



**Merseyside Violence
Reduction Partnership
– Child and Adolescent
to Parent/Caregiver
Violence and Abuse
(CAPVA) research
study
2023**

C A P V A
CHILD ADOLESCENT TO PARENT/
CAREGIVER VIOLENCE AND ABUSE



Merseyside Violence Reduction Partnership – Child and Adolescent to Parent/Caregiver Violence and Abuse (CAPVA) research study

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About this report

Merseyside is one of several areas allocated funding since 2019 by the UK government to establish a Violence Reduction Unit. To inform the continued development of the Merseyside Violence Reduction Partnership (MVRP) since November 2019, Liverpool John Moores University (LJMU), have been commissioned to evaluate the MVRP as a whole (Quigg et al, 2020, 2021, 2022), and selected work programmes. In addition, since 2022/23, LJMU have been commissioned to implement additional research to fill gaps in local knowledge. This report forms one of a suite of outputs from the 2022/23 work programme, and specifically presents a research study examining child and adolescent to parent/caregiver violence and abuse across Merseyside. All MVRP research and evaluation outputs are available on the LJMU² and MVRP³ websites, or via the work programme lead, Prof Zara Quigg (z.a.quigg@ljmu.ac.uk).

Whilst we instinctively recognise the needs of children and young people as a priority, in order to help those children and young people we must also explore the experiences and support needs of parents/caregivers (and other siblings in the household). This report takes a focus on parents/caregivers.

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² <https://www.ljmu.ac.uk/research/centres-and-institutes/public-health-institute>

³ <https://www.merseysidevrp.com/>

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1. Executive summary

1.1 Background and study aim and objectives

The Merseyside Violence Reduction Partnership (MVRP) aims to support the implementation and embedding of a public health approach to preventing and responding to violence across Merseyside. A key part of this approach is to enhance understanding of violence, and to facilitate whole system and place-based approaches to addressing key issues affecting the local community. Child and adolescent to parent violence and abuse (CAPVA) is a form of family abuse where a child uses a range of harmful behaviours towards a parent/caregiver [1]. CAPVA can affect any family from any community and can have devastating impacts on an individual's life, not only for the parent/caregiver but also for the child/young person. In response to growing awareness and local partner concerns regarding CAPVA, in 2022 the MVRP implemented a multi-agency stakeholder event on CAPVA. The event aimed to raise awareness of CAPVA and share examples of prevention and response approaches, and to facilitate discussions about whether or not further work is needed to ensure local and regional responses to CAPVA meet the needs of children and adolescents and their parents/carers, and the practitioners and multi-agency teams supporting them. Critically, the event highlighted the need to improve understanding of the nature, extent, and impact of CAPVA across Merseyside, current service provision and interventions, and areas for development across the whole system. Thus, the MVRP commissioned the Public Health Institute (PHI), Liverpool John Moores University (LJMU) to conduct a research study to enhance understanding of CAPVA, and prevention and response approaches across Merseyside. The primary objectives of the study are to explore:

- The nature and extent of CAPVA.
- Factors that increase risks of exposure to CAPVA (and further harm), and factors that can protect people from harm.
- The impacts of CAPVA on children, families, services, and the wider community.
- The range of practice models and interventions being implemented in Merseyside to prevent and respond to CAPVA, and the perceived and/or actual impacts of these approaches.

1.2 Summary of methodology⁴



Literature review

A rapid literature review was conducted to provide critical context to the study on a variety of factors relating to CAPVA (see [75] for a more detailed review).



Advisory group and stakeholder workshop

An advisory group was established, and stakeholder (n~26) workshop held to support this study. Their main roles were to offer expert advice and guidance on study design, to help map out service provision and to act as gatekeepers to recruit participants/services to the study.



Engagement with stakeholders

Semi-structured telephone or online interviews were conducted with key partners (n~24); and an online practitioner survey ran simultaneously across relevant services and organisations (n~33).



Engagement with parents

Semi-structured telephone or online interviews were conducted with parents/caregivers (n~9) who have experienced CAPVA; and an online parent/caregiver survey ran simultaneously, shared by services and across social media (n~18).

⁴ The full methodology can be found in Appendix 1.

1.3 Key findings

Defining what is CAPVA

Practitioners exhibit a shared understanding of child/adolescent to parent violence and abuse (CAPVA). While some variations in terms like child to adult violence (CAV), child on parent violence (COPV), and child on parent abuse (COPA) exist, most agree on the need for a standardised definition. Both practitioners and parents highlighted how CAPVA covers a range of abusive behaviours beyond physical violence, resembling domestic/intimate partner violence. Some practitioners discussed parallels between current CAPVA discussions and past domestic violence debates. One practitioner highlighted that a shift was needed in how society see the issue of CAPVA as currently it is not on people's agendas in the same way domestic violence between partners is. Although similarities are noted, practitioners grapple with labelling young people as perpetrators. Survey findings underscore that CAPVA is not a new issue but highlights that there is still a limited understanding of CAPVA among parents, practitioners, and policymakers in Merseyside. Despite challenges, a significant portion of practitioners feel confident in recognising CAPVA in clients.

Types of abuse

The study finds that CAPVA is rarely confined to a single form of abuse, with most parents and caregivers experiencing multiple types. While physical abuse is often the most reported, other forms like verbal, emotional, and financial abuse are considered "lesser" and less frequently reported to authorities. Coercion tactics are common, involving manipulation, threats, and self-harm. Sexual violence is believed to be less prevalent. Experiences of abuse change over time, escalating in severity for some parents, leading to fears for their safety as their children grow older. Emotional abuse is pervasive, with threats, insults, offensive comments, and humiliation being commonly reported. Destruction of property, restrictions on behaviour, and financial abuse are also prevalent forms of abuse experienced by parents and caregivers, often involving manipulation, intimidation, and violence.

Extent of abuse

A significant portion of both parents (64.7%) and practitioners (84.8%) agree that CAPVA is a problem in Merseyside. A majority of practitioners (65.5%) perceived an increase in CAPVA incidents in the past year compared to the previous year, while none reported a decrease. Barring our own practitioner/parent surveys the data presented in this review exclusively originated from support services - we encountered difficulties in obtaining any police-related data regarding reported CAPVA incidents in Merseyside. Overall, the data was limited and posed challenges for the services to acquire. Service data that was provided included referral numbers, the demographics of those seeking support, information on child/young person committing the abuse, the type of support provided, and the outcomes of the support offered. However, most data systems employed by support services are still in their early stages, leading to gaps, recording errors, inaccuracies, or incomplete data, which, in turn, make it difficult to comprehend the full extent of CAPVA across Merseyside. Furthermore, practitioners attributed a lack of reporting by families to individual thresholds of what constitutes abuse, influenced by personal experiences of adverse childhood experiences (ACEs) and varying tolerances due to exposure of abuse in growing up. Participants believe CAPVA is highly prevalent, often unreported, and a relatively new research focus. Shame and guilt associated with CAPVA deter families from seeking support, though some practitioners note a shifting trend with increased awareness and reduced stigma, enabling more families to come forward. Services might not explicitly inquire about sensitive topics like family violence, leading to cases only surfacing when families present for other reasons and develop rapport with practitioners.

Demographics of those involved in CAPVA.

Whilst evidence on the prevalence of CAPVA across Merseyside (and elsewhere) is lacking, data collected as part of this study suggests that women/mothers may be a key at-risk group. Data from services shows that the majority of individuals received support are women, and the majority of study survey respondents were women. Practitioners noted that females, due to societal roles and physical vulnerability, are more likely to be victims of CAPVA. However, some practitioners reported a shift in Merseyside, with a 50/50 split between male and female committing CAPVA and differences in the types of abusive behaviours exhibited. Children/young people's behaviours typically peak in their early to mid-teens, prompting families to seek support when challenges become more difficult to manage physically. While the norm is early to mid-teens, the age at which children are supported by a services was perceived to have decreased, with some as young as six receiving support.

Impacts of CAPVA

Parents/carers acknowledged that CAPVA has a profoundly negative impact on their lives. Practitioners confirmed that CAPVA can severely affect the mental health and well-being of parents/caregivers, leaving them feeling helpless, disempowered, and lacking confidence. Parents/caregivers described experiencing psychological trauma due to CAPVA, leading to feelings of fear, being undermined, and disempowered as parents. The fear of their child's abusive behaviour and potential financial consequences often left them feeling isolated and unable to discuss the issue due to the stigma surrounding it. This isolation was compounded by the shame and embarrassment parents/caregivers felt about being abused by their own children. Wider negative impacts included strained relationships with partners, isolation from family and friends, financial strain due to damages and costs of dealing with abuse, and even potential job loss due to controlling behaviours of the child. The impacts extended beyond the immediate family, affecting siblings, wider family members, local communities, and even neighbours who were exposed to the abusive behaviour. There was concern about the long-term effects of CAPVA on the child/young person, with worries about their ability to form healthy relationships in the future and potential criminalisation due to their violent behaviours. Practitioners stressed the need for a trauma-informed approach and addressing root causes to prevent long-term negative consequences.

Risk factors

Practitioners identified a range of risk factors contributing to the likelihood of families experiencing CAPVA. These factors, consistent with wider literature, included childhood trauma such as family breakdown, domestic violence, and significant life changes like moving or accidents. Adverse childhood experiences (ACEs) were seen as influential, particularly when children witnessed domestic violence, leading them to learn such behaviour. Neurodevelopmental disorders like attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD), traumatic brain injuries, and experiences of grief and loss were also recognised as potential risk factors, with practitioners highlighting how these conditions could lead to violent behaviours. Low socioeconomic status was associated with higher vulnerability to CAPVA due to increased stress and financial pressure. Parenting style and attachment were discussed, noting the importance of teaching children responsibility and the impact of blocked care and trust⁵. Social media's influence, exposing children to toxic

⁵ A child that has experienced early life trauma can form a mistrust of the world and the people around them; this is described as blocked trust. Whereas blocked care can happen when parents experience prolonged stress, which suppresses their capacity to sustain loving and empathic feelings towards their child.

communication and negative content, and contextual/community factors such as child criminal exploitation and lack of positive role models were also recognised as contributing to CAPVA risk.

Protective factors

Education was viewed as a protective factor against CAPVA, with strong communication between parents and schools being crucial to ensure consistent boundaries and behavioural expectations. Swift intervention was deemed essential to prevent further harm, as delaying support could exacerbate the issue. Early identification of neurodiverse conditions, given their association with CAPVA risk, was highlighted, emphasising the need for early screening. Practitioners stressed the importance of setting boundaries and adopting an assertive parenting style that fosters responsibility early on to build children's confidence and resilience. Establishing a secure attachment between parents and children from the beginning was seen as critical, particularly in cases of adoption and kinship care. Respite for families dealing with CAPVA was considered protective, offering breaks to manage parental stress and reduce the frequency or severity of abusive behaviour, especially for children with additional needs.

Strategies and interventions to prevent and respond to CAPVA across Merseyside.

Currently, Merseyside lacks a comprehensive system-wide approach to preventing and addressing CAPVA, although various individual services and organisations offer support for CAPVA. For example, the Merseyside Police and Crime Commissioner (PCC) has initiated the Respect Young People's Programme (RYPP) in collaboration with Merseyside's Domestic Violence Service (MDVS) to address abusive behaviours of children and young people towards their parents/caregivers. Training initiatives and interventions related to CAPVA and its prevention are available through organisations such as Merseyside Youth Association (MYA), Sefton Women's and Children Aid (SWACA), and others. While many services offer general family support mechanisms, only a few have specific CAPVA interventions or policies. Collaboration between organisations is increasing to provide more efficient and flexible support to families across Merseyside. Notable CAPVA specific interventions offered across Merseyside include the Who's in Charge? Programme, Non-violent Resistance Training, CAPA First Response, and Respect Young People's Programme, aiming to equip parents, children/young people, and practitioners with tools to prevent and mitigate the impact of CAPVA.

Impacts of support

Around half of the participating parents in the survey reported receiving support from services related to CAPVA, while those who were interviewed often lacked awareness of available CAPVA-specific interventions. Some parents engaged in interventions like Non-Violent Resistance (NVR) training and Who's in Charge? training, while others received support from organisations such as Child and Adolescent Mental Health Services (CAMHS), Youth Offending Teams (YOT), the Young Person Advisory Service (YPAS), Parental Education Growth Support (PEGS), the Paul Lavelle Foundation, and more. Peer support was highlighted as a significant positive outcome, with parents and caregivers valuing the opportunity to share experiences and connect with others facing similar challenges. These connections extended beyond the sessions, as some parents formed support networks through platforms like WhatsApp. Practitioners noted the gradual but impactful changes resulting from interventions, focusing on small victories that cumulatively improved family dynamics. Positive impacts included improved relationships, rebuilt trust, and better communication within families, with practitioners emphasising the importance of shared responsibility and mutual understanding in addressing CAPVA and fostering healthier interactions.

Provision across Merseyside

The practitioner survey revealed that just under half of the participants (48.5%) felt confident in supporting clients who have experienced CAPVA and a similar percentage reported confidence in signposting clients for further support. However, only a small minority believed that adequate support existed for parents/caregivers and children/young people affected by CAPVA (3.2% and 3.1% retrospectively). The majority of practitioners (87.5%) expressed the need for more training to effectively prevent and respond to CAPVA. Some practitioners believed that sufficient support was available in Merseyside, but families often struggled to access it due to lack of awareness about available resources. Those who perceived adequate provision often attributed it to specific training, services they provided, or their extensive experience, while acknowledging that colleagues with less familiarity might struggle to know where to direct families for CAPVA-related support. Practitioners also highlighted challenges such as overcapacity and workload pressures that hindered effective assistance, leading to long waiting lists for services and exacerbating the issues associated with CAPVA. Parents and caregivers similarly expressed dissatisfaction with available resources, describing ineffective interventions and long waiting times for support services. Some practitioners noted a gap in how the police handle CAPVA-related incidents, with uncertainty about appropriate actions leading to varying responses. Many parents reported having contacted the police in relation to CAPVA (70.6%) but often found limited effectiveness in their responses.

Challenges for families seeking support.

Various barriers to accessing support for CAPVA were identified by participants. These barriers included time commitment and travel costs for parents/caregivers to attend intervention programmes, often leading to incomplete participation and missed benefits. Transport barriers also prevented families from accessing services, highlighting the importance of offering virtual support options. Stigma, shame, and guilt associated with CAPVA were recognised, leading to self-blame and a fear of judgment, discouraging parents/caregivers from seeking help. The normalisation of abusive relationships and cultural norms of keeping family issues private further reinforced the stigma. Parents/caregivers with mental health issues faced challenges in reaching out for support, as did neurodiverse children's parents/caregivers. Lack of knowledge about where to find support and failing to receive the right support often meant families reached crisis points before seeking help. Lack of trust in services also emerged as a barrier, with past negative experiences deterring families from engaging with professionals. Some parents/caregivers were discouraged from disclosing CAPVA due to concerns of social services' involvement. Lack of support from family members, particularly partners, was recognised, and insufficient capacity in services hindered the provision of effective assistance. Funding limitations often led to a lack of resources and staff to support families. Moreover, the inconsistency in training and service availability across different areas contributed to a sense of a postcode lottery.

Areas for development

Participants in the study expressed a lack of consensus regarding the responsible organisations to address CAPVA. Some service users found themselves overwhelmed by the number of professionals involved in their cases, while others experienced a lack of responsibility from any service. Suggestions emerged for specific organisations or professionals, such as youth workers, to handle CAPVA due to their skill in engaging with children and families. Flexibility within services was highlighted as important, with both face-to-face and online sessions being considered valuable options, though barriers to online engagement were noted. Tailoring intervention programmes to individual cases and providing ongoing support after programme completion were emphasised to address the non-linear

nature of improvement in CAPVA cases. Participants stressed the need for increased awareness, training, and collaboration among various services to effectively tackle CAPVA. Improved provision in education, early intervention, support groups, helplines, enhanced service capacity, funding, and better data collection systems were also identified as crucial factors to address CAPVA effectively.

1.4 Recommendations

System wide recommendations

To enhance responses to CAPVA across Merseyside, system-wide developments are needed supported by a collaborative multi-agency approach. Critically, it is imperative for services and organisations to record CAPVA under its own umbrella and implement a rigorous data collection mechanism that enables a greater understanding of the nature, extent, impacts and risk (and protective) factors for CAPVA to inform prevention activity. Furthermore, more funding and resources are needed in order to raising awareness of CAPVA and the current available support across the community, practitioners, and services. Equally vital is the necessity to allocate additional funding to enhance existing support and to introduce innovative measures to aid families affected by CAPVA. In addition, organisations should be encouraged to provide specialist CAPVA training for practitioners, and the development and enhancement of support provision that recognises the diverse and evolving needs of children, young people, and families. Key recommendations for whole system change include:

- 1. Establish a Merseyside CAPVA Multi-Agency Steering Group:** Create a multi-agency steering group including representatives from third sector organisations, police, health and social care, education, and the community. The group would have a key role in driving the development of responses to CAPVA across Merseyside, linking into relevant regional and local violence prevention governance and practice structures. This may include: identifying priority areas for preventing and responding to CAPVA (see below for examples based on this research) and mechanisms for implementation (providing clarity on the role and responsibilities of different organisations); enabling the sharing of best practices; and supporting the co-design, co-commissioning and/or co-delivery of prevention activity, that enables more timely and effective support provision for children, young people, and families.
- 2. Enhance CAPVA data collection and sharing within and across organisations:** Support the development and implementation of a rigorous data collection mechanism that enables a greater understanding of the nature, extent, impacts and risk (and protective) factors for CAPVA to inform prevention activity. This should ensure that data is collected across services in a comparable way, and systems are established to support the sharing of data within and across services as relevant levels (e.g. aggregated and individual level). Through the sharing and regularly review/analyses of data on CAPVA, this would facilitate a coordinated response, ensuring that families receive appropriate support and interventions without gaps or duplication. Whilst all service types should work to enhance their CAPVA data collection and sharing processes, specific attention should be given to police data systems to enable identification of incidents of CAPVA and timely referral to support agencies.
- 3. Training for practitioners:** Provide comprehensive training for professionals who frequently interact with children, young people, and families such as social workers, case workers, therapists, educators, healthcare providers, and the police. This training should focus on recognising the signs of CAPVA, appropriate intervention strategies and effective communication techniques, neurodiversity, and trauma-informed care. Ongoing professional development can ensure practitioners are equipped to address the complexities of CAPVA cases particularly in roles with a high turnover of staff. Universal training for wider practitioners should aim to raise awareness of

the issues and support provision and referral pathways. Such training should be short and accessible (e.g. online) to ensure practitioners can attend, as well as regular refresher session to ensure best practice across organisations.

4. **Public awareness campaign:** Develop targeted public awareness campaigns to destigmatise CAPVA and encourage reporting, and awareness and engagement with support provision. Use various platforms including social media and community events and advertise in highly frequented locations such as GP surgeries, schools, and public transport to inform parents, children, and professionals about the signs of CAPVA, available resources, and avenues for support. Furthermore, having one central hub/website that organisations and parents can use which includes guidance for practitioners and information on suitable services/interventions for parents, would help streamline support and reduce confusion.

Intervention specific recommendations

This study has identified several approaches that may help to prevent and/or mitigate the impacts of CAPVA which partners may wish to consider when developing and implementation local or regional responses to CAPVA.

5. **Support website and helpline:** Develop one dedicated website/webpage tailored for children, young people and parents and caregivers experiencing CAPVA. This platform would offer comprehensive information on CAPVA and a directory of support services and offer in Merseyside. Additionally, the website could be complemented by a helpline with extended hours, connecting parents/carers to CAPVA-trained practitioners for guidance once immediate crises have passed, emphasising the option to contact the police if in immediate danger. By providing this helpline, the aim is to enable families to seek advice without lengthy referral processes, potentially reducing crises and subsequent police interventions. Moreover, this service ensures ongoing support for parents even after completing an intervention, fostering long-term assistance for families.
6. **Increase police awareness of support services:** As first responders to incidences of CAPVA police officers need to be aware of relevant support services. Police officers could carry cards with contact information to relevant support services or have a list of services available on electronic devices which would allow officers to provide support contacts in a moment of crisis.
7. **Parent/caregiver support groups:** Support the development of parent/caregiver support groups. One of the biggest impacts for parents/caregivers from attending the various interventions was the formation of support groups and having a network of individuals who have experienced similar circumstances. Such groups can enable peer support and create safe spaces for parents/caregivers to share their experiences, challenges, and strategies for managing CAPVA. These support groups can provide emotional validation and a sense of community, reducing isolation and promoting healthy coping mechanisms.
8. **Engage schools in prevention:** Collaborate with schools to integrate CAPVA prevention programmes into the school curriculum from a young age as a form of early prevention. This could coincide with current provision available in schools on violence prevention and could be offered as a module on some of these programmes. These programmes can cover topics such as conflict resolution, emotional regulation, communication skills, and empathy-building, some of which will have been previously covered on pre-existing programmes. By empowering students with these skills, schools can contribute to creating a culture of respectful relationships and prevent CAPVA (and other forms of violence) in the long-term.
9. **Tailor interventions to ensure they are person/family centre, considering neurodiversity:** Ensure that service provision is person and family centred, and recognises that approaches may need to be tailored for neurodiverse individuals. Agencies should work with families to tailor interventions to each person's specific needs, strengths, and challenges. Furthermore, the education system

plays a pivotal role in identifying and addressing CAPVA, yet neurodiverse children often lack appropriate support in mainstream schools, leading to behaviour-related issues at home. Helping schools to support these individuals could help reduce the number of students expelled from school. Schools and other organisations should link in with organisations who specialise in neurodiversity for example the Brain Charity, for guidance and training.

- 10. Research and evaluation:** Allocate resources for CAPVA research and evaluation of prevention efforts. Regularly assess the impact of implemented programmes, identify areas for improvement, and refine strategies based on evidence.

1.5 Conclusion

CAPVA poses a significant challenge to families, professionals, and communities. Insights drawn from parent/carer and practitioner interviews and surveys highlight CAPVA as a considerable problem across Merseyside. Merseyside, despite its vibrant community and resources, faces several challenges when it comes to addressing CAPVA. These include underreporting due to shame or fear, limited awareness among parents and professionals about CAPVA, and gaps in available support services tailored to this specific issue. Additionally, the stigma attached to admitting that one's child is abusive can hinder parents from seeking help. Similar to previous research [2] a lack of a universally accepted definition for CAPVA exacerbates the problem. Addressing CAPVA's multifaceted challenges requires collaboration and comprehensive strategies. Raising awareness, training professionals, defining responsibilities, securing funding, enhancing data recording, and recognising the nuances of neurodiversity are vital components. By navigating these complexities, Merseyside can pave the way toward fostering safer, more empathetic, and supportive environments for families contending with CAPVA.

2. Literature review

2.1 Defining child and adolescent to parent/caregiver violence and abuse (CAPVA)

Child and adolescent to parent/caregiver violence and abuse (CAPVA) is a form of family abuse where a child uses a range of harmful behaviours towards a parent/caregiver in an attempt to get their own way, hurt or punish, communicate distress and/or control their environment [1]. Variation in the definitions of CAPVA make cross study comparison difficult [2]. For example, some studies [3, 4] group both single incidences of violence towards parents and repeated offences together as CAPVA, whereas others only consider ongoing abuse as CAPVA [5, 6], resulting in both over and under estimation of the extent of the issue.

