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POLICING CHILDHOOD CHALLENGING VIOLENT OR AGGRESSIVE BEHAVIOUR:

RESPONDING TO VULNERABLE FAMILIES



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***Policing Childhood Challenging Violent or Aggressive Behaviour:
responding to vulnerable families***

In the varied topography of professional practice, there is a high, hard ground overlooking a swamp. On the high ground manageable problems lend themselves to solution through application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solution. Schon (1987)

The aim of the project informing this report set out to critically analyse ***Policing Childhood Challenging Violent or Aggressive Behaviour: responding to vulnerable families*** by reflecting on more than 9 months of reported incident data. There is an accepted barrier in developing analysis of Childhood Challenging, Violent or Aggressive Behaviour (CCVAB) due to the 'nature of the beast'. Generally speaking, families do not, or will not, discuss violence in the home in most situations: be this adult to adult/ child to adult/ adult to child. For this reason, the data analysed only represents those families who were in contact with Northumbria Police during the data collection period; and in all probability represent the 'tip of the iceberg'.

It is acknowledged the data is an insight only rather than a whole view of CCVAB across Northumbria Police force operational area. This insight is a necessary step for developing a more informed approach to ***Policing Childhood Challenging Violent or Aggressive Behaviour***. An exploratory research approach was applied for establishing a new approach to recording incidents or APVA as described by the Home Office Guidance, involving those aged 13-16 years and allow flexibility to MASH personnel to include a wider range of incidents if, in their professional opinion, they determined the incident was APVA (but included children younger than 13 years or older than 16 years). It is understood in academic terms the robustness of information gathered does not reflect rigorous research protocols, however the information gathered does support exploratory research frameworks. Exploratory research allows exploration of existing problems rather than expecting a final or conclusive solution for problems to be determined¹. The purpose of collating the data enabled a more detailed understanding to build over time that may provide the basis for future 'action research' projects to be developed

To generate the data, Northumbria Police embarked on a new way of documenting calls for assistance from families relating to CCVAB incidents. For some families the request was made after they had either spoken to, or tried to speak to, the Duty Social Work team. For other families the request for help was made when their own attempts at de-escalating the situation failed. Whilst Northumbria Police had attended many

¹ See for example Bulmer, 1977; Crotty, 1998; Stebbings, 2001; Cohen et al, 2005; Bryman, 2015; Walliman, 2015

incidents over time for CCVAB these historical incidents tended to be recorded as a range of criminal behaviour in the same way Domestic Violence can be recorded as a series of criminal behaviour, ranging from Assault to Public Affray.

At times the officers attending are unable to offer any real intervention due to the age of the child involved, something that is beyond their control. For this reason, the thoughts of Schon come to mind where *'In the varied topography of professional practice, there is a high, hard ground overlooking a swamp...'* or the 'outsider' professional lens that CCVAB is seen. The professional lens (such as that of a responding officer) can allow for application of theory, where *"On the high ground manageable problems lend themselves to solution through application of research-based theory and technique"*. In practice this would include the Home Office Guidelines for Adolescent to Parent Abuse (2015). Unfortunately, the Home Office Guidance does not include advice on what to do for any child under the age of 'Adolescence'. This oversight means there is no mechanism for the police to detail the incident other than refer the family to relevant Child Service agencies. Current and previous evidence from research and working with families experiencing CCVAB details how CCVAB can commence from age 2-3 years and more frequently commences between the ages of 6-9 years than at any other age. This means that at the time of police involvement the escalation of CCVAB behaviours may have been ongoing for more than 6 years, without any intervention, support or professional awareness of the situation. This unreported and unsupported position can leave families *'In the swampy lowland,'* where *'messy, confusing problems defy technical solution'*. For this reason, recording police response to incidents for CCVAB has allowed Northumbria Police to gain insight into the incidents their officers attend and the age range of those involved. This dataset captured age, behaviour displayed, localities and how many siblings witnessed CCVAB. The information generated provides an informed overview of 'Policing CCVAB' in Northumbria Police force. This collated information can help inform operations and responses by officers in the future. The process of recording incidents in this way is both innovative and insightful and can support new approaches as well as contributing to the national debate currently ongoing at the Home Office.

To enable Northumbria Police to develop officer responses a dataset was established in January 2019, the purpose being to record incidents officers attended, identified as APVA under the Home Office guidance. Northumbria Police MASH units were instrumental in supporting the new approach. Awareness Raising Training was provided to officers about APVA, with MASH units applying this new recording system to child or adult notifications being submitted via the unit to help ensure detailed aspects were recorded and noted, for example, if siblings were present in the home and the age of siblings. The dataset was implemented across Northumbria Police from mid-March 2019. In December 2019, the information collected was passed to the research team for analysis. The dataset was established to support the aim of

the study and provide sufficient information for analysing police responses to Childhood Challenging, Violent or Aggressive behaviour.

The sections in this report present the findings mapped to the objectives for the project including:

- Current discussion relating to CCVAB- what it is and how this is defined
- Objective 1: Prevalence of CCVAB responses made by Northumbria Police
- Objective 2: Pre-indicators for CCVAB behaviours that lead to the request for police intervention
- Objective 3: Commonality of behaviour traits displayed requiring police response
- Objective 4: Outcomes for children displaying CCVAB in contact with Northumbria Police
- Recommendations for future 'Policing of Childhood Challenging Violent or Aggressive Behaviour and responding to vulnerable families'

Glossary of terms

ACE:	Adverse Childhood Experience
APVA:	Adolescence to Parent Violence and Abuse
CCVAB:	Childhood Challenging Violent and Aggressive Behaviour
CPVA:	Child to Parent Violence and Abuse
Child/ children:	<p>For the purpose of this report the term 'child', 'children' and 'childhood' recognises that:</p> <ul style="list-style-type: none">• in the United Nations Convention on the Rights of the Child (UNCRC) a child as anyone under 18 years of age (Office of the High Commissioner for Human Rights, 1989)• the notion of anyone under 18 years is also applied across legislation in England, Wales and Northern Ireland. <p>This means discussions about CCVAB in the home can include all children and young people under the age of 18- United Nations Convention on the Rights of the Child (UNCRC) an age is also used in legislation across England, Wales and Northern Ireland. and if adding the Special Educational Needs and Disability (SEND) indicators, all children and adolescents up to the age of 25 years (as noted within the Children and Family Act, 2014).</p>
DV	Domestic Violence is more readily referred to as Domestic Abuse by Northumbria Police however many organisations do continue to use Domestic Violence. The use of 'Domestic Violence' in this report recognises that wider use is still used
EHCP:	Educational Health Care Plan
NVR	Non-Violent Resistance: the NVR approach began in civil right movements and has been adopted and developed to help families cope with CCVAB. NVR success is based on research studies to date and has helped support all types of families. NVR has proved significantly successful for adoptive and foster care families as well as those providing Kinship care. The purpose of Non-Violent Resistance is to identify ways in which family members can work with the child displaying CCVAB in a way that supports the child and helps de-escalate situations or CCVAB episodes. For some children previous experiences of ACEs inform their behaviour whilst for other children a diagnosis of SEND may limit their ability to discuss their feelings, leading to CCVAB occurring
Parent:	for the purposes of this report we use the term 'parent' to mean anyone who has parental authority or is in the parental position for the child in question, rather than any biological or 'marriage' related relationship to the child in question.
RESPECT	Respect Young People Programme (RYPP) -The RYPP is for families where children or young people aged between 10 and 16 are abusive or violent towards the people close to them, particularly their parents or carers. The programme avoids blame and works together with both the parents/ carers and young person, seeing them all as part of the solution. The programme is designed to enable families to identify negative behaviour patterns and work towards positive outcomes. The RYPP is delivered via weekly structured sessions and takes about 3 months to complete.
SEND:	Special Educational Needs and Disability
VCB:	Violent Childhood Behaviour

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Section 1:

Defining Childhood Challenging, Violent or Aggressive Behaviour

How Childhood Challenging Violent or Aggressive Behaviour (CCVAB) is discussed both historically and more recently was instrumental in establishing the dataset perimeters. In 2017, Thorley and Coates felt they were 'Grappling with an Enigma' when trying to explain Child to Parent Violence and Abuse (CPVA) due to the various limitations of definitions created. For example, was there a difference in behaviour displayed between:

- CPV - Child to Parent Violence compared to
- CPVA- Child to Parent Violence and Abuse or
- VCB- Violent Challenging Behaviour or
- VCB - Violent Childhood Behaviour or
- APVA - Adolescence to Parent Violence and Abuse

Alternatively, were definitions developed by professionals depending on which lens they saw the behaviour through? Or were terms used to reflect what families described the behaviour to be? Or perhaps terms varied depending on the age of the child. For this reason, they introduced Childhood Challenging Violent or Aggressive Behaviour (CCVAB) as an umbrella term for all of the previously used acronyms. Adopting CCVAB as a single definition allowed for all children to be included up to the age of 18 years old (as per legal definitions) and onto 25 years old for those with SEND. This definition recognised that many of the behaviours displayed were not 'towards' parents directly and could involve property damage, be directed at siblings or be displayed indirectly towards others including peers at school or school staff.

Childhood Challenging, Violent or Aggression Behaviour was first noted as different to other forms of inter family violence by Harbin and Madden (1979) when they used the term '*Battered Parents*'. Harbin and Madden felt that battered parents related to *both to actual physical assault and to verbal and nonverbal threats of physical harm*' (1979 Abstract) involving mainly adolescent males. Harbin and Madden felt family subtleties or undercurrents were distinctly different to those seen in domestic violence or child abuse. These early discussions led to Child to Parent Violence and Aggression (CPVA) being used to describe '*Any harmful act by a child, whether physical, psychological or financial, which is intended to gain power and control over a parent or carer*'.

CPVA was the used in a number of studies over time to describe this different type of behaviour displayed in the family home². In 2001, Cottrell used the same definition in her work around the abuse of parents by teenage children. CPVA or Adolescent to Parent Violence and Abuse (APVA) continued in all subsequent discussions, publications or media coverage that followed³. This definition was then reflected in behaviour management programmes such as Non-Violent Resistance (NVR) (Coogan & Lauster, 2015).

The main problem of describing CCVAB as *Any harmful act by a child, whether physical, psychological or financial, which is intended to gain power and control over a parent or carer* was the use of the word 'intent' - was the behaviour intentional or not? This is an important point when using behaviour management approaches for or with families: does the child's 'intent' lead to an intervention to 'solve' the issue, for example RESPECT YPP or NVR. The focus of the debate around 'intent' is how the behaviour is viewed:

- ◆ Was it deliberate?
- ◆ Was it consciously planned?
- ◆ Did the child understand the consequences before displaying such behaviour?
- ◆ Was this an unconscious 'reactive' behaviour rather than a planned 'pro-active' behaviour?

If using APVA or CPV/CPVA, the behaviour is seen to be targeted by the child or adolescent towards the parent, yet new understanding has shown this is not always the case. New understanding of neurodevelopment illustrates how children's behaviour is not always pre-determined or premeditated and therefore not with 'intent' as such. For this reason, the Challenging Behaviour Foundation are seeking to ratify one multi-agency definition that is applied throughout, where the *'emphasis was to encourage carers and professionals to find effective ways of understanding a person's behaviour and its underlying causes'* rather than viewing the behaviour in isolation. To help clarify what is meant by 'Challenging Behaviour' **The Challenging Behaviour Foundation** suggest more widely used definitions are used:

² For example by Patterson *et al* (2002), Coogan (2011) Holt (2013) Coogan and Lauster (2015) and Coogan (2018)

³ see for example, Walsh and Krienert, 2007; Sung Hong *et al*, 2012; Calvete *et al*, 2013; Patuleia *et al*, 2013; Ibabe *et al*, 2013; Fréchette *et al*, 2015; Lyons' Bell *et al*, 2015; Contreras and del Carmen Cano, 2016; Ibabe and Bentler, 2016; Gerard, 2017; Kuay *et al*, 2017)

'Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities.' (Emerson, 1995)

'Behaviour can be described as challenging when it is of such an intensity, frequency, or duration as to threaten the quality of life and/or the physical safety of the individual or others and it is likely to lead to responses that are restrictive, aversive or result in exclusion.' (Royal College of Psychiatrists, 2007)

These definitions may prove to be more helpful than previous definitions, as they do not include any presumption of intent.

Added to the difficulty for the police responding to incidents reported, or any other professionals involved with the family, is how current policy and guidance is provided in England. At this time, only the Home Office Guidance regarding APVA is available:

Adolescent to parent violence and abuse (APVA) may be referred to as 'adolescent to parent violence (APV)' 'adolescent violence in the home (AVITH)', 'parent abuse', 'child to parent abuse', 'child to parent violence (CPV)', or 'battered parent syndrome, Home Office (2015, p.3- 1.1)

This definition is repeated in the Domestic Violence Bill (2019). This guidance discusses APVA from the age of 10 years old. Consequently, interventions such as RESPECT are not available to younger children. This means when Northumbria Police respond to incidents involving children under the age of 10 there is no national guidance or directive to follow. As the age of criminal responsibility commences at 10 years old in England, police officers have limited capacity to record any potential 'criminal activity' that may have occurred – such as affray or criminal damage. The 'age barrier' continues to influence studies about CCVAB that focus on older children over the age of 10, rather than all children irrespective of age. Thorley and Coates (2017, 2018) highlighted the problems of recognising CCVAB (including APVA) to the exclusion of younger children, showing how CCVAB commenced before the age of 10. They felt that it is an escalation of behaviour that is seen in APVA reports rather than when the behaviour started. Similar findings were shown by Breman and McRea (2017), in their study of Kinship Carers, that suggested 5 years of age was markedly higher than any other age group. In 2008, Parentline analysed 3128 long calls relating to physical aggression and 6549 long calls relating to verbal aggression showing that

- 26% of calls relating to physical aggression were concerning children under 9 years of age and
- 17% of calls relating to verbal aggression were concerning children under 9 years of age.

They provided evidence to show the escalating nature of CCVAB rather than something that starts during adolescence. Only 29% of CCVAB started in adolescence with the majority starting sooner:

- 13% from birth,
- 27% during toddlerhood,
- 10% commencing school and a further
- 21% in middle childhood.

Ulman and Strauss (2003), stated that CCVAB could commence during the toddler years but was often disregarded. They felt that CCVAB was only recognised if significant harm or injury occurred; something more likely to be evident during adolescent CCVAB than perhaps CCVAB from younger children.

If studying CCVAB as an adolescent issue identifying when 'Adolescence' occurs needs to be clarified, for example, does adolescence apply:

- when puberty begins?
- during the 'traditional' age of 13-14 years (Silver, 2018)?
- follow World Health Organisation suggestions -10 years of age?
- at the age of criminal responsibility -10 years of age in England?

To try to offer a solution Sawyer *et al* (2018) suggest '*The ages of 10-24 years are a better fit with the development of adolescents nowadays*' but as Sawyer *et al* (ibid) point out determining age from a biological perspective is problematic. Chronological age does not always reflect developmental age; yet chronological age continues to be the main focus for deciding if the behaviour displayed is APVA. Using chronological age ignores children with SEND who have a variable development age.

More difficulties arise for attending officers in how families discuss their child's behaviour. Many parents do not identify their child's behaviour as challenging, violent or aggressive and might discuss difficult relationships or difficult instances rather than contextualising the behaviour as an emerging

pattern; this can leave officers uncertain about what response families would like them to provide. Part of the issue for families is how society views CCVAB as a situation of children holding a position of 'authority' over their family. Society tends to struggle with the concept of children 'in charge', rather than adults having power and control over their children. Through the 'stronger person' lens CCVAB is a misnomer, because parents are vulnerable to their children yet continue to have "socially and economically more power, and in some cases, they are stronger physically" (Ibabe, 2016; p.1538). What is clear across all discussions is that more needs to be done to support families. In January 2019, Her Majesty's Government published a draft Domestic Violence Bill, that included their response to views from contributors:

You Said (p.44):

"It is important that adolescent to parent violence is recognised as distinct from intimate partner violence if patterns of violent and abusive behaviour by all children are to be taken seriously."

In response the Government stated:

We will: We will draw together best practice and develop training and resources to improve the response to victims of adolescent to parent violence. We will also promote and embed existing Home Office guidance and general principles in addition to working with experts to develop service-specific guidance.

The inherent problem with the response published is the continued focus exclusively on adolescence. There are many reasons why CCVAB is not reported sooner including: parents feeling ashamed or humiliated or parents feeling self-conscious or confused (Kennair and Mellor, 2007; Kuay et al, 2017). For some families reporting can become age dependant and seen as an age-stage norm, so that parents are led to believe they are simply over anxious (Gallagher, 2014). For this reason, very often, only those within the immediate family (who live in the same household) are aware of CCVAB until such time the family are in crisis. These types of views are supported by social concepts of 'blame the parent' and address the 'poor parenting' of children, who behave in ways that might be seen as socially unacceptable (as previously noted by Margolin and Baucom, 2014).

Section 2:

Prevalence of CCVAB responses recorded by Northumbria Police

As detailed in the previous section, establishing how common CCVAB is and how many callouts Northumbria Police respond to can vary greatly. Much of the literature surrounding CCVAB discusses children over the age of 10 and as such 'Adolescents', therefore any incidents involving children under the age of 10 years old may remain unknown. In addition to unrecorded incidents involving children under the age of 10 there are unreported incidents, such as those responded to by the family themselves or recorded by support services without sharing of information with the police; for example, the RESPECT programme. Families can request or be referred to the Respect Young People's Programme funded by the Crime Commissioner's office via Children's Services across the Northumbria Police force area. This means that Northumbria Police may not be aware of incidents of CCVAB until such time they attend incidents involving families who are at 'crisis point'.

Following completion of the Domestic Homicide Review (DHR) of Sarah⁴ by Northumbria Police, they determined a proactive response was needed if they were to develop how their officers attended and reported incidents of CCVAB. This built on the recommendation made in the review of a "*failure to identify domestic abuse, specifically Adolescent to Parent Violence and Abuse, and to fully recognise the risk posed by 'Michael'*". In setting out the parameters for new ways of recognising and recording CCVAB Northumbria Police worked with the team to generate better understanding of what CCVAB means for their force, and in this way develop the information necessary to meet the requirements of **Local Recommendation 2** in the DHR of Sarah:

Safer Northumberland Partnership to coordinate a piece of work to identify the most appropriate referral pathways in future cases of APVA, and for this information to be disseminated to staff within all agencies

⁴ Safer Northumberland Partnership completed a DHR for the death of 'Sarah' age 45, by her son aged 16 who was known to have CCVAB and SEND. To progress from this DHR Northumbria Police actively sought ways of developing incident responses and referral pathways with partner agencies. This proactive approach led to the new system of recording and referring CCVAB (APVA) incidents via the MASH to be trailed. The following link provides an overview to the DHR indicated: <https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Child-Families/Safeguarding/Seven-Minute-Guide-Sarah-DHR.pdf>

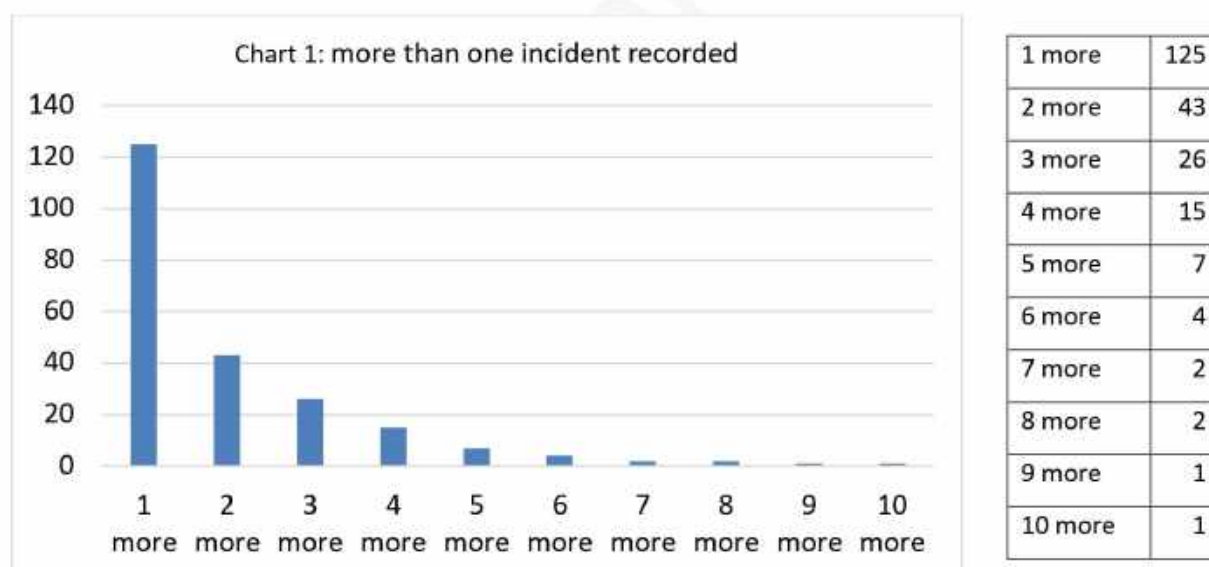
The dataset parameters reflected discussions around CCVAB and the limitations of viewing APVA only from the Home Office Guidance (2015) as APVA, or as CPVA with intention, or applying a 'perpetrator/ victim' lens. At time of starting the study no collated dataset specifically recording incidents of CCVAB by any police force existed. Building on reports and publications to date the dataset recorded "*prevalence of CCVAB*" within Northumbria Police responses, including:

- Number of incidents responded to- daily, weekly, monthly
- Age of child displaying CCVAB
- Known previous incident responses for CCVAB involving the same child
- Relationship of child to parent/ carer
- Gender of child
- any known or suspected SEND
- geographical location
- others present including siblings
- any previous or associated records for the child/ family of incidents in the home
- CCN/ ACN notification
- Behaviour reported when requesting assistance from Northumbria Police
- Criminal activity reported when requesting assistance
- Action taken by officers attending including if the child was arrested and
- What 'crime' was committed leading to possible arrest of the child
- Outcome following attendance by officers to the incident for the child and family members

The project commenced in January 2019 and the dataset recorded incidents of CCVAB from March 2019 across Northumbria Police force operational area. To help capture a record of how many incidents were responded to Raising Awareness sessions took place with frontline officers and MASH staff as well as partner agencies. Due to the nature of the incidents responded to the Multi-Agency Safeguarding Hub (MASH) were responsible for detailing incidents of CCVAB. It is wholly feasible that discrepancies in data generated and recorded as part of the project may occur due to the transmission of incident reports and detailing these within the dataset. If there are omissions in the data recorded the reliability and validity of the number of incidents Northumbria police respond to can be compromised by not providing a full and accurate reflection. Northumbria Police recognise that not all officers may view the incident under the new system of recording or may pass the incident report to 'another' area such as a multi-agency partner without recording the incident themselves. This would lead to lower numbers of incidents recorded compared to the number of

incidents officers actually attended. The nature of developing new processes is such that change practice can take time to embed into organisations. However, in order to review the value of recording CCVAB specifically in a more structured way depends on the dataset being established and an acceptance discrepancy may exist.

It is essential a dataset is established if Northumbria Police are developing and building their future responses of 'Policing CCVAB', particularly with regard to the DHR of Sarah. Without these indicators any developments would be built on presumption or require a significant number of correlated incidents to be analysed and then collated. In the DHR for Sarah there was much criticism of teams failing to be more responsive when contacted, as well as a history of multiple incidents and concerns reported not only to Northumbria Police but other organisations that collectively failed Sarah in addressing her concerns. What is immediately noticeable in the 515 incidents recorded over the 10-month period, is the number of families already known to Northumbria Police. The dataset analysis showed that 226 children involved in 515 incidents were known to Northumbria Police and officers had already visited the family on at least one previous occasion, as shown in Chart 1.



For the majority of responses police officers noted one further record that involved the same child/family. In discussions with Northumbria Police some officers felt the age when CCVAB starts is before the onset of adolescence and that they, as officers, attend incidents where CCVAB had escalated to the point families were seeking help in a 'crisis' situation with older children. The age of onset of CCVAB compared to the age of the child involved in incidents officers attend is seen in the data collected. One child aged 11 years old had 6 additional records related to them. More

concerningly 8 children aged 13-15 years old had more than 6 additional records noted, suggesting families might be contacting the police as the default way of trying to get help should other organisations not be available to them when they need help. This suggests that frequency of incidents attended by Northumbria Police increases as the level of CCVAB displayed increases; in the same way records of increased concern were reported in the Domestic Homicide Review for Sarah. The issue of repetitive incidents occurring that required officer intervention to help families living with escalating behaviour was noted in incident records:

Case Study A: Male child aged 11 years

Summary of case:

Child is a known offender who gets aggressive with mother and brother when he doesn't get his own way. Mother is described as an intimidated witness. There have been previous known incidents in September with police attending and the offender being removed by Children's Services. His mother was hospitalised on the xx/xx/2019 and he assaulted his brother. After speaking to his mother, the brother refused to give a victim statement so no further action was taken.

On the (following day) an incident occurred at the home:

Failed to finish dinner and denied sweet snacks. He has become aggressive and angry...become violent towards his brother (8).....Mum has been fearful as his behaviour continued to escalate and called the Emergency Social Services Line. Behaviour continued to escalate and mum has video evidence of him attacking her and brother. He threw a stone through the front window. The police were called and he left the address. He was found at McDonalds and taken home then stayed the night at his grandmother's.

To the officers attending the mother described:

'Being frightened for her own safety' and that she 'cannot control him'

Escalating behaviour alongside increasing numbers of incidents reported was also noted in the DHR for Sarah:

Within the timeline for this report many risk issues and concerning behaviour were reported by the family and other paediatrician to ... staff. As well as demonstrating the extent to which the family alerted professionals to increasing concerns around Michael's

behaviour, this timeline also clearly indicates that his level of risk, including aggression and assaults, had markedly increased in both frequency and severity in 2015, with 23 incidents/concerns in 11 months.

As part of this project six officers were interviewed. All of the officers who had recorded data in the new dataset were noted by their officer 'number'. As 'outsiders' to Northumbria Police personnel, the project team selected several officers for interview to reduce the risk of data bias⁵. As happens in much research the number of officers available for interview from those identified reduced the potential number of officers from ten identified for interview, to six officers participating in interview discussion. The interviews employed a semi structured approach. The interviews provided depth to the data generated from the dataset, by expanding officer response and experience when responding to CCVAB incidents specifically. During interview officers noted they repeatedly respond to the same child and family but that they recognise how families may be in crisis. During interview officers discussed a range of factors influencing the child's behaviour:

we'd already been to the house numerous times in regards to different people but mainly this lad. We knew what he'd done and who was in the house but we also knew that he had difficulties such as mental health and possibly learning disabilities. (Officer interview)

Such repeated or additional incidents support Northumbria Police's efforts in attempting to change how CCVAB is responded to, not only by themselves but also other allied organisations. The idea that parents would seek the support of Northumbria Police over alternative routes would suggest that families feel Northumbria Police are supportive as a service provider. Thorley and Coates (2018, 2017) found parents were very positive about the police responses to them when they sought help and often more supportive than any other organisation; particularly when reaching crisis point. This supportive approach was described during officer interviews:

it's parents at their wits end who are struggling to deal with behaviour. In this case the child was about 12 years old and had autism, they were throwing stuff around. There was a younger child in the home and dad worked away on the rigs. The parents had sought support elsewhere but we were their last resort they had nowhere else to turn. We are the service that can't say no, but it feels often like it's a social issue or a CAMH's issue and we're a sticking plaster. The mum had had a lot of interventions for lots of

⁵ Data bias can exist when the organisation itself selects representatives for interview to outsiders by selecting those the organisation feel reflect the views the organisation wish to portray.

behaviour and when dad was away, she was the target. We don't come in thinking 'is there an offence' more 'how can we help'. (Officer interview)

This positive relationship built by Northumbria Police can provide the foundation for developing a pro-active approach in developing their response to CCVAB. Locally placed community officers can use the information analysed to work with locally based organisations, particularly where there is a significantly higher rate of officers attending incidents.

