Interobserver Reliability of an Adapted Version of the Child Maltreatment Assessment Form

Alexis Brough

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BACHELOR’S DEGREE IN BEHAVIOURAL PSYCHOLOGY
Dedication

This research report is dedicated to the children and youth supported by child welfare agencies. Through courage and perseverance in spite of adversities comes great triumph.
Abstract

Across Canada, local child welfare agencies provide an array of services, not only for youth in need, but also for the entire family involved. As such, it is important for child welfare agencies to continue to expand research and frequently evaluate the needs of clients who are receiving their services. Recently Brown (2015) examined the characteristics of clients (children and their families) who received supervised access support from a child welfare agency in Eastern Ontario. Brown conducted a file review using an adapted measure of the Child Maltreatment Assessment Form from the 2008 Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2008, Trocme et al., 2008). The present study aimed to assess the interobserver reliability of the adapted form through a retrospective file review in which 50% of the client files used in Brown’s (2015) study were analyzed by a second observer. Therefore, the purpose of the present study was to determine the reliability of the data collected by Brown. An overall interobserver agreement score of 98.8% was obtained, thereby establishing a high degree of reliability of the modified assessment form.
Acknowledgements

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Chapter I: Introduction

“Childhood should be carefree, playing in the sun; not living a nightmare in the darkness of the soul,” (Pelzer, 1995, P.98). Although this quote may be disturbing to some, it is the reality that some children face while growing up in an abusive or neglectful home. Factors that may contribute to this painful experience include exposure to conflict, abandonment, and caregiver capacity problems. Childhood is a crucial time for development that when interrupted by emotionally upsetting events, may lead to serious, long-term mental health and social issues (Karakurt & Silver, 2014). According to Reinert and Edwards (2009), these issues have the potential to negatively influence a child’s life well into adulthood if not properly treated. Because of the importance of a happy and healthy childhood, it is essential to provide children with the most adequate care available.

Each year, many families are referred to local child welfare agencies across Canada (About Children’s Aid Society, 2014). These child welfare agencies provide an array of services, not only for the youth in need, but also for the entire family involved. Although there is a common misconception that child welfare agencies’ main focus is to take children away from their families, this is a last resort approach used only when the child is deemed in danger and there is little to no evidence showing that there can be an immediate improvement in the home. The main mission of the Chile Welfare agency is to strengthen families, protect youth, and promote the well-being of each family member (About Children’s Aid Society, 2014). Some of the services offered to families include: supervised access visits, kin or foster placements, and a variety of referral options including parent training and counselling. Although the child welfare agency provides many valuable services for families, it is important to continue to expand research in order to develop and modify current services to better suit the needs of clients within each community.

One study that has recently expanded understanding of families in Canada is the Canadian Incidence Study of Reported Child Abuse and Neglect 2008 (CIS-2008, Trocme et al., 2008). The CIS-2008 was a nation-wide study that examined the incidences of child maltreatment reported within the child welfare system. Since the CIS-2008, two studies in which other researchers adapted parts of its assessment method, gathered data of their own. Doyle (2012) created a revised version of the CIS-2008 Child Maltreatment Assessment Form to review child abandonment cases at a child welfare agency in Eastern Ontario. Brown (2015) also conducted a rile review at this agency, using an adapted version of the CIS-2008 Maltreatment Assessment Form (Appendix A), to identify the characteristics of caregivers and children who attend supervised access visits. Although these studies have increased knowledge, their results have not yet been used to modify current services. The results from these studies have the potential to increase understanding of client needs in the agency’s catchment area. However, before the results of these studies can be used to guide decision making, it is important to determine the reliability of the data collection.

In concurrence with the CIS-2008 (Trocme et al., 2008), this study aims to enable the child welfare system to make the most knowledgeable decisions about the treatment programs for children and their families. The aim is to assess the interobserver reliability of data coding in Brown’s (2015) adapted study. Ideally, it is hoped that the findings of this study can contribute to enhancing treatment options for families in the communities served by the agency. Assessing the reliability of this adapted study will provide insight to the dependability of the data which in
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turn, would provide the agency with the proper information needed to enhance their treatment options to best meet the needs of their client population.
Chapter II: Literature Review

The Relationship between Childhood Maltreatment and Adult Functioning

A home may be considered unsuitable for a child to live in for a number of reasons, such as a caregiver’s inability to properly care for a child due to mental health or drug dependency issues (Barth, 2009). A substantial amount of literature has shown that growing up in an unsuitable home, where the child is often stressed or worried, can put a child at risk of developing multiple serious disorders. These disorders may include, but are not limited to: post-traumatic stress disorder (PTSD), depression, anxiety, borderline personality disorder (BPD), along with many other emotional, social, and behavioural diagnoses (Karakurt & Silver, 2014). Studies show that a significant proportion of children with mental health needs have experienced maltreatment (Burge, 2007). This co-occurring relationship indicates that experiencing child maltreatment may lead to the development of psychological disorders, along with many other serious problems.

According to Karakurt and Silver (2014), children who are abused or neglected are more likely to do poorly in school and have difficulty forming life-long relationships. Contributing to this are impairments in the child’s ability to trust and seek comfort in others (Haugaard, 2000, as cited in Karakurt & Silver, 2014). The development of these insecure attachment styles may be overtly characterized as behavioural problems, as the child will often lash out aggressively towards others (Karakurt & Silver, 2014). Low self-esteem and difficulty determining one’s own identity are other issues that may also surface from a traumatic childhood (Karakurt & Silver, 2014). Due to the many serious and long-term issues that may arise as a result of a stressful childhood, it is essential for these families to receive the proper treatment needed for the youth to appropriately recover from these events (Karakurt & Silver, 2014).

