Report on Who's in Charge (WiC) Programme for the Humberside Office of the Police and Crime Commissioner

Full Report

Executive Summary:

- *Who's in Charge* is a solution-focused support programme for parents and caregivers of children aged 8 to 18 years, who are experiencing Child and Adolescent to Parent Violence and Abuse (CAPVA).
- The WiC programme delivered through Blue Door received 398 referrals between April 2020 and September 2022; 92% of clients were female and 76% of clients had more than one child.
- This evaluation used focus groups and interviews with clients and staff and routinely collected referral data to examine the strengths, weaknesses, opportunities, and threats of the programme.
- Developments to WiC include: 1) early intervention with younger children and siblings (aged 4-8), 2) specific sessions about neurodivergent children, 3) establishing a clear referral map and, 4) expansion of online and digital resources will provide opportunities for service growth and early intervention for families.
- Lack of clarity on behalf of external agencies about the most suitable CAPVA intervention for families, difficulties in streamlining referrals, and the frequency of the intergenerational impact of violence and abuse has the potential to be addressed by situating WiC within a wider programme of violence interventions, such as the Violence Prevention Partnership (VPP) or the Serious Violence Duty.

Key Recommendations*:

1. Development of a full referral map in – and out – of the Who's in Charge Service that includes the eligibility criteria. This would provide opportunities for co-work in areas of specialism beyond the Who's in Charge Service.
2. Clearly defined outcome measures with a 6-month (and possibly 12 month) follow-up to assess behavior change and re-engage with families as required.
3. Develop an early intervention route into Who's in Charge Service for younger children (ages 4 – 8) and emerging needs of younger siblings.
4. Develop a neurodiversity package within the Who's in Charge Service (with links to external referrals directed to appropriate services).
5. Opportunity for the Who's in Charge Service to provide outreach and training for law enforcement, education, social care, primary care and mental health services. This could also include additional resources / support tailored for grandparents and other types of parenting relationships.
6. Expand and develop the online and digital resources to extend and increase delivery capacity. Zoom and WhatsApp very positively received but potential not fully realized.
7. Alignment with Violence Prevention Partnership (VPP) and Serious Violence Duty could help address systemic, intergenerational domestic abuse and provide resources to support many of the above recommendations.

*Based on interviews with staff and parents and informed by wider scoping review of other projects and existing research.

HUMBERSIDE POLICE & CRIME COMMISSIONER

UNIVERSITY OF HULL

Section 1: Research Context, Methods and Findings

Who's in Charge

Who's in Charge is a solution-focused parenting support programme developed by Eddie Gallagher in Australia (in Holt, 2015). Emerging from support groups for mothers who experienced CAPVA, the aim of the programme is to empower parents through a supportive environment and solution-focused discussions, to build self-esteem and reduce shame, and to encourage practical changes by implementing consequences to change unwanted behaviour. Based on the idea that parental guilt about being victimised by their child may contribute to sustaining unbalanced power dynamics in the parent-child relationship, *Who's in Charge* emphasises parental assertiveness and self-care, while discouraging victim-blaming perspectives on CAPVA. This programme acknowledges that young people engaged in CAPVA are unlikely to meaningfully engage with CAPVA interventions initially, and that sessions with CAPVA instigators and victims together may cause violence and abuse to escalate. For these reasons the *Who's in Charge* programme focuses on working to support and empower parents, who are likely more motivated than the young person to enact change in the home. The programme is aimed at parents and caregivers of children aged 8 to 18 years.

Who's in Charge is a structured group support programme, typically consisting of nine sessions in a three-part structure, involving worksheets, hand-outs, and group discussions. The first part of the programme focuses on understanding the nature of CAPVA, related parental attitudes about their child's behaviour, and exploring the roles of entitlement, shame, and power in the parent-child relationship. The second part of the group focuses on the use of consequences in parenting, aiming to empower the parents to become more confident and assertive. This section also explores the difficulties of identifying appropriate consequences and implementing them in a safe and practical manner for both the parents and child. The final section of the programme supports parents to sustain and reinforce changes within the home, as well as exploring topics such as anger (both from the parent and from the young person), self-care, and assertiveness. The programme is followed up 2 months after completion with a group session exploring goal achievement and evaluation of the impact of the programme, as well as providing support for parents to set future goals and sustain changes.

Who's in Charge is recognised as an emerging effective practice from the Youth Justice Board for England and Wales (Baker & Bonnick, 2021). There are no specific protocols for working with neurodiversity, English as a second language, or additional learning needs. Gallagher (in Holt, 2015) highlights that due to the use of handouts and worksheets in sessions, those who struggle with reading and writing may experience barriers in the programme, however there are no recommendations for ameliorating these difficulties. Anecdotally, Gallagher reports that over two-thirds of young people demonstrate meaningful changes in CAPVA-related behaviours. There are no published quantitative data relating to programme effectiveness, Gallagher states that a qualitative evaluation was conducted in 2007, however this report is not currently available.

The *Who's in Charge* Service in Humberside is managed and delivered by *Blue Door*, a Community Interest Company (CIC) based in Scunthorpe, Grimsby and Hull. They are a specialist service that provides support to anyone that has experienced domestic abuse and sexual violence in North and Northeast Lincolnshire, or experienced rape and serious sexual offences in Hull and the East Riding of Yorkshire through a variety of advocacy, outreach workers, groups and programmes.

Overview and Definition

Over the past decade there has been a growing acknowledgment of the prevalence of child/adolescent to parent violence and abuse (CAPVA), however it remains one of the least studied types of family and interpersonal violence (Simmons et al., 2018). There exists no legal definition of CAPVA in the UK (Sanders, 2020) and defining precisely what CAPVA is becomes further complicated by different disciplines using inconsistent definitions and varied conceptual frameworks on which interventions are based. Broadly, CAPVA describes a range of violent, harmful, or controlling behaviours, which includes acts, by a child under the age of 18 years, of psychological, physical, emotional, coercive, sexual, or financial abuse toward a parent or primary caregiver (Brennan et al., 2022; Holt, 2016).

Some studies include any single incident of CAPVA in the definition whereas other categorise CAPVA as "a pattern of behaviour" (Simmons et al., 2018) which complicates the range of experiences that be defined as CAPVA. Furthermore, there are many terms which refer to this phenomenon, such as Child to Parent Violence (Wilcox et al., 2015), Child to Parent Abuse (Simmons et al., 2018), and Adolescent Violence in the Home (Sutherland et al., 2022). The variations in the labels and definitions of CAPVA reflect the lack of consensus among disciplines and agencies regarding how CAPVA is conceptualised and understood in context.

This report will use the term CAPVA, in recognition that abuse is not always physical, nor always well-represented by the term 'violence', and to acknowledge the wide age range of young people who enact CAPVA.

Prevalence of CAPVA

The prevalence of CAPVA in the UK is currently difficult to distinguish, due in part to the inconsistent definitions and variety of methods which can be used to assess prevalence rates. Further obscuring true prevalence rates of CAPVA is the hidden nature of this phenomena, similar to other types of abuse, victims feel high levels of shame and stigma which can result in hesitance to disclose what is happening or lead to a fear of repercussions from their child (Burck et al., 2019). Additionally, some parents and caregivers choose not to report occurrences of CAPVA due to mistrust of police or social services, worries about their child being removed from the home, or fears of criminalising the young person and affecting their future as an adult (Brennan et al., 2022).

In large-scale population surveys from the US, Canada, and Australia, prevalence rates range from 4.6% to 20% (Holt, 2021), and one examination of CAPVA across five European countries (England, Ireland, Bulgaria, Sweden, and Spain) estimated that CAPVA affects 1 in

10 families (Wilcox et al., 2015). Community based survey data often reveals even higher prevalence rates. Simmons et al.'s (2018) literature review estimated the prevalence of physical CAPVA to be between 5% and 21%, and psychological CAPVA to be between 33% and 93%, however this study did not differentiate between single instances of violence and patterns of behaviour, which likely contributes to the large range of these prevalence estimates.

In the UK, a small number of studies have utilised self-report survey data from young people to estimate the prevalence of CAPVA. One cross-sectional study examined CAPVA among 890 secondary school students in England (aged 11 to 18 years) and revealed that 64.5% of the sample reported an incident of either psychological (64.4.%) or physical (4.3%) CAPVA in the last 6 months (McCloud, 2017). However, these results do not necessarily represent patterns of abuse because the responses 'sometimes' and 'often' are combined in these figures, which may lead to inflation of the rates of abuse. Another study explored the prevalence of CAPVA among a sample of 210 college students in England (aged 16 to 18 years) and reported lower frequencies of psychological and physical patterns of CAPVA (Baker, 2021). This study more clearly distinguished between one-off incidents and patterns of behaviour, revealing that 94% reported psychological aggression and 18% of the sample reported physical aggression to parents at least once. The author devised six thresholds of patterns of physical and/or psychological abuse to identify potential cases of CAPVA; overall 10% of the sample met these criteria.

It is also possible to estimate the prevalence of CAPVA by examining police and crime statistics and youth justice samples. Although these data are likely to be lower than the true prevalence, due to under-reporting on behalf of victims, and potential areas of bias in arrest and prosecution rates leading to boys being more likely to be identified in these samples (Sanders, 2020). Brennan et al. (2022) examined CAPVA-related offences across London, using Metropolitan Police Service (MPS) incident data from 2018 to 2020, as well as data from the annual Crime Survey for England and Wales (CSEW) from 2011 to 2020. Their analysis revealed that 60% of incidents reported to MPS involved physical violence (violence against the person), with a lesser proportion consisting of criminal damage (25%). Though this data is limited because MPS only record a primary offence, therefore it is possible that multiple offences were committed but only one could be recorded. Furthermore, analysis of CSEW data revealed that approximately 40% of CAPVA victims did not report any offence to the police, which limits the utility of using police and crime statistics to estimate CAPVA prevalence.

Methodology

This report provides an independent review of the Who's in Charge programme, which is conducted through The Blue Door based in North and Northeast Lincolnshire. The aim of this review is to investigate the referral processes, programme delivery, and outcomes of Who's in Charge, in order to provide further information about the strengths of the programme and to enable identification of opportunities for enhancement.

