevance to photographers /videographers, data collectors, communications or media teams, and programmes staff.

Q5. Who should it be used with?

It is good practice to take these steps when collecting data or personal information or imagery from anyone. Therefore, this tool should be used with anyone that a practitioner is collecting data from to ensure the approach is disability-inclusive and safe for children with disabilities.

Q6. Understanding consent and assent for children with disabilities

Informed consent is the free and voluntary act of giving permission to participate, share information or have one's information shared. To fully consent, a child, and where applicable, their parents or legal guardian(s), have to clearly comprehend all the relevant facts, details of the information enquired, expectations of their involvement, their right to withdraw from participation whenever they choose, and their right not be coerced by circumstances or individuals (including parents or legal guardians).
Legally, informed consent must be obtained from all individuals that are of legal age to consent, which in most jurisdictions is 18 years of age. In some

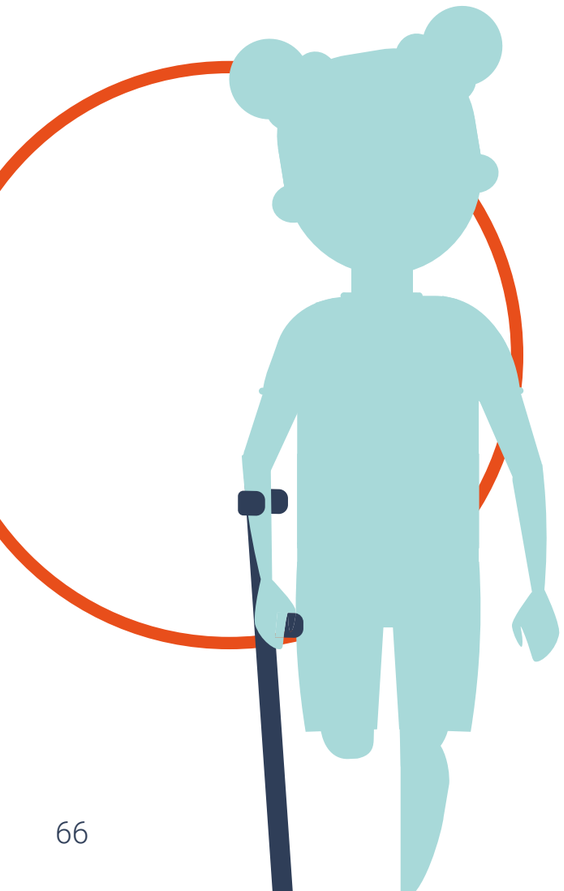
jurisdictions, children can be of legal age before they turn 18. Accordingly, informed consent must be obtained from all children of legal age of consent and where applicable, from their parent or guarding as established by law. As standard of practice, informed consent should be obtained directly from all children who are old enough to expressly give their consent.

Assent is the expression of willingness or agreement to participate, share information or have one's information shared in part or in full even when the legal age of consent has yet to be attained. It relies on the existence of dissent, i.e. that a child can object to or decline to take part. Assent applies in both instances where:

a) the child fully understands all the facts and comprehends the information provided, expectations of their involvement, potential risks and benefits involved; and

b) children who may not fully understand these facets.

Assent recognises the emerging developmental capacities of children irrespective of whether they can fully provide informed consent or not. However, assent cannot substitute informed consent for children of legal age of consent, regardless of the status of their evolving mental capacities. Even in cases where a child has undoubtedly expressed assent, informed consent about their participation must still be secured from their parent or other by a legal guardian established by law.



Q7. How should this tool be used?

This tool is comprised of a checklist which practitioners can use to guide their work before, during and after the data collection activity.

The checklist is guidance only and is not exhaustive. It is also important to use individual judgement. For example, if a child with disabilities is saying that they are comfortable with their case study or photo being used, but their body language or demeanour suggests they are uncomfortable, then you may judge it best not to use their information at all.

If a practitioner is not confident that standards of disability inclusion have been met when collecting data, then data should not be used as this could put a child with disabilities at increased risk of harm.

