Difficulties Identified Among Parents and Children who Use Enhanced Support Services to Obtain Supervised Access: A Child Welfare Study

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Abstract

Children who are involved with the Children’s Aid Society because they have been abused, neglected, or exposed to domestic violence or substance abuse, are more likely to do poorly in school, experience mental health issues, behavior problems, and express difficulty forming life-long relationships. Because these consequences are so serious, it is essential for families to receive the proper support to prevent child maltreatment, and to assist children with recovery from the negative events they have experienced. Arguably, supervised access visits between children and their non-custodial parents are crucial to ensure the development of a strong child-parent relationship among families with children in care. In order to understand the needs of this population, the present study examined a random sample of client files who received supervised access support from an Enhanced Support Services (ESS) worker. The files could have opened in any year, but must have closed between January 1, 2013 and December 31, 2013. A total of 46 client files met this criterion. Half of the files were reviewed using an adapted version of the Canadian Incidence Study of Reported Child Abuse and Neglect-2008 Maltreatment Assessment Form (CIS-2008; Trocme et al., 2010). The adapted CIS assessed: the clients’ history of involvement with a child welfare agency, police involvement during the original referral, household information, caregiver and child risk factors, mental health issues, supports for the family, child’s information, type of maltreatment the child has perpetrated on others (if any), and individual, familial, and societal resilience factors. Results indicated that caregivers with closed child welfare files and no access to children who had become crown wards were more likely to have a cognitive impairment than files that required no further services. Children from these families were more likely to present with a physical disability, and be younger than children whose family files were closed for other reasons. Families in which children were made crown wards with no access had fewer individual and familial resilience factors than families whose files were closed because no further services were required. Drawing on the Family Preservation model, the data gathered from this study will be used to inform and enhance the services provided by the ESS workers for agency clients.
Acknowledgements

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Chapter I: Introduction

Supervised access visits between children and their non-custodial parents are crucial to ensure the development of a strong child-parent relationship among families with children in care. The Ontario Children’s Aid Societies (CAS) facilitate supervised access, as their goal is to ensure that protection and permanency are in the best interest of each child. There is considerable stigma about families who have involvement with the Children’s Aid Society. Many label these families as “crazy” and “unstable”; but these accusations hold no supporting evidence. Indeed, there is minimal research on the characteristics of children and their biological parents who partake in supervised access visits. Therefore, the purpose of the present study was to review a number of client files from a local Children’s Aid Society, who stopped receiving facilitated supervised access from the agency’s Enhanced Support Services (ESS) workers in 2013, to determine the relevant characteristics, difficulties, and resilience factors present within these children and caregivers. The chosen files were assessed using an adapted version of the Canadian Incidence Study of Reported Child Abuse and Neglect- CIS-2008, developed by Trocmé et al., after Doyle (2012). This assessment scale was adapted to evaluate the characteristics of children and biological parents involved with supervised access at the Children’s Aid Society. The literature review explains the purpose of providing supervised access; critically examines the characteristics of both caregivers and children who receive supervised access; identifies the obligations and roles of a Children’s Aid Society and the local ESS workers, and provides an overview of the results concluded from the CIS study. Subsequent sections describe the method and the adaptation of the measure, present the results from this study and discuss the implications of the findings for future research and practice in the child welfare field.
Chapter II: Literature Review

In 2007, approximately 67,000 children in Canada lived in out-of-home care (Trocme & Mulcahy, 2010). Children come into care for a number of reasons. Often their caregivers are unable to provide adequate housing, are diagnosed with mental illness, are involved in criminal activity, domestic violence, substance abuse, and/or are unable to provide basic parenting skills (Simms & Bolden, 1991). While in care, child protection services provide assistance to the biological and foster parents to try to reunify the family and to ensure permanency exists for the child, which is the long-term goal (Lopez, Del Valle, Montserrat, & Bravo, 2013). In some circumstances, reunification is not in the best interest of the child, and crown wardship must be pursued. However, when reunification is the desired outcome for permanency, supervised access is the most important intervention that can be implemented (Biehal, 2007).

Supervised Access Visits

Supervised access is referred to as court ordered visitation, which occurs between children and their non-custodial parents, typically at the discretion of a child protection agency (Galley, 2008). According to Haight et al. (2005), supervised access visits between children and their biological parents are a successful component in developing a positive parent-child relationship, which may ensure permanency when children are returned home. While children are in care, child protection services facilitate supervised access visits between the children and their non-custodial parents to support this relationship. Children who are visited by their parents more frequently are less likely to develop negative characteristics, and are more likely to thrive in their natural development (Hess, 1988).

Child protection workers observe supervised access visits and this provides an opportunity to assess the parents’ ability to care for the needs of the child. The worker documents the interactions between parents and their children in order to identify any concerns or behaviour patterns that arise and that may need to be addressed to ensure the child’s safety. Rella (2010) discussed the importance of providing supervised access to these children, under the condition that the parents are able to promote positive attachments. Children come into care because there are protection concerns with the primary caregivers; if these concerns can be controlled during supervised access, access should be supported. For example, parents who have a substance addiction would refrain from attending access when under the influence of drugs or alcohol. Unless a parent is incarcerated at the onset of the child entering care, supervised access is supported at the discretion of a court order or child protection agency.

Child protection workers must consider a number of variables when determining the frequency of supervised access, such as legal court orders, and the impact of other resources such as educational classes, availability of community resources such as detoxification programs, or the child’s school schedule (Hess, 1988). If the society requires a mother to attend parenting courses to develop such skills, then the child protection worker must be flexible to ensure that access does not occur at the time of the parenting class. Other variables that can influence the frequency of access include the local agency policies, supervised access resources, parental progress, and placement related considerations.
Although the literature is minimal, Hess (1988) identified supervised access as a component that strengthens positive relationships between children and their parents, and reinforces emotional well-being. Hess (1988) also concluded that children who receive supervised access with their parents were more likely to be discharged from care and returned home.

**Characteristics of Caregiver’s who Receive Supervised Access**

There are a number of environmental and parental characteristics within families that often precede children entering into care (Gourdine, Smith, & Brown, 2013). Factors such as poverty, inadequate parenting skills, limited community resources and social supports, mental illness, single parent families, and lack of education, all contribute to stressful circumstances that negatively impact family functioning (Maupin, Brophy-Herb, Schiffman, & Bockek, 2010; Berry, Charlson, & Dawson, 2003; Gourdine, Smith & Brown, 2013). Berry, Charlson, and Dawson (2003) also identified domestic violence as a reason why children enter care. To effectively function with many of these conditions support is required from community resources. However, it is noted that many of the families involved with supervised access lack access to community resources because of insufficient funds, transportation, no fixed address, or intellectual disability, which results in families becoming susceptible to dysfunction, and children experiencing a greater risk of being apprehended and placed in care (Maupin et al., 2010).

Gourdine, Smith, and Brown, (2013) identified the negative impact of substance abuse and unstable family relations on effective parenting. Unstable families, and families that lack support from their relatives, are identified in most child protection cases as; parents that are not together or are in romantic relationships with others; parents who introduce their children to numerous toxic partners; or parents who have limited involvement with their own families that may have support to offer. Unfortunately, unstable families become a generational pattern, which makes it difficult for child protection agencies to find kinship services that will care for, and support, the children.

