Scales of Child Caring and Protection: Development of
a Parenting Capacity Risk Management System

L. M. McKay

A thesis submitted to the School of Community Services in partial fulfillment of the
requirements for the degree of
Bachelor of Applied Arts in Behavioural Psychology

St. Lawrence College
Kingston, Ontario
Canada
February 2012
DEDICATION

I would like to dedicate this thesis to my two sons, Liam and Aidan, who are a constant source of pride and inspiration for me. I would also like to dedicate my thesis to Arnie for having put up with all the tears.
ABSTRACT

A forensic parental capacity assessment (FPCA) may be ordered by the court to determine a parent’s ability to safely and adequately care for a child. Research establishing the validity and reliability and standardizing the procedures for this type of assessment has yet to be done. An extensive literature review revealed a myriad of variables and conclusions, often contradictory, and for the most part unhelpful. An extensive review of testing instruments and techniques revealed a lack of standardization and lack of studies relating the techniques to various correlates of parental ability. Formulating definitive conclusions as to causation or determination of factors of higher magnitude risk is difficult due to the many and overlapping factors associated with child maltreatment. Current FPCAs incorporate the use of empirically derived tests for assessing many of the factors associated with child maltreatment in order to determine correlates of child abuse to parental capacity. However, no test has yet been created to measure these traits comprehensively in one instrument. The purpose of the present study was to distill from the existing literature a manageable number of potential predictors of parental capacity. This resulted in the development of the research version of the Parental Capacity Risk Management Inventory (PC-RMI). This process was modelled on the development of the Level of Service/Case Management Inventory (LS/CMI) (Andrews, Bonta, & Wormith; 2004) and the Youth Level of Service/Case Management Inventory (YLS/CMI) (Hoge, Andrews, & Leschied; 2002) both of which are predicated on risk, needs, and responsivity (RNR) (Andrews & Bonta, 2010) model of forensic risk assessment. The PC-RMI incorporates static predictive factors and dynamic need factors and clinical considerations to structure clinical judgment. These factors are tallied to provide a level of risk of child maltreatment.

Ten archival files were accessed and the researcher compiled PC-RMI scores on each. The researcher was blind to the FPCA determined outcomes during the scoring process. High level of agreement was found between PC-RMI scores and previous FPCA recommendations. Based on these outcomes, the PC-RMI warrants further development. Such an instrument would afford standardization thereby adding to the efficiency, consistency, and reliability of the FPCA process.
ACKNOWLEDGMENTS

The writing of this thesis would not have gone so well without the help of some key individuals.

I would like to acknowledge Dr. Robert Rowe of the Family Court Clinic whose expertise in forensic psychology and parental capacity assessments, combined with his “evil” sense of humour made the whole thing possible and enjoyable.

I also gratefully acknowledge my college supervisor, Dr. David Villeneuve, whose advice, editing skills, and patience with my constant re-writes brought the whole project together.
### TABLE OF CONTENTS

DEDICATION ........................................................................................................ i
ABSTRACT .......................................................................................................... ii
ACKNOWLEDGMENT ......................................................................................... iii
TABLE OF CONTENTS ..................................................................................... iv
LIST OF TABLES ............................................................................................... vi

CHAPTER
I.  INTRODUCTION .............................................................................................. 1

Overview ............................................................................................................. 1
Purpose ............................................................................................................... 1

II.  LITERATURE REVIEW .................................................................................... 3

Child Maltreatment ........................................................................................... 3
Canadian – American Differences & Similarities .............................................. 3
Etiological Theories ............................................................................................ 4
  Risk Factors Considered Individually ............................................................... 4
  Additive and Interactive Effects of Risk Factors .............................................. 4
The Concept of Protective Factors ..................................................................... 5
Theories of Abuse ............................................................................................... 5
Forensic Parental Capacity Assessments .......................................................... 6
Current Practice and Problems with FPCA Measures ...................................... 7
  Widely-used Measures ................................................................................. 8
  General Clinical Measures .......................................................................... 9
  Measures Linked to Parenting Capacity ...................................................... 9
Best practices .................................................................................................... 10

III.  METHODOLOGY .......................................................................................... 12

Development of the PC-RMI ........................................................................... 12
  Establishing Criteria & Format ..................................................................... 12
  Components .................................................................................................. 13
Coding and Scoring ........................................................................................... 13
Psychometric Properties ................................................................................... 14
Concurrent Measures ....................................................................................... 15
  Shipley Institute of Living Scale (SILS) ......................................................... 15
  Paulhus Deception Scales (PDS) ................................................................. 15
  Millon Clinical Multiaxial Inventory-III (MCMI-III) ..................................... 15
  The Child Abuse Potential Inventory (CAPI) ............................................. 16
  Parenting Stress Index (PSI) ....................................................................... 16
Conflict Tactics Scales ...................................................................................... 16
  Revised Conflict Tactics Scales (CTS2) ......................................................... 16
  Conflict Tactics Scale: Parent-Child Version (CTSPC) ................................ 17
Semi-Structured Interviews ........................................................................................................17
Parent-Child Observations ........................................................................................................17
Collateral Sources ......................................................................................................................17

IV. RESULTS ................................................................................................................................19

V. DISCUSSION ..........................................................................................................................20
Interpretation of Results ............................................................................................................20
Outcome ......................................................................................................................................20
Strengths and Limitations .........................................................................................................20
Multilevel Challenges ...............................................................................................................22
  Client Level ..............................................................................................................................22
  Program Level ..........................................................................................................................22
  Organizational Level ................................................................................................................23
  Societal Level ............................................................................................................................23
Contribution to the Behavioural Psychology Field ....................................................................23
Recommendations ......................................................................................................................24

REFERENCES ...........................................................................................................................25

APPENDICES
Appendix A: Glossary of Common FPCA Terms .....................................................................29
Appendix B: PC-RMI Definitions & Scoring Guidelines ............................................................32
Appendix C: Parental Capacity – Risk Management Inventory (PC-RMI) .............................48
Appendix D: Oath of Confidentiality (13-09-11) ....................................................................52
Appendix E: Interview Sample Questions ..............................................................................53
LIST OF TABLES

TABLES

1.1 Score-based PC-RMI Risk/Need Level Guide ........................................................................ 19
1.2 Concurrence between PC-RMI and Currently Utilized FPCA Measures ............................ 19
Chapter I: Introduction

Overview

A parental capacity assessment examines factors associated with adequate parenting by measuring and observing a parent’s capacity to cope effectively with the child’s temperamental and developmental characteristics while recognizing, coping, and managing their own strengths and weaknesses to do so (Donald & Jureidini, 2004). Effective parenting includes being able to “act in the best interests of a child” (Symons, 2010).

A forensic parental capacity assessment (FPCA) is conducted to determine a parent’s ability to safely and adequately care for a child as required by law (Pezzot-Pearce & Pearce, 2004). In order to comprehend the complexities involved in the evaluation of a parent’s capacity to adequately parent, it is necessary to understand several key terms used frequently in the literature and the processes involved (see Appendix A for glossary of some common FPCA terms). Lack of parental ability may be categorized as child maltreatment. Child maltreatment includes abuse (physical, emotional, or sexual), endangerment, exploitation, neglect, and/or maladaptation (abuse leading to developmental delay) of a child (Budd, Connell, & Clark, 2011). An FPCA is similar to, but differs in important ways from, a custody and access (C & A) PCA. Unlike C & A PCAs, which determine custody arrangements between divorcing parents, FPCAs are ordered by the family court to determine if parental rights should be terminated and, if not, what protections need to be put in place to assure continued adequate care of the child. The FPCA in Canada is a court-mandated assessment of parents who have currently had their child(ren) removed by the Children’s Aid Society (CAS). The CAS is petitioning in such cases for the termination of parental rights and the placement of the child in the permanent custody of the court or crown wardship. An FPCA at the Family Court Clinic (FCC) is a forensic investigation of the parent(s) and child. The court – not the parent or parents - is the client of the assessor. Parents are directed to FCC by the family court.

FCC provides an “independent” and objective opinion for the court through the FPCA process. FCC is part of the outpatient clinic affiliated with Queen’s University and is a division of child and adolescent psychiatry at Hotel Dieu Hospital serving Kingston and surrounding areas in Ontario. Parents involved with FCC have typically been accused of child maltreatment or been found to have inadequately addressed the needs of their children. The court uses the assessment data and FCC recommendations to assist in determination of parental capacity, possible interventions, and the supervision and placement of at-risk children. Once ordered, participation in the FPCA is mandatory for parents and family members involved in court custody investigations to assist in determining terms of custody or permanent removal of the children. Failure to comply with the court order may reflect negatively on specified individuals in judicial decision-making regarding custody and is sanctionable by the courts.

Purpose

This study will provide preliminary data on the relationship between the FCC parent capacity assessment protocols and a research version of an empirically-based risk assessment protocol. Empirical support for FPCA testing to date is minimal and requires review (Budd, Connell, & Clark, 2011; Symons, 2010). It is critical to determine the validity and reliability of an FPCA’s accuracy in measuring and predicting variables that are directly related to parental
capacity in forensic custody populations in order for the FCC to form accurate determinations and to develop risk management strategies. To ascertain an FPCA’s predictive validity, it is necessary to formulate a research-based list of risk factors correlated with parental capacity and the likelihood of continued or future maltreatment of the child. There is abundant research on perpetrators of child maltreatment and risk factors linked to abuse (Belsky, 1993). However, conclusions are often contradictory or overlapping, and describe a multiplicity of traits and attributes. This lack of consistent research findings makes formulating definitive conclusions as to causation or determination of factors of higher magnitude risk difficult (Belsky, 1993).

The present study was designed to operationally define some of the most cited risk factors in the literature, and seek an optimal method of combining them into a predictive algorithm that can be applied to individual cases. The outcome of the study will be the creation of a risk/needs management system utilizing the concepts of the Risk, Needs, and Responsivity (RNR) model developed by Andrews and Bonta (2010), and aspects of both the Level of Service/Case Management Inventory (LS/CMI) for offenders (Andrews, Bonta, & Wormith, 2004) and the Youth Level of Service/Case Management Inventory (YLS/CMI) (Hoge, Andrews, & Leschied; 2002). The scale will act as a risk management guide for implementing FPCAs that focus on relevant factors directly associated with parental capacity and offer treatment strategies to reduce or manage those risk factors. It is hypothesized that a manageable number of empirically derived factors related to parental capacity can be distilled from the literature and combined into a preliminary version of a standardized predictive instrument. This will save time and money spent examining factors unrelated to, or minimally related to, parental capacity.
Chapter II: Literature Review

Child Maltreatment

In Canada, any form of emotional, physical, or sexual abuse, neglect, or exposure of domestic violence to a child by an adult is considered to be child maltreatment (Public Health Agency of Canada [PHAC], 2008).

Reported incidence rates, or number of new cases reported in a given year, of child maltreatment in Canada for children under 16-years old was 235,842 with 36% substantiated (PHAC, 2010). These numbers are presumed to be an underestimate due to under-reporting. Canadian prevalence rates, or number of children maltreated over their lifetime, are estimated to be in the 19% to 25% range. Exposure to family violence is more prevalent than physical abuse.

Canadian – American Differences & Similarities.

Because a large portion of available literature on the topic of child maltreatment and related topics examined in this paper are derived from studies conducted on U.S. populations, it is important to be aware of definitional and statistical differences between Canada and the United States (U.S.).

In Canada, incidence rates are highest for exposure to domestic violence (35%), followed by neglect (34%), physical abuse (20%), emotional abuse (9%), and sexual abuse (2%) in reported cases (PHAC, 2010). In contrast, the U.S. incidence rates differ in that neglect (78%) is the leading cause of reported child abuse cases (U.S. Department of Health and Human Services [DHHS], 2009). This may be due to the fact that exposure to domestic violence is not listed as a U.S. category of child maltreatment as it is in Canada. According to the 1999 General Social Survey on Victimization (GSS) as reported by Statistics Canada (2001), exposure to domestic violence refers to a child seeing, hearing, being used as a “tool” during the violent incident by the perpetrator, and/or experiencing negative consequences afterwards (e.g. having to move, losing a parent). Exposure to domestic violence in the U.S. is categorized as a form of neglect which may account for their higher rates in that domain. Another notable difference between the countries is the ethnicities of children most frequently involved in child maltreatment cases. In Canada, Aboriginal children are investigated for child maltreatment four times more than non-Aboriginal children on a per capita basis. Whereas in the U.S., African American (22%) and Hispanic children (21%) combined equal the maltreatment rate of White children (44%) (U.S. Department of Health and Human Services [DHHS], 2009).

Concurrence between the two countries regarding child maltreatment relates to the age of the victim with younger children having the higher the likelihood of abuse (DHHS, 2009; PHAC, 2006; PHAC, 2008). Likewise, more mothers (61% in the U.S. and 91% in Canada) than fathers are perpetrators of child maltreatment (DHHS; PHAC). This likely represents the fact that more mothers are the primary caregiver of children. Child maltreatment based on gender is also similar with findings indicating more boys than girls are physically abused, and more girls than boys are sexually abused. Both Canadian and U.S. statistics show that child maltreatment, while not improving, has remained stable in the past decade.
Etiological Theories

Belsky (1993) explains in his assessment of the etiology of child maltreatment that a multitude of established risk factors needs to be explored to determine cause and effect. Examination of risk factors in isolation would seem to be a reasonable first step in understanding this phenomenon (Vondra & Toth, 1989).

Risk Factors Considered Individually.

Review of the literature found commonly cited parent risk factors to include lack of emotional stability, poor impulse control, lack of empathy, abusive childhoods (Dixon, Hamilton-Giachritsis, & Browne, 2004), lack or perceived lack of social support, negative emotional reactivity (especially to aversive child behaviour), teenage mothers with multiple, closely-spaced births (Belsky, 1993), poverty or low socioeconomic status (Sidebotham & Heron, 2006), negative affect, and low self-esteem (Belsky, 1993). The Canadian Incidence Study (CIS) of Reported Child Abuse and Neglect identified risk factors in several domains (PHAC, 2008). Parent factors included being the victim of domestic violence (46%), lack of social support (39%), mental health problems (27%), and substance abuse (alcohol 27% and drugs 17%). Belsky attributes such multiply identified risk factors on the diversity, complexity, and comorbidity of variables linked to child maltreatment. Others suggest that individual risk factors include personality traits, attribution styles, living conditions, and the cumulative effects of external stressors (Vondra & Toth, 1989).