This evaluation combined focus group interviews, individual interviews, and routinely collected data about the Who's in Charge programme to examine the referral processes currently in place and explore the views and experiences of clients and staff who have been involved in the programme. The dataset provided by The Blue Door revealed essential information about the delivery of the programme and routinely collected information from clients from 2020 to 2022. To expand upon this information and provide a deeper understanding of the programme, focus groups with Who's in Charge clients and staff, and an interview with the Who's in Charge manager were conducted.

Participants for the two focus groups and the individual interview were identified and recruited through The Blue Door, and data collection and analysis were conducted by the research team at the University of Hull. Ethical approval was granted from the FACE ethics committee at the University of Hull, and all participants provided informed consent verbally. The client focus group consisted of four parents and grandparents who had completed, or were currently participating in, the Who's in Charge programme. The staff focus group was conducted with three employees of The Blue Door who facilitate the Who's in Charge programme, their job titles included Family Harm Prevention Worker, Senior DA Prevention Worker, and Young Person's Harm Prevention Worker. An individual interview with the Who's in Charge manager was also conducted. All qualitative data collection used a strengths-based approach which focused on positive experiences and outcomes of the programme and explored what could be done to further enhance the Who's in Charge programme.

We conducted a SWOT analysis of each qualitative data source, which enabled us to identify the overall Strengths, Weaknesses, Opportunities, and Threats of the Who's in Charge programme from the perspectives of clients, staff, and the delivery manager. The findings were combined to provide an overall impression of what is currently working well and to identify areas which could be expanded upon to provide additional value or opportunities to enhance and streamline the delivery of the programme. The following sections provide an overview of the findings from the routinely collected data, focus groups, and the individual interview, and recommendations based upon these findings will be discussed.

All results are presented anonymously and although we interviewed the manager separately, we have taken the decision to merge any quotes from the manager with the wider staff group to avoid breaching anonymity. Any identifying details or context were altered or removed for the same reasons, and we have generally sought to include those quotes that are representative of the general sentiment and that don't relate any personal details.

Results: Referral and Demographic data

Between April 2020 and September 2022, the Who's in Charge programme at Blue Door received 398 referrals (see Table 1). The service demonstrated rapid growth between

the first and second year of operation and appears to be maintaining this level of service into the third year. Overall, 45 out of the total 398 were repeat referrals, demonstrating that the service is continually reaching new clients and the majority are not re-referred. Clients were referred from a range of agencies and organisations, the three most common referral pathways were from Children and Family Support Services (*N* = 99), Children and Young People Services (*N* = 91), and directly from the young person's school (*N* = 74).

Table 1: Who's in Charge (Blue Door) Referral Information

		2020-2021	2021-2022	2022 (APRIL – SEPTEMBER)	TOTAL (2020-2022)
NUMBER OF REFERRALS		35	243	120	398
REFERRED FROM	Blue Door Support Services CIC	9	20	15	44
	Children and Young People Services	8	55	28	91
	Children and Family Support Services	7	62	30	99
	Self-referred	4	23	7	34
	School	5	42	27	74
	FASST	1	15	5	21
	Young Minds Matter	1	4	3	8
	Police	0	10	1	11
	Family Hub	0	3	0	3
	CAHMS	0	1	0	1
	Compass GO	0	1	0	1
	Carelink	0	1	0	1
	Health Visitor Team	0	1	0	1
	Youth Offending Services	0	2	2	4
	Carer group/agency	0	2	0	2
	Adoption and Fostering Team	0	0	1	1
	Mind	0	0	1	1
	Agency not on system	0	1	0	1
NEW OR REPEAT	New	35	219	99	353
	Repeat	0	24	21	45

Table 2 demonstrates the demographics of the adult clients referred to Who's in Charge. Most people referred to WiC were female (92%), White British (91%), and had been assessed to be a standard level of risk (90%). Only one individual in the data from 2020 – 2022 was assessed to be a very high level of risk. The ages of adult clients referred to WiC ranged

from 25 to 76 years, with a mean age of 40 years (SD = 8.41), although it should be noted that 15 clients had not provided their age or date of birth, and therefore were not included in this analysis.

The number of children of people referred to WiC ranged from 0 to 8. Those recorded as having 0 children typically meant that the children were not currently in the care of the client, or the client was a grandparent or other relative. 76% of clients had more than one child (see Table 2). Nearly one third (28%) of clients were classified as registered disabled in relation to mental health, far higher than physical (4%) or learning disabilities (2%). The genders and ages of children, and whether they had any disabilities or additional needs, were not recorded.

TABLE 2: Demographics of clients in Who's in Charge (Blue Door) 2020-2022

		2020-2021	2021-2022	2022 (APRIL – SEPTEMBER)	TOTAL (2020-2022)
GENDER	Female	30	229	111	370
	Male	5	14	9	28
AGE	18 - 35	9	85	35	129
	36 – 50	20	122	61	203
	51 +	6	26	19	51
	Unknown	0	10	5	15
RISK LEVEL	Standard	30	218	110	358
	High	4	24	9	37
	Very High	0	0	1	1
	Unknown	1	1	0	2
NUMBER OF CHILDREN	0	2	12	3	17
	1	8	46	22	76
	2	13	70	40	123
	3	5	66	30	101
	4+	7	49	24	80
DISABILITY	Physical	2	3	10	15
	Mental health	7	75	29	111
	Learning	0	5	3	8

Results: SWOT Analysis

These results are based on the interviews conducted with parents and grandparents who have gone through the *Who's in Charge* programme and staff who manage and deliver the programme for *Blue Door*. The results are structured in the form of a 'SWOT' analysis (Strengths, Weaknesses, Opportunities and Threats) which provides a useful way of organising what information people told us that has directly informed the Key Recommendations at the start of this report.

Strengths:

The importance of group-based work, peer-support and the use of a WhatsApp group were deemed to be particularly beneficial by both parents and staff:

> *you knew people weren't going to judge you because everyone was in the same boat (…) so you can just be open and honest about the things you were struggling with and I think that's important, and you have to kind of give that vulnerability to get something out of it* (Parent)

> *for someone to be able say 'come on we'll support you' and there's peer support within the group I think that's huge, and you can actually see them start to grow in the group as the weeks go by* (Staff)

This sense of support was further enhanced by the use of a WhatsApp group which allowed parents to talk to each other and offer support 24/7. As one staff member put it:

> *we started at the end of the group saying 'how about you form a WhatsApp group between you all', because obviously we only work Monday to Friday 9-5, so then they've got that added support after we finish working, and we've been doing that now for every group that we've done (…) I do that's very beneficial to have that and have it as a closed group and not an open, rolling program* (Staff)

This sense of being able to talk to other people living through the same experience was deemed hugely valuable by the parents. In particular, the sense of not being judged – or having to explain – made people feel more comfortable talking about their experiences. The 'closed' WhatsApp group allowed this sense of group cohesion and support to develop and sustain itself after the programme ended.

Related to this, one surprising result was the value parents and staff placed on the 'online' delivery of the programme using Zoom. At one level it feels counter-intuitive that remote delivery would make people feel comfortable, but the overwhelming opinion was that the online format worked well, made people feel more comfortable and safer:

> *when I'm doing the Who's in Charge program [online] I've found definitely that people … if they're not sat in a room with somebody, they seem to be able to be more open, and maybe tell us more than they would tell us if they were in a room being looked at directly by somebody. So, I think they actually feel more open to sharing their experiences online* (Staff)

> *[on Zoom] we've got a lot less people missing sessions, I think because it's online for those who maybe have previously worried about the anxiety of how they're portrayed in front of people and face to face, this is a nice barrier and a nice support and protection for them* (Staff)

Whilst some parents expressed initial anxiety about meeting online, they all told us that they quickly became more confident as they had used various video-conferencing platforms during COVID-19 lockdown. The logistical advantages of not having to travel (especially in terms of managing childcare, work obligations and travel costs) were seen as very beneficial. Similarly, familiar surroundings made parents feel more relaxed and less like they were under a

'microscope'. **Key Recommendation 6** which proposes the development of the online and digital capacity of the project stems from these strengths identified through the interviews.

Beyond the clear importance of the group dynamics and peer-support, another major strength that was identified was the way in which the programme engendered a positive mindset and behaviour change in parenting style:

> *things changed for me straight away, as in my mindset, but things we were implementing took time* (Parent)

> *sometimes you can feel like the process is slow, but it is going in the right direction and it's just about having the momentum and the motivation and having the support behind you to just keep going* (Parent)

> *what I like is when they [clients] say 'really enjoyed it, can't wait for next week, it can't come quick enough'. And it's just all the positivity, because they come on that group so negative, so negative, and I always say that by about week 2 or 3 you will start to look at things differently and you will become more confident and help your self-esteem, you'll be talking with the other parents, you'll all associate with each other … and I just love it, some weeks I can just well up with that feeling of how far they've come in such a short space of time* (Staff)

Underpinning this positive change was a strong sense of 'mission' by the staff who clearly felt a commitment to the programme, to the families on it, and to each other. A core strength of the programme is therefore the cohesion and shared vision of the staff group:

> *I absolutely love it [Who's in Charge]. I just think that it's such a good thing that's come across to this area* (Staff)

> *on top of that, on offer through the service, we get our case supervision, personal supervisions, and we can also have clinical supervision as well, so there's a really positive network of support from colleagues and management and the whole Blue Door team* (Staff)

> *the people that we've got on our staff (…) they're very much client-focused and on getting that result* (Staff)

The relationship between staff commitment and parent group dynamics cannot be underestimated. Unfortunately, it is also difficult to measure, meaning that there is currently no way to meaningfully assess the importance of these relationships. **Key Recommendation 2** could however include a measure for these relational dynamics that can then be related to changes in child / adolescent behaviour.