2.2 CAPVA and UK policy

Until recently, CAPVA has gone unrecognised within UK social policy resulting in it being under reported and under researched [2, 7]. There are no specific policies or laws relating to CAPVA resulting in many organisations utilising pre-existing policy frameworks for example, domestic violence policies [1]. Some services and organisations believe that CAPVA falls under the remit of domestic violence, however, according to the Home Office, domestic violence is “any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality” [8]. Therefore, any individual who abuses their parent whilst they are under the age of 16 would not meet this threshold. Further to this, established domestic violence policies fail to recognise parents and children as both victims and victimisers [9]. Whilst there are some similarities between CAPVA and domestic violence in the nature of the abuse, there are some crucial differences for example, the differing power dynamic between parents/caregivers and children/adolescent [1]. In addition, domestic violence services encourage victims of a domestically violent relationship to separate from their abusive partners; the opposite is true of a child to parent relationship. Further to this, there is a consensus amongst professionals of not wanting to criminalise children which differs from domestic violence where victims are often encouraged to report the abuse to the police [1]. This absence of a CAPVA-specific policy has meant there is a lack of consistent and universal guidance for services and practitioners to access and utilise. The lack of policy and guidance for professionals is exacerbated by a current lack of legal definition of CAPVA in the UK and no official way of recording cases should they occur [10].

2.3 Understanding the extent of CAPVA

At local, national, and international level evidence on the extent of CAPVA is limited, primarily due to the stigma surrounding this issue leading to many parents/caregivers not reporting to services, or only reporting when the harm has reached crisis point; and insufficient frameworks and processes for recording CAPVA across services. Collectively, this leads to many CAPVA incidents going unrecognised and unreported, or where it is reported, being recorded as another issue or within written case notes [1]. Several data sources have the potential to provide some insights into CAPVA however, including statutory and non-statutory data sources, and research studies or population level surveys. For example:

- Whilst CAPVA is not formally recorded in the Crime Survey for England and Wales (CSEW), secondary analyses of CSEW data estimates that 1.2% of all violence reported in the survey is

related to CAPVA, and that approximately 40% of CAPVA victims did not report the offence to the police [11].

- There are a few studies within the UK carried out with children/young people to assess their levels of committing CAPVA. One study with secondary school children found that 10% of participants had exhibited CAPVA behaviours towards a parent/caregiver [12]. Similarly, a study utilising 890 secondary school students found that CAPVA was prevalent amongst 64.5% of their participants with psychological abuse more prevalent than physical abuse (64.4% and 4.3% respectively) [13].
- In a UK study of families (n=209) receiving support from family support services, 54% of assessments carried out by social workers had reports of children abusing their parent/caregivers [14].
- A study of adoptive parents/caregivers across England and Wales (n=390) found that 16% were victims of violence by their children [15].
- During 2017 to 2021, the Metropolitan Police Service recorded around 4,500 offences against parents where children (aged up to 19) were listed as the suspect or accused. Of these, nearly half of children were aged 15-17 years (47%), 28% aged 11-14 and 24% aged 18-19. Less than one in ten children were proceeded against, reducing from 15% in 2017 to 4% in 2021 [16].
- Evidence from London's Violence Reduction Unit (VRU) CAPVA needs assessment report (2022) found that practitioners felt the severity of cases which they have encountered over the last 12 months had worsened with both practitioner and parent/caregiver interviews revealing that CAPVA was more likely to be reported to the police if physical incidents with injuries consistent with grievous bodily harm (GBH) or actual bodily harm (ABH) had taken place. Further to this, police officers interviewed said that they have noticed an increase in homicide cases, where a child/young person had killed their elderly parent/caregiver/grandparent, which was suggested to be associated with mental health issues brought on by the pandemic, as well as individuals who are more prone to violence and becoming volatile during lockdown due to confinement within the household [11].
- Caseload data across four local authorities in England (2016-2017) revealed that of youth offending cases, 21-27% were CAPVA related. Further to this in police domestic abuse cases within those local authorities, in 64%-67% of incidences, the suspect was found to be under 18 and perpetrating violence towards a parent [17].
- Data provided by the service Parentline (run by Family Lives) reported that between 2007 and 2008 over 2,000 calls were made to Parentline regarding CAPVA, which went on to increase to 7,000 over the two years following (this was in addition to 22,537 calls regarding non-physical aggression from children towards parents with in the same time period) [18].

Given the lack of a clear and consistently used definition of CAPVA, and reporting and recording mechanisms, coupled with the stigma surrounding the issue, it is likely that the prevalence is much greater than current data and studies suggest. Further evidence from London's VRU CAPVA needs assessment indicate practitioners expect that levels of CAPVA will increase in future [11]. Whilst these data sources and research studies can provide an indication of the extent of CAPVA, they also highlight gaps in intelligence and variations in data, and critically, the need to better understand the issue.

Earlier studies have found that research methods used to explore CAPVA are focused on looking at findings already reported, rather than looking at the issue in its entirety [19]. Much of the previous CAPVA research draws upon data that looks at who is involved in CAPVA and what is happening, as opposed to understanding prevalence across populations, and underlying risk and protective factors.

Due to the cross-sectional nature of the research methods used to explore CAPVA, a focus on longitudinal research needs to take place in order to observe the process over a longer period of time and identify risk and protective factors [1, 20].

2.4 Impacts of CAPVA

The impacts of CAPVA affect a range of individuals, including the child/young person and parent/caregiver directly involved, but also any siblings, grandparents, extended family, and the wider community [1]. Studies have shown the severe emotional impacts CAPVA has on parents/caregivers who are victims, in particular mothers [1, 3, 21]. This includes, but is not limited to, stress, anxiety, depression [3, 18, 22, 23] and in some instances, suicidal thoughts, especially when the abuse is prolonged [24]. Parents often experience feelings of guilt and parental failure, particularly in cases where the child has to be removed from the family home for safety [15, 24]. The impacts on the child/young person can also be substantial and can include educational impacts, mental health challenges, substance misuse, peer violence, and severe impacts on familial relationships (not only with parents but also wider family i.e. siblings and grandparents) [1, 14, 21]. Police involvement can have an impact, with criminalisation affecting the child/young person's life chances [25, 26]. Critically, some studies suggest that CAPVA could be one part in a continuous loop of violence leading to later perpetration or victimisation of violence with intimate/dating partners [27].

2.5 Risk factors

A range of factors can increase risk of exposure to CAPVA. Studies suggest that experience of CAPVA can vary by gender. Most research indicates that male children are most likely to commit CAPVA [9, 28], however, some evidence contradicts this with several studies suggesting that the gender of the child/young person varies [4, 28]. Several studies have found that the types of abuse committed varied between genders with sons more likely to utilise physical abuse and daughters more likely to use other forms of abuse i.e. verbal, emotional, psychological, and financial abuse, and so it is more likely that the son's violence gets reported (e.g. to the police) and the daughter's abuse is less apparent [29]. Furthermore, several studies suggest mothers are significantly more likely to experience physical abuse compared to fathers [22, 30]. CAPVA can begin at any age, with one study reporting CAPVA from ages as early as five years old [23] however data and research studies suggest that it typically peaks between the ages of 14 to 16 and slows down at 18 years old (however this may be due to recording practices, and children being classed as adults from age 18 plus) [4, 28, 31].

Domestic violence between parents in a household, historical and/or current, is believed to be a significant risk factor for both being a parent/caregiver who is a victim of CAPVA as well as a child committing CAPVA [32, 30]. The CSEW identified that separated/divorced women were more likely to have experienced domestic abuse which is a significant risk factor for CAPVA [33].

Poor mental health in children and young people is believed to be a substantial risk factor for committing CAPVA [29, 34]. Children who have experienced past trauma and have developed attachment problems have been found to be violent towards their parent/caregiver and can result in a cycle of violence that can be generational [35, 36]. Other studies indicate that adolescents who display behavioural problems at home may also be likely to exhibit those behaviours in other settings for example being disruptive in school [20]. Children/young people on the verge of ending up in the care system [14], and adoptive families are at greater risk of experiencing CAPVA [15].

2.6 CAPVA interventions

In recent years, interventions specifically addressing CAPVA have started to emerge, however few interventions are thoroughly evaluated, and the availability and accessibility of interventions across and within areas in the UK can vary substantially [37]. Until there is an overall agreement on the definition, law, policy, and guidance on CAPVA, families with lived experience are likely to receive insufficient and uncoordinated support from services who each have their own concept, definition, and ideas of how to address CAPVA [38]. There is no single service that is solely responsible for preventing and responding to CAPVA. Previous research indicates that a multi-agency response should be used, including health professionals, schools, social services, housing, the police, and youth justice services [39]. According to a recent literature review there are five well regarded and widely delivered CAPVA programmes in the UK: Non-violence Resistance (NVR), Who's in Charge?, Step Up, Break4Change, and Respect Young People's Programme (RVPP) [1]. Where evaluation on those programmes has been carried out, the results appear positive [1]. There are other avenues for support too, for example self-help books [40, 41]. Whilst some parents felt these books have positively supported them, there is no evidence of their effectiveness, and they are unlikely to be useful in complex cases [1]. Helplines are also available, such as the parent support line ran by the UK charity Family Lives which offers more flexibility and accessible support (formerly known as Parentline Plus) [18].

3. Findings

3.1 Defining what is CAPVA

Generally, there was a clear consensus amongst practitioners on what they believe falls under the umbrella of CAPVA. Most participants acknowledged that CAPVA is child/young person or adolescent to parent violence and abuse. Definitions altered slightly with some organisations using the acronyms CAV, COPV, and COPA. Some practitioners stated the importance of including any other caregivers within the definition i.e. foster parents, grandparents, or other carers, as well as siblings who may be impacted. Other practitioners disliked the term 'violence' in relation to talking about children. However, most felt that there needed to be one standard definition on what CAPVA is across all services, so all agencies have a clear understanding of the issue. Whilst a few of the parents/carers interviewed had "*never heard of [CAPVA]*", those familiar with the term defined it as child/adolescent to parent violence.

"I think it is language that's different, you know, adolescent on parent there's lots of different sort of language and it is about having that shared language across services, isn't it?" (Practitioner 3).

There was recognition that CAPVA encapsulated a range of abusive behaviours beyond physical violence. Several parents equated CAPVA to intimate partner violence "*I very much see it the same as domestic abuse*" (Parent 4). Several practitioners touched on the similarities of CAPVA and domestic violence⁶ with some practitioners stating that current discussions around CAPVA are comparable to discussions they had 15 years ago regarding domestic violence. One practitioner felt that there would need to be something extreme to happen for there to be any governmental buy in and any positive culture changes to be enacted. They felt a shift was needed in how society sees the issue of CAPVA as currently it is not on people's agendas in the same way domestic violence between partners is.

"It's domestic violence by a young child. Yeah, because that that's what it is, you know. And it's not just the physical, it's the mental, the emotional, the financial. You know, and you're like a prisoner as well because you're scared to go out because you don't know what you're gonna come back to, if you're gonna come back to a home and stuff" (Parent 1).

"I think we're at a stage where we're treating this like we did domestic abuse 15 years ago. We've got women and men who are terrified of their children. I think, look, it is going to happen. We are going to see someone get murdered. I mean, there are children who've murdered their parents already across the country, but I think we're gonna end up with a situation where someone's gonna have to die or a couple of people are gonna have to die before we address the elephant in the room and say, there is a fundamental societal issue around this now" (Practitioner 13).

Other practitioners were against labelling CAPVA as domestic violence and felt it should be called by its own name, however, they were unsure what that might be. They noted that there was a lack of confidence among practitioners, with some finding it easier to deal with it and understand it if they label it as domestic violence as that is more familiar to them.

⁶ Referring to domestic violence and domestic abuse.

“Probably a lack of confidence, you know, because some people will still place it as like domestic abuse and it's not domestic abuse some people will try and categorise it into something what they know” (Practitioner 1).

Most, however, acknowledged that whilst you are not “supposed” to class it as domestic violence, there are significant similarities and there needs to be more clarity in the legislation for children/young people under the age of 16 who display these behaviours.

“For me legislation wise it's under 16 and these are children so we're not supposed to class it as domestic abuse but it's similar to intimate partner violence, but you're not supposed to say that, but the characteristics are there however we don't want to label young people as perpetrators because that can do severe harm to them later on” (Practitioner 15).

Nearly half (48.5%) of practitioners who completed the practitioner survey had engaged in CAPVA work for more than 6 years, indicating that CAPVA is not a new issue. A small number of practitioners (3.0%) and none of the parents agreed/strongly agreed that there was a good understanding of CAPVA across generally across Merseyside. Furthermore, just over one in ten (12.1%) practitioners and a small minority (5.9%) of parents agreed/strongly agreed that there was a good understanding of CAPVA amongst policymakers and practitioners in Merseyside. Two thirds (63.6%) of practitioners agreed/strongly agreed that they felt confident recognising CAPVA in clients.

3.2 Types of abuse

Nearly parent/caregivers and practitioners felt CAPVA was almost never just one type of abuse, in reality most parents/caregivers will have experienced multiple forms of abuse (Box 1). Some practitioners felt that physical abuse was probably the most reported type, however, that was most likely due to other forms of abuse deemed as “lesser forms” (i.e. verbal, emotional, and financial abuse), resulting in less parents/caregivers reporting this to the police or services. This was supported by a police officer interview who felt parents called the police when behaviour had escalated to a point where it was unmanageable or there was a danger to other siblings within the household. The use of coercion was also seen as a frequent form of abuse such as the child/young person using blackmail, self-directed harm, and other forms of manipulation to get the parent/caregivers to do what they want. Whilst it was acknowledged that sexual violence could be present in some cases, it wasn’t believed to be a common form of abuse, for example no parents/caregivers interviewed for this research reported sexual abuse *“I’m not saying sexual abuse doesn’t happen, but that’s probably the one not as prevalent for CAPVA” (Practitioner 5).*

“That’s normally when the parent would phone the police, when they have got to a point where they can’t control it anymore. They don’t know what to do so they look to the police for support. It’s become violent and there might be other children in the house, especially if parents had sort of younger children in the house.” (Practitioner 24).

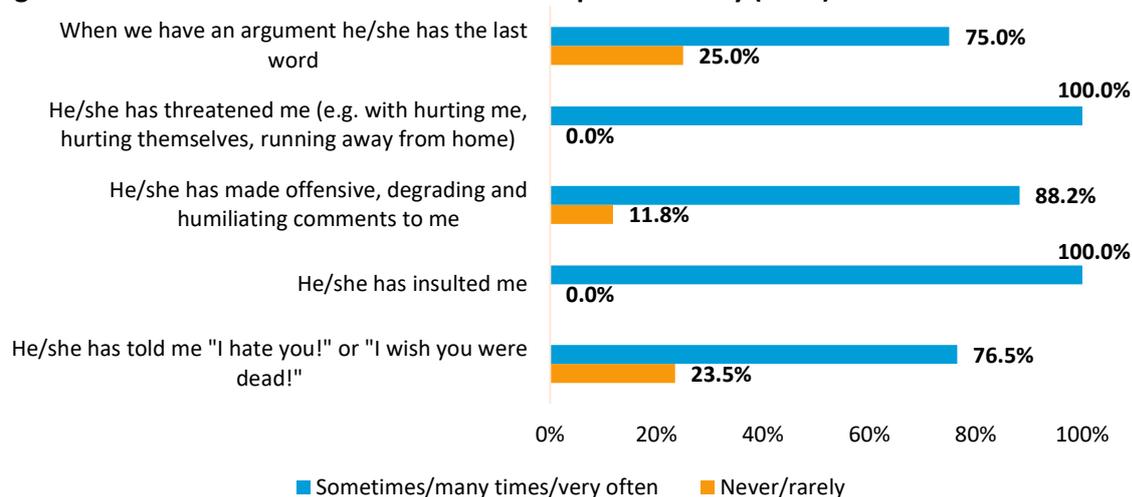
Some parents highlighted that the types and severity of abuse they experienced changed and escalated over time. Several parents said they did not *“feel safe in [their] own home” (Parent 4)* and felt a need to *“protect themselves” (Parent 3)*. Some lived in *“constant fear of things escalating” (Parent 4)* especially as their children got older.

“To be honest, that is my biggest, biggest fear of the lot. It absolutely terrifies me because he’s getting bigger, he’s getting stronger” (Parent 5).

Emotional abuse:

Findings from the parent survey indicate levels of abuse were high (sometimes/many times/very often) across all questions relating to emotional abuse with all parents reporting their child had threatened them (e.g. with hurting me, hurting themselves, running away from home) and insulted them. In addition, a high number of parents also reported that their child sometimes/many times/very often has made offensive, degrading, and humiliating comments towards them (88.2%), been told “I hate you!” or “I wish you were dead!” (76.5%) and when having an argument, the child always gets the last word (75.0%; Figure 1).

Figure 1: Emotional abuse statements from the parent survey (n=18)



All parents/carers interviewed suffered some form of emotional abuse. They reported being:

- Threatened and accused *“I'm going to call ChildLine, I'm going to report you to social services and I'm going to call the police on you ... I think [parent] is really concerned that [adolescent] will escalate accusations against them and whether that be from a physical perspective or even where there's always this underlying fear as to what [adolescent] may say and to the point where he is uncomfortable being completely alone with them because you don't know what they may accuse you of” (Parent 4).*
- Humiliated *“And do you know the worst one out of it, weren't the violence, the punches and the kicks and stuff like that. The worst part about it was getting swilled with a glass of diet coke. I've never felt so demeaned. It was horrible” (Parent 6).*
- Intimidated *“And it was stuff with knives he would take knives out the kitchen and he would just hold them towards me. Just like, you know, I could hurt you if I wanted to. And I it would just be this battle of, like...but truth was, I was intimidated by it and he would sense that” (Parent 7).*
- Manipulated *“One of the things [adolescent] always says is you know where we don't do enough and you feel incredibly guilty that, you know, maybe we haven't done enough... always have to hand [adolescent] money and I'm feeling guilty if I don't” (Parent 4).*

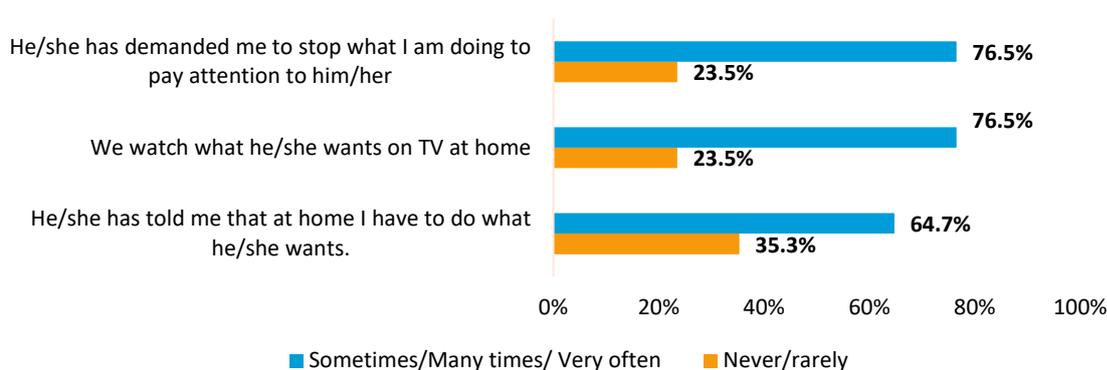
Destruction of property:

Several parents suffered the destruction of property. One parent noted that the destruction was often *“targeted... at something that I valued” (Parent 7)*. Another said *“It was just, the violence was just escalating, you know, the house was getting smashed to pieces, I mean, like every door in the house was smashed. She was setting fire to her bedroom, you know, she was really, really dangerous. Setting fire to her bedroom, setting fire to anything the, you know, under the trees in the garden” (Parent 1).*

Restrictions:

The parent survey found that over three quarters (76.5%) of parents reported that their child had demanded they stop what they are doing in order to pay them attention. The same number of parents also reported that they had to watch what the child wants to on TV at home. Two thirds (64.7%) of parents said that their child had told them at home they have to do what they want (Figure 2).

Figure 2: Restriction statements from the parent survey (n=18)

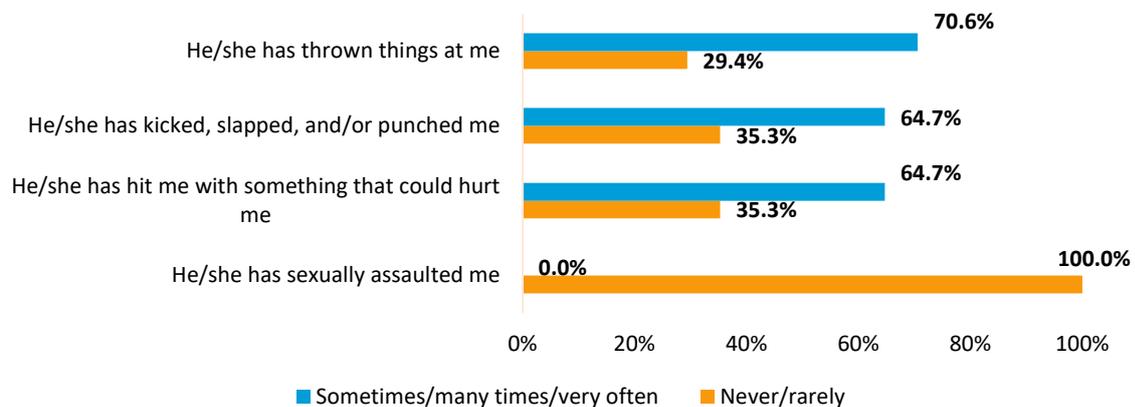


Parents mentioned being locked in or out of their own homes and the need to think about extra keys and exits to avoid this happening *“she locked the front door and refused to let us out and was threatening us with, well threatening me sorry and refused to let me out, and my son was scared. So, I rang the police then and said I need help I don't know what to do” (Parent 2).*

Physical violence:

Seven in ten (70.6%) parents reported their child had thrown things at them. Two thirds (64.7%) reported that their child had hit them with something that could hurt them, and the child had kicked, slapped, and/or punched them. No parents reported being sexually assaulted by their child (Figure 3).

Figure 3: Physical violence statements from the parent survey (n=18)

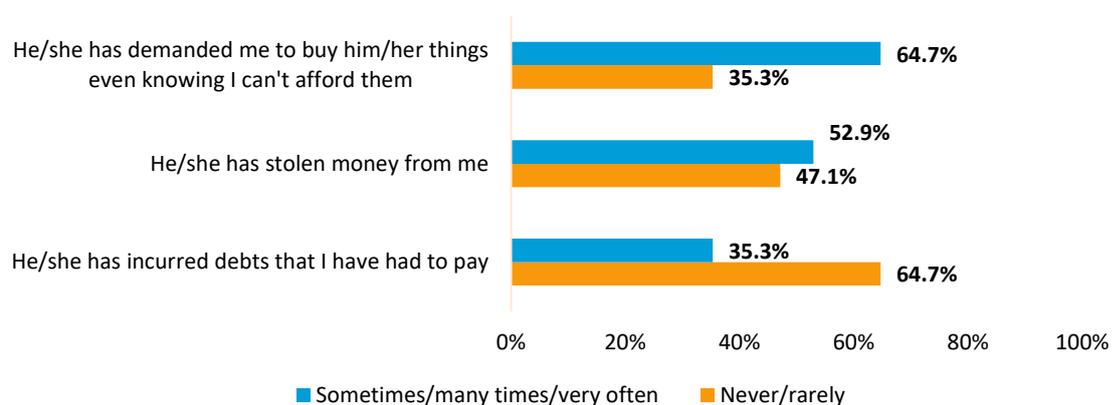


Some parents/carers described being pushed, punched, kicked, bitten, spat at and, having things thrown at them *“So it started with, basically just hitting and escalated where she was dragging me round by my hair, punching, biting, spitting” (Parent 2).*

Financial abuse:

Two thirds (64.7%) of parents from the survey reported that their child had demanded they buy them things even knowing their parent cannot afford them. Half (52.9%) of parents reported their child had stolen money from them and 35.3% had a child that had incurred debt that they then had to pay (Figure 4).

Figure 4: Financial abuse statements from the parent survey (n=18)



Some of the parents/caregivers mentioned that their children had taken their credit cards or run up debts they had to pay off *“We had a problem with gaming this started earlier while we were at my mums. They were only 10 when this happened and they spent like a grand in two weeks...They haven't often stolen money from me, but they have done, they have taken my card and used my card details” (Parent 7).*

Box 1: Examples from practitioners on the types of CAPVA abuse

I've had parents who've literally been head-butted to the floor, kids who have had their siblings and their parents held at knife point. Parents, who've been locked out of their homes while kids threatened to hurt their sibling or burn the house down. Kids who are so verbally abusive, intimidating and controlling within the home environment to the point where parents are walking around on eggshells, frightened to say or do anything.