Gourdine et al. (2013) completed a study with families who had their children removed from their care. Substance abuse, drug addiction, or single parenthood, were present in each family’s circumstances. Abusing substances and illicit drugs was a familial concern (for both caregivers in the relationship, not just one or the other) for more than half of the parents whose children were placed in care. Because of these addictions, many caregivers are unable to abstain from using while they are receiving supervised access. Most who are addicted continue to use as a means of coping with the stress of losing their children (Rella, 2010). In this circumstance, when treatment was pursued, more than one intervention was required for parents before they began to improve without relapse (2013). In addition, Biehal (2006) identified a study conducted by Goerge (1990) that examined the discharge process and the probability of reunification for families with child welfare involvement. Children who were apprehended for abuse and neglect reasons were less likely to be returned home; while children who were placed in care due to their caregiver’s emotional or behavioural problems were more likely to be returned. Drug and substance abuse was identified as a behavioural problem. These findings indicate that caregivers who abuse drugs can return to being acceptable parents to their children, once they overcome their addiction.
Furthermore, Zhang and Anderson (2010) completed a study with single mothers who had been victims of domestic violence and had child welfare involvement. It was determined that these mothers were 2.7 times more likely to also have a mental illness diagnosis, and/or suffer from substance abuse, which significantly impacted their ability to care for their children. Bartholet (1999) recognized alcohol and cocaine to be the primary drug of choice, followed by marijuana and methamphetamines. Caregiver’s use of these drugs resulted in their children being apprehended from their care.

**Characteristics of Children who Receive Supervised Access**

Along with parents, children who are brought into care and experience supervised access are also susceptible to developing negative characteristics. Infants and middle school-aged children are at the greatest risk for entering into care, because their needs are so demanding, and parents with the previously mentioned characteristics struggle, or are unable to provide adequate parenting to meet these needs (Gourdine, Smith, & Brown, 2013). Children with difficult behaviour and disabilities are at greatest risk for being maltreated (Algood, Hong, Gourdine, & Williams, 2011). Female children and youth are more likely to be sexually abused, and male children are more likely to be physically abused (Gourdine, Smith, & Brown, 2013; Mersky, Berger, Reynolds, & Gromoske, 2009).

Pritchett, Gillberg, and Minnis (2013) compiled related literature and determined that children who have entered care are more vulnerable to problems with their emotional and behavioural development. Research has clarified that children who are maltreated by their caregivers are likely to display inconsistent mood, anxiety, and characteristics of post-traumatic stress (Bellis et al., 2001; Pritchett, Gillberg, and Minnis, 2013). Gyamfi et al. (2012) examined mental health conditions with two groups of children: one who had child welfare involvement and the other who did not. Children whose families had child welfare involvement had greater signs of anxiety and depression than those who had no child welfare involvement. Furthermore, Overbeek, De Schipper, Lamers-Winkelman, and Schuengel (2014) completed a study with 155 children in the Netherlands who had been exposed to inter-parental violence between their primary caregivers. Families in this study had child welfare involvement, but may have never had their children removed from their care. Distorted attachment, post-traumatic stress, and social engagement disorder, were identified characteristics that become risk factors for children when they are exposed to domestic violence.

Child neglect is also a concern with children who come into care and receive supervised access. According to Berry, Charlson, and Dawson (2003), children who experience chronic neglect are more likely to suffer from negative repercussions than children who experience one incident of physical abuse. Research confirms that children who are neglected often display physical elements of neglect such as constant hunger and fatigue, poor hygiene, inappropriate dress for weather conditions, inconsistent growth, and cognitive development. A positive correlation between child neglect, school failure, and emotional difficulties also exists (Gaudin, 1993; Kurtz et al., 1993). A greater concern with child neglect, noted by professionals, is that neglect becomes a behavioural pattern that is learned and repeated generation after generation with families involved with child protection agencies (Berry, Charlson, & Dawson, 2003; Gaudin, 1993; Kurtz et al., 1993).
Ontario Children’s Aid Societies: Role of an Enhanced Support Services Worker

Early interventions provided by community supports and services assist at-risk families with treatment of the acknowledged protection concerns (Berry et al. 2003). Service providers work collaboratively with parents to ensure the resources they need are available to support the return of their child home (Berry et al., 2003). The Ontario Children’s Aid Societies are non-profit agencies that provide support to children and their families when a protection concern exists. If the agency cannot directly support the circumstances of the family, it can provide referrals to community resources that can provide the adequate support. Community services such as counseling, academic courses, rehabilitation services, and financial aid assistance, are all used to support families involved with child protection services.

The Ontario Children’s Aid Societies abide by the Child and Family Services Act of Ontario, and follow strict ministry standards. The local society that participated in this study is committed to strengthening families, protecting children and youth, and promoting their well-being. The society employs a number of workers that support families and assist them with connecting to other community resources. It is crucial that caregivers receive treatment and support to ensure they can demonstrate the capacity and skills required to care for their children. While treatment is pursued, and children are living with kin or in foster care, it is important to provide biological parents and their children with supervised access. The local Children’s Aid Society employs Enhanced Support Services (ESS) workers who provide consultation, in-home support, individual or group support, transitioning adolescents, and facilitation of supervised access. During supervised access the ESS worker provides support to both the parents and the children, as they assist with strategies to increase positive attachment. ESS workers connect caregivers with community resources, provide them with written resources, and assist with teaching specific parenting skills and behaviour management procedures related to the care of their children. When supervising family access, ESS workers are required to document diligently what transpires during the visit, with strong attention on the initial encounter with the parent and the child; the structure of the visit; if the parent is able to identify and meet the needs of the child during the visit; and the goodbye at the end of the visit. If the ESS worker has concerns, he/she will address them at the onset, if they are critical to protect the child. If a concern is not critical, it can be addressed after the visit, or before the next, as a learning opportunity for the parent. Supervised access can occur at the agency, in the community, or at the home of the caregiver.

Canadian Incidence Study of Reported Child Abuse and Neglect

The Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) was created to estimate the incidence of family characteristics related to child abuse and maltreatment (Trocme et al., 2008). The study reviewed 15,980 child maltreatment investigations at 412 child protection agencies across Canada. The main objective of the assessment was to provide an accurate estimate of the incidence of characteristics that are involved with child maltreatment. Such characteristics include: sustained physical, sexual, or emotional abuse; neglect; exposure to intimate partner violence; severity of physical and emotional harm; length of the child welfare investigation and previous involvement; and the result of out-of-home placement as a consequence of child maltreatment. The assessment included a variety of categories to identify the type and
severity of child maltreatment. It is important to note that the study did not include unreported child maltreatment cases; that is, investigations that were only completed by the police and not verified by child protection services. In 2008, the study confirmed an increase in the number of child maltreatment referrals from previous studies in 1998 and 2003. 235,842 investigations were conducted in 2008, compared to 235,315 in 2003 and 135,261 in 1998. The awareness and support that the media now provides and the number of resources available to report child maltreatment, have assisted with the increase of reports (“What is abuse,” 2010). Trocme et al., 2008, believe that the frequency has not increased; rather, there is now more awareness.

There are further relevant findings from the 2008 CIS. Families with children under the age of one were at the greatest risk for investigation, with a rate of 51.81 children per every one thousand investigated. The investigated incidence rate declines as children age, as 43.14 children aged 1-3 were investigated and 34.26 children aged 12-15 were investigated, per every one thousand investigations. These findings indicate the number of child abuse investigations decrease as children age. It is important to note the CIS did not include any child welfare referrals in which an investigation was not open for examination. Only files open for investigation were included in this study.

According to the CIS results, the categories of maltreatment that were found to occur most frequently were: exposure to intimate partner violence (34% of cases) and child neglect (also in 34% of total cases investigated). On a positive note, only 8% of the total investigations conducted resulted in a change of residence for the child. Of this 8%, 4% of the children were admitted into an informal kinship placement, which confirms children were able to reside with their family without being brought into care. Four percent were brought into care and placed into a foster or kinship home; and less than 1% were placed in treatment or group homes. The distributions of child functioning concerns indicated that 46% of the children investigated had a minimum of one concerning attribute. Academic difficulties were the most frequent characteristic evident in 23% of the investigations, while depression, anxiety and withdrawal ranked second, evident in 19% of investigations. In regard to parental caregivers, investigations indicated 94% of primary caregivers were a biological parent of the child in their care. In the investigations reviewed, 78% of the caregivers had at least one identified risk factor. The study suggested that the greatest concern was caregivers who were victims of domestic violence (46%). Thirty-nine percent admitted to having few social supports and 27% indicated mental health concerns.

