December 2021

National Consortium on Aggression toward Family/Caregivers in Childhood & Adolescence (AFCCA)

Building Understanding to Improve Outcomes for Families

Acknowledgements

Aggression toward Family/Caregivers in Childhood & Adolescence (AFCCA) is a difficult subject for many to discuss. While many know of its existence (often under different names and descriptions), it is frequently unreported and not widely discussed. The individuals exhibiting the behaviour as well as their parents / caregivers speak of the shame, stigma, and isolation they commonly experience when they do bring light to the discussion.

The National Consortium on Aggression toward Family/Caregivers in Childhood & Adolescence (AFCCA) intentionally chose to center this body of work on the many voices with lived experience. More than 100 young adults, parents, caregivers, and siblings shared their lived experiences and expertise to shape key learnings, help to codevelop recommendations, as well as test and validate emerging conclusions. Collectively they represent a cross-Canadian geographic perspective, and include perspectives from biological, adoptive, and kinship families, youth who had experienced child welfare and child protection systems including alternative living arrangements, neurodiverse individuals, and first voice youth advocates. Their extensive sharing and incredible candor have been invaluable to the work of the Consortium, and their guidance is woven into all aspects of this report.

The Consortium acknowledges and appreciates the engagement from the many professionals, services providers, researchers, and practitioners who offered their time and insights into the development of this body of work. Uniformly these individuals recognized the complexity of this issue and spoke with compassion and empathy for the individuals and families they had observed in their clinical practices, research, professional responsibilities, or respective communities.

The Consortium gratefully received funding from Kids Brain Health Network and operational support from Adopt4Life. The Consortium thanks both organizations for their exceptional support, while also acknowledging that the findings and conclusions included in this report are those of the Consortium membership and may not reflect the opinions of either organization.

About This Document

This document incorporates the collaborative insights, findings, and recommendations from individuals with lived experience, interested practitioners and professionals, as well as the full table of Consortium members and guests. Throughout this report the names of individuals have been changed or reflected simply as an initial (marked with an *) to protect the individual’s privacy, or that of their child/adolescent/other family members.

Except where noted (ie. Literature Review, Policy Briefing & Recommendations, Operational Definition), this summary report has been prepared by Tracy Moisan, Program Director, and Lauri Cabral, Chairperson, for the National Consortium on Aggression toward Family/Caregivers in Childhood & Adolescence.

Contents

Foreword

In 2019, in response to the needs expressed by their community families, Adopt4Life – Ontario's Association for Kin, Customary Care, and Adoptive Parents and Caregivers – formed a working group to better understand the issue of aggression toward parents and caregivers by a child or youth. Over the following year, countless parents and caregivers came forward to bravely share their stories, frequently painting a picture of desperation and raising concerns that what they were experiencing was resulting in lasting harm with limited solutions.

With the onset of the global Covid-19 pandemic in 2020, the cries for help increased dramatically and came to the attention of Kids Brain Health Network.

Individuals living with neurodevelopmental disabilities and their families were faced with a dramatic reduction in supports as a result of the pandemic, and multiple public reports cited growing concern over the mental health of children with any form of disability throughout the pandemic. Related research highlighted increases in challenging behaviours including aggression toward family members, and a correlation between this behaviour and risk of family instability and breakdown. Parents and caregivers (both adoptive and biological) spoke of relying on emergency first responders who didn't understand these kinds of situations. Families were overwhelmed and expressed urgent needs for mental health support.

Kids Brain Health Network and Adopt4Life share a commitment to helping find solutions for the challenges identified by the families we work with. We have heard clearly and directly that this issue is causing immeasurable harm to entire families across Canada. The shame, stigma, grief, and isolation expressed by individuals who are brave enough to speak about this issue is immense, and we must not turn away from these difficult conversations.

It is impossible not to feel a shared sense of urgency in finding improved ways to support both the children and adolescents most directly impacted by this issue, and their parents and caregivers working so desperately to keep everyone in their family safe. The learning and conclusions of the Consortium provide a clear path for steps that we can all take together, in support of vulnerable children and youth and their families. It's time to act.

James Reynolds
Chief Scientific Officer
Kids Brain Health Network

Julie Despaties
Executive Director and Founder
Adopt4Life

Weathering the Storm

The young adults with direct lived experience who were engaged early in the Consortium's work spoke directly about the need to recognize this behaviour in a child or adolescent as something to be prepared for, something that could be expected to happen in many situations, and something that could be successfully weathered with the right understanding and support.

Maude Champagne, RSW, MSW, member of the Consortium, shared a metaphor that beautifully illustrated what was being heard from both families and practitioners.

> The wind is a force of nature that is all around us, all the time.
> It's just there, an accepted part of our environment.
> Sometimes it manifests as a gentle breeze, with no visible trace of its existence.
> Sometimes it picks up speed and rustles the leaves on the trees.
> Sometimes it continues to build in intensity, but we still withstand its strength.
> And sometimes, the wind becomes so unexpectedly strong it turns into something new - a tornado that batters many of the things in its path and knocks people off their feet.
>
> When the wind becomes a tornado, it is difficult to weather the storm alone. We pull out our emergency supplies that were built up in advance. We connect with others to ensure everyone is cared for. Still, we can be left feeling scared and traumatized by the experience. We often look to our community for support and safety in the storm.

Families need the same understanding and community of support to weather the storm that is aggression toward family/caregivers, in childhood and adolescence.

All design and art in this report has been created by Designer Selina Chung.

Executive Summary

Aggression toward Family/Caregivers in Childhood & Adolescence (AFCCA) is a pattern of behaviour in childhood or adolescence, characterized by aggressive behaviour by a child or adolescent towards family members. This causes significant harm (physical and/or psychological) to both the child/adolescent and the person(s) the behaviour is directed towards, and other witnessing family members.

The National Consortium on Aggression toward Family/Caregivers in Childhood & Adolescence (AFCCA) was formed to gain a better understanding from Canadian stakeholders and to explore the breadth of perspectives the participating individuals, families, and organizations have on this issue, to consider how best to improve outcomes for Canadian children, their families, and their communities. Research from international sources is combined with information obtained from Canadian experiences to highlight key issues and understandings.

Meaningful family engagement was a core principle of the Consortium and **over 100 family members with lived experience (including parents, caregivers, young adults who experienced AFCCA as a child/adolescent, siblings) were consulted.** These first voice experts provided ongoing guidance to the Consortium members through 1:1 interviews, multiple focus groups, qualitative discussions, and a series of online questionnaires.

The voices of youth and young adults who spoke with the Consortium were clear in what they wanted understood:

- Most importantly, they want to be **seen, heard, and respected** in conversations about this issue. Their experiences are invaluable to deeper understanding and possible strategies that will create actual change for youth.
- For many youth, AFCCA can be viewed as a communication problem, where the child/adolescent is struggling to communicate. **Behaviour is a form of communication.** Young adults with lived experience suggest that individuals who were supported in developing more effective communication skills or self-regulating skills had fewer incidents of aggression over time.
- Particularly for youth with related neurodevelopmental disabilities, disrupted early attachments, adverse early childhood experiences, or developmental trauma, **AFCCA may be a "normal" pattern of behaviour that can be expected.** Preparing parents/caregivers to better understand and anticipate this behaviour may result in earlier skill building and more effective interventions before families reach a crisis.
- Young people spoke about **the need for connection and community** to better support children/adolescents experiencing AFCCA. They are talking about where they live, their teachers, their peers, their neighbors, their own self-defined family relationships. They are not primarily thinking about professionals, clinicians, and practitioners. They want a true community who understands, the people directly in their lives to understand, and they want a sense of genuine belonging.

Additionally, parents and caregivers provided rich insights from their extensive experiences, that directly informed the findings, conclusions, and recommendations contained in this report:

- **There is immense shame, blame, and stigma experienced by all family members** (including most notably parents, caregivers, and the youth themselves) when AFCCA occurs. Families confirmed repeatedly they did not seek help due to stigma, a lack of confidence that professionals have both the knowledge and willingness to help, as well as the fear of repercussions from child welfare and/or justice systems. This leads to further isolation and exacerbation of the situation, **leaving families at greater risk of instability and breakdown.**

- AFCCA is being **experienced by both adoptive and biological families,** particularly for families of children with complex needs or neurodevelopmental disabilities.

- Families are living with an **unexpectedly high level and frequency of dangerous behaviour in their home** and are raising urgent concerns about the safety of their child/adolescent, other children in the home, and themselves. Of the families who shared experiences with the Consortium, **76%** reported experiencing daily or weekly incidents of aggression, and **55%** reported the intensity of those incidents to be 8/10 or higher.

- Parents and caregivers who do seek support for their families want to **remain at the center of care for their child/adolescent** and should be regarded as an expert in the individual needs of their family.

- **Families are having to fight to remain together.** There is a discernable pattern where parents/caregivers face repeated direction that the only way to access the necessary therapeutic interventions for their child is to relinquish custody of their child to their respective provincial child welfare agencies. Frequently a child's need for intensive therapeutic supports is responded to with the unnecessary use of the child welfare/child protection and/or youth justice systems. Multiple parents / caregivers spoke of the need for a "3rd way", forced to develop their own solutions for more effective crisis response.

> "There is far too much stigma associated with this; most people will not talk about it even to a close relative or friends. It's a family secret unless it becomes too impossible to manage on one's own."
>
> "...This is a very hidden and misunderstood issue...families often withdraw rather than seeking help. There's a lot of shame and guilt involved. Families like ours need strong support from professionals who genuinely display unconditional positive regard for each member of the family and who can offer realistic and practical strategies and solutions."
>
> "..we've seen this across all kinds of children and youth and families. You can see it in situations where we have histories of attachment and complex developmental trauma in adoptive families and children and youth and care, but we've also seen it in intact biological families. Perhaps also there are more specific developmental delays or neuro-complex issues as well." The spectrum is pretty broad of what families you'll see this in."
>
> —Voices of parents, caregivers, and practitioners, sharing experiences to the Consortium

- In all cases, they face **extensive roadblocks and barriers to accessing the help so desperately needed.** These include inequitable systems responses, where families from marginalized communities more frequently experience inadequate or biased response, lack of qualified / skilled services and professionals, geographical isolation, and gaps / lack of clarity in public-policy for the support of children and youth with complex needs.

The Consortium's findings highlight that **each family is unique** and that their needs vary and change over time. Successful strategies or approaches must be flexible and able to adapt. The families who are finding some measure of improvement / success are most often finding ways to develop integrated, coordinated circles of support, where the **parents/caregivers and the youth themselves are equal and full partners** alongside other individuals who share a genuine connection to the child/adolescent.

These circles of support will likely also include multi-disciplinary professionals and health providers responsible for various aspects of the child/adolescents' plan of care. Additionally, parents/caregivers and practitioners also highlighted these elements of a coordinated plan:

- **Peer support networks and peer relationships** (both formal and informal) that help to reduce shame and feelings of blame, as well as increasing parents' capacities.
- **Respite programs, both in-home and out-of-home,** that are trauma-informed, attachment-informed, and understand the contributors to AFCCA.
- **Learning and skills-development programs** that focus on earlier intervention and skills within families, mitigating the need for more intensive crisis-intervention later.
- **Trauma-informed, attachment-informed therapeutic models and practices** were noted to be of long-term benefit.
- **Youth justice diversion programs,** particularly those with a **restorative justice practice or objective,** were cited as being helpful in avoiding unnecessary entrenchment with the justice system, or criminalization of youth.

Families across Canada are experiencing the devastating consequences of AFCCA. The Consortium has identified clear, specific actions and recommendations which can offer immediate benefit to children, youth, parents/caregivers, and communities. The policy and program recommendations identified and prioritized by the Consortium are organized into a series of foundational pillars that would be expected to evolve and further develop over time.

These following 10 pillars serve to outline recommended next steps from a "lifecycle" orientation, considering holistically broad community understanding and engagement, building on the strengths of families, and improving the outcomes for individual children and youth/adolescents.
The 10 pillars are:

1. Awareness
2. Education
3. Anti-Stigma
4. Research
5. Creating the Right Door
6. Early Intervention
7. Family / Youth-Directed Circles of Support
8. Effective Crisis Response
9. Financial Supports for Families
10. Transitions to Adulthood

Full details of each pillar and the accompanying recommendations are contained within both the main report, and in full as Appendix C: AFCCA Policy Framework and Recommendations.

> **"It's not about the parents, and it's not about the child. It's about what do we need to do right now."**
>
> **—C.*, Youth first voice advocate**

Respecting Cultural Connections and Collaboration

We acknowledge the Indigenous Peoples of all the lands that we call home today. We do this to reaffirm our commitment and responsibility in improving relationships between nations and to improving our own understanding of local Indigenous peoples and their cultures. This Consortium welcomed guests and speakers from across Canada and acknowledges that together, we work and gather on the treaty lands and un-surrendered territories of the First Peoples of Canada. We pay tribute to their legacies and teachings, as we seek to strengthen ties with the communities we seek to serve. From coast to coast to coast, we acknowledge the ancestral and unceded territory of all the Inuit, Métis, and First Nations people who have called this land home since time immemorial. We further acknowledge the painful historical legacies of harm and intergenerational trauma experienced by Indigenous families and their children. We acknowledge and welcome our shared responsibilities to ensure health and wellbeing for all creation for generations to come, as we seek to move forward with a true spirit of reconciliation and collaboration.

The Consortium has developed its findings and recommendations regarding Aggression toward Family/Caregivers in Childhood & Adolescence (AFCCA) while being aware that definitions of 'family', 'caregivers', 'community', 'need' and 'appropriate intervention', etc. will have different meanings for various communities, notably for Black and Indigenous, families newly arrived to Canada, and other systematically marginalized groups.

The Consortium acknowledges that traditional interventions and responses to AFCCA - in particular child welfare, child protection, and youth criminal justice systems interventions—have had, and continue to have, a disproportionately negative impact on Black and Indigenous families and youth. The young people in these communities continue to suffer from systemic inequalities and barriers that are responsible for ongoing intergenerational harm and trauma.

The Consortium does not presume to speak for all communities and supports the belief that individual communities may wish to develop or adapt their own frameworks and recommendations. To this end, the Consortium is committed to sharing information and resources about AFCCA with interested Black, Indigenous, and racialized communities, and to collaborating meaningfully with organizations that work with these groups and can bring an intersectional approach, with a view to sharing and learning from each other.

The Consortium further believes that resources and funding should be made available so that engaged communities can create their own culturally relevant and appropriate processes for developing frameworks that best meet their needs to care for the health and well-being of their children.

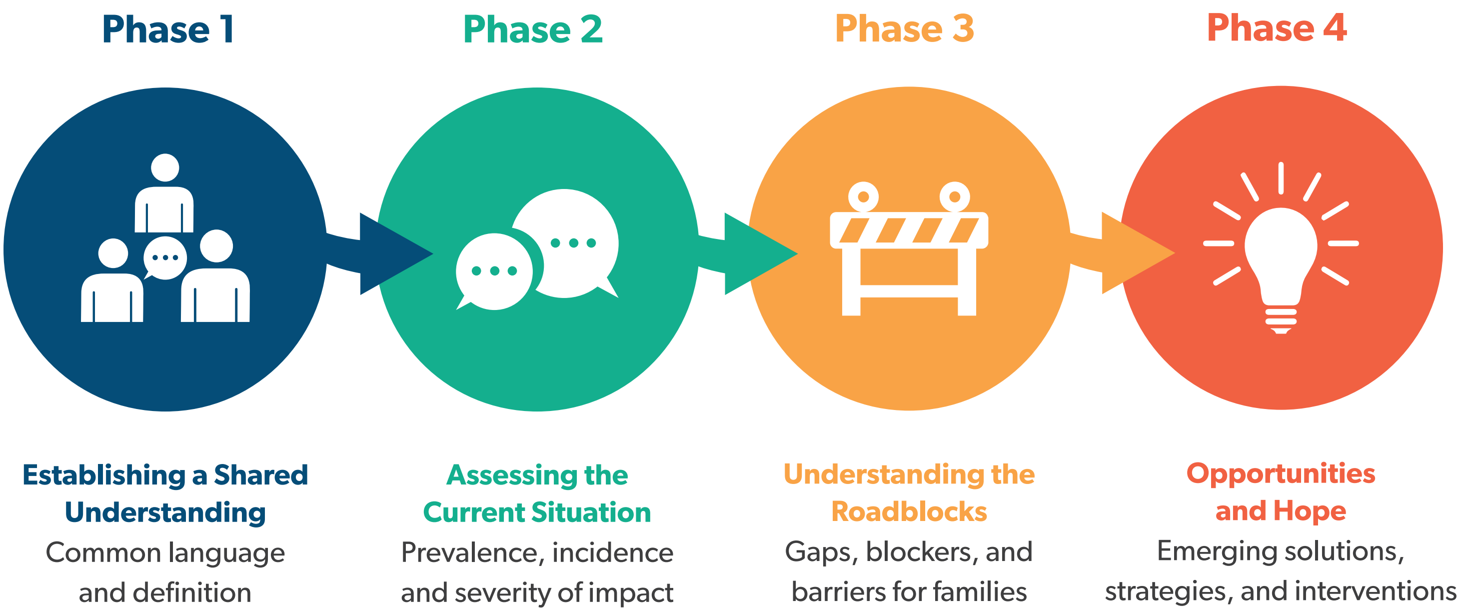
Introduction to the Consortium

Aggression toward family/caregivers in childhood and adolescence has been described as one of the most under-researched and lesser known forms of family violence (Holt, 2011; Simmons et al., 2018; Thorley & Coates, 2019), despite its apparent prevalence and serious impacts. In 2013 – 2015, the European Union DAPHNE project 'Responding to Child to Parent Violence' undertook a collaborative approach to study the serious problem of 'violence by children towards their parents'; with their work spanning England, Ireland, Spain, Sweden, and Bulgaria. A growing body of international research has followed, with recognized peer-reviewed and published studies in countries across North America, the EU, Australia, and more (see Appendix A for literature review references).