Practitioner 6

I was talking to another practitioner where the young person, to get a reaction from the mother, would put knives like sharp steak knives on the top of doors. So as the doors were opened the knives would fall down.

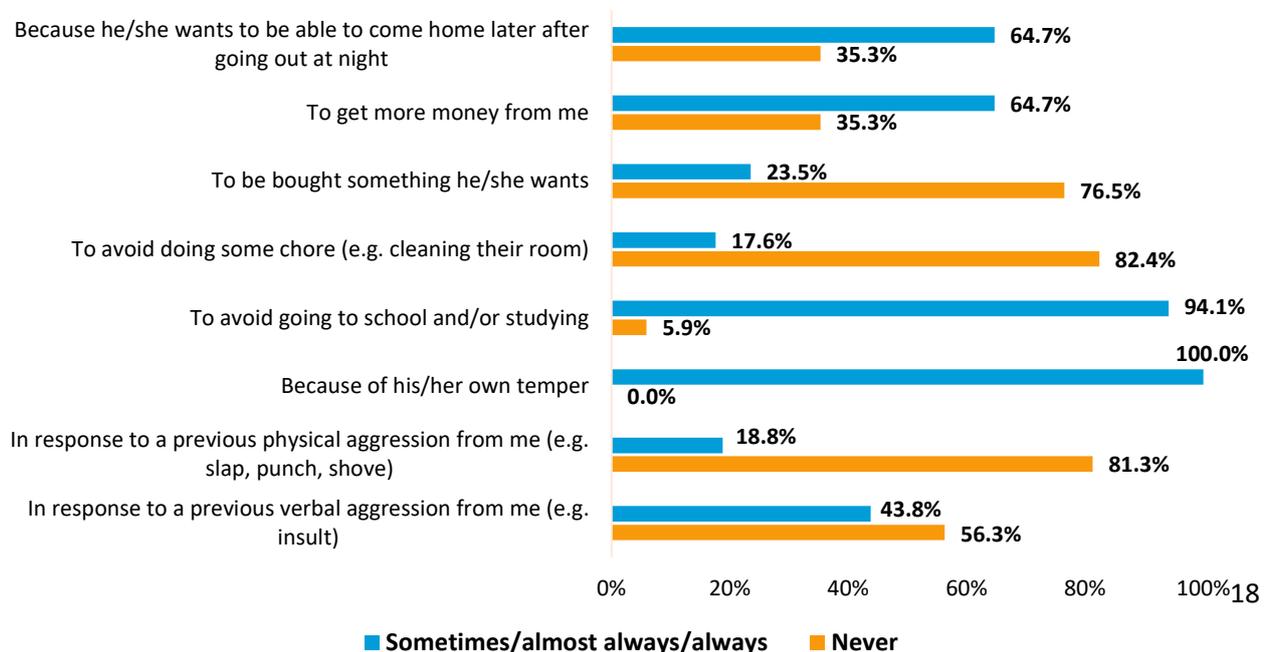
Practitioner 1

We got a call from a mum who's had it, she's had her fingers broken, suffered really serious injuries, and she told us it was her son. We turned up and there was lighter fluid on the wall and he had a lighter, so straight away, we were like, OK, he clearly doesn't want us there. That was a threat to us so we backed off and when we eventually went in the house, he had taken over the whole living room with cannabis posters and just really aggressive imagery. The stair rail was completely missing, there was doors hanging off the hinges. Mum had a black eye, little siblings were clinging next to mum just absolutely terrified, and you could see the kind of fear in the eyes.

Practitioner 18

Parents who completed the parent survey were asked some reasons why their child might exhibit some of these behaviours, all (100%) said it was sometimes/almost always/always because the child/young person's own temper, followed by to avoid going to school and/or studying (94.1%), to avoid doing some chore (e.g. cleaning up his/her room) (82.4%) and to be bought something he/she wants (76.5%). Four in five (81.3%) also noted that the child committed CAPVA in response to physical or verbal aggression (43.8%; Figure 5) from them.

Figure 5: Reasons parents had for their child committing CAPVA (n=18)



3.3 Extent of abuse

Two thirds (64.7%) of parents and 84.8% of practitioners agreed/strongly agreed that they believed CAPVA is a problem in Merseyside. Nearly two thirds (65.5%) of practitioners felt the number of CAPVA incidences they have encountered has increased in the last 12 months compared with the previous year, 34.5% felt incidences had stayed the same and no practitioners felt CAPVA incidences had decreased.

The prevalence of CAPVA across Merseyside was difficult to determine due to the lack of consistent data collected across services. Practitioners had an anecdotal indication of how prevalent the issue is however this was based off their experiences supporting families, rather than any data from CAPVA-specific referral pathways/support services or wider data collection systems. In addition, when asked to provide data, many services said they would have to allocate a member of staff to pull this data together which in turn creates even more demand on services who are already over capacity. Furthermore, securing data from the police in relation to incidences of CAPVA was also problematic due to CAPVA not being recorded precisely on the police databases. There was no way of accurately identifying cases of CAPVA even by going through reports case-by-case due to officers not always recording that the incident was a child/young person against a parent/caregiver.

One reason why practitioners felt reporting rates were low was that each individual has their own tolerance level of what they deem abuse. This could be because they have experienced ACEs themselves, where they have grown up around abuse and are therefore desensitised to it, or in general have different tolerances which may decrease their likelihood of reporting abuse.

“Every parent will have a different tolerance or have become desensitised to the kinds of abuse, and it will be one specific thing that they just go ‘I can't take that, I can't take being spoken to like that or I can't take watching trashing of my stuff or their stuff. I can't bear seeing the way they intimidate their younger siblings or their older sibling’. It's very variable. And so, it's interesting when parents actually present there is no particular thing that a parent will go ‘I can't cope with this’, because it will be so different for everybody with different benchmarks, honestly” (Practitioner 6).

Practitioners felt CAPVA was hugely prevalent but that many families never report it to any services. One practitioner quoted prevalence figures similar to those found in the literature, and for families who adopted, they noted that this figure could be significantly higher.

“I think it's massive, it's underreported, and I think it's undocumented” (Practitioner 13).

“Doesn't research say it could be as prevalent as one in ten families? So that's what I talk about when I run workshops, other research suggests that it might be more prevalent in adoptive families, that it could be as high as a third” (Practitioner 16).

Further to this, some participants felt that the shame and guilt associated with CAPVA means many families would not come forward for support resulting in the low number of reports. The taboo nature of the issue may lead to families feeling isolated and not knowing where to turn for support. However, practitioners who have supported families for many years acknowledged that whilst CAPVA was not a new issue, more people appear to now be aware of it resulting in the taboo being lifted and allowing more families to seek support.

“Many years ago, there used to be a programme called Tulip and it was child to adult violence. I think people are being more educated, the shame’s moving away, and people are more inclined to ask for help now. So, although it’s increased... I don’t think it’s actually gone through the roof, I actually just think people are less ashamed to ask for help” (Practitioner 22).

Additionally, some practitioners felt services and practitioners are not explicit enough when asking families about sensitive topics such as family violence; noting that CAPVA may only come to light when families present at a service for a different reason and upon building a rapport or relationship with the practitioner, they will disclose their experiences of abuse.

“I think it’s really prevalent, but I don’t think it’s been recognised. I think there’s a lot of shame and a lot of secrecy within families. And I think families feel really isolated and often that’s what we see and so I’m not sure how explicit we are as practitioners in asking about violence because I think it’s quite a difficult thing for families to talk about and it may sometimes come out and when that’s not being the presenting concern necessarily” (Practitioner 3).

3.4 Demographics of those involved in CAPVA

Parents/caregivers

The parent survey found that respondents were most likely to be female (76.5%).⁷ When asked about their relationship to the child/young person, most reported being their mother (76.5%), adoptive mother (5.9%), stepfather (5.9%), father (5.9%), or foster parent (5.9%). Over half (58.8%) of parents reported that they are still currently experiencing CAPVA.

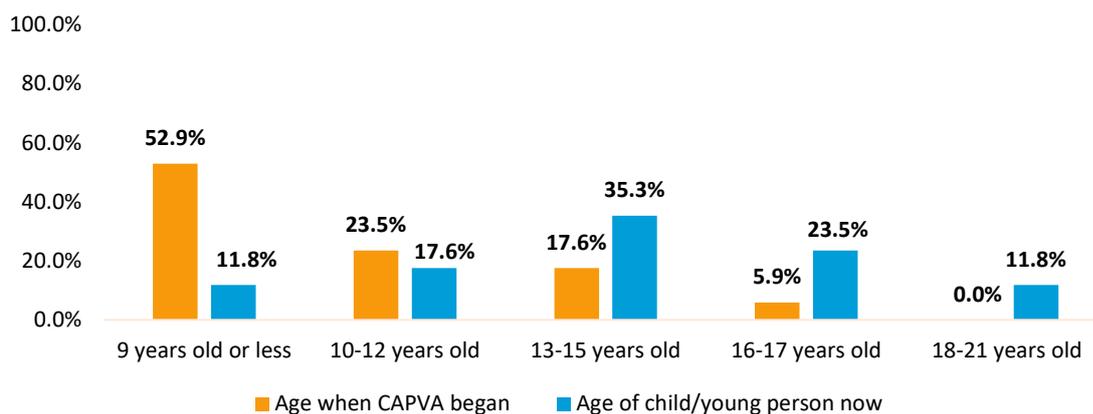
Similar to findings from the parent survey and to previous research, most practitioners felt that female parents/caregivers were most likely to be the victims of CAPVA. This was thought to be due to societal factors with females tending to be the primary caregivers. Similarly, in families where parents/caregivers have separated, the mums generally tend to take on more care responsibilities as a lone parent/caregiver. Furthermore, females are seen to be more physically vulnerable than males and they are therefore an easier target for abuse. When reflecting on the demographics that accessed their service, most practitioners reported that the majority of individuals who attended their interventions were female.

“Particularly for mums because mum’s bear the brunt of it, particularly as they tend to be the primary caregivers in society and can be particularly prevalent when mums are lone parents” (Practitioner 2).

Children and young people

Similar to previous research on the topic the parent survey found that males (58.8%) were most likely to commit CAPVA compared to females (35.3%) and some parents preferred not to say (5.9%). Most parents reported that the behaviour started when the child was 9 years old or younger (52.9%), while 23.5% reported they were 10-12 years old, 17.6% 13-15 years old and 5.9% 16-17 years old. When asked how old the child is now one third said 13-15 years old (35.3%) (Figure 6).

Figure 6: Age of child/ young person when CAPVA behaviours began and the current age of the child/ young person (n=18)



Half of parents reported that the behaviour was at its worst between the ages of 13-15 years old (47.1%), followed by 10-12 years old (23.5%), 9 years old or less (23.5%), 16-17 years old (11.8%) and 18-21 years old (11.8%).

⁷ Full survey results can be found in the appendices.

Some interviewed practitioners agreed with existing research that suggests males are most likely to commit CAPVA. However, contrary to the wider literature, others acknowledge that across Merseyside there has been a shift, with a 50/50 split between males and females. They felt that the types of abusive behaviours exhibited between the two genders generally were different. Males tended to present to services after committing physical abuse, which was noted as likely why the prevalence of male committing CAPVA may seem higher, whereas females tend to use less recognisable types of abuse such as coercion and control, which may be more likely to go under the radar.

“We get a lot of female referrals, which is surprising to a lot of professionals, I think it’s quite interesting, but in my experience, the girls that I’ve worked with are very clever, whereas the lads will have their outrage and they’ll show their anger and frustration and be physical. We’ve got physical girls, but there is emotional abuse and financial abuse. They’re very clever at manipulating certain situations, and the parents don’t actually sometimes identify that” (Practitioner 18).

The typical age a child/young person becomes known by services differs greatly. Most services reported that families seek support when the child/young person’s abusive behaviour reaches its peak, which is typically in their early to mid-teens as they become older, bigger, and more difficult to manage physically. This was supported by a police officer who stated that in general they tend to see teenagers between 14 to 18 potentially because at that age the young person is capable of causing more harm to parents and wider family members. However, services felt the age the child presents at the service has been decreasing in recent years, with some as young as six receiving supports.

“Teenagers aged 14 to 18, that sort of group I have had to deal with. I don’t know whether that’s because at that stage of sort of development they are physically more capable of causing harm to a parent and the parent may not be as physically able to control that behaviour” (Practitioner 24).

“I have noticed over the years that we get a lot of referrals for 12-year-olds. I think it is something about that early teenage- and also hormones are playing a part and I think there’s also, from a parent’s point of view, that fear of the child getting older, I can’t just pick them up and move them, and also this fear of this is still happening now they are this age, what is our family life going to look like when they’re 16 and they’re bigger than me?” (Practitioner 16).

3.5 Impacts of CAPVA

Parents/caregivers

Parents/caregivers acknowledged that CAPVA had a detrimental impact on their lives. Practitioners reported that CAPVA can have a huge impact on parents/caregivers' mental health and wellbeing. Parents/caregivers can be left feeling helpless, lacking in confidence, and disempowered. Parents/caregivers reported significant psychological trauma due to CAPVA, they described "cowering" in fear "of not just what she'd do to [them], of what she'd do to herself" (Parent 2). They often felt "scared", "undermined" and "disempowered to parent and when their kids become abusive, they can't react to that without the fear of going and getting knicked" (Parent 6). Trust was an issue – a few parents said they needed to lock doors and hide valuables in a safe "because you just couldn't trust what she was capable of" (Parent 1). One parent described how it had impacted all aspects of their life especially their mental health "it's affected my mental health and basically my whole life" (Parent survey respondent) Another reported that despite CAPVA lessening in their household they have been left with "PTSD".

"Although we are in a much better place now, I feel that I am left with some form of PTSD. I get triggered (anxiety, tears, panic) very quickly in response to relatively minor resistance, refusal, threats, or aggression. Any bouts of more extreme aggression although less frequent floor me very quickly. I don't often enjoy being at home, even when things are calm" (Parent survey respondent).

"It made me feel like a bad parent, that I couldn't provide for my child in the way that they needed – or that I was being used by a manipulative teen to try and get their own way and that made me feel very low that I didn't have the tools to cope and assert control over the situation" (Parent survey respondent).

Due to the stigma surrounding CAPVA, parents/caregivers can often feel isolated. Parents/caregivers reported feeling ashamed and embarrassed that "you're the grown up like and the kids are sort of battering you" (Parent 8). Many of them "felt guilt" and "self-blame" for their child's behaviour, citing bad parenting, poor mental health, and marital breakups as possible reasons. All parents/carers acknowledged the stigma associated with CAPVA. They recognised that CAPVA was still very much a "hidden" and "taboo subject" (Parent 3) which acted as a barrier to seeking support. One parent felt that "it's OK now to talk about domestic abuse, but it isn't OK to talk about our child abusing" (Parent 4).

"I suppose I've sort of touched on it a few times, haven't I? About shame and embarrassment and you just don't talk about it. And I think you minimise it. With people, because it's just it's unpalatable to think that these behaviours are common from your child where it very much was a taboo. So yeah, it's not something you want to discuss" (Parent 7).

"I think there is often a veil of silence almost around sort of child on parent violence, so I think it's a bit of a taboo, you know, people don't talk about it. People may not be knowledgeable about the degree of violence. So, a lot of our work is about supporting families to build that support and lift that sort of veil of silence" (Practitioner 3).

“It’s the same issue we faced [with] domestic abuse generally. The trauma that victim survived and experienced, can be profound, and if it’s not addressed, can impact their mental health for the rest of their life, that’s very significant” (Practitioner 2).

Practitioners felt that if CAPVA was left to escalate, the abuse could become extremely violent resulting in serious physical harm and even death. There could also be long-term mental health problems, for example, low mood, depression, anxiety, lack of confidence and self-esteem. In addition, due to long-term prolonged abuse, a parent/caregiver could be left feeling suicidal or harm themselves. Furthermore, parents/caregivers could turn to other health harming behaviours such as substance misuse and gambling.

“I think it probably destroys that emotional confidence, psychological well-being, their self-esteem. I think it probably erodes family life” (Practitioner 1).

“I think it’s absolutely devastating, and you know, looking at one extreme, the impact would be death. You know, that could be through a violent assault, and it could be through suicide, on the extreme end, it could be death.... It could be parents turning to drugs and alcohol, parents turning to gambling” (Practitioner 5).

Parents reported the impacts CAPVA can have on various relationships, some felt their relationship with their child had been significantly impacted with one parent wishing their child no longer lived with them *“a breakdown in relationship to the point I wished they no longer lived with me. I’m scared of them” (Parent survey respondent)*. Some parents reported how it had put a strain on their relationship with their significant other *“its broken up the family” (Parent survey respondent)*. Parents/caregivers discussed efforts they made to hide the fact that they were being abused by their own children leading to isolation and breakdown in relationships outside their immediate family. Parents reported that they would *“keep [bruises] hidden” (Parent 2) and “limit people coming into the house” (Parent 4)* because *“you don’t wanna admit it firstly, you don’t wanna admit that your child is attacking you, smashing your house up, speaking to you like rubbish” (Parent 1)*. Parents also tried to keep CAPVA hidden from family members *“because [they] didn’t want them treating [their children] differently” (Parent 4)*. This meant that parents/caregivers often felt *“dead lonely” and “isolated”, unwilling and unable to talk to anyone about what was happening.*

“I felt guilt, I felt it was all my fault and I didn’t want to see anyone because I didn’t want them to know what was happening. So I become very isolated and pushed people away” (Parent 2).

“The parents don’t want to talk to their friends and family about it because they’re ashamed. So that’s, you know, there’s more isolation there” (Practitioner 16).

CAPVA was also reported to have devastating financial implications. Parents/caregiver highlighted that having to pay for damages to property and/or pay off accumulated debt had a huge impact on their lives. Several also paid for private mental health services even though *“it’s not really within our budget, but we do because we just want, we feel guilty, but also want the best” (Parent 4)*. Practitioners reported that children can have so much control over their parent/caregiver’s whereabouts that they can lose their jobs or are unable to seek employment. One parent’s experience reiterated this, stating that their child blackmails them with ringing the police, so that they might lose their job.

“With parents, you know, controlling if they can go out and not. Jeopardising their careers, which will have huge financial implications” (Practitioner 1)

*“I fear being at home alone with them. They threaten to ring the police on me knowing it will impact my job and films me all the time. I am fearful of my future and safety”
(Parent survey respondent).*

Children/young people

It was seen to be detrimental for a child/young person to have such a high level of control over a parent/caregiver. Having that much power over another person at a young age was viewed as having potentially long-lasting, negative impacts on future relationships. This sentiment was echoed by parents who expressed concern that their child’s behaviour would have long-term repercussions on future relationships – that the abusive behaviours *“exhibited at home will continue into other relationships”* (Parent 4). One parent felt that children engaging in CAPVA would likely need therapy and support in adulthood, to deal with the *“terrible guilt and shame”* (Parent 6) of their abusive behaviour.

“You’re worried for your son and you’re worried for the man he’s gonna be and you’re like, you’re like, if I don’t get this right, that I am perpetuating violence of women in the future- his partner, his children. And that can make you panic because you think well, you know, people say things and if you put up with it” (Parent 7).

“I think for a child to have that level of control within a relationship within home, I think that can feel really quite scary for young children and adolescents as well. I think it can inform future relationships as well and affect future relationships and interpersonal difficulties” (Practitioner 3)

Most parents reported significant breakdowns in relationships, including the parent-child relationship, siblings, and wider family *“we don’t have a great relationship. They can be very withdrawn”* (Parent survey respondent). This led in many cases to the child/young person having to leave the family resulting in them feeling unloved, isolated, and lonely.

“They felt remorse afterwards and at one point we had to put them in a homeless shelter for teens as we couldn’t manage her behaviour. That made her feel unloved and unwanted, which was far from the truth, we just couldn’t cope, and nobody would help. She couldn’t get help for her ADHD, mental health, and drug use” (Parent survey respondent).

Several practitioners discussed the importance of having a trauma-informed approach to CAPVA. Practitioners discussing how abusive and violent behaviours towards parents/caregivers could lead to criminal implications, as well as a pattern of behaviour which could lead to further crimes as an adult. This could potentially result in having a criminal record, which can have repercussions throughout their life. One parent reported that their child was currently in prison *“My child is now in prison for assault and other related issues”* (Parent survey respondent).

It was felt that practitioners and professionals often focus on the acts of violence rather than trying to assess and address the root causes of the violence, leading to unmet needs. Exhibiting these behaviours can lead to guilt and shame later in life, which can be detrimental to the child/young person’s mental health, relationships with their family, and long-term trauma, and may result in them needing support services into adulthood.

“If they do end up with a criminal record it’s because parents have got no option but to call the police, and that’s kind of going to follow them through their whole life. Feeling that they’re bad, they fit into this kind of box of being bad. I think people focus on,

professionals maybe, will focus on the violence initially, a lot more than why the violence was happening. So, we were kind of trying to firefight the violence and then that, you know has a negative impact on them because they again were made to feel like they were naughty. They were misbehaving, nobody liked them. When in actual fact they were crying out for help so I think if it's if it's not addressed properly, then the impacts would probably be long lasting trauma and maybe criminalisation and moving into that kind of lifestyle as an adult" (Practitioner 12).

"It's extremely traumatic because it's happening and they're at their brain developmental stage where when it [CAPVA] happens and they don't want it to happen, it's an explosion that rage and not being able to control what you're doing can lead to a huge amount of regret. I think the long-term impact is huge" (Practitioner 13).

Wider family and local communities

Many practitioners discussed the impacts of CAPVA, not only on the parent/caregiver and child/young person involved, but also on siblings, wider family, local community, and schools.

"I think it doesn't just impact the immediate family in the family home. It's the wider family and the community as well and obviously the behaviour in schools and everything." (Practitioner 17).

Parents who had partners/husbands spoke of the challenges CAPVA had on their relationship as a couple. Their child's behaviour dominated conversation and limited their ability to go away on their own. Several parents recounted *"wanting to leave"* and one even asked for *"a divorce because [she] didn't think it was fair that the two of [them] should have to suffer"* (Parent 1).

Practitioners discussed how siblings living in the same household are not only at risk for witnessing abuse, resulting in them developing their own ACEs, but also experiencing abuse themselves. Practitioners felt that sibling's needs might be under prioritised as parents/caregivers try to deal with an abusive child/young person, which can impact the sibling's wellbeing – *"his brother has become withdrawn and doesn't ask for much as he know if he does his brother could lash out"* (Parent survey respondent). Practitioners explained that the sibling relationship can also be damaged as they can become resentful of their sibling, which can result in "secondary trauma". Parents reported how CAPVA has had a huge impact on siblings, most reporting that the siblings do not get along, are scared *"they are scared of her and don't understand why she behaves this way"* (Parent survey respondent) and for some siblings, exposure to CAPVA has had long-term psychological consequences.

"Again, he became quite withdrawn in himself. He was scared is the bottom line of it. He was scared of her. He was scared of being alone. Even now, he's 15 and he doesn't like conflict. If someone is shouting and arguing they walk away, and you can see it on them. He physically doesn't like it and so it's had a big impact on him" (Parent 2).

"It can have a devastating impact on siblings. Everyone's living on eggshells and on tenterhooks. Everyone's ready for fight or fly. I mean, it's hugely stressful. So it has an incredibly adverse effect on parents too. And the child that's behaving in this way becomes the sole focus of everybody's attention, which means nobody else gets the attention that they also need and deserve" (Practitioner 6).