Most studies that examined the characteristics of children and their families within the child welfare system combined all types of maltreatment. However, researchers (Petrenko, Friend, Garrido, Taussig, & Culhane, 2012; Doyle, 2012) have demonstrated the importance of examining specific populations when assessing the characteristics of those with child welfare involvement. Petrenko, et al. (2012) studied children who were specifically exposed to physical abuse, sexual abuse, physical neglect, and supervisory neglect by their caregivers. Results indicated that children exposed to sexual or physical abuse were at greater risk for externalizing negative behaviour problems; whereas children who experienced physical abuse and physical neglect was more likely to experience internalized problems (2012).

Doyle (2012) addressed the characteristics of children who were abandoned or at imminent risk of abandonment. Assessments of the family’s previous CAS involvement;
the specifics of the initial referral; and the risk factors of the children and their caregivers involved were obtained. It was concluded that a greater number of abandonment referrals were received for children in their early teenage years. Struggles with attachment, depression, and suicidal ideation were evident among children who were abandoned or at risk of abandonment due to current caregiver-child conflict. Rates of mental health conditions were higher in Doyle’s assessment, in comparison to the original Canadian Incidence Study Report (Trocme et al, 2012). The Petrenko et al. and Doyle studies suggest it is important to examine specific populations within the child welfare system as the characteristics of children and families may differ across populations.

The Present Study

The purpose of the present study was to examine the characteristics of clients involved with Enhanced Support Services workers at a local Children’s Aid Society using an adapted version of the Canadian Incidence Study of Reported Child Abuse and Neglect Maltreatment Assessment Form (Trocme et al., 2008). It was hypothesized that the caregivers receiving supervised access were individuals who have been victims of domestic violence, were involved with limited community resources, had been diagnosed with a mental health condition, and had limited parenting skills. It was proposed that the children involved with supervised access had witnessed domestic violence, been exposed to physical, emotional, or sexual maltreatment, or neglected. The review aimed to describe and assess the characteristics of children and their caregivers who used the supervised access service. The evidence gathered may help child protection services to ensure their workers have the sufficient skills and proficiencies to assist families with these challenging characteristics in the future.
Chapter III: Method

Setting

Family and Children’s Services of Frontenac, Lennox and Addington (FACSFLA) offers a number of services to support families with child welfare involvement in and around Kingston, Ontario. When a child welfare referral is made, a Family Services worker completes the initial investigation to verify whether or not the allegations are true. The Family Services worker provides support to ensure the child is protected. If a child is apprehended and placed in care or with kin, he/she receives support from a children’s services worker. The same worker typically supports siblings, even if they do not reside in the same foster or kin home. If a family requires further support, a worker can request an Enhanced Support Services (ESS) worker for the file. An ESS worker provides a variety of resources such as in-home support, extended care and maintenance for youth, and facilitation of supervised access. When an ESS worker is assigned to facilitate a family’s supervised access, the file is opened to the ESS worker in the agency database as “Family Visiting”. Client files are stored in an electronic database, Frontline For Windows (FFW), from which information was retrieved on the client files selected for review.

Procedures

Participants

Because this study was a file review, there were no direct participants. However, the files that were chosen for review were selected based on the following criteria: The file had to be open during any year to an Enhanced Support Services worker for assistance with supervised access, coded in the FFW database as “Family Visiting”. The file then had to be closed from this service between January 1, 2013 and December 31, 2013. These client files could have previous CAS involvement, or have remained involved with the society once the family visiting service closed. Files open to Enhanced Support Services workers for other services such as in home support, or adolescence life skills were excluded.

Consent Procedures

Consent to review and analyze the selected files was obtained from the executive director of the FACSFLA (Appendix A). The consent gave permission for the student researcher to access the Frontline For Windows (FFW) database and gather information from the files that were eligible for review in the study. Prior to obtaining consent from the society, the student had to submit a proposal to the St. Lawrence College Ethics Board (REC-P) and seek their approval. To protect client confidentiality, all assessment forms were coded from an initial template key. The template key and data will be stored for the next ten years in a locked cabinet in the human resources department at FACSFLA.

Selection Procedure

A total of 46 files met the criteria for inclusion in the review. However, due to time constraints, only 23 were reviewed. The selection process consisted of listing the client files in alphabetical order based on the client’s last name, and reviewing the first on
the list. Following the file selection, each alternate client file was reviewed and the assessment form was completed.

**Measures**

An assessment form (Appendix B) was constructed as an adapted version of the Risk and Resilience Factors for Child Abandonment, created by Doyle, 2012. Doyle adapted her version of the assessment scale from the original Canadian Incidence Study of Reported Child Abuse and Neglect conducted in 2008 by Trocme et al. The following were the critical sections included in the assessment form for this file review.

*Original Referral Information*

This section included information about the original referral that opened the file to a child protection worker. The year the file was opened, under what eligibility code (the Children’s Aid manner of coding what the type of referral was), whether or not the referral code was verified, the source of the referral, and the reason for the referral.

*Family Visiting Referral Information*

When a file is opened to an Enhanced Support Services worker to assist with supervising access, the file is opened to the ESS worker as a family visiting referral. This section of the assessment form documented the year the file was opened and closed for family visiting, and the age and gender of all the children involved in the client’s file. All children were identified in this section, whether or not they attended supervised access.

*Previous CAS Involvement*

This section of the assessment form was created to gather insight as to whether or not the families referred to ESS workers for family visiting have had previous involvement with a Children’s Aid Society. This section identified how many previous referrals the family has had, if the child was maltreated, and where the child resided when the family’s file was opened for family visiting.

*Police Involvement at Original Referral*

This section identifies whether or not there was any police involvement at the time of the original referral.

*Household Information*

This information is relevant to the family visiting referral. This section identified which caregivers visit which children, if both biological caregivers visit together, the level of education of the caregivers, the family’s ethnicity, and their preferred language.

*Caregivers Who Visit Risk factors*

The information gathered in this section identified caregiver risk factors that were relevant to child protection concerns. This section of the assessment identified if the caregivers who visit the children abuse alcohol and/or drugs, have cognitive impairment, mental or physical health issues, few social supports, or are victims/perpetrators of domestic violence. This section also identified if there are other adults living in the
home, if there is a custody and access dispute, and characteristics of the family’s housing situation.

Supports for the Family
This section determined the number of supports the family had in place from community resources. Supports could have included, but were not limited to, family/individual support groups, financial assistance (ODSP, Ontario Works), drug and mental health treatment services, food bank, or supportive family members.

Child Information
In this portion of the assessment, questions identified characteristics of the children involved with supervised access. The criteria covered different forms of abuse, the child’s functioning, and exposure to partner violence. This section was critical to assess what exactly the child had been exposed to, and the detrimental effects these exposures had on the child.

Type of Maltreatment Child has Perpetrated Against Others
This section examined the behaviour of the client’s children directed toward others, specifically whether the child had been alleged to cause physical, emotional, or sexual harm to others. Different adjectives were listed to describe which type of physical, emotional, or sexual deviancy occurred.

Identified Strengths of Child and Family
The final section was created for this study, and identified the strengths that the children and members of the family possess. This section is important because it identified strengths that can be built on to ensure the greatest benefits for the family. This assessment looks directly at the individual, familial, and social resilience of the specified client file.

Rating
To assess both the caregiver and the child’s risk factors, the rating scale from the CIS study was used with the following choices: “Confirmed”, “Suspected”, “No”, or “Unknown”. “Confirmed”, indicated that the behaviour was documented in the file, and the author observed this during the file review. “Suspected”, indicated that there was allegations of, and concerns had come up more than once about the specific behaviour, but nothing was every confirmed. This could include, for example, a case note from a previous worker, community resource, or a consultation with the society’s Psychologist that suggests a child has symptoms of ADHD; however the child was never formally assessed and no diagnosis confirmed. “No” indicated that the behaviour was never documented as present. “Unknown” meant that there was no indication of the behaviour documented anywhere in the file.