Despite the growing international awareness and understanding, this issue remains under-researched in the Canadian context, particularly through trauma-informed, child-rights and neurodevelopmental lenses.

The National Consortium on Aggression toward Family/Caregivers in Childhood & Adolescence was formed to gain a better understanding from Canadian stakeholders and to explore the breadth of perspectives the participating individuals, families, and organizations have on the issue in order to consider how best to improve outcomes for Canadian children, their families, and their communities. Research from international sources is combined with information obtained from the Canadian perspectives to highlight key issues and understandings.

The Consortium was organized into 4 phases, which began in the summer of 2021, against the backdrop of the continuing Covid-19 pandemic. Consortium members met virtually as a full group and in smaller working groups over a period of approximately six months, through to November 2021.



Phase 1

Establishing a Shared Understanding

Common language and definition

Phase 2

Assessing the Current Situation

Prevalence, incidence and severity of impact

Phase 3

Understanding the Roadblocks

Gaps, blockers, and barriers for families

Phase 4

Opportunities and Hope

Emerging solutions, strategies, and interventions

Consortium members (see next section) were invited to participate in one of five specialized "subgroups", based on their individual expertise / area of focus. These five subgroups met independently throughout the term of the Consortium to seek community inputs, consolidate findings and data, form recommendations, and develop conclusions. Several Consortium members worked across subgroups, where their experience spanned multiple areas. Together they provided a unique lens to the:

Voice of Families
(incl. youth/young adults, siblings, biological, adoptive, kin and customary care parents/caregivers)

Voice of Practice
(incl. clinical psychology, psychotherapy, and occupational therapy)

Voice of Social Systems
(incl. child welfare/protection, child and family services, and police /youth justice)

Voice of Academics
(incl. social work, psychology, neuroscience, and criminology)

Voice of Policy
(incl. both provincial and federal public policy)

Meaningful family engagement was a core principle of the Consortium and over 100 family members with lived experience (including parents, caregivers, young adults who experienced AFCCA as a child/adolescent, siblings) were consulted. These first voice experts provided ongoing guidance to the Consortium members through 1:1 interviews, multiple focus groups, qualitative discussions, and a series of online questionnaires. Feedback to the Consortium was sought and collected between June - October 2021. Honorariums were provided to youth / young adult first voice experts, recognizing the importance of their contributions and knowledge.

Consortium Participants

The Consortium sought to bring together diverse Canadian perspectives, with membership including individuals from British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, and New Brunswick.

Membership was voluntary, and individuals were not offered / eligible for any financial compensation (see earlier reference to honorariums provided to youth first voice experts).

We are thankful for the dedication, thoughtfulness, and humble curiosity that these individuals brought to the Consortium's work:

Voice of Families

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Special Advisor, Laidlaw Foundation
Former Provincial Advocate for Child and Youth, Ontario

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Voice of Policy

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First Voice Advocate

What is Family?

In their 2019 report, **Family Violence in Canada: A Statistical Profile**[1], Statistics Canada defines "family" to include:

"…**spouses** (legally married, separated, divorced and common-law), **parents** (biological, step, adoptive and foster), **children** (biological, step, adopted and foster), **siblings** (biological, step, half, adopted and foster) and **extended family members** (e.g., grandparents, uncles, aunts, cousins and in-laws). "

In examining the issue of AFCCA, the Consortium elected to apply a broader definition that accounts for the caregivers who are the primary care providers for children / adolescents residing in alternative living arrangements outside of the family home, ie. child & youth workers, respite workers, therapeutic residential staff, etc.

Further, the young adult / first voice experts who shared their experiences with the Consortium were clear in saying that "family" also included self-identified family relationships, as defined by the youth themselves.

For the purposes of this report and the resulting findings and recommendations from the Consortium, 'family/caregivers' include all of these possibilities.

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[1] Statistics Canada, (2019), Family Violence in Canada: A Statistical Profile. Retrieved from: https://www150.statcan.gc.ca/n1/pub/85-002-x/2021001/article/00001-eng.html

Understanding the Problem: Key Insights and Learnings

The primary focus for the Consortium can be synthesized into 4 key areas:

- Uncovering a preliminary view of the **current state experiences of families in Canada,** and their experiences with AFCCA, including indicators of incidence and severity of impact to individuals and families.
- Developing a **common view of the problem through a shared set of terminology, language, and definition** that is both appropriate and supported by individuals and families, and also understood by the professionals who seek to support them.
- Broadening our collective understanding of **the reasons to be hopeful,** in terms of where families are finding (or building on their own) **strategies that provide relief, safety, and greater family stability** accompanied by what would have been most helpful earlier on.
- Highlighting the many **complex barriers that stand in the way of healing, safety, and family preservation,** including policy, financial, geographic, cultural, and logistical factors that impede families/caregivers from accessing the help they desperately seek.

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1. Current State Experience for Many Canadian Families

In June 2021, as a context-setting initiative for the Consortium, the Voice of Families subgroup sought input from parents and caregivers who self-identified as experiencing AFCCA in their homes, via 1:1 interviews and conversations, live group discussions, and via an online questionnaire. All these engagement channels were shared / offered primarily towards established parenting support groups.

46 parents/caregivers responded to the first online questionnaire. An additional 10 mental health practitioners completed the same questionnaire, as did 15 Consortium members. All groups were asked to identify which category they primarily belonged to, prior to completing the questionnaire. In total 71 respondents completed this first questionnaire. Collectively, their responses highlighted growing safety concerns for all family members and for the child/adolescence themselves. Anecdotal reports from the parallel interviews and focus groups confirmed the same findings.

1.1 Who is the behaviour most often directed toward?

Respondents were asked who the behaviour was most often directed at, and could select all answers that applied. Their answers showed the aggressive behaviour was most commonly directed toward:

76%	**parent(s) or caregiver(s)**
48%	**sibling(s)**
27%	**self-harm towards the youth themselves**
15%	**pets/animals in the home**
7%	**other extended family members**
4%	**peers / friends**
21%	**all of the above**

Several Consortium members anecdotally highlighted that in their experience, mothers were more likely to be the target of aggressive behaviour toward a parent. This finding would need to be further assessed and researched before drawing conclusions.

1.2 What ages of youth are most commonly involved?

Parent/caregiver responses indicated that this behaviour was being observed in children as young as 2 years of age, with some respondents reporting predictive behaviour observed in children <2 years of age.

Analysis of parent/caregiver responses revealed that extreme behaviour causing significant physical / psychological harm was noted in younger children (under 12), and commonly escalated or became more entrenched during the onset of teen / adolescent years (see Operational Definition for additional information).

Parents of children with neurodevelopmental disabilities frequently highlighted the need to consider a child's developmental age vs. chronological age, and the intersections between developmental stage and developmental trauma. Additionally, several respondents highlighted the importance of exploring frequency and intensity of the aggressive behaviour as a child's age and developmental stage progressed.

A small number of parents/ caregivers spoke of behaviour continuing past the age of 19+ into young adulthood. This data may be more reflective of the audience sample, vs. a statistical finding – however the accounts heard from parents with adolescents entering young adulthood reflect behaviour causing significant harm and warrant further research and understanding.

> **"You just think that you're going to cope and manage and get through it and it'll get better, and you don't realize until you're really, really in the thick of the crisis"**
>
> **—B*, Parent/caregiver who experienced AFCCA with her child, now a young adult**

1.3 What does the behaviour most commonly include?

Respondents were presented descriptions of possible actions and asked if each was commonly represented within the child/adolescent's behaviour in the home (and with the ability to select all that applied). Collectively their responses showed:

90%	**Angry / aggressive outburst toward others**
89%	**Psychological / emotional injury or harm to others**
87%	**Destroying Property**
86%	**Aggressive Language or swearing**
82%	**Aggressive body language/ posturing**
79%	**Physical injury or harm to others**
74%	**Threats of harm to others**
62%	**Physical injury or harm to self**
52%	**Psychological injury or harm to self**
39%	**Dangerous / risky behaviour outside the home (ie. stealing, weapons, illegal drugs, etc.)**

1.4 How do families think about frequency and intensity?

Family engagement, focusing on seeking input from those lived experiences, has remained critical in developing a thorough understanding of what the current state looks and feels like for many experiencing AFCCA in their homes.

Similar to the initial outreach conducted in June 2021, a second round of community outreach and engagement was completed in July 2021, focusing on the experiences of over 60 parents and caregivers who participated in at least one of the following: online questionnaire, live 1:1 qualitative interview, virtual focus group led by a Consortium member.

50 respondents, all parents and/or caregivers, completed the second online questionnaire, answering questions about the frequency and intensity of the behaviour they were witnessing in their families, from their child or adolescent. The information reported is alarming:

76% reported experiencing daily or weekly incidents of aggression

55% reported the intensity of those incidents to be 8/10 or higher.

Families were reporting living with an unexpectedly high level and frequency of dangerous behaviour in their home, and were raising urgent concerns about the safety of their child/adolescent, other children in the home, and themselves.

1.5 Who's being impacted or harmed?

As noted elsewhere in this report, the direct lived experiences shared by first voice advocates, as well as parents/caregivers has been invaluable in shaping the evolving understanding and perspectives of AFCCA. One such area is in how we consider the question of who is being impacted or harmed by the aggressive behaviour described here.

It is the position of the Consortium that the child/adolescent themselves must be at the center of how we consider impact or harm. They themselves suffer guilt, shame, stigma, blame, and other psychological impacts from the lasting outcomes of this behaviour. The impacts ripple outwards from there, crashing into parents and caregivers, who deal with many of the same harmful effects, plus the additional layer of physical harm or injury. Extended family members, especially siblings in the home who are witnessing violence, suffer as well. Collectively, the impacts from AFCCA touch communities and society as a whole.

Primary impacts to the child/adolescent themself include:

- Escalating mental health issues (including anxiety, trauma, depression)
- Diminishing self-esteem and self-worth,
- Damaged family relationships, with parents and caregivers as well as siblings
- Barriers to belonging (exclusion from schools, clubs, churches, community, etc)
- Dysregulation in other settings including school or other social / community settings
- Criminalization of the child / adolescent
- Depiction as a violent perpetrator
- Entry / re-entry into the child protection system (applies to both adoptive and biological families)
- Placement instability for children in care, or post-adoption
- Risk of entrenched behaviour into adulthood

Primary impacts to the parents, caregivers, and siblings include:

- Significant risk of physical and/or psychological injury within their home
- Onset or escalation of mental health issues (incl. anxiety, trauma, depression)
- Secondary trauma from exposure to violence in the home
- Damaged family relationships, within and between the entire family unit (incl. filial trauma)
- Isolation of family members (from extended family, friends, community), suffering shame/blame
- Increased risk of separation/ divorce between parents
- Investigation by child protection services (both parents and siblings)
- Placement instability for other siblings in the home
- Loss of employment (due to at-home care requirements of their child)
- Financial strain on families, due to costs of family-funded supports / services, damage repairs, etc.

Primary impacts to community and society include:

The experiences reported by parents/caregivers regarding their child entering / re-entering the child protection system (either through voluntarily placement or apprehension) as a result of these patterns of behaviour and lack of effective family supports places a significant cost on the child welfare system, with the cost of ongoing specialized care required in foster home, group home, or residential placement settings.

There are systemic long-term risks to youth, and costs to society, that result from entrenched involvement with under-resourced and ill-equipped social systems, ie. children's mental health, youth justice, and child welfare. Related North-American studies (Childhood Externalizing Behavior: Theory and Implications, 2004, Journal of Child & Adolescent Psychiatric Nursing) draw the conclusion that **"childhood aggression is a strong predictor of adult crime and violence"** (see Appendix A: Literature Review). This contributes to an increase in the incidence of domestic violence and intimate partner violence, and a pressing societal need for violence prevention.

1.6 **Co-existing conditions and neurodiversity**

The Consortium did not attempt to assess or define causality; and recognizes the need for much greater research in this area.

Parents/caregivers who participated in the online questionnaire (n=50) were asked if there were co-existing conditions or diagnoses present with their child/adolescent, and if they felt that those differences played a part in the behaviour expressed by their child. Strikingly, 94% of respondents identified 1 or more co-existing condition or diagnoses that they felt influenced their child's behaviour. Many (64%) identified 3 or more co-existing neurodevelopmental conditions or disabilities.

Most commonly referenced were anxiety, Fetal Alcohol Spectrum Disorder (FASD), Autism Spectrum Disorder (ASD), attachment / reactive attachment disorders, and sensory processing disorders. Additional diagnoses referenced included developmental trauma, ADHD, learning disabilities, intellectual disabilities, and Oppositional Defiance Disorder. In total more than 28 co-existing conditions, diagnoses, and/or disabilities were referenced.

Luka's* Story:

Luka is a biological parent to a 16 year old son, Lewis, who was diagnosed with autism at 3, followed by a diagnosis of obsessive compulsive disorder and cognitive delay. Their challenges amplified in puberty. She recalls "When they're a toddler and they're having a meltdown you can move them…but you can't do that with a five-foot-ten, a hundred and forty pound young man".

Over the past 5 years, Luka, Lewis' dad, and his step-mom have all experienced aggression directed towards them. Lewis' needs proved to be too extraordinary for them to handle and he is currently living in a special needs care agreement within a staffed resource and has 2:1 support. Luka shared that "it's very humbling to think that you can, you know, you get to the point where you realize that you have to put your child in care". Luka states that Lewis' "needs just proved to be too extraordinary for us to manage even with two households."

"I remember thinking…how am I going to give a child up into care…It's terrifying to think that this child that you raised, this cute little toddler can react like this to you."

Luka acknowledges that she struggles with trauma of her own, and finding how to move forward. She has found that with a lot of help and support, she can maintain a healthy relationship with her child.

"Parents (or caregivers) shouldn't have to scream so loudly in order to get the help they need…they just keep being told, nope, nope, there's no resources available."

1.7 Struggling to preserve families

Parents/caregivers who provided feedback to the Consortium consistently spoke of their strong desire to keep all of their family members safe and together. Many also spoke of facing repeated suggestions or direction that the only possible way to access the necessary therapeutic interventions for their child was to relinquish custody of their child to their respective provincial child welfare / child protection agencies.

Relying on the consistent reports of parents, caregivers, and service providers, it is clear that families are having to fight to stay together, even while facing extensive roadblocks and barriers to accessing the help so desperately needed. A pattern emerged for several families of being investigated by child welfare, only for the family to be cleared and no support or referrals provided.

“Child welfare policies have very little room to actually support families staying intact, and instead guide families towards disruption and placement breakdown.”

—J.*; adoptive parent of a youth experiencing AFCCA

The findings of the Consortium show that this is experienced by both adoptive and biological families, particularly for families of children with complex needs or neurodevelopmental disabilities. Far too often, a child’s need for intensive therapeutic interventions or supports is instead responded to with the unnecessary and inappropriate use of the child welfare/child protection and/or youth justice systems.

“At all steps in the process of seeking help (locally, regionally, provincially) we faced extensive roadblocks and deterrents, all while being continuously asked to relinquish custody of our son.”

—T.*; adoptive parent of an adolescent experiencing AFCCA

Jordan’s* Story:

Jordan’s daughter joined their family through adoption at 13 months old. By the time her daughter was a toddler, Jordan, who had worked with children and families for many years, noticed that Lisa’s behaviors were not typical tantrums. Lisa was diagnosed with reactive attachment disorder at 4 years old. By the time she was 12, there was regular aggression directed towards her mom and witnessed by her younger sister, coupled with a lot of self-harm.

Jordan describes her family’s first experience with Lisa entering a crisis center. “Experiencing that was sort of my first taste of parenting her or being her mom in a different way.”

“Within months of that first crisis stay, it became glaringly apparent that I would not be able to keep all of my children safe under the same roof - which was an impossible decision.”

Jordan and her husband were adamant to maintain their parental rights, determined to find a solution where they could still be Lisa’s mom and dad and she could still have her sister and her brother, even if they weren’t going to be able to live under the same roof. They believed that Lisa remaining in their home was not a safe option for any of the remaining family members.

Jordan and her family were engaged with their local Childrens’ Aid Society, seeking post-adoption support and help for Lisa. Jordan reports that their CAS would only discuss two choices: they could bring Lisa home, or they could relinquish parental rights. The clock was ticking. So they set out to create a third option on their own, from within their village of friends and extended family.

“It’ll be two years in August that she has been living with a family friend, and we really do our best…to parent her in sort of a village approach. She has these two homes where she belongs in both, and we can provide her with everything she needs and not take anything away, but really quite the opposite and she, she can have all of us”. Jordan and her husband have a private agreement in place with Lisa’s other caregiver, and they manage co-parenting responsibilities accordingly.

In speaking about the process prior to creating this option for Lisa, Jordan notes, “…having to fight, fight, fight, and spend so much time talking about all of the negative things about your kid changes you as a parent. Eventually I started going into meetings with a whole other opening. I would say she’s an incredible gymnast. She’s hilarious. She’s this, she’s that and then I would say, and these are the behaviors we’re dealing with and this is why we need help”.

Like many other adoptive parents, Jordan frequently faced service providers who did not understand Lisa’s challenges, or their commitment to remain her parents. “…every time I got knocked down with, “Is this adoption breakdown? Because if not, there’s nothing we can do”.

“Really the solution is not difficult when we all just sort of flip our thinking to keeping that child in focus and think outside of the box. And I think as a collective we can do that for all of our children.”

