Documented Symptoms in Children Exposed to Domestic Violence

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ABSTRACT

Children who experience trauma due to exposure to domestic violence are at risk of both physical and emotional harm and may exhibit symptoms of trauma that impact their functioning. This raises questions regarding the number of children who do exhibit symptoms and whether child protection workers document these symptoms during the post-investigative stage of service delivery. The present study examines the documentation of child symptoms in a review of 70 files in which children were receiving ongoing child welfare services due to exposure to domestic violence. The results of the file review indicate that children who have been exposed to domestic violence continue to exhibit symptoms during the post-investigative stage. However, there were very few cases in which the child protection worker attributed these symptoms to the trauma the child experienced. Practice implications, including the need for increased training for both trauma and assessment, are discussed.

RESUMÉ

L'exposition des enfants à la violence conjugale constitue une forme de mauvais traitement psychologique, dont certaines manifestations sont reconnues dans les typologies de la maltraitance physique et émotionnel. De plus, ces mêmes enfants évoluent dans un climat violent qui leur occasionne des symptômes reliés au trauma ayant un impact sur leur fonctionnement. Nous nous sommes intéressés à savoir si l'intervenant qui mène une évaluation en protection de la jeunesse tient compte de ces symptômes à la conclusion de son enquête et fait le lien au trauma. Cette recherche dépouille au-delà de 70 dossiers d'enfants exposés à la violence conjugale et passe en revue la documentation des intervenants cherchant spécifiquement la notation des symptômes et le trauma. La recherche conclut en soulignant d'abord que le trauma persiste chez les enfants suivant une exposition à la violence conjugale et qu'il s'avère souvent difficile pour l'intervenant de reconnaître le lien entre les symptômes manifestés et le trauma. Des pistes d'intervention, incluant la nécessité d'une formation plus approfondie au niveau de l'impact du trauma et de l'évaluation sont également discutées.

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1. INTRODUCTION

Child welfare workers in Ontario are legally mandated by the Child and Family Services Act (CFSA, 2000) to provide services to children who have experienced some form of trauma (i.e., abuse, neglect, including exposure to domestic violence). Child protection services are provided to children exposed to domestic violence under clause 37(2), sub clauses (a) to (g.1), Child Exposure to Partner Violence.

1.1 Population

An increasing number of children receive child protective services due to their exposure to domestic violence. The literature describes the impact of domestic violence as a traumatic experience for children and outlines the many risks for those exposed to domestic violence, in terms of emotional harm, developmental impacts and risk of physical harm when caught in the cross-fire of adult relationships (Gurwitch, Sullivan & Long, 1998; Gunnar, 1998; Hughes, 1997;Ko et al., 2008; Lynch & Cicchetti, 1998; McNally, 1991; Pepler, Catallo, & Moore, 2000; Perry, 2006; Perry & Pollard, 1995, 1998; Rossman & Ho, 2000; Stien & Kendall, 2004; Stover & Berkowitz, 2005).

In addition, the literature suggests that the services typically provided by child protection agencies may place greater emphasis on the situation and needs of the adult victim than the experience and needs of the child victims (Davies & Krane, 2006, 2007; Echlin & Osthoff, 2000; Johnson, 2008; Nixon & Tutty, 2007; Postmus & Ortega, 2005).

The number of children who are receiving child protective services due to domestic violence and who display symptoms, including symptoms related to trauma, is not known. This is significant for the field of child welfare as child protection agencies

need to ensure that the services being provided meet the needs of those they are mandated to protect.

1.1.1 Epidemiology

From 1998 to 2003 the number of child welfare investigations in Canada, initiated due to the child's exposure to domestic violence, more than doubled (Canadian Incidence Study, 1998, 2003). In 1998, there were 21,132 child welfare investigations in Canada where the reported maltreatment stemmed from the child's exposure to domestic violence (Canadian Incidence Study, 1998, p. 39). Of these, 13,232 or 63% were substantiated and 5,612 or 26% were suspected, meaning that children in 18,844 files received child protection services due to domestic violence.

In 2003 there were 49,995 child welfare investigations in Canada where the reported maltreatment stemmed from the child's exposure to domestic violence (Canadian Incidence Study, 2003, p. 45). Of these, 35,116 or 70% were substantiated and 6,655 or 13% were suspected, resulting in child protection services being provided on 41,771 files. This represents a 45% increase in child protection files opened due to domestic violence during the five-year period spanned by the 1998 and 2003 Canadian Incidence Studies.

The findings of the 2003 Canadian Incidence Study demonstrated that 21% of children exposed to domestic violence exhibited physical, emotional or cognitive health issues at the time of the investigation (as per the child functioning characteristics utilized in the study) (Canadian Incidence Study, 2003, p. 68). However, it is also noted that 'although a child exposed repeatedly to spousal assault may not show symptoms of emotional harm at the time of the investigation, the long-term traumatic nature of such

situations is well-documented' (Canadian Incidence Study, 2003, p. 46). The number of domestic violence files in which child symptoms become apparent and are documented during the subsequent post-investigative phase of child protection service delivery is not known.

The purpose of this study is to gain further understanding about children receiving child protective services due to exposure to domestic violence. Specifically, the study will consider:

1. How many children receiving child protection services due to exposure to domestic violence exhibit symptoms in the period of service delivery following the initial investigation, i.e., on-going services?
2. What kind of symptoms do child welfare social workers document?
3. Is there a relationship between the type of exposure to domestic violence (single incident vs. multiple incidents) and

   (a) the number of child symptoms documented by child welfare social workers?

   (b) the type of child symptoms documented by child welfare social workers?

   (c) the child's age?

   (d) the child's gender?
4. Are the child's symptoms reflected in the goals and objectives identified in the family's Service Plan?

It is hoped that the study will facilitate an increased understanding of the impact of trauma on the child's subsequent functioning, and whether this impact is reflected in documentation completed by child welfare professionals providing protective services due to exposure to domestic violence.

Chapters 2, 3, 4 and 5 will outline the literature review, methodology, findings and discussion respectively. Chapter 6 will provide a conclusion to the study.

2. LITERATURE REVIEW

2.1 Theoretical Perspectives

The following three theories provide a theoretical foundation for the analysis of information gathered by child protection workers regarding a child's safety, security and development within ever-widening circles of caregiver and family relationships. Beginning with the interaction between a newborn and the primary caregiver, these theories allow the child protection worker to consider the impact of the overall physical and mental health of caregivers, including the health of their relationship and any external forces impacting the family, when assessing the child's developmental progress. It should be noted that, as the child ages and begins to interact in a variety of environments, the scope of information-gathering and assessment within the ecological framework would expand accordingly.

2.1.1. Regulation Theory

Regulation theory operates within the mother-infant dyad in the microsystem of the nuclear family. The central premise of Schore's (2003) theory is that development is actually the child's increasing capacity, over time, to self-regulate. Self-regulation is the 'convergence point between psychology and neuroscience' (Schore, 2003, p. 5) in that the adaptive or maladaptive development of the child's brain during early years may have a significant impact on later psychological health and functioning.

The second major concept of this theory is that the immature, developing brain of the infant is shaped and regulated by the adult brain of the primary caregiver (mother) within the context of the parent-child relationship. The mother's brain forms the template for the organization and wiring of the infant brain's response to its environment (Schore,

2003). This is accomplished through the reciprocal and mutual transfer of affect between the infant and mother during nurturing or caregiving activities, in response to both positive and negative (ie: stressful) situations for the infant.

The child's increasing capacity for self-regulation facilitates the possibility of engaging in new and more complex interactions with his environment, thereby continuing the process of stimulation and brain development.

Mary Gordon succinctly summarizes the essence of regulation theory:

> "I like to state the scientific reality behind parenting…in three words: *love grows brains*. The three requirements for optimal brain development are good nutrition, good nurturance and good stimulation. A newborn's brain has billions of neurons, but the pathways connecting those neurons are largely undeveloped. It is the experiences the baby has in the first months and years that will 'wire' the brain and prepare him for future learnings. It is vital that the baby's needs are met in the context of a healthy and loving parent-child relationship." (Gordon, 2005, p. 18).

Regulation theory is significant to the field of child welfare when assessing the development and needs of very young children. While attachment behaviours may become overt in the child at approximately eight months of age, regulation theory supports the supposition that the covert relationship foundations have been in place within the parent-child relationship since birth. Therefore, it is important for child welfare workers to consider the parent's mental health as it is central to the regulation of the infant's brain. For example, unresolved trauma in the primary caregiver may impact their ability to effectively and consistently respond to the infant's needs, thereby impacting self-regulation and ultimately attachment style (Benoit, 2000; Cozolino, 2006; Levy & Orlans, 1998)

In addition, an accurate evaluation of the parent's capacity to accurately read and respond to the child's cues is essential as this, in turn, impacts the infant's physiological state and affect regulation. Any situation that may impact the parent's ability to be emotionally available and responsive to the infant, i.e., substance abuse, inter-partner violence, must also be addressed. Therefore, in situations of domestic violence, one wonders how exposure to domestic violence informs the behaviour of children who witness this violence.

2.1.2 Attachment Theory

Attachment theory operates primarily within the microsystem of the nuclear family. It initially involves the mother-infant dyad and gradually expands to include the biological father or mother's partner, as well as other significant caregivers. This developmental theory allows the child's development to be viewed within the context of the specific attachment relationship developed between the infant and his primary caregiver (usually described as the mother). The initial work of John Bowlby identified this relationship as being as crucial to the infant for survival as the meeting of biological needs (Benoit, 2000; Waters & Cummings, 2000). The attachment relationship, one facet of the parent-child relationship, is an unequal relationship between the adult and the child, with the adult providing safety and protection to the vulnerable child. This relationship is initiated by the child and develops when the attachment system is activated, occurring when the child is in distress (emotional distress, physical pain, or illness) and demonstrates attachment behaviours (i.e., any behaviours in which the child seeks proximity to the caregiver, plus any other behaviours, such as crying, that may

elicit caregiving responses). How the parent consistently responds to the child when the attachment system is activated will determine the predominant attachment style of the child to that particular caregiver. The child can develop different attachment styles to different caregivers and, in some situations, this can be a protective factor (Benoit, 2000; Levy & Orlans, 1998).