The Child Welfare System

Although the primary focus of the child welfare system is to keep children safe and out of immediate danger, it also seeks to provide supports for all involved members of the family. The main mission of the child welfare agency is to strengthen families, protect youth, and aid in promoting the well-being of each family member (About Children’s Aid Society, 2014). The child welfare agency provides a variety of services for families, including: supervised access visits, kin or foster placements, and many referral options, such as parent training and counselling.

Counselling can potentially be beneficial, not only for the children, but also for their parents and other family members involved. According to Karakurt and Silver (2014), social support is a very important element that should be embraced while recovering from upsetting events. Social support not only provides the individual with comfort, but it is also an effective tool to buffer against the development of mental disorders (Karakurt & Silver, 2014). Counselling may also help the child deal with the stigma attached with his/her past which may be evoking feelings of shame, guilt, and self-blame (Karakurt & Silver, 2014). Parents may also benefit from counselling, as it is common for them to have traumatic histories of their own (Haight et al., 2005). It is important for all members of the family to seek help, especially if the child is going to stay within the birth parent’s care.

Most children form attachments to their caregivers, even when that caregiver is not providing adequate care for the child (Ziberstein, 2014). According to Ainsworth and Bowlby (1980, as cited in Ziberstein, 2014), this attachment forms in infancy when the child seeks...
comfort, nurturance, and protection to satisfy their internal needs. Because of the attachment between children and their birth parents, it is important to maintain that relationship if there is no direct danger to the child. Unfortunately, some children have to be apprehended from their parents in order to obtain the proper love, care, and support needed, which, according to Ellingsen, Stephens, Storksen (2012), are the primary criteria needed to have a well-functioning family. Although some children are not able to grow up with their biological families, Ellingsen et al. (2012) state that some children are able to make a deep connection with foster families and some may think of their foster family as their only family. The child welfare agency provides apprehended children with foster, kin, or adoption placements in order to provide the child with a safe and healthy home life. When children have no legal guardian who can appropriately care for them or make adequate decisions about their future, the children become crown wards.

Children in care, especially children who are permanent wards, need increased monitoring of their mental health (Burge, 2007). According to Marie Bountrogianni (Personal communication, February 23, 2004, as cited in Burge, 2007), the permanent ward population is growing, while adoption rates are decreasing. These changes are placing further pressure on family and child service workers to provide adequate housing and long-term care plans. According to Burge (2007), 78.8% of crown wards have experienced maltreatment. Alongside youth who are crown wards, foster children also show higher rates of mental illness compared to community samples (Burge, 2007). Children in foster care also have higher rates of developmental delays and disabilities, which make children in care more likely to develop dual diagnoses (Burge, 2007). Professional literature suggests three substantial influences on the development of a mental illness: the biological parent’s mental health, the maltreatment the child endured, and the negative effects of being apprehended from one’s biological family (Burge, 2007). The impact of having multiple moves after being apprehended is also considered an additional variable contributing to the development of a mental illness (Burge, 2007). Other diagnoses such as ADHD, developmental disabilities, and mental retardation are also more prevalent among children in care (Burge, 2007). Although children may not be able to live with their biological family, it is important to maintain that relationship if there is no immediate threat to the child.

**Supervised Access Visits**

Parent-child interactions play a critical role in the development of a child’s identity (Haight et al., 2005). Because of this, family reunification is one of the primary goals of the child welfare agency (Haight et al., 2005). Even if the child is not able to live with their biological family, it may be in the best interest of the child to continue to develop these relationships. Maintaining the parent-child relationship, even when the child is placed in care, can establish some permanency in the child’s life.

Supervised access is a scheduled visit between a child and a family member that takes place in a safe, neutral, and child-focused environment to examine the parent-child interaction (Supervised Access, 2014). Supervised access visits can be used to help ensure that permanency still exists for the child while the child is placed in care (Lopez, Del Valle, Montserrat, & Bravo, 2013). Visits are planned, supervised, and evaluated by caseworkers to keep the child safe, as well as to provide biological parents or family members with insight as to what they can improve on (Hess, 1988). The emotional well-being of the child is always the number one priority when there is no physical or immediate threat present (Hess, 1988). The child welfare agency provides the children and biological families with a safe environment in which relationships can be maintained and further developed. These meetings between biological caregivers and their
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children are considered necessary for strengthening the emotional well-being of the child and strengthening the positive parent-child relationship (Hess, 1988). According to Hess (1988) children are more likely to return home from care if they are regularly attending supervised access visits. Biehal (2007) describes supervised access visits as the most important tool needed when there is a possibility for family reunification. Another positive aspect of supervised access visits is that they provide a trial period before children go back into the care of their biological families. Workers who supervise the visits often give the caregivers constructive criticism, to help them build toward a better functioning relationship between themselves and their child. Because of supervised access visits as a support offered by the child welfare agency, further research could contribute to developing and modifying services to meet client needs.

The Canadian Incidence Study of Reported Child Abuse and Neglect 2008

The CIS-2008 (Trocme et al., 2008) was a nation-wide study that examined the characteristics of families and children involved in child maltreatment cases. This report obtained data from 112 child welfare agencies across Canada to describe and assess the characteristics of the investigations, caregivers and children involved. The CIS-2008 addressed protection concerns to provide the data needed by agencies to make knowledgeable alterations to their services to prevent child maltreatment.

According to the CIS-2008 (Trocme et al., 2008), there were approximately 85,440 verified child maltreatment investigations in 2008 in Canada. Maltreatment cases were broken down into five categories including: emotional maltreatment, physical abuse, neglect, sexual abuse, and exposure to intimate partner violence. The CIS-2008 (Trocme et al., 2008) indicated that exposure to intimate partner violence and neglect were the most common forms of child maltreatment reported, each present in 34% of all cases, respectively.