Parent/caregiver reports clearly demonstrate that Jordan's story is sadly not unique. Additional verbatim feedback, all from parents or caregivers and from across multiple Canadian provinces, included:

> "We've been fearful of accessing services, as when we asked for help with our son, Children and Family Services suggested removing our daughter instead."
>
> "We did ask CAS if they can offer us respite or any other additional family support services and they said no. Nothing was available."
>
> "All support ended at 16. Had to relinquish parental rights if we wanted to obtain further support after 16"
>
> "Post adoption support from CAS was ineffective; then when we kept asking for help they opened a child protection investigation. It was unnecessary, ineffective, uninformed, and required legal intervention on our part. As soon as we initiated legal action, the child protection concerns suddenly were considered resolved."

First voice advocates, particularly young adults who engaged with the Consortium spoke clearly on this issue – they did not want to see unnecessary child welfare / child protection involvement in their families, and they did not believe that those agencies / ministries were equipped to understand, support, or help to improve the outcomes for youth exhibiting AFCCA.

2. Language & Definition

The phenomenon of aggressive behaviour by children / adolescents towards their parents,caregivers, or other family members has been researched and explored outside of Canada for quite some time. As detailed in the academic literature review completed by the Voice of Academics subgroup within the Consortium (see Appendix A), international research highlights studies and findings from other countries and jurisdictions, some dating back two decades. However, definitional and methodological differences, as well as a lack of consensus over terminology have resulted in this issue being described in different ways. Other countries alternatively refer to this as child-to-parent violence & aggression (CPVA), adolescent-to-parent violence (APV), adolescent to parent abuse (APA), among others, to describe the patterns where aggressive behaviour is exhibited by children / adolescents and directed towards family members, resulting in physical and/or psychological harm (see Appendix A: Literature Review).

In Canada, Adopt4Life and other organizations began employing the language of "CPVA", to bring a descriptor to what they were hearing reported from the families in their Parent2Parent Support Network. The language was recognized as troublesome and potentially damaging, however the desperate cries for help from families needed to be heard and acknowledged. In a blog post in March 2021, **"Language Matters—What We've Learned during the First Year of Talking about CPVA"**, on behalf of the Child to Parent Violence and Aggression Working Group at Adopt4Life, Lauri Cabral wrote:

"There is a sincere desire to frame the conversations in a positive language, and with greater context on what conditions often exist in a child's early life that contribute to their responses to past traumas. These concerns are important to hear and reflect on, particularly when considering the underlying fears about the potential harms in labelling, shaming, or stigmatizing a child who is acting in a way that does not define who they are. This struggle is not unique to our dialogue in Canada; in countries around the world where this topic has been extensively researched and studied, there are many descriptors applied ('violence', 'abuse', 'aggression') which may raise concern about stigmatizing vulnerable children and youth."

> **"Language is important. It kicks off protocols"**
>
> **—I.*, Consortium member, family and youth advocate**

Jamie's* Story:

Jamie was diagnosed with autism at age 14. As a young adult, she is an advocate for children and youth in the autistic community as well as a champion first voice lead for change within the child welfare system. She has interacted with numerous individuals in different living situations, including those who are or have lived with violent behaviour in the household in one format or another.

In her own life, Jamie shared that she ``didn't always understand the context of the situations that I would find myself in socially and so I was accused of being rude or a bad child". In her experience, she notes, "it wasn't that that child was behaving badly because they wanted to…if I can't use my words, or I can't get out what I want to say, I may hit myself in the head, or I may lash out at other people."

"Sometimes when we see that violence, it is a communication breakdown."

"We've lost that way to connect, and it's broken down….sometimes it's overstimulation…. can be that it's a mental health thing and when we work with individuals on the spectrum and certainly within the world of disability as a broad sense you can also be dealing with coexistences of mental health issues. So, for me it's anxiety and panic disorder, which can mean that there have been times that I've needed to make sure that I was in a safe space."

Jamie reflected on the "many layers that can be going on in a household". She cautions that "no matter at what level it is whether it's parent to child, child to parent, sibling to sibling or child to child violence, not addressing that, not bringing that up and working through that, that doesn't go away. That informs who that person is going to be, and how they're going to respond to other authority figures and other people in their lives".

In sharing her own reflections, Jamie further reminds others of the important need to consider language and the complexities of the experience directly from the child/youth's perspective:

"…disabled children, disabled people in general, we are at a pretty vulnerable point in society. I live on the fringe of society. Society thinly tolerates my existence…The instant I'm labeled violent dangerous, aggressive, my place in society which I have fought so hard to get, that's out the door. "

Early on in the Consortium's work, the Voice of Families subgroup sought direct input from young adults with first voice experience through an online focus group with participants from Ontario, Prince Edward Island, and Manitoba. In discussing the issue of language and terminology, their guidance was quite consistent – they agreed on the importance of finding new language that respected the youth involved, avoided pathologizing, criminalizing, or stigmatizing youth, while also emphasizing that it was absolutely critical to continue the conversations and shine a light on what they were experiencing.

"You can't stop talking about this. If we can't even talk about it, even knowing what's happening…well, nothing's going to change."

—S*; young adult first voice advocate

2.1 Considerations in developing a new name/terminology

Importantly, respondents were asked to consider 11 other possible descriptors / naming conventions, including the reference to Child to Parent Violence and Aggression. There was no discernable consensus on naming, although responses did confirm the concern about words such as "abuse", "violence", and "violent" as being more harmful than helpful.

Simultaneously, respondents voiced concerns that some of the proposed naming conventions obscured the severity and intensity of what families were experiencing, further contributing to a lack of understanding of the true needs of the child/adolescent.

Throughout the term of the Consortium, discussions of naming and language continued to be refined and evaluated, with ongoing collaboration across various stakeholder groups and an acknowledgement that no single name would likely encompass all of the various nuances and aspects to this complicated issue, and the depth in varying perspectives on language.

> **"…as soon as you're labeled in foster care as a violent child, you're (placed) in a group home, or you have trouble finding foster homes…they don't know the whole story…I could be labeled violent, but they don't know that maybe I was protecting my brother from my stepdad…"**
>
> **—J*; first voice advocate / young adult**

> **"there's a big difference between…a child who may be dysregulated and they just need help to calm, from when you have a family who's experiencing trauma and PTSD as caregivers. We need to capture that severity."**
>
> **—B*; Family advocate / peer support provider**

> **"Sometimes what appears to be manipulative behavior is about survival techniques and the child feeling like, "I'm going to try these things because my body, my brain are telling me that I can't survive unless I do".**
>
> **—A*, Consortium member, practitioner, researcher, clinician**

2.2 Aggression toward Family/Caregivers in Childhood & Adolescence

After careful evaluation of the extensive inputs to the Consortium, a proposed new naming convention for Canadian purposes has been developed.

The language seeks to enable families to succinctly ask for help while conveying the severity of their situation. It further seeks to enable social systems and practitioners to recognize the situation and identify optimal supports for children/youth and their families. It avoids stigmatizing or pathologizing children / adolescents, recognizing a developmental stage rather than a child / person.

Importantly, the proposed language also seeks to honour the lived experiences of those who contributed to its definition.

> **Aggression toward Family/Caregivers in Childhood & Adolescence (AFCCA)**
>
> Aggression toward Family / Caregivers in Childhood & Adolescence (AFCCA) describes a pattern of behaviour in childhood or adolescence, characterized by aggressive behaviour by a child or adolescent toward family members or other caregivers. This causes significant harm (physical and/or psychological) to the child/adolescent, the person(s) the behaviour is directed toward, and other witnessing family members.
>
> This stems from a common difficulty in which the child struggles to find co-regulation with the adult, resulting in progressive challenges with self-regulation.
>
> Aggression toward Family / Caregivers in Childhood & Adolescence is most often directed to parents, primary caregivers, and siblings in the home, but can also be directed toward other caregivers in other settings. The behaviour commonly becomes entrenched and escalates over time.

Readers may refer to the Operational Definition later in this document for additional descriptors and references.

3. Reasons for Hope: What's Working for Families

This quote, from a young adult first voice advocate sharing her expertise with the Consortium speaks so clearly to the importance of moving beyond shame, stigma, or blame and instead focusing on what can be done to improve safety and stability for youth and their families.

> **"It's not about the parents, and it's not about the child. It's about what do we need to do right now.**
>
> **—C.*; first voice youth advocate**

> **"Can you teach us to walk in the storm, instead of working to avoid it?"**
>
> **—B.*; Family advocate, parent with lived experience**

3.1 Desired Successful Outcomes

In the July 2021 questionnaire referenced earlier, parents/caregivers were asked what they would consider as measures of success for their family – what would successful outcomes look like?

From the 50 respondents, notably only 62% identified the elimination of violent, aggressive, or dangerous behaviors in their home. After discussion, the Consortium's belief is that for many families, the complete eradication of this behaviour is understood to be unlikely, given the deep complexity with other co-existing conditions or disabilities, environmental factors, and developmental milestones.

More commonly, parents/caregivers expressed a desire for 1 or more of these outcomes as ones that would significantly improve conditions for their families:

92%	improved self-regulation for child/adolescent
88%	reduction in violent, aggressive, or dangerous behaviourers
78%	improved parent/child relationships
72%	creating healthier methods of communication
70%	improved sibling relationships
70%	enhanced safety for other caregivers in the home
68%	enhanced safety for other children in the home
66%	reduced risk of family disruption / separation
62%	enhanced safety for the child/ adolescent themselves
58%	increased parent / caregiver understanding and capacity
56%	improved attachment with primary parent / caregiver

> **“People can’t change if they do not feel physically and emotionally safe. Once safety is achieved you can move to developing a skill set. Our job as parents, is to help our children feel emotionally and physically safe, or to move them in that direction.**
>
> **Sometimes the parents aren’t feeling safe, physically or emotionally….We have to look at how do we get the family system to experience or to move towards feeling physically and emotionally safe.”**
>
> —K*.; multi-disciplinary practitioner treating families experiencing AFCCA

The young adults with lived experience spoke in depth about the need to consider this behaviour, in some children/adolescents as a form of communication. They agreed it was not always effective in communicating what they intended or desired, but it remains that behaviour is communication. Importantly, they asked for help and support in developing more effective communications skills that would in turn support their underlying unmet needs.

As a group, they expressed that individuals who were supported in developing more effective communication skills or self-regulating skills had fewer incidents of aggressive behavior over time.

River's* Story:

River grew up in foster care. She participated in AFCCA behaviour herself as a youth and has witnessed AFCCA in multiple contexts. She is a mom to a child that exhibits AFCCA and she has also experienced it as a foster mom. She works and studies in this area.

River describes her neurodiverse son as a "very sweet, lovable, brilliant little 10-year-old…but he does have that form of expression with his behaviour". She views AFCCA as "a brain sensitivity, and there's many factors that affect it including trauma and attachment. It also has some biological components, so it has nothing to do with anything that anyone's done to cause it, it's just a wiring difference in the brain."

"There's always hope…you can heal trauma at any age, you can always learn different ways of communication and learn new positive coping strategies, there's a good reason for everything and behaviour is communication."

"The amazing children that I get to work with, their brains are wired in such a complex way. It's about the behaviour, because that child is amazing, that parent is amazing." River notes that when a family can find a way to adapt the environment to allow success, she's seen so many families realize positive gains. She concludes,

"…a lot of the multi-disciplinary teams that are flexible to the family's needs and the joy and the brilliance of that child - those are the ones that have success."

3.2 Strategies & supports that may help

Parents and caregivers openly shared their own experiences of what they have found helpful for their respective families. 50 parents/caregivers provided input to the questions:

- What is working well, from your existing external supports?
- Are there other services or programs that you believe are helpful?
- Is there existing legislation / public policy that is effective in helping support your family?

Practitioners were asked from their lens:

- Are there existing treatments, interventions, or protocols that you follow with a family experiencing this behaviour?
- Are you aware of any programs currently in place (within Canada or internationally), that you believe could be helpful for supporting individuals demonstrating this behaviour?
- Please describe any programs or services that you're aware of that could be modified or adapted to be culturally appropriate for equity-seeking groups in Canada?

Their answers were quite varied, but also reveal some common elements:

- The families who feel they have found successful strategies that improved safety and stability generally stated that the **parents/caregivers remain experts and full partners** in a broader circle of support for their child.
- **Holistic, integrated, comprehensive circles of support** that often included multiple different disciplines and practices – but importantly **also included people, passions, or interests that were meaningful to the child/adolescent** and have positive impact on the family as a whole, according to parent/caregiver reports.
- **Peer support networks and peer relationships** (both formal and informal) were referenced as extremely helpful for parents/caregivers, both in reducing shame and feelings of blame, but also in increasing parents' capacities and understanding.
- **Respite programs, both in-home and out-of-home,** that are trauma-informed, attachment-informed, and understand the contributors to AFCCA, may provide everyone in the family an opportunity to rest, re-group, and maintain more calm, safe home environments.
- **Learning and skills-development programs** were frequently cited by practitioners, based on practice experiences. Many of these programs focus on earlier intervention and skills / capacity building within families, with the intent to avoid the need for more intensive crisis-intervention later on. Examples included: Circle of Security, Non-Violent Resistance, Parent-Child Interaction Therapy, and others.
- **Trauma-informed, attachment-informed therapeutic models and practices** were noted to be of long-term benefit, both by parents/caregivers and practitioners. Examples included: Dyadic Developmental Psychotherapy, Nurturing Attachments, the Attachment, Regulation, and Competency Framework (ARC), and others.
- **Youth justice diversion programs** (both formal and informal) enshrined in Canada's Youth Criminal Justice Act, particularly those with a **restorative justice practice** or objective, were cited both by Consortium members and multiple families as being helpful in avoiding unnecessary entrenchment with the justice system, or criminalization of youth.

A full list of all the programs, services, interventions and strategies cited by parents/caregivers and practitioners is included in **Appendix B: Interventions and Possible Strategies.**

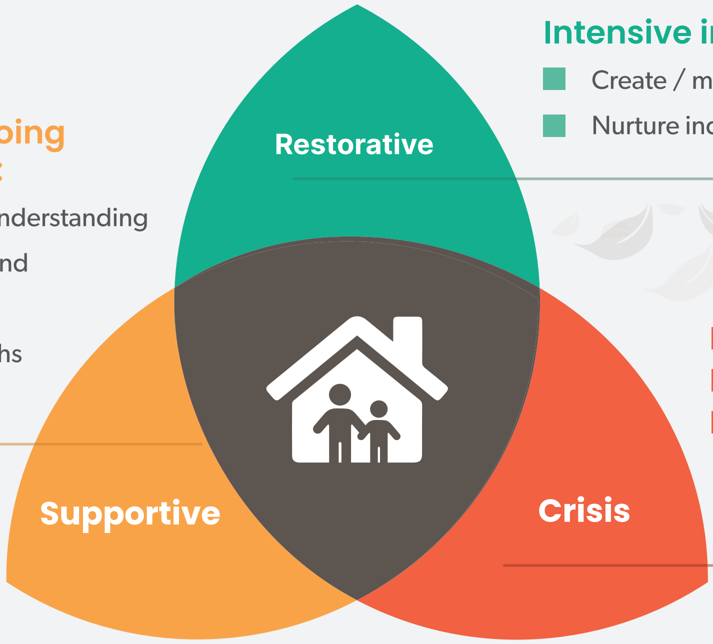
3.3 **Family / Youth Directed Circles of Support (aka. It Takes a Village)**

The lived experiences of all family members demonstrate that families are unique, their needs vary, and that what works for some families won't necessarily work for others. It is also clear that needs change over time, and that any successful strategy or approach must to be flexible and able to adapt.

As noted above, the families who said they view themselves as finding successful strategies that improved safety and stability generally have created or developed a broader circle of support for their child, where the **parents/caregivers are experts and full partners** alongside other individuals who share a connection to the child/adolescent, or who may share a passion or interest of the child's/adolescent's. All of these people are on a team that will likely also include multi-disciplinary professionals and health providers responsible for various aspects of the child/ adolescents' plan of care.

The Consortium believes that a best practice may be to seek to support the development of family / youth directed circles of support where a range of supports, strategies, interventions, etc. can be employed in a holistic, responsive way, depending on an individual / family's unique needs.