The overt attachment behaviours that become evident at approximately eight months of age, reflect "…the operating characteristics of an underlying control system that collates information about the infant's state, the state of the environment, and past and current access to the caregiver…" (Watters & Cummings, 2000, p. 165). In other words, these behaviours provide insight regarding the child's experience to date, with regard to parental abilities, the parent's capacity to consistently respond to the child's emotional and physical needs, the family environment and, subsequently, the child's capacity to explore and respond to his environment, thereby maximizing development (i.e., the degree to which he is able to utilize the primary caregiver as a secure base).

Three initial attachment styles were outlined through the work of Mary Ainsworth (Benoit, 2000; Levy & Orlans (1998).

Secure: In this attachment style, the caregiver is able to accurately read the infant's cues and is able to respond consistently, promptly and sensitively in the majority of situations. This allows the child to effectively utilize the caregiver as a secure base from which to explore his environment and facilitate development.

Anxious-Insecure: In this attachment style, the caregiver has difficulty reading the infant's cues and is generally unavailable (either physically or emotionally) to respond promptly or accurately. "An infant who experiences his or her caregiver as consistently

responding in rejecting ways learns to avoid the caregiver in times of need." (Benoit, 2000, p. 15).

Avoidant-Insecure: In this attachment style, the caregiver is unpredictable in their response to the child due to: difficulty in accurately reading cues, unrealistic expectations of the infant, or placing their needs ahead of those of the child. "These infants' behaviour toward their caregiver at times when their attachment system is activated, suggests that they are unsure as to whether and how the caregiver will respond." (Benoit, 2000, p.15).

A fourth attachment style has been identified through the contributions of Main & Solomon (Levy & Orlans, 1998).

Disorganized: In this attachment mode, the responses of the primary caregiver are so inconsistent and unpredictable that the child also interacts with his caregiver inconsistently, moving between all attachment styles. This results in disorganized behaviour that appears bizarre and often contradictory when observed in the child. Children with this attachment style exhibit behaviours indicative of both high anxiety and avoidance of the caregiver, and have difficulty controlling their emotional and behavioural responses.

Attachment theory is significant to the field of child welfare as it contains descriptors that are widely used by professionals working with families and children. While child protection workers cannot diagnose attachment disorders, the descriptors commonly used within the theory allow child protection workers to document concrete observations describing the attachment relationships within the parent-child relationships. This assists with service delivery in terms of identifying strengths as well as areas where support would be beneficial. As attachment behaviours begin to be observed at

approximately eight months of age, this theoretical framework may facilitate early intervention when necessary.

The terminology associated with attachment theory has also become known within the court system and use of attachment descriptors assists the judiciary in discerning key dynamics within the parent-child relationships.

2.1.3. Ecological Theory

The global environment of the child needs to be considered when applying an ecological framework to evaluate child development. In an ecological framework, development is defined as '…the person's evolving conception of his ecological environment and his relation to it, as well as his grown capacity to discover, sustain…' (Bronfenbrenner, 1979, p. 9). The significant difference between an ecological approach, as compared to traditional psycho-social approaches, is that the emphasis is placed on the *content* of what the child experiences through their environment (i.e.: what is perceived by the child and how does he/she interpret the experience?). From an ecological perspective, what matters most for development is how the child perceives his environment rather than objective reality. While Bronfenbrenner (1979) acknowledges the crucial part played by biological forces (genetics) in child development, an ecological framework considers the interaction of both biological and social forces.

Within an ecological framework, the child's environment is analyzed in systems. At the centre of the environment is the microsystem of the nuclear family. In the early years of the child's life, this system would be the primary system utilized in order to

analyze and assess information gathered pertaining to both biological and social aspects of family functioning.

Within this framework, the individual relationships between the child, his parents and any siblings would be considered, as well as the inter-relatedness of the members of the nuclear family microsystem. The smallest, most innermost system for the infant, within this microsystem, is the relationship with his primary caregiver – a two person system, or a dyad. This dyad (often discussed as being the mother and infant) facilitates development via reciprocal relations – the interactions between the child and his environment (with the parent-child relationship being at the centre of that environment).

The capacity of this dyad to effectively facilitate healthy development is crucially dependent on the presence and participation of third parties. If the third party (biological parent or other partner) is absent or disruptive, then the developmental process within the initial dyad is inconsistent or breaks down (for example, situations where domestic violence is present within the family environment). In situations of domestic violence, the parent within the infant's dyad, usually the mother, may be unable to maintain focus on the child in order to effectively read his cues and facilitate his emotional and physical well-being.

As the child ages, the systems considered in assessment would also expand to include relationships in the extended family, at daycare or school, etc. The child's global environment also includes the exosystems that may also impact him and/or his environment via his parent's participation in them. These include areas such as his parents' socio-economic status, involvement in criminal activity or substance use, etc.

This theoretical framework is pertinent for the field of child welfare as it facilitates the gathering of information related to the child's development across several dimensions and, in addition, allows risk factors to be evaluated within those same areas. At the centre is the child himself, with his genetic background, personality, current health status and level of functioning. Next, the social worker is able to view the child's development within the context of his relationship with his primary caregivers to determine the effectiveness of those relationships in meeting the child's emotional and physical needs, stimulating his development and ensuring his safety. The child's development is further observed within the nuclear family (taking into consideration adult relationships, parental mental or physical health issues, parental substance use, sibling dynamics/issues, etc.). Finally, any impact on the child's development from exosystems outside the immediate family environment is also taken into consideration (housing, parental employment, parent's social network, criminal involvement, etc).

2.2 Impact of Exposure to Domestic Violence on Child Development

Every child is unique and each child experiences trauma in his/her own way. Working through trauma and loss is different for every child and is often dependant on their age, stage of development, their innate strengths and the resources available to them. As children cannot always use words to express their feelings, they often express reactions to trauma through their behaviours and other emotional responses. Given that child protection professionals provide service to a traumatized clientele, an awareness of the types of behavioural and/or emotional responses that may be exhibited by children

who have experienced trauma, including exposure to domestic violence, is pertinent to their work.

2.2.1 Observable Impacts

Trauma can have a pervasive impact on a child's developmental progress and level of function. The extent to which the child is impacted can depend on the child's age and developmental stage and the frequency with which the trauma occurred (i.e.: single event versus chronic events) (Gurwitch, Sullivan & Long, 1998; Herman, 1997; Kerig, 2000; Perry, 2006). The literature attributes some observable symptoms exhibited by children to the impact of trauma and categorizes these as externalizing or internalizing behaviours.

Some externalizing behaviours include hyperactivity, acting out, temper tantrums, impulsivity, increased aggression; conflict with siblings or peers, bullying, cruelty to animals, regression and/or loss of previously acquired skills (language skills, feeding, dressing, toileting, etc). (McNally, 1991; Pepler, Catallo & Moore, 2000; Perry, 1995; Perry, Pollard et al., 1995; Rossman & Ho, 2000). In school age children, including adolescents, difficulties with peer and family relationships, academic performance, depressive symptoms, as well as engaging in high-risk behaviours and/or juvenile delinquency can become apparent (Hughes, 1997; Ko et al., 2008; Lynch & Cicchetti, 1998; Wright, 1999).

Internalizing behaviours can include nightmares and other sleep disturbances, somatic complaints (e.g., headaches, stomach aches) as well as fear of separation, attention difficulties or difficulty concentrating, social withdrawal, anxiety, depression, or

other mood problems (Gurwitch, Sullivan & Long, 1998; Hughes, 1997; Pepler, Catallo & Moore, 2000; Perry, Pollard, et al., 1998; Rossman & Ho, 2000). There can be overlap between externalizing and internalizing behaviours, as well as between environments (i.e.: family, school, etc). For example, difficulties with attention or concentration (non-observable) can factor into difficulties in academic performance (observable).

In some children, the behaviours noted above may be seen as criteria for a diagnosis of Post Traumatic Stress Disorder (PTSD) as criteria specific to children have been included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) since the mid-1990's (Gurwitch, Sullivan & Long, 1998). The symptoms of PTSD can be organized into three categories: re-experiencing (the traumatic event), avoidance and numbing, and increased arousal. There are many PTSD criteria which are similar for children and adults (i.e.: distressing dreams, difficulty sleeping, irritability/anger, difficulty concentrating, hypervigilence) (Kerig, et al., 2000, p. 165-169). However, what is unique for children is the age-specific repetitive play with which they relive the traumatic experience (Gurwitch, Sullivan & Long, 1998; Herman, 1997; Kerig et al., 2000; McNally, 1991; Stien & Kendall, 2004).