The CIS-2008 examined the characteristics of the children who fell victim to maltreatment. Reported child maltreatment occurrences were nearly identical for males and females with only slight variations. Child functioning was documented by examining each child’s behavioural, cognitive, physical and emotional functioning. These included factors such as: depression/anxiety/withdrawal, suicidal thoughts, self-harming behaviour, ADD/ADHD, attachment issues, aggression, running, inappropriate sexual behaviour, youth criminal justice act involvement, intellectual/developmental disability, failure to meet developmental milestones, academic difficulties, fetal alcohol syndrome/fetal alcohol effects (FAS/FAE), positive toxicology at birth, physical disability, alcohol, drug/solvent abuse or any other abnormalities that may have been present. The most frequently reported functioning concern was academic difficulties which was present in 23% of cases, followed by depression/anxiety/withdrawal in 19% of cases.

The CIS-2008 examined not only the characteristics of the youth involved in the investigations, but also the characteristics of the primary caregiver(s) involved. About half of the caregivers involved in the investigations (45%) were between 31 and 40 years old. In 91% of the investigations, the primary caregiver was female. Caregiver risk factors were identified as one or more of the following: drug/solvent abuse, cognitive impairment, mental health issues, few social supports, victim of domestic violence, perpetrator of domestic violence, history of foster care or group home. Being a victim of domestic violence was the most frequently reported caregiver risk factor. The study also examined other caregiver characteristics such as their employment, number of moves, and hazards in the home as they were all factors that could contribute to an unhealthy home environment. Subsequently, other researchers have
contemplated how these nation-wide findings compare to the client sample size within other small communities.

**Child Abandonment and Family Breakdown**

Since the CIS-2008, revised measures of the Child Maltreatment Assessment Form have been used to gather data about the characteristics of children and caregivers involved in the child welfare system. Doyle (2012) created an adapted measure of the CIS-2008 (Trocme et al., 2008) Child Maltreatment Assessment Form to describe and better understand child abandonment cases at a child welfare agency. Doyle (2014) found more frequent mental health issues in children from the Frontenac, Lennox, and Addington area compared to the national incidence rate examined in the CIS-2008 (Trocme, et al., 2008). Doyle’s study (2014) also showed that the children in this area were using more alcohol and drugs and presented higher levels of aggression when compared to the overall results displayed in the CIS-2008 (Trocme, et al., 2008).

**Characteristics of Parents and Children who Use Enhanced Support Services to Obtain Supervised Access**

Brown (2015) also collected data from a child welfare agency, using an adapted version of the CIS-2008 Child Maltreatment Assessment Form to describe the characteristics of parents and children who received supervised access. Current literature supports supervised access visits as being one of the most common programs used with families, however, there is very little research examining the characteristics of the individuals involved in these interventions. Although these studies have expanded understanding, they have not yet been used to modify current services. Examining the client characteristics identified in these adapted studies has the potential to help to better understand the needs of clients in the agency’s catchment area. The reliability of data coding in these studies has not yet been examined.

**The Importance of Reliability**

It is essential to frequently assess the characteristics of clients and the treatment options available to them in order to meet the specific needs of each family. There is little published literature on the assessment of client characteristics, and the available studies often do not provide an assessment of reliability. The accuracy and reliability of data collection methods have been core issues since the inception of scientific research (Rapp, Carroll, Stangeland, Swanson, & Higgins, 2011). There are many factors that may influence the accuracy and consistency of data collection, leading to incorrect data, analysis, and conclusions. Researcher infidelity, lack of researcher training, and complex data collection methods are a few of the many factors that may lead to inaccurate data (Berk, 1979, as cited in Acklin, McDowell, Verschell, & Chan, 2000). It is essential for the data collected to be reliable, as the data could be influential in identifying the needs of clients. There are many steps that can be taken to prevent unreliable data, such as ensuring that the researcher is appropriately trained on the data collection method (Najdowski et al., 2010). However, even then, there are still many flaws that can influence the reliability of data.
Interobserver Agreement

Interobserver Agreement (IOA) is a widely accepted method used for determining the accuracy and reliability of evaluations and research (Ledford, Wolery, Meeker, & Wehby, 2012). Reliability refers to the stability of measurement over time or across raters, and that is exactly how IOA is obtained (Hollenbeck, 1978, as cited in Olswang, Svensson, Coggins, Beilinson, & Donaldson, 2006). If a data collection method is reliable, then two or more raters should obtain the same results (Garrity, Luiselli, & McCollum, 2008). IOA is evaluated by calculating the agreement between two independent observers who coded the same data sets (Kleinmann et al., 2009). IOA is calculated by dividing the number of agreements by the number of agreements plus disagreements and multiplying the result by 100. An IOA score equal to or exceeding 80% is widely seen as an acceptable score (Garrity et al., 2008).

Purpose

As mentioned, there is a lack of research on the characteristics of clients who are involved in the child welfare system. The few studies that have analyzed a client population have rarely provided an assessment of the reliability of the data coding process. Accordingly, the purpose of this study was to determine the reliability of Brown’s (2015) adapted measures of the Child Maltreatment Assessment Form by collecting IOA.
Chapter III: Method

The present study sought to assess the IOA reliability of an adapted measure (Appendix A) of the Child Maltreatment Assessment Form. The revised assessment form (Appendix A) was adapted from the CIS-2008 study (CIS; Trocme et al., 2008), and was modified by Brown (2015), as a thesis project that was reviewed and approved by the St. Lawrence College Research Ethics Board.

Measure

The assessment form consisted of ten sections, each with a varying number of items, designed to identify client characteristics in the client population who had received supervised access visits.