Data collection, case study and consultation checklist

Indicator	Yes/No/not applicable	Comments/ Action Required
Obtaining consent		
Have the child's communication needs been ascertained and a sign language interpreter or other assistance required for communication organised beforehand?		
Have proper efforts been made to obtain consent from children with disabilities directly as opposed to relying on other adults to give consent on behalf of a child with disabilities who may misrepresent their wishes?		
Has the individual collecting consent or data from children with disabilities been trained on disability rights and disability-inclusive child safeguarding?		
Even if a child does not have additional communication requirements, they may feel uncomfortable or pressured with a stranger asking them. In such cases, has a parent, carer or other adult close to the child helped with explaining the activity or proposed collected information to them, including their right to decline?		
Has the child been given sufficient time to understand what is being asked of them, and with enough time before the proposed activity so they don't feel pressured to agree there and then?		
Is the data being collected in an environment that the child is comfortable in (and preferably familiar with)?		
Is the environment in which the data is being collected in safe and accessible?		

Indicator	Yes/No/not applicable	Comments/ Action Required
Obtaining consent (continued)		
Do you have a consent/assent form which is accessible to children with disabilities? This may include the use of smiley faces at the end of each question, pictures, easy read text, or in different formats such as large font or braille.		
Have you recorded consent from the child, or where relevant, their parents or guardian? This may be written consent (using an inclusive form as above) or may be audio or video recording if this is more accessible than a written form. It is not sufficient to obtain only verbal consent which is not recorded.		
Has an independent adult been asked to witness the child providing informed consent/assent and have they also signed to confirm consent was given freely and voluntarily?		
Do all consent/assent forms include a section to explain exactly what type of informed consent/ assent was obtained and why it was deemed accessible or appropriate to collect it in that way?		
Does the consent/assent form have a contact section so you can contact the child in the future to reaffirm consent or show them the published result?		
Does the child and their parents or guardian have your contact details so they can easily get in touch to have their image or information taken down if they no longer want it to be public?		
Have you fully explained the information you are planning to collect and what it will be used for in an accessible way?		

Indicator	Yes/No/not applicable	Comments/ Action Required
Obtaining consent (continued)		
For photos and case studies, have visual examples of the proposed web posts, Tweets, Instagram posts, articles etc been produced and shown to the child to demonstrate how the information will be used? If the child has a visual impairment have the images been described to them?		
Have you explained how images on webpages or platforms such as Twitter, Facebook or Instagram can be stolen and reused in years to come in ways that have not been agreed in an accessible way?		
Capturing and using personal information		
Before taking a photo or video, has the child been asked where they would like to sit or stand and if there is anything they would like in the image with them? (e.g. Children in wheelchairs may not want to be pictured in their wheelchair but pictured seated or standing with supports). Has the child been encouraged to take ownership of the images collected.		
After taking the photo or video, or collecting the case study, has the child been shown (or described if the child has a visual impairment) exactly what will be shared? Only use the images or stories which the child has felt positive about and agreed to be used.		

Indicator	Yes/No/not applicable	Comments/ Action Required
Capturing and using personal information (continued)		
Have you destroyed any material the child is not happy with?		
Do you believe that the images you have captured empower children with disabilities and demonstrates their agency and individuality? Do not photograph children in compromising circumstances. (e.g., no photos of children with disabilities crawling on the floor, in pain or suffering)		
Where possible, have you proactively collected information where children with disabilities are portrayed in ways that reflect how they see themselves as opposed to how others see them?		
Have you shared the captions or descriptions of images or video images that you plan to use, and are these agreed to and confirmed by the child? Do not describe the child in a way which they did not agree with and avoid captions that are exaggerated (for example, overemphasising victimhood or herohood).		
Have you ensured that images of children with disabilities do not have any personally identifiable information visible in them (e.g. name of school or school uniform) which can be used alongside their disability type to make them easily locatable?		
Is information being collected in a way which isn't putting the child at additional risk of harm? For example, never touch a child's assistive devices such as their wheelchair or hearing aid for the sake of a better photo.		
In consultations and interviews, have you ensured that the child has had enough time to consider the question fully and has had a chance to answer? In group settings, some children with disabilities may need more encouragement or time than others.		