2.2.2 Non-Observable Impacts

2.2.2.1 Basic Aspects of Post-Natal Neurological Development

The human brain has evolved over millions of years to promote survival of the human species (Ontario Early Years, 1999; Perry, 1995, 2006; Perry, Pollard et al., 1998; Society for Neuroscience, 2005; Stien & Kendall, 2004). The structure of the brain develops sequentially, from least complex to most complex, mirroring the evolutionary

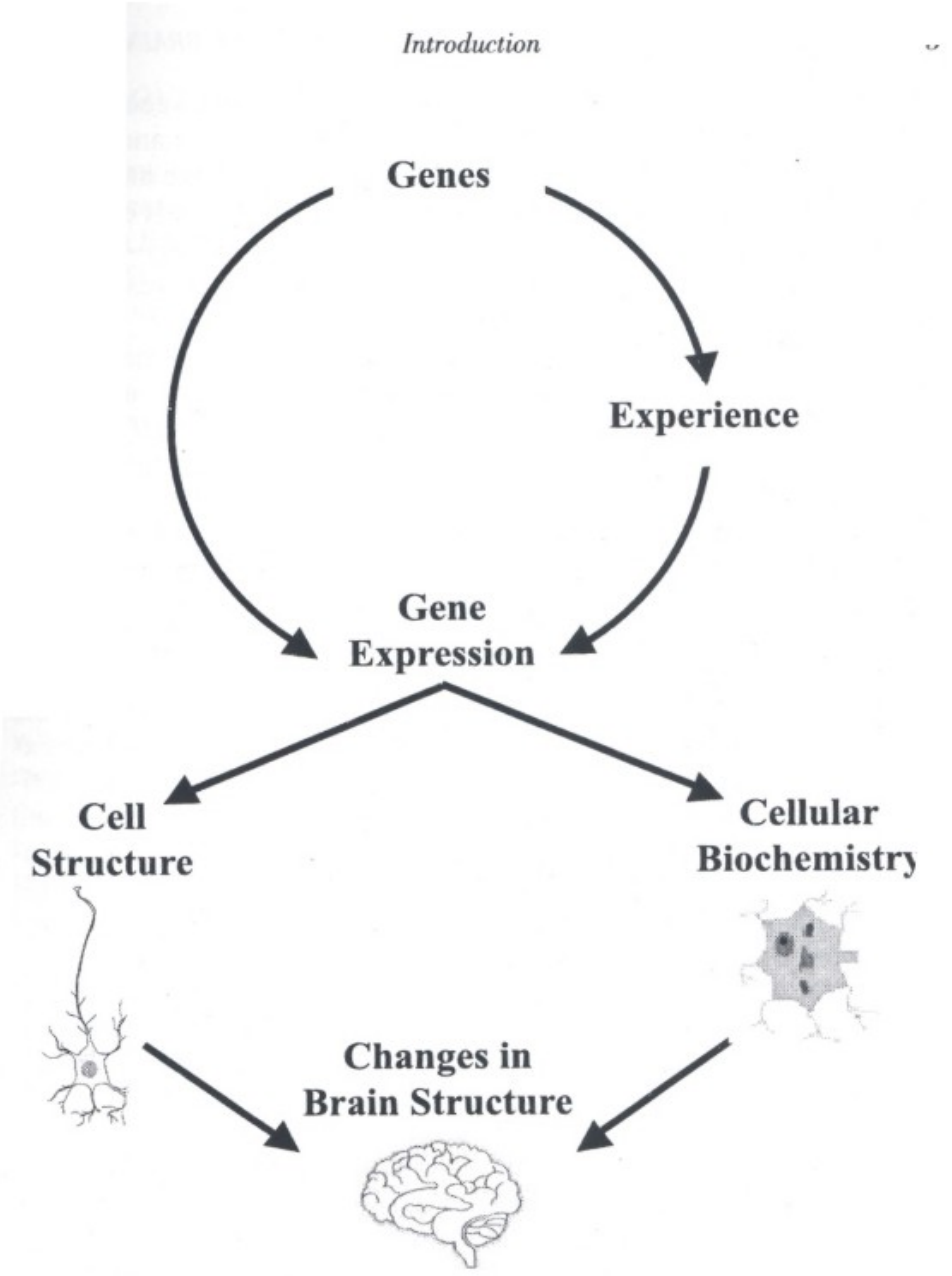
development of the human species (Perry, 2006, 2007; Society for Neuroscience, 2005; Stein & Kendall, 2004). The brain's functions are organized in a hierarchical fashion, with the least complex functions occurring in the brain stem and the most complex functions occurring in the neocortex areas.

At birth, the infant's brain is not yet fully developed. The average brain weight at birth is 350 grams. By 12 months, the average brain weight has increased to 1000 grams and is very close to the adult average of 1200 to 1400 grams. "A PET scan of a healthy newborn shows no activity in the prefrontal cortex and minimal activity in the sensory and motor areas of the cortex. In contrast, lower centers of the brain…are very active as is the brain stem" (Stien & Kendall, 2004, p. 43). Seventy percent of brain development occurs post-natally (Cozolino, 2006; Perry, 1995, 2006; Schore, 2003). This continued development is significant for the field of child welfare as post-natal child development lies within its mandate.

There are two important aspects of early brain development significant to the field of child welfare. One is the fact that some aspects of brain development are '*use-dependant*' (Ontario Early Years, 1999; Perry 1995; Perry, Pollard et al., 1998; Society for Neuroscience, 2005; Stien & Kendall, 2004). One third to one half of the 30,000 genes impact the development and regulation of the nervous system (Stien & Kendall, 2004). Of these, half depend on stimulation from the environment to be fully activated (see Figure 1).

Figure 1

Gene Transcription



Two Pathways to Neurobiology. Some genes activate without any influence from the environment. However, many of the genes that are dedicated to the development and regulation of the nervous system depend on environmental stimulation to be activated.

(Stien & Kendall, 2004, p. 5)

Specialized genes control the experience-dependent aspects of brain development by allowing the brain to be shaped and re-shaped by learning (experiences and/or interaction with the environment) (Child Trauma Academy, 2006; Cozolino, 2006; Ontario Early Years Study, 1999; Perry, 1995, 2006; Society for Neuroscience, 2005; Stein & Kendall, 2004).

The second aspect of brain development that is important for child welfare is *brain plasticity*. This is the brain's capacity to develop in an adaptive or maladaptive manner in response to the infant's interaction with the environment. Because a young child's brain is rapidly developing, it is more malleable than an adult brain. (Ontario Early Years, 1999; Perry, 1995, 2006; Stien & Kendall, 2004). The concept of brain plasticity is significant for the field of child welfare in that child protection workers need to be aware of all aspects of the child's environment, especially for very young children who are vulnerable and less likely to exhibit observable symptoms.

2.2.2.2 Impact of Trauma on Neurological Development

Trauma can have a negative impact on brain functioning for both adults and children. In adults, trauma impacts a brain that is already organized and developed. Trauma is an experience and in children it may shape the development of a child's malleable brain via the child's physiological responses to the traumatic stress (Gunnar, 1998; Perry, 2006; Perry, Pollard et al., 1995; Society for Neuroscience, 2005; Stien & Kendall, 2004).

The human organism has limited options in terms of responses to perceived or real threat experienced in situations of trauma:

Hyperarousal Continuum ('fight or flight'): When children experience negative stressful events (physical or psychological), the brain perceives a threat to the organism and the 'fight or flight' stress response is activated. This involves increased levels of hormonal secretions, with the two major stress hormones being adrenalin and cortisol. In chronic situations, repeatedly excessive levels of hormones can negatively impact brain activity and structure. "In response to a violent and chaotic environment, [the child] is likely to develop an overactive stress response and an under-developed cortex." (Stien & Kendall, 2004, p. 10).

In addition, chronically high levels of cortisol can negatively impact different regions of the brain. (Gunnar, 1998; Perry, 1995, 1998; Stien & Kendall, 2004) The areas involved in learning and memory, concentration and attention, as well as the area that processes negative events undergo considerable development in the first year of life. Repeatedly high levels of cortisol can lower the threshold for activation of the stress response.

> "Children exposed to significant threat will 'reset' their baseline state of arousal, such that even at baseline – when no external threats…are present – they will be in a physiological state of persisting alarm" (Perry, 2006, p. 32).

Dissociative Continuum ('freezing'): Children, particularly young children or infants, often cannot fight or flee in response to threat. Although they may initially cry to elicit caregiver assistance, children experiencing trauma in their relationship with their primary caregiver, may not receive help if they cry – they may experience increased stress. The child may simply freeze and ultimately dissociate (Gunnar, 1998; Perry, Pollard et al., 1995; Society for Neuroscience, 2005; Stien & Kendall, 2004). If the child is repeatedly in an unnecessary state of alarm, due to chronic stress or traumatic events, it is difficult

for them to be cognitively and emotionally available to process the 'normal' experiences of life required for adaptive development.

In the field of child welfare, the client is the child who, in many instances, has experienced trauma. Thus, child welfare professionals to be aware of current research that may expand their knowledge regarding the impact of trauma on children, as well as the behavioural symptoms related to trauma. This is pertinent to their work when conducting psychosocial assessments, in order to provide effective service.

2.3 Comparable Research

2.3.1 Canadian Incidence Study (2003)

The findings of the 2003 Canadian Incidence Study appear to corroborate the information obtained in the literature review, suggesting that child development can be negatively impacted by the trauma of abuse and neglect, including exposure to domestic violence. Investigations where exposure to domestic violence was the primary category of child maltreatment accounted for 25% (29,370) of all substantiated investigations. At the time of the investigation, emotional harm was identified in 14% of cases where children were exposed to domestic violence, with 9% serious enough to require treatment. In addition, results pertaining to child functioning indicated that children exposed to domestic violence experienced depression or anxiety (13%), learning disabilities (6%), developmental delays (4%), ADD/ADHD (6%), violence towards others (4%) and other uncategorized emotional or behavioural problems (17%). Overall, in 21% (6,036) of substantiated investigations, children exposed to domestic violence experienced physical, emotional or cognitive health issues, while in 22% (6,502) of

substantiated investigations children experienced behavioural issues. In total, children experienced challenges in functioning in almost one third of substantiated investigations (32% or 9,325 investigations). The children in these investigations were fairly evenly divided between gender groups (52% males, 48% females) and the gender groups were evenly divided throughout age groups, except in the 4 to 7 year-old group where 55% were male and 45% were female.

Among substantiated investigations related to a single incident of exposure to domestic violence, 33% of children experienced challenges related to function, whereas among substantiated investigations related to multiple incidents of exposure to domestic violence, 52% of children experienced challenges related to function (Trocmé, et al., 2005, p. 50 - 51).

The findings noted above are cross-sectional data and can only infer that these symptoms are present in children who have been exposed to domestic violence, as there may be other variables in the child's experience that contribute to the child's level of function. That is, no causal linear relationship can be determined by this data.

