Responding to Adolescent Violence in the Home

A Trauma-Informed and Evidence-Based Guide to Support Families

THE CENTRE FOR WOMEN & CO.

Specialist Domestic Violence & Women's Wellbeing Services

At The Centre for Women & Co., we recognise Aboriginal and Torres Strait Islander peoples as the First Peoples of this nation. We value and celebrate the uniqueness of knowledges, histories, languages and cultures that have been created for over 60,000 years. We pay respect to the Traditional Owners past, present and emerging, of the land which we work, including the Yugambeh, Jagera and Quadamooka peoples.

About us.

The Centre for Women & Co. is a specialist DFV and wellbeing service in Logan and the Redlands. Our services are currently funded by the Department of Justice and Attorney-General. We have been delivering services for the past 28 years.

About this guide.

Adolescent violence in the home (AVITH) has been recognised as a challenge due to the limited research available on intervention models and successful responses. This guide provides general information and examples of tools and activities that can be used by DFV practitioners or by other practitioners whose core business is impacted by DFV. It is requested that this guide be used with caution to follow Queensland's DFV Practice principles, standards and guidelines as well as protocols for multi-agency response and appropriate referral pathways. Queensland's DFV Services - DFV Practice principles, standards and guidance (2020) can be found via this link hwww.cyjma.qld.gov.au/resources/dcsyw/violence-prevention/dfv-practice-principles-guidelines.pdf.

Practitioners should look at a young person's behaviour and reactions through a safety and stability lens. When housing, safety or finances are unstable, it is extremely difficult for a young person not to be reactive to stimuli (perceived or real). Parents in these situations will also struggle to regulate their children due to their own trauma and instability. Furthermore, safety and stability must be achieved to some degree before any meaningful work can be commenced.

Legend.

The term 'young person' will be used to refer to anyone aged between 10 and 18 years who may be using violence and may be a victim-survivor of violence or abuse. The acronym 'AVITH' will be used to refer to adolescent violence in the home to cover the broad scope of violence at home used by young persons, such as parent-young person violence and sibling-young person violence.

Thank you.

Counsellors, Managers, Project Workers, Marketing, Comms & Engagement Team, and the Local Link Team at The Centre for Women & Co. Thank you to Dave Burck from YFS, co-author of 'Renew' and Side-by-Side Facilitator.

Overview.

The purpose of this guide is to assist practitioners who support young persons using violence in their home. Responses to AVITH in the home should focus on the harm minimisation strategies to ensure safety of the mother and other children in the home. For AVITH work to be practical and therapeutic, the parent using violence must not reside with the family.

Currently, there is no existing definition of AVITH (Moulds, Day, Mayshak, Mildred, & Miller, 2018). AVITH is described as a pattern of violent or abusive behaviour used by a young person within the family. Whilst most young persons using violence are male, The Royal Commission into Family Violence, 2016, acknowledges that AVITH is less gendered when compared to adult family violence.

AVITH is a unique form of family violence involving the parent-young person and sibling-young person relationships and is distinctive from intimate partner violence. The mother/carer is responsible for the young person, and thus, risk and responsibility are inexplicably linked.

Therapeutic approach.

AVITH responses should avoid labelling young persons as violent. This prevents recognition of their behaviour within a trauma response or through a trauma lens needed to support behaviour change. Young people healing from trauma need to move towards accountability for their violence and learn skills to support choosing behaviour free of violence. Practitioners can support the young person to be accountable for their use of violence whilst maintaining a trauma-informed approach (MARAM, 2020).

Responses and interventions for young peoples' use of violence should cover a range of areas: attachment, communication skills, parenting confidence, problem-solving skills and emotional regulation skills. Consideration should be given to provide support for any health and wellbeing needs, such as social/education engagement, learning issues, drug or alcohol misuse/abuse, mental health issues, or therapeutic responses to their experience of violence or abuse (MARAM, 2020). The primary focus should be on improving family relationships to prevent the use of violence.