Inter-observer Reliability
Brough (2015) conducted a study, to determine the inter-observer reliability of the adapted assessment tool, on half of the reviewed files to assess its dependability. Upon training, the second observer independently reviewed 50% of the files in the present
study. Files were randomly selected using the Microsoft Excel Random Selection procedure. There was 98.8% agreement between the two observers, which indicates very high inter-observer reliability. More detail about the procedures followed to obtain inter-observer agreement may be found in Brough (2015).
Chapter IV: Results

To receive services from an Enhanced Support Services (ESS) worker at the local Children’s Aid Society, a family’s child protection file must be open. It was determined that 21.7% of the 23 files reviewed were open initially under eligibility code 53A, which indicated, “the caregiver has a problem and is unable to care for the child”. Additionally, 17.4% of the files opened under eligibility code 53B, which indicated, “the caregiver has a problem causing risk that the child is likely to be harmed”. A 101I was the third most frequent eligibility code evident, which included an additional 17.4% of the referrals. These files were initially opened for “a request for agency information and/or case consultation”. Referral sources were varied, with 30.4% from hospitals, 26.1% from a police officer, and 13.0% from an “other” resource. The following was the source of referral for a single file (4.3%) in the review sample: file transferred jurisdictions, neighbour, day care / school, relative, shelter, physician, and primary caregiver. It is important to note that the hospital will call when a child is born and a birth alert has been published indicating the child is to be apprehended and not discharged into the biological parents care.

Each file reviewed was opened to an ESS worker in 2011, (4.3%), 2012 (30.4%) or in 2013 (65.2%), with all files closing to the same ESS worker in 2013. Table 1 displays the reason for which each file closed. Requiring no further services and children becoming crown wards with no access accounted for the majority of closed dispositions, nearly 70.0%. An additional 13.0% demonstrated acceptable parenting skills during supervised access and were able to obtain unsupervised access visits. Access was terminated for a single file due to the caregiver not being motivated (Not Motivated /Access Terminated).

<table>
<thead>
<tr>
<th>Reason File Closed</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CW-No Access</td>
<td>7</td>
<td>30.4%</td>
</tr>
<tr>
<td>NFSR</td>
<td>9</td>
<td>39.1%</td>
</tr>
<tr>
<td>Lack of Cooperation</td>
<td>3</td>
<td>13.0%</td>
</tr>
<tr>
<td>Not Motivated /Access Terminated</td>
<td>1</td>
<td>4.3%</td>
</tr>
<tr>
<td>Access Unsupervised</td>
<td>3</td>
<td>13.0%</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Thirty percent of the files reopened for family visiting services between the initial closing date and November 2014. 69.6% of the files remained closed, which suggests permanency was determined for these children.

Previous CAS Involvement and Suspected Maltreatment

All of the files reviewed had previous involvement with a children’s aid society. Twenty-one percent of families had four previous referrals; 17.4% of families had five previous referrals, and an additional 17.4% had a single previous child welfare referral. Suspected maltreatment was evident in 60.9% of files from the total sample. From this total, 52.2% of the maltreatment cases were verified, and 39.1% followed up with an examination by a physician. In accordance with the original referral, 26.1% of the current
caregiver(s) were charged with criminal charges. The remaining 73.9% had no charges laid or only an investigation was conducted, with no further charges considered.

**Caregivers Who Visit**

A total of 36 caregivers visited their children from the 23 files reviewed. Table 2 below presents the characteristics of these caregivers. All caregivers who visited were related to the child by blood. In some circumstances a biological father attended access where he also visited with his stepchildren. In one case the maternal grandparent was the only caregiver who attended supervised access. Ninety-one percent of biological mothers attended supervised access and 60.9% of biological fathers. Thirty-nine percent of these biological parents visited their children together, where the additional 60.9% participated in separate access visits. All families who visited spoke English as their primary language. Ninety-one percent of families were identified as Caucasian and 8.7% of families identified as Native.

Table 2: Characteristics of Caregivers

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Frequency</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Biological Relative</td>
<td>23</td>
<td>100.0%</td>
</tr>
<tr>
<td>Bio Mother</td>
<td>21</td>
<td>91.3%</td>
</tr>
<tr>
<td>Bio Father</td>
<td>14</td>
<td>60.9%</td>
</tr>
<tr>
<td>Bio Parents Visit Together</td>
<td>9</td>
<td>39.1%</td>
</tr>
<tr>
<td>Bio Parents Visit Separate</td>
<td>14</td>
<td>60.9%</td>
</tr>
<tr>
<td>Family Primary Language (English)</td>
<td>23</td>
<td>100.0%</td>
</tr>
<tr>
<td>Family Identified as Caucasian</td>
<td>21</td>
<td>91.3%</td>
</tr>
<tr>
<td>Family Identified as Native</td>
<td>2</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

**Identified Difficulties of Caregivers Who Attend Supervised Access**

Table 3 displays the difficulties identified in the caregivers who participated in supervised access. Domestic violence (caregiver was the victim, the perpetrator, or both) was evident in more than 60.0% of the families who attended supervised access. An additional 11.1% of the families did not have confirmed domestic violence, but it was suspected. Forty-four percent of the caregivers who visited abused drugs, with an additional 13.9% suspected to have used. Alcohol abuse was also the substance of choice for 41.7% of caregivers. However a greater number of families (47.2%) were confirmed to not be abusing alcohol.

Fifty eight percent of families confirmed or were suspected to have few social supports. In terms of health complications and diagnosis, 36.1% of the visiting caregivers were confirmed to have a mental health condition. Thirty-three percent of caregivers had a cognitive impairment, and 13.9% identified as having a physical health condition.
Table 3: Difficulties of Caregivers Who Attend Supervised Access

<table>
<thead>
<tr>
<th>Difficulties</th>
<th>Confirmed</th>
<th>Suspected</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Abuse</td>
<td>41.7%</td>
<td>11.1%</td>
<td>47.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>44.4%</td>
<td>13.9%</td>
<td>41.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>33.3%</td>
<td>11.1%</td>
<td>55.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>36.1%</td>
<td>11.1%</td>
<td>52.8%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Physical Health</td>
<td>13.9%</td>
<td>0.0%</td>
<td>86.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Few Social Supports</td>
<td>38.9%</td>
<td>19.4%</td>
<td>41.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Victim of DV</td>
<td>63.9%</td>
<td>11.1%</td>
<td>25.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Perpetrator of DV</td>
<td>61.1%</td>
<td>11.1%</td>
<td>27.8%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

A child custody order was evident in most child protection cases; 87.0% of the families reviewed had a child custody order in place. However, only 13.0% of these families were currently in a child custody dispute between caregivers. The location where the caregiver who visited currently resided was also identified. 52.2% of caregivers lived in a community rental; 21.7% resided in a shelter; and an additional 21.7% were categorized to reside in an “other” residence. Families in the “other” category typically identified themselves to be homeless, “couch surfing”, or living with another family member or friend.

Supports for the Family

A number of available community supports were identified such as parenting skills support groups, in home support from local professional, counselling, public housing or a shelter, welfare, drug rehabilitation, ODSP, mental health services, food bank, methadone clinic, supportive relatives, day care, and a variety of others. Seventy-three percent of the families received support from 1-3 different community resources, and 26.1% of the families received support from 4-6 different community resources. It is noted that all files were receiving support from at least one community resource, in addition to the support they were receiving from the CAS.

Children Who Visit

A total of 36 children visited a minimum of one biological caregiver, while the Children’s Aid Society supported supervised access. During this time, 78.3% of the children resided in a foster home; 13.0% lived with kin families; and the remaining 8.6% of children were placed in a group home or “other” residence. From the 36 children who attended access, 19 were female and 17 were male. The youngest child to attend access was newborn; the eldest was fifteen. The average aged child was four-years-old; the modal age was 0.