Parents also discussed how it can affect their relationship with their wider family. One parent recounted how their stepchildren will *"only come to the house when [adolescent] is not here"* (Parent 1). Another parent discussed how nobody in their social circle will invite them out or spend time with

them as a family – *“no one invites us out as a family, very rarely will family come and visit at our home. We have all missed out on experiences as a family” (Parent survey respondent).*

Practitioners discussed the impacts that CAPVA can have on neighbours and how traumatising it can be to listen to abuse and how neighbours may experience feelings of uncertainty about whether they should intervene or not because they are worried about repercussions or not wanting to get involved. A few parents/caregivers mentioned that their neighbours were aware of the circumstances, and this had not affected their relationship with them. Only one parent felt that a couple of neighbours *“judge [her] now” (Parent 2)*. Several parents stated the impact of their child’s behaviour on the community was negligible as they were *“impeccably behaved” (Parent 4)* outside the home.

“So you’ve got neighbours on either side who have to listen to all of that as well, and that as a massive impact on them, that’s quite traumatising for neighbours, who are having to listen to things that are going on and they’re too scared to report. They don’t want the police. You don’t want to be blamed for the police turning up, it’s antisocial behaviour, really, isn’t it?” (Practitioner 18).

3.6 Risk factors

Practitioners identified a number of risk factors that may contribute to an increased likelihood of a family experiencing CAPVA. These views are reflected in wider literature, which suggested these risk factors are not specific to families residing in Merseyside but factors that can increase any family's risk of experiencing CAPVA.

“A child doesn't wake up in the morning and decide they're going to be belligerent and how can they make their parents lives really miserable. There's always a root cause 99.9% of the time” (Practitioner 14).

Several parents believed that *“trauma”* experienced in childhood was a catalyst for CAPVA. These included *“family breakdown”, “domestic violence”, “moving into a new house with a new partner”,* and *“an accident”*. Other contributing factors perceived by parents/carers included *“school stressors”, “friendship issues”, “drugs and the alcohol”, “decline in mental health”* and *“poor parenting”*.

Child/young person experiencing Adverse Childhood Experiences (ACEs)

A variety of ACEs were mentioned as key risk factors for both committing and being a victim of CAPVA. One specific ACE risk factor that was continually mentioned was when a child/young person witnessed domestic violence within the household. This behaviour is then learned and committed by the child/young person themselves. One practitioner discussed working in minority communities and how domestic violence can be learned through experiencing it at home (Box 2).

“I think for a young person who lives in a home where there is a domestic abuse relationship, you know, parents are involved in a domestic abusive relationship, even if that relationship stopped when you've got learned behaviour and you've learned that it's OK to hit mum or vice versa, then it becomes sort of... So, I think that's quite prevalent in what young people see and then display those behaviours, well my dad used to batter you, so I need to take that mantle” (Practitioner 22).

Box 2: Case example of how a young person who has witnessed domestic violence in the household growing up can learn and go on to commit the same behaviours.

“We had a woman; the child was worked with the dad in their family business, what had happened was the child threw a plastic box full force at her face, which resulted in her ending up needing to get stitches and she had to go to the hospital. The hospital called us because she had told the hospital what had happened. There had been multiple instances where she'd fled onto the streets and screamed for help, this adolescent child is chasing her down the road and hitting her in the middle of the street in broad daylight. Ultimately, what happened in that case was, there was a history of domestic violence, there were also younger siblings. We ended up getting her out the family home and she went to refuge, and we worked with her to stay away from the home, but I think that's not the only case where we've had domestic violence already in the home and maybe the perpetrator [of domestic violence] will target one of their children to teach them those behaviours. When that child's targeted in that way, that builds their understanding of how they should behave and so it's no surprise to us that when they reach the age of 17, they completely take over the perpetrator's behaviour” (Practitioner 18).

Similar to the wider literature, having a parent who misuses substances, low resilience or poor mental health in the child/young person, and having substantial stress in the family home were also considered potential risk factors for CAPVA.

*“If a young person has got parents who are misusing substances or there is domestic abuse within the household, I think these are all the kinds of factors that increase risk”
(Practitioner 12).*

“Mental health as well may be a risk factors that might exasperate some of the difficulties” (Practitioner 3).

Some practitioners discussed how grief and loss at a young age can have lasting repercussions on the child/young person’s behaviour and their future relationships with parents/caregivers. An example of a case study from another area in the UK discussed how grief and loss can manifest in CAPVA behaviours later on. Despite this example coming from another area in the UK, grief and loss can affect any family therefore can translate to any area. The case study provided in Box 4 discusses how the child/young person experienced grief at a young age which caused them to have an insecure attachment to their mum. By accessing support the family was able understand the root cause of the behaviour and over time to mend their relationship (Box 3).

Box 3: Case example of how grief at a young age can manifest as CAPVA when the child gets older.

“I worked with a parent up in [another area], who had a 14-year-old child, and they were very abusive towards their mum, didn't want to spend any time with her, came home from school air pods in, go upstairs slam doors if mum tried to get them downstairs, they would shout and destroy stuff. They very rarely came down to eat with her, she had no relationship with them. I did a couple of sessions with her, and we looked at root cause. Their father was killed in a car crash when their mum was six months pregnant, so they never got to know their dad, but they grew up with grief. Now, as soon as they had that conscious thought of life and death, which we all have, they realised that actually they didn't want to attach to their mum because then they might lose her like they lost their dad. So actually it would be easier for them not to connect with her. I mean they really needed her but equally they couldn't bear or tolerate the loss that that would mean. So they had to distance themselves from her, she had that lightbulb moment when we talked about that she was like, “oh, my God, of course, that's what they're doing”. So we came up with some strategies where she would get a blackboard for the bottom of the stairs. So when they came home from school, the blackboard would say, there's a snack in the fridge or a chocolate milk and a pack of crisps ready for you for after school. So they knew she was thinking about them, and she used to do that. Then she'd leave on the blackboard, I've got pizza for dinner if you want to join me, and they would start joining her for dinner. One of the things that she used to do whenever she used to see them was ask ‘So how are you? What you doing? What you up to? Who are you hanging out with?’. I call that interrogation rather than invitation, so I said if they did join you for dinner don't ask them anything just say ‘Oh my God you should have seen what happened to me today’ and talk about yourself. Three months later, after doing this and understanding what was going on for them, she sent me an e-mail and she said, I just can't believe the change in my relationship with my child, she said. We were dancing around the kitchen to music on Christmas, having a giggle together, and she said this time last year I couldn't wait for them to leave” (Practitioner 14).

Low social economic status

Some practitioners recognised that CAPVA can affect any family from a variety of different backgrounds but felt that the added financial pressures and stress from families with lower social economic status makes them more vulnerable to harm.

“I think poverty has got a massive role, and that's not making excuses for negative behaviour, because obviously people can live in poverty and they don't experience any of this. I do think where there's low income because then there's more stress, there's more gambling, there's more risk-taking behaviours and it can become this toxic environment” (Practitioner 5).

Practitioners highlighted homelessness, looked after children/young people, and families that face significant financial difficulties, can result in a large amount of stress on a family and as such, are risk factors for CAPVA. Foster families receive money to help provide and look after the child, however, this is not the case with children/young people looked after by wider family members, resulting in the child/young person having less opportunities and feeling resentment towards their family for not being able to provide, particularly material belongings in the same way as their peers. Further to this, the lack of stability and uncertainty can lead to frustration and anger which can significantly damage the parent/caregiver and child's/young person's relationship.

“I've been with families when they've literally been evicted, and I've sat in housing options with them, and you know the stress. The anger at the system or the anger at what's gotten them there so, that might be a breakup of a relationship. It might be the lack of finances. I've seen young people resent their parents for like not doing better, why has that family got those trainers and their house and whatever else they've got, why isn't my mum providing that? They're not sort of old enough or emotionally intelligent enough to see the bigger picture” (Practitioner 8).

“If you was to place a young person with a foster carer, they get an amount of money around £400 a week or more per child. When they go to a grandparent or carer that's attached to the family, they don't get anything. Kinship carers are a charity and they support kinship [carers], but there is no financial help or support [for kinship carers] so when the young person's demanding the latest Xbox or the latest trainers, or trying to just keep in with their, you know, group within society and the carers can't keep up with those demands, we do see an in an influx of violence” (Practitioner 18).

Parenting style and attachment

Several practitioners discussed the importance of providing a child/young person with responsibility from a young age. Having an indulgent parenting style can lead to a child/young person not understanding responsibilities, resulting in low self-esteem and confidence long-term.

“When a child isn't expected to do anything i.e. make their bed every morning, feed the cats, walk the dog, help with making tea, help with the washing up, and bring their dirty washing down all these things are little responsibilities. How can a child who is receiving, receiving, receiving from a very indulging parent getting a lot for giving nothing for doing nothing? If the child is encouraged to take some level of responsibility, then the child gets the opportunity to feel satisfied with themselves, pleased with themselves. They get to build a little bit of self-esteem; they get to build a bit of confidence. If we don't give children responsibilities, how can they grow that?” (Practitioner 6).

One practitioner discussed families who have blocked care and or blocked trust. Blocked care can happen when parents experience prolonged stress, which suppresses their capacity to sustain loving and empathic feelings towards their child/young person. A child that has experienced early life trauma can form a mistrust of the world and the people around them; this is described as the child developing blocked trust. Blocked care can develop when parenting a child/young person that has blocked trust [42]. This can lead to a break down in the parent/caregiver to child/young person relationship, potentially resulting in CAPVA.

Family structure

Another risk factor was single parent/caregiver families or if parents/caregivers have separated, as this can be a catalyst for CAPVA particularly when different households have different boundaries.

“A lot of them are from single family, single caregivers that you find that is the break in relationship with them and things that have happened and then the children, they've got different boundaries from different people” (Practitioner 10).

Adoption was also seen as a significant risk factor. Prior trauma can lead to distrust, anger, frustration, and leaving a child feeling unsafe. Further to this, settling into a new family regardless of age can result in insecure attachments leaving both parent/caregiver and child/young person feeling resentful.

“I work with children who have experienced developmental trauma. I think that for me is the major driver. That kind of experience of the world is an unsafe place, anything can happen at any time. You can't rely on people to keep you safe. You can't really believe adults that they're gonna be there forever. They may reject you if you do something they may, they may stop loving you and you may be having to move to another place again. I think the anxiety created by that and you know just that perception, that inner working model of the world is unsafe thing. I think that creates that survival response of I need to just be ready to defend myself” (Practitioner 16).

A lack of community or wider family support was believed to be a potential risk factor as families have nowhere to turn for respite or support. Being a looked after child/young person either by a grandparent, carer, or wider family primary caregiver was also seen to be a significant risk factor.

“A lack of community support and a lack of extended family support as well” (Practitioner 3).

“Children who are looked after by their grandparents. Young carers will be another one” (Practitioner 1).

Neurodevelopmental problems and traumatic brain injuries

Neurodevelopmental disorders were mentioned by almost all of the parents/caregivers interviewed. Most of their children/young people had a diagnosis of ADHD and ASD. Three had a specific diagnosis: oppositional defiance disorder, manipulative coercive attachment disorder, and pathological demand avoidance. A few parents were concerned that their child's abusive behaviour would be misconstrued as *“naughty behaviour”* rather than a consequence of their neurodiversity *“I haven't got a kid who's just violent. I've got a reason for why he's doing it” (Parent 5)*. Practitioners felt that in most cases there is an element of neurodiversity and that this was a common theme running through most referrals - *“I'd go as far to say 98% of our cases that come through are either diagnosed, on the pathway to being diagnosed, or parents or education have raised concerns that that they may need to*

be on that pathway” (Practitioner 18). Some neurological disorders such as ASD and ADHD were noted as affecting behaviour, either making the individual more prone to violence or having poorer emotional regulation and/or increased risk-taking behaviours.

“There are conditions which have a theme of aggression within them and also a lack of empathy is inherent within some conditions as well. ADHD is linked to risk taking. It’s linked to impulsivity and those two, that combination can often result in addictions, which again can lead on to individuals behaving in a way that most of us wouldn’t entertain. There are conditions, autism in particular, actually individuals can really find it difficult to cope with everyday occurrences and changes to routine that wouldn’t affect you and me at all [but] will really challenge somebody with autism to the extent that they will need to lash out either on themselves or on those around them” (Practitioner 4).

One practitioner spoke about how a traumatic brain injury in early childhood could have lasting impacts into adolescence and adulthood. These brain injuries can manifest over time in several ways including aggression, anxiety, and impulse control therefore it is important to pick up on these injuries early on.

“What you might see is a child at the age of three running into a lamppost on their tricycle, having quite bad brain injury, but then that’s forgotten by the time that they are 14, when the hormones are kicking in and actually the violence they are now starting to display is as a direct result of that brain injury when they were three, but the passing on of information isn’t there and so I think that screening is really, really key” (Practitioner 4).

Social media

Children/young people’s exposure to social media, especially at a young age, was seen to be problematic as practitioners believed it erased *“parental presence”*. Furthermore, seeing people behave online in a negative way and receiving no consequences where *“toxic communication”* has become normalised was seen to be a reason why some children/young people behave the way they do. Access to online content also allows children/young people to view negative content, for example, explicit music videos, violent videos, and online hate. Some practitioners felt that there was a lack of positive role models for children/young people.

“There are platforms that specifically push you into places where you will find people who don’t bear any consequence for being hateful in the way they speak to somebody, and I think that is becoming a very normal part of existence, as is gas lighting in every relationship. So these things, these horrid ways of communicating, toxic ways of communicating are becoming normalised and I think those are some of the precursors to the way, to the reason children behave in the way that they do” (Practitioner 6).

Criminal exploitation

A number of professionals believed that a child or young person's exposure to exploitation or spending time with peers engaged in criminal activities significantly influences their behaviour at home. This exposure can lead to conflicts within the household when a parent attempts to establish boundaries and enforce rules, resulting in friction between the parent and child. These professionals also highlighted the absence of positive role models in a child or young person's life, which might contribute to exhibiting abusive behaviour not only in the community but also within the home.

“So you know environments where you're seeing that role model and how people function, so I think that's probably a driver where people have less opportunities...I think, you know, you've only got to walk the local shops and the amounts of cannabis that gets smoked amongst youngsters and I do wonder whether that causes a lot of the anger issues.” Practitioner 5

“In my experience, it's been where the child has been vulnerable to sort of potentially exploitation outside the home. Such as child criminal exploitation where they're involved in or involved groups of people who are a negative influence on them outside of the home where the parent tries to stop them from being involved by telling them they can't go out late at night or they are trying to put those boundaries in place for their child's own safety. The child fights back against those boundaries and that control, it then develops to a point of violence” (Practitioner 24).

3.7 Protective factors

Education

Education was believed to be a strong protective factor, and having good communication between parents/caregivers and school was thought to be very important. The school could help liaise with the families and understand what was going on at home to help put things in place whilst the child/young person was in an education setting. For example, ensuring that the school and parents set similar boundaries and behavioural expectations both within school and at home. Further to this, if the child/young person was exhibiting poor behaviour whilst in school, it would give teachers a better understanding of why a child/young person might be acting in this way.

“Schools a big one, school is a big support for a lot of parents that they have healthy communication with the school and that what mum’s trying to implement at home schools trying to follow that through vice versa” (Practitioner 9).

Rapid response to meet client needs

Some practitioners felt it was essential to intervene as quickly as possible. Once a family presents to a service with CAPVA, the service needs to allocate them to an appropriate intervention as quickly as possible to help reduce the risk of further harm. Similar to domestic violence support, if services do not intervene quick enough the issue can worsen exponentially.

“We’re trying to make sure that any parents experiencing CAPVA and the child displaying CAPVA can have timely Interventions to support, just like any other form of domestic abuse, if you don’t intervene quickly enough, the trauma grows and the trauma festers” (Practitioner 2).

Furthermore, practitioners felt earlier identification of neurodiverse conditions needs to take priority. Due to the links between these conditions and risk of committing CAPVA, there needs to be an emphasis on screening for neurodiverse conditions.

“Proper screening for young people so for ADHD, for instance and lots of different conditions actually, there is no screening. It’s very rarely picked up until something very difficult happens, like expulsion from school. So screening is really important, particularly for ADHD and Autism and brain injury” (Practitioner 4).

Setting boundaries

Practitioners felt that being able to set boundaries and having a more stringent parenting style such as expecting children/young people to take ownership of responsibilities early on, was key to building a child/young person’s confidence and resilience. It was felt that parents/caregivers being too lenient, providing too much, and having little or no expectations can lead to behavioural problems.

“I do believe well communication, a range of emotional intelligence whereby you are able to express yourself where you’re able to have a discussion, boundaries, we’ve become incredibly indulgent in our parenting. So I think the parent who manages to care for children more assertively with boundaries, who gives a little but also expects some responsibilities in their kids, their kids to take some responsibilities. I think in fact, that’s probably the key thing in terms of a protective factor, I was talking to a parent and she has just realised that the more she gives and gave to her children, who are now adults, the more they expected her to give, and the less they respected her” (Practitioner 6).

Having a secure attachment

Parents/caregivers having a secure attachment with their child from the “antenatal period, getting it right from the beginning” (Practitioner 5) was believed to be crucial. An insecure attachment can occur with biological parents, however, it is noted as being particularly prevalent in adopted children/young people and looked after children/young people, so working with adoptive families early on to develop that familial bond was discussed as a key protective factor.

“I think having a secure attachment seems to [be a protective factor]. But then I don’t work with any children who I would say have a secure attachment. So, I’m in this little corner of the world, so it’s hard for me to. I mean, I am obviously aware that CAPVA happens outside of adoption and kinship care” (Practitioner 16).

Respite for families

For parents/caregivers with children/young people exhibiting abusive behaviours having respite was mentioned as a protective factor. Respite helps to reduce parental stress, helps parents/caregivers to manage their own feelings and gives parents/caregivers and children/young people a break from each other, which in turn can result in reduced feelings of stress in the household as well as reductions in the frequency or severity of CAPVA. This was particularly important if a child/young person has additional needs.

“Respite which is in short supply for a child with additional needs. So that mum and dad or carers can get a break cause a protective factor is to give space to allow the parents or the carers to be able to process and manage their own frustrations and concerns. They need a break” (Practitioner 2).

“One of the things I brought up and I was bringing it up for years, is there needs to be respite before it gets to the point where and we tried it and she didn't cope with the foster carers and I don't think children like that could actually go in a family home, they need to be where she is now is amazing. It's one-on-one and it's just, you know it's another girl and it works. It really does work for her, you know, she has calmed down a lot. Don't get me wrong, she has an issue with the staff but you know that's a teenager as well. I do think respite is a big thing, my family lives abroad, my partner has got a really small family. So, we were always stuck. So, I think you know there needs to definitely be a respite place and like they were saying ohh there's a respite place, but you've got to go with her. Well, no, we want a break from her” (Parent 1).

3.8 Strategies and interventions to prevent and respond to CAPVA across Merseyside

Whole system or place-based approaches to CAPVA

No system-wide approach to preventing CAPVA and supporting families who are or have experienced CAPVA currently exist across Merseyside, however, there are several services and organisations that individually have CAPVA support in place. The Merseyside Police and Crime Commissioner (PCC) 2021/22 annual report stated that they have worked on implementing Liverpool's first targeted service to tackle the behaviour of children/young people who are abusive towards their parent/caregiver. The PCC endorsed and funded the Respect Young People's Programme (RYPP; refer to 3.12 intervention case study 4) implemented by Merseyside's Domestic Violence Service (MDVS). Following the MVRP CAPVA event, Merseyside Youth Association (MYA) have also offered practitioner CAPVA awareness training (Box 4). This complements wider training offered by services or organisations focused on CAPVA or related issues (e.g. neurodiversity).

Box 4: Merseyside Youth Association (MYA) practitioner CAPVA awareness training

2x online sessions delivered (half day each) to a range of practitioners (approx. 40 practitioners).

Topics covered included:

- Terminology of CAPVA
- Statistics (Nationally and local)
- Lived experience story (soundbite)
- Understanding what CAPVA is.
- Risk factors
- Types of abuse
- Reasons/causes for abusive behaviour (models of typical interactions) including neurodiversity.
- Interventions and support (specific to Merseyside)

Next steps: MYA are currently developing short films based on real case studies which aim to highlight the complex and individualised experiences of CAPVA.

A number of services support families experiencing CAPVA through existing support mechanisms (e.g. general family interventions, counselling, parenting programmes, financial aid, and housing assistance), but only a few have clear interventions/policies on CAPVA (e.g. see Box 5 SWACA and Box 6 MDVS), but these are specific to the service, and delivery may not cover the whole of Merseyside. Whilst many services supporting children, young people, and families/carers will support those experiencing CAPVA within their existing support provision, some organisations are beginning to work more collaboratively to pool their referrals to support families more efficiently to help ensure they are provided with support as quickly as possible (e.g. across Wirral). In doing so, it gives families the flexibility to select programmes that would suit their needs best (e.g. access to programmes delivered at various locations and time of day), which gives parents more options and opportunity to engage in support.

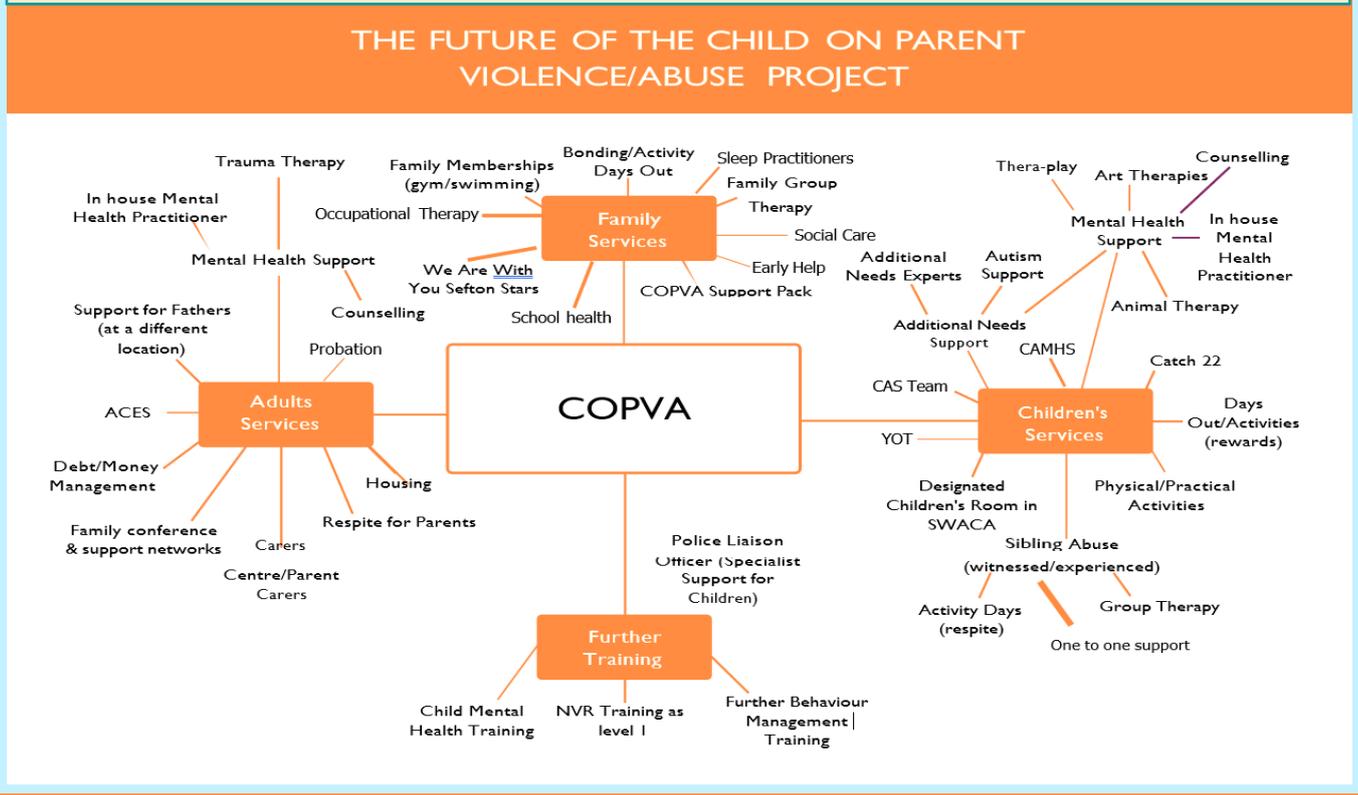
Box 5: SWACA service, data and child on parent violence and abuse plan

Sefton’s Women and Children Aid (SWACA) was founded in 1974 to provide professional, holistic services to families. SWACA provides support through a dedicated adult caseworker, a children's worker, and a sibling worker, offering support through safety plan development, advocacy, therapeutic support (e.g., empowerment of parents, education, training, behavioural management plans, and fair consequence development). Support is provided on a one-to-one, family or group basis.

