**Assessing Children and Young People in the Context of Domestic Abuse (DA) and Parental Substance Misuse (SM)**

**Introduction**

The purpose of this document is to provide guidance and practice expectations to operational social work teams in respect of their work. The principles in this document can be used in all casework but it is focused on the specifics of domestic abuse and substance misuse.

This document does not replace any statutory or other guidance and should be considered in the context of good practice assessment information which was distributed across the service in April 2018.

The emergent evidence from sampling case files, reading assessments and from case file audits is that there is not strong evidence that social work staff, assistant or team managers or CP chairs demonstrate a strong enough understanding of good casework in what is recorded in case files. It maybe that some of what needs to change relates to recording practice but given that the case record is the only accepted source of evidence of our practice and impact on children and young people, there does need to be improvement.

In setting out what ‘good’ looks like it is usually helpful to also say what it is not. The document is not meant as a critique of any individual or team, it is simply an articulation of what has to change. Your task, individually and collectively in your teams, is to commit to applying the principles set out below to your work. I will expect to see evidence of this in casework from the date below.

Richard Nash 8 June 2018.

1. **Setting the Scene and Planning**

Before knocking on the door of the family home to assess either DA or SM it is important to understand the starting position of the adults in the family. They are unlikely to want to disclose anything other than the bare minimum and they will probably want to minimise and deny as much as they can. They are unlikely to be completely honest. This is a natural starting position and reflects human nature, the fear of consequences (ie their worry you will remove their children) and other factors such as embarrassment and shame. They are also unlikely to be comfortable discussing the impact of their behaviours on their children.

However, for us, these are non-negotiable. All assessments must cover off and be convincing in terms of;

1. The extent to which we have asked a succession of questions, and challenged where appropriate the responses given by the adults in terms of their explanation and understanding of their behaviour
2. The extent to which we have checked out, understood, asked and understood the impact on the children and young people in the household
3. Our understanding of what has to change and by when, our assessment of the parents capacity to change in light of the history, the level of insight and understanding the parents have of the impact on the child
4. Is it safe for the children to continue living where they are?
5. The social work view of the parents capacity and willingness to change.

The only issue for debate, between worker and line managers, is how to safely get this information during the course of the assessment. Clearly, asking probing questions may get aggressive responses and we need to manage this possibility well and keep ourselves safe, whilst working out how we get the information we need.

The basic requirement of both assessment visit and visit to implement a CP or CIN plan is to get to the bottom of the negative behaviours of the adult, the impact on the child(ren), the insight of the adult and the evidence of change.

***Practice Point 1: Visits must be planned and the worker must be clear about what they need to achieve.***

Example: Mother discloses that she uses ‘cocaine’. We cannot and must not be satisfied with this information without detail. Social worker must ask about what time of day? Where are the kids?, How much do you spend? How many times a week/a day? When you say cocaine what do you mean? Do you smoke it? What other drugs? When you buy it does your dealer come to the house? Do your kids know? What do you think is the impact on them?

The social worker needs to ask but also feedback as to the likely and actual impact on the kids of the adults’ behaviors’. However, get the adult to go first because you need to test their insight.

The social worker must work out the level of addiction and in relation to cocaine whether it is ‘crack cocaine’.

The social worker must work out the level of insight that the mother has and the likelihood of change. It is often good to ask ‘so what are you (the mother) going to do to change?

Other adult(s) who live in the household also need to be seen. The best way of doing this is to talk to them separately and to check what the mother has said ‘fits’ with what they say.

Current practice does not reflect that these questions are asked and nor that this is an expectation of managers or CP chairs that this information is sought. Casework that does not include evidence of ‘detail’ cannot be accepted.

1. **Talking to and seeing children**

Clearly talking to, and interacting with children and young people in the household is an essential part of our visit. Communication needs to be based on age and understanding, but the basic task is to use careful and skilled questioning to find out what knowledge they have of the alleged parental behaviour and what impact it has on them.

Care must be given as to what is asked and how it is asked. It is important also that kids get a chance to respond to open questions, that are a mixture of positive and less positive opportunities to respond (ie ‘3 things that you really like’ and ‘3 things that you would want to change’).

Spending time with kids, using materials to aid conversations and getting a sense of what it might be like to be this child is essential. Again kids won’t necessarily feel comfortable giving the whole picture and the social work task in this respect is to consider and judge what to ask, when, how and the extent to which you may put the child under pressure.

***Practice Point 2: Direct work with children and young people needs to be planned and thoughtful. What do I need to ask? How? When?***

Example: Visiting a 7 year old and 2 year old on CP plan because of parental DA. Review conference is 3 weeks away and on the face of it there has not been continued DA. This visit should be focussed on the views of the 7 year old, their view of whether things at home are the same? better? or worse? Ask about what they really like, what they don’t, what would they change if they could? You can ask directly about parental arguments, you can ask about night times. It is really important that you can report back to conference what you believe, on the basis of what the child has said, what has changed.