Additive and Interactive Effects of Risk Factors.

Vondra and Toth (1989, p.11) point out that “maltreatment is not the outcome of any single factor – whether parental psychopathology or the experience of maltreatment in childhood, child temperamental or behavioural deviance, marital conflict or violence, economic hardship and job stress, inadequate and ineffective social supports, or sociocultural mores that encourage punitive, authoritarian parenting.” Many of the risk factors overlap, but consensus indicates that the more risks one has, the higher the risk of child maltreatment (Belsky, 1984; Budd, Connell, & Clark, 2011; Vondra & Toth, 1989).

Risk factors related to child maltreatment may also include family factors (e.g. role models, attachment styles, and communication styles), child factors (e.g. difficult temperament, cognitive ability), availability to intimate and social supports, and socioeconomic status (SES) (Vondra & Toth, 1989). According to Vondra and Toth, SES is the one factor that can be called both a cause and an effect of maltreatment. It can clearly create an ongoing cycle of abuse from one generation to the next. Likewise, Sidebotham and Heron (2006) opine the greatest risk factors to be distal factors of socioeconomic deprivation and parental background (e.g. childhood abuse, education) or distal factors, rather than proximal factors such as family dynamics or child factors (e.g. disposition, premature birth). In one study it was determined that parents who were abused in childhood, demonstrated poor parenting skills and had three particular risk factors (living with a violent adult, suffering from a mental disorder, and being a parent under 21 years old) were at increased risk of perpetrating child maltreatment (Dixon, Hamilton-Giachritsis, & Browne, 2004). However, the authors noted that the majority (93.3%) of those abused in childhood did not continue the cycle of abuse. Dixon et al. suggest that this discontinuance of
child maltreatment by future generations may be indicative of childhood victims developing a greater number of protective factors to offset the cycle of abuse.

The Concept of Protective Factors.

In theory, protective factors have the ability to offset risk factors if the balance is towards the positive (Belsky, 1984; Vondra & Toth, 1989). Through an analysis of empirical studies on the etiologies of maltreatment, Belsky (1993) was able to narrow down some protective factors associated with positive outcomes. Protective factors include such traits, abilities, or circumstances that protect an individual’s emotional well-being from negative or harmful external influences including social support networks (especially having a supportive partner [Quinton, Rutter, & Liddle, 1984]), academic success, self-efficacy, participation in leisure activities, being an employed mother (Sidebotham & Heron, 2006), having secure parent-child attachments, and even appearance. According to Quinton, Rutter, and Liddle (1984), maintaining one’s appearance may attract a better, more supportive (emotionally and financially) partner, and may promote emotional well-being. The theory of protective factors requires further research as the majority of current literature focuses primarily on risk factors (Dixon, Hamilton-Giachritsis, & Browne, 2004).

What is clear is that maltreatment exists on a continuum and that risk factors and protective factors are multiple and overlapping (Belsky, 1993). Belsky concludes that there is no single cause of child maltreatment, and furthermore, no single factor is either “required” or “enough” to predict maltreatment.

Risk factors can clearly be idiosyncratic stressors of any description that interact with the biological and psychological ability of the parent and the child to cope. These are explored in next section.

Theories of Abuse

There are several widely accepted theories on parenting styles and their roles in maltreatment. Attachment theorists such as Bowlby (1969) propose that children who develop secure attachments with their parents in infancy form an “internal working model” of positive relationships resulting in future adulthood relationships that are more sensitive, receptive and secure (Zeanah, Berlin, & Boris, 2011; Bartholomew & Horowitz, 1991; Vondra & Toth, 1989). The supposition is that abusive/neglectful parents are less positive and less responsive which creates insecure attachments and proliferates the cycle of abuse and dysfunctional attachments. Maltreated children have been shown to display increased rates of insecure attachment patterns (Cicchetti & Barnet, 1991).

In a meta-analysis of physically abusive and neglectful parents, Wilson, Rack, Shi, and Norris (2008) found that physically abusive parents displayed more aversive behaviour or negative affect (e.g. anger, disapproval) and neglectful parents showed less involvement with the child (e.g. ignoring, detachment or disengagement). As Belsky (1993) points out, most people view child abuse as abhorrent, but society still holds many antiquated and violent beliefs such as continued acceptance of corporal punishment for children (e.g. spanking), regarding children as “property”, and the denigration of childhood caregivers (e.g. teachers, stay-at-home mothers). Such lack of emotional and societal support for both the children and the parents sets the stage for neglect and/or abuse. Neglect has been associated with uninvolved and inconsistent parenting
related to the uninvolved parenting style that may lead to attachment issues (Wilson, Rack, Shi, & Norris).

Young children living in homes with high levels of adult conflict or domestic violence are more likely to exhibit attachment disturbances (Zeanah, Berlin, & Boris, 2011). Likewise, children who are moved frequently through the foster care system often have difficulties forming secure attachments (Zeanah, Berlin, & Boris, 2011). These conflictual, unstable, and abusive situations affect a child’s attachment abilities. Such behavioural patterns have been associated with increased risk of the child developing externalizing behaviour problems (Fearon, Bakermans-Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010). However, behaviour problems and attachment issues often improve when parental care also improves (Zeanah, Berlin, & Boris).

Bronfenbrenner (1977) conceptualizes human development as the interaction between the individual and multilevel systems that make up one’s environment (e.g. home, school, community, government) with each having influence upon the other. The Canadian Incidence Study of Reported Child Abuse and Neglect took a similarly ecological approach by examining multiple contexts of child maltreatment (PHAC, 2008). Domains correlated with child maltreatment were child factors (23% had academic difficulties and 19% mental health issues such as depression and anxiety), socioeconomic factors (51% had full-time employment and 33% received social assistance), and housing (55% lived in rental accommodations). As Vondra and Toth (1989) emphasize, every factor is so interwoven in a web of influences, that denying these associations or failing to address them collectively, may overemphasize the importance of one factor at the cost of an equally significant factor.

Belsky’s (1984) model measures stressors and supports (risks and protective factors) present in a person’s life that may affect an individual’s capacity to function or cope positively or negatively depending upon current life experiences. It is the weighting of these balances that affect discrepancies in parenting capacity amongst individuals.

Social learning theories describe behaviours as being learned through social interactions, observations of others, and subsequent reinforcement of the behaviours that strengthen them (Davison, Blankstein, Flett, & Neale (2008). Behaviours, whether positive or negative, are modelled, shaped, internalized, and learned throughout a child’s interaction with social and environmental stimuli.

An eclectic approach incorporates aspects of all these theories and accepts that lives are a complex interaction of a variety of personal variables and environmental circumstances in which examination of one factor cannot be done in isolation without considering the whole. This interaction of variables is what makes the FPCA process so complex.

**Forensic Parental Capacity Assessments**

FPCAs are performed with parents and families in which child abuse has been verified or suspected. In all such cases, the children will be under the protection of the CAS either through in-home monitoring, placement into temporary foster homes, group homes, with other family members, or residential care (Budd, Connell, & Clark, 2011). Based upon a survey of Ontario child welfare cases conducted by Bala and Leschied (2008), removal of the child is predominantly requested by the CAS (63%), conjointly between CAS and parents (22%), or even by the parents themselves (9%). Due to the expense and invasive nature of FPCAs, one is only issued if deemed necessary by the court.
Assessors in Canada require extensive qualifications due to the challenging nature of FPCAs. Bala and Leschied’s (2008) survey revealed that almost 50% are PhD-level psychologists, almost 33% multidisciplinary teams (which are preferred by judges), 15% psychiatrists, and less than 10% social workers.

Although court orders specify the parties involved in the assessment procedure, the procedures employed by the psychologist in the assessment process can vary substantially. As Bala and Leschied (2008) point out, there are no standardized procedures or binding guidelines for implementing these assessments in Canada. Therefore, as Zervopoulos (2010) emphasizes, it is important that FPCAs focus on measures relevant to the particular case and the scope of the evaluation. Unlike typical clinical assessments, Gould (2004) emphasizes the fact that forensic assessments need to be designed to produce reliable, valid, and predictive outcomes for judicial decision-making. Gould suggests that FPCAs include semi-structured interviews allowing flexibility in questioning so as to be relevant for each individual case while still including necessary components of the interview. Along with interviews, FPCAs should incorporate psychological testing. The use of standardized measures is pertinent for FPCAs if the psychologist is careful to link the measure to the legal requirements of the construct assessment so that only the specific traits and/or abilities as demanded by the court are examined and superfluous factors are ignored (Otto, Edens, & Barcus, 2000). Gould (2004) also recommends self-report measures for generating hypotheses, collateral investigations of files and other sources directly related to the case for substantiating or disputing data, and direct behavioural observations of parent-child interactions.

According to Bala and Leschied (2008), common criticisms of FPCAs from the court are the over-reliance on clinical rather than in-home observations (which are often only one session) and self-report measures uncorroborated by pertinent collateral information. In this survey, the courts reported that results from psychological testing, intervention recommendations, and assessments focused on parenting capacity directly were most valuable in formulating decisions. The courts were only interested in new information gathered for the assessment (rather than reiterating previously reported data) that was fact-based and determined through the use of validated testing.

In the integration of data into the final report for the court, there is some debate as to whether recommendations or just explanations of findings should be included (Bala & Leschied, 2008). According to Budd, Felix, Poindexter, Naik-Polan, and Sloss (2002), the APA Committee on Professional Practice and Standards (1998) recommends acknowledgment of limits to the conclusions and avoidance of unsupported opinions and recommendations. Bala and Leschied’s report indicates that approximately 75% of judges and CAS workers prefer to receive recommendations as opposed to only 56% of parents (presumably because recommendations often reflect negatively on parental outcomes). This currently leaves the issue to be determined by the particular preferences of the practitioner and court in different jurisdictions not only in the formulation of decisions but in the pertinent measures to use.

Current Practice and Problems with FPCA Measures

To determine parental capacity, an instrument must be able to reliably and predictably assess a parent’s potential for being able to care for a child in the future based on their past parenting record, the caretaker’s current parenting skills, and whether or not it is likely they will be able to change past behaviours and learn new, more appropriate parenting skills
While there are none currently available to measure parental capacity directly, there are various instruments utilized in FPCAs to aid in the decision-making process.

**Widely-used Measures.**

Bow, Gould, Flens, and Greenhut (2006) surveyed psychologists to determine the usage of psychological tests in child custody evaluations. Almost all respondents were concerned with determining psychopathology and personality functioning (96.6% and 88.8% respectively) and only 32.6% with parenting capacity. Determination of parental capacity is the purpose of an FPCA and yet few assessors were focussing on these factors. This may be the case because as discussed above, there are few demonstrably valid measures of the construct of parental capacity currently available.

In an attempt to address these concerns, several studies have examined the types of psychological tests most commonly used by forensic psychologists and their utility in FPCAs (Carr, Moretti, & Cue, 2005) and which tests are most relevant for parenting capacity evaluations (Lally, 2003). Some of the more utilized psychometric instruments include standardized tests such as intelligence tests (e.g. the Weschler Adult Intelligence Scales), personality tests (including the Millon Clinical Multiaxial Inventory-III [MCMI-III] or the Minnesota Multiphasic Personality Inventory 2 [MMPI-2]), and measures of socially desirable responding (like the Paulhus Deception Scale [PDS]). The tests and inventories most recommended and utilized for personality testing in FPCAs were the MMPI-2 (90.6%) and the MCMI-III (58%). Based upon extensive research on the MMPI-2 validity scales, Carr et al. (2005) recommend its routine use in FPCAs.

Families involved in child protection matters often experience a multitude of life stressors (e.g. poverty, mental health issues, violent neighbourhoods) that are atypical as compared to normative sample families used for standardized testing (Budd, Felix, Poindexter, Naik-Polan, & Sloss, 2002). The most commonly utilized standard measures (i.e. intelligence tests, personality inventories) have been empirically validated, but they are generalized tests of abilities and traits that may not necessarily be applicable for use in FPCAs as they do not directly measure parenting capacity (Otto, Edens, & Barcus, 2000). However, such measures as the MCMI-III and the MMPI-2 are widely used and accepted by psychologists for relating personality traits and types of responding to parental abilities (Blood, 2008; Carr, Moretti, & Cue, 2005; Lally, 2003). The assumption is that personality tests may uncover traits linked to parenting abilities although predictive validity related to parenting capacity has not been empirically verified (Budd & Holdsworth, 1996). The criticism that the MCMI-III is normed to clinical populations (and therefore less likely to be valid in parenting capacity assessments) has been disputed with the counterargument that many of the normed-sample consists of couples in high-conflict relationships as is frequently found in parents undergoing an FPCA (Bow, Gould, Flens, & Greenhut, 2006).

According to Otto, Edens, and Barcus (2000), the psychological test chosen should identify the specific constructs pertinent to the FPCA as set out in the court referral. In other words, tests must be selected based on their ability to reliably measure the traits needed to be examined by the court. It cannot be assumed that a psychological test used in one application is appropriate or valid in another context.
General Clinical Measures.

There is relatively little empirical data to support the validity of utilizing general clinical instruments in isolation with this particular population (Blood, 2008; Budd, Felix, Poindeexter, Naik-Polan, & Sloss, 2002; Carr, Moretti, & Cue, 2005; Otto et al., 2000). Instead, a combination of relevant measures must be selected so that FPCAs may test for a variety of court-ordered requirements. Some believe there are no current measures applicable for use in an FPCA. An argument against the use of psychometric measures is the lack of evidence as to their ability to assess the caregiver’s current and potential ability to parent which is the crux of an FPCA (Conley, 2003-2004). There is a multitude of valid and reliable instruments designed to measure particular traits, thoughts, and behaviours pertaining to a variety of constructs; but an instrument for reliably assessing parental capacity has yet to be empirically validated.