1. Original Referral Information. This section was used to gather relevant information about the original referral that led to opening the file up to supervised access visits. In this section, the researcher determined the year the file was opened, the referral code, whether or not the file was verified, the source of the referral, and the reason the referral was made. The researcher also gathered information such as the year the file was opened for family visiting, the reason for closing family visiting, and whether or not the file was reopened for family visiting between the closing date and November 2014. All children listed on the file were to be identified in this section, regardless of whether they attended family visiting or not. Information such as their age when access occurred and their gender was also included.

2. Previous CAS Involvement. This section consisted of multiple questions guided towards understanding the family’s previous history with the child welfare agency. It was used to identify whether there were any previous referrals on the file, and if so, how many previous referrals there were in total. The researcher was also to include information such as whether the child was previously reported for suspected maltreatment, the maltreatment was verified and examined, spanking was previously used as a form of punishment in the home and where the child resided during family visiting.

3. Police Involvement at Original Referral. This section of the assessment form identified whether there was any police involvement at the original referral that opened the file up to supervised access visits.

4. Household Information. In this section, the researcher collected information about the child’s caregiver(s) who attended the supervised access visits. It recorded which caregiver(s) visited the child, their relationship with the child, whether the mother and father visited together, if they are related to the child by blood, and which children on the file attend the family visiting. This section also identified the highest education level completed by the caregiver(s), the ethnicity of the family, and the primary language of the family.

5. Caregivers Who Visit Risk Factors. The purpose of this section was to identify the risk factors of the caregiver(s) who visit the child. It determined whether the following factors are present: alcohol abuse, drug/solvent abuse, cognitive impairment, mental health issues, physical health issues, few social supports, victim of domestic violence, and perpetrator of domestic violence. This section also identified if there was a child custody order or child custody dispute, where the caregiver(s) who visits resided during the access visits, if the home was deemed overcrowded while the child was present in the home, the number of moves in the past year while living with the child and whether or not the family was suffering from financial difficulties.
6. **Supports for the Family.** This section of the assessment form identifies any supports that the family may be receiving. This includes: parenting skills support group, in-home support, counselling, housing/shelter, welfare, drug rehabilitation, Ontario Disability Support Program (ODSP), mental health services, food bank, domestic violence services, recreational services, medical assistance, methadone clinic, Continued Care Youth Services (CCYS), day care, or if the family has supportive relatives. There is also an ‘other’ section listed to determine any other types of supports that the family may receive.

7. **Child Information.** This section was used to determine characteristics of the child who attends the visits by determining if the following are present: depression/anxiety/withdrawal, suicidal thoughts, self-harming behaviour, ADD/ADHD, attachment issues, aggression, inappropriate sexual behaviour, Youth Criminal Justice Act (YCJA) involvement, intellectual disabilities, developmental disabilities, physical disabilities, academic difficulties, alcohol abuse, drug/solvent abuse.

8. **Type of Maltreatment the Child Exposed to.** This section dealt with the type(s) of maltreatment the child was exposed to while living in the home. This includes identifying: if there was physical abuse, what type of harm resulted from the physical abuse, sexual abuse, neglect, emotional maltreatment, exposure to intimate partner violence. Subcategories of these types of abuse were included to more precisely identify what the child had endured (See Appendix A for further details).

9. **Types of Maltreatment the Child Perpetrated Against Others.** This segment was designed to document whether the child had engaged in any physical, emotional, or sexual abuse towards others.

10. **Identified Strengths of Child and Family.** This section is used to identify any strengths that the children or caregivers possess. This section determined individual resilience, family resilience, and social resilience that were specified on the client file. This section included subsections of strengths to more precisely identify what sort of positive measures the family and children had engaged in.

**Rating System**

The assessment form required data to be coded in different ways depending on the item. Items required either a fill in the blank answer, a written answer, or circling the appropriate answer such as in sections 5 and 7 where the caregiver and children risk factors had to be identified. In these sections, four possible responses were available to the researcher for selection. These options were: “Confirmed”, “Suspected”, “No”, and “Unknown”, and were to be chosen with regards to different risk factors that may be present, such as alcohol abuse, mental health issues, and developmental disabilities. If the child or caregiver often presented with signs or symptoms of a risk factor, or the risk factor was confirmed by a medical doctor, the “Confirmed” option was selected. If the child or caregiver presented with few signs or symptoms of a risk factor, but showed some indication of the risk factor, the option to be selected was “Suspected”. If the caregiver or child showed no signs or symptoms of a risk factor, and displayed evidence against that risk factor, the option was selected as a “No” answer. If the file at hand displayed no information regarding the risk factor at hand, an “Unknown” option was selected for the final answer. To appropriately fill out the assessment form, the researcher was thoroughly trained on the criteria to be met for each response option.
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Procedure

File Selection. The files used in the present study were selected from the 23 client files used in Brown’s (2015) study. The file numbers used in Brown’s (2015) study were given to the researcher, entered into Microsoft Excel, and 50% of the file numbers were randomly selected for a total of 12 files.

Rater Training. The student researcher was trained by Brown who thoroughly explained each section of the assessment form and described how to correctly code the data to complete each assessment form. A designated question period was planned where the student researcher was able to ask questions and go over any uncertainties in regards to data collection. A ‘test’ assessment form was also completed by the student researcher, not to be included in the study, to assess the researcher’s understandings. This test was done by completing an assessment form individually until faced with a dilemma or uncertainty. If the researcher felt that there was a need for help or clarification through a certain section of the assessment form, the original researcher clarified and helped the researcher through that particular question. Discrepancies between the original researcher and the researchers were discussed and clarified.