<u>Summary of Strengths:</u>

1. Importance of group-based work, peer-support and use of WhatsApp group are particularly valuable
2. Online format works well, increase in attendance and increased comfort and feeling of safety for participants
3. Positive mindset & behaviour change in parents, 'breaking the cycle of abuse'

4. Passionate staff who are good at building relationships with participants, and staff feel well supported within the team, with multiple avenues of seeking support

Weaknesses:

There were two weaknesses identified during the interviews. The first of these is a dissonance between the parent and staff group regarding the role of neurodiversity in a child's behaviour:

> *it still confuses me as to which behaviours are driven by the autism and that I need to be compassionate to and understanding of, and which behaviours are the ones that need the consequences and the challenging and dealing with … and it's just trying to find that balance* (Parent)

> *I (….) have a child with ADHD, ODD, autistic tendencies, anxiety disorder, attachment disorder to me, and it (…) was a minefield of what is classed as learned behaviours, whether that's within the home or outside of the home like at school, or what is actually linked to my child's conditions* (Parent)

> *"[they're saying] 'my son's got to be diagnosed, there's something wrong with him' … however what we say to them is 'even though your child, you think and you believe that he has got some diagnosis, all our tools and strategies are the same for everybody', because not all children with a diagnosis misbehave like some of the children do who come on our programs, or some of the children of the parents on our programs* (Staff)

> *I think sometimes referrals are probably mis-referred, because the child might be diagnosed with ADHD or autism, and it's probably not the right particular programme- there might be other agencies that should be involved, but due to time scales and waiting lists and things like I just feel like, it's very rare that we'll say 'no I'm not accepting that', unless it's obvious that we can't, but then if we're able to give the parents some strategies to deal with the behaviour until such a time that the child can get through the waiting list if they need a diagnosis, then we're more than happy to take them on* (Staff)

No single programme can realistically be expected to meet the complex needs of every child. The staff group generally seemed to ascribe to the view that they can offer help with the parenting skills whilst the parenting group exhibit some frustration about more specialist needs regarding neurodiversity. Some of this dissonance is almost certainly to do with the nature and focus of the Who's in Charge programme compared to how parents make sense of their children's behaviour. This issue represents one of the key challenges for the *Who's in Charge* programme and is the cornerstone of **Key Recommendations 1 & 4.**

Another weakness that both parents and staff pointed to is the limited age range of the *Who's in Charge* which is aimed at 8 – 18 years of age. The consensus was that many behaviours are entrenched by age 8 and it would be a very good idea to extend Who's in Charge or develop a sister programme aimed at younger children as an early intervention initiative. The perceived benefit of this is that it would avoid needless suffering for the parents, nip the problem in the bud and reduce the risk of 'learnt behaviour' from other

siblings in the family household (a pressing concern as 76% of clients had more than one child):

> *because this is an 8-18 program, I think when you get the older children I think their behaviour is so entrenched (…) and I'm not saying it won't change, but I think it takes that behaviour longer to change, because I think that by the time they get to 17 or 18 they're not bothered because their behaviour is that entrenched* (Staff)

> *in assessments we ask parents 'when did your child's behaviour start to concern you?' and I would say that a massive percent of them would say 'I started to notice by the time they were 18 months or 2 years of age and they weren't behaving developmentally appropriately (…) but if you've got parents who are only coming to us when their child is 8, 9, 10 , 11, 12, and they've been experiencing this behaviour since the child was 18 months … how can we recoup 8 or 9 years in 8 weeks? And a lot of the time we do it successfully* (Staff)

These comments directly inform some the findings in the 'Opportunities' section below. It was very clear from the parent group that many of them had been wrestling with their children's behaviour for many years before reaching the Who's in Charge programme. A history of blocked access to services, misplaced advice from well-meaning (but largely unhelpful) law enforcement and education services and a great deal of 'self-medication' to manage an increasingly fraught homelife suggests that an earlier engagement with families would reap dividends and potentially head off other social problems stemming from CAPVA. **Key Recommendation 3** is intended to address this finding.

Summary of Weaknesses:

1. Conflicting perception of the role of neurodiversity in child's behaviour in clients vs. staff
2. Limited by age range of program (8-18), especially because behaviour is more 'entrenched' in older children, and it can be more challenging to make changes in an 8-week program

Opportunities:

Two clear opportunities relate to the aforementioned weaknesses regarding neurodiversity and the age-range of the programme. **Key recommendations 3 & 4** respond to these opportunities to either develop the programme with 'plug-ins' or 'add-ons' that meet these needs. For example:

> *I think if intervention is done earlier with a child then the outcome could be a lot better, whereas some children and families do not get this opportunity, so they suffer, suffer, suffer for long, long periods of time, and by the time children get to their teenage years some stuff is lost, some stuff you just can't reprogram, some things you can but for others that is it, because if you don't get it at an early enough age then it's a whole different can of worms, so the whole process earlier and intervention earlier is a must* (Parent)

it would be nice to cover that age group wouldn't it, like going back to the wish list, if maybe we could have a slightly different program that could deal with the behaviours of much younger children as well, to nip it in the bud while they're young, rather than them then becoming teenagers that are more difficult to handle (…) it would be nice to offer the service to younger families and parents with younger children that are starting to show those traits of becoming defiant and threatening, and starting to hit and kick out and swear at parents, it would be nice to do that for a younger age so that it doesn't start to escalate and become more difficult to manage as older children (Staff)

Another element that many of the parents felt would be beneficial was more meaningful advice and support about how to stay calm, manage family life and cope with the stresses and strains that led man of them to struggle with their own health and wellbeing. For some people, this meant becoming too reliant on alcohol or painkillers, for others it was the damage done to their own confidence and mental health. These represent hidden needs that create additional pressures on families and services:

I think maybe that's a piece that's missing, is that mental health support. I know we do have our individual workers and they are very good, but they're not counsellor-type level trained, and yeah, I guess if we are the key ones to be at the root of moving our children forward then we need our own support too (Parent)

everyone tells you to stay calm but they don't tell you how, they just tell you 'the best thing to do is stay calm" well how the hell do I stay calm when I've got someone coming at me with a pair of scissors, coming at my face, how the hell do I stay calm in that situation? (Parent)

[we need] more mental health support for the children and for the parents, and in a more timely manner

A (interjects): the earlier the better- sorry

B: yeah! I could have done with this course this time last year (2 x parents)

A further opportunity identified by the staff group was the benefit of increasing the number of programme facilitators who have completed the full Who's in Charge training. This would enable more online groups to be run and potentially extend this contact with families over a longer period:

I think expanding on the team that we've got would be amazing, so we can get even more people, as you can imagine there's only 4 or 5 of us so there's only so many we can reach in one cohort, as SM said it's a closed group so nobody can sort of dip in and out (Staff)

if we could possibly keep them on the program for 2 years, and they wanted that, all of our work is very much client-led (Staff)

At one level, it is unsurprising that staff would advocate for more staffing resources. However, the more interesting dynamic in terms of opportunities, is the capacity to develop the programme around a range of related needs not currently being met by the programme (**Key Recommendation 3 & 4**) and use the capacity of online and digital resources to extend

the programme across all four counties in the Humber region (**Key Recommendation 6**). This represents an opportunity to realise the benefit of the programme more fully and, if aligned with some stronger outcome measures, demonstrate the efficacy of the work undertaken (**Key Recommendation 2**). In short, the restrictions of COVID-19 lockdown have generated greater computer literacy by staff and parents, and this represents an opportunity to realise some economies of scale if the project was resourced to do so. This resourcing could include additional staffing as well as some digital hardware to ameliorate any residual digital illiteracy or exclusion post-COVID-19.

A final opportunity relates to the limited awareness of the Who's in Charge programme. Both staff and parents expressed some frustration with the police and school response to this type of domestic abuse in their home, suggesting a need for some partnership engagement and clearer referral routes. These opportunities are represented in **Key Recommendations 1 & 5** which are fundamentally about external engagement, awareness raising and routes into Who's in Charge:

> *parents phone the police and are told 'it's your child deal with it' and the phone is hung up … I know the police force is run ragged just like we are, but I think it's just that understanding, and that training and support for them to realise it's happening in our communities (…) and I know we're keen to try and train up a lot more within the local Humberside police so they understand that it is happening in our community* (Staff)

> *my experience with the police and my child's behaviour is not a healthy … good one … at all. I'll give you an example, CAHMS said to me the next time my child is violent and hurts me to ring the police, I thought 'oh my god I've got to ring the police'. I was at the lowest, so low it was unreal, I didn't know what to do and I didn't know where to turn, and so I rang the police and I got a lecture off the policeman on the other end of the phone, saying 'do you realise what you are doing? Your child will have this on their record for the rest of their life', so then he made me feel that I was the person in the wrong, well no, my child was, because my child was hitting me all the time and that is not right or acceptable one bit, so my experience with the police has not been the best at all* (Parent)

<u>Summary of Opportunities:</u>

1. Adaptions to Who's in Charge for use with younger children (ages 4-8), for early intervention or use with younger siblings
2. Adaptions to Who's in Charge for use with neurodivergent children & additions to address mental health needs & self-care strategies for parents
3. Increase in facilitators who have completed the full Who's in Charge training would be beneficial for the team, and would enable more groups to run online – potentially would also enable staff to keep in contact with families for longer & have more consistent contact
4. Defining and collecting objective outcome measures (that are meaningful measures of change/impact for the families, not just for engagement with the program), especially relating to child violence/abuse & family safety/risk

5. More awareness in police of CAPVA – opportunity for Who's in Charge to conduct outreach and training for police

Threats:

One of the most commonly cited frustrations by both staff and parents was the difficulties in getting referred to Who's in Charge and the confusion sometimes caused by other parenting programmes with slightly different goals:

> *I've been waiting quite a few months to get her [a client] on the Who's in Charge program, so I did all the assessments and keep in touch with her, and she was due to start (…) the next core group, then they said 'we want her to do this parenting program before Who's in Charge', and I'd got this parent ready to start Who's in Charge program and now I have to close it* (Staff)

> *You have to jump through hoops to get the help, you have to prove that you are not a bad parent, so straight away that question is there straight away, so you believe that what you are doing is wrong and that you are a bad parent, until you do these courses and someone says it's not you, it's that process that can take far too long for some of us* (Parent)

Similarly, the response from the police when contacted by parents was generally viewed as underwhelming:

> *[police] need to understand that [CAPVA] is happening in our community and when these parents reach out you can guarantee they've dialled the number 30 or 40 times before they've actually had the confidence to call and say 'I'm being physically abused, mentally abused by my child' to then be told 'it's your child, it's your problem, you have to deal with it' … it's not very helpful* (Staff)

> *I've got a couple of clients where parents have called the police quite a few times and they either haven't been out or they've come out and said to them 'stop it, be kind to your mum' and then they're gone* (Staff)

These types of obstacles represent a real and present danger to Who's in Charge as they effectively block referrals and negatively impact the initial engagement with Who's in Charge facilitators due to poor prior experiences. Sometimes this is about competition between services that can lead to confusion for parents – and sometimes it is a lack of awareness about what advice and support is available to parents. **Key recommendations 1 & 5** could alleviate some of these issues and provide clarity to partner organisations about support that is available for parents struggling with this poorly understood form of domestic abuse. One route that could further alleviate this threat is to align Who's in Charge with either (or both of) the Violence Prevention Partnership (VPP) or the Serious Violence Duty as a form intergenerational domestic violence prevention. **Key Recommendation 7** proposes this avenue as a potential way to raise awareness, improve referrals, and ensure Who's in Charge is clearly located within a wider partnership programme of interventions.

