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An Exploratory audit into Violence and Aggression within a Child and Adolescent Mental Health Service Highlighting the Need for an Improved Response to Adolescent to Parent Violence

Key words Adolescent, Violence, Aggression, Domestic Abuse

Take Home messages

- If a child/ young person is presenting with violence and aggression it is highly likely that there is violence and aggression within the home, this needs to be risk assessed and a management plan put in place

- Violence and aggression in young people requires a multi-agency response. Agencies need to have a clear framework for how they work together and contribute to any risk management/ response plan

- Where violence and aggression are identified within the home, support from specialist domestic abuse services should be offered.

Abstract

There has been an increase in the number of young people presenting to child and adolescent mental health services (CAMHS) with concerns relating to adolescent to parent violence. It can be difficult to manage these behaviours and professionals within CAMHs have often sought support from a number of external agencies including the police and social care. In many of these cases there is conflict within the multi-agency network around the child with little clarity around who should be offering support. This is particularly apparent in crisis situations. The lack of conceptual clarity surrounding agency responses to adolescent to parent violence (APVA) may ultimately lead to an increase in risk towards the identified young person, their siblings and parents.

The audit examined 20 cases known to CAMHS within an NHS Trust in England where violence and aggression was considered to be a factor. The audit sought to explore themes from these cases which may lead to improvements in practice. The results highlighted the high prevalence of adolescent to parent violence within the identified cases and the difficulties practitioners faced in addressing these issues.

Background

APVA can be difficult to define and does not currently have a legal definition in the UK. However, the following definition is often used within the salient literature to describe APVA:

Any harmful act by a child, whether physical, psychological or financial, which is intended to gain power and control over a parent or carer" (Harbin and Madden 1979)

This definition highlights the importance of the concept of power and control in APVA and the impact this may have on parent and child interactions. However, this definition also focuses on the abusive behaviour and as such can shift the focus towards the negative attributes of the young person while failing to recognise the child's on-going vulnerability. As such, simply focusing on the violence and ignoring the context of the wider behaviours within the family may not accurately reflect the underlying complexity within families or the experiences of immediate or wider family members. Moreover, Burck et al, (2019) found that ignoring the

mother's experience of APVA perpetuated feelings of shame in the mother which then in turn impacted on subsequent engagement with support services.

APVA therefore is a complex systemic issue which requires a full understanding of the relationships involved. APVA is likely to involve a pattern of different abusive behaviours, forms of abuse can include physical violence, damage to property, financial abuse and emotional abuse. Coercive control is commonly seen in APVA but there are also cases where there is little coercive control and the presenting difficulties relate to extreme bursts of anger and physical violence (Department of Health DoH 2016). Understanding these patterns is vital in understanding the support needs of the family. Research to date has identified that there is no single cause of APVA. Coundry and Miles (2014) found that families described a range of attributing factors including substance misuse, mental health problems, learning difficulties and a family history of domestic abuse. While research into adverse childhood experiences (ACEs), (Bellis et al, 2014) has linked specific types of adversity in childhood with an increase in violent behaviour generally, there is no research into the link between ACEs and adolescent to parent violence. Common ACE's include physical, sexual or emotional abuse, parental separation, bereavement, exposure to domestic abuse, mental illness, alcohol or drug misuse and parental incarceration within the family home.

It has been highlighted that APVA is the least researched form of family violence (Bakhtadze 2016) and the lack of a clear definition alongside the hidden nature of APVA family violence further compound these issues. Groves and Thomas (2014) highlight these concerns referring to the 'dark figure' of hidden crime relating to domestic abuse and child abuse of which APVA encapsulates both. Due to the hiddenness of APVA the true extent of the phenomenon is largely unknown with reported whole life prevalence rates varying widely from 3% to 27% (Gallagher, 2008 ; Holt, 2012).

However, despite the paucity of available evidence, as awareness of APVA increases it is likely that services will continue to see a growth in presentations (Bakhtadze 2016) and this includes Child and Adolescent Mental Health Services (CAMHS). It is also recognised (Bonnick 2010) that as practitioners continue to struggle to understand the causes of APVA, it remains difficult to provide appropriate support for families.

Within the CAMHS service audited it was anecdotally noted that there was an increase in young people presenting with violent and aggressive behaviour. Therefore a decision was made to explore this further, the audit focused on a broad range of issues but the focus of this article is the findings relating to APVA.

Aim

The aim of this audit was to examine a sample of cases known to the CAMH service, where violence was known to be an issue in order to:

- Identify the prevalence of APVA within the sample and explore the response by services
- Highlight key themes across all cases.
- Consider any potential learning to support clinicians in working with this group in the future

Setting

The setting for the audit was one CAMHS service in an NHS trust in England. The service works with children and young people from the age of 0-18 years, their families and carers. The young people they work with are experiencing severe or complex mental health problems

and may have been diagnosed with neuro-developmental disorders, which have a significant impact on the child's development and cause distress to the child and their carers.