2.3.2 Other Comparable Research

A search on the PsychInfo and Social Work Abstracts databases identified literature that discussed the specific impacts of domestic violence on child functioning. While the difficulties identified for children who have been exposed to domestic violence are similar to the impacts of trauma noted above (Herrenkohl et al., 2008; Holt et al., 2008) some important considerations in terms of service issues, are made:

a) Varied opinions exist regarding the impact of what the child actually witnesses (i.e., observing physical violence, hearing verbal violence, or witnessing aftermath such as bruising). It is suggested that the severity of the violence appears to influence the child's response to trauma (Holt et al., 2008). Therefore, depending on the child's verbal ability, documenting an accurate account of what the child experienced is pertinent to fully understanding the child's presentation and level of function.

b) The end of the intimate relationship does not necessarily mean the end of the violence "…post-separation contact is potentially an abusive experience for children…" (Holt et al., 2008, p. 800) as children can be exposed to verbal negativity towards the mother, verbal threats, or abduction. This dynamic needs to be considered by both child welfare service providers and the judiciary when determining access between perpetrators and their children.

c) The preschool age group may have a greater exposure to domestic violence as they are young, dependent and likely to spend more time in the home (as opposed to older school-aged children) (Holt et al., 2008). Preschool children who have been exposed to domestic violence may exhibit a disorganized attachment style, as mother is both a "..source of comfort and fear for the child." (Holt et al., 2008, p.802). Knowledge of attachment theory and how disorganized attachment is manifested behaviourally is pertinent to the child welfare professional in terms of the assessment process.

d) Particular impacts are also noted for adolescents (Herrenkohl et al., 2008; Holt et al., 2008) such as difficulty in intimate relationships due to inadequate role models, emotional distress due to inappropriate expectations to care for younger siblings (i.e., parentification, school difficulties, pregnancies at a young age, delinquency, and

substance abuse). Child welfare professionals providing service to older children need to be aware of these potential responses to exposure to domestic violence so that appropriate treatment or services can be provided.

These behavioural symptoms could be used when documenting the impact of trauma, secondary to the exposure to domestic violence, in a child welfare context.

2.4 Child Welfare Intervention in Domestic Violence Files

2.4.1 Historical Service Delivery

Tension has traditionally existed between the child welfare and Violence Against Women (VAW) sectors (Davies & Krane, 2006, 2007; Devaney, 2008; Echlin & Osthoff, 2000; Johnson, 2008; Nixon & Tutty et al., 2007; Postmus & Ortega, 2005). There are two primary underlying reasons for this tension. One is the differing definition of client by each sector. The VAW sector views the woman/mother as the victim of partner abuse, whereas the child welfare sector identifies the child as their client and, when in need of protection, intervenes to ensure the child's safety (Davies & Krane, 2006, 2007; Echlin & Osthoff, 2000; Johnson, 2008; Nixon & Tutty etal, 2007; Postmus & Ortega, 2005). The second relates to the differing intervention philosophies in the two sectors. The services provided by the VAW sector through shelters and counselling services offer safety, support and encouragement to leave the abusive relationship, whereas the child protection intervention may place the onus on the victim (mother) to protect her children and leave the abusive relationship. The mother's perceived 'failure to protect' may result in children being apprehended from the non-offending parent. This has raised concerns that the mother may not disclose the abuse and/or access services due to fear of losing

custody of her children (Davies & Krane, 2006, 2007; Echlin & Osthoff, 2000; Johnson, 2008; Nixon & Tutty et al., 2007; Postmus & Ortega, 2005).

In addition, child welfare interventions in situations of domestic violence have been criticised due to an apparent lack of sensitivity to other factors that impact women following a disclosure of partner abuse, such as:

(a) The violence frequently escalates during the period following the disclosure or abusive incident, placing the woman (and thereby the child) at increased risk (Davies & Krane, 2006, 2007; Echlin & Osthoff, 2000; Johnson, 2008; Nixon & Tutty et al., 2007; Postmus & Ortega, 2005).

(b) The mother may be unable to adequately provide for her child(ren) due to a sudden decrease in financial and other resources, if she leaves the abusive relationship (i.e.: loss of family home, financial resources, social network, etc) (Davies & Krane, 2006, 2007; Echlin & Osthoff, 2000; Johnson, 2008; Nixon & Tutty et al., 2007; Postmus & Ortega, 2005).

(c) Finally, child welfare interventions have been criticised for the perceived revictimization of the mother, rather than placing responsibility and accountability on the offending parent. (Davies & Krane, 2006, 2007; Devaney, 2008; Echlin & Osthoff, 2000; Johnson, 2008; Nixon & Tutty et al., 2007; Postmus & Ortega, 2005). As noted by Devaney (2008),

> "One depressing finding from the study was the very low number of men who were challenged about their behaviour…or who were prosecuted….this raises the issue of whether social workers should be primarily concerned with assessing the risk to children or in assessing the risk that men present" (Devaney, 2008, p. 451).

As research has demonstrated that child abuse and domestic violence frequently co-occur (Button & Payne, 2009; Moles, 2008) continued collaboration between the two sectors is necessary in order to provide services that meet the needs of both the adult and child victims. While there has been increased collaboration between the sectors over recent years, there continue to be service issues within child welfare which, if improved, would benefit overall service delivery. Some issues, as outlined by Mole (2008) are: improved assessment skills, consistent use of attachment theory, expanded training (on the dynamics of domestic violence as well as the impact of trauma), improved clinical supervision for child protection workers, and an improved ability on the part of child welfare professionals to work with the abusive partner including holding them accountable for their actions. As most abusers are not reported to police, they do not come into contact with the judicial system. Therefore, it is imperative that both the child welfare and domestic violence sectors are able to intervene with the abusive partner in order to support the non-abusive parent and maximize safety. This may include offering supports to the non-abusive parent, requiring supervised visitation for the abusive partner, and requiring that the abusive partner leave the family home, rather than the children (Devaney, 2008; Moles, 2008).

In a study conducted by Button and Payne in 2009, the three areas of training identified most frequently by child welfare workers themselves, were: warning signs of extreme violence, that is, "abuser lethality" (p. 366), increased knowledge of the mental health implications of domestic violence and increased ability for effective interaction with abusers.

The study identified that the greatest barriers for the implementation of such training within child welfare agencies were lack of time, distances involved for staff attending training, and lack of staff. As responses for the latter were higher for child welfare respondents in the study (as compared to other social service agencies) this likely relates to the high staff turnover in the field.

2.5 Summary

Information obtained in the literature review outlined the types of behaviours (externalizing, internalizing, as well as Post Traumatic Stress symptoms) that may be evident in children who have been exposed to trauma. The data collected within the Canadian Incidence studies suggests that these symptoms have been noted in children who have been exposed to trauma, including domestic violence, during the investigative stage of child welfare service delivery. However, the degree to which these symptoms were noted by child protection workers on an ongoing basis was not known, nor whether identification of child symptoms and problematic functioning, was addressed in service delivery (i.e., the Plan of Service developed with the family). These queries led to the research questions identified in the present study.

3. METHODOLOGY

3.1 Context

3.1.1 Current Practice Context in Ontario

An overview of the current Ontario child welfare context is provided in order to clarify the methodology of the present study. The field of child welfare in Ontario is experiencing a practice shift as a result of the Provincial government's "transformation" model. The transformed service model is intended to

> "…streamline decision-making in child welfare and to differentiate the protection function of child welfare from that of assisting families in raising their children." (Ministry of Children & Youth Services, 2005, pp. 10).

The intent is to move Ontario child welfare agencies towards a strengths-based practice, requiring increased client engagement. Rather than focus solely on identifying family problems, pathology and attempting to predict risk level, the proposed model will have a more balanced approach, looking at both the family's strengths and areas requiring change, while keeping child safety at the forefront. Assessments will be based on the needs of the child, within the child's environment.

Where domestic violence is the identified protection concern, the revised practice environment would hopefully facilitate the continued central premise of safety and well-being for the child, e.g. determining appropriate services for any symptoms of trauma observed, while allowing the child protection worker to consider the strengths and safety needs of the adult victim.

In Ontario, a child protection agency becomes involved with a child and his family when a referral is made by a service professional (including police services) or other member of the community. The nature and severity of the information received

from the referent will determine the response by the agency, which may include: (a) an investigation (i.e., face-to-face visit with the family and/or child); or (b) a link to relevant community resources (e.g., family counselling); or (c) the report is not investigated (i.e., new factual information is received, refuting the initial allegation). For each referral, the decision of how to proceed is derived from the Eligibility Spectrum (OACAS, 2006). If the agency response is an investigation and the referral allegations are verified, the file typically transfers to Ongoing Services, usually by or before the 60-day service time frame (unless the file can close within the investigative stage).

At the present time, many domestic violence files are managed within the co-located Violence Against Women (VAW) project, which is comprised of child protection workers and counsellors from the VAW sector providing joint service delivery. Protection services provided within the project include both investigative and ongoing services.

3.1.2 Current Recording Environment

Once it is determined that a file will receive on-going child protective services, a central task of the child protection worker is to develop an accurate assessment of the child's developmental progress and functioning, including any contributory factors existing within the family environment.

In 2004, the Differential Response Sub-Committee of Ontario Children's Aid Societies recommended that "…a comprehensive child welfare assessment, which includes a review of critical risk factors, but also includes an environmental and functional assessment of families…" (Differential Response Sub-Committee, 2004, p. 22) be adopted within any revised child welfare practice environment. The Sub-Committee

further stated that such assessments would be "…critical in ensuring the best service response over the long term for a child and family. A good assessment will help identify which services are needed, when and for how long. A clear understanding of outcomes and goals will help identify the activities that need to be completed, and by whom" (Differential Response Sub-Committee, 2004, p. 22). This approach was further supported within the provincial government's 2005 Transformation Agenda, which proposed a standardized strength-based child and family assessment (Ministry of Children & Youth Services, July 2005). While the use of ecological theory in assessing child development and family functioning is supported as a recommended approach to child welfare assessment by both the Ontario Differential Response Sub-Committee report (2004) and the provincial Transformation Agenda (2005), no specific theoretical framework has been identified.