Family / Youth Directed Circles of Support



Intensive interventions that :

- Create / maintain safety for all family members
- Nurture individual well-being and family relationships

Proactive and ongoing interventions that :

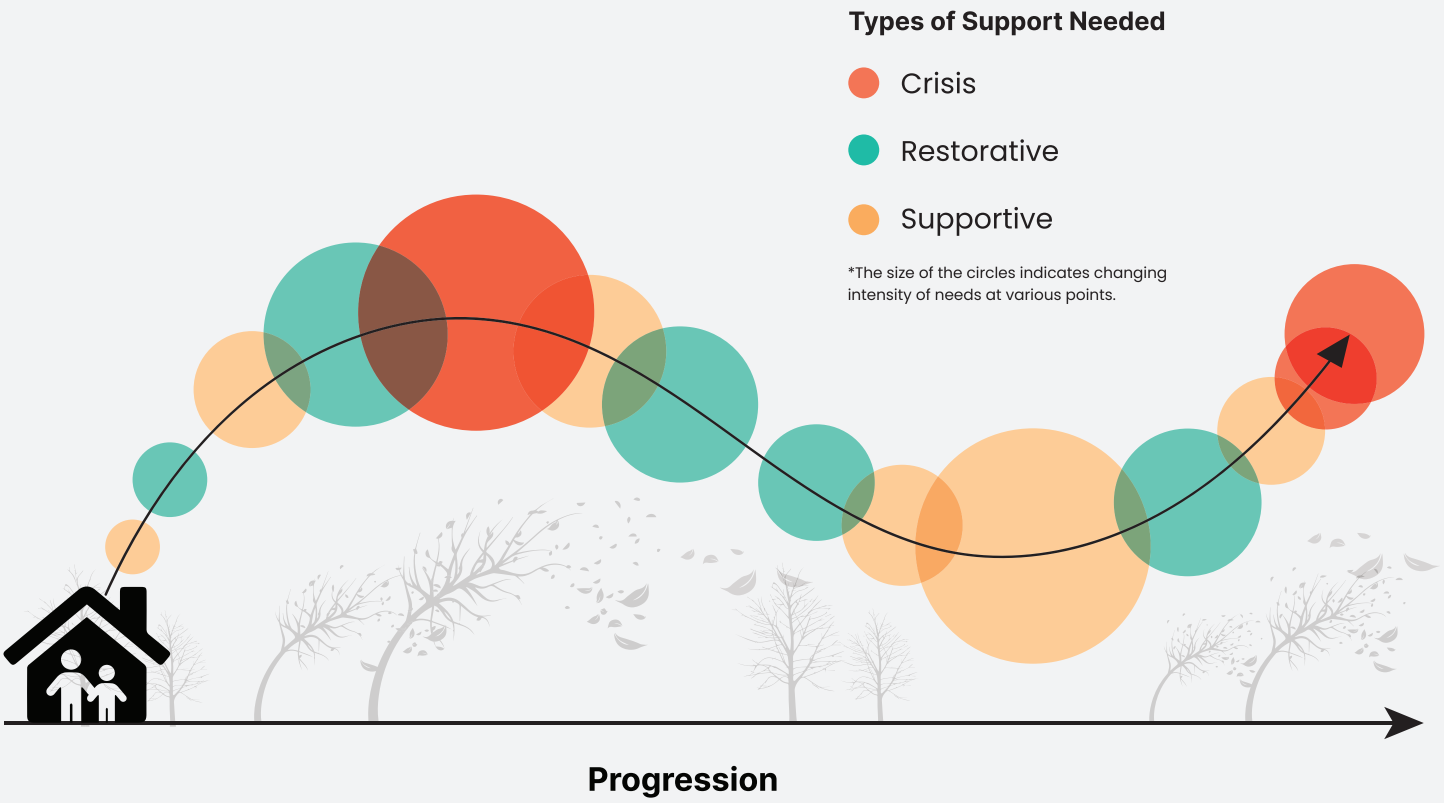
- Build awareness and understanding
- Recognize indicators and respond appropriately
- Build on family strengths and capabilities

Extreme interventions required to ensure :

- Crisis management / resolution
- Family preservation
- interactions with social/ community systems (youth justice, child welfare, etc.) are addressed appropriately

With such an approach in place, families may be more able to "weather the storm", and respond effectively to changes in their child/adolescent's needs, their environment, their developmental trajectory, etc.

The intent of such a model is that it becomes responsive to the question "what do you need to be safe and healthy, right now?".



*The size of the circles indicates changing intensity of needs at various points.

Supports and interventions that are less intensive, and can be responsive as needed, with a focus on building on existing family strengths and capabilities. As needs intensify, restorative measures can be introduced that focus on creating / maintaining safety for all family members. In the most critical periods (including those where families may be facing breakdown or disruption), extreme interventions may be required to resolve urgent or dangerous situations or address unwanted interactions with various social and community systems, while always maintaining a focus on family preservation.

Shay's* Story:

Shay and her partner have three children whom they adopted when their middle son Ric was five. Prior to joining their family, the children experienced severe abuse and neglect and experienced multiple foster care placements. Ric is diagnosed with FASD, has sensory processing challenges, a communication disorder, a mild intellectual disability and an attachment disorder. According to his mom, he is "funny, and athletic, and incredibly caring around animals – it's people who are just hard for Ric. In particular, there is disrupted attachment with myself and his younger brother which has resulted in significant safety concerns as he's become older and a teen".

"Right now we're probably as good as we have been in years. It doesn't look anything like what I thought it would".

They currently have a very effective family-led plan where all of their needs (Shay and her partner, Ric, and his siblings) are considered. "It's not just about keeping Ric okay; it's about keeping our whole family okay", Shay explains.

It has been a long and arduous trip to get to where they are today. Over the last year, they entered into a co-parenting model, meaning that Ric is home with his family for part of the week, and he has a second home that is staffed 24/7 where he spends the other part. The two homes share decisions daily, while Shay and her partner remain Ric's parents and full legal guardians.

Under this family-led model, Ric has a core team that includes Ric himself, his parents, the primary co-parent from the extended respite provider, his attachment therapist, a child and youth worker, and his FASD worker. They meet bi-weekly to actively work through an ongoing plan of care and ensure they are all aligned on how the team works together supporting Ric – he sometimes attends those meetings as well, at his choice. He also has an extended clinical team that come in and out as needed. They have worked with occupational therapy and have found sensory based strategies to be very helpful. Recently, they have added an equine assisted learning coach to the team, recognizing Ric's passion for horses. They have one-to-one therapeutic programming with a child and youth worker for Ric and there is also therapeutic programming for he, his siblings, and parents to help with the attachments between the five of them.

Shay comments that post-adoption support and Child Protection services being co-mingled "was incredibly damaging and put the entire family at risk". Multiple times they were encouraged to consider adoption disruption as "the best way to get Ric the help he needed". Shay notes additional conflicts in having the same people in the same agency decide on child protection issues and whether to allocate ongoing post-adoption support funding. "In Ontario, CAS is one of the agencies that often sits at the regional service resolution table, putting them in a conflicting position of approving or rejecting what can be expensive plans of care - and then possibly being required to have to find additional unplanned budget to fund them."

On the brink of family breakdown, their cries for help were repeatedly rejected and they had to appeal multiple times even when completely depleted and exhausted. For Shay and her partner, peer support within the adoption and FASD communities was essential. "Talking with other families who had been here before us, who understood what was happening, who could help us navigate what was coming, and frankly could just hold space with us, has been crucial".

The family was eventually able to work within the Complex Special Needs process in Ontario to find a creative way to preserve their family, while keeping everyone safe. Eight months into this model, the physical violence has been significantly reduced, and they continue to work on psychological safety for everyone in the family.

"Ric is safe, his siblings are safe, we are safe. He says he thinks things are better than before. And we've been able to rebuild some family connections for Ric, through everybody just being in a better place".

4. Understanding the Barriers: What's Getting in the Way

Overwhelmingly, the parents/caregivers who shared their experiences with the Consortium felt they did not have good, or in many cases even adequate, supports in place to effectively help their child / adolescent. Even the families who shared their successful strategies were careful to qualify these as having come with great difficulty and intense, prolonged effort.

None of the individuals with lived experience, nor the practitioners and professionals supporting them, spoke of supports and strategies that were easy to find, easy to access, or easy to maintain.

The Consortium has learned of significant barriers to accessing help; some which appear to affect all families and communities and others which undoubtedly impact already systematically marginalized groups to a greater extent. Furthermore, the many intersectionalities experienced by families (ie. the parent of a Black child, with a neurodevelopmental disability, who lives in a rural community) create additional barriers that are even more difficult to resolve.

> **"We had supports, but no one truly understood what was happening."**
>
> —B.*, parent of a child experiencing AFCCA

4.1 **Inequitable Systems Responses**

First voice advocates noted that there may be systematic differences in how AFCCA is recognized and responded to. Many families spoke of inconsistent, subjective responses to their requests for help and support, particularly from social systems such as police, youth justice, and child welfare.

As noted in the Operational Definition section of this report, cultural differences including perceptions of 'respect' shown toward parent/caregivers, and cultural norms for socially acceptable behaviour including aggression toward family members, systemic racial stereotypes, etc. all contribute to how this issue is considered.

> **"Talking to a local Chief, the pervasive fear of why families in his community won't share that this is happening is because of this systemic longevity of 'my children are going to be taken away'…he said to me, 'I feel that if I looked at the prevalence of this happening in my community it's a hidden crisis'."**
>
> **—K.*, Consortium member, practitioner supporting families and Indigenous communities experiencing AFCCA**

4.2 **Acknowledging privilege**

Responses to the Consortium from many parents and caregivers frequently spoke of the seemingly impossible burdens they were asked to overcome to get help for their families. Many spoke of needing exceptional financial means to access privately funded services or to bridge the gaps in publicly available mental health and therapeutic programs, and the flexibility and economic security to leave paid work / employment to care for their child.

Commonly they required advanced coordination and 'case management' skills to navigate complex processes and systems, and superior advocacy skills to negotiate around systemic blockers and convince others to intervene. In many examples, parents/caregivers spoke of needing to have advanced understanding of specific child rights legislation in their respective provinces in order to demand alternative systems responses or processes.

> **"We need to acknowledge the role that poverty can play - poverty results in overcrowding living spaces, potentially more surveillance by police and child protection. We also need to recognize the impact of police interventions in specific communities, and trauma of families fleeing war torn countries, or intergenerational trauma."**
>
> **—A.*; Consortium member**

4.3 **Geographical Isolation**

Families living in rural or isolated communities across Canada report facing a greater barrier to accessing specialized services or supports for their children / adolescents. Additionally, the benefit they might receive from access to peer supports is hindered when only delivered via live / in-person formats. Families spoke painfully of the isolation they already felt in experiencing this issue, compounded by further isolation in the ability to find help.

An unforeseen benefit resulting from the changes to many social supports and services during the Covid-19 pandemic has been the move to more virtual / online delivery of programs and services. The greater opportunities currently available to access a wider range of online / virtual / remote programs and health providers may prove beneficial in partially resolving this barrier.

“Parents need access to equitable resources and supports within the community they live in; often parents of children with disabilities can feel really isolated even within their own families”

—B*; Consortium member, parent with lived experience, family advocate

. . . .

4.4 **Gaps & Unclear Mandates in Public Policy**

Parents/caregivers spoke extensively about the systems and processes they must navigate in order to find, access, and/or fund the right supports for their child. Province by province, support for children and families with complex needs is handled in very different ways, by different ministries / jurisdictions, and with little consistency for families. Often mandates for supporting complex needs are intermingled between ministries responsible for child welfare / child protection as well as complex health conditions (ie. Autism, FASD, etc.). This may further contribute to the conflict and confusion for adoptive, kinship, and customary care families regarding the role of Children’s Aid Societies / Departments of Children & Family Services in accessing therapeutic supports for a child.

Commonly, AFCCA is regarded as a social services issue, requiring a social services solution, rather than as a public health issue. Families experience rigidly defined systems and programs that were intended to provide relief and support, but when they do not cleanly fit into the rules and guidelines established, they describe being turned away without help or guidance.

“I have zero faith in our current medical or provincial systems in place at this current time to support families such as ourselves. Without a complete overhaul of the system to actually support families with children with extreme behaviour and medical needs, we will continue to be families in crisis and doing it on our own without adequate support.”

—Z.*, Parent of a child experiencing AFCCA in their home

4.5 **Lack of Qualified / Skilled/ Informed Professionals**

Uniformly parents, caregivers, professionals, and individuals with lived experience all spoke about the extensive gaps in finding supportive individuals who were aware of, skilled/trained in, or understood AFCCA. That commonly extended to health providers, mental health practitioners, emergency first responders, police / youth justice, educators, etc.

Parents/caregivers frequently shared experiences where, in the absence of broad awareness and understanding, situations became more escalated, more urgent, and sometimes more dangerous because the individuals who were supposed to help unintentionally created a more volatile, or unsafe environment.

> **"Due to the extreme self-injury and aggression of our child, in order to have an ambulance come, the police had to be dispatched as well. Thankfully we were able to finally calm our child and the presence of the kind officers may have assisted with that. However they were ill equipped to know how to handle the situation."**
>
> **—*Parent of a child experiencing AFCCA in their home**

4.6 **Daily Living Challenges for Families**

Families also described a number of barriers that speak to challenges they face in their day to day lives, that may be invisible to service providers or professionals, but which may also have easier opportunities to significantly improve the experience for both children and parents. Those barriers include:

- Transportation to/from appointments (travel time, cost of parking, access to a vehicle);
- Conveying complex information to a parent who may be already overwhelmed (need help taking notes, understanding next steps / required follow up, completing paperwork that may be confusing or in another language);
- Flexibility in contact methods (time/day of when to call may interfere with work schedules and ability to follow up, modality of contacts assumes access to technology);
- Childcare requirements (other children in the home who require simultaneous care);
- Ability for parents/professionals to speak openly, without a younger child present and feeling shame / blame;
- Assumed understanding of rights, resources, alternatives (lack of explanation, or navigation assistance).

> **"Supporting families of kids with needs is not comprehensive.It is scattered and inefficient and devolves most of the responsibility…from service providers to parents who are already exhausted."**
>
> **—A*, parent of multiple children experiencing AFCCA in their home**

Sam's* Story:

Nine years ago, Sam and her husband became parents to a then-9 year old girl. Prior to joining their family, their daughter Michelle suffered many adverse experiences and also lives with a developmental delay.

The first time she was admitted to hospital, Michelle was 12 and saying that she wanted to kill herself. Several months earlier she had disclosed that she'd been sexually assaulted while in foster care. Sam remembers the hospital staff saying they wanted to help Michelle. "That was the only time that people actually seemed to care, and demonstrated any sort of belief in us, and a belief that they could offer some support."

Sam reports other experiences where their local hospital wouldn't engage with them or Michelle at all. At a particularly difficult time, she and her husband were forced to make a decision that if Michelle became escalated or dysregulated again, their goal would be to drive to another hospital that they understood had a good children's mental health practice. "So, our goal was to get on the highway, and get as far south as possible. So, my husband, he sat in the driver's seat. I sat in the middle backseat, and my daughter was beside me to my right, and my job was to take the blows as he drove as fast as he could to get to the hospital. Michelle is physically strong, so when she is dysregulated it can be very scary."

Reflecting on the barriers to getting help for her daughter, Sam highlights "…a lack of understanding of what developmental trauma looks like, a lack of understanding that my husband I lived in an abusive relationship with our teenager. My husband was told by multiple people "buck-up, why are you letting your little girl beat you up?". He's not letting her beat him up, he's preventing her from attacking me."

Sam has also been struck by the lack of coordination with social services. She further reports, "…there was a lot of time where people seemed to only say 'it's not my problem, it's not my responsibility, I'm not accountable for doing this'. I asked multiple people who's in charge, who's responsible, what ministry, what organization, what person is accountable for keeping my child safe from herself and no one could say. That was me. No one was willing to raise their hand, to say I can help you with that."

"There's the justice system, and then there's police, and they have different information there. And then there's the hospital outpatient versus the ER versus the family doctors and they don't communicate. Social services, they don't communicate, and no one's communicating with all of those groups."

As an adoptive parent, Sam faced additional hurt and perceived blame, and harmful lack of understanding from professionals when seeking help for her daughter. "We were told multiple times by crisis workers, 'well why don't you give her back?' 'She's not your real kid'. Or from the police, 'why don't you just return her".

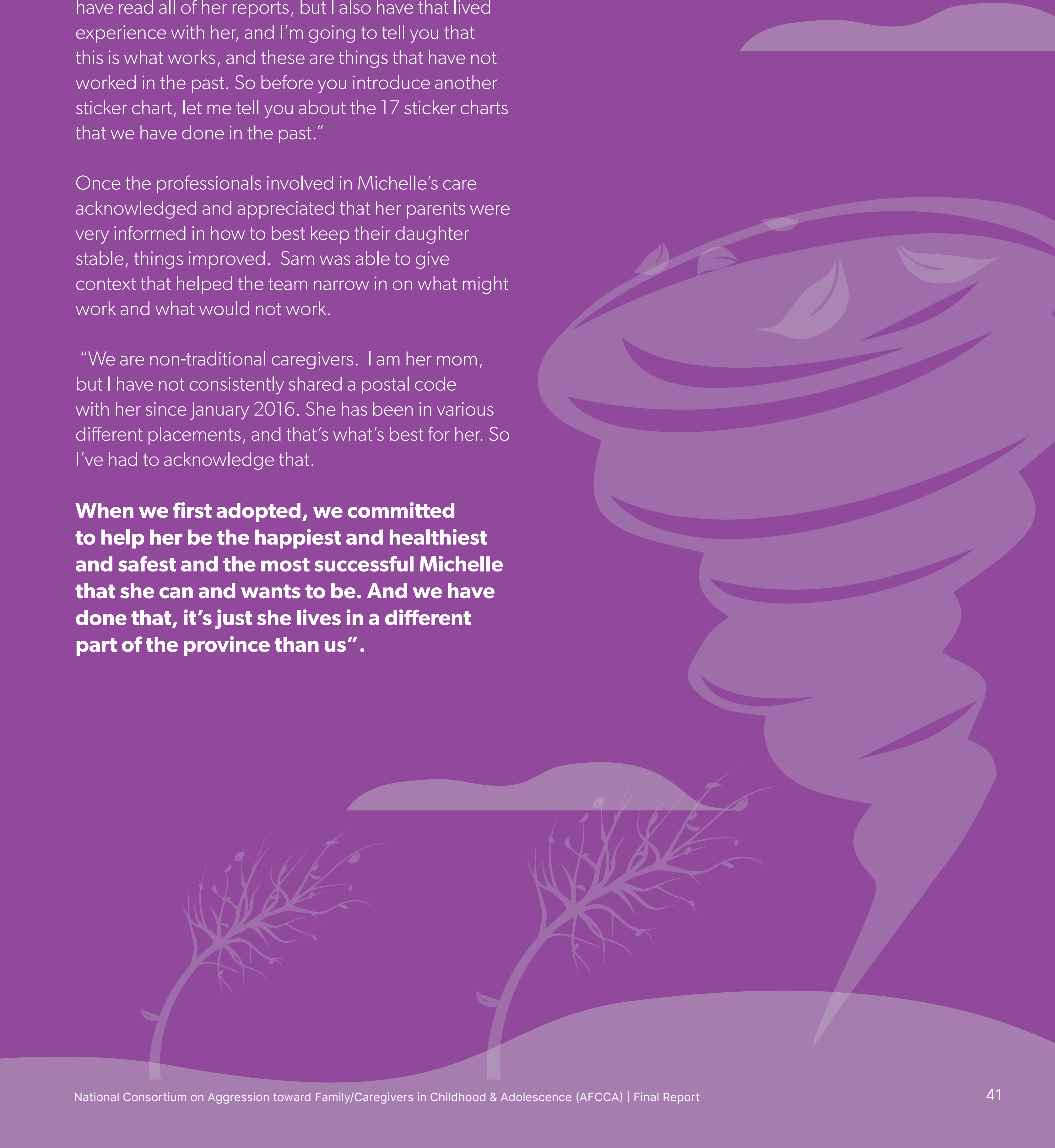
Over time, the family developed a team that includes case management, behavior support, social work, and a group home team. They have worked with both the youth and adult justice systems, including mental health diversion programs such as the Developmental Services Ontario dual diagnosis diversion program. According to Sam, they are "cautiously optimistic that we are "good right now".