Section 2: Recommendations: reports involving the same family/ child (building on local recommendations 2, 3, 4, 5, 6, 7 of DHR for Sarah)

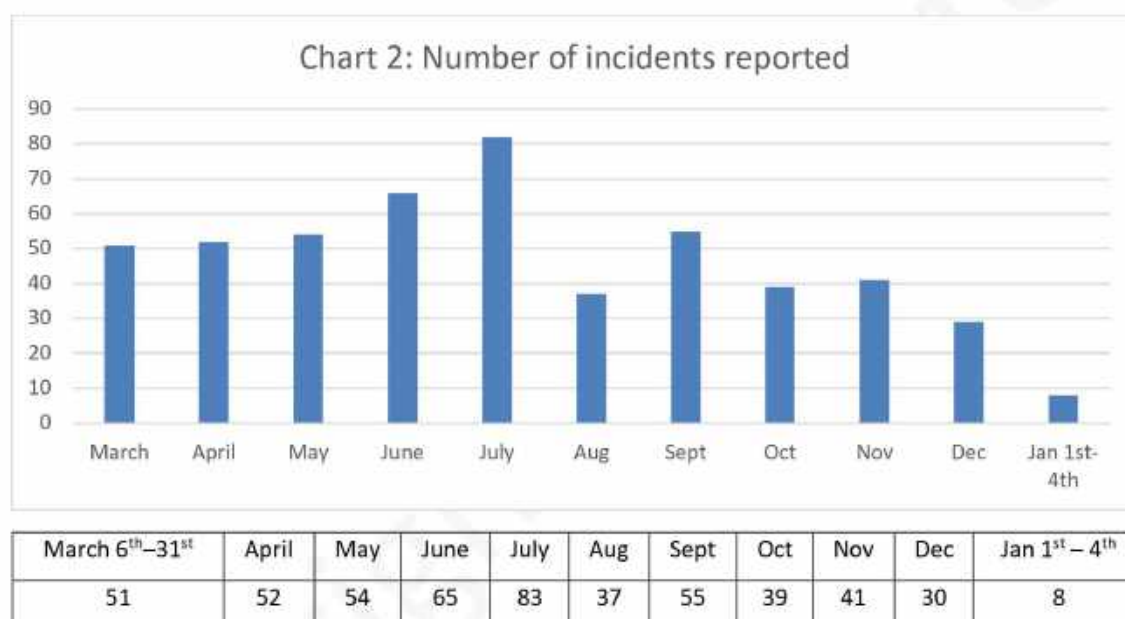
- ◆ Designate a named officer (this may be part of MASH potentially funded by VRU's⁶) who is the named contact for Northumbria Police at a local level who can
 - Collate all reports to Northumbria Police for the same child/ family
 - Collate responses and actions taken by Northumbria Police when attending incidents of CCVAB
 - Contact organisations involved in the child/ family to follow up actions taken by Northumbria Police- for example when referring the family to Children's Services updating records to include actions by such services.
 - Monitor ongoing data indicators for their respective area regarding CCVAB incidents
 - Lead, liaise and co-ordinate local parent support groups in the first instance to help get these established for high risk families such as: Foster Carers (LAC -Looked After Children), Adopters (PLAC -Previously Looked After Children), Kinship/ Special Guardian's and parents of children with SEND to raise awareness and enable these parents to have confidence in reporting CCVAB at the earliest stage, rather than waiting until a crisis is reached should this occur⁷.

⁶ It may be possible for this post to be funded by the Violence Reduction Units (VRU's) in seeking to reduce the number of violent incidents in the home that officers attend particularly those involving 'Assault'

⁷ A previous pilot set up in Northumbria Police by a school proved to be very successful and was self-sustaining after 5 supported sessions. This has led to more open and honest discussion by families relating to CCVAB incidents.

Section 2.1: Number of CCVAB incidents responded to

Establishing a dataset at the beginning of the exploratory project allowed the prevalence to be more accurate and offered insight into peak periods that was previously unknown. Between 6th March 2019 and 4th January 2020 Northumbria Police responded to 515 incidents of CCVAB representing an average of almost 2 incidents per day. Across this time period there is an increase in incidents recorded month by month between March to July as detailed in Chart 2.



From the data gathered there is insufficient evidence to state the reasons for this increase. The notable reduction during August would support previous debate around the difficulties some children have during their school day that leads to an increase in CCVAB at home. Between March and June there is a steady growth in the number of incidents reported, this is a time when children of school age are preparing for academic assessment such as the Statutory Assessment Tests (SATs) or GCSEs. These assessments and exams are known to increase periods of high stress affecting more than a proposed 50% of pupils⁸. SATS preparation often commences during the Easter period for year 6 pupils (aged 10-11 years) if not earlier, with the assessment period beginning in May. Following this assessment period for year 6 pupils in England pupils begin to prepare for their

⁸ For example, see: the Guardian May 1st 2017: More primary school children suffering stress from SATs, survey finds. and House of Commons Briefing Paper Number 07980, 19 June 2017 SATs and Primary School Assessment in England and TES 19th March 2019 YouGov poll also finds 96% of primary heads are concerned about the pressure of KS2 SATs on pupil wellbeing

transition to Secondary school. The transition into Secondary School can be a major period of high stress for many pupils. For pupils aged 15-16 years GCSEs revision often commences from February (if not sooner) following which pupils complete their GCSE exams during May/June before

- ◆ planning to continue into 6th form education if offered by the school
- ◆ moving into further education college provision
- ◆ moving into employment via a modern apprenticeship
- ◆ moving into employment without an apprenticeship
- ◆ repeating both English and Maths if they do not achieve the necessary government determined grade in their GCSE efforts.
- ◆ move out of education, training and employment completely (NEET)

Similar to younger children undertaking a transition, the transition for 16-year olds is also significant. It is therefore notable that it is July- the period of transition for the majority of pupils- where there is a significant increase in incidents. August is the main holiday period from schools in England and is the majority of the summer recess period. During August there is a notable reduction of incidents by more than 50%, from almost 3 incidents per day in July (83 incidents over 31 days) to just over 1 incident per day in August (37 incidents over 31 days). It is possible that there is less stress in the home for some children such as those who are reluctant school attenders, or parents themselves may be under less pressure due to their own vacation time therefore more relaxed in managing their children's needs.

During September, when pupils move into their secondary school or progress into their post-16 studies, the number of CCVAB incidents increases from 38 incidents in August to 55 incidents in September. This suggests there is a need to develop more understanding of the relationship between school and CCVAB incidents. Exploring the relationship between education provision and CCVAB provides the opportunity for schools to work alongside Northumbria Police. Schools are well placed to identify those pupils at higher risk of displaying CCVAB during increased stress periods such as national assessment or examinations periods of time or during transition. With increasing concerns over pupil school exclusion due to CCVAB displayed in school and how these children are more vulnerable to 'county line' recruitment or gang activity the sharing of information will benefit all parties. Schools could help provide more detailed information of high-risk vulnerable pupils, who may or may not be known to MASH personnel. Northumbria Police can indicate pupils who may be struggling to regulate their behaviour or have SEMH (Social, Emotional or Mental Health) needs that

the school are unaware of. The need to consider how attending school may influence CCVAB incidents particularly in the home, is further noted in December, when incidents again reduce to 1 per day. During December many schools operate 'off timetable' with a range of school excursions, parties, productions or more social occasions prior to the holiday period for Christmas. Previous survey responses such as Adoption UK identifies schooling as a significant trigger for CCVAB incidents, something that has also been seen in families whose children have SEND where interventions such as 'Team Teach' are adopted to manage pupil behaviour. The correlation between schooling and CCVAB requires further study to establish if schooling is a significant indicator.

Close examination of any other possible significant dates was not seen, there appeared to be no notable increase on any particular day of the week or at weekends. School half term and Easter periods showed a slight decline for that month but not sufficiently so to be of note. This was slightly surprising as it had been anticipated there may be an increase at weekends or on a Sunday prior to returning to school on Monday. The evidence to date did not show any particular pattern emerging with regard to day of the week.

How the prevalence of CCVAB in the Northumbria Police conurbation sits compared to prevalence of CCVAB in other areas across England is unknown, due to lack of detailed recording of CCVAB specifically. Current suggestions for prevalence of CCVAB vary between 10% of children to 3%. Stevenson (2016) reported that as many as 1:10 parents experience parent abuse whilst Bonnick (2016) suggests 3% is the figure most professionals agree on (citing Gallagher's discussions), whilst Selwyn and Meakins (2015) highlighted discrepancies of 3% and 27%. This lack of focused data does not help provide insight into how common CCVAB is without a comprehensive collation of, for example:

- ◆ Children's Services records
- ◆ Child Protection records
- ◆ Family Court records
- ◆ Police records
- ◆ Criminal Court records (either both Magistrate and Crown Court)
- ◆ Youth Service records
- ◆ Child Health records (such as CAMHS or CYPs)

It needs to be remembered however that after collecting and analysing the data from different sources this will only point to known CCVAB not CCVAB overall, due to under-reporting of CCVAB incidents by those living with children who display CCVAB.

Section 2.1: Recommendations: Number of CCVAB incidents responded to (building on Recommendation 2 of DHR- Sarah)

- ◆ Develop co-ordinated information sharing between education providers and a local area named Northumbria Police officer, to inform Northumbria Police when
 - pupil stress periods may increase CCVAB incidents during exam/ assessment/ transition periods so officers are aware of pupils who are at higher risk of displaying CCVAB during these periods
 - pupils are excluded from school for displaying CCVAB in school, so officers are aware of school status and reasons for this when responding to incidents.
- ◆ Increase officer awareness of key periods that increase the risk of CCVAB incidents being reported so they are prepared should they need to respond and
- ◆ Develop partnership working with schools during known peak periods for potential CCVAB incidents either in school (which the school manage at this time) or at home (where police intervention may be requested) via a designated named officer in each of the police areas- (this could be situated within MASH and funded by the Violence Reduction Unit⁹)
- ◆ Undertake further research to identify specific child stressors

⁹ There is increasing concern about outcomes and behaviours of those excluded including 'gang' membership, 'county lines' and 'knife crime' that reflects the work of the VRU and behaviour of those children displaying CCVAB

Section 2.2: Gender of child and relationship to family unit

The majority of previous research-based reports have suggested it is predominantly boys who display CCVAB as opposed to girls. However, there are some problems with these reports for example:

- the statistics do not include how many males-females are representative in the specific locality/ region/ country- some local areas have a population of more male than female children
- the reports do not always include how society views behaviour, where male child behaviour (particularly during adolescence) may be viewed more threatening than female behaviour due to physique or societies' own cultural beliefs
- The statistics only reflect known displays of CCVAB rather than all displays of CCVAB

Within Northumbria Police there were more incidents involving male than female children which would support much of what is already written. Northumbria Police recorded 335 incidents involving male children

- 309 incidents involving a son
- 20 incidents involving a grandson (may have been residing in Kinship care)
- 2 incidents involving a stepson and
- 4 incidents involving a foster care son

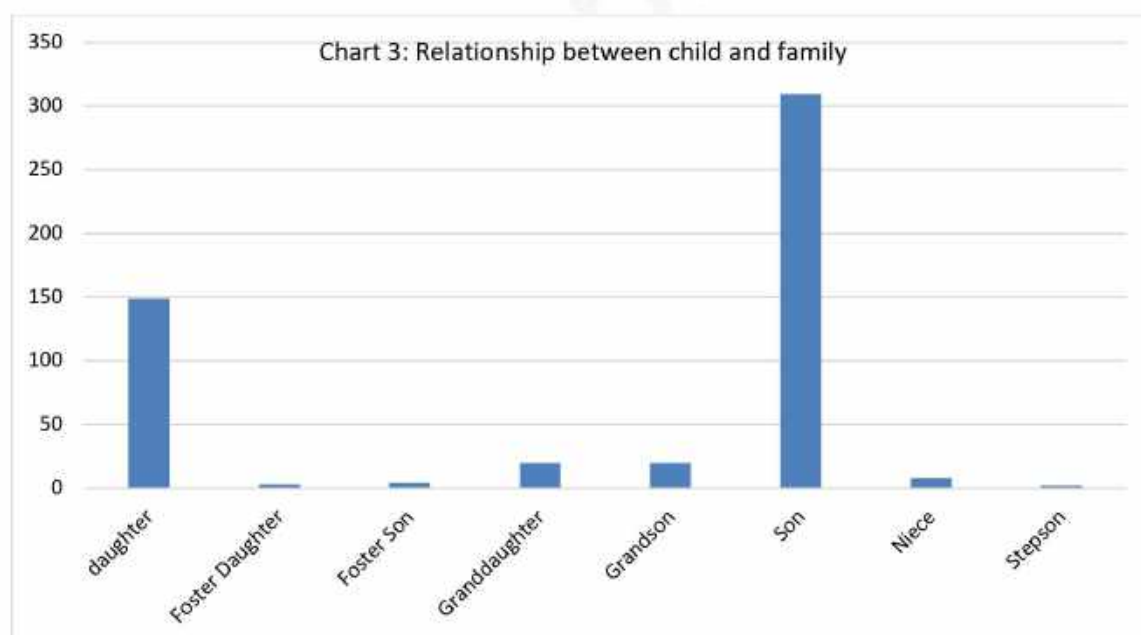
Compared to 180 incidents involving a female child

- 149 involving a daughter
- 3 involving a foster daughter
- 20 involving a grand-daughter (may have been residing in Kinship care)
- 8 incidents involving a niece (may have been residing in Kinship care)

Some local areas within Northumbria Police may have more male-female children statistically therefore it could be anticipated more males than females come to the attention of Northumbria Police. Cultural expectations may also influence reporting of incidents something that would need further research to determine. From the incidents attended there were more females than males reported for their behaviour by a non-biological parent. In the incidents responded to 6.5% of males were grandsons compared to 13.5% of females who were grand-daughters and a further 5% were nieces. For these families it is significantly more female than male children who are displaying

CCVAB. Northumbria Police also responded to 4 incidents involving foster sons compared to no incidents involving foster daughters. However, if foster children are added to those in Kinship or Special guardianship care then the impact of trauma cannot be overlooked. Step-sons were also included in incident reports but no step-daughters supporting previous suggestions of a higher incidence in blended families involving male children. Gallagher (2008) acknowledged there were specific family typologies where CCVAB appears more prevalent including the child's gender (more boys than girls) which would seem to be the case across Northumbria Police at this time.

Discussions about families who experience CCVAB include a lot of debate about the relationship between these children and their parent/ carers, with a significant number of reports suggesting 'mothers' as 'victims'. There are also suggestions of higher risk in single parent families (see for example Gallagher 2008) or adopter families (whilst simultaneously over-looking foster carers or kinship carers) or where there has been a history of domestic violence in the family household¹⁰. Northumbria Police attended incidents at a range of families including foster carers, carers who are relatives, as well as 'birth' parent families as detailed in chart 3:



¹⁰ Similar to the findings of Cottrell and Monk (2004)

The incidents responded to contrast with previous claims that there is a much higher incidence of children displaying CCVAB in blended families. However, what is not known from the data is

- how many 'sons' lived in a single parent family with their mother¹¹ or
- the gender of any other child in the household or
- the 'health' of the relationship between parent/carer and child.

This should be included in any future data collection or notes during incident reporting to help establish support for single parents, if indeed there is a higher incidence in single parent households across the operational area. MASH collaboration would help inform officers if the child is adopted recognising the increased risk of CCVAB in adopter households. To establish any trend in specific family groups Northumbria Police would need to include all possible family group sub-sets to accommodate the wide variety of families in society today, for example:

- Married/ co-habiting Heterosexual couple with birth child/ children displaying CCVAB
- Married/ co-habiting LGBT couples with birth child/ children displaying CCVAB
- Single birth parent – female- with child/ children displaying CCVAB
- Single birth parent- male- child/ children displaying CCVAB
- Blended family – with child/ children displaying CCVAB (birth mother)
- Blended family – with child/ children displaying CCVAB (birth father)
- Heterosexual couple with adopted child/ children displaying CCVAB
- LGBT couple with adopted child/ children displaying CCVAB
- Kinship or Special Guardian couple with child/ children displaying CCVAB
- Kinship or Special guardian single parent with child/ children displaying CCVAB
- Heterosexual couple with foster child/ children displaying CCVAB
- LGBT couple with foster child/ children displaying CCVAB
- Widow parent with child/ children displaying CCVAB
- Widower parent child/ children displaying CCVAB

The complexity of trying to identify specific families who may or may not be at higher risk is beyond the remit of Northumbria Police and why it is important to remember

¹¹ See for example Kennair and Mellor, 2007; Ibabe et al, 2013; Ibabe, 2016

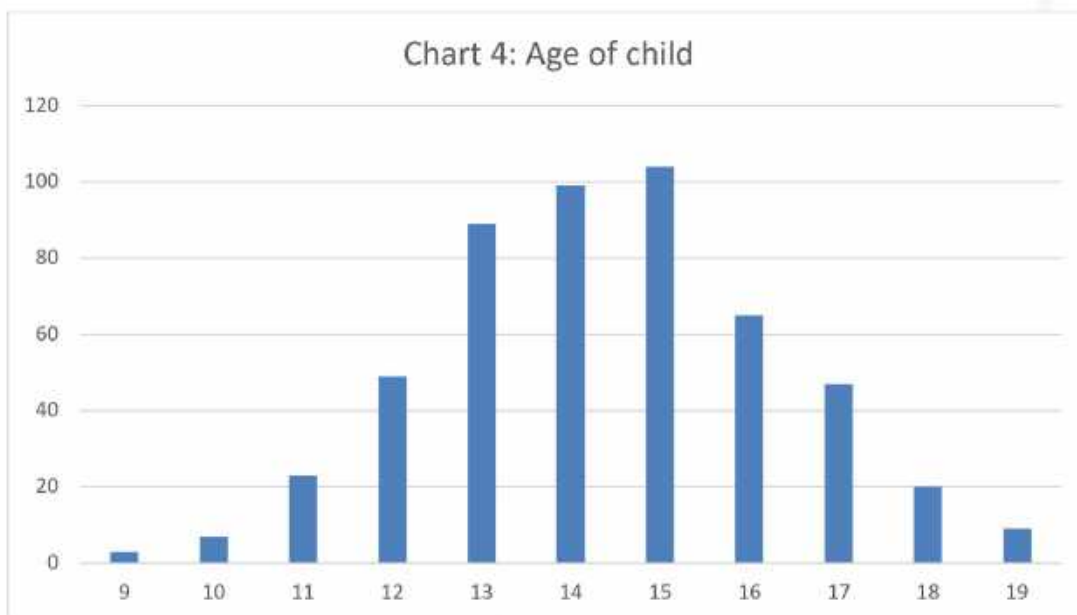
There is NEVER just one cause for any complex behaviour and 'explanations' of someone's behaviour may be in terms of the individual (both genetic/ biological and past experience), the family and the wider society. All of these play a part. (Gallagher, 2008)

**Section 2.2: Child's gender and relationship in the family
(building on Recommendation 1 and 5 of DHR - Sarah)**

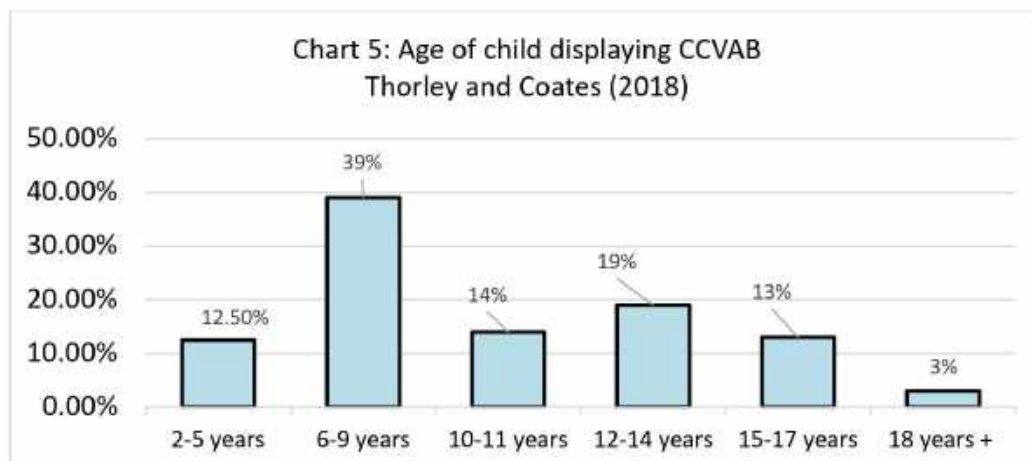
- ◆ Develop wider understanding of the nature of children who display CCVAB across Northumbria Police operational area including all partner organisations as part of MAP (Multi-Agency Partnership)
- ◆ Recognise the social/ cultural impact on children across the operational area that may increase the risk of CCVAB occurring or being reported
- ◆ Designate a named officer (this may be part of MASH) who can work as part of a MAP with those supporting LAC, PLAC and Kinship/ Special Guardian as well as Single Parent Households- raising awareness for these parent/ carers to enable them to have confidence in reporting CCVAB at the earliest stage rather than waiting until a crisis is reached should this occur.

Section 2.3: Age of child involved in CCVAB incidents responded to

Due to the nature of Home Office guidance and the criminal age of responsibility in England, police officers may anticipate that they will only be required to attend incidents involving children over the age of 10 years. Within the data generated children displaying CCVAB requiring police response did follow previous suggestions of this behaviour being an 'adolescent' issue as shown in chart 4:



Northumbria Police recorded 340 incidents involving children aged between 12 and 15 years of age. The majority age of children displaying CCVAB reported to Northumbria Police was 15 years of age – with 103 incidents. This is similar to the findings of Condry and Miles (2014) who identified 1892 cases of CCVAB in the home reported where the majority were 13-19 years old. However, officers attending did wonder if they predominantly see 'older children' as families find it increasingly difficult to manage their older/ larger/ stronger children leading to the family crisis situation arising. Officers felt that when they attended incidents it wasn't at the start of behaviour that families found difficult to manage but at a point where they were no longer able to cope unaided. Officers believed that children began to display CCVAB at an earlier age prior to coming to the attention of Northumbria Police. Again, this is something previously found in studies about CCVAB, for example Thorley and Coates (2017 and 2018) found the age of the start of CCVAB displayed was 6-9 years as shown in chart 5.



As shown Thorley and Coates found that adolescence is in the lowest age range for CCVAB starting to be displayed. Ulman and Straus (2003) also found the majority of children in their study started displaying CCVAB at an age before adolescents (or 10-19 years of age). Ulman and Straus (ibid) found 1/3rd of their survey group involved 3-5-year olds that were violent to a parent over the previous 12-month period compared to 1:10 for those aged 14-17 years. Selwyn *et al* (2014 p.146) found similar in their study of adopted children and although they accept the hormonal impact of adolescence, they noted

Many parents described a rapid escalation of challenging behaviour in their child, as they approached puberty. Adopters reported that children were on average 11 years old (range 5-17 years, SD 2.9) when difficulties began to escalate. One in five families saw the onset and escalation of difficulties at this time.

this suggests an earlier onset for the behaviour than adolescence, if significant escalation is noted at age 11 years. Within their study (*ibid*) they found that where the placement had broken down, for adopter parents, the onset of CCVAB tended to be at 8 years old. Ulman and Strauss (2003) found the early years to be the most common period for CCVAB starting and that there were two peak periods before a decline. The first peak was seen at 6 years of age (a rise of 4% from 5 years of age) then declining at age 7 years of age. The second peak was at aged 9 years (increasing by 5% from age 8 years) before a decline by 5% at age 10 years. Similar patterns were found by Thorley and Coates (2017, 2018).

The main reason why children do not come to the attention of the police earlier, during pre-adolescence, is due to how families are responded to by

- other service provision such as CAMHS or CYPs (for Mental Health related conditions) or
- society itself or
- 'seeing' the behaviour as the extreme end of age-stage development such as toddler tantrums, or
- linking the behaviour to a diagnosed cognitive condition such as ADHD or Autism

When talking about CCVAB in younger children families feel they 'know' something is not 'right' but do not know why, this is often viewed as over anxious parenting. Another reason why these children are not recognised earlier may be because there is an over reliance on looking at aggressive behaviour being only 'violent' behaviour that leads to physical harm and overlooks property damage or emotional violence. Research studies of early childhood have shown 'physical' aggression starts as early as infancy; when the ability to harm others through biting and kicking starts (Trembley *et al*, 1999 and 2018, Vitaro *et al*, 2006). A new view about childhood aggression has recently been released using a range of longitudinal studies (Girard *et al* 2019, Online 2018). The studies suggest a different interpretation for childhood aggression to previously held traditional opinions of 'learned aggression'.

Direct observations from longitudinal cohort studies of early development supported the perspective that engagement in physical aggression is instead at its peak during infancy and early childhood, in particular during the toddler years, with less frequent engagement in physical aggression as children develop; rather than onset in late childhood or adolescence

It is suggested that rather than learn 'aggressive' behaviour children 'unlearn' instinct behaviour or rather develop their learning to understand different ways to regulate their behaviour. The new studies suggest 'aggression' reduces as other skills increase such as cognitive and language development as well as social information processing skills that help children to decode social cues. These new studies may help explain why some children with high ACEs continue to display CCVAB beyond early childhood. In contrast the new studies suggest 'indirect forms of aggression' increased between late childhood to adolescence for some children as language, cognitive and social skills increased. The majority of discussions for CCVAB to date along with interventions provided for CCVAB tend to focus exclusively on adolescence leaving families with younger children little or no

support. The information from new studies suggests there is a need to reconsider how CCVAB is seen and how children displaying CCVAB are understood and supported.

Section 2.3 Recommendations: Age of child displaying CCVAB

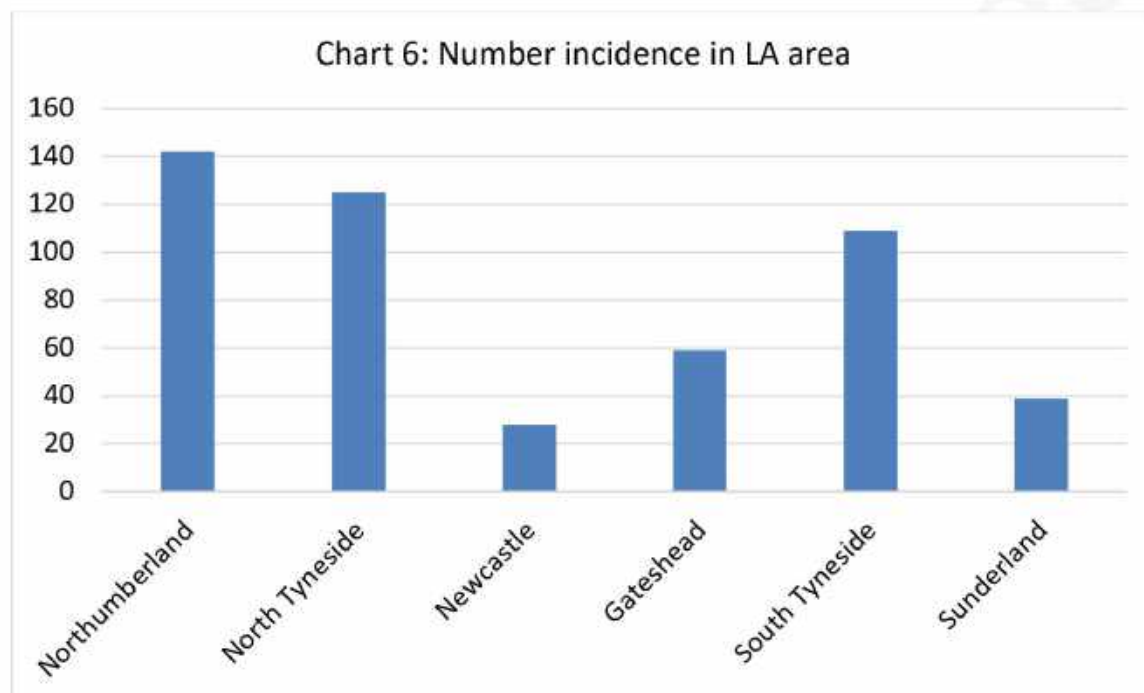
(building on National Recommendation of DHR- Sarah and recommendation 1)

1. To review current understanding of 'domestic violence' and if this represents all children who display CCVAB
2. To review age criteria and support for families where children are under the age of 10 years
3. Develop co-ordinated information sharing between education providers, children's services and a local area named Northumbria Police officer to promote inter-agency information sharing (this may be situated within MASH and potentially funded by VRU) for
 - a. Pupils who display behaviour that reflects CCVAB- it should not be presumed this only occurs within their school setting or the home setting as two distinct separate incidents rather this should be seen as an overall behaviour
 - b. pupils who are excluded from school for displaying CCVAB in school, particularly those children in primary school settings or Nursery settings
4. Lead, liaise and co-ordinate local parent support groups in the first instance to help get these established for high risk families such as: Foster Carers (LAC -Looked After Children), Adopters (PLAC -Previously Looked After Children), Kinship/ Special Guardian's and parents of children with SEND to raise awareness and enable these parents to have confidence in reporting CCVAB at the earliest stage, rather than waiting until a crisis is reached should this occur, irrespective of the child's age¹².
5. Develop positive relationships between a named Northumbria Police representative and the family support group to encourage families to discuss when they are struggling to control their child's behaviour before this becomes an 'incident' and include families of children under the age of 10 years

¹² A previous pilot set up in Northumbria Police by a school proved to be very successful and was self-sustaining after 5 supported sessions. This has led to more open and honest discussion by families relating to CCVAB incidents.

