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DOMESTIC VIOLENCE IN A CHILD WELFARE CONTEXT: INTERPERSONAL VIOLENCE, POVERTY, AND THEIR LINK TO PARENTING ABILITIES

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DOMESTIC VIOLENCE IN A CHILD WELFARE CONTEXT: INTERPERSONAL VIOLENCE, POVERTY, AND THEIR LINK TO PARENTING ABILITIES

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Abstract

The current study examined the prevalence of co-occurring woman abuse and poverty in a sample of mothers from the Children's Aid Society of London/Middlesex. This study sought to determine the extent to which domestic violence and poverty influence the parenting abilities of single mothers by examining parenting capacity scores on the Ontario Risk Assessment Model (ORAM). The findings indicated that poverty compromised the parenting abilities of mothers in this sample. This study challenged current literature on domestic violence and parenting, which emphasizes deficiencies in the parenting of women who are experiencing abuse, by indicating that survivors of domestic violence may be compensating for the abuse they are experiencing. Furthermore, co-occurring poverty and violence was not subject to a cumulative negative effect on parenting. Implications of the findings for both practitioners and policy makers in the fields of domestic violence, child welfare, and social assistance are discussed.

Keywords: Domestic violence, Woman Abuse, Poverty, Child Welfare, Parenting Abilities

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Introduction

Numerous studies are now noting the negative effects that child maltreatment can have on the long-term well-being and functioning of an individual that extends well into their adult years. As children, victims of maltreatment will manifest different maladaptive behaviours that vary as a function of the type of abuse they experience (Hurley, Chiodo, Leschied, & Whitehead, 2003). Further, research suggests that there is considerable overlap in the effects of the different forms of abuse (Chiodo, Leschied, Whitehead, & Hurley, 2005). Due to the aversive outcomes that result from maltreatment, many abused children tend to have difficulties relating to and associating with their school-aged peers. This difficulty is compounded by the fact that child abuse and neglect may inhibit the socio-emotional development of children. The inability to develop at an age-appropriate rate interferes with these children's ability to properly interpret the emotions and intentions of their peers, as well as appropriately regulate and express their own emotions (Rogosch, Cicchetti, & Aber, 1995). In general, child maltreatment disrupts the otherwise progressive pattern of development in children, causing disruptions in virtually all spheres of life including their emotional, intellectual, and social development, which can lead to any combination of emotional and/or behavioural disorders in childhood and later into adulthood (Wolfe, 1999).

While child maltreatment and child neglect are well documented and thoroughly researched, studies linking child maltreatment to woman abuse and interpersonal violence within the context of the home environment have only come to the forefront of the academic community within the past decade (Edleson, 1999). The proliferation of research in this field has resulted in the acknowledgement that the link between exposure

to violence and its effects on children is more complex than originally thought (Carlson, 2000). Furthermore, research is now beginning to address the specific mechanisms through which woman abuse is connected to child maltreatment. One of the main issues with linking these two phenomena in the past has been an acknowledgment that services created to address domestic violence were intended to meet the needs of women, and not necessarily their children (McKay, 1994). Conversely, child welfare services were created to meet the needs of children, and not necessarily their mothers. Perhaps the most significant problem resulting from the fragmentation of services is the fact that there appears to be a relatively limited picture of the overlap between child maltreatment and woman abuse occurring in the same families (Edleson, 1999). While it is known that co-occurring exposure to domestic violence and child maltreatment is increasingly bringing families to the attention of child welfare services, less is understood about the caregivers who are exposed to domestic violence and who are involved with the child welfare system (Kohl, Edleson, English, & Barth, 2005). The need for the development of services that link woman abuse and child welfare is becoming more apparent as studies are emerging citing the prevalence of both types of abuse in the lives of children and the negative effects they have on a child's functioning (Carlson, 2000).

The present study examined the prevalence of co-occurring woman abuse and child maltreatment in a sample of mothers and children involved with the child welfare system. Specifically, this study sought to determine the extent to which domestic violence is influencing the parenting abilities of single mothers by examining the experiences of survivors of domestic violence as compared to the experiences of those not experiencing violence who are also being served within the child welfare system. The following

review of the literature provides a context for the current study by outlining how woman abuse appears to be related to child maltreatment, the effects of exposure to domestic violence on children, the child welfare authorities' responses to survivors of woman abuse, woman abuse and its link to poverty, and finally, woman abuse and its impact on parenting abilities.

Literature Review

Domestic Violence in a Child Welfare Context

While the province of Ontario does not currently consider exposure to woman abuse and inter-parental violence as a primary reason for admission into the care of a child welfare agency, the literature clearly shows the negative effects of exposure to partner violence on children. What is also clear in the literature is the prevalence of co-occurring exposure to violence for mother and child (Leschied, Chiodo, Whitehead, & Hurley, 2006; Mbilinyi, Edleson, Hagemeister & Beeman, 2007; Rodger & Leschied, 2008). In a review of the literature, Edleson (1999) found that, "the majority of studies reviewed indicate that in 30% to 60% of families where either child maltreatment or adult domestic violence is occurring one will find that the other form of violence is also being perpetrated" (p.136). The examination of exposure to domestic violence in the context of child protection agencies is of particular relevance because it is known that children who are victims of co-occurring violence are at a higher risk for becoming either victims or perpetrators of violence in adulthood (Osofsky, 2003).

One of the reasons cited for co-occurring domestic violence and child maltreatment suggests that woman and children are often hurt while trying to protect each other from their abuser (Mbilinyi et al., 2007). With regards to domestic violence and

neglect, Hartley (2004) found a significant number of families with more severe domestic violence occurring in the home to have confirmed allegations of a lack of supervision. This may be due in part to the multiple stressors that survivors of woman abuse face on a daily basis and their inability to cope with the demands of parenting given the traumatic nature of the abuse many of them are coincidentally enduring within their homes.

McKay (1994) cited five possible reasons why battered women themselves can become abusive or neglectful towards their children. These include: their attempts to give their full attention to the batterer in an attempt to control the violence in the home; that some battered women may prefer to discipline the children because they view themselves as more in control of their anger and frustration than the batterer; some women may over-discipline their children in an attempt to control the children's behaviour and in turn protect them from more severe punishment from the abuser; and/or the woman's anger and frustration with her own abuse may combine with the stress of parenting and set the stage for the maltreatment of their children.

Exposure to Domestic Violence and its Effects on Children

In general, trauma experienced during childhood is known to have particularly deleterious effects on the development of children. Of particular concern is that of prolonged or repeated trauma in childhood, as it "forms and deforms the personality" (Herman, 1997, p. 96). Living in a world where caretakers are supposed to keep them safe from harm, childhood trauma eventually forces children to protect themselves with their underdeveloped psychological defences. Children, like adults, are known to develop coping mechanisms that allow them to adapt to their environments and survive in a world that is unpredictable and unsafe for them. The difference between coping mechanisms

developed in adulthood and those developed in childhood is that childhood trauma alters the neurodevelopmental course and functioning of a child's developing brain (Perry, 2001). Specifically, Perry states that children experience neurophysiological adaptations to the fear they experience during prolonged or repeated trauma that eventually alters the development of a child's brain "resulting in changes in physiological, emotional, behavioural, cognitive and social functioning" (p.4). Children and youth who suffer childhood trauma are known to exhibit problems with emotion regulation, somatic complaints, sleep disturbances, anxiety, depression, dissociative responses, chronic hypervigilance, recreational drug and alcohol use, and compulsive sexual behaviour, to name a few (Herman, 1997).

While a child's response to their exposure to domestic violence may vary by age, gender, and family dynamics for example, children exposed to woman abuse tend to exhibit similar symptoms and behavioural problems as children exposed to other forms of child maltreatment (Echlin & Marshall, 1995). Specifically, children exposed to domestic violence may show immediate signs of emotional distress, anxiety, and anger; short-term reactions such as difficulty relating to peers, anxiety and/or depression, and aggression or conduct problems; and long-term adjustment problems related to depression, reduced self-esteem and violence/aggression towards dating partners in adolescence and adulthood (Carlson, 2000). Furthermore, violence occurring in childhood has also been associated with poor school performance, feelings of personal guilt for the violence that is occurring between their parents, self-harming behaviours, psychosomatic complaints, sleep disturbances, bedwetting, and over-eating, to name a few (Astbury, Atkinson, Duke, Easteal, Kurrie, Tait, et al., 2000).

Negative outcomes are more likely seen in children who experience both child maltreatment and exposure to woman abuse as opposed to those children exposed to only one form of violence (Osofsky, 2003). Bourassa (2007) indicates that youth exposed to both types of abuse in the home exhibited externalizing behaviours, as evidenced by delinquent or aggressive behaviours, significantly more frequently than those exposed exclusively to inter-parental violence. Similarly, Spilsbury, Belliston, Drotar, Drinkard, Kretschmar, Creeden, et al. (2007) found that child co-victimization increased the odds of children reaching significant levels of trauma as compared to those who witnessed domestic violence alone. Furthermore, children have been found to be at higher risk for developing more health problems when they are both physically abused and exposed to domestic violence (Graham-Bermann & Seng, 2005).

There is a growing body of research outlining the effects that child maltreatment and exposure to domestic violence can have on youth violence and other externalizing behaviours exhibited in adolescence. Fagan (2005) looked specifically at abuse occurring during adolescence. The researcher examined involvement in crimes such as general offending, drug use, and later intimate partner violence for individuals in adolescence, those transitioning to adulthood, and those in early adulthood. Results indicate a highly significant relationship between adolescent physical abuse and all types of criminal activity committed during all three time-periods. As compared to non-victims, victims of adolescent abuse reported double to triple the frequency of offending in adolescence and the transition to adulthood. Furthermore, in relation to the literature on family stressors in the home and its effect on children, results indicate that the frequency of offending is moderated by the family's income, place of residence, and family structure. Specifically,

rates of offences during adolescence are greatest for victims living in low-income, urban, single-parent homes. This study illustrates, not only the effects that abuse occurring during adolescence can have on adolescent behaviours, but also the ways in which externalizing behaviours exhibited during adolescence carry on into adulthood. Results from this study indicating increased use of illicit drugs following physical child maltreatment are echoed in the findings of another study which found that physically abused youth were four times more likely than sexually abused or neglected youth to report moderate/high substance use (Wall & Kohl, 2007).

Similarly, Fang and Corso (2007) found that child maltreatment and neglect were significant predictors of youth violence perpetration for both males and females, although results were more significant for males. Much like Fagan (2005), these researchers found that poverty, low educational levels, and living in high-crime areas significantly increases the likelihood of adolescents perpetrating violent offences. Furthermore, in relation to males, results indicate that physical child maltreatment has a significant effect on their perpetration of intimate partner violence.

Family Stressors and Dependence on Social Assistance

There is a substantial body of research indicating that families that are in receipt of social assistance are more likely to come into contact with child protection agencies (Leschied et al., 2006). However what is less certain is whether or not this link is due to actual economic factors, reporting biases, and/or a combination of the two factors (Berger, 2005). Based on data from a national U.S. survey on family violence, Berger reported that families with incomes that were between 100 and 200% below poverty cut-off are significantly more likely to engage in physical abuse. This finding was

particularly salient when examining a group of single-parent families, wherein families with incomes below 200% of the poverty line were more likely to engage in physical maltreatment as compared to those single-parent families with higher incomes. In general, the link between child maltreatment and poverty has been attributed to mechanisms such as the possession of fewer resources that enable parents to provide adequate levels of care for their children by way of shelter, food, clothing, education, and health care; poverty may make parenting more difficult due to the stressors associated with living below the poverty line; and/or higher overall levels of stress may result in harsher parenting (McGuinness & Schneider, 2007).

A recent study published by Scaramella, Neppl, Ontai & Conger (2008) evaluated the effects that economic hardship had on the behavioural adjustment of subsequent generations. Findings from this study suggested that socioeconomic hardships experienced during adolescence may place the following generation at risk for behavioural problems. Specifically, these authors found that experiencing poverty in adolescence places these youths at greater risk for becoming parents in adolescence as well. Findings also suggest that younger adolescent parents were found to use harsher disciplinary tactics with their young children, which tended to lead to more externalizing behavioural problems among these children. In turn, greater levels of externalized behaviours were associated with harsher parenting in subsequent years for these adolescent parents. This study points to the long-term effects of poverty and the intergenerational transmission of these negative effects.

Herrenkohl & Herrenkohl (2007) published a longitudinal study focusing on the overlap and predictive factors involved with multiple forms of child maltreatment and

family violence in general. These authors found a strong association between different types of abuse (physical, sexual, neglect, and exposure to domestic violence) and stressors such as family conflict, personal problems, and external constraints on the family. They also found that in general, child maltreatment was predictive of internalizing and externalizing behaviours in adolescence. The authors acknowledge that stressors may exist in the family which impede the development of positive family functioning and which in turn may even increase the likelihood of child maltreatment. Their major finding however indicated that the lasting, adverse effects found in adolescence by way of internalizing and externalizing behaviours appear to be linked to the victimization itself.

Some of the major stressors outlined by these authors were insufficient income, parental unemployment, and problems with housing. These are findings echoed in other research that has related family coping to poverty. Findings indicate that one of the major factors associated with outcomes and child welfare services revolves around the increased number of families that are dependent on social assistance (Leschied, Chiodo, Whitehead, & Hurley, 2006). Driscoll & Moore (1999) conducted a study examining the effects of welfare on children by analyzing the relationship between welfare dependency and child outcomes. Their major findings indicate that the *fact* of dependence on social assistance has greater consequences than the *amount of time* a family remains dependent on social assistance. This is related to these author's other major finding which indicates that there is a considerable difference between children whose families have been in receipt of social assistance and those who have not. This difference is related to the experience of being on social assistance itself and may stem specifically from stigma, the

negative effect of welfare on the mother by way of motivation, depression, and self-esteem, and in general, factors that lead the family to become dependent in the first place. Therefore, this study points to the need for a focus on the contextual factors that lead to dependence on social assistance. Driscoll, et al. (1999) also found that in general, children with histories of dependence on social assistance reported consistently higher scores on the Behaviour Problems Index (BPI) and specifically, that long-term poverty was significantly associated with higher scores on the BPI.