The service works across four teams in four locality bases and covers the whole county in which it is based. The service provides generic community CAMHs support alongside more specialist teams, such as eating disorders, dual diagnosis and intellectual disability teams.

Recruitment

All team leads within the CAMHs service described above were approached via email invitation and asked to identify all young people who were presenting with violent and aggressive behaviours. The initial approach included a brief summary of the proposed audit and details of how the audit would be carried out. The audit was also discussed in a team meeting with all of the team leads present. All team leaders were followed up with 2 reminder e-mails following the meeting

Audit sample

A total of 20 cases were identified from a range of CAMHs teams. The practitioners working with the young people were provided with a brief description of presenting issues that would fit the criteria and asked to identify anyone appropriate on their caseload (see box 1). Each team responded to the request with the exception of the specialist team for intellectual disabilities, who were unable to identify any cases which fitted the criteria. Within the cases there were 10 males and 10 females. 17 of the young people were recorded as White British, 2 classified as 'mixed other' (as recorded on system, not auditors choice of language) and one young person was White European. The age range of young people was 9 to 16 years.

Box 1- E-mail sent to CAMHs Teams requesting identification of appropriate young people.

I am currently planning to undertake an audit in relation to young people who are presenting to CAMHs with violence and aggression. Please can you identify anyone on your team's caseload who may be suitable. The parameters are below

- Violence and aggression reported by young person, parent or carer as a main difficulty within the presentation
- Any age at presentation
- Any co-morbidities, such as substance misuse, developmental disorders, mental health diagnosis to be included
- Violence and aggression directed at any individual or group

With thanks

Data collection

The records of each case were examined in-depth based on the intended audit objectives using the following questions and prompts used to gather the audit data:

- Who are the main targets of violence for example family members or professionals?
- At what age is violence and aggression first recognised as an issue?
- Which agencies are involved in the young person's care and what support do agencies offer to that young person?
- How do agencies work together and how are the networks coordinated?
- Had the identified young person experienced any forms of abuse?
- What difficulties were raised by professionals or family members in the care offered to the young person?

Recording of Audit Data

Audit data was recorded in a table under headings for each of the audit questions, both numerical and free text data was recorded

Ethical considerations

The audit was registered within the trust's auditing department in line with trust policy.

The auditor ensured that client confidentiality was maintained. When service user data was added to the table it was allocated a number and no personally identifiable information was recorded in the table. The audit was undertaken in line with guidance regarding general data protection regulations (GDPR) to ensure that only anonymised data was used in the analysis. Broad categories were used to prevent individual cases being easily identifiable, for example due to ethnicity.

If the auditor had concerns about the nature in which a referral to social care had been made or around lack of appropriate safeguarding action, the intention was to alert the line manager as per the trust safeguarding escalation policy.

During the auditing process the auditor was not aware of any potential conflict of interest matters

Results

Targets of Violence and Abuse

In all cases reviewed APVA was identified as an issue. Parents were the main target of violence. Where mum was in contact with the young person, for example, she was a target of violence in all but 1 case. Father was the target in 10 of the 17 cases where there was contact In the category for 'other family member' the most prominent family member represented was maternal grandmother.

Age at presentation to CAMHs and longevity of violence

The average age when the young people in the audit initially presented to CAMHS with APVA was 11 years while their average age at audit was 14 years. At the point of the audit all were recorded as still experiencing issues with violence.

Within the cases examined girls appear to have presented at services on average at the age of 8.8 years and boys at 12.3 years.

<u>Agencies involved in young people's care</u>

It was clear from the audit that multiple agencies were involved in young people's care (Table 1), with the maximum number of agencies involved in one case, being 6. This highlights the number of agencies that may have involvement with APVA families and also the potential complexities across professional networks.

The most common agency involved was children's social care with 19 of the 20 cases recorded as having some level of involvement from social care, however the level of involvement varied. Six young people were in care, 5 were on child protection plans, 6 had been referred and had assessments or been redirected to more appropriate services, such as the family service and 2 young people were supported by the children with disabilities team.

There was evidence in the clinical records that CAMHs practitioners were not always able to understand why social care were not more actively involved and there were reports from families that they felt disappointed by the lack of support received. The auditor considered the documented reports of families to ascertain their experiences. Although it is not possible to fully understand the experience of families without speaking to them directly from the records, we can see that in the 11 cases where it was possible to gauge whether families felt that social care had been helpful 2 families were positive, and 9 families were negative about the service offered. In 2 of the cases where families were negative about their experiences child protection proceedings had been instigated, but in the other 7 cases, the reason for their negative report appeared to be the lack of support they were offered, particularly in the early stages of difficulties.

