ATTACHMENT JH 2

This is the attachment marked “JH 2” referred to in the witness statement of Joanne Carol Howard dated 8 July 2015.

THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

Report by Jo Howard – 2009 Fellowship

ADOLESCENT VIOLENCE TO PARENTS: CURRENT INTERVENTIONS IN THE UNITED STATES AND CANADA AND IMPLICATIONS FOR AUSTRALIA

Investigation: To study programs and projects in the United States and Canada in relation to adolescents who abuse their parents and siblings, with a particular focus on prevention and early intervention.

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Jo Howard August 14th, 2010

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As a mother I see those holes but I'm oblivious to them at the same time because I just want to see my son – why do women stay with their husbands when they punch the crap out of them? Because…they hope one day that it might change. I look at those holes and I think what does the future hold for him…who's he going to put a hole through?

It's a regular thought I have...If you're going to talk to your mother in the way that you do, what are you going to be like when you're married?

Is this going to be his attitude to women…and to the way a family exists?

I don't want him to be violent; a person who's going to do something horrible in society. I'm scared of things like that…because he's bottled things up. I don't want him to have a criminal record…I'd rather him not be punished but be treated. I'm really afraid of what he's got inside him…I want him to have a normal and a happy life.

My biggest concern is when they know a girl better…I pray it doesn't happen but I can see how they've treated their sister

(Howard & Rottem, 2009)

1. Introduction

My interest in adolescent violence in the home arises from 25 years working with families and family violence in clinical practice and supervision, management and policy.

As a family violence worker I worked with mothers who had left a violent partner, only to experience their son's violence. The patterns and types of violence used by sons were disarmingly similar to women's ex-partners. Violence included physical assault, emotional and psychological abuse, financial abuse, social abuse and very commonly damage to property. As a family therapist I worked with shocked and distraught parents who felt powerless to stop their adolescent son's and daughter's abuse, disrespect and violence. Parents commonly reported adolescent violence to younger siblings who were unsafe and traumatised by the violence. Parents were fearful their adolescent was using alcohol or drugs, developing mental health problems, having difficulty at school or engaging in anti social behaviours. Most adolescents would not engage with services; parents reported services they turned to for support were not helpful. They felt there was no where to turn.

Adolescent violence in the home is a stand alone issue but more commonly co occurs with a range of other problems – mental health, drug and alcohol use and school retention. Despite its frequency it is rarely acknowledged as a problem, let alone assessed for and responded to. As well as the negative effects on family members, adolescent violence in the home means adolescents themselves lose family connections, face additional risk factors and do not get the opportunity to learn skills and attributes that will take them forward in life and promote healthy, respectful and stable relationships.

There are few integrated, community based programs which engage both adolescents and parents to treat adolescent violence in the home. There can be a tendency to understand the violence in a dichotomised way; for example as either the parents' or adolescent's fault. Because adolescents do not readily engage with the service system, most treatment is with parents, usually through group programs. Whilst these programs are valuable, they lack the capacity for more systemic and family centred change.

It seemed finding better ways to engage with adolescents and support family members to make changes to stop the violence would significantly benefit adolescents as well as other family members. Male adolescents who have experienced family violence as children are at higher risk of using violence against partners in adult life (as well as against their mothers). There was a window of opportunity to prevent intergenerational transmission of violence, as well as family relationships.

Adolescent violence in the home appears to be increasing. The many risk factors for adolescent violence in the home and the complexity of this issue inspired me to consider a Churchill Fellowship to better understand why adolescent violence in the home occurs and importantly, how we can improve assessment, treatment and prevention. I was interested to explore how a coordinated community response might better address this issue.

Adolescents who use violence in the home deserve the opportunity to be supported to make changes in their lives. Parents and siblings who are abused by adolescents deserve to live safely and free from fear. Victoria's and Australia's policy context across many domains – family violence, child protection, alcohol and drug and mental health – stress the importance of family centred approaches and early intervention, of community based interventions and breaking down service silos. There is enormous scope to develop and implement a program that works with adolescents and their parents, that is coordinated and includes community

'buy in' and that provides an excellent service response. The time is ripe for change and innovation.

I hope this report will provide the basis for awareness raising and discussion about adolescent violence in the home and ultimately contribute to a coordinated, integrated and family focused model of care.

2. Acknowledgements

It has been a significant privilege to travel to the United States and Canada to meet with so many talented, passionate and skilled people. I have been interested in the issue of adolescent violence in the home for over 15 years and will be forever grateful to the Winston Churchill Trust. I would also like to acknowledge my referees during the application process – Professor Cathy Humphries (Alfred Felton Research Program, Melbourne University) and Michele Wright (Acting Executive Officer, No To Violence). Without their passion for the increased safety of family members, particularly women and children and their belief in, and encouragement of me, I would possibly not have had this experience.

People I would like to thank for their support over the years include:

- Julian and Imogen, my son and daughter who have always supported their mother's passions
- Trish Parker, Family Casework/Counsellor at Inner South Community Health Service who has worked to support parents who experience adolescent violence for many years. Trish has passionately contributed to building a network of practitioners working with adolescent violence in the home and has significant expertise in this field.
- Helen Wirtz, Family Casework/Counsellor and narrative therapist who is a passionate advocate for women and children who experience family violence
- Linda Betts, for her unfailing support and encouragement and belief in me.

In the US and Canada several people extended their support by inviting me to stay and/or looking after me 'after hours'. These included Peter Monk (Child & Youth Mental Health, Victoria, Canada), Tom Perzynski ('Step Up', Toledo, Ohio), Lily Anderson and Greg Routt ('Step Up', Seattle, Washington). These people have been working in the field of adolescent violence in the home for many years and generously shared their considerable expertise and resources.

The universe also delivered Lynette Bretton, a Churchill Fellow from the UK, also researching adolescent violence in the home. Lynette provided warmth, friendship and a mechanism to bounce around thoughts and ideas.

I would also like to acknowledge the other practitioners working in child protection, family violence, adolescent services, law enforcement and mental health who gave so generously of their time and knowledge across the United States and Canada. I met inspiring, passionate, talented people to whom I am extremely grateful.

3. Executive summary

Jo Howard

Project description

Adolescent violence in the home is being more widely recognised in Australia, the United States, Canada and parts of Europe as an increasing, complex and multifaceted issue with serious ramifications for parents, siblings and broader society, as well as the adolescents. Severity of violence ranges from verbal abuse to serious assault. Destruction of property is almost always present. Most adolescents who are violent to family members experience a range of other problems – drug and alcohol use, anti social behaviour, school disengagement and mental health problems. Whilst some adolescents may stop the use of violence without service intervention, many will not; in fact some will progress to using violence against intimate partners in later life, some will become homeless as a result of their violence and others will continue to experience a range of associated problems which challenge the opportunity for a safe, happy and healthy life.

In April and May 2010 I travelled to the United States and Canada to investigate:

- Risk factors and determinants for adolescent violence in the home
- Best practice and evidenced based interventions to treat adolescent violence in the home
- Best practice and evidenced based interventions to prevent adolescent violence in the home

Findings

There are numerous and interrelated determinants for this form of family violence; the most significant being a child's experience of family violence. Other influential determinants include parenting styles, the experience of trauma (including child abuse), being a victim of bullying, mental health and emotional problems, special needs (developmental/learning disorders and autism spectrum), struggles with school, marital conflict, high conflict separation and divorce (usually involving custody battles), substance abuse and parental health problems, mental health problems or substance abuse issues (Anderson & Routts, 2010).

Some parents report the violence seems to 'come out of the blue' with no apparent reason why it occurs. Whilst most adolescent violence in the home can be attributed to interrelated determinants, some adolescent violence to family members may be related to their individual personality or genetic predisposition, rather than specific determinants. Although an understanding of the determinants that influence the use of violence in the home is useful in both prevention and treatment, it is not necessary to attribute determinants or causality in order to support parents and adolescents to stop the violence.

Determinants also include socio economic, social and community determinants and the domains of school, neighbourhood and peers. For example there appears some difference between the influence of determinants that contribute to adolescent violence in the home in higher socio economic status families where parenting style is often a key contributor,

compared to determinants in lower socio economic status families where poverty and social disconnection make a key contribution.

An ecological framework[1] identifies key determinants for adolescent violence in the home across a number of determinants. The determinants for adolescent violence in the home relate closely to those suggested by VicHealth (2007) for violence against women and include:

Societal determinants:
- influence of media, advertising and consumerism
- increased emphasis on the rights of adolescents (leading to adolescent 'entitlement')
- gender inequality and rigid gender roles
- community, social and academic disconnection and isolation, often as a result of poverty

Community determinants:
- weak community and parental sanctions against the use of violence
- community or peer violence
- neighbourhood characteristics (service infrastructure, unemployment, poverty)

Individual and relationship level:
- Mothers' and children's experience of family violence, and the impact of trauma on the mother/child relationship, parenting and the child's development
- Authoritarian, controlling and/or abusive parenting
- Indulgent parenting which is risk adverse and supports adolescent entitlement
- Disengaged parenting which lacks boundaries and is conflict avoidant
- 'Splitting' between mother and father, where one parent does not support, or seeks to undermine the other
- Children's and parents' biological, behavioural and relational issues including parental conflict, developmental delay and mental health, drug and alcohol use and health problems.

The multiple pathways that lead adolescents to use violence in the home requires multiple and flexible responses for treatment and prevention across the three levels of determinants. It is beyond the scope of this Fellowship to articulate responses at a societal or cultural level; suffice to state addressing these broader determinants is important in prevention.