As the characteristics of the children involved with supervised access were analyzed, it was important to note their ages as this variable influences the total percentage under each identified category. Thirty-three percent of the children reviewed were under 12 months of age. For this third of the population, it was difficult to determine many of the characteristics identified above because they are not yet evident in the child’s behaviour. Because of their young age, it is difficult for professionals to evaluate such characteristics unless the child is displaying critical signs of the behaviour. In addition, 61.1% of the children were between the ages of two and 10, and were able to
verbalize and demonstrate a further range of behaviours. The remaining 5.6% of children were aged between 12 and 15 years. The generally young age of the children also reflects the low incidence of suicidal thoughts, self-harming behaviour, YCJA involvement, and substance abuse.

Table 4 displays the identified difficulties of all children who attended supervised access. Children who were identified on the families’ files but did not attend supervised access during the time the file was open, were not included in this analysis of characteristics. It is to be noted that “intellectual disability” was considered to be a diagnosed academic, learning, cognitive, or comprehensive delay. An “academic difficulty” was a characteristic that the child presented without a diagnosis; for example the child struggled with concentration or reading, and this was noted on the file, but the child was not diagnosed to have a cognitive delay or dyslexia. A “developmental delay” was identified as a form of development where the child was considered a “late bloomer” for the behaviour, and no diagnosis was ever established. For an infant this included sitting, standing, or walking, and for an older child this could include speech and motor development. Development was considered difficult if the child developed the behaviour, but at a later stage in development than others. Accurate stage of development was measured using the Nipissing District Developmental Screen, utilized by the CAS agency.

Table 4: Difficulties of Children Who Attend Supervised Access

<table>
<thead>
<tr>
<th>Difficulties</th>
<th>Confirmed</th>
<th>Suspected</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression/Anxiety/Withdrawal</td>
<td>25.0%</td>
<td>13.9%</td>
<td>58.3%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Suicidal Thoughts</td>
<td>0.0%</td>
<td>0.0%</td>
<td>97.2%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Self-Harming Behaviour</td>
<td>2.8%</td>
<td>0.0%</td>
<td>94.4%</td>
<td>2.8%</td>
</tr>
<tr>
<td>ADHD/ADD</td>
<td>8.3%</td>
<td>0.0%</td>
<td>88.9%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Attachment Issues</td>
<td>22.2%</td>
<td>27.8%</td>
<td>47.2%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Aggressive Behaviour</td>
<td>22.2%</td>
<td>2.8%</td>
<td>72.2%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Inappropriate Sexual Behaviour</td>
<td>0.0%</td>
<td>2.8%</td>
<td>94.4%</td>
<td>2.8%</td>
</tr>
<tr>
<td>YCJA Involvement</td>
<td>0.0%</td>
<td>0.0%</td>
<td>97.2%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Intellectual Disability</td>
<td>19.4%</td>
<td>5.6%</td>
<td>72.2%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Developmental Delay</td>
<td>47.2%</td>
<td>5.6%</td>
<td>44.4%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Physical Disability</td>
<td>36.1%</td>
<td>2.8%</td>
<td>58.3%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Academic Difficulty</td>
<td>30.6%</td>
<td>5.6%</td>
<td>61.1%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>2.8%</td>
<td>0.0%</td>
<td>94.4%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>2.8%</td>
<td>0.0%</td>
<td>94.4%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Other</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The most evident characteristics exhibited among children who attended supervised access were: the presence of a developmental disability (47.2%), a physical disability (36.31%), and suffering from academic difficulties (30.6%). According to Metcalfe, Harvey, and Laws (2013), academic difficulties become evident in children when they begin school, between the ages of three and six. If all children under the age of three in this analysis were excluded, an adjusted figure of 50.0% of the children involved with supervised access would be suffering with academic difficulties.
The data analysis also identified that 38.9% of the children suffered from, or were expected to suffer from, depression, anxiety, or withdrawal, and an additional 22.2% struggled with aggressive behaviour and maintaining positive attachments with their caregivers. Another 27.2% of children were suspected to have poor attachment with their visiting caregiver, which can make access visits very difficult. It was noted that no children exhibited behaviours associated with suicidal thoughts, inappropriate sexual behavior, or had any involvement with the youth criminal justice act.

**Forms of Maltreatment the Child was Exposed To**

The assessment scale identified any maltreatment the child(ren) was exposed to while in the care of their biological parents. Identified maltreatment within the family that occurred with children who do not attend access was not documented. Any child brought into care at birth was rated as “not applicable” in all maltreatment categories unless abuse occurred during an access visit and was identified. Any child who lived in the home with their caregiver from birth until they were apprehended was rated as “unknown” unless the abuse was identified. Neglect was the most common form of abuse that children experienced, as fifteen of the twenty-three files (65.2%) reviewed, identified the child to have been subjected to some form of neglect. Eighty-six percent of the families neglected their child in one or two ways; the additional 13.3% neglected their children in three or more ways. Physical neglect (46.7%) was the most common form of neglect, followed by physical harm caused by failing to supervise (40.0%), medical neglect (33.3%), and abandonment (33.3%).

Emotional maltreatment and physical abuse both occurred in 34.8% of families. From this total, 62.5% of children were physically abused because they were shaken, pushed, grabbed, or hit with a hand. An additional 62.5% of children who were emotionally maltreated were exposed to verbal abuse or belittling. A further 50.0% of emotionally maltreated children were inadequately nurtured or lacked affection from their caregivers, which contributed to a lack of positive attachment with their caregivers. A single file included a child being exposed to sexual abuse. In this circumstance, the child was fondled, exploited, and maltreated through “other” sexual abuse.

Exposure to intimate partner violence was evident among 69.9% of children who attended access. Seventy-five percent of these children were directly exposed to two forms of adult conflict. From the files, 93.8% were exposed to emotional violence; 75.0% were directly exposed to physical violence; 12.5% were exposed to non-partner physical violence; and 6.3% of children were indirectly exposed to physical violence.

**Identified Strengths of the Child and Family**

Figure 1 displays the frequency with which individual, familial, or social resilience factors were present among the families of the cases reviewed. Overall, the most frequent strength was that 78.3% of families had relationships with the children’s grandparents or extended family. Fifty-two percent of caregivers exhibited strong intellectual functioning, and 47.8% of siblings resided together.
When categories are examined independently, the greatest identified strengths for “individual” included strong intellectual functioning (52.2%), sociable (34.8%), and extracurricular talents (26.1%). The most frequent strengths for “family” included relationship with grandparents and/or extended family (78.3%), siblings reside in the same residence (47.8%), and biological parents are in a relationship (43.5%). “Social” strengths as a whole were less common among families. The greatest social strengths were consistent school attendance (26.1%), involvement with social supports and community services (26.1%), and commitment to social organizations (21.7%).

**Post-Hoc Analysis Comparison**

A total of 16 files were closed from services with an ESS worker because they no longer required services or their children were made crown wards with no access. This allowed for a post-hoc comparison of the two groups. Seven of these 16 files were categorized as “Crown Ward, No Access” (CW-No Access”) and the additional 9 as “No Further Services Required” (“NFSR”). The average age of the children whose services concluded because they were made a crown ward with no access was 2.8 years (2.67), while children whose visits were terminated because no further services were required, averaged an older age of 6.6 years (4.09), t(df)= value, p<.05. These ages reflect the number of newborns that participated in access. Typically if a child is apprehended at birth, the risks of the family are extremely evident and have persisted for a length of time. Change in a positive direction is less common, which makes the child become a crown ward with no access at a younger age, for the purpose of adoption, as many infants are placed in a resource home when they are apprehended at birth.
Table 5 compares the percentages of confirmed difficulties for all caregivers within the crown ward no access category and the files that required no further services. From the total 36 caregivers involved with an open child protection file, 12 caregivers were included in a file that closed for CW-No Access; and 14 caregivers file closed because they no longer required services (NFSR). Within the 12 CW-No Access caregivers, 50% were male and 50% were female. The NFSR caregivers were not as equally divided between genders, with 64.3% identified as female and 35.7% as male. The number of children in each category was equivalent to the number of caregivers who visited, although visits did not all occur as one-to-one. Twelve children became crown wards with no access to their biological caregivers, and 14 children’s files were closed because their caregivers required no further services. The percentages were calculated based on the total number of confirmed files in each category.