Responses of Child Welfare Authorities to Survivors of Abuse

According to Mills (2000), the child welfare system is fraught with biases and assumptions when it comes to the assessment of domestic violence in child protection cases. In addition to biases involving income levels among parents involved in a child welfare context, Mills cites that most child welfare workers believe that a battered woman has a duty to protect her children and as such they may actually be judged more harshly by child protection workers than her abusive partner. "Under these circumstances, the mother is not only a victim, but is also held liable for the violence" (p.200). As such, there has been a great deal of tension documented between child welfare and domestic violence agencies (Friend, 2000). Given that mothers are often viewed as the primary caregivers responsible for the well-being and safety of their children, part of the discord between the two groups of service providers may be at least partially explained by the fact that most survivors of domestic violence are regarded as resistant and reluctant to address the violence in the home because they are not coming to the attention of child welfare authorities voluntarily in seeking assistance with issues of domestic violence (Landsman & Hartley, 2007).

The removal of children from the home by child welfare services too often serves to further re-victimize the mother who is viewed as responsible for both her own abuse as well as that of her children due mainly to her inability to both protect herself and also to be an effective parent (McKay, 1994). As such, little or no responsibility is placed on the perpetrator of the abuse, who in effect is failing to protect the children from his own acts of violence (Echlin & Marshall, 1995). As far as the development of policies and practices is concerned, constructing males as perpetrators and offenders, combined with a failure to acknowledge their identities as fathers, there are serious consequences that result from not recognizing these men as 'domestically violent fathers' (Featherstone & Peckover, 2007). This is important if policies are to be developed that both ensure the safety of women and children, as well as improve the involvement of men in the lives of their children.

Domestic Violence and its Impact on Survivors

In general, research in the field of domestic violence has shown that there is a link between woman abuse and heightened levels of depression, trauma symptomatology, self-harming behaviours, and suicide attempts among survivors (Humphreys & Thiara, 2003). Specifically, survivors of domestic violence have been found to be at greater risk for current poor health, substance use, depressive symptoms, developing a chronic disease, as well as chronic mental illness and injury (Coker, Davis, Arias, Desai, Sanderson, Brandt, et al., 2002).

Depressive symptoms have been said to affect a woman's ability to establish and maintain supportive relationships (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008). Furthermore, these authors cite that depression can affect general abilities to perform

day-to-day tasks, parent their children effectively and maintain their physical appearance. As symptoms of PTSD begin to emerge with many women experiencing violence, so too does an emerging inability to be self-sufficient and independent (Helfrich, et al., 2008). In an analysis of data compiled from women living in a shelter, these authors found that as compared to the general U.S. population, these women had greater occurrences of sadness or anxiety, as well as major depression. Furthermore, these women reported higher levels of fear and phobias, higher levels of obsessive-compulsive disorder, as well as experiencing higher levels of bi-polar disorder than the general population. The women in this study also reported higher levels of mental or emotional problems that interfered with their ability to function at school, work, or manage daily activities in general. Their results also reveal that these women are experiencing psychological symptoms that impact their social functioning. This finding indicates that women who are survivors of intimate partner violence are suffering from symptoms that prevent them from maintaining friendships and interacting with others effectively in social environments.

Women experiencing domestic violence in essence begin to lose their ability to keep themselves and their children safe. This reflects what is known about PTSD symptomatology and the ways in which it can alter an individual's ability to function and process information (Herman, 1997). Also, women are noted to isolate themselves socially due to depressive and other psychological symptoms. This inability to process information and stay connected to those who may offer support may also lead to a decrease in a woman's ability to parent her children in a way that ensures the best possible outcomes for her and her children.

Impact of Domestic Violence on Parenting Abilities

The link between domestic violence and child maltreatment is evidenced in findings by Woodward & Fergusson (2002). In general, the results of their longitudinal study showed that families characterized by high levels of physical punishment against children also had high levels of marital conflict and inter-parental violence. In fact, according to these authors, inter-parental violence was one of the five key risk factors predicting child physical maltreatment. According to Sidebotham & Heron (2006), while there may not necessarily be a causal relationship between domestic violence and child maltreatment, the relationship between them may be due more to underlying risk factors that are common to both. Specifically, these authors cite socio-economic factors and parental background as risk factors that may be common to both domestic violence and child maltreatment. As such, these authors believe that domestic violence should be seen as an adverse outcome just as much as it should be seen a risk factor for child maltreatment.

Given the interconnectedness of woman abuse and child maltreatment, it is apparent that this is an area of research that is in need of further development. With only a few studies examining the effects of domestic violence on parenting, what has been reported is that in general, physical and psychological abuse of women by their intimate partners negatively affects a woman's parenting capabilities by way of creating stress in parenting (Levendosky & Graham-Bermann, 2001). Specifically, these authors found that the effects of domestic violence on parenting are mediated by the effects that domestic violence has on their psychological well-being and marital satisfaction. Similarly, by way of self-report, parenting effectiveness appears to decrease when high levels of

psychological distress are present as a result of experiencing domestic violence (Levendosky, Huth-Bocks, Shapiro, & Semel, 2003). Furthermore, it appears that mothers of children exposed to domestic violence are suffering from a range of stressors and complications such as higher levels of depression, achieve less education, do not access available social supports, are represented by lower socio-economic status, and live in homes with higher levels of household dysfunctions (Letourneau, Fedick, & Willms, 2007). Consistent with the literature on domestic violence and post-traumatic symptomatology, it appears as though women who are suffering from psychological distress stemming from the abuse are also suffering from impairments to their parenting abilities due to the trauma they have suffered.

With regards to a woman's parenting style, it has been found that domestic violence plays a significant role in predicting parenting warmth as evidenced by the degree to which a mother is supportive of their child, enjoys spending time with their child, and is positive towards the child. (Levendosky & Graham-Bermann, 2000). These authors suggest that chronic abuse may in fact be depleting the mothers' abilities to provide emotional support to others. Furthermore, findings from this study indicate that in families where mothers are psychologically abused, children are likely to take on the characteristics of the male abuser when interacting with their mothers, as evidenced by antisocial behaviours. The authors suggest that mothers who adopt a more authoritarian parenting style as evidenced by higher levels of control and lower levels of warmth, may be doing so to protect their children from the potentially damaging effects of living in high-risk families that have higher levels of poverty and violence. Letourneau, Fedick, & Willms (2007) found similar results with mothers of children exposed to domestic

violence showing lower levels of positive discipline, warm and nurturing parenting, and consistent parenting as compared to mothers of children not exposed to domestic violence. Furthermore, these authors found that mothers of children exposed to domestic violence show a greater increase in positive discipline and less of a decrease in warmth and nurturing as their children age, as compared to other mothers. This finding supports Levendosky & Graham-Bermann's (2000) belief that mothers who are survivors of woman abuse will tend to compensate for the abuse their children witnessed by being more attentive towards them.

Applying Relational-Cultural Theory (RCT) (Comstock, Hammer, Strentzsch, Cannon, Parsons & Salazar, 2008) to this finding, it is proposed that women who experience violence may be connecting with their children as a means by which to build resiliency in the interconnectedness and healing that can take place for individuals involved in growth-fostering relationships. Since RCT is based on the assumption that the experiences of isolation, oppression, disempowerment, marginalization, and shame may be counterbalanced by the presence of connections on the individual, familial, and societal levels (Comstock, 2008), perhaps survivors of domestic violence are connecting with their children as way to protect themselves and their children from the negative effects of trauma and abuse. It should be noted however, that positive parenting and warmth, are negatively affected by the presence of depressive symptoms, as the woman may have little time, energy, patience, and attention to devote to these more demanding types of parenting if she is preoccupied with violence in the home (Letourneau, et al., 2007).

Due to the aversive effects that woman abuse can have on parenting, findings from these studies indicate a need to remove the abuser from the family environment in order to protect the women and children involved (Levendosky & Graham-Bermann, 2000). The problem with this notion is that too often, women who are battered do not see themselves as being capable of parenting alone without a strong, male role model for their children. This may be one of the primary reasons many of these women choose to remain in abusive relationships. As a society, we have internalized beliefs that a family headed by a single female is somehow broken, deficient or abnormal (Bilinkoff, 1995). According to Bilinkoff, women are often taught by society that they are primarily responsible for the success or failure of intimate relationships and of their families. This is especially true of survivors of domestic violence, as the perpetrators often blame the women for the abuse they are enduring. As such, promoting the empowerment of women and their ability to parent is a complex issue.

The complexity of being able to separate the factors that may be contributing to negative parenting styles is further compounded when one examines attachment styles to explain some of the mechanisms that may be underlying child maltreatment committed by a survivor of domestic violence. It is known that primary attachment styles can determine the propensity for engaging in violence towards a child by way of affect regulation (Alexander & Warner, 2003). In other words, the ability to engage in abusive behaviours is affected by a parent's ability to regulate their emotions, self-soothe, and process strong emotions when parenting.

Some women may be contending with additional concerns when it comes to parenting that makes it difficult for them to fathom a world where they are to parent alone

(Bilinkoff, 1995). First, women may struggle to control their children's behaviours by way of rules and regulations because they may view it as controlling and coercive in the same way that they saw their partner's exercise of control as abusive. Many women may see control of their children's behaviours as an imposition of their will and may associate their control over their children's behaviours with the control they suffered at the hands of their partner. Second, some women may buy into the notion that they have to make up for the absence of the father figure by over-indulging their children, whether or not she can afford to do so. Third, the woman may begin to inappropriately confide in and use the children for support. Due to the isolation she has suffered from the abuser, children often become confidants and tend to act as buffers for the lack of social support in the woman's life. Lastly, mothers who are survivors of domestic violence tend to perceive similarities between their children and their fathers, with a particular association between abusive fathers and their male children. The above noted concerns need to be navigated through and explored if a survivor of woman abuse is to be a successful sole parent with a clearer and more balanced view of her life and future with her children.

Domestic Violence and Welfare Dependence

Given what is known about the links between domestic violence and child maltreatment, and also given that a high percentage of the families coming to the attention of child welfare authorities are dependent on social assistance (Leschied, et al., 2006), the link between domestic violence and low socio-economic status warrants examination. Studies examining this link indicate that the high prevalence rates of domestic violence among welfare recipients may be due to factors such as domestic violence acting as a barrier to a recipient's ability to obtain and maintain employment;

abusers may be interfering with a woman's ability to work either by way of injury or by preventing their partner from going to work; and domestic violence and its effects on survivors both physically and psychologically may be interfering with a woman's ability to engage in activities that promote self-sufficiency such as job searching or job training (Tolman & Rosen, 2001). Furthermore, these authors state that the link between poverty and domestic violence may be partially due to the fact that women often have to decide between staying with an abusive partner and leaving, with leaving often resulting in homelessness, utility shut-off, and food insufficiency. In this sample of welfare recipients, the authors found high prevalence rates of recent and lifetime domestic violence among participants. Furthermore, they also found that women living in greater poverty and who had less than a high school education were more likely to have health problems. The authors cite traumatic symptoms resulting from domestic violence as the reason for the increased rates of health problems among these welfare recipients. In turn, these health problems appear to be acting as barriers to achieving economic self-sufficiency by way of obtaining permanent employment.

The health problems and barriers to employment that can result from victimization can also compromise a woman's ability to remain in compliance with regulations and participation requirements outlined by many social assistance programs. If prevented from seeking and maintaining employment or job training opportunities, many women risk losing their benefits and as such may remain trapped in the abuse they are trying to escape (Tolman & Raphael, 2000). This is of particular concern since the same authors state that studies outlining prevalence rates of domestic violence among welfare recipients are higher than rates for women in the general public. Tolman and

Rafael state that "domestic violence may limit the terms and conditions of employment, its duration, or its sustainability, rather than employment itself" (p.679). In other words, more problematic than an abusive partner's control over whether a woman works or not is their control over where she obtains employment, who they are in contact with at work, and how long they maintain employment, all of which relate to how much money a woman is able to make at her job and therefore, how long she is dependent on assistance.

Poverty and Parenting

The literature in this field indicates that poverty in general has negative effects on the functioning and well-being of a family. Recent research is beginning to focus more on the ways in which families appear to function well despite all of the hardships and challenges that are known to coincide with living in poverty (Raver & Leadbeater, 1999). This shift in focus can be attributed to the knowledge that not all families living in poverty are investigated by child welfare authorities for abuse or neglect (Lee & Goerge, 1999). These authors state that instead of being attributable to poverty itself, perhaps child maltreatment can be attributed to some of the underlying factors that can be associated with living below the poverty line. According to these authors it may be that parents living in poverty, feeling frustrated by their situation, develop a sense of inadequacy which can in turn lead to depressive symptoms and some of the social isolation outlined above. These factors then may be leading to abuse and neglect by way of feelings of futility and a lack of social supports to buffer the effects of depression.

Similarly, a recent study by Kiernan & Huerta (2008) indicates that maternal depression is associated with a reduced ability on the mother's part to engage in positive and supportive interactions with her child. Specifically, maternal depression was found to

be most noticeably associated with harsher disciplinary practices, such as hitting and shouting. The authors note that these findings may potentially be mediated by the presence of social and community supports available to mothers exhibiting depressive symptoms. The presence of family or spousal conflict may also be mediating these relationships.

In general, while it is known that economic hardships can cause emotional and psychological distress for parents that can affect their ability to effectively parent their children, factors such as self-efficacy and social supports have been said to counteract these effects (Raikes & Thompson, 2005). For these authors, self-efficacy affects the levels of stress that parents feel as a result of financial hardships due to the fact that those high in self-efficacy will have higher expectations for success and a greater sense of adequacy when it comes to parenting. Their findings indicate that family income alone does not determine parental stress, but instead it is best explained by examining how psychological resources such as self-efficacy and social support modify the effects of low income on parental stress. It may be that parents who are higher in self-efficacy are better able to deal with environmental stressors and are therefore better able to deal with the stresses associated with parenting. Age of the mother also appears to be mediating the effects of poverty on a woman's ability to parent. A child born to a very young mother who also lives in an area of high poverty levels appears to be at a higher risk for substantiated reports of child maltreatment than those who are born to an older mother or one who lives in an area with lower poverty rates (Lee & Goerge, 1999).