Michelle currently is the only resident in a house that is staffed 24/7. Sam states that "it took a lot of advocacy, a lot of me yelling when my voice wasn't being heard". In her experience, parents are not being treated as partners in the process. ``I need them to listen to me because I am the expert in my daughter. I have read all of her reports, but I also have that lived experience with her, and I'm going to tell you that this is what works, and these are things that have not worked in the past. So before you introduce another sticker chart, let me tell you about the 17 sticker charts that we have done in the past."

Once the professionals involved in Michelle's care acknowledged and appreciated that her parents were very informed in how to best keep their daughter stable, things improved. Sam was able to give context that helped the team narrow in on what might work and what would not work.

"We are non-traditional caregivers. I am her mom, but I have not consistently shared a postal code with her since January 2016. She has been in various different placements, and that's what's best for her. So I've had to acknowledge that.

When we first adopted, we committed to help her be the happiest and healthiest and safest and the most successful Michelle that she can and wants to be. And we have done that, it's just she lives in a different part of the province than us".



Operational Definition

Establishing a shared understanding of, and common language for, the issue of aggression by a child or youth towards a family member or caregiver was a core objective at the onset of the Consortium. However discussions about this can be difficult to talk about openly, without shame or blame, and without stigmatizing either children or their parents/caregivers.

An important body of work led by the Voice of Practice subgroup within the Consortium, and supported by the full Consortium table, includes the development of a standard operational definition. The operational definition draws on existing published data (from both Canadian and International references), clinical reports and experience from practitioners who provided input, as well as newly emerging insights from the collective Consortium work.

It's important to clearly state that the following operational definition is intended to support greater clarity and consistency in examining this issue, and how it's understood.

It is not intended or supported to be used as a diagnostic tool, in any form.

Prepared by:
Dr. Catherine Horvath, Mary-Jo Land, and Kim Barthel; with support by Tracy Moisan

Section	Findings
Definition	Aggression toward Family / Caregivers in Childhood & Adolescence (AFCCA) describes a pattern of behaviour in childhood or adolescence, characterized by aggressive behaviour by a child or adolescent toward family members or other caregivers. This causes significant harm (physical and/or psychological) to the child/adolescent, the person(s) the behaviour is directed toward, and other witnessing family members. This stems from a common difficulty in which the child struggles to find coregulation with the adult, resulting in progressive challenges with self-regulation. Aggression toward Family / Caregivers in Childhood & Adolescence is most often directed to parents, primary caregivers, and siblings in the home, but can also be directed toward other caregivers in other settings. The behaviour commonly becomes entrenched and escalates over time.

Features

Primary behavioural indicators include:

Repeated / persistent physical and emotional harm toward others, or threat of. In parent/caregiver reporting to the Consortium, 90%+ indicated that physical aggression toward others was the primary characteristic, and 94% also noted psychological harm and aggression to others in the family.

Additionally, there are frequent/common patterns in behaviour that include one or more of:

- Threatening or intimidating others;
- Aggressive posturing or body language;
- Damaging / destroying property.

Associated Features

Other features that may be observed in individuals include:

- Physical and psychological harm to self, or threatening to harm self;
- Verbally aggressive language, and sustained angry outbursts;
- Difficulty communicating, ie. thoughts, needs, and emotions;
- And less frequently, aggressive sexual behaviour.

Additional family indicators may include:

- History of traditional parenting approaches or interventions not being successful in changing the child/adolescent's behaviour over time;
- Disrupted family dynamics, including escalating family disruption or breakdowns, or placement instability (for children with a child welfare history).

Prevalence

Canadian research in this area is in its infancy, and published data has limitations that should be understood and considered, including involvement from special interest / advocacy groups, application of international terminology and standards, and emphasis on targeted populations.

Much of the existing Canadian research draws from adoptive families, although this issue is observed in all family types including biological, adoptive, kinship, customary care. International prevalence research provides a longer history of reporting. However, within those constraints there remains clear evidence that a significant number of children and adolescents, and their families, are impacted by this issue.

Internationally:

- In 2013-2015 the European Commission Responding to Child to Parent Violence report undertook to explore the "serious and growing problem of Child to Parent Violence" in Spain, Bulgaria, Ireland, Sweden and England. Prevalence rates of 10-20% were referenced, citing different sources by country. *(Source: Responding to Child to Parent Violence: Executive Summary. Retrieved from: https://helenbonnick.files.wordpress.com/2021/04/rcpv-executive-summary-may-2015_english.pdf)*

- Additional UK-led research states that the number of adoptive families experiencing Child to Parent Violence Aggression may be in the range of 30% *(Source: Coates, Al; Child to Parent Violence: The Adoption Issue. Retrieved from: www.alcoates.co.uk/2020/10/challenging-childhood-violent-and.html)*

Additionally, there are frequent/common patterns in behaviour that include one or more of:

- Statistics Canada's Family Violence in Canada report found that in 2019, 22% of all police-reported family violence was by a child toward a parent, caregiver, or sibling. *(Source: Statistics Canada, Family Violence in Canada, 2019. Retrieved from: https://www150.statcan.gc.ca/n1/daily-quotidien/210302/dq210302d-eng.html)*. This reference and statistic are inclusive of children who harm not only parents/caregivers, but also siblings. It is important to note that the statistic cited here does not refer to the age of the child, but rather to their relationship to the parent, caregiver or sibling. Thus, further research is needed to examine the complex contexts of AFCCA, including the implications of both age and familial relationship.

- A new interdisciplinary pilot study is currently underway (September 2021) conducted by Professors Christine Gervais (Criminology) and Elisa Romano (Psychology) from the University of Ottawa. Their survey and interview-based research focusing on families' experiential accounts is being undertaken through child rights and trauma-informed approaches; preliminary findings are anticipated in February 2022.

Life During Covid-19:

The global pandemic has elevated both the awareness and growing understanding of this complex issue. Recent research highlights a concerning increase in both the incidence and severity of childhood/adolescence aggression in the family and home, particularly as extended isolation, heightened anxiety, and the absence of regular supports for aggression, continued.

The UK study, Experiences of Child and Adolescent to Parent Violence in the Covid-19 Pandemic, described:

- a 70% increase in parent-reported incidents of child to parent violence during lockdown
- 69% of participating practitioners reported an increase in referrals for families experiencing child / adolescent to parent violence
- 64% of practitioners surveyed identified that the severity or incidence of violence had increased.

(Source: Experiences of Child and Adolescent to Parent Violence in the Covid-19 Pandemic. Retrieved from: https://www.law.ox.ac.uk/sites/files/oxlaw/final_report_capv_in_covid-19_aug20.pdf)

Development and Course

Development can be quite varied, often influenced by two variables: access to effective early intervention and supports, as well as individual progression. When families are not effectively supported, behaviour often becomes more entrenched. Parent/caregiver feedback to the Consortium, together with practitioner observations and clinical experience, show that:

Extreme behaviour is frequently observed throughout childhood, that present serious risk to children and their families. Aggression toward Family / Caregivers in Childhood & Adolescence is experienced in younger children through to adolescents and young adults (early 20's). Family reports suggest that predictive behaviour can be seen even in children < 2 years of age.

There is commonly an increase in frequency and intensity, and severity of harm as the behaviour becomes entrenched. Aggression may appear to become more intentional, and/or may become a reflexive strategy by the child/adolescence, to meet their needs.

Often severity, intensity, and frequency increase significantly during adolescence and the onset of puberty. There is anecdotal evidence to suggest that behaviour sometimes "peaks" and later diminishes in young adults, however progression is often quite varied on an individual basis. Parents/caregivers reports to the Consortium indicated 76% are experiencing frequent harmful behaviour (35% daily / 41% weekly) in their home; and alarmingly 55% ranked the severity an 8 or higher out of 10.

Risks and Prognostic Factors

Family feedback provided to the Consortium confirmed there were often underlying conditions, including Autism Spectrum Disorder, Fetal Alcohol Spectrum Disorder, sensory processing disorder, and other neurodevelopmental conditions. Anxiety was frequently identified by families, as were attention-deficit disorders.

In both biological and adoptive families, parents / caregivers and youth themselves identified that adverse experiences in childhood that contributed to experiences of permanency disruptions, attachment disorders, developmental trauma, etc. is quite common in individuals experiencing this behaviour. An individual's access to skilled services and supports is frequently also a challenge, where those in remote / rural communities lack access to community-based programming.

Without attributing causation, these can all be considered notable risk factors.

Anecdotal evidence to the Consortium, from young adults with lived experience, suggested that individuals who were supported in developing more effective communication skills and/or self-regulation skills, also noted fewer instances of aggressive or violent behaviour over time. Family reports indicate that when the parent/caregiver (both in the home and alternative living settings) is skilled in supporting effective communication and self-regulation, outcomes are also improved.

Where there are co-existing or contributing neurodevelopmental conditions, there may be unique risk factors specific to those conditions, which may in turn influence appropriate interventions.

Cultural Related Issues and Factors

First voice advocates (primarily young adults with lived experience) noted that there may be cultural differences in how Aggression toward Family / Caregivers in Childhood & Adolescence is recognized and responded to. This requires greater examination and validation before drawing conclusions.

It's possible that cultural differences including perceptions of 'respect' shown toward parent/caregivers, and cultural norms for socially acceptable behaviour including aggression toward family members, systemic racial stereotypes, etc. all contribute to how this issue is considered, particularly in systematically marginalized communities.

It will be necessary to consider the many dimensions and intersections of culture that influence perception and experience with this issue, including:

- Race or ethnicity
- Systemic racism
- Indigenous history in Canada
- Gendered perspectives
- Cross-cultural adjustment for newcomers to Canada
- Understanding of neurodiversity /neurodevelopmental differences

Impact to Children and Families

Intense stigma, shame, and blame are often experienced by all family members, including the child/adolescent themselves. Effective, timely, coordinated supports and services are not consistently available to families, leading to significant family distress and hardship that often escalates to a point of family disruption or breakdown – impacting the family unit as well as all family members witnessing violence.

Primary impacts to the child/adolescent themself include:

- Escalating mental health issues (including anxiety, trauma, depression)
- Diminishing self-esteem and self-worth,
- Damaged family relationships, with parents and caregivers as well as siblings
- Barriers to belonging (exclusion from schools, clubs, churches, community, etc)
- Dysregulation in other settings including school or other social / community settings,
- Criminalization of the child / adolescent
- Depiction as a violent perpetrator
- Entry / re-entry into the child protection system (applies to all families)
- Placement instability for children in care, or post-adoption
- Risk of entrenched behaviour into adulthood

Primary impacts to the parents, caregivers, and siblings include:

- Significant risk of physical and/or psychological injury within their home
- Onset or escalation of mental health issues (incl. anxiety, trauma, depression)
- Secondary trauma from exposure to violence in the home
- Damaged family relationships, within and between the entire family unit (incl. filial trauma)
- Isolation of family members (from extended family, friends, community), suffering shame/blame
- Increased risk of separation / divorce between parents
- Investigation by child protection services (both parents and siblings)

- Placement instability for other siblings in the home
- Loss of employment (due to at-home care requirements of their child)
- Financial strain on families, due to costs of family-funded supports / services, damage repairs, etc.

Primary impacts to Community and Society:

The European Union's research multi-year Daphne project concluded that "children who learn to use violence as a strategy are more likely to go on and use violence in future adult relationships".

Further, North-American studies (Childhood Externalizing Behavior: Theory and Implications, 2004, Journal of Child & Adolescent Psychiatric Nursing) draw the conclusion that "childhood aggression is a strong predictor of adult crime and violence". This contributes to an increase in the incidence of domestic violence, intimate partner violence, and a pressing societal need for violence prevention.

Disturbingly, there are countless anecdotal examples across multiple provinces of parents/caregivers who reported to the Consortium that their child had entered / re-entered the child protection system (either through voluntarily placement or apprehension) as a result of these patterns of behaviour and lack of effective family supports. This places a significant cost on the child welfare system, with the cost of ongoing specialized care required, in foster home, group home, or residential placement settings.

There are long term risks to youth, and costs to society, that result from entrenched involvement with under-resourced and ill-equipped social systems, ie. youth justice and child welfare. Prevention and early intervention strategies can mitigate these risks, as well as alleviate demand on over-burdened health and mental health care systems.

Commonly Observed Co-Existing Conditions

There is no single explanation or approach that fully explains this pattern of behaviour in childhood and/or adolescence. Much of the published research (Canadian and international), together with family reports to the Consortium, recognizes that children and adolescents with this behaviour very frequently have other developmental, neurodevelopmental, or otherwise related conditions, including:

- Autism Spectrum Disorder
- Fetal Alcohol Spectrum Disorder
- Sensory Processing Disorder
- Anxiety
- Developmental trauma
- Developmental disabilities
- Attachment disorders
- ADHD
- Conduct / defiance disorders

Individuals with lived experience, as well as parents/caregivers, reported that physical or psychological harm to self, or attempts to, were often present. Clinical experience suggests that self-harming activities are only indicative when they are also accompanied by instance of harm to others.

Guiding Principles

The insights of those with lived experience were critical in establishing a set of core guiding principles towards developing go-forward recommendations, common terminology and language, and possible strategies that would better support families. These principles provide an over-arching perspective through which individual strategies and interventions can be assessed, when considering their impact to youth and their families.

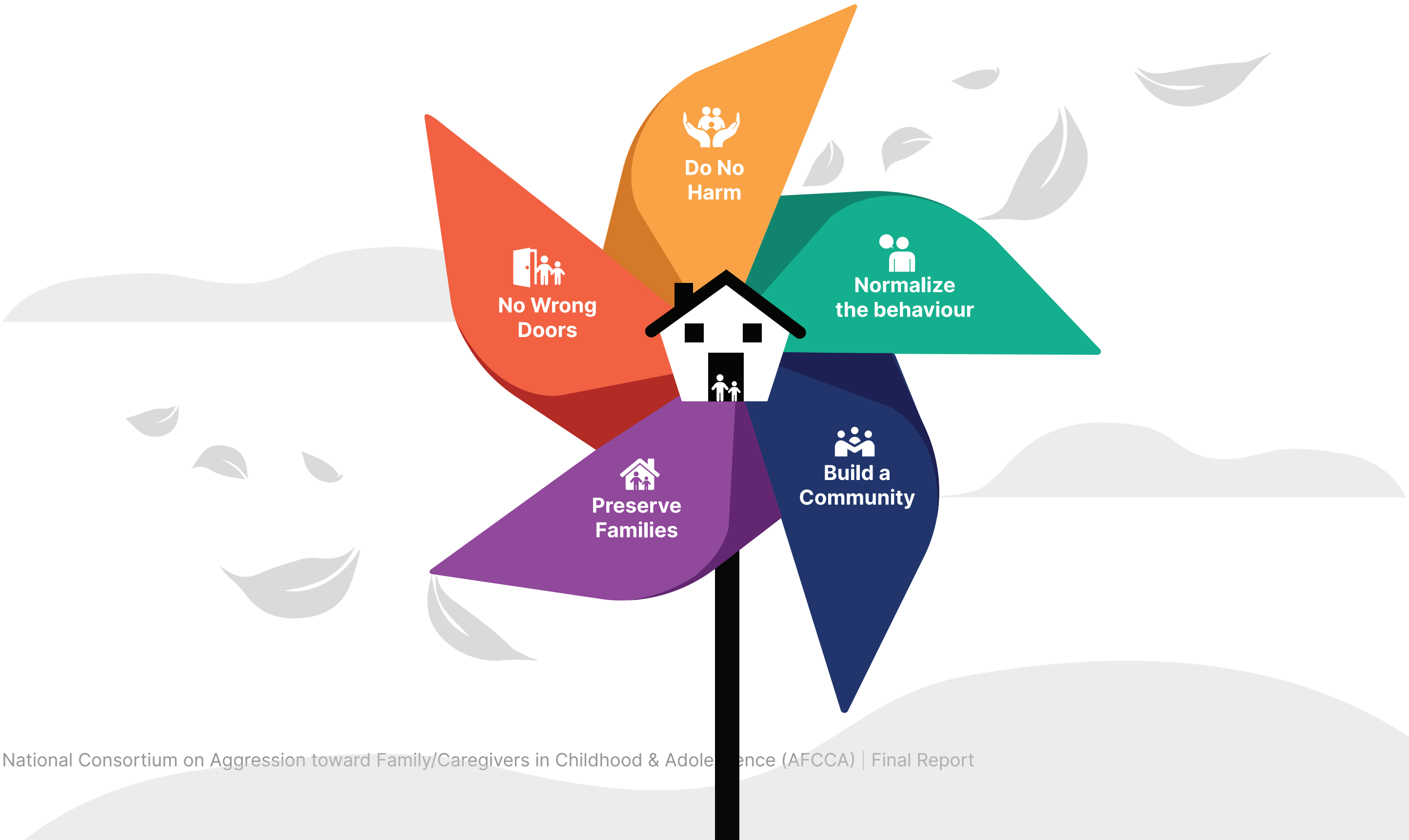
No Wrong Doors
Regardless of where or how a family seeks help and support, there should be an easy, frictionless mechanism to get them to the most effective supports based on their specific needs and circumstances.