Table 5: Confirmed Characteristics of Caregivers: NFSR, CW-NoAccess

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>No Further Service Required</th>
<th>Crown Ward No Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Abuse</td>
<td>35.7%</td>
<td>41.7%</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>42.9%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>42.9%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>42.9%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Physical Health</td>
<td>21.4%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Few Social Supports</td>
<td>28.6%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Victim of DV</td>
<td>71.4%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Perpetrator of DV</td>
<td>71.4%</td>
<td>58.3%</td>
</tr>
</tbody>
</table>

From the eight characteristics that were recorded, five were more frequently present among caregivers whose file closed for no further services. These included: being a victim or perpetrator of domestic violence (71.4%, respectively), a cognitive impairment (42.9%), mental health diagnosis (42.9%), and physical health deficit (21.4%). Files that closed because the children were made crown wards with no access displayed greater use of alcohol (41.7%) and drug (50.0%) abuse, and were more likely to have fewer social supports (66.7%). However, differences between the two groups when looking at all caregivers were not statistically significant. When exploring the characteristics in comparison within their own category both exhibit caregivers being a victim of domestic violence as the most frequently observed characteristic. Seventy-one percent of caregivers whose file closed for no further services were victims, and 66.7% of the caregivers whose file closed because their children were made crown wards with no access were victims. The NFSR population had an additional 71.4% of its caregivers be a confirmed perpetrator of domestic violence, where access to very few social supports ranked as the second most observed characteristic within the CW-No Access category (66.7%). The third most frequent difficulty present among the caregivers was alcohol abuse (35.7%) for the NFSR population, and being a perpetrator of domestic violence (58.3%) for the CW-No Access group.

The difficulties children faced are identified and listed below. Table 6 displays the confirmed troubles of children whose file closed to an ESS worker because they were made a crown ward with no access to their biological caregiver, or no further services
were required for their family. The most frequent difficulties among children in the NFSR population included: intellectual disability (35.7%), academic difficulty (35.7%), and developmental delay (28.6%). In the CW-No Access category developmental delay (66.7%) was most common followed by physical disability (58.3%), and academic difficulty (41.7%).

Table 6: Confirmed Characteristics of Children: NFSR vs. CW-No Access

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>No Further Service Required</th>
<th>Crown Ward No Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression/Anxiety/Withdrawal</td>
<td>21.4%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Suicidal Thoughts</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Self-Harming Behaviour</td>
<td>0.0%</td>
<td>8.3%</td>
</tr>
<tr>
<td>ADHD/ADD</td>
<td>7.1%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Attachment Issues</td>
<td>21.4%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Aggressive Behaviour</td>
<td>21.4%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Inappropriate Sexual Behaviour</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>YCJA Involvement</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Intellectual Disability</td>
<td>35.7%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Developmental Delay</td>
<td>28.6%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Physical Disability</td>
<td>7.1%</td>
<td>58.3%</td>
</tr>
<tr>
<td>Academic Difficulty</td>
<td>35.7%</td>
<td>41.7%</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>7.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>7.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

A Chi–Square analysis was performed to determine if there were any statistically significant differences among the characteristics of children and caregivers. The analysis compared all caregivers in the file review and no statistical differences were found. However, when the primary caregivers were considered independently, they were more likely to have a cognitive impairment, \(X^2(2) = 7.2, p<.05\) (85.7%). Examples of cognitive delays among this population included Down syndrome, autism spectrum disorder, Asperger’s, and fetal alcohol syndrome.

The Chi-Square analysis was also conducted for the difficulties the children face who were included in the comparison sample. Children in the CW-No Access group were more likely to have a physical disability \(X^2(3)=8.65, p<.05\). There were also more reports of developmental delays in this category, but the difference was not significant. Examples of developmental delays that were most frequent included autism or Asperger’s. Physical disabilities included, but were not limited to cleft lip, cerebral palsy, or a growth development, which required leg splints.

The total number of resilience factors exhibited by the crown ward no access group and the no further services required group were compared. Table 7 displays the number of individual strengths. Every file closed because no further services were required demonstrated at least one independent resilience factor. Seventy-one percent of caregivers in the NFSR group revealed one or two strengths, while the additional 28.6% showed three or four independent strengths. The files that closed from services because a child was made a crown ward with no access exhibited much lower rates of independent
strengths. Sixty-six percent of families did not have any individual strengths and 33.3% possessed only one or two.

The mean for each category was calculated and compared. For individual resilience factors, the NFSR families possessed a mean of 2.07 resilience factors, whereas the CW-No Access families only presented a mean of .5, which was significantly lower, t(24) = 4.62, p<.001. The CW-No Access families also had fewer familial resilience factors than the NFSR families, and this approached significance, t (24) = 2.027, p = .054. The NFSR mean was 2.71 and the CW-No Access files a mean of 1.75 familial resilience factors. Social resilience factors were the least common for the NFSR population and the second-to-least common within the CW-No Access group. Overall the NFSR group exhibited a mean of 1.07 factors while the CW-No Access category mean was .75. This was not significant. Overall the NFSR population had a greater number of resilience factors, which could make the difference of closing services and sending children home, versus applying for crown wardship and keeping children in care.

Table 7: Individual Strengths

<table>
<thead>
<tr>
<th>Number of Independent Strengths</th>
<th>NFSR</th>
<th>CW-NoAccess</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>1-2</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>3-4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>5-6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Mean (and SD)</td>
<td>2.07 (.91)</td>
<td>.50 (.79)</td>
</tr>
</tbody>
</table>

Table 8 exhibits the total number of family strengths in each file category. In general, family strengths were more evident in both file categories than any other strength assessed. Only three caregivers did not exhibit any family strengths (1=NFSR; 2=CW-No Access). Both the one or two, and three or four family strength classifications comprised 42.9% of NFSR families. A single family had five or six strengths. Fifty percent of the crown ward no access families revealed one or two family strengths; 33.3% acquired three or four.

Table 8: Family Strengths

<table>
<thead>
<tr>
<th>Number of Family Strengths</th>
<th>NFSR</th>
<th>CW-No Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>1-2</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>3-4</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>5-6</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Mean (and SD)</td>
<td>2.7 (1.26)</td>
<td>1.75 (1.13)</td>
</tr>
</tbody>
</table>

Social strengths (displayed in Table 9) were the least evident, with 11 families in both file categories not having any identified. When social strengths were identified, most families only presented one or two (NFSR=64.3%; CW-No Access=33.3%). Each group had one family who presented three or four social strengths.
Table 9: Social Strengths

<table>
<thead>
<tr>
<th>Number of Social Strengths</th>
<th>NFSR</th>
<th>CW-No Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>1-2</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>3-4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>5-6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Mean (and SD)</td>
<td>1.07 (.91)</td>
<td>.75 (1.05)</td>
</tr>
</tbody>
</table>

Overall the NFSR population had a mean of 1.95 resilience factors, across all domains. The CW-No Access families had a mean resilience factor average of 1.00, which indicated the NFSR families are more resilient than the CW-No Access families. Although it was not statistically significant, it is noted that 67% of CW-No Access families had fewer social supports, which could influence their ability to parent efficiently, without adequate supports in place. In summary, families whose file closed because the child was made a crown ward with no access demonstrated fewer individual and familial resilience factors than families whose file closed because no further services were required.
Chapter V: Discussion

Purpose of the Study

The purpose of the present study was to identify what factors and characteristics were evident among families who received support from an Enhanced Support Services worker to facilitate their access visits. There were high rates of mental health problems, substance use, domestic violence, cognitive impairments, and lack of positive social supports identified across the board. Families experiencing these difficulties were in considerable distress, and unable to provide for their children, who in many cases had highly demanding behaviour and critical medical needs. Contingent on these life choices and uncontrollable environmental factors, children suffered from absentee parents, or parents who loved them deeply but could not meet their needs. Caregivers who were under the influence, suffered from a mental health condition, or lacked the capacity to parent and meet the ever-changing needs of a growing child, put their child at risk of harm.