If the family continues to receive services in the post-investigative stage, the recording requirements include a review of the Safety Plan initiated during the investigation, as well as the completion of the Family and Child Strength and Needs Assessment (Ministry of Children & Youth Services, 2006).

The ***Family & Child Strength and Needs Assessment*** is an actuarial based instrument completed within one month of the initial investigation, i.e., within 60 days of total service delivery, or at six-month re-assessment intervals. The purpose of this assessment tool as stated within the Ontario Child Protection Tools Manual, is as follows:

> "The Ontario Family & Child Strengths and Needs Assessment is a clinical instrument that assists the CPW to identify the presence of parent/caregiver and child strengths and resources as well as to identify the needs of family members….permits the CPW to monitor a family's progress and the impact of service provision" (OACAS, 2006, p 37).

There are two sections to this assessment tool. The Parent/Caregiver Strengths and Needs section contains eleven behavioural domains, with each domain rated along a Likert-type 4 point scale ranging from 'a' (strong adjustment) to 'd' (severely limited adjustment). Similarly, the **Child Strength and Needs** portion has nine behavioural domains, rated in the same manner (Emotional/Behavioural, Family Relationships, Medical/Physical, Child Development, Cultural/Community Identity, Alcohol/Drug/Substance Use, Education, Peer/Adult Relations, Unlawful Behaviour). Each response is given a numeric value. These numbers are not summed but are utilized within a chart at the conclusion of the document and outline the most serious needs and greatest strengths, for each family member. The lowest score on any domain indicates the area of highest priority. The domains with the highest scores indicate areas of strength. There is a narrative field at the conclusion of the document where workers can include "areas of needs or strengths that are not included in the categories assessed by this tool" (OACAS, 2006, p 37).

Emotional and behavioural child characteristics are one of the five areas of the Child Strengths and Needs assessment that builds on information collected within the initial risk assessment tool that was completed during the investigation phase. Others areas are: substance use, adult relationships/conflict, mental health and resources/basic needs. Therefore, the opportunity exists for information regarding child symptoms to be included over time.

Once the Family and Child Strengths and Needs Assessment is completed, the initial Plan of Service is then developed with the family. The Plan of Service outlines the services to be provided to the family as well as tasks or objectives for each family member, taking into consideration the identified protection concerns.

A ***Disposition B*** is completed at the conclusion of each recording cycle (completed every 6 months). This document provides the rationale for continued service provision to the family, the current eligibility code and contains a narrative-based field.

3.2 Sample

This study involved the review of 70 case files of families receiving child protection services during the post-investigative, or ongoing, stage of service delivery. All of the files reviewed remained open for child protective services due to the child being exposed to domestic violence. While there is no specific mention of domestic violence in the Child and Family Services Act, services are provided to children exposed to domestic violence under clause 37(2), sub clauses (a) to (g.1) (see Appendix A). Domestic violence cases are categorized according to level of risk, using the Eligibility Spectrum (OACAS, 2006) under Section 3, Scale 3: Child Exposure to Partner Violence (see Appendix B). In this section of the Eligibility Spectrum, the rating scales of A to I (extreme and moderate levels of risk) fall above the intervention line and cases within these categories would be deemed eligible for service.

3.3 Sampling

In 2008, there were 778 files opened or re-opened under Section 3, Scale 3, sections A to I in one child protection agency in Ontario (see Table 1).

Table 1

2008 Data: Number of Files - Rating Scale 33 A to I: Child Exposure to Partner Violence

# Cases Opened or Re-opened	Jan.	Feb.	March	April	May	June	July	August	Sept.	Oct.	Nov	Dec.	Total 2008
33A	0	1	0	0	2	0	0	2	0	1	0	0	6
33B	0	0	0	0	0	1	0	0	0	0	0	0	1
33C	0	0	0	0	0	0	0	0	0	0	0	0	0
33D	0	0	0	0	0	0	0	0	1	0	0	1	2
33E	2	1	2	4	7	4	5	0	5	1	4	2	37
33F	43	37	42	34	43	38	35	34	38	27	39	28	438
33G	1	1	0	1	1	0	0	0	0	0	0	0	4
33H	24	26	11	28	29	26	25	18	17	21	9	16	250
33I	3	4	1	1	5	6	4	5	2	2	3	4	40
	73	70	56	68	87	75	69	59	63	52	55	51	778

(Data obtained from the Manager, Information Systems & Records, March 16, 2009)

The 778 file numbers were entered into a computerized formula, by the agency's Manager of Information Technology, in order to produce a selected random sample of 70 files. However, the agency's computer system was not able to predetermine those files where ongoing services had been provided. Therefore, of the original 70 files selected, 61 were disqualified, as follows:

- 43 were closed at the conclusion of the investigative stage;
- 8 were closed following a 'Brief Service' (a link to community services);
- 4 were identified as being transferred to Ongoing Services, however, no documentation in the Ongoing phase was available for review;
- 3 had the wrong eligibility code (computer error);
- 3 could not be found in the computerized database.

If a selected file was disqualified, the next file on the randomized list was selected to review. Due to the fact that ongoing services could not be identified within the computerized recording environment, a further 336 computer files were opened and verified (to determine if the file transferred to ongoing services). These were verified consecutively, immediately following each eliminated selected file, until a file was found that met the criteria of the study. The sampling unit during the file review was the family, due to the structure of the computerized program, i.e., one file is opened per family. However, for the purposes of data analysis, the cases refer to the children found within the study sample of 70 files.

3.4 Methods of Data Collection

3.4.1 File Review

The research utilized one method of data collection, a file review. Each child protection agency in Ontario utilizes an independent computerized recording system for file documentation. Each family receiving services from the agency has their own file, divided into sections (a) for the initial investigation and (b) for ongoing services. Any subsequent referrals would appear beneath the ongoing services documentation. While the computerized recording system does allow for case notes to be created within the database, this practice is not consistent throughout the agency. Many of these contained dates and times of client contact only, with no content. When content was available it was reviewed. In many files, the same content was found in multiple documents, i.e., case information was cut and pasted between documents. Symptoms located in different documents but within repeated written content were included only once.

On average it took approximately 30 to 40 minutes to review and read each family's file in the computer database and then to document the data obtained. The documentation within the database was not created sequentially and multiple views existed within some documents. In some cases, it took some time to determine which children were being assessed within each file. In the computerized database, each file has a **People Profile**, identifying all adults and children contained within the file. In many cases, the children identified within the Family and Child Strengths and Needs Assessment were not necessarily the same as those identified within the database's People Profile. For example, four children might be identified within the People Profile but only two children were being assessed. In some situations, the discrepancy was due to the fact that the two children not included in the assessment were siblings no longer residing with the parent receiving services. Understanding the family constellation was further complicated by the fact that the children were referred to by numeric identifiers.

Although the focus of the study was the documenting of symptoms in Ongoing Services, i.e., post-investigative stage, there was very little descriptive data in the documents recorded by child protection workers during this phase of service delivery. This resulted in the entire computer file being reviewed in order to obtain any descriptive information regarding the child's functioning and/or situation. The implications of this will be discussed in the discussion section of this thesis.

The family's paper file was not consulted.

3.5 Data Collection Instrument

A guide for data collection was developed, in order to standardize the file review process for the study. Information pertaining to the following variables was collected:

Child Age and Gender

Information collected under these variables pertained to specific child characteristics gathered in order to obtain data about the age, including chronological developmental stage, and gender of any child for whom symptoms were documented.

Documented Symptoms

This information pertained to any descriptors of the child's behaviours, (e.g., reactions, or response to caregivers, peers and others) found within file narratives in the computerized recording database. These data were then coded according to a list of child symptoms, which can be found in Appendix C and D. Recoded data, according to each file, may be found in Appendix E.

Information about the child's functioning gathered from the file was considered to be relevant and a potential response to a traumatic experience, even if the child protection worker did not identify it as such within the documentation.

Exposure to Domestic Violence

This variable described the type of trauma experienced by the child, i.e., single incident or multiple incidents. This data was recorded due to the fact that the literature suggested the frequency of traumatic occurrences could be pertinent to the impact on the child (Gurwitch, Sullivan & Long, 1998; Herman, 1997; Kerig, 2000, 1997; Perry, 2006).

Information was also collected pertaining to the type of violence the child witnessed e.g., none, verbal/aftermath or physical, as it further expands on the child's experience of the domestic violence.

Level of Risk

Information collected for this variable pertained to the risk level of the file (as assessed by the social worker) and the assigned Eligibility Code (see Appendix B). A rating of "severe" (33A to 33E) indicated that harm to the child had occurred, "moderately severe" (33F to 33I) indicated that risk of harm was present, and "minimally severe" (33J to 33K) indicated that no harm had occurred.

Child Functioning Scores

Data collected for this variable were the scores of the child's portion of the Family Strength and Needs assessment tool, which reflect the child's current level of functioning across nine behavioural domains, as assessed by the family's protection worker in the post-investigative service delivery stage (see Appendix E).

Plan of Service

Data collected for this variable looked for mention of the child's experience and situation within the Plan of Service developed with the family. The data collected was either affirmative or negative, i.e., "yes" or "no".

Length of Service

This variable pertained to the length of time, in months, that the family received protective services, the rationale being that increased time may have provided increased opportunity for child symptoms to be documented.

3.6 Data Analysis

3.6.1. Data Transformations

The data collected under 'Documented Symptoms' (i.e., descriptors of the child's Behaviours) were coded utilizing a list of child symptoms primarily adapted from the Canadian Incidence Study (2003) and which also included three additional categories, specific to Post Traumatic Stress symptoms (see Appendix C). The list of potential symptoms was not a validated measurement instrument for child symptoms. It was intended as a guide to assist in categorizing any recorded descriptors of child functioning.