Some adolescents 'grow out of' the use of violence and abuse without intervention. Their use of violence may be a transitional 'phase' as they mature from childhood to adolescence. Others require integrated interventions across services including youth justice and courts, school, mental health, alcohol and drug and family counselling.

Best practice responses acknowledge adolescent violence in the home as a relational issue which requires changes from adolescents and parents. This response explores contributing factors which support the adolescent's use of abuse and violence and ways family members can change to stop the violence. It acknowledges the importance of a coordinated

[1] An ecological model for understanding violence was proposed by the World Health Organization in its report World Report on Violence and Health (WHO 2002). This report recognizes that factors influencing violent behavior or vulnerability to violence lie at multiple and interacting levels of influence – individual/relationship, community/organizational and societal/cultural. I also acknowledge the work of VicHealth's document Preventing violence before it occurs (2007) .

community response to address co-occurring issues including drug and alcohol use, mental health problems and school disengagement. It acknowledges the social and community determinants which influence parents and adolescents. Treatment options must be flexible and provide support to parents, adolescents and siblings and to parents where adolescents refuse to engage. Best practice treatment is family centred delivered through juvenile and/or family violence justice programs which are able to engage with adolescents (and parents) who would not usually engage with services and give a clear message about the unacceptability of violence. These programs provide comprehensive assessment and referral, case coordination and a coordinated community response. They are also more effective in protecting siblings who have been abused.

Best practice responses include five core components:

- Safety – of the adolescent and other family members
- Accountability and responsibility for the use of violence
- Empathy
- Respect
- Non violent problem solving

Treatment goals for adolescents and parents include learning new skills such as non violent conflict resolution, time out, understanding and communicating feelings, anger management and taking responsibility. Where safe to do so, treatment includes restoration of family relationships. A restorative justice approach privileges accountability (restoring harm), community safety (reducing risk) and competency development (building skill) ('Step Up', 2010). The most significant predictor of sustainable change for adolescents who use violence in the home is the ability to empathise with the thinking, feelings and experience of another. 'Making amends', the process of repairing the harm or damage caused by the behaviour, is a key change component in moving from violence and abuse to respect and responsibility.

Prevention

Prevention of adolescent violence in the home is best achieved by:

- support to women and their children who experience family violence,
- parenting programs, particularly those targeting parents of pre-adolescent children,
- school and community programs which encourage peaceful conflict resolution and negotiation and develop children's empathy, self respect, communication, respect for others, responsibility and accountability.

There is tremendous scope for innovation and leadership in prevention, early intervention and treatment of adolescent violence in the home. There are challenges and opportunities for Victoria and Australia to consider more systemic, coordinated and integrated ways to prevent and respond to adolescent violence in the home by being inclusive to adolescents and parents - how can family members (parents and siblings) be protected and safe whilst at the same time ensuring interventions do not place the adolescent perpetrator at greater risk? How can an adolescent be encouraged and supported to take responsibility and stop their violence, whilst at the same time maintaining their connections with family, work, study and education? How can parents be encouraged to reflect on their parenting style and make changes in a way that does not lead the parent to feel blamed and shamed?

Recent policy and practice change in Victoria including reorientation and development of child protection and family services, development of integrated family violence services (including women's, children's and men's programs), a greater family friendly focus in drug

and alcohol and mental health and changes to how police and the criminal justice system respond to violence in the home, provide opportunity to build an integrated, coordinated, flexible and family centred response which works with adolescents and their parents.

4. Key recommendations

1. An innovative diversionary juvenile justice program based on the 'Step Up' model should be piloted in Victoria.
2. Adolescent violence in the home must be acknowledged as a form of family violence.
3. The safety, security and wellbeing of all family members, including the adolescent, must be a priority in assessment and treatment.
4. Assessment of sibling's safety and wellbeing is a key component of best practice response.
5. Best practice responses are integrated, coordinated, flexible, family centred and engage and treat adolescents and parents.
6. Education and training about adolescent violence in the home, particularly assessment and referral options, must be provided to staff in juvenile courts, mental health and alcohol and drug services, family, youth and family violence services.
7. Juvenile courts, youth services, adolescent mental health and adolescent drug and alcohol programs should screen for adolescent violence in the home as part of assessment.
8. Respite care must be available for adolescents who have been removed from the home because of their violence.
9. Women with children who have experienced family violence must have greater access to support to address the impact of trauma on the child and mother, on the mother/child relationship and on the mother's parenting.
10. Infant, child and adolescent and adult mental health systems must play a greater role in supporting women and children who have left family violence and families where adolescents use violence in the home.
11. Policy development relating to children, families, young people, alcohol and drug, ental health, youth justice and family violence must be inclusive to the issue of adolescent violence in the home, its impact on family members and best practice integrated service system response.
12. Research must explore long term outcomes for adolescents who continue to use adolescent violence in the home and their family members and for those who receive intervention.

5. Outcomes

This Report will be disseminated to state and federal government departments, policy and practice bodies and interested agencies including:

- Victorian Department of Human Services (youth, family services, family violence, child protection)
- Victorian Department of Health (mental health, drug and alcohol)
- Victorian Department of Justice (youth justice)
- Australian Department of Family and Housing, Community Services & Indigenous Affairs (FaHCSIA)
- Australian Department of Health & Ageing
- VicHealth, DV Vic, Victoria police, SAFER project, Centre of Excellence in Child and Family Welfare, Australian Institute of Family Studies
- presentation of the findings in key journals;
- media representation relating to Report findings;
- conference and workshop presentations;

- training, consultation and supervision to services working with children, adolescents, families and family violence

Adolescents who use violence in the home have the right to assessment and treatment which supports them to stop their use of violence and move towards respect and responsibility. It is hoped this Report will stimulate policy development and support funding for enhanced responses to prevent and respond to adolescent violence in the home.

6. Program

April 5, 2010
Patricia Van Horn, Ph. D., Associate Clinical Professor Psychiatry, Department of Psychiatry
Associate Director, Child Trauma Research Program
San Francisco General Hospital
California

Walesa Kanarek, Coordinator,
Casa de las Madres women's shelter
San Fransisco

April 6
Sara Fewer, Program Manager & Jeanine Hays, Program/Policy Associate & Debbie Lee, Senior Vice President
Family Violence Prevention Fund
San Francisco, California

April 12 and 13
Gail Ryan, Director, Kempe Perpetration and Prevention Program
Assistant Clinical Professor, Department of Paediatrics
Kempe Centre
Colarado

April 15, 19 & 21
Peter Monk, Team Leader
West Shore Child and Youth Mental Health
Victoria, Vancouver Island

April 20
West Shore Child & Youth Mental Health,
Adolescent Violence in the Home community forum

Gerry Van Oosten, Therapist
Child & Youth Mental Health
Ministry of Children and Family Development
British Columbia
Canada

April 22
Marnie Stickley, Coordinator Elder Abuse Team
Domestic Violence Unit, Vancouver Police
British Columbia

April 23
Heather Whiteford, Manager, Victims Services Division
Family Services of Greater Vancouver
British Columbia

April 26, 27 & 28
Lily Anderson & Greg Routt, Coordinators & facilitators, Kings County 'Step Up' Program
King County Superior Court
Seattle, Washington

Judge Philip Hubbard, Jr
King County Superior Court
Seattle, Washington

Matthew David, Area Manager, Partnership for Youth Justice
King County Superior Court
Seattle, Washington

May 3 & 4
Carolyn Goard, Director, Member Programs and Services
Alberta Council of Women's Shelters,
Edmonton

May 7, 10 & 11
Tom Perzynski, Family Counsellor & Debbie Lipson Kaplan, Coordinator, Family Violence Intervention Program & Amy Lentz, Probation Officer/Facilitator & Hans Giller, Probation Officer/Facilitator
Lucas County Juvenile Court,
Toledo, Ohio

May 14
Colleen Schmidt, Manager,
Day One
Minneapolis, Minnesota

Jeffrey Edelson, Therapist and author
Private Practice
Minneapolis, Minnesota

May 15
Graham Barnes, Resource Specialist
Battered Women's Justice Project
Minneapolis, Minnesota

May 18, May 19 & 20
Linda Riddle, Chief Executive Officer
domestic abuse intervention programs
Duluth, Minnesota

Melanie Ford, County Attorney
Saint Louis County Courthouse

Duluth, Minnesota

May 25
Louise Logue, Manager Youth Services
Ottawa Police,
Ontario, Canada

Caroline Gagnon, Senior Policy Analyst, Family Violence Prevention Unit
Public Health Agency of Canada
Ottawa, Ontario
Canada

May 26
Bailey Reid, Program Coordinator,
Neighbours, Friends and Family Project
Ottawa, Canada

May 28
Peggy Papp, Senior Faculty member, Director of the Project for Adolescents and Their Families & Michael Davidovits, Assistant Director of the Project for Adolescents and Their Families
Ackerman Institute,
New York

Note: The Program above highlights the key professionals and agencies visited as part of my Churchill Fellowship, however I want to acknowledge and thank the many other staff at key agencies with whom I met.

7. Definition and terminology

Adolescent violence in the home is a complex issue. It is frequently misunderstood as normal adolescent 'acting out' or 'anger' or a consequence of a mental health or substance abuse issue. It is commonly referred to by terms including 'teen violence to parents', 'youth violence', 'teen abuse', 'teen violence to parents' and 'adolescent violence to parents'.