A final threat to the programme is the possibility that the staff team may be reluctant to engage with hiring facilitators with different skill sets or alternative perspectives. We have already pointed to the commitment and passion of the staff team earlier under 'Strengths' but this double-edged sword insofar as has to the potential to act as a barrier to new facilitators:

> *We need to make sure that person is right for our team first and foremost, and then right for the Who's in Charge program* (Staff)

> *I think you've got to have had your own children*
>
> *A: yes, definitely*
>
> *B: regardless of whether your home is really good or not, I think you need the experience of having your own children* (2 x Staff)

Whilst this risk may be minor, it is important to acknowledge as the general direction of travel in all the **Key Recommendations** is towards the development of the Who's in Charge service. This inevitably comes with changes that could, for example, lead to engagement with services or staff with different skill sets. The key to successfully developing Who's in Charge will be walking the line between retaining its programme integrity and not using this as a barrier to exploring new ways of helping families overcome this extremely complex form of domestic abuse.

<u>Summary of Threats:</u>

1. Lack of awareness of CAPVA in police & other referral agencies causes difficulties in referrals and reduces parent (impacting initial relationship with Who's in Charge staff on referral).
2. A danger that hiring new facilitators seen as a threat to small, tight-knit team that acts as an obstacle to the development and sustainability of the service.

Section 2: Scoping Interventions and Research in the Child / Adolescent to Parents Violence and Abuse (CAPVA)

Key Insights from Review of Existing Policy

1. Inconsistent definitions of CAPVA and a lack of governmental policies or strategies contributes to the difficulties providing early intervention in CAPVA and limits our knowledge about the prevalence of CAPVA in the UK.
2. CAPVA is a form of gender-based violence, with most victims being women. However, the gender of young people, and related CAPVA behaviours and attitudes, is unclear and warrants further research to enable tailored and early interventions.
3. The age range of young people who instigate CAPVA is large. Current definitions typically state the age range as being between 10 and 18 years, however this limits services ability to provide early support for families with younger children, or extended support for families with adult children.
4. Young people who instigate CAPVA typically have a background involving witnessing or experiencing domestic abuse and have high rates of substance abuse and mental illness. This is particularly relevant for young people in kinship care.
5. Current frameworks used to understand CAPVA, such as feminist or social learning theories, tend to miss out subtle contextual factors, such as pain or alternate communication methods, that could contribute to violent behaviours to parents from neurodivergent young people.
6. The manner in which CAPVA is conceptualised differs between stakeholder groups, which can lead to unmet expectations and difficulties communicating needs. A nuanced understanding of parent/caregiver and young people's understanding of violence and abuse would enable practitioners to tailor interventions and may enable increased engagement in CAPVA interventions on behalf of parents and young people.
7. Developing integrated multi-agency responses to CAPVA should be prioritised for all cases, but particularly where the young person refuses to engage with interventions, where the parents/caregivers or young person have high support needs or are particularly vulnerable and at serious risk of harm, and in cases of kinship care.
8. Professional training across services that may come into contact with families experiencing CAPVA is necessary. Improved awareness of how to identify and manage CAPVA, with clear protocols regarding risk-assessment and safeguarding is critical to enable early intervention, harm reduction, and decreased stigma regarding CAPVA.
9. Existing interventions provide crucial support for parents/caregivers who are victims of CAPVA, and group-based formats that encourage peer-support are valuable. However, delivery teams should be aware of each family's specific needs to enable tailored support and to provide interventions that align with the family's beliefs and values.

Gaps in Existing Research

1. Lack of research and acknowledgement of adult child to parent violence and abuse & changing culture of children living in the family home into adulthood
   - related: in intimate partner violence/abuse a change (such as having a child) or end of a relationship is a risk factor for increasing abuse – it may be possible that the transition from 'child' to 'adult' (as signalled by leaving education, beginning a job, a shift in parent-child to parent-adult child dynamic) is also a risk factor for increasing violence.
   - related: if so, is there a change in motivation/'intent' behind the violence?
2. How CAPVA is conceptualised from the perspective of young people, especially regarding responses to perceived threat (physical, emotional, psychological, identity/social roles, environmental), feelings of injustice, & intent of violence
3. Dialectical approaches in interventions (in response to differing conceptualisations of CAPVA between stakeholders)
   related: especially for CAPVA in families with neurodivergent young people
4. CAPVA interventions specifically in kinship care contexts that may need particular focus on the young person's experiences of abuse, neglect, trauma, and loss, and the higher support needs of kinship carers
5. Interventions should more explicitly consider the inclusion needs of neurodivergent individuals, families with additional learning needs or who are unable to read/write, and families for whom English is a second language
6. Randomised controlled trials are lacking in the literature, though they are rarely straightforward to implement in these contexts. Consideration of cluster randomised trials in future research may be more practical. As well as the need for longitudinal studies, particularly that which follow young people into adulthood.

Conceptualising CAPVA

Much of the previous literature has attempted to conceptualise CAPVA and explore contributory factors through single-theory frameworks. For example, social learning theories emphasise the role of exposure to violence as a child, by either being the victim of child abuse or witnessing domestic abuse, and proposes that through transmission of intergenerational violence and observational learning the young person develops violent and abusive behaviours themselves (Margolin & Baucom, 2014). Other perspectives, such as feminist approaches, emphasise the gendered nature of the violence and focus on gender inequality, control of women, and misogyny when exploring contributory factors (Burck et al., 2019). More recently, researchers have been promoting the advantages of using multifactor frameworks, in order to synthesise existing research and to address the fact that complex behaviours in young people (e.g., violence and abuse) are determined by interactions of multiple processes at the individual, family, community, and societal levels. Bronfenbrenner's

social ecological model (1979) is particularly useful in this regard and is increasingly being utilised to explore the context of CAPVA (Simmons et al., 2018).

It is important to note that the manner in which CAPVA is conceptualised not only varies between disciplines, but also appears to differ between stakeholder groups. As previously mentioned, academics tend to focus on conceptualising CAPVA within a particular framework, such as feminist or socio-ecological models, which seek to identify risk factors and causes of CAPVA. Those situated in criminal justice disciplines generally focus on the reporting of crimes and recidivism rates of young offenders arrested for CAPVA-related offenses. It is a unique feature of CAPVA that the victims (parents/caregivers) usually have an obligatory relationship with the instigator of the abuse and violence that they have experienced and have an on-going duty of care for the young person. This may be why most interventions to prevent CAPVA are aimed at the parents, families and caregivers of the young person (Toole-Anstey et al., 2021). This another unique feature of CAPVA which puts the onus of responsibility for preventing abuse on the victim, unlike other forms of interpersonal abuse.

There are further differences in how CAPVA is conceptualised between service providers, parents/caregivers (victims) and young people (instigators). It has been reported that parents often view their child's violent and abusive behaviours through a pathological lens of diagnoses and disorders (Clarke, 2015). This can provide some comfort to parents by repositioning self-blame regarding the abuse in the context of impulse control disorders. Understandably, clinicians recommend against this strategy of conceptualising CAPVA due to the risk of normalisation of violence leading to unwillingness on behalf of the parents to report crimes or implement strategies to resist or prevent violence (Baker & Bonnick, 2021). Though, it should also be noted that a young person's diagnosis of mental illness or recognition as neurodivergent can open doors to specialist services and community support, (Clarke, 2015) therefore acknowledgement of the young person's diagnoses and integration into interventions is not inherently harmful. Qualitative studies have indicated that parental blame is a common explanatory factor for parent/caregiver victims of CAPVA. Williams et al. (2017) demonstrate that mothers and grandmothers questioned their competency in parenting and felt responsible for the violence they had experienced, whilst also attributing blame to the absence of a father figure and impact of their child lacking a male role model. In studies of CAPVA in kinship care it is interesting to note that in these contexts, the caregivers largely conceptualised the violence and abuse as originating from the young person's previous experiences of trauma and loss (Breman et al., 2018; Holt & Birchall, 2020). This is likely because the nature of a child being in kinship care often means that the child cannot live with their birth parent(s) due to a combination of reasons involving abuse and/or neglect, parental mental illness or substance abuse, or parental imprisonment or bereavement (Hallett et al., 2021), therefore the trauma the young person has experienced is likely a salient factor to these families, in ways it may not be for families where children are living with their birth parent(s).

There is a notable absence of the views of young people who instigate CAPVA in the literature. One thematic analysis of adolescent's accounts of CAPVA in the UK (Papamichail &

Bates, 2022) demonstrated that the young people, similar to the parents in Williams et al.'s study, viewed the absence of their biological father as a contributory factor to their violence. Though unlike the findings of Williams et al. (2017), half of the young people lived with a step-father, indicating that a sense of rejection from their biological parents contributed to their conceptualisation of CAPVA, rather than the lack of a male role model. The theme of rejection was a consistent finding in Papamichail and Bates' study (2022), which reported that the young people also felt rejected by other members of their family. Feelings of jealousy due to the perception that their mother preferred their siblings or stepfather was a frequent finding, alongside a deep desire to improve relationships with their family members.

