Wednesday, 28 May 2025

(10.00 am)

LADY SMITH: Good morning, and welcome back to Phase 9 of our case study hearings looking into the provision of residential care for children with healthcare, additional support needs and disability requirements.

We turn today to evidence from the world of academia, and I think we're going to start with two people coming in together; is that right, Ms Innes?

MS INNES: That's correct, my Lady.

A report has been prepared for the Inquiry, which is in draft at LIT-000000392, on the provision of education in residential settings for disabled children and young people and children with additional support needs. This is looking at key legislation and policy developments, covering the period 1974 to 2024, although, in fact, it extends prior to 1974 as well.

The authors of the report are Dr Gillian MacIntyre, Dr Ailsa Stewart and Professor Andrew Kendrick from the University of Strathclyde. They are going to give evidence essentially in two shifts; so Dr MacIntyre and Professor Kendrick will give evidence together first, and then, for a later time in the report, Dr Stewart will join Dr MacIntyre.

LADY SMITH: Thank you very much.

Professor Andrew Kendrick (affirmed)

Dr Gillian MacIntyre (affirmed)

LADY SMITH: My thanks to both of you for coming along this morning. As I've said, welcome back, Andrew. It's good to see you again.

PROFESSOR KENDRICK: Thank you.

LADY SMITH: One of these days, we'll let you off the hook, but not yet.

Gillian, welcome.

DR MACINTYRE: Thank you.

LADY SMITH: I'm really grateful for the work that you and your other colleague have already done in providing the detailed draft report that we've got and for your preparedness to come and be put on the spot about it this morning.

You know the ropes. The screens in front of you will bring up the document, to the various parts we'd like to discuss with you. If either of you have got any questions at any time, or you think we're failing to ask you questions that we should be asking you, do volunteer.

If you need a break, that's fine. I usually break at about 11.30 anyway for the morning break, so you can bear that in mind.

Otherwise, if you two are ready for me to hand over to Ms Innes, I'll do that. Is that all right? Thank you.

Ms Innes.

Questions from Ms Innes

MS INNES: Thank you, my Lady.

If I might start with you, Gillian, thank you for providing a copy of your CV to the Inquiry.

We understand that you're a Senior Lecturer in Social Work at the University of Strathclyde; is that right?

DR MACINTYRE: Yes, I'm actually a Reader in Social Work. I just recently got promoted.

LADY SMITH: Congratulations.

DR MACINTYRE: Thank you.

MS INNES: You tell us that your programme of research focuses on learning disabilities, mental health, citizenship and human rights.

DR MACINTYRE: That's correct, yes.

MS INNES: And you have provided the Inquiry with a list of various research and publications that you've undertaken throughout the years.

I think you have been at the University of Strathclyde since 2007; is that right?

DR MACINTYRE: Yes, that's correct.

MS INNES: Prior to that, you were at the University of

Glasgow, where you obtained your PhD in 2007; is that right?

DR MACINTYRE: Yes.

MS INNES: Thank you.

Andrew, we have your curriculum vitae as well.

Since you last gave evidence to the Inquiry, I think you've undertaken research and published a report for Redress Scotland in relation to discipline and punishment in childcare settings in Scotland?

PROFESSOR KENDRICK: That's correct.

MS INNES: So I think that's probably the --

PROFESSOR KENDRICK: The main bit.

MS INNES: The main bit, yes, thank you.

PROFESSOR KENDRICK: The advantage of being retired.

MS INNES: Now, if I can turn to the report prepared, which is at LIT-000000392, and this report is currently in draft.

If we can look, please, first of all at page 9, and if we look at the aims and objectives, we can see there that you were asked to look at relevant Scottish legislation and policy in relation to the provision of education in residential settings for children and young people with disabilities and additional support needs over the period 1974 to 2024.

You then set out the various objectives, which are:

to set out and describe relevant legislation and policy; secondly, to identify changes in language and terminology over time; thirdly, to establish any implementation gaps between legislation, policy and practice; and then, finally; to explore how potential developments in policy and legislation may impact on the education of children and young people with additional support needs or disabilities in residential care in the future.

So those were the agreed objectives in terms of the research; is that right?

DR MACINTYRE: That's correct, yes.

MS INNES: Then you go on to tell us about the work that you undertook to meet these objectives and you set out the material that you considered.

Were there any particular challenges in addressing these objectives?

DR MACINTYRE: So I think one challenge was the breadth of material, because obviously this was a very specific topic that we were asked to look at, but when we started to explore the relevant documentation that was available, what we realised was that the breadth of the topic was greater than we had originally anticipated.

So while the particular focus was on residential education for disabled children and young people and those with additional support needs, actually that covers a very vast range of legislative and policy areas. So we were looking at, obviously, education provision, but also looking at social work and health legislation, policy and provision. Looking at disability as a concept was more complex, perhaps, than might have been anticipated, and also looking at taking a very much human rights focus to the work as well.

So what that meant was that there was quite a complex overlap between the different policy areas that we were exploring, and so that made the process quite complicated.

MS INNES: We'll come back later on in the evidence to explore that issue further in terms of one of the themes that has come out of your work.

If we can move on, please, to page 10, and to 1.5, 'Understanding disability', you start that by saying that disability is a contested concept.

Can you please explain what you mean by that?

DR MACINTYRE: Yes. So I think the key message to take from that is that this is something that has been -- that has changed over time. So you could argue that disability is a socially constructed concept that has been informed by a range of different approaches. So we started with very much focusing on the medical model of disability, and within the medicalised approach, which is probably still the dominant approach to how we understand disability, the focus is very much on individual deficit, looking at impairment.

But there has been, over the years, a number of challenges to the dominance of the medical model, and the kind of most familiar challenge has come from what's called the social model of disability that looks at the broader social and structural factors that create disability. So it's not so much about the impairment itself that creates disability, but it's the way in which society responds to that impairment that creates disability.

So depending on your perspective, the concept is contested.

MS INNES: If we go on over the page, to page 11, there's a paragraph beginning:

'According to Stalker and colleagues, our understanding of disability depends on how this is framed.'

And you say:

'Framing can be informed by a range of different models and concepts ranging from the medical model [which you have just mentioned] to the social model and beyond to a more nuanced understanding of disability offered by the social relational model.'

So perhaps if we can just go back to: what is the medical model of disability?

DR MACINTYRE: So the medical model of disability, as I said, is very much focused on impairment. It's looking at the biological causes of disability, if you like. So it's seen very much as something that's inherent to the individual. So it's a very individualised approach to understanding disability. Key role for medical professionals, in terms of treatment and cure, and so, if we think about it in terms of power, the power is seen as being very much with the medical profession, rather than with the person with the disability, who's seen as someone who is passive, dependent and in need of treatment and cure.

So that would be the, kind of, more medicalised approach to understanding disability.

MS INNES: Over what timeframe was that model of disability prevalent?

DR MACINTYRE: Well, I think from the early work that we've carried out, you can see the dominance of the medical model, particularly in the, kind of, real need to categorise people, classify people according to different types of disability. So it was prevalent from the very early stages of this piece of work that we've carried out, and actually some people would argue that it still remains the most dominant way of understanding disability.

So the medical profession, if we look at hierarchies of power, if we were to look at mental health, for example, the medical profession would still be seen as being at the top of that hierarchy.

Now, there has been subsequent challenge from the disability rights movement, from the service user movement, the survivors movement, to reclaim some of that power, and that really started to, kind of, gain influence around the 1960s, 1970s but up until that point, the medical model was really the dominant approach to both understanding and responding to disability, I would say.

MS INNES: Okay.

You mentioned there that some would argue that that is still dominant. What do you mean by that?

DR MACINTYRE: Well, I think if you were to look at -- well, if you look at current policy and legislation, we -- it says explicitly -- so maybe trying to think of an example.

So if we look at the UN Convention on the Rights of People with Disabilities, for example, it says explicitly that it's informed by the social model of disability, but when that filters down into local policy and practice, we still understand disability primarily in medical terms and we look at ways in which we can treat and cure people, essentially.

So although the social model has become much more influential, in practice terms, the medical model is still probably very influential in certain settings.

MS INNES: Okay.

Is there anything you want to add to that, Andy?

PROFESSOR KENDRICK: No, I think that was a good résumé.

MS INNES: Okay.

So if we look, then, at the social model, did that become more prevalent then from the 1960s onwards?

DR MACINTYRE: Yeah.

MS INNES: And you've already explained what that is and we'll look more at that as we go through your report.

But you also mentioned something here called the social relational model, set out in the work of Carol Thomas. Can you explain that?

DR MACINTYRE: Yes. So the social model itself has been very influential in challenging the dominance of the medical model, but a lot of people with lived experience of disability were finding that they were a bit dissatisfied with the social model in terms of its simplicity, in terms of it looks at societal barriers but ignores the individual impairment, and people with lived experience of disability say -- would say -- would argue, 'You can't ignore the impairment, you can't ignore the pain that that causes me or the inconvenience it gives me in my life'.

So Carol Thomas tried to, kind of, refine the social model, and she offers a much more nuanced understanding of disability, where the impairment itself is acknowledged and she talks about what she defines as impairment effects, so the effect that the impairment has on a person's day-to-day life. She also acknowledges the social and structural barriers in the same way that the social model itself would do, but she also focuses on the relational aspects of disability.

So, for her, one of the central components of how disability is experienced is based on how other people treat you as a disabled person. So it's called the psycho-emotional effects of disability, and what she's really talking about is the way in which we, as individuals and communities and societies, react to and treat disabled people, and how, as a disabled person, I might internalise and respond to that. So it's about that interaction between the individual disabled person and the attitudinal responses of others.

So it's a more, kind of, complex but more nuanced way of understanding disability, that does acknowledge the impairment, but also acknowledges the structural barriers that people experience.

MS INNES: If we go on over the page to page 12, you refer to Stalker and Moscardini, and you say that they say that:

'... disability is located in the social, cultural, material and attitudinal barriers that can exclude a person from mainstream life, rather than individual deficits.'

As you say, this draws primarily on the social model, but also the social relational model of disability that you've described.

DR MACINTYRE: Yeah, that's correct. So it's about the interaction between those individual deficits and all of those other barriers, essentially.

MS INNES: If we move on to page 13, please, you refer there to the UNCRPD definition that you've already mentioned, that that was primarily based on the social model, and you note it there, and it says:

'Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.'

Is that the definition that you have focused on in your report?

DR MACINTYRE: Yes. I would say that we used this as our working definition, primarily because it does explicitly talk about that intersection, so the interaction between the individual impairment with the various structural barriers, but also touching on equality and rights within that definition as well. So we use that as our working definition.

MS INNES: Then below that definition, you explain that in the report, you refer to 'disabled children and young people' as opposed to 'children with disabilities'.

Can you explain why you use that term?

DR MACINTYRE: Yes. So I think it doesn't always sit comfortably with us, the use of identity-first language, rather than people-first language, and actually People First, the self-advocacy movement, have been very influential in promoting person-first language, so a 'person with a disability', so I'm a person first, and you can see that in some of the legislation that we'll go on to talk about.

However, the use of identity-first language is much more in alignment with the social model of disability, and really it's about saying that disability is something that's imposed on people, rather than an innate characteristic. So the disability is something that comes from an external source, and I think it's really about trying to, kind of, illustrate that, really. So people are disabled by a range of different barriers, societal attitudes and structures.

Also, there has been a, kind of, movement to reclaim identity-first language, and if we look at mental health again, for example, the Mad Studies movement, so people take pride over this particular aspect of their identities and see that as a strength, a collective action, I guess.

MS INNES: Then you go down to the next paragraph, where you acknowledge that specific changes in language have appeared over time and, obviously, historically there are terms used in legislation which would now be considered discriminatory and outdated; is that right?

DR MACINTYRE: That's correct, yeah.

MS INNES: If we move on to the next page, to page 14, where you talk about language used or definitions used in the education setting, as it were.

First of all, you refer to the Education Act 1945, which set up a three-tier categorisation of disabled children and young people: the educable, the trainable and the ineducable and untrainable. So that was the definition, essentially, towards the beginning of the timeframe that the Inquiry's looking at.

DR MACINTYRE: That's correct, yeah.

MS INNES: Then there was a shift to special educational needs, and then on to additional support needs in 2004.

In terms of additional support needs, you explain that the term can be transient in nature for some people?

DR MACINTYRE: Yes.

MS INNES: Can you explain this, please?

DR MACINTYRE: So one of the issues with the term 'additional support needs' is that it's a much broader and more -- many would argue a more inclusive category. So it doesn't only apply to disabled children and young people, but can apply to children who have experienced a range of barriers to their education, and some of those might not be fixed or permanent, but they might be temporary or transient in nature.

So things like, for example, parental separation, bereavement, substance use, those types of issues are less likely to be fixed and permanent in the same way as a disability might be, and so that was the, kind of, rationale for making that point about it being a transient label.

MS INNES: Essentially, you go on to say that this definition is much broader than previously, and if we look down to the bottom of this page, the final paragraph begins:

'While this might potentially be a more inclusive and less stigmatising approach, it raises questions, given the 768 per cent increase in pupils recorded as receiving additional support for learning since the change in the legislation in 2004.'

I think that's from an Accounts Commission report from this year; is that correct?

DR MACINTYRE: Yes, that's correct.

MS INNES: The statistic that there's been that increase.

DR MACINTYRE: Yes.

MS INNES: What issues does that give rise to?

DR MACINTYRE: Well, I think one of the issues is that with a rise of that significance, there are clear resource implications in terms of support that would be required within the classroom. For example, if you think about a primary school class with 30 children, potentially almost every child in the class will have some form of additional support need. What that means is that we're talking about a very varied group, it's not a homogeneous group, and that means for teachers and providers of education, there's a real need to be very flexible in their approach and to have a very broad knowledge of a very wide range of issues in order to ensure that all children with additional support needs are getting their needs appropriately addressed.

I don't know, Andy, if you would want to add anything?

PROFESSOR KENDRICK: I think it sort of reflects an ongoing development in terms of disability, and I think disability, particularly in terms of learning disability or learning difficulty, from the early 20th century, it's been recognised, there's been an expanding, more inclusive definition from terms like 'mentally defective' or 'idiot' or 'imbecile', through to 'special educational needs', broadened the definition, and 'additional support needs' has broadened it even further over -- in the current century.

MS INNES: Then the next sentence goes on to say that:

'[At present], only a small percentage, 3 per cent, attend specialist educational provision, with more than 90 per cent of those receiving additional support for learning attending mainstream schooling.'

So in terms of the specialist settings that we're looking at in this case study, it's a relatively small percentage of the whole number of children with additional support needs.

DR MACINTYRE: Yes, that's correct.

MS INNES: We're on page 15, and there's a paragraph beginning:

'A further key point to note here is that all disabled children and young people are likely to be considered to have an additional support need, but not all children with additional support needs have disabilities.'

Then you go on to say:

'There is a very real chance that the needs of disabled children and young people can be hidden by being subsumed within this category.'

Can you explain that?

DR MACINTYRE: Yes. So I think it's an issue that we, kind of, return to at various points throughout the report, and I think the point that we're trying to make is that while there are lots of positive aspects and benefits from taking a much more inclusive approach, it makes it very difficult to meet the very specific needs of some groups of children and young people, and disabled children and young people may become hidden within a much broader category.

I think there's a point you might come to later in the report, where it says that if a child's additional support need is not affecting other people, there's a chance that it will be overlooked, and I think that potentially is the case for many disabled people, where if their behaviour isn't being troublesome or they aren't causing disruption in the classroom, for example, their needs may be overlooked within this much broader category.

MS INNES: I suppose that concept of the disabled child or a child with additional needs being essentially a problem for other people, that might feed back into a more historical attitude to why children with disabilities and additional support needs or learning disability were put into specific institutions that we know about historically?

DR MACINTYRE: Yes, and I think we can kind of see elements of that historically right through to the present day, because even when we look at current policy which talks about, you know, the presumption of mainstreaming, there's always: 'except in certain circumstances', and one of the circumstances is usually around the impact on other children in the classroom or if it would be too costly to provide education within that setting.

So that -- the, kind of, historical attitude about disability as a problem, although we can see that it's changed and we can see the language has developed and we've become much more inclusive, the roots of that are still there, to some extent.

PROFESSOR KENDRICK: I think that's it and, certainly historically, the residential provision was seen as a way of segregating disabled children from the wider community, and was the primary form of care when we go back, you know, into the sort of early 20th century, even into the '40s and '50s, and broader in terms of children in care more generally, residential care was a primary provision.

LADY SMITH: What you say, Andy, fits with evidence I've heard, for example, that parents might be told, in relation to a very young child, better that he or she is 'with their own type'.

PROFESSOR KENDRICK: Absolutely.

LADY SMITH: And then they're put away.

PROFESSOR KENDRICK: Absolutely, and at that point, where there was voluntary provision and parents could just, in a sense, hand over children to the voluntary residential agencies, that was a very common solution, in a sense.

MS INNES: In the next section of your report, at 1.7, you talk about numbers of disabled children and young people, and this is another theme that comes out in your report.

You say in the first sentence here:

'There have been well documented difficulties in collecting data on disabled children and young people.'

What did you find in relation to this issue?

DR MACINTYRE: I think one of the key things that we found was that it felt almost impossible to come up with a definitive answer to the question in terms of how many disabled children and young people we're talking about, and that's partly because definitions change over time. It's partly because sometimes professionals may not have the knowledge or skills to be able to identify particular types of disability. It may be because families are reluctant to ask for help.

So we found that, over the years, different sources provided different figures, depending on the definition of disability that was being used, depending on where the data was coming from. Different agencies collect different figures, different types of data. So it was almost impossible to really provide a definitive answer on numbers, and you'll see that throughout the report. It's really complex.