File Review. The files were accessed in Frontline for Windows (FFW), the agency’s client database, by inputting the client’s file number, then searching for all required information by reading the client files. The student researcher opened each selected file on FFW, and searched for the information required on the assessment form. Depending on the section of the assessment form, some information was to be inputted by listing an answer, circling an answer, or writing an answer (See Appendix A for further details). Most sections on the assessment form included an ‘other’ option, where the researcher was able to identify any information relevant in that section that was not included as an option on the original document. The student researcher was not given any access to the assessment forms completed by Brown to ensure that the coding was done independently.

Interobserver Agreement and Determining Reliability. Once the scores were obtained from all 12 client files, the student researcher then directly compared her ratings to those from Brown’s (2015) study. IOA was then calculated. No qualitative data were included in the IOA calculation. IOA was calculated by dividing the number of agreements by the number of agreements plus disagreements and multiplying by 100. Agreements were based on whether or not the two researchers had answered each question the same way by either circling or writing the appropriate answer. Some sections in the assessment form allowed for the researcher to identify multiple answers. For these questions, agreements were based on how many options were the same between researchers, regardless of whether they were identified as an answer, e.g., if both researchers did not identify ‘strong self-esteem’ as an individual resilience factor for an individual, that was considered an agreement between researchers, as they both determined that was not a factor.

The assessment form included 2906 possible agreement options for determining IOA between researchers. All data was entered into a Statistical Package for the Social Sciences (SPSS) data file. For each variable coded, each rater’s score was recorded, along with the nature of agreement between them. Once the scores were obtained for each individual question, all of the totals were combined to give a final IOA score.
**Informed Consent.** This research protocol was reviewed and approved by the St. Lawrence College Research Ethics Board. Consent to collect the data was also obtained from the executive director of the child welfare agency.
Chapter IV: Results

Interobserver Agreement

Table 1 presents interobserver agreement for each section of the modified assessment form, expressed as a percentage. IOAs ranged narrowly between 98.04% and 100%. An overall IOA score of 98.8% between the two raters was calculated across all sections of the assessment form. This was found by taking the number of agreements (2906) divided by agreements plus disagreements (2940) then multiplying that score by 100. An IOA score equal to or exceeding 80% is widely recognized as acceptable (Garrity et al., 2008). Therefore, the IOA for the ratings in the present study indicates a very high degree of consistency in data coding. The coded data collected in the present study is almost identical to the data collected by Brown (2015), with only minor incongruities. This IOA score is also evidence for the face validity of the modified rating form, as it appears to be effective in assessing the stated aims of the study.

Table 1:
Percentage of agreement across sections.

<table>
<thead>
<tr>
<th>Assessment Form Section</th>
<th>IOA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Original Referral Information</td>
<td>98.21%</td>
</tr>
<tr>
<td>2. Previous CAS Involvement</td>
<td>98.95%</td>
</tr>
<tr>
<td>3. Police Involvement</td>
<td>100%</td>
</tr>
<tr>
<td>4. Household Information</td>
<td>100%</td>
</tr>
<tr>
<td>5. Caregiver(s) Who Visit Risk Factors</td>
<td>98.24%</td>
</tr>
<tr>
<td>6. Supports for Family</td>
<td>99.07%</td>
</tr>
<tr>
<td>7. Child Information</td>
<td>99.44%</td>
</tr>
<tr>
<td>8. Types of Maltreatment was the child exposed to</td>
<td>98.04%</td>
</tr>
<tr>
<td>9. Types of Maltreatment has the child perpetrated against others</td>
<td>100%</td>
</tr>
<tr>
<td>10. Identified Strengths of Child and Family</td>
<td>98.51%</td>
</tr>
</tbody>
</table>
Chapter V: Discussion

The purpose of this study was to assess the interobserver reliability of Brown’s (2015) adapted version of the Child Maltreatment Assessment Form. The purpose was established to ensure that the client’s characteristics were accurately depicted in Brown’s study. IOA was calculated to be 98.8% across all sections of the adapted form showing a very high degree of reliability between similarly-trained observers. These results indicate that the client characteristics coded in Brown’s study are accurately represented as a sample of the population of client characteristics.

Strengths

The results of this study served as a strength as a high degree of reliability was obtained. Many factors contributed to achieving this level of reliability, such as effectively training the rater on how to use the form, and how to obtain the appropriate information from each file.

The amount of training that the researcher engaged in is considered a great strength. A lack of researcher training can potentially lead to incorrect data being obtained. A benefit to this study was that the author of the adapted study, Brown (2015), trained the researcher directly. During the training session, the researcher was able to practice filling out assessment forms and was encouraged to ask questions to ensure thorough understanding of the measure and the information that needed to be obtained.

Additionally, this study was implemented in a timely manner. The file review was completed quickly and consistently due to the researcher’s ability to implement all the procedures herself.

Even though the procedures were implemented independently by the researcher, another strength to this study is that it incorporated collaboration between researchers. By obtaining a high IOA score, Brown’s (2015) data can be considered reliable, therefore increasing the value of her findings.

Limitations

A limitation to this study is that some sections of the assessment form may be unclear. There were some inconsistencies between the rater on sections 8 through 10 on the assessment form. The data in the present study was obtained from family files who were attending supervised access visits. However, Brown (2015) based the data on the families’ entire child welfare history, regardless of whether the children attended supervised access. Through discussion, the researcher and Brown (2015) determined that this had not been clarified in the training session. After discovering this, each researcher reviewed the completed client files for a second time, answering section 8-10 according to the involvement with only the current children who attended access.