Maternal History of Abuse and its Link to Parenting Abilities

In the literature, mothers with their own history of childhood abuse are often seen as being a part of an intergenerational cycle of violence wherein they often either maltreat their own children or become victims themselves and therefore increase the odds their children will become perpetrators due to the violence they have witnessed (Moehler, Biringen & Poustka, 2007). According to Attachment theory, parent-child relations can lead to changes in how an individual interprets the acts of others and regulates their affect (Alexander & Warner, 2003). According to these authors, childhood maltreatment can lead to the development of an insecure adult who can later display symptoms that range from depression and anxiety to PTSD, all of which can affect a person's ability to relate to others, regulate their affect and interpret the emotions of others correctly. These factors can be said to later affect a person's ability to properly parent their child due to their deficits in interpreting the emotions of others, their inability to communicate effectively with others, and their inability to control their own emotions.

According to a finding by Sidebotham & Heron (2006), parents with a history of abuse in their own childhood were almost twice as likely to be investigated and registered by child welfare authorities than those without a childhood history of abuse. These authors also indicated that there may be factors that are mediating the effects of parental history of abuse. Mainly, they indicate that the impact of a parent's childhood history of abuse is mediated by its effects on parent's educational level, psychiatric history, economic influences, and parental age.

These findings are echoed by Levendosky & Graham-Bermann (2001) and Leschied, Chiodo, Hurley and Whitehead (2005). These authors found that a maternal

history of abuse was a significant predictor of maternal psychological functioning, as were negative life events and a lack of social supports. It appears as though women who have been traumatized early in life may be carrying a vulnerability into adulthood which makes them more susceptible to domestic violence and the psychological reactions that are associated with it, thus affecting their ability to parent effectively.

Woodward & Fergusson (2002) found that the youth in their study who reported higher levels of physical punishment at the hands of their mothers were more likely to have been raised by a mother who had experienced relationship difficulties with her own mother during adolescence. Furthermore, the mothers who were exposed to higher levels of parental strictness during their own childhood reported using more severe physical punishment methods when parenting their children. Specifically, these authors indicate that their results point to a psychological profile for mothers who may be at highest risk for perpetrating violence towards their children, with young women who have a personal history of abuse and who entered motherhood at an early age being at the greatest risk. Furthermore, parenting a behaviourally difficult child in a dysfunctional family environment where there are high levels of inter-parental violence also increases the risk for perpetration of violence in these women.

Given the negative effects that domestic violence can have on the psychological well-being of women survivors and the development of the children who witness it, the following questions warrant further examination in the current data set collected from the Children's Aid Society: Does domestic violence influence a mother's ability to effectively parent her children? And, do poverty levels affect her ability to parent effectively? Furthermore, given the overlap and interrelatedness of child maltreatment

and family stressors: Is maternal dependence on social assistance related to parenting capacity if there is co-occurring domestic violence in the home?

The current study involves the secondary use of data to explore the link between domestic violence and parenting abilities. Of primary concern for the present study is the overlap and interrelatedness of child maltreatment, family stressors, and the intergenerational nature of child maltreatment. Drawing from studies outlining the effects of dependence on social assistance and the behavioural problems exhibited by youths and adults that have been maltreated, this study seeks to examine whether or not domestic violence and poverty influence a woman's ability to effectively parent her child(ren).

Given the intergenerational nature of child abuse and the fact that single mothers are facing additional challenges by way of their own mental health and lack of economic stability, it is evident that this is a subset of the population in great need of interventions. By honing in on the challenges caregivers are facing, such as poverty and current levels of domestic victimization, a more accurate picture of the specific effects and antecedents of childhood maltreatment can be depicted. Ultimately, studies like the present one under consideration will hopefully contribute to the body of knowledge used to formulate effective intervention programs. The purpose of the present study is to examine the links between woman abuse, dependence on social assistance, and the ability to effectively parent children in light of the challenges many women are facing. Furthermore, this study seeks to contribute to the body of knowledge that links poverty to negative child outcomes and the possible contributing factors that may link domestic violence to poverty and a history of abuse.

The following hypotheses are outlined in light of what is known about the effects of domestic violence and poverty on a woman's ability to parent her children:

Hypothesis 1. Compared to those not experiencing violence, women who are survivors of domestic violence will have poorer parenting capacities as evidenced by parenting scores on the Ontario Risk Assessment Model (ORAM).

Hypothesis 2. Compared to women who are not dependent on social assistance, women who are dependent on social assistance will have poorer parenting capacities as evidenced by parenting scores on the Ontario Risk Assessment Model (ORAM).

Hypothesis 3. Women who are survivors of domestic violence and who are dependent on social assistance will have poorer parenting capacities than women who are affected by only one or neither of these factors.

Hypothesis 4. A greater proportion of children who are Crown Wards will have a mother who is on social assistance and/or is a survivor of domestic violence.

Hypothesis 5. Women who have higher parenting capacity scores on the ORAM will demonstrate a greater severity of violence as evidenced by higher scores on the cumulative risk assessment tool.

Hypothesis 6. Survivors of domestic violence who are on social assistance will have a greater severity of violence in the home than survivors who are not on social assistance as evidenced by higher scores on the cumulative risk assessment tool.

Method

Participants

This study reviewed a subset of files from an original sample of 2,316 child protection cases drawn from 1995 and 2001 and collected from the Children's Aid

Society (CAS) of London and Middlesex County. The subsequent sample represents a proportionate random sampling of the original population of cases. This sampling resulted in 1041 cases examined from the London CAS.

Cases selected for analysis for the current study had the following information available: records related to dependence on social assistance; information on the levels of domestic violence in the home; a cumulative risk assessment score on the Ontario Risk Assessment Model (ORAM); a parenting capacity score drawn from the ORAM; and information on the type and severity of child maltreatment. Since the present study sought to examine the parenting abilities of women in the sample, only files where the mother was identified as the primary caregiver in the home (n = 850) were selected to investigate the hypotheses.

Sample Characteristics

An examination of the 1041 cases revealed that 29% of the cases involved a child who was in the care of the CAS, having been formally removed from the home. Forty-four percent of the children received some form of service while remaining in their home. The remaining 27% were out of care and not receiving any ongoing services from the CAS. The length of CAS involvement with the family was less than one month in 20% of the cases, which referred to the length of time the family of the child under study had been in contact with the CAS from the point of first contact to the date of the most intrusive or intensive intervention. The length of involvement ranged from under one month to 431 months ($M = 66.42$, $SD = 72.15$).

Family Status. Approximately 37% of the children were from single-parent households. Further, almost 82% of the cases involved the child's mother as the primary

and sole caregiver at the time of CAS' initial inquiry. In only 10% of the cases was the father the primary caregiver. The low percentage of single fathers in the sample points to the need to examine the needs and concerns of women as primary caregivers. The majority of cases involved a young mother parenting a very young child at the time of initial contact with CAS. Most often, the child under investigation was under the age of one year (12%) at the time the case was opened. Overall, 41% of the children were under the age of 5 years (M=7.23, SD = 4.99). On average, the children in the sample were parented by a mother who was between the ages of 19 and 23 (M = 23.83, SD = 5.61) years of age. Approximately half of the children in the sample were female (51%).

The majority of mothers were of Canadian/French Canadian origin (82%), with the remainder of the sample composed mainly of mothers from Native Canadian (8%) and European descent (4%). Twenty-five percent of the caregivers had a history of prior involvement with CAS both as a child and as a parent, with 31% of the biological mothers involved with the CAS as children. Twenty-four percent of this sub-sample had been Crown Wards and 17% had been placed in Foster Care, reflecting a high maternal history of childhood maltreatment and prior involvement with CAS for this group of mothers.

Maltreatment Histories. Based on the Ministry's Risk Assessment protocol, an examination of risk as it relates to the child and their family by type of maltreatment was completed. Results indicate that for neglect, 39% of the sample was assessed as being at intermediate (12.4%), moderately high (11.8%), or high risk (14.8%). For family violence, 44% were assessed as being at intermediate (20.2%), moderately high (18.2%), or high risk (5.4%). Family violence was defined as substantiated cases of maltreatment

(physical abuse, sexual abuse, neglect, or exposure to violence in the home), violence against the mother, or a combination of maltreatment towards the mother and child (Leschied, et al., 2006). In 53% of the cases, physical or sexual violence was identified as being directed from the parent to the youth under study. In regards to woman abuse and violence in the home, spousal violence was identified as being an issue in the life of the family in 50% of the cases. Specifically, 19% of the children in the study were exposed to some form of domestic violence in the home. These cases included those witnessing excessive arguing, verbal abuse, physical assaults, psychological abuse, or sexual abuse on the part of the woman's current partner (Chiodo, et al., 2005). In 31% of the cases, children were concurrently exposed to violence as well as physically victimized. Some of these findings appear to be higher than a recent national study (Black, Trocme, Fallon, & MacLaurin, 2008) reporting Canadian prevalence rates of 34% of cases involving some form of domestic violence; 25% of substantiated cases involving exposure to domestic violence; and 9% involving co-occurring exposure to domestic violence and another from of maltreatment (versus 50%, 19%, and 31% in the present sample). Overall, results indicated that 73% of the sample had experienced some form of violence in the home, whether in the form of direct victimization, as a result of exposure alone, or as a combination of the two forms of victimization.

Economic Data. An examination of employment status revealed that 45% of the sample was unemployed. Forty-six percent of the sample was on some form of social assistance at the time of referral. Sixty-two per cent of these individuals were identified as being in receipt of Welfare or Ontario Works, while the remaining 38% were on a more long-term form of social assistance such as a disability pension from the Canada

Pension Plan (CPP), or the Ontario Disability Support Program (ODSP). Twenty-five percent of the sample was also identified as having been homeless at some period throughout their lives.

Mental Health Status of Caregivers. In addition to contending with poverty and dependence on social assistance, 29% of the sample was identified as having a primary caregiver who had been formally diagnosed with a major mental health disorder. In cases where a formal diagnosis could be identified, Depression/Anxiety was the most prevalent diagnosis with 48% of these individuals having been formally diagnosed by a medical doctor. Substance abuse and other major mental health disorders were found in 24% and 28%, respectively, of the sample where a formal diagnosis could be identified.

Children's Mental Health Status. In regards to the children's mental health, 30% of the children in the sample had prior involvement with a children's mental health service. Seventy percent of this identified sub-sample of children had received some form of counselling, while the remaining 30% were identified as having received some form of inpatient or residential care. While only 8% of the families/children in the sample were found to be on a waiting list for another family service or agency, it should be noted that 80% of these cases were found to be waiting for receipt of a children's mental health service.

Cases in the sample were also assessed to determine if the child under study had ever demonstrated a behavioural, psychological, or physiological concern. Twenty-six percent of the children in the sample where a primary concern could be identified from information in the file were exhibiting behavioural concerns as evidenced by a formal diagnosis, or an observation made by a health professional (e.g. social worker).

Furthermore, 25% of the children in the sample identified as having had prior contact with a children's service had been involved with the young offender system. In cases where there had been a prior disposition, 40% had been involved with probation, 15% had spent time in an open custody setting, and 10% of these youths had been in a closed custody facility.

Materials

Children in Care Data Retrieval Instrument. A standardized coding instrument was designed by previous investigators (Leschied et al., 2006). The instrument included 111 items that outlined a family's current and historical mental health, violence, level of involvement with the agency, and access to social services. The instrument also outlined the children's past and present access to mental health services, involvement with youth corrections, and their psychological, behavioural and academic functioning. A manual was created by the principal investigators outlining the inclusionary and exclusionary criteria for information drawn from the case files.

Ontario Risk Assessment Model (ORAM). The ORAM was developed by the Ontario Association of Children's Aid Societies as a way to standardize information to assess risk at the time of referral (Leschied et al.). The ORAM is used by child protection workers when completing a risk analysis for each child upon referral. The risk assessment instrument consists of five assessment categories or *influences* related to; the child, caregiver, family, abuse/neglect, and intervention. Within each of these influences are risk *elements*. The ORAM consists of 22 risk elements in total. Each element includes five scales of severity ranging from zero (0) to four (4) (Leschied et al.). The current study also made use of a 'cumulative risk assessment score' which is not part of the Risk

Assessment used by Ontario CASs. The cumulative risk assessment score reflects the total score of the 22 individual risk elements described above (Leschied et al.). Each element is assessed on a scale of zero (0) to four (4) with zero being the absence of risk and four being maximum severity. Cumulative risk assessment scores can therefore range between 0 and 88 (Leschied et al.).

Procedure

Consent to access files was given by the Child Welfare Authority acting in *loco parentis*. Information was drawn from case files by a team of trained, supervised researchers in order to enhance reliability. All file reviews were conducted at the CASs to protect the privacy and confidentiality of those whose files were selected for review. Information drawn from case files was coded using the instrument designed by the previous investigators. The current study made use of secondary data in which individual identifiers had been removed. Appropriate inferential statistics were applied relevant to the hypotheses tested so that appropriate conclusions from the data could be drawn.

A subset of files from a sample of 2,316 child protection cases from 1995 and 2001 collected from the Children's Aid Society (CAS) of London and Middlesex County were analyzed. Data were analyzed from two points in time to allow for comparisons that might illustrate factors contributing to understanding potential changes in the children coming into care. In order to compensate for the fact that random sampling cannot guarantee that the combined sample drawn from two time periods will be representative of the proportion of children seen at CAS, the data were weighted so that the final sample contained the same proportion of children taken into care for each year from which they were drawn.

Severity of violence was assessed using the participant's cumulative risk assessment score on the ORAM. The parental capacity score was assessed using the risk assessment scores drawn from the ORAM. Specifically, the parenting capacity score was calculated by adding items CG1, CG2, CG3, CG4, CG5, CG6, I1, and I2 on the ORAM (see Appendix B for a description of each of the items related to parenting capacity). Maltreatment type, which is also used to illustrate severity of violence, and the caregiver's employment status/reliance on social assistance was drawn from the case files and recorded in the data collection instrument. The presence of violence in the home was also drawn from information on the ORAM and was rated from low to high risk based on whether there was the presence of verbal aggression (moderately low risk), isolation and intimidation/threats to harm (intermediate risk), incidents of physical violence in the home/imbalance of power and control (moderately high risk), and repeated or serious physical violence in the family (high risk).

Results

The purpose of the present study was to examine the links between woman abuse and the ability to effectively parent children in light of the challenges that many female survivors of violence face. Primarily, this study sought to examine the relationship between mothers' experiences of violence and how factors such as dependence on social assistance influence their parenting abilities. Hypotheses tested were based on the notion that the lower the parenting capacity scores were on the ORAM, the less a woman's ability to parent had been compromised by the effects of poverty, domestic violence, or a combination of the two. Similarly, higher cumulative risk assessment scores were

indicative of a greater severity of violence in the home and therefore a greater likelihood that a woman's ability to effectively parent her children may have been compromised.