For further descriptions of data transformations, please refer to Appendix I.

3.6.2. Data Analysis

The following processes, within the SPSS computer program, were utilized to analyze the data obtained in the file review:

Cross-tabulations and frequencies were utilized to provide descriptive data for the children contained in the sample.

Spearman correlations were performed to examine the relationship between Type of Exposure (single incident or multiple incidents of violence) and other variables included in the initial study objectives (number of symptoms, type of symptoms, child's age and gender).

In addition, a Spearman correlation was performed with the following pairs of scaled variables:

a) Level of Risk by Number of Symptoms

b) Child Functioning Ratings (FSNA) by Number of Symptoms

c) Length of Service by Number of Symptoms

Spearman correlations were utilized, as the number of symptoms was not normally distributed.

Finally, a multiple regression analysis was performed to examine the relationship between the Type of Exposure, Age, Gender and the Number of Symptoms.

3.7 Consents

An application to the McGill Research Ethics Board was completed and granted (see Appendix G). Client consents were not necessary as data was gathered from files, with no direct client contact.

The agency's Director of Professional Standards reviewed the research proposal and other required documentation. Permission was then granted with a confidentiality agreement in effect (see Appendix H).

3.8 Confidentiality

The information recorded from each file was kept in strict and complete confidence. Only coded information was removed from the premises of the agency. While completing the data collection, the initials of each child were recorded in order to differentiate children within multiple children families, in case this was needed for discussion purposes. However, once the data were analyzed and discussed, the identifying information was deleted. Following the completion of the research, all non-identifying data was stored in a locked storage room at the McGill Centre for Research on Children and Families, where it will be kept for five years.

4. FINDINGS

In this chapter, the findings of the file review will be outlined. Any documented phrases describing child symptoms included in this chapter have not been edited and have been reproduced exactly as found in the recording database. To protect the child and family's identity, all names have been eliminated.

4.1 Description of Sample

4.1.1 Description of Children

The review of 70 files produced data for 131 children. As can be seen in Table 2, there were slightly more male than female children. Most children were under 12 years of age with the largest age category being the preschool group. Most children were found in files of moderate risk.

Table 2

All Children: Age Category, Exposure Type and Risk Category by Gender

	All Children					
Variable	**Male (*n* = *72*)**		**Female (*n* = *59*)**		**All (*n* = *131*)**	
Age Category	*n*	*%*	*n*	*%*	*n*	*%*
Preschool	34	47	37	63	71	54
School-Age	32	44	14	24	46	35
Adolescent	6	8	8	13	14	11
Type of Exposure						
No Exposure	1	1	2	3	3	2
Single Incident	18	25	9	15	27	21
Multiple Incident	53	74	48	82	101	77
Level of Risk						
Severe Risk	5	7	5	9	10	8
Moderate Risk	66	92	52	88	118	90
Minimal Risk	1	1	2	3	3	2

Most children (128 or 98%) were exposed to incidents of domestic violence, with 101 children (77%) found in files where multiple incidents of domestic violence had

occurred and 27 children (21%) found in files that were opened after single events of violence.

Fourteen children did not witness any violence. Three of these children had no exposure to violence due to the fact that the violent incident(s) occurred prior to their birth (file numbers 19, 25 and 61). The remaining eleven children were not at home when the incident occurred or the incident took place outside the family home. The findings were fairly evenly divided between children who witnessed verbal violence and/or the aftermath of violence (injuries, property damage, etc) (58 children) and those who witnessed physical violence (55 children) (see Table 3). Four children (3% of the sample) had no documentation on file pertaining to their exposure to domestic violence.

Table 3: Children Witnessing Violence by Type of Exposure

	Type of Exposure to Domestic Violence							
Child Witness	**No Exposure (*n=3*)**		**Single Incident (*n=27*)**		**Multiple Incidents (*n=101*)**		**Total (*n=131*)**	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Did not witness	3	100	7	26	4	4	14	11
Verbal/aftermath	0	0	14	52	44	44	58	44
Physical	0	0	5	19	50	50	55	42
Not documented	0	0	1	3	3	2	4	3
Total	3	100	27	100	101	100	131	100

4.2 Findings According to Study Objectives:

4.2.1 ***Research Question 1****: How many children receiving child protection services due to exposure to domestic violence exhibit symptoms in the period of service delivery following the initial investigation, i.e., on-going services?*

There were 59 children (45% of the 131 children represented within the file sample) for whom symptoms were documented. Most of these children were male, and

most were under 12 years of age. The 7 adolescent children with documented symptoms represent 50% of the total adolescent age category in the study. Some children had more than one symptom documented.

(see Table 4).

Table 4

Children with Documented Symptoms by Gender and Age Category

	Age Category			
Gender	**Preschool**	**School Age**	**Adolescent**	**Total**
Male	17	21	3	41
Female	11	3	4	18
Total	28	24	7	59

In less than one percent of the files (3 files, .04%) was a link documented between the trauma of exposure to domestic violence and the symptoms exhibited by the child. In one file, the following was documented: "(the child's)…vivid descriptions of the trauma he experienced on just one of many occasions; both boys admitting to waking up scared; and (the child's) admission of being fearful at times and feeling unsafe, confirms the emotional and psychological impact of violence on children even when they are not direct witnesses to the violence occurring in the home" (File 17).

In a second file, the child protection worker recorded that "…The family doctor…did refer (the child) to Dr. G. (pediatrician), due to parents concerns with regards to obsessive behaviours and nervous ticks. Dr. G. assessed (the child) in March 2007. He noted that (the child)'s nervous body ticks were not due to Tourette's syndrome or any other neurological disorder. She is displaying behaviours consistent with high anxiety in

her surroundings. Dr. G.feels that (the child)'s behaviours are directly linked and consistent with ongoing adult conflict causing her anxiety." (File 9)

In a third file, the child protection worker recorded the following: "(Child) has been impacted by ongoing exposure to domestic violence" and included two descriptors (File 4).

In another file, the child protection worker recorded the following: "Child has been traumatized as she no longer has her belongings and her cats are still with the abuser." (File 47), however no descriptors of child symptoms were documented.

There were 72 children (55% of the 131 children represented within the file sample) for whom symptoms were not documented. Most of these children were female, and most were under 12 years of age. Fifty percent of the adolescent age category had no symptoms documented.

4.2.2 ***Research Question 2****: What kind of symptoms do child welfare social workers document?*

The type and frequency of documented symptoms is outlined in Table 5. Of those symptoms reported, Post Traumatic Stress symptoms were most frequently documented, followed by Developmental Delay. It must be noted that the symptoms outlined below may not accurately represent the child's overall experience, as this table presents *only* the frequency of the symptoms identified and documented by the social worker.

Table 5

Frequency of Documented Symptoms

Type and Frequency of Documented Symptoms			
Symptom	**Frequency in Sample**	**% *(n=59)***	**% (*n=131*)**
Depression/Anxiety	8	14	6
ADD/ADHD	7	12	5
Violence towards others	1	2	0.5
Running	1	2	0.5
Other beh/emotional problems	9	15	7
Special education services	4	7	3
Irregular school attendance	1	2	0.5
Developmental delay	14	24	11
Other health conditions	4	7	3
Psychiatric disorder	1	2	0.5
YCJA involvement	1	2	0.5
PTSS-A (re-experiencing)	8	14	6
PTSS-B (avoidance-numbing)	13	22	10
PTSS-C (increased arousal)	21	36	16
Total Frequency	93		

** Percentages in Table 5 are illustrated according to the frequency of documented symptoms per child (n = 59, total sample, n = 131). As some children had more than one symptom, percentages do not total 100%.

The 59 children for whom symptoms were documented exhibited 93 symptoms in 14 different categories. A higher number of children had externalizing symptoms (53) than internalizing symptoms (22). This is not surprising, as externalizing symptoms would be more readily observed in general, including by social workers, as well as reported by caregivers and/or daycare and educational staff. More males than females exhibited externalizing symptoms, which is consistent with the literature. A higher proportion of females exhibited internalizing symptoms, which is also consistent with the literature (55% of females compared to 29% of males).

Data pertaining to Post Traumatic Stress Symptoms (PTSS) (as interpreted by Kerig, Fedorowicz, et al, 2000) were also collected. Although a higher number of males exhibit PTSS-A (avoidance-numbing) and PTSS-C (increased arousal) symptoms,

females were proportionately higher in all 3 categories (17%, 39% and 44% respectively) as compared to males (12%, 15% and 32%). Of note is the finding that 100% of females with documented symptoms had one type of Post Traumatic Stress symptom recorded. The highest frequency for both genders was recorded in PTSS-C (increased arousal symptoms), which included descriptors of non-specific aggression (see Table 6).

Table 6

Documented Symptoms by Gender and Age**

Documented Symptoms by Gender and Age										
Type of Symptom	**Gender**				**Age Category**					
	Male (*n = 41*)		**Female (*n = 18*)**		**Preschool (*n = 28*)**		**School-Aged (*n = 24*)**		**Adolescent (*n = 7*)**	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Internalizing	12	29	10	56	8	29	11	46	3	43
Externalizing	40	98	13	72	26	93	21	88	6	86
PTSS Total	24	56	18	100	16	57	21	88	5	71
PTSS – A	5	12	3	17	3	11	4	17	1	14
PTSS – B	6	15	7	39	4	14	7	29	2	29
PTSS – C	13	32	8	44	9	32	10	42	2	29

** Percentages in Table 6 are illustrated according to the number for each variable (i.e, gender or age category) within the total number of children with documented symptoms (n = 59). This is due to the fact that some children had more than one symptom, therefore percentages do not total 100%.