Do No Harm
Practitioners, social systems, policymakers, and communities must be informed and aware, in order to understand and respond effectively, and ensure the child and family are not further harmed. Be humble and curious.

Normalize the Behaviour
For many children, particularly with early trauma, disrupted attachments, and/or neurodevelopmental conditions, these patterns of behaviour are common and can be expected; parents and caregivers should be prepared and supported in this.

Build a Community
Holistic, comprehensive supports are required, with coordinated approaches and interventions. The family must be at the center of determining what their child needs; and approaches must be flexible and adaptable for each family. Anyone in relationship with the child/adolescent can learn to respond in a way that the child needs.

Preserve Families
Early interventions are important and preferred. When families need more help, prioritize maintaining family attachment even in untraditional ways. Each family is unique, and creative solutions are possible.



Recommendations for Policymakers and Professionals

As introduced in the foreword to this report, families across Canada are experiencing the devastating consequences of AFCCA, and the impacts to everyone involved. The Consortium has identified clear, specific actions and recommendations which will have immediate benefit to children, youth, parents/caregivers, and communities as a whole. This section provides suggested next steps and recommendations for implementation, with an emphasis on policy makers (at all levels of government) and professionals / service providers who are likely to be engaged with families experiencing AFCCA.

The policy and program recommendations identified and prioritized by the Consortium have been organized here into a series of foundational pillars that would be expected to evolve and further develop over time. Those 10 pillars serve to consider recommended next steps from a "lifecycle" orientation, considering holistically broad community understanding and engagement, building on the strengths of families, and improving the outcomes for individual children and youth/adolescents.

Aggression toward Family/Caregivers in Childhood & Adolescence (AFCCA) Policy Recommendation Framework

The detailed proposed public policy recommendations for each have been prepared by the Voice of Policy subgroup, and can be found in Appendix C: AFCCA Policy Recommendation Framework. The key findings and summary recommendations for each of these 10 pillars are included below.

Awareness

Finding: There is insufficient broad public awareness or understanding of AFCCA. Awareness programs need to be developed and made available to a broad section of individuals and professionals.

Families and Caregivers: including core/extended families, foster parents, and personnel of child welfare, alternative living arrangements, and respite providers.

Professionals/ Paraprofessionals: including service providers, researchers, law enforcement, youth justice systems, educators/schools, child welfare, child & youth workers, and health professionals, including mental health service providers and emergency/first responders.

Policy Makers: at the municipal, provincial, and federal levels.

Age-appropriate awareness kits should be developed in support of siblings and other youth who live with AFCCA, considering both chronological age and developmental stage.

Professional and national associations of professionals and paraprofessionals that work with, or advocate on behalf of, children/youth and families, including health professionals, should develop awareness packages for their members and should disseminate through existing educational venues/events, or through certification programmes.

Education

Finding: While broad general awareness of AFCCA is important, targeted educational programmes for families/caregivers and for professionals should also be developed.

Educational programmes for families and care givers should assist them to have a deeper understanding of the issue, techniques for addressing their lived experiences and connections to appropriate resources (both early intervention resources and effective crisis interventions when needed).

Educational programmes for professional and paraprofessionals should be targeted at both the undergraduate/graduate candidate and those already practicing (ie. ongoing certification) and should focus on how best to identify the issue and effective/techniques interventions for supporting the family/caregivers. Any profession in healthcare, social care, child welfare, education, justice, etc. that are likely to encounter families experiencing AFCCA should be included.

Because the Canadian research regarding AFCCA is emerging, a national repository / knowledge hub of information and resources, which would be regularly updated and include both Canadian and International resources, should be made available to families, researchers, and professionals. (see https://aidecanada.ca as a related example)

Anti-Stigma

Finding: AFCCA is under-reported by individuals and families / caregivers due to stigma and/or fear of repercussions from child welfare and/or justice systems.

Families and children/youth themselves repeatedly confirmed they did not seek help due to this stigma and fear. This leads to further isolation and exacerbation of the situation, leaving families at greater risk of instability and breakdown.

Awareness and education materials and campaigns that are developed, as part of implementing the above recommendations, should have an anti-stigma orientation. A broad, public anti-stigma campaign, geared towards parents / caregivers AND children /youth, that specifically target stigma, shame, and blame would be valuable in mitigating this challenging dynamic.

Research

Finding: There is, at this point, a paucity of Canada-specific research regarding the prevalence of, root causes of, early signs of, and effective interventions for, AFCCA. Canadian-based research into AFCCA is an important priority.

The Consortium also notes that because the root causes of AFCCA may vary (including neuro-atypical development, trauma, attachment issues, etc.) there is a need for research and program evaluations into various effective interventions.

Canadian-based research into AFCCA is an important priority. There are a small number of AFCCA-related Canadian research projects currently underway, including the current pilot project supported by Queens' University, studying Non-Violent Resistance (NVR) as an effective family-centered intervention, and an interdisciplinary pilot study conducted by Professors Christine Gervais (Criminology) and Elisa Romano (Psychology) from the University of Ottawa. Their survey and interview-based research focusing on families' experiential accounts is being undertaken through child rights and trauma-informed approaches; preliminary findings are anticipated in February 2022.

The development of a Centre of Excellence mandated to disseminate findings of research, including family/youth-friendly summaries that are focused on knowledge mobilization and accelerating implementation of evidence-based strategies and programs would be an important step forward.

Creating the Right Door

Finding: The Consortium has found that families experiencing AFCCA often find themselves being "bounced" from program to program, from agency to agency as they seek supports and services to assist them. Rather than ensuring "no wrong door", families need the creation of the right door.

It is often the case that this "bouncing around" takes place when a family is in crisis, thus exacerbating the situation. Narrowly defined programs and services intended to provide assistance are often inaccessible to families at the time of most intense need. Families across Canada, in all settings (urban, rural, geographically remote), need to be able to access knowledgeable and informed supports quickly and easily.

Rather than ensuring "no wrong door", families need the creation of the right door – an easily accessible entry point for holistic engagement with families, children, and youth that offers understanding, coordinated and appropriately-funded services and supports, flexible respite options, and ongoing care services.

One such example may be the recently announced intent to introduce needs-based "Family Connections Hubs" by the British Columbia Ministry of Child and Family Services.

Early Intervention

Finding: While the Consortium is aware that more research is needed into root causes and early signs of AFCCA, we are also aware that prevention and early intervention is required. With effective awareness, education and anti-stigma campaigns, families may be more equipped to seek help earlier in the development and progression of AFCCA.

As well, professionals that work with children and youth may be able to detect signs of AFCCA earlier and work with families/caregivers to seek appropriate supports. Families have reported that when they do raise concerns or seek help, they are often disregarded or not believed by the professionals involved with their children. When families seek help, service providers should prioritize early intervention to avoid the worsening of the situation.

Research into AFCCA should focus on the root causes and on refining the understanding of early indicators. As appropriate, prevention programs should be developed on the basis on this research, that can be further assessed and evaluated for positive impact on children/youth.

Family/Youth-Directed Circles of Support

Finding: Families must be enabled and empowered to remain at the center of all decision making and planning processes involving their child. Wherever possible, a coordinated, holistic plan of care is invaluable in ensuring that families and the professionals supporting them have a shared view of a child's goals, strengths, needs, and supports that the child either is receiving or needs.

Families may wish to co-develop an overarching family or youth-directed circle of support, in line with the principle that families (parents, caregivers, and individuals themselves) are the most informed on what's most necessary for their loved one.

Across the many families and youth who shared their experiences and insights with the Consortium, there were commonalities in what most said was needed in their circles of support to strengthen and preserve their family units in a healthy manner. These common threads were supported by reports to the Consortium by clinicians and service providers:

- **Recognize and empower the allies who are supporting youth / parents / caregivers:** Consistently, youth and families spoke of the need for an ally – someone who would play the role of coach, champion, note-taker, caretaker, translator, etc. Typically, these are not clinicians or service providers – rather they are family/youth identified, and are critical to have at the table as a core part of the circle of support.

- **Remove the barriers to accessing help:** Even once supports or services have been identified, the Consortium has heard consistently that parents and caregivers often face significant barriers in accessing those supports. For families living in rural or geographically isolated locations, qualified / informed practitioners and services frequently do not exist and virtual access may be limited. For children/youth from Indigenous communities, alternative supports that are culturally relevant and appropriate may not be available or sufficient to meet the need.

  Further, numerous practical considerations pose barriers to successfully navigating and accessing established supports: the need for childcare for other children in the home, other prerequisite processes/requirements to access health care services, transportation costs and availability, inaccurate assumptions of pre-existing connections to other information or resources, parents' fatigue in navigating complex systems and structures while seeking help.

- **Build peer connections and peer support:** Family members are expressly seeking peer connections, both for support and guidance. For parents/caregivers, this may be connections with other parents/caregivers who are on the same journey and can offer understanding, acceptance, and suggestions. For youth and young adults, this may look more like social connections and genuine friendships in which they can confide, trust, and be understood. For all family members, the existence of supportive peer connections is an important factor in ending shame, stigma, and isolation.

- **Build on existing strengths within the youth and family:** Families need individualized, responsive supports and care, that are relevant to their unique needs. There is significant benefit in deliberately assessing the strengths and capabilities that a child/adolescent possesses, and considering how that strength can be applied to move towards more positive outcomes. More broadly, the same approach of considering the strengths of the entire family unit can be equally beneficial. In recognizing and building upon the strengths, passions, and capabilities of the family, both the allies and professionals supporting a family can better understand how to help most effectively.

- **Solution-focused wraparound supports are critical for family preservation:** The Consortium understands that AFCCA has various root causes and presents variably both from family to family, and within a family where there are multiple children or adolescents. It is crucial that each child or youth and their family experiencing AFCCA have a multidisciplinary assessment to identify the appropriate mix of professional or clinical interventions and supports that will address the child/youth/family needs at the current time.

The needs assessment, together with an understanding of the youth and family's strengths should form the basis of the holistic plan of support and care for children and youth, and plan of support for families. Effective and timely supports must then be provided, with the flexibility to manage, update, and maintain the components of care as needs evolve over time.

Effective Crisis Intervention

Finding: Traditional approaches to dealing with the needs of families experiencing AFCCA, particularly those experiencing incidents of aggression that create risks to individuals' safety, frequently are ineffective and rather, risk doing more damage than help. Parents and caregivers have directly said that what they need is more effective measures for crisis response, that focus on de-escalation and preserving family safety.

These traditional approaches include the tendency to use child protective measures to remove children/youth from the family or the use of intrusive youth criminal justice measures, rather than recognizing or responding to a child or youth in need of complex treatment.

Families have told the Consortium they are contacting 911 and/or Children's' Aid for assistance as absolute last resorts, in the absence of seeing any other options available; and importantly that they do fearing that these interventions will in fact further escalate the situation or cause more trauma to their child/adolescent.

Families want support to help address the needs of their children and to help keep their families together. Instead, parents and caregivers (both biological and adoptive) often feel pressured or intimidated into relinquishing custody of their children in order to access the required services/supports necessary to ensure safety – resulting in children entering / re-entering the child welfare system unnecessarily and leading to family disruption and breakdown. Parents should not have to give up their parental rights in order to get help or treatment for their child.

Additionally, adoptive families often find that child protection workers have a dual role as post-adoption support workers and families find that there is a conflict in these two roles that can further lead to under-reporting of this issue for fear of reprisal.

Police can be very helpful in de-escalating situations and in using pre-charge diversion options, but it is not always the case that they are helpful or informed on AFCCA. There are promising trends noted in various regional police pilot programs regarding alternative response mechanisms that would be beneficial for families experiencing AFCCA, including mobile crisis units that are mental health focused vs. traditional police response and police pairing with social workers, particularly those that are youth-oriented. Further evaluation of these programs and their applicability to situations involving AFCCA are warranted.

The Consortium acknowledges that in some circumstances, where there is an imminent risk of extreme violence to any individual, that a police response may still be required and appropriate to prioritize the safety of the (potential) victim.

There are systemic barriers and lack of appropriate available community resources that result in inconsistent use or application post charge diversion programs by individuals at the court level, that could potentially be beneficial in addressing the root cause(s) of an adolescent's behaviour. Inconsistencies in the application and delivery of extra-judicial sanction programs, diversion programs and strategies, and restorative justice programs frequently limit their effectiveness and ability to help youth and adolescents with improved long-term outcomes. Entrenching a youth in the justice system does not generally produce the desired long term outcomes, and charging a youth with a crime can have long-term deleterious consequences.

Among the detailed recommendations provided are two key points to call attention to:

- All levels of government responsible for policing and other emergency responders should ensure that capacity is built in its front-line responders for appropriate response to families experiencing a crisis due to AFCCA, emphasizing de-escalation and ensuring that interventions do not inappropriately entrench the youth in the criminal justice system.

- Governing bodies (at the municipal, provincial, and federal levels) responsible for youth justice and policing should encourage collaboration between police, crown attorneys and should ensure that police officers, crown counsels, and probation officers consistently apply the principles established in the Youth Criminal Justice Act for available alternatives in order to avoid deeper entrenchment in the criminal justice system.

Financial Support to Families

Finding: The financial impact on families experiencing AFCCA can be significant. A comprehensive review of financial support and tax relief programs, at both the provincial and federal levels, should focus on removing administrative barriers to families, ensuring better awareness, earlier access, and greater stability over time.

Financial impacts are due to various reasons, including but not limited to:

- The need to self-finance various services, including counselling, extended respite care (in home or out of home), alternative residential care, etc. that are either not funded by provincial or federal governments or with long untenable waitlists.
- The need to take time from work/business, and sometimes to leave the workforce altogether, to either provide care in the home, seek/coordinate services, or advocate for their children's complex needs.
- The costs associated with damage to property, housing, or essential living items, resulting from instances of AFCCA.

Currently a hodgepodge of financial or tax programmes are available to families, with significant variance province by province (and families report inconsistencies within provinces). Families spend an inordinate amount of time researching the programmes, eligibility criteria, and navigating the administrative hurdles of program applications, intakes, coordination, and renewals.

Families find that the eligibility criteria for programs vary from program to program and are narrowly defined. Programs are short term in nature while families have needs over the long term. As well, families often find that civil servants or other personnel responsible for administering financial programs act as gatekeepers rather than facilitators.

Some families report that the relaxation of eligibility and rules for financial programs for families during the Covid-19 pandemic such as those to Ontario's Special Services at Home / SSAH eligible expenses has been helpful, and better enables a family-centric approach to care.

Transitions to Adulthood

Finding: The Consortium has found that there are consistently no clear pathways for families experiencing AFCCA whose youth/adolescent is chronologically transitioning into adulthood. Youth/adolescents deserve clear pathways of care, with effective transitions to appropriate and effective adult services.

Too often, just as a family is beginning to finally implement a plan of care for their child/adolescent, the child has aged and is no longer eligible for programs in place for children and youth. They must start all over again navigating and advocating in the adult services sphere, where there is no recognition of the individual's long-standing needs, challenges, and/or disabilities.

For older youth in the care of child welfare services, they will frequently experience not only a complete lack of supports and services but also the lack of caring adults who can assist with navigation and advocacy. The issue of "transition to adulthood" is a longstanding one experienced by many families of youth with care needs; and experiencing by youth "aging out of the system".

Youth/adolescents deserve clear pathways of care, with warm uninterrupted handoffs to appropriate and effective adult services. Families, caregivers and youth with direct lived-experience should be involved in developing provincial pathways of care strategies, and should be fully involved in the development of individualized pathways of care specific to their needs.

The work currently underway in multiple Canadian provinces to move towards equitable standards or indicators of readiness to determine when a youth is ready to leave the child welfare system should be expanded and incorporated into the appropriate provincial legislations. The Consortium looks to the report "Equitable Standards for Transitions to Adulthood for Youth in Care", October 2021, for additional guidance from first-voice experts.

In Conclusion

The National Consortium on Aggression toward Family / Caregivers in Childhood & Adolescence was formed as a time-limited project with very specific goals. It was originally intended to bring together key stakeholders across provinces with a diverse variety of perspectives, experiences, and disciplines for 4 highly structured meetings over a period of 6 months to frame the problem and co-develop a possible path forward. We aimed to find common agreements where possible on the definition, terminologies, gaps and future opportunities.

We could not have anticipated the number of first voice advocates, parents, caregivers, and family members that stepped forward to help us understand the true nature of the issue or how they were experiencing it in their homes and their lives. Neither could we have anticipated the commitment of the participants in the Consortium in doing their part to make sure that change is possible.

The original goals set out for the Consortium have been achieved. We have a consensus on what to call it. We have a definition. We have a better understanding of the gaps, and we are ready to pursue future opportunities. **There is so much hope.** Improvements can be made, and these changes will have a significant impact on the lives of children and youth, their families, and on society as a whole. Capacity for earlier, less intensive interventions must be expanded in parallel with providing the help required to assist families in crisis now.

Knowing this makes it urgent to keep going. In this vein, the Consortium intends to continue, with the proviso that the voices of lived experience continue to act as the "truth testers", and that the Consortium voices expand to include an increasingly diverse group of communities and individuals.

The Consortium will adapt to focus on continued learning and with a greater focus on action, as we call on all levels of government and communities to move forward in acting on these important recommendations.

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Appendices

Appendix A: **AFCCA Literature Review**

Appendix B: **Interventions and Possible Strategies**

Appendix C: **AFCCA Policy Framework and Recommendations**

Appendix D: **Existing AFCCA Canadian Research Projects**

Appendix A: AFCCA Literature Review
Brief Literature Review for Consortium Report

Christine Gervais[1] , Danika DeCarlo Slobodnik[2] and Maude Champagne[3]

Aggression toward family/caregivers in childhood and adolescence (AFCCA) remains one of the most under-researched and lesser known forms of family violence (Holt, 2011; Simmons et al., 2018; Thorley & Coates, 2019), despite its apparent prevalence and serious impacts.