However, the FPCA process does not utilize psychological inventories as the primary data source, or as a means of assessing parenting capacity or best interest standards. Because of the complexity of FPCAs, usually more than one instrument is used to assess specific areas of concern. Even then, psychological testing should be only one part of a multi-modal approach to the FPCA (Blood, 2008; Budd, Felix, Sweet, Saul, & Carleton, 2006; Carr, Moretti, & Cue, 2005; Gould, 2004). Collateral sources, interviews, and observations must also be undertaken in conjunction with these psychological assessments in order to formulate more accurate clinical judgements as to actual parental capacity (Bala & Leschied, 2008; Carr et al. 2005). Due to the nature of FPCAs and the associated likelihood of positive responding bias in this population, multiple information gathering techniques are necessary to avoid misinterpretation of results (Carr et al., 2005).

Measures Linked to Parenting Capacity.

Commonly used measures that would seem to more directly meet parenting capacity criterion include conflict scales such as the Revised Conflict Tactics Scales (CTS2) and the Conflict Tactics Scales: Parent-Child version (CTSPC), stress measures (e.g. the Parental Stress Inventory (PSI), and child abuse inventories (especially the Child Abuse Potential Inventory [CAPI]) that are more clearly linked with risk factors of child maltreatment. The PSI was the parenting inventory recommended and used by 25% of psychologists surveyed for FPCAs (Gould, Flens, & Greenhut, 2006). A criticism of the PSI concerns its exclusion of fathers in the normative sample (Yanez & Fremouw, 2004). However, it is typically mothers who care for the children and are therefore at a presumably higher risk of stress and of being the perpetrator of child maltreatment.

Another criticism of the PSI described by Milner and Crouch (1997), was that compared with other measures assessing biased positive responding, the “defensive responding scale” of the PSI was less effective than other instruments such as the CAPI (as cited in Carr, Moretti, & Cue, 2005). Carr et al. recommended the CAPI as the best tool for assessment of positive self-presentation. The CAPI, and other tests such as the MCMI-III, incorporate built-in methods to detect impression management or positive response bias by examinees of FPCAs (Bala & Leschied, 2008; Carr et al, 2005).

Given the obvious demand characteristics of the assessment situation, the detection and interpretation of response bias is critical to the FCPA process. Some FPCA respondents tend to over-report positive qualities and under-report negative ones – leading to invalid tests and
requiring assessors to utilize other methods of evaluation (Carr et al., 2005). Positive responding is a common problem with FPCAs because presenting oneself as a good parent means that the respondent may not lose their child (Carr et al., 2005; McCann, Flens, Campagna, Collman, Lazzaro, & Connor, 2001). Therefore, it is important that psychologists pay attention to tests with built-in measures to detect invalid responding (Blood, 2008).

The results on some measures are indicative or act as cues to assessors that the possibility of response bias must be taken into consideration. The MCMI-III used in FPCA’s often demonstrates elevations on personality traits (e.g. histrionic, compulsivity, and narcissism) which rather than indicating a personality disorder, researchers suggest is associated with making oneself look good for the purpose of attaining positive test feedback (Carr et al., 2005; McCann et al., 2001). Positive response bias on the CAPI has also been correlated with higher scores on its Rigidity Scale which assesses an individual’s expectations of others. Carr et al. explains that these parents may lack the insight to see that they have unrealistic expectations of the child so do not manipulate their responding to such questions. Carr et al. recommend utilizing these types of items on tests for detection of child maltreatment.

Whichever measurement device is utilized it is always imperative that such tests are current, empirically-validated, and within the practitioner’s scope of competence referred to as “best practices”.

**Best Practices**

Zervopoulos (2010) effectively describes standards as being the procedures a psychologist “should” follow, and guidelines as being “aspirational goals” for which to “strive”. Ethical guidelines for forensic psychologists recommend using current, research-based methods (Committee on Ethical Guidelines for Forensic Psychologists, 1991). Canadian psychologists performing FPCAs must adhere to the guidelines and standards of practice governed by provincial laws and codes of ethics established by the Canadian Psychological Association (CPA, 2000). Connell (2008) explains that qualified psychologists with competency in the evaluation process follow established ethical standards of practice and guidelines through the use of pertinent, current, reliable, evidentiary methods as necessary components of a valid assessment. In Canada, the standard directly relevant to child protection matters is the APA “Guidelines for Psychological Evaluations in Child Protection Matters” (1999) that suggest FPCA evaluations include assessment of parent capacities most related to child maltreatment, assessment of the child’s needs (e.g. developmental needs, attachment, mental health), assessment of the parent’s ability to meet the needs of the child, and recommendations on intervention needs and likelihood of success (Bala & Leschied, 2008). Research must rely upon current research and best-practices from other fields which have empirical backing such as domestic violence, attachment styles, and parenting skills (Symons, 2010) that are either proximally or distally related to child abuse and neglect. Connell (2008) suggests that such gathering of information should be undertaken with neutrality and that conclusions be based on solid data and objectivity.

Reform based on the increasing numbers of children in the Canadian welfare system was enacted through legislation in Bill 210 of the Child and Family Services Act (2006) with amendments made to section 54 in 2007 calling for increased scope of FPCAs (Bala & Leschied, 2008). The amendment extended the focus of parental capacity assessment to also include a more ecological evaluation of all individuals involved in the FPCA including “medical, emotional,
developmental, psychological, educational, or social assessment” (Bala & Leschied, 2008, p.18). The methodology employed to obtain the required information for the court is determined by the assessor involved in the case. Judicial decision-making relies heavily on FPCA reports. In 22% of cases, the FPCA recommendations differ from those suggested by the CAS (Bala & Leschied, 2008). In 79% of those cases, the judge defers to FPCA reports. An FPCA is often the objective piece of evidence required to finally settle a case (Bala & Leschied).

Adherence to all these factors assists in the formulation of reliable and valid FPCAs. Still more research is required to assist the evaluator by establishing which assessment tools effectively and predictably measure specific aspects of parenting capacity. The difficulty lies in the lack of empirical research and the multiple, comorbidity of variables that must be examined when performing an FPCA (Belsky, 1993, Budd, Connell, & Clark, 2011). Development of a parenting capacity risk management inventory will assist evaluators with this process by separating risk factors into specific need areas in order to calculate level of risk and relevant treatment options based on parent responsivity factors.
Chapter III: Methodology

Development of PC-RMI

The Level of Service/Case Management Inventory (LS/CMI) (Andrews, Bonta, & Wormith; 2004) and the Youth Level of Service/Case Management Inventory (YLS/CMI) (Hoge, Andrews, & Leschied; 2002) are two of the most widely used instruments used to assess risk/needs in offender populations (Andrews, Bonta, Wormith, Guzzo, Brews, Rettinger, & Rowe, 2011). Based on similarities between maltreating parents and offender populations, and the predictive validity of the Level of Service inventories, it seemed reasonable to develop a tool utilizing relevant aspects of these instruments and the RNR model would be applicable for use in FPCAs.

Establishing Criteria & Format.

A comprehensive review of empirical literature aided in the compilation of data on risk and need factors associated with parental capacity and child maltreatment. Recognized correlates of these outcomes were then categorized into (static) risk factors (traits the caregiver possesses but cannot be changed or targeted for treatment such as age, convictions, or prior incidents of abuse) and (dynamic) need factors. Dynamic needs are critical in determining possible interventions. Dynamic needs in FPCAs are those associated with child maltreatment and risk of parental incapacity, but can at least potentially be modified if addressed appropriately. Each need must be treated separately using best practices (typically cognitive behavioural therapy) and taking client responsivity into consideration. Responsivity refers to using methods most suitable and relevant for the particular caregiver’s mental and physical requirements (e.g. if the parent is illiterate, interventions requiring little or no reading and writing must be implemented).

Once risk and need factors were categorized, operational definitions of each were formulated using definitions from empirical research and in consultation with the forensic psychologist (Appendix B). The purpose was to limit the vast number of cited risk factors into cohesive and more manageable need areas or categories on which to focus FPCAs.

Consolidation of data involved including well validated predictors and excluding variables that were either poorly related to outcome or redundant with established predictors. This data integration process resulted in the development of a preliminary version of the Parental Capacity – Risk Management Inventory (PC-RMI) (Rowe & McKay, 2011). The PC-RMI is a parenting capacity risk management system designed to structure and guide decision making (Appendix C). One of the creators of the YLS/CMI (Dr. Hoge) was consulted to ensure approval of the creation of a similar instrument for use with parents and to receive feedback and suggestions to improve the PC-RMI. Factors were then dichotomously coded to aid in determining inter-rater reliability (IRR) and to compute statistical analyses for predictive accuracy of current FPCA measures.

Static risk factors are ranked according to their magnitude of presentation and frequency and assigned correlating scores. Dynamic needs are presented as either present or not rather than weighting each factor with an assigned numerical value. Dynamic needs are categorized and tallies from each section ranked as to severity of risk. A total of 126 items representing four sections in two domains of static and dynamic needs as well as two domains delineating strengths and barriers to parenting were developed. A fifth section entitled Risk Management Review is a compilation of scores in each domain and summarizes test results.
Components.

Static factors offer a snapshot of the parent’s current situation and are useful for treatment follow-up comparisons. Section I – Static Needs includes measures of being the a) Perpetrator of Child Maltreatment (5 items) and of b) Personal Victimization (5 items). Unlike the remainder of the PC-RMI which tallies items, the Perpetrator of Child Maltreatment portion of the scale is an actuarial measure with scores assigned to each item. Total static needs include 10 items representing a possible total score of 15 risk fixed factors.

The dynamic need areas are listed in Section II – Dynamic Parenting Needs and Section III – Proximal Parenting Cues. The Dynamic Parenting Needs domain is divided into 9 categories (63 items). These include Child Factors (9 items), Community Support (6 items), Spousal/Partner Relationship (7 items), Lifestyle (7 items), Stressors (7 items), Personality/Temperament (8 items), Caregiver Attitudes (7 items), Substance Abuse (6 items), and Caregiver Mental/Physical Health (6 items). Proximal Parenting Cues are divided into 3 categories including Parenting Skills (8 items), Parenting Style (7 items), and Attachment (7 items). Total dynamic needs include 85 items amenable to change. Total static and dynamic needs represent a possible overall score of 100 before adjustments.

Section IV – Parental Responsivity Factors are divided into two categories: Strengths and barriers. Strengths (18 items) consist of a list of variables associated with mediating risk. While scores on this section do not affect the total score on the instrument, they do provide a list of possible existing resources that may be utilized when formulating treatment options and interventions. Barriers (18 items) delineate factors that may detract from treatment success and suggest possible impediments to treatment regimens. Responsivity factors may be discretionally used by the assessor as a ‘clinical override’ if after completing the entire FPCA it is determined that other factors were not captured by the test batteries and require note.

Section V – Risk Management Review consists of section and total test scores as well as an option for clinical override. The clinical override may be used to either increase or decrease total PC-RMI scores. If the override is utilized, an adjusted final score is calculated. Scores are categorized into risk factors (low, moderate, and high). Items endorsed in Sections II to IV are designed to guide case management protocol and to determine use of override option. High and moderate risk parents would be recommended for responsivity-based interventions focussed on their specific dynamic need areas in the final document to the court.

Dynamic factors are the areas in which behaviour modification is possible. The PC-RMI is based on static risk items (n = 10; 7.9%) and dynamic need areas (n = 85; 67.4%). The balance of the scale (n = 36; 24.7%) highlights parental responsivity factors relating to strengths and barriers to treatment implementation. The focus on dynamic risk and responsivity reflects the importance of addressing factors amenable to change and to its relevance as a prevention and solution oriented tool.

Coding and Scoring.

Items listed in Section I – Perpetrator of Child Maltreatment are scored based on the frequency of abuse. Number of incidents under Perpetrator of Child Maltreatment include 0 (not present), 1 (mild), 2 (moderate), and >3 (severe/chronic). The exception to this rating is Item 6 – Prior removal of a child. In this instance incidents are assessed as 0 (never), 1 (once), 2 (moderate), and >3 (severe). In all cases, frequencies of ‘0’ are considered to be “not present”
and receive a score of ‘0’. Incidents greater than 3 are considered to be “severe/chronic” and are assigned a score of ‘2’. Mild (1) and moderate factors (2) both score a ‘1’ in an attempt to prevent over estimating risk and skewing results with a negative bias against parents. Under Personal Victimization, items are checked off to indicate if a factor occurred or not and receive a rating of ‘1’. See Appendix B for complete descriptions of risk factors and scoring criteria.

The balance of the PC-RMI is utilized as a checklist rather than as an actuarial measure. Items are checked-off to indicate whether a particular factor is present or not. Check marks from the domains in each section are added together to establish a level of risk. To determine the level of risk, the number of items checked in each domain of Sections I, II, and III are tallied. The tally scores are placed in boxes at the end of the test beside each category. Total static and dynamic scores are added together to obtain a total PC-RMI risk/need level. Scores are then compared with the PC-RMI risk/need level guide in order to determine static, dynamic, and overall total risk/need levels. The parent’s overall level of dynamic risk before a clinical override is implemented is calculated by summing the total checked boxes in each domain. These overall total dynamic PC-RMI tallies are designated as Very Low Risk (0-10), Low Risk (11-25), Moderate Risk (26-40), High Risk (41-60), or Very High Risk (61-100) of child maltreatment.

Strengths and barriers are tallied but are not used in the calculation of total risk/needs. These scores are used for clinical interpretation of risk. They form a “clinical override” in which assessors have the option to utilize clinical judgment and expertise based upon interviews, observations, and collateral sources to incorporate client strengths and barriers at their discretion to total scores in order to increase or decrease final risk/need level. Although this is a subjective opinion, it is recommended that an override be accompanied by written logical and reasonable rationale for its implementation. This is also common practice with other predictive forensic instruments such as the LSI (Andrews, Bonta, & Wormith, 2004).