This report uses the term 'adolescent violence in the home' in order to:

- include parents, siblings, other family members and pets as victims of this form of violence
- conceptualise adolescent violence in the home as a form of family violence which occurs in an intimate context and in the privacy of the home, similar to adult family violence
- conceptualise adolescent violence in the home as a form of power and control by adolescents against family members.

This report understands adolescent violence in the home as different from normal adolescent 'acting out' because behaviours are not isolated, reactive events, but occur on a regular basis. Behaviours are not 'expressive' but are 'instrumental'; they are designed to gain power and control over family members. The *impact* of these behaviours is profound for those who experience it with family members commonly adjusting their own behaviours in order to prevent the abuse and violence (Patterson et al, 2002).

I use the phrase "Adolescents who *use* violence against…" because the word '*use*' highlights these acts of violence are strategic with the intent to control and have power over others.

Adolescents '*use*' violence to get their own way. Their violence is not a random, arbitrary act but a strategy that gets results.

I use the term 'experience of family violence', rather than 'witness to family violence' when children are present in the home and family violence occurs. The term 'witness' detracts from the significant impact of living in a home where family violence occurs. Even if children are not physically hurt, hearing and seeing their mother being beaten, degraded, insulted, frightened, crying, disrespected, intimidated and hurt is a powerful and traumatic *experience*. The use of the word 'experience' as opposed to 'witness' focuses on the impacts of the abuse and violence, rather than whether they were watching it. The term 'witness' implies a passive role; yet children who experience family violence are actively engaged in interpreting, predicting, assessing their role in causing the violence, worrying about the consequences and/or how to prevent the violence, problem solving and/or taking measures to protect themselves, physically and emotionally (Lieberman & Van Horn, 2005). The significant and traumatic effects and impacts on a child's development and wellbeing do not appear to differ whether they have 'witnessed' it or directly 'experienced' it.

'Adolescence' is defined as the period of life between ten and nineteen years of age (Goodburn & Ross, 1995). Adolescents are frequently referred to as 'teenagers', 'juveniles', 'youth' and 'young people' in the literature. This report refers to 'adolescence' as the period of life between ten and eighteen years of age.

'Parents' is used in a broad sense and refers to parents of the adolescent, other adult family members and carers. It is important to note out-of-home carers (relatives or foster carers) also experience adolescent violence in the home.

8. Victorian and Australian context

Adolescent violence in the home is only recently being acknowledged in Victoria and Australia, despite data that supports the need for greater awareness and service response. There are currently no coordinated, integrated and family inclusive service responses.

Parents who are abused by their children will often deny or minimise their victimisation – this reinforces the assumption it is not a common problem (Monk, 2010). One in ten police family violence call outs in Victoria, Australian relate to adolescent violence in the home. There has been a 26% increase in police call outs related to this issue between 2003 and 2006 (Victorian Police, 2008).

A recently released report by the Victorian Department of Justice which gathered data about family violence over a nine year period (1999-2008) showed a consistent 13% of family violence incidents recorded by police involved incidents where a parent was the victim (DoJ, 2009, 45). 9% of all family violence incidents recorded by police and 4% of all the aggrieved family members in finalized intervention order applications involved parents as victims of violence from their adolescent children (DoJ, 2009, 46). Across the court data, approximately 8% of family violence incidents involved an order by a parent/step parent against a child or step child, some of whom were adult children (DoJ, 2009, 45).

Mothers were likely to experience violence from their adolescent child/step child than fathers, however fathers are frequently victims. In 2007/8, 74% of parents who sought an intervention order against their child were mothers, 26% were fathers (DoJ, 2009, 45). In a Western Sydney study, 51% of sole mothers stated they had experienced abuse and violence from their adolescent (Stewart et al, 2006).

Service system responses

The service response to adolescent violence in the home is mostly siloed, working with the adolescent or the parents/siblings and working from a victim/perpetrator dichotomy. Adolescent violence in the home presents as an issue across family, parenting, youth, youth justice, family violence, out-of-home care, child protection, mental health and drug and alcohol services. It frequently co-occurs with other issues. There are few respite options to place adolescents who have been removed from the home because of their violence.

Treatment modalities include group programs and counselling for parents, youth and family mediation, family conferencing and family dispute resolution. Adolescents who present to youth services with family grievances may not disclose their use of violence or may blame their parents. Youth services may inadvertently support the violence through advocating for the adolescent's rights, without having assessed the adolescent's use of violence and gained family members' perspectives.

Youth mental health services may understand adolescent violence in the home as a 'symptom' of a psychiatric disorder and therefore a mental health problem. This may be the case with more serious mental health problems including bipolar disorder and schizophrenia. Parents report medication is helpful in reducing and stopping the violence Anderson & Routt, 2010). Whilst adolescent violence in the home may be a symptom of severe mental illness, it is important not to attribute causality to the mental health issue. Adolescents who use violence in the home and have a diagnosed serious mental illness must still hold responsibility for their use of violence and be held accountable for their behaviour. This may be more challenging for adolescents with mental health problems than for those who do not have these problems; however this acknowledgement helps motivate them to work on learning skills and with medication compliance.

Researchers such as Perry (1999, 2002) and Shonkoff (2002) have drawn attention to the importance of understanding psychiatric and developmental problems such as Attention Deficit Disorder, Attention Deficit Hyperactive Disorder, Conduct Disorder, Oppositional Defiance Disorder as symptoms of trauma and therefore occurring within a context of family relationships and patterns, as opposed to individual pathology.

Because adolescent violence is not conceptualised as a form of family violence, family violence services may feel it is not their mandate to respond. Policy reform that privileges the rights of children to safety leaves services unclear how to respond when children are perpetrators (even though they may also be victims). Family violence policy has rightly understood family violence through a gendered lens. The issue of adolescent violence in the home raises challenges to this conceptualisation of family violence and questions of which component of the service system should respond.

Where adolescent violence in the home conflates with other criminal behaviour, drug and alcohol use and/or mental health issues, these other issues often become the priority for intervention and the adolescent's use of violence is relegated to a lesser issue. Police and family workers are conscious removing the adolescent from the home may be a trajectory that includes, if it doesn't already, drug and alcohol use, criminal activities, sex work, social exclusion, disengagement from work, education or study/training and increased risk of mental health problems. The road to homelessness often begins with adolescents leaving home and having to fend for themselves at a time they are most vulnerable. For this reason,

and the lack of safe and appropriate alternatives, removal of adolescents from the home is a last resort.

Parents of adolescents who use violence in the home have highlighted the urgent need for respite or 'cooling off' facility to allow 'breathing space' for family members (ISCHS, 2008). Some programs in the United States provide this facility.

Whilst the court can issue an Intervention Order against an adolescent, it is unclear if breaches are responded to. The service system has not articulated a response to Intervention Order breaches by adolescents. For these reasons the criminal justice response to adolescent violence in the home is lukewarm at best.

Victorian courts can recommend or mandate violent men to attend a men's behavioural change program. Men's behavioural change programs rightly argue it is neither appropriate nor relevant for adolescents to participate. There is a clear service gap for male adolescents who use violence against family members and/or to intimate partners. The Gain Respect, Increase Personal Power (GRIPP) program, piloted through Victoria's youth justice system, does not specifically address adolescent violence in the home and targets only male adolescents. There is an additional service gap for female adolescents who require service intervention.

9. Current directions in the USA and Canada

Adolescent violence in the home occurs at similar rates as in Australia. US and Canadian data indicates between 7% and 18% of parents have been victims of physical violence from their adolescent children at some time, a figure that rises to 29% in the case of single parents (Agnew & Hugley, 1989; Cornell & Gelles, 1982; Pagelow, 1989; Paulson, Coombs & Landsverk, 1990; Peek, Fischer & Kidwell, 1985). Canadian research estimates 1 in 10 parents are assaulted by their children (DeKeserdy, 1993). US and Canadian statistics reveal an increasing number of girls involved in and charged with physical assaults, including against their parents.

Canadian and US studies indicate the violence begins when the child is between 12 and 14 years old (Cottrell, 2001, 7), estimating the peak age for violent adolescents at between 15 and 17 years (Evans et al, 1988; Wilson, 1996).

In King County, Washington State 65% of juvenile domestic violence court filings pertained to adolescent violence in the home with police referring approximately 800 cases a year to the prosecutor's office ('Step Up' Introductory Pack, 2010). In 2007, 46% of family violence committed by juveniles was against mothers and 15% against fathers. Male offenders accounted for 67% of the violence and female offenders 33% (Sellick-Lane, 2007).

9.1 Determinants and risk factors

No one theory accounts for the complexity of interrelated determinants and risk factors that contributes to adolescent violence in the home. Risk factors do not operate in isolation, but interact in ways that can be moderated or exacerbated by other variables including both risks and assets (Ryan, 2007, 161). Most of these determinants conflate; adolescents who use violence in the home may be engaged in criminal activity, using drugs and/or alcohol, not engaged in school, work or study and experienced mental health issues, particularly depression and anxiety.

The determinants for adolescent violence in the home are best understood through a social ecological framework (VicHealth, 2007). This framework enables an integrated and systemic understanding of why adolescence violence in the home occurs through understanding determinants across societal/cultural, community and relationship/individual determinants. Each determinant intersects with and influences the others.

