The multi-agency response to children living with domestic abuse

1. Contextual Information

1.1. A report published on 19 September 2017 by Ofsted, Care Quality Commission, HM Inspectorate of Constabulary, and HM Inspectorate of Probation, shares the findings from a Joint Targeted Area Inspection (JTAI) programme examining the multi-agency response to children living with domestic abuse.

1.2. The inspection - carried out in six geographical areas - focused on how effective local authorities, children's social care, health professionals, police and probation services were in safeguarding children living with domestic abuse.

1.3. The JTAI reviewed the practices of the individual agencies, as well as multi-agency working arrangements. It also conducted a literature review; considered relevant national data; spoke to survivors of domestic abuse; and surveyed teachers in a small number of schools.

1.4. The multi-agency response to children living with domestic abuse: prevent, protect and repair, reports on current response and service provision, explores commonalities and draws out key observations:

- It is essential to maintain focus on the perpetrator of abuse.
- Children need to be understood and supported as individuals as their experience and needs may differ – children and young people should always be considered within the context of responding to domestic abuse.
- Responses need to be age appropriate to the child or young person, to allow for different levels of understanding and awareness at different ages.
- A holistic view, not just of one incident or person in the family, is needed.
- It is good practice to acknowledge and work with complexity, for instance where mental health, substance misuse or other factors may be present.

- It is important to avoid putting too much responsibility on victims, and ensure appropriate support is in place for them.

- Be aware that separation can be as, if not more, dangerous to victims and that leaving an abusive situation may not mean the end of domestic abuse.

- Domestic abuse is often a pattern across a timeline, rather than an isolated incident - it is crucial to recognise that ongoing work is needed.

- We must begin to consider how to move from crisis response to prevention and earlier intervention.

- Responding effectively in a crisis is not enough - professionals should be enabled to respond well in non-crisis and post-crisis situations.

- Improving information and education for children and young people may support them to be aware of what they are experiencing and encourage them to talk about it.

2. Key Findings

2.1. The principal findings from the JTAI that are discussed in more detail in the remainder of this report are as follows:

- Professionals have made progress in dealing with the immediate challenges presented by the volume of cases of domestic abuse. However, domestic abuse is a widespread public health issue that needs a long-term strategy to reduce its prevalence

- Accepted practice in tackling social problems is to prevent, protect and repair. While much good work is being done to protect children and victims, far too little is being done to prevent domestic abuse and repair the damage that it does. Work with families was often in reaction to individual crisis

- Work with families was often in reaction to individual crises. Agencies can be overwhelmed by the frequency of serious incidents, particularly higher risk ones. However, keeping children safe over time needs long-term solutions.

- The focus on the immediate crisis leads agencies to consider only those people and children at immediate, visible risk. As a result, agencies are not always

looking at the right things, and in particular, not focusing enough on the perpetrator of the abuse.

- There is still a lack of clarity about how to navigate the complexities of information sharing. There needs to be greater consistency in the definition of harm, and in the understanding of whose rights to prioritise.

2.2. The report draws out the learning from multi-agency working arrangements, as well as learning for individual agencies, against each of the key findings.

Key Finding 1: Professionals have made progress in dealing with the immediate challenges presented by the volume of cases of domestic abuse. However, domestic abuse is a widespread public health issue that needs a long-term strategy to reduce its prevalence	
Multi-agency learning	• Whilst a lot of good work has been done by agencies to improve the understanding of domestic abuse, there needs to be a more systematic focus on perpetrators' behaviour and preventing abuse of their victims. • The main priority for professionals is to ensure the safety and well-being of children and victims of abuse • Ongoing support for victims, children or perpetrators, worked best when it was family-centred and the most successful interventions seen were multi-agency based e.g. In Hounslow, there is a *'One Stop Shop'* service for parents who are subject to DA; in Wiltshire, agencies used daily 'domestic abuse conference calls' to share information • Inspectors noted strengths in working with communities and minority groups in some local authorities
Health	• Midwifery was highlighted as a strength by inspectors in five out of six local authority areas with evidence that midwives were knowledgeable about the risks of domestic abuse and the additional risks to unborn children **Good Practice:** • In Salford, inspectors highlighted the emphasis on early intervention by midwives as an area of good practice • Good information sharing between agencies, and good assessment and intervention with families using a *'family-led'* approach • An outreach team supported couples with healthy relationship work when domestic abuse had been identified
Local Authority	**Good Practice:** • Good use of age-appropriate tools to understand the range of risks that children face (Lincolnshire) • Strategic overview of domestic abuse undertaken that aided the understanding of patterns and trends (Lincolnshire)
Key Assurance Questions:	
Multi-Agency	1. What work is undertaken in respect of perpetrator behaviour and preventing abuse of their victims
	2. Is any work being undertaken with communities and minority groups
Health	1. Do Health partners have robust pathways re domestic abuse and has there been any recent audit activity
Local Authority	1. Does the LA understand patterns and trends re domestic abuse?
	2. What age-appropriate tools are used to understand the range of risks that children face