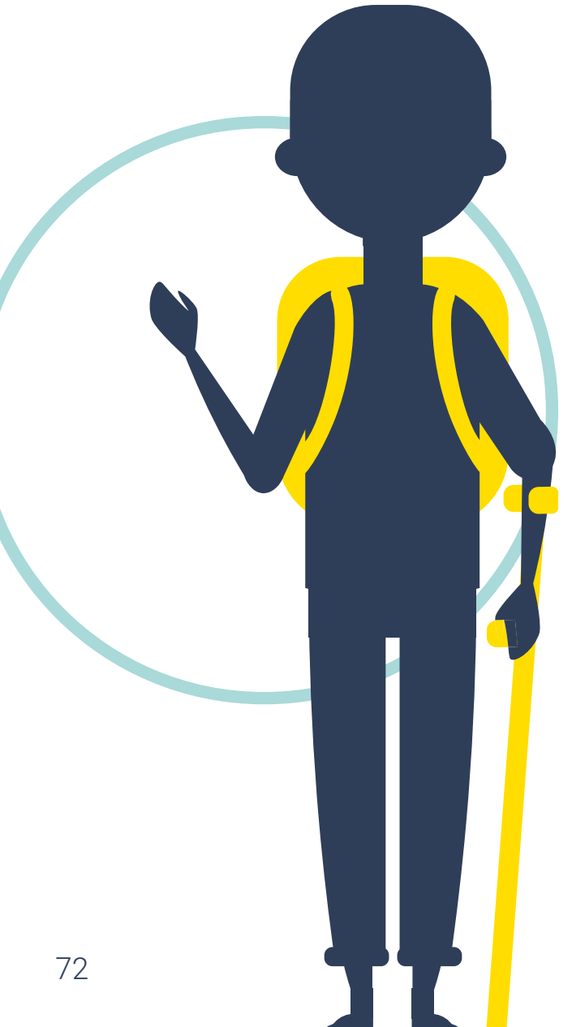
Indicator	Yes/No/not applicable	Comments/ Action Required
After the data has been collected		
During the editing process, have you stayed in touch with the child (or relevant parent or guardian) so that you can reaffirm consent if you make any changes to captions or chosen images etc?		
When writing up case studies, are you writing it as closely as possible to the exact words and in the tone that the child with disabilities conveyed to you?		
Once the information is ready for publication, have you sent copies to the child for them to finally approve? This may not always be possible or relevant but is good practice.		
Are you using imagery or case studies which is relatively recent and relevant? For example, a child may no longer use a wheelchair and be uncomfortable with past photos of them still using a wheelchair. Do you have a full record of the informed consent for images and case studies which are in use?		
A child's functioning may change over time, or their self-identification as a person with disabilities may alter as they reach adolescence or adulthood. It is therefore important that they reserve the right to rescind their consent for their information to be shared. Have you immediately stopped using any imagery or case studies where this has been indicated by the child? Have you proactively contacted the child with disabilities to confirm they are still happy for you to use them?		

Tool 12 Language dos and don’ts: Applying appropriate language when talking about disability

Q1. What is this tool?

This tool provides some general advice on what language to use and not use in order to protect the rights and wellbeing of children with disabilities in work organisations deliver.

Whilst this tool provides some clear advice on dos and don’ts, practitioners will need to be aware that what is deemed as appropriate language is constantly changing. Practitioners will need to use this tool as a means to start a more in-depth conversations about the ways language can cause harm and encourage practitioners to consider the ways language is linked to safeguarding.



Q2. Why is it important?

Organisations and practitioners need to understand that language itself can cause harm and be a form of emotional abuse. Inappropriate language can shame, belittle or intimidate children with disabilities and is a form of bullying and emotional abuse. This is particularly true for children with disabilities whose life-long self-esteem and self-worth may be determined by how they are characterised and described by others.