Determinants do not signal causality. They are contributing factors and this contribution may be mitigated by protective factors. Not all adolescents, even those with significant risk factors, will go on to use violence in the home. It is important not to demonise adolescence as a developmental stage and adolescents themselves. Similarly, whilst factors such as parenting style may contribute to adolescent violence in the home, it is important not to blame parents. Most parents do the best they can and a range of interrelated variables impact both on parenting style and adolescents' use of violence in the home.

A cultural or societal perspective examines the influence of broad cultural values and belief systems. From this perspective, adolescent violence in the home occurs in a context that:

- applauds the use of power, control and violence by males (and increasingly females) to get their way and assert authority
- celebrates anti authoritarianism and rebelliousness
- privileges 'instant gain' over 'delayed gratification'
- supports the rights of the individual over the family (and therefore adolescent 'entitlement')
- privileges consumerism and acquisition of 'things' to gain acceptance and importance
- has cultural views about mothering which privilege putting children before oneself, particularly male children
- has weak sanctions against gender inequality and maintains rigid gender roles
- privileges male dominance, decision making and control of resources.

The media, marketing and advertising promote adolescent entitlement and minimise adolescent responsibility whilst promoting parental over-responsibility and insecurity about their child's future. It has been argued (MacKay, 2007) parenting is almost exclusively 'childcentric', rather than the parenting of previous generations which focused on how children and adolescents can contribute to society. Rather than having a focus on the development of relationship skills, parents may be 'aspirational' and 'super competitive'. This, coupled with a child centric focus means significant emphasis on children having "…towering self esteem and unabashed assertiveness…" (Ibid).

Parents who seek to build 'towering self esteem and unabashed assertiveness' may be inadvertently contributing to the development of adolescent entitlement, self centeredness and abuse of, and violence to others. Good self esteem and assertiveness (as opposed to MacKay's 'towering self esteem and unabashed assertiveness') are not contributors to adolescent violence in the home; rather they are strong protective factors against using violence. Many adolescents who use violence in the home have low self esteem and are unassertive. It is important to distinguish between 'towering self esteem' and entitlement and 'unabashed assertiveness' and abuse and violence.

"Childcentric' parenting (as defined by MacKay) is more likely the domain of middle class and higher socio economic status parents. Whilst it is important not to make broad generalisations about socio-economic status and its relationship to adolescent violence in the home, parenting that is overly 'childcentric' may contribute to adolescent violence in the

home. Conversely, parenting that is too 'adultcentric', and neglects children's needs may also contribute to adolescent violence in the home.

Advertising and marketing significantly influences how parents raise their children through convincing them they and their children require products in order to be 'successful' and by instilling fear in parents that unless their children have the right products, they will be 'lesser than'. Adolescents' success is seen as a direct reflection on parents' success. Western culture emphasises the importance of success and winning; parents are fearful their adolescent may be left behind or fail in life if they miss out or do not keep up with the acquisitions and pursuits of other adolescents. Adolescents learn to play on this fear to get what they want.

Parents today face pressures that did not exist in previous generations. The media has emphasised the risks and dangers faced by adolescents – drug and alcohol abuse, depression and suicide and assault. A strong focus on academic achievement means parents may focus on academic success and minimising risks. They may become over responsible for adolescent's outcomes and expend considerable energy 'saving' their adolescent from negative consequences. Parental over concern and over responsibility encourages adolescents to blame others rather than take on personal responsibility.

Garrido (2005) highlights the high levels of stress experienced by parents; the fact adolescents are not required to take on responsibility until adulthood and consumer society with its stress on instant gratification and numerous possibilities for unhealthy influences and practice such as pornography, violence, alcohol and drugs. Family life is less relational than in past generations with adolescents spending more time alone and away from family interactions, for example by using their computers or watching television in their rooms. Television and computer games normalise hyper masculinity and use of violence.

Adolescents are developmentally self-focussed. Advertising and marketing capitalises on this and promotes 'entitlement' to influence adolescent spending and purchase of goods. The media's and popular culture's promulgation of an 'I want it and I want it now' mentality encourages adolescents to feel entitled to use any means to get their wants and needs met. Many parents of adolescents who use violence in the home report the violence is precipitated by the parent not supporting the adolescent's demand, often for money or material goods. What may start out as arguing and temper tantrums can eventuate to abuse and violence as adolescents push for their 'rights' and parents acquiesce to avoid conflict. The media may play some part in encouraging adolescents to be more 'rights' focused and confrontational to parents. Early adolescence is a time when children develop moral and ethical considerations. Parents who do not communicate and uphold their expectations about their adolescent behaviour may inadvertently encourage an adolescent who prioritises his own needs and wants, over the rights of others.

At a relationship and individual level there will be some adolescents who use violence in the home due to severe mental health, developmental or neurological problems. Buka & Earls (1993) suggest an interaction of child health and neurological status, early academic skill development and success and family functioning and parenting style contribute to the occurrence of adolescent violence.

At a relationship and individual level, two key determinants for adolescent violence in the home are:

- a child's and/or mother's experience of **family violence** and **trauma** with the mother having left the violent partner and now parenting on her own
- **parenting styles** characterised by excessive indulgence, lack of boundaries and/or control/authoritarianism.

These risk factors may be interrelated – for example a child who has experienced family violence may also be parented in an indulgent way because his mother wants to compensate for the child's experience of violence and not having a father in the home.

9.1.1 Family Violence and trauma

Impact on infants and children

A child's experience of family violence is a significant determinant for adolescent violence in the home and violence to others (Perry, 2002; Shonkoff et al, 2003), particularly intimate partners (Bobic, 2004; Ulman & Strauss, 2003). An estimated 95% of adolescents in the 'Step Up' program, Seattle had experienced family violence (Anderson & Routt, 2010). Social learning theory contends adolescents who experience their parent's violence will likely assume violence is acceptable (Kratcoski, 1985).

Perry's (2006) "neurosequential model of therapeutics" is based on an understanding of how trauma affects the developing brain and the importance of therapeutic approaches designed to change these negative impacts through the development and stimulation of new neural pathways. The ways in which children are affected by family violence differs for each child. Factors such as gender, age, stage of development, mental health of the mother, relationship with mother, siblings and father, school and community environment and poverty all contribute to how a child makes sense of, and is affected by family violence.

Early childhood is a crucial period in a child's development. It is a time of rapid growth of the central nervous system and when the foundations for a child's values and attitudes are formed. The experience of trauma, common when children experience family violence and/or child abuse, triggers a range of biological and chemical approaches which affect their emotional, behavioural, cognitive, social and physiological functioning (Perry, 2001). Children who experience trauma may not reach their normal developmental milestones. This places them further at risk of violence as they experience a sense of failure and disconnection in educational and social contexts (Van der Kolk, 1996). They may experience anxiety, are easily frustrated and stressed, have decreased trust, difficulty with affect regulation and are hyper vigilant to the possibility of threat making them more inclined to lash out against others, be impulsive and experience cognitive distortions. Children who experience complex trauma may lack capacity to regulate their emotions, and therefore be prone to enraged and avoidant emotional reactions to minor stimuli (Van der Kolk, 2005).

Impact on mothers

Attachment is the result of an interaction among what the child brings to his earliest relationships, what the caregiver brings to these relationships and the quality of subsequent experiences (Lindsrom in Ryan, 1999, 33). Violence against women is an assault not only on the mother, but on the mother/child relationship. It prevents a mother bonding with her child, and negatively impacts on the child's attachment to his mother and on her ability to parent. Her experience of abuse and violence may include physical injuries and physical effects such as insomnia, lethargy, headaches and eating disorders; psychological and emotional effects such as anxiety, depression, loss of self worth and confidence and feelings of guilt, shame and blame. Because the woman has left a violent partner does not mean the effects of violence will cease.

Many men who are violent to their partners, parent in an authoritarian and controlling way, with physical punishment and threats used to control their child. When the parental relationship ends, the mother may experience difficulties parenting as her child experiences a new found freedom from control. At the same time, her child will have learnt attitudes and values about women and mothering from his father lead him to be disrespectful to, and dismissive of his mother's authority. Fathers may use contact visits with the children to undermine and criticise his ex partner. He will actively seek to undermine the relationship between mother and child and tell the children to disobey and disregard their mother.

The effects of the violence on mothers and children leaves mothers in an extremely difficult position of being unable to parent actively and assertively, and having to parent children who are also traumatised and encouraged to disregard their mother's authority.

When boys are raised by violent men, they learn from observing their father's behaviour and directly being told by their father that women are not of equal status to men. They learn it is appropriate and acceptable to use violence against others, particularly women. They learn power and control is more important than equality and respect. They grow up to treat their mother in the same way as their father has.

Most adolescents who experience family violence choose not to use violence against others. Whilst the experience of family violence is a key risk factor for adolescent violence in the home, protective factors including individual resilience, biological make up of the adolescent, and influence of other supports such as extended family, peers and the community mitigate this risk.

9.1.2 Parenting

Whilst parenting style contributes to adolescent violence in the home, it is important to contextualise this contribution and not assume that all adolescent violence in the home occurs as a result of inadequate or poor parenting. Parenting style is significantly influenced by a parent's own childhood experience and trauma, family violence, parental conflict, drug and alcohol use and mental health. Nevertheless it appears some parenting styles are more supportive of, rather than causal of, adolescent violence in the home.

Four styles of parenting are risk factors for adolescent violence in the home. These are:

- indulgent parenting which is risk adverse and supports adolescent entitlement
- parenting that lacks boundaries and is conflict avoidant
- authoritarian, controlling and/or abusive parenting
- 'splitting' between mother and father, where one parent has clear boundaries and expectations but is not backed up by the other.