Similarly, some sections of the assessment form conjoined risk factors such as “depression/anxiety/withdrawal.” This can potentially be unclear, as the assessment did not differentiate whether the presence of a risk factor was based on a medical diagnoses or by presenting symptoms. The researchers decided that for this study, sections such as “depression/anxiety/withdrawal would be considered present if the child or caregiver is presenting symptoms of one or more of the options. This leads to a coding based on opinion, and some may not believe the individual is presenting with symptoms, while others may differ. However, most files on FFW should indicate an official medical diagnosis of any kind.
Another limitation is that the information included on the assessment form was obtained only from the FFW database. If clients were receiving any supports, had any risk factors or had any other relevant information that were not reported on their FFW client file, then that information was not included on the assessment form. If a client characteristic or any other missing information was not identified on the client file, then it may not have been accurately represented.

Another limitation of this study is that the results may not be used to modify or create further services for clients. Even though the purpose of this study was to identify client characteristics of those families who receive supervised access visits from the child welfare agency, it is up to the agency whether these results have any implications for their services. The agency has been provided with a sample of its client characteristics.

Implications for the Behavioural Psychology Field

This study contributes to the field of behavioural psychology in multiple ways. First, it has added to research on this topic. It has also introduced the staff at this child welfare agency to Behavioural Psychology, and has highlighted how the results of relevant statistics and behavioural methods can be interpreted and used to create and modify current treatment options for the agency’s clients.

Multilevel Challenges

Client Perspective. In a child maltreatment case, it is sometimes difficult to separate a caregiver from his/her child or vice versa, particularly when the caregiver was not purposely harming the child, or had a disability which resulted in capacity issues. It is important for all child welfare agencies to offer the services needed to protect children and aid in strengthening and building healthy relationships between family members. A challenge may be that each individual and each family is different; the child welfare agency may not provide services that are tailored for each family. The family must also be willing to accept the help that the child welfare agency has to offer in order to learn and grow from previous faults.

Program Level. Family and children service workers, enhanced support service workers, and other related staff see child abuse and neglect cases on a daily basis. Because these events become normative for workers, there is the possibility that they could become numbed emotionally and desensitized to the situation. Burnout can negatively affect the quality of work that workers put into their cases.

Organizational Level. This particular child welfare agency is a non-profit organization that is funded by the government. Budget cuts often lead to staff dismissals and possible resource and service restrictions.

Societal Level. Meeting and interacting with children who have been abused, neglected, or mistreated is a difficult experience for most individuals. It is often quite easy for society to judge or place blame on parents who are not taking care of their children, regardless of the reasoning behind the mistreatment. Regardless of how society views child maltreatment, many people often do not report suspected child maltreatment cases.

Many cases of child maltreatment go unreported every year. Children who grow up in a society that has not helped them to escape from abusive or neglectful situations may not feel safe within their community, and may become angry at society as a whole.

This study sought to assess the reliability of Brown’s adapted CIS-2008 assessment tool, in order to help minimize these multilevel challenges. The result of Brown’s study can now be used to address client needs, by altering services accordingly. This information provides the organization with an understanding of their current population that can be used to modify their services at a
program level. The clients may also benefit from this, as they will be receiving more tailored services to suit their needs. By establishing the interobserver reliability of Brown’s rating tool, this child welfare agency can gather a great deal of information about their clients, which may help the agency to better gauge what needs to be done in order to ensure that their clients are receiving appropriate services.

**Recommendations for Future Research**

As stated previously, one of the main challenges in conducting this research was understanding the complex assessment form. Therefore, it is recommended that the rater training be carefully considered before future data collection. Ratings could be skewed or unreliable if two or more observers interpreted questions differently. All observers and/or researchers are trained to use the assessment form, and how to obtain the required information. It is recommended that raters spend a great deal of time familiarizing themselves with the form to identify and deal with any uncertainties.

It is also recommended that future studies use a larger sample of files when assessing/checking IOA. The larger the sample size, the more likely the results will generalize to the population of client files. Lastly, researchers should not be pressed for time while filling out assessment forms, as relevant and necessary data could be missed.
INTEROBSERVER RELIABILITY

References


INTEROBSERVER RELIABILITY


Appendix A: Assessment Form

Risk and Resilience Characteristics for Supervised Access Client’s
(Adapted from the CIS-Maltreatment Form)

CODE: ______________________

1. Original Referral Information

Year file was opened: ________________

Referral Code: ___________________________  Verified: Yes or No

Source(s) of Referral:
- Primary caregiver
- Hospital Crisis Service/Shelter
- File Transfer
- Relative
- Day Care Center
- Other: _________
- Child (Referred)
- Neighbour/ friend Anonymous
- Police Officer
- Community Physician

Reason for call (incident or circumstances):

Family Visiting Referral Information

Year file was opened for Family Visiting: ______________________

Year File was closed for Family Visiting: ________2013__________

Reason For Closing Family Visiting Service:

Reopened for Family Visiting between closing date and November 2014:   Yes   /  No
INTEROBSERVER RELIABILITY

Age of all children under family’s file, when access occurred: Gender of child:
A.
B.
C.
D.
E.

2. Previous CAS Involvement (Before Original Referral Identified Above)

Previous Referral(s): Yes No Unknown
- If YES how long sense previous referral: ________
- How many previous referrals in total: _________

Child previously reported for suspected maltreatment (any referral):
Yes No Unknown
- If YES was the maltreatment verified by a worker: Yes No Unknown
- Was the child examined by physician/nurse: Yes No Unknown

Where did the child reside during the family visiting (supervised access) involvement:
- Foster Home (In care)
- Kinship Placement (placed voluntarily by caregiver)
- Kinship Placement (placed involuntarily by caregiver)
- Kinship Foster Care (In care, living with Kin)
- Group Home Residential/Secure Treatment
- No placement
- Other: __________________________

Caregivers previously used spanking as a form of discipline: Yes No Unknown

3. Police Involvement (at original referral):
- No Charges being considered Charges laid
- Investigation Only Unknown N/A
4. Household Information (at family visiting referral):