MS INNES: At the bottom of the page here, you've got a quote from the Scottish Government, and this is from 2022, in which it was said that:

'Disability statistics are important for monitoring discrimination and equality. Good quality disability data will help with understanding the issues faced by disabled people and may be used to inform policy formulation and service delivery.'

So I think it's obviously been recognised that these statistics are important. This relates to disabled people, whether children or adults, but I suppose you need to know the whole figure before you even subdivide it in any way.

DR MACINTYRE: Yeah -- yeah, because if we don't have those accurate figures, it's almost impossible to provide adequate and appropriate support and services, and that's recognised within the UN Convention on the Rights of the Child and the Rights of Persons with Disability. So this is not an issue that's unique to us in Scotland; it's a, kind of, international issue with problems with data collection around disability, and something I think that, as you say, is now being acknowledged and hopefully addressed.

MS INNES: If we go on over the page, to page 16, we see some data under 'Population', at 1.8, that you were able to find. So, for example, in the Scottish Census in 2011, it found that 4.8 per cent of Scottish children were reported as disabled. That then seems to be subdivided into having day-to-day activities limited by disability. Is that the definition that was used in the census?

DR MACINTYRE: Yes, so it's about severity of disability, and the way that that's measured is whether your daily activity is limited a lot by your disability or limited only a little. So the numbers with more severe disabilities or the proportion is smaller. But the 4.8 per cent, that seems to remain quite consistent, roughly -- well, it, kind of, maybe goes up to around 7 per cent at some points, but that is a good estimation, I would say.

MS INNES: At the bottom of the page, you refer to, I think, a recent blog by McTier from November 2024, which is looking at children up to the age of 15 who have a disability has risen from 5 to 8 per cent.

Do you know what that statistic was based on?

DR MACINTYRE: Yes. So that was on additional work that McTier and colleagues at CELSIS had carried out, which was an analysis of the 2022 census data, but I don't think it's fully published yet. So he's been writing about it, but I don't think there's a comprehensive report available yet. But it's an analysis of the 2022 census.

MS INNES: If we look on to page 17, and under section 1.9, where you look at children who are on the Child Protection Register or children who are being looked after or children who are in secure care, I think we see from those statistics that it would appear that there's a higher proportion of children who, for example, are looked-after who have disabilities than who are in the general population; is that right?

DR MACINTYRE: Yes. Yes. So it seems quite consistent that across each of those -- so if we look at child protection, look at looked-after children, and then particularly if we look at secure care, the proportion of disabled children and young people is higher.

MS INNES: Then just at the bottom of the page, you note that: 'Several studies have shown that disabled children and young people are at a greater risk of harm and abuse than non-disabled children and young people.' And I think one of the studies that you refer to has been carried out by Anita Franklin, who has been commissioned by the Inquiry to prepare a separate report, so I'm not going to go into that --

DR MACINTYRE: Okay.

MS INNES: -- but just to note that that's been found and that's consistent with your reading of the research in this area.

DR MACINTYRE: Excellent. Thank you.

MS INNES: If we can move on to page 19, please, and the bottom of that page, there's a reference there to an article, Kendrick and Taylor, 'Hidden on the ward: the abuse of children in hospitals', which was written in 2000, and I wonder, Andrew, if you could tell us a bit more about this article and what you were considering?

PROFESSOR KENDRICK: Well, this was written in the 1990s, so published in 2000, and this was linked with the work that I was involved in at the time through Skinner and through the Kent Review, and my colleague, Julie Taylor, who is in the nursing profession, who is now a professor, and has done a lot of work in relation to child protection, and we were looking specifically at issues around the abuse of children in hospitals, which hadn't been dealt with to a great extent at that time, certainly in the UK.

Another driving factor was the -- Beverley Allitt had been convicted of child abuse and, I think, the death of children at that time, so it was just picking up on that in the specific setting of hospitals.

MS INNES: What did you find in that research?

PROFESSOR KENDRICK: Well, I think we found that it was occurring and that hospitals needed to be aware of the issues of child protection in hospitals in the same way that the broader range of residential settings needed to be aware of it.

MS INNES: Then if we go on over the page, to page 20, there is a section there headed, 'Disabled children and young people: a hidden population', and towards the end of the first paragraph, you say:

'As we highlight in this review, disabled children and young people are not always well represented within policy and legislation and their needs are often overlooked or subsumed within policies that attempt to meet the needs of all children ...'

Including them.

Do you know why that is? Why are they hidden?

DR MACINTYRE: I think it's because if we look at something like the GIRFEC approach, which is, you know, obviously the key way in which we work with children in Scotland, the approach is very much you're a child first, a disabled child second, and the idea is that all children's needs should be met within this one approach.

As I said previously, I think that's very commendable, and it does a huge amount to tackle potential stigma and discrimination that disabled children and young people experience. However, it does mean that when children or young people have very specific needs, those are not always well acknowledged within policy and legislation, and there is a, kind of, growing understanding that trying to promote equality doesn't mean that we treat all children the same, and that we do have to acknowledge the particular needs of disabled children and young people.

And even within the category of disability itself, a lot of the work that I do is with people with learning disabilities, for example, and even within the category of disability, we talk a lot in legislation policy, when we mention disability, we don't really recognise the very specific needs of people with learning disabilities within that. So there's a real, I think, tension between trying to meet the needs of everyone and to be inclusive and non-discriminatory, while at the same time acknowledging the very specific needs of different populations.

PROFESSOR KENDRICK: Just to pick up, historically, they were literally hidden; they were hidden away in asylums, in residential schools in the countryside. So, you know, it's -- over time, that idea of hidden may have changed, but it's something consistent.

MS INNES: When you say, Gillian, that people perhaps with learning disability are hidden, is that because legislation and policy sometimes focuses more on physical accessibility?

DR MACINTYRE: Perhaps, but also I think when we talk about disability generally, we don't -- so, for example, looking at gender-based violence, and there's a lot of work being done recently around disabled women's experiences of gender-based violence, but it doesn't acknowledge the very specific needs of people with learning disabilities, which are around things like capacity, cognition, communication, so some of those issues are often overlooked.

And I think you are probably right, that we do immediately think of accessibility issues when we think about reasonable adjustments in relation to disability.

MS INNES: Now, if we can move on in the report, please, to page 22. This is a chapter which just sets the historical context, and this is before 1945. I just want to ask a couple of things in relation to this chapter.

If we look, please, at page 24, we see reference, in about the middle of the page, to the Mental Deficiency Act, which was passed in 1913, and at this time: 'School boards were required to identify "defective" children in their area who were classed as "idiots", "imbeciles, "feeble-minded persons" or "moral imbeciles". Those who were considered capable of benefiting from education were placed in special schools.' And I think that's, perhaps, referring to what you just mentioned about segregation and categorisation, Andy?

PROFESSOR KENDRICK: I think that's right, and these may well have been hospitals as well, where there would be educational facilities, but the extent to which they provided education, I think, at that time would have been questionable anyway, and often there wouldn't be teachers in these institutions or hospitals. Any education would be considered -- it would be done by nursing staff.

So even though it's acknowledging it, I think the extent to which it was put in place and in practice, you know, is questionable.

MS INNES: Then we see it goes on to refer to the 1918 Education Act, which introduced compulsory education for all children, but it forced parents to have disability assessments carried out on their children, and later on in the paragraph you note that:

'Some parents refused to have their children assessed for fear that they would be taken away.'

Because of this approach?

PROFESSOR KENDRICK: Yeah, that's right. So in that sense, that fear of -- well, a fear that continues to exist in terms of social work, often, that children would be removed from their home because of issues of disability.

MS INNES: Then if we move on to page 26, we can see the beginning of the chapter in relation to policy and legislative developments between 1945 and 1973, and if we could move on in this chapter to page 28, and towards the bottom of that page, there's a section headed:

'3.2. A growing recognition of the educational needs of disabled children and young people.'

Then if we go on to the next page, it says: 'It was not until the passing of the Education (Scotland) Act in 1945 that it was officially recognised that the broad purpose of education was essentially the same for [disabled children as for other children].'

What was the major change that the 1945 Act brought in?

PROFESSOR KENDRICK: I think it was in terms of the idea of identifying children who required special educational treatment, but you will see that, in terms of the definition in section 1.4, it's talking about suffering a disability of mind or body, so still that sort of medical focus.

Although it talks about 'include education by special methods', there was never any real definition about what these special methods were, and certainly in terms -- at that time, the segregation of children was still primary.

And again, although this is focused on saying all children, we have already seen from the introduction and go on to see this, that some children will still be defined as ineducable, so that no form of education would be provided, and these children would be placed in hospitals, as I say, with no attempt to school them.

LADY SMITH: But didn't the legislation envisage that a child could be incapable of being educated, but might be able to be trained? Because that seemed to be a different concept.

PROFESSOR KENDRICK: Yes, so they also talked about -- that's right, not educable, but trainable, and then ineducable. So there is this, yeah, rather disturbing categorisation of children incorporated into the legislation.

DR MACINTYRE: I think also the untrainable, though. So there was people who were trainable, but there was also a group who were untrainable as well.

PROFESSOR KENDRICK: Yeah, that's right.

LADY SMITH: And it seems that we're to infer if you get to trainable, you're not capable of being educated, so you really are at the bottom of the heap.

PROFESSOR KENDRICK: That's right.

DR MACINTYRE: Yes.

LADY SMITH: Is the way the legislation seemed to regard children, if you get to that stage. Tragic.

MS INNES: If we can move on to page 30, please, there's reference to section 42 of the Act, allowing the education authority to decide whether a child was 'incapable of receiving education or training in a special school or cannot be educated or trained in association with other children.'

So that follows on from the discussion that we've just had.

PROFESSOR KENDRICK: That's right, yeah.

MS INNES: 'In these cases, it must report to the local authority for the purpose of the Mental Deficiency Act and to the General Board of Control for Scotland that the child has been found incapable of receiving education or training in a special school.' And I assume at that stage there might be then a transfer to a hospital setting?

PROFESSOR KENDRICK: At this point, probably children were in hospitals and were being assessed under the new legislation.

MS INNES: At the bottom of the page, you refer to some commentary in relation to the 1945 Act, and noting that education authorities did have a duty to provide education, albeit for those deemed capable of being educated.

But then you go on to refer to Petrie, who highlighted some issues with implementation of these principles, and what sort of issues were there?

PROFESSOR KENDRICK: Well, I think -- generally, I think we must reckon, with post-war, that there were general resource issues simply because of the impact of the war and, you know, the economy at the time was recovering, rationing was still in force, so there were these general issues.

But in terms of Petrie suggesting that the education of disabled children at this time was not prioritised, that it would be given to junior staff, that it would then be handed over, there wouldn't be somebody with a specific role for this, and I think, possibly, if you could just scroll up to the next page, just to -- I think there were issues in terms of the way in which -- so the way in which parents were involved, because it was very much -- and I suppose, again, it comes back to the idea of the power of the professionals to be stating what appropriate measures should be taken in terms of the education of children, and that the advice to parents would be: this is what needs to be done because of the Education Act.

MS INNES: Just going down the page that we're looking at, there's a paragraph beginning:

'In 1947, the Secretary of State for Scotland requested the Advisory Council on Education in Scotland to review the provision made in Scotland for primary and secondary education of pupils who suffer from disability of mind or body or from maladjustment due to social handicaps.'

Then, on the back of that, there were several reports -- you say eight reports -- in relation to the education of particular groups.

What came out of those reports?

PROFESSOR KENDRICK: Well, each of the reports focused on a different type of disability, so physically handicapped, blind or partially sighted, deaf or those with partial hearing, the maladjusted, and I can't remember whether it was mental deficiency. So looking specifically at issues around prevalence and looking at the nature of provision and, in a sense, highlighting the categorisation of children with disability along the medical model that we've suggested.

And I mean, we don't go into a huge amount of detail in this report, but each of the reports is set out in the report that I submitted earlier to give detail on the issues to be found.

I think that residential provision was still seen as the primary form of provision, despite, as we'll see, that the statements about children remaining in the family and in the community might have been high-level policy at the time; when it came to local provision, there was still this emphasis on segregation, either in residential or in special schools.

MS INNES: You note there that: 'Consistent across the reports, was the opinion that children should not be removed from home to a residential institution --

PROFESSOR KENDRICK: That's right.

MS INNES: -- unless they themselves will clearly profit from the transfer, or unless their retention in a day school would be prejudicial to other pupils.' But are you saying that in implementation, people were looking at the exceptions?

PROFESSOR KENDRICK: I think that, and I think we will see throughout, from the '40s, '50s and '60s, although there's this repetition of this commitment to keeping children within the communities and within families, nevertheless, special education, either special day schools or residential provision, continued to be the main form of provision across Scotland.

MS INNES: If we go on to the next page, at the top of page 32, we see the response was to publish a circular, and if we look into the quote, you say that: 'The circular argued for the development of the theme of integration', and there seemed to be a suggestion that, over time, as medical knowledge improved, it ought to be possible for more children with special educational needs to remain at home?

PROFESSOR KENDRICK: Yeah, and I think that's it, that this in a sense was the Scottish Education Department taking the commitments in the individual reports and making this statement, but I think, as we will see, that the implementation of this -- because, you know, this was early on in the '50s -- that it took, you know -- we're talking into the '70s and '80s before we were starting to see any major shift in terms of provision.

LADY SMITH: So this circular was 1950s?

PROFESSOR KENDRICK: Yes.

LADY SMITH: Yes.

MS INNES: At the bottom of the page, we see reference to the Special Educational Treatment (Scotland) Regulations from 1954. So were these also a reaction to the output of the Advisory Council report?

PROFESSOR KENDRICK: That's right. So in the Education Act 1945, that gave the ability to produce the regulations, and on the back of the advisory committee reports, the -- these regulations then set out these nine statutory categories of pupils requiring special educational treatment, and that -- yeah, so the one I couldn't quite remember was mentally handicapped pupils when I went through the list previously.

MS INNES: Yes. So these categories essentially come from the categories used in the Advisory Council report?

PROFESSOR KENDRICK: That's right, yeah.

MS INNES: If we go on over the page, to the top of page 33, essentially it says that deaf and blind pupils who, as it says, are not mentally handicapped, had to be educated in a special school?

PROFESSOR KENDRICK: Yeah. So --

MS INNES: But other children could potentially be educated in mainstream school.

PROFESSOR KENDRICK: That's right, yeah.

I think it comes back again to what Gillian was talking about earlier, which is a focus on severity in terms of disability. So we'll see that, you know, the blind and partially sighted are seen as separate categories, and so there's that idea of -- and in the advisory committee report, sorry, as I recall, there are these gradations of disability set out at that time.

DR MACINTYRE: I wonder if it also -- sorry to butt in -- I was thinking, I wonder if it also relates to a sort of early form of making reasonable adjustments, and certain groups where it was felt it wouldn't be possible -- for deaf children or blind children, the level of adjustment that would be needed would be so great that it wouldn't be possible, potentially.

PROFESSOR KENDRICK: Yes.

MS INNES: If we look down this page, there's reference to the Education (Scotland) Act 1962, which made further changes to the 1945 Act, but was there any change to the definition of special educational treatment, as it then was?

PROFESSOR KENDRICK: No, not at this point. The changes in relation to this were primarily in terms of the development of the National Health Service and just ensuring that reference was updated for that.

So, in a sense, that section 5 is a repeat of what was set out in the 1945 Act.

MS INNES: Then if we go over the page to page 34, and as you've mentioned, the NHS came into being, and you refer to hospitals.

There's a large paragraph which ends referring to two hospitals, Lynebank and Craig Phadrig Hospital, if we scroll down. Thank you. You note just before that that the Scottish Consortium -- now Commission -- for Learning Disability noted that the creation of the NHS brought about an expansion of mental deficiency hospitals, and then in the 1960s, even though there was a recognition of the need for more care in the community, there was further expansion of institutional provision, with these two hospitals opening in the late 1960s.

Then you go on to note a statistic that, at that time, there were 1,533 children in these mental deficiency hospitals, which represented about one-fifth of all the patients that were in those hospitals; is that right?

PROFESSOR KENDRICK: That's right. I think one of the points is that prior to the National Health Service, I think that disabled children and children with learning disabilities, along with adults, could be across the range of hospitals. They might be in the poor house. They might be in some of the other types of hospitals. Children were in sanatoria and the fever hospitals because infectious diseases caused -- you know, polio, tuberculosis, created, in a sense, impairment for these children.

So with the National Health Service, there was -- there started to be a rationalisation in terms of these hospitals, but also, in terms of that, because adults and children who were being placed in the mental deficiency hospitals may have been spread over a range of institutions, and there you see the expansion in this particular type of provision.

MS INNES: If we go over the page, you refer to the National Assistance Act having been passed in 1948, and you refer to local authorities having to provide for the welfare of the disabled, sick and other persons, as well as regulating homes for the disabled and aged persons.

That would apply to children as well as adults; is that right?

PROFESSOR KENDRICK: Yeah.

MS INNES: Then if we scroll down just below the quotation, there is a paragraph beginning:

'The Act also placed a duty on local authorities to provide residential accommodation.'

But it allowed local authorities to delegate responsibilities, I think, to voluntary agencies, and what was the effect of that?

PROFESSOR KENDRICK: Well, I think part of that is that this overlaps with the Children Act 1948 as well, which specifically addresses children, and in terms of the Children Act and this Act, in acknowledging the role of voluntary agencies and the charities, a lot of the residential schools at that time for disabled will have been run by the charitable sector, and children would have been being placed in those -- in terms of the point we made earlier, Lady Smith, in terms of parents handing over the responsibility of disabled children to the charities. And they were the much larger part of the sector at the time. The local authority residential sector was relatively small in the 1940s and 1950s.