Service data on CAPVA between September 2020- May 2023 [70, 71]:

Parent referrals (N=270)	Child referrals (N=181)
<ul style="list-style-type: none"> Two in five (40.7%) referrals were accepted, 55.9% rejected and 3.3% waitlisted. The main reasons for rejection included no response (31.1%), did not want support (29.8%), did not attend assessment (21.2%) and already active in service (11.9%). 25-34 years old (17.3%), 35-44 (48.2%), 45-54 (20.9%), 55+ (13.6%). Female (99.1%), Male (0.1%). White British (94.6%). Disability (61.8%); of those who reported having a disability half (51.8%) had a mental health condition, 14.5% had a long-term health condition and 10.0% had a physical condition. 	<ul style="list-style-type: none"> Most (80.1%) referrals were accepted, 13.3% rejected and 6.6% pending/waitlisted. Reasons for rejection included advice/information provided only (4.2%), already active in service (8.3%), did not attend assessment (37.5%), did not want support (8.3%), no response (16.7%), ineligible for support (age) (4.2%) and needs better met elsewhere (signposted) (20.8%). 5-9 years old (32.7%), 10-14 years old (47.1%) & 15-19 years old (20.3%). Male (56.2%), female (43.1%), non-binary (1.0%). White British (82.4%). Disability (51.0%); of those who reported having a disability nearly half (45.5%) had a long-term health condition, over a third (37.2%) had a mental health condition and 8.3% a learning disability.

Given the novelty of this service’s focus, there are currently no established guidelines or policies for caseworkers to adhere to when delivering support. The map below illustrates the potential placement of CAPVA support within the service, with the goal of establishing a future model based on this mapping.



Box 6: Merseyside Domestic Violence Service data

Merseyside Domestic Violence Service (MDVS) has supported Merseyside families for the past 20 years. The grassroots charity has two bases across Merseyside in Liverpool and St Helens. The service aims to safeguard women and girls, children, and young people for a variety of different problems and harms. The service's main ethos is to tackle domestic abuse through education and by supporting those affected to improve their lives. They do this through a range of programmes that aim to educate, empower, and innovate change. The service also works with non-convicted perpetrators providing them with programmes to change patterns of abusive behaviours.

Service data focused on referrals for children/young people who have been referred to the service. The PCC funded Respect Young People's Programme (RYPP), utilised by the service to support those committing CAPVA, is discussed in more detail in the next section of the report (3.12 intervention case study 4).

Child/young person referrals Sept 2022- May 2023 (N=60)

- Most children/young people resided in Liverpool (89.8%), followed by Sefton (5.1%), Knowsley (3.4%), St Helens (1.7%).
- Most (75.0%) referrals were accepted by the service, 20% were placed on the services waiting list, 3.3% were signposted to another service, 1.7% were rejected.
- 5% of the children/young people were repeat referrals.
- Nearly a quarter (73.3%) of clients had social service involvement.
- Two in five (41.7%) had only one child living in the household, 36.7% had two, 16.7% three and 4.9% had 4+ children living in the household.

Child/young person demographics

- Over half (53.3%) of the referrals were for children/young people aged 10-14 years, 28.3% 15-19 years and 18.3% 5-9 years.
- Just under three in five (58.4%) were female, 41.6% male.
- Most (88.3%) of the referrals were White British.
- One fifth (18.3%) reported having a learning disability.
- The majority (86.7%) reported having psychological problems or neurodiversity (including ADHD, ASD, Foetal Alcohol Syndrome, substance misuse).
- Over one in ten (16.7%) reported having physical health problems.

Child/young person behaviour

- Half (53.3%) of the referrals referred to violence and/or aggression towards their mother, 21.7% towards wider family (grandparent, carer other than parents i.e. aunt, foster carer), 20.0% towards sibling and 15.0% against their father.
- At the start of support three quarters (75.5%) were assessed as being high risk for committing CAPVA and 24.5% as medium risk.
- At the closure of their case 40.8% were classed as high risk and three in five (59.2%) were classed as medium risk.
- A quarter (25.9%) of cases were ongoing, 20.7% were awaiting assessment, 20.7% didn't engage/disengaged, 19.0% cases were closed with a positive outcome, 12.1% were classed as not suitable for CAPVA intervention, 1.7% were signposted to another service for support.

Organisations that support families experiencing/experienced CAPVA across Merseyside

The tables below illustrate services across Merseyside that have been identified as supporting families in relation to CAPVA, as well as training for practitioners so they can better support those families. The tables include what local authority the service covers, who the service or support is aimed at, and what activities are currently being undertaken (Table 1). Table 2 consists of CAPVA-specific interventions currently running across Merseyside. More information on several of the individual interventions is presented as case studies in the next section of the report.

Table 1: Summary of wider services who support families who are or have experienced CAPVA

Service name	Area (Local authority)	Support or intervention summary	Website	Target group
Centre for Adoption Support	North England	Intervention/training: Dyadic developmental psychotherapy, trauma focused CBT, free online training videos, 3 stage support programme for families which involves a 1-day CAPVA workshop, an introduction to the principles of NVR and a workshop on how to manage challenging child/young person behaviour at a practical level	https://www.adoptionmatters.org/cfas/	Parents/care givers
MYA*	Merseyside	Training: CAPVA awareness presentation looking at definitions, terminology, neurodiversity in CAPVA, demographics, CAPVA and the pandemic, power and control, hidden harm, harmful behaviours, possible explanations, victimisation of parents, feelings of parents/carers, flashpoints in the day for the child/young person, cycle of violence and worsening over time, suggested methods of praise, Eddie Gallagher's entitlement vs responsibility and support	https://mya.org.uk/	Practitioners
MDVS*	Merseyside	Intervention: RESPECT programme (see case study 1)	https://www.mdvs.org/	Child/young person
Brain charity*	Merseyside	Training: Neurodiversity training for criminal justice system staff and a service for parents/caregivers	https://www.thebraincharity.org.uk/	Practitioners, parents/care givers
PSS service	Merseyside (Liverpool/Wirral)	Support for families who have been through unsteady times. Wellbeing centres support provided through support groups and peer support groups.	https://psspeople.com/	Parents/care givers
Liverpool City Council*	Liverpool	Intervention: e.g. THRIVE: a 6-week course for parents/caregivers and practitioners to discuss the fundamentals of how a child's/young person's brain develops, how to support children/young people through change, and how to identify behaviours. They also offer a free advice resource booklet for parents and carers	https://ehd.liverpool.gov.uk/kb5/liverpool/fsd/course/bookings.page?e=course/DC7-ZEY4Aok	Parents/care givers, Practitioners

Liverpool CAHMS	Liverpool	Information: Website contains information resources and signposts to support services	https://www.liverpoolcamhs.com/training-resources/child-on-parent-abuse/	Parents/care givers, Practitioners
Liverpool Safeguarding Children Partnership (LSCP)	Liverpool	Training: Half day course to raise awareness of CAPVA and learn how to identify it, recognise good practice, and understand the similarities and differences between CAPVA and intimate partner violence	https://liverpoolscp.org.uk/events/event/da-t3-child-on-parent-domestic-abuse	Practitioners
South Liverpool Domestic Abuse Service (SLDAS)	Liverpool	Telephone and face to face emotional and practical support. Therapeutic programmes or self-esteem course. Activity groups at our Garston venue and local community buildings. Specific young person's services.	https://sldas.org.uk/	Parents/care givers
Youth Justice service*	Wirral	Intervention: Who's in Charge? (see case study 1); Non-violent resistant (NVR) training (see case study 2)	https://www.wirral.gov.uk/communities-and-neighbourhoods/crime-reduction/youth-offending-service	Parents/care givers, child/young person
Family Matters (funded by Wirral's safeguarding partnership) *	Wirral	NVR group sessions for parents/caregivers, as well as signposting to appropriate services for parents who are not suited to NVR. Specific CAPVA case managers for the whole family unit. Prevention work with child/young person. PEGS booklet for parents/carers	https://www.familymattersuk.org/	Whole Family Unit
Paul Lavelle foundation*	Wirral	Intervention: 8-week programme for parents/caregivers affected by CAPVA, then set a 2 month goal, followed by a 9th session to evaluate; specific adolescent response and family group conference teams to support the child being abusive, e.g. Who's in Charge? (see case study 1); Nurturing online course for parents/caregivers	https://paullavellfoundation.co.uk/	Parents/care givers
It's Never Ok	Wirral	Signposting/referral: Parents/caregivers are signposted to Who's in Charge? (via Family Matters) or the L.E.A.F project (via Open Door – see below)	https://itsneverokwirral.org/	Parents/care givers
Open Door Charity	Wirral	Intervention: Run the L.E.A.F project which looks at inter-family dynamics that could result in aggression or communication breakdown between parents/caregivers and children/young people. This comes with the option to complete a 4-week stress management	https://www.opendoorcharity.com/empowerment/couloours/	Parents/care givers, child/young person being abusive

		course for any family member (Colours) and support sessions to discuss experiences with those in a similar situation. L.E.A.F also offer de-escalation training for parents/caregivers		
Sefton Council*	Sefton	Intervention: SWACA funded COPVA project supporting parents/caregivers and siblings, separate support for child/young person causing harm, multi-agency steering group	https://www.sefton.gov.uk/miscellaneous-pages/domestic-abuse-support/	Parents/caregivers, siblings, abusive child/young person
Sefton CAMHS*	Sefton	Intervention: Non-violent resistant training (see case study 2)	https://www.seftonliverpoolcamhs.com/	Parents/caregivers
Sefton CVS*	Sefton	Signposting/referral: Signpost families to SWACA	https://directory.seftoncv.org.uk/organisations	Parents/caregivers, Practitioners
Sefton supporting families team*	Sefton	Intervention: Direct one-to-one support from key workers to parents/caregivers	https://sefton.gov.uk/childrens-services/	Parents/caregivers
SWACA*	Sefton	Intervention: Parental support in the form of developing safety plans, behaviour management plans, de-escalation techniques, self-referrals for parents/caregivers, have a designated adult and child caseworker, CAPVA information leaflet available online.	https://swaca.com/child-on-parent-violence-and-abuse/	Parents/caregivers
St Helens Council*	St Helens	Raising awareness of CAPVA through partnership forums, engage national charities and support groups to develop local responses to CAPVA, training for practitioners in services who work with families that have been identified as having risk factors for CAPVA, ensure CAPVA is identified through the Edge of Care service, family support workers for those identified as experiencing CAPVA	https://www.sthelens.gov.uk/article/7263/Information-for-families	Practitioners, parents/caregivers
St Helens The Best Me CIC	St Helens	Intervention: Non-violent resistant training (see case study 2)	https://www.sthelensbestme.com/	Parents/caregivers
The First Step	Knowsley	Knowsley's only domestic abuse support service and provides 1-1- support, supports individuals who are high risk through advocacy, emotional support and legalities and provides refuge.	http://www.thefirststep.org.uk/	Parents/caregivers
Knowsley Council	Knowsley	Safeguarding form for adults who are at risk to signpost them to support.	https://forms.knowsley.gov.uk/AdultSafeguarding	Practitioners, parents/caregivers
*Organisation has been involved in this research project i.e. practitioner interviews, attended the workshop, circulated practitioner survey.				

Table 2: Summary of CAPVA specific interventions

Service name	Area (Local authority)	Overview	Website	Target group
Respect Young People's Programme (RYPP)* (Case study 1)	Liverpool	RYPP is recognised programme by the Youth Justice Board Effective Practice Unit. The programme consists of weekly structured sessions and can take 3 months+ to complete. The sessions vary in techniques used, with some focusing on the child/young person, some focusing on the parents/caregivers and others with the entire family unit	https://www.respect.uk.net/pages/115-rypp	Respect Young People's Programme (RYPP)* (Case study 1)
Who's in Charge?*(Case study 2)	National	Group training for parents/caregivers and practitioner training (train the trainer)	https://www.hosincharge.co.uk/	Parents/caregivers
Non-violent resistant (NVR) (Case study 3)	National	For parents/caregivers: regular 2-hour introduction to NVR online sessions, 10-week course for parents of adopted children/young people showing problematic behaviours, 8-week online SEN group course and general parent course both for parents/caregivers of children/young people displaying problem behaviours For practitioners: level 1 and 2 4-day course covering the basic concepts and principles of the NVR parenting approach to better support parents/caregivers struggling with their children/young people showing problematic behaviours	https://nvrpc.org.uk/	Parents/caregivers, practitioners
CAPA First Response* (Case study 4)	National	Bespoke training packages and courses for practitioners working with families affected by CAPVA, free advice for families and 1-1 family sessions	https://capafirstresponse.org/	Practitioners, Parents/caregivers
Holes in the Wall	National	This is an online blog run by Helen Bonnick aimed at collating significant research and work on CAPVA in one place. It includes a practitioner guide, written by Helen, and frequent advertisement of training courses ran by other CAPVA supporting services.	https://holesinthewall.co.uk/	Practitioners
Halo*	Merseyside	6-week programme for parents/caregivers and children/young people showing abusive behaviours developed using elements of NVR, Duluth wheels, and a solution focused approach, which involves groupwork, 1-to-1 sessions, and counselling, as well as a 6 week follow up	https://haloltd1.wixsite.com/website	Parents/caregivers, child/young person being abusive (6-16 years)

*Organisations involved in this research project i.e. practitioner interviews, attended the workshop, circulated practitioner survey

3.9 Intervention case study 1: Respect Young People's Programme

Respect Young People's Programme (RYPP)



Background

The Respect young people's service [74] supports professionals to respond effectively to children/young people's use of violence and abuse in family and intimate relationships. Respect delivers training and workforce development via its flagship intervention, the Respect Young Peoples Programme (RYPP), to support families experiencing CAPVA.⁶ The RYPP is delivered by expert services trained by Respect and is aimed at families where children/young people (aged 8-18 years) are abusive or violent towards people close to them, particularly their parents/caregivers. The RYPP combines a range of theoretical models – primarily a cognitive behavioural approach along with interventions aimed at influencing criminogenic features of the young person's immediate environment (primarily parenting, family life, and school). The programme encourages all members of the family to take a role in stopping the abuse and learning respectful ways of managing conflict, difficulty, and intimacy across a minimum of 3 months.

RYPP practitioners run weekly sessions, using a range of tools and techniques (see theory of change model Figure 7) to provide support, insight, and solutions to help to improve family relationships. Variations on materials and additional exercises to support neurodiversity and additional needs are available.

Sessions take place with the whole family, individually with the parent/caregiver, and individually with the child/young person. The RYPP consult with families and experts to ensure that the programme is a good fit for the children/young people.⁷ The RYPP is recognised by the Youth Justice Board Effective Practice Unit and is delivered across several Local Authorities and Police Crime Commissioner areas in England, including Merseyside.⁷

Outcomes and impacts

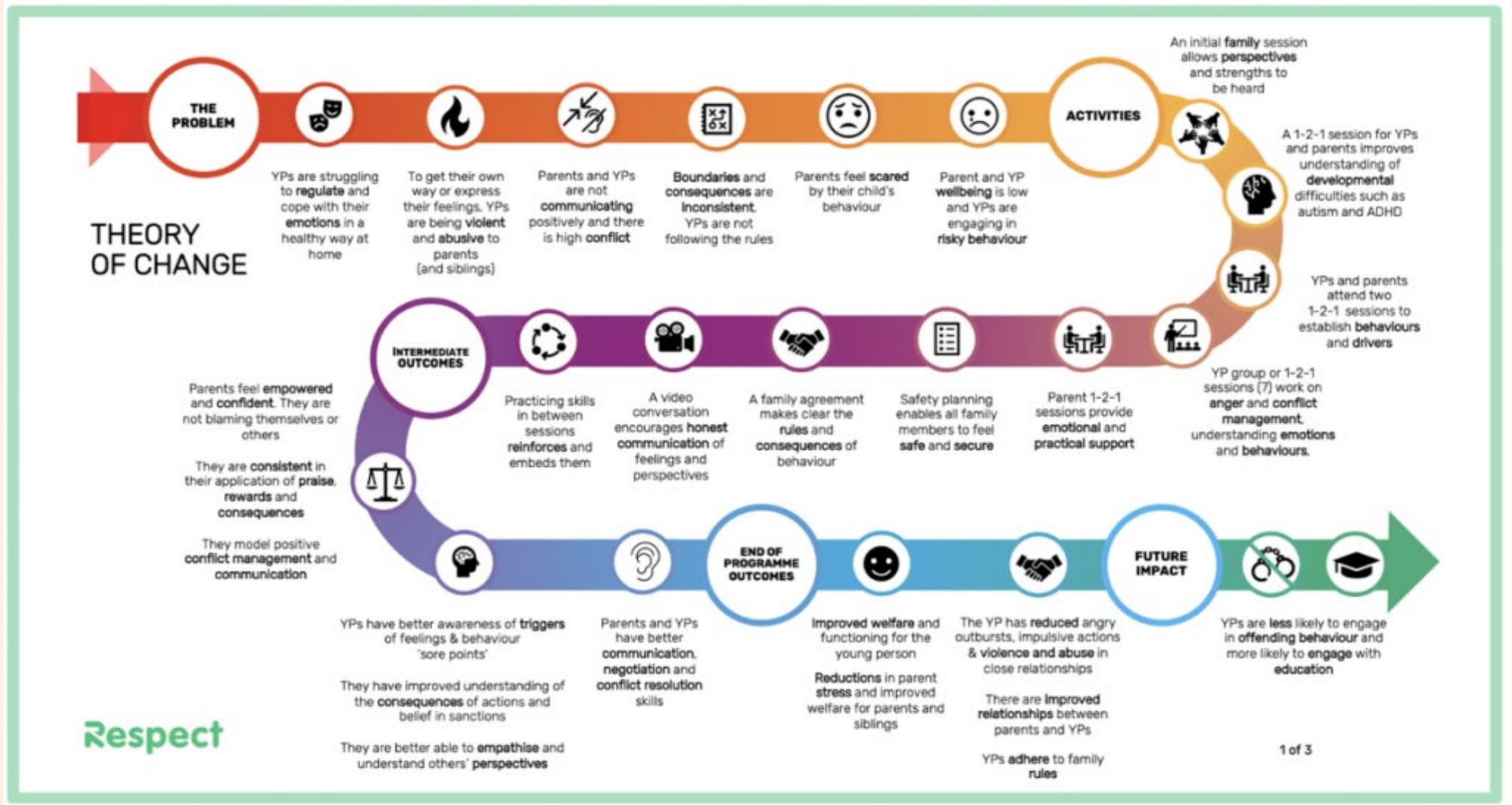
There are several intermediate outcomes (e.g. increased parental empowerment, the child/young person having better awareness of their triggers, and improved communication and conflict resolution within the family), end of programme outcomes (e.g. reduction in stress for the parents/caregivers, fewer angry outbursts from the child/young person, and improved relationships within the family), and future outcomes (e.g. children/young people are less likely to engage in offending behaviour and more likely to engage with education)⁸ expected during and following the RYPP (see Figure 7). To ascertain whether participation in the RYPP improved outcomes for children/young people, an analysis of the outcomes data of all families who completed the programme was carried out by Realising Ambition, taking a specific focus on the improved mental health for all participants taking part in the RYPP and capturing data on the child's emotional and behavioural changes. In the final report the Social Research Unit stated:

“Over the course of the Respect Young People's Programme, all scales within the parent-report SDQ and the majority of scales within the child-report SDQ demonstrated significant improvement between pre- and post-test. Encouragingly, the overall mental health of young people (as represented by the total difficulties scores) and also their behaviour (both conduct difficulties and pro-social) improved according to the reports of both parents and children – a positive result considering the focus of the intervention is on reducing adolescent-to-parent violence. Two-thirds of parents reported improvements in their child's overall mental health and conduct, with scores in the abnormal range reducing by 23% and 27% respectively” [73].

The RYPP is targeted at reducing risk factors associated with later offending/aggressive behaviour such as:

- Early conduct disorder
- Poor attachment
- Poor academic attainment / school engagement
- Ineffective / permissive parenting
- Low empathy
- High entitlement
- Poor conflict resolution skills
- Poor emotional regulation
- Risk taking behaviours

Figure 7: Respect programmes theory of change [72].



⁶ <https://www.respect.uk.net/pages/44-work-with-young-people-s-violence-and-abuse>

⁷ <https://www.respect.uk.net/pages/115-rypp>

⁸ <https://www.liverpoolcamhs.com/training-resources/child-on-parent-abuse/>

3.10 Intervention case study 2: Who's In Charge?



Who's in Charge?

Background

Who's in Charge? (WIC) is a 9-week programme aimed at parents/caregivers whose children/young people are being abusive or violent toward them or who appear out of parental control. The structure of the programme consists of eight, two and a half hour sessions with a two-month follow up to review residual learning. Sessions are delivered face-to-face and online, either one-to-one or in a group setting. The programme aims to support and empower parents/caregivers to encourage practical changes through the implementation of meaningful consequences. WIC also refer to other services whereby somebody can get online support one-to-one without necessarily accessing the programme.

"It's a part therapeutic, part knowledge-based programme. It spends the first three to four weeks really working therapeutically with the parents very reflexively taking away the blame, taking away the punishment and just exploring the issue without being personal to you. So, we get to really look at the issue and what our ideas are about why it happens and then we have some extra exercise activities along the way, some lovely handouts and then the sort of week four through to eight is really looking at developing consequences that are absolutely pertinent to your own child.... And then the last couple of sessions are looking at learning to be more assertive, our parenting styles and also our own self-care" (Practitioner 6).

The service offers training to practitioners to allow agencies to deliver the WIC programme within their organisation. Practitioners take part in a three-day training course, where they are taken through the programme experientially, picking out key points and the salient parts of each week. The training element of the programme has run since 2012, resulting in the training of thousands of practitioners across the UK and other countries.

Facilitating factors

Sessions which are delivered in a group setting, where parents/caregivers can connect with others who have also experienced CAPVA, was felt to be a key facilitating factor in that it encourages peer support, reduces isolation, and allows parents to share what has worked for them. The option to deliver sessions on a one-to-one basis and online was also considered a facilitating factor, as it increases the programmes reach and allows people who may not be able to leave the house (whether that be due to CAPVA or other reasons) to access support.

"It's a group programme and obviously that's lovely because parents feel so isolated and it gives them the opportunity to feel connected to others and to hear that they're not the only one" (Practitioner 6).

"Lots of online programmes have existed through the last three years and are still existing because some parents can't attend a physical group because their kid is at home and they can't leave the house. So for a lot of people, they can access programmes where they wouldn't have if they were face-to-face" (Practitioner 6).

The programme runs a peer group meeting for trained practitioners every quarter. This was felt to encourage the sharing of best practice to continuously develop the workforce, and as such, improve the delivery of the programme.

"We work collaboratively with everybody's organisation that we train, we try to support and that's why we offer the peer group support network because the learning keeps happening" (Practitioner 6).

Working solely with parents/caregivers was felt to be beneficial as it removes any potential barriers associated with involving the child/young person and allows significant impact through working with the parents/caregivers alone.

“Some programmes are reliant on working with the child and the parent can be fully sabotaged by the child who goes ‘I’m not interested, I don’t want to do it, buggo off’... Who’s in Charge is a bit of a golden nugget because it doesn’t rely on their cooperation, but it can have an incredible impact on the outcome of their behaviour by simply supporting the parent more adequately” (Practitioner 6).