Practitioners working with young people must be mindful of collusion (the conscious or unconscious alignment with pro-violence attitudes, beliefs and thinking). Collusion occurs when a practitioner implies that the use of violence is understandable or acceptable. Collusion can strengthen pro-violence risk factors and potentially worsen AVITH. Caution is essential where a practitioner works one-on-one with the young person without the parent/carer. Practitioners must challenge young people to work towards accountability and positive change (MARAM, 2020; Reimer, 2020). This can be done by validating the emotion but not the violent behaviour and regularly engaging with the supervisors for support (MARAM, 2020; Reimer, 2020).

Risk assessment.

Young person's risk assessment and management must consider age, developmental level, and individual circumstances and tailor therapeutic responses as required (MARAM, 2020). Currently, there is no AVITH-specific risk assessment tool available. However, an adolescent MARAM is in development. Screening questions have been included for practitioners to better understand what is happening in the home. Practitioners are reminded to refer to the DFV Common Risk and Safety Framework. When deciding whether to assess a young person directly, practitioners should consider whether it is safe, appropriate and reasonable.

Risk management should incorporate a therapeutic and holistic response that includes high-level collaboration between services. Young people may also be victims/survivors of family violence, and responses should consider their experiences. Services that engage with young people all have a role in supporting young persons and their families (MARAM, 2020).

When assessing AVITH, it is essential to determine if sibling violence is occurring. Violence against siblings and other children in the family home may be severe, including sexual abuse, and place those children at high risk. A survey of participants into AVITH by Monash University found that violence against siblings was often "dismissed as normal sibling behaviour, or minimised within the family due to feelings of shame and guilt" (Fitz-Gibbon, Elliot & Maher, 2018, p. 180). Support should be provided to the mother/carer to understand that violence against siblings can be harmful and that physical assault and emotional abuse are different from 'normal' sibling rivalry (MARAM, 2020).

Working with young people and trauma.

As cited in Nowakowski & Rowe (2015), van der Kolk et al. (2009) stresses that when children are exposed to trauma at home, they become distressed and unable to control their internal states. This can lead to feelings of helplessness. This feeling can teach children to move from fearful stimulus to fight/flight/freeze response, meaning they cannot learn from the experience. Children who have experienced adverse childhood experiences remain in a constant state of alarm even in times of rest and safety (Perry, 2006). When external pressures are introduced (such as a school task or a disagreement with a peer), a child who has experienced trauma becomes more reactive - even to minor stressors (Perry, 2006).

AVITH should be responded to differently than adult violence. Violence by a young person can result from trauma. Interventions that support young people who have experienced adverse childhood experiences are more likely to be successful if aimed at incorporating and enhancing attachment responses (Nowakowski-Sims & Rowe 2017). Three essential elements for delivering trauma-informed care should include developing safety, promoting healthy relationships, and teaching self-management and coping skills (van der Kolk & Courtios, 2005).

Responses.

AVITH interventions are often group programs whereby the parent and young person both attend the program. There is limited research on the efficacy of these programs and limited AVITH programs (Fitz-Gibbon, Elliot & Maher, 2018; McCulloch, Maher, Fitz-Gibbon, Segrave & Roffee, 2016). However, Holt (2016) argues that AVITH work requires nuanced approaches that allow workers to respond to the young person's unique history of both experiencing and using violence. A one-on-one approach in supporting young people with trauma and attachment issues may be practical (Holt, 2016).

Working with Aboriginal and Torres Strait Islander families.

This resource guide acknowledges the complexity of AVITH in Aboriginal and Torres Strait Islander communities. Specifically, the cause of violence must be considered in the context of broader colonial violence and intergeneration impact of dispossession, forced removal of children, the interruption of cultural practices, marginalisation and poverty. Working with Aboriginal and Torres Strait Islander families requires a holistic healing and family centred approach that involves the social, emotional and spiritual and cultural wellbeing of individuals and community (CSYW, 2020; Ourwatch, 2015; QMHC, 2016).