Caregiver who visits:

Caregiver A: ☐  Caregiver B: ☐  Caregiver C: ☐  Caregiver D: ☐

Relation to child:

Mom and Dad visit together:  Yes  No
Related to child by blood:  Yes  No

Child(ren) who attend supervised access:  Age(when access occurred):  Sex:

Child A: ☐
Child B: ☐
Child C: ☐
Child D: ☐
Child E: ☐

Highest education level completed by the Caregiver(s) who visits:

- Some Elementary
- Completed Elementary
- Some High School
- Completed High school
- Some Post Secondary
- Completed Post secondary

Ethnicity of Family:

Primary Language of Family:
5. Care Giver(s) Who Visits Risk Factors:

- **Alcohol abuse**
  - Confirmed
  - Suspected
  - No
  - Unknown

- **Drug/solvent abuse**
  - Confirmed
  - Suspected
  - No
  - Unknown

- **Cognitive Impairment**
  - Confirmed
  - Suspected
  - No
  - Unknown

- **Mental Health Issues**
  - Confirmed
  - Suspected
  - No
  - Unknown

- **Physical Health Issues**
  - Confirmed
  - Suspected
  - No
  - Unknown

- **Few social supports**
  - Confirmed
  - Suspected
  - No
  - Unknown

- **Victim of domestic violence**
  - Confirmed
  - Suspected
  - No
  - Unknown

- **Perpetrator of domestic violence**
  - Confirmed
  - Suspected
  - No
  - Unknown

- **Child custody order**: Yes No Unknown

- **Child custody dispute**: Yes No Unknown

Where does the caregiver(s) who visits reside:

- Own Home
- Rental
- Public Housing
- Hotel
- Shelter
- Unknown
- Other

Home was deemed “overcrowded” when children lived at home: Yes No Unknown

Number of moves in the past year (children living with the caregiver(s) receiving supervised access): 0 1 2 3 4

Family deemed to suffer from financial difficulties: Yes No Unknown
INTEROBSERVER RELIABILITY

6. Supports for Family: (circle all that apply)

- None
- Parenting Skills Support Group
- In-Home Support
- Counselling
- Housing/Shelter
- Welfare
- Drug Rehabilitation
- ODSP
- Mental Health Services
- Food Bank
- Domestic Violence Services
- Recreational Services
- Medical Assistance
- Methadone Clinic
- CCYS
- Day care
- Supportive Relatives
- Other: _______________

7. Child Information

Child Functioning (circle all that apply)

Depression/anxiety/withdrawal: Confirmed  Suspected  No  Unknown
Suicidal thoughts: Confirmed  Suspected  No  Unknown
Self harming Behaviour: Confirmed  Suspected  No  Unknown
ADD/ADHD: Confirmed  Suspected  No  Unknown
Attachments issues: Confirmed  Suspected  No  Unknown
Aggression: Confirmed  Suspected  No  Unknown
Inappropriate sexual behaviour: Confirmed  Suspected  No  Unknown
YCJA involvement: Confirmed  Suspected  No  Unknown
Intellectual disabilities: Confirmed  Suspected  No  Unknown
Developmental disabilities: Confirmed  Suspected  No  Unknown
Physical Disabilities: Confirmed  Suspected  No  Unknown
Academic Difficulties: Confirmed  Suspected  No  Unknown
## INTEROBSERVER RELIABILITY

<table>
<thead>
<tr>
<th>Alcohol abuse:</th>
<th>Confirmed</th>
<th>Suspected</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug/solvent abuse:</td>
<td>Confirmed</td>
<td>Suspected</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Other</td>
<td>Confirmed</td>
<td>Suspected</td>
<td>No</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

### 8. What types of Maltreatment was the child exposed too? (Circle all that apply)

#### Physical abuse:
- Shake/push/grab/Hit with hand
- Punch/ kick/bite/Hit with object
- Choking/ poisoning/ or stabbing
- Other physical abuse:

#### Physical abuse caused what type of physical harm:
- No harm
- Broken bones
- Head trauma
- Bruises/cuts/scrapes
- Burns/scalds
- Fatal
- Other

#### Sexual abuse:
- Penetration
- Attempted penetration
- Oral sex
- Fondling
- Sex talk or images
- Voyeurism
- Exhibitionism/ Exploitation
- Other sexual abuse

#### Neglect:
- Failure to supervise: physical harm
- Failure to supervise: sexual abuse
- Permitting criminal behaviour
INTEROBSERVER RELIABILITY

- Physical neglect
- Medical neglect (includes dental)
- Failure to provide psych. Treatment
- Abandonment Educational neglect

**Emotional Maltreatment:**

- Terrorizing or threat of violence
- Verbal abuse or belittling
- Isolation/confineinent
- Inadequate nurturing or affection
- Exploiting or corrupting behaviour

**Exposure to intimate partner violence:**

- Direct witness to physical violence
- Indirect exposure to physical violence
- Exposure to emotional violence
- Exposure to non-partner physical violence

9. What types of Maltreatment has the child perpetrated against others: (Circle all that apply and Code PC for Primary Caregiver; F for Family Member; or O for someone outside family)

Child has engaged in following acts of Physical or emotional abuse:

- Shake/push/grab or throw Hit with hand
- Punch/ kick/ or bite Hit with object
- Choking/ poisoning/ or stabbing Other physical abuse
- Terrorizing or threat of violence Verbal abuse or belittling
- Isolation/confineinent Exploiting or corrupting behaviour
- Child has caused Physical harm to others
- Bruises/cuts/scrapes
- Other:

Child has engaged in following acts of Sexual abuse towards another:

- Penetration
- Attempted penetration
- Oral sex
- Fondling
INTEROBSERVER RELIABILITY