**Psychometric Properties.**

An oath of confidentiality was signed by the author allowing access to restricted files for the purpose of FCC approved research (Appendix F). Consent to access files is considered an FCC internal file review and as such does not require research ethics board approval.

Data collection, review, and analyses of the revised PC-RMI were conducted at FCC. Ten parents (n=10) representing six (n=6) files were randomly selected from FPCAs performed in the last year (2011). Case files were chosen randomly so that those examined consisted of a variety of case scenarios ranging from single-parent cases to those involving multiple parents, children, and other family members. Two files involved one parent and one child. Four files involved two parents having 1-4 children apprehended by the CAS.

Inter-rater reliability (IRR) between two raters would have independently assessed the relationship between the PC-RMI and the FPCA outcomes for the 10 assessments. Due to time constraints, IRR stats for the comparison between PC-RMI scores, and the outcomes of the actual cases were not obtained. In order to obtain some measure of reliability, one rater was used to compare PC-RMI results with archival data.

Archival files of prior FCC clients who had undergone FPCAs were examined. Ten client files were compared independently by the rater to determine concurrence between test measures and initial results derived by assessors using standard FPCA protocols. Based on results, it was concluded that the current, preliminary version of the PC-RMI was sufficiently reliable to be employed in preliminary validation work.
Coded variables were examined and then analysed for relevancy of procedures and measures used at FCC in formulating FPCA conclusions and/or recommendations for the court. Analyses included thoroughly reviewing conclusions and test results from the archival files and comparing those recommendations with the total PC-RMI risk/need level to determine if final report conclusions match the scores or results derived from using current FCC FPCA practices. The PC-RMI utilizes factors that are concurrent with empirically-founded parenting capacity factors as being predictive of child maltreatment. Equivalent results between methods currently implemented for FPCAs and the PC-RMI would indicate that current measures are targeting key predictors of child maltreatment and parenting incapacity.

**Concurrent Measures**

Instruments analysed were those currently utilized by FCC for FPCAs. The FCC FPCA measures include:

**Shipley Institute of Living Scale (SILS).**

The SILS (Shipley, 1982) is a test of vocabulary and pattern recognition that is used as a general screening device of intellectual performance and impairment. It consists of two subtests: vocabulary which lists 40 words with four other words from which the examinee must circle another word of similar meaning, and abstraction which consists of 20 abstract chains with blanks after each one which the examinee fills in to complete the pattern. Scores from the two subtests are calculated to determine an estimated intelligence quotient (IQ). Developers recommend integrating the SILS with other assessment procedures and tests to get a more thorough assessment of the examinee. The SILS has demonstrated both reliability and validity for its measures.

**Paulhus Deception Scales (PDS).**

This is a 40-item self-report instrument that measures the degree to which a client may be responding in a socially acceptable manner (Paulhus, 1999). It is used to determine distorted responding in testing. The scale focuses on impression management and self-deceptive enhancement. The PDS uses a Likert-type scale from 1 meaning “not true” to 5 meaning “very true” in which examinees circle the answer they feel best describes themselves. This is a standardized measure with empirical support, validity, and reliability.

**Millon Clinical Multiaxial Inventory-III (MCMI-III).**

The MCMI-III is a revised version of the original MCMI devised by Millon (2009). It is a diagnostic instrument used to determine personality patterns, pathology, and syndromes linking clinical theory and diagnostic categories as listed in the DSM-IV-TR. The MCMI-III is recommended only for use with individuals exhibiting dysfunctional emotional and interpersonal symptoms or who are participating in psychotherapy or psychodiagnostic evaluations. The MCMI-III is a widely utilized instrument with norm based data derived from clinical samples.
The Child Abuse Potential Inventory (CAPI).*

The CAPI (Milner, 1986) is a screening device used in suspected physical child abuse cases. The CAPI assists in discriminating between physical abusers, neglectful parents, and at-risk parents. As with all self-report measures, it is recommended that multiple other collateral sources are used concurrently due to the seriousness of decisions regarding child welfare. The inventory consists of 160 agree/disagree statements, contributing to 12 scales. The scales fall under the categories of Abuse (77 items), Lie (18 items), Random Response (18 items), Inconsistency (20 items), Distress (36 items), Rigidity (14 items), Unhappiness (11 items), Problems with Child and Self (6 items), Problems with Family (4 items), Problems from Other (6 items), Ego-strength (40 items), and Loneliness (15 items). The Lie, Random Response, and Inconsistency scales are designed to detect response styles that could affect the validity of the test results.

Parenting Stress Index (PSI).*

The PSI (Abidin, 1995) is a screening and diagnostic assessment that measures relative magnitudes of stress in parent-child interactions. It focuses on parent characteristics in the context of family variables that may impact parental functioning. The PSI identifies and measures stressors in three domains: child characteristics, parent characteristics, and situational/demographics. These factors are considered additive – meaning the more an individual exhibits, the more stress one is likely to experience. The goal is to use the PSI as a preventative measure to identify stressors early in order to provide interventions before problems escalate. The PSI uses a Likert-scale format consisting of 120 statements that entail a combination of multiple-choice or yes/no responses. Totals are grouped into child and parent domains to yield a total stress score.

Conflict Tactics Scales.

The Conflict Tactics Scales (Straus, Hamby, and Warren, 2003) are divided into two tests: the Revised Conflict Tactics Scales (CTS2) which is an updated version of the CTS, and the CTS: Parent-Child version (CTSPC). Both instruments consist of statements followed by Likert-type scales indicating frequency of behaviours with eight options from once to never. The CTS assessments are brief and quick to complete making them widely used measures. It is recommended that both partners complete the tests for more reliable results.

Revised Conflict Tactics Scales (CTS2).*

The CTS2 is a revised version of the CTS for use in research and clinical applications to include more questions, reliability, and validity (yet to be empirically-established). Unlike other similar psychological tests, no standard scores or diagnostic interpretation is delineated. Instead, the CTS2 is used to determine patterns of family violence. The CTS2 is recommended for use as a tool to guide interviews and interventions in order to assess frequencies of behaviours before and after treatment. The CTS2 is unique in that it is designed to assess current maltreatment of children instead of depending upon retrospective reports. The CTS2 consists of 78 items in five categories: negotiation, psychological aggression, physical assault, injury, and sexual coercion occurring within the past year and over the lifetime of the child by both partner and self.
**Conflict Tactics Scale: Parent-Child Version (CTSPC).**

The CTSPC consists of 35 items that are divided into categories of nonviolent discipline, psychological aggression, weekly discipline, neglect, physical assault, and sexual abuse occurring within the past year and over the lifetime of the child by both self and partner.  
*Due to copyright laws, a copy of these tools is not provided.*

**Semi-Structured Interviews.**

Assessors use a template or interview guidelines to assist in the direction of the interviews. Questionnaires utilized are at the discretion of the individual assessor. See Appendix E for a sample page of suggested interview questions utilized by the presiding psychologist at FCC. Regardless of the interview guidelines, an interviewer may include all items suggested in the guidelines or they may choose to broaden or limit questions depending upon the relevance to the particular case. Sometimes there is an abundance of material already present in the case file so reiteration of questions that have already been adequately answered is redundant. The number of interviews is at the discretion of the case assessor and will usually depend on the amount of information deemed necessary to develop pertinent clinical decisions.

**Parent-Child Observations.**

Depending upon the client, observations of parent-child interactions may take place in one of the observation rooms at CAS or FCC, in the playground on CAS property, or within the client’s home. In the observation rooms, assessors sit in an adjacent room with a two-way mirror for viewing the parent-child interactions with a sound system for listening to the dialogue between the parties. These observations are conducted with the parent’s knowledge. The rationale for this type of observation is either to avoid distracting the child thereby improving the naturalistic responding of the child to the parent, or the parent is not permitted visitation with the child in the home due to court-mandated restrictions. Some CAS offices have a playground on the grounds to perform observations of parent-child behaviour outdoors in a more natural environment. In-home observations take place at the caregiver’s home which have the benefit of occurring in a more natural setting. The disadvantage is that observers and the location itself may inadvertently become confounding variables or distractions to parent-child exchanges due to the multiple extraneous and uncontrollable environmental stimuli present. The type of observation and the number of observations conducted are at the discretion of the assessor (assuming the parent has permission from the court to have access to the child in a variety of settings). Assessors take extensive notes while conducting observations. These notes are later used for reference in completion of the FPCA.

**Collateral Sources.**

Collateral sources refer to valid and reliable evidentiary resources obtained from external or more distal information bases essential for completion of the FPCA. Researching collateral sources requires the retrieval of additional information relevant to the case that can be used to clarify or dispute current or past data. Collateral source collection may involve obtaining school or employment records or any documentation with direct relevance to the case, and it may
involve interviewing teachers, neighbours, case workers, or anyone with pertinent information about the parent or caregivers implicated.
Chapter IV: Results

Possible PC-RMI scores were rationally divided into risk/need levels based on total static needs, total dynamic needs and total overall risk/need level. Table 1.1 illustrates risk/need “bins” based upon PC-RMI scores.

Table 1.1

Score-based PC-RMI Risk/Need Level Guide

<table>
<thead>
<tr>
<th>Risk/need level</th>
<th>Very low</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>Very high</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total static needs</td>
<td>0</td>
<td>1-2</td>
<td>3-4</td>
<td>5-10</td>
<td>11-18</td>
</tr>
<tr>
<td>Total dynamic needs</td>
<td>0-12</td>
<td>13-23</td>
<td>24-36</td>
<td>37-47</td>
<td>48-82</td>
</tr>
<tr>
<td>Total risk/needs</td>
<td>0-12</td>
<td>13-25</td>
<td>26-40</td>
<td>41-57</td>
<td>58-100</td>
</tr>
</tbody>
</table>

FPCAs on ten parents were blindly coded using the PC-RMI (Table 1.2). The correlations between the FPCA measures utilized to make the initial case recommendations and the PC-RMI demonstrated a concurrence rate of 9 cases out of 10 (90%).

Table 1.2

Concurrence between PC-RMI and Currently Utilized FPCA Measures

<table>
<thead>
<tr>
<th>Parent</th>
<th>Overall Risk/Need Level</th>
<th>PC-RMI</th>
<th>FPCA Measures</th>
<th>Concurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>2</td>
<td>Moderate*</td>
<td>Moderate/High</td>
<td>Moderate/High</td>
<td>X</td>
</tr>
<tr>
<td>3</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>4</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>5</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>6</td>
<td>Low</td>
<td>Low</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>High</td>
<td>High</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>High</td>
<td>High</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Moderate</td>
<td>High**</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>High</td>
<td>High</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

*PC-RMI used clinical override in this case to raise moderate level to moderate/high
**High rating of FPCA measure in this case was based on high static needs of this client
Chapter V: Discussion

Interpretation of Results

Although only minimal data were analysed, results of the PC-RMI being in concurrence with 90% of archival files examined indicates that findings support the correlational relationship between the measure and traditional FPCA methods. It must be noted that after initial comparison of results in one of the cases (parent #2), there was a discrepancy in the initial recommendations presented to the court with PC-RMI findings. This was a more complicated case requiring additional information from collateral sources, interviews, and observations. More in-depth investigations using these additional methods yielded pertinent information not picked-up by the PC-RMI alone. This is the reason for the clinical override option in this instrument. Incorporation of supplementary relevant findings to the clinical override section yielded an increased risk/need level that matched file and PC-RMI findings. Initially, there was a slight discrepancy between the two measures. In this case, the clinical override was implemented resulting in concurrence between the measures. However, the only way to obtain reliable comparisons would have been to implement the clinical override in all ten cases, not just where the measures failed to agree.

The results were not in concurrence were for parent #9. This case involved a high number of static risk factors that had accumulated over a long period of time. Collateral sources and clinical interviews revealed a history of child maltreatment and CAS involvement that crossed generations. This parent had made significant changes in recent years that resulted in a much lower dynamic needs score. The PC-RMI was designed to measure dynamic behaviours that have occurred within the last year while the parent was still in contact with the child. Static factors are consulted and influence overall test totals but it remains up to the individual assessor as to how to weight static factors against dynamic factors. In this case, the assessor chose to rate the parent’s past history as being a significant factor affecting her future parenting ability and designated her as high risk for child maltreatment.

Outcome

The purpose of this study was to provide preliminary data on the relationship between the FCC parent capacity assessment protocols and a research version of an empirically-based risk assessment protocol. This study managed to operationally define many of the most cited risk factors in the literature. These risks/needs were categorized into static, dynamic, and protective factors that lead to the development of the PC-RMI. Preliminary findings indicate that the PC-RMI is an effective a tool in assessing parental capacity as compared to current FCC protocols. However, there are several strengths and limitations that need to be mentioned.

Strengths and Limitations

The primary strength of this study was the development of a pilot version of a much needed standardized instrument (the PC-RMI) for FPCAs. Standardized instruments provide for more predictive, valid, reliable, and time-efficient assessment analysis.

This study also utilized methodologies that have been repeatedly scientifically validated, and have an extensive history of successful application in the realm of the prediction of criminal
risk. This allowed the development process and the design of the preliminary instrument to be modelled on such instruments. It allowed the project to progress in a more timely fashion than if no such model were available.

The development of a preliminary checklist or tool (the PC-RMI) that may be used by other researchers of FPCAs as a template from which to base selection of psychological measures pertinent to a particular case is of relevant use to FPCA assessors. The PC-RMI may serve as a foundation from which to further expand upon or narrow down and clarify parental capacity risks and needs. The caveat is that decisions regarding parental capacity should not rely solely on PC-RMI results. The purpose of the PC-RMI is to act as an adjunct with other measures to determine risk of child maltreatment as part of a comprehensive and systematic assessment. The PC-RMI is not an exhaustive list of risks and needs so must be incorporated with other instruments to enhance accurate decision-making. No cut-off scores have been established due to the lack of sufficient client data so cannot be used as the primary method of evaluation.