Other considerations.

There is growing research that while experiencing DFV is a significant contributor to intergenerational violence, mental health and drug and alcohol problems also contribute to AVITH (Douglas & Walsh, 2018). No one factor determines young people's use of violence. Emerging research indicates that aggressive behaviour is particularly prevalent among children with cognitive behaviour and developmental and Neuro-disability, including ADHD, ASD and Asperger's and ODD (Coogan, 2014; Douglas & Walsh, 2018). As cited in Burck, Walsh & Lynch (2019), Coogan (2018) warns that Neuro-disability and mental health diagnosis are not concrete causal factors for AVITH, rather a risk factor, again highlighting the complexity of AVITH.

Mothers/Carers.

The impact of AVITH on the health and wellbeing of families can include depression, high stress, and feelings of shame, sadness, powerlessness, isolation, frustration and anger (Coogan, 2014; Fitzgibbon, Elliot & Maher, 2018). Mothers who expressed shame and stigma surrounding AVITH were afraid that they would not be taken seriously or blamed for their child's behaviour if they spoke out (Miles & Condry, 2015). The shame, stigma and blame for mothers experiencing AVITH are exacerbated by the idea that it is their responsibility to manage and protect their children.

Often responses to AVITH encourage the mother/carer to put consequences in place. This places responsibility on the mother/carer for the violence she is experiencing and labels AVITH as a 'parenting problem'. This further strengthens the shame and guilt. Setting boundaries and consequences is challenging when the mother/carer is in an environment of undermining, coercion and control (Humphreys & Absler, 2011). Secondly, mothers/carers must not be tasked with setting boundaries that would place them at any risk. AVITH is far from a parenting issue, such comments from practitioners and agencies often only seek to further isolate the mother/carer from seeking support.

Screening questions.

On the right is a list of behaviours some young persons may use against their mother/carer or siblings. *This is not a risk assessment tool.* It may be beneficial to ascertain how frequent these behaviours are occurring in the home (Daily, Weekly, Monthly or Rarely).

As stated in the AVITH overview, practitioners should refer to the Queensland Common Risk and Safety Framework. The Family Violence Multi-Agency Risk Assessment and Management Framework Practice Guide is also helpful when assessing AVITH.

- Uses put-downs or name-calls.
- Uses intimidation to obtain wants or win arguments.
- Uses threatening looks.
- Screams or yells.
- Threatens to hurt/stands over.
- Pushes, grabs or shoves.
- Throws, kicks or breaks items.
- Has harmed or killed a pet.
- Uses demands or orders.
- Slaps, hits, kicks or punches.
- Threatens to or uses weapons.
- Attempts to strangle/choke.

Non-violence plan.

Practitioners may struggle to build and maintain rapport whilst also maintaining a trauma-informed approach and avoiding collusion. To address the violence as soon as possible without causing the young person to disengage, consider creating a non-violence plan. Start with general goals, then as rapport builds, move to more specific goals as part of the safety plan. There are several safety risks when working with young people. Young people may use violence towards mothers/carers or the practitioner in a session. Monitoring emotions and avoiding triggering or escalating situations is recommended.

Example of a non-violence plan for practitioners and the young person:

- Ask the young person what rules there needs to be for people to feel safe working together.
- Ask the young person to agree to this contract outside of sessions (at home).
- Discuss sharing this non-violence plan with the mother/carer.

This will give the young person and practitioners something to monitor in between sessions to ensure safety at home.

This is a basic example of a general non-violence plan developed during an initial session.

Plan:

1. Respectful communication - No put-downs or interruptions.
2. Safe space - No physical abuse towards others.
3. Be open-minded and non-judgmental.
4. The session may need to stop if people feel unsafe.

Behaviour that looks like anger.

Anger includes cognitive, affective and behavioural components. Anger can be experienced on a spectrum from annoyance to rage. For a young person, it is essential to differentiate the experience and expression of anger (Kerr & Schneider, 2008; Orygen, 2016).