Impact of Domestic Violence

The first hypothesis assessed a mother's ability to parent if there was domestic violence present in the life of the family. Given that spousal violence was identified as being an issue in the life of the family in 50% of the cases, it was hypothesized that women who are survivors of domestic violence will have poorer parenting capacities as compared to their non-abused counterparts due to the victimization they are contending with. A one-way ANOVA was used to test for statistical significance. An examination of the mother's parenting capacity scores did reveal that, although not significantly different [$F(1, 848) = 3.083, p > .05$], women who are survivors of domestic violence tended to have higher mean scores on the parenting capacity items (CG1 through CG6, I1 and I2) on the ORAM as compared to those not experiencing violence. Means and standard deviations are presented in Table 1.

Links to Poverty

The second hypothesis assessed a mothers' ability to parent in light of the presence of poverty. Approximately half of the sample (46%) was identified as being on some form of social assistance at the time of referral. Given the high prevalence rates of poverty and unemployment in the sample, it was hypothesized that a mother's dependence on social assistance would negatively influence her parenting abilities as compared to mothers who are not on social assistance. A significant difference was found between the two groups [$F(1, 753) = 36.093, p = .001$], indicating that the presence of poverty in the lives of these mothers may be affecting their parenting as evidenced by

Table 1

Means and Standard Deviations of Parenting Capacity Scores for Survivors of Domestic Violence as Compared to Those Not Experiencing Violence

	N	M	SD
Victim	450	14.77	9.14
Non-Victim	400	13.60	10.32

Note. Parenting Capacity Score = Caregiver Influence/Abuse-Neglect; Caregiver Influence/Alcohol-Drug Use; Caregiver Influence/Expectations of Child; Caregiver Influence/Acceptance of Child; Caregiver Influence/Physical Capacity to Care of Child; Caregiver Influence/Mental-Emotional-Intellectual Capacity; Caregiver's Motivation; Caregiver's Cooperation with Intervention. Lower parenting capacity scores indicate a lower likelihood that a woman's ability to parent had been compromised.

higher parenting capacity scores on the ORAM. Means and standard deviations are presented in Table 2.

Links to Co-Occurring Domestic Violence and Poverty

The third hypothesis examined the cumulative effects of being a survivor of violence and suffering from poverty on a woman's ability to effectively parent her children. Specifically, it was hypothesized that women who are survivors of domestic violence and who are dependent on social assistance will have higher scores on the parenting capacity index compared to women who are suffering from only one or neither of these two factors. An analysis of variance indicated a significant difference in

Table 2

Means and Standard Deviations of Parenting Capacity Scores for Mothers on Social Assistance as Compared to Those Not on Assistance

	N	*M*	*SD*
SA	417	15.70	8.19
No SA	339	12.15	7.94

Note. SA = Social Assistance. Parenting Capacity Score = Caregiver Influence/Abuse-Neglect; Caregiver Influence/Alcohol-Drug Use; Caregiver Influence/Expectations of Child; Caregiver Influence/Acceptance of Child; Caregiver Influence/Physical Capacity to Care of Child; Caregiver Influence/Mental-Emotional-Intellectual Capacity; Caregiver's Motivation; Caregiver's Cooperation with Intervention. Lower parenting capacity scores indicate a lower likelihood that a woman's ability to parent had been compromised.

parenting scores between women who were on social assistance, those who were experiencing spousal violence in the home, those who were on social assistance and experiencing spousal violence concurrently, and those who were experiencing neither at the time of referral [$F(3, 803) = 9.410, p = .001$]. Means and standard deviations are presented in Table 3. The Tukey HSD procedure was used to compare the mean scores of the four groups. As expected, post hoc tests revealed that women who were suffering from neither of these factors scored significantly lower ($M = 11.47$, $SD = 9.30$) on the parenting capacity index than any of the other groups examined. Results revealed that mean scores for women who were on social assistance, those who were experiencing

Table 3

Means and Standard Deviations of Parenting Capacity Scores for Women by Risk Group

	N	*M*	*SD*
SA	161	16.38	10.46
SV	188	14.16	11.99
SA & SV	258	15.24	6.36
Neither SA no SV	201	11.47	9.30

Note. SA = on social assistance at time of referral. SV = spousal violence in the home. Parenting Capacity Score = Caregiver Influence/Abuse-Neglect; Caregiver Influence/Alcohol-Drug Use; Caregiver Influence/Expectations of Child; Caregiver Influence/Acceptance of Child; Caregiver Influence/Physical Capacity to Care of Child; Caregiver Influence/Mental-Emotional-Intellectual Capacity; Caregiver's Motivation; Caregiver's Cooperation with Intervention. Lower parenting capacity scores indicate a lower likelihood that a woman's ability to parent had been compromised.

spousal violence in the home, and those who were on social assistance and experiencing spousal violence concurrently were all significantly different than the mean score of women who were experiencing neither risk factor, $p < 0.05$ for all pairwise differences. In other words, women in this study fared better on the parenting capacity index if neither stressor is present in their lives. Furthermore, this finding indicates that while each individual factor individually may present a risk and may adversely affect a woman's ability to parent, the cumulative effect of these factors occurring concurrently does not increase women's scores on the parenting capacity index.

Mean scores revealed that women who are experiencing neither of these factors scored the lowest mean score on the parenting index, followed by women who were experiencing violence alone, and women who were experiencing violence and were on assistance concurrently. Women who were on social assistance alone had the highest mean score on the parenting capacity index indicating a greater likelihood that parenting had been compromised by the presence of poverty for this group of mothers.

The fourth hypothesis examined whether a greater proportion of Crown Wards would have a mother who is on social assistance and/or who was a survivor of domestic violence. Of the 1041 cases examined, only 33 were identified as Crown Wards. Therefore, this hypothesis could not be tested as the sample size would not yield enough power to support the analysis.

Severity of Violence

Severity of violence was assessed by using a cumulative risk assessment score, comprised of the total scores for all 22 risk assessment items on the ORAM. The cumulative risk assessment score ranges between 0 and 88, with higher scores indicating a higher severity of violence present in the home of the child under investigation. The fifth hypothesis predicted that women with diminished parenting capacity as evidenced by higher parenting capacity scores would demonstrate a greater severity of violence in the home as evidenced by higher scores on the cumulative risk assessment measure. A Pearson Correlation Coefficient revealed a significant positive correlation between these two measures. According to this finding, as parenting capacity scores increase, indicating a potentially diminished parenting capacity, cumulative risk assessment scores also increase indicating a greater severity of violence in the home, $r(204) = .43$, $p < .01$.

The sixth hypothesis predicted that survivors of domestic violence who are on assistance will have greater severity of violence in the home as evidenced by higher cumulative risk assessment scores than survivors who are not on social assistance. Results indicate that there is a significant difference between survivors of domestic violence who are on assistance as compared to survivors who are not on assistance [$F(1, 103) = 9.94, p = .002$]. This finding indicates that dependence on social assistance is linked to the levels of violence in the home for women who are experiencing woman abuse. Means and standard deviations are presented in Table 4.

Table 4

Means and Standard Deviations of Cumulative Risk Assessment Scores for Survivors of Domestic Violence on Social Assistance as Compared to Survivors Not on Assistance

	N	M	SD
DV - SA	78	35.78	10.40
DV - No SA	27	28.50	9.90

Note. DV = survivor of Domestic Violence. SA = on social assistance at time of referral.

Discussion

The present study examined the extent to which a woman's parenting abilities are influenced by the presence of poverty and/or intimate partner violence in the home. Parenting abilities were assessed by using a parenting capacity score composed of six Caregiver Influence and two Family Influence elements on the ORAM. Higher scores on the parenting capacity index are indicative of a greater risk posed to the child in care. For the purposes of this study, higher scores were also indicative of a greater likelihood that a woman's parenting capacity may have been compromised by the effects of being socioeconomically disadvantaged and/or being a survivor of woman abuse. While much is known about the effects of child maltreatment on children, studies examining the effects of domestic violence in the home have been coming to the forefront of the research community only in recent decades (Edleson, 1999). Even less appears to be known about the mechanisms by which domestic violence is linked to child maltreatment. The present study sought to illuminate some of the challenges women in this population face when attempting to parent their children in a child welfare context, given the presence of the above noted risk factors.

One of the most obvious issues cited in the literature with linking these two social challenges appears to be that services that have been created to service women who are survivors of domestic violence were not created to service their children concurrently (McKay, 1994). Similarly, child welfare services were not created to meet the needs of mothers who are also experiencing interpersonal violence in the home. As such, researchers are beginning to point to the fact that very little is known about caregivers who are involved with both child welfare and domestic violence services (Kohl et al.,

2005). Given that the child welfare system in Canada is substantiating exposure to domestic violence at significantly high rates (Black et al., 2008) it is evident that this is a segment of the population who is in great need of attention.

As a society, we have grown accustomed to assuming that mothers are the primary caregivers responsible for the well-being and safety of their children. As such, women who are survivors of domestic violence appear to be judged more harshly than their abusive partners because they are seen as having "failed" to protect their children from the abuse they may have been exposed to (Mills, 2000). In turn, removing children from the home is said to further re-victimize the woman and also make her accountable for the abuse she is suffering (McKay, 1994).

The present study examined the extent to which some of the assumptions regarding the negative effects of poverty and woman abuse on parenting were present in this CAS sample. The findings indicate that the relationship between parenting and the contextual factors that are known to produce significant stress for parents is complex. In general, the findings point to the need for further examination of the *specific* effects that the presence of factors such as violence and poverty in the home can have on a woman's ability to effectively parent her children. Specifically, results indicate that the presence of violence in the home is linked to women's scores on the parenting capacity index. This finding indicates that their ability to parent may have been compromised by the presence of violence. However, the trends in parenting capacity scores did not reach statistical significance, perhaps challenging the notion that women's abilities to parent are affected by violence in as detrimental a manner as indicated by previous research.

Although the presence of domestic violence did not appear to affect their ability to parent as significantly as one might have expected, what was evident was the effect that poverty and caretakers' reliance on social assistance had on their parenting capacity scores. Results indicate that poverty may be compromising a woman's ability to parent, due perhaps to the challenges known to be associated with living an economically disadvantaged life. Furthermore, findings from this study point to the fact that while individual risk factors such as poverty and violence may potentially compromise a woman's ability to parent, the *cumulative* effect of having both present concurrently does not appear to affect parenting capacities as would be expected. Finally, results also indicate that the presence of poverty in the lives of these mothers is linked to levels of violence in the home if the mother is a survivor of domestic abuse.

This discussion will link current findings to previous literature in the field of domestic violence, poverty, and child welfare. It will also discuss the implications of the findings both for practitioners and for policy makers in the field. Finally, some of the limitations inherent in the research design will be reviewed and directions for future research will be proposed.

Relevance of Current Findings

Poverty and Parenting. Previous research has linked reliance on social assistance to a greater likelihood that the family will come to the attention of child welfare authorities. The exact nature of this link appears largely unknown however, as it is not known whether the increase in reporting is due to a reporting bias, actual economic factors that affect parenting, or a combination of the two (Berger, 2005). Results from this study indicate that those single-parent families who were living well below the

poverty line were more likely to engage in physical maltreatment as compared to single-parent households with higher incomes. This may be related to the findings of the current study, which found that single mothers who were dependent on social assistance were found to score higher on the parenting capacity index, indicating a greater risk posed to the child in care. Some of the possible explanations that have been cited to explain the negative effects that poverty can have on parenting suggest the following: parents may be lacking the adequate resources to parent their children properly due to the economic restraints they are facing; parenting may be affected by the high levels of stress associated with living in poverty; and/or that elevated stress levels may be contributing to the use of harsher parenting tactics (McGuinness & Schneider, 2007).

Eighty-two percent of the total sample under investigation was found to involve the child's mother as the primary and sole caregiver at the time of initial inquiry. Furthermore, 46% of the sample was found to be reliant on some form of social assistance at the time of CAS inquiry. Given these findings, it is evident that single mothers are a subset of the population who are in great need of attention and additional resources if the goal is to aid families who come to the attention of the CAS with the least intrusive measures possible.

Previous research has also directed attention to the needs of mothers living in poverty. Driscoll, et al. (1999) indicate that one of the main differences between children whose families are known to be dependent on social assistance and those who are not is that their mothers are known to experience negative effects from being dependant on social assistance. Specifically, this effect is evidenced by less motivation, greater levels of depression, and lower self-esteem for these mothers. In relation to depressive

symptoms, Kiernan & Huerta (2008) indicated that maternal depression appears to affect a woman's ability to engage with her child in a positive manner. Furthermore, these authors indicate that maternal depression was also associated with harsher disciplinary actions.

It is important to note once again that not all parents living in poverty are investigated by child welfare authorities for suspected child maltreatment. Lee & Goerge (1999) suggest that it is the frustration and feelings of inadequacy that can arise when living in poverty that may be leading to depressive symptoms and/or feelings of isolation, which may in turn be affecting a parent's ability to provide care to their children in a non-punitive manner. Similar inferences may be made from the results of the present study. Twenty-nine percent of the total sample of primary caregivers were identified as having been formally diagnosed with a major mental health disorder. Depression/anxiety was the most prevalent diagnosis with 48% of these individuals having been diagnosed by a medical professional. These findings, combined with those indicating the high prevalence rates of poverty and dependence on social assistance, support previous literature which suggest a possible mechanism by which poverty and involvement in the child welfare system may be related. Current findings are also pointing to the fact that it is the negative effects that living an economically disadvantaged life has on the mental health and well-being of a primary caregiver that contributes to their involvement with child welfare authorities, and not the fact that they are on social assistance alone.

As previously suggested (Lee & Goerge, 1999), perhaps the current sample of mothers also suffer from feelings of inadequacy stemming from the levels of poverty they are contending with which in turn, are leading to depressive symptoms and social

isolation that may be affecting the ways in which they parent their children. Future research should investigate the specific effects and antecedents of these caregivers' depression. It is through this investigative pathway that researchers may determine more concretely the specific mechanisms by which poverty negatively affects a woman's ability to parent her children.