Key Finding 2 There is still a lack of clarity about how to navigate the complexities of information sharing. There needs to be greater consistency in the definition of harm, and in the understanding of whose rights to prioritise.	
Multi-agency learning	• There is not a clear and consistent understanding about what information professionals can share within and across agencies. • The **Adoption and Children Act 2002** extended the definition of harm to include *'impairment suffered from seeing or hearing the ill-treatment of another'*. However, this definition of harm does not appear to be fully taken into account in information-sharing practice between agencies. • There are misconceptions about what the law requires, particularly within health services where staff did not have a consistent understanding of when information could be shared within health and with other agencies. • There was a lack of consistent understanding of when agencies should share information quickly even where they have issues obtaining parental consent. • Inspectors found that professionals across health, social care, police and probation asked about domestic abuse when recording systems included prompts, but sometimes, even where there were prompts, considered they could be ignored. This was most often in health services. • Across the workforce, there were examples of a lack of skill in identifying risk, which leads to information not being shared in a timely way. There was a tendency to see information in isolation, rather than the bigger picture, which meant professionals did not see the need to share the information. There were also weaknesses in recording information.
Health	• The complexity of the health service and of the systems across the health service are barriers to information-sharing • Multi-agency information on children was sometimes missing from school nurse records • School nurses did not always have access to important information from other agencies (due to not being represented at meetings) • 2 x areas: school nurses not having access to information from other parts of the health service • 3 x areas: school nurse documentation did not always record domestic abuse information **Good Practice:** • Monthly safeguarding care meetings in a GP practice, which brought together a range of individuals including a community police officer, military welfare officer, community mental health, and troubled family work

	• 1 x area: Partnership between a GP practice and a domestic abuse service that enabled people to book appointments with independent domestic violence advisers **Areas for Development:** • Not all GP practices have well-established meetings about vulnerable families where information on known or emerging vulnerabilities, including domestic abuse, can be shared between health visiting, school nursing and primary care • 1 x area: Inspectors found three instances of GPs not being asked to contribute to assessments completed by social workers.
Probation	• *'Virtual partners'* such as the National Probation Service (NPS) and CRC, find communication more of a challenge. • 2 x areas: there were concerns that the CRC was not always included appropriately, for example at strategy discussions or core group meetings. • 1 x area: In one area, it was evident that the full implications of the changes to CRC and NPS had not been fully understood and knowledge of the roles of the organisations was lacking
Schools	**Areas for Development:** • In a minority of cases, teachers' concerns may not be shared with all of the appropriate professionals due to perceived barriers around 'confidentiality'. One teacher felt that this 'restricted a clear understanding of a child's situation' or involved leaving out a key piece of information • Teachers also felt that sometimes not enough information was shared with them by other agencies to help them protect or work with children living with domestic abuse. This included any historically significant information about the abuse, as opposed to just current incidents • Referrals relating to emotional harm to children are not always taken as seriously by children's social care as those relating to physical harm or neglect • Agencies need to share information more readily and more efficiently with schools in order to protect children better. In some areas inspected, there has been work to make improvements in this area through the implementation of *Operation Encompass*, where police contact a school's 'key adult' by 9am if a child has been involved in an incident of domestic abuse. Providing information is managed securely and appropriately, Operation Encompass can be an effective information-sharing model

Key Assurance Questions:	
Multi-Agency	1. Is the partnership clear on information sharing and risk assessment?
	2. Do the partnership have an understanding of the changes in CRC and NPS
Health	2. What is the level of involvement of GPs re domestic abuse?
Probation	1. Are CRC routinely invited to strategy discussions/ core group meetings?

Key Finding 3: Accepted practice in tackling social problems is to prevent, protect and repair. While much good work is being done to protect children and victims, far too little is being done to prevent domestic abuse and repair the damage that it does. Work with families was often in reaction to individual crisis	
Multi-agency learning	• Communicating a better understanding of the behaviour and attitudes of those perpetrating abuse. • Perpetrators often present a continued risk to their partners and children. If agencies fail to address the perpetrators' behaviour, the perpetrator can leave their home without any follow-up action and repeat the behaviours from afar or in a new relationship. • There needs to be a focused effort across agencies to develop and test interventions. • Not all agencies inspected were providing services to help respond to the emotional needs of children • Professionals did not always recognise that, though not always, separation could escalate risk. They did not sometimes realise that the abuse does not end when people stop living together. • Children sometimes feel as though they are to blame for the separation of their parents. Understanding the emotional impact, and the signs of the emotional impact, can be more challenging for professionals than identifying physical injury
Social Care	**Areas for Development:** • Varying needs of individual children meant that some were less well understood than others. This means that attention was not always given to all brothers and sisters within the same family. • The voices of very young children was sometimes missing from assessments. This was sometimes because they were seen as too young to give a view
Health	**Areas for Development:** • Children were not always considered by adult mental health professionals. Inspectors identified that this was because adult mental health services worked in isolation and did not explore childcare responsibilities or contact with children • The focus of the needs of the adult patient was also sometimes a factor in children being missed by other health practitioners • The complexity of health services and health systems can make it hard for all children to be seen and their experiences fully taken into account. This lack of coordination and collaboration adversely affects continuity of care.
Police	**Good Practice:** • Consistent engagement by Police with children during their attendance at each incident can build a relationship with children that will encourage them to engage with adults who can help them