DR MACINTYRE: I think the other thing to say in relation to that is because of that ability to delegate responsibility to the charitable sector, it meant, to some extent, local authorities were able to step back slightly from their responsibilities, particularly around the provision of community-based services at that time. So what we had was a rise in the number of residential institutions run by charities and private agencies, but less kind of development from the local authority sector.

MS INNES: If you go on over the page to page 36, there is reference to the Children Act 1948.

Was there anything specifically in that Act in relation to children with disabilities?

PROFESSOR KENDRICK: No. I mean, disabled children, in a sense, fell under the rubric of children in need, so there wasn't specific reference to disability. Actually, as we say, the references to disability are to do with parents, rather than to children themselves, and their ability to look after children.

MS INNES: If we go on to page 38 and to the bottom of the page, you are referring there to the Kilbrandon Report, and you say that had significant implications for disabled children and young people; in what way?

PROFESSOR KENDRICK: Well, I think one of the main issues in terms of the Kilbrandon Report is that it was looking at the specific group of children who were placed in care through the courts, either because of offending or for child and protection issues or being outwith control. But at that time, the number considered in terms of child protection issues was very small, relatively, I think 500 or so, whereas those who were offending was in the area, I think, of about 20,000. So the focus was very much in terms of children and young people who were offending.

But in terms of disabled children, one of the things that the Kilbrandon Report recognised is that many disabled children were placed inappropriately in approved schools, rather than in other forms of care, and I think the Kilbrandon Report -- again, this is covered in my report, possibly in more detail in terms of specifics, the insufficient residential provision for maladjusted children and the need for specialist residential provision.

So the Kilbrandon Committee identified numbers of children and young people who were placed in approved schools, as they saw, inappropriately.

MS INNES: If we go on to page 40, picking up on that, just above the section beginning 3.6, there is a quote from Toman. He commented on the evidence that:

'Children in List D schools had similar backgrounds and difficulties to those experienced by children in the

List G schools.'

And then says:

'In reality, the placement depended largely on which network picked up the child and his problems and the nature and amount of the offending involved.'

PROFESSOR KENDRICK: I think this is something that has been acknowledged over time, is that children and young people will be identified, either by education, either by social work or through health authorities, and that sometimes that initial starting point can determine which type of residential provision they are placed in. So the List D schools were followers of the approved schools, while the List G schools were providing educational provision for those who had been identified by the educational authorities.

But, in a sense, that was part of the whole thing that Kilbrandon identified; was that young offenders, those children in need, needed to be looked at in terms of their needs, rather than in terms of the offending or care and protection or whatever.

MS INNES: Just below that, at 3.6, we see reference to a specific document that was published by the Scottish Education Department in 1967 in relation to special education.

PROFESSOR KENDRICK: Yeah.

MS INNES: If we go on over the page, we see that there's a paragraph beginning:

'The report discussed the complexity of ascertainment.'

What's meant by that?

PROFESSOR KENDRICK: Well, ascertainment was the process by which in the Education Act 1945 and subsequent legislation would be how disabled children were identified through professional assessment and review.

But, in a sense, I think in relation to -- the particular working groups were focusing on some of the complexities in terms of how you ascertain or how you identify these different forms of disability.

Maladjustment, I think, was sort of highlighted by that, was the, in a sense, vagueness of the term. What does 'maladjusted' mean, you know? And I think at some point we talk about, you know, maladjusted -- or young offenders will be maladjusted, but not all maladjusted children are offenders. But, again, it's about definition.

Some of the arguments in these documents almost seem circular in terms of how these definitions are made or attempted to be addressed.

MS INNES: You note below the quote -- there's reference to 'Jones', the paragraph beginning with the reference to

'Jones'.

PROFESSOR KENDRICK: Yeah.

MS INNES: You say:

'Jones commented that the working parties agreed on three principles for general application: increased emphasis on gaining the co-operation of parents, taking a team approach, and the need for a continuing process of ascertainment and review.'

So I suppose two of those seem quite forward-thinking, but not the last point?

PROFESSOR KENDRICK: I mean, some of these documents are certainly -- we weren't able to access all of the four reports, but I was looking at the one on ascertainment of the blind and partially sighted, and it is -- for the most part, it is very medically focused, so it is on how a medical doctor will identify these different gradations of blindness or sight impairment.

Also, they broaden -- they do include other aspects in terms of the health of the child, the intellectual capacity of the child. It's still very medically focused.

I think -- two points. Over this time generally, there had been the shift, in terms of looking after children, away from the segregation of children, so that when children were boarded out, as we saw in the Foster

Care study and Residential Care, this was separation. Once children were placed in care, parents were not to be involved. This started to change through into the 1960s, and you started to see that parents would continue to be involved in the care of their children, and this is reflected in this, so that in terms of disabled children, there should be increasing involvement in relation to the co-operation of parents.

But also in taking a team approach; that idea that Kilbrandon highlighted in terms of the importance of social work, health, education, to be coming together to give these professional assessments, although still very much focused on: it's the professionals who are making, in a sense, these decisions.

MS INNES: At the bottom of this page, you say that the definition of special education was then amended in the Education (Scotland) Act 1969, and what changes did that make?

PROFESSOR KENDRICK: So this removes the terms, if you recall from the early legislation, of children who suffer a disability of mind or body. So now special education now means education by special methods, appropriate to the requirements of pupils whose physical, intellectual, emotional or social development cannot be adequately done without such special methods.

So it's a move away from that deficit focus in terms of specific disabilities.

MS INNES: Okay.

If we can look on, please, to page 44, where you refer to a report published in 1970 about information on disabled children and young people in the care of local authorities back in 1966. You say that this was identified by distributing questionnaire cards to local authorities and voluntary agencies.

The report estimated that 12,500 children were in care and, working the statistics through, at least 9 per cent of children in care were disabled.

PROFESSOR KENDRICK: Yeah.

MS INNES: So I suppose that reflects what we saw in relation to more recent statistics, that a higher proportion of children in care had disabilities.

PROFESSOR KENDRICK: Yeah, and this would have been an underestimate as well, because it was only in terms of the cards that were returned. The report didn't indicate what sort of response rate there was in relation to these -- to the returns in relation to the disabled children.

Also, I think it's important that when they're talking about in care here, it's those who were placed under the Children Act 1948 or those who were placed in care by their parents on a voluntary basis, and these figures don't include children in approved schools. So that's why approved schools aren't in the list of residential establishments.

MS INNES: If we go down to the bottom of the page, there was discussion in the report about the benefits that may be derived by the handicapped child from the society and stimulation provided by the company of normal children.

But then towards the bottom of the page, there's talk of co-operation between local authorities and voluntary agencies in considering how the needs of disabled children and young people could be better met.

It then says 'disabled children and young people in hospital', and it noted that children who are described as ineducable and untrainable and others with special emotional and physical handicaps were not, as a rule, suitable for care in any kind of children's home, and then highlighted a serious shortage of psychiatric units and services for children and adolescents with emotional disorders.

It goes on, it highlights the clear role of residential special schools for some disabled children and young people and the overall shortage of provision for the maladjusted child. That goes on to the top of the next page.

PROFESSOR KENDRICK: Yeah.

MS INNES: So it appears to focus on these specific settings.

Then if we go to page 45, it says:

'The report highlighted the importance of stimuli within the home, such as well-equipped play space, opportunities for creative work, reading or looking at books [or] music'. And then it says:

'Perhaps most important of all, however, is that children should be given frequent opportunities of talking to adults.'

PROFESSOR KENDRICK: Well, I think this is starting to see much more the idea of relationship in terms of caring for children.

MS INNES: Okay.

Now, after this, you go on to refer to a couple of other items: the Chronically Sick and Disabled Persons Act 1970, which I think refers to, again, local authorities having to ascertain numbers of disabled children in their area and publish information, and they had a duty to provide certain things.

Did that have much impact in relation to disabled children?

PROFESSOR KENDRICK: Do you know this?

DR MACINTYRE: Oh yes. So I think -- could we scroll on to the next page, if that's possible? Thank you.

So it set out a range of provisions that should be put in place for -- well, disabled people generally, but also it did look at education of children as well, and I think Clements and Read, who provided quite an in-depth analysis of policy and legislation at this time in relation to human rights and disabled people, talked about this piece of legislation being the cornerstone of community care provision.

So it seems that it has been a really significant piece of legislation in terms of acknowledging the rights of disabled people to be present in the community and to be able to access a whole range of services/supports within their local areas.

So, again, it talks about the home setting, and I think that comes across as a theme throughout the report, the importance of living in a home, even if it's not your own home, a home-like environment, and we can see that in the provisions of this legislation.

So this was seen as really significant, but I think some other writers at the time, like Colin Barnes, for example, argued that it didn't have the impact on the lives of disabled people that many commentators and people who had been campaigning for this might have hoped for.

So important, but probably didn't go quite far enough.

MS INNES: Okay.

Then you go on in the report to refer to the European Convention on Human Rights, and you note certain aspects which are of relevance.

But I want to move forward to the conclusions in relation to this time period.

At the bottom of page 48, you refer to the move from segregation to inclusion, but you say implementation was patchy and slow, and a potential postcode lottery.

Then you go on to refer to Turner, noting the specific reference to Glasgow, that there was actually an expansion of segregated provision.

At the top of page 49, it says that extensive expensive specialist provision encouraged a tendency to send children to that sort of provision.

PROFESSOR KENDRICK: Again, if you've got provision, you use it, and I think that, you know, that's been -- that's certainly an issue over this period of time.

DR MACINTYRE: They had invested a lot of resources in developing that provision, so then I think they found themselves in quite a tricky position about what to do, because they found themselves at odds with national policy.

PROFESSOR KENDRICK: Even though national -- as was said earlier -- even though national policy was stating this idea of moving towards integration, still I think there wasn't really a thrust up to this point in terms of local authorities really picking up on it and moving it forward.

MS INNES: Now, my Lady, I'm going to move to the next period after the break.

LADY SMITH: I promised you a break at about 11.30. I don't want to break that promise, if that's all right. We'll have a pause just now.

Thank you.

(11.30 am)

(A short break)

(11.45 am)

LADY SMITH: Andy, Gillian, welcome back. Are you ready for us to carry on?

DR MACINTYRE: Yes.

LADY SMITH: Thank you.

Ms Innes.

MS INNES: Thank you, my Lady.

If we can move to page 53 of your report and in the first paragraph on that page. So we're now in a chapter looking at the period from 1974 to 1995.

In the introductory paragraph, one of the issues that you highlight is that there was a move in both legislation and policy towards de-institutionalisation, and one of the things that you mention is that these changes were largely influenced by an increase in awareness of abuse in long-stay hospitals that resulted in amplified public concern over treatment of disabled people, the work of pressure groups and increased recognition of concepts such as normalisation and integration.

Just focusing on awareness of abuse; how did that come to light and then impact the long-stay hospitals?

DR MACINTYRE: So I think there was growing awareness of abuse in a number of long-stay hospitals at the time, and that really caught the public attention and was captured by the media, which led to a real kind of public concern and a public outcry, which therefore led to the series of public inquiries, as set out there.

So very much there was, you know, concern about the treatment of disabled children within institutions, and really, at this time, much greater public awareness of the group who had been previously hidden from their consciousness and a growing demand to change things and to do something about that.

So that was the purpose of these inquiries, which led to a recommendation of a process of de-institutionalisation.

PROFESSOR KENDRICK: Just to pick -- this is also in terms of the use of residential childcare. This is the period where there was a significant reduction of the number of children in care, but also the switch from the use of residential care to the use of foster care, and so these were sort of in parallel and in line in terms of the move towards community care and community provision.

MS INNES: If we move on to page 58, and to a section 4.3, 'Educational settings', you are looking there at some figures that were available, I think, in the Warnock Report that, in Scotland, in September 1976, there were 13 independent schools which catered wholly or mainly for handicapped pupils, and they provided 500 places.

It then also identified the number of children in hospital education, and it notes that there were 867 children in 15 mental deficiency hospital schools, and then there's a separate statistic of 508 children receiving education in 45 hospitals.

Is that hospitals other than mental deficiency hospitals?

PROFESSOR KENDRICK: Yeah, that's my understanding.

MS INNES: Then there's also figures available from the McCann Committee Report, and these identified eight residential schools for provision with physically handicapped children. Six of these were grant-aided.

So are these different to the independent schools noted in the Warnock Report?

PROFESSOR KENDRICK: Yes. Yeah, they're a different category.

MS INNES: We see the table on the screen summarising the different statistics there.

If we look at the eight residential schools, the category of children -- so, first of all, it notes that there were eight residential schools which had risen to 12 by 1975.

PROFESSOR KENDRICK: Actually, I picked up that there is a mistake in this table. The eight residential schools relate to physically handicapped children, and the 12 residential schools relate to maladjusted children. So they're actually two separate categories, and that can be amended in the report.

MS INNES: Thank you.

Now, if we can move on to page 60, please.

You are discussing there a survey in terms of children who were in hospital, and there's a quote saying that: 'School was often the highlight of the children's day.' And then it says:

'The survey described the life of the children on the ward and found that the large nursing charges which are still evident in many wards, coupled with frequent changes of staff, make the central requirement of continuing adult/child relationships difficult to attain.'

So I think this was a report by the Scottish Education Department --

PROFESSOR KENDRICK: That's right.

MS INNES: -- in relation to education and mental handicapped hospitals, and it seems to again identify the importance of relationships.

PROFESSOR KENDRICK: That's right and, in a sense, the relationships were achieved in terms of the schools and the education, but for the time that children were actually on the medical wards, then it meant that the nursing staff simply didn't have the time, in terms I think -- which is how I interpret the large nursing charges, was the idea that they didn't have the time to spend time with the children.

MS INNES: Then if we go into the next section, 4.4, where you refer to the relevant terminology, this, I think, changed over this period.

At the bottom of the page, you have a paragraph beginning:

'Concepts such as normalisation and integration and the social model of disability were influential in challenging ideas around segregation, leading to the promotion of integration of disabled children and young people in mainstream settings.'

Then you say:

'Although now largely discredited, the concept of normalisation was highly influential in promoting de-institutionalisation and the integration of disabled people.'

Are you able to tell us a bit more about this and the impact of normalisation?

DR MACINTYRE: Yeah. So the idea of normalisation, it originated in Scandinavia, and the idea is, it's about individuals adopting -- disabled individuals, sorry, adopting socially valued roles so that they can be more integrated into local communities. It's about valuing the contribution that disabled people can make, which was previously overlooked.

So this idea of normalisation, it's been really very influential. So it started in Scandinavia, and then someone called Wolf Wolfensberger developed the concept further in the United States, and he, kind of, came up with this concept of social role valorisation, which was about disabled people taking on roles that would be valued by the rest of society.

But it became quite controversial, because the idea was that -- the principle, the concept of normalisation, the focus was very much on: what can disabled people do to fit in to the existing structures within society? At quite an extreme level, one of the examples that Wolfensberger gave was that someone with, you know, a facial disfigurement, for example, could consider having plastic surgery to make themselves look more acceptable and more normal, if you like.

So that is where the kind of critique of the concept of normalisation has come in, because while it was really important in terms of the right to be part of the community, the right to be valued and to have the roles that you play recognised, the onus was very much on disabled people to fit in, rather than looking at what adjustments can society make in order to make that process more inclusive. So the focus is very much on integration, rather than inclusion, and I think that's the key difference.

LADY SMITH: Of course, it all depends on how you define the norm.

DR MACINTYRE: Exactly, yeah.

LADY SMITH: People are all different. The reality is there's probably nobody that fits the scientific norm that sits right in the middle of the line.

DR MACINTYRE: Exactly.

LADY SMITH: Whereas you are probably going to go on and say we've got more to a stage, I hope, of trying to look at disabled people and work out what they can do and value that, rather than focus on what they can't do.

DR MACINTYRE: Yeah.

LADY SMITH: And we're still a long way from it at this stage.

DR MACINTYRE: Yes, yes, but that's the move, towards a sort of strengths-based approach.

LADY SMITH: Yes.

MS INNES: If we move on, please, to page 61 and to the bottom of the page, a paragraph headed, 'Education in 1970s Scotland', you say:

'From 1974 onwards there was a growing recognition of disabled children and young people's right to education. As a group, they were no longer considered uneducable and there was an increased focus on the possibility of education in mainstream settings.'

Then you go on to refer to the Education (Mentally Handicapped Children) (Scotland) Act 1974, which discontinued the ascertainment of mentally handicapped children as unsuitable for education at school.

So is it, at that point, that the references to uneducable --

PROFESSOR KENDRICK: And untrainable. That's right, yes.

So uneducable and untrainable that was set up in the 19 4 Act, those are then scrapped, in a sense, in terms of this legislation, and then education authorities had to provide for the education of these children, and that would include those who were living in hospitals.

MS INNES: So that's a change from the 1945 Act?

PROFESSOR KENDRICK: That's right.

MS INNES: You then go on to make reference to the McCann Committee Report, looking at secondary education of physically handicapped children in Scotland.

What changes came about as a result of this report?

PROFESSOR KENDRICK: Well, this focused very much in terms of the needs of physically disabled children and, in a sense, acknowledging the improvements in medical treatment, but also in terms of technology and the adjustments that could be made in mainstream schools so that there would be a lesser need for special educational provision, that more children with physical disability would be included in mainstream schools.

In a sense, you know, at this point it is starting to push the commitments that we've seen have been made over many years in terms of integration into mainstream schools.

