Advanced Family Violence Training for Child Intervention Staff: A Review of the Literature

This literature review was conducted as part of a collaborative research project conducted by Calgary Counselling Centre researchers in partnership with Alberta Human Services: Child Intervention, Family Violence Prevention and Homeless Supports (FVPHS) and The Alberta Centre for Child, Family and Community Research. In this review the authors examine Canadian incident rates for domestic violence in child welfare cases, the co-occurrence of exposure to domestic violence and other forms of child maltreatment, current risk assessment tools, and safety planning practices used with families in which domestic violence is a concern. Family violence training programs for Child Intervention staff are reviewed and the best and promising practices are identified.

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Executive Summary

Protecting Alberta family members from family violence is a priority for the multiple systems and service providers involved with these families. Alberta Human Services: Child Intervention (HS:CI) personnel play an essential role in assessing the risks and needs of families who come into contact with Child Intervention services. However, Child Intervention staff indicate a need for education and training in order to enhance their understanding and ability to effectively work with family violence clients.

This literature review on family violence training for Child Intervention staff was conducted as part of a collaborative research project between Alberta Human Services: Child Intervention, Family Violence Prevention and Homeless Supports (FVPHS); Alberta Centre for Child, Family and Community Research and Calgary Research; and Calgary Counselling Centre. The purpose of this literature review was to provide information on best and promising practices in the areas of risk assessment and safety planning when family violence is a concern as well as training programs for Child Intervention staff that address family violence casework.

This review will contribute to the on-going development of the Casework Practice Model utilized by HS:CI and inform the development of a framework for advanced family violence training for Child Intervention staff in Alberta. Critical points identified in this literature review are highlighted below.

Collaboration between Multiple Systems and Service Providers is Required

Given the co-occurrence of family violence and child maltreatment, ongoing collaboration between multiple systems and service providers is required to:

- Enhance understanding between policy-makers, front line responders and other service providers involved in working with families impacted by family violence.

- Develop and deliver comprehensive and effective risk assessment and safety planning practices for families in which family violence is a concern.

- Develop differentiated programs and services that protect children, meet the needs of victims of domestic violence, hold offenders accountable for their abusive behaviour, and when appropriate engage them in ensuring the safety of their children and the caregivers involved in their children's lives.

Education and Training in Family Violence Makes a Difference and is an Identified Need by Child Intervention Staff

Equipping Child Intervention staff to effectively work with family members impacted by family violence requires training. Researchers Saunders and Anderson (2000) and Saunders, Holter, Pahl, Tolman and Kenna (2005) found that family violence training makes a positive change when participants: (a) examine their perspectives and biases and how these impact their work with family violence clients, (b) enhance their knowledge and skill in assessing risk to family members and learn to develop safety plans that meet the changing needs of these families, and (c) learn to effectively work with the multiple systems and service providers required to address the needs of family violence clients.

Training Does Not Guarantee Change

Training alone does not guarantee change in practice. Training needs to be prioritized and time and resources need to be provided. Training needs to be reinforced in practice through supervision and monitored through on-going reviews.

Evaluation of Programs and Training is Essential

Strong evaluation components need to be incorporated in new initiatives in order to inform the continuous improvement of training programs. Compliance to changes in policy and practice is an important evaluation criterion as change in practice does not happen automatically. Evaluation criteria also need to consider if changes in practice contribute to more families becoming safe environments in which children and all other family members can grow and flourish. Based on this premise, training evaluation criteria need to consider: (a) how training affects the participants' work with family violence clients and (b) the effects of Child Intervention services in the lives of these clients. As part of the program evaluation, anticipated changes in practice need to be clearly identified and the anticipated outcomes for families specified. Finally, this literature review provides important information that needs to be considered in the development of risk assessment and safety planning policy and practices within HS:CI. Key findings from this review will also be integrated into the framework for advanced family violence training to be developed as part of this collaborative research project.

Introduction

This literature review was conducted as part of a collaborative research project

conducted by Calgary Counselling Centre researchers in partnership with Alberta Human

Services: Child Intervention, Family Violence Prevention and Homeless Supports (FVPS) and the

Alberta Centre for Child, Family and Community Research. The purpose of this research project

was to inform the development of a framework for advanced family violence training for

Alberta Human Services: Child Intervention (HS:CI) personnel. At the time of writing, Child

Intervention personnel in Alberta received information on family violence in Delegation

Training and in the *Protection Against Family Violence Act* (PAFVA) mandatory, on-line training.

Recently, a new *Enhancement Policy Manual* (June 2012) was released. This manual

contains policies and procedures that guide casework staff when delivering services under the

Child, Youth and Family Enhancement Act (CYFEA). It reiterates information provided in the

PAFVA training, refers caseworkers to the PAFVA guide, and amplifies the importance of Child

Intervention workers being able to effectively assess and intervene with family violence clients.

These training initiatives provide important information regarding family violence and outline

the policies and procedures required of Child Intervention staff when working with clients

impacted by family violence.

A need for advanced family violence training for HS:CI personnel has been identified. In

order to ensure the HS:CI Casework Practice Model reflects best and promising practices which

are addressed and reinforced in the advanced training, this literature review examines research

and practice based articles relevant to risk assessment and safety planning as well as family

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violence training programs offered in Canada and other parts of the world. Each of the following topics is examined and implications for practice and training are highlighted:

- Historical perspectives regarding family violence and child maltreatment and the implications of these perspectives on risk assessment, safety planning and the continuum of care[1] provided to family violence clients.

- Rates of exposure to family violence in child protection cases and the co-occurrence of exposure to family violence and other forms of child maltreatment. Caseworkers' responses to these concerns are examined and implications for practice and training are highlighted.

- Current risk assessment and safety planning practices used with family violence clients are identified and a brief overview of best and promising practices is provided. Further information is provided in the *Family Violence Risk Assessment and Safety Planning* by *Child Intervention Staff: An Environmental Scan* document submitted as one of the deliverables for this collaborative research project.

- Family violence training programs for Child Intervention personnel are examined and critical areas for consideration in the development of advanced family violence training are identified. Further information on family violence training is provided in the *Advanced Family Violence Training for Child Intervention Staff: An Environmental*

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[1] The concept of a continuum of care reflects the need for families to receive differentiated services that relate to their particular situation. These services may commence prior to the family coming into contact with HS:CI (i.e., care may be considered as being provided by front line responders in health, education, and/or the police and may continue after their involvement with HS:CI has ended. The idea of a continuum of care builds on the idea of a response continuum discussed in the Family Violence and Bullying 101 training materials developed by the Cross-ministry initiative in 2009.

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Scan document submitted as one of deliverables for this collaborative research project.

Family Violence and Child Maltreatment: Perspectives, Policies and Practice

Historically, family violence and child maltreatment were addressed by service providers who saw the etiology and treatment of family violence very differently (Carter, Weithorn & Behrman, 1999; Fleck-Henderson, 2000). Women's advocates described intimate partner violence in terms of gender, power, privilege and control. Women were considered to be the victims of the abuse and men were identified as the assailants. Children's needs were considered to be addressed once the woman's safety was ensured. Traditionally, offenders were disregarded in the continuum of care extended to their family members. Today, domestic violence service agencies have expanded their services to include the needs of men and women who are victims of family violence, children who have been exposed to family violence and programs for family violence offenders (Rosewater & Goodmark, 2007).

The child protection system, on the other hand, is legally mandated to protect and care for children when families are not able to provide normal child care functions (Nixon, Tutty, Weaver-Dunlop & Walsh, 2007). The rights of children and their needs for a safe, nurturing environment take precedence and in situations involving family violence, caregivers - usually mothers - are held responsible for protecting their children (Fleck-Henderson, 2000). While changes in legislation and policy pertaining to child protection and family violence have occurred the potential impact of these changes and their effects for victims and children are still being evaluated (Nixon, Tutty, Weaver-Dunlop & Walsh, 2007). For example, Nixon, Tutty,

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Weaver-Dunlop and Walsh (2007) raise concern that mandatory reporting requiring professionals to report incidents of family violence involving children may put women and children at greater risk due to women being deterred from seeking services for fear their children will be removed from their care by the child protection system.

Each of these traditions has knowledge and experience that needs to be considered when seeking to assess and address the needs of family violence clients. Collaborative practice that draws on the strengths of these traditions has been encouraged by national initiatives such as the Greenbook Initiative in the United States. Banks, Hazen, Coben, Wang and Griffith (2009) examined two large studies which were conducted in the United States (US) and looked at the extent of collaboration between children services agencies and domestic violence service providers in an attempt to identify the role collaborative efforts played in changing child welfare policies and practice. These researchers concluded that collaborative practice between child welfare agencies and domestic violence service agencies had mixed results with regards to changes in child welfare policies and practice. Case study sites connected with the Greenbook Initiative indicated "improvements in child welfare agency screening and assessment, advocacy for adult domestic violence victims, and multidisciplinary approaches to case planning" (p. 505) resulted from collaborative practice between domestic service agencies and child welfare agencies. In sites where collaborative practice was found to influence improvements in practice, the researchers postulated that:

- The availability of federal funding and technical support,

- The strength of the partnerships and

- The ability of those involved in local collaborations to implement changes to policy and practice all played a role in bringing about these improvements.

The important role legislators and policy-makers play in the development and sustainability of collaborative services to families impacted by domestic abuse was highlighted in this study.

Legislators and policy-makers, like other service providers, hold different perspectives regarding family violence and the importance of intervening with families in which children have been exposed to family violence (Nixon, Tutty, Weaver-Dunlop & Walsh, 2007). For example, in Canada each province is responsible for developing and implementing its child protection legislation and related policies. Nixon, Tutty, Weaver-Dunlop and Walsh in their policy and legislative review found six of ten Canadian provinces and one territory had extended their definition of child maltreatment to include exposure to domestic violence. Even though these jurisdictions include children's exposure to domestic violence as a form of maltreatment, variations in how the risk to children is conceptualized continue to exist. In Alberta the *Child, Youth and Family Enhancement Act* (CYFEA) was proclaimed in 2004 and according to the CYFEA exposure to domestic violence is a factor that *may* lead to the emotional injury of a child. Thus, exposure to family violence needs to be identified, assessed and appropriately addressed in the development of child protection service plans.

Perspectives of researchers and the definitions of child maltreatment used by researchers may also vary from the perspectives and legal definitions identified in a particular jurisdiction's legislation. For example, due to the expansion in the number of domestic violence investigations in Alberta, MacLaurin et al. (2005) identified exposure to domestic violence as one of five main categories of child maltreatment (i.e., physical abuse, sexual abuse, neglect,

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emotional maltreatment and exposure to domestic violence) used in their research and reported in the 2003 *Alberta Incidence Study of Reported Child Abuse and Neglect.* Nevertheless, in Alberta, the *Child, Youth and Family Enhancement Act* and the *Protection Against Family Violence Act* provide the definitional frameworks for family violence used by HS:CI while incidence studies provide valuable information to policy-makers and program developers. While definitions of child maltreatment may vary between jurisdictions, current incidence studies indicate the problem of children being exposed to domestic violence cannot be overlooked. Thus, two important incidence studies are considered in the following section of this review.