It should also be noted that, in addition to the high prevalence rates of poverty, the majority of cases in the present sample involved a young mother parenting a very young child at the time of the CAS' initial inquiry. Most often the child was under the age of one year when the case was opened and the majority of the children under investigation were under five years of age. On average, these mothers were between the ages of 19 and 23 at the time of the initial inquiry. In addition, a large percentage of these mothers had a history of childhood maltreatment and prior involvement with CAS themselves. Specifically, 31% of the biological mothers were found to be involved with the CAS as children, with 24% of this sub-sample having been Crown Wards and 17% placed in Foster Care as children. Also noteworthy is that 26% of the children in the sample were exhibiting behavioural concerns as evidenced by a formal diagnosis, or an observation made by a health professional of some degree of disorder.

Taking these findings together, some inferences may be made in relation to a recent study published by Scaramella et al. (2008) which points to the long-term effects of poverty and the intergenerational transmission of these negative effects. These researchers reported that younger parents were found to use harsher disciplinary tactics with their young children, which tended to lead to more externalizing behavioural problems among these children. Greater levels of externalized behaviours were in turn

found to be associated with harsher parenting practices in subsequent years for these adolescent parents. One of the effects of poverty may very well include passing along the negative effects of harsh parenting practices. This intergenerational transmission of poverty and maladaptive parenting may be placing families who are involved with the child welfare system at risk for continuous involvement and greater rates of externalized behavioural disorders for children (Hurley et al., 2003). This line of inquiry also merits further investigation as maladaptive coping strategies, which are perhaps being passed on to subsequent generations by way of poorer parenting and harsh disciplinary tactics, may be affecting the ways in which subsequent generations learn to cope with the stresses of parenting and living with economic disadvantage.

Domestic Violence and Parenting. Given that many studies in the field are reporting that domestic violence appears to negatively influence a woman's ability to parent by way of creating stress in parenting due to the physical and multiple psychological effects of experiencing violence in the home (Levendosky & Graham-Bermann, 2001; Levendosky et al., 2003), it was hypothesized that women in the present sample who were identified as survivors of domestic violence would score higher on the parenting capacity index, as compared to those not experiencing violence, indicating a greater risk posed to the child in care. While the mean scores for survivors of woman abuse were found to be, on average, higher than those of women not experiencing violence as predicted, the difference between the mean scores of these two groups was statistically non-significant. This contradicts many of the findings from previous research which indicate that the effects of domestic violence should have affected the current sample's parenting capacity scores much more significantly than was found. What this

finding may be suggesting is that women are attempting to compensate for the abuse their children are being exposed to (Levendosky & Graham-Bermann, 2000) by attempting to foster more supportive and nurturing relationships with their children. This notion is supported by the findings of a recent study (Letourneau et al., 2007) which indicates that mothers of children exposed to domestic violence show a greater increase in positive discipline and less of a decrease in warmth and nurturing as their children age, as compared to other mothers.

In this regard, survivors of woman abuse may be attempting to build resiliency both for themselves and for their children in an attempt to counter-balance the negative psychological effects that have been previously cited as affecting the parenting abilities of these mothers. This line of investigation warrants further research in order to examine some of the possible links between domestic violence and the mechanisms by which woman are able to parent their children positively and overcome the expected detriments of experiencing violence in the home. Furthermore, given the high prevalence rates of depression and anxiety in the current sample, further studies should examine the extent to which these mothers' levels of mental health concerns are associated with poverty, domestic violence and/or both. In addition, if an association were found, it would be worthwhile to explore the mechanisms by which survivors of domestic violence are able to overcome the apparent effects of depression in ways which those who are experiencing poverty are not able to achieve.

The third hypothesis examined the interactions between domestic violence and poverty in relation to parenting capacity scores. It was hypothesized that the cumulative effect of having both factors present in the lives of mothers would compromise their

ability to parent. As expected, results indicate that the absence of poverty and domestic violence is associated with a decreased risk that parenting would be compromised for women in this CAS sample. This finding is noteworthy since this is an already high risk child welfare sample. Therefore, while individual risk factors affect parenting in isolation, there is no significant difference between the groups that were experiencing domestic violence alone, poverty alone, and a combination of the two, compared on the basis of the group mean scores. Contrary to what was expected, these findings indicate that the cumulative effect of experiencing violence and poverty concurrently in the home does not significantly affect scores on the parenting capacity index. Again, this finding may be indicating that women who are experiencing domestic violence in the home are developing other resiliency factors that are not evident in the analyses conducted in the present study. It should be noted that, in support of this proposition, women who are experiencing neither of these factors scored the lowest mean score on the parenting index, followed by women who were experiencing violence alone, and women who were experiencing violence and were on social assistance. Women who were on social assistance alone scored the highest mean score on the parenting capacity index. This finding suggests that women in this study are demonstrating greater negative effects resulting from the presence of poverty, and not from the presence of domestic violence.

It was also hypothesized that women who scored higher on the parenting capacity index, indicating a greater risk posed to the child, would also show a greater severity of violence as evidenced by higher cumulative risk assessment scores on the ORAM. Findings from the current study indicate that as parenting capacity is compromised by the presence of risk factors such as the presence of domestic violence and poverty, children

in the present sample are coincidentally at risk for increased levels of severity of violence in the home. This finding coincides with research cited previously which suggests that parenting in the presence of economic hardships and violence in the home is difficult and may be negatively affected by these two factors. What is not known from this analysis is the *extent* to which the presence of each of these factors individually affected results. This question warrants further examination to determine the individual effects that abuse and poverty have on levels of severity of violence in the home.

As expected, results indicated that survivors of violence who are on social assistance demonstrated a greater severity of violence in the home as compared to survivors who are not on social assistance. This finding supports previous research (Tolman & Rosen, 2001) which indicates that high rates of domestic violence among welfare recipients may be related to the abusive power and control tactics that domestically violent men use to isolate and exert control over their partners. Specifically, these authors indicate the abusive men may be forcing women into poverty by way of preventing them from attaining and maintaining work. Furthermore, the link between domestic violence and dependence on social assistance may be related to the health problems that are often present among survivors of violence which may in turn prevent them from maintaining gainful employment. The *increase* in severity of violence among survivors on assistance warrants further examination. It may be that this finding is related to some of the above noted stressors associated with living in poverty. A possible mechanism underlying this finding may be that the same depressive symptoms and feelings of inadequacy that are proposed to be present for women suffering from the

effects of poverty are also affecting their male partners in a similar manner. The primary difference may be in the manifestation of these symptoms.

Implications for Child Protection

Several important implications for child protection workers can be identified from the results of the present study. Of greatest importance is the manner in which these findings further illustrate the effects of poverty and domestic violence on parenting of women in a child welfare context. What is evident from these findings is that those working with women who are parenting in light of poverty and dependence on social assistance need to be aware of the ways in which poverty is known to affect levels of depression, and feelings of isolation, frustration and inadequacy among caregivers (Lee & Goerge, 1999).

Several suggestions for social work have been proposed based on a study which examines the perspectives of survivors of domestic violence and the professionals in the child welfare field that provide service (Shim & Haight, 2006). Since women who are contending with violence are often required to make drastic changes at a time when they have often experienced multiple traumas and emotional upheaval, it is suggested that supportive services be created and made available to these women. Specifically, the authors indicate the importance of providing material and emotional support for survivors by way of stable housing, financial support, counselling services, and strong social supportive networks in order to decrease the likelihood that a woman will return to an abusive partner. These suggestions are in line with the findings of the current study which point to the need to support women who are often parenting in light of depressive symptoms. Furthermore, these authors indicate a need to closely examine the tendency to

focus on safety plans that involve a woman leaving her abusive partner, as many survivors of violence find this too overwhelming to do initially.

Furthermore, service providers need to be aware of the ways in which external controls or interferences placed on clients can divert time and energy away from family responsibilities for these women, as well as limit their choices by way of the restrictions placed on them (Wuest, Ford-Gilboe, Merritt-Gray, Berman, 2003). According to these authors, women are contending with harassment and abuse from the ex-partner, health problems associated with past and ongoing abuse, the costs of seeking and obtaining help, as well as the undesirable changes to patterns of living that often result from leaving an abusive partner. Those working in the field of child protection therefore should be aware of the ways in which the above mentioned factors create stress for survivors of domestic violence as they attempt to overcome the trauma and abuse they have experienced.

Findings from the current study point to the need to focus less on the effects of violence on parenting, and more on the mechanisms by which other factors such as the presence of poverty and/or mental health concerns appear to exacerbate the negative effects of domestic violence. Similarly, while it is important to consider the effects that exposure to domestic violence has on children, assuming that bringing the child into the care of the CAS will be the only effective response in order to ensure the safety of a child, may be an erroneous assumption to make (Chiodo et al., 2005). As an alternative to traditional foster care placements, it is suggested that kinship care be examined as a means to protect children, maintain attachment, preserve familial and cultural elements, as well as give mothers an opportunity to work through the issues that brought them to

the attention of the CAS in the first place (Raghunandan & Leschied, 2008). This is especially true considering the results from the current study which indicate that domestic violence alone does not appear to negatively influence a woman's ability to parent in as negative a manner as has previously been cited. It is suggested that "in embracing the complexities of domestic violence as it is experienced by women, child protection workers might explore how women are living in abusive relationships, how such relations shape their daily lives and decisions, including those related to their experiences as mothers and the care of their children" (Davies & Krane, 2006, p. 420).

Implications for Counsellors

In addition to needing to be aware of the above-noted implications for those who practice in the child welfare field with regards to the effects of poverty and domestic violence, counsellors also need to be aware that while exposure to domestic violence necessitates reporting to child welfare authorities (Canadian Counselling Association, 2007) reporting may result in the removal of children from the home. This would in turn necessitate the need to address feelings of grief for both mothers and children in treatment (Raghunandan & Leschied, 2008).

Given the links between poverty, domestic violence, and depression, as well as feelings of inadequacy and social isolation that often result, counsellors working with women suffering from either one of these social ills should ensure that they promote healing that is based on mutually empathic and growth fostering relationships (Comstock et al., 2008). Relational-Cultural Theoretical (RCT) frameworks enable counsellors to acknowledge the victimization of these women given that "RCT is based on the assumption that the experiences of isolation, shame, humiliation, oppression,

marginalization, and microaggressions are relational violations and traumas that are at the core of human suffering" (Comstock, p. 280). In other words, being able to address and label the contextual factors for these women who are contending with violence and poverty may address the isolation and shame that contribute to the stress and hardships these women often face. The hope is that by addressing and labelling the contextual contributors to women's sense of isolation and shame, counsellors may better enable and encourage these women to establish and identify growth fostering relationships that may help to promote resilience and strength in these women (Comstock).

In general, counsellors need to address the feeling of social isolation many women experience when they are coping with poverty and violence in the home. Counsellors need to ensure that they are encouraging women to make the connections to their community and social circles that will provide them with the support they need in order to reduce depressive symptoms and related feelings of inadequacy and shame. Similarly, counsellors need to be aware of a need to increase self-efficacy and improve the self-esteem of women, who are often viewed as having "failed" to provide material comforts and safety for their children. Clinicians would be doing a disservice to their clients if they did not encourage women to challenge some of the assumptions about parenting and the mother-blaming (Caplan, 2000) that is too often inherent in the current climate reflected in societal attitudes.

Implications for Policy Makers

In regards to poverty, policy makers need to closely examine current policies and practices inherent in social assistance legislation. Policy makers need to be aware of the ways in which current policies limit the very people the services were intended to serve.

Ontario's *Ontario Works* legislation was intended to be used only as temporary assistance until recipients were able to obtain employment or a more permanent form of assistance such as ODSP or CPP. What legislators have failed to account for thus far is what happens to the individuals who fall in between those two categories and for whom *Ontario Works* is, and will continue to be, their primary and only form of financial support. Policy makers need to be aware of the ways in which poverty and living on limited social assistance affects parents' ability to nurture and care for the very people who will one day be this country's future.

The presence of domestic violence in family life also presents many challenges for Canada's law makers and policy makers. One of the challenges present for policy makers involves the complexities associated with creating laws that service all parties involved when it comes to protecting children and respecting the rights of parents. Jaffe, Johnston, Crooks, & Bala (2008) point to the importance of creating parenting plans that consider patterns of domestic violence, safety, and prognosis such that scarce resources may be properly allocated to fit the needs of survivors and their children. These authors suggest that the implementation of differentiated parenting plans, such as restricted access arrangements utilizing supervised access programs, supervised exchanges, parallel parenting, or co-parenting arrangements, would benefit families because they would be receiving services which are tailored to their needs. In general, it is suggested that policy makers examine the experiences of women as survivors of domestic violence and as mothers if sensitive and effective collaborative interventions are to be developed (Davies & Krane, 2006).

Limitations

The present study has some inherent limitations in the research design and available data. Firstly, while the data retrieval instrument covers a wide range of variables, certain variables under investigation were limited with regards to the amount of detail that could be derived from a single item. For example, assessing whether family violence was an issue in the life of the family was assessed by a single item on the data retrieval instrument. The availability of additional information with regards to the frequency, severity, and duration of violence in the home would be helpful in order to paint a more accurate picture of the role that violence plays in the lives of these families (Chiodo et al., 2005). Secondly, since sampling was based on a convenience sample, the generalizeability of the findings to all women who are contending with poverty and domestic violence outside of this CAS sample and geographical area is limited. Thirdly, the use of retrospective data may have had an effect on the results due to the fact that the integrity of the data examined is dependent on the presence and accuracy of the information present in each family's file. Similarly, data drawn from physical case files was scored by researchers. Inconsistencies may have resulted from the scoring of certain items on the instrument which were more subjective in nature. Finally, the ORAM may not be inclusive enough to assess some of the variables that would help to further illuminate the precursors or antecedents of some of the factors the current study sought to examine.

Directions for Future Research

Some of the limitations of the current study should be seen as opportunities for future research. The specific nature of this study and the fact that it focuses on parenting

abilities in a child welfare context would be strengthened in future investigations by linking multiple child welfare services throughout the province and the country. Larger sample sizes would begin to address some of the limitations associated with data drawn from a convenience sample.