MS INNES: Then if we go on to page 63, there's a paragraph beginning:

'Priestley considered the education of the group of children who, in the 1970s, were referred to as "maladjusted children" in Scotland just prior to the publication of the Warnock Report. He noted that maladjustment is often relative to time and place rather than a constant state and he went on to discuss the problems in diagnosis and assessment.'

This is a term that we have often heard and you mentioned already in your evidence.

PROFESSOR KENDRICK: That's right, and I think it is about, you know, that maladjustment seems to be a sort of a broad category, taking in a whole range of children, and this is highlighted then, in terms of Priestley saying the lack of consensus on approach, because it covers a broad range of children, and as we've seen, the idea that children will be placed -- we have seen maladjusted children in approved schools, we have seen them placed in a whole range of other residential settings, as well as special schools.

So I think this was a major concern in terms of Scottish education at this time.

MS INNES: At the end of that paragraph, you refer to a work by Riddell writing about the same period, and noting that there would have been ongoing uncertainty about how to educate this group of children who were regarded at the time to be potentially disruptive and challenging.

PROFESSOR KENDRICK: Again, I think this comes back to what Gillian discussed, in terms of it's the extent to which children -- where children's behaviour is manifested in the school setting, and that balance in terms of the education of the majority of the children or the education of this group of children, as to how they should be educated.

MS INNES: Then if we go on to page 64, in a paragraph headed, 'A move towards de-institutionalisation', in the first paragraph there, there's reference to a National Development Group for the Mentally Handicapped, set up by the Secretary of State for the DHSS in 1975, and it was argued by Tyne that one of its biggest achievements was to convince government that a large hospital could never be regarded as a satisfactory home for a child.

We know that it took some time for the large long-stay hospitals to be shut down, so I wonder if you can shed some more light on that.

(Pause)

LADY SMITH: Andy, Gillian, you probably realise that some people are connecting to this hearing remotely, and it looks like somebody had forgotten to switch off their microphone.

DR MACINTYRE: All right, no problem.

LADY SMITH: Right.

DR MACINTYRE: Sorry, where were we? We were talking about why there was the delay?

MS INNES: Yes.

DR MACINTYRE: So, yeah, I think the commitment -- because it is set out in the report from the Scottish Consortium for Learning Disabilities that that commitment to end de-institutionalisation was around since the 1960s, but it took a significant amount of time for that to actually be operationalised.

I guess -- so I think the acknowledgement that -- it's what we talked about previously, about the importance of a home-like setting for disabled children and young people was really crucial, but that delay in implementation, I guess it was, when you think about the scale of the issue in terms of closing these hospitals, which was home for hundreds of disabled people, that process actually took a really long time and a lot of resources in order to implement that move towards community care.

I think something that's probably quite important that we haven't really acknowledged here is that I think one of the drivers towards that closure of the long-stay hospitals was around the potential for cost savings as well. So the institutions were becoming increasingly unwieldy, very expensive to run and to manage, so alongside the concerns about this wasn't an appropriate setting for children and young people, concerns about abuse, it was only when it was acknowledged that there was the potential for this move to community care to potentially save money, that that was when we started to see a real momentum build up around de-institutionalisation. But it took a long time to get to that point.

LADY SMITH: I guess another problem was that for many of the residents, they had been long term, by definition, long-term living in a hospital.

DR MACINTYRE: Yes.

LADY SMITH: They had no feel for familiar practices that would operate in the community. It wasn't a question of returning them to the home norm.

DR MACINTYRE: Yes.

LADY SMITH: They didn't have a norm there, and they were going to have to be supported to build up a new way of life.

DR MACINTYRE: Yes. And I think another issue in relation to that was there was resistance in local communities as well about the idea of resettlement of people from long-stay institutions into those local communities. So that would have been another issue. Parents/families maybe feeling anxious and resistant to the closure of the hospitals as well.

LADY SMITH: People were frightened of what was going to happen, what was going to be visited upon the community.

DR MACINTYRE: Yeah.

LADY SMITH: Ms Innes.

MS INNES: If we move down to the bottom of the page, we see reference to the Warnock Report. You say there was a sea-change in the understanding of special educational needs, and you go on to say that the publication of this was a critical moment, both in terms of how disability was understood and the introduction of special educational needs, and in terms of expectations around the education of pupils who formed this group.

Can you tell us a bit more about why this report marked such a sea-change?

PROFESSOR KENDRICK: Do you want to pick up on the integration aspect? You have covered some of that, but --

LADY SMITH: Andy, can you make sure you are close enough to the microphone?

PROFESSOR KENDRICK: Yes, sorry. I was partly whispering to Gillian.

LADY SMITH: I'll know if the stenographers aren't coping, but I want to hear you.

Start again. Thank you.

DR MACINTYRE: Okay. Yes, so I think it was probably a really significant moment in education terms, because I think it was the first time that the idea of integration for all was seen as a realistic possibility. I think one of the major shifts at this time was the move from the categories, the previous nine categories of impairment that had informed all of educational provision up until that point, to this all-encompassing move towards special educational needs.

Now, that kind of term was then critiqued later on, but at the time, when the Warnock Report was published, this kind of category was seen as something that was really inclusive and really kind of opening the way for integration or, as Warnock said, known as 'mainstreaming' in America, 'normalisation' in Scandinavia and Canada. It really represented a sort of change in belief that integration was actually possible for disabled people. That was kind of published in a way and acknowledged in a way that it hadn't been up until that point.

PROFESSOR KENDRICK: And I think also in terms of being more inclusive, as you see on that page, Warnock is suggesting that around 20 per cent of children were likely to experience learning difficulties in which terms special educational needs was defined, which is, again, a much higher percentage than we've seen previously.

MS INNES: If we go down to the bottom of this page, we see reference to a quote where she talks about childcare staff, and she says:

'Childcare staff in residential special schools spend at least as much time with the children as do the teachers. Demarcation lines between childcare and teaching are rightly blurred.'

Do you know what --

PROFESSOR KENDRICK: Well, I think certainly in terms of the '60s and '70s, in terms of education within residential schools, care staff and education staff were often seen as having very different roles, and care staff didn't -- weren't seen as having, in a sense, educational roles for the time that children were outwith the classroom, and similarly teachers were focused on the classroom.

I think Warnock here is -- when she's saying they are rightly blurred, it's how it should be, but I think over the years when -- certainly when we have looked at the education of looked-after children, the focus of care staff on the education has often been minimal.

So I think at this time there was a very clear demarcation, often, in terms of the different roles.

DR MACINTYRE: Could I maybe just add to that, just to say that I think a theme throughout the report is -- or it becomes more prominent in the later part of the report, about residential education only being used in very specific circumstances. One of the circumstances which is set out here in this quote is around when it's very difficult to separate out a child's educational needs from their care needs, and in situations where it's almost impossible to do that, so when someone needs extensive care at the same time as being educated, that is the circumstances in which residential education is appropriate. That is almost a caveat that you'll see coming up again later on.

So it's something to do with, as Andy says, that interrelationship between care and education, and not being able to separate those out, and acknowledgement of that. That would be the case when -- circumstances under which residential school would be appropriate.

LADY SMITH: I suppose they were beginning to shift to a mindset that's more that of, if you like, a type of home-schooling. When a child is home-schooled, they'll be conscious of being at home, and within the care wrapper of home should be all the time. Why should it be any different because they're in a residential school? They don't have the back-up of going home at night or going home every weekend.

PROFESSOR KENDRICK: Well, that's absolutely right, but even into the 1990s/early 2000s is when the real focus on the education of children in care was highlighted because of deficits in the provision of education within -- particularly within residential care settings.

LADY SMITH: But it will also filter through into your recruitment policies, when recruiting teachers.

PROFESSOR KENDRICK: Absolutely, yes.

LADY SMITH: You're not simply looking for quality educators; you're looking for quality educators who have the skills required to care for the children that they are educating, insofar as they can do that in the classroom setting.

PROFESSOR KENDRICK: Absolutely, yes.

DR MACINTYRE: Even in relation to The Promise today, they talk -- the children and young people talk very much about recruiting staff on the basis of their values and their ability to care, rather than their qualifications. So it's that ability to care that's important for children. I'm not saying qualifications --

LADY SMITH: You actually need both.

DR MACINTYRE: Yeah, no, I'm not saying qualifications are not important, but, yeah.

LADY SMITH: You may have seen the comment in, I think, a recent publication by the Care Inspectorate of them being concerned about that approach.

DR MACINTYRE: Yeah. Okay.

LADY SMITH: I think it's them.

MS INNES: If we can move on, please, to page 66 and towards the bottom of the page, you refer there to the circumstances in which Warnock considered that education in residential special schools would be needed, and the first point, for example, points out what you were just saying, Gillian, about somebody needing a particular level of care which would be beyond the combined resources of the day special school and family, but doesn't require for admission to hospital.

Then at (ii), another instance where learning difficulties and other barriers to educational progress are so severe that the whole life of the child needs to be under consistent and continuous educational influence.

Then over the page, at (iii), again, similar to what you've been saying, a child with a severe disability who cannot be provided for at home.

Then (iv), where there are poor social conditions or disturbed family relationships which either contribute to or exacerbate the child's educational difficulty.

So these are the classes that she seemed to identify as being when residential special education would be required.

If we go on again in her report, please, to page 68, if we look down the page, there is some critique, I think, of the Warnock Report, and you talk in the paragraph that we're seeing on the screen that Warnock herself later wrote: '... that the committee was forbidden to count social deprivation as in any way contributing to educational needs.' She therefore herself seemed to think that she wasn't able to look as broadly as she might have wanted to.

DR MACINTYRE: Yeah. I thought that was really interesting and significant, this kind of -- the use of the language being forbidden to look beyond that remit.

I think what it does show is that, despite what we've said about the kind of influence of normalisation, the influence of the social model of disability, we're still, when we think about the criteria and the remit that Warnock was given, we're still focusing very much on that very individual deficit-based approach, and not really acknowledging the broader social circumstances and environment, which I think was a real missed opportunity to really address some of the inequalities faced by disabled children and young people as well.

MS INNES: Then towards the bottom of the page, we see that the follow-up to the Warnock report was a White Paper on special educational needs in Scotland, published in 1980.

I think if we move on to page 70, we see that the same year, there was the Education (Scotland) Act 1980, but did it make any change to the definition of special educational needs?

PROFESSOR KENDRICK: This didn't make major changes, and I think this was to do with the timing. As we will see, there was a further Education (Scotland) Act in 1981, which actually took forward the White Paper, and the 1981 Act amended then the Education (Scotland) Act 1980.

So I think there were some minor things in the Education (Scotland) Act 1980 originally, but the major changes came the following year with the 1981 Act.

MS INNES: If we look on to page 71 and a reference to Turner, where it was noted that around this time there was growing official concern about entry to special schools being dependent on a diagnosis of mental handicap based on IQ scores and an assessment of the social status of the child's family.

So splitting that out, I think you mention and you go on over the page to talk about IQ scores. Can you tell us about the significance of that?

DR MACINTYRE: I think the key issue with -- again, IQ testing is something that has been critiqued over the years, and I think we have said here in the report it's interesting because this continues to be relevant in contemporary debates around access to services and support.

It appears that when we are perhaps -- in the current situation, when we are trying to restrict access to services and support, we use IQ as a criteria for ensuring that only a very small number of people can actually access services.

However -- I think that's not really what you're -- sorry, I've kind of lost my train of thought. Can you just remind me --

MS INNES: In the section, Turner says there was a concern about entry to special schools being dependent on essentially IQ scores, and you then go on to say that was prevalent at the time, it was then discredited, and it's come back. So I think that's what you are covering there.

DR MACINTYRE: Yeah.

PROFESSOR KENDRICK: As I recall, earlier in the report, there is discussion of the banding of IQ scores in relation to the categories of educable, trainable and ineducable, and it's to that use of IQ scores that the critique is being made, although as Gillian has said, there's an ongoing discussion and debate about that.

MS INNES: The other thing that Turner mentions at the bottom of page 71 is that entry to special schools was also dependent on an assessment of the social status of the child's family.

Do you know what was being discussed there?

PROFESSOR KENDRICK: Well, I think that was an acknowledgement -- and I think it sort of leads on from that idea of the separation of children from disreputable or deprived families which was seen very much in earlier years continued into the 1970s and 1980s. So value judgments were being made on the families because of issues of poverty.

MS INNES: If we go back to page 72, in about the middle of the page there, as you've said, the 1981 Act was the Act that effectively implemented some of the recommendations of the Warnock Report; is that right?

PROFESSOR KENDRICK: That's correct, yes.

MS INNES: This Act then adopted the term 'special educational need', and so the definition at this stage was broadened, was it?

PROFESSOR KENDRICK: Yes, that's right. Although, again, in reading this legislation, I find a certain circularity, so that 'special educational need' -- provision for special education need were defined as needs caused by a learning difficulty which calls for provision for special educational needs to be made for him.

So I think there's still a lack of clarity in terms of the definition of special educational needs. It talks about, in the section underneath about -- if you could just scroll down slightly -- in terms of significantly greater difficulty than the majority of children, so that's talking about the idea of in mainstream schools. If we go down further, to 'suffers from a disability which prevents or hinders from making use of educational facilities'.

So there's ideas it's -- special educational needs is defined in terms of a learning difficulty. Disability is included here as a term in terms of defining a special educational need.

So there's still that lack of -- a certain lack of clarity. So although it's a move on --

LADY SMITH: The first two categories involve a significant -- I hesitate to use the word 'significant' because it's a problem in the first one -- a considerable degree of judgment.

PROFESSOR KENDRICK: Absolutely.

LADY SMITH: Potentially subjective judgment.

PROFESSOR KENDRICK: Absolutely.

DR MACINTYRE: I think it's very -- it's a relative, you know, relative definition, as in it's your difference from the norm.

LADY SMITH: But you're back to what's the norm and what the perception of the norm is by the person who is exercising this judgment.

DR MACINTYRE: Yeah. So you're right, it's very subjective, and I think one of the major critiques is it really kind of -- it results in othering, othering discrimination, because it's about emphasising the difference from the mainstream population.

MS INNES: If we go down this page, there is reference to work by Riddell in relation to the Act as amended by the 1981 Act, and she says:

'[This] was a product of the social democratic political agenda of the 1970s, [but] it was implemented in the very different political climate of the 1980s and 1990s, where the major concern was to increase efficiency and effectiveness by introducing the market into the public sector.'

Then she goes on to say that:

'SEN policy in Scotland developed relatively slowly for two decades, reflecting elements of bureaucracy, professionalism and legality.'

Are you able to explain a bit further what she's referring to here?

DR MACINTYRE: Yeah. So I think essentially the argument that she's making is that, actually, when the Act came to be implemented -- I'm not sure if it was unforeseen resource constraints, but it certainly was at a time when there was real concern about cost savings.

So perhaps some of the intentions that had underpinned the legislation in terms of access to better educational provision for all children became dominated by concerns about finances, and that might be perhaps where we start to see attempts, as I was referring to in the discussion about use of IQ testing, attempts to ration services and tighten eligibility criteria for support. So the context in which all of this was operationalised was very different.

I think Riddell, she talks a lot about ideas around bureaucracy and the overly complicated nature of the system. I think one of her major critiques is about the lack of decision-making ability that's been passed on to parents and children, so the dominance of professionals within legislation and within that decision-making process.

So we're kind of talking about a time of financial constraints, where the bulk of decisions are still being made by professionals and not really in partnership with families.

MS INNES: Okay.

If we then move on to page 75 and to another piece of legislation, the Disabled Persons (Services, Consultation and Representation) Act 1986, and you say that:

'[This] aimed to improve services for disabled people by strengthening their voice by making provision for representation and placing additional duties on local authorities.'

You refer to some general duties, but if we look down the page, we see that there was a provision in relation to education. So the Education Department had to obtain an opinion from the appropriate authority, normally the Social Work Department, as to whether a child was a disabled person, before carrying out a future-needs assessment.

Then the Social Work Department, if they gave the opinion that a child was a disabled person, am I right in thinking that the Education Department then had to prepare a report on the needs of that child?

DR MACINTYRE: Yes. Yes, that's correct.

MS INNES: If we look down just below the reference, you say:

'The Act suggested that greater understanding of disability and improvements in services had made it possible for disabled people to live active, fulfilling and independent lives in local communities.'

So did this Act signal a move forward?

DR MACINTYRE: I think probably the most significant thing -- that's quite a -- I was just thinking, that's a really optimistic statement, sorry.

I think the most significant thing about the Act was the kind of emphasis on participation and service user voice, and giving people the support that they needed and the tools that they needed to be able to advocate for themselves and for their families and to, you know, make representation to have their rights upheld. So I think that was the most significant thing that this legislation did.

I think it was really important in terms of acknowledging the right to a future needs assessment and the right to having your needs assessed as a disabled person, but I don't know if I would say that it necessarily led to, you know, people leading active and fulfilling independent lives in the community, although I guess that would have been the vision behind it.

MS INNES: Yes, I think if we go on to page 76, you quote from Barnes and say that there was an argument made that the Act merely paid lip service to meaningful collaboration between disabled people and service providers and that several barriers to participation remained?

DR MACINTYRE: Yeah. Yeah.

So Barnes has written quite a powerful -- because I think that this piece of legislation had great potential, but Barnes has written quite a powerful critique of what impact it really actually had.

MS INNES: Then, just below that, we see at section 4.10, you move to the onset of care in the community, and we see that you note that from the 1980s into the 1990s, there were various reports, the Griffiths Report followed by the White Paper on care in the community, and then at the bottom of the page, the Community Care Act being passed in 1990.