Anger may help a person regulate other negative emotions that can be perceived as threatening or inappropriate. For example, if sadness is considered a sign of weakness, feelings of sadness may be regarded as intolerable through external or internal learnings. (Orygen, 2016). It's important to note that while the surface feeling might look like anger, the anger may be masking another feeling the young person has trouble understanding or feeling (ACF, 2013). Encourage the young person to find a way to describe their emotions. If appropriate, support them in mapping and identifying how they 'feel' anger throughout their body (Orygen, 2016).

Young people who have experienced trauma struggle to separate the past and present. Consequently, they may be triggered by smells and sounds that remind them of the trauma (ACF, 2013). These young people may be in a constant state of alarm and may be more reactive even when there is no present threat (Perry, 2006).

To support a young person who has experienced trauma or adversity with anxiety and difficult feelings, help them to:

- identify warning signs in the body,
- unpack events that trigger anger,
- learn ways to avoid such events,
- and manage the feeling of anger (deep breathing, visualisation, positive self-talk, grounding techniques).

Young people may experience feelings of shame when talking about anger. Practitioners should validate feelings, experiences and thought processes whilst avoiding collusion. The use of violence is not an anger problem and being responsible for the use of violence is part of the young person's recovery. Ask the young person to identify ways they currently manage their anger and explore areas of personal strength.

Instrumental violence and pro-violence beliefs.

Instrumental violence is a planned, calculated behaviour characterised by an absence of emotion (Flight & Forth, 2007; Calvete et al., 2014). When a child is exposed to aggressive behaviour, the child or young person learns that instrumental violence is a way to obtain goals (Routt and Anderson, 2011). This makes violence a powerful reinforcement for repeat behaviour (Routt and Anderson 2011).

Additionally, children may try and understand the reasons for the violence they witness in their home. They may try to rationalise a parent's violent behaviour to help them cope with the idea of that parent being imperfect. When these unhealthy attitudes or beliefs are not addressed, the child is potentially at risk for embracing an anti-social rationale for using violence (Holt, Buckley & Whelana, 2006). Children do not just witness aggression. Instead, they learn how aggression is functional in intimate relationships. As cited in Holt et al. (2006), Graham-Bermann, & Brescoll's (2000) research found a direct connection between a young person's beliefs of male privilege, the acceptance of violence in the family and the level of abuse the mothers experienced. Children and young people exposed to DFV in the household have a role model that reinforces pro-violence beliefs and behaviours (Fakunmojou & Rasool, 2018). This exposure to family violence can lead to males accepting violence towards women (Ibabe & Jaureguizar, 2010; Morris, Wrug & Windle, 2015). The acceptance of violence is a driver for violence against women (Ourwatch, 2015).

Young people who use instrumental violence know they will use violence when they ask the parent either for something or to do something. While a traumatic response may trigger violent behaviour, violence is maintained by pro-violence beliefs rather than negotiating. Work should assist young people in building self-regulation skills and challenging their belief systems about violence in relationships and their role in their relationships. By exploring their story, new space can open up to grow and learn (Sheehan, 1997). Improved balanced connectedness in the parent-child relationship may promote empathy and prosocial behaviour in young persons over time (Yoo, Feng & Day, 2013).

Self-regulation.

Self-regulation is the ability to withstand highly emotional reactions to upsetting stimuli and calm oneself, adjust to a change in expectations and manage feelings of frustration without an outburst.

Children develop foundational skills for self-regulation in the first five years of life (Williams, 2018). This period is critical for brain development. Self-regulation is related to school success, academic achievement and lifelong wellbeing.

Trauma impacts a person's capacity to regulate levels of arousal. As the first five years of life are critical for self-regulation, if trauma or adversity was experienced in this critical period, self-regulation might be impaired or unlearned (Williams, 2018).