All age categories had more externalizing and Post Traumatic Stress symptoms recorded than internalizing symptoms. The highest number of externalizing symptoms were found in preschool children (26), followed by school-aged children (21). The highest number of Post Traumatic Stress symptoms, which included descriptors of non-specific aggression, was found in school-aged children (21). Externalizing and Post Traumatic Stress symptoms were fairly evenly divided in the adolescent age category (6 and 5 respectively).

4.2.3 ***Research Question 3****: Is there a relationship between the type of exposure to domestic violence (single incident vs. multiple incidents) and the following:*

4.2.3.1 The number of child symptoms documented by child welfare social workers.

A Spearman's correlation was conducted to determine the relationship between the type of exposure and the number of symptoms. A significant relationship was noted between exposure to multiple incidents of domestic violence and a larger number of documented symptoms (*rho* (N=131 = .16, $p < .05$).

4.2.3.2 The type of child symptoms documented by child welfare social workers.

A Spearman's correlation was conducted to determine the relationship between the type of exposure and the type of symptoms. The study noted a significant relationship between multiple exposures to domestic violence and internalizing symptoms (*rho* N=131) = .15, $p < .05$). It is important to note that internalizing symptoms, as observed by child protection workers, were documented less frequently than externalizing symptoms in the entire sample.

4.2.3.3 The child's age.

A Spearman's correlation was conducted to determine the relationship between the type of exposure and the age of the child. There was not a significant relationship between the type of exposure to domestic violence (either single or multiple incidents) and the age of the child (*rho* (N=131 = -.145, $p < .27$).

4.2.3.4 The child's gender.

A Spearman's correlation was performed to determine the relationship between the type of exposure and the gender of the child. There was also not a significant

relationship between the type of exposure to domestic violence (either single or multiple incidents) and the child's gender (*rho* (N=131 = .026, p < .85).

Table 7 outlines the relationships between the type of exposure to domestic violence and these four variables.

Table 7

Type of Exposure to Domestic Violence**

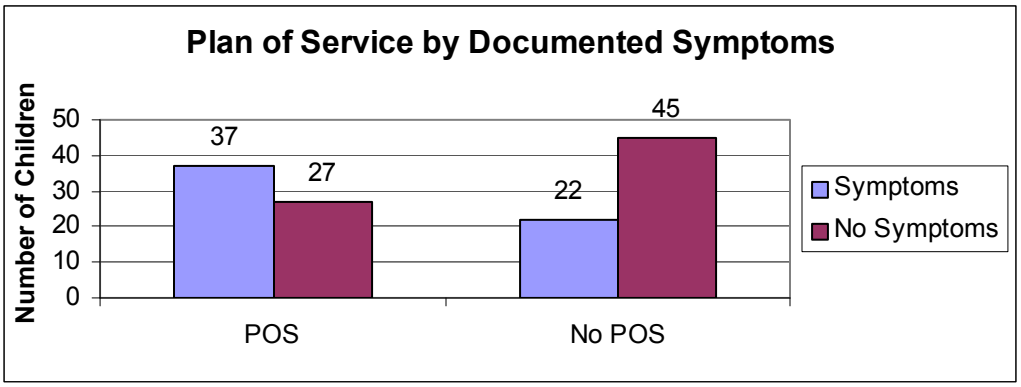
Type of Exposure (Children with Symptoms, *n = 59*)						
Variable	**Single**		**Multiple**		**Test of Significance**	***P* value**
Gender	*n*	*%*	*n*	*%*	Spearman's	*p*<.85
Male (*n=41*)	6	15	35	85	Correlation	
Female (*n=18*)	3	17	15	83	(*n.s.*)	
Age Category					Spearman's	*p*<.27
Preschool (*n=28*)	3	11	25	89	Correlation (*n.s.*)	
School-Aged (*n=24*)	4	17	20	83		
Adolescent (*n=7*)	2	29	5	71		
Symptom Type					Spearman's	*p*<.05
Internalizing (*n=22*)	2	9	20	91	correlation	
Externalizing (*n=53*)	8	15	45	85		
PTSS (*n=42*)	3	7	39	93		
Total # of Symptoms (*n=59*)	9	15	50	85	Spearman's correlation	*p*<.05
One	5	8	29	49		
Two	3	5	17	29		
Three	1	1	1	1		
Four	0	0	2	3		
Five	0	0	1	1		

4.2.4 ***Research Question 4:*** *Are the child's symptoms reflected in the goals and objectives identified in the family's Plan of Service?*

In 30 files (42.9%), the child was reflected in the service plan developed with the family. That is, there were tasks, objectives or treatment plans, specifically related to the child. However, of note is the finding that in 50% of the files (35 files) the child's experience was not reflected in the service plan (see Figure 2). There were 67 children represented in these 35 files.

Figure 2

Plan of Service by Documented Symptoms



The 67 children were fairly evenly divided in terms of gender and 87% were under the age of 12. Over half of the adolescents in the entire sample (9 children, 64%) were not reflected in the family's service plan (see Table 8).

Table 8

Documentation in Plan of Service

	Children Reflected in Plan of Service			
Variable	**POS (*n* = *64*)**		**No POS (*n* = *67*)**	
Gender	*n*	*%*	*n*	*%*
Male	32	50	27	40
Female	32	50	40	60
Age Category				
Preschool	34	53	37	55
School-Aged	25	39	21	31
Adolescent	5	8	9	14
Documented Symptoms				
Present	37	58	22	33
None	27	42	45	67

While most of the 67 children (61 children) were receiving services in files opened under moderate risk levels, 6 children were receiving services in files opened under serious risk levels (with 3 receiving service in files where a serious violent incident had occurred). Of the 67 children not included in service plans, most witnessed multiple events of violence (43 children) and 9 children witnessed single events of violence.

Of the 67 children contained in these 35 files, 45 children (67%) had no symptoms documented. However, of great significance was the fact that 22 children (33%) did have symptoms documented, but no treatment or service options were identified for them.

4.2.4.1 Children not included in Plan of Service, with documented symptoms

One third of the children with documented symptoms (22 children, 33%) were not included in their family's service plan. Of concern is the fact that 50% of these children (11 children) were preschool aged. The youngest child in the file is usually considered

the most vulnerable in terms of risk and early intervention is often prioritized. However, no intervention was included in the service plan for these 11 children.

Most of these children were receiving service in files where the risk level was rated as moderately severe. However, two children were in files rated as extremely severe. All of the 22 children in this group had witnessed either single or multiple incidents of domestic violence (see Table 9).

Table 9

Children with No Plan of Service, with Documented Symptoms, by Gender

Children with No Plan of Service, with Documented Symptoms *(n = 22)*						
Variable	**Male (*n = 16*)**		**Female (*n = 6*)**		**All *(n = 22*)**	
	n	*%*	*n*	*%*	*n*	*%*
Age Category						
Preschool	7	44	4	66	11	50
School-Aged	7	44	1	17	8	36
Adolescent	2	12	1	17	3	14
Type of Exposure						
None	0	0	0	0	0	0
Single Incident	5	31	1	17	6	27
Multiple Incident	11	69	5	83	16	73
Level of Risk						
Severe	2	12	0	0	2	9
Moderate	14	88	6	100	20	91
Minimal	0	0	0	0	0	0

4.2.4.2 Children not included in Plan of Service, no documented symptoms

Forty-five children (63%) out of the 72 children for whom no symptoms were documented, were also not reflected in their family's service plan, even in terms of preventative measures (i.e.: participation in groups for children who have witnessed violence). This was despite the fact that 32 children witnessed the violence and 36 children were receiving services in files where the allegations of harm were verified. Most of the children with no documented symptoms, who were not included in the

family's Plan of Service were female, and again were in the most vulnerable preschool age category.

*4.3 **Additional Findings***

4.3.1 Child Functioning: Child Ratings – Family Strength & Needs Assessment

In addition to descriptors of child symptoms found in narrative segments of the computerized recording package, the child ratings within the Family Strength and Needs Assessment (FSNA) were also collected (see Appendix J).

Of note are the results for 22 children with documented symptoms who were not reflected in the family's service plan. Of these, 8 children (35%) were rated low on multiple factors, 6 children (26%) were rated low on a single factor. There was no documentation on file in this assessment tool for 3 children. In total, 14 children (61%) of the children in this category obtained low ratings for significant areas of functioning (limited emotional/behavioural adjustment, strained family relationships, limited or severely limited development, academic difficulty (with 1 IEP in place) and one child exhibiting significant unlawful behaviour (see Table 10).

Table 10

Low Child Functioning Ratings: Children with Symptoms, no Plan of Service

Functioning Domain	Rating	# of low ratings*
Emotional/Beh..	Limited emotional adjustment	4
Family Relationships	Strained	5
Child Development	Limited development	3
	Severely limited development	1
Cultural Community	Limited cultural/comm. identity	8
Education	Academic difficulty	3
IEP	IEP in place	1
Peer/Adult Social Rel.	Limited social relationships	3
Unlawful Behaviour	Significant unlawful behaviour	1
Total		29

* represents 14 children

In addition, the FSNA scores for the 72 children with no documented symptoms appeared to be problematic in that 7 children (10%) scored low on multiple factors and 19 children (26%) scored low on a single factor (see Table 11). Eight children were not assessed with the FSNA.

Table 11

Low Child Functioning Ratings: Children with No Symptoms

Functioning Domain	Rating	# of low ratings*
Emotional/Beh..	Limited emotional adjustment	3
Family Relationships	Strained	12
Child Development	Limited development	1
Cultural Community	Limited cultural/comm. identity	16
Substance Use	Alcohol, drug or substance use	1
Education	Academic difficulty	1
IEP	IEP in place	1
Peer/Adult Social Rel.	Limited social relationships	2
Total		37

* represents 26 children

In total, 26 children (36%) with no documented symptoms received low ratings from child protection workers for significant areas of functioning. However, no descriptive data was recorded which would justify these scores.

The FSNA also includes a segment where the child's status regarding Individualized Education Plans (IEPs) can be documented. Most children did not have an IEP in place while 11 children (8.4%) had an IEP documented. However, 35 children (27%) had no documentation on file regarding their IEP status (see Table 12).