Incident Rates of Exposure to Domestic Violence in Child Protection Cases

According to the 2008 *Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2008,)* exposure to intimate partner violence includes: direct witness to physical violence, indirect exposure to physical violence, exposure to emotional violence and exposure to non-partner physical violence (i.e., the child has been exposed to violence between a caregiver and a person who is not a spouse/partner, for example a neighbour, grandparent, aunt or uncle). In this research it was found that intimate partner violence was present in 34% (29,259 cases) of substantiated child welfare investigations[2] in Canada.

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[2] The term "substantiated" is used when the balance of evidence for a child welfare case indicates that abuse or neglect has occurred (CIS-2008).

Primary Category of Substantiated Child Maltreatment in Canada in 2008

Sexual Abuse
3%

Physical Abuse
20%

Emotional Maltreatment
9%

Exposure to Intimate Partner violence
34%

Neglect
34%

Figure 1. Primary Categories of Child Maltreatment
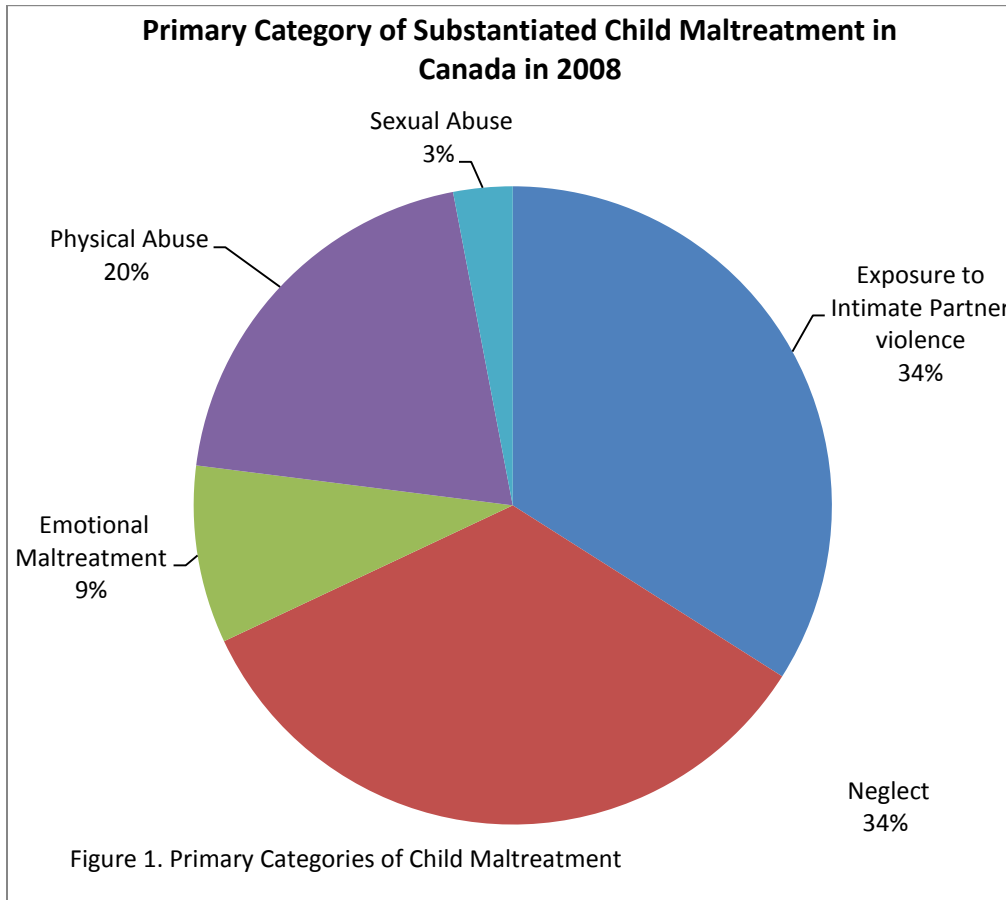
The authors of the CIS-2008 reported that 46% of the primary caregivers in substantiated investigations were victims of family violence. Au Coin (2005) reviewed the Canadian 2004 *General Social Survey* and found that 40% of all victims of spousal abuse had children who witnessed the abuse. In the 2003 *Alberta Incidence Study of Reported Child Abuse and Neglect* exposure to domestic violence was the primary or secondary form of maltreatment in 8,488 cases. Over two thirds (68%) of these cases were substantiated and in another 21% of these cases exposure to family violence remained suspected. Exposure to family violence was unsubstantiated in only 11% of cases. Exposure to family violence was identified as the primary

category of child maltreatment in 23% of substantiated cases[3] of child maltreatment in Alberta in 2003. These statistics highlight the importance of addressing the needs of children exposed to family violence in practice and in advanced family violence training.

In both the 2008 *Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2008,)* and the 2003 *Alberta Incidence Study of Reported Child Abuse and Neglect* the Aboriginal heritage of children was identified in an attempt to further understand factors that contribute to Aboriginal children coming into contact with child protection services. Children with Aboriginal heritage were identified in 29% of the substantiated cases of child maltreatment in Alberta in 2003. In cases in which exposure to family violence was the primary category of child maltreatment, 30% of the children were of Aboriginal heritage. These statistics support the importance of child protection programs and advanced violence training to address the needs of families with Aboriginal heritage.

Exposure to Domestic Violence and Other Forms of Child Maltreatment

Exposure to domestic violence (EDV) and other forms of child maltreatment were found by Canadian and United States researchers to co-occur in between 30-60% of child welfare cases (Edleson, 1999; Edleson, Mbilinyi, Beeman, & Hagemeister, 2003; Jouriles, McDonald, Slep, Heyman, & Garrido, 2008; Kracke & Hahn, 2008). The majority of incidents of EDV were found to take place in the victim's home (87%), with 29% of the children exposed being under the age of two years. Overall 61% of the children directly witnessed the incident (Stanley, Miller, Foster, & Thomson, 2011). McGuigan and Pratt (2001), in a large US longitudinal study of

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[3]Percentage based on a sample of 1,584 substantiated child maltreatment investigations in Alberta in 2003.

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children exposed to domestic violence during the first 6 months of their lives, found these children were at increased risk for child maltreatment over the first 5 years of their lives. McGuigan and Pratt also found that domestic violence preceded other forms of child maltreatment in 46 of the 59 cases of co-occurrence (78%). Children who experienced EDV were more likely to experience anxiety and depression (internalizing behaviours), as well as aggression and attentional issues (externalizing behaviours) (McFarlane, Groff, O'Brien, & Watson, 2003). In severe abuse cases (i.e., critical injury or death of a child) domestic violence was identified as a concern in over 40% of these families. Unfortunately, these prevalence rates may under represent the number of children who experience exposure to intimate partner violence and some other form of child maltreatment.

Under Identification of Family Violence in Child Protection Investigations

The under identification of family violence in child protection investigations has been identified as a concern that needs to be addressed by child protection workers. Kohl, Barth, Hazen, and Landsverk (2005) researched the identification of domestic violence by child welfare workers during investigations of child maltreatment using the *National Survey of Child and Adolescent Well Being* , which is based on data gathered from 36 U.S. states. Their sample consisted of 3,135 female caregivers and the child welfare workers who had the best knowledge of these cases. The female caregivers completed a self-report measure of domestic violence (Conflict Tactics Scale, 1990) and the child welfare workers' risk assessments were reviewed to identify the number of cases in which family violence was identified by the child welfare worker. These researchers found that *43% of caregivers* reported a lifetime prevalence of *less severe* DV victimization, 19% reported *severe* DV victimization, and 31% of caregivers

reported DV *victimization in the past year* on their self-report of domestic violence. However, *child welfare workers identified domestic violence in only 12% of these case*s (Kohl et al., 2005). Various predictors of under identification were identified using logistic regression analysis. Under identification of family violence was seven times more likely when the primary caregiver was identified as abusing substances. When the secondary caregiver was identified as abusing substances, the rate of under identifying decreased to 29% of the cases. In families with the highest number of risks identified, workers were more likely to also identify family violence as a concern.

Response of Child Protection Workers to Domestic Violence and Child Maltreatment

Researchers have found that Canadian child protection workers responses to cases involving exposure to domestic violence (EDV) vary depending on whether the violence occurred in isolation or with another form of child maltreatment (Black, Trocmé, Fallon & MacLaurin, 2008). Black et al. (2008) and Fleck-Henderson (2000) found that children who were the subjects of investigations involving substantiated EDV were less likely to be removed from their homes when compared to children experiencing only other forms of maltreatment. Findlater and Kelly (1999); Mills and Yoshihama (2002); and Nuszkowski et al. (2007) reported that child protection workers involved with families in which intimate partner violence co-occurred with some other form of child maltreatment were more likely to make an application in court to have the children removed from their homes and to provide on-going services to the families (Black et al., 2008). The under identification of family violence in child maltreatment investigations and inconsistent responses to substantiated cases are concerns that need to be considered by child protection agencies and addressed in advanced family violence training.

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Schechter (1996) identified five factors that must be considered when family violence has been identified as co-occurring with another form of child maltreatment: Child Intervention staff need to uphold the safety of victims of family violence and children as a goal; hold assailants, not their victims, accountable for the abuse; attempt to preserve the relationship between the children and their non-abusing parent/s; and, recognize there are times when keeping the family together can be a dangerous goal (Schechter, 1996). However, doing so can be challenging.

When Child Intervention workers are assessing situations in which family violence is a potential concern, victims may be hesitant to fully disclose incidents of family violence due to shame, embarrassment, or fear of their partners (Fogarty, Burge, & McCord, 2002, as cited in Kohl et al., 2005, p. 1206). Carter, Weithorn and Behrman (1999) found that victims were concerned their children would be removed from the home (Carter, Weithorn, & Behrman, 1999) and Fleck-Henderson (2000) found that victims may not see leaving the home as the safest option. Child intervention workers may also feel fear about offending the victim during the assessment; have a sense of powerlessness or lack of control over the situation; and perhaps hold beliefs about the victim's lack of initiative (Fogarty et al., 2002, as cited in Kohl et al., 2005, p. 1205; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). How each party understands, identifies and responds to the presence of family violence needs to be considered in risk assessment, safety planning and in developing a service response. Understanding how different perspectives, policies and practices impact the safety of family members needs to be addressed in advanced family violence training.