Characteristics of CAPVA

Gender

Some authors argue that CAPVA should be renamed child/adolescent to *mother* abuse to highlight that it is a gender-based issue, and to be more reflective of how CAPVA often manifests in real-world contexts, whereby the female caregiver (often mother) is the victim (Burck et al., 2019). Similarly, some studies have concluded that 'typical' profiles of instigators and victims are white males aged 14-17 and white adult females, respectively (Hong et al., 2012). The evidence reported in the majority of the literature reflects that CAPVA is a gendered phenomenon, with mothers being more likely than fathers to be the victim of CAPVA overall (Simmons et al., 2018). Baker's (2021) exploration of adolescents' views on CAPVA was the first study to reveal insights from the young person's perspective regarding why mothers are more likely to be targets. The young people in this study highlighted the role of their mother as primary caregiver meant closer physical proximity, as well as being more actively involved in parenting decisions. Furthermore, the young people described how they perceived their mother to be a 'safer' target; not only physically but also emotionally, with one participant stating, "I knew Mum would stay … no matter what would happen". The gendered nature of CAPVA is also evident in studies which focus on kinship care; Holt and Birchall's (2020) qualitative project investigating CAPVA in kinship care contexts in the UK reported that 24 of 27 participants were grandmothers. A similar qualitative examination of family violence in kinship care in Australia reported that 96% of 101 kinship carers in this study were female, predominantly grandmothers (68%) or an aunt (18%) (Breman et al., 2018).

When focusing on gendered prevalence of young people who enact CAPVA, the sample which is being studied is important to take into consideration. For example, although one review reported that in criminal justice samples males constitute 59-87% of instigators, in community and clinical samples the same review found no significant differences in prevalence of CAPVA between female and male instigators (Simmons et al., 2018). This may reflect that the gender of the child/adolescent often influences arrest, and prosecution rates; with boys being more likely to be identified in criminal samples (Sanders, 2020). However, it may also reflect that girls and boys use different types of controlling and abusive behaviours, or that gender of the victim influences how likely they are to report CAPVA (Selwyn & Meakings, 2016).

Age

In a similar manner to the variation in definitions of CAPVA, the age range of young people who are instigators of CAPVA is also a contentious issue. The majority of studies focus on young people aged between 10 and 18 years old (Brennan et al., 2022); the lower cut-off reflecting the minimum age of criminal responsibility in England and Wales (Brown & Charles, 2021). Simmons et al. (2018) argue that pre-adolescent children (under the age of 13) should not be included in CAPVA literature because their developmental stage precludes them from intending harm as a result of their actions. However, the usefulness of defining CAPVA based on 'intent' is diminished in the context of neurodivergent young people (Baker & Bonnick, 2021). Additionally, many definitions of CAPVA do not specify intent, but rather focus on the pattern of abusive behaviours and feelings of fear and control experienced by the victim (Paterson et al., 2002). By limiting our understanding of CAPVA to it being instigated only by teenagers may serve to perpetuate the hidden nature of this phenomena, by overlooking families with younger children who are struggling, and ignores the necessity of early interventions into violent and abusive behaviour (Thorley, 2017).

The upper age of 18 years is also debated in the literature. Although legally, in the UK, a young person aged 18 or over is considered an adult, in developmental terms adolescence is often considered to extend up to the age of 24 years (Sawyer et al., 2018). Furthermore, the number of young adults continuing to live with parents in the UK has increased by 24% since 2011 (Sharfman & Cobb, 2022). This has important implications for our conceptualisation of CAPVA, as much of the literature demonstrates that incidents of CAPVA tend to escalate over time in a similar manner to other types of domestic abuse (Simmons et al., 2018). There is a distinct lack of research that involves adult-aged children, however emerging research demonstrates that this phenomenon is present but often not captured in literature due to CAPVA services typically only providing support to under 18's and age-related exclusion criteria in research samples (Baker & Bonnick, 2021). One Australian study reported that 25-30% of cases dealt with by a specialist police-social services scheme involved violence and abuse instigated by an adult child living at home (Hamilton & Harris, 2021). Additionally, Brennan et al.'s (2022) examination of CAPVA offences across London revealed that 65% of cases reported to the police involved a young person aged 19 to 25 years, demonstrating that CAPVA does not end when a young person legally becomes an adult. It is of particular importance to recognise the continuation of violent and abusive behaviours into adulthood, not only from the perspective of supporting victimised parents, but also because research suggests that young people who have enacted CAPVA may then go on to perpetrate intimate partner violence in adult relationships (Ibabe et al., 2020).

Domestic abuse

Exposure to domestic abuse at home, and being the victim of child abuse or neglect, is a frequently observed factor which contributes to a young person instigating CAPVA. Numerous studies have demonstrated that young people who instigate CAPVA report high levels of witnessing inter-parental violence, typically abuse directed at mothers from fathers (Contreras & Cano, 2016; Simmons et al., 2022). Qualitative studies that focus on the perspective of parents and caregivers victimised by CAPVA state that it was the participants'

view that male children may enact abusive and violent behaviour directed at their mother because it is what they saw their father do (Brennan et al., 2022). The authors also note that feelings of resentment and fear may be channelled into abusive behaviours toward the mother. This may be due to anger that their father has left the family home (for example, due to the mother and children escaping domestic abuse, or the father being arrested), or feeling betrayed that the mother had 'allowed' them to witness or experience abuse from their father.

Similarly, being the victim of abuse or neglect as a child has also been observed as a contributory factor to CAPVA. One meta-analysis on the relationship between parent-to-child violence and child-to-parent violence reported that the likelihood of children instigating CAPVA was increased by 71% when they had been the victim of abuse from a parent (Gallego et al., 2019). Additionally, Simmons et al.'s (2018) review of CAPVA literature estimates that across community, clinical, and offender samples 50-80% of young people instigating CAPVA had been the victims of violence and abuse perpetrated within the family unit. Previous experiences of violence and abuse is of particular importance when exploring CAPVA in samples of young people in foster or kinship care, or who have been adopted, because these young people have often suffered multiple forms of abuse early in life (Thorley, 2017). Selwyn and Meakings (2016) describe how CAPVA frequently plays a role in the struggles of adoptive families or the break-down of adoptions. The authors highlight the isolation of the parents, who often felt blamed by social services, excluded from decision-making discussions with agencies, and lacking in options to seek help.

Mental health and Neurodiversity

Multiple reviews into CAPVA have identified that young people with mental health concerns are more likely than their peers to engage in CAPVA (Baker & Bonnick, 2021; O'Hara et al., 2017; Simmons et al., 2018). However, the precise role of psychopathology in young people who instigate CAPVA is still unclear. It is important to note that although psychological disorders and neurological/neurodevelopmental disorders (i.e., neurodiversity) may co-exist, they are separate entities that affect people differently. Psychological disorders are typically related to emotional, behavioural, and mood symptoms that cause distress and negatively affect daily functioning. The term 'neurodiversity' is an umbrella term to describe alternate thinking and processing styles typically seen in autism spectrum disorder, attention deficit hyperactivity disorder, and Tourette's syndrome, to name a few. The use of the term 'neurodiversity' communicates the idea that neurological differences are normal and valuable variations in the way that humans can process and use information, and therefore should not be seen as pathologies that necessitate a cure (Dyck & Russell, 2020).

Studies have reported that young people who enact CAPVA display high levels of general psychological distress, depression, and low self-esteem (Calvete et al., 2013). Furthermore, young people who have been charged with a CAPVA-related offence are more likely to have previous experiences of psychiatric hospitalisation and suicide attempts compared to other young offenders (Kennedy et al., 2010). Qualitative research from the UK with mothers experiencing CAPVA from their pre-adolescent children reported that all the participants in the study conceptualised CAPVA as resulting from mental health struggles,

such as anxiety or emotional dysregulation (Rutter, 2020). Similar qualitative research with young people in the UK who enact CAPVA revealed that six (of eight) participants were involved with Child and Adolescent Mental Health Services (CAHMS), and five related their violent behaviour to emotional dysregulation and feeling "out of control" (Papamichail & Bates, 2022).

The role of substance use has been more clearly outlined as it relates to CAPVA. Pagini et al. (2009) explored associations with verbal and physical aggression to fathers and discovered that substance use significantly increased the risk of CAPVA. Similarly, Calvete et al. (2013) assessed 1072 adolescents in Spain, and reported that substance use significantly predicted increasing CAPVA over time. However, Baker's (2021) qualitative research from young people's perspectives revealed that the type of substance used had differing effects on CAPVA, for example, some participants reported that using cannabis helped them to relax and would mean they were less likely to be verbally or physically aggressive. This research also explored situations in which substance use might increase CAPVA, and the young people reported that the psychoactive effects of stimulants (such as cocaine) might cause violence, or the reaction of their parents to their drug use may also initiate CAPVA (for example, parents taking the drugs away or disciplining the young person for using drugs). It is important to note that substance use in young people can be co-morbid with mental health diagnoses, and may also be related to witnessing substance use in the home, or maladaptive coping responses to past trauma (Baker & Bonnick, 2021), therefore it is important to contextualise the relationship between substance use and CAPVA based on the wider circumstances of the family.

In CAPVA literature, the role of neurodiversity and developmental disabilities in young people is often framed as a causative factor (Simmons et al., 2018). Disorders such as autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), and oppositional defiance disorder (ODD) are frequently named as risk factors that may lead to CAPVA, often due to the emotional dysregulation, impulsivity, and struggles with social interactions inherent in these disorders (Baker & Bonnick, 2021). However, as noted by Sutherland et al. (2022), this view can be problematic due to the range of factors which may induce violence from neurodivergent young people, such as physical pain, fear, or methods of communication. Furthermore, the authors argue that current frameworks used to understand CAPVA, such as feminist or social learning theories, tend to miss out these contextual factors that could contribute to violent behaviours to parents from neurodivergent young people. Some studies caution against framing neurodiversity as an explanatory cause of CAPVA, describing how parents may use their child's diagnosis as a reason to tolerate violence (Baker & Bonnick, 2021), while others describe how parents may attempt to assuage feelings of self-blame by positioning disorders such as ASD and ADHD as the sole cause of CAPVA (Clarke, 2015). Crucially, there has been little evidence that demonstrates that CAPVA is *caused* by developmental disabilities, and therefore the role of neurodiversity would be best understood by taking a socio-ecological perspective on understanding violence in this context (Sutherland et al., 2022). Taking such an approach would be particularly useful when developing CAPVA interventions, due to the lack of resources for these families, and questions

regarding the suitability of existing interventions into CAPVA for young people with developmental disabilities or additional learning needs (Holt & Lewis, 2021).