What impact did this have on the care or education of disabled children?

DR MACINTYRE: I think, you know, it didn't focus explicitly on children and the education of disabled children, but I think what it did was change expectations about where disabled people, including children, should be. So it changed that expectation that people should be living in local communities rather than institutions.

We had already seen a sort of shift towards a questioning over the suitability of residential education, but I would expect that this piece of legislation and the kind of rhetoric around it would have really kind of strengthened that argument about the expectation being that disabled children should be living in their local community, ideally with their family, where possible.

PROFESSOR KENDRICK: As I said earlier, this is going along the lines of, in terms of children in care, the shift from residential to foster care, the strategies in local authorities at the time, which were really focusing on keeping children out of care, in the community through family support, and then in terms of foster care. At this point, residential care is almost being seen as a last resort.

MS INNES: If we look on to page 77, and the bottom of the page, at section 4.11, you refer there to ongoing interest and concern around disabled children and young people receiving education in residential settings.

You refer to a working group in 1982 in relation to the mental health needs of children and young people in Scotland.

At the top of page 78, you go on to say:

'It addressed the role of residential care in that context and identified a lack of training and high levels of staff turnover as a concern.'

Then it goes on to talk about that this was particularly problematic, given the skills required.

PROFESSOR KENDRICK: Well, I think that's -- as we see the reduction in residential care, we can see that in terms of those children who still need residential care, there's, in a sense, an increase in terms of the complexity of issues across the whole spectrum, and that at this point, there's very limited training for residential care workers in relation to the care of children.

MS INNES: Then we see that it mentions where residential school placements should be made in certain limited circumstances.

The final bullet point there refers to where there is a need for containment and control.

Do you have any observations in relation to that sort of phraseology around that time in the 1980s?

PROFESSOR KENDRICK: Well, I think that that -- and again, in relation to social work, there's always been the paradox or the dilemma between care and control, and for certain young people, as has been seen necessary, the continuance of secure care and other forms of residential care, that there needs to be that ability to address the behaviour of children and young people whose behaviour would often be caused by the traumas that they've previously experienced.

MS INNES: If we go to the bottom of page 78 and then on to page 79, there's reference to an analysis of the Office of Population Censuses and Surveys data from the 1980s, showing that generally there was limited information on the circumstances of disabled children and young people living away from home. It says:

'It was highlighted that the chance of a disabled child spending time in local authority care was ten times greater than for a non-disabled child.'

It refers to different types of settings that children were placed in.

So this seems to indicate that even where children are in care, if they're disabled, they're likely to spend much longer in care.

PROFESSOR KENDRICK: Yes, because, again, at this time, I think that, although spoken about, there had been from previous times in the '50s -- '40s and '50s, there was an increasing focus on the need to engage with parents and to keep parents involved.

The research at this time showed that often parents weren't as engaged as could have been. Residential placements were often at a distance, which made visiting difficult. Often, once a child had been placed in residential care, there was that idea that that's the issue solved.

So, yes, there were certainly issues at this time in terms of the ongoing contact with family.

MS INNES: Then you refer to a study by Utting in England in 1997 finding that disabled children and young people living away from home were extremely vulnerable to abuse of all kinds, including peer abuse, and it was argued that high priority needed to be given to protecting them.

PROFESSOR KENDRICK: That's right. Utting, as you will know, was the parallel report to the Kent Report in Scotland, which highlighted the same issues, and previously in the report we have talked about the range of factors which affect disabled children and mean that they are more vulnerable to abuse, and part of that is the isolation of being placed in residential care.

MS INNES: Then you also mention Skinner's review of residential childcare in Scotland, and you note that two of the five situations identified where a residential home or school might offer the best placement for a child are of relevance to disabled children and young people.

PROFESSOR KENDRICK: Yeah. Those are reflecting the situations in Warnock and in the Mapstone Report.

MS INNES: You note below that Skinner also identified additional complications when children with learning difficulties and special education needs were excluded from school and highlighted the importance of social work and education working together, and also health needs. So these three areas were all needing to work in co-operation.

PROFESSOR KENDRICK: I think that the Skinner Review was significant in terms of the shift in the focus towards the education of children and young people in residential childcare and the health needs of children and young people, which developed in work through the 1990s and the 2000s, with an increasing focus on addressing those specific needs.

MS INNES: Then you go on from there to discuss the signature of UNCRC, but if we move towards the conclusion of this chapter, at page 86, you discuss certain developments, the move towards de-institutionalisation that you've discussed.

You also then refer to the significance of the signature of UNCRC at the time, and what significance did that have?

DR MACINTYRE: I think the key point is that it placed increased value on all children, including those with disabilities, and talked explicitly about their rights in relation to a number of key provisions, including access to suitable education.

So I think it was about recognising the value and the worth of disabled children in a way that perhaps hadn't been acknowledged to the same extent previously.

MS INNES: If we go on to page 87, you note:

'It should be acknowledged that policy and legislation at this time stopped short of requiring mainstream or inclusive education for all disabled children and young people.'

So we saw reference in the Warnock Report to the use of the word 'mainstreaming' as being an American concept, I think. But policy and legislation over this period didn't go that far; is that right?

PROFESSOR KENDRICK: Yeah.

MS INNES: Okay. So there were still segregated settings?

DR MACINTYRE: Yes, still segregated settings, and still the value of those settings continued to be recognised, and there was a number of important caveats, I think, around when integration or mainstream education might not be the best option for a child.

MS INNES: If we go on to the next page, at page 88, you note that over this period:

'Overall, it appears that there were missed opportunities to more fully acknowledge the structural barriers faced by disabled children and young people.'

What missed opportunities were there?

DR MACINTYRE: I think it was in relation to the point that we discussed earlier when we talked about Warnock herself talking about the fact that she was forbidden from looking at the social and the structural barriers that children and young people might face. So, as Riddell has argued here, what we continue to do at this time period is locate the difficulties within the individual, rather than looking a bit more broadly at some of the other factors that might impact on education, and what that does is kind of perpetuate any inequality that exists.

LADY SMITH: Gillian, can you tell me what the structural barriers were that you think Riddell had in mind?

DR MACINTYRE: I think she would have been referring to -- I think the key thing would be poverty, actually. I think that would be --

LADY SMITH: How did she think that was impacting on children having opportunities if they were disabled?

DR MACINTYRE: Well, I think she talks a lot about poverty and disadvantage and she talks about families where those who are most disadvantaged are least likely to be able to access the services and support that they need. They're much less likely to speak up for themselves and advocate on their behalf and they don't have the resources to support them to do that.

LADY SMITH: So are we then down to practicalities such as travelling to a centre where assistance might be available?

DR MACINTYRE: Yeah. Yeah.

LADY SMITH: I suppose in those days arranging for something to be delivered that would help them, that kind of thing?

DR MACINTYRE: Yeah.

MS INNES: Looking down on this paragraph, you refer to commentary by Demetriou, where you talk about the development of categorisation, that:

'The development of categorisation that does not include disabled children and young people and their families merely serves the interests of the state rather than the interests of disabled children and young people. The usefulness of labelling and categorisation is therefore questioned and in some ways adds to the existing challenges in identifying and responding appropriately to the needs of disabled children and young people if the implications are not well considered. He suggests that labels and consequently categorisations should be used as a starting point rather than the end point and used as and when they are advantageous to the child's education.'

So one might say that categorisation and labelling is a bad thing, but he seems to be suggesting that it has its uses?

DR MACINTYRE: Yeah, I think there's a real tension there. So I think what we believe is that a move towards a much more inclusive approach, so a broader category such as special educational needs, is more beneficial because it is inclusive of a greater range of need, but what Demetriou is arguing is that actually, as you say, labelling sometimes can be really helpful because it means that your specific needs are being acknowledged and recognised and it means you are much more likely to be able to access support that you need to have those needs met.

Whereas if you're within a much broader category, your needs may be overlooked or there may just not be the specialist resources to meet those needs.

So there is a real tension there, between this drive towards mainstream provision, but also recognising on the other hand that sometimes we do need to acknowledge that people do have specific needs that they need support to meet.

But I think one of the issues is that this kind of idea of ascertainment was really almost about categorisation for the purposes of the organisation rather than to meet the needs of the individual. So basically it was about fitting people into provision, rather than saying: 'Okay, what are your needs and how can we meet them?' It was like: how can we categorise people and fit them in a box?

So that type of labelling is not positive, but the kind of labelling that Demetriou is talking about is much more about labelling to meet and identify and acknowledge specific needs.

LADY SMITH: So are we talking about there being a risk of if you only have the broad category, a policy then being designed so as to meet the broad category?

DR MACINTYRE: Yeah.

LADY SMITH: And perhaps there then being omitted necessary policy to meet some very specific needs within that broad category?

DR MACINTYRE: Yeah. That's exactly it. I think it's a real dilemma in terms of future directions, because we do want to be inclusive, but we also don't want to overlook very specific needs.

PROFESSOR KENDRICK: I think the point we've got to now, beginning in the 1990s, is where we are starting to maybe have this shift around voice, around participation. Similar in terms of children in care. Children in care with the Children Act 1995 became 'looked-after' and 'accommodated', that was then.

Again, I think the importance in terms of what Demetriou was saying is that it does not include disabled children and young people and their families, is about -- coming back to the point that Gillian made earlier about how they themselves want to be and consider that they should be referred to, so that 'care experienced' is now how those children who have been in state care considered they should be.

So I think that is about the sort of issues of power again that Gillian has raised, which we have seen over this whole period in terms of that relationship between professionals.

I was going to give you the last --

DR MACINTYRE: No, I don't -- you summed it up so well, I don't think I've got anything to add really.

Thank you, Andy.

MS INNES: If we look down to the next paragraph on this page, you note again that throughout the period the challenges with statistics and data collection remain and there's no clear picture that emerges in relation to that. So the problem with adequate allocation of resources and suchlike remained over this period.

Over the page, at page 89, you do indicate that, despite these challenges, a number of positive developments took place, particularly moving from segregation to integration, and I think, as you've just mentioned, the growing commitment to hearing the voices of disabled children and young people.

So I've come to the end of chapter 4 and that's the end of Professor Kendrick's involvement in this report. Perhaps if we might break for lunch.

LADY SMITH: We'll stop now for the lunch break and then resume for the next chapter at 2 o'clock.

Thank you very much.

(12.50 pm)

(The luncheon adjournment)

(2.03 pm)

LADY SMITH: Good afternoon.

Now, Ms Innes, we're going to add another witness to the panel, I think; is that right?

MS INNES: We are, my Lady. Dr Ailsa Stewart will be added to the panel at this stage.

LADY SMITH: Thank you.

Dr Ailsa Stewart (affirmed)

LADY SMITH: Thank you for joining the panel this afternoon.

Are you comfortable with me using your first name or would you prefer Ms Stewart?

DR STEWART: Yes, of course.

LADY SMITH: Thank you for that, Ailsa.

Now, I know you have been listening to the evidence so far today, so you know how our system works. But let me also say to you: if you have any questions, do ask. If you think we should be asking questions that we haven't asked, do tell us.

If you need a break at any time, just speak up. I usually break at around 3 o'clock anyway -- you can bear that in mind -- for a short time.

Otherwise, if you're ready, and, Gillian, if you're ready --

DR MACINTYRE: I'm ready, yes.

LADY SMITH: -- we'll get to where you were and move on.

I'll hand over to Ms Innes now.

Thank you.

Questions from Ms Innes (continued)

MS INNES: Thank you, my Lady.

Ailsa, thank you for providing a copy of your CV to the Inquiry. We understand that you're currently a lecturer in the School of Social Work and Social Policy at the University of Strathclyde?

DR STEWART: That's correct.

MS INNES: You tell us, I think, that you've been at the University of Strathclyde since 2006, and prior to that, you worked with the Nuffield Centre for Community Care Studies at the University of Glasgow?

DR STEWART: That's correct.

MS INNES: Your research interests have focused on exploring and explaining the experiences of people with mental health problems, learning disabilities and those experiencing homelessness, and that's coalesced around consideration of safeguarding and protecting adults at risk of harm in an ethical manner, alongside the use of a citizenship model to promote inclusion of marginalised groups?

DR STEWART: That's correct.

MS INNES: You have also provided us with a list of relevant research materials and publications. Thank you.

Now, if I can take you back to the report at LIT-000000392, and we see that chapter 5 starts at page 91. This looks at 'Developments in Legislation and Policy from 1995 to 2024'.

But if I can take you straight into the substance of this chapter, which you then subdivide into various time periods, the first time period that you look at is from 1995 to 2001.

If I can take you, please, to page 103.

Towards the bottom of this page, we see reference to the Disability Discrimination Act 1995, and you set out some of the relevant provisions there.

If we go on to page 104, and look at the bottom of that page, there's reference there to some critique in terms of the impact of the Disability Discrimination Act. In particular, it is noted that it had little impact on Scottish schools.

Can you tell us a bit more about that, please?

DR MACINTYRE: So, yeah, I think the main critique of this was -- and I think it's a common critique that we've actually discussed, is that there's often very little time for a new piece of legislation or policy to bed in before we move on to the introduction of a new piece of legislation. So the Disability Discrimination Act was very hard fought for by people with disabilities, but it had little impact because we moved very quickly on to look at the Additional Support for Learning Act in 2004.

So I think the critique that Ferrie is making is that that allowed insufficient time for the DDA to really have any impact.

MS INNES: If we move on to page 107, at that point you are looking at the position after the coming into force of the Children (Scotland) Act 1995, and if we look at the paragraph beginning:

'According to Stalker, the Act had limitations and was less far-reaching than equivalent legislation in England.'

It refers to assessment of children in need, and then it notes that: '...there was no requirement on

Scottish local authorities to keep registers of disabled children and young people as there was in England, which may contribute to the lack of clarity over numbers discussed throughout this report.'

DR MACINTYRE: That's correct, and I think that would be, you know, considered a real missed opportunity at that point, and I think, you know, we're making progress now, as we said earlier but, at that particular point, the decision was made not to keep that register or to gather that information, and that's been problematic for a number of years.

I think the other issue that Stalker raised was about lack of provision generally in Scotland in comparison to England, in terms of the sorts of provisions that were to be made available within the legislation.

MS INNES: Going to the bottom of the page, we can see that there was a renewed focus on the closure of long-stay hospitals.

If we go on over the page, to the bottom of page 108, there is again a reference to research carried out by Stalker and colleagues in relation to children with complex health needs who spent significant time in healthcare settings, and they provided some statistics around the April 1999 to March 2000 period, that 1,399 children and young people with complex needs had stays of more than four weeks in hospital.

It goes on:

'Importantly, the study found that there was confusion about the legal status of children who had been in hospital settings for over three months. There was also evidence that educational provision in some settings was fragmented and variable.'

So this is, again, going back to the hospital setting, albeit in, I suppose, more modern times, and there still seem to be issues about children staying there for a long time and also impact on education.

Are you able to tell us more about that?

DR STEWART: Yeah, I mean, I think that's the case, that certainly what Kirsten Stalker and her colleagues found was that it was better in some hospital settings than others, but that was very dependent on the particular setting, and also there was concern about the legal status of the children who had been in hospital for over three months, on what legal basis were they actually being maintained in the hospital, for example, and there was less clarity about that. Some of that, from recollection, was linked to poor record-keeping as well during that period.

MS INNES: Then in the next section, 5.7, you talk about the educational context and ongoing concerns and outcomes for disabled children and young people.

You refer to the Riddell Committee, which was set up in 1999 to address significant concerns regarding the education and support for children with severe and low incidence disabilities.

What was the outcome of this committee?

DR MACINTYRE: I think, overall, this was a really, kind of, significant point in time in relation to education of disabled children and young people, and I think the Riddell Committee set the foundations for the Moving Forward Report that comes next and then the introduction of the Education (Additional Support for Learning) Act in 2004. I think this was the, kind of, beginning of that movement, if you like, and really, kind of, started to identify some of the persistent challenges that remains around -- so we have this commitment towards integration or inclusion of children within mainstream education. Progress has been slow, and it was looking at some of the challenges around that. So ...

MS INNES: We see, in the bullet points, various recommendations, including, for example, greater inclusion, better inter-agency co-operation, more effective partnership between parents and professionals and the need to listen to children's wishes about their education, so themes that you've already --

DR MACINTYRE: Yeah, and I think that's another key point, is that if you look at those recommendations, they echo previous recommendations that we talked about this morning, and then further recommendations that we'll see as we go through the afternoon. It's very similar issues that are being raised, so, kind of, key points; as you say, joint working, partnership with parents, children's voices. They seem to be, kind of, persistent themes across the time period.

MS INNES: Just below the bullet points, you refer to the Education (Disability Strategies and Pupils' Educational Records) (Scotland) Act 2002, but you say this was primarily in relation to physical and informational barriers?

DR MACINTYRE: Yeah, that's correct. So it was about -- it was around developing an accessibility strategy for schools, but the primary focus was on physical disabilities.

MS INNES: If we go on to the next page, page 110, towards the bottom of the page, we see reference to Section 15 of the Standards in Scotland's Schools etc. Act 2000, which came into force in August 2003.

What was the significance of Section 15?

DR MACINTYRE: So this is about the establishment of the presumption of mainstreaming. So that was introduced in 2000, but is now seen as being really important and really significant in terms of our expectations around the education of disabled children and young people, and really I think what we're seeing here is a, sort of, expectation that all children should be educated in mainstream settings unless there's particular, like, barriers or reasons why that wouldn't be beneficial to them or to their educational needs.

MS INNES: If we go on to the top of page 111, you say that:

'This represents a sea-change in education policy, albeit one that was implemented somewhat incrementally.'