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Button and Payne (2009) found that while child protection workers knew more about domestic violence than other social service personnel, they did not know as much as they felt they needed to know in the following areas: communicating lethality (i.e., when the risk assessment indicates a risk of lethality but the client does not recognize this potential danger), worker safety, coping with the frustrations that arise in family violence cases, intervening with offenders, and dealing with the critical mental health issues. Supervisors in child protection services also identified that barriers to having workers become informed in these areas (i.e., the co-occurrence of family violence and other forms of child maltreatment) exist and include lack of time and staff shortages (Button & Payne, 2009).

In summary:

- Responses to family violence and child maltreatment vary depending on how these phenomena are defined in legislation, policies and standards for practice.

- In practice, service providers' responses to family violence clients are also affected by: (a) the service providers' knowledge and skill in assessing the presence of family violence and other forms of child maltreatment, (b) their ability to identify associated risks to family members, (c) their knowledge and skill in developing appropriate safety plans and (d) the capacity they have to provide differentiated services based on the needs of the various family members.

- Child protection personnel recognize a need for further education and training in each of these areas.

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In order to more fully understand best and promising practices, the literature - including peer-reviewed journals and on-line materials - related to each of these areas was examined. Conference presentations and materials were also reviewed and relevant findings are included in the following information.

Risk Assessment

The need for Child Intervention staff to assess risk, safety and the well-being of children is obvious. However, after years of deliberation, there is little consensus regarding the best methods and instrumentation to fulfill this need (LaLiberte, Bills, Shin, & Edleson, 2010). Currently, various forms of risk assessment are utilized by Child Intervention personnel. Three types of risk assessment may be used in cases where there is a concern regarding the co-occurrence of child maltreatment and exposure to domestic violence. They are: a clinical assessment, an actuarial assessment, and an actuarial risk scale (Holder 2008). The first type, a clinical assessment, also known as professional judgement, is derived from subjective opinions of the professionals involved. Even though this form of assessment is guided by a practice base, training, education, and experience, research has shown that this approach results in inaccuracies in assessment (Holder, 2008; Shlonsky & Friend, 2007). Actuarial instruments or assessments on the other hand make predictions about risk that are based on the measured relationship between identified outcomes and different objectively measured variables (Holder, 2008). A problem with actuarial instruments is that those instruments without a theoretical basis examine mostly historical and unchangeable risk factors (i.e., early family experience or educational attainment) making them less comprehensive (Baumann, Law, Sheets, Reid, &

Graham, 2005; Holder, 2008). The third type of assessment is actuarial risk scales. These scales are considered to be more dynamic as they can be used to explore contextual and environmental factors that have the potential to be altered (e.g., drug use, financial stability, or attitudes and beliefs), while still assessing static variables (Holder, 2008). There is an assumption that practitioners will use tools in their intended ways, which may not always be the case, and thus tools cannot be used to entirely replace expertise (Gillingham & Humphreys, 2010).

Shlonsky and Friend (2007) identify two additional types of assessments including: safety assessments, which are made up of consensus-based lists of factors thought to be related to the likelihood of immediate harm and structured contextual assessments, which are detailed appraisals of individual and family functioning. These tools allow caseworkers to: (a) more reliably assess whether the child may be safe if left in the home (safety assessment), (b) generate more reliable and valid predictions of the likelihood of future harm (actuarial risk assessment), and (c) to compile a detailed file that can be used to develop an individualized service plan (contextual assessment).

The Standard Decision Making model (SDM) is another type of risk assessment that encompasses several assessment tools, including risk, safety, and family strengths and needs (LaLiberte, Bills, Shin, & Edleson, 2010). SDM tools are meant to assist child protection practitioners in decision making, promote consistency in decision making, and help target children in need of service (Gillingham & Humphreys, 2010). Gillingham and Humphreys (2010) conducted an ethnography to examine how child welfare workers in Queensland, Australia used four SDM tools in the intake and investigation stages of work with families in which

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domestic violence was a potential concern. The four SDM tools used include the Screening tool,

Response Priority tool, Safety Assessment tool, and the Family Risk Evaluation tool. The

Screening tool is designed to assist practitioners in making decisions about which cases should

be accepted for investigation, while the Response Priority tool is designed to help practitioners

determine the timeline for investigation (Gillingham & Humphreys, 2010). The Safety

Assessment tool is to be used during an investigation to determine whether a child is *safe*,

conditionally safe and in need of a safety plan, or *unsafe* and requiring removal from his or her

parents or caregivers (Gillingham & Humphreys, 2010). The Family Risk Evaluation tool is an

actuarial risk-assessment tool to be used at the end of an investigation to determine the level

of risk to a child, and inform decisions about whether further involvement of the department is

required (Gillingham & Humphreys, 2010).

Gillingham and Humphreys' (2010) study revealed a discrepancy between the stated

expectations regarding the use of the SDM tools and caseworkers' actual practice, and the

intentions of caseworkers and their actual daily practice. Another concern raised by Gillingham

and Humphreys (2010) is that the SDM includes few questions directly related to the

assessment of DV. For example, item 10 of the Safety Assessment simply asks for a yes/no

response to assess if domestic violence exists in the home and poses a risk of serious physical

and/or emotional harm to the child (LaLiberte et al., 2010). LaLiberte, Bills, Shin, and Edleson

(2010) identify a total of only three DV related questions in the entire model.

Edleson et al. (2007) looked into some other assessments developed to measure the

impact of EDV on children. At the time of their study, common measures used were the Family

Worries Scale (Graham-Bermann, 1996), the Things I Have Seen and Heard measure (Richters &

Martinez, 1990, as cited in Edleson et al., 2007, p. 965), and the Children's Perception of Interparental Conflict Scales (Grych, Seid, & Fincham, 1992). These authors note that while these instruments measure the emotional and behavioral consequences of a child's exposure to DV, they do not give adequate information about the child's actual exposure to such experiences (Edleson et al., 2007). Clinicians also used an adaptation of the Conflict Tactics Scale (Straus, 1979) to assess children's levels of EDV. These tools had not been psychometrically tested with children exposed to domestic violence and researchers (Edleson et al. , 2007) queried the suitability of using these measures in this manner. The Juvenile Victimization Questionnaire (JVQ; Finkelhor, Hamby, Ormrod, & Turner, 2005) and Victimization Scale (Nadel, Spellman, Alvarez-Canino, Lausell-Bryant, & Landsberg, 1996) address a larger variety of violence exposure including: school, neighborhood, war, and domestic violence. Edleson et al. (2007) note that these measures as a group can be useful as broad screening measures for violence in general, but appear to be lacking in their ability to thoroughly measure children's EDV by failing to reach beyond exposure to physical violence, identifying victims or perpetrators, and by asking too few questions regarding DV exposure.

To address these short-comings, Edleson et al. (2007) began to create the Child Exposure to DV (CEDV) scale which would become a psychometrically tested, 46-item child self-report scale. The scale was reviewed by an international panel of experts, and pilot tested with children ages 10 to 16 (Edleson et al., 2007). The CEDV focuses on the types of violence to which a child is exposed, how they are exposed to each form of violence, how the child is involved in the violent incidents, and information on other forms of victimization, as well as risk and protective factors (Edleson et al., 2007). The scale assesses children's exposure to violence

on six subscales (1) level of violence in the home, (2) exposure to violence in the home, (3) involvement of violent events at home, (4) exposure to violence in the community, (5) presence of other risk factors, and (6) other forms of child victimization (Edleson, Shin, & Armendariz, 2008). This scale is available online at http://www.mincava.umn.edu/cedv/[4] and can also be found in Appendix A of this review.

LaLiberte et al. (2010) found that child welfare professional respondents asked to use the new CEDV scale found it to be a useful instrument in assessing children in child welfare cases for future risk of EDV, and that it could be incorporated in a variety of ways. Concerns regarding child welfare workers potentially using information provided by children on the CEDV in court, which could put the child in a difficult and unsafe position, were raised by the researchers (LaLibetre et al., 2010). Another concern arose when one quarter of the respondents surveyed in the study reported that they did not offer the CEDV to the child; the researchers were unsure if this decision was due to a dislike of the CEDV measure specifically, or if this reflected a generalized aversion to the use of any type of assessments eliciting a child's report about their EDV (LaLiberte et al., 2010). Due to these issues, LaLiberte et al. (2010) recommended that clear protocols and guidelines for how the CEDV should be used were imperative. The CEDV can be accessed at http://www.mincava.umn.edu/cedv/. LaLiberte et al. (2010) concluded that the CEDV when used with children fitting the instrument's criteria was an effective and comprehensive measure that assessed children's experiences with domestic violence.

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[4] Note: To access the hyperlink, right click on your mouse and click on the "Open Hyperlink" option. This will take you to the webpage where you can access the CEDV.

In Canada, two of the more commonly used tools include the Spousal Assault Risk Assessment (SARA; Kropp & Hart, 2000) and the Ontario Domestic Assault Risk Assessment (ODARA; Hilton et al., 2004). The SARA consists of a 20-item checklist which covers a variety of areas including: criminal history, psychological functioning, and current social adjustment (D. of J. Government of Canada, 2009). When used by law enforcement professionals, correctional officers, and government agencies, the SARA is designed to assess the risk of future abuse in adult male offenders, as well as incorporate the evaluator's professional judgement as part of the assessment (D. of J. Government of Canada, 2009). The SARA's interrater reliability is reported to be high and its internal consistency moderate, but its predictive validity is modest (Heckert & Gondolf, 2004). It is unclear if the SARA's psychometric properties have been tested on a child welfare sample. Indicators of the SARA can be found in Appendix B.

The ODARA is an empirically based actuarial risk assessment tool developed for front-line police officers, but is also available for use by victim services, health care workers, probation and correctional services personnel, and DV caseworkers in some provinces (D. of J. Government of Canada, 2009). The ODARA assesses risk of future wife assault in addition to the frequency and severity of these assaults, and it has also been found to be useful in correlating high ODARA scores with more severe assaults in the future (D. of J. Government of Canada, 2009). While the ODARA is a risk assessment tool which has some promise for use by child welfare personnel, it has not been normed on a child welfare sample. The items making up the ODARA can be found in Appendix C.

Another promising assessment tool that was found to have reliable psychometric properties that transfer well to the field was the California Family Risk Assessment (Wagner &

Johnson, 2003, as cited in Shlonsky & Friend, 2007). This assessment tool was designed to objectively assess child or family functioning in various areas including: substance abuse, mental health, physical health, family relationships, housing, and social support (Shlonsky & Wagner, 2005). A sample of the California Family Risk Assessment can be found in Appendix D

The California Family Risk Assessment is not specifically designed to assess a child's exposure to domestic violence but is a useful tool to be used in conjunction with instruments and processes designed for this purpose (Shlonsky & Friend, 2007). The need to assess and differentiate between risk factors for different family members is extremely important and is discussed below.