Indulgent parents expend considerable time and energy to ensure their child does not face risks or disappointment. Rather than parent in a way that supports their child to reach developmental milestones such as self responsibility, separation and independence, they excuse poor behaviour and are overly responsible. Consequently the adolescent develops high expectations that others should meet their needs and does not take responsibility or accountability for decision making and actions. Violence against parents begins when parents finally draw a line about how much support they will give their child. The adolescent feels outraged and entitled to 'up the ante' through the use of violence to get his needs and wants met.

Parenting can lack boundaries or be inconsistent for many reasons including parental health and wellbeing. Parents with substance or mental or physical health issues or who have experienced family violence may find it difficult to set and enforce parental expectations because their own 'survival' takes priority over parenting. The impacts of poor mental health and physical health and trauma may mean parents do not have the physical, emotional and psychological resources to parent consistently and effectively.

Parents who do not adequately supervise their adolescents nor give them guidance and direction may inadvertently support adolescents to feel 'entitled' to use violence (Wilson, 1996). Adolescence is a period of moral and ethical development. Adolescents need parental guidance and example to learn empathy for others, delayed gratification and impulse control.

In some circumstances where parents are unable to effectively parent, an adolescent will take on the 'parenting' role, where they take on adult responsibilities and a caring role but in a way that is authoritarian and controlling.

A number of studies have highlighted the absence of a hierarchical structure in families where adolescent violence in the home occurs (Ibabe, 2009; Wilson, 1996). Lack of hierarchy is evident in parenting that lacks clear boundaries and where parents prioritise being their children's 'friend' or 'peer', rather than their parent. Parents feel uncomfortable about stating and enforcing boundaries and saying 'no'. They find it easier to placate rather than risk conflict. They are conscious not to be strict or repressive (possibly because this is how they perceived their parents).

Authoritarian, controlling or abusive parenting may 'work' when a child is physically weaker than the parent but once a child reaches adolescence and the developmental task of forging their own separate identity, they resort to abuse and violence to gain autonomy and stop the abuse and violence. Children learn control and power are more important than negotiation and resolution and that abuse and violence is acceptable.

9.1.3 Other risk factors

Other risk factors for adolescent violence in the home include:

- Poverty and community and social disconnection
- Adolescents' and/or parents' poor mental health
- Adolescents' and/or parents' alcohol and drug use
- School difficulties – behavioural problems, learning difficulties, academic failure, bullying and being bullied, absence and truanting
- Anti social behaviour and criminal activity.

Mental health

Adolescents with mental health issues are highly represented in adolescent violence to parents programs. This is not surprising given the link between childhood trauma and adolescent violence in the home. One clinician (Kelli at Youth Forensic in Victoria, Canada) estimated 70% of the youth forensic mental health clients use violence against family members. Another (Cottrell, 2001) found 50% of abusive adolescents she worked with had a mental health diagnosis. Approximately 54% of adolescents attending 'Step Up', Seattle had a mental health or developmental diagnosis including aspergers, autism, oppositional defiance disorder, depression, obsessive compulsive disorder, ADHD and bi polar (Anderson & Routt, 2010). Clinicians described common 'personality clusters' for adolescents who use violence in the home including emotional dysregulation and poor impulse control. It is

important children and adolescents are assessed for the experience of childhood or current violence, trauma, child abuse and neglect.

School difficulties

Many adolescents who use violence in the home also experience difficulties at school including poor academic performance, social rejection by peers, being bullied or bullying others, behavioural problems and low connectedness to school. Some pass through the school system with a learning disability or developmental delay. The use of violence in the home both co-occurs with school difficulties and contributes to them. 75% of juveniles fronting King Country Juvenile Court are at risk of dropping out of school or have already (Anderson & Routt, 2010).

Alcohol and drug use

Alcohol and drug use may contribute to adolescent violence in the home because they exacerbates adolescent/parent conflict and reduce the capacity to resolve family problems, increases other risk factors such as school problems and increases the risk of adolescents withdrawing from family life, adhering to family rules and engaging in anti social behaviours. Kennair and Mellor (2007) noted it was common for parental abuse to be precipitated by conflict related to the adolescent's drug and alcohol use. 66% of adolescents in a recent Australian research project on adolescent violence in the home had substance abuse issues (Haw, 2010).

10. Best practice interventions which respond to adolescent violence in the home

A best practice intervention is one believed to be more effective at delivering a particular outcome than any other intervention, method, process, etc when applied to a particular condition or circumstance. The multi determinants for, and complexity of adolescent violence in the home, means best practice response is coordinated across a range of services, offers conjoint parent/adolescent support and intervention and acknowledge the interface of gender, child development, family violence and trauma.

As a culture, we often respond to the path from victim of violence to violent offender, in punitive rather than ameliorative ways (Van Horn & Hitchens, 2004). However, the importance of engaging and working with adolescents as best practice, means that the criminal justice system (police and courts) offers a pathway to engage with adolescents and family members, who would not otherwise engage with 'the helping professions'. Whilst entry into therapeutic programs such as 'Step Up' may occur through the criminal justice system, it does not mean that this process is punitive.

Using the criminal justice system as an entry point to service delivery for adolescents who use violence in the home differs from the role of the criminal justice system where men use violence against women. Whilst there are similarities between work with adult men who use violence against women and adolescents who use violence in the home, key differences such as adolescents' dependence on adults for nurturing and safety, their developmental needs and a focus, where it is safe, on family reparation require divergent approaches. Adolescents do not have access to the power of adult men and may be concurrent victims as well as perpetrators of violence. Adult men who use violence in the home are grown men, and fully responsible for their violence

Best practice intervention for adolescent violence in the home is influenced by attachment and trauma, systems, family violence, feminist and child development theory. Practitioners

such as Perry (2001) and Shonkoff (2002) highlighted the link between victimisation and offending in their work on attachment and trauma. Given many perpetrators of adolescent violence in the home may also be victims of child abuse or family violence, it is important to move away from conceptualising parents as 'victims' and adolescents as 'perpetrators'.

Best practice response:

- engages adolescents who would not otherwise engage with 'the helping professions'
- uses the 'velvet hammer of the law' to send a strong message the use of violence is unacceptable
- maximises family members' safety by ensuring the violence is addressed by mandating the adolescent (and their family) to attend treatment
- provides a coordinated and integrated response across child protection, youth and youth justice, police, mental health, alcohol and drug, schools and family services
- addresses co-occuring risk factors
- maximises opportunities for adolescents to make change (evidence suggests most adolescents will only change if their parents also change)
- provides opportunities for adolescents and parents to make change and learn new ways to relate and communicate
- provides a peer based mechanism for supporting and 'audiencing' change
- provides a 'mirror' for parents and adolescents about their behaviour and its effects
- provides an opportunity to make amends and for family reparation.

Referral pathways

Adolescents frequently refuse to engage with services. For this reason a best practice response is one where the 'velvet hammer of the court' can mandate them to engage and actively participate. Court based programs such as Toledo, Ohio and Seattle, Washington's 'Step Up' program and San Francisco Youth Family Violence Court offer an entry point where parents have called police because of their adolescent's violence. Adolescents are given a court option to be charged with an offence or attend a parent/adolescent treatment program. Almost all choose to attend the program.

Whilst there is debate about the value of being mandated to attend treatment programs (particularly in relation to men's behavioural change programs), feedback from parents and adolescents about their participation in 'Step Up' reveals the high regard the program is held. Despite initially not wanting to attend, adolescents become engaged and make significant change.

Screening and Assessment

Assessment needs to take account of the unique characteristics and context of the adolescent and family members and is seen as a 'process, not an event' (Washington State Juvenile Court, 2004). This means a shift away from blaming individual family members – the adolescent for the violence, the parent for shortcomings in parenting – and focusing on meeting the needs and goals of family members and increasing family safety.

Assessment provides an opportunity to 'unpack' the story behind the adolescent's use, and parents' experience of violence. Assessment ascertains whether individual and/or family based interventions should be used and provides information to begin a process of reparation or 'making amends' as part of treatment. Assessment must be undertaken separately with mothers and fathers, as 65% of adolescents reported experiencing family violence, with 88% identifying the father as the abuser (Buel, 2002, 6). Adult family violence

and the consequent safety issues must be addressed before the adolescent can address their own use of violence.

The 'Step Up' program assessment is undertaken by the program coordinators; in collaboration with other relevant agencies, such as mental health services and youth probation.

Assessment for adolescents should consider:

- type, severity and frequency of their violence to others
- past or current experience of child abuse, family violence and trauma
- associated risk factors for abuse and violence, including alcohol and drug use, poor mental health, disengagement in education, training and/or employment
- attitudes and values which support violence to others
- safety – their own and others
- parental discipline (to screen for parental abuse to adolescents)
- violence to siblings
- family relationships and dynamics
- emotional connection with family members – parents, siblings and extended family
- their understanding of why they use violence, the effects and consequences of their violence (on self and others) and willingness to take responsibility to make change
- risk and protective factors
- motivation to make changes in their use of violence and in their relationship with family members.

Assessment for parents should consider:

- safety – their own and other family members
- past or current experience of family violence, child abuse and trauma
- adolescent's child development history
- parental risk factors including mental health and drug and alcohol problems
- impact of the adolescent's violence
- contexts and patterns of the violence
- parenting and discipline styles
- parental alignment
- parental strengths – strongly aligned parental values and attitudes, ability to nurture, strong and positive parenting style
- capacity to protect the adolescent's siblings
- family context including housing, financial position, community linkages and supports, other family members' support
- motivation to make changes in parenting and in the relationship with the adolescent.