The PC-RMI provides assessors with a tool from which to quickly review files, compile results, and make recommendations to the court. The division of the PC-RMI into the various domains allows for assessors to determine an estimated risk of child maltreatment and to act as a guide for treatment strategies to reduce or manage those risk factors.

An additional strength of the PC-RMI is the quantity of dynamic risk factors addressed. Since dynamic factors are those subject to change through intervention, the PC-RMI may be used repeatedly with parents over time to measure treatment effects and progress. This in turn allows for ongoing and relevant modifications to intervention implementation.

There are also strengths related to the PC-RMI static risk factors. Since static items remain constant over time, multiple applications of the PC-RMI to parents are liable to produce more consistent results adding a measure of reliability to the instrument. Although static risks do not change once they have occurred, the commission of additional child maltreatment offences, aging, and other changes over one’s lifetime have the potential to increase one’s risk of future occurrences if dynamic needs have not been addressed or rectified. The PC-RMI will demonstrate such changes with repeated use.

As in all studies, this report contains several major limitations. Of particular note is the 16-week time limit for completion of this project. The volume of variables involved with child maltreatment and the comingling of many factors, paired with the minimal and often conflicting data, requires a substantial amount of time for sorting through all the information. Such an extended time period was not possible during the writing of this report. Such time constraints also made it impossible to perform IRR that is necessary for scientifically-based research. Related to time limitation is sample size limitation. Time restrictions resulted in associated restrictions in the number of cases available for analysis.

Limitations to all such studies consisting of multiple and often overlapping traits will be the ability to discern cause and effect within a complex contextual situation. It is unlikely that any single factor will be discovered as the cause of child maltreatment or as the determinant of specific responses in each child. However, it is hypothesized that consistent, methodological, systematic research will reveal significant indicators of abusive behaviour that will ultimately lead to preventative treatment and mediate interventions. The creation of measures and methods to gather and assess such data is the first step towards finding solutions to child maltreatment and more effectively and predictably assessing parent capacity.
Psychological instruments currently implemented by FCC were analysed as to their relevance in FPCA procedures, but it remains unknown whether the particular tool utilized was the best measure of the particular variable in question (e.g. the MCMI-III or the MMPI-2). Although instruments designed to measure similar constructs were not compared, the literature review verified use of the MCMI-III, the CAPI, and the PSI as valid and reliable tools as compared with other similar measures (Carr, Moretti & Cue, 2005; Gould, Flens, & Greenhut, 2006; Lally, 2003).

The SILS, PDS, and conflict tactics scales were not assessed in previous studies of parental capacity so their relevance in FPCAs is unsure. However, all have substantial reliability and validity ratings as to their psychometric properties (Paulhus, 1998; Shipley, 1982; Straus, Hamby & Warren, 2003) but would require a future normative sample based on FPCA or similar clients to provide more robust verification for their continued use in FPCAs. Results of this study help contribute to the utility of these instruments for measuring parents’ current levels of functioning, deception, and ability to cope with conflict. All these instruments are focused on variables identified in empirical research as risk factors of child maltreatment. The use of SILS would be a valid option for parents demonstrating cognitive impairment. The conflict tactic scales are suitable for identifying maladaptive coping strategies in conflict situations. The PDS could be viewed as relevant for any type of psychological testing to either verify built-in deception scales of various concurrent instruments or to supply a deception measure to cover instruments that do not have invalid responding markers. The use of the PDS in FPCAs may be even more relevant due to the empirically reported tendency of this population to employ manipulative responding on such tests. Until enough data on FPCA cases are accumulated, the selection of relevant psychometric instruments must rely on current research and normative samples of similar populations such as offender scales while acknowledging that such populations may vary significantly from one another.

**Multilevel Challenges**

**Client Level.**

Forensic parental capacity assessments are court-mandated rather than voluntary so the challenge with the parents is to be able discern self-biased, positive self-reporting when analyzing psychological test results, interviews, and observations. This population is highly motivated and empirically demonstrated to yield invalid responses to assessors due to the fact that a negative report to the court may lead to termination of parental custody of the child. Therefore, it is critical to implement instruments that have been proven to detect invalid responding and make careful note of discrepancies and contradictions in self-disclosure during interviews and observations.

**Program Level.**

Court-ordered requests for parental capacity assessments must be clear and specific as to what information is required to be tested by assessors in order for relevant assessment procedures and methods to be utilized. Then it is important to make sure instruments selected to measure such factors have been empirically shown to assess these variables both reliably and predictably. The challenge is to determine the particular instruments that accurately measure for these risk
factors and that these factors are directly related to a lack of parental capacity to the point where
at child may be at risk. There has been little research to demonstrate the correlation of specific
risk factors to parent incapacity which leaves assessors having to oftentimes rely on clinical
judgment and expertise in conducting the assessments and utilizing measures they feel are best
suited to making determinations as to parental capacity and what is in the best interests of the
child.

Organizational Level.

At the organizational level, the problem lies in the lack of qualified forensic assessors and
the high case load of parents requiring assessment. Due to the critical nature of these assessments
in reaching timely conclusions so that a child is not at risk of continued or sustained harm, time
is of the essence. At the same time, hasty testing may lead to a lack of thoroughness of the
investigation and lead to inaccurate conclusions and recommendations to the court. A parental
capacity assessment takes a minimum of six weeks to complete with many lasting two- to three-
months. In order to form valid and reliable conclusions, parental capacity assessments cannot be
hurried. There is a need for more qualified assessors so that mistakes, which have the potential of
seriously hurting a child and the family, do not happen.

Societal Level.

Prevention of child maltreatment should be a priority to everyone in any society. However, there is not much money to be made in the child welfare system so funding is often very limited. Word needs to get out as to the conditions many of our children are living in so that the cycle of abuse can be terminated as soon as possible. There needs to be more education as to risk factors of child maltreatment so that abuse can be detected earlier rather than too late. For parents at-risk of maltreating children, there needs to be more government support of programs to teach proper parenting skills and to make funds available that these parents can easily access help.

Contribution to the Behavioural Psychology Field

This study highlights the importance of accurate assessment of functional behaviours and
the need to focus on dynamic factors that are susceptible to change through the use of best
practices and recognition of client responsivity. The analyses of forensic parental capacity
assessments add to the slowly growing body of research evidence by providing a preliminary
template (the PC-RMI) relevant for rating, assessing, determining interventions, and making
recommendations to the court. Creating a list of risk factors, categorizing and ranking them into
pertinent need areas, gives assessors a visual, descriptive, and standardized tool that is
parsimonious yet comprehensive for analysing risk of parental child maltreatment. Addressing
relevant identified needs with appropriate, caregiver-focused treatment based on cognitive
behavioural interventions formulated to meet the specific responsivities of each parent will lead
to important skill acquisitions necessary for improving parental abilities and maintaining family
unification. The implementation of accurate, predictive psychometric testing can be used to focus
on significant parental needs as a supplementary and complementary tool to pinpoint problem
areas, discrepancies, and consistencies as compared with concurrent measures to assist in ascertaining identification of pertinent needs.

Tools such as the PC-RMI support the process by creating a standardized instrument that may be used to identify parent’s specific needs based on the severity of risk. Implementation of such a guide or checklist allows the selection of psychological assessment measures correlated and most suited to significant needs rather than using instruments in an almost haphazard way with no focus or orientation on traits most symptomatic of the individual parent’s capacity to parent or maltreat a child. The use of current empirical research, statistical methods, and valid, reliable measures, helps to entrench the field of behavioural psychology within the realm of applied science.

**Recommendations**

As research indicated, it was apparent that empirical studies in the area of parental capacity was minimal (Budd, Connell, & Clark, 2011; Symons, 2010). The wide range of factors associated with child maltreatment and parenting was extensive but often coalescent. These factors impede the determination of possible causes and effects or assignment of rank to specific risk factors. It is anticipated that the recently formulated PC-RMI of risks and needs may serve as a preliminary guide to enable focus on explicit need areas. It is emphasized that the data presented in this study and the creation of the PC-RMI are rudimentary beginnings to a project that requires much more intensive research by others in the field for future implementation. Based on the aforementioned limitations, there is a need for prospective studies.

A recommendation would be to determine whether or not one need is more statistically significant than others in the examination of correlations between parental capacity and child maltreatment. Refinement of the PC-RMI by future researchers may produce a more utilitarian instrument practical for effective prediction and subsequent valid and reliable recommendations to aid in judicial decision-formulation of parental capacity.

Another recommendation is to modify current interview guidelines to follow the format of the PC-RMI in order to ensure addressing all of the items during the interview in the same order. This would lead to a more structured interview format and make cross-referencing and PC-RMI completion more parsimonious and accurate.

It is suggested that future research expand the number of files studied as well as to broaden the research base from one clinic to include other family court clinics and other locations or facilities that perform FPCAs to increase the data base and establish base rates.

Finally, it is imperative to establish inter-rater reliability so that changes to the existing PC-RMI may be effected accordingly.
References


27


Appendix A: Glossary of Common FPCA Terms

Child Maltreatment

In Canada, child maltreatment refers to harm or risk of harm to a child. The maltreatment may consist of physical, emotional, and sexual abuse, neglect, and exposure to domestic violence that may lead to negative consequences for the child such as behavioural, emotional, physical and psychological problems for the child (PHAC, 2006). Maltreatment may involve harm by commission or by omission.

Harm by Commission

a) Physical Abuse
Physical abuse refers to the application of any unreasonable force directed bodily towards a child such as hitting, pushing, burning, grabbing roughly, or restraining that may result in bruises, burns, cuts, broken bones, concussions, and even death (PHAC, 2006). This may involve physical or corporal punishment inflicted on the child involving “generally acceptable mode(s) of physical punishment, but is overdone, prolonged unduly, or excessive force is used” such as continued or lengthy beating, shaking, kicking, etc. done to control the child and may or may not result in physical injury (Ontario Child Welfare, 2006).

b) Emotional Abuse
Emotional abuse involves behaviours directed at the child that result in emotional, spiritual or psychological harm and may include verbal threats, teasing, or degrading comments, and/or mannerisms such as angry looks, rolling eyes, or any behaviours that result in the child feeling anxious, depressed, fearful, sad, or angry (PHAC, 2006).

c) Sexual Abuse
Sexual abuse involves an adult or youth obtaining sexual gratification from a child through sexual contact or activities such as penetration, attempted penetration, oral sex, and other sexual acts including sexual exploitation that consists of posting photos of the child on the internet sites or prostituting them (PHAC, 2006). Sexual abuse may also include non-contact such as sexual harassment, suggestiveness, or exhibitionism (Ontario Child Welfare, 2006).

Harm by Omission

a) Neglect
Neglect involves a parent or caregiver not supplying necessary physical and psychological care for a child. Examples include lack of supervision, food, clothing, shelter, schooling, health care, and abandonment that may result in physical harm to a child (PHAC, 2006).

Exposure to Domestic Violence
Exposure to domestic violence can involve both harm by omission such as a child seeing and/or hearing violence between adult family members or between partners, or it can involve harm by commission such as the child being used as a “tool” during the violent incident by the
perpetrator, both of which may result in the child experiencing negative consequences afterwards (e.g. having to move, losing a parent) (Statistics Canada, 2001).

**Parental Capacity**
Parental capacity is considered to be a parent’s potential for being able to care for a child in the future based on their past parenting record, the caretaker’s current parenting skills, and whether or not it is likely they will be able to change past behaviours and learn new, more appropriate parenting skills (Leitenberger, Manglicas, Pauker, Smith, Steinhauer, & Goncalves, 1993).

**Parental Ability**
Parental ability refers to the parenting skills currently possessed and utilized by the parent including strengths and weaknesses (Leitenberger et al., 1993).

**Parental Capacity Assessment**
Looks at parental abilities and assesses the caretaker’s capacity for positive change based upon historical and current parenting behaviours (Leitenberger et al., 1993).

**Forensic**
The term forensic refers to any investigation that takes place within a legal context.

**Risk**
According to Standard 6 of the Child Protection Standards (CPS) in Ontario (2007), risk is defined as: “An estimation of the likelihood of future child maltreatment due to family characteristics, behaviour or functioning and/or environmental conditions. Risk of maltreatment exists on a continuum from low to high risk. Some risk of maltreatment is present in every family even if it is very low.” (CPS-06:S6).

**Risk Factors**
Risk factors are traits, attributions, living conditions, or stresses that as they accumulate, increase the likelihood of child maltreatment.

**Static Risk Factors**
Static risk factors pertain to unchangeable indicators of risk such as historical factors including sex, age, number of crimes, incidents of abuse, or children abused (Yokley, n.d.). These are useful for determining the likelihood of reoffending but are not the focus of interventions.

**Dynamic Risk Factors or “Needs”**
The term dynamic refers to the malleability of the risk factor. Dynamic risk factors include traits, situations, and attitudes that are subject to change (growth, deterioration, or movement) throughout one’s life (Yokley, n.d.). These risks are referred to as “needs” because interventions can be implemented towards these factors to produce meaningful and long-lasting change.
Protective Factors

Protective factors are inherent coping strategies and skills that an individual possesses to deal with stressors. Protective factors may also consist of external factors such as supports that assist the individual in overcoming obstacles (Belsky, 1993; Vondra & Toth, 1989). Like risk factors, these too are cumulative although current research as to their subtractive abilities has not been empirically proven. As a result, in this study protective factors are viewed as positive traits or abilities that may be utilized in addressing risks but are not used to offset them.

Best Interests of the Child

FPCAs must always put the mental and physical welfare of the child ahead of the needs of the parents so as to ensure and enable future and continued well-being of the child.