Risk factors reflected in families in which the co-occurrence of child maltreatment and/or DV exists have been identified in a number of studies. For example, Stith et al. (2009) found that the two strongest risk factors for neglect of children in general are: the parent-child relationship, and the parent's perception of the child as a problem. The latter is also a risk factor for child physical abuse. These authors recommend that these risk factors be considered when assessing the potential for future child maltreatment. Fallon, Ma, Black, and Wekerle (2011) found the parent's age to be a potential risk factor with younger parents being at increased risk of child maltreatment. Different explanations for this include the idea that having children during adolescence and young adulthood impacts identity development of the parents in a negative way thereby impacting parenting and parent-child-relationships (Fallon et al., 2011). Dixon, Browne, and Hamilton-Giachritsis (2005) note that the combination of being a parent under the age of 21, having a history of mental illness, and living with a violent adult accounted for 53% of the intergenerational transmission of child maltreatment, with a parent's

age being the most significant risk factor. Mothers who had abused their children were more likely to have a mother themselves with emotional problems, a higher likelihood of having been sexually abused, of running away from home, and of having trouble with the law (Fallon et al., 2011).

Other parental risk factors identified by Lavergne et al. (2011) include alcohol or drug problems, aggressiveness or impulsivity, mental or physical health problems, marital conflict, having been maltreated as a child, having few social supports, criminal activities, and financial difficulties. Interestingly, Kohl, Barth, Hazen, and Landsverk's (2005) research on the identification of DV during child maltreatment investigations found that workers were *seven times more likely to under identify* DV in investigations where caregiver substance abuse was present, even though this is a clear risk factor. In cases where the secondary caregiver was involved in substance abuse, child welfare workers were less likely to overlook the presence of DV (Kohl et al., 2005). Factors that currently appear to be more predictive of whether a child will be taken into care in cases of DV are related more to the parental figure's history of maltreatment, abuse and neglect of other siblings in the family, and the chronicity and degree of maltreatment of the child (Lavergne et al., 2011). It is important to take these risk factors into consideration when assessing incidents of DV and child maltreatment.

Risk Assessment: Recommendations and Effective Strategies
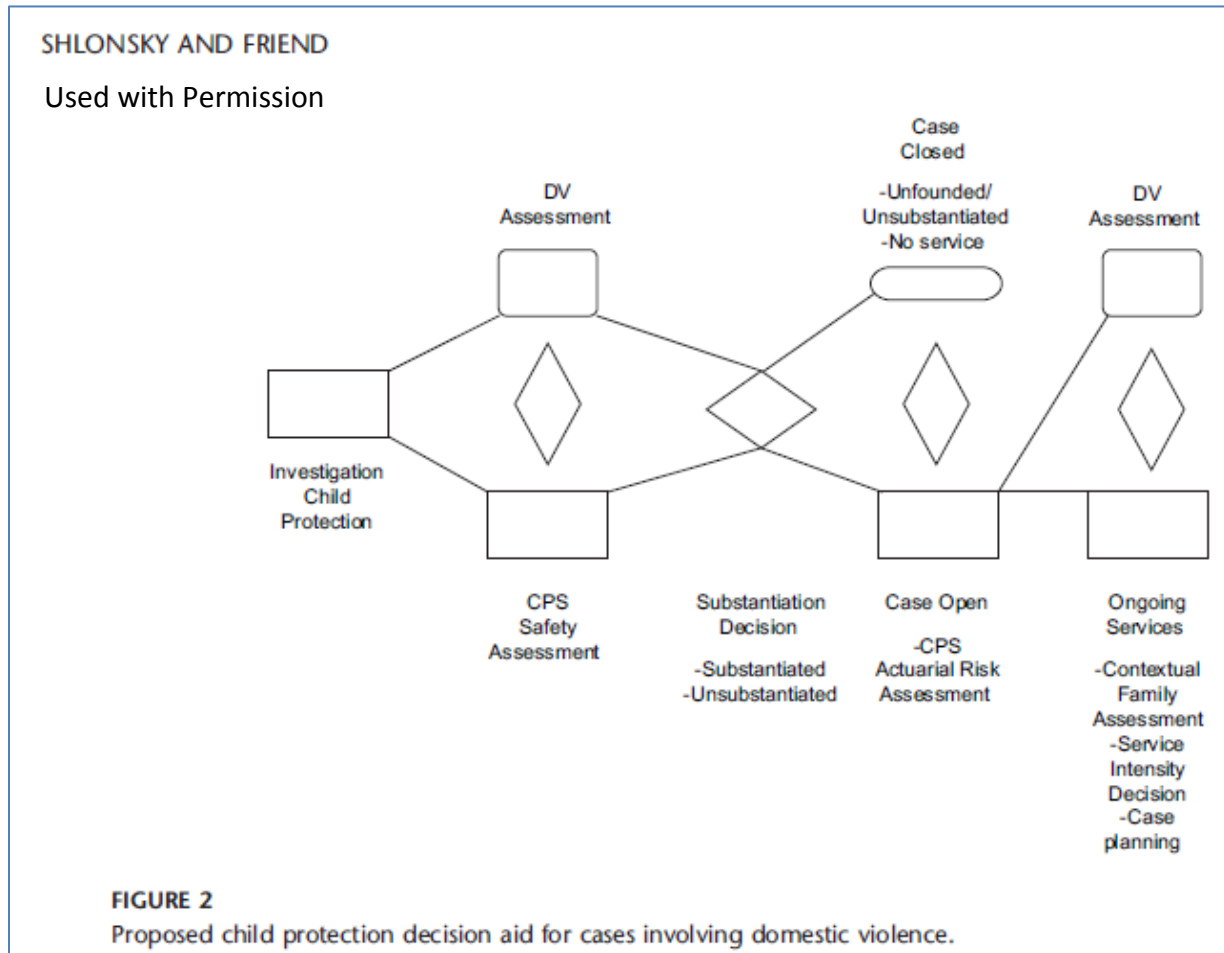
In reviewing the literature, several recommendations and effective strategies for family violence risk assessment were identified. Darlington, Healy, and Feeney (2010) recommend that when Child Intervention staff respond to family violence referrals, it is important to initially assess the risk for children and the parenting capacity of the caregivers. A relationship-building

approach which focuses on the wellbeing of the children and family as a unit is also

recommended. Stevens and Cox (2008; as cited in Gillingham & Humphreys, 2010, p. 2612)

suggest that families be conceptualized as complex adaptive systems, and that those using

linear assessment tools should factor in concepts from complexity theory (i.e., families' capacity

to adjust in adverse and complex situations) which would lead to more realistic forms of risk

assessment.

As mentioned earlier, under identification of family violence by Child Intervention staff

is a concern. Kohl et al. (2005) found that child welfare workers tended to overlook family

violence when caregivers had been previously involved with child welfare services (CWS). Thus,

these authors emphasized the importance of caseworkers assessing all possible risks - including

child maltreatment, family violence and substance abuse - when a family has had multiple

experiences with CWS due to child maltreatment.

Shlonsky and Friend (2007) recommend a nested assessment approach be used with

families in which child maltreatment and domestic violence are concerns. The risk of child

maltreatment recurrence needs to be the first-order assessment, after which more than one

type of risk assessment instrument may be employed, or a hierarchy of instruments may be

utilized. An example of this approach can be found in Appendix E. Shlonsky and Friend (2007)

note that when child protection workers proceed through their common approach of: (a)

screening, (b) assigning a service priority, (c) conducting a safety assessment, (d) determining

whether maltreatment occurred, (e) completing a risk assessment, and (d) developing a service

plan, they can enhance this approach by including DV risk assessments at various points along

this continuum of care. An illustration of Shlonsky and Friend's (2007) framework for service

decisions, which considers the risk level of both child maltreatment recurrence and DV is depicted below.

SHLONSKY AND FRIEND
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FIGURE 2
Proposed child protection decision aid for cases involving domestic violence.

Shlonsky and Friend (2007) also considered the training needs of child protection workers relating to risk assessment. They found that child protection workers need more specific, focused training in: (a) understanding risk assessment, (b) how to conduct interviews that are sensitive to the issues surrounding domestic violence, and (c) determining where and when to intervene. The need for child protection agencies to make a long-term investment in staff education in order to enhance workers' ability to think critically when dealing with the complexity of child welfare investigations is also identified (Gillingham & Humphreys, 2010). For example, when using instruments that rely on victim self-report, it is important that workers

have training in engendering a battered woman's trust. The caregiver may accurately perceive that being honest may put her at risk of losing her children (Shlonsky & Friend, 2007) and as a result may be reluctant to engage with Child Intervention staff.

Training goals should go beyond risk assessment and seek to: (1) increase the worker's recognition that family violence is related to the safety of the child and that interventions targeting domestic violence and supporting the adult victim are ultimately linked to the child's safety, (2) increase the identification of family violence in child maltreatment cases, and (3) increase the referrals made to appropriate family violence services once it is identified (Kohl et al., 2005). Darlington et al., (2010) identified that capacity building of child welfare staff needs to focus on training, supervision, service development and program evaluation.

Taggart (2009), a consultant to the Greenbook Initiative, identified five specific strategies that child welfare agencies can use to improve their responses to DV in cases of child maltreatment. These strategies are: (1) analyze the available DV data, (2) clarify the intake and removal thresholds related to children's EDV, (3) develop and implement DV protocols or practice guidelines, (4) expand and deepen DV training, and (5) ensure that child protection services staff have access to DV specialized expertise. These recommendations clearly support the need for the proper implementation of risk assessment, which is directly related to DV training, and is integral to effective on-going safety planning.

Safety Planning Practices

Safety planning is considered to be the most common form of intervention offered to women living in abusive environments, and yet a disconnect between theory and practice exists

in terms of defining or standardizing the safety planning process (Campbell & Hardesty, 2004).

While most professionals in the human services fields agree that safety planning is a critical

element to assisting victims of domestic abuse, there appears to be little to no documented

evaluation of the effectiveness of safety planning – partly due to the inconsistent and varied

safety planning tools currently in use (Campbell & Hardesty, 2004). Various researchers have

suggested that effective safety planning is dependent upon the effectiveness of the risk or

danger assessment that is implemented (Campbell & Hardesty, 2004; Jaffe & Juodis, 2006).

When "lethality factors are recognized . . . appropriate safety planning can begin" (Jaffe &

Juodis, 2006, p.19). Safety planning – as a process – is thought to be most effective when the

victim(s) are directly involved, and when planning is understood as being context and case

specific (Campbell & Soeken, 1999; Lempert, 1996). In the majority of cases, the purpose of

safety planning is to "work with the woman to identify how she can act to better keep herself

safe from further acts of intimate partner violence" (Campbell & Hardesty, 2004, p.89). It is

critically important that children are not overlooked throughout this process as children are in

frequent need of effective safety planning, particularly if they are developmentally aware of the

risks and capable of taking action (Campbell & Hardesty, 2004).