Interventions

There exists a range of interventions aimed at reducing CAPVA and supporting young people and families who are living with CAPVA and its effects. These interventions take place in a range of settings such as child and adolescent mental health services, youth offending services, safeguarding and child protection services, and community-based services ran by charities and local authorities. It has been noted in the literature that due to a lack of recognition of CAPVA in governmental policies and no clear protocols for when CAPVA is identified, practitioners may take an 'ad-hoc' approach (Holt & Retford, 2013). However, this can be problematic as typically the safeguarding and risk-assessment procedures follow a domestic abuse framework which may not be appropriate for the family. For example, Brennan et al. (2022) emphasise the necessity of multi-agency collaborations, such as Multi-Agency Risk Assessment Conferences (MARAC), and note that while referrals can be made to MARAC, it is likely unsuitable for many cases of CAPVA because of the dual need to safeguard both young people and the parents/caregivers.

The following sections outline some of the existing CAPVA interventions (other than Who's in Charge) in the UK followed by a discussion.

Respect Young People's Programme

The *Respect Young People's Programme (RYPP)* is an intervention programme designed for families in England with children (aged between 8 and 18 years) who are violent or abusive. The programme works with both parents/caregivers and their children to provide support and encourage active participation in the reduction of violence and abuse in the home. *RYPP* draws from several theoretical models, with cognitive-behavioural methods taking a central role. The integration of these theoretical models, combined with the holistic approach of considering influences from the home, school, and wider community, the programme is situated within a social-ecological framework (Social research unit, 2016).

RYPP is delivered through structured weekly sessions over the course of three months. This typically consists of nine sessions with the young person, seven sessions with parents/caregivers, and two for the whole family (Baker & Bonnick, 2021). The delivery model is flexible and can be extended if there are additional needs or high levels of potential harm, it is reported that the programme can be completed with only the input of the young person or the family, but is most effective when the whole family is involved (Social research unit, 2016). The focus of *RYPP* is to reduce harm and abuse by developing de-escalation and conflict resolution skills and understanding the beliefs and behaviours related to anger and abuse. Two core components of the programme are a mutually agreed-upon behavioural contract, which focuses on ensuring safety by implementing consequences and rewards, and an

observed conversation between the young person and their parents/caregivers based on principles of restorative justice (Baker & Bonnick, 2021).

RYPP emphasises the inclusion of neurodivergent young people in the programme and can support both parents/caregivers and young people with psychoeducation sessions focusing on CAPVA in the context of neurodivergence (Baker & Bonnick, 2021). An evaluation of RYPP interventions delivered online during the COVID-19 pandemic highlighted the importance of adapting interventions for neurodivergent young people and tailoring sessions for their needs (Rutter et al., 2022). For example, it was observed that young people with ADHD found it more difficult to engage with sessions when the programme was delivered online, whereas some of the young people with ASD had less anxiety about interacting with others online vs. in-person and therefore became more engaged in the sessions. Dartington Social Research Unit were commissioned to conduct an outcome evaluation of *RYPP* using a pre- and post-programme methodology (Social research unit, 2016). This report revealed that young people experienced significant improvements to overall mental health, as well as conduct difficulties and pro-social behaviour (as measured by the child-report version of the Strengths and Difficulties Questionnaire). Additionally, parents/caregivers reported significant improvement in their child's conduct problems, emotional symptoms, peer problems, hyperactivity, and pro-social behaviour (as measured by the parent-report version of the Strengths and Difficulties Questionnaire).

Non-Violent Resistance

Non-Violent Resistance (NVR) was developed as a CAPVA intervention by Hain Omer in 2004 in Israel (Omer, 2021), and has been used within the UK in many settings since this time (Jakob, 2006). NVR is rooted in the socio-political philosophy of non-violent resistance, as advocated by Mahatma Gandhi and Martin Luther King Jr., and developed specifically for CAPVA by incorporating aspects of systemic family therapy and strengths-based approaches. NVR has been utilised for parents who are experiencing violent or abusive behaviour from their children, this includes a wide range of ages from children as young as 4 (Weinblatt & Omer, 2008) up to adult-aged children (Golan et al., 2018). This intervention is designed to be delivered without direct interaction with the young person.

The *NVR* programme is typically delivered flexibly in weekly sessions and supportive phone or video calls over the course of three to four months, either individually or in a group format, however it can be adapted to be delivered over a shorter period of time, or extended when further support is required (Baker & Bonnick, 2021). The *NVR* approach has been adapted for use by various organisations and localities throughout the UK, and therefore includes minor differences in the terminology and approaches that are included in the programme (Samuel et al., 2022). Generally, *NVR* aims to support parents to reduce violence and abuse from their child and improve familial relationships by focusing on four main areas of intervention: a) resistance by supportive parental presence, b) prevention of escalation, c) creating a network of support, and d) reconciliation gestures (Van Holen et al., 2016). Parental presence is a core feature of *NVR* which is characterised by resisting violence while

simultaneously building a supportive relationship, this incorporates an understanding of a "new authority" style of parenting (Omer et al., 2013). This is characterised by shifting away from authoritative parenting that is based on obedience and control of the child, and instead emphasises authority based on parental self-control, structure, and support (for the child and wider social support for the parent). Practical techniques of implementing parental presence within *NVR* can include parents giving a formal announcement to their child of their commitment to non-violent resistance of unacceptable behaviours, and 'sit-ins' whereby the parent chooses to be physically present in situations where their child is being violent or abusive, communicating that they will not be ignored or isolated while demonstrating non-violent responses to their child's behaviour. Parents are supported to identify escalation patterns and taught de-escalation strategies, such as delayed responses to incidents. Parents are encouraged to build a supportive network of family, friends, and professionals such as social workers or teachers, in order to reduce isolation and shame arising from keeping their child's violence secret. Gestures of reconciliation, such as thoughtful gifts or engaging in shared activities, are particularly encouraged, and should be unilateral (parent to child) and unconditional. The aim of these gestures is to build positive elements of the relationship and develop a secure attachment between parent and child (Weinblatt & Omer, 2008).

Several studies which explore the efficacy of *NVR* have been conducted internationally with samples of children who have a variety of diagnoses and within different settings. Weinblatt and Omer (2008) conducted an RCT with 41 families affected by CAPVA, and reported that parents who completed *NVR* reported a significant decrease in their own feelings of helplessness and in problematic behaviours from their child, they also reported a significant increase in perceived social support, compared to the wait-list control group. *NVR* has had success in programmes adapted for specific diagnoses. Schorr-Sapir et al. (2022) conducted an RCT with the families of 101 children with ADHD and reported significant and sustained improvements to externalised and internalised behavioural symptoms in the children and improvements to parental helplessness and emotional regulation. Additionally, a decrease in ADHD symptoms were found on completion of the *NVR* programme but were not sustained at the 4-month follow-up. Similarly, *NVR* approaches to CAPVA have been shown to be effective for parents of adult children with ASD (Golan et al., 2018), children with anxiety disorders (Lebowitz et al., 2014) and children with OCD (Omer & Lebowitz, 2016). Furthermore, *NVR* has been evaluated through pre- and post-test designs and was demonstrated to be effective in reducing CAPVA for children in foster care (Van Holen et al., 2016). In the UK, an interpretative phenomenological analysis of 10 adoptive mothers who used *NVR* to reduce CAPVA reported that despite *NVR* being "hard work" it led to a successful reduction in violence and challenging behaviours for the majority of families who took part (Samuel et al., 2022). This study highlights that some parents struggled with a discrepancy between their own values and that of *NVR* and the authors suggest that parents whose values are incongruent with *NVR* will be less committed to implementing the intervention with their children. Also in the UK, *NVR* has been reported as a successful and efficacious intervention for CAPVA within CAHMS settings (Newman et al., 2014) and within a young people's specialist substance misuse service (Attwood et al., 2020).

Step-Up

The *Step-Up* programme was developed in 1997 in order to address the rising issue of CAPVA in the youth justice system in Washington, USA (Correll et al., 2017). *Step-Up* has been adapted for use in other counties, and has been used in the UK since 2009, though typically it is a shorter programme that is delivered under different names, depending on the local authority in which it is based (Baker & Bonnick, 2021). *Step-Up* utilises a cognitive-behavioural approach within a restorative justice framework and aims to reduce CAPVA, reduce shame, increase accountability, and build respect between all family members by teaching effective communication and de-escalation skills (Correll et al., 2017). There are no reported age limits, though the majority of literature focuses on teenagers (Toole-Anstey et al., 2021). However, this may be a consequence of much of the literature originating from the US, where the programme is largely aimed at young people with convictions or who are in youth justice systems, which therefore would likely exclude most younger children.

In the UK, *Step-Up* is typically delivered over 12-21 weeks with up to 2 ½ hour sessions for young people and parents individually, and some sessions delivered to the family as a group. This programme can be delivered on a one-to-one basis, though has been reported by a British evaluation that delivering the programme as a group is beneficial for parents to achieve greater social support and enabled facilitators to better identify difficulties that the families were facing (Dunkley-Pritchard, 2016). Each session begins with a 'check-in' using restorative justice inquiry to review any incidents over the past week and explore how the parents and child reacted, while building respect and empathy. The young people set a behavioural goal each week and are encouraged to share their progress and any struggles they had meeting their goal. The check-ins with parents and young people are to encourage accountability, and to enable them to receive peer-support on a regular basis. There are multiple sessions throughout the programme which teach participants about cognitive, emotional, and behavioural processes which are often present in CAPVA. Sessions also provide practical tips about improving communication, anger management, and problem solving, using the 'Abuse' and 'Respect' wheels (adapted from the Duluth Model for intimate partner violence) as tools to understand CAPVA and violence reduction (Gilman & Walker, 2020).