Definitional and methodological differences have led to a varied literature base, a lack of consensus over terminology and prevalence, as well as limitations for appropriate interventions (Holt & Lewis, 2021; Simmons et al., 2018). Alternatively referred to in other countries as child-to-parent violence & aggression (CPVA), adolescent-to-parent violence (APV), and adolescent to parent abuse (APA), among others, this form of aggressive behaviour is exhibited by children and adolescents and directed towards parents or caregivers, often resulting in physical, psychological, and/or verbal harm (Cottrell, 2001).

Although research remains sparse, prevalence studies indicate that a significant number of families are affected by AFCCA (Holt, 2016; McCloud, 2021). In Canada, violence by children[4] toward parents, caregivers or siblings accounted for 22% of all police-reported family violence in 2019 (Conroy, 2021). Earlier Canadian survey data found prevalence rates of upwards of 65% for verbal and psychological AFCCA[5] and between 9.5% and 13.7% of physical forms of AFCCA (Pagani et al., 2004, 2009). Similarly, estimates from the United States found AFCCA[6] rates between 14 to 20% for physical violence and 34 to 64% for verbal and psychological violence (Ulman & Straus, 2003).

In the United Kingdom, estimates also vary, in part due to lack of definitional consensus, diverse methodological approaches and family compositions, but range from as low as 3% to over 65% - inclusive of both physical and psychological forms of AFCCA (McCloud, 2021; Miles and Condry, 2016; Selwyn &Meakings, 2016).

Prevalence rates for all forms of aggression are likely higher than those presented in the literature due to parents' unwillingness to report them because of feelings of isolation, shame, stigma, and parental failure, as well as out of concern for potentially criminalizing consequences for their child (Condry et al. 2020; Holt, 2011; McCloud, 2021; Selwyn, Wijedasa, & Meakings, 2014).

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[4] This reference and statistic are inclusive of children who harm not only parents/caregivers, but also siblings. It is important to note that the statistic cited here does not refer to the age of the child, but rather to their relationship to the parent, caregiver or sibling. Thus, further research is needed to examine the complex contexts of AFCCA, including the implications of both age and familial relationship.

[5] Pagani et al. (2004, 2009) referred to the behaviour as APVA (Adolescent to Parent Violence and Aggression).

[6] Ulman & Straus (2003) refer to CPV (Child to parent violence).

[7] Data collection methods vary from quantitative to qualitative, but tend to be primarily quantitative (file reviews and surveys) (Agnew &Huguley, 1989; Pagani et al., 2003; Lyons et al., 2015); while some studies have involved qualitative interviews and focus groups (Paterson et al., 2002; Cottrell & Monk, 2004; Clarke et al., 2017), others included mixed methods (Holt, 2011; McCloud, 2021;Selwyn, Wijedasa, & Meakings, 2014).

Risk Factors

Child maltreatment and childhood adversity

Various forms of AFCCA have been associated with child maltreatment and children's exposure to intimate partner violence (IPV) (Cottrell & Monk, 2004; Lyons et al., 2015; Selwyn & Meakings, 2016; Papamichail & Bates, 2020). Research has shown that in addition to exposure to physical abuse and IPV (Paterson, et al., 2002; Cottrell & Monk, 2004; Selwyn, Wijedasa, & Meakings, 2014), maltreatment and its impact on stress responses (see McCrory et al., 2012), as well as attachment styles (see Zeanah, 2009), Adverse Childhood Experiences (Thorley & Coates, 2019), and school-based violence, including bullying (Calvete et al., 2015)are factors that increase the risk for AFCCA.

In their study in the United Kingdom, Papamichail & Bates (2020) found that adolescents[8] who showed evidence of AFCCA faced adversities including exposure to IPV, parent-to-child violence, emotional neglect, parental separation and divorce, and loss and abandonment.

While multiple factors may increase the risk of AFCCA (McCloud, 2021; Selwyn & Meakings, 2016), some adopted children may be at higher risk due to their past experiences with trauma. Results from Selwyn, Wijedasa, & Meakings' (2014) extensive UK study showed that the majority (72%) of children with adoption orders were placed because of maltreatment and they were more likely to have been abused and neglected than the wider population of children in care.

While Selwyn et al.(2014) and Palacios et al. (2019) did not initially nor explicitly focus on AFCCA, their examination of rates and experiences of adoption disruption or adoption breakdown in their respective studies, revealed how AFCCA was connected with such adoption-related challenges. In their 2014 study, Selwyn, Wijedasa, & Meakings found that both the adopted children who remained in the home and those who left the home (i.e. the adoption was disrupted) exhibited significantly high levels of social, emotional, and behavioural difficulties and many had traumatic histories of abuse and neglect prior to their adoptions.

Despite the evidence indicating that children who experience a greater number of moves in care and delayed entry into long-term care are at greater risk for emotional and behavioural difficulties and tend to have poorer outcomes (Jones et al., 2011), the experiences of adoptive, kinship and customary care families with AFCCA remain limited in the literature.

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[8] A limited number of qualitative studies have included the views and experiences of children/adolescents (Calvete et al., 2015, 2014; Papamichail& Bates, 2020), while even fewer have focused on siblings (Selwyn, 2019), and other relatives, including grandparents in a kinship care context (Holt & Birchall, 2020). Future studies must also consult children and youth directly and inclusively about their own experiences, and not rely solely on parents' or adults' perspectives.

Neurodevelopmental Disorders

Aggressive behaviours toward family members is an issue reported in the neurodevelopmental disability community as well. According to the DSM- 5, neurodevelopmental disorders are "a group of conditions (…) characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning (American Psychiatric Association, 2013)." Autism spectrum disorder (ASD), Fetal alcohol spectrum disorder (FASD) and Attention-Deficit/Hyperactivity Disorder are common neurodevelopmental disorders that may involve the issue of aggressive behaviours.

From a community consultation conducted by the Ontario Brain Institute, stakeholders identified the need for pharmacological and non-pharmacological treatments for aggressive behaviour in individuals with neurodevelopmental disorders as one of the top research priorities (Ontario Brain Institute, 2017).

FASD
In a need assessment for caregivers of children with Fetal alcohol spectrum disorder, violence and aggression were rated as the most difficult situation to overcome (Green, et al.. 2014). During the pandemic of Covid-19, caregivers have reported higher incidents of aggressive behaviours of children towards family members leading to parental trauma, injuries and placement instability (Champagne et al., 2021).

ASD
More research was done on ASD compared to FASD regarding the prevalence and treatment of aggressive behaviour. In ASD, risk factors include greater impairment in language, cognition and adaptive functioning and children who engage in repetitive behaviours (Dominick et al. 2007, Kanne & Mazurek, 2011). The prevalence of aggressive behaviours towards caregivers may be as high as 68% according to Kanne and Mazurek (2011). Treatments usually consist of pharmacotherapeutic treatment and ABA-based therapies (Coccaro & McCloskey, 2018).

Aggression in childhood and adolescents in the context of neurodevelopmental disorders greatly impacts caregivers, the family unit as well as our society. Several authors have highlighted the needs for multidisciplinary support to impacted families (Coccaro & McCloskey, 2018).

Conclusion

Despite the growing body of international research cited above, AFCCA remains under-researched in the Canadian context, and particularly through trauma-informed, child-rights and neurodevelopmental lenses. Further research in Canada is also required to consider appropriate early interventions for families, including support-based and non-criminalizing and non-stigmatizing approaches (Condry et al. 2020; Miles & Condry, 2015; Thorley & Coates, 2018), as well as comprehensive ones that aim not only to mitigate harm and familial distress but also to prevent potentially more extreme consequences, such as parricide (Weegar, 2017).

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Appendix B: Interventions and Possible Strategies

In the online questionnaire completed in July 2021 by the Consortium, parents, caregivers, and practitioners were asked a series of open-ended questions regarding their experiences of what they had found helpful for their respective families.

50 parents/caregivers provided input to the questions:

- What is working well, from your existing external supports?
- Are there other services or programs that you believe are helpful?
- Is there existing legislation / public policy that is effective in helping support your family?

Practitioners were asked related questions, from their lens:

- Are there existing treatments, interventions, or protocols that you follow with a family experiencing this behaviour?
- Are you aware of any programs currently in place (within Canada or internationally), that you believe could be helpful for supporting individuals demonstrating this behaviour?
- Please describe any programs or services that you're aware of that could be modified or adapted to be culturally appropriate for equity-seeking groups in Canada?

Their responses have been grouped and categorized below.

None of these strategies, programs, and interventions have been further evaluated or assessed by the Consortium for their effectiveness from an evidenced-based perspective. The Consortium is aware however that many of those listed do have independent published program evaluations that assess their effectiveness for varying populations.

Family & Community Access
Peer support networks
Youth support groups
Family / community connections
In-school student success teams

Learning & Skills Development Programs
Circle of Security
Parent-Child Interaction Therapy (PCIT)
Non-Violent Resistance (NVR)
Understanding & Managing Aggressive Behaviour (UMAB)
SAFE Baby Court Teams
Crisis Prevention Institute (CPI)
ABA Behaviour Management
SNAP Community of Practice Project

Public-policy driven Programs

Coordinated Service Planning (Ontario)
Complex Special Needs program (Ontario)
Children & Youth with Special Needs CYSN (British Columbia)
Children and Youth with Support Needs (CYSN) Service Framework (British Columbia)

Trauma-Informed, Attachment-Informed, Therapeutic Models and Practices

Dyadic Developmental Psychotherapy (DDP)
Nurturing Attachments
Attachment, Regulation, and Competency Framework (ARC)
Neuro-sequential Model of Therapeutics (NMT)

Pharmaceutical aids

Multiple medications
CBD oils

General categories

Multi-disciplinary teams to develop an integrated plan
Integrated service planning tables
Youth justice diversion programs
Restorative justice programs
Respite programs – in home
Respite programs – out of home
Specialized residential placements – out of home
Neuropsychological Assessments

Appendix C: AFCCA Policy Framework and Recommendations

Prepared by:
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As introduced in the foreword to this report, families across Canada are experiencing the devastating consequences of AFCCA, and the impacts to everyone involved. The Consortium has identified clear, specific actions and recommendations which will have immediate benefit to children, youth, parents/caregivers, and communities as a whole. This section provides suggested next steps and recommendations for implementation, with an emphasis on policy makers (at all levels of government) and professionals / service providers who are likely to be engaged with families experiencing AFCCA.

The policy and program recommendations identified and prioritized by the Consortium have been organized here into a series of foundational pillars that would be expected to evolve and further develop over time. Those 10 pillars, and the detailed findings included under each one, serve to consider recommended next steps from a "lifecycle" orientation, considering holistically the broad needs of communities, building on the strengths of families, and improving the outcomes for individual children and youth.

Aggression toward Family/Caregivers in Childhood & Adolescence (AFCCA) Policy Recommendation Framework

Awareness

Finding of the Consortium

There is insufficient awareness or understanding of AFCCA. Awareness programs need to be developed and made available to

- Families and Caregivers (including foster parents, and personnel of child welfare, alternative living arrangements, respite providers, etc.)

- Professionals/ Paraprofessionals (including service providers, researchers, law enforcement, youth justice systems, educators/schools, child welfare, child & youth workers, and health professionals, including mental health service providers and emergency/first responders)

- Policy Makers (at the municipal, provincial, and federal levels)

Policy Recommendations

1.1 Federal and provincial governments, through their departments of health/public health, should make funds available to develop an awareness kit for families/caregivers and, once developed, should promote the awareness kit through the media including social media.

1.1.1 Age-appropriate awareness kits should be developed in support of siblings and other youth who live with AFCCA, considering both chronological age and developmental stage.

1.2 Professional and national associations of professionals and paraprofessionals that work with, or advocate on behalf of, children/youth and families, including health professionals, should develop awareness packages for their members and should disseminate through existing educational venues/events, or through certification programmes.

Education

Finding of the Consortium

While awareness of the issue is important, educational programmes for families/caregivers and for professionals should also be developed.

Educational programmes for families and care givers should assist them to have a deeper understanding of the issue, techniques for addressing their lived experiences and connections to appropriate resources (both early intervention resources and effective crisis interventions when needed).

Educational programmes for professional and paraprofessionals should be targeted at both the undergraduate/graduate candidate and those already practicing and should focus on how best to identify the issue and effective/techniques interventions for supporting the family/caregivers. Any profession in healthcare, social care, child welfare, education, justice, etc. that are likely to encounter families experiencing AFCCA should be included.

Because the Canadian research regarding AFCCA is emerging, a national repository / knowledge hub of information and resources, which would be regularly updated and include both Canadian and International resources, should be made available to families, researchers, and professionals. (see https://aidecanada.ca as an example)

Policy Recommendations

2.1 The federal government should provide funding/resources for the establishment of a AFCCA Centre of Excellence which would have a national mandate for education and for developing and maintaining an electronic repository/knowledge hub of resources.

2.2 Federal and provincial governments through their health/public health departments, should provide funding to develop educational programs for families/caregivers including age / developmental stage-appropriate educational programs.
2.3 Professional associations and academic institutions should ensure that education about AFCCA is including in the undergraduate/graduate curriculum.

2.4 Professional associations should include education about AFCCA in their ongoing certification programs for their respective members.

Finding of the Consortium

The Consortium believes that AFCCA is under-reported by families due to stigma and/or fear of repercussions from child welfare and/or justice systems; this is further supported by the research cited in the Consortium's accompanying literature review. Families and children/youth themselves repeatedly confirmed they did not seek help due to this stigma and fear. This leads to isolation and exacerbation of the situation.

Because the Canadian research regarding AFCCA is emerging, a national repository / knowledge hub of information and resources, which would be regularly updated and include both Canadian and International resources, should be made available to families, researchers, and professionals. (see https://aidecanada.ca as an example)

Policy Recommendations

3.1 Awareness and education materials and campaigns that are developed, as part of implementing the above recommendations, should have an anti-stigma orientation.

3.2 Federal and provincial governments should develop and disseminate a broad, public anti-stigma campaign(s), geared towards parents / caregivers AND children / youth, that specifically target stigma, shame, and blame.

Finding of the Consortium

Despite the growing body of international research cited above, AFCCA remains under-researched in the Canadian context, and particularly through trauma-informed, child-rights and neurodevelopmental lenses. Further research in Canada is also required to consider appropriate early interventions for families, including support-based and non-criminalizing and non-stigmatizing approaches.

The Consortium also notes that because the root causes of AFCCA may vary (including, neuro-atypical development, trauma, attachment issues, etc.) there is a need for research and program evaluations into various effective interventions.

Canadian-based research into AFCCA is an important priority.

Policy Recommendations

4.1 Federal and provincial governments should make funding available to be directed towards research into prevalence, root causes, early signs and effective interventions for AFCCA utilizing an intersectional approach..

4.2 As per recommendation 6.1 and 6.2 (below), funding should also be made available for demonstration projects that could test effective interventions for AFCCA, including supports to families.

4.3 As per recommendation 2.4 (above), funding should be made available to develop a Centre of Excellence that would be mandated to disseminate findings of research, including family/youth-friendly summaries that are focused on knowledge mobilization and accelerating implementation of evidence-based strategies and programs.

Creating the Right Door

Finding of the Consortium

Rather than ensuring “no wrong door” the Consortium believes that families need the creation of the right door – an easily accessible entry point for holistic engagement with families, children, and youth that offers understanding, coordinated and appropriately-funded services and supports, flexible respite options, and ongoing care services. Families across Canada, in all settings (urban, rural, geographically remote), need to be able to access knowledgeable and informed supports quickly and easily.

One such example may be the recently announced intent to introduce needs-based “Family Connections Hubs” by the British Columbia Ministry of Child and Family Services.

Policy Recommendations

5.1 Provincial ministries responsible for child/youth services should designate a lead agency or organization in each of their service districts that would be responsible for receiving the request for help and for coordinating the response.

5.2 Provincial ministries responsible for child/youth services should create easily accessible communications channels that families can access which would connect them to the local agency providing the above noted service.

5.3 Provincial ministries providing government funding for child/youth services should mandate that all agencies receiving such funding be familiar with these lead agencies, and have an established process for the “warm transfer” of a family in need to the appropriate service / agency.

Early Intervention

Finding of the Consortium

While the Consortium is aware that more research is needed into root causes and early signs of AFCCA, we are also aware that prevention and early intervention is required. With effective awareness, education and anti-stigma campaigns, families may be more equipped to seek help earlier in the development and progression of AFCCA.

As well, professionals that work with children and youth may be able to detect signs of AFCCA earlier and work with families/caregivers to seek appropriate supports. Families have reported that when they do raise concerns or seek help, they are often disregarded or not believed by the professionals involved with their children. When families seek help, service providers should prioritize early intervention to avoid the worsening of the situation.

Policy Recommendations

6.1 Federal and provincial governments should ensure that a key component of awareness and educational materials and programs (per recommendations above), families should be made aware of the early signs of AFCCA and know where to go for help.

6.2 Provincial governments should develop a roster of services and organizations that can provide early interventions to families and the children/youth and make these publicly available.

6.3 Professionals that work with children and youth should be aware of services available to families, children/youth experiencing AFCCA and make timely referrals to appropriate services.

6.4 Professionals who offer services to families, children/youth experiencing AFCCA should prioritize early intervention.

6.5 Research into AFCCA should focus on the root causes and on refining the understanding of early indicators. As appropriate, prevention programs should be developed on the basis on this research.

Family/Youth-Directed Circles of Support

Finding of the Consortium

Families must be enabled and empowered to remain at the center of all decision making and planning processes involving their child. Wherever possible, a coordinated, holistic plan of care is invaluable in ensuring that families and the professionals supporting them have a shared view of a child's goals, strengths, needs, and supports that the child either is receiving or needs.