There was also some evidence of potential conflict between agencies as to who should take the lead role. For example, in one case social care were advocating for CAMHS to be more actively involved in making a formal diagnosis, whilst CAMHS felt that the impact of emotional abuse from parents to the young person required a higher level of involvement from social care. In another case a family were advised by CAMHS that if their child's behaviour should become unmanageable, they should attend the emergency department (ED), when they attended ED they were told that it was not the appropriate place to access support.

The police were the next most common agency to be involved with the young people in the audit with 17 out of the 20 cases recording some involvement. In the majority of these cases either there were no charges brought for the young person or charges were related to non-violent offences. However, it was also noted that in the cases examined, none of the charges related to physical violence within the home. In most cases police involvement in relation to violence within the home entailed de-escalation of the situation when the family was in crisis.

Table 1 shows the prevalence of other agencies involvement in each case:

Table 1- Agencies involved in the care of young people in the audit

Agency involved	Number of Cases agency involved with
Youth offending team	7
Paediatrician	5
Specialist schools	4
Private health care	3
Physical health	2
Special education needs coordinator	2

Emergency department	1
A Place to Call our Own (Autism support)	1
Health education team	1
Not in employment or education services	1
0-19 service	1

There was no evidence in any of the records that any assessment of the risk related to domestic abuse had been carried out and high-risk cases subsequently referred to Multi-agency Risk Assessment Conferences (MARAC). In none of the cases explored had domestic abuse services been utilised as part of the network

Multi-agency working

In 11 cases there was a clear multiagency process such as looked after process child protection, child in need or care programme approach. In 3 cases only a single agency was involved and in a further 6 cases there was evidence of multi-agency working, but there was no clear process guiding this work. In these 9 cases where there was no identified process, there appeared to be more conflict within the network. In the cases where only one agency was identified it is possible that other agencies were involved but the lack of a multi-agency framework made it more difficult to identify who might be involved.

Difficulties raised by professionals or family members in the care offered

Within the record there were indicators of two main areas of difficulty. The first was concerned with family members and young people expressing dissatisfaction with the support offered by services. This seemed to focus mainly on the lack of support and intervention being offered. Some families had been referred to both CAMHs and Social Care on multiple occasions before a service was offered.
The dissatisfaction in families was mirrored by professionals, as it was often clear that professionals were unsure as to which service was the most appropriate support for families when APVA was the main issue. This seemed to be more prevalent in the younger age group and in those where the violence was mainly targeted within the family, rather than in the community.

Strengths and limitations

This was a small-scale audit in one NHS trust. The cases were selected by practitioners themselves and as such there may have been some bias in the cases selected. Equally cases where violence had not been disclosed would not have been included and as discussed above APVA can be very difficult for families to disclose. However, this audit highlights the complexities around APVA that are presented within a CAMHS community setting and identifies some of the challenges faced in working with this group. As such, this article has the potential to raise awareness and inform the growing debate and discourse in this complex area of care.
The audit focused on the use of case files, it is acknowledged that this can provide a limited picture of the overall case and may not fully reflect practice. (Laird et al 2017)

Discussion

This article has explored issues relating to child or adolescent to parent violence which were not always fully recognised by those working with families. The level of risk presented by this violence was not explored in any of the cases and no referrals were made for parents experiencing abuse to domestic abuse support services.

To date the literature available and most recent Government guidance (Home Office 2015) focuses on APVA and as such omits consideration of this issue for younger children. For example, the present audit highlighted the average onset of violent behaviour in children as 11 years, which whilst fitting with the world health organisation definition of adolescence as between 10 and 20 years of age (Sawyer et al 2018), the audit identified cases where the violence began at the age of 9 and so would be excluded from the definition of APVA. This focus on adolescents may mean opportunities for early intervention with much younger cohorts are missed (John 2021).

In the present audit the level of intervention from social care agencies varied hugely between cases. There was evidence to suggest that in some cases the CAMHS practitioners were not able to understand why social care were not more actively involved and reports from families that they felt disappointed by the lack of support received. There was evidence within the written records of uncertainty between agencies as to their own role and the role of other agencies when APVA is an issue. The national guidance surrounding APVA (Home Office 2015) highlights the importance of agencies developing clear process around this type of abuse in order to clarify roles and responsibilities for different organisations.