Barriers

Stigma was felt to prevent parents/caregivers from accessing support due to feelings of shame. It was recognised that WIC may be missing some families experiencing CAPVA, who are not accessing the services related to domestic abuse or youth offending, as they tend to rely on these services for referrals.

“There’s a fear of maybe saying all that stuff out loud, because what kind of the judgments people might make about me as a parent you know it’s a tricky area really” (Practitioner 6).

“We’re only seeing a small proportion of those parents experiencing CAPVA, we are missing all those parents who could be helped whereby there will become other social issues because we’re relying on them, we’re only looking in the domestic abuse arena or we’re only looking in youth offending or we’re only looking at those agencies that are responding to something that’s glaringly obvious. But we’re missing all the other parents” (Practitioner 6).

Outcomes and impacts

Feedback from parents/caregivers’ interviews suggests that the programme impacts the whole family, with some parents suggesting that the programme has changed their lives. Following the programme, practitioners reported that parent feedback shows a 66% improvement rate in child/young person behaviour and parents/caregivers have described seeing a significant drop in violence.

“In our feedback I think we have something like 66% absolute improvement rate, which is extraordinary really, for some parents to come back and say the violence has really dropped” (Practitioner 6).

*“This parent came, and she had a child with ADHD and she came every week to the programme, and she just didn’t do anything, she didn’t implement anything. Then, she came back after the half term break and she went ‘I went home and said to my husband, right, I’m gonna prove to her that it doesn’t work’ and she said, and I put everything in place and so did my husband and it’s nine days the violence had stopped and she said I wanted to prove this programme was sh*t, but it isn’t, it’s changing things” (Practitioner 6).*

Sustainability and next steps

WIC was considered to be sustainable by practitioners. However, the issue of CAPVA was felt to be under investigated and under resourced. It was highlighted that a range of resources are needed for CAPVA, or else the issue will continue to become more prevalent.

“I think in terms of our partnership, it’s sustainable, we’re a business partnership. I think it’s a hugely under invested issue and if we do not invest in a range of resources around this issue, then we’re going to get what we were talking about earlier, which is a whole generation of people who will meet their needs by using abusive behaviour because they’ve been taught that they can because they can’t help it” (Practitioner 6).

In the future, it was suggested that updating their resources and creating new videos to show other parents/caregivers stories would be beneficial.

“I think we’d probably like to do some new videos to go along with the work and the training because they’re really helpful for parents when they hear other parents, which is really invaluable” (Practitioner 6).

3.11 Intervention case study 3: Non-violent Resistant Training

Non-violent Resistant Training



Background

Non-violent resistant (NVR) training is an approach which has been developed to work with parents/caregivers to effectively respond to aggressive, violent, self-destructive, and controlling behaviour in children, adolescents, and young people. NVR can be provided by family therapists, clinical psychologists, and other mental health professionals who have been trained in the use of this approach. To obtain a certificate in NVR Therapy and Intervention, therapists attend an eight-day training course, two clinical supervision days (augmented by attendance at peer-supervision groups), read selected texts and papers, keep a reflective log of their NVR client work, and submit three 2,000-word case studies.⁴

Trained professionals work with parents/caregivers to help them to plan, prepare, and carry out action against violence in life outside the session, and encourage gestures of reconciliation to reconnect with the child/young person. Resistance against violence is developed step by step, building on what parents'/caregivers' experience in the process, the support they are able to receive, and their growing confidence. There are four main areas which parents implement during NVR.

Four main areas to NVR

- 1. De-escalation** – parents/caregivers learn how to manage risk, how to regulate themselves, and how to no longer get motivated by their own limiting beliefs (i.e. 'I must take control of my child/young person'), which is often expressed in the heat of the moment.
- 2. Breaking taboos** – parents/caregivers learn to strategically break any rules their child/young person has set up for the family. Parents/caregivers are supported in overcoming their tendencies to avoid necessary action because of fear or shame.
- 3. Taking non-violent action** – Parents/caregivers raise their presence using carefully planned, delayed action within the home and in the outside environment.
- 4. Reconciliation gestures** – Child-focused reconciliation works to bring back a dialogue between the parent/caregiver and child/young person, in which the parent/caregiver can look after the child's/young person's needs.

The parents/caregivers receive support via therapy sessions, which they will, at least initially, attend once per week to discuss and plan how to overcome the violence and reflect on the steps taken in the previous week⁵. The therapy sessions allow parents/caregivers to gain an understanding of their strengths and how to use these to overcome the violence. Additional support via telephone calls and by email or video conferencing is available for parents/caregivers to receive encouragement and advice and express their frustration. Helpers meetings are established for parents/caregivers and other adults from outside of the family to form a support network⁵.

Outcomes and impacts

Several outcome studies have concluded that NVR is effective in improving the behaviour of a significant number of children/young people, increasing parents' confidence, and reducing their feelings of helplessness, as well as cultivating a more peaceful atmosphere in the family. The retention rate of the therapy sessions is 90%.⁵

The three parents (interviews) who attended NVR training particularly liked the opportunity to share their experiences with *"people who are going through exactly the same thing that we are ... finding out that there were other people that were going through it, it was a sort of release"* (Parent 3). All found the training enabled them to *"understand escalations"* and provided them with effective strategies and tools to manage them. Wait times, availability and the need for some post-intervention follow up were highlighted as areas that needed improvement.

⁴ <https://thechildpsychologyservice.co.uk/therapy-information/non-violent-resistance-nvr/>

⁵ <https://www.partnershipprojectsuk.com/non-violent-resistance-nvr/parents/>

3.12 Intervention case study 4: CAPA First Response

CAPA First Response

CAPA FIRST RESPONSE CIC
Child to Parent Abuse

Background

CAPA First Response is a 'first response' service to families and professionals impacted by a child/young person using abusive or violence behaviour in the home. The service will work with families with children/young people up to the age of 18, or up until the age of 25 if there is a neurodivergent issue (whether that's diagnosed or undiagnosed). In the first 30-minute support session, CAPA First Response works to identify the root cause of the child/young person's behaviour and uses that to establish a way forward to build relationships between parents/caregivers and their child/young person.

Four elements to the service:

- 1) Free advice and support sessions
- 2) 1-2-1 sessions, offering more intense support
- 3) Delivering training to professionals
- 4) Raising awareness – including an offer of a free 2-hour networking event to professionals

“Once you can figure out the root cause, then it's connecting the parent because what happens is most children and young people are vilified in this position. Whereas what I'm looking to do is say your child is saying there's a problem and nobody's listening. So, I'm gonna have to make you listen” (Practitioner 14).

They receive referrals from parents/caregivers, young people, and professionals. To reduce barriers when referring into the service, they offer support with filling out the referral form. The service relies on funding, but staff reported that the *“training arm obviously brings in an income which allows us to continue to do the front facing work for families and professionals.”* Additionally, client work is conducted on a donation system, where parents/caregivers can pay what they can for the support. CAPA First Response have to make it clear to parents/caregivers that although they do not have to pay for sessions, without funding, they will not be able to sustain their service.

“Our 30-minute advice and support sessions, we always trying to keep those free. Our one-to-one support what we say to parents, listen, if you've said you can afford £5, if you can still afford that then could you contribute that... We try not to have any stigma around it, but we're also really clear that we can't offer it if we don't get funding. So, it's trying to keep that balance” (Practitioner 14).

The service also runs commissioned training, as well as in-house training for practitioners, usually virtually. The training is a three-hour webinar via zoom, which is a general introduction to CAPVA. A more thorough one day training course is also offered, which is also conducted remotely. The training sessions build a network of professionals to encourage collaboration and the sharing of best practice. This lends itself well to the priorities of CAPA First Response, as taking a multi-agency approach was felt to be important to responding to CAPVA. The service works with organisations across the third sector and public sector, as well as other organisations around the UK. More recently they have been working with the police to overcome barriers associated with CAPVA and the police.

“We do a lot of collaborative work and that's really, really important. We can't ask families to work in silos. So, I don't expect others organisations to work in silos and I don't believe that's the answer to this issue” (Practitioner 14).

Facilitating factors

Working remotely has allowed CAPA First Response to work across the UK and other countries.

“We're UK based, and we're known throughout the UK, we're known throughout Scotland and Ireland and that's the beauty of having a remote service.” (Practitioner 14).

One of the biggest facilitating factors was felt to be the time and effort taken to understanding what a parent/caregiver and child/young person are going through. Encouraging empathy was felt to lead to meaningful connection and trust with clients and helps to overcome the barriers they've experienced (such as stigma and shame).

“It's about understanding why it happens and getting a parent to connect with that because sometimes, parents will come to you, and they've had enough and they can't do it anymore and it's understanding what's going on for the parent when that happens and why a child is doing it in the first place. Because often up until that point, parents have come with lots of stigma and shame that they've done something wrong” (Practitioner 14).

Challenges/barriers

Services are often competing for the same funding, which can prevent or limit multi-agency working.

“The way funding works is we're all pitted against each other to fund and it's like come on, we need to be working together.” (Practitioner 14).

Sometimes parents/caregivers lack the compassion and empathy to understand that the child/young person is often struggling too, with some parents/caregivers thinking there is something wrong with their child/young person and wanting them to be “fixed”.

“I think the barrier is really connecting with that compassion and empathy with the parent when they're really focused on the fact their child has done something wrong... the focus is on there's something wrong with the child. And I think that's one of the barriers” (Practitioner 14).

Impacts and outcomes

Practitioners noted that parents/caregivers can identify why their child/young person may be behaving in a particular way, which allows for understanding and a baseline for which a relationship can develop.

“I think it's about when you have those light bulb moments with a parent and they're like, Oh my God. I get it” (missing practitioner)

Sustainability and next steps

Due to building capacity, CAPA First Response are looking to grow their team, moving away from freelance practitioners to hiring contracted practitioners. They are also looking to develop champion roles to allow practitioners to develop their skills and take them back to their workplace.

“We do have a lot of families open to us and due to that we're building capacity of the team as well” (Practitioner 14).

“We're very keen on pushing the champion roles where we train up and we support” (Practitioner 14).

CAPA First Response are also “putting together a resource book” to address their FAQ's and increase understanding of what they do.

3.13 Impacts of support

Just under half of the parents who participated in the parent survey reported they had received support in relation to CAPVA. Parents/caregivers who participated in an interview were generally unaware of any CAPVA specific interventions they could access. Three parents completed NVR training and one completed Who's In Charge? training. Seven parents received support from CAMHS. Other initiatives that parent accessed included: YOT, YPAS, PEGS, Paul Lavelle Foundation, Parent Line, Kinship Care, Domestic Violence Unit, and the Dewi Jones Unit at Alder Hay Hospital.

“There seems to be very little acknowledgement in children services that this exists and given that work in children's services that you know that it's not really talked about, it's not as prevalent as it should be. I think it's not recognising that this is abuse” (Parent 4).

Peer support was mentioned by several parents and practitioners as one of the biggest impacts from the interventions. Many felt that just having the opportunity to share their experiences and having a peer group all going through the same or similar thing was very helpful for many parents/caregivers. Some practitioners mentioned that parents/caregivers who attended the interventions have set up their own WhatsApp group to support each other outside the sessions. Building positive relationships and having a support network where they can share their experiences without feeling judgement or shame was believed to be a huge positive which can have lasting impacts past when the interventions had finished.

“They all really liked the fact that there were conversations between us. So yes, we were given input, but the bits that are really remembered were being able to share a bit of my own experience listening to others own experience, to have that validated, to have my progress validated, to have my struggle seen and heard was just powerful and to have to have a thought that someone thought about this, someone's giving us a bit of a road map and OK” (Parent 7).

“I think one of the biggest things was parents build relationships, I remember on my second course, parents decided to set up their own WhatsApp group, to support each other, get each other's contact numbers and feel comfortable to be able to just ring. To say I'm really struggling, can we just have a chat or to share ideas on what has worked for them, and the other parent hasn't tried. Supporting each other outside of the nine sessions and once we finish the course” (Practitioner 7).

“The therapeutic value of them all sitting together and talking about, you know, their issues and concerns, there was shared, lived experience, people who is, non-judgmental environment basically” (Practitioner 11).

Practitioners discussed positive impacts that some families had experienced from accessing their services. Most acknowledged that impacts for families are not massive or immediate and that violence would not stop overnight, but via smaller wins that made a difference over time. Other services monitored success of the programme based on how much support they could get for a family for example financial assistance, housing support, and employment which can help alleviate some stress from the household which can in turn reduce CAPVA. One practitioner discussed how the support they provided helped parents put responsibility back on the child/young person, reduced parent blame and helped improve the broken power dynamics.

“Well, if you don't get me to school, I'm gonna get a detention’, but that's not my fault... put the responsibility back on them, “then you need to get up a bit early and get into

school. If you do go to school late, then obviously the consequences, you will get a detention, but that's nothing to do with me'. So it's putting the responsibility back onto them, overtime, once you balance the scales and give them the responsibility, then you start getting treated with respect etc.. They won't like the change at the beginning because maybe you've not put the routines and being assertive in that way before” (Practitioner 7).

Several practitioners discussed how improved family relationships was one of the biggest impacts of support. They felt the interventions allowed parents/caregivers and their child/young person to rebuild their relationship, mend broken trust, and improve family life substantially.

“This is a communication breakdown and it's a loss of trust and I work at that relationship, whereby rebuilding those relationships and looking at what the child need, what does the parent need and being compassionate with all of that. But it's gonna take two to bring this relationship back together. This isn't about blame the parent. It's not a parenting issue. It's not about blaming the child. Let's vilify the child. This is about recognising it as something wrong or we need to work on it together” (Practitioner 14).

Practitioner examples of CAPVA reduction and positive impacts of support

One service spoke about how their programme helped a mum who was being controlling by her child to leave her house and get some independence back. Whilst most people would take this for granted this was seen as a big win for that parent.

“There was one in particular, when the mum came in really proud of the fact that she actually stepped outside and moved further away from her front door and told her child what she was going to do and then the next time she actually went to the shop. So that was a massive thing for that mum to be able to go to the shop and that same mum actually told the child, that she wouldn't be going to bed when the child told them to. That mum for me stands out because she made a friend as well and she's gone the cinema with a friend and, yeah, so she stood out. And I think overall it's the peer support that you've mentioned, that's a huge one” Practitioner 9.

A service in Wirral discussed how small, short-term impacts can add up to bigger long-term impacts, in addition to the importance of peer support.

“I think what really works well is that within the first two weeks when they try simple, small little steps. If they notice a change for the positive that builds their confidence, I think that's very helpful and they think I've tried all these other courses, nothing seemed to help, but this, something seems to be working here. Then by week 4, you start seeing the smile on the face. You start seeing a flicker of light of life inside their eyes and things like that. And they actually love coming to the courses then, once they know that something seems to be changing, then hang on a minute, it looks like something could happen because they always come on this thinking nothing's ever gonna change, it's always gonna be the same, I can't live through this. I don't know where to turn. I don't know what to do et. But just by simply coming on and meeting other people in the same boat is a great opportunity for them to realise I'm not suffering on my own. It's not me. I'm not that bad parent I think I am, that parent who can't even cope with a child or something. Actually, there are other people and I'm not on my own in this and I think that's really important” Practitioner 7.

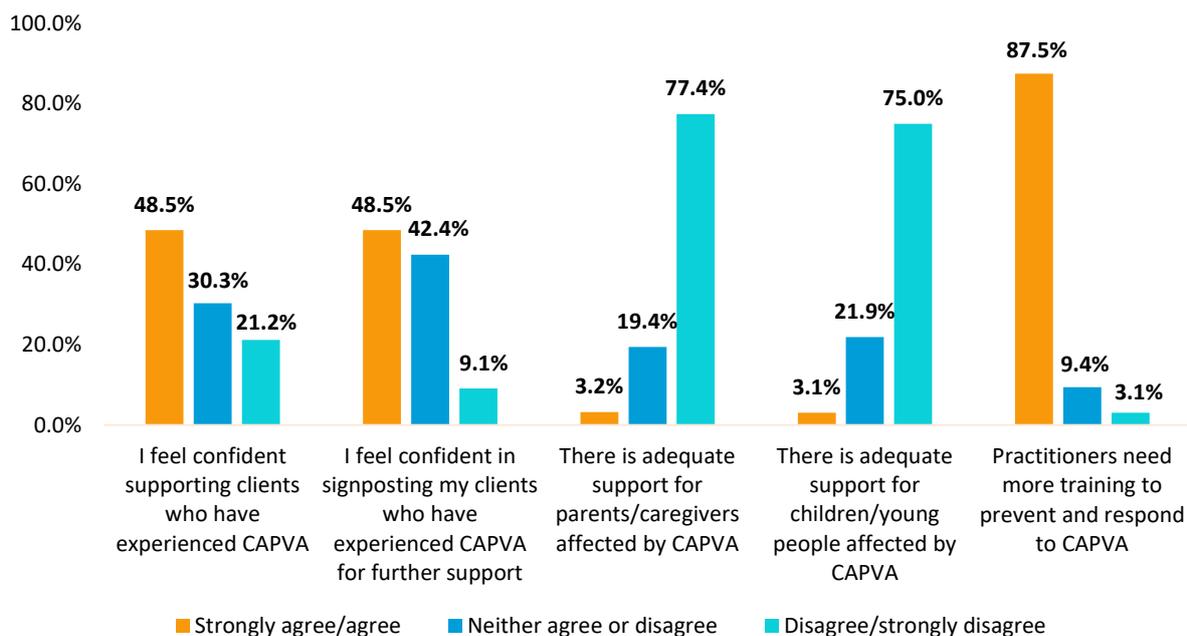
Another service measured impacts though the amount of financial aid they provided to a parent as well as improvements in wellbeing scores

“So some of that data is around the amount of money that we've managed to get for people so that they can afford to pay their bills. Some is around their sense of wellbeing and how much better they feel about themselves. And so we use different tools for different services. So in the counselling services, they have a couple of tools that they use, which obviously measure wellbeing, in info and advice, we've got much more tangible outcomes; practical interventions that we've done” Practitioner 4.

3.14 Views on provision across Merseyside

Just under half (48.5%) of the practitioners who participated in the practitioner survey agreed/strongly agreed that they feel confident supporting clients who have experienced CAPVA, and the same proportion said they felt confident sign-posting clients who have experienced CAPVA for further support. A small minority (3.2% and 3.1%) of practitioners felt there was adequate support for parents/caregivers and children/young people affected by CAPVA respectively. The majority (87.5%) felt practitioners need more training to prevent and respond to CAPVA (Figure 8).

Figure 8: Practitioner survey views on support relating to CAPVA



Some practitioners felt there was enough support available in Merseyside but acknowledge that it was difficult for some families to know how to access the support that is available. One practitioner said *“I think there is more support out there than people realise. In my personal opinion there can always be more support for people, but I think there is a lot of support around, but people don't necessarily know how to access it”* (Practitioner 24). Practitioners who felt there was enough provision across Merseyside acknowledged that they are services that have received practitioner training, their services provide a CAPVA specific interventions or because they have a wealth of experience helping families with a number of complex issues. It was believed to provide them with a different perspective to other practitioners who have had no training on CAPVA, which could be due to a high turnover of staff, and they might find it difficult to know what support is available and where to signpost parents/caregivers if they attend their service regarding CAPVA. Parents/caregivers felt when they did seek support they were often signposted to inappropriate and ineffectual interventions (e.g., parenting courses) delivered by people without lived experience of CAPVA. One practitioner also felt that this was also important *“a person with lived experiences discussing their own experiences”* (Practitioner survey respondent).

“The provision is there I would say so..... I think you know it's all there for them [families], we'll say we're always here after the group if you want to talk on a one-to-one basis or we'll meet with you on a separate occasion or whatever it is really. So, we try and make as you know as much opportunity as possible really” (Practitioner 21).

“It depends on which social workers you speak to and whether they know community stuff that's going on, like coaching, family coaching, young people's coaching and life coaching etc. If you've got good links with your third sector organisations, then you make something happen. If you don't know [where to signpost], then you sit on your backside saying we don't have the provision for that, so it's a complete mess basically” (Practitioner 15).

Many practitioners felt services were over capacity and over worked, so therefore, didn't have the scope to help families as effectively as they may like. With lots of services over stretched this can result in families being placed on long waiting lists for support, resulting in CAPVA and its resulting impacts worsening. Parents/caregivers commented on the lack of *“resources and provision”*, the *“long wait lists”* with several parents/caregivers reporting that they had to access support privately due to lack of capacity in services and long waiting lists.

“Over the years we have used a lot of professional help and parenting courses, which are an absolute waste of time, sorry, that sounds awful, doesn't it? I know they're there to help, but you really do feel when you are going through something like this, and you've got people who have had no experience of this and are just on it for just to widen their knowledge or broaden their knowledge. And you're like, well, actually, I get attacked and they're like ohh no, and you've you feel like such the bad parent” (Parent 3).

“I would probably, I don't know statistically, but I would say no based on the fact that we haven't got enough family support, we haven't got enough time for social workers as in their caseloads are so big. I'm involved in some work around, there's an Ofsted improvement plan going on and there's a nine month waiting lists for some of the mental health charities, huge waiting lists for CAMHS. We've got children self-harming and still not being able to get support quickly. Everything is so under pressure” (Practitioner 8).

Other services felt that there wasn't really anyone else offering the support for CAPVA that they offer. Some felt that when practitioners heard about the work they were doing, they immediately wanted to know how they could refer in a family.

“There isn't anybody else offering the service that we offer at the moment and every time I say to a professional. Ohh yeah, we've run this programme and they're like, how do we refer? You know, they jump on it straight away. I met a team yesterday and on the back of that had a referral today. I think it is a case of at the moment, I wouldn't like to say we're the only, but we're the only known organisation that's offering this service and it's I think it's in demand” (Practitioner 18).

A police officer talked about the protocol for responding to CAPVA incidents and emphasised the importance of handling such incidents in the most efficient and risk-mitigating manner possible (Box 7). They highlighted the intricate nature of these calls and how they formulate a rationale to ensure the best possible response while minimising future risks. One officer discussed that, quite often, once the initial crisis subsides, parents typically opt not to pursue any legal action. This pattern resembled the officers' experiences with domestic violence incidents they had previously encountered *“Once we are there and the immediate source of risk is gone parents would then be like, oh, it's fine, it's fine, don't worry about it, nothing's happened, which is very similar to intimate partner abuse that you attend as well, that once that immediate risk is gone, it's then, oh, I don't want you to do anything else” (Police Officer).*

Box 7: Police response to a CAPVA call out.

- Upon arrival, the police typically separate the involved parties (at times, the child/young person might have fled the premises, potentially leading to concerns about a missing young person).
- Immediate attention is given to assessing and addressing welfare needs, such as attending to any injuries.
- Interviews are conducted separately with the involved parties to understand the underlying causes that led to the incident.
- Personal information of the individuals involved is gathered, following which the officer devises a strategic plan for the most appropriate course of action.
- Sometimes, if both parties have sufficiently calmed down and feel it's safe, the child/young person may remain at home. However, in other cases, the child/young person is relocated to another family member's residence (ensuring careful assessment of potential risks to avoid creating another victim).
- In severe cases, the officer might opt to arrest the child/young person due to safety concerns. However, this is considered a last resort to prevent subjecting the young individual to a traumatic custody experience and potential criminal record.
- Parents are offered and encouraged to access support services, such as social services. A safeguarding referral form is completed to direct parents to the appropriate support service.

Both parents/caregivers and practitioners felt there was a gap in how the police handle call outs relating to CAPVA. There was a feeling that police aren't really sure what they can do *"not wanting to rock the boat"* apart from criminalising and arresting children/young people. Parents felt frustrated by the police's inability to take action because their children were minors. Whereas practitioners sensed police were not really sure where they can signpost families so don't respond to call outs adequately.

"So phoning the police and they came out on the second time and they were like stop being a naughty girl -that's it" (Parent 6).