Best Practices

In an FPCA, best practices involve utilization of procedures or techniques empirically proven to be the most currently effective and practical for conducting assessments.
Appendix B: PC-RMI Definitions & Scoring Guidelines

SECTION I. STATIC NEEDS

a. Perpetrator of Child Maltreatment

In Canada, child maltreatment refers to harm or risk of harm to a child. The maltreatment may consist of physical, emotional, and sexual abuse, neglect, and exposure to domestic violence that may lead to negative consequences for the child such as behavioural, emotional, physical and psychological problems for the child (PHAC, 2006). Maltreatment may involve harm by commission or by omission.

i. Physical child abuse

Physical abuse refers to the application of any unreasonable force directed bodily towards a child such as hitting, pushing, burning, grabbing roughly, or restraining that may result in bruises, burns, cuts, broken bones, concussions, and even death. This may involve physical or corporal punishment inflicted on the child involving “generally acceptable mode(s) of physical punishment, but is overdone, prolonged unduly, or excessive force is used” such as continued or lengthy beating, shaking, kicking, etc. done to control the child and may or may not result in physical injury (Ontario Child Welfare, 2006). Verbal abusive behaviour are not considered unless they are specifically aggressive in nature (i.e., threats to harm child).

0 = Not present. Physical abuse has never been witnessed or suspected by parent.

1 = Minor. Physical abuse or threats to harm has occurred on at least one previous occasion with no serious injury. Serious injury is present if there are marks on the child, they require medical attentions, or the abuse comes to the attention of an outside agency/hospital or a weapon is present.

2 = Moderate. Physical abuse or threats of harm has occurred more than once but no injuries OR physical abuse or threats have been perpetrated on more than one child with no serious injuries.

>3 = Severe/Chronic. Physical abuse is considered severe or chronic. It must include multiple physical occurrences with at least one serious injury. It must also be physical.

ii. Sexual child abuse

Sexual abuse involves an adult or youth obtaining sexual gratification from a child through sexual contact or activities such as penetration, attempted penetration, oral sex, and other sexual acts including sexual exploitation. Sexual abuse may include non-contact such as sexual harassment, suggestiveness, or exhibitionism.

0 = Not present. Sexual abuse has never been witnessed or suspected by parent.

1 = Minor. No physical contact during sexual abuse but some sexual element or involvement between the parent and ANY child.

2 = Moderate. This must include sexual contact or suspicion of sexual contact between the parent and ANY child. The sexual contact is not considered invasive (i.e., touching above clothes) or MAY be interpreted as innocuous.

>3 = Serious. Sexual contact with ANY child that is confirmed AND the abuse involves a clear sexual motive or is invasive.
iii. Domestic violence
Exposure to domestic violence can involve both harm by omission such as a child seeing and/or hearing violence between adult family members or between partners, or it can involve harm by commission such as the child being used as a “tool” during the violent incident by the perpetrator, both of which may result in the child experiencing negative consequences afterwards (e.g. having to move, losing a parent).

0 = Not present. A child under their care has never been exposed to domestic violence.

1 = Minor. Child has been exposed to one minor incident of conflict between the parent and other adult AND this has had no negative impact on the child.

2 = Moderate. Child has been exposed to minor incidents of conflict between the parent and other adult OR multiple children have been exposed to parental conflict AND this has had no negative impact on the child.

>3 = Severe/Chronic. The parent has exposed any child to acts of physical violence including threatening behaviour OR parental conflict in the home has resulted in a negative impact on any child.

iv. Child neglect/Fail to protect
Neglect involves a parent or caregiver not supplying necessary physical and psychological care for a child. Examples include lack of supervision, food, clothing, shelter, schooling, health care, and abandonment that may result in physical harm to a child.

0 = Not present. Neglect has never been witnessed or suspected by parent.

1 = Minor. Neglect has occurred on at least one previous occasion with no serious or negative impact.

2 = Moderate. Neglect or exposure of child to a dangerous situation/individual has occurred more than once OR neglect has been perpetrated on more than one child with no negative impact.

>3 = Severe/Chronic. Neglect or exposure of child to a dangerous situation/individual has resulted in multiple occurrences of neglect or failure to protect the child with obvious negative impact.

v. Prior removal of child
The parent has had at least one child removed from their care by CAS in the past. This does not require official CAS action but may involve informal agreements to have the child stay with another guardian as a result of parenting concerns.

0 = Never. The parent has never had a biological or step-child that was in their care removed from their home due to CAS concerns.

1 = Once. Child(ren) have been temporarily removed from the home on ONE previous occasions. The removal of multiple children must be stemming from the same incident or concern.

2 = Moderate. A child or children have been removed from the home on two occasions as a result of separate incidents.

>3 = Severe. A child or children have been removed on more than two occasions due to separate events OR the parent has ever had a child permanently removed from their care (i.e., adopted or CAS ward).
b) Personal Victimization

Scoring: An item is checked off as either having occurred (witnessed or experienced by the parent as a child and the allegation confirmed) or not occurred. Each item checked is tallied as the number of past occurrences of personal childhood maltreatment.

i. Victim of childhood abuse
   Includes: physical and sexual abuse. Parent was a victim of childhood physical or sexual abuse from a parent or guardian.

ii. Victim of neglect
   Parent was subjected to childhood neglect by his/her parents/caregivers.

iii. Victim of domestic violence
   Parent was exposed to domestic violence as a child.

iv. In custody of CAS as child
   The parent was removed from the family home by CAS on one or more occasions as a child as a result of physical abuse, sexual abuse or neglect. This does not include removal due to behavioural problems.

v. Insecure attachments to primary
   The parent’s history suggests that there was a lack of secure attachment to a primary parental or guardian figure as a child. Descriptions of avoidant, ambivalent or disorganized attachments to parents are likely to be present.

Scoring for DYNAMIC NEEDS – Sections II & III:

Check-off the box beside the item if it applies to the parent otherwise leave blank. For some items, there are spaces to fill in collateral information that may be helpful for case management guidelines.

Determining Level of Risk – Sections II & III:

Low Risk = 0-1 check-marks/domain
Moderate Risk = 2-3 check-marks/domain
High Risk = >3 check-marks/domain

Determining Total Level of Dynamic Risk Before Override:

Very Low Risk = 0-12
Low Risk = 13-23
Moderate Risk = 24-36
High Risk = 37-47
Very High Risk = 48-82
SECTION II. DYNAMIC PARENTING NEEDS

a) Child Factors

i. Age
   Present if the parent has an infant or toddler under age 2.

ii. Disruptive behaviour disorders
   May includes ADHD:
   Attention deficit and hyperactivity disorder that is suspected or diagnosed and demonstrated by the child’s lack of ability to remain focused on tasks for more than a few minutes at a time, easily distracted, or by hyperactive behaviours such as being unable to sit still, being excessively boisterous and disruptive all presented outside the norms of expected behaviours for the child’s current stage of development.
   And/or ODD/CD:
   The child has been diagnosed or is suspected of having oppositional defiance disorder or conduct disorder due to behavioural problems such as rule breaking, disruptive behaviours, aggressiveness, truancy, suspensions, stealing, disputing with authority figures.

iii. Difficult temperament
   As an infant, the child was/is ‘cranky’, colicky, cries frequently, has temper tantrums, doesn’t settle-down easily, or sleeps poorly. This results in an excessive demand on the parents’ time. As an older child or adolescent they may present as highly irritable, moody, or avoidant. In every case the features must be more than would be typically present in a child that age.

iv. Poor adaptation
   The child does not adjust well to their environment or to new experiences. They do not exhibit self-efficacy.

v. More than two children in home

vi. Physical disability
   The child has a physical disability so requires more medical, financial, and support from caregivers.

vii. Anxiety
   The child has been diagnosed or self-reports incidents of anxiety including consistent worrying, baseless fear, or phobias manifested beyond what would be expected for the situation and lasting for more than a few days. Separation anxiety or poor adaptations to transitions or new environments also qualify.

viii. Poor attachment capacity
   The child demonstrates a lack of affection or bonding with the parent and avoids parent, or is insecurely attached thereby appearing clingy and fearful of separation from the parent.

ix. Developmental delays
   The child does not meet developmental milestones expected for their age. Has an IQ in the borderline or MR range.
b) Supports & Resources

i. Limited parental supports
   The parent lacks positive support from BOTH of their own natural parent(s) for any reason (e.g., conflict, death, separation, non-contact, distance etc). If they have limited contact or are not receiving any tangible supports (money, accommodations, drives, child-care) then this is checked.

ii. Lack of family supports
   The parent receives no support from parents AND any other family member (sisters, aunts, etc.). The parent has no meaningful family contact or is completely isolated from family.

   Note: If this item is checked then Limited parental support must also be checked.

iii. Poor quality social supports
   The parent lacks friends who are able or willing to offer positive support to help the parent with child rearing difficulties.

iv. No professional support
   The parent has no current support or an inadequate support system. This would include but not limited to mental health treatment, counsellors, social work, and child/parenting groups. CAS is NOT considered a support. Check whether the parent is unwilling or unable to utilize appropriate services in their community.

v. Isolated
   The parent has purposely isolated themselves from contact with others. They are socially withdrawn. The parent is unable to interact socially with others either due to logistics of their situation or through self-inflicted isolation where the parent chooses to remain socially aloof or avoids contact with others.

vi. Unsupportive partner
   The parent’s partner is unsupportive of their parenting, goals, house rules, decision-making, etc. This creates inconsistency and tension in the home in regards to parent-child interactions that are undermined by the partner. Parents may allow themselves to be triangulated by the child.

c) Spousal/Partner Relationship

i. Conflict/poor interactions:
   Parent-partner interactions often result in arguments and lack resolution. There is a lack of respect for the opinions of others and interactions often are used to degrade or insult the other partner. The frequency and intensity are excessive. This may be represented by an unstable relationship. Parent-partner relationship is emotionally heated with lots of ups and downs, arguing then making-up, crying and laughing.

ii. Violent partner/exposed victimization
   The parent remains in contact with an intimate partner who is violent towards them or there has been an episode of domestic violence in the last six months.
iii. Current threat/restraining order
The parent is perceived by another party as a threat. There is a restraining order or no-contact condition on the parent.

iv. Criminal partner
Partner has a criminal record.

v. Partner abusing drugs/alcohol
The parent is knowingly with a partner who is abusing either alcohol or drugs.

vi. Divorce/custody/access dispute
The parent is currently having a divorce, custody or access dispute with their partner.

vii. Hostile/violent towards partner
The parent is physically abusive or controlling of their current partner.

DVRAG score:
Complete for males if there is a previous episode of domestic violence meeting assessment criteria.

d) Lifestyle

i. Unstable relationships/multiple partners
Current relationship has been “on and off.” There have been more than one break-up or termination in the current relationship OR the parent has a history of unstable relationships. This includes having multiple children with multiple partners.

ii. Transient
There have been more than three changes in address in the last year or there is currently no fixed address.

iii. Unsuitable living conditions
The home is unsafe due to location building (rotten foundation, leaking roof), or hazardous conditions within the home (e.g., lead paint, missing railings, broken steps) or is unhealthy (e.g., poor sanitary conditions, lack of cleaning, filthy).

iv. Criminogenic lifestyle
The parent lives in a neighbourhood where crime or drugs are common-place or the parent allows criminal activity to occur in the home. Most (more than 50%) of their friends have criminal records or are involved in drug use. The parent associates regularly with people who may have a harmful effect on the child emotionally or physically. These people may be prior offenders, people with their own history of child abuse, those involved in crime, or those involved in dangerous activities such as alcohol and drug abuse, or reckless, aggressive, abusive behaviours. The parent has a criminal record. Any of the aforementioned items warrant checking this risk category.

v. Unemployed or unstable work
The parent is currently unemployed for any reason with the only exception of providing full-time child-care. Employment must be on a full-time or near full-time basis. Check this item
also if the individual is currently employed but has not worked for more than half of the last six
months or if their employment is not legitimate.

vi. **Lack of education/job skills**
    The parent does not have a grade 12 or equivalent diploma AND any trades skills necessary for obtaining reasonable employment.

vii. **Unproductive**
    The parent does nothing useful with their spare time such as volunteering, pro-social leisure activities, self-help/improvement groups, upgrading education or job skills.

e) **Stressors**

i. **Poverty/insufficient finances**
   The parent is unable to meet monthly financial obligations due to a lack of income.

ii. **Depends on social assistance**
   The primary source of income for the parent is currently social assistance (e.g., Ontario Works, ODSP, or Child Benefit Allowance).

iii. **Single parent**
   They live alone without the assistance of another parent.

iv. **Social problems**
   There is an excess of conflict in social or peer relationships that interfering with their functioning. They involve themselves in drama or gossip.

v. **Pregnant/unplanned**
   The parent is currently pregnant or their partner is pregnant AND the pregnancy was not planned. If there was a lack of planning (medical) for the welfare of the child this item is also checked.

vi. **Trauma**
   A recent event the parent has experienced that has caused any trauma- or coping-related problems.

vii. **Age** (under 21 years old)

f) **Personality/Temperament**

i. **Emotional instability/reactivity**
   The parent tends to be unstable emotional. Easily frustrated and angered. Tend to be volatile in the interactions with others. Mood swings or rages. The parent is unable to effectively control their own emotions. Their moods easily fluctuate from one situation to the next causing other people to be wary of their own behaviours so as not to trigger an emotional outburst in the parent. The parent is apt to respond quickly and easily to stressors (especially aversive child behaviour) with negative outbursts such as yelling, making degrading comments, anger, and crying.
ii. Aggressive/hostile
The parent tends to act in a physically or verbally aggressive manner towards others. Has a life history of conflict. The parent lacks ability to effectively resolve disputes without being aggressive. Tend to be hostile and instigate with others and views innocuous social cues as having malicious intent.

iii. Lacks empathy/callous
Parent has a difficult time taking on the perspective of others. This includes being self-centered or “cold”. Not concerned with the impact of their conduct or the wellbeing of others.

iv. Superficial/lacks depth
Interpersonal interactions are shallow. The individual tends to not be close with others. Their interpersonal relationships tend to lack depth and emotional reciprocity. Short lasting friendships. They may tend to only engage in relationships with others for exploitative reasons.

v. Irresponsible/poor judgment
Tend to not follow through with obligations. Makes promises with little ability to follow through. The parent predictably misses appointments, counselling sessions, CAS visitations, parenting classes, and self-help meetings without due cause. Missed appointments, absences from work, and avoiding responsibilities are the norm. May be reckless or place people in danger due to their behaviour (e.g., drunk driving, child neglect). They demonstrate poor judgement.

vi. Dishonest/deceptive
Shows a tendency to lie or engage in deceptive practices during interpersonal interactions and relationships. They are manipulative. They may be described by others as a pathological liar, dishonest, or a con man. They are apt to tell stories and engage in hyperbole. The parent is overly concerned with impression management and social desirability.

vii. Impulsive/lacks self regulation
They tend to makes decisions quickly, on the spur of the moment, without thought or planning. They react to the immediate situation with little thought of the future. Tend to be short sighted and engage in activities or behaviours that maximize short-term rewards at the expense of long-term success.

viii. Arrogant – self-centered/egotistical

g) Caregiver Attitudes

i. Anti-child attitudes
The parent tends not to like children. Views children as difficult and a burden and does not look upon parenting as a rewarding experience. Can judge their attitudes by the emotional proximity to children (they are not close to any, hate them) or behavioural patterns (they avoid children). Children do not seem to meet their standards in a variety of ways. Tend to be rigid on their views of how children should and should not act and has little room for compromise or “child-like behaviour”. Looks unfavourably upon children and is generally annoyed at their presence.
ii. Anti-parenting attitudes  
Hold a negative view of parenting in general. Sees parenting as restricting personal freedom or individual goals not related to children or family.

iii. Unrealistic expectations of child  
Hold children to standards that will likely not be met. Expectations for children fare exceed developmental level or simply realistic behaviour of children in general.

iv. Rigid stance on parenting  
The parent has poor attitudes towards support services such as CAS. Is not open to and does not take well suggestions to improve parenting. They may be adversarial or argumentative with service providers over their parenting. They know best phenomenon. Suggestions on parenting from others are viewed as inadequate and rarely adopted unless forced.

v. Disengages responsibility  
The parent uses techniques to disengage responsibility for their involvement in a variety of transgressions. They are apt to deny involvement or place the blame on external sources. May tend to minimize harm or diffuse responsibility Examine their explanations for poor parenting in particular.