Young people may be unable to self-regulate, which often leads to aggressive behaviour and correlates with insecure attachment styles (Nowakoski-Sims & Rowe, 2017 & Osbuth, Hennighausen, Brumairu & Lyons-Ruth, 2014). The disruption of the neural network development created by trauma compromises the ability to manage emotional states.

The field of restorative neurobiology has emphasised the positive impact of repetitive motor activity (Perry, 2009 & Siegel, 2013). Repetitive activities, including breathing, music, movement, drumming and mindfulness, can support and promote neural circuits associated with emotional regulation and resilience (Siegel, 2013; Perry, 2009; Williams, 2018).

Siegel (2013) identified that emotional regulation could be a violence prevention tool. Techniques that strengthen emotional regulation may provide a protective function to those caught in the cycle of abuse and reduce emotionally related aggression. Self-regulation can reduce rigid, impulsive and overemotional behaviours, as cited in Ford & Blaustein (2013).

Window of tolerance.

The 'Window of Tolerance' (WOT) is a zone where differing levels of emotional arousal can be processed without disrupting system function. Some people can operate within this zone despite intense feelings. For others, certain emotions like sadness or anger can be disruptive to functioning - even at mild emotional arousal. A person's behaviour can become disrupted if arousal moves beyond the window's boundaries (Seigel, 2012).

When someone is outside their WOT, their function becomes impaired as they move towards hyper-arousal or hypo-arousal. When outside the Window of Tolerance, emotions may flood the conscious awareness. This is often referred to as 'flooding' or 'hijacking'. Once outside the WOT, the nervous system moves into survival mode – fight, flight, freeze or fawn. People can either feel overwhelmed and go into hyper-arousal or can shut down and go into hypo-arousal. When someone is in a state of arousal, the brain's executive functioning goes offline in favour of the lower brain related to threat response, emotions, and coordination. At this time, people are less likely to think logically, with reasoning or about long term consequences (Farrel, 2019; Seigel, 2012). Those who have experienced trauma may have a narrower Window of Tolerance. Understandably, survival mode and related lower brain thinking may occur more easily or more often than those who have not experienced trauma. Thus, widening the WOT is key to the healing process.

Parents, teachers, and Counsellors can support young people to regulate by identifying and labelling feelings. Siegel refers to this as "name it to tame it". This process allows for understanding and validation for the young person. (Siegel & Payne-Bryson, 2011). Support for young people should be encouraged to focus mindfully on noticing how they feel, how their body feels and assisted in identifying what they can do to feel right again. Supporting the young person and parents with the new learnings of skills and strategies of the WOT can help promote self-regulation effectively.

A feelings thermometer might allow the young person to rate their feelings during the day or in a session. This assists in helping the young person, parents, and Counsellor identify when the young person is possibly moving outside their window of tolerance and move towards incorporating strategies and grounding techniques that can be used in their daily life. Assisting the mother/carer to understand their own WOT will also be beneficial as they can support their young person. Supporting mothers/carers with new learnings of skills and strategies on the WOT can help promote self-regulation for themselves and assist with co-regulating with their young person.

The brain.

Experiences in early childhood have disproportionate power in shaping the brain. 80% of the brain's significant structural changes have taken place by four years of age. The experiences that occur during this time have a disproportionate and considerable influence on the brain, whether positive or negative. Traumatic experiences can change the structure and function of key neural networks involved in regulating stress and arousal (Ludy-Dobson & Perry, 2010).

As the brain develops through genetics and experiences, the more particular events experienced, the stronger the neural pathways. Exposure to trauma during rapid brain growth often has a lasting neurodevelopmental impact and organisation of the brain (Taylor, 2013). Due to their developing brain, children and young people are particularly vulnerable to the effects of trauma. The impact depends on age, developmental stage, trauma, severity and duration (Bristow, MacNamara & Mitchell, 2020).