"No, as I say we had the police just last year, it was well over 50 times, and it would be sort of like OK. Yeah. They were very accommodating and very polite, articulate, and as soon as the police go, it was back to normal. So, you get to the point like why am I phoning the police because they're not doing anything and she knows she can do what she likes and no one is arresting her or taking her away, putting her in respite...social services were saying, well, if there's any problems, call the police, CAMHS were saying any problems, call the police. Well, that's not gonna solve the issue. Like I said to you before the police couldn't do anything, and once they went, they were back to the way they were" (Parent 1).

"Sometimes police might think we don't want to rock the boat, or we don't want to criminalise the young person and we send them back home and we speak to the parents. But actually, that young person and that whole family might need support and it's a police thing. The police don't know where to sign post. Then again, it depends on which officer you meet and how they respond to that family or that young person. So it's all because there's no specific pathway, it's all over the place" (Practitioner 15).

Of the parents who participated in the survey 70.6% reported that they had to contact the police in relation to CAPVA.

3.15 Challenges for families seeking support

Time commitment and travel costs to attend

Practitioners recognised that it is difficult for parents/caregivers to commit to a programme or intervention for a set number of weeks. Where parents/caregivers cannot attend a session, they often do not get the full benefits of the programme as one participant explained, services do not have the resources or facilities to run the session again for the parents to catch up.

“I think sometimes, the fact that it goes on for eight weeks is a big commitment, big commitment for families and I'd like to change the opportunity of a parent can't attend or something's happened. I don't want them just to sort of read a bit of paperwork that we sent out as attachments. I'd rather have the opportunity to do a one-to-one, just for an hour. Cutting it down but keep them going. Rather than just reading a piece of paper because that doesn't help them. I don't want to miss people that have had to miss sessions for personal reasons. But we don't have the time or the facilities to be able to offer that, especially when I'm case holding and everything” (Practitioner 7).

In addition to this, not being able to access support due to transport barriers, such as a lack of funding, prevents families from being able to travel to the service location. To overcome this barrier, it was felt to be important to offer support virtually.

“But the barrier for that is that, imagine we're running a course in one area, but I've got someone from another area. People who can't physically get there or haven't got the funding to get there. So, the barriers are formed then. By virtually doing it, you're able to access all areas because it's just a click of a button and coming live on screen” (Practitioner 7).

Stigma, shame, and guilt

Stigma associated with CAPVA was recognised as leading parents/caregivers to feel emotions of shame and guilt, where parents/caregivers will not seek support due to self-blame and fear of judgement.

“So, I think there's a lot of shame and a lot of isolations that those families experience and a lot of judgment. I think that's what family's say to us, about actually feeling really judged, and there's nothing worse than having your child who's violent against you as a parent. Those patterns can become really entrenched. So a barrier for me is about how we actually reach out to families, how do we lift that sort of vale of silence and connect with families at a much earlier stage so they notice these patterns and they're feeling more empowered and have more resources” (Practitioner 3).

“For the whole family is obviously detrimental because the amount of shame around it, a lot of families don't go seeking support because there's a lot of self-blame on parents and they feel they're gonna be judged so, I think families tend to go underground, cause whichever culture you're from, there's a hell of a lot of shame around this” (Practitioner 15).

The normalisation of abusive relationships and a culture *“where you don't grass”* was seen to reinforce the stigma associated with CAPVA, where cultural norms support the notion that abusive relationships should be a private home issue that is dealt with personally.

“I think its normal behaviour, because we've got a very hard man sort of culture where you don't grass. It's a private home issue. If there's issues in the house, you keep it to yourself, and this is how young people see and then they go into abusive relationships themselves and its normalised” (Practitioner 15).

Parent's mental health

Several practitioners recognised that some parents/caregivers may have mental health issues, which pose a barrier to accessing support. One participant explained that some parents/caregivers are just trying to get by day-to-day, and they may not have the capacity to reach out for CAPVA support, with further barriers placed on parents/caregivers due to a lack of understanding from professionals who feel that parents/caregivers should be able to reach out for support, regardless of their own circumstances. Another participant described a case where the mum was agoraphobic, meaning that she was not able to leave the house to access support, and although this was ok during the Covid-19 lockdown, outside of that, she would not have been able to access support.

“Sometimes I think mum might not have had a good parenting experience, she might not have been parented well herself, or she might be depressed, have mental health problems and just not have the energy if somebody's really down. I've met lots of mums just crying, you think, how are you even like getting the shopping let alone managing 'Johnny' bouncing off the walls and everything else that's going on and your homeless, imminent homelessness and everything else. I think there is still that mind-set that it's just something you should be able to do. I think even with some professionals, often even with support service that kind of finding out what's at the bottom of it sometimes rather they deal with the behaviour rather than what's causing the behaviour” (Practitioner 8).

Parents/caregivers having mental health issues was also seen to prevent the implementation of programmes or interventions, due to not being able to cope with the fallout of implementing boundaries within the family. It was recognised that in these instances, parents/caregivers will accept violent and abusive behaviour from their children/young people as it is often less difficult than facing the obstacles associated with implementing recommendations from services.

“Sadly, some of these mums have got so many issues going on themselves that they need the guidance as well. Support and maybe even counselling. You know, some of the issues that have gone on in their lives. It doesn't help the situation either. So, there's so much coming at it from all angles. If they're finding it hard to get through daily life or some things that have happened to them and their ACEs, it's gonna make it hard for them to then, you know, they don't think about the boundaries and fights because it's just they want an easy life really rather than, you know, obstacles all the time” (Practitioner 9).

Not knowing where to get support/failing to get the right support

A number of parents felt that their experiences were not taken seriously by services, saying they often felt dismissed or blamed for their own child's behaviour.

“Take it seriously. I was dismissed and ignored as it was my own child assaulting me” (Parent survey respondent).

Parents/caregivers not knowing where to access support and failing to get the right support means that families often reach crisis point before seeking help. One participant explained that it is only when a child/young person's behaviour becomes extreme that parents/caregivers will seek support, as they did not consider it a problem beforehand, and by this point, behaviours are already entrenched making it difficult to overcome.

"It's difficult, because first of all, if they're in the eye of the storm of this, they're not gonna necessarily recognise it or put a name to it. They're just gonna put it down to childhood behaviour. It's only when they get really in the thick of it when behaviour kind of steps up. That's when it might be a bit too late in the day" (Practitioner 1).

"You know they're at the cusp of, you know, criminal justice services and all that" (Practitioner 3).

Even when families are seeking support, professionals might not know what to do or they may have a lack of knowledge on the subject. In cases where families are not given the appropriate support, they are likely to stop engaging and are less likely to seek help in the future due to feeling discouraged and lacking trust in services. Parents/caregivers discussed non-CAPVA specific services they accessed – these were primarily social services and the police. They felt that CAPVA was not always acknowledged or recognised by services and that *"no one seemed to know what to do when it was a child on parent"* (Parent 2).

"Yeah, I think probably identification and then people being aware of it as well, like you know, are professionals aware that this is a kind of, you know, a specific type of violence on its own and so it maybe a lack of training and education as well across the professions" (Practitioner 7).

"I don't think they're directed to the right kinds of targeted support. So again, if they feel like they're not getting the right answers or what they need, they're going to stop asking and, or if they get a negative response from like their behaviour, they're less likely to then go and ask for help and say that they're struggling" (Practitioner 7).

"You know, maybe people have come forward in the past and then there hasn't been the response that they've wanted or needed, so then it's a kind of well I won't try again next time" (Practitioner 12).

Several parents/caregivers highlighted the difficulty of addressing CAPVA when neurodiverse children are involved. One mother expressed concern that neurodiversity was not adequately acknowledged but rather *"pushed to one side"* (Parent 5) when discussing CAPVA.

"It's more difficult to get a SEND child, who doesn't actually know that's not what you should be doing, you can't push mum down the stairs because she could die" (Parent 6).

Lack of trust in services

As mentioned, a lack of trust in services was recognised by several participants as a barrier to seeking support. In instances where families have had previous negative experiences with professionals, they may be reluctant to engage in support, with professionals having to overcome this barrier by reassuring service users that they can provide help and they will not judge them.

*“If you've got a family that had professionals in their life a lot, and they've not had a particularly great experience, they're gonna be reluctant to engage with yet another service. So, it in a way, it's a bit of the sales job because we're going in and we're selling ourselves, as you know, please work with us. We will help you to change your life and we're not gonna be nosey and in your business or you know just, you know, judging you on everything and that can be quite, that I'd say that's the only barrier that some of the families that we work with and their own attitudes to working with professionals”
(Practitioner 18).*

Several practitioners discussed families not disclosing CAPVA due to concerns of social services becoming involved, with parents fearing that they will not be understood and may have their child/young person removed from the home.

“In my experience people are really worried about talking to social services about CAPVA. I think there is that worry that they won't be understood. And I've sadly worked with quite a few families over the years where, you know, in the kind of the scuffle CAPVA, they've either pushed the child away or they've held them or so the child has gotten hurt and then it's become a kind of a child protection issue and the parents have been you know, kind of treated as if as it was an abuse situation. In my experience, it's not been understood that well, if it gets to that by social care” (Practitioner 16).

*“I think they don't know where to go for support, and they're scared that if they ask for support, that social care will get involved and their kids will get taken off them”
(Practitioner 8).*

*“I would normally speak to the parents and try and engage them with social services. I try and let them know that it isn't a negative thing that you can actually ask them for support without them sort of sweeping in and taking children away, you know, that's not the case. I think there is a huge amount of stigma around social services, social service involvement and a huge misunderstanding and misconception about what their role is, especially if parents have never had any previous dealings with social services”
(Practitioner 24).*

Lack of support from family

One participant discussed partners being a barrier to seeking support, where one member of the family does not want other members of the family to engage in support, or they themselves do not want to engage. In these instances, it was felt that the partner will disrespect what the other parent/caregiver is trying to implement, which can be a barrier to its success.

“Partners can be a barrier. You know, partners not wanting someone to go on the course or the partner not being able to come on the course and kind of disrespecting what the parents bringing back” (Practitioner 20).

Lack of capacity in services

Parents commented on the lack of *‘resources and provision’*, the *‘long wait lists’* particularly with reference to CAMHS and inappropriate and ineffectual interventions (e.g., parenting courses) delivered by people without lived experience of CAPVA.

“So, over the years we have used a lot of professional help, a lot of it like parenting courses are an absolute waste of time. Sorry, that sounds awful, doesn't it? I know they're there to help, but you really do feel when you are going through something like this that you're sat with people who have had no experience of this [CAPVA] and they're just on courses to widen their knowledge or broaden their knowledge. You're like, well, actually... I get attacked and they're like ohhhh no, you know, and you feel like such the bad parent” (Parent 3).

“For the process not to take so long, professionals dragging their heels until you are at crisis point and it's taken into the police's hands where they feel they have to intervene to give the help required” (Parent survey respondent).

Services identified that there is a lack of capacity and funding to support families affected by CAPVA. Often services are delivering courses alongside other responsibilities so it can be difficult to manage the demand for the service. More funding was felt to be needed to increase the capacity through employing more staff.

“We, I haven't got enough capacity to do what we're doing, you know. And there's a big demand. You know, so increasing that capacity and to reach out and to offer that ongoing support I think is a big thing for me in our service because I think we need to get better at being creative” (Practitioner 3).

One service explained that they hired more staff to allow their programme to run more frequently, however, due to other responsibilities, they have not had the capacity to be able to run these additional sessions. Practitioners who participated in the survey reported that they spent . between 0-25% of their time on CAPVA, indicating that for most practitioners CAPVA is only a small part of their many responsibilities.

“I've always said that over the last year, if we had instead of running one session every three months, if we had more. So they did train more facilitators but because they're all case holding, so this is an extra thing for them to do, they haven't got the capacity. So capacity is a big thing. Having the staff and the capacity to be able to run one or two courses alongside each other from the same service, which we've not been able to do since June 2019 when we started so, we need more money off the government, don't we?” (Practitioner 7).

Another practitioner discussed how support can be *“a bit of a postcode lottery”* and depending on what social worker the family is assigned with, that can have an impact on what support is offered to that family. One parent discussed how their experiences of support has been completely different to others also they knew going through similar experiences of CAPVA. Parents were often critical of services. One parent complained that the lack of continuity of care in social services meant having *‘to tell another person the same story and stuff like that’* (Parent 1).

“Nine out of ten times, that child probably won't get support. Sometimes we've got counselling like listening ear, which is a commissioned in service, but they have already told us we can't take on any more people because we can't get the counsellors for the young people. So, if it's specific CAPVA-related, like I said, it depends on who gets the case because there isn't a specific programme in [Merseyside] it's all hit and miss” (Practitioner 15).

“The ability for other parents to access the service, I am part of a parent group of 8 mums, but I’m the only one to be offered that specific service when 6 out of the 8 have suffered” (Parent survey respondent).

Where training is available, it was felt to be inaccessible as many services face funding barriers and cannot afford to send practitioners on courses. Training being too time consuming was also felt to be a barrier as professionals often do not have the capacity to attend. It was suggested that training should be delivered on varying levels, whereby people can access the relevant level, depending on the extent to which they see and deal with CAPVA within their service.

“I think it needs to be realistic training. So, if it's training that takes it out too much time for people, then if the capacity isn't there, they're not gonna go on it. If it costs too much, that's a barrier. And so, I think it needs to be. And with some things there might be different levels of training, so there might be a kind of I don't know a half a day more basic than if you're a worker that's doing intense family support, you might need more, so there might be training around recognising it and some small wins and there might be training more, in depth training for people who are dealing with that family and doing intense work perhaps” (Practitioner 8).

3.16 Areas for development

Which services had responsibility for CAPVA

Participants felt that there is a lack of consensus regarding which organisations should deal with CAPVA. Examples were given by participants outlining cases where service users were overwhelmed due to the number of professionals involved in their case and alternatively, examples were given where no service wanted to take responsibility for CAPVA.

“I've reopened one, I closed it and then I reopened it because there was that many professionals involved that it was a bit overwhelming for that young person and it was a massive duplication of work because we're involved with youth offending and they touch on some of what we do, but then all of a sudden there was no one involved and the situation hasn't changed or got better, so we still keep, we still keep in touch with them in some way to know what's going on” (Practitioner 18).

“It's about creating a clear awareness of what the problem is and being strong enough as professionals to give it the credence that it deserves and acknowledge that there's a concern here and we need to do something about it, rather than going it's not my problem” (Practitioner 13).

Suggestions were made by participants for specific organisations to deal with CAPVA, such as youth workers, who are used to and good at engaging with children/young people and families. It was felt that youth workers are able to build trusting relationships with service users, which is a key facilitator to addressing CAPVA.

“Maybe like youth work people who are good at engaging with young people and families, you know? That work, alongside families that don't just go after one failed visit that stay for a couple of years to really help them navigate and build that relationship, cause that relationship quite often is the intervention” (Practitioner 5).

Some practitioners discussed how important it is for services and organisations to work collaboratively, it was felt that if services had a clear referral pathway that everyone followed, there would be less confusion regarding what support is available. If services could share information more openly this could benefit families by spreading resources more efficiently, reduce waiting times, and prevent further harm.

“Clear referral processes and identification to prevent further incidences and with other children in the family” (Practitioner survey respondent).

“I feel the communication across all services needs to be improved. The sharing of information and ideas of what works and what doesn't when working with victims of CAPVA would be so beneficial- a shared resource that can be referred to and is relevant” (Practitioner survey respondent).

Flexibility within services

Services having the flexibility to tailor their offer to the needs of the service users was seen to be important, for example, offering sessions both face-to-face and online. Having the ability to deliver sessions virtually via video conferencing was identified as a way to engage with service users who would not typically engage in a face-to-face setting, for example, due to lack of confidence. Despite this, several barriers were associated with online sessions, such as some people not participating. It

was felt that “*you get a lot more*” from face-to-face delivery, thus having the flexibility to offer both is key.

“That's good that that's kind of flexible and like it has that flexibility to it. Also some parents don't feel comfortable in or don't have the confidence in speaking out, unmuting and speaking out. So, we had one for the whole eight weeks just typing all the time because she didn't feel comfortable” (Practitioner 7).

“If it's just purely on Teams when you've got all those faces, it gets busy and you know some parents, you'd never see them or they'd never comment. So people will kind of lurk in the back of teams. So I think face-to-face will be much better. But I do think it has got its place over Teams. If you've got parents who can't get out, work or yeah, but I'd prefer face-to -face. I think it's, you get a lot more from it” (Practitioner 18).

Additionally, services adapting their programme to address the needs of each individual case was felt to be important. Going through the same programme, in the same way with each service user was seen to potentially discourage parents/caregivers if they were to finish the programme and not see any change within their family.

“There's a lot of programmes that work one through 10. So we start at number 1 one and we go through to number 10 and then we come to an end. Brilliant. Don't have a problem with them. I'm not suggesting there's anything wrong with them. But what I have found is when I do a programme with a parent and I go through one through 10 and you get to number 10 and nothing's changed or it's not changed or, you know things aren't different, the parent will become disengaged and [think] that they're doing something wrong. So I could start at chapter 10 with one family and then I might go to chapter one and perhaps to five. Depends what's going on for that family” (Practitioner 14).

Support after the programme finishes

Participants recognised that patterns are usually entrenched in families and as such, improvement is not likely to be resolved within the set number of weeks that they have support, nor is improvement linear. For that reason, support should be extended following involvement in a CAPVA programme. One service user recognised that if there is a big change in the child's/young person's life, or within the family, then the child/young person may regress and as such, it is better to already have support there, rather than to start again.

“Our experience is that if there's big changes in the family or the child's life that it might actually, you know these issues might kind of flare up again. And then it's kind of better if the support is there rather than people having to go through the whole rigmarole of applying for support again” (Practitioner 16).

“These are patterns that have become quite entrenched within families. So by a ten-week programme you might see change, but it's that change doesn't happen in a linear way, it can be a bit messy, it can be two steps forward, one step back and families need that ongoing support. We're limited in what we can offer in terms of our capacity. So there is something about that extension of support and services being creative to meet this need. I think we try and fit families into boxes and that doesn't always fit” (Practitioner 3).

The same was felt for professionals accessing training for CAPVA, where those accessing training require more support in terms of how to implement learning into practice in order to support service users who are affected by CAPVA.

“I was also involved in the programme Break for Change, which was one of the first evidence-based programmes and I used to go and train on that and when I did the one day training well, I found is professionals would be saying, well, this is great, but what now? It's great that you've come up for a day to deliver us training. Great. We found out about it but what do we do now with the families that are identified?” (Practitioner 14).

Awareness raising and training

It was felt that not enough people know about CAPVA and further awareness raising and training was needed for professionals on working with families who have experienced CAPVA, and how to work with those families in a trauma-informed way. Practitioners felt this was particularly important among both the support services in the community as well as statutory services (such as police) to reduce stigma and increase the likelihood of people accessing support. Several participants suggested the use of a campaign for CAPVA, such as a public information campaign, to raise awareness of the issue and address the stigma associated with it. There was consensus amongst parents/caregivers that *“acknowledgement”* and *“greater awareness”* of CAPVA was required. According to some parents, making *“it known that this is a thing that happens. It's not just that you spoil your kids”* (Parent 3) would have a big difference. One parent hoped if services were more aware of CAPVA, that it might be recognised sooner and improve believability that it exists.

“I think people need to believe you a lot earlier on, you know at this does I hope this doesn't sound snobby, but we weren't the typical social care family... so I don't think they believe that it could actually happen” (Parent 1).

“I've wondered over the years like would some kind of public information campaign be helpful? Because, you know we hear about healthy eating, don't we? And lots of other things that affect families. And if it really does affect one in ten families, that's an awful lot of people. To kind of get that idea that you know, in CAPVA, both the child and the parents are the victim. You know, it's not that the child's a perpetrator because there's reasons why this is happening. You know very complex reasons. Umm, but just for people to know more about it, for, you know. Would that address the stigma” (Practitioner 16).

“It needs a major campaign and that, addressing all the negatives about it, about the shame about it and that and treating it as what it is, it's abuse it should be reported” (Practitioner 19).

Practitioners felt that there is inadequate training for professionals with regard to CAPVA, with some practitioners having little knowledge of the subject, what support is available, and where to signpost families for interventions.

“The problems that we've got is there's nothing there. Apart from a very limited understanding and programmes. We don't have the training in place. We don't have the resources in place. We don't have the commitments in place” (Practitioner 13).

Parent/caregiver felt that *“social services and the police”* (Parent 1) need better awareness. They recommended an approach *“like you do for domestic violence”* (Parent 3) and suggested the need for *“advertising campaigns”, “flyers and posters”* and the dissemination of *“just little things like the*

booklet, if you can make more people aware of it and if you can add to it, do that. I just think I don't think the resources are more publicised than they should be and that's a real shame" (Parent 6). Furthermore parents/caregivers believed more education/training is needed to increase understanding of the role neurodiversity plays in CAPVA and for professionals to learn to listen and enable *"children's voices to be heard" (Parent 3).*

"No, he's not a naughty kid who needs, like, kind of locking up, but also understanding that, you know, making it clear to people hang on if a child's got a diagnosis of pathological demand avoidance (PDA) they could be in fight or flight. It isn't OK to go around being violent and punching people. No, it's not. And, but equally there can be other reasons behind it that makes sense" (Parent 5).

It was suggested that Early Help staff should be trained as they will be working with people who are affected by CAPVA. By having access to training, they will be able to support families dealing with CAPVA within their organisation, rather than referring to other services.

"It would be really good to train the Early Help staff because they will almost definitely be coming across this. But they will be dealing with this in a general family support way. So, whether that's giving mum parenting tips, maybe if they know about SWACA, maybe offering a referral to them, but they may not know about strategies themselves that they might be able to help themselves without having to refer into another agency if they knew more about what works, what doesn't" (Practitioner 8).

Some parents/caregivers spoke of the need for training around strategies and tools to deal with CAPVA. Learning how to recognise and manage unacceptable and escalating behaviour was seen as vital. One parent also felt there was also a need for *"work around healthy relationships between parents and their children" (Parent 6).*

"Some strategies / tool on how we can deal with it, so the adult mental health team were really good and giving us some strategies as to, you know, what is and isn't acceptable behaviour and that actually we don't need to accept these behaviours at home and if things are escalating that actually we should really be calling the police and not just dealing with it Umm but I think Yeah, I think that would be at some training and how to manage these behaviours when they're happening" (Parent 4).

"I learnt a lot of coping strategies were great! Separating the relationship from the behaviours really helped. Realising I need to take care of myself" (Parent survey respondent).

Improved provision in education

Participants identified a gap within education where children/young people who are neurodiverse do not typically receive the support that they need. Often these children are placed in an SEN school, or systems *"that just kind of house them"* and do not offer the support they require. Education plays a crucial role in early identification of issues as well as an important protective factor for a number of harms.

"It's just, it's not there. If you look at the numbers of children being expelled from school, so behaviour playing out in the classroom and there are huge numbers of children who are neurodivergent within that client group, there is very little help for them and which is why their school placements fail. They end up then going into free schools or systems that just kind of house

*them and then off into the criminal justice services. So we are failing them at the moment”
(Practitioner 4).*

Children/young people who are neurodiverse and are not sent to a SEN school are often labelled as the “naughty kid” within mainstream education, which they then conform to due to feeling rejected by the education system and having negative attitudes towards learning. It was felt that these children/young people are often “set up to fail”. Having suitable provisions in place for children/young people in schools was recommended for reducing levels of violence and aggression outside of school as “one of the key triggers to the violence and aggression at home is the education situation”.

“There is a massive gap in education in this country, and as soon as children are labelled in main mainstream school as the naughty kid, they conform to that and they feel rejected by the education system. They then get a negative attitude towards learning and there's no bringing them back from that. If that happens early on in the high school sort of stages say year 7-8 there's no returning from that. If it was recognised when they were going into high school and then suitable provision was put in place so that they aren't being set up to failing, you'd probably get a massive reduction in aggression and violence in the home because a lot of the time, one of the key triggers to the violence and aggression at home is the education situation” (Practitioner 18).