The present study examined the effects of poverty and domestic violence on a woman's ability to parent. In light of the current findings, future research should focus on determining in more concrete terms whether or not depression in particular and feelings of inadequacy are related to poverty by way of a lack of self-efficacy due to a lack of financial resources. Furthermore, it would be helpful to determine the mechanisms by which poverty seems to influence a woman's ability to parent her children, while experiencing domestic violence appears to not have the same effects for these women. In relation to this finding, future research should focus, in more positive terms, on determining the mechanisms by which women are building resiliency and protection factors in their interactions with their children. Future research should take a more strengths-based approach in order to celebrate the remarkable abilities of these women to parent effectively in light of the extreme stress, and psychological and physical effects they are contending with on a daily basis.

In general, future research should address the needs of women from their perspective and with their input. Too much is presumed but little is really understood about how women who are contending with these challenges are able to parent on a daily basis. The current study used objective information retrieved from data files to assess the extent to which poverty and domestic violence influence parenting abilities. Research in the field would benefit from the use of first-hand accounts of women's experiences

parenting as well as an examination of some of the antecedents and precursors to the effects indicated in the present study.

Summary

Despite the limitations outlined above, the current study is a significant contribution to the fields of domestic violence, poverty, and parenting in a child welfare context. The findings of this study contribute to the body of knowledge on poverty and parenting by indicating that poverty appears to compromise the parenting abilities of mothers in this sample. Furthermore, the current study challenges some of the literature on domestic violence and parenting which emphasizes the deficiencies in the parenting of women who are experiencing abuse. Findings indicate that woman abuse does not appear to compromise the parenting abilities of women in this sample in as detrimental a manner as was expected. This study also highlights the fact that co-occurring poverty and violence is not subject to a cumulative negative effect on parenting.

This study is relevant for service providers and policy makers working in the child welfare, domestic violence, and social assistance fields. Findings point to the need to focus resources and attention to the eradication of poverty due to its adverse effects on the parenting of future generations of citizens and policy makers. This study also promotes a need to reconsider current assumptions about the parenting abilities of women who are survivors of violence. By focusing on the strengths of these women as survivors and mothers, future studies drawing from findings of the current study may illuminate effective protective and resiliency measures that may aid in improving the parenting of women afflicted by other social ills in society.

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Appendix A

Data Retrieval Instrument

DATA RETRIEVAL INSTRUMENT

Alan Leschied Ph.D., Dermot Hurley M.S.W., Paul Whitehead Ph.D., and Debbie Chiodo, M.A.

ITEM

1. CAS File ID ____
2. Child Case ID _____ __
3. Family Case ID _____
3b. Primary Eligibility Spectrum Code: ___

4. Year of Referral ____ (1995 or 2001)

5. Date of Birth _____(D/M/Y)

6. Age in months at time of case opening ___

7. Age in months at time of case closing ___

Current Referral Data

Data for the purposes of the following sections will be based on the most intrusive level of intervention for the youth through the CAS

8. Date of Initial Inquiry to CAS __ __ __ (D/M/Y)

9. Date of Admission to Care _____(D/M/Y)

10. Number of months following initial inquiry to care (8 minus 9) ___

11. Age at time of admission to care ___(In months)

12. Gender __ (male= 1; female = 2)

13. Type of current CAS Intervention

Counselling/Parent __
Counselling/Child __
Foster Care __
Group Home __
Failed to engage family __
No intervention provided __
Other (state) __ _____

14. Source of referral to CAS

Child __
Parent __
Extended Family __
Neighbour __
School __
Physician __
Other agency __
Anonymous reporting __
Friend __
Police __
Unknown __
Other (state) __ _____

15. Disposition of case with CAS

Contact / No follow-up __
Investigation completed __
(Allegation not substantiated) __
Brief assessment/intervention __
(less than 30 days/file closed)
Case opened for monitoring __
Counselling with CAS __
Referral to another children's service __
Temporary care agreement __
Crown wardship __

16. Was child/family on waiting list to be seen by a children's service or family agency at the time of CAS referral? ___ (Yes = 1, No =2,)

17. If yes to above, specify which agency (s) _____

18. Was child/family being seen by a children's service/family agency at the time of CAS referral? ____ (Yes = 1, No= 2)

19. If yes to above, specify which agency (s) _____
20. Was primary caregiver on social assistance at the time of referral? ___ (Yes = 1, No =2, Don't know =3)

21. If yes, identify. ___ (Welfare = 1 Social Assistance =2)

22. Occupation of primary caregiver at time of inquiry

Professional __
Managerial __
Skilled(trade) __
Unskilled __
Unemployed __
Unknown __
If other, specify _____

Family Information

Parental Information (99 = unknown)

23. Biological mom's age __ **(at time of child's birth)**
24. Biological father's age __ **(at time of child's birth)**
25. Mother's age at time of first born __
26. Father's age at time of first born __

27. Country of origin of mother __ **(See CAS country codes)**
28. Country of origin of father __ (See CAS country codes)

Siblings

29. Number of full biological siblings residing in the home at initial inquiry ___
30. Number of siblings (any type) residing in the home at initial inquiry __
31. Number of siblings overall (any type) __

32. Gender of siblings Males __
Females

33. Family arrangement at the time of Inquiry

Single care giver (mother)
Single care giver (father) __
Single parent (never married) __
Birth parents together (common-law) __
Birth parents together (married) __
Step parenting arrangement (bio - Mother) __
Step parenting arrangement (bio father) __
Mother with partner __
Father with partner __
Separated biological parents/joint custody __
Adoption __
Extended Family __
Family Friend __
Foster Parents __

34. Primary caregiver at time of CAS initial inquiry

Mother __
Father __
Extended family __
Family friend __
Partner __
Other __ Specify_____

34 b. Individual identified as presenting greatest risk to child at time of referral.

Mother __
Father __
Extended family __
Family friend __
Mother's Partner __
Father's Partner __
Sibling (any type) __
Teacher/Person in authority __
Health Care Provider __
Babysitter __
Other __ Specify_____

35. Did child experience a death within the primary family? ___ (Yes=1, No=2)

36. If yes, indicate: ___ (Parent/Caregiver =1, Sibling =2,)

History of Prior CAS Intervention of Family and Child

37.Number of previous *family contacts* with CAS (Prior to most intensive/intrusive disposition)

0 ___ 1-10 ___ 11-20 ____ 21-30 ___ 31-40 ___ 41-50___ 50-+ ____

38. Number of previous *child implemented* interventions with CAS _ _ (00-99)

39. Number of planned *child* interventions with CAS _ _ (00-99)

40. Has *family* ever been involved in a prior CAS implemented intervention? ___ (Yes=1, No = 2,)

41. If yes, what type of prior CAS intervention? (note: within CAS care)

parent management training __
parent counselling __
child counseling __
Prior placement __
Other (state) __ _____

42. Number of prior *family* contacts with children's services *other than* CAS prior to CAS initial inquiry (Check one)

0 __ 1 -10 ___ 11-20 ____ 21-30 ___ 31-40 ___ 41-50___ 50-+ ____

43. Number of prior *child* contacts with children's services *other than* CAS prior to CAS initial inquiry (Check one)

0 __ 1-10 ___ 11-20 ____ 21-30 ___ 31-40 ___ 41-50___ 50-+ ____

44. Length of Time of CAS Involvement of the Family ___ (Months)

45. Length of Time of CAS Involvement of the Child ___ (Months)

46. Number of Admissions to CAS Residential Care (Check one)

0___ 1-3 ____ 4-6 ___ 7-9 ___ 10-12___ 12-+ ____

47. Previous parental/caregiver contact with CAS

As a child __
As an adult __
As a parent __
Unknown __

48. Was the biological father ever involved with CAS as a child? ____ (Yes = 1, No = 2, Don't Know =3)

49.If yes, what was the nature of that involvement?

Crown Ward ___
Temporary Care ___
Protection Order ___
Foster Care ___
Group Home ___
Counseling ___
Father's File not accessed ___

50. Was mother ever involved with CAS as a child? ____ (Yes = 1, No = 2, Don't Know =3)

51.If yes, what was the nature of that involvement?

Crown Ward ___
Temporary Care ___
Protection Order ___
Foster Care ___

Group Home ___
Counseling ___
Mother's File not ___
accessed

Child's History with the Mental Health, Young Offender, Educational, Developmental Services System

52. Secondary Assessments Available prior to or coincidental with current CAS Involvement

Mental Health _
Educational _
Medical _
None _
Other _ (state_____)

53. Prior contact with *other* Children's Services

Children's Mental Health __
Young Offender System __
Other (state) __ _____

54. If yes to Young Offender System

Has youth been charged __
Has youth been found guilty __
Was / has diversion been used __
Has there been a prior disposition __
If yes to above was disposition
- Secure Custody __
- Open Custody __
- Probation __
- Fine __
- Community Restitution __

55. Has child ever been involved with a children's mental health service? __ (Yes= 1; No=2, Don't know =3)

56. If yes, was it

Family counselling __
Individual counselling __
Day treatment __
Inpatient/residential __
Other (state) __ _____

57. Has child been in an out of home placement prior to the current CAS involvement? ___ (Yes= 1; No=2, Don't know =3)

58. If yes, what type

Foster __
Group __
Custody __
Residential Treatment __
Hospital __ (Mental Health Service)
Extended Family __
Other (State) __ _____

59. Is the Childs primary concern one of these: (Select one)

Psychological (emotional) _____
Physiological _____
Behavioral _____
Other (State) _____
None _____

60. Is there evidence to suggest that the child has Attention Deficit Disorder? __ (Yes = 1; No = 2)

61. Is there evidence to suggest that the child Conduct Disorder? ___(Yes = 1; No = 2)

62. Is the child currently on medication, or have they ever been on medication for an adjustment related disorder? ____ (Yes = 1; No = 2,)

63. Is there evidence that the child has repeated a grade? ___ (Yes= 1, No = 2)

64. Has child/youth been expelled from school in the last 12 months? __ (Yes= 1; No= 2)

65. If yes, how many times? _ _ (99 = doesn't indicate)

66. Has child/youth *ever* been expelled from school? __ (Yes= 1; No= 2)

67. If yes, how many times? _ _ (99 = doesn't indicate)

68. Has child/youth been suspended from school in the last 12 months? __ (Yes= 1; No= 2)

69. If yes, how many times? _ _ (99 = doesn't indicate)

70. Has child/youth *ever* been suspended from school? __ (Yes= 1; No= 2,)

71. If yes, how many times? _ _ (99 = doesn't indicate)

72. Has chronic absence from school been identified? ___ (Yes=1, No = 2)

FAMILY HISTORY OF MENTAL HEALTH AND OTHER CONCERNS

73. Was biological father involved with a children's mental health center? ___ (Yes=1, No=2)

74. Was biological mother ever involved with a children's mental health center? ___ (Yes=1, No=2)

75. Was spousal violence ever an issue? ___ (Yes=1, No=2)

76. Was caregiver to child violence ever an issue? ____ (Yes=1, No=2)

77. Is either caregiver on the child abuse registry? ____ (Yes=1, No=2)

78. Have any of the child's caregivers been convicted of a criminal offense? ___ (Yes=1, No=2)

79. Has primary caregiver been *formally* diagnosed with a major mental disorder? ____ (Yes=1, No=2)

80. If yes, what was the nature of the disorder?

depression __
post partum depression __
anxiety __
bipolar disorder __
schizophrenia __
anti-social personality __
substance abuse __
Other __ (specify _____)

81. Is there file evidence *suggesting* the presence of a major mental disorder (in the absence of a formal diagnosis)? ____ (Yes=1, No=2)

82. If yes, what was the nature of the disorder?

depression __
post partum depression __
anxiety __
bipolar disorder __
schizophrenia __
anti-social personality __
substance abuse __
Other __ (specify _____)

83. Is there a history of a chronic medical condition in the primary caregiver? ___ (Yes=1, No=2)

84. Has family ever been considered homeless? ___ (Yes=1, No=2)

85. Are living conditions viewed as a relevant factor in the child/youth not being discharged from the care of the CAS ____(Yes=1, No=2)

THE FOLLOWING SECTION RELATES TO DEVELOPMENTALLY CHALLENGED CHILDREN (DC) RECEIVING SERVICE *THROUGH THE CAS*

86. Has child *ever* been involved with developmental services programs? ___ (Yes=1; No=2)

87. If yes, at what age did involvement first begin? _ _ (in years; birth = 00)

88. What was the nature of developmental services involvement?

In-home parent support __
Respite care __
Group home __
Other (state) __ _____
N/A __

THE FOLLOWING SECTION RELATES TO MEDICALLY FRAGILE CHILDREN (MFC) RECEIVING SERVICE THROUGH THE CAS

89. Is child considered medically fragile? ____ (Yes = 1; No = 2)

90. If yes, name the disorder. _____

91. Primary reason for referral of medically fragile child

No other available resource __
Diminished parenting capacity __
Request for respite care
Other (state) __ _____

92. Has MFC previously received service from

Respite care __
Children's Hospital of Western Ontario __
CPRI __
Other residential resource __ Specify _____

Family Immigration

93. Was child exposed to war / trauma prior to immigration? ___(1= Yes; 2 = No)

94. Was there contact with a child welfare agency prior to immigration to Canada?
___ (1= Yes; 2 = No)

95. Length of time in Canada _ _ _ (months)

96. Does family identify itself as:

New Canadian __
Refugee __
Immigrant __
Neither __

CAS Court Involvement

97. Was court litigation required?

Yes __
No __

98. Did the court accept Primary CAS recommendation?

Yes __
No __
N/A __

99. If rejected, reason if any indicated?

_____

_____

Appendix B

Ontario Risk Assessment Model (Risk Information Summary)

Risk Information Summary

Risk Assessment Information (Ratings will be: 4, 3, 2, 1, 0, 9; See manual for detailed description for rating guidelines)

CG1: Caregiver Influence / Abuse – Neglect ___
CG2: Caregiver Influence / Alcohol/Drug Use ___
CG3: Caregiver Influence /Expectations of Child ___
CG4: Caregiver Influence / Acceptance of Child ___
CG5: Caregiver Influence /Physical Capacity to Care for Child ___
CG6: Caregiver Influence / Mental/Emotional/Intellectual Capacity ___

C1: Child's Influence / Child's Vulnerability ___
C2: Child's Influence / Child's Response to Caregiver ___
C3: Child's Influence / Child's Behaviour ___
C4: Child's Influence / Child's Mental Health and Development ___
C5: Child's Influence / Physical Health and Development ___

F1: Family Influence / Family Violence ___
F2: Family Influence / Ability to Cope with Stress ___
F3: Family Influence / Availability of Social Supports ___
F4: Family Influence / Living Conditions ___
F5: Family Influence / Family Identity and Interactions ___

I1: Intervention Influence / Caregiver's Motivation ___
I2: Intervention Influence / Caregiver's Cooperation with Intervention ___

A1: Abuse/Neglect Influence / Access to Child by Perpetrator ___
A2: Abuse/Neglect Influence / Intention and Acknowledgement of responsibility ___
A3: Abuse/Neglect Influence / Severity of Abuse/Neglect ___
A4: Abuse/Neglect Influence / History of Abuse/Neglect Committed by present Caregivers ___

100. Overall Risk Assessment ___
101. Cumulative Risk Assessment Score (CG1-A4) ___

102. Cumulative Risk Assessment Score by Social Worker ___

103. Coder ___ (Initials)

Appendix C

Manual for the Children in Care Data Retrieval Instrument

Manual for the Children in Care Data Retrieval Instrument[1]

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April 24, 2002
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Introduction

The purpose of this project is to assist in understanding the increasing demands on the London and Middlesex Children's Aid Society. This is not a study of the Children's Aid Society in itself. Rather, focus for the increasing demands on the Children's Aid Society relate to many factors that lie outside of the Agency and reflect the influences of policy, legislation, resource allocation and demographic trends in the community.