Safety assessment

Screening for adolescent violence in the home should mirror screening for men's violence to women, and explore risk and safety factors for all family members, type, severity and frequency of violence and the impact on parents, carers, siblings and pets. Domestic violence risk and safety assessments are useful to adapt to adolescent violence in the home. A safety assessment screens for adult family violence as well as the adolescent's use of violence.

Male and female adolescents who are violent in the home may hold strong gender stereotypes that male control and domination over females is normal and acceptable. They may believe girls and women are of lesser value and importance than men and boys (Canadian Children's Rights Council, 2002). Beliefs and attitudes about gender and violence should be a lens in assessment which informs treatment and group process.

Whilst factors such as parental discipline or parent/child attachment are components of parental assessment, it is important not to give the adolescent the message their abuse is justified or can be blamed on parents. If the adolescent violence is occurring in a context of an adolescent living with an adult perpetrator of violence against them and/or other family members, the adult family violence must be addressed before therapeutic work can commence to address the adolescent's use of violence.

Assessment may need to include the possibility for respite care in response to immediate safety issues and/or give family members 'breathing space'. Where it is unsafe for the adolescent to remain at home child protection is notified. Where assessment identifies issues precluding the adolescent's or parents' participation in the program, referral is made to the relevant agency, for example drug and alcohol treatment for these issues to be addressed before the family can attend 'Step Up'.

Treatment

Treatment requires the therapist to be both an advocate for the adolescent, for example to support their engagement in school, whilst at the same time holding them accountable for their use of violence.

Five core components in working with families where the adolescents use violence in the home are:

- Safety – of the adolescent and other family members
- Accountability and responsibility for the use of violence
- Empathy and 'making amends'
- Respect
- Non violent problem solving[2]

Key treatment goals with adolescents include:

- taking responsibility for behaviour and being accountable for the effects of their behaviour on others
- demonstrating empathy for those they have abused and assaulted
- deciding on and implementing actions to 'make amends' for their use of violence
- learning skills such as non violent conflict resolution, 'time out' techniques and assertive communication
- engagement in work, training or school.

Key treatment goals with parents include:

- exploring family history, particularly adult family violence, and its impact on their child and their parenting
- 'making amends' for abusive, harsh or violent parenting

[2] This section on 'Treatment' is strongly influenced by the 'Step Up' program guidelines and parent and adolescent workbooks.

- learning new skills such as boundary setting, use of consequences, 'time out', communication, conflict resolution and encouraging responsibility and accountability for behaviour in their child
- restoration of family relationships (where it is safe to do so)

Case coordination/case review

Case coordination is an important component of treatment due to the multiplicity of complex issues most adolescents and parents will be facing. Case coordination and case review provide a mechanism to plan and monitor treatment goals for cessation of violence. Case review provides an opportunity to monitor and witness change and celebrate positive gains. One agency, for example a juvenile justice facility or family service, will hold a case coordination role. Case coordination has a strong focus on communicating and coordinating with relevant agencies, particularly schools. Maintaining the adolescent's connection to school is a strong protective factor for positive family life and in decreasing other risk factors. 'Step Up' particularly prioritises building relationships with schools, including 'alternative' schools. Most courts delivering adolescent violence in the home programs also have strong partnerships with drug and alcohol and mental health services, including drug treatment courts.

Regular case coordination/case review meetings include participation by all agencies involved in the family's care, as well as the family. This might involve mental health, child protection, drug and alcohol, school welfare, police, probation, victims' services, as well as family members. Some court based programs' case coordination meetings are chaired by the court judge.

10.1 Court based group counselling models

Several collaborative models between the police, courts and youth and/or domestic violence justice systems in the United States demonstrate success in adolescent violence in the home treatment[3]. These programs begin from the standpoint adolescent's sense of entitlement is predictive of abusive behaviour (Buel, 2002, 6). These diversionary models borrow in part from men's behavioural change approaches to family violence prevention; particularly the domestic abuse intervention program (Minneapolis) and a cognitive behavioural treatment model. They also influenced by systemic and structural family therapy, feminist, attachment and trauma and child development theory. Children and adolescents over 10 years of age and their parents and carers are able to participate.

'Step Up', is an integrated, evidence based program that supports adolescents who use violence against family members to stop the violence. 'Step-Up' was instigated in 1997 in response to the high number of cases of adolescent violence toward family members presenting in Seattle's juvenile court. In 1997, 606 counts of family violence were filed, a 100% increase since 1995. The majority of these cases involved an adolescent assaulting a parent (Ashley, 1998). The percentage of female offenders (ranging from 20% to 32% during the five years from 1992 to 1996) and of male victims (ranging from 22% to 28%) were also considerably higher than for family violence cases handled in adult courts (Ibid). Most offences were against the mother of the offender (Ibid). The court model was based on evidenced based practice to reduce youth offending across all youth offending domains.

[3] The 'Step Up' program curriculum can be accessed online http://www.kingcounty.gov/courts/Clerk/DomesticViolence/Step-Up.aspx or http://www.mincava.umn.edu/documents/stepup/intro/stepupintroduction.html

'Step Up' is delivered in Seattle, Washington (where it originated), three locations in Illinois (Dupage County Juvenile Court, Cook County and Peoria County), and Toledo, Ohio. A juvenile court in Winconsin is soon to commence the program.

There are slight differences between the programs, for example Toledo has a family violence court (incorporated in their juvenile court) and judge but Seattle does not. 'Step Up's' coordinated community response comprises the family violence court judge, probation officers, police prosecutor, lawyers and community agencies. It comprises a 20 week program in which parents and adolescents participate. High risk adolescents (those with two or more co occurring issues) receive 'wrap around' family support, coordinated by 'Step Up' with treatment providers.

Parent participation in 'Step Up' is mandatory. 'Step Up' has strong links with mental health, child protection, alcohol and drug and schools to enable a coordinated, holistic and integrated response. For example there are eight education and employment programs to which adolescents can be referred (King County Juvenile Court Intervention Services, 2010). The program is successful in addressing other risk factors for adolescents including drug and alcohol use, academic failure and mental health problems. It has an almost a 100% success rate in terms of adolescent recidivism for violence in the home.

Both Seattle and Toledo courts deal with adolescent violence in the home and with adolescent perpetrators of violence in intimate relationships. The Coordinated Community Response[4] model used for adult domestic violence (daip, 2010) has been adapted to inform key elements of coordinating systems that respond to adolescent family violence. Elements include the development of protocols for probation follow-up of family violence offenders, communication between treatment providers and probation and consistency in response to family violence offenses.

A police training video on adolescent family violence educates responding officers about mandatory arrest laws, how to communicate with victims and assessing and responding to family safety issues. The response of the criminal justice system to adolescents who are violent in the home has significant impact on the outcome for the adolescent and their family. Coordination between 'Step-Up' and the juvenile justice system has been crucial to its effectiveness in helping adolescents change their behavior.

Most adolescents who use violence in the home will neither disclose their use of violence nor engage with services to address their violence. 'Step Up', delivered through the juvenile justice court, enables engagement with adolescents because they are court mandated to attend. Adolescents who attended the 'Step Up' program reported being in detention was a significant incentive to making changes. Whilst neither adolescents nor their parents commonly want to undertake the program, most reflect participating has enabled significant improvement to their lives and has been invaluable in supporting more positive, caring and productive family relationships. They are glad they participated.

Slight differences in approaches exist between Seattle and Toledo but in essence when adolescents are arrested because of their violence, their participation in 'Step Up' means they will not have a criminal record. The prosecutor makes the decision whether or not to file charges, or send the case to Diversion (if it is a first or second time non-felony offence). The only input the parents have is when the Victim Advocate in the Prosecutor's office talks

[4] An effective CCR enables practitioners and advocates to analyse problems and to implement meaningful changes in how things are done in a coordinated, integrated and systemic manner.

with them about the violence. The Victim Advocate assesses the risk level to parents and family members and informs the prosecutor in order to support decision making as to whether the adolescent is too high risk to go to Diversion. If they go to Diversion and follow the counselling ordered (such as 'Step-Up') the charges are dropped and there is no criminal record. If they do not go to Diversion, the court process is applied; they are charged and go on probation. Participation in 'Step-Up' is a condition of probation. If adolescents drop out of 'Step Up' they are required to face court.

The 'Step Up' Seattle Victim Advocate program in the prosecutor's office is unique. Most juvenile courts in the United States do not have this. It is modelled after adult domestic violence court victim advocate programs which provide information and support to the victim, (including attending court) explain the court process and do a domestic violence risk assessment to provide information to the court about the severity of the violence.

When adolescents are arrested they are taken to a juvenile justice centre and held in detention until the next working day when they attend court. The judge is privy to the context in which the violence occurs and hears the adolescent's, parents' and agencies' viewpoints. A Diversion Committee can also order the adolescent to make undertakings as part of diversion. The judge can order Conditions of Release in order to be able to go home from detention, which may include curfew, school attendance, no unwanted physical contact, following a Step-Up Safety Plan etc (Anderson & Routt, 2010).

Pathways to 'Step Up' in the United States include a police response where the adolescent is arrested and held in detention (usually for no more than 24 hours until the next available court hearing). Adaptation of the Step Up program model to an Australian context would probably not include the element of detention or custody for a number of reasons including cultural differences about detaining adolescents, the lack of detention facilities, cost, resourcing and lack of existing processes.