Section 2.4: Area incident per Local Authority

The data generated allowed for a more focused understanding of where incidents of CCVAB occurred and where officers may be called out more frequently than perhaps their peers to deal with reported incidents, for example across the North or South of the Tyne. Across the force area Northumberland and North Tyneside had the highest number of incidents over the data period as shown in Chart 6 (also refer to Appendix 1 for detailed charting of location and age).



In total there were 142 incidents across 20 local areas in Northumberland. Northumberland is mainly a large rural area bordering Scotland to the North and Cumbria to the West. Northumberland does contain a small number of more urbanised conurbations. Out of the 142 incidents reported in Northumberland 39 incidents (27.5%) were recorded in Ashington, making Ashington the area with the highest number of incidents in Northumberland. Across Ashington there is a significant increase in incidents for children aged 13 years to 15 years. Out of the 39 incidents overall 25 children (64%) aged 13-15 years old were involved in incidents. This peak decline's rapidly at age 16 years reducing from 10 incidents involving children aged 15 years to 2 incidents for children aged 16 years. There has been previous discussion across research publications noting a decline as young people get older. However, the level of reduction between 15 years and 16 years is such that further

exploration for this reduction is warranted. Is the decline due to the age range population of young people in Ashington or is the decline due to other factors such as families moving out of area?

The overall age range in Northumberland for children displaying CCVAB requiring the attendance of officers was between 9 years and 19 years. For children aged 9 years there is little in reality officers are able to do, the child is under the age of criminal responsibility and under the age for referral to RESPECT (RYPP). Although it is only one child living in Blyth being under 10 years old can leave both child and family without the help they need, at a time they need help. Unlike Ashington the peak age for incidents were more variable across other areas in Northumberland, for example:

- **Bedlington** (12 incidents)- 3 of the 12 children were aged 13 years but there were no incidents involving children aged 14 or 15. The highest age range with 5 incidents (almost half of those reported) involved young people aged 17 years
- **Blyth** (19 incidents) - there were no incidents for children aged 13 years, the peak age range for Blyth was 14-16 years with 15 of the 19 incidents involving children in this age range. The majority age for Blyth was 15 years of age accounting for 8 young people- almost half of all incidents recorded in Blyth
- **Cramlington** (17 incidents) There were no incidents involving children under the age of 13 years in Cramlington but a spike of 6 incidents at aged 13 years. This in itself is significant – is this because CCVAB does escalate over time or is it purely an adolescent concern? It may be that these young people were involved in incidents in previous years. If this is a sudden onset at age 13 years this would need further exploration to establish the potential cause
- **Morpeth** (12 incidents)- Morpeth had a steady range in children involved in incidents from 10 years to 17 years of age with no significant peak age ranges
- **Seaton Delaval** (18 incidents) was different to all other local areas where 17 of the 18 incidents involved children aged 15 years. The remaining incident involved an 'adult' aged 18 years. To have all incidents involve children of the same age across a single local area is unusual and concerning. Further interrogation of these cases is warranted, particularly with mounting concerns for 'county line' and gang activity.

Northumberland borders North Tyneside to the south and some of the smaller local areas are part North Tyneside and part Northumberland. This makes it more difficult for Northumbria Police when referring children to children's services and other allied organisations as these services reflect the Local Authority boundary. There were 125 incidents in North Tyneside, a coastal area lying between Newcastle to the West and Northumberland to the North. North Tyneside has 17 conurbation areas where CCVAB has been reported to Northumbria Police. The overall age range in North Tyneside for was between 9 years and 19 years. As with Northumberland the actions available to officers when attending incident's involving children aged 9 years are limited, by the age of criminal responsibility and the age for referral to RESPECT (RYPP). There are 2 local areas where the majority of all CCVAB incidents occurred in North Tyneside:

1. **Wallsend** had 54 incidents equal to 43.2% of all incidents in North Tyneside.

Across Wallsend the age range varied between 11-19 years. What is notable is the sharp increase between 12 years and 13 years. In Wallsend 7.5% of incidents involved children aged 12 years old and this increased significantly to 17% for children aged 13 years. Further increases were noted at age 14 years to 24% and at 15 years to 28%. This period of increase then declined at aged 16 years to 11%. This points to a definitive 'peak' between the ages of 13-15 years old during a period of significant hormonal change and neurological development.

2. **North Shields** had 23 incidents equal to 18.4% of all incidents across North Tyneside.

In total almost 2/3rds of all incidents in North Tyneside were situated in Wallsend or North Shields. As with Northumberland and North Tyneside, the boundary for North Shields lies to the east of Wallsend within the same Local Authority. In the same way Wallsend showed a notable peak between the ages of 13 years and 15 years North Tyneside also reflected a peak during these 'adolescent' years. In North Shields the number of incidents notably increased between the ages of 11 years and 12 years, from 4% to 13% respectively. This increase continued to 26% at 15 years before returning to 13% at 16 years.

Of the remaining areas across North Tyneside, Killingworth is notable due to the age of those involved. Although only 6% of all incidents were in Killingworth, 75% of these incidents involved children aged 11 years sitting outside of the 'peak' age range for other areas in the same Local Authority. This was also seen in Annitsford where there were 2 incidents both involving children

aged 11 years. In contrast there was 1 incident in Palmersville that involved an 18-year-old (technically an adult). These indicators highlight why it is difficult to determine a specific age for CCVAB occurrence and the number of variables that arise when analysing reports.

There is a need to understand why the highest number of incidents are across Wallsend and North Tyneside specifically, areas that have shared boundaries. One possibility is the impact of Adverse Childhood Experiences on children and the behaviour they display as previously highlighted by Thorley and Coates (2019). If indeed adversity in childhood is an indicator of a higher risk of CCVAB occurring Newcastle would contradict this indicator. The North East overall has a higher level of adversity in childhood compared to England yet only 42 incidents (8%) of the 515 incidents were in Newcastle, the region's main city centre. The predominant area for CCVAB reports in Newcastle was in Newcastle central area, which accounted for 68% of all incidents. Unlike North Tyneside and Northumberland, the age range for Newcastle was 13-19 years. In Newcastle there were no incidents involving children under the age of 13 years old and no incidents involving children aged 14 or 15 years. The prevalent age of incidents involved those aged 16 and 17 years (31% of all incidents in Newcastle). There were only 3 areas recorded to have reports of CCVAB for Newcastle as a Local Authority: Lemington, Forest Hall and Newcastle Central. In Lemington there were no incidents involving children under the age of 16 years old. This suggests that across Newcastle there is a prevalence of CCVAB for older children rather than children overall.

Collectively 60% of all CCVAB incidents reported were found in the North of Tyne geographical area that Northumbria Police provide services for; namely North Tyneside, Northumberland and Newcastle. To the South of the Tyne, Northumbria Police provide services to Gateshead, Sunderland and South Tyneside. Of these three areas South Tyneside had the highest level of CCVAB reports. There were 7 local areas in South Tyneside and a total of 109 incidents, equal to 21% of all incidents responded to across Northumbria Police force operational area.

Three areas across South Tyneside collectively shared 89% of all reports of CCVAB in the Local Authority:

1. **South Shields** had 59 incidents equal to 54% of all incidents across South Tyneside.

South Shields as a single local area has the highest number of recorded incidents equal to 11.46% of all incidents recorded, with Wallsend the 2nd highest local area at 10.5%. Across South Shields there

were no recorded incidents for children under the age of 11 years old. In this way South Shields resembles previous discussions that CCVAB is an adolescent concern involving children aged between 11 years old and 18 years. However, as with all these discussions it must be remembered these children reflect only those known rather than all children who display CCVAB. There is a variable level of incidents across the age range for South Shields, but there is also a notable 'peak' period between the ages of 12 years old and 15 years old. Incidents involving children 11 years of age accounted for 6.8% of incidents, at 12 years of age this increases to 13.5%. Although there is a small increase (less than 1%) between the ages of 12 years and 13 years for those aged 14 years the increase is notable. Almost three times the number of incidents of 12-13 year olds 35.6% of all incidents in South Shields involved those aged 14 years of age. The significance of this increase at 14 years of age is more notable when compared to the number of incidents at 15 years. The number of incidents recorded involving those aged 15 years is 8.5% showing a significant reduction from those aged 14 years. Reasons for this notable decline need further exploration and as previously noted should include a correlation (if any) to known adverse childhood indicators. South Shields has some of the highest levels of ACE indicators across England at this time (Thorley *et al*, 2019). The level of 'deprivation' in South Shields is noted by officers when attending incidents

Its not how I would live things were thrown all over, broken toys ...the house was in poor condition I wouldn't live there (Officer 3 interview)

2. **Jarrow** had 24 incidents equal to 22% of all incidents across South Tyneside

The boundary for Jarrow lies to the west of South Shields running alongside the River Tyne. Similar to South Shields, Jarrow does not have any incidents recorded for children under 12 years of age so fits the 'adolescent' profile. Unlike South Shields, and most other areas, the incidents of CCVAB 'trough' between 13-15 years. Children aged 12 years were involved in 16.7% incidents which decreased to 12.5% for children aged 13 years and 8% for children aged 14 years. At 15 years of age there was a significant increase at 21% that continued to those aged 16 years. The highest age range in Jarrow is 16 years of age accounting for 33.3% of all incidents in Jarrow. This trend is unusual and the reverse of other areas locally as well as previous research suggestions. Whilst there is a 'peak' and 'trough' pattern the age range for highest incident's do not reflect current understanding around adolescent CCVAB. Scrutinising the demographical data for Jarrow might help explain this anomaly.

3. **Hebburn** had 14 incidents equal to 13% of all incidents across South Tyneside

When viewed as a single local area Hebburn is not significantly higher than other individual local areas but it is the 3rd highest area in South Tyneside and has boundaries linking to Jarrow to the East and Gateshead to the West. Collectively these 3 areas – South Shields, Jarrow and Hebburn that lie adjacent to the River Tyne have the majority of all CCVAB incidents in South Tyneside. Similar to Jarrow, Hebburn does not reflect current understanding of children who display CCVAB with reference to ‘peaks’ and ‘troughs.’ There are no recorded incidents for children under 11 years of age. Children 11 years of age account for 7% of all incidents in Jarrow but this sharply increases for children 12 years of age. Children 12 years of age account for 35.7% of incidents; this trend then begins to decrease between the ages of 13-15 years from 21.5% to 14% respectively. There are no incidents for children over 15 years of age. Reasons why children of aged 12 years are the most predominant requires more scrutiny. There are a number of variables that may inform children’s behaviour at this age, not solely hormonal change and neurological development.

Similar to Newcastle, there were very few incidents reported in Sunderland also a city centre in the Tyne and Wear conurbation area. Sunderland recorded 39 incidents over the dataset period equal to 7.5% of all incidents recorded with the majority of these incidents (61.5%) occurring in Sunderland itself. Also similar to Newcastle the dominant age group for incidents recorded is 16 years to 19 years of age. In Sunderland 10% of incidents involved children aged 11-15 years equal to the same number of incidents for children aged 16 years. The peak age range for Sunderland is 17 years at 18% and 18 years at 15% in Sunderland centrally.

There are 3 further areas across Sunderland where CCVAB was recorded:

1. **Washington** is a ‘New town’ development area previously belonging to a larger number of ‘Pit villages’ and local communities. Northumbria Police recorded 7 incidents of CCVAB accounting for 1.3% of all officer responses and 18% of incidents in Sunderland specifically. Similar to Newcastle there were no incidents for children under 16 years with the majority of incidents involving those who are of 17 years equal to 71% of all incidents recorded in Washington. At this age the number of Youth Offenders would also need to be considered for example, ‘gang’ related activity or behaviour that involves alcohol or drug taking.

2. **Houghton** is also historically a 'pit' village area that reflects the same trends as Washington, where the majority of CCVAB incidents involve those over the age of compulsory schooling, 16 years of age.
3. **Hetton-le-Hole** had one incident reported and recorded involving someone who was 18 years of age, technically an adult.

This suggests that across Sunderland there is little evidence of CCVAB involving younger adolescents or younger school age children and where incidents are reported they involve older children or adults (if aged 18 years or more). It is therefore more likely these older 'teens' enter into the Youth Justice system as being 'responsible' for their behaviours.

The metropolitan borough of Gateshead lies opposite Newcastle and is joined to the east by Hebburn and to the south by Durham. Gateshead represented 11.5% of all recorded incidents of CCVAB during the data collection period. Similar to South Tyneside there were 3 local areas that accounted for the majority of incidents. Gateshead, Blaydon and Felling. The remaining areas of Birtley, Rowlands Gill and Ryton had one incident each whilst Dunston had 3 incidents. Dunston was the only area that had incidents involving children aged 11 years, this age group were absent from all other areas across Gateshead. What is most noted in the incident reports for Gateshead is the varied ages of the children involved. Whilst Dunston had 3 incidents all involving a child aged 11 years Blaydon had 7 incidents that all involved a child aged 13 years. It is unusual for all incidents in one localised area to involve children of one specific age range. Felling had 6 incidents and these were predominantly involving children aged 14 years (with 1 incident for a child aged 13 years and 1 incident for a child aged 17 years).

In Gateshead locality the age range was from 10 years to 17 years with a peak age range of 13 years to 15 years. In Gateshead locality there were 40 incidents recorded (as opposed to the whole metropolitan Local Authority area) 68% of these incidents involved children aged 13 to 15 years. There is a marked increase between children aged 12 years (5%) and children aged 13 years (22.5%). The increase continues for children aged 14 years (32.5%) before beginning to decline at 15 years (22.5%) and 16 years (7.5%). The incidents of CCVAB in Gateshead locality reflect the 'peak' and 'trough' pattern seen elsewhere across the Northumbria Police operational area.

Section 2.4 Recommendations: Identifying local age-range trends

(building on local recommendation 1, 5, 6 and 7)

- Continue to record incidents of CCVAB as a dataset building what has been achieved to date
- Designate a named officer (may be part of MASH) to oversee the data generated at sufficiently regular intervals to inform operational practice and procedure
- Disseminate information generated to inform officers of peak age ranges, peak periods in time and anomalies within these for specific local areas
- Collate information gathered and share with all those involved with these children locally- Schools in particular need to be involved due to the peak age ranges of children involved in incidents reflecting compulsory school age
- Collate police records and correlate with school exclusion information in specific local areas working with those monitoring 'gang related activities, 'county lines' and other activities known to involve vulnerable children
- Use information generated from incident records alongside known adverse childhood experiences in focused locations to gain insight into social and cultural impact

Section 3:

CCVAB risk indicators leading to Northumbria Police incident reports

Discussions to date about CCVAB have led to a range of suggestions for the 'causes' of the behaviour seen including parenting approaches, neurological disorders, mental ill health or learned behaviour (reflecting the traditional view of how children learn behaviour). Newer understanding about the impact of trauma on cognitive development has also shed light into reasons for CCVAB¹³ as a result of operating in a higher state of 'alert' that leads to sub-conscious reactive behaviour (see for example NMT by Dr Bruce Perry and debate around Neurological development in the early years¹⁴).

In DSM-V and ICD-10/11¹⁵ there are a range of mental health and behaviour disorders listed that can increase the risk of CCVAB for example, ADHD or those on the Autistic Spectrum. This is not stating that CCVAB '**will occur**' but that it '**might** occur' as a co-morbid behaviour. For this reason, the data included further information about the child, including if they were known to have any SEND diagnosis (and an EHCP¹⁶ in place) or were under investigation for a SEND condition. For Northumbria Police to be effective when attending incidents, they need to know what, if any, diagnosed conditions may influence the behaviour of the child involved in the incident. In the DHR for Sarah her son did have a diagnosed condition that was influencing his behaviour, that consequently led to her death:

Michael had significant involvement with ... from a young age, with his first referral being at the age of five. Within the years considered by this review his contact was with a number of services within ...in relation to assessment and ongoing treatment. He was diagnosed as having, ADHD, Autistic Spectrum Disorder (ASD), Moderate Learning Difficulties and Psychosis.

¹³ See for example publications and videos provided by Perry B .D., (The Child Trauma Academy). (2013) 1: The Human Brain [Video webcast]. In *Seven Slide Series*. and Sarah-Jayne Blakemore (2012) *the Mysterious Workings of the Teenage Brain*

¹⁴ Such as those identified by Perry and the ACE studies: The Adverse Childhood Experiences Study (**ACE Study**) Kaiser Permanente and the Centers for Disease Control and Prevention (1995-1997)

¹⁵ DSM-V is the Diagnostic and Statistical Manual of Mental Disorders whilst ICD10 is the International Statistical Classification of Diseases and Related Health Problems- Mental Health and Behaviour Disorders are listed under category V

¹⁶ An EHCP is an Educational Health Care Plan that outlines the needs of the child and which services will be commissioned to support the child.

Across Social Media support platforms for families there are over 5000 families seeking support via the VCB Facebook closed group network for CCVAB displayed by children with SEND¹⁷. This clearly is an important factor when officers attend incidents especially if families are contacting their local police for help in times of crisis.

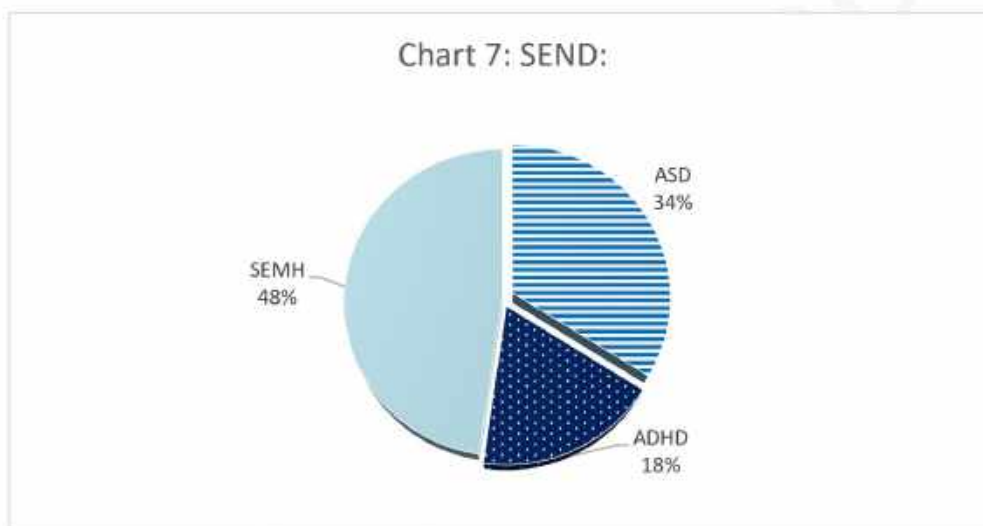
What is not discussed in the Home Office Guidance (2015) is the difference between chronological age and developmental stage, sometimes known as developmental age. The Home Office Guidance applies chronological age for police officers across England to refer to; this incorrectly presumes chronological age equates to developmental age. For children with SEND there is a real possibility that the child will have a range of developmental stages (ages) that may not reflect their chronological age. This means that when officers attend incidents, they do need to consider the child's developmental stage as well as the child's chronological age in any decision-making process.

¹⁷ This network is ran by Yvonne Newbold, a recognised and respected advocate for understanding CCVAB in children with SEND

Section 3.1: CCVAB and Special Educational Needs and Disability (SEND)

Of the 515 reports collated by Northumbria Police 153 children (30%) reportedly had SEND according to the parent/carer; although there is no confirmed record detailing if the child had an EHCP in place for their SEND. There were 3 main categories of SEND reported by parents to officers that were subsequently detailed in the incident report:

- 52 children had Autistic Spectrum Disorder (ASD)
- 28 children had Attention Deficit Hyperactivity Disorder (ADHD)
- 73 children had Social, Emotional or Mental health conditions, (SEMH)



At a time of increasing concern for children's mental wellbeing across England it is notable that parents of 66 children (43% of those with SEND) reported their child had SEMH (Social, Emotional or Mental Health difficulties) and a further 5% reported their child had SEMH as a co-morbid condition in one of the following:

- ASD, Obsessive Compulsive Disorder (OCD) and SEMH
- ADHD and Oppositional Defiance Disorder (ODD)
- ASD and Schizophrenia
- ASD, ADHD and SEMH
- ADHD, Dyspraxia and Attachment Disorder

Previous studies have shown that there is an increased risk when children have SEND particularly when there are a range of co-morbid conditions that include SEMH. Over 54% of families involved in Thorley and Coates (2018) lived with children displaying CCVAB who were diagnosed with SEMH either solely or as a co-morbidity. Thorley and Coates highlighted that for the majority of families in their studies SEMH included Attachment Disorders, Post Traumatic Stress Disorder, Complex Trauma and Global Development Delay. Adopters, Foster carers, Kinship carers and Special Guardians repeatedly state these particular disorders are seen in children they live with who display CCVAB, in particular Attachment difficulties.

The 'Coventry Grid' (2015) Section 6.1 explains why attachment difficulties can lead to behaviour described as CCVAB:

Typical Presentation in Attachment Problems-

Difficulty coping with extremes of emotion and recovering from them (e.g. excitement, fear, anger, sadness)...May provoke extreme emotional reactions in others ...Shows emotional displays to people child does not know (indiscriminate) and tends to carry on longer (e.g. temper tantrums occur anywhere and at any time)... (my extract and emphasis)

The need for officers to be aware of how SEND can influence behaviour is a fundamental necessity to their training for responding to incidents, to ensure the safety of all involved and recognise children with SEMH and those with co-morbidity conditions. In their study Thorley and Coates (2019) found the majority of their families included three co-morbid conditions for the children displaying CCVAB that alongside *Learning Difficulties*: Attachment, Anxiety, Foetal Alcohol Disorders or Mental Health indicators such as anxiety and depression. Anxiety and depression have been suggested in previous studies of CCVAB (Paulson et al. 1990; Calvete et al., 2012; Ibabe and Jaureguizar, 2012, Ibabe et al 2014b and 2014c). More specifically Kennedy *et al* (2010) recognised that in the United States where adolescents had been criminally charged for their behaviour there was a significant increase in suicide attempts and psychological stress.

The 'Coventry Grid' (2015) Section 6.1 also highlights how those with ASD may display behaviour described as CCVAB

Typical Presentation in ASD-

Extremes of emotion may provoke anxiety and repetitive questioning and behaviour... Does not easily learn management of emotions from modelling ... Emotions take over from

logic/knowledge of what one should do... Does not show displays of emotion to everyone ... Cognitive empathy is poor (my extract and emphasis)

In the data generated Autism was a reported condition for 19 (13%) children reported to have SEND when officers attended. Parents reported 2 children (1.4%) had Foetal Alcohol Spectrum Disorder (FASD) a condition often included in ASD generically. Officers do recognise the impact of specific conditions, during interview one officer who had attended an incident involving a 12-year-old girl reported to have Foetal Alcohol Syndrome noted:

...there was a hole in the wall between the bedroom and living room she had kicked the whole plasterboard down, ...(she)destroyed a whole partition wall ...I've had no training on APVA or mental health, this is not a normal child reaction

CCVAB as a behavioural aspect of ASD has been known for some time, for example in the DHR for Sarah her son Michael was known to display CCVAB and that this behaviour was escalating.

Michael's difficulties had presented from an early age....As Michael grew, his behavioural difficulties escalated, with signs of psychosis becoming apparent throughout 2015

In 2011, Anderson completed studies involving 1,380 children with ASD where they found 56% of their study group displayed CCVAB:

This new study provides confirmation that aggression is a major issue for caregivers of children on the autism spectrum, validating the experience of many and laying the groundwork for future research. It underscores the need for interventions to address aggression in children with ASD, and to support families coping with it (op.cit).

Attention Deficit Hyperactivity Disorder (ADHD) was reported by parents to officers for 18 children (13%), as a single diagnosis. In the same way as children with SEMH some children had ASD or ADHD as a co-morbidity. When including those children reported to have a co-morbidity the number of children with ADHD increased from 13% by a further

- 18% (25) children reported to have ADHD and ASD
- 0.7% (1) child reported to have ADHD, Epilepsy and Dyspraxia

- 0.7% (1) child reported to have ADHD and Dyspraxia
- 0.7% (1) child reported to have ASD, ADHD and FASD (Foetal Alcohol Spectrum Disorders)
- 1.4% (2) children reported to have ADHD and FASD

Previous discussions about CCVAB and ADHD have been made, including Ibabe *et al* (2013 p.527)

*Serious mental illnesses, such as schizophrenia or bipolar disorders, seem infrequent in adolescents who abuse their parents. However, behavior disorders such as **attention-deficit hyperactivity disorder**, show special relevance.* (my emphasis)

Overall the data collected by officers includes a range of diagnosed cognitive conditions that have previously been linked to CCVAB, yet specific guidance for officers when dealing with incidents involving children with SEND is not included in the Home Office Guidance. At present officers have to rely on their own understanding to inform them what action they should take when parents tell them their child may have or does have SEND. This personalised individual view can impact on providing effective support for families if there is no policy directive to follow. In his study Coogan (*Ibid*) noted children and young people were initially referred to CAMHS for ADHD or SEMH and it was only after the initial consultation any discussion included CCVAB. Officers face a similar dilemma, where they respond to incident reports and after arriving families explain the behaviour as part of a reported SEND condition.

Historically there is evidence that children who display CCVAB may be diagnosed with ASD or ADHD as an explanation for the child's behaviour. Gallagher (2008) found when the focus for behaviour was towards a medical condition, if a condition could not be identified the behaviour was seen to fall in one of the DSM-V areas such as Attention Deficit Hyperactivity Disorder. Alternatively, the Home Office may consider previous studies that have compared CCVAB and DSM-V classifications (American Psychiatric Association, 2013) which suggest *Disruptive, Impulse-control and Conduct Disorders*¹⁸ (Ibabe *et al*, 2014c) alongside Attention Deficit Hyperactivity Disorder. If the new Home Office Guidance recognises SEND impact on behaviour officers attending incidents can refer the child to Health Services and Children's Services as the more appropriate response team for the family. However, it needs to be made clear that a diagnosis of ASD or ADHD or any other condition, in itself,

¹⁸ The American Psychiatric Publishing Textbook of Psychiatry, (6th Ed.) (2014) . Chapter 22. Indicates that within Disruptive, Impulse-Control, and Conduct Disorders *The common thread that runs through these disorders is an underlying construct of emotional and/or behavioural dysregulation that results in impulsive behavior, aggressiveness, and pathological rule breaking. ... they are classified within DSM-5 together with disorders of impulse control that typically persist into adulthood.* (Hales R. E, Yudofsky S. C, Weiss Roberts L) (eds)

does not mean that the child will display CCVAB without this explicit clarity there is a real risk of encouraging assumption or bias to occur about children with SEND cognitive disorders.

Section 3.1 Recommendations: Identifying SEND and CCVAB behaviour

(building on National recommendation and Local Recommendations 1, 3, 4 6 and 7)

- Designate a named officer (may be part of MASH potentially funded by VRU) to collate named personnel involved with family so they are able to refer the child directly to relevant team professional by ascertaining
 - Does the child have an EHCP in place (this will help establish if the child is considered a child until age 25 as set out in Law)
 - Name of social worker in EHCP
 - Name of health professionals in EHCP
 - Name of school to identify: Safeguarding Lead, SENCo and where relevant Virtual School Team
 - If no EHCP in place who has been involved in identifying SEND to date-
 - name of GP this will help determine name of School Nurse Team, Health Visitors and so forth
 - name of School: name of year tutor or similar relevant person
 - Designated Teacher and Virtual School Team if involved with the child
- Designated named officer to summarise CCVAB incident and send referral to MASH partners for further action
 - Designated named officer to be informed of all follow up actions made via MASH partners for including in child's record with Northumbria Police, this will help officers called to any subsequent incidents
 - If no information is forthcoming after 3 months following the referral made by Northumbria Police- designated officer to query current position of MASH partners and record as need be
- Provide officers with basic training to enable them to understanding how CCVAB may be displayed by children with higher risk SEND indicators and recognise not all children with SEND will display CCVAB
- Provide introductory training to officers relating to ADHD and ASD to enable them to respond appropriately when attending incidents for children with these known conditions.

Section 3.2: CCVAB and Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences are evident for increasing the risk of mental health and behaviour difficulties in children, young people and adults. Nowakowski-Sims and Rowe (2017 p.266) noted *Childhood adversity places youth at risk for internalizing behaviors (i.e. anxiety and depression) and externalizing behaviors (i.e. aggression)*. The need for more comprehensive understanding of ACEs in the context of CCVAB is needed and could help explain why a higher prevalence of CCVAB occurs in

- specific local areas, or
- specific age groups or
- in particular families such as adoptive, foster care, kinship care or Special Guardian

It is now recognised that experiences and neurological brain patterning, developed during pre-natal and early post-natal periods influence how the growing child thinks and behaves, for example see Perry's NeuroSequential Model (2006) and Van der Kolk's (2014) discussion about 'The Body Keeps the Score'. Van der Kolk recognised that even when in a safe and secure environment the internalised feelings and sensations previously experienced continue to inform the wellbeing and externalised behaviour. Understanding ACEs provides reasons why children who are Looked After, Previously Looked After or children with SEND can be proportionally more likely to display CCVAB than their peers.