What are you referring to?

DR MACINTYRE: I think really it's about the fact that this was, you know -- I think we can see the commitment in various pieces of legislation over the time period, but we never quite get there, to the point of really mainstream for all, if you like. So the commitment is there, but there's a number of persistent issues that mean that it doesn't happen, and there's always a number of caveats that say: well, this might be the case for most people, but there's always going to be exceptions to that.

And I think there was probably -- well, as we talked about earlier, there's some geographical variation in terms of how that kind of policy around the presumption of mainstreaming has been implemented. If we look at the situation in Glasgow, for example, where there was a strong commitment to specialist provision and a big investment in that.

DR STEWART: I think the other thing -- just, this, I think, illustrates quite nicely is another theme that comes -- runs through the whole report, which is about aspirational policy taking time to actually be implemented and there are lots of barriers that are around that might prevent that, and one of which is, without question, is about resources that are currently being invested in. How do you get the money out of these resources and redirect them into enhanced provision, for example, in mainstream schools? That takes time. It doesn't happen overnight. So that delays things.

MS INNES: On page 111, just below this, there's reference to 'The same as you?', which was launched by the Scottish Executive in 2000.

What was the purpose of this review?

DR MACINTYRE: So this was a national review of learning disability services in Scotland. And at the time, it was seen as really significant because it was the first time a review of that scale had been carried out that focused specifically on learning disabilities.

One of the things I think that was particularly important and significant was the level of involvement of people with learning disabilities within the review process itself. It was one of the first examples of really successful user engagement in policy development and consultation at the time. So that was seen as a real, kind of, significant change, particularly for people with learning disabilities, whose voices are often overlooked and excluded.

I think the other thing that was really significant about 'The same as you?' is it looked at provision from birth until death, so it took a whole-life approach to learning disabilities and looked at childhood all the way through to older age.

DR STEWART: There was also, in the engagement and consultation processes, I think the first time we'd really seen the use of things like accessible information, different ways of communicating with groups of -- this group of service users that actually built on their strengths and their abilities, rather than trying to gather their voices using traditional methods.

MS INNES: If we go on over the page, to page 112, we see that the review aimed to increase social inclusion, but it was accepted that the need for some special schools remained:

'At the time of the review, almost two-thirds of children and young people recorded as having additional support needs due to learning disability attended mainstream schools.'

But then you go on to refer to a review of progress on 'The same as you?', looking at feedback, and you note that particular issues were identified and which are relevant to education.

So what did the review of the review, if you like, identify in terms of the experience of children and young people with learning disabilities?

DR STEWART: I think one of the, kind of, key issues that came out of that review of the review, if you like, was that certainly for older people who participated in the process, they felt their education hadn't been a priority and that they had been, to some extent, excluded from that process and how much they could potentially have benefited from that.

And particularly when you contrasted that to children with learning disabilities who had experienced education, they really were able to talk quite effectively about the benefits of that experience and what it had given to them.

Particularly parents, I think, were quite vocal in talking about the way in which attendance in mainstream settings had enhanced their child's skills, their abilities, and particularly in terms of communication, but also in building relationships with children who didn't have a learning disability, and so saw that as a further opportunity to give people the chance to be more fully involved in their communities.

MS INNES: If we scroll down a little on this page, there's a bullet point beginning:

'All carers of children with learning disabilities mentioned that communication was their children's greatest barrier.'

There were gaps in communication support, with insufficient access to speech and language therapy, and there was a significant challenge in respect that different communication systems were being used in different areas.

Can you tell us a bit more about that, please?

DR STEWART: Well, a lot depended on the particular skills of the staff in the schools, for example. If they had, like, Talking Mats, for example, as a system that the staff in their school were particularly familiar with, that would be the one used there. But you then might go into a neighbouring authority and there were different, kind of, pictorial, graphic, symbol-based communication.

So if a child, for example, went from one local authority to another, they may be then confronted with a whole different communication system, which could have set them back in terms of their education.

DR MACINTYRE: I think the other thing just to add to that is that I think there is -- or at that time in particular, there was an issue with a lack of resource around speech and language therapy, and that was a very scarce resource that wasn't available in all areas of the country. So there wasn't enough investment in those allied health professionals, I think, to support this particular group.

MS INNES: Now, moving on to page 114, and to the bottom of that page, where you move on to the next period, which is 2001 to 2009, you say that: 'This period was marked by significant legislative developments in education and other relevant policy areas.' Obviously, this is post-devolution, so there were more policy initiatives in Scotland.

You say here:

'A central focus at this time was on ensuring that different agencies work together effectively.'

You say that this is captured in the For Scotland's Children Report.

Did this report focus, to any extent, on the experiences of disabled children and young people or was it more general?

DR STEWART: My recollection -- I might be wrong here, but my recollection of this particular document -- review, sorry, was that it was actually aimed more at agencies and how they worked more effectively together. There have been, I think, long-standing -- I'm sure you'll know -- challenges around multi-disciplinary and multi-agency working, and this was yet another attempt to try, within the context of children's services, to look at pushing the services more effectively together.

MS INNES: Yes. If we go on over the page to page 115 and, at the top of the page, you say there how it called for a national approach, and there's a quotation in relation to children with disabilities saying that:

> '[They] are not receiving the care, education or training opportunities that they require. For many, education outwith the mainstream and their community can lead to isolation and exclusion.'

So that seemed to be an ongoing issue identified in that report.

DR STEWART: Yes.

MS INNES: You then go on, at paragraph 5.11, to refer to the reform of Scotland's mental health system.

If we scroll down to the bottom of the page, there's reference to the introduction of the Mental Health (Care and Treatment) (Scotland) Act 2003.

What was the significance of this for children and young people?

DR MACINTYRE: I think one of the things that was -- probably I think the main significance was that it actually acknowledged children and young people as either having potentially their own mental health issues or being affected by parental mental ill-health in a way that the 1984 Act hadn't done. So the 1984 Act didn't particularly acknowledge the needs of children, whereas this Act set out very clearly what the needs of children were.

If we're able to scroll down just a little bit further, we can see -- so obviously the report is based on a series of principles, which are the Millan Principles but, within that, there was an additional Code of Practice that focused specifically on the needs of children and young people, and it sets out just below there in the report exactly what we need to think about when we're considering children and young people's experiences.

So it relates very much -- it can be mapped very nicely onto the Millan Principles. So the Millan Principles talk very much about past and present wishes of the patient, and we can see here that we're talking about the wishes and feelings of the child and the views of any carers. The role of the carer. So in this instance, the named person, so the carer's needs and circumstances would be seen as being really central here too. Any information that's necessary to care for the child.

I think what's also really important is then we think about, when a child is subject to compulsory measures, what provisions we need to put in place to support them around their educational needs when they're in hospital being detained under the Mental Health Act.

DR STEWART: Just to say that I think one of the kind of key aspects around that is the way in which sometimes that can be impacted. So, for example, a child may be too ill to be receiving education, or they may only be in the hospital detained on compulsory measures for a very short period of time and therefore it's difficult to put that in place.

MS INNES: In relation to the Code of Practice, bullet points that we see on the screen, the third bullet point says:

'The importance of providing any carer with information that might assist them to care for the child.'

That was something that was set out in the code of practice as being necessary?

DR MACINTYRE: Yes.

DR STEWART: Yes.

MS INNES: Okay.

Then if we go on, over the page, please, to page 117, it does talk there about the local authority's responsibility for making arrangements for education of children who are unable to attend school because they were subject to measures under the Act. So it made clear where the responsibility should lie.

There is a paragraph beginning:

'The Code of Practice for the 2003 Act also considered the placement of children on adult psychiatric inpatient units.'

What did the Code of Practice say in relation to that?

DR MACINTYRE: I think the issue there is that we have to think about the likely impact that that might have on the child. It's viewed as being undesirable for children to be placed in adult settings. However, there is a real lack of provision, specially for children and young people, so children and young people do from time to time end up within adult settings.

It's acknowledged that that can be a particularly distressing time for children and young people, and so there's a number of things that need to be taken into account.

So the named psychiatrist, for example, should have expertise in working with children and young people. Nursing staff should also have experience of working with children, should be available to provide direct care to the child.

But then we see that the Mental Welfare Commission, when they were looking at that, found that often those things weren't happening. So they were identifying that good practice wasn't always taking place.

So we know that there are a number of things that should happen around good practice, but it wasn't always happening on the ground.

MS INNES: This is an area, I think, that the Mental Welfare Commission continue to review?

DR MACINTYRE: Yes.

DR STEWART: Yes, that's correct.

MS INNES: Now, if we move on, please, to page 118, and paragraph 5.12, where you are talking about additional support needs and, at the bottom of that page, you refer to a survey carried out by Meltzer in relation to the mental health of young people looked after by local authorities in Scotland, and this was published in 2004.

You say that it addressed health, educational achievement and lifestyle behaviours.

Going on over the page, in terms of special educational needs, it says just under a third of children had officially recognised special educational needs, although only 5 per cent had an SEN statement, suggesting that they may not have been accessing the educational support that they needed. Importantly, children with special educational needs were more likely to be found in residential care.

Are you able to tell us a bit more about these aspects that are highlighted in the report in relation to children with special educational needs being found in residential care, but also those who don't seem to have the particular SEN statement?

DR STEWART: I mean, I think what that illustrates is the difficulties of definition and identification of children with disabilities. So it may be only the fact that they're in the residential setting which has highlighted, perhaps, some of the special educational needs that they may have. It may not have been picked up in mainstream education. And therefore, in some ways, it's perhaps not surprising that only 5 per cent of the identified children had an SEN statement.

So what that also obviously clearly illustrates is they weren't getting the support they needed. Now, that may have impacted on where they've ended up in terms of the care setting. We obviously can't tell that. But I think what it does say is that not only where these children had barriers around being looked after in terms of their education, but actually their disability and the fact that they didn't have an SEN statement meant that identifying the appropriate supports for them would be even more difficult.

DR MACINTYRE: I think there's another issue, just to pick up on that, around how someone receives a statement in the first place, and I think there's evidence that suggests that families and parents often have to work quite hard and to advocate quite hard on behalf of their child to actually have the assessment, to have the statement, issued.

I guess it relates back to the point that we talked about earlier on around disadvantage, and families from more disadvantaged backgrounds may be less able to advocate on behalf of their child.

So there's an inequality there in terms of who gets a statement in the first place, and obviously, as Ailsa says, when you then don't have the statement, you don't have access to the support that you need.

I think there is perhaps, at times, a reluctance to provide a statement, because it then sets out very clearly what the duties and the responsibilities are in terms of the provision of services, and in a time of resource constraints, probably there has been some reluctance to issue some statements.

MS INNES: In the paragraph below that, that we see on the screen, you then refer to the publication of the Moving Forward Report, which provided context for what ultimately became the Education (Additional Support for Learning) Act 2004.

Moving on to that Act, if we can look, please, on to page 120, it talks about the new legislative framework being around the concept of additional support needs. You say that this appears to be a significant departure from previously held views.

Can you explain why it was such a significant departure?

DR MACINTYRE: So this is, as we talked about earlier on, the shift from special educational needs, which was seen as othering, I guess, in some ways, so comparing children with disabilities to everyone else who were part of the norm, if you like. So that was the premise of special educational needs. Whereas the concept of additional support needs recognises that everyone potentially may have an additional support need at one time or another. So, in that respect, it's a much more inclusive policy -- sorry, inclusive concept, and a much more inclusive approach. And as we said earlier, it can potentially be quite transient in nature, because an additional support need may not be permanent or fixed.

So in that respect, I think it was an attempt to create an acknowledgement that everyone may need additional help with their education at various points and so was much more inclusive in that respect.

DR STEWART: And it moved beyond just thinking about disability or impairment to think about the other broader social and structural barriers.

MS INNES: If we move on to page 121, and the paragraph beginning:

'Perhaps in recognition of this potential ambiguity ...'

So you're talking about a potential ambiguity around the term of 'additional support needs'.

You refer to the Code of Practice that accompanied the Act:

'... [highlighting] four factors that may give rise to ASN; the learning environment, family circumstances, social and emotional factors and disability or health need.'

Then you go on:

'Yet Moscardini argues that while policy and legislation set out the underlying principles of support and their application in practice, an arguably weak understanding of the concept of additional support needs has led to the term being used as a proxy for special educational needs, further highlighting the ambiguity around the term.'

So can you explain what's meant by -- or what was being highlighted by Moscardini's critique?

DR MACINTYRE: I think what he was really saying was it wasn't clear that everyone fully understood the new concept of additional support needs and didn't really completely understand what it encompassed or who it encompassed, and so actually people were using the term 'additional support needs' interchangeably, when they were actually talking about special educational needs, and not really thinking about that broader category of people who we might be talking about here, so thinking about the learning environment and family circumstances as well, which is much broader than what the previous special educational needs would have, kind of, highlighted.

I think really what that illustrates is -- we talked earlier about the implications of additional support needs within a classroom setting -- the need for much greater knowledge and education and training around the concept, so that people understand what it is that we're actually referring to, who it is we're referring to and how best that we can work with people who are subsumed within that category.

MS INNES: Then if we move on to page 123 and to paragraph 5.14, dealing with 'Key provisions under the 2005 Act', you note that: 'The 2004 Act made it a duty for the responsible educational authority to make adequate and efficient provision for such additional support as is required by a particular child or young person and to keep this under consideration, unless this would result in unreasonable public expenditure being incurred.'

Do you have any knowledge, from the research, about how this has operated in practice?

DR STEWART: Do you mean in terms of was there a threshold or a limit after which --

MS INNES: Yes.

DR STEWART: I don't know the answer to that question.

DR MACINTYRE: No. I mean, we know -- you know, we know the criteria for the presumption of mainstreaming, but I don't know if there's a specific --

DR STEWART: Figure.

DR MACINTYRE: -- figure or cut-off point. That's something that we could try to find out, though, if it would be useful.

LADY SMITH: Yes, please.

MS INNES: Thank you.

If we move on to page 124, in the paragraph beginning, 'Within the context', you refer to Hammill and Clark considering the role of the special school at this time, and it appears that they were saying the context in which they were operating was changing rapidly and they saw it as inevitable that special schools would close.

Did they see that as a negative or a positive?

DR STEWART: I think one potential negative would be that the knowledge, skills and expertise built up in special schools might have then not been as available to the mainstream settings, and I think the idea that they certainly purported in their work was thinking about the ways in which skills and expertise could be harnessed by mainstream settings by working in partnership with more specialist settings.

MS INNES: Then below that, at paragraph 5.15, you talk about a joint report by HMIe and the Care Commission reviewing school care accommodation generally.

If we go on to the next page, page 125, this report considers, I think, inspections of 34 residential special schools in Scotland at that time?

DR STEWART: Yeah, that's correct.

MS INNES: If we go on to page 126, various positives are identified.

If we look down to the paragraph beginning:

'The report also commented on additional approaches and creative individualised strategies and the effective use of timeout in a positive, supportive environment. While nearly all schools used methods of de-escalating challenging behaviour, the quality of practice in relation to de-escalation and restraint varied.'

So that was a particular issue highlighted over the course of these inspections. Is that correct?

DR STEWART: That's correct, yeah.

MS INNES: And from this report, they suggested certain things, like effective risk assessment, as being important and suchlike.

If we just look down to the final paragraph on this page, they note that concerning the implementation of the 2004 Act, despite the fact that some schools were making best efforts to obtain background information on children and young people from education authorities, that was often inadequate.

I think they probably highlight that as an issue that, I suppose going back to what we saw a moment ago, that the person caring for the child needs to have full information.

DR MACINTYRE: Yeah. I think it illustrates the point that we've raised around the need for greater partnership working and greater joined-up working between different agencies and involving the family, where possible, as well.

DR STEWART: And poor recording has been a significant challenge across joint working for a long time, and part of the problem is around the lack of joined-up information systems across agencies, and that's a reflection of that.

MS INNES: Then if we go on to page 129, we see that, at paragraph 5.16, you start considering GIRFEC, and I wonder if we can, in this section, go straight on to page 131 and towards the bottom half of that page, and to commentary by Stalker and Moscardini on GIRFEC.

What did they identify as the risk of this policy in respect of the needs of disabled children and young people?

DR STEWART: I think it's an example of what they would consider to be a universal policy, meant to deal with all children -- treating all children the same, which is obviously laudable, but all children are not the same, and the needs of disabled children and young people were -- they were concerned that they would be further excluded by the systems and the structures around GIRFEC not actually meeting their needs effectively. Things like the My World Triangle and the resilience matrix not being couched in language that was appropriate, for example, for disabled children.

DR MACINTYRE: I think it's a really nice illustration of the dilemma that we talk about throughout the report and that we've been discussing today around that attempt to be inclusive and take a universal approach, while also meeting the needs of -- very specific needs and often complex needs of specific groups of children and young people, and trying to do that in a way that's non-discriminatory. So it's a real kind of challenge.

MS INNES: If we go on to page 132, we see a paragraph beginning:

'Critiques of GIRFEC from the perspective of those with disabilities have largely focused on the lack of participation of children and families in the process of creating plans and designing relevant interventions.'

You refer to Mitchell and Colville and Jundler, highlighting the importance of professional beliefs around child capacity and their understanding of what constitutes a competent view.

So that seems to be one area where GIRFEC has been critiqued from the perspective of disabled children.

DR MACINTYRE: Yeah, and it's actually -- probably unintentionally -- but quite discriminatory, that approach, in terms of assuming that because someone is a particular age or they have a particular condition, that they therefore lack capacity or they therefore are not capable of providing a competent view on something, and it's something that -- it doesn't only apply to children. We see it a lot in work with people with -- adults with learning disabilities or adults with dementia, for example, the assumptions that we make around capacity. So I think it's a really important point.