Families may wish to co-develop an overarching family or youth-directed circle of support, in line with the principle that families (parents, caregivers, and individuals themselves) are the most informed on what's most necessary for their loved one. These circles of support should recognize the core principles that families (parents, caregivers, and youth with lived experience) have specified:

- Recognize and empower the allies who are supporting youth/ parents /caregivers
- Remove the barriers to accessing help
- Build peer connections and peer support
- Build on existing strengths within the youth and family
- Identify the solution-focused wraparound supports critical for family preservation

Effective and timely supports must be provided with the flexibility to manage, update, and maintain the components of care as needs evolve over time.

Policy Recommendations

7.1 The federal government or provincial governments should provide funding for a series of demonstration projects that would pilot specialized AFCCA peer-support programmes for parents and caregivers, such as those existing today from Adopt4Life (Ontario), the Family Support Institute (British Columbia).

7.1.1 Attention should be paid to ensuring that demonstration projects are inclusive of diverse cultural and racial communities, with projects developed and/or adapted by the communities they are intended to serve.

7.1.2 These demonstration projects should be evaluated by researchers and the programme expanded as appropriate.

7.2 Provincial governments should ensure that mechanisms in place for complex care coordination (including service resolution tables, coordinated services planning, or equivalent provincial processes) are mandated and resourced to serve children/youth and families experiencing AFCCA, and that those mechanisms explicitly welcome and include the presence wherever possible of the youth / adolescent, their parents / caregivers, and identified allies.

7.3 The federal government or provincial governments should provide funding for a series of demonstration projects across the country that would pilot and test multidisciplinary assessment and intervention models for children and youth and families.

7.4 Federal government should fund the above noted Centre of Excellence to make information easily accessible and available, in multiple formats, to families, children/youth to assist them in accessing information, services and referrals. This may begin with the establishment of the knowledge repository / hub referenced above, but later expand to include broader connections to established mental health & wellness resources, including crisis response services.

Finding of the Consortium

Traditional approaches to dealing with the needs of families experiencing AFCCA, particularly those experiencing incidents of aggression that create risks to individuals' safety, frequently are ineffective and rather, risk doing more damage than help. Parents and caregivers have directly said that what they need is more effective measures for crisis response, that focus on de-escalation and preserving family safety.

These traditional approaches include the tendency to use child protective measures to remove children/youth from the family or the use of intrusive youth criminal justice measures, rather than recognizing or responding to a child or youth in need of complex treatment.

Families want support to help address the needs of their children and to help keep their families together. Instead, parents and caregivers (both biological and adoptive) often feel pressured or intimidated into relinquishing custody of their children in order to access the required services/supports necessary to ensure safety – resulting in children entering / re-entering the child welfare system unnecessarily and leading to family disruption and breakdown. Parents should not have to give up their parental rights to get help or treatment for their child.

Police can be very helpful in de-escalating situations and in using pre-charge diversion options, but it is not always the case that they are helpful or informed on AFCCA. There are promising trends noted in various regional police pilot programs regarding alternative response mechanisms that would be beneficial for families experiencing AFCCA, including mobile crisis units that are mental health focused vs. traditional police response and police pairing with social workers, particularly those that are youth-oriented.

Policy Recommendations

8.1 Provincial ministries responsible for child welfare/protection services should examine their policies to ensure they are focused on prioritizing supports and services aimed at family strengthening and preservation.

8.2 Provincial ministries responsible for child welfare/protection services should set out in policy that AFCCA is not in and of itself a child protection issue, but instead indicates a child/adolescent in need of treatment or coordinated service planning.

8.3 Provincial ministries responsible for child welfare/protection services should work to separate child protection services from adoption/post-adoption services to ensure that there is no conflict of interest.

8.4 Federal or provincial governments should establish a toll-free number, similar to a tele-health model, for families to access guidance during difficult times or should build on the capacity of existing services to ensure that these can provide the kind of supports and guidance that families experiencing AFCCA need.

8.5 Crisis phone lines that are likely to encounter individuals or families experiencing AFCCA should ensure that their responders have AFCCA awareness training and are trained in appropriate responses to families and/or youth experiencing a crisis due to AFCCA.

8.6 All levels of government responsible for policing and other emergency responders should ensure that capacity is built in its front-line responders for appropriate response to families experiencing a crisis due to AFCCA, emphasizing de-escalation and ensuring that interventions do not inappropriately entrench the youth in the criminal justice system.

8.7 Governing bodies (at the municipal, provincial, and federal levels) responsible for youth justice and policing should encourage collaboration between police, crown attorneys and should ensure that police officers, crown counsels, and probation officers consistently apply the principles established in the Youth Criminal Justice Act for available alternatives in order to avoid deeper entrenchment in the criminal justice system.

8.7.1 Diversion options, ie. both pre- and post-charge, or during community supervision, should include restorative justice approaches, recognizing the opportunities for community healing and family preservation inherent in such approaches. The framework being applied by the New Brunswick Department of Justice and Public Safety's Restorative Justice Working Group may be beneficial to consider for wider adoption and use in other jurisdictions.

Finding of the Consortium

The Consortium is aware that the financial impact on families experiencing AFCCA can be significant. This may be due to various reasons including but not limited to:

- The need to self-finance various services, including counselling, extended respite care (in home or out of home), alternative residential care, etc. that are either not funded by provincial or federal governments or with long untenable waitlists.

- The need to take time from work/business, and sometimes to leave the workforce altogether, to either provide care in the home, seek/coordinate services, or advocate for their children's complex needs.

- The costs associated with damage to property, housing, or essential living items, resulting from instances of AFCCA.

Currently a hodgepodge of financial or tax programmes are available to families, with significant variance province by province. Families spend an inordinate amount of time however researching the programmes, eligibility criteria, and navigating the administrative hurdles of program applications, intakes, and coordination.

Families find that the eligibility criteria for programs vary from program to program and are narrowly defined. Programs are short term in nature while families have needs over the long term. As well, families often find that civil servants or other personnel responsible for administering financial programs act as gatekeepers rather than facilitators.

Policy Recommendations

9.1 The federal and provincial governments should ensure that financial and tax programmes available to families will include families that experience AFCCA.

  9.1.1 Federal and provincial government should ensure that financial and tax programs are reviewed to remove administrative barriers to families so as to ensure better awareness, earlier access, and greater stability over time.

9.2 The federal government should review its eligibility criteria for Employment Insurance Caregiving Benefits programs to ensure financial supports are available to families experiencing AFCCA who need to leave the workforce.

9.3 The federal and provincial governments should ensure that civil servants and others involved in administration of financial programs have an awareness of AFCCA and deliver programs using an anti-stigma approach, with a view to family strengthening and preservation.

Finding of the Consortium

The Consortium has found that there are no clear pathways for families whose child is chronologically transitioning into adulthood. Too often, just as a family is beginning to finally implement a plan of care for their child/adolescent, the child has aged and is no longer eligible for programs in place for children and youth. They must start all over again navigating and advocating in the adult services sphere, where there is no recognition of the individual's long-standing needs, challenges, and/or disabilities.

For older youth in the care of child welfare services, they will frequently experience not only a complete lack of supports and services but also the lack of caring adults who can assist with navigation and advocacy.

The work currently underway in multiple Canadian provinces to move towards equitable standards or indicators of readiness to determine when a youth is ready to leave the child welfare system should be expanded and incorporated into the appropriate provincial legislations. The Consortium looks to the report "Equitable Standards for Transitions to Adulthood for Youth in Care", October 2021, for additional guidance from first-voice experts.

Policy Recommendations

10.1 Provincial ministries responsible for child/youth services, adult social services and health service should create clear pathways of care, with warm uninterrupted handoffs to appropriate and effective adult services.

  10.1.1 Families, caregivers and youth with direct lived experience should be involved in developing provincial pathways of care strategies

10.1.2 Families, caregivers and youth with direct lived experience should be fully involved in the development of individualized pathways of care specific to their needs

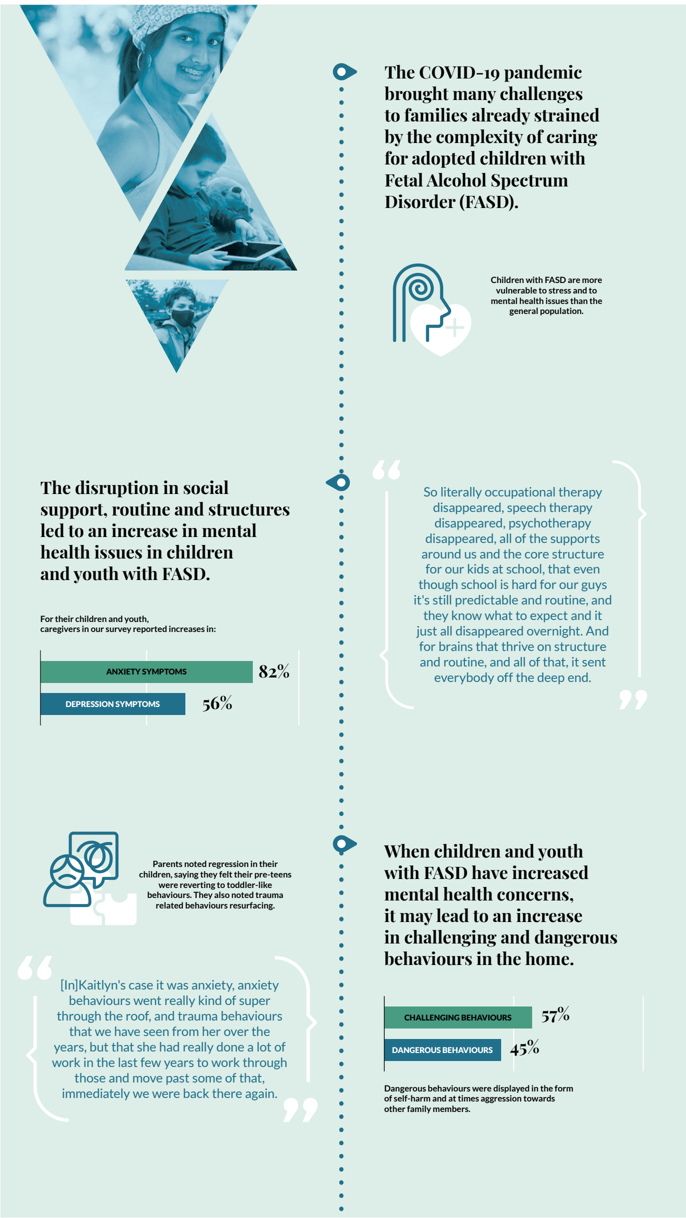
10.2 Provincial ministries responsible for child/youth services should work to ensure that the models currently being tested in certain provinces that use standards or indicators of readiness to determine when a youth is ready to leave the child welfare system should be expanded and incorporated into the appropriate provincial legislations.

10.3 Provincial ministries responsible for child/youth services should ensure that for children/youth exiting the child welfare system, navigation and advocacy supports are made available for as long as these are required.

Appendix D: Existing AFCCA Canadian Research Projects

These two Canadian research pieces of research were presented directly to the Consortium. Both researchers, Maude Champagne and Karine Tremblay, are also members of the Consortium.

Project: Responding to the COVID-19 pandemic challenges for families with children impacted by neurodevelopmental disorders



The COVID-19 pandemic brought many challenges to families already strained by the complexity of caring for adopted children with Fetal Alcohol Spectrum Disorder (FASD).

Children with FASD are more vulnerable to stress and to mental health issues than the general population.

The disruption in social support, routine and structures led to an increase in mental health issues in children and youth with FASD.

For their children and youth, caregivers in our survey reported increases in:

ANXIETY SYMPTOMS	82%
DEPRESSION SYMPTOMS	56%

> “So literally occupational therapy disappeared, speech therapy disappeared, psychotherapy disappeared, all of the supports around us and the core structure for our kids at school, that even though school is hard for our guys it's still predictable and routine, and they know what to expect and it just all disappeared overnight. And for brains that thrive on structure and routine, and all of that, it sent everybody off the deep end.”

Parents noted regression in their children, saying they felt their pre-teens were reverting to toddler-like behaviours. They also noted trauma related behaviours resurfacing.

> “[In]Kaitlyn's case it was anxiety, anxiety behaviours went really kind of super through the roof, and trauma behaviours that we have seen from her over the years, but that she had really done a lot of work in the last few years to work through those and move past some of that, immediately we were back there again.”

When children and youth with FASD have increased mental health concerns, it may lead to an increase in challenging and dangerous behaviours in the home.

CHALLENGING BEHAVIOURS	57%
DANGEROUS BEHAVIOURS	45%

Dangerous behaviours were displayed in the form of self-harm and at times aggression towards other family members.

Caregivers reported being exhausted by having to provide constant supervision and expressed a need for respite and mental health support.

Many caregivers reported increased symptoms of anxiety, depression and isolation during this time.

ANXIETY SYMPTOMS	71%
DEPRESSION SYMPTOMS	53%
FEELING OF ISOLATION	59%

Some caregivers even expressed they had experienced Post Traumatic Stress Disorder (PTSD) as a result of the difficult experiences they faced with their child.

> “I would say that for a child that has an attachment disorder, being at home with the family without relief from that... and without the ability to like... decompress, is just an extremely loaded situation.”

Caregivers also noted that the tumultuous environment also had an impact on other siblings in the home. In multiple cases, these siblings also have FASD, trauma and attachment injuries as part of their history.

The combination of all of these factors has led to placement instability in multiple cases.

It was noted that those caregivers with the highest reported frequency of dangerous behaviours in the home were also the ones who experienced placement instability for their child.

Recommendations

- Mobile crisis unit is an essential service for several families of children and youth with FASD.
- Enhanced support to address mental health needs of caregivers as well as of the children and youth.
- Provide resources for FASD-informed respite options that are accessible and safe during the COVID-19 pandemic as well as post-pandemic.
- Build awareness among first responders on de-escalation techniques and special concerns when dealing with youth with FASD during a crisis situation.
- Develop interventions to respond to the dangerous behaviours and aggression some children and youth may display during times of crisis to keep themselves and their loved ones safe.

Responding to the COVID-19 pandemic challenges for families with children impacted by neurodevelopmental disorders

Maude Champagne	Neuroscience PhD Student | Mitacs Intern
Dr James Reynolds	Principal Investigator
Rachel Willis	Neuroscience Student

“Retrieved from: https://kidsbrainhealth.ca/wp-content/uploads/2021/04/infography_challenges-covid-19_final-5.pdf”

Project: When adoptive parents experience a filial trauma with a child suffering from a developmental trauma

When adoptive parents experience a
Filial Trauma
with a child suffering from a developmental trauma

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Introduction

- Children that have experienced multiple traumas with their original caregiver are more likely to form a developmental trauma that affects several domains of impairment such as attachement, affect regulation, behavioral control, self-concept (Cook et al., 2005)
- Children placed in foster-to-adopt program arrive with a lot of traumatic baggage that will have an impact on the new parents who take care of him.
- Secondary trauma refers to physical, mental and emotional health issues experienced by a caregiver who engages empathically with their traumatized child and mirrors their symptoms of PTSD (Figley, 1995).

Socio-demographic characteristics of the sample	N	Mean (min-max)
Gender		
Women	9	
Men	1	
Average age (N=10)		50 (38-60)
Marital status		
In a relationship	7	
Separated/Divorced	2	
Single	1	
Educational Level		
Pre-University	1	
University	9	
Number of children per family (N=11)		2,5 (1-6)
Children's gender (N=11)		
Girl	3	
Boy	7	
Not known	1	
Average age at arrival in the family (N=11)		1,97 (0-4)
Average age at time of interview (N=11)		12,88 (7-17)

Research objective

The purpose of this study is to better understand the secondary trauma experience of parents who adopt a child with developmental trauma.

Method

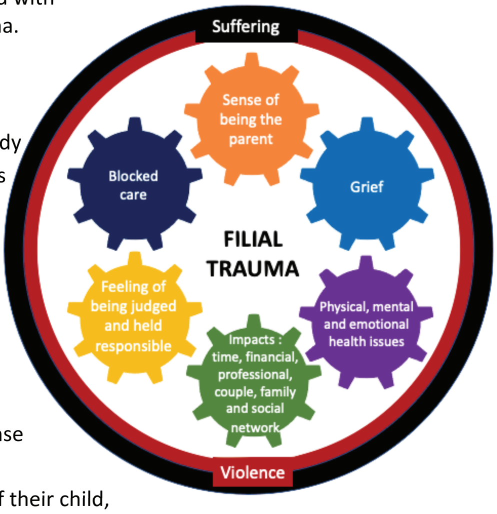
1. Exploratory qualitative study
2. Semi-structured interviews (1h30/3h)
3. N=10 Foster-to-adopt parents

Results

- Parents in the sample shared that they experienced a range of extreme emotions, physical and mental health problems associated with secondary trauma.
- They shared being rejected or assaulted by their child on a daily basis.
- **5 of the 10 families had to place their child in a rehabilitation center or hospital because of his challenging behaviors or aggression.**

Secondary trauma alone cannot account for the complexity and specificity of these parents' experience. They experience

Filial Trauma.



Discussion

- They have expressed difficult emotions that undermine their sense of being the parent of that child (Pagé, 2012)
- The parents we met, remained committed to being the parent of their child, but the daily suffering relating to the relationship, was extremely intense and difficult to withstand.
- This is what we called **Filial Trauma**.
- Filial trauma refers to multiple dimensions that are part of the gears of the wheel of suffering surrounding the parent-child relationship. They all turn in an inter-influential way.

Presented at the ICAR7 summer school session.

Tremblay, K. (2020). Du trauma secondaire au trauma de filiation : l'expérience de parents adoptifs d'un enfant présentant un trauma complexe, [From secondary trauma to filial trauma: the experience of adoptive parents of a child with developmental trauma],[Mémoire de maîtrise inédit, Université du Québec en Outaouais]. http://di.uqo.ca/id/eprint/1180/1/Tremblay_Karine_2020_memoire.pdf