There is significant support for Achenbach and Edelbrock (1978) who suggested children's behaviour can be an accumulation of both internal and external manifestations; something Bonnick (2016) also noted:

The further I have looked at the issues the more I am drawn to the centrality of trauma for many of the young people across the board, whether in witnessing DV, experiencing CSE, being involved in gangs or criminal activity.

For some children their internalised feelings can include:

- struggling to decode social cues
- low self-esteem
- social isolation

- attention seeking
- low self-confidence
- poor self-image or notions of worthlessness.

These internalised feelings can then lead to externalised aggressive behaviour. Children's inability to regulate their emotions or 'control of behaviour' has been the focus of a number of discussions, including:

- parents who have unrealistic expectations
- parental deficit in communication skills
- poor parent discipline/supervision or inability to provide appropriate emotional support¹⁹ as seen in the DHR for Sarah:

*Sarah's contact with agencies demonstrated a mother devoted to her son, who, with the help of her own parents, fought hard to provide a safe environment for him, whilst also managing her own health difficulties and maintaining two jobs. As Michael's behaviour worsened, the increasing despair of the family can be seen as they tried to make agencies understand the depth of their concerns and the difficulties they were having in managing these. **Despite these attempts, focus was often placed by agencies on Sarah's parenting** and the need to control Michael's behaviour, even when his presentation clearly demonstrated increasing risk, and indicated that the interventions needed were beyond those of behaviour management (my emphasis)*

For some children the adversity they experience during childhood is as a result of their relationship with their parent/ carers for example, those children who experience child abuse. If children experience child abuse as an ACE this can inform their behaviour responses and can be an indicator in CCVAB. Northumbria Police operate in an area that has significantly higher ACE indicators than average for England how these increase the risk of CCVAB occurrences is unknown. What is known is that there are different forms of aggression and aggression is used for different 'functions' (Girard *et al*, 2019). The Home Office definition of APVA and current definitions of CCVAB describe 'proactive aggression'

which is calculated, instrumental, and predatory in nature, has been linked to gang membership, substance abuse, delinquency, anti-sociality and psychopathic features in adulthood. Proactive aggression has been argued to coincide with a social learning

¹⁹ See for example Kennedy *et al*, 2010; Calvete *et al.*, 2012; Ibabe, 2014 and 2016 and Nowakowski-Sims and Rowe, (2017)

model of aggression, in so much as the aggression can be operationalized as a learned behaviour that is goal driven. That is, the aggression is used to obtain an instrumental goal or reward (e.g., a desired object or social status within the peer group), and reinforced via operant conditioning (i.e., goal attainment). Within this framework, proactive aggression ought to either remain stable, or increase overtime. (Girard et al, 2019 p.826)

Discussions of CCVAB as a 'learned' behaviour applies the 'proactive aggression' view. These 'proactive' aggression positions support the belief that CCVAB is a 'learned' behaviour, for example CCVAB displayed by children living in domestic violence households²⁰. On the other hand, 'reactive aggression' is also possible for children displaying CCVAB who have experienced Domestic Violence:

Reactive aggression on the other hand, often provoked by anger in reaction to a perceived threat, is defensive in nature and has been associated with internalizing difficulties such as negative affect, depression, anxiety and additionally problems with self-regulation. Reactive aggression has predominantly been operationalized within Berkowitz's frustration model of aggression (Berkowitz 1988, 1989) given that the aggression is reactive rather than instrumental. It is a consequence of perceived provocation resulting in anger and retaliatory responses. Deficits in self control, emotional regulation, and impulsivity are characteristics of high levels of reactive aggression. As a result, reactive aggression is likely to decrease with brain maturation across development and as children become better able to self-regulate. (Girard et al, 2019 p.826)

In the majority of guidance for CCVAB management, there appears to be little recognition for 'reactive aggression'. Emerging understanding of the neurodevelopment impact of ACEs, as well as neurodevelopment behaviours used to diagnose conditions such as ADHD or ASD, acknowledge the difficulties children can have in learning to 'self-regulate'. This means officers attending incidents need to be aware of different types and functions of aggression rather than adopt one view. Any new policies or guidance should include proactive and reactive possibilities, particularly at a time when the importance of 'connection before correction' (trauma informed approaches). Trauma informed approaches are currently being developed across all services supporting children and families in education, health and social care for the areas serviced by Northumbria Police. For this reason, it is worth considering the range of ACE indicators across the Northumbria Police operational area as these are fundamental aspects of children's lives. To consider ACE outcomes for children it is necessary to understand the family units some children live in that lead to ACEs. This understanding

²⁰ The traditional view that behaviour is 'learned' reflects the work of Bandura and the Bobo Doll and behaviourists such as Skinner

of home life underpins which ACEs may impact on children's development and subsequent behaviour. Using information about children across the force's operational area, opens up understanding about those children officers are involved with.

ACEs: The Toxic Trio and CCVAB

The '**Toxic Trio**' of adverse childhood experiences are substance misuse, domestic violence and adult mental ill health. Concern for the 'Toxic Trio' led to the Children's Commissioner report 2018²¹ about:

- *Domestic violence and abuse (DV&A) within the household*
- *Parental substance misuse (alcohol or drugs)*
- *Parental mental health issues*

However there continues to be a lot of discussion about the level of ACE risk posed, particularly around what is a lower risk or higher risk; for example,²²

Higher Risk?

- *Chronic emotional neglect due to parental use (including alcohol/cannabis/benzos/opiates/other drugs)*
- *Illegal substance use exposing children to crime*
- *Drug/alcohol use resulting in violence*
- *Chaotic substance use resulting in chronic absence from school*

Middle Risk?

- *Occasional drunkenness seen by children*
- *Smoking around children*
- *Drug/alcohol use resulting in aggression*
- *Occasional miss school due to parent's alcohol/drug use at a party*

Lower Risk?

- *Occasional alcohol consumption above guidelines posing bad example*
- *Occasional cannabis use unknown to children*

²¹ Children's Commissioner (2018) Estimating the prevalence of the 'toxic trio' Evidence from the Adult Psychiatric Morbidity Survey Vulnerability Technical Report 2 July 2018

²² Presented within Fitzgerald, N, Heywood, S and Winterbottom, J (2013) Reducing harm to children and families affected by parental substance misuse: assessment of need and services in Midlothian and East Lothian. Page 18

- A parent smoking (even if not in presence of children)

What is known is that some children in the Northumbria Police operational area do grow up in a 'Toxic Trio' household.

Toxic Trio 1: Domestic Violence and CCVAB

Domestic Violence is a recognised ACE that can lead to children becoming Looked After in Corporate Care. Breman and Macrae (2017, p.5) explained becoming a child in corporate care currently or previously is, in itself, a traumatic experience as well as a transitional experience that children have little or no say in due to the Court Order processes determined by adults. They found *"Just under half the carers reported experiencing family violence caused by the child in care. The majority of violence was caused by boys and younger children of both genders, suggesting trauma and distress emanating from children's experiences of trauma and separation from their parents"* (ibid p.5) a factor recognised in other studies²³. This highlights how Domestic Violence in itself may not be the cause of CCVAB but the combination of domestic violence and separation from family. Domestic Violence as an ACE indicator is a factor for children in Northumbria Police operational area. For the year ending 31st March 2019, 6959 children had domestic violence noted in child protection assessment data as detailed:

Table 1	Domestic violence
North East	13,550
Gateshead	991
Newcastle upon Tyne	1,767
North Tyneside	576
Northumberland	1,366
South Tyneside	628
Sunderland	1,631

Reference source: Table C3: Number of episodes¹ with assessment² factor information, in the year ending 31 March 2019 by local authority and factors identified at the end of assessment- Year: 2018-2019 Coverage: England

Children living with domestic violence experience higher levels of anxiety than their peers due to the uncertainty of when the violence will occur. This higher level of anxiety can lead to a loss of confidence, self-esteem and stigma as well as secrecy and shame. Buckley *et al* noted that these

²³ see for example Cottrell, 2001, and more recently Coogan and Lauster, 2015; as well as Selwyn and Meakins, 2015; who similarly highlight this issue.

children and young people were 3 times more likely to engage in challenging behaviour at school, resulting in further 'punishment' and shame. What is notable for police is the number of 'Children in Need'²⁴ due to Domestic Violence in Sunderland and Newcastle. Both Sunderland and Newcastle have a high number of families living with Domestic Violence but have some of the lowest incidents of CCVAB. Previous studies have suggested that living with domestic violence increases the risk of CCVAB occurring particularly in adolescence, yet the evidence for Sunderland and Newcastle would dispute this suggestion. Alternatively, Northumberland also has the highest number of CCVAB incidents and also a higher level of Domestic Violence whilst South Tyneside has a lower level of Domestic Violence but a higher level of CCVAB. What the evidence shows is that for some children who have ACEs due to domestic Violence there may be an increased risk of CCVAB occurring but this is not a definitive risk given there are areas with high levels of domestic violence and low levels of CCVAB.

Toxic Trio 2: Substance Misuse and CCVAB

On the 24th April 2018, the Department of Health and Social Care announced further details about the government's pledge to support children of alcohol-dependant parent/carers²⁵. An estimated 1:5 children in the UK live with a parent who is an alcoholic²⁶ equal to six children in every classroom in England (for class sizes of 30 pupils).

Children living with the adversity of parental substance misuse are:

- twice as likely to experience difficulties at school
- three times more likely to consider suicide
- four times more likely to become alcohol dependant themselves
- five times more likely to develop eating disorders²⁷

²⁴ Children in Need (CIN) is a term used for all children who are being supported by Statutory Sector provision across a range of services and includes those children with SEND, Young Carers, children who are looked After in corporate care and children of families where the parent is disabled or has a range of medical needs. The number of children classified as in need is reported each year following collation of data on 31st March of each year.

²⁵ The All Party Parliamentary Group (APPG) (2018) Manifesto for Change can be accessed and downloaded from: <http://liambyrne.co.uk/wp-content/uploads/2017/02/Children-of-Alcoholics-A-Manifesto-for-Change-pages.pdf>

²⁶ The National Association for Children of Alcoholics (2018)- Nacoa (The National Association for Children of Alcoholics) is a registered charity (No. 1009143), founded in 1990 to address the needs of children growing up in families where one or both parents suffer from alcoholism or a similar addictive problem. For more details go to: <http://nacoa.org.uk/children.html>

²⁷ As reported by the APPG (2018)

Living with parental Substance Misuse, as an ACE indicator, is a factor for children in the police operational area. For the year ending 31st March 2019, 12800 children had substance misuse noted in child protection assessment data as detailed:

Table 2²⁸	Alcohol misuse	Drug misuse
North East	5,920	6,880
Gateshead	515	487
Newcastle upon Tyne	829	954
North Tyneside	324	314
Northumberland	752	789
South Tyneside	239	253
Sunderland	784	808

It is interesting that South Tyneside has the lowest level of adult substance misuse given South Shields, in South Tyneside, has the highest level of CCVAB incidents. In contrast Newcastle and Sunderland have the highest levels of adult substance misuse yet the lowest levels of CCVAB incidents. In some homes the parent may be misusing drugs and alcohol, or in some homes it will be one substance rather than both. A major adversity for children is the relationship between substance misuse and domestic violence as an adverse childhood experience. In the information booklet for teachers²⁹, NACOA (The National Association for Children of Alcoholics) suggest pupils living with parental substance misuse are six times more likely to also witness domestic violence. Public Health England has recorded a range of data regarding substance misuse across England and whilst this does not specifically distinguish between parents and non-parents it does help provide an environmental and societal overview of the area. For the year 2017/2018, compared to the benchmark for England, every region in the North East was 'worse' for NHS admission episodes linked to alcohol related conditions. It is not unreasonable to consider a significant number of these adults are parents. Children living with parents who misuse substances are much more likely to misuse substances themselves. The North East as a region continues to have the highest NHS

²⁸ Reference for Table 2:- Table C3: Number of episodes¹ with assessment² factor information, in the year ending 31 March 2019 by local authority and factors identified at the end of assessment. Department of Education (2019)

²⁹ Available to download at: <http://www.nacoa.org.uk/media/files/Information%20for%20Teachers.pdf>

admission episodes for alcohol related conditions of under 18's³⁰. These factors evidence the relationship between

'ACE → underage substance misuse → CCVAB incidents'

The longer-term issue is that of alcoholic specific death that confirms the high levels of substance misuse in the police force operational area yet simultaneously suggest adult substance misuse in itself is not influential in increasing the risk of children displaying CCVAB

Table 3: Alcohol specific deaths	Rate per 100,000	Northumbria Police Area	Rate per 100,000
England	10.6	Newcastle upon Tyne	15.6
North East Region	16.0	Northumberland	11.9
		Sunderland	21.0

As detailed the North East Region has a significantly higher number of Alcohol Related deaths recorded than that of the UK average. In the Northumbria Police operational area Newcastle, Sunderland and Northumberland are of interest. Newcastle and Sunderland have higher levels of alcohol specific deaths but lower levels of CCVAB incidents. The Public Health England report: *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2017 to 31 March 2018*, identified the majority (53%) of people over 18 receiving help for substance misuse were those addicted to opiates, with alcohol dependency the second highest category (28%). During the period 2017-2018, NDTMS began collating data from adults who were also parents for the first-time. The data collected allowed NDTMS to identify that only 8% of parents indicated a child protection plan was in place for their family that recognised their children as Children in Need suggesting the majority of children living with adult substance misuse continues to be unknown.

As reported by Hardy (2017), parental substance misuse is noted in a number of child protection plans and in addition to the substance misuse there are often interlinked ACEs including domestic violence, neglect, mental ill health and the risk of emotional or physical abuse³¹. The Institute of Alcohol Studies (2017) explored the effect of non-dependent parental drinking on children, highlighting non-dependent drinking could also influence children's decision-making leading to risk

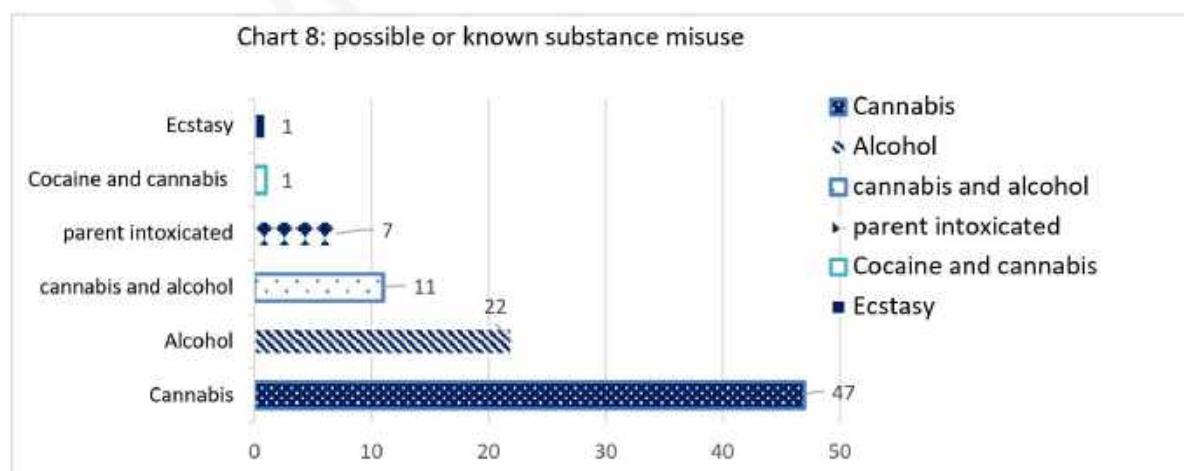
³⁰ Only Hartlepool was the exception to being 'worse' than the benchmark set for England and recorded by Public Health England.

³¹ For example: Smith L (2017)

taking behaviours. The main barrier to identifying the risk posed by parental alcohol misuse is lack of data. Numerous studies discuss the physical and psychological impact on the children of parents who are dependent on alcohol or drugs. Newer studies highlight this is an issue for children whose parents are occasionally under the influence of a substance also³². McGovern *et al* (2018) discussed parental non-dependant substance misuse. They found the majority of studies estimate 2-4% of children live with 'harmful' drinkers and a further 12-29% lived with hazardous drinkers - this means 1 in 3 children in every class in England could have children living with parental substance misuse. Of equal importance is the number of children living with parental drug use, currently estimated to be 8% of all children, with as many as 4% of these living with both alcohol and drug parental misuse. In addition, where parental substance misuse was evident the majority of families were found to be 'vulnerable' suggesting substance misuse is one of several ACEs for children. There is a higher risk of children living with parental substance misuse struggling to externalise difficulties leading to higher levels of *conduct disorder, oppositional defiant disorder, attention difficulties, violent and rebellious behaviour* (McGovern *et al*, 2018) something also found in children who display CCVAB. The relevance of ACE impact and CCVAB builds on what is already known:

- Higher levels of ACEs increase the risk of Alcohol or Drug misuse in underage children
- Alcohol or Drug misuse by adolescents has been seen as a causal factor in CCVAB studies

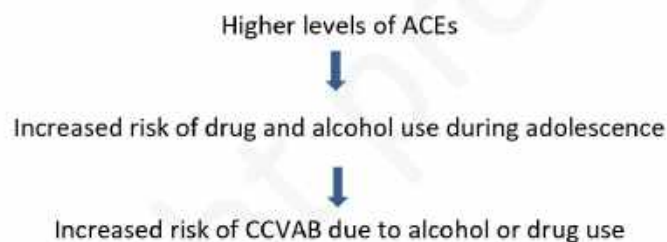
In the dataset officers recorded 89 incidents (17.3% of all incidents recorded) involved substance misuse by children displaying CCVAB, as indicted in Chart 8:



³² Currently, there are two guidelines available, the first is that of unit approach - calculating how many units of alcohol are consumed over the period of the week; alternatively, the World Health Organisation provide an Alcohol Use Disorder Identification Test as a screening tool that identifies three levels of drinking: hazardous (posing harm to self or others), harmful (causing physical and mental health problems to self as a direct result of drinking alcohol) and alcohol dependence (drinking above harmful levels and desire to continue to do so, as well as struggling to control drinking needs).

- ◆ 47 incidents included Cannabis misuse by the child
- ◆ 22 incidents included Alcohol misuse by the child
- ◆ 11 incidents included both alcohol and cannabis misuse by the child
- ◆ 1 incident included Ecstasy substance misuse by the child
- ◆ 1 incident included Cocaine and Cannabis substance misuse by the child
- ◆ 7 incidents included parental alcohol misuse

There are few studies to date that have looked into ACEs and alcohol or drug related CCVAB specifically. There are studies that have looked at ACEs and risk-taking behaviours in young teens including increased risk of substance misuse. There are also studies that have considered substance abuse in adolescence and CCVAB, but very few have considered



However, there is evidence³³ that children in police force operational area do engage in higher levels of substance misuse than their peers across England during adolescence:

Table 4	Alcohol specific conditions under 18 ³⁴	Substance misuse 15-24 years ³⁵
England	32.9	87.9
Gateshead	74.4	127.6
North Tyneside	81.2	149.1
Newcastle	43.3	72.6
South Tyneside	106.5	162.4
Sunderland	92.6	99.1
Northumberland	45.2	128.4

³³ Data source: March 2019 Health Profiles for England

³⁴ Hospital admissions for alcohol-specific conditions –under 18 year olds, crude rate per 100,000 population, 2015/16-2017/18

³⁵ Directly standardised rate per 100,000 (aged 15-24 years) for hospital admissions for substance misuse, 2015/16-2017/18

Hospital admission of under 18 year olds across England for alcohol-specific conditions is 32.9 per 100,000 population (2015/16-2017/18). Across all of the Northumbria Police operational areas the hospital admission rate is higher. However, it is important to note this is the hospital admission rate not the rate of young people drinking alcohol (many young people consume alcohol but do not need hospital admission). Across England the hospital admissions rate for 15-24-year olds due to substance misuse is 87.9 per 100,000 population (2015/16-2017/18). Across the Northumbria Police only Newcastle has a rate lower at 72.6. However, the underage alcohol consumption rate in Newcastle is higher than the average for England which is 43.3. This may explain why incidents for Newcastle involved only those over 15 years of age and no children under 15 years of age.

South Shields in South Tyneside had the highest level of CCVAB incidents and South Tyneside has the highest level of underage drinking and substance misuse across the Northumbria Police operational area. Admission for alcohol related illness is 106.5 more than three times that of England; and for drug misuse 162.4 almost double that of England. Officers responding to incidents in South Tyneside particularly in South Shields may understand that substance misuse can lead to CCVAB incidents but may not be aware that higher ACEs increase the risk of substance misuse in adolescents. This means the CCVAB may appear to be a result of the child's substance misuse rather than the child's ACEs.

South Tyneside is not the only area with two to three times the National average for underage alcohol consumption: Gateshead (74.4), North Tyneside (81.2), and Sunderland (92.6) also have higher levels. Wallsend is part of North Tyneside and has the second highest level of CCVAB incidents. North Tyneside also has higher than average drug misuse by 15-24-year olds at 149.1 per 100,000 along with Gateshead (127.6), and Sunderland (99.1) against the England indicator of 87.9. What needs to be remembered is that these adolescents are those who are known because of their hospital admission and there are many more who engage in substance misuse that are unknown. The drug and alcohol levels across the force operational area needs to be fully investigated to consider if the cause of the behaviour is substance related; and if so, what are the underlying reasons for substance misuse. Officers are aware that substance misuse is a factor in CCVAB incidents they attend, in one case study a parent stated:

X had to call the police for the third time in three weeks due to the violent behaviour of her son (15) who had pushed her (was being very aggressive)and locked himself in the bathroom).. he has ADHD and autism, the medication that is supposed to keep him calm is not working.....worried he is misusing alcohol and drugs. Mum had a planned meeting with the Early Help Team but was feeling despair and was not confident as previous

meetings failed to give her a strategy to improve Xs behaviour. She was told to just call the police which she feels is having a detrimental effect on all concerned (timeline case study 1)

I think he'd been using drugs as there was a smell in the room when we'd been up to see him. He was aggressive towards us and continued and I think it took four of us, which isn't ideal and doesn't look good. (Officer interview)

In a further timeline officers identified 8 previous incidents within a 12-month period, involving a female child aged 12 years who was intoxicated and becoming increasingly aggressive with her mother. Officers are also concerned about the wider implications for families:

There was adult as well as younger sibling vulnerability, following violent abuse from two adolescent children (15 and 16) within the home over a period of time, where drug use was also suspected. The young person (16) had indicated he had taken a range of both legal highs and illegal drugs. (officer interview)

The mother's statement identifies her distress

I'm sick and tired of Xs behaviour and I don't know how much more I can take. It breaks my heart that my family are being torn to pieces...I understand he has mental health problems....it is not an excuse for his behaviour and actions (incident report review)

This family were referred for a risk assessment under S47 Children Act (1989) as younger siblings in the home were being affected by his behaviour. (incident report review)

To gain a better understanding of risk-taking behaviour by those 11-15 years of age the NHS (2018)³⁶ collects *Smoking, Drinking and Drug use among Young People in England (SDD)* from pupils in secondary schools that are completed in school under exam type conditions without involvement of parents or teachers. From information gained 44% of secondary pupils stated that they had drunk alcohol. Drinking alcohol involved children aged 11 years old (15%) and increased in step by step

³⁶ NHS digital (2018) Statistics on alcohol, England. (2018) (PAS) National Statistics 1st May 2018. (part 5 Drinking Behaviours among Children) <https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2018/part-5>

fashion to those aged 15 years (73%). For the majority of under 18's alcohol consumption was over the weekend however, there were pupils who accessed alcohol during the week. On average young people had drank 9.6 units of alcohol in the previous week. The average for pupils aged 11-13 years was 6.9 units and for 15-year olds around 10 units. The highest consumption of alcohol was by those aged 14 years who drank just over 11 units in the previous week. The alcohol consumption rate for pupils in the North is between 72-77.6%. It is interesting that children aged 14 years are the highest number of underage children consuming alcohol and the highest number of children displaying CCVAB across the Northumbria Police force area. Of particular concern is the number of young people who consume alcohol prior to suicide, it is estimated that as many as 1:3 young people have consumed alcohol prior to their suicide. This is relevant to Northumbria Police given the number of incidents they attend involving children reported to have SEMH.

Balance North East recognises the difficult position the North East has for underage alcohol consumption. They also recognise the relationships between other risk-taking behaviours where 40% of 13-year olds and 58% of 15-year olds who consume alcohol also smoke cigarettes, misuse substances and engage in unprotected sex. All of these risk-taking behaviours are recognised as risk indicators for those who have higher levels of ACEs. The Department for Education³⁷ (2018) *data for 2016-17 showed school exclusions for alcohol and drug use have increased substantially in recent years with fixed term exclusions up by 34% since 2012-13 and permanent exclusions up by 95% since 2010-11.* (p.5). The relationship between young people, ACEs and CCVAB cannot be overlooked given the age range for CCVAB incidents police attended.

Toxic Trio 3: Parental Mental Health and CCVAB:

In a briefing report published by the House of Commons in April 2018 about mental health prevalence, services and funding³⁸ and the *Improving Access to Psychological therapies (IAPT)* initiative, it was estimated that 1:6 people had experienced a common mental health disorder in the previous week. It was also observed younger people and those living in areas of deprivation were less likely to recover from the specific condition presented even after intervention. The discussion showed the number of people accessing IAPT in the North East at 16%. This supports previous suggestions of mental health outcomes related to ACEs. Living with parental mental health as an ACE indicator is a factor for 7,976 children in the Northumbria Police operational area:

³⁷ Department for Education (2018) Permanent and fixed period exclusions in England: 2016 to 2017. Published 2018. www.gov.uk/government/statistics/permanent-and-fixed-period-exclusions-in-england-2016-to-2017

³⁸ See House of Commons Library- BRIEFING PAPER, Number 6988, 25 April 2018,

Table 5:	Adult MH	Child Self Harm
Gateshead	790	125
Newcastle upon Tyne	2,128	201
North Tyneside	635	48
Northumberland	2,049	194
South Tyneside	735	100
Sunderland	1,639	296

Table C3: Number of episodes¹ with assessment² factor information, in the year ending 31 March 2019 by local authority and factors identified at the end of assessment
Department of Education (2019)

However, once again Sunderland and Newcastle have notably high levels of Mental Health concerns yet low levels of CCVAB incidents. The lack of support for those with Mental Health needs continues to be a concern in England as outlined in media reporting at the end of 2018³⁹ suggesting 1:6 people aged 16-64 were experiencing mental health difficulties, some of whom will be adolescent children who display CCVAB as found when officers attend incidents:

'We knew quite a bit and we'd already been to the house numerous times in regards to different people but mainly this lad. We knew what he'd done and who was in the house but we also knew that he had difficulties such as mental health and possibly learning disabilities.' (Officer interview)

We are the service that can't say 'no' but it feels often like it's a CAMHS or social care issue and we're a sticking plaster. (Officer interview)

More recent discussions suggest the number of adult mental health difficulties is higher and is actually ¼ of adults (1:4) across the population. This is relevant to children who may display CCVAB if, as suggested, between 33%-66%⁴⁰ of children living with parental mental health will themselves go on to experience mental health difficulties, and up to 90% of parents with mental health difficulties (known to social workers as part of their caseload) will also participate in substance misuse. There are 6,000 suicides per year in England, it is now understood the majority of mental health conditions (75%) are established by 24 years of age and frequently commence much earlier during the teen years. The North East also has the highest suicide rate across England. In September 2018, the Office for National Statistics published details of suicides⁴¹, noting in 2017 there were

³⁹ Brown and Trigg (2018) BBC News Mental health

⁴⁰ A factor also noted by Jo Aldridge (2019)

⁴¹ ONS (2018). Suicides in the UK: 2017 registrations. Registered deaths in the UK from suicide.