DR STEWART: And it relates back to the point we have made a few times today about professional knowledge and understanding around this particular group of children and young people.

MS INNES: Then you talk about communication, it goes on to talk about communication and barriers being created, and it says:

'Research by Morris suggests that some staff may assume that disabled children and young people may not have views of their own and that their views will concur with their parents.'

Certainly at this time, did that continue to be an issue?

DR MACINTYRE: Yes.

DR STEWART: Yes.

DR MACINTYRE: Yes, I think so, and I think, you know, we have to always be careful that we don't assume that a child and a parent or a disabled person and a carer will share the same understanding of what might be in someone's best interests, for example.

MS INNES: Then you go on to work by Stalker and colleagues again, and you say that they highlighted the lack of confidence and skill in practitioners in communicating effectively with disabled children, impacting on their ability to engage with GIRFEC.

Can you tell us a bit more about this issue of a lack of confidence amongst practitioners?

DR STEWART: I mean, I think, again, it goes back to knowledge and understanding of children and young people with disabilities or disability more generally. If you think about being in a classroom with children with different types of needs, different types of disabilities, and having the knowledge, the detailed knowledge, of their particular condition and how that might impact their learning, that's quite a lot for individual staff to have that breadth of knowledge about. So that tended to affect the ways in which -- how confident staff felt about dealing with the whole mainstream agenda, if you like, but particularly in thinking about GIRFEC, the assumptions that that might set up for staff in working with individual groups.

DR MACINTYRE: I think the other -- just to maybe add very quickly to that, I think there is an assumption that communication and the ability to work with disabled children and young people is somehow some kind of specialist skill that requires particular expertise. And if you think about the social work profession, for example, someone in a generic children and families team may feel that they don't have that specialist expertise. But, actually, if we think about good practice and communicating effectively with disabled children, all children and young people might benefit from that more accessible communication style. So it doesn't necessarily need to be framed as something that's a specialist level of expertise, but I think that's what the perception is.

MS INNES: If we move on over the page, to page 133, there was then a national review of services to disabled children.

What were the key findings of this review in relation to disabled children and young people?

DR STEWART: I mean, I think it acknowledged the need for a much clearer plan of action directly -- with relation to GIRFEC, that related specifically to the needs of disabled children. Again, it would be looking, like, as I mentioned earlier, the triangle -- the resilience matrix, et cetera, and the SHANARRI wellbeing indicators, to adapt them, to develop them in a way which more effectively delivered for disabled children, for example.

MS INNES: If we move on to page 135, we can see issues raised by key informants. So a lack of information about what was available and how to access it; little or no co-ordination between agencies; the child or family's needs having to fit in with services, rather than a person-centred approach; and an absence of a single named person acting as a central co-ordinating point. So these pick out some of the themes that you've already identified in your evidence, I think.

Now, if we move down to the bottom of this page, it says that:

'The report concluded by suggesting that despite some advances, there was a long way to go before the priorities set out in GIRFEC would be realised for disabled children and young people. Throughout this review, there was a strong message around viewing a disabled child as a child first and a disabled person second.'

I think this takes us back to some of your earlier evidence in terms of identity-first language or people-first language?

DR MACINTYRE: Yes.

MS INNES: What was the issue that arose here, which you say contradicts somewhat?

DR MACINTYRE: So I think the kind of key philosophical underpinning of GIRFEC, if you like, is that all children should be seen as children first, and so that, kind of, undermines that approach of identity-first language, which would be you would be seen as a disabled child and, by looking at the child first, while there's so many, you know, positives and benefits to that, we'd risk overlooking, I think, some of the key support needs that the disability brings with it.

So I think that is -- I think perhaps one of the benefits of the identity-first language is that it puts the disability front and centre and it, kind of, challenges us to think about: what adjustments do we need to make to take this disability into account?

MS INNES: Now, if we move on to page 136, you discuss, under paragraph 5.19, the signature of the United Nations Convention on the Rights of Persons with

Disabilities, the UNCRPD, and you go on on page 137 to set out particular articles within that Convention which are of relevance to children and young people.

So, for example, Article 24, focusing on what we're looking at specifically:

'Article 24 expresses a recognition of the right of persons with disabilities to education and calls on states to ensure an inclusive education system and lifelong learning.'

Then the next article goes on to discuss data, and you talk about this more on page 138, under reference to 'General Comment 9', where it notes that:

'In order to fulfil their obligations, it is necessary for state parties to set up and develop mechanisms for collecting data.'

So this seems to be given quite a lot of significance by the UNCRPD?

DR MACINTYRE: Yeah.

DR STEWART: Yeah.

MS INNES: Do you know if there were any changes following upon signature of this Convention in order to deal with these data issues?

DR STEWART: I mean, I think there has been a recognition around the challenges of data collection in Scotland, and there is a new strategy around the collection of data as it relates to disability. I think that's partly as a result of legislation and policy in Scotland becoming more aligned from a rights-based approach with the UNCRPD, for example.

But I think the challenges remain, particularly around, as they've identified here, the clear definition of disabilities. So although we may have a national definition around disability, it doesn't get us away from the difficulties of the, you know, different types of learning disability, different types of neurodiversity, different types of autism, of visual impairment, of hearing impairment. So that creates, within itself, real challenges that remain around the data collection.

They say here, for example, that extra efforts are needed to collect this data because of issues that we've discussed this morning around being hidden by parents being -- people being concerned about: 'What does it mean if I say my child's disabled? Will they think I'm okay to look after this child?' Et cetera. So I think that does remain, although I think attempts are clearly being made to gather more effective data.

MS INNES: If we go on to page 139, you refer to Riddell saying that UNCRPD has been influential in promoting inclusive education, but it is noted, at the end of that paragraph, that the UK entered a reservation to the effect that children with disabilities could be educated outside their local community if more appropriate education provision is available elsewhere. So, I suppose that's a specific reservation.

DR MACINTYRE: Yeah, and I think that for people who were advocating for inclusive education, that was probably viewed as quite disappointing.

DR STEWART: Although it's consistent throughout the report, I think, that there's always a caveat around ensuring that there's still an opportunity for specialist provision.

MS INNES: Then you refer to work by McCusker and colleagues saying that the overall impact of UNCRPD on social work practice has been limited. I suppose that may be because it's not been incorporated.

Do you know if it's the Scottish Government's intention to incorporate this Convention into domestic law?

DR MACINTYRE: I think it was considered as part of the Scott Review of Mental Health and Capacity Law, but my understanding is currently that the decision has been not to move towards incorporation, and I think part of the issue is because of some of the challenges when matters are not devolved to the Scottish Government.

So I think the, kind of, proposal, as it currently stands, is that it would be closely aligned to the CRPD, without moving towards full incorporation at this stage.

MS INNES: My Lady, I'm conscious of the time. I'm going to move to another time period.

LADY SMITH: Let's take a break just now.

I mentioned I normally take a break about this point in the afternoon, and if it's all right with you both, we'll do that just now.

(3.00 pm)

(A short break)

(3.10 pm)

LADY SMITH: Ailsa, Gillian, welcome back. Are you ready for the last stretch?

DR MACINTYRE: Yes, thank you.

DR STEWART: Yes, thank you.

LADY SMITH: Ms Innes.

MS INNES: Thank you, my Lady.

We're going to start by looking at the period 2009 to 2015.

First of all, at page 143, at the top of the page, you note there that the 2004 Act was amended by the Education (Additional Support for Learning) (Scotland) Act 2009, and of particular significance in that Act was an extension to the definition of a child with additional support needs in section 1 of the Act to include any child looked after by a local authority. So that is a presumption which can be displaced; is that right?

DR MACINTYRE: Yes, that's correct.

DR STEWART: Yes, that's correct.

MS INNES: Now, if we move on, please, to page 144, at the bottom of the page, you talk about the Doran Review. What was the purpose of the Doran Review?

DR STEWART: It was really looking at the role of residential schools specifically with complex additional support needs, and you can see here that there was a real recognition of the lack of consensus around definitions, and it also called for further data collection and strategic planning.

But one of the other things within the Doran Review was looking at community-based services and, in particular, increasing information that was available on what the available resources actually were, and I think there was a concern that, nationally, we weren't clear about the range of resources that were actually available across the country and how these could be accessed.

And I suppose one of the other important aspects was around accessible assessment of individual children for all disabled children and young people, and again I think there was an issue here in terms of assessment around what we have talked about before, in terms of more advantaged families having greater access to assessment than those families in disadvantaged settings.

MS INNES: At page 146, at the top of the page, you say the key message from the review was around the importance of getting the right help at the right time in the right place from a sympathetic and respectful adult who understood and did not overprotect.

I think that's really the line that underlines the Doran Review.

DR STEWART: Yes.

MS INNES: The outcome of this review, has it been reviewed?

DR MACINTYRE: Yes, there's a ten-year strategy that was developed as a result of the -- I'm sorry, I can't remember the date, but there was a ten-year strategy published after Doran that was -- the role of which was to implement the 21 recommendations from the Doran Committee.

MS INNES: I think there is a ten-year strategy which, well, although it's ten years, I think might be 2017 to 2025 --

DR MACINTYRE: Okay.

MS INNES: -- or maybe 2015 to 2027, something like that, and that sets out a strategy.

But are you aware of any work that's been done to analyse the impact of the recommendations?

DR STEWART: No, I don't think so.

MS INNES: Okay.

Now, can I ask you, please, to look on to page 154, and I think to the bottom of that page. You again are referring to Stalker and colleagues and, in this context, you have been looking at child protection and concerns about abuse of disabled children.

It goes on over the page, to page 155, to say that:

'She expressed a concern that disclosures made were sometimes minimised.'

I think, again, the issue of confidence of practitioners or lack of confidence comes up.

DR MACINTYRE: Yeah.

MS INNES: Can you tell us about that, please?

DR MACINTYRE: I think it's quite interesting. I think this was work that Kirsten Stalker carried out with Julie Taylor and it looked at child protection and disabled children, and I think what they found, which is quite interesting, was that professionals were more reluctant to intervene in cases where the child had a disability because -- well, one of the reasons that they suggested was because they felt empathy or sympathy towards the parent of a disabled child and so were more likely to make allowances or make exceptions in those circumstances, so that potential abuse was unintentionally minimised, because it was -- I think the perception was: this is a really tough role to have and it must be really stressful, so we have to be quite understanding of these stressful situations, which resulted in abuse sometimes being overlooked.

I think there was also issues around communication and disabled children perhaps not having the communication necessary to be able to disclose abuse, and sometimes I think there were issues that behaviours that might be demonstrating that abuse was happening were passed off as behaviours associated with disability, rather than behaviours associated with abuse.

MS INNES: Although you mentioned parents there, that, you know, it's quite difficult for the parents and issues were minimised, I suppose that could also apply to professional carers.

DR MACINTYRE: Professionals as well, yes, yes.

MS INNES: Now, if we move on to page 156, we move into the most recent period, 2016 to 2025.

Just at the bottom of page 156, we see there reference to the Scott Review recommending the strong alignment of the principles in UNCRPD, aiming to promote autonomy, decision-making and support. You referred to the Scott Review in your evidence earlier, and I think this is where we see the Convention coming back in again in this context.

DR MACINTYRE: That's right.

MS INNES: If we could move on, please, to page 158. You refer there, under paragraph 5.31, to the Education (Scotland) Act 2016.

What changes were made by the 2016 Act?

DR MACINTYRE: I think the most significant change there was around an extension of the right to be involved in decision-making that was extended to children aged 12 and over, who were considered to have capacity to make decisions in relation to their educational needs, and it sets out the definition of when a child could be considered to have capacity.

So it talks about sufficient maturity and understanding, and then it talks about being able to make a decision, communicate a decision, retain -- understand the decision and retain memory of the decision, which is the same definition of capacity that's set out in the Adults with Incapacity Act, actually.

So it's really about promoting decision-making for children and young people, providing information and advice to support them to do that, and I think -- I'm not sure if it also talks about other ways to facilitate communication, perhaps through advocacy or other accessible adaptations like the use of Talking Mats, for example.

MS INNES: If we can move on to page 160, you start at the bottom of that page, at 5.32, to refer to the Independent Care Review.

If we go on to page 161, I think you note that it wasn't necessarily clear how many disabled children and young people were spoken to in the context of the Independent Care Review, but you have a quote there above paragraph 5.33, where it says:

'Scotland must make a particular effort to understand and act upon quieter voices, including infants and non-verbal children and those with learning disabilities. No group should ever be considered hard to reach.'

DR STEWART: Yeah, and I think that's important in reflecting what we've been saying earlier about the importance of children's voices coming through in policy and legislation. I just thought it was interesting, in terms of that review, that it was difficult to identify how many of the -- I think it was 5,500 children they spoke to actually had disabilities.

MS INNES: Then just below that, you note that before The Promise was published, further guidance was published by Scottish Government on the presumption of mainstreaming?

DR STEWART: Yeah, that's correct.

MS INNES: You say that the guidance was intended to bridge the gap between legislation, policy and lived experience.

Can you explain why it was thought that guidance was necessary?

DR STEWART: Well, I think what you can see through the report is that aspirations in legislation and policy take some time to migrate to practice for all of the reasons that we've discussed throughout today and to impact on lived experience and, I think, again, this is a way of trying to bridge that gap, by giving clearer guidance on how to achieve, for example, improved outcomes and deal with children equitably.

But, again, I think it's quite a challenging thing to achieve, is to make sure that legislation and policy actually -- at the end of the day, the whole point of it is to make a difference to the outcomes for people with the lived experience, and that's something, I think, which we've singularly failed to do a lot of the time.

LADY SMITH: You could say that it goes back to the basic task of achieving such clarity in the legislation that nobody is left in any doubt as to what it means. You can write any amount of guidance you like, but that's not the law. The law is what's in the primary legislation.

DR STEWART: I think that guidance often -- and we've seen this in learning disability and mental health, it's an interpretation of the legislation for a particular group of professionals and, therefore, might vary across professionals who have to work together, and that creates an even greater tension.

LADY SMITH: And then people read guidance and they don't read the legislation.

DR STEWART: No. Practitioners have great difficulty keeping up to date with guidance that's directed at them, never mind tracking that back to the actual legislative framework. I think that --

DR MACINTYRE: I think the landscape becomes really cluttered. So it's very hard, as a busy practitioner, to be able to identify which particular piece of legislation this guide -- because there's so much guidance that it's sometimes hard to trace it back to the relevant legislation.

LADY SMITH: I think I'm probably right in assuming that, even with your expertise, you were surprised when you started putting this report together just how much there had been this century --

DR MACINTYRE: Yes.

LADY SMITH: -- in terms of relevant primary legislation, regulations and secondary legislation and guidance.

DR STEWART: Absolutely.

DR MACINTYRE: And the pace at which it has developed over the last 20 years has been incredible.

DR STEWART: I think particularly since devolution, I think for practitioners, the framework is so complicated and so interrelated that to keep on top of that is incredibly challenging, and particularly if -- just to use social work as an example, if you're a social worker in a children and families team who doesn't deal with children with disabilities every day, but suddenly has someone in their caseload with a disability, well, wait a minute, I have to then reframe everything away from my standard specialist knowledge into adding in this other layer, and I think for us it became very quickly apparent that it was just such a hugely fragmented and complex area that it was going to be really difficult to nail down.

LADY SMITH: If you take somebody in social work practice --

and I have in mind perhaps somebody relatively newly qualified -- and they haven't dealt with a child with disabilities of any sort, and then they've got to, and they don't have at their fingertips what is the up-to-date legislation, is it hard for them to go about finding out what they're supposed to be applying?

DR STEWART: It's something that we -- just to talk about social work education for a second, but it's something that we try to instil in students, is about developing your range of resources and information provision before you go into practice, because you cannot rely on your local authority to give that information to you. So where do you get your information from? Is it reliable? Is it robust? How will you find out?

They cannot possibly know every section of every piece of legislation that they're likely to come up against, so you have to know where to get it. That, for me, is a key message.

LADY SMITH: It must be hard.

DR STEWART: Very difficult.

LADY SMITH: It's hard for lawyers as well, believe it or not.

DR MACINTYRE: Yes. The other thing is that not all qualifying social work programmes would teach exactly the same content. So if you happen to have someone like

Ailsa or I who have got a particular strong interest in disability, that will get covered on the curriculum, but in other universities, they may not get that same level of depth. So you could have someone newly qualified who'd actually had very little training, because there's no minimum standard across each client group that you might work with in terms of how much education you have to have.

So, yeah, it's --

LADY SMITH: Hard, I can see that.

DR MACINTYRE: Yeah.

LADY SMITH: Thank you.

Ms Innes.

MS INNES: Thank you, my Lady.

If we move on, please, to page 163, and to reference to the Morgan Review of Support for Learning. This was published in 2020, and you set out its remit and say that it considered how additional support for learning works in practice across all provisions, day and residential schools, mainstream schools and special schools, and you note at the bottom of the page that: 'The review went to great lengths to engage with children and young people to obtain their experience.'

Is that something particularly notable about this review?

DR STEWART: Yeah, I think if you link back to 2000 and 'The same as you?' and the kind of different approaches that were taken to engage with people with learning disabilities, I mean, I think some of the things that the Morgan Review did well was getting children together, for example, in focus groups, so that they were able to share experiences with each other, but also just things like -- and it's on the screen there, about meeting with members of the Scottish Youth Parliament, et cetera. So, you know, really, kind of, reaching out, and I think they tried quite strongly to engage hidden voices, people that hadn't been heard from particularly effectively in the past.