In general, the parent does not accept responsibility for their role in contributing to problems with their child and tend to blame others (including the child) such as teachers, child’s friends, their spouse, their parents, psychologists, etc. and therefore is more likely to be resistant to parenting skills training or training to help better their skills.

They are cocky and overly self-confident and may convey an air of superiority over others. They view themselves as having more than adequate skill level despite evidence to the contrary. They are not good assessors of their own abilities and have an exaggerated sense of their own knowledge, skills, and status.

vii. Criminal attitudes/beliefs
They have attitudes that are favourable towards engagement in criminal activities or drug use. They tend to identify with other criminal and tolerate many forms of antisocial activities. Regular involvement in antisocial activity and criminal friends suggest adherence to criminal norms of conduct.

h) Substance abuse

i. History of alcohol abuse
The parent has a history of alcohol use interfering with at least one major life domain. Alcohol has led to parenting problems, family problems, legal problems, medical problems, employment problems, or relationship problems at any point in their lifetime. Excessive use (binging, passing out, withdrawal) without impacting on social and community functioning also applies.

ii. History of drug abuse
The parent has a history of drug use interfering with at least one major life domain. Alcohol has led to parenting problems, family problems, legal problems, medical problems,
employment problems, or relationship problems at any point in their lifetime. Excessive use (binging, passing out, withdrawal) without impacting on social and community functioning also applies.

iii. Moderate use
   The parent currently uses illicit substances of any kind.

iv. Chronic use
   The parent currently uses alcohol or illicit substances in excess. They use substances every day or almost every day.

v. Substance abuse interferes with life
   The parent’s current use of alcohol or drugs is interfering with at least one major life domain. Alcohol has led to parenting problems, family problems, legal problems, medical problems, employment problems, or relationship problems at any point in their lifetime.

vi. Substance abuse interferes with parenting
   The parent’s current use of alcohol or drugs is interfering with their ability to parent.

i) Caregiver Mental/Physical Health

i. Cognitive impairment
   The parent has been diagnosed with a severe learning disorder or has been identified as having an IQ in either the borderline intellectual range or the developmentally-delayed range.

ii. Severe psychopathology
   Has received a recent diagnosis or there is sufficient basis for identifying the parent as suffering from a severe mental illness that is grossly affecting their functioning. These would include, but are not limited to, any Mood Disorder, Anxiety Disorder or Thought Disorder. A confirmed diagnosis of any Personality Disorder would also qualify

iii. Suicidal
   The parent has had one or more previous suicide attempts or has been institutionalized or self-reported prior suicide attempts or ideations.

iv. Physical disability
   The parent/primary caregiver has a physical disability requiring on-going medical and financial support leading to frequent periods away from home due to illness or experiencing prolonged periods functionally impaired due to the disability from completing everyday tasks at home.

v. Chronic illness/pain
   The primary caregiver experiences prolonged periods functionally impaired from completing everyday tasks at home due to unremitting pain.

vi. Medication issues
   There are ongoing issues with the parent’s lack of compliance with medication regimens or there have been documented instances of adverse affects from current medications that impede functioning. The parent has been diagnosed with a mental or physical disorder requiring
medication but the parent does not agree that medication is necessary so “forgets” to take meds, lets prescriptions run out, or does not get prescriptions filled resulting in manifestation of symptoms detrimental to parenting such as aggressive, impulsive behaviours, lethargy, mood swings, etc.

SECTION III. PARENTING PROXIMAL CUES

j) Parenting skills

i. Lacks consistency
   The parent displays an inconsistent approach to rule setting and boundaries with their children. Tend to make rules up as they go along. Children will not have set expectations and are unlikely to know from day to day how their parent will react. The parent behaves on a regular basis in a way that is not predictable to the child in regards to discipline, rules, monitoring, verbal interactions (responds predictably rather than one way one day and another way the next day). The parent/caregiver fails to use age-appropriate rules that are understood by the child.

ii. Inadequate monitoring/supervision
   The parent fails to display age appropriate supervision of children. They tend to not properly supervise their children and by doing so may place them at risk for harm. They may not know or care what their child is doing. This needs to be done at all times without being overly protective and intrusive. Leaving them with inappropriate supervisors or child-care qualifies or leaving them in the care of others for inappropriate reasons (e.g., to do drugs).

iii. Ineffective punishment/behavioural management
   The parent fails to use fair, predictable, consistent, age appropriate discipline without the use of force or physical contact such as time outs, loss of privileges rather than corporal or physical punishment. The parent tends to rely on threats or physical punishment OR has no clear age appropriate behavioural management strategy. They fail to utilize praise usefully.

iv. Limited knowledge of child development
   The parent has limited knowledge of what to expect from a child in terms of abilities as the child progresses through various stages of development. Knowledge may be learned through activities such as parenting classes, proper modeling by others, experience, family physicians, and reading.

v. Unable to identify needs of child
   The parent does not properly recognize the needs of children under their care OR understanding the impact of past or current events of their emotional wellbeing. Parent tends to believe children are overly resilient or immune to improper care or a detrimental environment. The parent is unable to address specific identified needs of children under their care.

vi. Fails to utilize parenting resources
   Despite opportunities the parent has resisted or refused to acquire adequate assistance in the community for parenting issues. They may use some in a superficial may but are considered to not be motivated to attend groups for self-improvement. The parent has not attended
sufficient groups or counselling or utilized parenting resources in the community despite some suggestion from others to do so.

vii. Poor teaching/modelling
The parent has shown inadequacies in teaching a child basic or functional skills. The parent either does not possess adequate skills to model or teach or is unable to promote necessary skill development in their children due to their approach.

viii. Lacks basic child care
The parent does not always see to the everyday needs of the child including bathing and hygiene, dressing them appropriately for weather conditions, education, and providing meals and snacks.

k) Parenting Style

i. Limited positive time spent with child
The parent does not spend quality time each day with the child. This does not involve placing the child in front of a computer or TV screen but being involved in interactional or rewarding activities with the child appropriate for their age.

ii. Authoritarian
Parent tends to have an authoritarian parenting style. This involves coercive, harsh, unfair, arbitrary discipline with an associated lack of emotional bonding with the child. Features may include:
- Have strict rules and expectations.
- Very demanding, but not responsive.
- Don't express much warmth or nurturing.
- Utilize punishments with little or no explanation.
- Don't give children choices or options.

iii. Permissive
This is classic overindulgent. The parent is more responsive than they are demanding. They are non-traditional and lenient, do not require mature behaviour, allow considerable self-regulation, and avoid confrontation. They are nondirective parents.

iv. Lacks involvement in decision making
Parent displays an over-reliance on others to make decisions. There is little input from the parent with regards to decision making for the child. They are non-engaged and involved with major aspects of their children’s lives. They either have relegated this to another or fail to be a part of decision making. In extreme cases they may allow children to make decision beyond their capacity.

v. Communication problems
There are poor parent-child interactions. Most interactions involve conflict or hostility. There is limited open, free, or honest communication. The parent stifles conversation. For younger children this may be observed through limited communication or a lack of empathetic listening.
vi. Sabotages other parent
They have made intended attempts to alienate the child from another parent/caregiver. They have used a child for a campaign of hatred directed at another or have made false accusations of abuse. If the child is polarized from one parent or automatically sides with one parent due to the influence of the other then this item applies. Child expresses deep negative feelings towards the other parent as a result of such actions.

vii. Lacks planning/structure
The parent fails to set a routine and plan ahead for the child. There is an insufficient amount of structure in the home for the developmental age of the child. Check if there is a lack of structure or routine in the home for the needs of the child.

1) Attachment

i. Insecure attachment
The parent-child interactions fail to demonstrate a secure attachment. An insecure attachment is demonstrated by the child not: using the parent as a secure base, signs of missing the parent when away, actively greets/happy to see on return, signals or seeks contact when upset, and will be independent if comforted.

ii. Disorganized attachment
The child avoids or is specifically fearful of the parent. If they repeatedly attempt to avoid the parent is overly unsettled or distressed by a separation then this item also applies.

iii. No expressive connection
The parent is unable to express warm feeling of affection and love for the child to the child. They lack fixed non-shifting positive attributions about their child. The child is unlikely to feel adored or special. Check if there is a lack of warmth or typically negative attributions made about the child.

iv. Resentful/restrictive
The parent is resentful of the child and restrictions that have been placed on her lifestyle due to child care needs. The parent views the child being an obstacle or an impediment to their success.

v. Unaware of child impact
There is a lack of awareness of the potential impact of life events on the child. The individual fails to understand the serious impact past events may have on a child or the potential impact of negative occurrences. They may dismiss harmful actions perpetrated on children as being benign but in particular their own past transgressions.

vi. Lacks empathic understanding
The parent lacks the capacity to see things from the child’s point of view within a balanced, accepting, and coherent frame. The parent is unable to comprehend the feelings of their child apart from their own.
vii. Child not positively reinforcing
    The parent fails to receive any positive benefits from their child. They view the child as a neutral or negative source of rewards. There are few, if any, positive qualities the parent draws upon with their child(ren) and they tend to be outweighed by negative aspects.

SECTION IV. RESPONSIVITY FACTORS

a) Strengths

i. Stable partner/family relations
    The parent has consistent, positive, and supportive relationships to assist in parenting goals.

ii. Supportive relationships
    The parent has at least one friend, relative, partner who is available, positive, and helpful in parenting goals.

iii. Prosocial involvement
    The parent is involved in a least one activity that builds social skills such as regular, ongoing participation in church, sports, arts, volunteering, etc.

iv. Above average intelligence
    Parent has an IQ of more than 100.

v. Educational achievement
    The parent has at least a grade 12 high school diploma.

vi. Employment achievement
    The parent has a demonstrated ability to maintain employment, has good references, and/or earned promotions.

vii. Stable accommodations
    The parent has been living in the same home for a minimum of 3 years.

viii. Even tempered
    The parent does not display mood swings. They have consistent, predictable moods appropriate to the situation and are not quick to get angry or frustrated.

ix. Amenable to interventions
    The caregiver is open to receiving help for themselves or their child. They are cooperative and collaborative with treatment providers.

x. Self-efficacy/self-appraisal
    The parent demonstrates self-efficacy in that they are able to recognize when help is necessary and does what is needed to obtain the help. The parent feels able to do whatever it is they are required to do.

xi. Married/commonlaw
    The parent is in a stable, supportive, non-conflicted household with a partner for more than two years.
xii. Sobriety
The parent has been abstinent more than one year. The parent has had no issues or lapses for more than two years regarding the substance of relevance (drugs/alcohol).

xiii. Communication skills
The parent is able to express themselves appropriately with others including child.

xiv. Healthy – mentally/physically
The parent does not have any diagnosed, chronic, or debilitating illness.

xv. Financially secure
The parent has adequate funds to provide for themselves and their children without relying on others for financial assistance.

xvi. Leisure activities
The parent is involved in pro-social activities or hobbies that they find fulfilling and prevents idle time.

xvii. Goal-oriented
The parent has future plans (small and large) and makes noticeable efforts to achieve them.

xviii. “Easy” children
The parent has children with no behavioural, emotional, mental, or physical health issues.

b) Barriers

i. Lack of support
Peers/partner/family undermines client’s attempts to seek help evidenced by their lack of help and derogatory comments or the caregiver does not have more than one other person whom they can share problems with or solicit help.

ii. Lacks insight
Parent is unable to access community support either because of logistics, lack of support facilities or having been expelled from available programs.

iii. Negative attitudes-programs/skills
The parent believes that help groups/community support/therapy/skills training do not work or are useless.

iv. Negative attitudes-facilitators
The parent believes that treatment providers are incompetent and unable to help them.

v. Self-efficacy imbalance
Parent holds extreme beliefs from feeling treatment could never work for them to believing they have done everything possible and have concluded that nothing works.

vi. Lacks intrinsic motivation
The parent expresses no desire to change nor exhibits any behaviour to create a better environment for themselves or the child.
vii. Logistics
Lacks money for travel, no car, lives in a rural setting, unable to leave work to attend meetings/seek treatment.

viii. Transient
There have been more than three changes in address in the last year or there is currently no fixed address.