5,821 suicides (10.1 deaths per 100,000). However, the North East continued to remain higher than other regions with a rate of 10.8 per 100,000 for 2017; something that is not helped when living with CCVAB without any support forthcoming:

incident record recognises the vulnerability of the mother, the boy (14) years old is noted as being much bigger in stature than his mother. The police also noted concerns about the mother's mental health and isolation, noting a previous suicide attempt approximately 9 months earlier. (incident record in timeline)

A mother was admitted to critical care following an overdose. She had been unresponsive when found by a relative. Once she regained consciousness, she stated to the nursing staff that she wanted to die because of the violence and abuse she faces from her 13 year old son, but also because of the debt she has accrued buying her son things to keep the peace in the family home. He had previously broken her finger and prevents her from leaving the home to visit friends. Both the child and the parent were referred to children's and adult social services, with the mother already known to a mental health team. (Incident report review)

For Northumbria Police attending incidents of CCVAB the mental wellbeing of the child is also a concern as seen in the case studies and interviews:

One case record has Child concern for domestic violence but there are 28 incident records, 2 have a firearms warning, the remainder include Child concern, Operation Encompass, domestic violence, self-harm, MARRAC, so there is lots happening and shows the complex situation the child was living in (incident report timeline review)

To date there is no evidence of how ACE risk indicators map against CCVAB incidents. While the evidence in this study is insufficient to prove impact it is interesting that levels of self-harm in those aged 10-24 years and school pupils with SEMH are higher in the same local areas reporting higher levels of CCVAB incidents. Northumberland had the highest level of CCVAB incidents, Northumberland also has the highest level of self-harm at 720.5 per 100,000 children and SEMH at 3.1% (1404 per 100,000) pupils. The level of self-harm and SEMH needs further investigation against the CCVAB incidents for this area to establish how many of the children displaying CCVAB have been identified with SEMH or self-harm behaviour as already seen by officers attending incidents:

The 15 year old boy was identified as vulnerable, having autism (specifically ADHD and Autism) and there was a high risk of DV in the home, there had been four Concern for

Child Notices (CCN) in the last 12 months. There was also concern for this young person as he had previously self-harmed and had attempted suicide in the past. He had previously hit his head against walls, a blade had been found in his bag and there were marks on his wrists. He was also displaying aggressive behaviour. (Officer interview)

South Tyneside also has a higher level of self-harm and SEMH than England, again further investigation needs to establish how many are also displaying CCVAB. However, it is important to consider the causes of SEMH or self-harm to assess if these are ACE or trauma related and any CCVAB seen is 'reactive' rather than 'proactive'.

North Tyneside has higher self-harm but lower SEMH and whilst SEMH is lower, the level of self-harm should not be overlooked when officers attend CCVAB incidents. In contrast Gateshead, Newcastle and Sunderland had the lowest levels of CCVAB but still have higher levels of either self-harm or SEMH than the average for England. This suggests further investigation is needed to establish any correlation between SEMH, self-harm and CCVAB; and if the self-harm or SEMH is a behaviour displayed as a result of ACEs, as highlighted in Table 6:

Table 6	Self-harm 10-24 years ⁴²	School pupils with social, emotional and mental health needs (2018)
England	421.2	193,657 (2.4%)
Gateshead	386.1	634 (2.2%)
North Tyneside	655.2	774 (2.2%)
Newcastle	437.8	1024 (2.6%)
South Tyneside	590.9	592 (2.7%)
Sunderland	328.2	1239 (3.1%)
Northumberland	720.5	1404 (3.1%)

It needs to be remembered that the indicators for self-harm and SEMH only reflect those known, and do not include those who self-harm but are not known or those with SEMH behaviour that has not been confirmed or diagnosed. Where SEMH behaviour has not been diagnosed or identified the behaviour could be viewed as CCVAB. Across the Northumbria force operational area 964 children

⁴² Directly standardised rate per 100,000 (aged 10-24 years) for hospital admissions for self-harm, 2017/18

were referred to Children's services or the period ending March 2019 for self-harm. This is a significant rise given the number of referrals raised from 990 in 2018 to 1330 in 2019 for the North East as a region.

The issue of Children's Mental Health across England has been featured almost weekly if not daily across social media for over 2 years, with significant comments regarding lack of service provision. As reported, the continued lack of provision is not new and reinforces Abdinasir and Pona's (2015) study of 'a teenager's pathway through the mental health system' highlighting waiting times of between 13 and 140 days and 15% of referrals denied access without further action. In 2016 the Children's Commissioner agreed with this estimate, that on average 28% of referrals were declined; something that appears to continue to be problematic across England⁴³. The argument for rejection was that the young person's mental health concern was not serious enough yet included those who had been referred following self-harm or concerns for life safety. Suicide is the leading cause of death for 15-24-year olds in England and almost all of those committing suicide had been in contact with service providers⁴⁴. The consequence of delay can include escalation of mental health difficulties, leading to increased risk-taking behaviours such as substance misuse that in turn can increase incidents of CCVAB. Child mental wellbeing needs further review in incidents of CCVAB given the number of incidents officers responded to that included discussion of the child's mental well-being:

One mother had called the police following her son (16) throwing a chair at her, it is noted on the case file that she believes he may have mental health issues or Autism or ADHD but never diagnosed as he refuses to accept any help and admit he has anger issues or any problems that may be the cause of his temper (Officer interview)

One record identifies from the outset that the child with significant mental health issues, Autism, epilepsy and chronic OCD had had a significant episode, resulting in injuries to her mother. This young person had an open case to children's services. Whilst the police attended, health professionals were also present, this led to no further action being taken by the police (incident case review)

⁴³ Crenna-Jennings and Hutchinson J (2018) Access to children and young peoples mental health services

⁴⁴ The Healthcare Quality Improvement Partnership (HQIP) (2017)

ACE: Poverty

The North East of England is a demographic area of multiple deprivation. Included in the ACE risk factors are those that are identified as increasing mental health illness, such as: divorce, domestic violence, poor housing and poverty. The level of child poverty for England is 1:4 (25%). Child Poverty is noted in Local Wards rather than the demarcation used by Northumbria Police of local areas. However, Northumbria Police can still compare level of child poverty against level of CCVAB incidents to decide if child poverty increases the risk of CCVAB incidents. Across Northumbria Police force operational area there are some of the highest levels of child poverty in England. In some areas child poverty rates are over 50% as detailed in Appendix 2. It is interesting some areas with the highest levels of child poverty- over 50% (1:2 children) such as Newcastle, have the lower levels of CCVAB. This would suggest that child poverty is not a prevalence indicator for CCVAB occurring. Alternatively, there are other areas, such as those in South Shields and Ashington where high levels of poverty might be a factor in higher levels of CCVAB incidents. Levels of poverty and causes of poverty such as parental mental ill health or unemployment would need to be mapped against other aspects known that increase externalised behaviour for children with a higher level of childhood adversity. For this reason, child poverty should not be discounted as a potential risk indicator for CCVAB occurrence.

Section 3.2 Recommendations: Identifying SEND and CCVAB behaviour

(building on National recommendation and Local Recommendations 1, 3, 4 6 and 7)

- Designate a named officer (may be part of MASH) to collate yearly:
 - ACEs risk taking behaviour by underage children known to occur across Northumbria Police operational area associated with higher ACE indicators
 - Areas of higher levels of child substance misuse
 - Known Toxic Trio indicators for the operational force area
 - Areas with high ACE risk indicators including adult behaviour indicators of ACEs
- Designate a named officer (may be part of MASH potentially funded by VRU) to collate quarterly:
 - Rates of CCVAB incidents to Local Authority and map ACE indicators for that area to reflect on potential correlation
 - Disseminate findings from this mapping to relevant senior officers across the force for wider dissemination and sharing

- Designate a named officer (may be part of MASH potentially funded by VRU) to refer children involved in CCVAB incidents who have misused substances to relevant MASH partners as a Safeguarding concern
- Provide ACE awareness training for all officers in Northumbria Police
- Provide Neuro-development training for all officers in Northumbria Police (this training can be part of ACE awareness) to enable them to respond effectively to children who have experienced significant childhood adversity
- Collate information gathered and share with all those involved with children locally- Schools in particular need to be involved

Section 4:

CCVAB requiring Police intervention

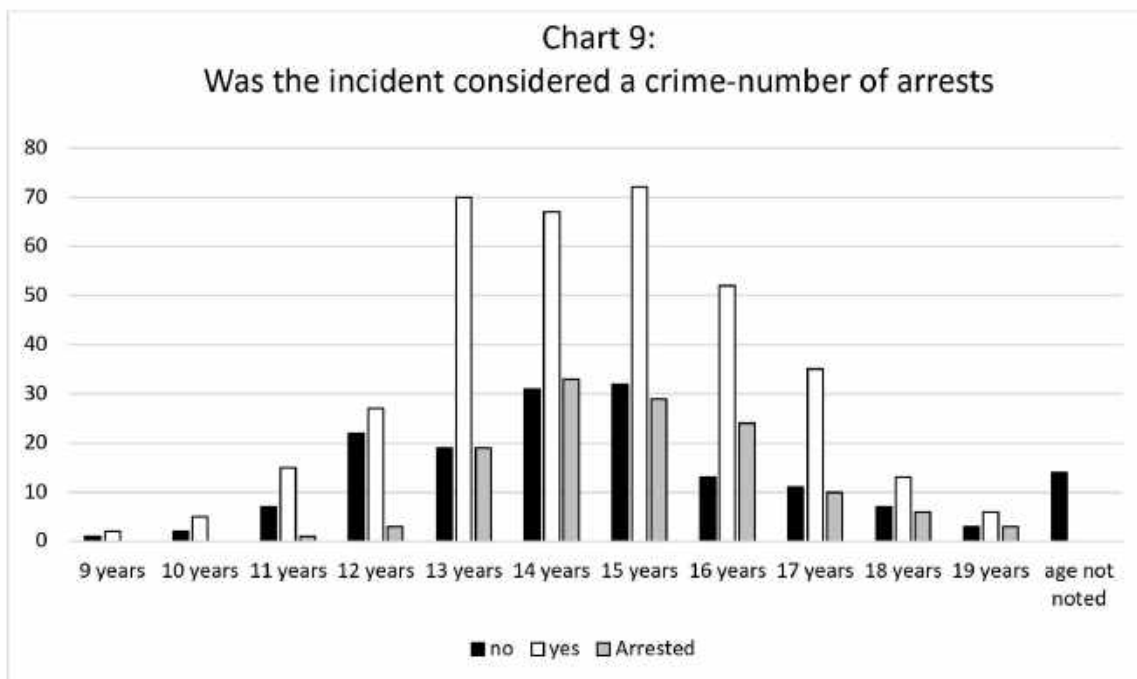
Within their report Thorley and Coates (2018) found 89% of CCVAB behaviour displayed by the first (or only child) was physical violence or aggression without weapons and 81% related to verbal threats that were aggressive. They found types of physical violence without weapons included kicking, biting, punching, slapping, grabbing, pushing or attempted strangulation, resulting in bruising or physical injury. Similar aggressive behaviour was identified in the DHR for Sarah:

As the situation deteriorated, both Michael's self-harm and the increasing risk to Sarah can be seen. Reports of abuse and assaults by Michael increased and included him swearing at his mother, hitting her, throwing things at her, grabbing her by the throat, threatening her with a knife, and stating that he was going to kill her.

Studies by Thorley and Coates, Parentline and Adoption UK have identified that for many families CCVAB occurs daily but is only reported if the behaviour escalates. Officers attending incidents recorded a range of 'offences':

- Assault- 236 incidents
- Affray- 15 incidents
- Aggression – 134 incidents
- Criminal Damage- 92 incidents

as well as public order offences, theft, threatening behaviour and multiple offences. Overall the majority of incidents were considered to be a 'crime' as indicated in Chart 9:



Overall 364 incidents were considered to be a 'crime', this means 30% of the incident's officers attended were not considered a 'crime' or the child was too young to be considered 'criminally responsible' as discussed by officers during interview:

you're getting seven and eight year olds, below the age of CR, smashing up the house or using knives and the mams are calling as they don't know what to do, I don't think we're trained for that (Officer 1, interview)

This raises questions about why officers are contacted by families; is this due to the police being viewed as a 'last resort' in a family's efforts to get help or are the police seen as the only responsive organisation? Whatever the reasons, the costs incurred by Northumbria Police when attending requests for help that are not part of their operational remit impacts on the service overall. After attending 364 incidents considered to reflect 'criminal' behaviour officers did not arrest all of the children involved. Following the incident reported officers arrested 128 children as shown in Chart 9. The youngest child to be arrested was 11 years old which is less than 1% of the children aged 11 displaying 'criminal activity'. As the age of the child increased into 'young offender' (that over 13-14 years of age) the number of arrests increased. Across every age range the number of arrests remained small compared to the number of incidents reported, as detailed in Table 7:

Table 7					
Age	CCVAB incident considered as Criminal behaviour	Arrested	Age	CCVAB incident considered as Criminal behaviour	Arrested
9 years	2	0	15 years	72	29
10 years	5	0	16 years	52	24
11 years	15	1	17 years	35	10
12 years	27	3	18 years	13	6
13 years	70	19	19 years	6	3
14 years	67	33	Total	364	128

The data highlights a wide range of outcomes for children displaying CCVAB involved in incidents attended by officers, for the majority of incidents there was no further action taken by the police themselves. However, no further action (NFA) simply means the police themselves were taking no further action but all incidents were referred to MASH partners such as the relevant Children's Services or Youth Teams. At present, following the referral the police are not updated of any action taken by the MASH partner. Speaking to officers revealed a number of problems when referral is made to a partner organisation following the decision of no further action by the police specifically, including no feedback from the service the child is referred to. This means when officers are involved in any further incidents, they have no knowledge of what, if anything, was put in place to support the child or the family since their previous visit. This is problematic when officers go to multiple incidents in the same household.

This breakdown in communication hinders rather than helps to support families and does not reflect the multi-agency partnership working advocated across government policies and guidance for more than 40 years⁴⁵. The main barrier to information sharing is confidentiality and data protection, however the MASH provision should be able to collate information and in doing so address many of the concerns noted in the DHR for Sarah. To effectively collate the information a system of information sharing needs to be made available for responding officers. One approach of providing this information sharing and collating of information is to have a named designated officer working in or with MASH teams.

More than half (55.5%) of the 364 crimes linked to incidents officers attended were identified as no further action of the 364 incidents attended (noted in Table 7) this raises questions about cost

⁴⁵ See for example the 'Court Report', Department of Health 1976

effectiveness of service provision. Northumbria Police do have to attend all incidents reported to them and this incurs a cost for the operational service provided. The involvement of officers in incidents where there is no criminal behaviour as such, or no further action where a crime has been recorded, suggests Northumbria Police may not be the most appropriate agency responding to families seeking help but remain the response organisation responsible for de-escalating the situation in crisis. Such incidents may be better responded to by another MASH partner. Officers openly discuss how they feel they are not the best qualified in some incidents:

I think we need specific training, how to link in to social services and this is where the system falls down as they (social workers) may have coping strategies and we turn up to a home with a uniform on which is a trigger point for some. We would benefit from training and knowing those strategies that doctors or social services know. (Officer 1, interview)

Following attending an incident where CCVAB was identified as 'criminal behaviour' and the child was arrested there were a range of caution and charge outcomes:

- 4 children received a 2nd youth caution
- 28 children were awaiting surgery with Northumbria Police (verbal discussion)
- 9 children were charged
- 8 children were released – common law
- 3 children were 'de-arrested'
- 4 children received their 1st youth caution
- 9 children – outcome unknown at time of completing dataset entry
- 2 children were 'bailed' by the police and referred to CPS
- 7 children were released under investigation
- 2 children received a simple caution
- 2 children received a 'summons'
- 10 children were referred for YOT triage
- 3 children received a youth conditional caution.

The most frequent incidents police officers attended were that of assault, followed by aggression, criminal damage, affray and public order offences.

Section 4.1 CCVAB: Assault

Assault can be classified as S.39 or S.47 in criminal law. Officers attended incidents for assault involving children aged between 9 and 19 as the perpetrator. There were 2 children aged 9 involved in incidents for assault. As previously highlighted in this report there is little officers can do when the child is aged 9 years old as they are below the age of criminal responsibility. It is therefore unsurprising that there was no further action taken by the police for these incidents. However, this does mean the family remain in status quo and may feel they were 'unsupported', or that the police were 'ineffective' in helping them, or the family may continue to report incidents to the police until such time their child is 10 years old and further action is possible. As the age of the child increased so did the number of incidents for assault:

- 5 children aged 10 years old
- 14 children aged 11 years old
- 21 children aged 12 years old
- 50 children aged 13 years old
- 51 children aged 14 years old
- 42 children aged 15 years old
- 21 children aged 16 years old
- 18 children aged 17-18 years old

There were 10 incidents involving children aged 18-19, technically these children are adults unless diagnosed as SEND when the age of childhood, in legal terms, can be extended beyond 18 years of age. As seen in the age of children displaying CCVAB there is a 'peak and 'trough' pattern for incidents of Assault.

Assault is defined under categories depending on the injuries sustained by the 'victim'; in the data for recording incidents the following 2 areas of Assault were noted:

- Common Assault (S.39 Criminal Justice Act, 1988) or
- Occasioning Actual Bodily Harm (S.47, Offences Against the Person Act, 1861).

The level of any prosecution and sentencing varies to the severity of injuries sustained during the assault. In 80% of incidents for assault no further action was taken by Northumbria Police⁴⁶.

However, police incident reports do indicate that officers referred children to a range of services. In this way the record suggesting NFA (in criminal proceedings) simply means no further action by the police specifically rather than no further action overall. For the remaining children involved in incidents of assault

- 15 children aged 13 years to 17 years were 'awaiting surgery'⁴⁷
- 1 child aged 11 years, 1 child aged 12 years and 5 children aged 14- 17 years were referred to YOT triage
- 1 child aged 12 years and 1 child aged 13 years received a Youth Conditional Caution
- 1 child aged 14 years and 1 child aged 17 years received their 1st Youth Caution
- 1 child aged 17 years received a 2nd Youth Caution
- 1 child aged 13 years and 3 children aged 15-17 years were under investigation
- 1 child aged 14 years and 1 child aged 18 years were released on Police Bail CPS
- 1 child aged 15 years and 1 child aged 18 years were charged with Assault
- 2 children aged 18 years received a simple caution

Alongside the data for incidents of Assault 23 children were involved in behaviour identified to include assault and other criminal acts:

- 1 child aged 12 years received a Youth Conditional Caution for assault and possession of a pointed article
- 5 children aged 14 years were involved in assault and damage. 1 child was awaiting surgery, 1 child was referred to YOT triage and for 3 children there was no further action.
- 1 child aged 14 years was involved in assault and theft with no further action.
- 3 children aged 15 years were involved in assault and theft, 1 child was referred to YOT Triage, for 1 child there was no further action and for 1 child the outcome was unknown at the point of recording the incident in the dataset
- 3 children aged 15 years were involved in assault and damage, 1 child was awaiting surgery, 1 child was de-arrested, 1 child was charged
- 1 child aged 15 years was involved in assault and public order offences and awaiting surgery

⁴⁶ refer to Appendix 3 for details of age and outcomes following incident

⁴⁷ Awaiting surgery is when the child will be seen and spoken to by Senior Police management personnel to discuss their behaviour and potential outcomes in future.

- 3 children aged 16 years were involved in assault and criminal damage. 1 child was awaiting surgery, the outcome was unknown for 1 child and due to multiple damage 1 child was charged
- 3 children aged 17 years were involved in assault and damage. 1 child was released on police bail and referred to CPS, 1 child was released under investigation and 1 child received a 2nd Youth Caution.
- 2 children aged 18 years were involved in assault and damage, both received a Simple Caution
- 1 child aged 19 was involved in assault and damage for which there was no further action.

Although there were a range of outcomes seen, it is evident that as the child gets older the behaviour can escalate and this in turn can lead to the child becoming involved in the Youth Justice system. The majority of incidents (84%) for assault were recorded as Common Assault S.39. Incidents for Common Assault can include up to 6 months imprisonment if prosecuted and found guilty at court. The majority of children displaying CCVAB recorded as Common Assault were not arrested when officers attended the incident. For incidents that included S.39 where there was no arrest made 14 children had 2 separate incidents of S.39 noted in the same record and 2 children had theft noted. The number of children arrested for S.39 incidents was 21%. Some children who were arrested under S.39 had further offences recorded: 1 child had S.39 and theft noted, 1 child had S.39 and possession of a pointed article noted.

Northumbria Police officers responded to 38 incidents of S.47 Assault following which there was no further action by the police for children in 24 of these 38 incidents. For those where action was taken:

- 3 children were referred to YOT triage, 1 child was involved in S.47 assault and theft
- 2 children awaited surgery. 1 child had assaulted emergency workers and was arrested for this under S.47, the other child was involved in a public order offence and assaulting 2 police constables under S.47
- 3 children were arrested and under investigation
- 2 children received their 1st Youth Caution
- 1 child was released on police bail pending CPS

Similar to findings in previous discussions such as that of Thorley and Coates (2017 and 2018), a significant number of children who display CCVAB do so in such a way that assault can and does happen. This reflects the nature of 'violent' and 'aggressive' behaviour. Due to the nature of CCVAB and the legal position many of these children are at risk of being 'criminalised' for their behaviours. For this reason, many families will 'drop' charges or not involve the police until such time they are seriously concerned of significant harm occurring. Officers are aware that parents are reluctant to make a statement that may lead to their child being arrested and charged:

It's not normal that the parents give statements and I'd been numerous times to this situation and they'd not wanted to give one but in this situation the mother was begging us to get social services involved and take him away as she was worried that they were going to take her younger children away. It must have been a horrible situation. I think that's why she's offered to give a statement. (Officer interview)

The need to raise awareness of SEND and the impact of ACEs informing children's behaviour is essential if effective support is to be implemented; not only for police officers across England but also all other services involved in supporting families. Focusing simply on the behaviour displayed fails to address any underlying causes of behaviour or any underlying known medical circumstance, and in this way fails not only to protect the child displaying CCVAB but all others around the child both inside and outside of the home.

4.2 CCVAB: Aggression

Northumbria Police responded to 134 incidents for aggression. The issue of incidents involving aggressive behaviour is complex. There is no legal definition of what aggression is or how to 'measure' the aggression displayed. This type of CCVAB very much relies on the officer's interpretation of the situation to determine if the behaviour they personally observe, or record through witness testimony, is sufficiently aggressive to warrant police intervention. There is no distinct 'charge' that can be applied when attending incidents of 'aggression' and should any crime be determined this will be placed in another category for example assault or criminal damage. The use of aggression is common across society but there is no common measurable indicator of what this means. Aggression is viewed from a personal position, so much so that what one person feels is aggressive behaviour another may disagree and decide the behaviour was not aggressive.

People across society generally use 'aggression' or 'aggressive behaviour' to describe the behaviour of other people or sometimes their own behaviour. The term can be used to describe behaviour that includes physically hurting another person (assault), verbally threatening another person, or damaging property (criminal damage). In psychology some social psychologists agree 'aggression' means *'behaviour that is intended to harm another individual who does not wish to be harmed'* (Baron and Richardson, 1994). More recently Anderson and Bushman (2002, p.28) described aggression as *"any behavior directed toward another individual that is carried out with the proximate (immediate) intent to cause harm. In addition, the perpetrator must believe that the behavior will harm the target, and that the target is motivated to avoid the behavior"*. These definitions help to explain why CCVAB is seen by the Home Office as a form of Domestic Violence to be included into previous and new Domestic Violence legislation.

Allen and Anderson (2017) suggest there are four distinct specific aspects that make aggression different to other behaviour:

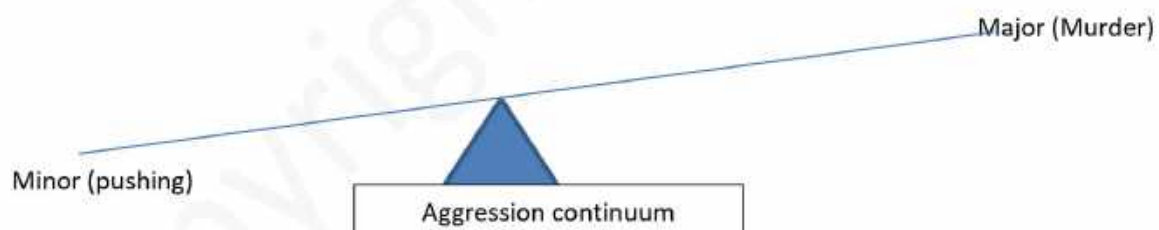
1. *aggression is an observable behavior—not a thought or feeling. Although aggressive cognitions (e.g., hostile attitudes, beliefs, thoughts, or wishes) and aggressive affect (e.g., feelings of anger, rage, or desire for revenge) can and frequently do serve as important precursors to aggressive behaviour....*
2. *Second, the act must be intentional and be carried out with the goal of harming another. This means that accidental harm (e.g., unintentionally elbowing someone in a crowded room)*

does not count as aggression. The focus on intent also outweighs the outcomes of the behavior in question (i.e., whether or not harm has actually occurred)....scenarios in which individuals attempt to harm another but fail to do so (e.g., a person shoots to kill someone but misses) are considered aggression.

3. *Third, aggression involves people, meaning that damaging inanimate objects (e.g., kicking a wall, smashing plates, or pounding one's fists on a table) is not considered aggression unless it is carried out with the intention of harming another person (e.g., slashing the tires on your enemy's car).*
4. *Finally, the recipient of the harm must be motivated to avoid that harm...*

These four distinct aspects could help officers attending incidents to decide if the behaviour was aggressive. Allen and Anderson (*ibid.*) suggest 'aggressive' behaviour shouldn't be seen as a different category to 'violence' or as a separate distinct area; they feel 'violence' is a 'sub-set' of aggression. Officers attending incidents for 'aggression' do recognise 'violence' as a part of aggression and can charge perpetrators with 'assault' (physical violence). Allen and Anderson suggest that

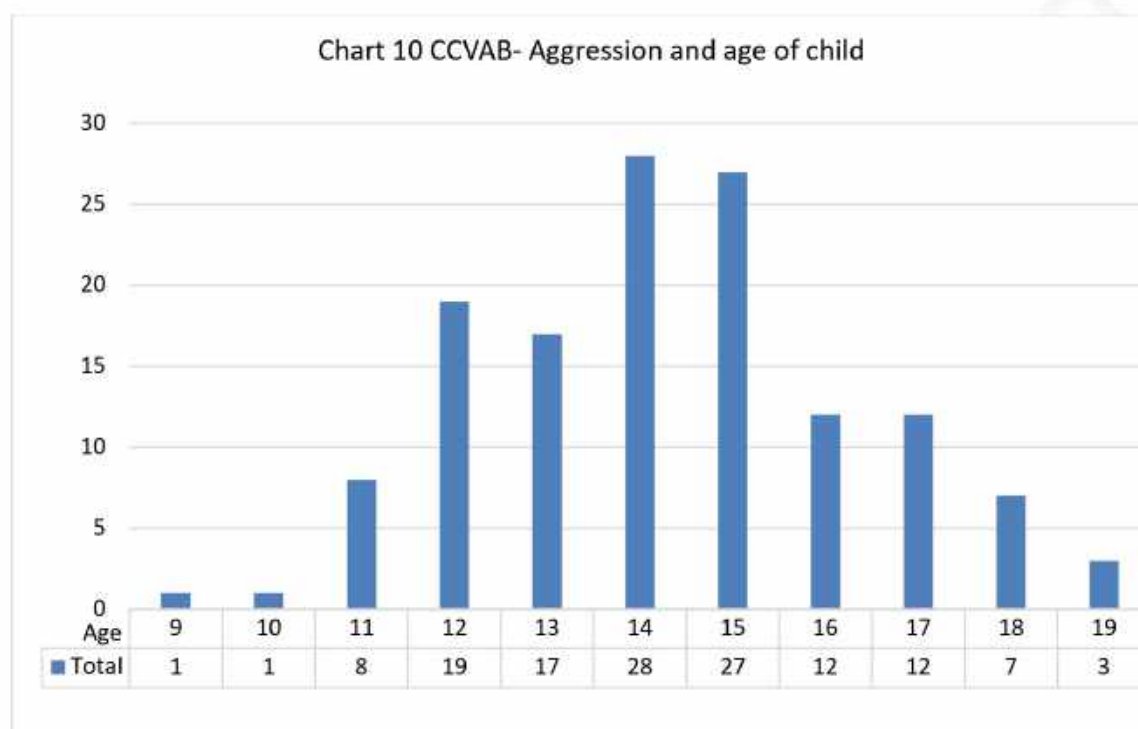
Aggressive and violent behaviors are best conceptualized as being on a continuum of severity with relatively minor acts of aggression (e.g., pushing) at the low end of the spectrum and violence (e.g., homicide) at the high end of the spectrum.



In summary what is being proposed is that aggression can be displayed without violence but violence cannot be displayed without aggression. This means the 236 incidents for assault are linked to incidents under the umbrella term 'aggression'. Not all acts of aggression are violent for example children who 'push' another child may not be considered as 'violent' behaviour but 'aggressive' behaviour; at the higher end of 'aggression' murder would be considered both 'violent' and 'aggressive'. The terms used can be inter-changeable, where incidents for 'assault' are considered violent and aggressive incidents but counted as 'violent crimes'. This nuance in wording means using

terms such as CCVAB and APVA need to be clear about what ‘aggressive’ means and what ‘violent’ means, and how these differ⁴⁸.