	Areas for Development: • Police records did not show how officers engaged with children e.g. what the child said and their demeanour. This critical information should be recorded more consistently to inform the initial risk assessment and shared as part of the police referral to children's social care services.
Probation	• Agencies, particularly probation providers, may be missing the bigger picture around containment of the perpetrator and their behaviour. For example, sometimes, probation providers assumed that a perpetrator was contained when sentenced to custody. However, they can continue their abuse from prison. • Probation providers also needed to respond better to new risks, such as when perpetrators entered a new relationship
Cafcass	**Good Practice** • Thorough and comprehensive analysis of risks of domestic abuse to the children and families was evidenced in a significant proportion of Cafcass cases. • Family court advisers used a good range of tools to assess risk of domestic abuse • Practice was appropriately proportionate to the role of Cafcass. This enabled children's needs to be identified and informed appropriate decision-making and advice to court **Areas for Development:** • In a minority of Cafcass cases, there was insufficient gathering of children's views • There was not consistent evidence that the needs of the child were sufficiently taken into account when considering how their views should be gathered • Information-gathering from other relevant agencies was not consistently robust. There was also variation in family court advisers' level of understanding about the emotional impact of domestic abuse on children
Schools	**Good Practice:** The following range of services were offered across a number of schools to help prevent, protect and repair the damage caused by domestic abuse: • posters for Childline, Safer Schools and NSPCC and assemblies to raise awareness. Some schools also offer *'Feel safe at home'* booklets • alongside visits from charities, some schools also had visits from local police officers to talk to children about domestic abuse and coercive control

	• training for teachers and for the safeguarding team aimed at identifying and referring children who are living with domestic abuse to the appropriate agencies • counsellors and play therapists to work with children who have suffered domestic abuse • one-to-one learning mentors to help children build emotional resilience • providing telephone numbers to parents who may need domestic abuse support services. One teacher gave an example where these can be disguised in keyrings or pens where the phone number looks like a bar code • referrals for parents to mediation or counselling services, in some cases for free. **Areas for Development:** • Sporadic or limited resources are available across agencies, particularly for direct work with those children who have witnessed domestic abuse • Not all schools covered domestic abuse in the home as part of their curriculum.

Key Assurance Questions:	
Multi-Agency	1. Have agencies developed and tested any interventions? 2. Do we understand the varying needs of children of different ages who are living in households were domestic abuse is prevalent?
Social Care	1. Does audit activity reflect the findings from the JTAI re needs of individual children and voice of the child in assessments
Health	1. Do adult-facing services effectively take into consideration children
Police	1. Has any audit activity been undertaken in respect of police engagement with children?
Probation	1. Probation to determine if the findings from the JTAI resonate with current practice
Schools	1. Is domestic abuse in the home covered as part of the curriculum?

Key Finding 4: Work with families ……. was often in reaction to individual crises. Agencies can be overwhelmed by the frequency of serious incidents, particularly higher risk ones. However, keeping children safe over time needs long-term solutions	
Multi-agency learning	• There is a pattern of *'incident-led'* responses - short-term and focused on the immediate incident, not the bigger picture (i.e. moving victims/ children away from the perpetrator). • Professionals sometimes failed to connect isolated incidents and build a picture that would lead to a different conclusion about the level of risk • Professionals must understand the history of the abuse and the trajectory of its severity • The wider implications of living with domestic abuse were not well understood • More could be done by agencies across all six local authorities inspected to work through the risks associated with being a family that services do not as easily reach. By challenging those attitudes and reframing what it means to be in a healthy relationship, there was evidence of some very effective multi-agency work by professionals who were sensitive to families' contexts. • Where risk was lower, there was evidence of some effective work to support healthy relationships between parents e.g. therapy with children; support for mothers accessing volunteering and self-esteem raising groups, as well as groups for perpetrators
Police	**Good Practice:** • In high-risk situations, the response from police was often assured. This included strong processes with quick arrests. The primary consideration was the initial safeguarding of the victim and children. **Areas for Development:** • The lack of a longer-term response was a particular issue for Police who often assessed risk in isolation and concentrated on the incident they attended rather than taking a more holistic approach. This included grading domestic abuse incidents in isolation without taking full account of the history of the case or full account of the history of people involved in the case.
Key Assurance Questions:	
Multi-Agency	1. Is the learning from the JTAI reflected in the Domestic Abuse; MARAC and Trio of Vulnerabilities training