Some pre- and post-programme evaluations of *Step-Up* have been conducted in the US, which demonstrated improved youth communication and family relationships, as well as reduced verbal and physical abuse and controlling behaviours (Organizational Research Services, 2005; Ryan et al., 2013). A recent evaluation of *Step-Up* in the US examined the influence of the programme on reducing recidivism rates in young people, compared to a control group who did not take part in the programme (Gilman & Walker, 2020). The authors report that although general recidivism was significantly reduced within 12-months of programme completion, there was no significant effect on reducing assault-related and domestic violence-related recidivism. A qualitative exploration of parents' experiences of taking part in *Step-Up* revealed that all the families (*n* = 15) reported no further involvement in youth justice services after completion and found the programme beneficial in reducing CAPVA and improving access to emotional support for the family (Correll et al., 2017).

However, the need for on-going support was highlighted by the participants and the authors recommend that the programme would benefit from the inclusion of follow-up sessions. In the UK, an evaluation of *Step-Up* revealed improvements in communication and a reduction in violent behaviours, and the authors highlight the value of beginning the weekly sessions with a communal meal for all families and the inclusion of fun activities (Dunkley-Pritchard, 2016). Parents reported improvements in self-esteem and particularly valued the group support element of the programme, the young people reported that they better understood how to manage their anger and take responsibility for their actions. The Cumbria Police and Crime Commissioner's website (Cumbria PCC, 2022) reported that *Step-Up* had been adapted for remote delivery during the COVID-19 pandemic and has continued as a hybrid model since July 2022, however no published evaluation of this adaption is currently available.

There are no specific protocols or adaptations for working with young people with mental health diagnoses, neurodiversity, or additional learning needs. Routt and Anderson (in Holt, 2015) state that if the parents or young person is experiencing mental health problems or current substance abuse, they must be receiving appropriate treatment outside of the *Step-Up* programme, and must not be currently using any substances. They also state that participants must be able to "comprehend the concepts and learn new skills". Although it is not clear how families are supported if an individual had additional learning needs or difficulties with comprehension skills, a previous study from Routt and Anderson (2011) includes young people with identified learning disabilities (14%) and identified mental health issues (38%).

Discussion of Interventions

The above CAPVA interventions are among the most frequently offered in the UK, although there are several programmes which have been developed for specific local authorities and organisations, such as Break4Change in southeast England and the Positive Relationships programme in London.

Although the interventions outlined above draw on different theoretical approaches, a common theme between them all is the necessity of providing parents and caregivers support and space to discuss their experiences. As CAPVA is often characterised by secrecy and stigma, the benefit of providing a safe and non-judgmental environment for parents to receive support and learn from each other's experiences is clear. The value of CAPVA interventions being delivered in a group-based format is frequently cited by parents as a highly valuable aspect of the various programmes (Dunkley-Pritchard, 2016; Rutter et al., 2022; Samuel et al., 2022). Although the positive aspects of group-based interventions are frequently noted, in Toole-Anstey et al.'s (2021) review of CAPVA interventions, the authors note that this method limits the ability of practitioners to tailor the interventions to each family's specific needs. The importance of personalised intervention delivery is further highlighted in Rutter et al.'s (2022) study, which reported that young people with ADHD struggled with the transition to remote delivery of RYPP, whereas those with ASD were more engaged in the sessions. This may indicate that for families who have additional needs or have

been identified as being high risk or vulnerable, further support to identify interactions of processes that lead to CAPVA at the individual, family, community, and societal levels is required to enable tailored responses and identify the most appropriate intervention format.

The role of young people's participation in the efficacy of CAPVA interventions is unclear; NVR and Who's in Charge do not require the young person to take part, whereas RYPP and Step-Up explicitly require their input. The benefit of focusing only on the parents/caregivers is that support can be offered to victims and changes to the family dynamic can still be made without the young person being present. This is an advantage because it is common that the young person will refuse to take part or acknowledge that their behaviour is a problem for themselves and others. Therefore, in families where the young person refuses to acknowledge the problem or participate in efforts to reduce abuse, interventions such as NVR and Who's in Charge are likely to be more useful. However, due to the co-occurring issues often present in CAPVA cases, such as substance misuse, struggles with mental health, and previous experiences of abuse and neglect, it is important to involve multi-agency collaborations when the young person will not engage. By encouraging multi-agency working in these contexts, it could further ensure that the young person's needs are being met and would increase avenues of accessing support for the whole family.

In families where the young person has additional learning needs or is neurodivergent, it would appear that RYPP and NVR would be most suitable, as both of these interventions have a growing evidence base which demonstrates the efficacy of these programmes across diverse populations (Golan et al., 2018; Rutter et al., 2022; Schorr-Sapir et al., 2022). There are a small number of published case studies of Step-Up in which the parent has learning difficulties (Dunkley-Pritchard, 2016), and two evaluations which include young people with mental health or developmental disorder diagnoses (Routt & Anderson, 2011; Ryan et al., 2013). However, there are no specific protocols or adaptions for working with these populations, which may present a barrier for practitioners delivering the Step-Up programme. The Who's in Charge programme is likely not appropriate for parents/caregivers who struggle with reading and writing, due to the use of worksheets and information sheets in each session. There is no published data regarding its suitability for families with neurodivergent children, however there are also no immediate contraindications for the use of Who's in Charge with such populations, therefore further investigations are necessary.

Section 3: References and Appendices

References

Attwood, J., Butler, C., Rogers, L., Batterham, M., Cousins, L., & Wilson, R. (2020). Non Violent Resistance parent training and adolescent substance misuse. *Journal of Family Therapy*, *42*(2), 222–251. https://doi.org/10.1111/1467-6427.12257

Baker, V. (2021). *Exploring adolescent violence and abuse towards parents: The experiences and perceptions of young people* [Doctoral thesis, University of Central Lancashire]. https://helenbonnick.files.wordpress.com/2021/11/baker_victoria_phdthesis_final_august2021.pdf

Baker, V., & Bonnick, H. (2021). *Understanding CAPVA: A rapid literature review on child and adolescent to parent violence and abuse for the Domestic Abuse Commissioner's Office*. Respect.

Breman, R., MacRae, A., & Vicary, D. (2018). 'It's Been an Absolute Nightmare'—Family Violence in Kinship Care in Victoria. *Children Australia*, *43*(1), 7–12. https://doi.org/10.1017/cha.2018.8

Brennan, I., Burnley, N., Cutmore, M., Holt, A., Lillis, J., Llewellyn, J., Macleod, S., Shah, M., Van Zanten, R., & Vicentini, L. (2022). *Comprehensive needs assessment of Child/Adolescent to Parent Violence and Abuse in London*. London's Violence Reduction Unit.

Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by Nature and Design*. Harvard University Press.

Brown, A., & Charles, A. (2021). The Minimum Age of Criminal Responsibility: The Need for a Holistic Approach. *Youth Justice*, *21*(2), 153–171. https://doi.org/10.1177/1473225419893782

Burck, D., Walsh, D., & Lynch, D. (2019). Silenced mothers: Exploring definitions of adolescent-to-parent violence and implications for practice. *Advances in Social Work and Welfare Education*, *21*(1), 7–18. https://doi.org/10.3316/informit.529927407399794

Calvete, E., Orue, I., & Gámez-Guadix, M. (2013). Child-to-Parent Violence: Emotional and Behavioral Predictors. *Journal of Interpersonal Violence*, *28*(4), 755–772. https://doi.org/10.1177/0886260512455869

Clarke, K. R. (2015). *Parents' experiences of being abused by their adolescent children: An Interpretative Phenomenological Analysis Study of Adolescent-to-Parent Violence and Abuse* [Doctoral thesis, University of Hertfordshire]. https://uhra.herts.ac.uk/handle/2299/17092

Contreras, L., & Cano, M. del C. (2016). Child-to-parent violence: The role of exposure to violence and its relationship to social-cognitive processing. *The European Journal of Psychology Applied to Legal Context*, *8*(2), 43–50. https://doi.org/10.1016/j.ejpal.2016.03.003

Correll, J. R., Walker, S. C., & Edwards, T. C. (2017). Parent Perceptions of Participating in a Program for Adolescents Who Are Violent at Home. *Journal of Family Violence*, *32*(2), 243–255. https://doi.org/10.1007/s10896-016-9847-6

Cumbria PCC. (2022). *Families Praise 'Step Up: Remote' Support during Lockdown*. https://cumbria-pcc.gov.uk/families-praise-step-up-remote-support-during-lockdown/

Dunkley-Pritchard, J. (2016). *Step-Up Programme (Group work pilot)*. Birstall Co-Location Centre.

Dyck, E., & Russell, G. (2020). Challenging Psychiatric Classification: Healthy Autistic Diversity and the Neurodiversity Movement. In S. J. Taylor & A. Brumby (Eds.), *Healthy Minds in the Twentieth Century: In and Beyond the Asylum* (pp. 167–187). Springer International Publishing. https://doi.org/10.1007/978-3-030-27275-3_8

Gallego, R., Novo, M., Farina, F., & Arce, R. (2019). Child-to-parent violence and Parent-to-child violence: A meta-analytic review. *The European Journal of Psychology Applied to Legal Context*, *11*(2), 51–59. https://doi.org/10.5093/ejpalc2019a4

Gilman, A. B., & Walker, S. C. (2020). Evaluating the Effects of an Adolescent Family Violence Intervention Program on Recidivism among Court-Involved Youth. *Journal of Family Violence*, *35*, 95–106. https://doi.org/10.1007/s10896-019-00070-2

Golan, O., Shilo, H., & Omer, H. (2018). Non-violent resistance parent training for the parents of young adults with High Functioning Autism Spectrum Disorder. *Journal of Family Therapy*, *40*(1), 4–24. https://doi.org/10.1111/1467-6427.12106

Hallett, N., Garstang, J., & Taylor, J. (2021). Kinship Care and Child Protection in High-Income Countries: A Scoping Review. *Trauma, Violence, & Abuse*, 15248380211036072. https://doi.org/10.1177/15248380211036073

Hamilton, G., & Harris, L. (2021). Parent abuse by dependent adult children living in the family home: A gap in the service? *Journal of Family Studies*, *0*(0), 1–17. https://doi.org/10.1080/13229400.2021.2018349

Holt, A. (Ed.). (2015). *Working with Adolescent Violence and Abuse Towards Parents* (0 ed.). Routledge. https://doi.org/10.4324/9781315750781

Holt, A. (2016). Adolescent-to-Parent Abuse as a Form of "Domestic Violence": A Conceptual Review. *Trauma, Violence, and Abuse*, *17*(5), 490–499. https://doi.org/10.1177/1524838015584372

Holt, A. (2021). International and cross-cultural research on violence against parents. In T. Shackelford (Ed.), *The SAGE Handbook of Domestic Violence* (pp. 841–858). SAGE Publications.