The majority of incidents police attended for aggression involved children aged 12-15 years as detailed in Chart 10:



To a degree it is understandable why aggression is more prominent during this age range, as the impact of hormonal adjustment during the teen years can cause changes in behaviour. As children in the teenage years are generally taller and physically stronger than those under the age of 10, their behaviour may make the ‘victim’ feel more threatened physically or mentally or both. Studies into neurodevelopment of the adolescent brain suggest the impact of adrenal stress along with growth hormones and gender hormones can affect the child’s ‘mood’. Additionally, during these development years teens develop their ability to read ‘social cues’. Reading social cues helps the teen to adjust their behaviour according to the accepted ‘norms’ of their family, culture, community, and home country. This means it is not only the family that have an influence on teen behaviour as teens move into independence and adulthood⁴⁹.

⁴⁸ Refer to appendix 4 for details of defining aggression outlined by Krahé (2013) and outlined by Parrott and Giancola (2007).

⁴⁹ See for example: Peper, J. S., & Dahl, R. E. (2013). Surging Hormones: Brain-Behavior Interactions During Puberty. *Current directions in psychological science*, 22(2), 134–139. <https://doi.org/10.1177/0963721412473755>

The difficulty for officers attending incidents is deciding if the behaviour is aggressive and of a nature that warrants arrest. Only 4 incidents for aggression led to further involvement by police, compared to 95% of incidents where no further action was taken. The involvement of officers in incidents for aggression needs to be reviewed given the high number of incidents that require no further action from the police themselves. The majority of these incidents were referred to a range of MASH partners, this suggests that it should be the MASH partner that is involved rather than officers from the outset. If the MASH partner feels police involvement is needed this can be considered. Following attending an incident for aggression

- 127 children remained at home and were not arrested and no further action was taken by police
- 3 children were arrested at the time of the incident, then no further action was taken by police
- 3 children were arrested and charged with S.39 Common Law⁵⁰
- 1 child arrested to prevent Breach of Peace under public disorder.

There are a number of referral pathways officers use after attending incidents for aggression. Officers attending incidents recorded a Child Concern for 495 children displaying CCVAB and 53 Adult Concerns. Identifying the incident as a Child Concern or Adult Concern can provide police with a timeline and alert officers to increasing frequency or escalation of violence should they be required to attend future incidents. To be effective and support children and adults living with CCVAB the timeline needs to be shared across all parties involved and updated to include relevant information to allow the 'whole picture' to be seen. MASH teams are well placed to provide this overview, but as yet officers frequently do not have up to date information when attending incidents particularly where aggressive behaviour is the reason they are attending.

The failure for recognising the risk escalating aggressive behaviour can have is documented throughout the DHR for Sarah. For some families the initial display of CCVAB may involve property damage with increasing levels of 'aggressive' threats towards personal injury, it may be that it is at this time families contact the police for help. It is also feasible families contact the police if the behaviour starts with verbal 'threats' and escalates in to property damage rather than physical assault.

⁵⁰ Section 39 of the Criminal Justice Act 1988 provides: Common assault and battery

4.3 CCVAB: Criminal Damage

In law Criminal Damage is covered in the Criminal Damage Act 1971 which sets out to protect property rights no matter how 'small' or 'large' so this can include mobile phones and personal items, to furniture or buildings. Northumbria Police attended 92 incidents for criminal damage involving children aged 11-19 years old. For the majority of children (63%) no further action was taken by Northumbria Police themselves and the majority of children were not arrested⁵¹. For the remaining children there were a range of outcomes including:

- 9 children were 'awaiting surgery' aged between 12 -17 years
- 1 child aged 14 years and 1 child aged 16 years were referred to YOT triage
- 2 children aged 16 years received their 1st Youth Caution
- 2 children aged 13 years and 1 child aged 16 years received their 2nd Youth Caution
- 1 child aged 16 years and 1 child aged 17 years were under investigation
- 1 child aged 13 years and 3 children aged 15 years were released under Common Law
- 1 child aged 15 years, 1 aged 16 years, 2 aged 18 years and 1 aged 19 years were charged with criminal damage
- 1 child aged 13 years was de-arrested
- 1 child aged 15 years was served with a summons

There were 5 further incidents that included criminal damage as well as other crimes and a majority outcome of no further action as follows:

- Criminal Damage and S.4 Public Order incident involving 1 child aged 16 years- no further action
- Criminal Damage and Affray⁵² incident involving 1 child aged 15 years - no further action
- Criminal Damage and Assault incident involving 1 child aged 15 years- no further action
- Criminal Damage and Aggression incident involving 1 child aged 15 years- no further action
- Criminal Damage and carrying an offensive weapon involving 1 child aged 17 years- charged

⁵¹ Refer to Appendix 3 for illustration chart of age of child and outcome from incident attended by Northumbria Police.

⁵² Public Order Act 1986, Section 3- A person is guilty of affray if he uses or threatens unlawful violence towards another and his conduct is such as would cause a person of reasonable firmness present at the scene to fear for his personal safety.

The limitation of the data is the lack of detail relating to criminal damage. The data did not include cost of item damage or personal value or what items were, how they were damaged and if repairable. However, two incident report case files included details where the families' housing was at risk due to the ongoing damage to the properties. The resulting damage was so costly that payments for this damage was no longer possible, this included: destruction of walls, doors, windows as well as furniture within the home. One parent had taken a life-threatening overdose as a result of the ongoing personal and property damage

In any future studies of this type detail of damage may be helpful to establish level of potential harm, such as crockery thrown at the family members which then broke or other items. For some children displaying CCVAB, as found in previous studies, children can and do use things to hand as opportunity weapons such as throwing a chair, knocking a table over, picking up crockery and throwing this. If damaged these items would be considered part of any criminal damage charge, something that has been seen over time:

Mumdrah (2017)

One hypothetical reference to collateral damage, that over the last 11 years has become a reality of:- an eight foot stretch of 150 year old T&G wood panelling now split, splintered and bowed out; ...six doors that no longer hang right, or close properly, and one with kick holes all across the bottom at different levels that represent the passing years like a height chart...- the 'road map' of our walls, criss crossed with skid marks from things hurled and whipped against them, - the oak kitchen table that survived our family for three generations, scarred with dozens of deep, double pointed dents from a claw hammer attack...- the long series of phones, laptops, controllers, a hairdryer and a tv, all smashed to smithereens.....- the dashboard of my land rover cracked and hanging off on the passenger side...- the two lonely bowls left intact from a full dinner set, and the cracks in the tiles where the missing ones landed...- the banisters that creak and wobbles...

Hollins (2017) reported similar findings as did Breman and MacRea (2017), who noted property damage was substantive for Kinship Carers. In their report Breman and MacRea (2017) found nearly 40% of their participants reported behaviour that included 'hit or kicked a wall, door or furniture' 'severe' enough to cause damage needing repair and therefore property damage. Officers do attend incidents where Kinship care is compromised:

I've been to a case with a grandma and a 14 and 3 year old. The 14 year old had lost his temper and had caused criminal damage. She's tried Social Services and then called the police, she was between a rock and a hard place and we're looking to protect the grandma. (Officer interview)

Beman and MacRea (2017) also found over 30% of Carers were involved in incidents where the child had destroyed something. In Thorley and Coates (2018)

- 78% of families where one child (or the first of multiple children) displayed CCVAB
- 72% of families where a second child also displayed CCVAB and
- 67% of families where three children displayed CCVAB

experienced damage to property and homes, including the child's own items. Often these instances of aggressive behaviour that cause criminal damage, can also be considered for 'violent' threat in which case these incidents may be considered as 'Affray'.

4.4 CCVAB: Affray

There were 15 incidents that included 'Affray' involving children aged 13-18 years old. In the Public Order Act 1986, Section 3-

A person is guilty of affray if he uses or threatens unlawful violence towards another and his conduct is such as would cause a person of reasonable firmness present at the scene to fear for his personal safety.

When officers attend incidents where 'aggression' is reported as the area of concern they have the option to arrest the child for 'Affray'; if the child's aggressive behaviour includes 'threatening' violence. There were 9 children arrested for Affray across the age range leading to a several outcomes⁵³

- No Further Action was identified for 4 children aged 13 years, 1 child aged 14 years, 2 children aged 15 years, 1 child aged 16 years and 1 child aged 17 years
- Awaiting surgery was identified for 1 child aged 13 years, 1 child aged 14 years and 1 child aged 15 years
- Review under investigation was identified for one child aged 16 years
- Not yet known was identified for 1 child aged 15 years
- 1 child aged 18 years was charged with S.39 Assault

For many families it is the threat of *unlawful violence towards another causing a fear for.. personal safety* that leads to the request for help from the police. As seen in DHR for Sarah the escalating threat of violence was the main concern the mother contacted a range of service provision about. The seriousness of the threat becoming reality is the decision officers need to make when attending incidents for Affray. The main problem for officers is the likelihood of either S.39 assault or S.47 Assault occurring should they leave without arresting the child. Officers noted 'threatening' behaviour in additional incidents they attended when Affray was not noted, this included:

- 1 child aged 15 years for threats with a knife, with no further action as the outcome
- 1 child aged 16 years and 1 child aged 17 years for threats, with no further action indicated
- 1 child aged 16 years for threats to kill, with no further action indicated

⁵³ Also detailed in Appendix 3

- 1 child aged 16 for in possession of a weapon and harassment, who was charged for these offences

Across all previous discussions the level of threat is a main concern for families who are afraid for their safety or the safety of other children in the household. The fear for personal safety or the safety of other children in the household is the main reason families seek to place children displaying CCVAB in the care of Children's Service's under Section 20⁵⁴ rather than continue to live with the risk of harm. Families can live in fear of their children due to the increasing or continuous 'threat'. For many families it is at the time of being unable to manage their child's behaviour due to the child's physical 'size' that leads them to contact the police for help, as children reach adolescence. During adolescence threats of violence causing injury to family members can feel more 'real' compared to threats made by younger children; however, the fear felt by adults can be caused by younger children as Coates (2017) experienced

I'd consider it the most challenging experience of my life, day after day the assaults continued both physical and verbal. They had always been present in our family, low level name calling and hitting when frustrated or upset but then it got worse. It spiralled downward after a trip away, with normal routines gone for a single day a new pattern of behaviour emerged. Early the next morning it started. 'Stupid daddy'. Then fighting, hitting and biting. Rages that would last hour after hour with me standing between her and the rest of the family. I tried to hold her to keep her safe but that would prolong the rages but if I let go she'd come back to start again. We knew all the standard techniques, time out, appropriate consequences, carrots not sticks. She was four-years-old and I'd become afraid of her, nervous of when the next assault would come, I was covered in bites, scratches and bruises.

Northumbria Police's system of recording a Child Concern or Adult Concern when attending incidents for Affray enables the seriousness of living in fear to be recognised, even if the police themselves are not required to take any further action.

⁵⁴ Parent/ carers can request a Section 20 to be applied if the family home position becomes untenable, or siblings are at risk of harm from CCVAB displayed within the home. Under Section 20 the LA has a duty to accommodate the child displaying CCVAB whilst the parent/ carers retain all parental rights for the child. However, where this has been applied there are numerous posts within social media that point to parental rights being breached.

4.5 CCVAB: Public order and Other incidents

Alongside the main incidents recorded there were a range of other criminal incidents involving children displaying CCVAB. For 2 children aged 12 years there was no record of what officers were asked to attend in the incident record. This may be an oversight or it may be that at the point of completing the data record the 'offence' was under discussion, neither child was arrested. Theft of a Motor Vehicle involved 1 child aged 13 years and 1 child aged 16 years; both were arrested and 1 child was charged.

Public Order⁵⁵ offences were identified for several children

- No further Action was indicated for 1 child aged 15 years, 3 children aged 17 years, 1 child aged 18 years and 2 children (adults) aged 19 years
- YOT triage was indicated for 1 child aged 14 years

Public Order offences were recorded under S.4 and S.5 of the Public Order Act, 1986. Further behaviours included 'range of behaviour' with no specific details of what these behaviours entailed, for 1 child aged 15 years. Theft was indicated for 1 child aged 15 years, while another child aged 15 was under investigation for theft. Other offences that were indicated as no further action included:

- Fraud by false representation
- Indecent photos of a child and criminal damage
- Malicious communication
- Drunk and disorderly

At this time, in the UK, there are limited options available for families who are subjected to these daily behaviours, particularly if such behaviour is deemed to result from 'poor parenting' as was noted in the DHR for Sarah:

There was also no evidence that staff understood why it would be difficult for the family to raise concerns of Michael's risks in his presence due to them being fearful of reprisals.

⁵⁵ Public Order Act 1986

*Despite these attempts, focus was often placed by agencies on **Sarah's parenting** and the need to control Michael's behaviour, even when his presentation clearly demonstrated increasing risk, and indicated that the interventions needed were beyond those of behaviour management (my emphasis)*

***There was also a great emphasis given to Sarah exerting parental control** and putting boundaries in place, despite the information she was provided that clearly demonstrated her to be a victim of abuse at the hands of her son. (my emphasis)*

At present the legal position does not help these families or officers attending incidents reported by these families. The Home Office is currently considering what guidance should be provided to officers dealing with CCVAB with a view to update their current guidance. The main problem with any guidance provided by the Home Office is the legal position of children under 10 years of age chronologically or under 10 years of age developmentally and the need to differentiate between the two age possibilities when responding to incidents.

Within the data records or incident reports there is no indication of officers noting a Child Safety Order⁵⁶ (CSO) being in place or suggested as a means of supporting families. Child Safety Orders are available to help support children displaying CCVAB and their families. The origins of Child Safety Orders were such that the use of 'Order' tends to be viewed only for children displaying 'anti-social behaviour' (ASBO) outside of the home. This has led to the Order being linked to 'poor parenting'.

Child Safety Orders have a clear purpose that is '*helping local authorities to positively intervene at an earlier stage in order to prevent the child's involvement in anti-social or **criminal-type behaviour from escalating into something more serious or becoming entrenched***' (my emphasis) (Ministry of Justice, 2007).

There is a plethora of evidence that confirms, without intervention, pre-adolescence CCVAB does escalate and is often more violent, more aggressive and more likely to require police intervention. Across the data there are a range of criminal incidents noted, the most frequent is 'assault'. These behaviours are 'criminal' behaviours and therefore would be included in the purpose of the Child Safety Order. Child Safety Orders can be used to support children under the chronological age of 10

⁵⁶ This places children under the supervision of the Youth Offending Team within England and Wales and can be used as a preventative intervention to reduce the risk of escalating behaviour that may be considered a criminal offence once the child is over 10 years of age as part of the Crime and Disorder Act 1998.

years when the age of criminality comes into effect in England if but only if the Child Safety Order is edited by the Home Office to include 'inside the home'.

Across all discussions to date it is widely accepted that interventions need to commence before adolescence if MASH services are seeking to reduce *criminal-type behaviour from escalating into something more serious or becoming entrenched*. If no effective intervention is provided CCVAB can and does escalate in frequency and level, as seen across the DHR for Sarah. When CCVAB escalates during adolescence if it is more violent and more aggressive the police may charge the child, once they are over the age of 10 years and under the age of 18 years⁵⁷ which was the outcome for Sarah's son Michael.

What is evident across all of the incidents Northumbria Police attend is that children displaying CCVAB are committing offences that cause harassment or distress or harm to others; which led to the incident being reported and responded to. It is also evident children who display CCVAB, if left unsupported, may continue and the CCVAB behaviour may escalate. Reasons why none of the children have been considered for a Child Safety Order by Children's Services or MASH teams is unknown. It is evident across the DHR for Sarah that the service she received did not '*...offer them assistance and services that reflect their needs. This should be done on a multi-agency basis...*' (Tees Safeguarding Children Board). For the CSO to be effective there is a need to develop a wider understanding of CCVAB and recognise that 'lack of parental' control is not always the 'fault' of the parent as noted in the DHR for Sarah.

⁵⁷ If the child is under 10 years they cannot be charged with an offence, if aged 10-18 years they can be interviewed within police custody. If they admit to CCVAB the child could then be given an informal caution, formal caution or be referred to the Family Court. If the child does not admit CCVAB and the police proceed this will be considered in the Youth Court which could lead to a criminal record

Section 4 Recommendations: CCVAB requiring Police Intervention

(building on National recommendation and all Local Recommendations)

- Designate a named officer (may be part of MASH) as named contact to collate:
 - all reports to Northumbria Police for the same child/ family
 - responses and actions taken by Northumbria Police when attending incidents of CCVAB
 - Contact information for organisations involved in the child/ family to follow up actions taken by Northumbria Police- for example when referring the family to Children's Services updating records to include actions taken by such services.
 - Monitor data indicators for potential escalation of number of incidents or escalation of behaviour by same child to develop a timeline
 - Lead, liaise and co-ordinate local parent support groups in the first instance to help get these established for high risk families such as: Foster Carers (LAC -Looked After Children), Adopters (PLAC -Previously Looked After Children), Kinship/ Special Guardian's and parents of children with SEND to raise awareness and enable these parents to have confidence in reporting CCVAB at the earliest stage, rather than waiting until a crisis is reached should this occur⁵⁸.
 - Discuss all options available for families and include the family voice- of adults and child
 - Discuss with the Home Office representatives the possibility of the Child Safety Order being used to support families by development age not chronological age and recognise this differential for children with SEND
 - Raise awareness of all officers and teams around the difference between chronological age and developmental stage
- Designate a named officer (may be part of MASH) to refer children involved in CCVAB to relevant MASH partners as a Safeguarding concern.
- Collate information gathered and share with all those involved with children locally- Schools in particular need to be involved

⁵⁸ A previous pilot set up in Northumbria Police by a school proved to be very successful and was self-sustaining after 5 supported sessions. This has led to more open and honest discussion by families relating to CCVAB incidents.

Section 5:

CCVAB – A Safeguarding issue

All discussions to date from a wide range of studies recognise children displaying CCVAB is a Safeguarding issue. There are inherent problems with the current system for recognising who is at risk when children display CCVAB depending on which professional 'lens' used to view the behaviour. Too many families report that Children's Services fail to recognise the risk to adults and focus almost exclusively on the child displaying CCVAB, rather than the whole family. In the DHR for Sarah this was highlighted throughout the findings. In all reports published Thorley and Coates (2017 and 2018) found families were overall reassured by police officers opposed to professionals from other organisations. Families felt that officers recognised adults could be at risk from the child and that they were more prepared to view the behaviour as the risk factor allowing them to 'see the whole family'. Families have raised concerns about how they are seen to be 'the problem' which encourages the 'fix' to be their responsibility, managed through parenting courses. This misnomer was also evident in the DHR for Sarah. Police officers as part of their role, will attend more incidents for domestic abuse than most other organisations, this may be why they are able to appreciate the whole situation and accept that if adults state they are afraid this should not be dismissed as being incapable of controlling their children.

Studies to date have shown that many families live with CCVAB either daily or 2-3 times per week (see for example Thorley and Coates 2017, 2018). This supports police 'feelings' that many families only contact the police when they are no longer able to cope or at the 'end of their tether'. Behaviour escalation and duration of physical 'assault' is understood to happen as children move through their childhood years into adolescence, for example *"She beat her dad up, she just started punching, and punching, kicking, and punching him, absolutely going berserk, I mean unhinged berserk..."* (Selwyn et al, 2014, p.148). Boorman (2016) summarised her experience *"violence came out of the blue. Before you knew it an ordinary day could turn into one which may involve broken glass, chaos, blood, spit, vomit, urine and tears..."* It is understandable that CCVAB is viewed as a form of domestic abuse, meeting many of the suggestions of what domestic abuse is:

Domestic abuse, or domestic violence, is defined across Government as any incident of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of their gender or sexuality. (Crown Prosecution Service, 2020)

The Crown Prosecution Service (2020) explain that

'Domestic abuse' covers a range of types of abuse, including, but not limited to, psychological, physical, sexual, financial or emotional abuse. 'Domestic abuse' can be prosecuted under a range of offences and the term is used to describe a range of controlling and coercive behaviours, used by one person to maintain control over another with whom they have, or have had, an intimate or family relationship.

Domestic abuse is rarely a one-off incident and is the cumulative and interlinked types of abuse that have a particularly damaging effect on the victim.

The 'domestic' nature of the offending behaviour is an aggravating factor because of the abuse of trust involved.

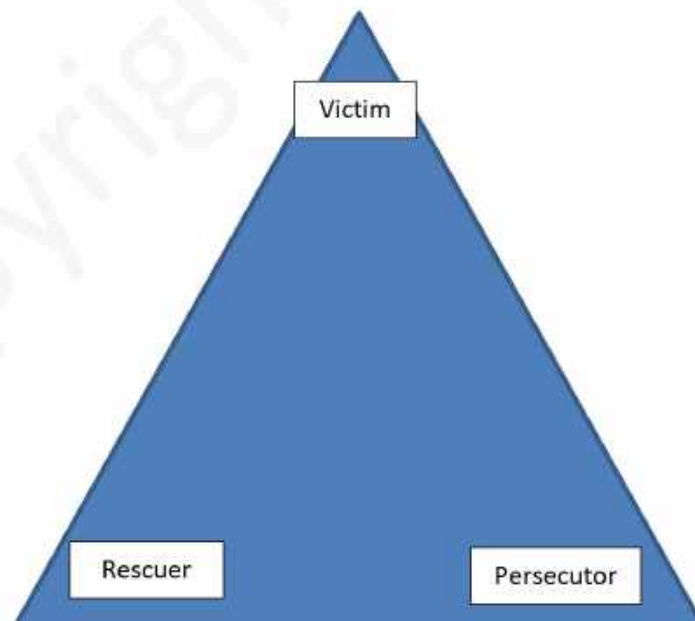
If the age of over 16 is disregarded the description of domestic abuse by the Crown Prosecution Service also describes children displaying CCVAB and their relationship with their family. The 'abusive' relationship is no less abusive because the child is under the age of 16. What is not made clear in the Crown Prosecution Service description is how known SEND conditions can influence behaviour, which includes the behaviour of those over 16 years old: for example, Mental Health diagnoses such as Schizophrenia or Psychosis.

Karpman's Drama Triangle⁵⁹ (1968) can be useful in recognising the different roles children and adults have in their relationship and how these can interchange during the day. The triangle is useful in showing how responsibility and power can change between individuals irrespective of age or position in the relationship at the outset. Those involved can 'switch' positions between:

- The victim:
 - Parents can feel they are the victim during episodes of CCVAB where they feel helpless or powerless to resolve the 'issue' of CCVAB
 - Siblings may feel 'victimised' if the focus of the CCVAB is towards them directly
 - Children displaying CCVAB may feel they are the 'victim' and their behaviour is caused by the persecution they have experienced or threat they feel they are under from parents or siblings

⁵⁹ Also known as a relationship triangle

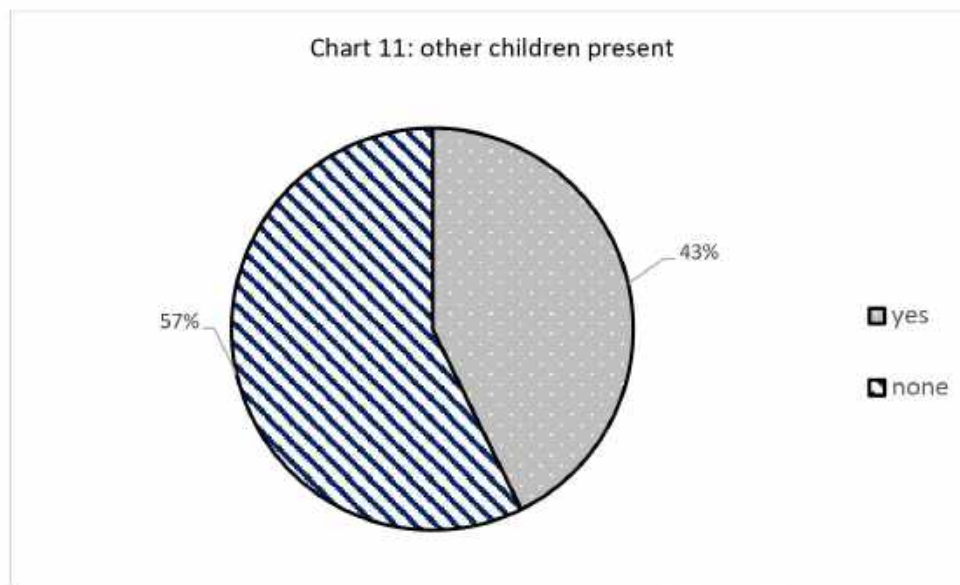
- The persecutor
 - Parents may feel the child displaying CCVAB is the persecutor of the situation they find themselves in
 - Siblings may feel the child displaying CCVAB is the persecutor
 - Siblings may feel the parent is the persecutor for not preventing or stopping their sibling being violent, aggressive or abusive towards them
 - The child displaying CCVAB may feel the parent is the persecutor and that their behaviour is in response to their 'persecution' or that their siblings are the persecutor
- The rescuer
 - The parent may be the rescuer in some situations where children display CCVAB if they are able to de-escalate the behaviour towards them or
 - Towards another adult or
 - Towards siblings
 - Police officers (or another 'outside' professionals') can be 'rescuers' when families are no longer able to cope without 'outsider' help



In Karpman's triangle Persecutors believe their behaviour is caused by other people's behaviour towards them rather than the behaviour they display is their own choice, so that they are 'made' to behave in a way they have not chosen to behave. For children with SEND, or a history of Trauma, studies suggest that displaying CCVAB can be 'triggered'; in this way, if the behaviour is 'triggered' the child feels it is '*not my fault*'. Persecutors can be controlling, blaming and angry which are all behaviour traits described by families living with CCVAB. Rescuers can be family members or professionals and support staff seeking to 'help'. At times it may be a sibling who is the rescuer, if they are able to de-escalate the behaviour (for example an older sibling who is able to de-escalate the behaviour of a younger sibling). Alternatively, it may be the parent who is the rescuer and is trying to de-escalate the CCVAB behaviour involves a sibling rather than an adult.

When the family reaches crisis parents might look to other family members for help or to service providers. When seeking help families describe their concern over increasingly 'aggressive' behaviour. Bushman and Huesmann (2010) describe traits linked to aggressive behaviour that reflect 'response' mode: physical, verbal or relational. These areas often overlap so that officers attending incidents need to establish what 'form' the aggressive behaviour is taking and which form of behaviour is the highest priority at that precise time to safeguard those present.

The importance of who to safeguard is complex, for example is the priority the child displaying CCVAB? Reports from families in contact with Children's Services report that they find the focus is solely on the child displaying CCVAB as the priority and a need to ensure there is no restriction or retaliation towards the child by any other household member that could be considered 'child abuse'. Officers completing data records recognised that the parent or another adult in the home could require Safeguarding and be the person at risk from the child. Recognising the adult needs safeguarding is seen in the number of Adult Concern Notifications (ACN) referred to MASH as part of identifying Domestic Violence by officers. When completing the incident report officers raised 52 Adult Concern records- in one household this was for 2 adults in the home. There was only 1 incident with an Adult Concern registered without a Child Concern also being registered. Officers also recognised the risk to siblings in their incident records. For some incidents the Child Concern was for the child displaying CCVAB. In 220 incidents other children, who also require Safeguarding, were present during the incident, as shown in chart 11:



The age range of other children in the home varied, where some children were older than the child displaying CCVAB and some children were younger than the child displaying CCVAB. The risk of harm for siblings living with CCVAB can be significant, Hollins (2017) noted 90.5% of behaviour displayed was violence or aggression towards others including:

- 'Pushing sibling down the stairs',
- 'holding young sisters head under water in the bath' and
- 'Slammed the car door on another child's hand on purpose...'

Thorley and Coates (2017, 2018) noted numerous incidents against siblings and Selwyn *et al* (2014) found this was the main reason for placing the child displaying CCVAB in Local Authority Care.

Siblings living with children who display CCVAB are in the same vulnerable position as any other child living with 'domestic abuse' and as such should be afforded the same service support as any other child at risk. To date there is little focused discussion for siblings. Caspi (2011, p.207) noted this is a much under researched concern *"In my professional practice, I have observed sibling violence is frequently accompanied by child to parent violence, although this co-existence, has not to my knowledge been studied."* Research to date acknowledges sibling abuse may occur⁶⁰ but sibling violence tends to be discussed separately, yet sibling safety is of prime concern for parents.

⁶⁰ Sibling abuse, similar to CCVAB, is a under-reported in that research to date for CCVAB acknowledge sibling abuse may occur but does not interrogate this as an independent area, nor provide depth of impact of sibling abuse upon siblings. Sibling abuse is noted for example within Home Office (2015), Coogan (2011). As early as 2000 Flowers included CCVAB and sibling abuse within the umbrella of domestic crimes alongside domestic violence, a discussion also noted in Lamanna

Section 5.1: Safeguarding, ACEs, SEND and CCVAB

It is evident that whilst there have been a number of studies to date seeking to provide clearer understanding of CCVAB, recognising CCVAB as a co-morbid

- SEND condition or
- ACEs cognitive behaviour outcome or
- SEMH related behaviour

does not appear to have been studied in any great depth; rather CCVAB has been studied as a 'part' of something else. There are studies for CCVAB that recognise CCVAB as part of 'something else' (such as Autistic Spectrum Disorders, Foetal Alcohol Syndrome, Attention Deficit Hyperactivity Disorder) however, not all children diagnosed with these behavioural conditions display CCVAB; in much the same way as not all children who have higher ACE indicators display CCVAB. Grouping CCVAB as 'part' of an existing medical diagnosis can lead to safeguarding risks being overlooked, as happened in the case of Sarah and her son Michael. The risk of overlooking or discounting CCVAB as a behaviour trait linked to an existing condition can leave parents unsupported, which occurred in DHR for Sarah resulting in her death.