In relation to the involvement from the police, in the present audit it was interesting to note that when violence was reported in the home it was much less likely to result in positive police action than when the violence was directed outside of the family. Holt and Retford (2013) highlighted the dilemma that the idea of criminality in children is problematic, as children are not necessarily criminally responsible, but their parents have responsibility for them, making traditional police powers much less helpful, this in turn may make it harder for families to access appropriate support.

Additionally, there is no evidence that Domestic abuse, stalking and harassment risk identification checklists (DASH-RICs) are being completed when intra-familial violence is disclosed. DASH-RICs are an assessment tool used by police and non-police agencies to identify and assess victims of domestic abuse, stalking and harassment. Gallagher (2008) suggested that APVA was often neglected as professionals find it hard to conceptualise the child as having power and control over their parent. The impact of this lack of recognition was that DASH-RICs had not been completed, domestic abuse services were not involved and domestic abuse within the household is not being addressed.Therefore there was no evidence in any of the records that any of the cases had been referred to MARAC.

It would be of interest to further explore if this theme is repeated in other geographical areas of the country.

From the case records reviewed in the current audit it was often hard to ascertain which agencies were involved and in some cases it appeared that there was very little involvement at all. For example, the 0-19 service, a service whose role it is to improve outcomes and reduce inequalities for children through universal and targeted support (Public Health England 2021), was evident in only 1 case.

In the present audit there was also a clear difference between cases where there was an identified framework (e.g. child protection plan or care programme approach) that drove the coordination of multi-agency working and those that did not. It may be that the cases that did not easily fall into an organisation's remit led to conflict and uncertainty about the necessary actions required. The high number (nearly a third) of cases where this is an issue is concerning. Curnin and Owen (2013) explored multi-agency working, they found that in order for different agencies to work together effectively systems need to be in place to ensure that information is shared in a timely manner, however they recognise that even if this information is shared if the agencies do not have a good understanding of each other's roles and ways of working then even with good information sharing effective multi-agency working will not be

achieved. Kazmierczak et al (2014) go further to suggest that whilst agencies continue to consider themselves as single and separate entities, they will continue to be unable to work together effectively. They suggest that there is a need to move towards a single agency, multi-professional response to complex issues.

The level of the domestic abuse within the parent/ carer relationship that was disclosed was much lower than the national average, with one in four women experiencing domestic abuse generally (Home Office 2012). This data indicates that in the audit group only one in twenty experienced/ witnessed domestic abuse in the home. Given that children who perpetrate parent abuse are more likely to have witnessed or experienced abuse or violence within the family home (Gallagher, 2008 ; Holt, 2009).it is more likely that it is not being disclosed and/ or recorded.

Conclusion

The findings of this audit have highlighted the difficulties services experience in intervening early when APVA is present within a family. Families were often clear with professionals that they would have liked more intervention earlier on in their difficulties, particularly due to the young age at which abuse became an issue.

In cases where there was a clear lead agency and process followed, there was less conflict in the network around the child.

A key finding within this audit was that in all cases audited when a young person was presenting with violent behaviour, there was a target of this violence and abuse within the family. However, this abuse and violence was not always fully understood, or risk assessed and therefore appropriate agencies were not always involved.

Mental health practitioners will have some of the skills in helping to assess and address some of the factors contributing to APVA but they will not be able to offer full support to a family in isolation. Therefore multi-agency working becomes key in ensuring safety and helping to reduce violence, however agencies need to move towards a system that enables a unified response.

Domestic abuse services offer a different understanding of the causes of violence, they can work with the victim/ survivor to help them protect themselves and in the case of young people can often offer early intervention if they themselves have experienced violence. Universal child health services also have a valuable role to play in early intervention with young people

It has been clear from this audit that there is a great variance in the type and quality of multi-agency working and much seems to be based on whether a presentation is considered socially based or mental health driven, often meaning a delay in services for families.
There is not currently a clear pathway of intervention for families experiencing these difficulties, a clear pathway would support practitioners to understand their role, complete the correct assessment and involve all appropriate services.

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Mental health diagnoses

Of the 20 cases reviewed 15 young people had been given some form of mental health or neurodevelopmental diagnosis. Table 2 outlines the different diagnoses given to the young people in the audit

Table 2- Diagnosis of young people in the audit

Diagnosis	Number of young people with diagnosis
Autistic spectrum disorder	9
Attention deficit hyperactivity disorder	8
Anxiety	7
Attachment disorder/ difficulties	3
Psychosis	2

Note- there is significant overlap in cases, with young people often having more than one diagnosis

In total 13 of the young people had been diagnosed with a neurodevelopmental disorder.

Forms of Abuse

15 young people were documented to have experienced some form of abuse within their lives, some experiencing multiple categories of abuse. Other traumas identified included, bereavement, parental separation, bullying and exploitation.