Issues in Safety Planning & Recommendations

Utilizing a context and case specific model of safety planning allows caseworkers to

acknowledge the victim's perspective. Spears (2000) stated, "Understanding the basis for

battered mothers' decision-making about their lives and the lives of their children will provide

the information necessary to effectively safety plan with them." Campbell and Hardesty (2004)

indicated that the recognition of the victim's perspective needs to be balanced by objective

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assessment tools. Campbell, Sharps and Glass (2000) bring this point home by reminding us that approximately half of both actual and attempted femicide victims of domestic violence did not think their partner was capable of killing them. These findings speak to the possibility that victim's may be unable to properly assess or communicate risk while developing a safety plan.

Campbell and Hardesty (2004) suggested that the Danger Assessment (DA) – a 17-item yes/no questionnaire – can be administered to women experiencing or at risk of experiencing domestic violence. This assessment tool may act as a "reality check" for those women unable to recognize the dangers in their relationship. The DA can be administered in a variety of contexts – hospitals, schools, shelters, or the court system – and can positively indicate when women are at high risk of violence (demonstrated when eight or more items are indicated as "yes"); the DA's accuracy is augmented by information gathered from women using a calendar assessment, where women mark instances of abuse on a calendar of the past year – a process shown to improve recall (Belli, Shay, & Stafford, 2001).

Campbell and Hardesty (2004) also discussed the importance of acknowledging observed patterns of abuse in domestic violence, as well as the situations that put victims and their children at the most risk and in need of a safety plan. For example, women have been found to be at increased risk during pregnancy and post-pregnancy, when biological children of the woman are living in the home, during custody battles or separations, and when the woman has said she has or is planning to leave the abuser (Campbell & Hardesty, 2004). Sheeran and Hampton (1999), in their article on supervised visitation in cases of domestic violence, note that unsupervised visitation and exchanges of children may increase the risk for victims and their children. Safety plans need to consider this type of risk factor and address their amelioration.

Safety planning with victims of family violence and their children are affected by the biases held by Child Intervention staff and other frontline workers involved with family violence clients. These biases can lead to victim blaming (Magen, 1999; Spears, 2000), which can place the responsibility for safety solely on the victim and divert attention away from the responsibility of the aggressor (Bourassa, Damant, Lavergne, Leessard, & Turcotte, 2008). Researchers conclude that "each case must be meticulously assessed individually rather than presuming that all victims of domestic violence are either fit or unfit to be good parents" (D'Ambrosio, 2008, p.658).

The recommendations for effective safety planning vary throughout the literature. However, common themes include: removing the abuser, receiving a court order to protect the victim(s), moving the victim(s) into a shelter or safe environment, checking or changing the victims' locks or location, and developing a plan for the woman and children in case the batterer returns to the home (D'Ambrosio, 2008). Other research suggests standardization and broader changes to policies, procedures, and training. Bonner and Waugh (2002) recommend training be used to help develop shared understandings of domestic violence and child abuse; a comprehensive overview of safety planning; protocols for developing and incorporating safety plans in practice; and clearly defining designated roles and responsibilities for everyone involved in working with family violence clients.

Family Violence Training Programs for Child and Family Services Personnel

The number of articles in the literature on domestic violence training for child welfare personnel is quite limited when compared with those available on the topic of family violence.

The majority of these articles are related in one way or another to the National Council of Juvenile and Family Court Judges (National Council) initiative that took place in the United States during the 1990s. This initiative is commonly referred to in the literature as the "Greenbook" initiative. This project led to a series of National Council publications including one entitled *Effective Intervention in Domestic Violence & Child Maltreatment Cases: Guidelines for Policy and Practice* (Schechter & Edleson, 1999). A recommendation that communities cross-train child welfare, domestic violence, and juvenile court system personnel is highlighted in this publication. It is further recommended that written materials on the identification and assessment of domestic violence and child maltreatment, referral processes, and safety interventions be developed and provided to those involved in working with families impacted by domestic violence and other forms of child maltreatment. The influence of this initiative is reflected in the prevalence of articles related to the various types of domestic violence training programs developed as part of the Greenbook Initiative (Fleck-Henderson, 2000; Mills, et al., 2000; Mills & Yoshihama, 2002; Nuszkowski, et al., 2007; Saunders & Anderson, 2000). Despite the impact of this initiative, a national follow-up study on the current training practices of domestic violence services agencies and child welfare agencies indicated over two-thirds of the child welfare agencies (73) and approximately half of the domestic violence services agencies (76) needed to expand their training efforts (Nuszkowski, et al., 2007).

The far-reaching influence of this US initiative is also evident in the Canadian literature related to domestic violence training for Child Intervention staff. For example, Bourassa, Lavergne, Damant, Lessard and Turcotte (2006) recommended that US training programs be adapted to the realities of the various Canadian provinces and used in the training of Child

Intervention staff. In light of this recommendation, and the very limited number of publications addressing family violence training in Canada, the US studies are predominant in this review. Canadian information has been included when available.

Historically, family violence, also referred to in this document as domestic violence and intimate partner violence, has been addressed by advocates of the battered women's movement and domestic violence services providers. Child maltreatment has been addressed by child welfare agencies. In the past, these agencies have worked independently and at times, they have been in conflict. The growing literature on the co-occurrence of child maltreatment and intimate partner violence clearly indicates a need for systemic changes and the need for training to address the co-occurrence of domestic violence and child maltreatment (Button & Payne, 2009; Findlater & Kelly, 1999; Nuszkowski et al., 2007). Postmus and Merritt (2010) considered factors that influenced child welfare workers' beliefs (i.e., educational level, length of time employed, level of experience) and found that younger workers with less child welfare experience removed children exposed to family violence from their homes more readily than workers with more professional experience. This finding supports previous research that found that child welfare workers with more experience were less likely to remove children from their homes (Saunders & Anderson, 2000). Postmus and Merritt conclude that child welfare agencies need to re-evaluate their policies, protocols and supervisory training to help ensure new workers learn how to best work with families in which family violence is a concern.

Collaborative practice and cross training are upheld as necessary means to enhancing services to families impacted by family violence. Button and Payne (2009); Findlater and Kelly (1999); Jones, Packard and Nahestedt (2002); Mills et al. (2000); Mills and Yoshihama (2002);

Nuszkowski (2007); Renner (2011) confer that collaborative work with police, child protective services, family violence services agencies and policy makers; and, cross training between child protective services workers and family violence services workers, is required in order to more effectively deal with domestic violence. Canadian researchers Cross, Mathews, Tonmyr, Scott, and Ouimet (2012) recommend that child welfare agencies interested in enhancing services provided to family violence clients need to: (a) reach out to other disciplines working with families experiencing or at risk of domestic violence in order to continue developing collaborative methods of working with these families, (b) seek and provide resources to support training and programming, (c) consider methods, such as differential response, that reduce the likelihood of stigmatizing parents, and (d) incorporate strong program evaluation components in order to increase the knowledge base about effective training and practice. Those working with individuals experiencing family violence also need to be aware of their own personal involvement with domestic violence and the effects of their experiences on their beliefs and attitudes towards those impacted by family violence and other forms of child maltreatment (Postmus & Merritt, 2010; Yoshihama & Mills, 2003). Four programs developed to address the above mentioned concerns are outlined below.

Overview of Family Violence Training Programs

Mills et al. (2000) provide an overview of the experience of four groups who developed and provided domestic violence training as part of the Greenbook Initiative. A key feature of the four programs was the development of a training curriculum involving multiple players from the child welfare and DV communities that led to new and important alliances. In New York,

Columbia University gathered a diverse group of representatives together from the child welfare and DV communities and worked closely with individuals in a CPS district who were testing a special DV assessment instrument. They developed a training manual that was widely disseminated. According to pre-test post-test data, the training resulted in a statistically significant change in worker attitudes toward DV (Magen & Conroy, 1998). More specifically, they were particularly successful in changing CPS male worker attitudes (Magen & Conroy, 1998).

In Boston, Simmons College worked with the Domestic Violence Unit to bring together an interagency team, which proved invaluable in their cross-training approach. This team met and continues to meet monthly to consult on DSS cases and to address organizational issues among the agencies and services represented. The training curriculum was summarized in a training manual produced for the Domestic Violence Unit and was made up of modules to be used flexibly according to the training needs of particular groups. Team members participated in an evaluation conducted by research faculty and students from Simmons College.

Temple University, in Philadelphia, worked closely with their Advisory Board, members of which represented many different systems involved in violence prevention and intervention. Because their trainees came from diverse professional organizations and agencies, networking was facilitated between people and organizations that would not otherwise have the time or inclination to communicate. The training model developed consisted of 24 hours of training in six three-hour sessions. An additional six-hour session on an elective topic was necessary. Those who completed the training session were awarded a certificate for Innovative Services to Violent Families. The topics covered included:

- New perspectives on family violence

- Focus on the victims of violence: case studies and applications

- Focus on the perpetrator of violence: case studies and applications

- Focus on systems: legal issues at the macro level

- Focus on human services: applications at the micro level; and

- Collaborations: working together to end family violence.

In Los Angeles, UCLA's interagency collaboration was also integral to the success of its program. Law enforcement personnel, prosecutors, judges, alcohol and drug treatment agency personnel, adult protective services, DV advocates and CPS supervisors were involved in the planning of the training and in the development of the curriculum. The topics addressed in the 1-day training included

- Changing attitudes; and

- Teaching assessment and intervention techniques.

UCLA's curriculum comes complete with the overheads and handouts used in the 1-day training. Mills and Yoshihama (2002) evaluated this program (See below).

Domestic Violence Training Program Evaluations

Saunders and Anderson (2000) evaluated a 2-day domestic violence training program modelled after the New York City training developed during the Greenbook Initiative. The training used an adaptation of the manual *Domestic Violence: A National Curriculum for Child Protective Services* (Ganley & Schechter, 1996) and was offered to participants in groups ranging in size from 8 – 44 people. Supervisors and workers were trained in separate groups. The training consisted for 14 sessions held at 10 sites. Topics covered in the training included:

- The relationship between DV and child abuse and neglect

- The dynamics of DV

- Identifying and assessing domestic violence; and

- Interventions and practice applications.

The evaluation of this training indicated that more participants would use various forms of assessment and brief interventions than indicated prior to training; the participants' understandings regarding who was responsible for the abuse shifted and post training they were less likely to blame victims and were more likely to hold the offender responsible for their actions. The belief that couples should be referred to couple's counselling significantly decreased.