The fetus of a pregnant woman exposed to violence has increased cortisol levels as early as 17 weeks. Ongoing exposure to DFV can have severe implications for the unborn child's brain development Australian Child and Young person Trauma, Loss and Grief Network, 2016). The child's experiences will contribute to the emotional and conscious map of the child's developing mind (van der Kolk, 2014).

The associated trauma of family violence reduces the capacity of the childhood brain to shape in response to the environment. Consequently, children and young people impacted by trauma often respond instinctively and at times inappropriately. When a threat is perceived, these young people are less likely to think logically as their emotions take over (ACF, 2013; Bristow et al., 2020).

Young people who have experienced trauma do not easily understand or engage with consequences for their behaviour. Their brains are over-activated and can take in very little, and they do not learn new information easily. Their memory systems continue to remain under stress. This affects their working memory, whereby even simple instructions can be severely compromised (ACF, 2013).

The brain develops from the lower brain (the hindbrain) to the higher brain (the cortex). When children are constantly under threat, experiencing fear or feeling unsafe, they spend more than typical amounts of time in their lower brain - focusing only on survival. The brain forms new connections and strengthens established connections through activity. Therefore, if a young person is almost always operating from their lower brain, their executive function, logical thinking, and reasoning brain connections will be relatively underdeveloped compared to their lower brain functions. However, helping the young person understand the power and process of neuroplasticity can change their perception of their abilities.

Attachment.

Attachment serves as a foundation for subsequent affective, social, cognitive and behavioural development across the lifespan. For a secure attachment to develop affect attunement between parent and child is vital (Hughes, 2004).

Family violence can disrupt attachment, leaving children at risk for a fragmented sense of self and disorganised attachment (Hughes, 2004; Nowakowski-Sims & Row, 2017). Women experiencing DFV can unwittingly transmit fear to their children, which can result in disorganised attachment.

Young people who have disorganised attachment are at greater risk for interpersonal violence (Siegel, 2001). Many young people who use violence in the home may have formed disorganised attachment (Burck, 2020).

It is essential to acknowledge the challenge for mothers who have experienced DFV in being able to provide support and be attuned to their children's needs. The experience of DFV can have a detrimental effect on parenting and reduce emotional availability (Seigel, 2013; Smith, Belton, Cook, 2020). Promoting healing and connection with attachment-based interventions may explore new ways of relating between the mother and the young person. They can redefine their attachment by communicating thoughts and emotional states where possible and appropriate. This is crucial in developing secure attachment in young persons (Nowakowski-Sim & Rowe 2017; Dubois-Comtois et al., 2013). Practitioners must remember that this recovery work requires time and ongoing support.

Shame, blame & guilt.

Parents who experience AVITH identified secrecy, shame and blame as central to their experience (Holt & Redford, 2013; Holt, 2016; Fitzgibbon, Elliot & Maher, 2018). Studies found that women experiencing AVITH often blamed themselves for what was happening (Douglas & Walsh, 2018; Howard, 2012; Routt & Anderson, 2011). The shame, guilt, embarrassment and fear can prevent disclosure, leading to social isolation and lack of service engagement.

Victim blaming is often part of a woman's experience when experiencing DFV, though where AVITH is concerned, victim-blaming is often compounded by the presence of mother-blaming culture. Parenting styles, including permissive, inconsistent and authoritarian parenting, have been labelled as contributing factors to AVITH (Howard, 2011). However, this can be considered 'mother blaming' and does not acknowledge the impact that DFV has on mothering (Burck, Walsh & Lynch, 2019; Ulman & Straus, 2003). AVITH is far from a parenting issue. Mothers/carers experiencing AVITH often experience a pattern of behaviour where the young person seeks to exert control over the parent.

Violence thrives in silence and in isolation. Therefore, it is important that practitioners show compassion and empathy. Furthermore, encourage mothers/carers to reach out to others for empathetic responses to break the silence and break free from shame.

Communication.