- Sex talk or images
- Voyeurism
- Exhibitionism/Exploitation
- Other sexual abuse

10. Identified Strengths of Child and Family

Individual Resilience

- Strong intellectual functioning
- Physically Appealing (appropriate hygiene)
- Sociable
- Easy going
- Strong self efficacy
- Strong self esteem
- Strong self confidence
- Extra curricular Talents
- Faith

Family Resilience

- Strong attachment to caring parent
- Authoritative Parenting
- Structure/Routine
- Expectations/Goal Setting
- Socioeconomic Advantaged
- Relationship w/ Grandparents/extended family
- Biological Parents Married (or in relationship)
- Sibling(s) residing in same residence

Social Resilience

- Involvement w/ social organizations & extra curricula’s
- Consistent school attendance
- Relationship with neighbourhood children
- Involvement w/ social support (counselling, peer tutor)
- Faith/ Attends Church
INTEROBSERVER RELIABILITY

Appendix B: Consent Form

Addressed to Executive Director: Steve Woodman, Family and Children Services of Frontenac, Lennox, and Addington

Project Title:
Determining the Reliability of two Adapted Versions of the Child Maltreatment Assessment Form

Principal Investigator:
Alexis Brough

Name of Supervisor:
Dr. Sheelagh Jamieson, C. Psych.

Request for Permission to Conduct a File Review

Invitation
I am a student in my 4th year of the Behavioural Psychology program at St. Lawrence College. I am currently on placement at Family and Children Services of Frontenac, Lennox, and Addington, working under the supervision of Amanda Hepburn (Enhanced Support Services Worker) and Dr. Sheelagh Jamieson, St.Lawrence College. As a part of this placement, I am completing a research project called an applied thesis. I would like to ask you for your permission to complete this project. The information in this form will help you to understand my project. Please read the information carefully and ask all the questions you might have as I will happily provide additional information.

Why is this study being completed?
This study is being completed in order to determine the reliability of two adapted measures of the Child Maltreatment Assessment Form (Trome et al., 2008) which have been or are currently being used in two other research projects by Bethanie Doyle (2012) and Amanda Brown (2014) at Family and Children’s Services of Frontenac, Lennox, and Addington. The results of this these research reports have the potential to uncover the needs of families within our community and may be beneficial to your agency. However, it is important to know that the data has been reliably and accurately recorded. The present study will help determine the reliability of the studies by collecting Interobserver Agreement (IOA) data.

What will you need to do if you take part?
There will be no direct participants taking part in this study; however, the study will consist of a file review. If you choose to take part in this study, you will be asked to provide the placement student with access to client files in the FFW program. All files will be selected from the Family and Children’s Services Kingston, Napanee, and Sharbot Lake online FFW database while the student is onsite in the student/volunteer office.

What are the potential benefits of this research study?
Because the data used in this project will be taken from client files, no immediate participants will benefit from this project. However, a number of potential benefits may be considered upon the completion of this project. If the analyzed data suggests that the adapted studies are reliable, the potential benefits of this project include providing a better understanding of the characteristics of the families involved with Family and Children’s Services. Information from this project may also be used to help improve treatment options for families in the future, as the information obtained may be used to further understand the needs of families.

What are the potential disadvantages or risks of taking part?
Because this project does not directly involve participants there are no disadvantages to taking part in this study.
INTEROBSERVER RELIABILITY

Will my information you collect from me in this project be kept private?
Only the researcher will be aware of which files were ultimately selected to be used in this study. This research report will only contain anonymous data, removing any identifiers. The clients will not be identified by name in any reports, publications, or presentations resulting from this project. Any confidential information used while obtaining data will be kept on the researchers password protected computer in an encrypted word document. All files will be coded with a number and no file numbers will be retained. The consent form from the agency, completed assessment scales, and all data collected (with non-identifying information) will be kept in a sealed envelope and stored in a locked filing cabinet at FACSFLA for 10 years after the thesis is completed.

Do you have to take part?
Giving consent for a file review is voluntary. It is up to you to decide whether or not you provide the placement student with access to client files for this research project. If you do decide to give consent for a file review, you will be asked to sign this consent form. If you do decide to give consent in this research project, you are still free to withdraw at any time, without giving any reason, and without incurring any penalty, or negative effects.

Contact for further information
This project has been approved by the Research Ethics Board at St. Lawrence College. The project will be developed under the supervision of Dr. Sheelagh Jamieson, C. Psych., my supervisor from St. Lawrence College. I really appreciate your cooperation and if you have any additional questions or concerns, feel free to ask me, Alexis Brough at (613) 661-4622 or by email alexis.brough@facsfla.ca. You can also contact my College Supervisor at 613-544-5400 ext. 1563 or by email sjamieson@sl.on.ca. You may also contact the Research Ethics Board at appliedresearch@sl.on.ca.

Consent
If you agree to give permission for this thesis research project, please complete the following form and return it to me as soon as possible. A copy of this signed document will be given to you for your own records. An additional copy of your consent will be retained at the agency and in a secure location at St. Lawrence College.

By signing this form, I agree that:

✓ The study has been explained to me.
✓ All my questions were answered.
✓ Possible harm and discomforts and possible benefits (if any) of this study have been explained to me.
✓ I understand that I have the right not to give permission and the right to revoke given permission at any time.
✓ I am free now, and in the future, to ask any questions I have about the study.
✓ I understand that no information that would identify clients will be released.
✓ I understand that Family and Children Services will receive a signed copy of this consent form.

I hereby give permission for Alexis Brough to conduct a file review.

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SLC Student Printed Name  Signature of SLC Student  Date

Director of Frontenac CAS  Signature of Director  Date

On-Site Supervisor  Signature of On-Site Supervisor  Date