Early intervention

Rather than “waiting for a crisis” before addressing CAPVA, early intervention to prevent CAPVA from becoming a significant issue was felt to be important. Participants acknowledged that although early intervention is important, they do not always have the capacity to work preventatively due to the high demands on their service.

“Because of the demand on our services we are facing now, that we might have to put a lower age limit on our work because we've got that many cases we might have to say we can't at the moment with the current capacity, we can't deal with the child under 8 or 9 because of the volume, but sort of almost counterintuitively to that, we also think a protective factor is getting in early, but you've got to have capacity to do that getting early and when it starts to show, CAPVA starts to display and try to put in strategy, help parents, carers and child, put in strategies early on that will last them to avoid by the time it gets to the young people or adolescents, you've got a much more significant issue” (Practitioner 2).

Parents/caregivers discussed the importance of shortening waiting times and getting support more efficiently rather than waiting to reach crisis point and the police becoming involved before services intervene.

“...for the process to not take so long and for professionals to stop dragging their heels until you are at the point of crisis and its taken into the polices hands and then they [professionals] feel they have to intervene allowing us to get the help required” (Parent survey respondent).

Support groups/helpline

Almost all parents spoke about the need for a support group/network, an online space or a helpline for parents experiencing CAPVA. They understood the need for a safe space where you are not judged

and you *“don't have to be embarrassed because your child is abusing you, you're not the only person there”* (Parent 1). They also appreciated the therapeutic value of the shared experience, in knowing *“you're not on your own...that there is a community of people out there that are in a similar boat”* (Parent 7).

“Someone to talk to would be a good start, someone who listened. A support groups just to know that there's somebody else out there going through what I was going through, to know that you're not on your own to. It's nothing you've done” (Parent 2).

Improving service capacity and gaining funding

In terms of additional funding, several participants explained how more funding would help to overcome CAPVA. One practitioner suggested utilising their CAPVA information booklet to raise awareness across different sectors, including secondary schools and the YOT. Making information accessible to people was felt to be *“extremely important”*.

“Use some of their (MVRP) money to condense this booklet into a small booklet form, that can be placed into secondary schools, or it can be placed into the YOT because we've never I mean, the production of that book cost me nothing. That cost me time. And then going to Liverpool City Council's digital team and going listen, please, can I be dead cheeky and can you help me with some design work? But we never produced any. We never produced a physical copy. Because we have no money to do it. So making that type of resource accessible is extremely important” (Practitioner 13).

Another practitioner felt that funding is needed to create a lifestyle-based intervention for children/young people with neurodiversity, which was considered so far as having been *“left out of the conversation”*.

“I think lifestyle-based interventions for people with conditions like ADHD to help them manage their symptoms would work really well. It's something we're trying to get funding. We've applied to several kind of private trusts to see if we can do some experimentation in that area. There are some really great changes you can make to your diet, your lifestyle, which will help you. So yes, I do think there's an awful lot that can be done, I think, generally speaking, neurology has been left out of this conversation, so I think it's just having it as part of the conversation is a good start” (Practitioner 4).

One service noted that they were seeking funding to expand their service across areas where provision was lacking and how supportive other local partners were of this. Specifically, acknowledging how local partners are recognising this as a key and potentially growing issue, and the need to implement effective interventions to fulfil current gaps in provision.

“I met with the assistant director yesterday of housing and communities in [area in Merseyside] we have received some referrals from there, but the assistant director said that this is a huge growing problem in that area and one that they want to address so we said to them we've just applied for funding from the Home Office to continue to deliver those interventions, including the CAPVA work over the next two years. So we said this is something we could include in the offer, would you welcome that? And they were like, yeah, absolutely. We you know, would be so grateful if you if you bring that to [area in Merseyside]” (Practitioner 17).

Evidencing impact

The lack of a clear data recording system specifically for CAPVA was noted by practitioners across several services. Some practitioners from charity organisations felt it was difficult for them to evidence their work and recognised that this was due to limited funding. Charities do not typically have the capacity to evidence their work effectively, nor do they want to spend their funding on data collection.

“So I think, one of the barriers is a cultural barrier, really the big statement organisations I think, really feel like they need to have us demonstrating evidence, everything we do, because there's a fear around the quality of what we deliver and I understand that. But it is a barrier because it's difficult for us to have the capacity to evidence everything we do, prove the impact, it's not something that we fundamentally want to spend our money on, and we don't have to spend our money on that” (Practitioner 4).

One police officer interviewed felt the issue lies in how CAPVA is recorded on the police system. Officers often categorise CAPVA cases as either domestic violence or general violent incidents, potentially diminishing the perceived risk level. This misclassification can lead to delays in families receiving timely support or, in some cases, families not being referred to support services at all. As a consequence, some families may slip through the cracks and remain unnoticed by support services, prolonging situations of abuse.

“Actually, if it was recorded as CAPVA then for instance, within the safeguarding referral unit it had own category of referrals that might enhance the service. I think it probably comes back to if it is not being recorded properly in the first instance or it doesn't have its own recording category then it's probably getting missed. If it's just being recorded as a violent incident, well, actually, that might on the safeguarding side of it, score quite lowly. So, I think that side of things could be tightened up probably” (Police Officer).

Practitioners noted the lack of any data system to record incidences of CAPVA as an area for future development. One practitioner felt this ownership should mainly fall to the police however, other services felt there needed to be a universal system to record CAPVA. Multiagency sharing and training around confidence to share data across Merseyside was believed to be essential to understanding the scale and scope of the issue and adequately fulfil the needs of families experiencing CAPVA.

“If this is happening, what are we doing, if we're not doing anything, why aren't we doing it? And Merseyside Police was sat on that group, we could say to them, what are the recorded incidences? And they said well we're not really recording it in that way so we can't record it. We can't give you any accurate data because it's not recorded as domestic abuse” (Practitioner 13).

4. Summary of key findings and recommendations

CAPVA poses a significant challenge to families, professionals, and communities. Insights drawn from parent/caregiver and practitioner interviews and surveys highlight CAPVA as a considerable problem across Merseyside. Merseyside, despite its vibrant community and resources, faces several challenges when it comes to addressing CAPVA. These include underreporting due to shame or fear, limited awareness among parents and professionals about CAPVA, and gaps in available support services tailored to this specific issue. Additionally, the stigma attached to admitting that one's child is abusive can hinder parents from seeking help. Findings reported by London's VRU CAPVA report [11] corresponded to findings from this report which highlights a surge in CAPVA reports to services in the past 12 months. Whether this increase is due to factors such as the COVID-19 pandemic or because awareness has increased in recent years decreasing stigma which in turn has allowed more families to come forward for support was difficult to establish.

Similar to previous research [2] a lack of a universally accepted definition for CAPVA exacerbates the problem. That being said, most practitioners interviewed had a good understanding of what falls under the umbrella of CAPVA and how to identify it in their client groups. However, contrary to this, results from both the practitioner and the parent surveys indicated that respondents felt there is very little awareness and knowledge of CAPVA in the general public, and both parents and practitioners agreed that knowledge and awareness within services, practitioners, and policymakers was low. This lack of awareness hampers timely interventions. Both practitioners and parents emphasised the need for comprehensive training and awareness campaigns to address this issue and reduce the associated stigma.

Across Merseyside there is no system-wide approach to preventing CAPVA or supporting families who have experienced CAPVA, however many organisations have provision in place to support families. Some organisations have their own CAPVA provision in place such as MDVS (RYPP) and MYA (practitioner training) while other services utilised CAPVA nationally available interventions for parents such as WIC, NVR and CAPA First Response and finally interventions to upskill practitioners to better support families in relation to CAPVA. A significant issue arises from the ambiguity surrounding which organisation holds responsibility for CAPVA interventions. The involvement of multiple professionals in some cases leads to confusion and duplication of efforts, while other cases lack any agency willing to take charge. In addition, funding constraints and limited resources hinder the timely provision of support for CAPVA-affected families in some cases, waiting until crises occur before intervening can escalate the situation.

Consistent with findings from the literature review, mothers appear to be the primary victim of CAPVA [22,30]. Findings from this study also highlighted sibling-to-sibling abuse as highly prevalent, however, very little research has been conducted on sibling-to-sibling violence and abuse. Commonality from this research coincides with previous research [12,13] on the types of abuse experienced by parents/caregivers. Results from both practitioners and parent/caregivers disclosed the most common forms of CAPVA were psychological abuse, controlling behaviours and financial abuse [11]. Furthermore, similar to previous research, families tended to reach out to services or the police when they had reached a point of crisis particularly when aggression escalated to physical violence, self-harm or damage to property indicating victims experiencing the "more common" forms of abuse can go significantly underreported [11].

There was some controversy around whether CAPVA should be classed as domestic abuse. Whilst some practitioners argued against classifying CAPVA as domestic abuse to prevent the criminalisation of children/young people and damaging familial relationships irreparably, parents/caregivers advocated to acknowledge CAPVA as a form of domestic abuse emphasising safety concerns for themselves and others if CAPVA isn't taken as seriously as domestic abuse.

Most parents who participated in the survey and interviews had called the police in relation to CAPVA at some point. These findings indicate that the police play a vital role in CAPVA incidences as well as victims' experiences of support. Both practitioners and parents felt that the police were unsure how to deal with CAPVA cases and how police can best support both parents/caregivers and the child/young person. Some parents/caregivers reported that their child knew the police would not intervene with more than a warning, therefore once the police had left the premises the behaviour would continue. Another parent reported contacting the police upwards of 50 times before the police intervened. Furthermore, securing data from the police in relation to incidences of CAPVA was also problematic due to CAPVA not being recorded precisely on the police databases. There was no way of accurately identifying cases of CAPVA even by going through reports case-by-case due to officers not always recording that the incident was a child/young person against a parent/carer. This suggests more training is warranted for police officers in relation to CAPVA, both in how officers support families at a point of crisis but also, in good data practices to help inform an accurate picture of the scope of CAPVA across Merseyside. This is substantiated in previous research which has found that the lack of policy and laws relating to CAPVA makes it difficult for police to know how to intervene and record incidences [2,7]. The findings from this research further support previous research that in most cases both police and parents are reluctant to progress to criminal charges even in the most severe cases of CAPVA [1,14,25,26].

The lack of clear data recording systems and evidence inhibits accurate understanding of the scale and impact of CAPVA. Charities, in particular, struggle with resource allocation for data collection. To better understand prevalence and to ensure family needs are being adequately met, data collected across all services should be prioritised. Several organisations discussed completing assessments pre and post to monitor impacts, however, for many of these services this information was not easily accessible, either because it is not recorded properly/saved electronically. When asked to provide data many services said they would have to allocate a member of staff to pull this data together which in turn creates even more demand on services who are already over capacity.

CAPVA can present unique challenges when considering neurodiversity. Neurodiverse children/young people, such as those with ASD, ADHD, or other neurodevelopmental conditions, may require specialised interventions to address CAPVA effectively. Parents discussed how CAPVA interventions need to be tailored to accommodate the diverse needs of neurodiverse individuals, fostering understanding, empathy, and effective support. Parents/caregivers found some interventions such as Who's in Charge? difficult to implement as it focuses on consequence, which some neurodiverse children/young people may not understand.

In conclusion, addressing CAPVA's multifaceted challenges requires collaboration and comprehensive strategies. Raising awareness, training professionals, defining responsibilities, securing funding, enhancing data recording, and recognising the nuances of neurodiversity are vital components. By navigating these complexities, Merseyside can pave the way toward fostering safer, more empathetic, and supportive environments for families contending with CAPVA.

4.1 Recommendations

System wide recommendations

To enhance responses to CAPVA across Merseyside, system-wide developments are needed supported by a collaborative multi-agency approach. Critically, it is imperative for services and organisations to record CAPVA under its own umbrella and implement a rigorous data collection mechanism that enables a greater understanding of the nature, extent, impacts and risk (and protective) factors for CAPVA to inform prevention activity. Furthermore, more funding and resources are needed in order to raising awareness of CAPVA and the current available support across the community, practitioners, and services. Equally vital is the necessity to allocate additional funding to enhance existing support and to introduce innovative measures to aid families affected by CAPVA. In addition, organisations should be encouraged to provide specialist CAPVA training for practitioners, and the development and enhancement of support provision that recognises the diverse and evolving needs of children, young people, and families. Key recommendations for whole system change include:

- 11. Establish a Merseyside CAPVA Multi-Agency Steering Group:** Create a multi-agency steering group including representatives from third sector organisations, police, health and social care, education, and the community. The group would have a key role in driving the development of responses to CAPVA across Merseyside, linking into relevant regional and local violence prevention governance and practice structures. This may include: identifying priority areas for preventing and responding to CAPVA (see below for examples based on this research) and mechanisms for implementation (providing clarity on the role and responsibilities of different organisations); enabling the sharing of best practices; and supporting the co-design, co-commissioning and/or co-delivery of prevention activity, that enables more timely and effective support provision for children, young people, and families.
- 12. Enhance CAPVA data collection and sharing within and across organisations:** Support the development and implementation of a rigorous data collection mechanism that enables a greater understanding of the nature, extent, impacts and risk (and protective) factors for CAPVA to inform prevention activity. This should ensure that data is collected across services in a comparable way, and systems are established to support the sharing of data within and across services as relevant levels (e.g. aggregated and individual level). Through the sharing and regularly review/analyses of data on CAPVA, this would facilitate a coordinated response, ensuring that families receive appropriate support and interventions without gaps or duplication. Whilst all service types should work to enhance their CAPVA data collection and sharing processes, specific attention should be given to police data systems to enable identification of incidents of CAPVA and timely referral to support agencies.
- 13. Training for practitioners:** Provide comprehensive training for professionals who frequently interact with children, young people, and families such as social workers, case workers, therapists, educators, healthcare providers, and the police. This training should focus on recognising the signs of CAPVA, appropriate intervention strategies and effective communication techniques, neurodiversity, and trauma-informed care. Ongoing professional development can ensure practitioners are equipped to address the complexities of CAPVA cases particularly in roles with a high turnover of staff. Universal training for wider practitioners should aim to raise awareness of the issues and support provision and referral pathways. Such training should be short and accessible (e.g. online) to ensure practitioners can attend, as well as regular refresher session to ensure best practice across organisations.
- 14. Public awareness campaign:** Develop targeted public awareness campaigns to destigmatise CAPVA and encourage reporting, and awareness and engagement with support provision. Use

various platforms including social media and community events and advertise in highly frequented locations such as GP surgeries, schools, and public transport to inform parents, children, and professionals about the signs of CAPVA, available resources, and avenues for support. Furthermore, having one central hub/website that organisations and parents can use which includes guidance for practitioners and information on suitable services/interventions for parents, would help streamline support and reduce confusion.

Intervention specific recommendations

This study has identified several approaches that may help to prevent and/or mitigate the impacts of CAPVA which partners may wish to consider when developing and implementation local or regional responses to CAPVA.

- 15. Support website and helpline:** Develop one dedicated website/webpage tailored for children, young people and parents and caregivers experiencing CAPVA. This platform would offer comprehensive information on CAPVA and a directory of support services and offer in Merseyside. Additionally, the website could be complemented by a helpline with extended hours, connecting parents/carers to CAPVA-trained practitioners for guidance once immediate crises have passed, emphasising the option to contact the police if in immediate danger. By providing this helpline, the aim is to enable families to seek advice without lengthy referral processes, potentially reducing crises and subsequent police interventions. Moreover, this service ensures ongoing support for parents even after completing an intervention, fostering long-term assistance for families.
- 16. Increase police awareness of support services:** As first responders to incidences of CAPVA police officers need to be aware of relevant support services. Police officers could carry cards with contact information to relevant support services or have a list of services available on electronic devices which would allow officers to provide support contacts in a moment of crisis.
- 17. Parent/caregiver support groups:** Support the development of parent/caregiver support groups. One of the biggest impacts for parents/caregivers from attending the various interventions was the formation of support groups and having a network of individuals who have experienced similar circumstances. Such groups can enable peer support and create safe spaces for parents/caregivers to share their experiences, challenges, and strategies for managing CAPVA. These support groups can provide emotional validation and a sense of community, reducing isolation and promoting healthy coping mechanisms.
- 18. Engage schools in prevention:** Collaborate with schools to integrate CAPVA prevention programmes into the school curriculum from a young age as a form of early prevention. This could coincide with current provision available in schools on violence prevention and could be offered as a module on some of these programmes. These programmes can cover topics such as conflict resolution, emotional regulation, communication skills, and empathy-building, some of which will have been previously covered on pre-existing programmes. By empowering students with these skills, schools can contribute to creating a culture of respectful relationships and prevent CAPVA (and other forms of violence) in the long-term.
- 19. Tailor interventions to ensure they are person/family centre, considering neurodiversity:** Ensure that service provision is person and family centred, and recognises that approaches may need to be tailored for neurodiverse individuals. Agencies should work with families to tailor interventions to each person's specific needs, strengths, and challenges. Furthermore, the education system plays a pivotal role in identifying and addressing CAPVA, yet neurodiverse children often lack appropriate support in mainstream schools, leading to behaviour-related issues at home. Helping schools to support these individuals could help reduce the number of students expelled from school. Schools and other organisations should link in with organisations who specialise in neurodiversity for example the Brain Charity, for guidance and training.

20. Research and evaluation: Allocate resources for CAPVA research and evaluation of prevention efforts. Regularly assess the impact of implemented programmes, identify areas for improvement, and refine strategies based on evidence.

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6. Appendices

6.1. Methods

Literature review

A rapid literature review was conducted to provide critical context to the study. The review summarises definitions of CAPVA particularly in relation to current UK policy, data on the nature and extent of CAPVA at national and/or local levels, risks and protective factors, impacts, and prevention and response approaches.

Establishment of an advisory group and stakeholder workshop

An advisory group was established to support this work. Membership included key stakeholders from support services across Merseyside (domestic violence services, safeguarding, a youth organisation), MVRP, and an academic experienced in CAPVA research. The advisory group acted as gatekeepers to the research and supported recruitment for interviews and the workshop. They have also reviewed research materials (including survey and interview guides) to ensure that questions were appropriate. The research team and advisory group met and communicated throughout the duration of the review.

A face-to-face multi-agency workshop was held in January 2023 to share ongoing work in this area across the different boroughs and identify partner views on areas for development. The workshop was attended by 26 key partners from across Merseyside which included representation from all local authority areas (Knowsley, Liverpool, Sefton, St Helens, and Wirral). A range of services and strategic and operational roles were represented including the Youth Justice Service, Local Authority, Public Health, Safeguarding Children Partnership, Children's Services, Early Help, Domestic Violence services, Child and Young Person Mental Health service, CAMHS, and training providers. Key topics discussed during the event included:

- Defining what is CAPVA, who it involves, risk factors and policies across Merseyside.
- Understanding what activities are currently being delivered by service across Merseyside to help families experiencing CAPVA.
- Identifying what each intervention/service is trying to achieve in relation to CAPVA and any short and long-term outcomes of support provided to families experiencing CAPVA.
- Outputs or measures currently being implemented across services to better understand what data is currently being collected for example how impacts of the programme are measured.
- Identifying gaps and areas for development for services to improve provision for families experiencing CAPVA across Merseyside.

Review of project documentation

Programme evidence, policies and operational documentation, and anonymised data was accessed and reviewed. Information collected through such review is used throughout the findings to complement data collected by other methods and provides wider context to the research findings.

Engagement with stakeholders

Semi-structured telephone or online (e.g. via MS Teams) interviews were conducted with key partners (n~24), covering a range of organisations and services that support parents/caregivers, young people, and their families relating to CAPVA. Services included family support services, youth offending, domestic abuse services, safeguarding, youth services, social care, police, and health. Discussions explored: how partners conceptualise, identify, and record CAPVA; views on the extent, nature, and

impact of CAPVA; risk and protective factors (considering key leverage points and mechanisms for preventing and responding to CAPVA); and, current strategies/policies and service provision/interventions/referral pathways. Participants were asked to share any relevant documentation and/or data that will aid understanding of CAPVA across Merseyside and approaches to preventing and responding (including impact). Interview times varied (42 minutes-1 hr 11 minutes). In addition, an online practitioner survey (n~33) ran simultaneously across relevant services and organisations. Practitioners were recruited via gatekeepers (usually their service leads) and gathered data on their roles as well as their views of CAPVA in Merseyside, and prevention and response approaches.

Engagement with parents/caregivers

Semi-structured telephone or online (e.g. via MS Teams) interviews were conducted with parents/caregivers (n~9). Parent/caregivers were recruited via a gatekeeper or through the online parent/caregiver survey (see below), which was advertised on services social media/newsletters. The discussions focused on the participant's experiences of CAPVA, support needs, and views and experiences of accessing support. Interview times varied (38 minutes-1 hr 35 minutes). An online parent/caregiver survey (n~18) was also implemented; the participants were recruited through gatekeepers or via services social media, newsletters, or email, and covered participant's experiences of CAPVA, support provisions, and barriers, and facilitators to accessing support.

1.2.6 Data analyses

Quantitative analyses were undertaken in SPSS (v28) using descriptive statistics. All qualitative interviews and qualitative data from the surveys were analysed using thematic analysis by means of NVIVO. The analysis is presented with illustrative quotes where appropriate to highlight key findings.

1.2.7 Ethical approval

Ethical approval was obtained from Liverpool John Moores University (REC no. 22/PHI/019), and the study adhered to the Declaration of Helsinki.

6.2. Practitioner survey questions

Demographics	% (n)
Gender	
Male	15.2 (5)
Female	84.8 (28)
Age (years)	
18-29	12.1 (4)
30-49	51.5 (17)
50+	36.3 (12)
Organisation	
Local authority department	21.2 (7)
Education (School)	9.1 (3)
Charity	36.4 (12)
Health service	33.3 (11)
% of role spent on CAPVA	
0-25%	72.7 (24)
26-50%	18.2 (6)
51-75%	0 (0)
76-100%	9.1 (3)
Time spent engaging in CAPVA work as a professional	
Two years or less	36.3 (12)
3-6 years	15.2 (5)
More than 6 years	48.5 (16)
What area/s across Merseyside do you work in (tick all that apply)	
Liverpool	60.6 (20)
Wirral	39.4 (13)
Sefton	12.1 (4)
St Helens	18.2 (6)
Knowsley	24.2 (8)
Target group organisation works with in relation to CAPVA (tick all that apply)	
Children (17 years or under)	84.8 (28)
Young adults (aged 18-24 years)	24.2 (8)
Parent/carers	72.7 (24)
Family groups	30.3 (10)

6.3 Parent survey questions

Parent survey demographics		% (n)		Parent survey family structure		% (n)
Age (years)				Number of children		
	30-39	23.5 (4)		One		23.5 (4)
	40-49	47.1 (8)		Two		41.2 (7)
	50-59	17.6 (3)		Three		17.6 (3)
	60+	11.8 (2)		Four		5.9 (1)
Gender				5+		11.8 (2)
	Male	11.8 (2)		Number of children who currently live with you		
	Female	76.5 (13)		None		5.9 (1)
	Other/prefer not to say	11.8 (2)		One		47.1 (8)
Ethnicity				Two		29.4 (5)
	White	100 (17)		Three		5.9 (1)
Sexuality				Four		5.9 (1)
	Heterosexual	88.2 (15)		5+		5.9 (1)
	Other	11.8 (2)		Current household composition		
Relationship status				Two parent family		41.2 (7)
	Single	35.3 (6)		Single mother		35.3 (6)
	In a relationship	64.7 (11)		Couple		5.9 (1)
Qualification				Lone person		5.9 (1)
	University level	41.2 (7)		Stepfamily		11.8 (2)
	Secondary/college level	47.1 (8)				
	Other	11.8 (2)				
Employment status						
	Employed	70.6 (12)				
	Unemployed	5.9 (1)				
	Carer	23.5 (4)				
Annual Income						
	>£20,000	14.3 (2)				
	£20,000-49,000	57.1 (8)				
	£50,000+	28.6 (4)				
Have a recognised disability						
	Yes	29.4 (5)				
	No	70.6 (12)				