Assessment is undertaken pre- and post program participation. This also informs evaluation. Assessment includes a behavioural checklist which covers:

- adolescent's use of violence (types, frequency, severity)
- social, mental health, alcohol and drug use and family history
- current and past adult family violence
- safety of family members and parental level of fear
- school – attendance, issues, challenges, support needs
- community involvement – social and community connection
- need for other services such as a drug/alcohol evaluation or mental health evaluation

Parents and adolescent are interviewed separately so both feel safe about disclosing information. Contraindications for adolescents attending the program may include significant mental health, alcohol and drug use and developmental or learning disabilities problems which interfere with the adolescent's ability to function and learn in the group. Adolescents with untreated alcohol and drug use or mental health issues are assessed and treated before attending the Step-Up program.

Many parents report being afraid to have their adolescent home once they are released from custody. For this reason, adolescents and parents develop a safety plan to prevent violence against family members and for parents to respond to violent behavior.

A safety plan is negotiated by the court, for example when the adolescent has their first court appearance or by 'Step Up' facilitators. It is developed with the parents, adolescent and 'Step Up' coordinator. Safety plans can be an important immediate response as well as used later to reinforce parent/adolescent agreements and reparation.

A safety plan:

- assesses safety concerns when parents are reluctant to have their adolescent released home because of violent behavior
- articulates a step-by-step plan about the adolescent's steps to prevent violence and how the parent will respond if violence occurs again
- involves family members with intervention as soon as possible ('Step Up' 2010).

Group work components of 'Step Up' include psycho-education (for example to explore the contributing factors to the adolescent's use of violence), discussion and weekly check in (where adolescents are tracked on both the 'abuse and control' and 'respect' wheels). Using a cognitive behavioural skills based approach helps adolescents learn ways to prevent violence and abuse, and parents learn effective parenting that supports non-violence in the home.

Components include a weekly check-in and learning a new skill. The program is delivered concurrently to adolescents and their parents with some specific adolescent and parents sessions. For this reason two facilitators need to deliver the program.

Parent sessions cover:

- learning ways to be safe
- understanding abusive behaviors
- modeling respectful behavior
- new options for limit setting
- adolescents' needs
- supporting positive change
- building a more positive relationship
- supporting yourself through change.

Adolescent sessions cover:

- understanding abusive behaviors
- identifying and understanding beliefs that support abusive behavior and respectful behavior
- gaining control over negative thoughts and feelings
- respectful communication
- accountability for abusive behavior
- understanding and expressing empathy
- ways to resolve conflict.

Concurrent parent/adolescent sessions cover:

- accountability
- violence prevention
- conflict resolution
- respectful communication ('Step Up' Seattle, 2010).

Case conferencing continues monthly in Toledo, Ohio whilst the adolescent is attending 'Step Up'. Monthly meetings are held in the court and presided by the judge. All parties involved with the family attend to review participation and progress and to problem solve challenges to change. Case conferencing is seen as therapeutic – for example an adolescent may read a 'making amends' letter written to his mother to the court and the judge comments on her/his experience of 'witnessing' this change. The judge may also reward a particularly remarkable change by giving the adolescent a reward such as a movie or CD voucher.

'Step Up' has been evaluated three times by independent research since 1997. Outcomes showed significant reduction in adolescents' use of violence and abusive behaviour. Adolescents who completed 'Step Up' had significantly lower recidivism rates than the comparison adolescents who were on probation with family violence charges. 'Step Up', Seattle notes overall fewer than 6% of adolescents choose not to complete their agreements and are sent back to the prosector's office for filing of charges in court and 95% complete diversion successfully ('Step Up' presentation, 2010).

The results from the 'Step Up' program Toledo reveal that out of 48 adolescents who graduated from the 'step up' program in the first two years, (July, 2007 - June, 2009), only 4 have had additional domestic violence charges filed.

Court based diversion is extremely cost effective. It costs US$450 per day for an adolescent to stay in detention, far less to deliver a group program. Prior to 'Step Up' adolescents were held in detention longer when parents expressed concern about release for safety reasons ('Step Up' Introduction, 2010).

10.2 Parent focused interventions

Many adolescents do not acknowledge their use of use of violence, nor engage in treatment. In the absence of parent/adolescent programs like 'Step Up' the majority of interventions focus on supporting parents to make change. Parent focused interventions are frequently based on systems and structural theory which explore family dynamics, challenge the adolescent's use of power and control over family life and support parents to regain control and authority through setting and maintaining limits and boundaries.

Parent based interventions support parents to change their parenting in order to attain treatment goals. Group programs offer additional support through hearing other parents' experiences. Whilst parent only programs are beneficial, not involving adolescents in assessment means issues such as abusive parenting, parenting drug and alcohol use, conflictual parental relationships and family violence may be overlooked.

Sole mothers

Sole mothers represent the highest demographic of parents who experience violence from their adolescent. Intervention with sole mothers needs to assess their own experience of violence and the impact of this on their parenting and child. Acknowledgement of additional challenges faced by sole mothers including lack of back up support, financial hardship and an undermining father who sides with the violent adolescent supports sole mothers to move away from guilt and self blame.

Programs for sole mothers of adolescents may be beneficial because they enable sole mothers to support each other and have a specific focus on sole parenting.

11 Best practice and evidenced based prevention

Preventative approaches mitigate risk factors and enhance the protective factors for adolescent violence in the home. Protective factors are characteristics or conditions that act as risk moderators, which help reduce the negative effects associated with risk factors. Primary prevention strategies need to target at risk populations such as women and children leaving family violence, as well as mainstream populations such as parents of primary school aged children. Adolescent violence in the home, like adult family violence, requires continued efforts to challenge the broader social/political forces that contribute to and reinforce violence in our culture (Monk, 2010).

An ecological framework for prevention addresses the determinants for adolescent violence in the home at societal, community and individual/relationship level. At a societal level, similar strategies used to prevent adult family violence also contribute to prevention of adolescent violence in the home. These include:

- changing organisational and workplace cultures
- communication and social marketing
- advocacy
- legislative and policy reform
- research, monitoring and evaluation (VicHealth, 2007).

Adolescent violence in the home is curiously absent from legislative and policy documents despite a clear need to implement preventative strategies at a societal level. These strategies include naming and responding to adolescent violence in the home in policy and programmatic reform across child and family services, child protection, youth, youth justice, family violence, mental health and drug and alcohol policy. Policy and program reform on adolescent violence in the home should highlight the importance of a coordinated community response and the importance of engaging adolescents in treatment.

Any intervention which supports children to reach their full potential and parents to parent effectively is a protective factor for adolescent violence in the home. Community strengthening interventions which address the broader risk factors for adolescent violence in the home include school based programs which give adolescents skills and techniques to improve communication, enhance problem solving and conflict resolution skills and build self esteem. These programs operate on the premise skill building will improve adolescent resilience and reduce the risk factors for violence. School based programs are frequently delivered in partnership with other services such as women's shelters. 'Start Strong'[5] and 'That's Not Cool'[6] are examples of programs developed by the San Francisco Family Violence

[5] Start Strong: Building Healthy Teen Relationships is designed to prevent intimate partner violence by working in communities at the individual, interpersonal, community, and policy levels to help 11 to 14-year-old youth develop healthy and safe relationships. website: http://www.startstrongteens.org/about/contact

[6] That's Not Cool is a national public education campaign designed to prevent teen dating abuse. Developed by the Family Violence Prevention Fund, in partnership with the Department of Justice's Office on Violence Against Women and the Advertising Council, That's Not Cool uses digital examples of controlling behavior online and by cell phone to encourage teens to draw their own line about what is, or is not, acceptable relationship behavior.

Prevention fund and delivered in partnership with schools. Whilst they specifically focus on 'teen violence', they are highly applicable to prevention of adolescent violence in the home. One off programs do not sustain change; programs need to be long term and integrated in school communities to be successful. They need to involve parents and community as well as adolescents. Research indicates programs based in preschools and primary schools have greater opportunity for success – the earlier the intervention the better.

Most prevention occurs at the individual/relationship level through direct participation such as parenting programs. Specific windows of opportunity for prevention lay in the interrelated areas of enhanced support to:

- women and children who experience family violence,
- children with trauma and attachment issues, particularly those in out of home care
- children at risk of academic failure and school drop out
- pregnant women and parents.

11.1 Women and children who experience family violence and trauma

Not all children with risk factors for adolescent violence in the home become violent, although children who experience trauma and abuse may have reduced capacity to feel empathy and functionally socially, which makes committing violent acts more likely (Garbarino, 1999). Attachment disorder in infancy is one potential cause for violent and/or aggressive adolescents

Women who experience family violence face a dual challenge. At the same time as others are trying to overcome the effects of violence on themselves they are parenting children who may be 'acting out' and have challenging and difficult behaviour. Mothers own experience of trauma may leave them anxious, depressed or suffering from post traumatic stress disorder. This makes it very difficult to respond appropriately to their children's 'acting out' whilst their child may engage in behaviours likely to exacerbate their mother's maladaptive responses (Lieberman et al, 2005, 17).

The increased evidence of disruption of mother/child attachment by the experience of family violence points to a need for intensive early work with mothers and children to strengthen the mother/child bond and attachment and support children to reach developmental milestones they were unable to because of their exposure to violence or trauma[7]. Research demonstrates the best predictor of a child's recovery from family violence is the relationship they have with the non offending parent or care giver. A mothers' awareness of the developmental risks for a child who has experienced family violence can motivate her to engage in parenting programs or counselling to reduce this risk.