Key Finding 5: The focus on the immediate crisis leads agencies to consider only those people and children at immediate, visible risk. As a result, agencies are not always looking at the right things, and in particular, not focusing enough on the perpetrator of the abuse	
Multi-agency learning	• The focus is often primarily on the victim, both in terms of keeping the victim safe and sometimes looking to the victim to manage the abusive situation. • Most agencies did not focus on the perpetrator of the abuse enough. Perpetrators often present a continued risk to their partners and children. If agencies fail to address the perpetrators' behaviour, the perpetrator can leave their home without any follow-up action and repeat the behaviours from afar or in a new relationship. • When a universal service first recognises that domestic abuse may be a factor, the first line of action should be to give access to specialist support that will target the perpetrator's behaviour. At this stage, the level of intervention needed to halt it becoming more serious is much less challenging (& costly) for the perpetrator to engage with • There is an assumption that is built into the system that the victim should leave the abuser. Commissioners still build a requirement into contracts that services only be provided when the victim and perpetrator have separated. This can be disastrous for children: disruption to the child's life; arrangements to leave cannot be made until after separation. The new ***system transformation planning*** in health is an opportunity to commission differently. • Schools also have an essential role in educating children about domestic abuse. Education for children about healthy relationships is already part of the curriculum, but it is often not part of the curriculum that is prioritised by schools.
Probation:	**Areas for Development:** • Inspectors found delays or waiting lists in relation to probation services in three of the local authorities inspected. In one area, this was the result of poor multi-agency working. In three areas, inspectors highlighted long waiting lists for domestic abuse interventions provided by the Community Rehabilitation Company (CRC).
Cafcass:	**Good Practice:** • In one Cafcass case, the perpetrator had mental health issues. The case was dealt with well because the family court adviser addressed the complexity of the relationship, including identifying coercive control and supporting the relationship while the perpetrator was under a restraining order. Sensitive direct work with the children and each parent involved good use of a range of

	effective tools, including specific domestic abuse tools. This supported a good analysis and understanding of risk and appropriate recommendations **Areas for Development:** • Notable absence of attention given to the perpetrators of abuse, compared to the victim. • There can be a lack of clarity from professionals about the impact of coercive control • It takes skill and insight to identify that untruths or attempts to distract or mislead by the victim may be a coping strategy • Some of the thinking and practice with victims in contexts of coercive control was inappropriate e.g. the use of written agreements that placed responsibility for managing the risk to children with the victim. This places the onus on the victim to police the situation. • Instances of language being used that incorrectly held victims responsible for the risk of domestic abuse. For example, reports that described an abusive situation as a *'lifestyle choice'* and reports stating that victims had learnt to *'make better relationship choices'*. • Instances of inappropriate practice, including a police log that had been updated to state that a safeguarding visit would not be completed because both parties were *'as bad as one another'*. • Significant gaps in the services available for adult perpetrators of domestic abuse meaning that the work to prevent further abuse by perpetrators was absent in too many cases seen. This presents serious risks for those children who are subject to repeated domestic abuse or to other children as the perpetrator moves on to live with another family.
Key Assurance Questions:	
Multi-Agency	1. Is the learning from the JTAI reflected in the Domestic Abuse; MARAC and Trio of Vulnerabilities training 2. As a partnership do we recognise and respond quickly to coercive controlling behaviour?
Health	1. Update to be provided to the Board re ***system transformation planning*** in health as an opportunity to commission differently.
Probation	1. Are there waiting lists waiting for domestic abuse interventions provided by the Community Rehabilitation Company (CRC)?
Education	1. Is the PSHE curriculum delivered by Sandwell Schools covering the current issues on domestic abuse 2. What support is offered by schools to children who are living in households with domestic abuse

3. Conclusion

3.1. Domestic abuse may be endemic, but it is not inevitable and it is possible for prevalence to decline.

3.2. Agencies in Sandwell should now use the findings from the JTAI as a platform to benchmark themselves against. This will help inform Sandwell address 's approach to domestic abuse

3.3. Developing practices could be helpfully borrowed from parallel areas of work. The contrast between practices identified in a recently completed JTAI on child sexual exploitation and the practices in domestic abuse is stark. Most practice in preventing child sexual exploitation is now intently focused on the perpetrators of this abuse. Local areas build perpetrator profiles and they focus on disruption whereas this appears to be lacking in the area of domestic abuse.