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An Evaluation of Two CAPVA Programme Models Across Three London Boroughs:

Executive Summary

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This report presents findings from an independent evaluation of Child and Adolescent to Parent Violence and Abuse (CAPVA) programmes funded by the London Violence Reduction Unit across Merton, Enfield, and Haringey. The evaluation examines programme implementation, family outcomes, and system-level changes to inform future commissioning and practice development.

Key Findings at a Glance

- **The relationship is the intervention.** Parents consistently identified the quality of their relationship with practitioners, not specific techniques, as the critical factor in positive change.
- **Reductions in violence were reported by parents who engaged with the programmes.** Physical violence showed the most substantial improvements. Eight of nine parents interviewed described reductions in violence, with families moving from 'warzone' conditions to calm.
- **Young people were not directly engaged by either programme model.** The reasons are complex: high referral thresholds meant that by the time families accessed support, children often presented with significant complexity and many already had multiple professionals involved, making additional CAPVA-specific direct work potentially duplicative or inappropriate.
- **Neurodivergence and CAPVA are deeply intertwined.** Practitioners across all boroughs identified neurodevelopmental conditions as present in the majority of their CAPVA caseloads.
- **Earlier intervention is needed.** Both programme models operated primarily with families already at statutory thresholds.
- **System gaps persist despite programme investment.** Transitions to adulthood, cultural responsiveness, and multi-agency coordination remain challenging.

Note on Scope and Limitations

This evaluation was undertaken during a pilot phase across two developing delivery models. The evaluation commenced approximately 16 months into programme delivery, meaning some families had already completed their intervention before data collection began. The evaluation sample is smaller than the number of families reached by the programmes, reflecting the sensitive nature of CAPVA, programme design features including eligibility thresholds and referral pathway restrictions, and the complexity of families' circumstances. Engagement challenges are treated as significant findings in their own right throughout the full report.

This evaluation is exploratory in nature, drawing on small samples: 11 parent survey respondents (with 4 matched pre-post pairs), 9 in-depth parent interviews, 30 practitioner survey responses at baseline and 22 at end-point, and 6 professional roundtable sessions (32 participants at baseline, 23 at end-point). Findings should be interpreted with appropriate caution regarding generalisability. However, the consistency of themes across multiple data sources strengthens confidence in the key messages.

Background and Context

Child and adolescent to parent violence and abuse (CAPVA) represents a complex and historically overlooked form of family harm. This small-scale pilot was designed to generate learning that could be adopted across London, with the evaluation taking a developmental rather than comparative orientation to understand how each approach functions within its specific local context. Following a comprehensive needs assessment published by the London Violence Reduction Unit (VRU) in April 2022, the VRU funded pioneering two-year

programmes in three boroughs (Merton, Enfield and Haringey) to strengthen local responses.

The VRU identified three primary objectives: reduce violence and abuse within the family home; repair familial relationships and improve feelings of safety; and improve system and partnership responses locally. This evaluation, conducted by Equality Collabs between October 2024 and November 2025, examines both programme implementation and impact.

The Two Programme Models

Merton's In-House Integrated Model (CAPHB)

Operating with a £100,000 annual budget, Merton embedded their Child and Adolescent to Parent Harmful Behaviour (CAPHB) programme within Children's Services. The model features a CAPHB Practitioner working jointly with families' lead caseworkers, alongside a part-time Development Lead focusing on the workforce. The approach is relationship-based, trauma-informed and flexible, delivering short-term interventions lasting up to 16 weeks.

Programme reach: 77 referrals received; just over half (40 of 77, 52%) did not meet the programme's strict eligibility criteria. Of the 37 eligible families, 32 (86%) engaged with the programme, though 14 subsequently disengaged due to a range of personal reasons. At the evaluation end-point, 11 had completed the intervention and 7 remained in support

Enfield and Haringey's NVR-Based Partnership Model

Operating with £261,836 combined annual funding, this provider-led model partnered with RISE Mutual CIC to deliver structured Non-Violent Resistance (NVR) interventions for families with young people aged 10-17. In practice, the intervention operated as a parent-focused programme. The model included dedicated CAPVA practitioners (1.8 FTE) supported by borough-based Champions (2 FTE total), offering up to 20 sessions over approximately 6 months. A fortnightly Risk and Practice Group coordinated responses to complex cases.

Programme reach: 103 referrals received; 51 (50%) closed prior to assessment. Of the 52 who completed suitability assessments, 36 started the intervention and 30 (83%) completed. The majority of attrition occurred before families engaged with specialist practitioners.

Programme Outcomes and Family Impact

Reductions in Violence and Harm

Physical violence showed the most substantial reductions. Eight of nine parents interviewed described dramatic decreases in violent incidents, with families moving from crisis conditions and multiple police call-outs to stability. Across the survey samples, minor injuries reduced from six parents reporting them to two, and specific behaviours such as pushing reduced from seven parents to three. Parents with matched pre-post data corroborated these patterns. Practitioners reported that several edge-of-care cases had been prevented from family breakdown following intervention.