Mills and Yoshihama (2002) evaluated the effectiveness of two training programs offered in Los Angeles and Orange County based on the curriculum developed by Friend, Mills and colleagues as part of the Greenbook Initiative. Both trainings focused on domestic violence and child maltreatment in order to develop workers skills in assessing and intervening with families in which these co-occur. The one-day training used teaching, role plays and exercises to encourage participants to try out newly acquired knowledge and skills. The more intensive fellowship program, which lasted for six days over a six month period, went into more depth in each area and offered leadership training for a select group of workers who were to become domestic violence resource personnel. Both trainings examined the role of child welfare workers with families in which domestic violence was a concern. Participants were also asked about their tolerance for domestic violence, if they viewed it as a social problem, their

approach to assessment and case management, perceptions of battered women, self-rated

competency and the extent of their professional experience.

The results of this evaluation revealed that following the training, the participants

reported they were more likely to view assessment of whether the mother was being abused as

a first task of child welfare workers. They were less likely to consider the mother as unable to

protect her children and had a greater understanding of reasons battered women might choose

to remain in an abusive relationship. These findings point to the effectiveness of the training.

However, the researchers conclude that the findings need to be interpreted with caution as the

results were based on self-reports and a considerable number of participants did not complete

the pre and post test components of the evaluation.

Several years after those involved in the Greenbook Initiative had developed and

offered their initial training programs; Nuszkowski et al. (2007) conducted a follow-up study

which focused on identifying the extent of domestic violence training reported by child welfare

agencies, and the extent of training on child maltreatment reported by domestic violence

agencies. The extent of co-training activities were tracked for both types of agencies and factors

associated with strong training performance (i.e., total number of trainings, types of trainings

and collaborative trainings conducted) were identified for each agency. Nine topics were

covered by approximately 90% of child welfare services agencies during both required and

optional training:

- Co-occurrence of DV and child maltreatment

- Co-occurring problems

- DV definition and prevalence

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- Dynamics of DV

- Exposure to DV as a form of child maltreatment

- Risk assessment regarding DV

- Safety issues when assessing for DV

- Safety planning regarding adult victims of DV; and

- Services and interventions for adult victims and children of DV.

Five topics were covered by more than 90% of the DVS agencies in required and optional training and included:

- Definition and prevalence of child maltreatment

- Co-occurrence of DV and child maltreatment

- Exposure to DV as a form of child maltreatment

- Services and interventions for child maltreatment; and

- Information on how to report child maltreatment.

This study also revealed that an ongoing need for extended domestic violence training existed in both the domestic violence services and child welfare services sectors.

Summary of Training Outcomes

Domestic violence training evaluations indicate that family violence training makes a difference. Training lowered workers' negative views of families experiencing violence while increasing workers' empathy toward the victim's circumstance. Training shifted workers' views regarding holding the victim responsible and slightly increased holding the perpetrator responsible. Further, workers were less inclined to send couples for joint counselling when inappropriate to do so and were less focused on insisting mothers leave the batterer in order to

protect the child. Workers also reported that training assisted them in feeling more confident when exploring the topic of family violence with family members. Training helped workers identify family violence and better attend to families experiencing domestic abuse.

Barriers to training were also identified and almost all of the studies showed that lack of time for workers was a barrier to them obtaining training. When asked about preferences in the form of delivery for training, child protection workers indicated they preferred classroom training, while supervisors were more open to web-based training. In most of the articles reviewed, child welfare personnel, at the time of reporting, indicated their training in domestic violence was insufficient to ensure they were effectively identifying, assessing and intervening appropriately with families in which domestic violence was a concern.

Conclusion

Given the co-occurrence of domestic violence and child maltreatment, ongoing collaboration between multiple systems and service providers is required to:

- Enhance understanding between policy-makers, front line responders and other service providers involved in working with families impacted by domestic violence.

- Develop and deliver comprehensive and effective risk assessment and safety planning practices for families in which domestic violence is a concern.

- Develop differentiated programs and services that protect children, meet the needs of victims of domestic violence, hold offenders accountable for their abusive behaviour, and when appropriate engage them in ensuring the safety of their children and the caregivers involved in their children's lives.

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Equipping those working with families impacted by domestic violence requires training and Child Intervention workers indicate a need for further education regarding domestic violence, risk assessment and safety planning, and collaborative practice. Researchers have found that education and training can make a positive change as participants examine their own perspectives and biases that impact their work with domestic violence clients, enhance their knowledge and skill in assessing risk to family members, learn to develop safety plans that meet the changing needs of these families, and work collaboratively with the multiple systems and service providers addressing the needs of family violence clients. Training needs to be prioritized and time and resources need to be provided. Changes in practice do not occur automatically following training. Lessons learned need to be reinforced in practice through supervision and monitored through on-going reviews.

Strong evaluation components need to be incorporated in order for programs and training to continually improve. Compliance to changes in policy and practice is an important evaluation criterion as change in practice does not happen automatically. The significance of change in domestic violence programs and training needs to consider if these changes contribute to more families becoming safe environments in which children and all other family members can grow and flourish. Based on this premise, program and training evaluation criteria need to consider the differences family violence services make in the lives of family violence clients.

Finally, this literature review provides important information that needs to be considered in the development of risk assessment and safety planning policy and practices

within HS:CI. The authors will also integrate key findings into the framework for advanced

family violence training to be developed as part of this collaborative research project.

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CHILD EXPOSURE
TO DOMESTIC VIOLENCE SCALE

(CEDV)
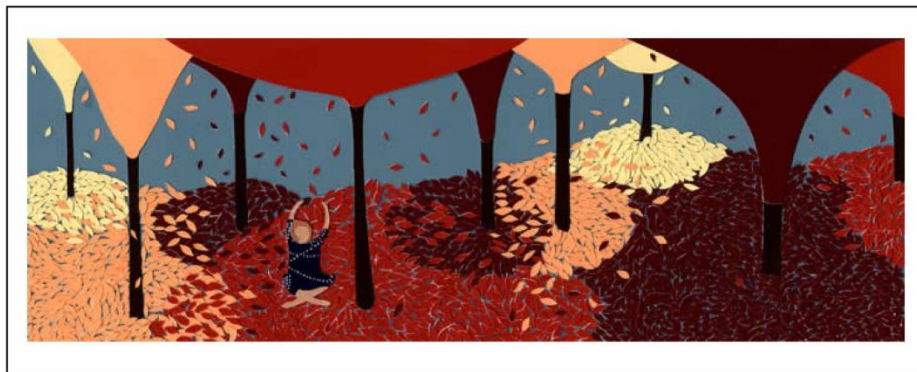
Original artwork by Ida Pearle. Artwork used with permission from the artist.

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Appendix A

<u>**Assessment of Child Violence Exposure to Domestic Violence**</u>

These directions are to be read aloud by the practitioner administering this measure.

This is a list of questions about your life and your family. It will probably take you about 30 minutes to fill out. If you have a question when you are filling this out, ask the person who gave this to you.

Your answers will NEVER be given to other people, so do NOT write your name anywhere. If you want to stop taking the survey, you can stop answering the questions anytime you want.

Think about the people you have ever lived with. There are lots of ways to think about the kinds of adults that kids live with. For example, some kids live with a stepparent, or a grandparent, or foster parents. Other kids live with just one parent and maybe a parent's girlfriend or boyfriend too. The questions in the survey are about the adults you have lived with. To make them easy to understand, we use the words "mom" and "mom's partner."

When you read the word "mom," think of the woman you have lived with and who has taken care of you, even if she did not give birth to you. For example, this person might be your mom, your stepmother, your grandma, or your foster mom. When you read the words "mom's partner", think of who that is in your life. For example, it could be your dad, your step dad, your grandpa, or your mom's girlfriend or boyfriend.

Please read all the directions and circle your answers to each question.

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Appendix A

Part One
There are two parts to each question.

⇒ First answer the question about how often something happened by circling your answer.

⇒ Then check off all the ways you knew about what happened.

⇒ If you answer "Never" in the first part, skip the second part and go on to the next question.

Never	Sometimes	Often	Almost Always

Example:
How often have there been fights at your school?

Never   (Sometimes)   Often   Almost Always

Circle never, then go to the next question.

How did you know about it?

☑ = I saw the outcome (like someone was hurt, something was broken, or the police came).
☐ = I heard about it afterwards.
☑ = I heard it while it was happening.
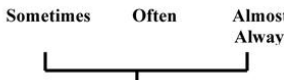☐ = I saw it from far away while it was happening.
☐ = I saw it and was near while it was happening.

---

1. How often do adults in your family disagree with one another?

Never   Sometimes   Often   Almost Always

Circle never, then go to the next question.

How did you know about it?

☐ = I saw the outcome (like someone was hurt, something was broken, or the police came).
☐ = I heard about it afterwards.
☐ = I heard it while it was happening.
☐ = I saw it from far away while it was happening.
☐ = I saw it and was near while it was happening.

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Appendix A

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| Never | Sometimes | Often | Almost Always |
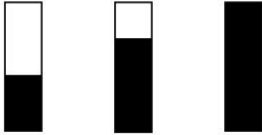
2. Has your mom's partner ever hurt your mom's feelings by:
   - calling her names
   - swearing
   - yelling
   - threatening her
   - screaming at her
   - other _____

Never → Circle never, then go to the next question.

How did you know about it?
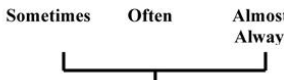
☐ = I saw the outcome (like someone was hurt, something was broken, or the police came).
☐ = I heard about it afterwards.
☐ = I heard it while it was happening.
☐ = I saw it from far away while it was happening.
☐ = I saw it and was near while it was happening.

3. How often has your mom's partner stopped your mom from doing something she wanted to do or made it difficult for her to do something she wanted to do? Such as
   - leave the house
   - go to the doctor
   - use the telephone
   - visit her friends or relatives
   - other _____

| Never | Sometimes | Often | Almost Always |

Never → Circle never, then go to the next question.

How did you know about it?

☐ = I saw the outcome (like someone was hurt, something was broken, or the police came).
☐ = I heard about it afterwards.
☐ = I heard it while it was happening.
☐ = I saw it from far away while it was happening.
☐ = I saw it and was near while it was happening.

4. How often has your mom's partner stopped your mom from eating or sleeping, or made it hard for her to eat or sleep?

| Never | Sometimes | Often | Almost Always |

Never → Circle never, then go to the next question.

How did you know about it?

☐ = I saw the outcome (like someone was hurt, something was broken, or the police came).
☐ = I heard about it afterwards.
☐ = I heard it while it was happening.
☐ = I saw it from far away while it was happening.
☐ = I saw it and was near while it was happening.

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Appendix A

Never   **Sometimes**   **Often**   **Almost Always**

5. How often have your mom and her partner argued about you? [*It is not your fault if your mom and her partner argue about you.*]

Circle never, then go to the next question.

How did you know about it?

☐ = I saw the outcome (like someone was hurt, something was broken, or the police came).
☐ = I heard about it afterwards.
☐ = I heard it while it was happening.
☐ = I saw it from far away while it was happening.
☐ = I saw it and was near while it was happening.