At this visit you need to also address the issue of parental arguments. This should not be generalised but specific. Focus on what you know (because you have previously asked searching questions, if you don’t know find out asap)) what are the trigger points for DA. These might be Friday night after drinking, tension about money, relationship problems, etc. Whatever you have previously determined this to be you need to ask the parents about triggers and what has been different in the way they have dealt with these. It is not realistic for triggers not to have occurred, so you need to start from the position of either DA has happened or the adults have changed their behaviour. Ask them to talk you through what has changed and gauge their insight and how convincing they are. Detail and asking searching questions are, again, vital. Casework must evidence this.

You MUST understand this and be able to comment on this in your next conference report. This can be triangulated with DA agencies and the police.

***Practice Point 3; The child’s case record must reflect the work completed in terms of what has been described in this document. This is not about recording more, it is about recording differently. Recording needs to cover basics on the purpose of the visit, who was seen and who wasn’t but also evidence of parental insight, indicators of change and most importantly information shared by the child.***

1. **Conference Reports**

Currently the general standards of conference reports are that they are not good enough. That is not to say all of them are poor, but too many of them are. It is the case that poor conference reports are signed off by managers and accepted by CP chairs. This suggests that there is not a good understanding of what is required as a basic minimum standard.

I have read conference reports, including manager and CP Chair comments that include:

* ‘Parent has made good progress’. This fairly common statement is not linked to evidence and often in searching for the justification for this statement it becomes apparent that ‘good progress’ relates to a parent attending meetings on time or keeping appointments with other agencies. This is not ‘good progress’ and cannot be accepted as such.
* ‘There has been no DA since September’. This comment cannot be justified in any way, as we don’t know this. What could be said is ‘there has been no reported DA since September’. However this is fairly meaningless and is obviously not the same as saying DA has not taken place between the parents
* ‘Parent takes cocaine’. This is also meaningless in terms of our work without a commentary about the ‘who, what, when, where’ or information on the impact on the child(ren)

Good conference reports focus on detailed analysis of the parental behaviour, the impact this has on the kids, the parents views on impact, capacity to change in light of the history, risk to the child, harm that the child has suffered and MOST IMPORTANTLY the views, wishes and feelings of each child. Information provided by the family must be triangulated with information held by other agencies.

If the conference report sets out evidence of the detail gathered, the insight of the parents, the views of the child(ren), the level of risk and prognosis for the future and an understanding of what has to change, it will become easier to make the right decisions for the kids involved. Currently we don’t do this well enough and we also don’t ask other agencies for their information and views in the right way. In the cases I have seen, there are numerous examples of where we have just asked for information about the child.

Example: As part of assessing how a child broke their arm we contacted the family GP and asked for medical information on the child. We didn’t ask for a view about whether the type of fracture was consistent with the explanation, we didn’t invite the GP to comment on any observations they made whilst interacting with the family. As a result, we simply got information telling us the kid had a broken arm. We already knew this. Blindly following the ‘process’ is never going to be good enough. We have to act with thought and care. Ask the question ‘what do we need to know?’

Example: As part of working with a 6 year old on a CP plan we felt that the mother was making good progress. We liaised with the school and asked for generic information about attendance and was told it was 95%. What we didn’t do is share our thoughts with the school on our assessment and the ‘good progress’ we thought she was making.

The school were not asked about their views of our assessment or their thoughts on the mother’s capacity to change. If we had of asked we would have found that a variety of adults, including unknown males were taking this child to school. The school, on the few times they had seen the mother, thought she was ‘on something’. The school didn’t tell us because we cancelled the last core group and they thought we knew. There is no excuse for us not to ask the right questions.

***Practice point 4; when contacting other agencies in the course of our work make this contact meaningful and focussed on the issues. Always ask specific questions as well as general ones.***

1. **Summary**

The impact we have on our children and our ability to make timely and positive interventions on their behalf depends upon our ability to implement the basics of practice well and record what we do smartly. This is not about doing more; it is about doing it differently. Often case records would benefit from fewer words but more meaning.

Please take this document seriously and implement it in your practice. The expectation is that when case records are looked at through audit or sampling there will be clear evidence of good practice. If you or your team require more support to achieve this, then ask.

The senior management team in our service is committed to improving the service by supporting good practice and demonstrating strong, open leadership. We want to be as helpful as we can to our operational teams so that we can ensure that all the vulnerable children and young people in Bucks who are referred to us, are safe.

Buckinghamshire County Council

Children’s Social care

Senior Management Team

8 June 2018