The CAS plays a unique role in being one of only two mandated youth resources in a community – the other being the young offender system. This portion of the research will focus on identification of factors relevant in understanding potential changes in the children and families served at two time periods – 1995 and 2001. It will also include ratings on a risk assessment measure that has recently been introduced as a means of identifying need with the children and families being served through the CAS.

This is the manual that corresponds to the items in the data retrieval instrument referred to as the *Children in Care Data Retrieval Instrument.* It provides definitions that correspond to the individual items in the Instrument.

Item

1. **CAS data file ID**
   ID number of the research assistants for the purposes of identifying files.

2. **Child case ID**
   ID found in the CAS file. Each child within a family will have their own ID number.

3. **Family Case ID**
   ID found in the CAS file. Siblings within the same file will share the same family Case ID.

3b. Primary Eligibility Spectrum Code:
Code assigned by CAS worker (1-5) indicating standards for investigation

4. **Year of referral**
   Will relate to the years understudy, either 1995 or 2001

5. **Date of Birth**
   Stated as month / day / year (eg. 02 10 94 – February 10, 1994)

6. **Age in months at time of case opening**
   This is stated as the age of the child under study when the case opened.

7. **Age in months at time of case closing**
   This is stated as the age of the child under study when the case has closed. If the case is still opened, you will leave this question blank.

CURRENT REFERRAL DATA

8. **Date of Initial Inquiry to CAS**
   Refers to the date of the first contact to the CAS for the child under review. Stated as the day/ month/ year

9. **Date of Admission to Care**
   Refers to the date at which the child under study was admitted to care as a temporary or crown ward. In the case of those children / youth not admitted to care as either temporary or crown wards will leave this item blank. Stated as the day / month/ year

10. **Number of Months following initial inquiry.**
    Refers to the time difference from the date of initial inquiry to the date of admission to care. In the case of those children / youth not admitted to care as either temporary or crown wards will leave this item blank.

11. **Age at time of admission to care**
    For those children admitted to care of the CAS as either temporary or crown wards. Expressed in total months.

12. **Gender**
    male= 1; female = 2

13. **Type of Current CAS Intervention**
    This item identifies the specific interventions that have been attempted through the CAS resources. It will include one or more of the following: Counselling/Parent; Counselling/Child; Foster Care and Group Home Care. There can be more than one intervention for the child under study. CAS case monitoring is *not* considered as an intervention when it is not accompanied by a formal intervention.

14. **Source of referral to CAS**
    This item relates specifically to the referral agent that resulted in the initial referral for the child under study. It will reflect the involvement of one of the following: Self/Child; Self/Parent; Extended Family; Neighbour; School; Physician; Police; Other agency or Anonymous reporting.

15. **Disposition of case with CAS**
    This item refers to the most intrusive/intensive disposition made for the child/youth in the year under study. The choices for disposition include: Contact / No follow-up; Brief assessment/intervention; Investigation complete (no further action); Case opened for monitoring; Counselling with CAS; Referral to another agency; Temporary care agreement or Crown wardship.

16. Was child/family on waiting list to be seen by a children's service at the time of CAS referral?

This item relates to evidence from the file that the child/youth under study was on a waiting list to be provided service with an agency other than the CAS at the time of the CAS' involvement.

17. If yes, specify the agency.

This item asks for the name of the children's service that the child/youth was waiting to be seen by at the time of referral to the CAS.

18. Was the child/family seen by a children's service/family agency at the time of CAS referral?

This item relates to evidence from the file that the child/youth under study was seen by any other service or agency other than CAS at the time of CAS' involvement. If yes, specify the agency.

19. If Yes, specify the agency or children's service

This item asks for the name of the agency that the child/youth was at the time of referral to the CAS.

20. Was primary caregiver on social assistance at the time of referral?

This item asks for information as to whether the child/youth/s primary caregiver was on social assistance at the time of the child/youth's most intensive/intrusive CAS intervention. If there is no stated evidence in the file of the caregiver being on social assistance the endorsement should be considered unknown.

21. If yes, identify.

This item reflects what type of social assistance the caregiver was on. The assistance can be either Welfare (or Ontario Works), or Social Assistance (i.e. pension, disability, CPP, etc.). Note that social assistance is an umbrella term for which many categories fall under.

22. Occupation of primary caregiver

This item seeks information about the occupational history of the primary caregiver. The categories to be considered are: Professional; Managerial; Skilled (i.e. Trade); Unskilled, Unemployed (i.e. Welfare, or Ontario Works), Unknown.

Family Information

This section will identify relevant family information from the child/youth's file.

23. Mother's age at time of child's birth

This item asks for the biological mother's age at the time of the child/youth under study expressed in years. Leave blank if not known.

24. Father's age at time of child's birth

This item asks for the biological father's age at the time of the child/youth under study expressed in years. Leave blank if not known.

25. Mother's age at time of first born

This item asks for the biological mother's age of the child/youth under study of her first born expressed in years. Leave blank if not known.

26. Father's age at time of first born

This item asks for the biological father's age of the child/youth under study of his first born expressed in years. Leave blank if not known.

27 & 28. Country of origin

The country of origin for both biological parents will be identified from the child/youth's file and the appropriate country code provided from the CAS files will be entered. The country codes are taken from the CAS files. A copy of the codes can be found in this manual in Appendix B.

29. Number of full biological siblings residing in the home at initial inquiry

This item refers to the number of biological siblings only living in the home at initial inquiry.

30. Number of siblings of any type of the child/youth under study living in the home at the time of initial inquiry

This item asks for the total number of siblings and stepsiblings, or any other combinations of the child/youth under study, living in the home at the time of CAS initial inquiry.

31. Number of siblings overall (any type).

This item refers to the total number of siblings living in or out of the home of the child under study.

32. Gender of the siblings of the youth under study.

This item asks for the breakdown of male and female siblings of the child/youth under study.

33. Family arrangement at the time of admission

This item asks for the primary characterization of the child/youth's family at the time of the most intensive/intrusive intervention provided through the CAS. One of the following items should be used: Single care giver (mother); Single care giver (father); Single parent (never married) ; Birth parents together (common-law); Birth parents together (married); Step parenting arrangement (bio - Mother); Step parenting arrangement (bio father); Mother with partner; Father with partner; or Separated biological parents/joint custody, Adopted parents, Friend, Extended Family.

34. Primary caregiver at the time of CAS initial inquiry.

This item will identify the primary caregiver of the child/youth under study. The choices for *primary* caregiver will be one of: Mother; Father; Extended family; Family friend or F

35. Did child experience a death within the primary family?

This item is endorsed in the affirmative if there is evidence that the child under study has experienced the death of either a parent/caregiver, or siblings.

36. If yes, specify.
This item requires identification of the primary family member who has passed away.

HISTORY OF PRIOR CAS INTERVENTION OF FAMILY AND CHILD

37. Number of previous family contacts with CAS _ _ _ (000-999)
This item includes all contacts that are available in the file, prior to the most intrusive disposition. This number will include telephone contacts and face to face contacts. This total will include family contacts, and contacts from other agencies about the child

38. Number of previous child implemented interventions with CAS (00-99)
This item will reflect the number of previous interventions planned by CAS *and* followed through by the child/youth under study. An intervention is defined as a formal intervention such as the designations in the following item.

39. Number of planned child implemented interventions with CAS (00-99)
This item will reflect the number of interventions provided within the CAS range of resources that were planned, but not carried through by the child under question. An intervention is defined as a formal intervention such as the designations in the following item.

40. Has family ever been involved in a prior CAS implemented intervention
This item is endorsed if family has ever been involved in a previous CAS interventions prior to the most intensive/intrusive intervention provided.

41. If Yes, identify.
It can include more than one of the following interventions: parent management training; parent counselling; child counselling; prior placement (foster or group home care).

42. Number of prior family contacts with children's services other than CAS prior to CAS initial inquiry.
This item relates to file-based information that documents other children's services other than those offered by CAS that have been involved with the family under study. This item will reflect services such as young offender, children's mental health, psychiatric or psychological assessment and hospital-based services if they were for behavioural, cognitive or mood disorders (excludes specific *physical* health related matters).

43. Number of prior child contacts with children's services other than CAS prior to CAS initial inquiry

This item relates to file-based information that documents other children's services other than those offered by CAS that have been involved with the child under study. This item will reflect services such as young offender, children's mental health, psychiatric or psychological assessment and hospital-based services if they were for behavioural, cognitive or mood disorders (excludes specific *physical* health related matters).

44. Length of Time of CAS Involvement of the Family

This item relates to the accumulated time that the Family of the child under study has been involved with the CAS from the date of first contact to the date of the most intensive /intrusive intervention with the CAS. The total time will be expressed in months as a three digit number (000-999).

45. Length of Time of CAS Involvement of the Child

This item relates to the accumulated time that the Child under study has been involved with the CAS from the date of first contact to the date of the most intensive /intrusive intervention with the CAS. The total time will be expressed in months as a three digit number (000-999).

46. Number Admission to CAS Residential Care

This item relates to the accumulated time that the Child under study was ever placed in a children's residential placement. This will include a custody placement, group or foster home, or residential treatment center.

47. Previous parental/caregiver contact with CAS.

This item asks for previous CAS involvement of either of the child/youth's parent. It is possible for a parent to have had CAS involvement as both a child and adult. If there is not specific reference in the file to this involvement the rating should be considered 'unknown'. The categories to be considered are: As a child; As an adult (in a non-parental role); As a Parent, and Unknown.

48. Was the biological father ever involved with CAS as a child?

This item seeks information about the biological father of the child/youth under study. To be endorsed 'yes' there must be specific reference in the file to the father being involved with CAS as a child.

49. If Yes, specify the nature of the involvement.

If the father was involved, state the nature of this involvement. This can be either: Crown Ward, Temporary Care, Protection Order, Foster Care, Group Home, and Counseling. If the father's file was not accessed, and you have no information stating the nature of the father's involvement as a child, you are to choose File not accessed.

50. Was the biological mother ever involved with CAS as a child?
This item seeks information about the biological mother of the child/youth under study. To be endorsed 'yes' there must be specific reference in the file to the mother being involved with CAS as a child.

51. If Yes, specify the nature of the involvement.
If the mother was involved, state the nature of this involvement. This can be either: Crown Ward, Temporary Care, Protection Order, Foster Care, Group Home, and Counseling. If the mother's file was not accessed, and you have no information stating the nature of the mother's involvement as a child, you are to choose File not accessed.

Child's History with the Educational, Mental Health, Young Offender, Developmental Services System

This section will address the history of the child under study with services prior to the child/youth being provided the most intensive/intrusive intervention through the CAS.

52. Secondary Assessments Available Prior to or Coincidental with the current CAS Involvement
This item refers to any evidence in the child's file that there has been a formal assessment provided by the following services: Mental Health; Educational; Medical (medical of a nature related to behavioural, cognitive or mood disorder), None and/or Other assessment. In the case of 'other' you are asked to specify what the nature of the 'other' assessment was.

53. Prior contact with other Children's Services
This item relates to any evidence in the file that the child/youth under study was ever involved in either the children' mental health or young offender system. In the case of 'other' you are asked to specify what the nature of the other contact was.

54. If yes to Young Offender System
This item relates only to those youth that have evidence in their file that they have been involved with the young offender system. If a youth has a history of young offender involvement, identify the area of involvement from the file. A youth may/will have more than one area identified. The items include: Has youth been charged; Has youth been found guilty; Has there been a prior disposition; If yes to above was disposition; Secure Custody; Open Custody; Probation; Fine and Community Restitution (hours). If the youth was not involved in the young offender system, the N/A should be endorsed.

55. Has child been involved with a children's mental health service?
This item relates only to those children/youth that have evidence in their file that they have been involved in the children's mental health system. This item is keyed as either yes or no, or don't know.

56. If yes, what was it?

If a youth has a history of children's mental health involvement, identify the area of involvement from the file. A youth may/will have more than one area identified. The items include: Family counseling; Individual counseling; Day treatment and/or Inpatient/residential, or Other. In the case of Other, you are asked to specify what the particular service was.

57. Has child been in an out of home placement prior to the current CAS involvement?

This item relates to any evidence in the file that the child/youth under study was ever in an out of home placement prior to the most intensive/intrusive intervention with the CAS. This out of home placement can refer to any residential placement – either young offender or children's mental health – or alternate care by an extended family member.

58. If yes, what type?

This item specifies the type of out of home placement that the child/youth may have experienced. It will include one or more of the following: Foster; Group; Custody; Residential Treatment; Hospital (for Mental Health Service) or alternate family member. In the case of other, please state the specific type of placement.

59. Is the child's primary concern one of the following?

This item refers to whether there exists evidence that the child under study has demonstrated either a psychological (emotional), physiological, behavioral, or other, health concern. There does not need to be a formal diagnosis made; however, any suggestions made by a health professional (i.e. case observations made by Social Worker) to suggest one of these concerns should be counted. In the case of no evidence presented, you will select None.