Describing CCVAB as 'violent' or 'aggressive' behaviour the child intentionally displays has led to the broader use of the term CPVA or APVA. The use of these terms to describe behaviour exclusively focuses on the behaviour rather than any underlying causes for the behaviour. This has led to a number of professionals viewing the behaviour through the 'naughty' lens of out of control children that require 'taking under control' or in need of 'police intervention'. This view sees CCVAB as intended and a form of domestic abuse meaning the police have to be involved for identifying any behaviour that is 'criminal'.

In the DCM-V and ICD-11⁶¹ indicators there is a diagnosable condition that CCVAB reflects, yet to date no family living with CCVAB has received this diagnosis or assessment for this diagnosis.

et al (2016) that pointed to the impact on children from living with domestic violence, not only that demonstrated by adults in the home.

⁶¹ ICD-11 World Health Organisation is currently updating the indicators and details of Behavioural Disorders and Neurological disorders to reflect new understanding in this area. The 11th edition of the International Classification of Diseases and Related Health Problems (ICD-11) is expected to be approved by the World Health Assembly in 2018

The criteria for diagnosis of Neurodevelopmental Disorders (World Health Organisation, 2016 and 2018) emphasise a need to assess 'adaptive functioning' and 'cognitive capacity'. Current practice suggests there is an emphasis on identifying how severe a Neurological condition is by 'adaptive functioning' (rather than any IQ score or cognitive functioning). Placing an emphasis on 'adaptive functioning' could support diagnosis of a range of conditions, including:

ICD-10/11- V 'Behavioural and emotional disorders with onset usually in childhood and adolescence' (World Health Organisation, 2016 and 2018; F90-F98); that are:

Disorders characterized by a repetitive and persistent pattern of dissocial, aggressive, or defiant conduct. Such behaviour should amount to major violations of age-appropriate social expectations; it should therefore be more severe than ordinary childish mischief or adolescent rebelliousness and should imply an enduring pattern of behaviour (six months or longer).

F91-0 Conduct disorder confined to family context (ICD-11)- World Health Organisation, 2018

Conduct disorder involving dissocial or aggressive behaviour (and not merely oppositional, defiant, disruptive behaviour), in which the abnormal behaviour is entirely, or almost entirely, confined to the home and to interactions with members of the nuclear family or immediate household.

F91-0 accurately describes CCVAB incidents officers attended and those described in previous discussions (including for example: Anderson, 2011; Calvete et al, 2012; Gordon and Wallace, 2015; Bonnick, 2016; Boorman, 2016; Adoption UK, 2017; Thorley and Coates, 2019).

Recognising CCVAB as a co-morbid condition for those children who have SEND, or those children with SEMH, or those with Neurodevelopmental impact following ACEs means CCVAB is a Health concern rather than a criminal behaviour concern. For Northumbria Police this would mean referring all children and family members to MASH for Health and Children Services intervention and support; which in reality is the current practice given the number of incidents that led to no further action by the police themselves. The cost to the NHS for supporting families is a factor, however at present Northumbria Police are incurring costs to attend incidents on a daily basis.

It is not suggested that all children who display CCVAB do have the Conduct Disorder F91-0 but some might. Assessment for this disorder should not continue to be ignored or overlooked, particularly as this is not the only diagnosis that may apply. In ICD-10 (WHO), F98-9 describes '*unspecified behavioural and emotional disorders with the onset usually occurring in childhood or adolescence*' (refer to appendix 4 for details). The World Health Organisation ICD-10/ ICD-11 is not the only diagnosis that is available. DSM-V (American Psychiatric Association, 2013) set out the criteria for Conduct Disorders. To be diagnosed the child must display at least three out of fifteen symptoms within the previous 12-month period and one of the symptoms must be displayed in the previous six months (see appendix 4 for behaviour indicators).

Incident reports by Northumbria Police could be used to support assessment by detailing the behaviour displayed that required the police to attend. Incident reports can also support how often incidents occur or are repeated. Incident reports from officers attending can help support families gain the diagnosis if used to evidence the behaviour that families need for any support to be forthcoming; such as that from Health or Children's Services. It is evident a significant number of children displaying CCVAB, particularly those with SEND or high ACE indicators (see for example Thorley and Coates, 2018) do meet the frequency criteria to be diagnosed with a conduct disorder (American Psychiatric Association, 2013).

DSM-V and more specifically the World Health Organisation ICD-10/ ICD-11 F91-0 *Conduct disorder confined to family context* recognises CCVAB onset pre-adolescence. DSM-V clearly states Conduct Disorders can appear as '*early as pre-school*' with '*Oppositional Defiance Disorder*' as a common pre-morbid condition. DSM-V note that middle childhood to adolescence is the time frame most Conduct Disorders manifest – a time when most CCVAB is reported to police officers. The category of Conduct Disorder diagnoses is in three areas:

- first when 'youth' shows one characteristic of Conduct Disorder prior to age 10,
- second Adolescent onset with no pre-indicator before age 10 and
- third where there are sufficient indicators to diagnose but no determinant age of onset.

To reach diagnosis requires 3/15 behaviours in 12 months and 1 behaviour in last 6 months to be displayed, using the data as an overview all of the following were shown for children involved in incidents attended by officers:

- **Aggression to people and animals**
 - Often bullies, threatens, or intimidates others
 - Often initiates physical fights
 - Has used a dangerous weapon that can harm others
 - Has been physically cruel to others
 - Has stolen while confronting a victim
- **Destruction of property**
 - Deliberately destroyed the property of others
- **Deceitfulness or theft**
 - Broken into someone else's house or car
 - Often lies to obtain goods or favours, or to avoid obligations
 - Steals items of a nontrivial value without confronting the victim

(For some children other areas detailed in Appendix 4 will also be included)

The importance of including internal and external circumstance was used by Simmons *et al* (2018) when they reviewed 60 years of CCVAB indicators. Using Bronfenbrenner's (1979) model of development they included a multi-factor approach and noted CCVAB is a “by-product of an interaction between specific kinds of individual, situational, and biological factors” (Simmons *et al*. 2018 p.31). They concluded that

In the 60 years since the first scientific study of CPA, our understanding of what it looks like and why it occurs remains fragmented and poorly developed. This is largely due to a weak theoretical foundation for much of the existing research, limited consideration of the multiple determinants of aggressive behavior, and the use of operational variables that do not reflect theoretical constructs (Simmons *et al* 2018 p.43)

If internal and external circumstance is an indicator for CCVAB it is essential officers understand how children engage with and perceive their world when deciding on how to proceed during incidents they attend. In the 21st century the impact of technological advances as an internal and external influence on children's views or behaviour has to be included in order to understand how children view their world. Children are being introduced to technology as a means of communication and socialisation and therefore technology plays an intrinsic part of children's worlds and was an area for consideration in the DHR for Sarah.

Section 5.2: Safeguarding current practice and response

Northumbria Police are working with local authority partners to understand further, and improve the whole agency responses to instances of CCVAB and are seeking to develop a wider understanding of CCVAB for all officers. This innovative approach means that all officers will be provided with the knowledge and skills to effectively support families when attending incidents reported to them. Restorative Justice and the Respect Young Peoples programme have been implemented across the force area via local authorities. These approaches are also recognised by the Violence Reduction Unit. These support programmes can be helpful for families in providing support, however in the same way as there are multiple reasons why children display CCVAB there needs to be a range of options available to parent/ carers for support. It is becoming more widely accepted that for many children 'behaviour is language'; particularly those with Speech, Language and Communication Needs or Social, Emotional and Mental Health Needs- what is the child trying to communicate? This highlights why it is necessary to recognise for some children a named intervention will be effective (albeit to varying degrees due to the individuals involved) and for others it will make little difference. It is for this reason all potential interventions need to be considered rather than limiting this to one or two only and recognise that if the wrong intervention is offered the lack of success is not due to families not engaging, but due to limited choice being offered to them.

There are a range of other options for families but these are not available across all of England for families to access, this means families tend to be referred to support and interventions that are available rather than the one best suited to their circumstance. Alternative options include:

- Break4Change: a programme developed in Britain that supports young people and family members using a creative approach such as art
- NVR- Non-Violent Resistance that includes trauma- informed practice and has been successful in supporting families who have adopted, are Kinship carers or foster carers and is available across Northumbria Police force operational area
- Low Arousal- a programme originally developed by Studio III in the UK to support children with SEND that displayed CCVAB but has gained wider appeal for supporting a range of families and is available across Northumbria Police force operational area

- EMDR (Eye Movement Desensitization and Reprocessing) if the behaviour is linked to significant trauma such as Post Traumatic Stress Disorder and is available across Northumbria Police force operational area via CAMHS

To safeguard all involved a 'whole' picture needs to be seen, rather than single instances or incidents; this can only be achieved if multi-agency discussions and sharing of information is honest and includes the views of all children involved and all adults.

It is important for professionals to recognise how their 'professional lens' views children and families and how this can lead them to pre-judge reasons for behaviour. Across all areas of professional practice including Education, Social Care and Health Care, there are numerous suggestions, blogs, guidance notes and videos on how to work with 'difficult parents' but are these parents difficult? It is feasible that some of these parents are not so much 'difficult' but desperately seeking help or reaching crisis point or left between 'a rock and a hard place'. The frustration of parents, particularly for children who have SEND, is openly discussed across media platforms such as Twitter, Facebook and similar. Parents have set up a large number of support networks where they discuss how to deal with 'difficult professionals'. The majority of the discussions highlight how families feel professionals fail to listen to them and they as are frustrated at this lack of listening. For this reason, it is important officers attending incidents appreciate hearing the details and 'listening' to those involved can mean different things; for example, being able to 'hear' what the perpetrator is trying to say may involve more than a spoken verbalised account if the child has SEND and struggles to communicate. For all involved in the reported incident the risk of appointing 'blame' is high- is it the parent's fault? Is it the perpetrators fault? Is it someone else's fault and if so who?

When officers attend incidents, they need to ensure everyone present is 'safe' and will remain 'safe' after they leave. To arrest, go onto charge and refer an individual to the Crown Prosecution Service for 'prosecution', or seek to 'caution' a young person, there needs to be a perpetrator and a victim. When attending incidents officers need to quickly establish if there is a perpetrator and victim present and any risks posed. This situation can influence officer thinking in so much as when the incident is reported to the police, officers are informed of the alleged 'crime', the alleged 'victim' and the alleged 'perpetrator'. Arriving with this information could lead officers to reach a pre-conceived view of the situation; especially if the family or the child has been involved in previous similar incidents. This makes it more difficult for officers to maintain an 'open' mind and evaluate the safety of all involved.

Bonnick (2019) provides a detailed discussion in *Child to Parent Violence and Abuse: A Practitioners Guide to Working with Families* for three aspects of working with families (Part 3, p151). This is an important area for officers to appreciate when attending incidents. Outside of the power relationship existing inside of the home (previously noted in the relationship between the child and adults) police officers themselves hold a position of power as representatives of the laws across society and their role in upholding these legal requirements. For some children the presence of officers inside their home may exacerbate the situation further, for others it may help de-escalate the situation. When attending incidents, it is vital police officers do have a level of control for the situation and retain this 'power' position, however it is also important parents or other adults do not feel they are now 'powerless'. This applies to all professionals involved with the family and emphasises the importance of including and encouraging all parties to be heard and have a voice. Previous studies and publications (such as that of Selwyn *et al*, 2014; Thorley and Coates, 2017/2018 and Bonnick, 2019) detail how a lot of families living with CCVAB feel 'disempowered' by professionals when they ask for help, reinforcing their sense of helplessness to change the situation they find themselves in.

Section 5 Recommendations: Safeguarding

(building on National recommendation and Local Recommendations -all)

- Designate a named Officer (may be part of MASH potentially funded by VRU) as named contact to collate:
 - all reports to Northumbria Police for the same child/ family
 - responses and actions taken by Northumbria Police when attending incidents of CCVAB
 - Contact organisations involved in the child/ family to follow up incident reports and CCN/ ACN referrals - for example when referring the family to Children's Services updating records to include actions taken by such services
 - Monitor data indicators for potential escalation of number of incidents or escalation of behaviour by same child to develop a timeline
 - Lead, liaise and co-ordinate local parent support groups in the first instance to help get these established for high risk families such as: Foster Carers (LAC -Looked After Children), Adopters (PLAC -Previously Looked After Children), Kinship/ Special Guardian's and parents of children with SEND to raise awareness and enable these

parents to have confidence in reporting CCVAB at the earliest stage, rather than waiting until a crisis is reached should this occur⁶².

- Discuss all options available for families and include the family voice- of adults and child
- Consider Child Safety Order by development age not chronological age
- Raise awareness of all officers and teams around the difference between chronological age and developmental stage
- Designate a named Officer (may be part of MASH) to refer all children involved in CCVAB to relevant MASH partners as a Safeguarding concern
- All officers attending incidents complete Child Concern Notification for the child displaying CCVAB (perpetrator) and any other children in the home irrespective of age of child
- All officers to complete Adult Concern Number for the parent/carer or other adults involved in the incident
- Named Designated Officer to collate information gathered and share with all those involved with children locally- Schools in particular need to be involved for example has the child been excluded for behaviour related incidents? This will provide a robust timeline and highlight if CCVAB is escalating or becoming entrenched. Emerging patterns of behaviour can then be identified and needs to include all incidents reported across all ages including those under 10 years
- Attending officers need to consider 'function' of the behaviour- could this be responsive aggression? Does the child have SEND? Is an EHCP in place? Does the child have a history of 'trauma/ ACEs' for example are the currently Looked After, Previously Looked After, Living with Kinship?
- Designated named officer (may be part of MASH team) in developing a flow diagram for all officers to refer to when attending incidents
- To work with the Home Office and MAP in developing a universal 'Safeguarding risk Assessment tool' that all organisations adopt

⁶² A previous pilot set up in Northumbria Police by a school proved to be very successful and was self-sustaining after 5 supported sessions. This has led to more open and honest discussion by families relating to CCVAB incidents.

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<http://www.theannainstitute.org/ACE%20STUDY%20FINDINGS.html>.

NOTE: This study has been replicated internationally and is widely recognised for predicting future indicators for children as they progress to adulthood, for example see

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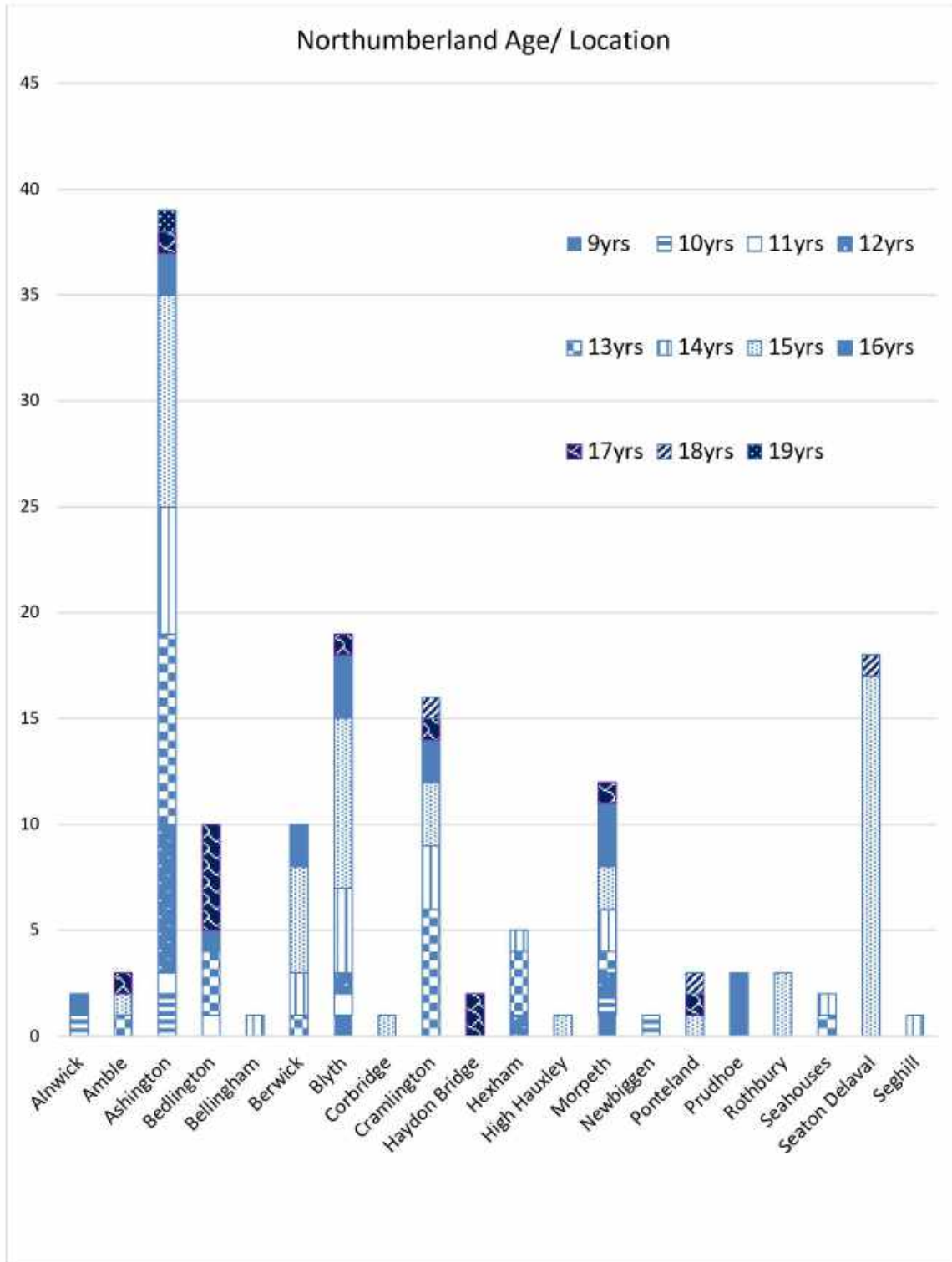
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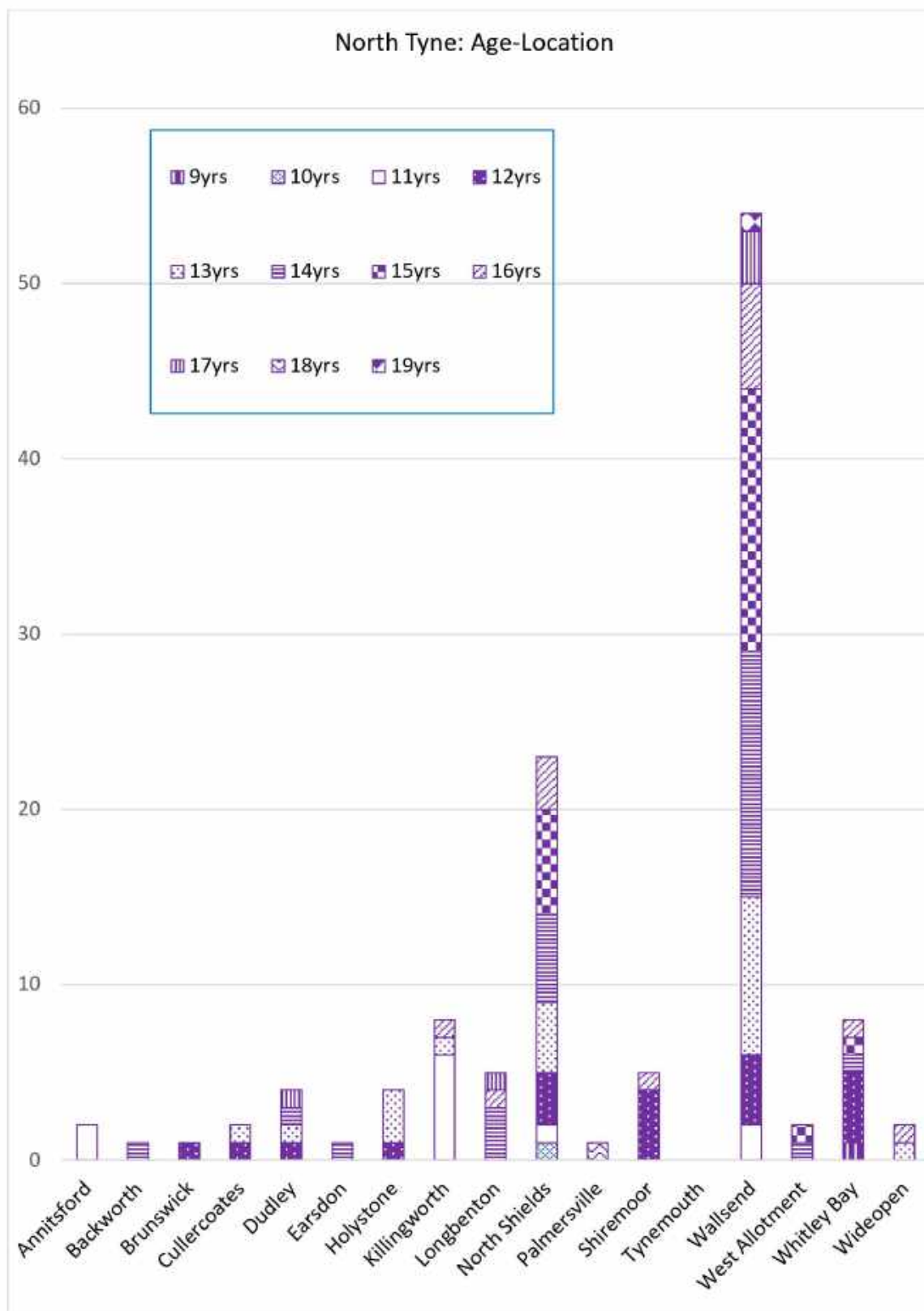
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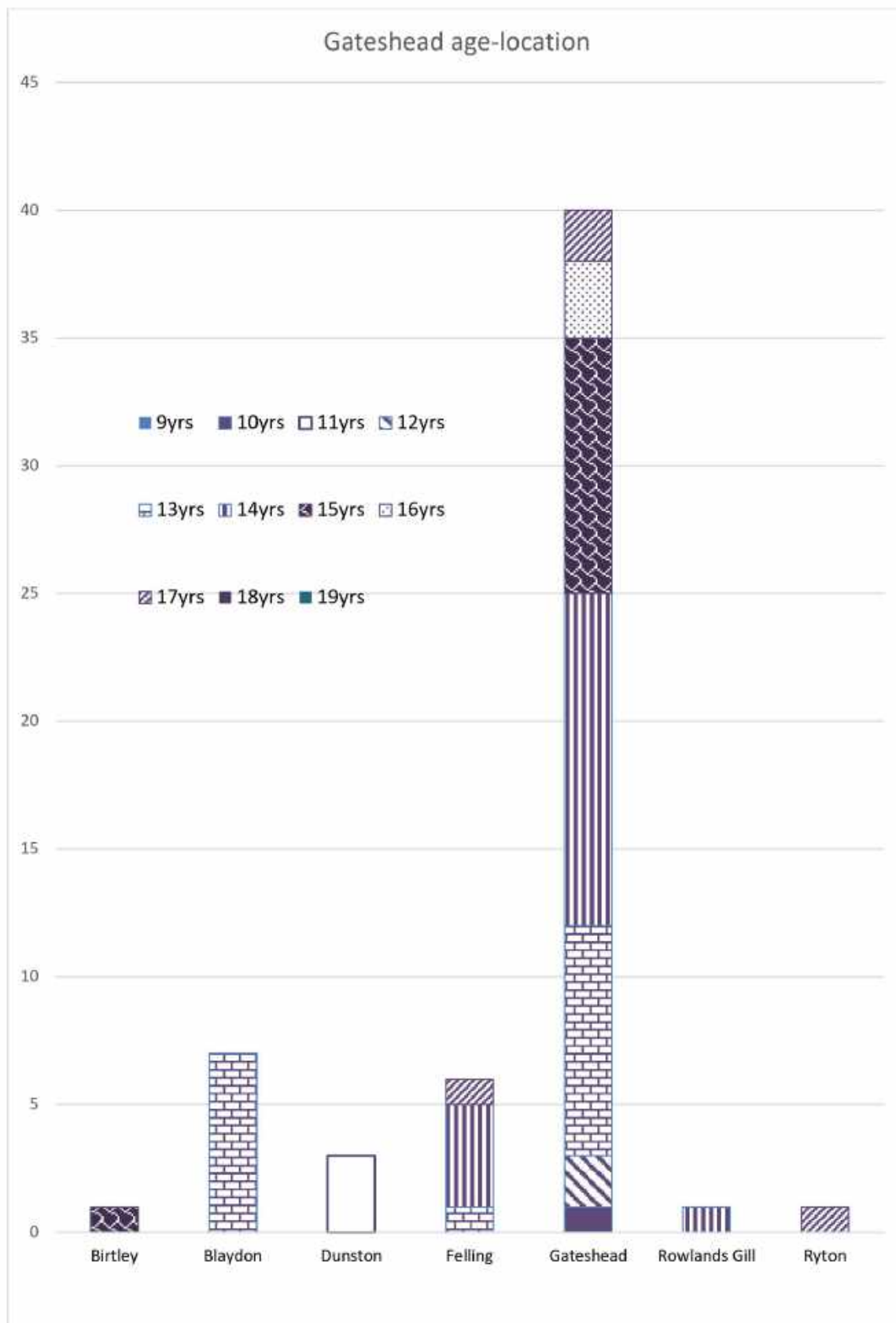
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Appendix 1:

Number of incidents by location (Local Authority area) and age

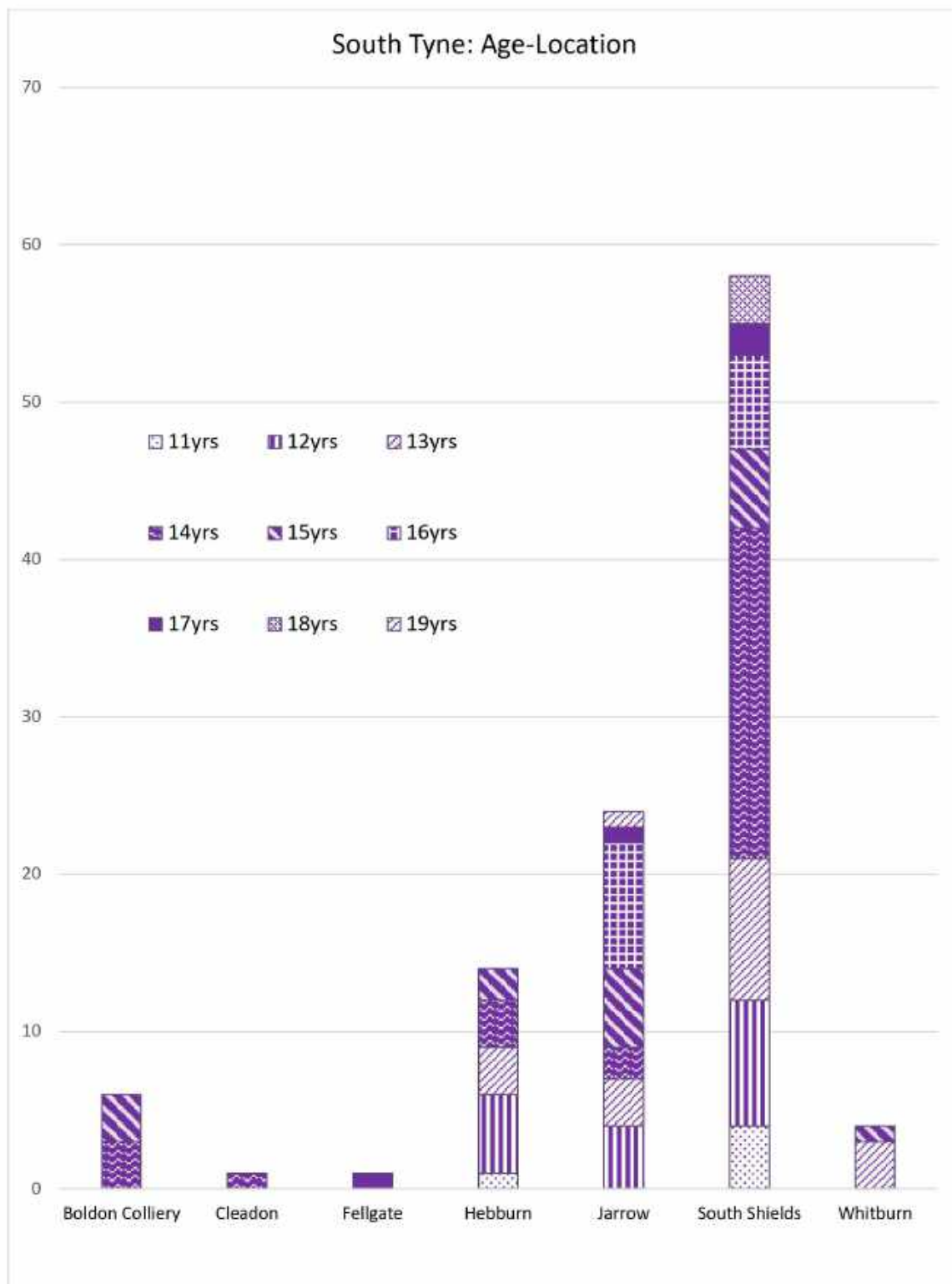






Newcastle Age/ Location	9yr s	10yr s	11yr s	12yr s	13yr s	14yr s	15yr s	16yr s	17yr s	18yr s	19yr s
Forest Hall						1	1		1		
Lemington								1	1	4	
Newcastle					4			6	7	1	1