By selecting closed files, the author was able to assess the outcome of the visits, which allowed for a post-hoc analysis of visits that were terminated because the file closed with no further services required or the children were made crown wards with no access to the caregiver who was visiting. The main findings that differentiated the two populations were: (a) the primary caregiver was most likely to have a cognitive impairment and (b) the children involved in the CW-No Access population were much younger and (c) demonstrated a physical disability. Many evidence-based studies focus only on participants’ weaknesses; however, this study also examined resilience factors.

The above findings are consistent with those of McConnell, Feldman, Aunos, and Prasad (2010), who used the data collected by the CIS-2003 to examine decision-making, child welfare referrals, legal involvement, and dispute resolution strategies, among files that indicated the caregiver had a cognitive impairment. Results in the present study indicated that neglect was the most common form of child maltreatment. Findings also identified that parents with a cognitive impairment, who struggle with learning and comprehending new material, may agree to a task not follow through because they simply did not comprehend the full requirements. Noncompliance or lack of cooperation indicates to a child protection worker that the parent does not care, or have the capacity to parent.

These findings inform us about the characteristics of children and families in need of services and can be used to suggest best ways to support and intervene. The availability of extra supports could be used to maintain healthier lifestyles and proactive child-parent relationships. In particular, the presence of a cognitive impairment suggests ESS workers should teach parenting skills to caregivers in a manner that an individual with a cognitive delay could comprehend and remember. Modeling, chaining, and coaching, combined with positive reinforcement, are all forms of teaching that produce successful outcomes for parent training.

The famous quote “it takes a village to raise a child” could be difficult to relate to, for the 58.3% of families who identified or were suspected to have few social supports. Few social supports were also an identified deficit for families with cognitive impairments and child welfare involvement. McConnell et al., suggest group-based, adult learning interventions to strengthen caregivers’ parenting skills, and improve their social
relationships with others. The struggles children involved with supervised access experience were also examined. Supporting children through these difficulties, either directly and/or by providing access to community supports, is crucial in ensuring their well-being and will help to interrupt any continued child welfare involvement cycle. ESS workers are not expected to solve all child welfare-related problems. However, when employees accept the role it would be beneficial for the individual to be attentive to the concerns of families they work with and mindful of tactics to mitigate any risks.

**Strengths and Limitations**

There are a number of strengths in this study, which include the large number of variables assessed by the adapted CIS form. The original CIS form demonstrated strong reliability and validity, which suggests the adapted measure likely measures what it is intended to. Inter Observer Agreement (IOA) analysis conducted in this study was very high. An additional strength is that this study examined closed files, which allowed the author to determine the circumstances under which the files were closed. A further strength is the contribution, and use of the results within the child welfare population, and the field of parenting with a cognitive impairment. Although there are very little evidence-based contributions to both the child welfare, and parenting with a cognitive impairment populations the findings from this study suggest similar results as the few publications currently available. The findings suggest the use of practical interventions that are known and available, and that can be implemented to increase the quality of life for caregivers and children who partake in supervised access visits. By identifying the most common difficulties caregivers are presented with, CAS agencies can ensure practices are in place to support these circumstances and attempt to reduce obstacles to accessing available resources. A final strength to this thesis is the collection of information about resilience factors, as many studies do not identify strengths of participants, rather just their deficits. Families that remain custodial caregivers of their children take for granted their familial support, individual strengths, and social provisions. As the study found, many families do not get to experience these supports.

Some limitations to the study include the population, which consisted of all English speaking families that were mostly Caucasian. The author could not assess whether culture or ethnicity could influence the difficulties present in the children and caregivers. There was also one file reviewed that did not contain much information because it was opened and closed without any services conducted. Information on this file was identified as “unknown”. It was suspected that the family changed jurisdictions but no evidence was available. Finally, the FFW database does not provide a field to document family strengths or resilience factors. In order to determine what community resources the family used, or what strengths they acquired, the author had to read in detail case notes submitted by various workers. These case notes were not identified as “strengths” by the worker, but instead just noted as conversations between professionals or correspondence between services. This begs the question; if an option was available on F.F.W. (such as a checklist) for workers to record which services a family does or does not access, would the worker be more willing to advocate for families to receive services they are currently uninvolved with? Without practices of positive scanning, a cynical viewpoint can make it difficult for any professional to promote the strengths of a family or be mindful about the skills the family already possesses.
The following are specific limitations that presented themselves in a variety of levels including societal, program, organizational, staff, and client.

**Multi-Level Challenges**

At the societal level, little empirical research has been conducted on the characteristics associated with children and caregivers who are involved with the Children’s Aid Society. Minimal data; data that was collected decades ago; or statistics calculated from general populations; are challenges that fail to identify today’s contemporary concerns. Many findings have concluded substance abuse to be more frequent among families with child welfare involvement in past, than found in the present study.

Birth history of the child was not recorded, but is recommended. Fetal alcohol syndrome is now well-known, and the adverse effects of alcohol during pregnancy are publicly visible. Although it was not counted and tracked, many of the files reviewed had children who were born addicted to a drug, or exposed to a toxic substance while in the womb.

A final challenge identified at the societal (and organizational) level, is the workers tendency to engage in negative scanning, or to identify few strengths within the families. Although some individuals reach a point where no strengths seem evident, there were a number of families who had a variety of strengths and were using services as much as they could. Nowhere in the CAS database is there a location to list the family’s strengths and resources. One location identifies the services provided to the family by the agency, but does not include any external services. Recommendations for developing a visible assessment of actual and potential strengths for each family are suggested to increase workers ability to identify strengths. This assessment form could be included in the ESS initial and final recordings.

**Program**

Although inter-observer agreement was conducted (see Brough, 2015) to assess the reliability of this file review, the author initially failed to clarify if sections eight through 10 on the assessment form were to be completed based on the family’s entire child welfare history, or only the history that included the children who attended access. Through discussion the author and Brough determined this was not clarified and each reviewed the completed client files for a second time answering sections eight, nine, and 10 according to the involvement with only the current children who attended access.

**Organizational**

A comparison was completed with the files that closed to the ESS worker in 2013; because their child was made a crown ward and the courts implemented no access; or the family simply required no further services from the ESS worker. In order to close a file the ESS worker must indicate with a drop-down selection box in FFW why the file has closed. When the author continued to explore the closing documents on these families’ files, it became apparent that files closed for “No Further Services Required” were closed for a variety of reasons. These reasons included: “child transitioned home to maternal grandparents” and “biological mother signed full custody to biological father; mother to have no access”, among others. Although it was not further explored, it would
worthwhile to expand the file review to include a follow up with these children. Some documents explain that the children transitioned to other family members’ care, others explain that the caregiver stopped attending access and did not cooperate with the society. Did family members adopt these children or did they only file for custody? Did children whose caregivers stopped attending access become crown wards? Or did the agency’s kin finders find family who were willing to take them? With an absentee caregiver, the society would be able to pursue crown wardship for children who were abandoned much quicker than if the caregiver was fighting for their child to be returned to their care with a lawyer. It is important to understand that when a family’s file closed for no further services required, it could have closed under conditions where access was beneficial, and the children transitioned into family care. However, because this term is not exclusively descriptive, access could have terminated for a variety of reasons that did not include the children returning to the care of their biological caregivers. It is noted that each of these families have a unique story and workers experience extreme differences from one family to the next which can make it difficult to identify which dropdown box is “the most correct” to identify why the file closed. However, it is important to note that these findings could influence the data that were collected for the comparison and this file review. Further research is suggested to determine a more accurate reason to why these files closed.

Staff

Limitations to this study included the previous involvement the author had with some of the families in the files reviewed. The author completed a previous placement, and was employed at the Children’s Aid Society prior to the thesis research. As a result, the author had contact with some families during a different time period than the involvement they had with a previous ESS worker that terminated in 2013. The current or previous involvement with the families made it difficult to complete the assessment form based on information only read from the file review, in comparison to the knowledge obtained from working collaboratively with the family and attending case conferences or discussions with other workers involved with the family.