Never   **Sometimes**   **Often**   **Almost Always**

6. How often has your mom's partner hurt, or tried to hurt, a pet in your home on purpose?

Circle never, then go to the next question.

How did you know about it?

☐ = I saw the outcome (like someone was hurt, something was broken, or the police came).
☐ = I heard about it afterwards.
☐ = I heard it while it was happening.
☐ = I saw it from far away while it was happening.
☐ = I saw it and was near while it was happening.

**Never**   **Sometimes**   **Often**   **Almost Always**

7. How often has your mom's partner broken or destroyed something on purpose, such as:
    • punching a wall
    • ripping a phone cord out of the wall
    • smashing a picture
    • other_____

Circle never, then go to the next question.

How did you know about it?

☐ = I saw the outcome (like someone was hurt, something was broken, or the police came).
☐ = I heard about it afterwards.
☐ = I heard it while it was happening.
☐ = I saw it from far away while it was happening.
☐ = I saw it and was near while it was happening.

5

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Appendix A

DO NOT WRITE YOUR NAME ON THIS PAPER.

| Never | Sometimes | Often | Almost Always |
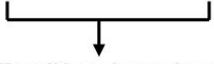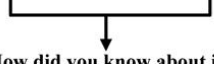
8. How often has your mom's partner done something to hurt her body, such as:
- hitting her
- punching her
- kicking her
- choking her
- shoving her
- pulling her hair
- other _____

Circle never, then go to the next question.

How did you know about it?

☐ = I saw the outcome (like someone was hurt, something was broken, or the police came).
☐ = I heard about it afterwards.
☐ = I heard it while it was happening.
☐ = I saw it from far away while it was happening.
☐ = I saw it and was near while it was happening.

| Never | Sometimes | Often | Almost Always |

8. How often has your mom's partner *threatened* to use a knife, gun, or other object to hurt your mom?

Circle never, then go to the next question.

How did you know about it?

☐ = I saw the outcome (like someone was hurt, something was broken, or the police came).
☐ = I heard about it afterwards.
☐ = I heard it while it was happening.
☐ = I saw it from far away while it was happening.
☐ = I saw it and was near while it was happening.

| Never | Sometimes | Often | Almost Always |

10. How often has your mom's partner *actually* hurt your mom with a knife, gun, or other object?

Circle never, then go to the next question.

How did you know about it?

☐ = I saw the outcome (like someone was hurt, something was broken, or the police came).
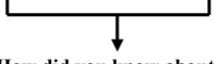☐ = I heard about it afterwards.
☐ = I heard it while it was happening.
☐ = I saw it from far away while it was happening.
☐ = I saw it and was near while it was happening.

6

DO NOT WRITE YOUR NAME ON THIS PAPER.

<u>Part Two</u>
**It's hard to know what to do when you see
someone getting hurt. In the questions on this
page the word "hurt" means hurting your
mom's feelings on purpose, threatening her,
physically hurting her, or stopping her from
doing things.**

**Choose the answer that best describes your
situation and circle it. There are no right or
wrong answers to these questions.**
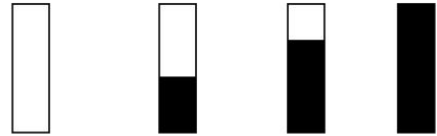
Never	**Sometimes**	**Often**	**Almost Always**

11. When your mom's partner hurts your mom, how
    often have you yelled something at them from a
    different room than where the fight was taking
    place?

    Never   **Sometimes**   **Often**   **Almost Always**

12. When your mom's partner hurts your mom, how
    often have you yelled something at them in the
    same room where they are fighting?

    Never   **Sometimes**   **Often**   **Almost Always**

13. When your mom's partner hurts your mom, how
    often have you called someone else for help,
    like calling someone on the phone or going next
    door?

    Never   **Sometimes**   **Often**   **Almost Always**

14. When your mom's partner hurts your mom, how
    often have you gotten physically involved trying
    to stop the fighting?

    Never   **Sometimes**   **Often**   **Almost Always**

15. When your mom's partner hurts your mom, how
    often has your mom's partner done something to
    you to hurt or scare your mom?

    Never   **Sometimes**   **Often**   **Almost Always**

16. When your mom's partner hurts your mom, how
    often have you tried to get away from the
    fighting by:
    - hiding
    - leaving the house
    - locking yourself in a different room
    - other _____

    Never   **Sometimes**   **Often**   **Almost Always**

17. How often has your mom's partner asked you to
    tell what your mom has being doing or saying?

    Never   **Sometimes**   **Often**   **Almost Always**

18. How often do you worry about your mom's
    partner getting drunk or taking drugs?

    Never   **Sometimes**   **Often**   **Almost Always**

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Appendix A

DO NOT WRITE YOUR NAME ON THIS PAPER.

		Never	Sometimes	Often	Almost Always

19. How often do you worry about your mom getting drunk or taking drugs? — Never, Sometimes, Often, Almost Always

20. How often does your mom seem sad, worried or upset? — Never, Sometimes, Often, Almost Always

21. How often does it seem like you have had big changes in your life? For example:
- moving homes
- staying in the hospital
- your parents getting a divorce
- the death of someone you're close to
- a parent going to jail
- other _____

Never, Sometimes, Often, Almost Always

22. How often have you heard a person hurt another person by making fun of them of calling them names in your neighborhood or at your school? — Never, Sometimes, Often, Almost Always

23. How often has someone from your community or at your school done or said any of these things to hurt you? — Never, Sometimes, Often, Almost Always

24. How often do you hurt a person's feelings on purpose, like making fun of them or calling them names? — Never, Sometimes, Often, Almost Always

25. How often do you physically hurt a person on purpose, such as hitting, kicking or things like that? — Never, Sometimes, Often, Almost Always

8

Appendix A
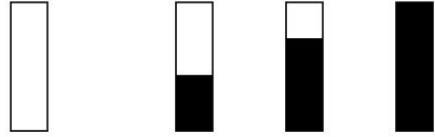
Never	Sometimes	Often	Almost Always

26. How often have you seen someone else in your community or school get hurt by being:
    - grabbed
    - slapped
    - punched
    - kicked
    - being hurt by a knife or a gun
    - other _____

Never	Sometimes	Often	Almost Always

27. How often has someone at school or in your community hurt you by:
    - grabbing
    - slapping
    - punching
    - kicking
    - threatening you with a knife or gun
    - other _____

Never	Sometimes	Often	Almost Always

28. How often have you seen someone being hurt or killed on television or in a movie?

Never	Sometimes	Often	Almost Always

29. How often have you seen someone being hurt or killed in a video game?

Never	Sometimes	Often	Almost Always

30. How often has an adult in your family hurt your feelings by:
    - making fun of you
    - calling you names
    - threatening you
    - saying things to make you feel bad
    - other _____

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Appendix A

DO NOT WRITE YOUR NAME ON THIS PAPER.

	Never	Sometimes	Often	Almost Always

31. How often has an adult in your family done something to hurt your body, like:
    - hitting you
    - kicking you
    - beating you up
    - other _____

    Never   Sometimes   Often   Almost Always

32. How often has someone who is <u>not</u> in your family:
    - touched your private parts when you didn't want them to
    - made you touch their private parts
    - forced you to have sex?

    Never   Sometimes   Often   Almost Always

33. How often has someone <u>in</u> your family:
    - touched your private parts when you didn't want them to
    - made you touch their private parts
    - forced you to have sex

    Never   Sometimes   Often   Almost Always

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Appendix A

DO NOT WRITE YOUR NAME ON THIS PAPER.

<u>Part Three</u>

34. If your mom and her partner fight, when did the fighting start? (Circle one answer.)

    1. I don't remember them fighting.
    2. They started fighting this year.
    3. They started fighting 2-3 years ago.
    4. They started fighting 4 or more years ago.
    5. They've been fighting for as long as I can remember.

35. Do you think your family has enough money for the things it needs?

    1. No, there are times when my family doesn't have enough money for food or rent or other things we need.
    2. We seem to have enough money to pay for what we need.
    3. We have enough money to buy extra things we don't really need.
    4. I don't know.

36. How old are you? _____

37. Are you male or female? (Circle one answer.)

    1. Male
    2. Female

38. What race or ethnicity do you consider yourself? (Circle all that describe you.)

    1. White/Caucasian/European American
    2. Black/African American/African
    3. American Indian/Native American
    4. Asian or Pacific Islander
    5. Latino/Latina/Hispanic
    6. Multi-racial/No primary racial or ethnic identification
    7. Other (What?) _____
    8. I don't know
    9. I don't want to answer this question

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Appendix A

DO NOT WRITE YOUR NAME ON THIS PAPER.

39. Where did you stay last night? (Circle one answer.)

    1. House
    2. Apartment
    3. Shelter
    4. Other (Where?) _____

40. Where do you live? (Circle one answer.)

    1. House
    2. Apartment
    3. Shelter
    4. Other (Where?) _____

41. Who are the people you live with? Circle all that apply.

    1. Mother   6. Mother's boyfriend or partner   11. Younger brother (s)
    2. Father   7. Mother's girlfriend or partner   12. Older brother (s)
    3. Step-Mother   8. Father's boyfriend or partner   13. Younger sister(s)
    4. Step-Father   9. Father's girlfriend or partner   14. Older sister(s)
    5. Grandmother   10. Grandfather   15. Other (Who?) _____

42. What is your favorite family activity? _____

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Appendix A

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This measure was created and produced by
Jeffrey L. Edleson and numerous student colleagues.
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Minnesota Center Against Violence and Abuse
School of Social Work
University of Minnesota
1404 Gortner Avenue
St. Paul, MN 55108-6142
mincava@umn.edu
Tel: 612-624-0721
Fax: 612-625-4288

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Appendix B

PROACTIVE RESOLUTIONS
Building Respectful Workplaces

Risk Factors Included in the
Spousal Assault Risk Assessment Guide (SARA)

Criminal History

1. Past assault of family members
2. Past assault of strangers or acquaintances
3. Past violation of conditional release or community supervision

Psychosocial Adjustment

4. Recent relationship problems
5. Recent employment problems
6. Victim of and/or witness to family violence as a child or adolescent
7. Recent substance abuse/dependence
8. Recent suicidal or homicidal ideation/intent
9. Recent psychotic and/or manic symptoms
10. Personality disorder with anger, impulsivity, or behavioral instability

Spousal Assault History

11. Past physical assault
12. Past sexual assault/sexual jealousy
13. Past use of weapons and/or credible threats of death
14. Recent escalation in frequency or severity of assault
15. Past violation of "no contact" orders
16. Extreme minimization or denial of spousal assault history
17. Attitudes that support or condone spousal assault

Alleged (Current, Most Recent) Offence

18. Severe and/or sexual assault
19. Use of weapons and/or credible threats of death
20. Violation of "no contact" order

For a rationale for and definitions of risk factors, see the *SARA* manual:

Kropp, P. R., Hart, S. D., Webster, C. D., & Eaves, D. (1995). *Manual for the Spousal Assault Risk Assessment Guide* (2nd edition). Vancouver, Canada: ProActive ReSolutions.