Sunderland Age/ Location	9yr s	10yr s	11yr s	12yr s	13yr s	14yr s	15yr s	16yr s	17yr s	18yr s	19yr s
Hetton le hole										1	
Houghton					2			2		1	2
Sunderland			1		1	2		4	7	6	2
Washington								1	5		1



Appendix 2

Child poverty rates in Local Wards served by Northumbria Police

Police Force area GATESHEAD	Level before housing costs	Level after housing costs
	17.34%- 6,914 children	27.31% - 10,893 children
22 Local Wards – 6 have higher than 33% child poverty including:		
Deckham- 37.11% = 820 children		Felling = 45.2% = 890 children

Police Force area NEWCASTLE	Level before housing costs	Level after housing costs
	23.53% = 12,843 children	36.03% = 19,667 children
26 Local Wards – 14 have higher than 33% child poverty including:		
Benwell and Scotswood 44.5% = 1457 children		Blakelaw = 42.5% = 1270 children
Byker 49.83%- 1492 children		Elswick 56% - 2,128 children
Fawdon 37.65% - 858 children		Fenham- 37.95% - 1004 children
Kenton 40.32% - 1224 children		Ouseburn 37.84% - 318 children
Walker 43.92% - 1373 children		Westgate – 51.27% - 602 children

Police Force area NORTH TYNESIDE	Level before housing costs	Level after housing costs
	15.75% = 6539 children	24.95% = 10,335 children
20 Local Wards – 4 have higher than 33% child poverty including:		
Chirton 41.87% - 1315 children		Riverside 40.38%- 1058 children

Police Force area NORTHUMBERLAND	Level before housing costs	Level after housing costs
	15.24% = 9356 children	24.18% = 14,857 children
66 Local Wards – 11 have higher than 33% child poverty including:		
Ashington Central 38.64%- 450 children	Cowpen 37.53%- 426 children	
Newbiggin Central and East 40%- 366 children	Hirst 40.14% - 556 children	

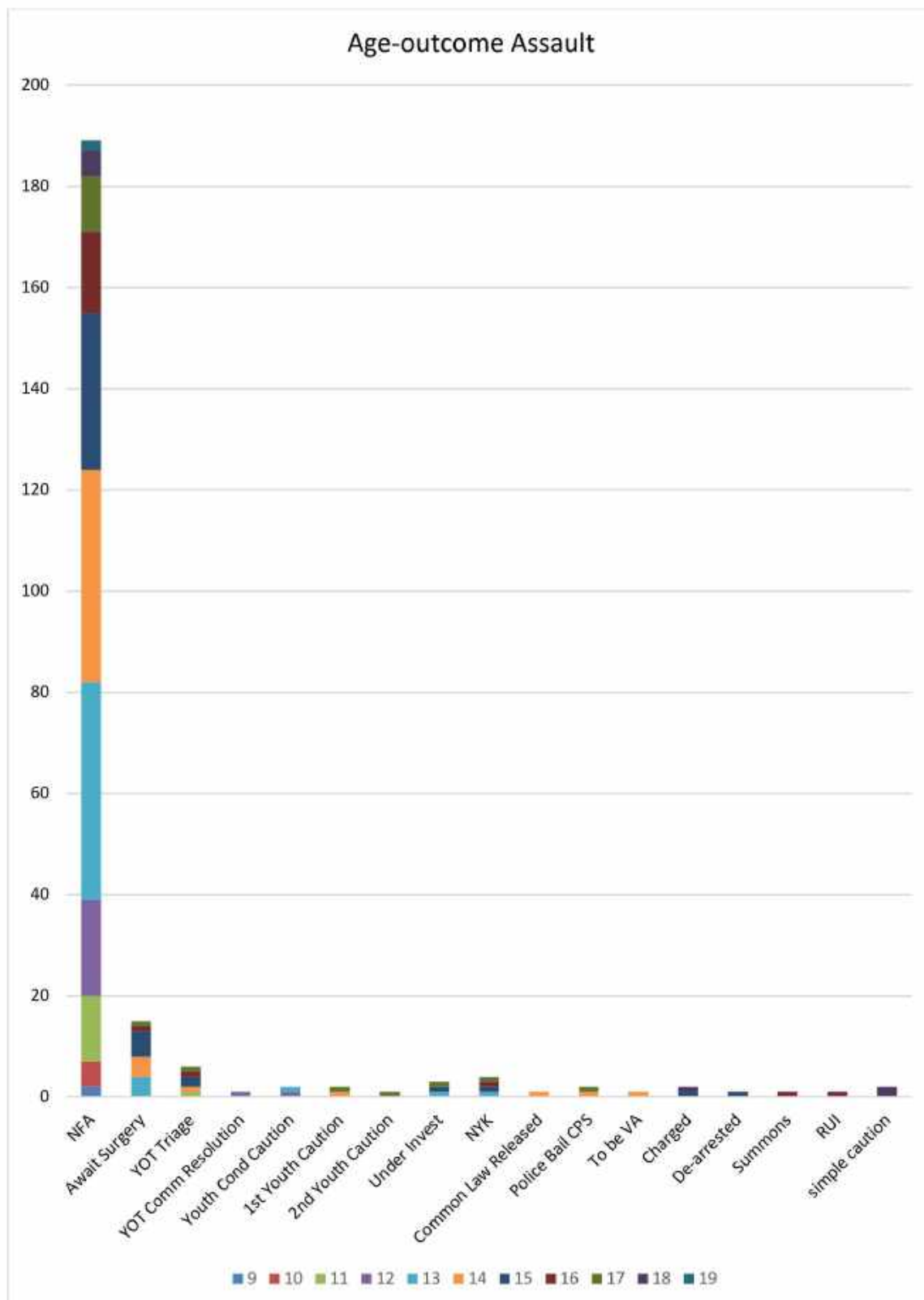
Police Force area SOUTH TYNESIDE	Level before housing costs	Level after housing costs
	20.68% = 6216 children	32.17% = 9670 children
18 Local Wards – 9 have higher than 33% child poverty including:		
Beacon and Bents 48.29%- 874 children	Cleaton Park 40.68%- 639 children	
Biddick and All Saints 42.01%- 9981 children	Simonside and Rekendyke 41.4%- 687 children	

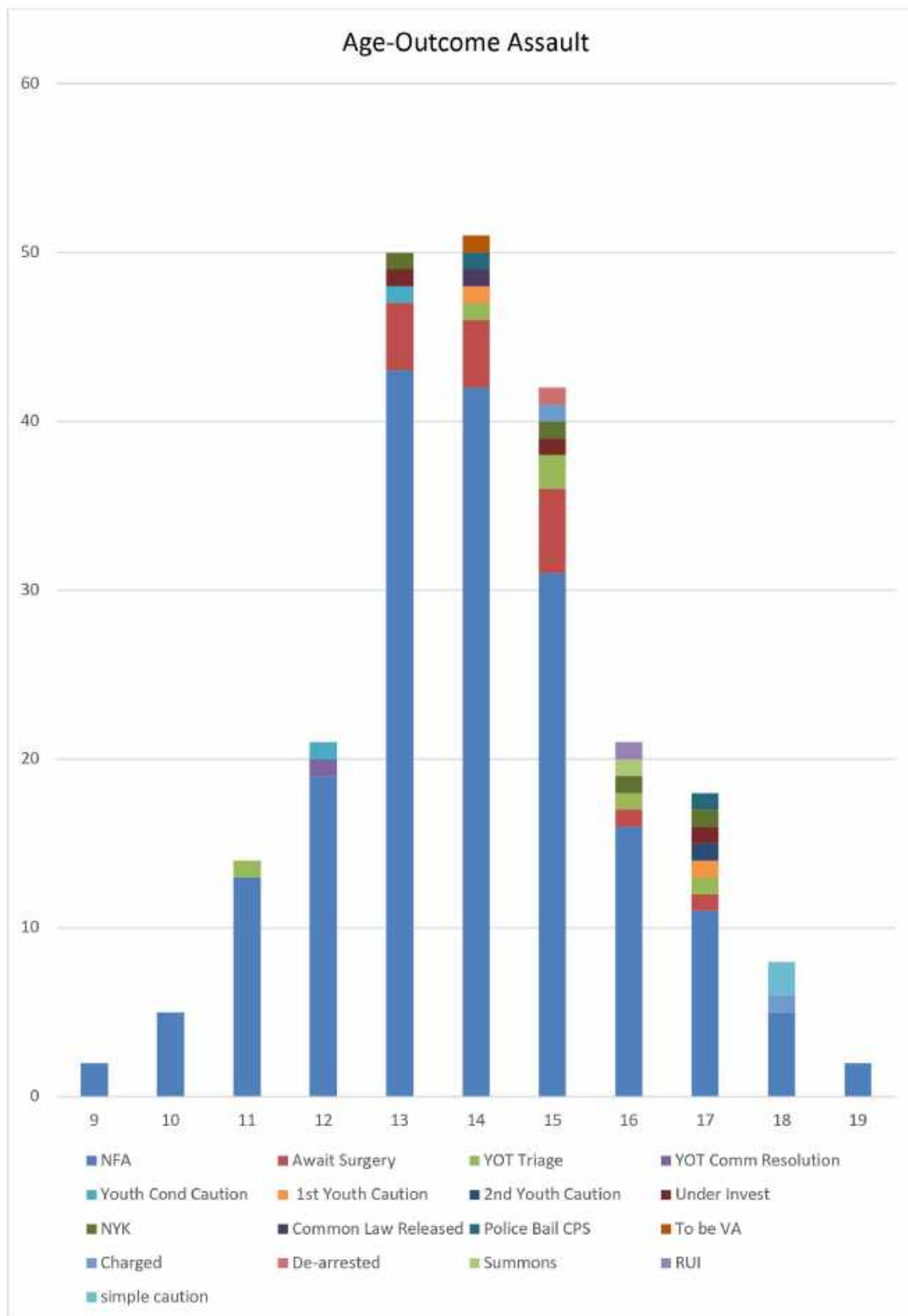
Police Force area SUNDERLAND	Level before housing costs	Level after housing costs
	19.77% = 11,329 children	30.84% = 17,672 children
25 Local Wards – 10 have higher than 33% child poverty including:		
Hendon 45.07% - 1118 children	Millfield 43.56%- 971 children	
Pallion 39.25%- 924 children	Redhill 41.15%- 1,105 children	
Sandhill 37.5% - 911 children	Southwick 37.73% - 898 children	

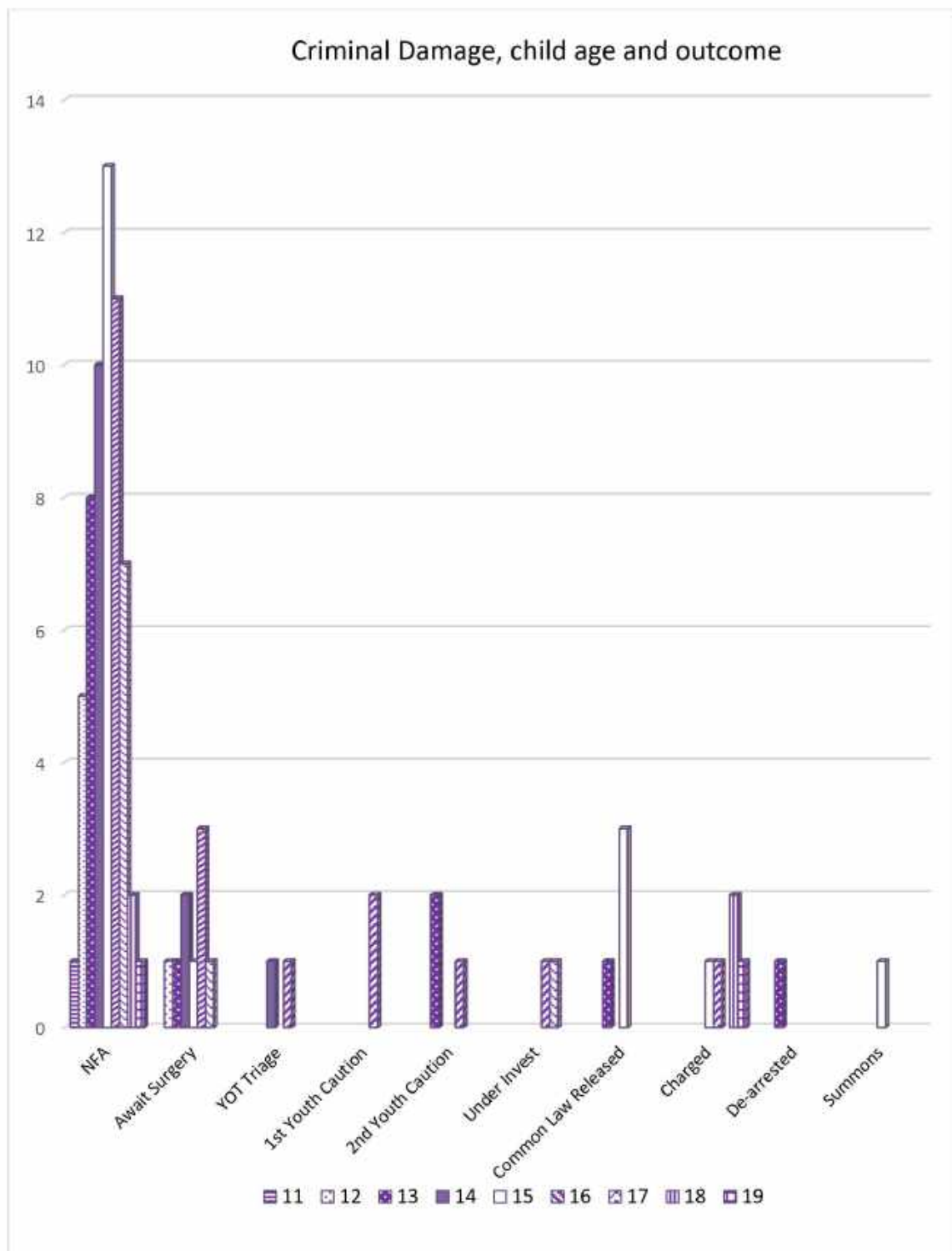
Appendix 3:

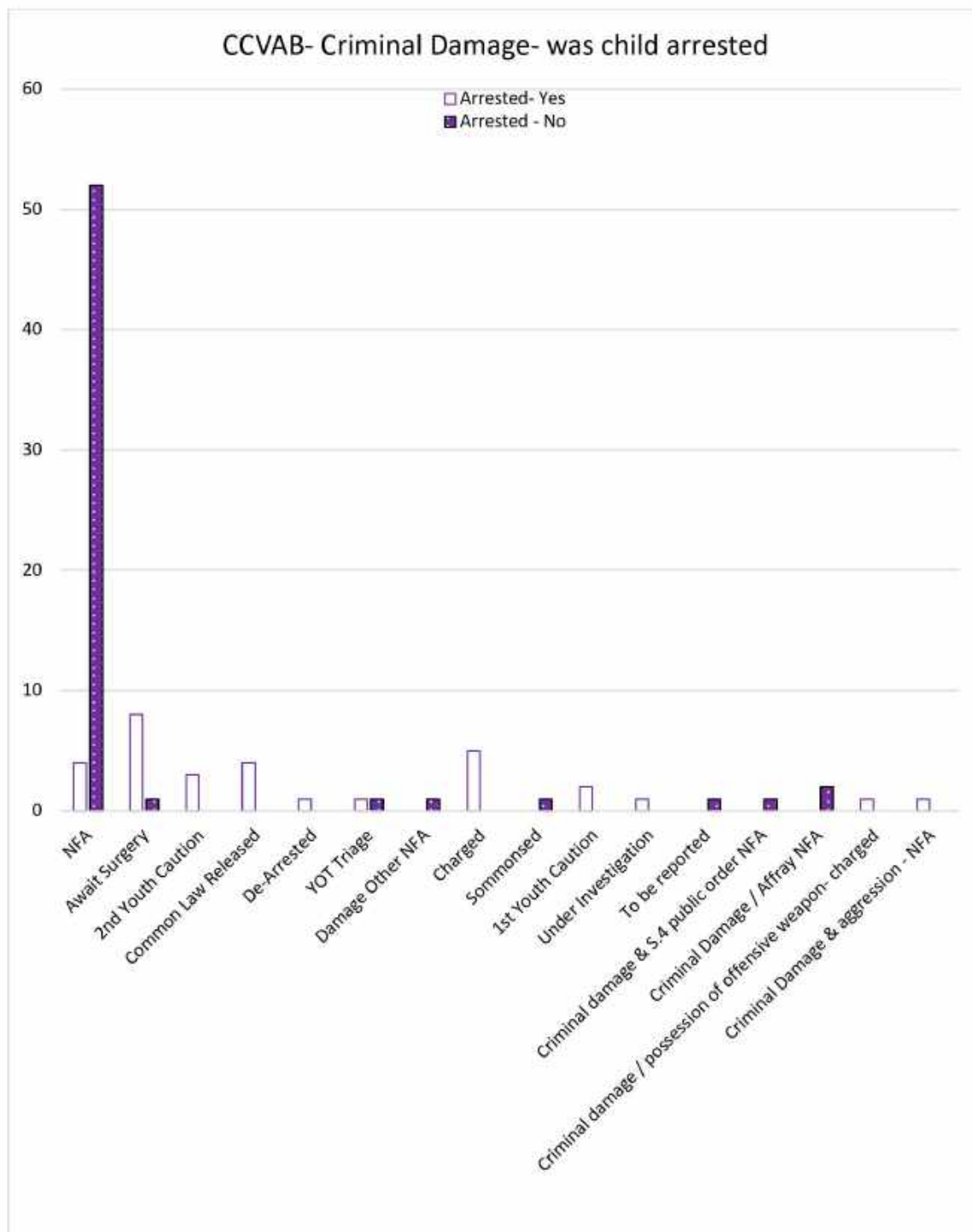
CCVAB- Offence

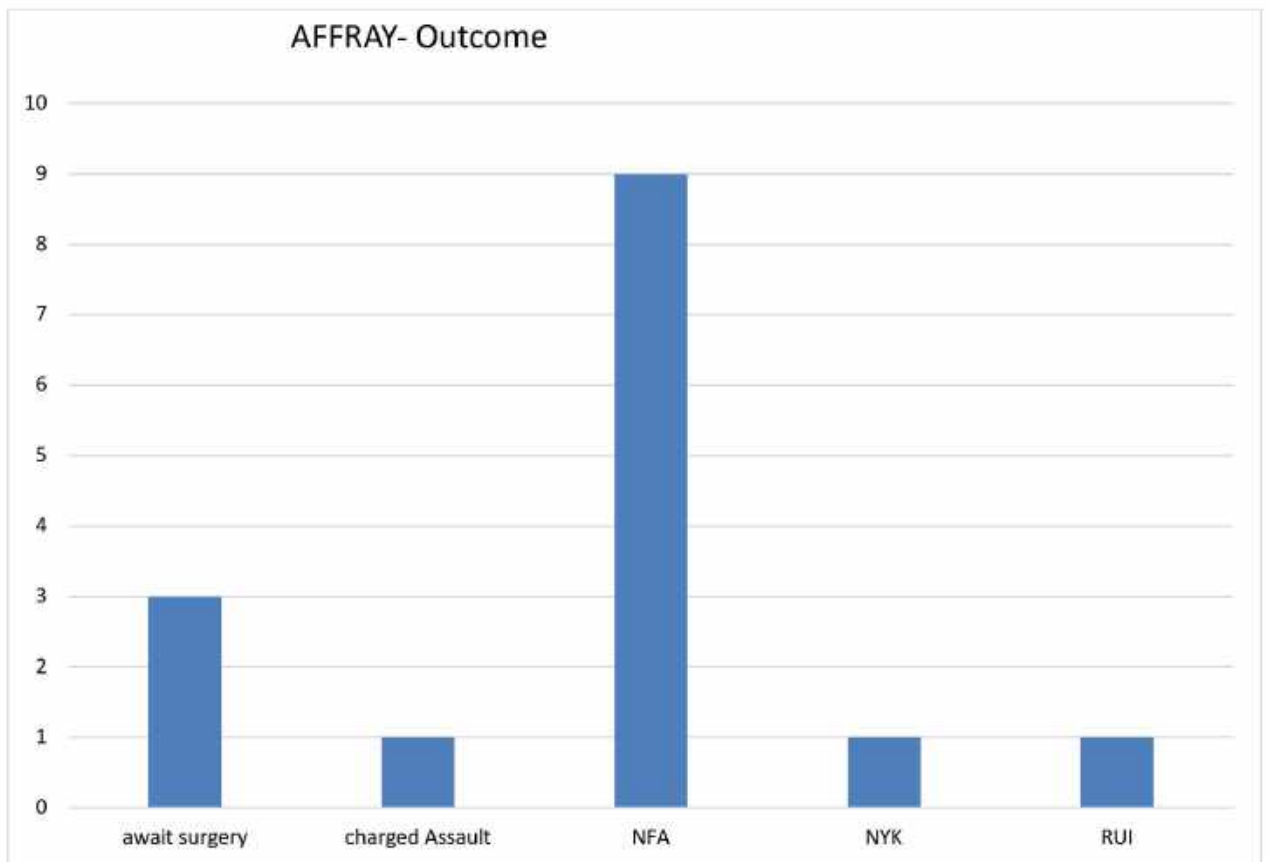
Outcome- Age











CCVAB Offence- Affray- Crime- Yes- (all)	Outcome NFA	Outcome Await Surgery	Outcome- Not yet known	Outcome - R.U.I	charge d assault
CCVAB- Affray -Arrest- No	4				
CCVAB- Affray -Arrest- Yes	4	2	1	1	
CCVAB Affray and S.39 Common Assault- arrested		1			1

Appendix 4:

Types of 'Aggression'

Aggression taxonomy proposed by Parrott and Giancola (2007): source Allen and Anderson (2017)

	<i>Direct Expression</i>	<i>Indirect Expression</i>
Active Expression	Subtypes	Subtypes
	Physical	Physical
	Verbal	Verbal
	Postural	Postural
	Damage to property	Damage to property
	Theft	Theft
Passive Expression	Subtypes	Subtypes
	Physical	Physical
	Verbal	Verbal
	Damage to property	Damage to property
	Theft	Theft

Aggression taxonomy proposed by Krahé (2013): source Allen and Anderson (2017)

	<i>Subtypes</i>	<i>Examples</i>
Response modality	Verbal	Shouting or swearing at someone
	Physical	Hitting or shooting someone
	Postural	Making threatening gestures
	Relational	Giving someone the “silent treatment”
Immediacy	Direct	Punching someone in the face
	Indirect	Spreading rumors about someone behind their back
Response quality	Action	Making another person engage in unwanted sexual acts
	Failure to act	Withholding important information from a colleague at work
Visibility	Overt	Humiliating someone in front of others
	Covert	Sending threatening text messages to a classmate
Instigation	Proactive/unprovoked	Grabbing a toy from another child
	Reactive/retaliative	Yelling at someone after having been physically attacked
Goal direction	Hostile	Hitting someone out of anger or frustration
	Instrumental	Taking a hostage to secure a ransom
Type of harm	Physical	Broken bones
	Psychological	Fears and nightmares
Duration of effects	Transient	Minor bruises
	Lasting	Long-term inability to form relationships
Social units involved	Individuals	Intimate partner violence
	Groups	Riots and wars

Appendix 5:
Behaviour diagnosis criteria:

ICD-10/ ICD-11,

World Health Organisation

The DSM-V manual

American Psychiatric Association, 2013

Criteria for Conduct Disorder diagnosis: Behaviour displayed

TABLE 1			
Aggression to people and animals	Destruction of property	Deceitfulness or theft	Serious violations of rules
1. Often bullies, threatens, or intimidates others	8. Has deliberately set fires with intention to cause serious damage	10. Broken into someone else's house or car	13. Stays out at night despite parental objections (beginning before age 13)
2. Often initiates physical fights	9. Deliberately destroyed the property of others	11. Often lies to obtain goods or favours, or to avoid obligations	14. Has run away from home at least twice for an extended period of time
3. Has used a dangerous weapon that can harm others		12. Steals items of a nontrivial value without confronting the victim	15. Often truant from school (beginning before age 13)
4. Has been physically cruel to others			
5. Has been physically cruel to animals			
6. Has stolen while confronting a victim			
7. Has forced someone into sexual activity			

DSM-V- cognitive disorders

Highlighting those seen in CCVAB:

A classification of disorders in the diagnostic and statistical manual of mental disorders (DSM) that are usually diagnosed in infancy, **childhood or adolescence and are characterized by an individual's inability to behave in a cooperative manner.**

A disorder diagnosed in childhood or adolescence age group **characterized by aggressive behavior, deceitfulness, destruction of property or violation of rules that is persistent and repetitive, and within a one year period.**

A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. These behaviors include aggressive conduct that causes or threatens physical harm to other people or animals, nonaggressive conduct that causes property loss or damage, deceitfulness or theft, and serious violations of rules. The onset is before age 18. (from DSM-IV, 1994)

Any of various conditions characterized by impairment of an individual's normal behavioral functioning, and caused by social, psychological, biochemical, genetic, or other factors, such as infection or head trauma.

Disorders characterized by persistent and repetitive patterns of behaviour that violate societal norms or rules or that seriously impair a person's functioning. Compare behaviour problems.

Mental disorder of childhood and adolescence characterized by repetitive and persistent patterns of conduct in which rights of others and age-appropriate societal rules are violated; the conduct is more serious than ordinary mischief and pranks.

Repetitive and persistent aggressive or nonaggressive behavior in which basic rights of others or social norms are violated. Self esteem is generally low, and an inability to develop social relationships and lack of concern for others may or may not be present.

American Psychiatric Association (2013) Intermittent Explosive Disorder involves impulsive or anger-based outburst of behaviour that start rapidly and are out of proportion to any trigger indicator.

*The outbursts often last fewer than 30 minutes and are provoked by minor actions of someone close, often a family member or friend. The aggressive episodes are generally **impulsive and/or based in anger rather than premeditated**. They typically occur with significant distress or psychosocial functional impairment. Aggressiveness must be "grossly out of proportion" to the provocation and accompanying psychosocial stressors (ibid) (my emphasis)*

American Psychiatric Association (2013)

the behaviour 'has very little build up' and 'The recurrent outbursts are neither premeditated, nor are they to achieve an outcome. Thus, outbursts are impulsive or based in anger, and are not meant to intimidate or to seek money or power'.

The American Psychiatric Association (2013) two types of Intermittent Explosive Behaviour.

The first type of types of Intermittent Explosive Behaviour is outlined as:

'characterized by episodes of verbal and/or non-damaging, nondestructive, or non-injurious physical assault that occur, on average, twice weekly for three months, These could include temper tantrums, tirades, verbal arguments/fights, or assault without damage. This criterion includes high frequency/low intensity outbursts'

The second type of Intermittent Explosive Behaviour is outlined as:

'is characterized by more severe destructive/assaultive episodes that are more infrequent and occur, on average, three times within a twelve-month period. These could be destroying an object without regard to its value or assaulting a person or an animal. This criterion includes high-intensity/low-frequency outbursts.'

DSM-V

child must be unable to control their violent or aggressive behaviour that includes '*Verbal aggression like temper tantrums, tirades, arguments or fights; or physical aggression toward people, animals, or property*'

DSM-V handbook (American Psychiatric Association, 2013) the following requirements:

- This aggression must occur, on average, twice per week for three months
- The physical aggression does not damage or destroy property, nor does it physically injure people or animals **or**

Within 12 months, three behavioural outbursts resulting in:

- Damage or destruction of property, and/or
- Physical assault that physically injures people or animals

(American Psychiatric Association, 2013)

diagnosis of Intermittent Explosive Disorder is limited to children aged six years or more