60. Is there evidence to suggest that the child has Attention Deficit Disorder?

This item will be identified as 'yes' if there is any evidence in the file that the child may have attention deficit disorder. A formal diagnosis is not needed, however, vague comments made by the social worker regarding "attention difficulties" will not suffice.

61. Is there evidence to suggest that the child has a Conduct disorder?

This item will be identified as 'yes' if and only if there is any evidence in the file that the child has a conduct disorder . There does not need to be a formal diagnosis made, however, vague comments made by the social worker regarding behavioral problems will not suffice.

62. Is the child currently on medication, or have they ever been on medication for an adjustment related disorder?

This item will be identified as "yes", if there is documentation that the child has ever been or is currently on medication for an adjustment related disorder.

63. Is there evidence that the child has repeated a grade?

This item will be identified as 'yes' if there is any evidence that the child has failed, been held back, or repeated a grade for what ever circumstance. If there is no evidence of such, you are to select 'no'.

64. Has child/youth been expelled in the last 12 months?

This item relates to any evidence in the file that the child/youth has been expelled from school in the last 12 months. This item is keyed as either yes or no.

65. Number of times expelled in the last 12 months

This item asks for the total number of times the youth was expelled in the last 12 months. Each interval of suspension is coded separately (eg. If child is expelled and allowed back into school where they are once again expelled this is counted as two events).

66. Has child/youth ever been expelled?

This item relates to any evidence in the file that the child/youth has ever been expelled during their academic career. This item is keyed as either yes or no.

67. If Yes to above/ Number of times ever expelled

This item asks for the total number of times the youth was ever expelled. Each interval of suspension is coded separately (eg. If child is expelled and allowed back into school where they are once again expelled this is counted as two events).

68. Has child/youth been suspended from school in the last 12 months?

This item relates to any evidence in the file that the child/youth has been suspended from school in the last 12 months. This item is keyed as either yes or no.

69. If yes to above / number of times suspended

This item asks for the total number of times the youth was suspended in those 12 months. Each interval of suspension is coded separately (eg. If child is suspended and allowed back into school where they are once again expelled this is counted as two events).

70. Has child/youth ever been suspended from school?

This item relates to any evidence in the file that the child/youth has been suspended from school ever in their academic career. This item is keyed as either yes or no.

71. If yes to above/ Number of times suspended

This item asks for the total number of times the youth was ever suspended. Each interval of suspension is coded separately (eg. If child is expelled and allowed back into school where they are once again expelled this is counted as two events).

72. Has chronic absence from school been identified?

This item relates to any evidence in the file that the child under study has demonstrated chronic absenteeism from school. This item is keyed as either yes or no.

FAMILY HISTORY OF MENTAL HEALTH AND OTHER CONCERNS

73. **Was biological father ever involved with a children's mental health center?**
This item seeks information about the biological father of the child/youth under study. To be endorsed 'yes' there must be specific reference in the file to the father being a ward of the children's mental health system.

74. **Was mother ever involved with a children's mental health center?**
This item seeks information about the biological father of the child/youth under study. To be endorsed 'yes' there must be specific reference in the file to the father being a ward of the children's mental health system

75. **Was spousal violence ever an issue?**
This item will be endorsed in the affirmative if there is identification in the child/youth's file that spousal violence was evident in the life of the family. Spousal violence is defined as violence that occurs between caregivers that the child/youth under study would have been exposed to. The relationships between caregivers can be one of formal marriage, common-law or casual relationship. The importance of this item is that it indicates whether the child/youth would have been exposed to violence on a regular basis.

76. **Was parent to child violence ever an issue?**
This item refers to violence that would have occurred, directed from the parent to the child/youth under study. It can reflect physical or sexual violence and should be distinguished from indirect exposure to violence (eg. Exposure to spousal violence) or child neglect.

77. **Is either caregiver on the child abuse registry?**
This item refers to whether any caregiver has ever been on the child abuse registry. There must be specific reference to this registry in the file.

78. **Have any of the child's caregivers been convicted of a criminal offense?**
This item will be endorsed in the affirmative if there is evidence in the child/youth's file that a caregiver was ever convicted of a criminal offense. A caregiver is defined broadly to include an adult that would have spent any period of time in the role of a 'parent' to the child.

79. **Has primary caregiver been formally diagnosed with a major mental disorder?**
This item will be endorsed in the affirmative if there is evidence in the child/youth's file that a caregiver has been formally diagnosed with a major mental disorder. Typically a psychiatrist will make this diagnosis although it may also be referenced in

a family doctor's medical note or a CAS case note. A caregiver is defined broadly to include an adult that would have spent any period of time in the role of 'parent' to the child.

80. If yes to above, what is the nature of the disorder?

This item refers to the specific nature of the formal diagnosis of the caregiver with a major mental disorder. Select whether the formal diagnosis is depression, post-partum depression, anxiety related disorders, Bipolar disorder, schizophrenia, anti-social personality disorder, or substance abuse, or other.

81. Is there file evidence suggesting the presence of a major mental disorder?

This item will be endorsed in the affirmative if there is evidence in the child/youth's file that a caregiver has a major mental disorder, in the absence of a formal diagnosis.

82. If yes to above, what is the nature of the disorder?

This item refers to the specific nature of the suggestive mental disorder of the caregiver. Select whether the evidence suggests a diagnosis of depression, post-partum depression, anxiety related disorders, Bipolar disorder, schizophrenia, anti-social personality disorder, or substance abuse, or other.

83. Is there a history of a chronic medical condition in the primary caregiver?

This item is endorsed in the affirmative if there is evidence that the caregiver has a history of some type of medical condition (e.g.. Diabetes).

84. Has family ever been considered homeless?

This item seeks information about the previous living conditions of the child/youth's family. This item will be endorsed in the affirmative if there is evidence in the file that the family has been homeless at any time in their lives.

85. Are living conditions viewed as a relevant factor in the child/youth not being discharged from the care of the CAS.

This item will be endorsed in the affirmative if there is evidence in the file that the child/youth would have been discharged from CAS care earlier if appropriate living conditions were available. Living conditions are considered as the *physical living conditions* of the family as separate from the *caring ability* of caregivers to provide a home for the child/youth.

This section of the inventory relates to the history of children/youth seen at the CAS who would be characterized in the file as being developmentally challenged (DC). This designation will be evident in the nature of prior services with the child and his/her family as being through developmental services or an assessment that characterizes the child/youth as being developmentally challenged.

86. Has child been involved with developmental services programs?

This is a specific item that relates to any evidence in the file that the child/youth under study has been involved with services provided through the developmental services system.

87. If yes, at what age did involvement first begin?
This item asks for the specific age at which the child/youth was first involved with the developmental services system. It is expressed in years (birth = 00).

88. What was the nature of developmental services involvement?
This item identifies the type of service the child/youth would have accessed through developmental services. It will include one of the following: In-home parent support; Respite care and/or Group home. The N/A response is indicated if the child/youth was not involved with this service either as a DC child or non-developmentally challenged.

This section of the inventory relates to children/youth seen at the CAS who would be characterized in the file as being medically fragile children (MFC).

89. Is child considered medically fragile?
This item will be endorsed if the contents of the file use the term medically fragile, or there are extenuating circumstances that relate to chronic physical illness or threats to the physical well being of the child.

90. If yes, name the disorder.
This item asks for the specific nature of the disorder of the child/youth to be stated.

91. Primary reason for referral of medically fragile child.
This item asks for specification of the reason for the child/youth to be referred to the CAS. The categories will ask for a judgment of the reviewer of the file as related to the primary reason for referral as being one of: No other available resource; Diminished parenting capacity or Request for respite care.

92. From where has MFC previously received service?
This item seeks to identify previous services used by the child/youth in the community as being one or more of the following: Respite care; Children's Hospital of Western Ontario; CPRI and/or Other residential resource.

Family Immigration

This section seeks information on those children/youth whose parents are new immigrants to Canada. If the child/youth is not of an immigrant family this section will be left blank.

93. Was child exposed to war / trauma prior to immigration?

This item will be endorsed in the affirmative if there is evidence on the child/youth's file of the child/youth being exposed to war or violence of some kind that would have been traumatizing.

94. Was there contact with a child welfare agency prior to immigration?

This item will be endorsed in the affirmative if there is evidence in the file that there *was a history of involvement with a child welfare agency prior to the family* immigrating to Canada. If there is no evidence of previous child welfare involvement the rating of 'unknown' should be used.

95. Length of time in Canada

The length of time the family has been in Canada will be identified in months. The length of time will be defined as the date of immigration (when known) to the date when the most intensive/intrusive CAS intervention was provided. This length of time will be expressed in months.

96. Does family identify itself as refugee or immigrant.

This item seeks information on whether the family has identified itself in the file as being either of refugee or immigrant status. Refugee status describes families who *seek protection through immigration*; are *imposed in their move to Canada and/or do not have the ability to freely return to their home country.* Immigrant status refers to those families who have freely come to Canada and have not been coerced in any way to leave their home country.

CAS Court Involvement

This section seeks information regarding court involvement with the CAS and the family as it relates to the most intensive/intrusive level of intervention provided by the CAS.

97. Was court litigation required?

This item will be endorsed as positive if there is evidence in the file of court involvement with respect to the most intensive/intrusive intervention provided by the CAS.

98. Did the court accept Primary CAS recommendation?

This item will be endorsed as positive if the file indicates that the court accepted the CAS' primary recommendation without alteration. N/A will be endorsed if there was no court action related to the CAS' intervention.

99. If rejected, reason if any indicated?

Following from (89), if the court rejected the CAS' recommendation a brief statement is to be made as to the reason noted for rejection by the court.

Risk Information Summary

This section asks raters to use the Ministry's Risk Assessment protocol in making judgements about risk as it relates to the child and their family. This section should be left to the last to complete as it will require a thorough understanding of the conditions that led to the child/youth being provided care through the CAS. The definitions for each of the items will be found in Appendix C.

Risk Assessment Information (Rating will be: 1=No/Low Risk; 2=Moderatley Low Risk; 3=Intermediate Risk; 4=Moderately High Risk; and 5=High Risk. See manual for detailed description for rating guidelines)

CG1 Caregiver Influence / Abuse – Neglect ___
CG2 Caregiver Influence / Alcohol/Drug Use ___
CG3 Caregiver Influence/ Expectations of child ___
CG4 Caregiver Influence / Acceptance of Child ___
CG5 Caregiver Influence / Physical Capacity to Care for Child ___
CG6 Caregiver Influence / Mental/Emotional/Intellectual Capacity

C1 Child's Influence / Child's Vulnerability ___
C2. Child's Influence / Child's Response to Caregiver ___
C3 Child's Influence / Child's Behaviour ___
C4 Child's Influence / Child's Mental Health and Development ___
C5 Child's Influence / Physical Health and Development ___

F1 Family Influence / Family Violence ___
F2 Family Influence / Ability to Cope with Stress ___
F3 Family Influence / Availability of Social Supports ___
F4 Family Influence / Living Conditions ___
F5. Family Influence / Family Identity and Interactions ___

I1. Intervention Influence / Caregiver's Motivation ___
I2. Intervention Influence / Caregiver's Cooperation with Intervention ___

A1. Abuse/Neglect Influence / Access to Child by Perpetrator ___
A2. Abuse/Neglect Influence / Intention and Acknowledgement of responsibility ___
A3. Abuse/Neglect Influence / Severity of Abuse/Neglect ___
A4. Abuse/Neglect Influence / History of Abuse/Neglect Committed by present Caregivers ___

100. Overall Risk Assessment
101.Cumulative Risk Assesment Score (CG1-A4)
102.Cumulative Risk Assessment Score of Social Worker

103. Coder
Enter the first letter of the first and last name of the rater of this protocol.

Information regarding maternal care giver. These two questions relate specifically to educational information pertaining to the child's mother.

104. What is the highest grade completed ___

105. Is there evidence of a learning disability ___ (yes = 1; no = 2)

Police Involvement Related to Family Violence. This section will only be completed if there is evidence of family violence in the file.

106. Have the police ever been involved following a report of domestic violence?
___ (yes = 1; no = 2)

107. If yes to above, have the police ever laid a charge?
____ (yes = 1; no = 2)

108. Is there evidence that a restraining order against the perpetrator was ever issued following domestic violence?
___ (yes = 1; no = 2)

109. Were the services of supervised access ever used following parental separation?
____ (yes = 1; no = 2)

This item relates to the income of the primary earner of it is noted in the file.

110. Who is the primary income earner in the family?

Father____
Mother____
It is joint ____
Not available ____

Appendix D

Approval of M.Ed. Thesis Proposal

APPROVAL OF MEd THESIS PROPOSAL FORM A

If the proposed research does not involve human subjects or the direct use of their written records, videotapes, recordings, tests, etc., this signature form, along with ONE copy of the research proposal should be delivered directly to the Graduate Education Office for final approval.	**If the proposed research involves human subjects, this signature form, along with ONE copy of the research proposal and THREE copies of the Ethical Review Form must be submitted to the Graduate Education Office for final approval.**

IT IS THE STUDENT'S RESPONSIBILITY TO PROVIDE A COPY OF THE RESEARCH PROPOSAL (INCLUDING REVISIONS) TO THE THESIS SUPERVISOR AND ALL MEMBERS OF THE ADVISORY COMMITTEE.

Student's Name: Andrea Hernandez

Field of Study: Counselling Psychology

TITLE OF THESIS: Woman Abuse in a Child Welfare Context: Interpersonal Violence and its Impact on Parenting Abilities

DOES THIS RESEARCH INVOLVE THE USE OF HUMAN SUBJECTS: YES ☐ NO ☑

Name of Thesis Supervisor: Alan Leschied

Name(s) of Members of the Thesis Advisory Committee: Susan Rodger
Jason Brown

APPROVAL SIGNATURES:

Graduate Student:

Thesis Supervisor:

Advisory Committee:
(at least one)

Ethical Review Clearance: _____

Review #: _____ Date: _____

Chair of Graduate Education: Date: 20/06/08

A STUDENT MAY PROCEED WITH RESEARCH WHEN A COPY OF THIS FORM CONTAINING ALL APPROVAL SIGNATURES HAS BEEN RECEIVED.

A COPY OF THIS PROPOSAL MAY BE MADE PUBLIC AND KEPT ON A TWO-HOUR RESERVE IN THE FACULTY OF EDUCATION LIBRARY