Improvements in Safety and Family Wellbeing

Parents reported improvements across multiple dimensions of family wellbeing. All nine parents interviewed described transformation from shame, fear and self-doubt to confidence and self-compassion. Parents reported enhanced feelings of safety, improved family relationships across cohesion, expressiveness and conflict dimensions, and substantially increased parenting confidence.

What Made Interventions Effective

All nine parents interviewed unanimously identified the quality of their relationship with programme facilitators as the critical success factor – more important than the specific intervention model or techniques. Parents consistently contrasted the warm, non-judgmental approach of CAPVA practitioners with previous experiences of statutory services. Specific NVR techniques – particularly de-escalation and strategic withdrawal – were valued for providing practical tools parents could implement immediately. Programme accessibility was strong, with rapid access and flexible delivery.

Barriers to Effectiveness and Unmet Needs

The absence of direct work with young people was the most frequently identified gap – no young people received direct support through the specialist CAPVA interventions during the evaluation period. Programme duration (ranging from approximately 3-6 months) was insufficient for families with complex needs, and lack of follow-up support was problematic. Interventions often arrived too late, after substantial escalation. Families presented with complex, intersecting needs – trauma, bereavement, domestic abuse, care system involvement – requiring longer-term, more flexible support models.

System-Level Change and Professional Development

Professional Knowledge, Skills and Confidence

By the evaluation end-point, all practitioners reported either 'good' (59%) or 'very good' (41%) understanding of CAPVA – a substantial improvement from baseline where only 17% reported 'very good' understanding. Confidence in identifying CAPVA improved, with 41% feeling 'extremely confident' (up from 20% at baseline). Specialist CAPVA support was selected by 100% of practitioners at end-point as an intervention strategy (up from 87%). Professional roundtables revealed a notable narrative shift from viewing parents as 'difficult' or 'non-engaging' to empathetic understanding of the barriers parents face when experiencing violence from their children.

Identifying and Responding to 'High Risk' CAPVA

Confidence in identifying high-risk cases improved, with 23% feeling ‘extremely confident’ at end-point (up from 7% at baseline). Practitioners developed more refined definitions of high-risk presentations, identifying six key characteristics: severe and escalating violence; parental fear and loss of control; coercive and controlling behaviours; complex family and environmental factors; wider safety concerns; and frequent agency involvement. However, practitioners consistently ranked having an assessment tool for identifying cases as their top priority, a gap addressed in the Systemic Gaps section below.

Multi-Agency Working and the CAPVA Champion Role

Multi-agency collaborative working showed meaningful progress, with 41% reporting multiple successful experiences at end-point (compared to 10% at baseline). However, 32% had not yet experienced successful cross-sector collaboration. The CAPVA Champion role was evaluated positively by 76% of practitioners, most effective in raising awareness (86%), improving case identification (67%), and supporting referrals (62%). However, practitioners identified inconsistent access and limited capacity as key limitations, reflecting high demand outstripping pilot-level funding.

Systemic Gaps and Areas Requiring Further Attention

Engaging Young People Directly

The absence of direct young person engagement through the specialist CAPVA interventions across all three boroughs is a significant implementation finding. Parents consistently identified this as the primary gap in provision. High referral thresholds selected for the most complex cases where young people's needs – including neurodevelopmental conditions, trauma histories, and resistance to services – made direct engagement particularly challenging. This represents a critical gap for future programme development.

CAPVA and Neurodevelopmental Needs

The overwhelming majority of children in families accessing CAPVA support had diagnosed or suspected neurodevelopmental differences – only one of eleven children in the survey sample had no developmental, learning or mental health difficulties. Practitioners expressed limited confidence in working with neurodivergent young people, with only 9% feeling 'extremely confident'. Merton's deliberate integration with SEND support services demonstrated successful potential for addressing this intersection. The intersection of CAPVA with autism in adolescent Black males, compounded by structural racism and single parenthood, was highlighted as requiring particularly tailored support.

Minoritised Communities and Transitions to Adulthood

Persistent challenges remain in working with minoritised communities, including language barriers, distrust of services stemming from discrimination, and service design not adequately adapted for diverse communities. Recognition of unique challenges for 16-25 year-olds increased from 61% to 85% of practitioners. Families described a 'cliff edge' where statutory services withdrew at age 18 despite ongoing risk, with practitioners concerned about violence patterns carrying forward into adult relationships.

Risk Assessment Frameworks

Practitioners consistently ranked having an assessment tool for identifying high-risk cases as their top priority. Current tools like the Domestic Abuse, Stalking and Harassment (DASH) risk assessment were frequently described as not fit for purpose for CAPVA, representing a significant practice gap requiring development of CAPVA-specific frameworks.

Conclusion

This evaluation demonstrates both the progress achieved in strengthening responses to CAPVA and the challenges that remain. The pioneering work undertaken by Merton, Enfield,

and Haringey has successfully raised awareness, built practitioner capacity, established specialist pathways, and delivered meaningful improvements for families. When families access appropriate support, positive changes are possible – attributable not to any single therapeutic model but to the quality of relationships that skilled, non-judgmental practitioners built with families.