We easily recognise and avoid offensive terms such as ‘retard’ or ‘cripple’. It is harder, however, to be aware of language choices that unintentionally other or exclude children with disabilities and cause them harm indirectly.

Language used by organisations and practitioners is directly linked to their ability to safeguard and ‘do no harm’ and organisations must make concerted efforts to carefully consider the language used in relation to disability throughout the work that is delivered.

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Q3. How should it be used?

This tool can be used in a number of ways, including:

- As a checklist for communications staff or those writing about disability.
- As a activity or exercise where individuals are asked to identify which language is appropriate or not.
- As a tool for a discussion n language and the safeguarding implications of discriminatory language or harmful words.
- As a tool for consultation with children with disabilities on the ways they wish to be spoken about or referred to.

All language sessions should end with delivery staff, local stakeholders and participants identifying other harmful language which needs to be avoided to better protect children with disabilities.

Q4. Who should it be used with?

As with all language, language relating to disability is closely linked to cultural norms, cultural beliefs and ingrained or unintentional prejudice. Therefore, all practitioners working with or talking about children with disabilities should be trained on the use of appropriate language and how this relates to keeping children with disabilities safe in the work an organisation delivers.

Q5. When should it be used?

This tool can be used as part of regular safeguarding training, as part of disability rights training and part of staff inductions within organisations. When working with local project stakeholders this tool can be used as part of project set up or prior to the delivery of activities including children.

Applying appropriate language when talking about disability

Avoid	Use	Why
(The) handicapped, (the) disabled	A child with disabilities/ children with disabilities	Put the person first. A disability is something someone has, not what they are. **Note some people or organisations of persons with disabilities identify as 'disabled'. Ask people what they prefer.**
Able-bodied children	Children without disabilities	Using 'able-bodied' implies that those with disabilities are not able.
Non-disabled	Without disability/ disabilities	Using non-disabled contradicts person first language. It is outdated and linked to the former use of disabled.
Normal, not normal	A child with or without disabilities/ children with or without disabilities	A child with disabilities is not abnormal.
The deaf/ blind etc. child	The name of the child	Refer to a child by their preferred name not by their disability.
Afflicted by, suffers from, victim of	Has [name of condition or impairment]	If a person has disability, it does not make them weak, a victim or someone to feel sorry for.
Confined to a wheelchair, wheelchair-bound, wheelchair user	Person using a wheelchair	A person who uses a wheelchair is not bound by the chair; they use it to enable them to be more mobile.
Differently-abled, people of all abilities, special needs, special child	A child with disabilities/ children with disabilities	Made-up words or euphemisms can be patronising and are incorrect. They fail to make visible the specific distinction that is the disability, or imply that children with disabilities are separate or different from children without disabilities. This can further exclude them.
Disabled toilets	Accessible toilets	The focus should be on the societal responsibility of accessibility as opposed to the label 'disabled'.
Mentally handicapped, mentally defective, retarded, subnormal, mentally retarded	Child with intellectual disabilities or cognitive or developmental disabilities	These phrases are deemed offensive as they suggest there is something abnormal or deficient.
Cripple, invalid	A child with physical disabilities/ children with physical disabilities	These are generic terms that are incorrect or suggest illness.
Spastic	Child/ren with cerebral palsy or a neurological condition	This is incorrect and has negative connotations in everyday use.
Mental, mental problem, mental patient, insane, mad	Child/ren with a mental health condition or child/ ren with psychosocial disabilities (if identifying as such)	Persons with mental health conditions are not medical patients. 'Insane' and 'mad' have negative connotations in everyday use.
Deaf and dumb, deaf mute	Child with a hearing impairment; D/deaf, user of sign language, mild, moderate or profound hearing loss, hard of hearing	These phrases are deeply offensive as they suggest that a person is unable to communicate in any form. The word 'dumb' also implies a person has low intelligence.
The blind	Child with visual impairment; blind children; blind and partially sighted children	Persons with visual impairments are not a homogeneous group. Blind and partially sighted is often used as a collective phrase but includes different degrees of vision.
Dwarf, midget	Child with short stature	This is incorrect and has negative connotations in everyday use.

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