So, again, I think anything that demonstrates that, harnessing children's voices and the development of their own -- or policy and legislation that's likely to affect them is to be noted.

DR MACINTYRE: I think it also represents a trend that we've talked about throughout the day around user voice, participation, and if you look at the Independent Care Review and the extent to which young people were included in that, led on that review in many ways, I think we can see the expectations around how we engage with children and young people or anyone who's the recipient of any piece of legislation and policy.

I think it would not be acceptable to carry out a review like this without engaging with children, young people and families.

So I think that is a change over time that we can see developing throughout the report.

MS INNES: If we go on to page 164, we can see there various issues that were highlighted by children and young people; for example, the importance of meaningful relationships between them and staff being important for learning, and various other points already dealt with in your evidence, but children and young people feeling involved in information sharing, communication needing to improve and suchlike. So you highlight a number of points there.

Then there are recommendations of the review. So at the bottom of the page, a recommendation is that children and young people must be listened to and involved in all decision-making relating to additional support for learning, which we have seen on a number of occasions now, I think, through the reviews that we've looked at.

DR MACINTYRE: Yeah. I think there probably is a key point, isn't there, about the remarkable similarity, when we look at the recommendations across each of the reviews. So it's about listening and involvement in decision-making. It's about parental involvement.

DR STEWART: Relationships.

DR MACINTYRE: It's about relationships being central. It's about joint working between different professional groups. And those same recommendations are repeated over time, so that probably tells us that we're not always doing it as well as we might hope to do.

MS INNES: If we move on to page 165, the paragraph beginning:

'The focus on formal qualifications means that other forms of progress are overlooked and this devalues and demoralises children and young people who learn and achieve in other ways.'

So although we've shifted over time from the idea of children being uneducable and untrainable, it appears that children and young people were saying that they weren't feeling that their progress was being valued.

Can you explain that further?

DR STEWART: Well, I think it's the bit about formal qualifications, and if you don't learn in that particular way and aren't able to, for example, sit an exam, or you have got lots of experience in a particular area but you don't have the opportunity to have training or to do a particular course that gets you a certificate, then that's not valued.

There's been lots of attempts around accredited prior learning, et cetera, to try and overcome that idea of formal qualifications but it's -- you know, if you don't fit into that -- I was going to say O-Levels, which shows my age, apologies -- degree, et cetera, et cetera, then you're, kind of, excluded from that, kind of, educational progress pathway.

MS INNES: In the next paragraph, it says:

'While the principles of inclusion and the presumption of mainstreaming are strongly supported, the review found that far too many children and young people report feeling isolated, lonely, rejected and sometimes actively disliked or uncared for.'

DR MACINTYRE: Yeah. Yeah. So I think that that's very powerful, isn't it, that kind of sense of feeling actively disliked. It does feel really powerful.

I think there is a discussion to be had around whether mainstreaming is the panacea that we, kind of, argue that it is, and if you trace that back to looking at the closure of day centres, for example, for adults with learning disabilities in Scotland, actually what happened when we closed day centres, with no other meaningful opportunities, we actually increased social isolation and loneliness.

So there is a, sort of, sense that mainstreaming, while it is something to aspire to, it doesn't necessarily prevent issues such as isolation, bullying, feeling excluded, even though you're allegedly part of the mainstream, you know.

So I think it's probably important that we hold on to that critique of what mainstreaming actually means and how it's experienced.

MS INNES: Going on to the next page, there's reference to the increasing levels of need and the impact of austerity on public services, which mean that processes of legislation have become distorted to manage levels of need and demand.

I think you've mentioned this again, earlier in your evidence, that whilst there might be an aspiration to provide a certain level of service, the resources aren't there to do that; is that what she was referring to?

DR STEWART: I think that and the eligibility criteria.

MS INNES: Yes.

DR STEWART: And ways of using definitions and the eligibility criteria to manage need.

DR MACINTYRE: I think really it's to the point I made not very well earlier about IQ, the use of IQ as a means to gatekeep access to services in times of austerity.

MS INNES: Then the next paragraph, you note that:

'The review also emphasised that the other significant factor which prioritises identification and response in providing support is how the child or young person communicates through their behaviour. The corollary is that children who have additional support needs that do not affect others are sometimes overlooked.'

And therefore are sometimes hidden.

Can you tell us a little bit more about this?

DR STEWART: I think we briefly talked about that this morning in the, kind of, introduction, didn't we, just that if you're someone who is in a mainstream setting, for example, but your behaviour affects other people in that because of your disability or behaviours associated with disability, then you're more likely to be moved to other settings, for example, or your additional support needs may be subsumed within a response to physical challenging behaviour, rather than dealing with the additional support needs.

MS INNES: Then towards the bottom of page 166, there is mention of variable relationships between local authorities and grant-aided special schools, and there is concern that the specialist provision is only considered when a child or young person has experienced repeated failure in mainstream or other specialist provision, and that reduces the impact that expertise can achieve in prevention.

Can you explain that, please?

DR MACINTYRE: I think it relates to a point that was made earlier this morning around -- well, it was in the context of residential provision that we talked earlier, but if we think about specialist provision as being seen as the provision of last resort, so it's used when repeated attempts at other types of input have failed, so by the time someone gets to that setting, lots of damage has already taken place and there's lots of barriers and challenges to overcome in terms of relationship-based practice, building trust, et cetera.

Whereas I think the argument here is that, actually, if we use that specialist expertise at an earlier stage, not necessarily removing people from mainstream settings and putting them into segregated provision, but if we used that specialist expertise within those settings, we could do much more preventative work, which would allow us to, you know, develop better relationships that might result in positive outcomes at an earlier stage.

MS INNES: If we move on to page 168 --

LADY SMITH: As you put it, Gillian, you may avoid being unable to remove irreparable damage that has occurred through repeated failure.

DR MACINTYRE: Yeah. Yeah.

MS INNES: At page 168, it says:

'Overall, it would appear that while the general direction of travel for education for disabled children and young people has seen an increased focus on rights, inclusion and participation, the Morgan Report suggests that there is still a long way to go.'

It sounds somewhat depressing.

DR STEWART: Yes, I suppose it is. But I think they very much pick up on the -- Angela Morgan very much picks up on the fragmented nature of implementation of additional support for learning.

DR MACINTYRE: I think that point is really important as well, you know, the point about the current situation appears to depend on, you know, a small number of committed individuals, and that's what results in the inconsistent and fragmented implementation.

And I think there's a sense that when things go well or when there is good practice, it's the result of a professional or a practitioner who goes above and beyond, and it shouldn't be seen in that way. It shouldn't be about doing something that's above and beyond your role. But the current situation appears to be that there's a small group of people who are doing this well.

MS INNES: One of the things you mention in the report is that there's a minimal requirement for ASN in initial teacher education, and given the numbers of children who are reported to have additional support needs, one would have thought that it should be a requirement for every teacher.

DR STEWART: Yeah, but I think it's still seen very much as a specialist aspect of teacher training.

MS INNES: If we can move, please, to the bottom of page 169, where you refer to a submission by the Children and Young People's Commissioner in Scotland to the Education Committee of the Scottish Parliament in 2003, where it was suggested that mainstreaming was a positive step, but the commissioner argued that disabled children and young people with ASN continued to be unfairly subjected to practices that impact negatively on their education as well as their personal and social development, and because their needs are not being met, they're not always able to access a full curriculum, experiencing part-time timetabling and informal school exclusion practices.

So the commissioner had identified these as ongoing issues?

DR STEWART: Yes, ongoing challenges, and I think that line in the quote there about experiencing integration rather than inclusion probably reflects that. They may be integrated physically in schools, but accessing the same curriculum as other children, with the same timetable, is oftentimes quite difficult, and not only for the reasons we have discussed already around knowledge and confidence of staff, but also about availability of appropriately trained staff.

MS INNES: If we can move on, please, to page 172, and towards the bottom of that page, this is referring to the implementation of The Promise. There's an update that was published by Who Cares? Scotland on progress in 2024, which you say provides a concerning picture about lack of progress, dilution of aims and data gaps.

What issue did this update particularly highlight?

DR STEWART: I mean, I think, as it says in the, kind of, quotation there, all of the priority areas they felt quite strongly needed more work but, in particular, the key concerns of the lack of progress in education.

But I think the other point there is about -- restraint is another area which is of some concern. But I think, more importantly, from our point of view for today, the briefing paper on residential care nor this Plan 24-30 specifically mentions disabled children and young people, although it did obviously provide some really useful context here.

So, again, it's a, kind of, illustration of that idea of this being for -- universal for all children, but actually, if we don't get into the details for disabled children and young people, they're likely to miss out on any advances that are made.

DR MACINTYRE: I think one of the other things in relation to the lack of progress with respect to education would be about an ongoing attainment gap as well. I think that's something that would be highlighted.

And also the points made by the Children and Young People's Commissioner about the lack of access to a full curriculum and so on would be another concern I think that Who Cares? would have.

LADY SMITH: You also, Gillian, in relation to that last point, I think, mentioned something you referred to as informal exclusions from school. What's that?

DR MACINTYRE: Informal exclusions --

LADY SMITH: It was the previous -- it was when you were talking about lack of access to the full curriculum and perhaps only getting a part-time access.

DR MACINTYRE: Oh, so it was the part-time access to the curriculum --

DR STEWART: I think it's informal exclusions are around things like: well, everyone else --

LADY SMITH: If we can go back to page 169, and it's just more than halfway down the page, above the indented paragraph, 'Our view', and you mention, as you just have done again there, they're not able always to access a full curriculum, and they may get part-time timetabling and informal school exclusion practices.

DR STEWART: I think what that means is if you're only getting a part-time timetable, then when every other child in school is in the classroom, you're not. So it may be you come in for half a day. So you're excluded from that morning.

LADY SMITH: So the school isn't offering anything to you at all?

DR STEWART: Yeah, and quite often that's the case for disabled children. Particularly I've had experience recently with children with autism in special units integrated into mainstream schools, where they have -- you know, they might be in two-and-a-half days a week, rather than five, or -- because they can't be offered certain classes for particular reasons, and it might be things like resources, like the right teacher, or it may just be that -- it could be something physical, for example, like PE, that there's no specialist provision available, so they get excluded informally from that class.

LADY SMITH: So it's not just, 'You can't get access to that part of the curriculum'; 'We can't afford any' -- I don't mean 'afford' in terms of cost -- 'We can't provide any supervision or any other activity for you during that period, so don't come to school'?

DR MACINTYRE: Yeah. Might it also be things like if someone had any kind of, you know, emotional or behavioural issues, it might be, 'Well, you know, you're clearly upset, just go home for the rest of today'. So it's not a formal exclusion, but it's a way of managing the impact of someone's disability or their behaviour, I think, potentially.

DR STEWART: Yeah. I mean, that happens regularly within these specialist units within schools, where someone's having a bad day and they aren't able to cope with it. Parents are phoned and they come in and they pick -- so that's an informal exclusion.

LADY SMITH: Thank you. That's very helpful.

MS INNES: Could we go on now, please, to page 176 and to the bottom of that page. You refer to a paper produced by the Care Inspectorate entitled 'Disabled children and young people thematic review in 2024', and this was exploring how well local authorities are applying GIRFEC principles to ensure disabled children and young people have their needs met and rights promoted and protected.

If we can move on to page 179, you set out there the various recommendations that the report made. We see, again, that the views of children and young people and their families must be considered; that, secondly, there must be a robust approach to gathering and analysing data; again, a bullet point in relation to taking action in response to views; there must be clearly defined information in relation to services; and then opportunities for, for example, early intervention and play and friendships must be maximised, and there should be adequate resourcing.

I suppose this again goes back to the theme that you've mentioned of the same themes coming out repeatedly in reviews.

DR MACINTYRE: Yes.

DR STEWART: Yes.

DR MACINTYRE: I think one thing that's a slightly different but quite interesting theme there is around the role of social work services in providing care and support to disabled children and young people. I think one of the main findings in that review was that the role of social workers was poorly understood.

And I think there's a lot of fear of working with a social worker and the stigma attached to that, and I think a lack of understanding that social workers can also provide you with support and care as well as, you know, more, kind of, formal child protection processes was not always understood by people. So I thought that was quite important and quite an interesting finding.

LADY SMITH: Does the inadequacy of data collection mean that there are local authorities that don't have any accurate idea of how many disabled children there are in their area?

DR STEWART: Yes.

LADY SMITH: And does that mean there's then a risk of not organising their social work services to have -- going back to what we were discussing earlier -- some of their social workers trained and kept up to date on the current law on provision for disabled children and how best to provide the service to them?

DR STEWART: Yes, I think there's a real correlation between the lack of data and the way in which services are developed, commissioned and then who you employ in order to deliver those services.

LADY SMITH: Yes. Thank you.

MS INNES: Now, if we move to the end of this chapter at page 194 and the final paragraph on that page, where you say:

'Perhaps one of the clearest messages from this work is that whilst considering the needs of all children in the same way is laudable, not all children can be treated in the same way if we want to achieve better outcomes.'

Which is a theme that you've already mentioned.

You then go on to say:

'Adapted engagement, assessment, intervention and practice methods are required for work with disabled children and young people and professional staff require support and information to enhance their confidence to work effectively with these groups to ensure enhanced outcomes. Subsuming the needs of disabled children and young people in universal policy frameworks appears to have reduced the focus on them.'

That seems to have been the clearest message over this period that we've been looking at in the more recent years.

DR MACINTYRE: Yeah, I think that would probably be one of our key findings, wouldn't it?

DR STEWART: Yes.

DR MACINTYRE: And that tension we talked about earlier, yeah.

MS INNES: Then you go on, in your final chapter, to consider various themes that I think we have already talked about.

If we can look, please, at page 197 and the bottom of the page, where you are talking about implementation gaps, and you say:

'All of this leads us to consider the extent to which change can be brought about by policy implementation alone and some commentators ... have suggested that legislation and policy on their own are not enough.'

So if legislation isn't enough and policy isn't enough, what more do you need?

DR MACINTYRE: I think resources is a key thing. So I think we need resources to be able to effectively implement certain legislation and policy and then we need to have improved education, training and support for those practitioners who are charged with the implementation of those new policies or legislation. So, yeah, resources, training.

Anything else?

DR STEWART: This is a particular hobbyhorse of ours, so I'll throw this in as well, but we are not good at really evaluating the impact of policy as it happens and tracking through the outcomes for people of the implementation of that particular policy. It was something we did, I think, relatively well in the '90s, but we haven't done it for a long time. And so a lot of this work that's being done has a, kind of, full stop, and then: well, okay, so what happened to those recommendations? Why weren't they achieved? What can we do to ensure that they are achieved in the future?

So that, for me, is a big gap when we get to the stage of: okay, that policy hasn't quite worked, we have got the same recommendations we had the last time; why didn't that happen, and what will be different about, you know, reaffirming those recommendations again?

MS INNES: Then at the bottom of this paragraph, the second section of it, you refer to the rights-based approach which, as you said at the beginning of your evidence this morning, you had had a rights-based focus to the work that you undertook.

In terms of your review of how things had developed over the whole period, what key messages did you find in relation to whether a rights-based approach had now been successfully implemented or not?

DR STEWART: I think the thing that -- the point that Tisdall is making here about wellbeing taking the precedence over rights, is this person -- is their wellbeing being effectively supported, often seen in isolation to other rights being observed while you think you're protecting them. So it's that tension which I think -- we think is probably still there, and the point that they make here around not being legally enforceable in the same way in terms of wellbeing -- sorry, in terms of rights, I think makes that tension almost quite hidden, which makes it difficult to tackle.

But I do think -- I think the rights-based approach has come on hugely in the period that we've looked at over last 50 years or so, and it has certainly -- in practice, I think, there's a real focus on a rights-based approach, and if you look at mental health as a particular example, there's been some useful strides forward there.

But whether it is always paramount I think remains to be seen.

DR MACINTYRE: I think in relation to education, you know, one of the things that we were striving for here was that every child should have the right to education, so no child is left behind, no child is seen as uneducable anymore. So people have the right to education, ideally in a mainstream setting in their local community.

But -- and we can see the progress that we've made towards that, but we keep coming back to these caveats about those exceptional cases where those rights don't seem to quite apply: if it's detrimental to the wellbeing of other children; if it's too costly to provide that education; we talked just now about the kind of process of informal exclusion, when it becomes too challenging to have people in that mainstream setting.

So I think we have made huge progress, but I think for those people with the most complex needs, who are the most disadvantaged and the most marginalised, there's still quite a way to go.

MS INNES: Thank you very much.

I don't have any more questions for you. Obviously we have your report as well as your evidence.

Thank you.

LADY SMITH: Let me add my thanks. We have really made you work your socks off; you in particular, Gillian, today, but thank you for coming along this afternoon to add what you can offer, Ailsa, that's been so helpful.

It's a great report. It's been hugely useful evidence. You must both be exhausted, so feel free to go.

Thank you.

DR STEWART: Thank you very much.

DR MACINTYRE: Thank you so much.

(The witnesses withdrew)

LADY SMITH: So tomorrow, Ms Innes?

MS INNES: Tomorrow, my Lady, we have Sarah Butters from Starley Hall giving evidence, and then in the afternoon, Sister Rosemary Kean from the Good Shepherd Sisters.

LADY SMITH: Yes, and we have heard from Sister Rosemary before.

MS INNES: We have, my Lady.

LADY SMITH: Yes. Thank you.

I'll rise now until 10 o'clock tomorrow morning.

(4.00 pm)

(The Inquiry adjourned until 10.00 am
on Thursday, 29 May 2025)

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