However, areas require attention: the inability to engage young people directly; challenges accessing support before crisis point; the intersection of CAPVA with neurodevelopmental needs; the lack of fit-for-purpose risk assessment frameworks; transitions to adulthood; and barriers faced by diverse communities. The two distinct models both demonstrated valuable strengths whilst facing similar challenges, suggesting that fundamental ingredients for success transcend organisational arrangements.

With sustained investment and commitment to addressing the gaps identified, there is real potential to transform how families experiencing CAPVA access the support they need and deserve.

Recommendations

The evaluation identified 19 evidence-based recommendations organised into strategic commissioning priorities and operational practice improvements. Each recommendation in the full report includes detailed rationale drawn from evaluation evidence.

Strategic and Systems-Level Recommendations

For VRU, local authority commissioners and senior leaders:

1. **Sustain and expand CAPVA provision with adequate resourcing.** Commission continued services beyond pilot funding with increased capacity. Funding should reflect realistic caseload sizes that enable relationship-building.
2. **Develop young person-centred CAPVA pathways.** Commission dedicated support for young people using harmful behaviours, including youth-focused therapeutic interventions, peer support and mentoring programmes, and age-appropriate engagement approaches.
3. **Integrate CAPVA commissioning with SEND and neurodevelopmental pathways.** Develop formal service integration between CAPVA interventions, child development centres and CAMHS through joint protocols and shared case management.
4. **Establish developmental funding models aligned with programme maturation.** Move from short-term pilot funding towards 3-5 year development funding recognising mobilisation (years 1-2) and consolidation phases (years 3-5).
5. **Commission early intervention and prevention-focused CAPVA services.** Develop lower-threshold support accessible before families reach social care involvement, expanding eligibility beyond cases with allocated social workers.
6. **Establish dedicated CAPVA support for transitions to adulthood (16-25).** Commission developmentally-appropriate interventions bridging child and adult services, ensuring services don't create 'cliff edge' at age 18.
7. **Develop pan-London CAPVA data collection framework.** Establish consistent data collection enabling prevalence tracking, service demand mapping, outcomes monitoring, and identification of equity gaps.

8. **Invest in culturally-specific CAPVA provision.** Commission services delivered by organisations rooted in minoritised communities, with culturally-adapted models, multilingual delivery, and community-based settings.

Practice and Operational Recommendations

For CAPVA service providers, local authority practice leads and frontline practitioners:

9. **Extend programme duration and develop follow-up protocols.** Move from standard programmes to flexible, longer interventions for complex cases, with 3-6 month follow-up contact to provide booster sessions and prevent re-escalation.
10. **Establish long-term outcome tracking mechanisms.** Develop systems to monitor family outcomes 6-12 months post-intervention through low-burden methods.
11. **Prioritise relational practice in recruitment, training and supervision.** Recruit practitioners for relational skills; provide training on building validating relationships; structure supervision to address compassion fatigue; ensure caseloads enable relationship-building.
12. **Develop comprehensive CAPVA toolkit and practice resources.** Create accessible toolkit including case scenarios, de-escalation strategies, approaches for neurodivergent young people, cultural competence guidance, risk assessment frameworks, and transition planning tools.
13. **Establish risk assessment and safety planning frameworks.** Develop standardised tools for identifying 'high risk' CAPVA, safety planning with families, threshold guidance, and managing cases where brief intervention has limits.
14. **Strengthen multi-agency case management for high-risk CAPVA.** Establish or strengthen dedicated CAPVA multi-agency panels with representation from all relevant services, formal escalation protocols, and information-sharing agreements.
15. **Expand CAPVA Champion capacity and accessibility.** Increase Champion capacity to enable regular consultation availability, presence across all service areas, training delivery, and complex case support.
16. **Adapt interventions for neurodivergent young people.** Develop specific guidance and training for adapting approaches for autistic young people, working with ADHD, and collaborating with SEND services.
17. **Embed culturally-responsive practice.** Provide cultural competence training addressing power dynamics; ensure access to high-quality interpreting services; develop culturally-adapted materials; create partnerships with community organisations.
18. **Embed research and evaluation engagement approaches that reduce shame and build trust.** Introduce evaluation at programme entry; create warm handovers; minimise repeated requests to revisit trauma; frame CAPVA support as addressing systemic issues.
19. **Integrate CAPVA awareness into universal and targeted services.** Deliver training to schools, primary care, youth services, housing, and domestic abuse services, enabling earlier identification and appropriate referrals.

Next Steps for London Local Authorities

For local authorities considering implementing or developing CAPVA programmes:

- **Invest in facilitator quality over model purity**. Relational quality matters more than the specific intervention model.
- **Plan for complexity from the outset**. Most families have intersecting needs including neurodevelopmental differences, trauma, and socioeconomic challenges.
- **Build in young person engagement**. Current models are incomplete without direct support for young people.
- **Allow adequate time for implementation**. Effective development requires longer than typical pilot funding periods.
- **Address workforce sustainability**. High turnover undermines knowledge-building.