The quality of communication between parents and the young person is significantly poorer than other non-abusive groups of young persons (Contreras and Cano, 2014). Verbal abuse used by a young person is damaging as it attacks rather than aims to resolve the issue (Eckstein, 2004). Verbal abuse escalates to physical or emotional abuse once the verbal abuse stops having the desired outcome (Oviedo, 2019).

Exploring and supporting improved communication styles of the young person can assist in further avoiding destructive forms of communication. Active listening skills, body language, assertive communication, and 'I' messages can help develop communication skills. Assisting the young person to improve their communication skills is part of a broader strategy that can be incorporated after the young person has developed safety planning and has started incorporating emotional regulation. Practitioners should explain the importance of healthy communication to mothers/carers as well.

Safety planning with the young person.

WHEN SAFETY PLANNING WITH A YOUNG PERSON, ALWAYS CONSIDER THE REQUIREMENTS OF YOUR ORGANISATION'S POLICIES AND PRACTICE FRAMEWORKS. YOU SHOULD ALWAYS CONSULT WITH YOUR SUPERVISOR TO ENSURE THE PLAN ALIGNS WITH YOUR ORGANISATIONAL REQUIREMENTS.

A young person's safety plan is generally shared with the mother/carer to support the young person to implement their safety plan. Permission is needed from the young person for this to occur.

A young person's safety plan might include:

- a list of contact numbers of agencies supporting the young person,
- a discussion of protective factors that the young person can continue to incorporate (e.g. identifying triggers early),
- a safe place for the young person to go if they feel they may progress to using violence,
- and named safe adult who can assist the young person and their contact details.

Discussion questions that may help to create a safety plan:

- Can you think of a time when you stepped away from an argument? What did you do?
- Did you find it helpful?
- Did you find it difficult?
- What have you found helpful in the past?
- What do you think is the reason for a safety plan?

Things to talk with the young person about the safety plan:

- The safety plan is not an excuse to leave the house or avoid something.
- Use the plan to incorporate some self-regulation strategies and think about how to deal with the problem.
- If the other person walks away, respect their time alone.
- After separation, return and make a plan with the other person about what to do next.

The young person and the person experiencing violence might decide

to put the conversation on hold due to being tired, upset or hungry. This is okay and likely a positive and necessary step to pause proceedings until there is more clarity and calmness. If the proceedings are paused, agree on a time when the conversation will be re-commenced.

Basic Example of Young Person's Safety Plan:

- I will pause and walk away when I notice…. (e.g. hurtful words, heart racing, flashes of heat).
- I will tell others ________ (insert codeword) when I need to take a time-out.
- What do I need from the adults around me?
- What other places can I go when I need to separate?
- While I am separated, I will use calming techniques (e.g. listening to music).
- I will chill out for _______ minutes until I feel calm and can be safe with myself and others.

When safety planning with the mother/carer, it's essential that the mother/carer understands that this does not mean that they are responsible for the use of violence by the young person, but it does acknowledge their contribution to the family safety (MARAM, 2020).

Safety planning with the mother/carer.

If a mother/carer is attending the service, a safety plan relevant to the mother/carer and other children in the house is required. Practitioners can refer to the Safety Planning Booklet available at www.centreforwomen.org.au.

Part of the mother/carers safety plan will be learning to identify when their young person has been triggered or is escalating. Support mothers/carers to recognise the warning signs. This will help the mother/carer to know when to separate. The earlier the escalating behaviour is detected, the easier it is to separate from the young person.

Warning signs:

Body Signs: facial expressions, moving closer, pacing, red face.

Verbal signs: raised voice, pressured voice, put-downs, criticism, swearing, name-calling.

Actions: slamming doors, throwing objects.

It might be helpful for the parent to identify how they are feeling when this is happening. This can help the mother/carer avoid getting caught up in the escalation. Acknowledge the mother/carer's difficulty calling the police for assistance when the young person is using violence - safety is the priority. Explore the possibility of a 'cool off' time. This can provide the mother/carer with respite. In the State of QLD, police cannot issue DVO for AVITH when the young person is under 18 years of age.

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