ix. Lack of overall stability
A lack of stability in most areas of the parent’s life including home, job, relationships, finances.

x. Poor historical adherence to plans/goals
A documented history of not meeting required goals; starting things but not finishing them.

xi. Rigidity or concrete thinker
Everything is “black and white” – no room for negotiation or others opinions.

xii. Superficial compliance/resistant
Parent not truly motivated to make necessary changes. They do not stick with programs or fulfill commitments to do so.

xiii. Acute psychopathology
The parent has a diagnosed psychiatric problem requiring medication or affecting their ability to function consistently and appropriately across time and situations.

xiv. Uninterested in self-improvement
Parent is fully capable of self-improvement (upgrading education, job skills, interpersonal skills, etc.) but sees no need to do so.

xv. Literacy < gr. 10

xvi. Medication non-compliance
The parent requires medication but is unwilling to adhere to it.

xvii. Poor interpersonal skills
The parent demonstrates difficulties with interpersonal relationships. They have poor conflict resolution skills and communication problems evident.

xvii. Poor coping skills
The parent lacks the ability to appropriately deal with life stressors as they occur. Demonstrated by an inability to adequately problem solve or find ways to reduce stress.
Appendix C: Parental Capacity – Risk Management Inventory (PC-RMI)  
Developed by Dr. R. Rowe & L. M. McKay (2011)

PC-RMI

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>☐ male</td>
<td>☐ female</td>
</tr>
</tbody>
</table>

Number of Children Currently Living in Home:

- a. Biological ______ Ages: _________________
- b. Step-children______ Ages: __________________

Relationship to Children:

Number of Children Currently in CAS Care:  
Number of Children Permanently Removed:

Date of Birth

Day _____ Month _____ Year _______

Today's Date

Day _____ Month _____ Year _______

Section I. Static Needs

a) Perpetrator of Child Maltreatment

- ☐ ☐ Physical child abuse
- ☐ ☐ Sexual child abuse
- ☐ ☐ Domestic violence
- ☐ ☐ Child neglect/Fail to protect
- ☐ ☐ Prior removal of child

b) Personal Victimization

- ☐ ☐ Victim of childhood abuse
- ☐ ☐ Victim of neglect
- ☐ ☐ Victim of domestic violence
- ☐ ☐ In custody of CAS as child
- ☐ ☐ Insecure attachments to primary

DVRAG score: _____  

Section II. Dynamic Parenting Needs – within the last year and/or while living with the child(ren)

<table>
<thead>
<tr>
<th>Child Factors</th>
<th>Supports &amp; Resources</th>
<th>Spousal/Partner Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age – infant, toddler</td>
<td>Physical disability (specify) _________________</td>
<td>Partner abusing drugs/alcohol</td>
</tr>
<tr>
<td>Disruptive Behaviour Disorders</td>
<td>Anxiety</td>
<td>Divorce/custody/access dispute</td>
</tr>
<tr>
<td>Difficult temperament</td>
<td>Poor attachment capacity</td>
<td>Hostile/violent towards partner</td>
</tr>
<tr>
<td>Poor adaptation</td>
<td>Developmental delays (specify) _________________</td>
<td>* DVRAG score: _____</td>
</tr>
<tr>
<td>More than two children in home</td>
<td>IQ: _______</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Limited parental supports</th>
<th>No professional support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of family supports</td>
<td>Isolated</td>
</tr>
<tr>
<td>Poor quality social supports</td>
<td>Unsupportive partner</td>
</tr>
</tbody>
</table>

Next steps:  
- Reviewing the completed PC-RMI form for risk assessment.  
- Identifying areas for intervention and support.

For more information on using the PC-RMI, please refer to the manual provided with the inventory.
<table>
<thead>
<tr>
<th><strong>d) Lifestyle</strong></th>
<th><strong>e) Stressors</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>✖ Unstable relationships/multiple partners</td>
<td>✖ Poverty/insufficient finances</td>
</tr>
<tr>
<td>✖ Transient</td>
<td>✖ Depends on social assistance</td>
</tr>
<tr>
<td>✖ Unsuitable living conditions</td>
<td>✖ Single parent</td>
</tr>
<tr>
<td>✖ Criminogenic lifestyle</td>
<td>✖ Social problems</td>
</tr>
<tr>
<td>✖ Unemployed or unstable work</td>
<td>✖ Pregnant/unplanned</td>
</tr>
<tr>
<td>✖ Lack of education/job skills</td>
<td>✖ Trauma</td>
</tr>
<tr>
<td>✖ Unproductive</td>
<td>✖ Age (under 21 years)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>f) Personality/Temperament</strong></th>
<th><strong>g) Caregiver Attitudes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>✖ Emotional instability/reactivity</td>
<td>✖ Anti-child attitudes</td>
</tr>
<tr>
<td>✖ Aggressive/hostile</td>
<td>✖ Anti-parenting attitudes</td>
</tr>
<tr>
<td>✖ Lacks empathy/callous</td>
<td>✖ Unrealistic expectations of child</td>
</tr>
<tr>
<td>✖ Superficial/lacks depth</td>
<td>✖ Rigid stance on parenting</td>
</tr>
<tr>
<td>✖ Irresponsible/poor judgment</td>
<td>✖ Disengages responsibility</td>
</tr>
<tr>
<td>✖ Dishonest/deceptive</td>
<td>✖ Over-confident/lacks self-appraisal</td>
</tr>
<tr>
<td>✖ Impulsive/lacks self-regulation</td>
<td>✖ Criminal attitudes/beliefs</td>
</tr>
<tr>
<td>✖ Arrogant</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>h) Substance Abuse</strong></th>
<th><strong>i) Caregiver Mental/Physical Health</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>✖ History of alcohol abuse</td>
<td>✖ Cognitive impairment (specify)</td>
</tr>
<tr>
<td>✖ History of drug abuse</td>
<td>✖ Severe psychopathology</td>
</tr>
<tr>
<td>✖ Moderate use</td>
<td>✖ Suicidal</td>
</tr>
<tr>
<td>✖ Chronic use</td>
<td>✖ Physical disability</td>
</tr>
<tr>
<td>✖ Substance abuse interferes with life</td>
<td>✖ Chronic illness/pain</td>
</tr>
<tr>
<td>✖ Substance use interferes with parenting</td>
<td>✖ Medication issues</td>
</tr>
</tbody>
</table>

**Section III. Proximal Parenting Cues - within the last year and/or while living with the child(ren)**

<table>
<thead>
<tr>
<th><strong>j) Parenting Skills</strong></th>
<th><strong>k) Parenting Style</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>✖ Lacks consistency</td>
<td>✖ Limited positive time spent with child</td>
</tr>
<tr>
<td>✖ Inadequate monitoring/supervision</td>
<td>✖ Authoritarian</td>
</tr>
<tr>
<td>✖ Ineffective discipline/behavioural management</td>
<td>✖ Permissive</td>
</tr>
<tr>
<td>✖ Limited knowledge of child development</td>
<td>✖ Lacks involvement in decision making</td>
</tr>
<tr>
<td>✖ Unable to identify needs of child</td>
<td>✖ Communication problems</td>
</tr>
<tr>
<td>✖ Fails to utilize parenting resources</td>
<td>✖ Sabotages other parent</td>
</tr>
<tr>
<td>✖ Poor teaching/modeling</td>
<td>✖ Lacks planning/structure</td>
</tr>
<tr>
<td>✖ Lacks basic child care</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>l) Attachment</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>✖ Insecure attachment</td>
<td>✖ Unaware of child impact</td>
</tr>
<tr>
<td>✖ Disorganized attachment</td>
<td>✖ Lacks empathic understanding</td>
</tr>
<tr>
<td>✖ No expressive connection</td>
<td>✖ Child not positively reinforcing</td>
</tr>
<tr>
<td>✖ Resentful/restrictive</td>
<td></td>
</tr>
</tbody>
</table>
### Section IV. Parental Responsivity Factors – Current presentation

#### a) Strengths

- Stable partner/family relations
- Supportive relationships
- Pro-social involvement
- Above average intelligence
- Educational achievement
- Employment achievement
- Stable accommodations
- Even tempered
- Amenable to interventions
- Self-efficacy/self-appraisal
- Married/common-law
- Sobriety
- Communication skills
- Healthy – mentally/physically
- Financially secure
- Leisure activities
- Goal-oriented
- “Easy” children

#### b) Barriers

- Lack of support
- Lacks insight
- Negative attitudes-programs/skills
- Negative attitudes-facilitators
- Self-efficacy imbalance - dependent
- Lacks intrinsic motivation
- Logistics
- Transient
- Lack of overall stability

### Section V. Risk Management Review

#### Section I – Static Needs

a) Perpetrator score

b) Victimization score

**Total Static Score** (from Section I):

#### Dynamic Needs

##### Section II – Dynamic Parenting Needs

a) Child Factors

b) Community Support

c) Spousal/Partner Relationship

d) Lifestyle

e) Stressors

f) Personality/Temperament

g) Caregiver Attitudes

h) Substance Abuse

i) Caregiver Mental/Physical Health

**Total Parenting Needs**

##### Section III – Proximal Parenting Cues

j) Parenting Skills

k) Parenting Style

l) Attachment

**Total Parenting Cues**

**Total Dynamic Needs** (add Sections II & III):

**Total PC-RMI Score** (add Sections I, II, & III):
Score-based PC-RMI Risk/Need Level:  (See Score-based Risk/Need Level Guide below)

<table>
<thead>
<tr>
<th>Risk/Need Level</th>
<th>Very Low</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>Very High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Static Needs</td>
<td>0</td>
<td>1-2</td>
<td>3-4</td>
<td>5-10</td>
<td>11-15</td>
</tr>
<tr>
<td>Total Dynamic Needs</td>
<td>0-10</td>
<td>11-23</td>
<td>24-35</td>
<td>36-50</td>
<td>51-85</td>
</tr>
<tr>
<td>Total Risk/Needs</td>
<td>0-10</td>
<td>11-25</td>
<td>26-40</td>
<td>41-60</td>
<td>61-100</td>
</tr>
</tbody>
</table>

Client-Based/Clinical Override

Use the client-based clinical override? (circle one)  
No  
Yes

List the reasons for decreasing parental capacity risk level. (Refer to Strengths in Section IV)

List the reasons for increasing parental capacity risk level. (Refer to Barriers in Section IV)

After considering clinical override, fill-in appropriate final risk/need level:

Final PC-RMI Risk/Need Level:  (very low, low, moderate, high, very high)

Notes:
CONFIDENTIALITY STATEMENT

It is Hospital Policy and law that all Hospital information is confidential. As a regular or temporary employee, student or volunteer of Hotel Dieu Hospital, you may handle recorded confidences between doctor and patient and/or information regarding personnel.

All Hospital records are to be treated as confidential material, to be protected for the privacy of the patient and the employee. No one is expected to read or discuss records unless his/her job so requires. Furthermore, no confidential information is to be discussed outside the Hospital.

Confidentiality is the right of every patient and everyone affiliated with the Hospital. Each of us is expected to respect that right.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT. I AGREE TO ABIDE BY THE HOSPITAL POLICY AS A CONDITION OF EMPLOYMENT, AS A STUDENT, REGULAR EMPLOYEE, TEMPORARY EMPLOYEE, OR AS A VOLUNTEER WITH HOTEL DIEU HOSPITAL.

[Signature]
EMPLOYEE, STUDENT OR VOLUNTEER SIGNATURE

[Signature]
WITNESS

Sept. 13/11
DATE

2011-09-18
DATE

To ensure our records are correct, please provide the following information:

Name: Lynn McKay
Telephone: (613) 382-7181

Address: 740-6 6th Concession
Ottawa, ON K0H 1Y0

Emergency Contact: Annie Drouh
Telephone: (613) 382-7181

Status: ☐ Regular Employee ☐ Temporary Employee ☑ Student ☐ Volunteer

Position: Beh Psychology Student
Dept: Family Court Clinic

Reporting To: Dr. Robert Rowe
Appendix E: Interview Sample Questions

Parenting Capacity

Parent-Child Interactions - III

SEMI-STRUCTURED INTERVIEW

R.C.R.

<table>
<thead>
<tr>
<th>NAME:</th>
<th>Court No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.O.B.:</td>
<td>DATE:</td>
</tr>
<tr>
<td>Case Worker</td>
<td>Reason for Referral:</td>
</tr>
<tr>
<td>Child Name</td>
<td></td>
</tr>
</tbody>
</table>

| Limits of confidentiality explained    | □         |
| Aware of report distribution           | □         |
| Signed consent                         | □         |

Initial concerns or expressions:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
### Release Plans: Long-term Goals

<table>
<thead>
<tr>
<th>Need Area</th>
<th>Proposed Release Plan</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodations</td>
<td>Future changes:</td>
<td></td>
</tr>
<tr>
<td>School</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment</td>
<td>Confirmed: Ideas</td>
<td></td>
</tr>
<tr>
<td>Family/Marital support</td>
<td>Spouse, Father, Mother, Other</td>
<td></td>
</tr>
<tr>
<td>Professional sources</td>
<td>List:</td>
<td></td>
</tr>
<tr>
<td>Other/Leisure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. What do you need to accomplish in the next six months?
2. What are your long-term goals?
3. Where would you like to be in five years?
4. How much thought have you put into your current plans?
5. What kinds of things do you have to do to reach those goals? (list intermediate steps)
6. How likely are things to work out for you in the long run?
7. How does your future look?
8. What will be difficult for you? Scale (1-10):

### Insight

1. Why do you think this has happened?
2. Why do you think your life has turned out this way?
3. What factors contributed to you being involved with CAS?
4. What impact has your behaviour had on you? What have been the consequences?
5. What do you have to do from keeping CAS away in the future?

### Level of Personal Insight

<table>
<thead>
<tr>
<th>Checks one:</th>
<th>NONE</th>
<th>SLIGHT</th>
<th>MODERATE</th>
<th>HIGH</th>
<th>VERY HIGH</th>
</tr>
</thead>
</table>