Client

Thirteen of the 23 families involved in this file review were only having access with their most recently-born child because their previous children were made crown wards and no access was permitted, or the families involvement was with their first born child (a statistical analysis determined the MODE for the age of the children who attended supervised access = 0 years). Because most of the children who attended access were three-years-old or younger, it was difficult to conclude whether the characteristics assessed are accurate for the child’s entire lifespan. For example, a child under the age of three will not display suicidal thoughts, academic difficulties, youth criminal justice involvement, or abuse drugs or alcohol; however he/she may present some of these behaviours in the future. Also, limited information was available on children who were older and had not previously been in the child welfare system. When a child is admitted to the care of the Children’s Aid Society at birth, his/her health records and milestones are all documented. However, an older child who enters the system will have minimal records available.
Implications for the Behavioural Psychology Field

The evidence gathered could help child protection services ensure their workers teach sufficient parenting skills and proficiencies to caregivers with cognitive impairments. Aunos, Goupil, and Feldman (2004) compared two groups of mothers with intellectual disabilities: mothers who had custody of their children, and ones who did not. Mothers who were involved with their community, (and were satisfied with the services they were receiving) had higher incomes, and whose children were younger, were more likely to have custody of their child. These findings suggest that mothers who have intellectual disabilities should have access to services within their community that are flexible and adapt to the needs of their children as they develop and reach different stages in their life. Although this research is promising, it was conducted on a small sample over a decade ago. A more recent study, with a larger population would reassure the accuracy of these findings for mothers with intellectual disabilities.

Recommendations for Future Research

There are a number of recommendations for future research. Including a section on the assessment form that indicates whether or not the child was exposed to some sort of substance prior to birth would be important. This information could be very helpful to families who adopt or raise a child with FASD or a cognitive impairment as a result of being exposed to substances in the womb. An additional recommendation is to include follow-up research on the children who were reviewed in these files. This would identify whether problematic characteristics not evident in infants or young children develop later. Another recommendation would be to identify whether any of the children in the files closed for NFSR were later made crown wards.
References


doi:10.1080/10911359.2013.747356


doi:10.1177/1063426610385119


http://www.oacas.org/childwelfare/signs.htm

exposure and aggressive parenting practices. *Children And Youth Services Review, 32*(6), 889-895. doi:10.1016/j.childyouth.2010.02.010
Appendix A: Consent Form from Agency

St. Lawrence College
Expanding Opportunities

CONSENT FORM

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

PROJECT TITLE:

CHARACTERISTICS OF PARENTS AND CHILDREN WHO UTILIZE ENHANCED SUPPORT SERVICES TO OBTAIN SUPERVISED ACCESS: A CHILD WELFARE STUDY

STUDENT:

AMANDA BROWN

COLLEGE SUPERVISOR:

DR. SHEELAGH JAMIESON, C.PSYCH.

INVITATION

I am a student in my 4th year of the Behavioural Psychology degree at St. Lawrence College, and am currently on placement at Family and Children Services of Frontenac, Lennox, and Addington. As a part of this placement, I am completing a special project called an applied thesis and am asking for your assistance to complete this project. The information in this form is intended to help you understand my project so that you can decide whether or not you want to participate. Please read the information below carefully and ask all the questions you might have before deciding whether or not to participate.

WHAT IS THE PURPOSE OF THE STUDY?

This study will review a random sample of the client files that have been opened to an Enhanced Support Services Worker, who assisted with facilitating supervised access between parents and their children; and the file was closed between January 1, 2013 and December 31, 2013. This file review will provide information about the characteristics of the parents and the children involved with supervised access.

WHAT WILL YOU NEED TO DO IF YOU TAKE PART?

This study does not apply to any individual participant’s, however the I.T. technicians will need to ensure the student has access to the current data bases at the agency which store client information (i.e., Frontline For Windows (FFW) and Open Text Content Server (OT)). It would also be helpful if a technician
provided the student with further training to ensure the data is collected accurately.

**WHAT ARE THE POTENTIAL BENEFITS TO ME OF TAKING PART?**
Because this is a file review, there will be no direct benefits for the participants it includes.

**WHAT ARE THE POTENTIAL BENEFITS TO OTHERS OF TAKING PART?**
Potential benefits of this research study to others include identifying the characteristics common to both the parents and the children involved with supervised access. This information may also assist Family and Children's Services with providing ESS workers with the adequate skills and resources that they need to treat and work collaboratively with these families to ensure that successful supervised access occurs.

**WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS OF TAKING PART?**
Because this is a file review, there will be no direct disadvantages for the participants it includes.

**WHAT HAPPENS IF SOMETHING GOES WRONG?**
There are no risks for taking part in this file review.

**WILL MY TAKING PART IN THIS PROJECT BE KEPT PRIVATE?**
At the beginning of the file review the families file number will be documented and each file number will be assigned a code. A master list of codes and file numbers will be kept in a sealed envelope and stored in a locked filing cabinet at Family and Children's Services of Frontenac, Lennox, and Addington for 10 years after the thesis is complete.

Any information disclosed which identifies the parent or child participant will be kept confidential. The file number will be converted into a non-identifiable code, which identifies the participants, so their names or file numbers will not be required on the assessment form.

This consent form and completed assessment scales will be kept in a locked filing cabinet at St. Lawrence College, and any electronic information will be stored on a password protected USB.

The participant's name or file number will not be identified in any reports, publications, or presentations from this project.

**DO YOU HAVE TO TAKE PART?**
It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign this consent form. If you do decide to take part, you are still free to withdraw at any time, without giving any reason, and without incurring any penalty.
THESIS PROPOSAL

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. If you have any additional questions or concerns, feel free to ask me by contacting me at 613 876 4766, or abrown81@student.sl.on.ca; or you may contact my College Supervisor at sjamieson@sl.on.ca. You may also contact the Research Ethics Board at appliedresearch@sl.on.ca.

CONSENT
If you agree to participate in the 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.
CONSENT

By signing this form, I agree that:

- The research project has been explained to me.
- All my questions were answered.
- Possible harm and discomforts and possible benefits (if any) of this project have been explained to me.
- I understand that I have the right not to participate and the right to stop at any time.
- I am free now, and in the future, to ask any questions about the research project.
- I have been told that my personal information will be kept confidential.
- I understand that the results of this project may be published or presented in a professional forum.
- I understand that no information that would identify me will be released or printed without asking me first.
- I understand that I will receive a signed copy of this consent form.

I hereby provide consent for Family and Children Services of Frontenac, Lennox, and Addington to participate:

Executive Director, FACSFLA:  

Signature:  

Date:  

SLC Student Signature:  

Date:  

Printed Name:  

Witness:  

Date:  

Printed Name:  
Appendix B: 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

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:**

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Confirmed</th>
<th>Suspected</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol abuse</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug/solvent abuse</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Issues</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Health Issues</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Few social supports</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim of domestic violence</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perpetrator of domestic violence</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child custody order:</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Child custody dispute:</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
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

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)
<table>
<thead>
<tr>
<th>Condition</th>
<th>Confirmed</th>
<th>Suspected</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression/anxiety/withdrawal</td>
<td></td>
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<tr>
<td>Suicidal thoughts:</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Self harming Behaviour:</td>
<td></td>
<td></td>
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<tr>
<td>ADD/ADHD:</td>
<td></td>
<td></td>
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<tr>
<td>Attachments issues:</td>
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<tr>
<td>Aggression:</td>
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<tr>
<td>Inappropriate sexual behaviour:</td>
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<tr>
<td>YCJA involvement:</td>
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<tr>
<td>Intellectual disabilities:</td>
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<tr>
<td>Developmental disabilities:</td>
<td></td>
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<tr>
<td>Physical Disabilities:</td>
<td></td>
<td></td>
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<tr>
<td>Academic Difficulties:</td>
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<tr>
<td>Alcohol abuse:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Drug/solvent abuse:</td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

8. What types of Maltreatment was the child exposed to? (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
• 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/confinement
• 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/confine ment 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
• 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