Standardized, Evidence-Based and Integrated Programs to Build Respectful Workplaces
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ODARA Item Summary

Do not use without the full scoring criteria as provided in the manual, Hilton, N.Z., Harris, G.T., & Rice, M.E. (2010). *Risk assessment for domestically violent men: Tools for criminal justice, offender intervention, and victim services*. Washington, DC: American Psychological Association.

Name:
Case #:
Date:

Score each item:
1 if present
0 if not present
? if missing

____ 1. Prior domestic incident of assault in a police or criminal record

____ 2. Prior non-domestic incident of assault in a police or criminal recor

____ 3. Prior custodial sentence of 30 days or more

____ 4. Failure on prior conditional release

____ 5. Threat to harm or kill at the index assault

____ 6. Confinement of the victim at the index assault

____ 7. Victim concern about future assaults

____ 8. More than one child

____ 9. Victim's biological child from a previous partner

____ 10. Prior violent incident against a non-domestic victim

____ 11. Two or more indicators of substance abuse

____ 12. Assault on the index victim when she was pregnant

____ 13. Barriers to victim support

____ Raw Score (sum of items scored 1)

____ Final score (see prorating table as needed; refer to actuarial table for interpretation)

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500 Church Street, Penetanguishene ON L9M 1G3
(705) 549-3181 ext. 2610

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Appendix D

California Family Risk Assessment

CALIFORNIA
FAMILY RISK ASSESSMENT

c: 06/02

Referral Name: _____   Referral #: _____   County: _____

County Name: _____   Worker Name: _____   Worker ID#: _____

NEGLECT		Score
N1.	Current Complaint is for Neglect	
	a. No 0	
	b. Yes 1	_____
N2.	Prior Investigations (assign highest score that applies)	
	a. None 0	
	b. One or more, _abuse_ only 1	
	c. One or two for _neglect_ 2	
	d. Three or more for neglect 3	_____
N3.	Household has Previously Received CPS (voluntary/court-order)	
	a. No 0	
	b. Yes 1	_____
N4.	Number of Children Involved in the CA/N Incident	
	a. One, two, or three 0	
	b. Four or more 1	_____
N5.	Age of Youngest Child in the Home	
	a. Two or older 0	
	b. Under two 1	_____
N6.	Primary Caretaker Provides Physical Care Inconsistent with Child Needs	
	a. No 0	
	b. Yes 1	_____
N7.	Primary Caretaker has a Past or Current Mental Health Problem	
	a. No 0	
	b. Yes 1	_____
N8.	Primary Caretaker has Historic or Current Alcohol or Drug Problem. (Check applicable items and add for score)	
	a. Not applicable 0	
	b. ____ Alcohol (current or historic) ... 1	
	c. ____ Drug (current or historic) 1	_____
N9.	Characteristics of Children in Household (Check applicable items and add for score)	
	a. Not applicable 0	
	b. ____ Medically fragile/failure to thrive ... 1	
	c. ____ Developmental or physical disability ... 1	
	d. ____ Positive toxicology screen at birth ... 1	_____
N10.	Housing (check applicable items and add for score)	
	a. Not applicable 0	
	b. ____ Current housing is physically unsafe ... 1	
	c. ____ Homeless at time of investigation ... 2	_____

ABUSE		Score
A1.	Current Complaint is for Abuse	
	a. No 0	
	b. Yes 1	_____
A2.	Number of Prior Abuse Investigations/Assessments	
	a. None 0	
	b. One 1	
	c. Two or more 2	
	(actual number: _____)	_____
A3.	Household has Previously Received CPS (voluntary/court-ordered)	
	a. No 0	
	b. Yes 1	_____
A4.	Prior Injury to a Child Resulting from CA/N	
	a. No 0	
	b. Yes 1	_____
A5.	Primary Caretaker's Assessment of Incident (check applicable items and add for score)	
	a. Not applicable 0	
	b. ____ Blames child 1	
	c. ____ Justifies maltreatment of a child ... 2	_____
A6.	Domestic Violence in the Household in the Past Year	
	a. No 0	
	b. Yes 2	_____
A7.	Primary Caretaker Characteristics (check applicable items and add for score)	
	a. Not applicable 0	
	b. ____ Provides insufficient emotional/psychological support 1	
	c. ____ Employs excessive/inappropriate discipline ... 1	
	d. ____ Domineering caretaker(s) 1	_____
A8.	Primary Caretaker has a History of Abuse or Neglect as a Child	
	a. No 0	
	b. Yes 1	_____
A9.	Secondary Caretaker has Historic or Current Alcohol or Drug Problem	
	a. No 0	
	b. Yes, alcohol and/or drug (check all applicable) ... 1	
	____ Alcohol ____ Drug	_____
A10.	Characteristics of Children in Household (check appropriate items and add for score)	
	a. Not applicable 0	
	b. ____ Delinquency history 1	
	c. ____ Developmental disability 1	
	d. ____ Mental health/behavioral problem ... 1	_____

TOTAL NEGLECT RISK SCORE _____   **TOTAL ABUSE RISK SCORE** _____

SCORED RISK LEVEL. Assign the family's scored risk level based on the highest score on either the neglect or abuse instrument, using the following chart:

Neglect Score	**Abuse Score**	**Scored Risk Level**
____ 0 – 1	____ 0 – 1	____ Low
____ 2 – 4	____ 2 – 4	____ Moderate
____ 5 – 8	____ 5 – 7	____ High
____ 9 +	____ 8 +	____ Very High

POLICY OVERRIDES. Circle _yes_ if a condition shown below is applicable in this case. If _any_ condition is applicable, override final risk level to _very high_.

Yes No 1. Sexual abuse case AND the perpetrator is likely to have access to the child victim.
Yes No 2. Non-accidental injury to a child under age two.
Yes No 3. Severe non-accidental injury.
Yes No 4. Caretaker(s) action or inaction resulted in death of a child due to abuse or neglect (previous or current).
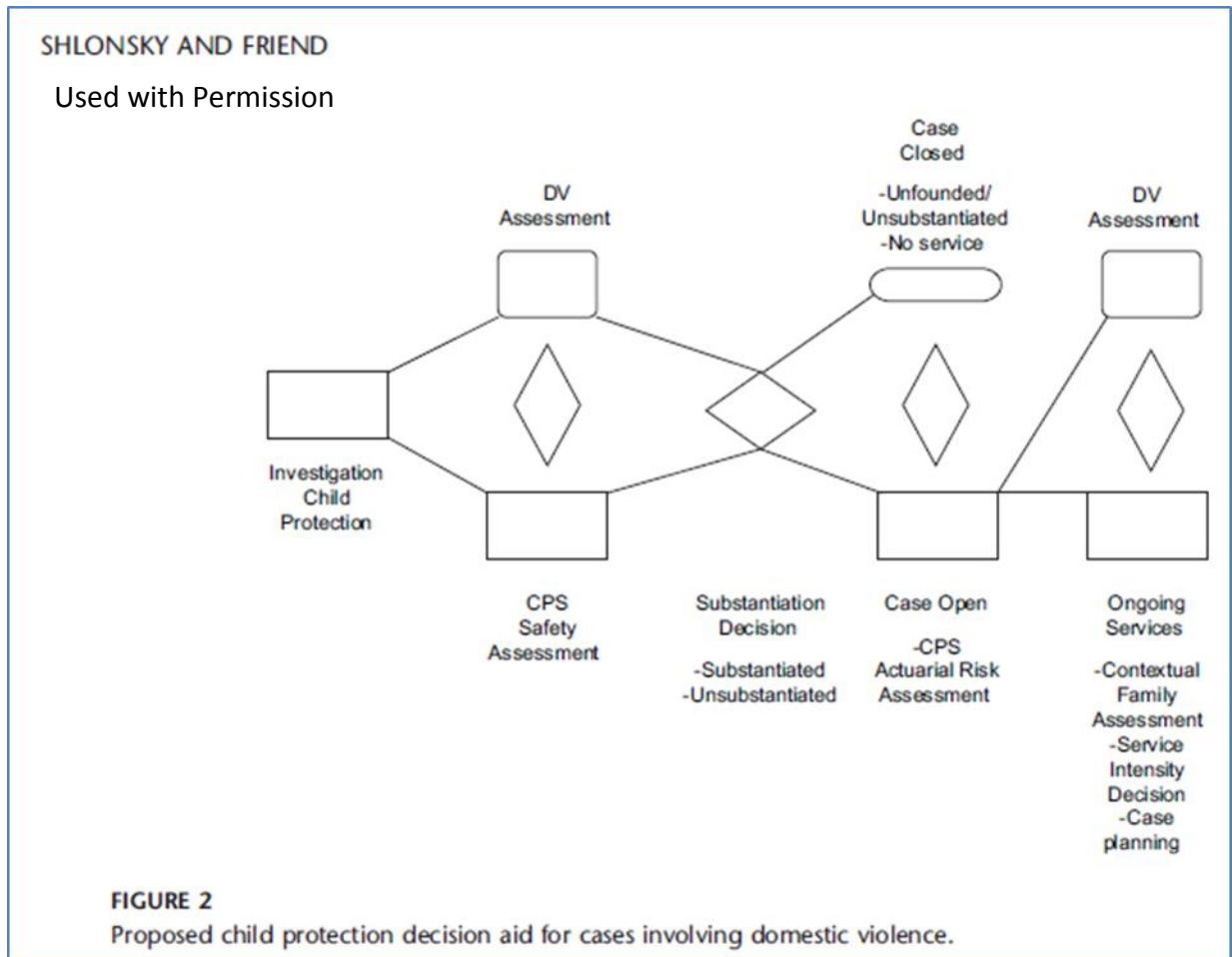
DISCRETIONARY OVERRIDE. If a discretionary override is made, circle yes, circle override risk level, and indicate reason. Risk level may be overridden one level higher.

Yes No 5. If _yes_, override risk level (circle one):   Low   Moderate   High   Very High

Discretionary override reason: _____

Supervisors Review/Approval of Discretionary Override: _____   Date: ____ / ____ / ____

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Appendix E

SHLONSKY AND FRIEND

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FIGURE 2
Proposed child protection decision aid for cases involving domestic violence.

Note: This diagram is taken directly from Shlonsky and Friend (2007) and is used with the authors' permission. Please see their article for more information on how to use this decision aid in the assessment, safety planning and intervention phases of work with families experiencing family violence.