Holt, A., & Birchall, J. (2020). *Investigating experinces of violence towards grandparents in a kinship care context: Project summary* [Project summary]. University of Roehampton.

Holt, A., & Lewis, S. (2021). Constituting Child-to-Parent Violence: Lessons from England and Wales. *The British Journal of Criminology*, *61*(3), 792–811. https://doi.org/10.1093/bjc/azaa088

Holt, A., & Retford, S. (2013). Practitioner accounts of responding to parent abuse—A case study in ad hoc delivery, perverse outcomes and a policy silence. *Child and Family Social Work*, *18*(3), 365–374. https://doi.org/10.1111/j.1365-2206.2012.00860.x

Hong, J. S., Kral, M. J., Espelage, D. L., & Allen-Meares, P. (2012). The Social Ecology of Adolescent-Initiated Parent Abuse: A Review of the Literature. *Child Psychiatry & Human Development*, *43*(3), 431–454. https://doi.org/10.1007/s10578-011-0273-y

Ibabe, I., Arnoso, A., & Elgorriaga, E. (2020). Child-to-Parent Violence as an Intervening Variable in the Relationship between Inter-Parental Violence Exposure and Dating Violence. *International Journal of Environmental Research and Public Health*, *17*(5), 1514. https://doi.org/10.3390/ijerph17051514

Jakob, P. (2006). Bringing non-violent resistance to Britain. *Context*, *84*, 36–38.

Kennedy, T. D., Edmonds, W. A., Dann, K. T. J., & Burnett, K. F. (2010). The Clinical and Adaptive Features of Young Offenders with Histories of Child-Parent Violence. *Journal of Family Violence*, *25*(5), 509–520. https://doi.org/10.1007/s10896-010-9312-x

Lebowitz, E. R., Omer, H., Hermes, H., & Scahill, L. (2014). Parent training for childhood anxiety disorders: The SPACE program. *Cognitive and Behavioral Practice*, *21*, 456–469. https://doi.org/10.1016/j.cbpra.2013.10.004

Margolin, G., & Baucom, B. R. (2014). Adolescents' Aggression to Parents: Longitudinal Links With Parents' Physical Aggression. *Journal of Adolescent Health*, *55*(5), 645–651. https://doi.org/10.1016/j.jadohealth.2014.05.008

McCloud, E. (2017). *Adolescent-to-Parent Violence and Abuse (APVA): An Investigation into Prevalence, Associations and Predictors in a Community Sample* [Doctoral thesis, University of Portsmouth]. https://pure.port.ac.uk/ws/portalfiles/portal/10501192/Elizabeth_McCloud_DCrimJ_Thesis.pdf

Newman, M., Fagan, C., & Webb, R. (2014). Innovations in Practice: The efficacy of nonviolent resistance groups in treating aggressive and controlling children and young people: a preliminary analysis of pilot NVR groups in Kent. *Child and Adolescent Mental Health*, *19*(2), 138–141. https://doi.org/10.1111/camh.12049

O'Hara, K. L., Duchschere, J. E., Connie, ·, Beck, J. A., & Lawrence, E. (2017). Adolescent-to-Parent Violence: Translating Research into Effective Practice. *Adolescent Research Review*, *2*, 181–198. https://doi.org/10.1007/s40894-016-0051-y

Omer, H. (2021). *Non-Violent Resistance: A New Approach to Violent and Self-Destructive Children*. Cambridge University Press.

Omer, H., & Lebowitz, E. R. (2016). Nonviolent Resistence: Helping caregivers reduce problematic behavours in children and adolescents. *Journal of Marital and Family Therapy*, *42*(4), 688–700. https://doi.org/10.1111/jmft.12168

Omer, H., Steinmetz, S. G., Carthy, T., & von Schlippe, A. (2013). The Anchoring Function: Parental Authority and the Parent-Child Bond. *Family Process*, *52*(2), 193–206. https://doi.org/10.1111/famp.12019

Organizational Research Services. (2005). *King County Step-up Program Evaluation*. Organizational Research Services.

Pagani, L., Tremblay, R. E., Nagin, D., Zoccolillo, M., Vitaro, F., & McDuff, P. (2009). Risk Factor Models for Adolescent Verbal and Physical Aggression Toward Fathers. *Journal of Family Violence*, *24*(3), 173–182. https://doi.org/10.1007/s10896-008-9216-1

Papamichail, A., & Bates, E. A. (2022). 'I want my mum to know that I am a good guy...': A thematic analysis of the accounts of adolescents who exhibit Child-to-Parent Violence in the UK. *Journal of Interpersonal Violence*, *37*, 9–10. https://doi.org/10.1177/0886260520926317

Paterson, R., Luntz, H., Perlesz, A., & Cotton, S. (2002). Adolescent violence towards parents: Maintaining family connections when the going gets tough. *Australian and New Zealand Journal of Family Therapy*, *23*(2), 90–100. https://doi.org/10.1002/j.1467-8438.2002.tb00493.x

Routt, G., & Anderson, L. (2011). Adolescent Violence towards Parents. *Journal of Aggression, Maltreatment & Trauma*, *20*(1), 1–19. https://doi.org/10.1080/10926771.2011.537595

Rutter, N. (2020). "I'm meant to be his comfort blanket, not a punching bag" – Ethnomimesis as an exploration of maternal child to parent violence in pre-adolescents: *Https://Doi-Org.Hull.Idm.Oclc.Org/10.1177/1473325020940774*, *20*(5), 1317–1338. https://doi.org/10.1177/1473325020940774

Rutter, N., Hall, K., & Westmarland, N. (2022). Responding to child and adolescent-to-parent violence and abuse from a distance: Remote delivery of interventions during Covid-19. *Children & Society*. https://doi.org/10.1111/CHSO.12622

Ryan, J. P., Helton, J., & Chiu, Y. (2013). *DuPage County step-up program evaluation report.* Urbana Children and Family Research Center.

Samuel, R., Holdaway, C., & Vella, L. (2022). How do adoptive mothers make sense of their experiences of using non-violent resistance therapy with their children? An interpretative phenomenological analysis. *Adoption & Fostering*, 03085759221115212. https://doi.org/10.1177/03085759221115212

Sanders, R. (2020). *ESSS Outline: Adolescent to Parent Violence and Abuse*. Iriss. https://doi.org/10.31583/esss.20200311

Sawyer, S. M., Azzopardi, P. S., Wickremarathne, D., & Patton, G. C. (2018). The age of adolescence. *The Lancet Child & Adolescent Health*, *2*(3), 223–228. https://doi.org/10.1016/S2352-4642(18)30022-1

Schorr-Sapir, I., Gershy, N., Apter, A., & Omer, H. (2022). Parent training in non-violent resistance for children with attention deficit hyperactivity disorder: A controlled outcome study. *European Child & Adolescent Psychiatry*, *31*. https://doi.org/10.1007/s00787-021-01723-8

Selwyn, J., & Meakings, S. (2016). Adolescent-to-Parent Violence in Adoptive Families. *British Journal of Social Work*, *46*(5), 1224–1240. https://doi.org/10.1093/bjsw/bcv072

Sharfman, & Cobb. (2022). *Families and households in the UK - Office for National Statistics*. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/families/bulletins/familiesandhouseholds/latest

Simmons, M., McEwan, T. E., & Purcell, R. (2022). A Social-Cognitive Investigation of Young Adults Who Abuse Their Parents. *Journal of Interpersonal Violence*, *37*(1–2), NP327–NP349. https://doi.org/10.1177/0886260520915553

Simmons, M., McEwan, T. E., Purcell, R., & Ogloff, J. R. P. (2018). Sixty years of child-to-parent abuse research: What we know and where to go. *Aggression and Violent Behavior*, *38*, 31–52. https://doi.org/10.1016/j.avb.2017.11.001

Social research unit, D. (2016). *The Respect Young People's Programme (RYPP)—Report Summary* (p. 11) [Outcomes monitoring]. Dartington Social Research Unit. https://hubble-live-assets.s3.amazonaws.com/respect/redactor2_assets/files/385/RYPP.pdf

Sutherland, G., Rangi, M., Llewellyn, G., Kavanagh, A., & Vaughan, C. (2022). *Toward a socio-ecological understanding of adolescent violence in the home by young people with disability A conceptual review*. www.anrows.org.au

Thorley, W. (2017). *Child -Parent Violence (CPV): An exploratory exercise*. University of Sunderland. https://www.academia.edu/30962152/Child_Parent_Violence_CPV_an_exploratory_exercise

Toole-Anstey, C., Keevers, L., & Townsend, M. L. (2021). A Systematic Review of Child to Parent Violence Interventions. *Trauma, Violence, & Abuse*, 152483802110536. https://doi.org/10.1177/15248380211053618

Van Holen, F., Vanderfaeillie, J., & Omer, H. (2016). Adaptation and Evaluation of a Nonviolent Resistance Intervention for Foster Parents: A Progress Report. *Journal of Marital and Family Therapy*, *42*(2), 256–271. https://doi.org/10.1111/jmft.12125

Weinblatt, U., & Omer, H. (2008). Nonviolent Resistance: A Treatment for Parents of Children with Acute Behavior Problems. *Journal of Marital and Family Therapy*, *34*(1), 75–92. https://doi.org/10.1111/j.1752-0606.2008.00054.x

Wilcox, P., Mortensen, U., Christoffersson, I., & Kommun, A. (2015). *Responding to Child to Parent Violence: Executive Summary*. http://www.rcpv.eu

Williams, M., Tuffin, K., & Niland, P. (2017). "It's like he just goes off, BOOM!": Mothers and grandmothers make sense of child-to-parent violence. *Child and Family Social Work*, *22*(2), 597–606. https://doi.org/10.1111/CFS.12273