These programs recognise:

- the importance of early life experiences, as well as the inseparable and highly interactive influences of genetics and environment, on the development of the brain

[7] Lieberman and Van Horn (2005) have significantly contributed to understanding the relationship effects of family violence and the opportunity to repair this through dyadic work. Their manual, "Don't Hit My Mommy: A Manual for Child-Parent Psychotherapy for Young Witnesses of Family Violence, 2005" addresses behavioural and mental health problems of infants and young children. Their approach is described as a relational- based model that focuses on the child-parent relationship. The goal of intervention is to increase the parent's and child's age appropriate capacity to be emotionally attuned to each other's motivations and needs, and changing mutually reinforcing negative interactional patterns.

- the central role of early relationships as a source of either support and adaptation or risk and dysfunction
- the powerful capabilities, complex emotions and essential social skills develop during the earliest years of life
- the capacity to increase the odds of favourable developmental outcomes through planned interventions (Shonkoff & Phillips, 2002).

Interventions with mothers focus on supporting her to:

- understand and recover from the effects of violence
- re-establish the relationship with the child outside the context of violence
- support, protect and nurture her child
- make sense of her feelings about the perpetrator of the violence and the child's relationship with the perpetrator.

Interventions with children focus on:

- achieving skills such as affect regulation, communication and impulse control
- learning non-violent conflict resolution
- behavioural and social skill enhancement
- academic skill promotion and school readiness

Interventions with women and children are frequently delivered by women's refuges and family support services, often in collaboration with infant and child mental health services[8]. Interventions privilege children's decision making, so children develop and direct therapeutic interventions, in partnership with the therapist. The clinical expertise of child and adolescent mental health clinicians supports refuge and community workers to understand and address the trauma of family violence with children and provides clinical assessment and interventions in more complex cases.

Programs like the Child Parent Psychotherapy Model (CPPM) (Lieberman et al, 2005) focus on strengthening mother/child attachment post family violence. The CPPM promotes child mental health through supporting mothers to be more responsive to their child's emotional and developmental needs which in turn builds the child's trust in the mother.

CPPM is a strengths based approach which acknowledges most of a young child's development occurs in the context of their relationship with their primary care giver (usually the mother). The CPPM supports the child to see her mother as offering safety and stability, in opposition to the experience of family violence which can compromise mother/child attachment. The therapeutic intervention provides opportunities not as easily accessible when there is a context of family violence – mothers are encouraged to enjoy and appreciate their children and to consider their developmental stages and behaviours.

An evaluation undertaken after 12 months showed children improved significantly more than those who were case managed and received community based treatment. Improvement was assessed by decreased behavioural problems and decreased traumatic stress symptoms.

[8] A number of women's refuges in the US and Canada have forged partnerships with child and adolescent mental health to develop and deliver these programs.

Therapeutic interventions can be supported in voluntary community setting where women may experience less stigmatisation than in clinical settings. Good outcomes can be achieved through playing and talking with children; by listening about their experience in the home and exploring their strengths and coping skills.

Programs to support mothers and/or children will obviously need to take into account the age and developmental stage of the child, gender, safety and risk factors and other variables in order to ensure they are relevant and meaningful. Mothers and children will be at different developmental stages and process the experience of violence differently. This means programs should provide both individual and dyadic therapy.

11.2 Women who are pregnant and living in family violence

A partnership between San Francisco General Hospital and obstetrics/gynaecology at San Francisco General Hospital supports pregnant women of violent men until their newborn baby is 6 months old. Where possible, and with the woman's consent and assessment of their safety, fathers are involved in the therapeutic process. Men are also referred to men's behavioural change programs and/or substance abuse and mental health programs.

Parenting programs for pregnant and new mothers need to include education about attachment, bonding and infant development. These programs should be mainstream and easily accessible to all women.

11.3 Mentors

A number of programs in the United States and Canada utilise mentors to support children and adolescent s at risk of using violence to others. The Kempe Centre Colarado coordinates a mentor program using university students, for children and adolescents in their mental health program.

The Coaching Boys Into Men campaign (San Francisco Family Violence Prevention Fund) invites men to be part of the solution by teaching boys violence never equals strength. The program engages athletic coaches through the Coaches Leadership Program to help shape the attitudes and behaviors of young male athletes. Because of the special relationship between coaches and players, coaches are poised to positively influence how young men think and behave both on, and off, the field. From speeches to the team, practice sessions, or simply casual conversation, coaches have many opportunities to impart their philosophies to athletes

11.4 Coparenting models where children have experienced family violence

Much of current therapeutic practice to support children who experience family violence focuses on mother/child attachment. Fathers are rarely involved in the therapeutic process. Therapeutic dyadic work with violent fathers and their child is controversial with concerns the mother's and children's safety may be compromised.

Whilst delivering therapy and group programs to men who have been violent is controversial, the reality is most children will have some form of contact with their father and/or parents may reunite at some stage. Criticism of the Family Court includes that it remains essentially adversarial and orders children on contact visits to violent fathers with inadequate regard for risk factors, inadequate communication with Child Protection, and a naïve optimism about their physical safety, let alone their emotional wellbeing (Johnson, 2009). For this reason, and because many mothers request parenting intervention with their partner, therapeutic work with violent fathers is worth consideration.

Best practice approaches to support mothers post violence are those that support her to process her feelings about the perpetrator of the violence and the child's relationship with him. This does not mean mothers should be encouraged to support the father/child relationship but it is important mothers understand their own experience of the violence and their feelings about the perpetrator may be very different from their child's.

San Francisco General Hospital in partnership with the San Francisco Family Violence Court and San Francisco Women's Shelter delivers a co-parenting model where a therapist works with mother/child and father/child dyads. This voluntary program aims to increase parental awareness of the impact of the violence/trauma and parental separation on the child and to work with both parents to better meet the child's emotional needs. Children attend therapy twice a week for a year; once weekly with their mother and once weekly with their father.
Families are referred through the family violence court. Participation in therapeutic work does not preclude a criminal justice response where a partner has been violent. The therapist is clear with the offending father the goal of therapy is to support the child's recovery from trauma and to pave the way for an enhanced father/child relationship. Fathers must give consent for information exchange between the men's behavioural change program they participate in and the program.

The program's evaluation domains include enhanced parental relationship (including increased safety of the mother and child), reduction of post traumatic stress symptoms and how these impact on the parent/child relationship and improved child development. Summative evaluation demonstrates increased parental focus on the needs of the child and some improvement in parental relationship with increased parental cooperation in relation to the children's wellbeing.

Some men's behavioural change programs are also reorienting program components to violent fathers (Duluth, 2010). Whilst the primary focus remains the safety of women and children, the program includes opportunities for fathers to learn about the impact of their violence on children and their mother, understand child development and take responsibility for minimising negative outcomes.

11.5 Parenting programs

Mainstream parenting programs provide support to parents and opportunities to learn about their child's developmental needs and new parenting skills. Parenting programs should be available to respond to different childhood ages and stages including preschool, primary school and adolescence. Some parenting programs can be targeted to specific risk populations such as sole mothers with sons (Howard, 1999) or women who have experienced violence, fathers or fathers who have used violence against partners.

12 Key principles working with adolescent violence in the home

Safety of others

Ongoing assessment of, and response to safety concerns of family members, including siblings, through regular check in with parents and siblings and agencies working with the family.

The perpetrator of violence is responsible for their violence

Adolescents who use violence are solely responsible for this behaviour, even if they have experienced violence themselves. Taking responsibility for violent behaviour is a pre-requisite for stopping it.

Lasting behaviour change involves attitude change
Effective change involves challenging attitudes that support the adolescent's use of violence. These attitudes may include the acceptability of power, control and violence and attitudes about the lower status of girls and women. Behavioural change will not be consolidated unless these attitudes change.

Parents, as well as adolescents must be involved in treatment where possible
Adolescent violence in the home is a product of interrelated determinants. A systemic approach that engages parents and the adolescent ensures treatment is cognisant of the many contributing factors that support adolescent violence.

Care coordination
Adolescent violence in the home usually co-occurs with other issues. Care coordination is vital to ensure all agencies have a shared vision for treatment and change, acknowledges the violence and its impact and prioritise the safety of all family members.

Making amends and empathy
The ability to empathise is a key attribute to stopping the use of violence. Adolescents are able to understand it is morally wrong to hurt others, to exercise inappropriate power over others is a violation of human rights and to stop using violence benefits the adolescent, as well as their family members.

Dealing with frustration, conflict and anger
The move to non-violence involves learning to deal with negative emotions, particularly stress, and regulate and contain negative emotional states. This requires learning non violent conflict resolution and accepting reasonable adult boundaries and limits.

Delayed gratification
Adolescents must learn to delay, rather than demand, gratification. Learning to plan and wait to achieve wants and needs is one way to take responsibility.

Adolescents need the ability to respect the needs of others
Adolescents who use violence are typically self centred. 'Other centredness', where the needs of all family members are considered and respected, is important to support respectful family relationships.

Addressing adolescent violence in the home contributes to broader family violence prevention
Adolescent violence in the home is one form of family violence. Intervention with adolescents to stop their use of violence must be part of the service system to prevent family violence and support the safety and wellbeing of those who experience it.

(Adapted from Howard & Wright, 2008)

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