Table 12

All Children – IEP Status

IEP Status	Frequency	%
Not documented	35	26.7
No IEP	85	64.9
IEP	11	8.4
Total	131	100

A Spearman's correlation was performed to determine the relationship between the mean of the FSNA Child Ratings and the number of documented symptoms. The relationship was positive, indicating that children with more problematic FSNA ratings also have greater numbers of documented symptoms (*rho* (N = 121) = .31, p < .001.

4.3.2. Potential Predictors: Age and Gender

A Spearman's correlation was performed to determine the relationship between the number of symptoms and the age of the child. The relationship was positive with older children having a larger number of symptoms documented. (*rho* (N=131) = .20, p < .05).

In a multiple regression analysis, examining the combined effects of age, gender and type of exposure on number of symptoms, the only statistically significant predictor was gender – the number of documented symptoms was higher for males than for females, *t* (131) = 2.38, p < .02.

A Spearman's correlation was performed to examine the relationship between gender and the type of symptom, as well as the number of symptoms, type of exposure to domestic violence and the Child Functioning scores (FSNA). In the present study, the data entry value for females and males were "1" and "2" respectively. Therefore, higher

numbers in the results are reflective of the male gender. Being male was associated with a higher number of symptoms and more externalizing symptoms.

4.3.3. Missing Documentation

In addition to the 67 incidents where children were not included in the family's Plan of Service, there were incidents of incomplete documentation for other factors (child's witness of violence, IEP status, plus child ratings on the Family Strength and Needs Assessment) (see Table 13). This resulted in 151 incidents of missing documentation in 70 files

Table 13

Incidents of Missing Documentation

Variable	Number of incidents of missing documentation
Child Witness to DV	4
CSN1 (FSNA)	10
CSN2 (FSNA)	10
CSN3 (FSNA)	10
CSN4 (FSNA)	10
CSN5 (FSNA)	11
CSN6 (FSNA)	12
CSN7 (FSNA)	18
CSN8 (FSNA)	14
CSN9 (FSNA)	17
IEP Status	35
TOTAL	151

4.3.4 Length of Service Delivery

A Spearman correlation was performed to examine the relationship between the length of service provided on the file and the number of symptoms documented. This relationship was not statistically significant (*rho* (N=131) = .10, $p < .20$).

5. **DISCUSSION**

The intent of the present study was to determine the number of children, exposed to domestic violence, who exhibited symptoms indicative of problematic functioning in the post-investigative stage of child protective service delivery. In addition to documenting the type of symptoms and the frequency with which these were experienced, the study objectives were to examine possible predictors (i.e., age, gender, type of exposure, etc) that might assist child protection workers in their assessment process and subsequent service delivery. Finally, an objective of the study was to examine whether the child's experience was reflected in the Plan of Service developed with the family.

5.1 Key Findings

The present study determined that:

- In 50% of the files (35 files) the child's experience was not reflected in the Plan of Service. Of the 67 children represented in these 35 files, one third or 22 children had documented symptoms that did not appear to be addressed in service planning and/or delivery.
- Children who have been exposed to domestic violence exhibit symptoms indicative of problematic functioning in the post-investigative stage of service delivery. In the present study, this number represented 45% of the total sample.
- The symptoms documented with the highest frequency were Post Traumatic Stress symptoms (frequency = 42). 100% of the female children in the sample exhibited at least one type of Post Traumatic Stress symptom.

- More externalizing symptoms were documented than internalizing symptoms, and males exhibited almost four times as many externalizing symptoms than females. A higher proportion of females exhibited internalizing symptoms. Most symptoms were documented in children under 12 years of age, however, fifty percent of the adolescents within the sample had documented symptoms.
- The number of symptoms increased with age.
- The type of exposure to domestic violence (i.e., single incident or multiple incidents) was positively correlated to both the number and type of symptom. The study noted a significant relationship between multiple exposures to domestic violence and internalizing symptoms.

5.1.2. Findings Pertinent to Service Issues

A most concerning finding of the study was the fact that in 50% of files, children were not included in the family's Plan of Service. Of the group within this category with documented symptoms, most were in the preschool age category and therefore most vulnerable in terms of risk. Although most had witnessed multiple events of domestic violence, no support or treatment services were identified. Over half of the adolescents in the entire sample were not reflected in the Plan of Service. In the sub-group within this category, children with no documented symptoms and no Plan of Service, most were female and, again, most were in the vulnerable preschool category.

As expected within files opened due to domestic violence, 98% of the children in the sample witnessed single or multiple incidents of violence. Of note, however, is the fact that 100% of the 22 children with symptoms but no Plan of Service witnessed

violence and 79% of the 45 children with no documented symptoms and no Plan of Service, witnessed violence. No treatment or service was identified for these children within the computerized recording package.

The result in the present study for witnessing multiple events was higher than that noted in the 2003 Canadian Incidence Study (Trocmé, et al, 2005) which perhaps relates to an increase in symptoms documented over time, during ongoing services, as opposed to the initial investigative stage.

Most children in the study had no symptoms documented. While this might be viewed as positive, the study determined that, in fact, these children appeared to experience challenges in functioning, as determined by the ratings allocated by the children protection workers in the Family Strength and Needs Assessment. However, no descriptors justifying the assigned ratings were documented in the computerized recording package.

Most children in this category were female, most were in files where the allegations had been verified and most had witnessed violence. This raises concerns regarding how these children are presenting given the trauma they have experienced, and the accuracy, quality and thoroughness of the assessment conducted for these children.

Documentation omitted in the computerized recording package was a frequent occurrence, with 151 incidents of missing documentation within 70 files (in addition to the 67 children who were not included in the Plan of Service). This is concerning in that the child is the client in child welfare and should be prioritized within service delivery.

In addition, missing documentation increases the agency's liability, as it may appear that service is being provided and/or decisions are being made without sufficient justifying information.

5.1.3. Findings Pertinent to the Assessment Process

The findings in the present study pertaining to the type of symptom (in terms of externalizing and internalizing symptoms) and gender are consistent with the literature. Males had more documented symptoms overall, as well as more externalizing symptoms recorded which may suggest that externalizing symptoms are more problematic to manage, therefore more readily identified, or less tolerated within various systems (i.e.: school, Youth Justice, etc). The findings are significant to professionals within the field of child welfare, as they need to remain vigilant with regard to their client's experience and current situation, in terms of assessing the child's level of functioning in relation to age and developmental stage.

The literature suggests that while children are often not diagnosed with Post Traumatic Stress Disorder, they frequently exhibit Post Traumatic Stress symptoms. A high frequency of Post Traumatic Stress symptoms is significant for child welfare professionals as this category of symptoms, which includes both externalizing and internalizing behavioural indicators, is not routinely highlighted in the assessment process and may require specific service approaches.

The findings of the study pertaining to the type of exposure to domestic violence are significant to assessment and service delivery in that the findings suggest that the type of exposure to domestic violence (single or multiple events) impacts both the number and

type of symptoms documented. Interestingly, the type of exposure appeared to impact the less-observable internalizing symptoms. Although these were less frequently documented overall, the finding suggests that child protection workers need to pay attention to the possibility of these more subtle symptoms being exhibited by their clients.

Of note is the finding that more females were represented in the group of children with no documented symptoms. More females were also represented in the group of children with no documented symptoms and no Plan of Service. This finding suggests that child welfare professionals need to be particularly vigilant when observing their female clients in order to gather complete and accurate information for assessment purposes.

> "The maltreated, dissociating girl daydreaming in the classroom is less bothersome to caregivers and teachers than the hyperactive, impulsive, and non-compliant boy. Girls are maltreated as much, if not more, than boys. Girls' brains process trauma with the same principles of neurodevelopment and neurophysiology as boys. Girls are damaged by trauma as much as boys, yet they are much less likely to get our help". (Perry & Pollard, 1998, pp. 46)

The study found that the number of symptoms increased with age. This could be expected as the child develops and begins to function in multiple environments where symptoms can be observed. Forty-seven percent of children with documented symptoms were in the preschool age category, indicating that symptoms can be observed at very young ages and the finding of the study suggests that these may increase over time. Therefore, child welfare professionals need to pay particular attention to both the chronicity of family violence as well as the severity of symptoms being exhibited, when

providing services to older children. Behaviours that may be attributed to pre-adolescent or adolescent acting out may actually have their roots in trauma.

5.2 Implications for Practice

5.2.1 Need for trauma-informed systems

Regrettably, by the time a child protection file is opened the child has, in many cases, already been impacted by their experience of trauma (of living with domestic violence, the potential impact on the parenting relationship and on the child's overall development). The only part of the child's experience that child welfare service providers can influence is the quality and effectiveness of the service provided to the child from the moment the file is opened.

In the field of child welfare, the child is the client.

> "Almost by definition, children served by child welfare have experienced at least one traumatic event, and many have long and complex trauma histories"(Ko et al., 2008, p 397).

As further outlined by Ko et al., (2008), child protection workers may be aware of the traumatic events that led to the child and his family being involved with child protective services, but may not be aware of the child's complete trauma history. Systematic information gathering regarding the child's trauma history is not current practice. In the present study, in all but three cases, the link between the traumatic experience and the child symptoms was not made.

Developing trauma-informed practices is pertinent for child welfare as child protection workers need to have an accurate understanding of what the child has experienced, at what age and developmental stage, in order to fully understand the child's

current level of functioning. More extensive screening practices for trauma would assist the child protection workers when assessing the child and determining appropriate services, hopefully promoting positive outcomes.

One improvement to service delivery, allowing for more complete and accurate documentation of child symptoms would be the implementation of the Child Welfare Trauma Referral Tool (Taylor, Steinberg & Wilson, 2006), as outlined by Ko et al., (2008) (see Appendix K). This would allow the child protection worker to gather information regarding any traumatic event the child may have experienced over time. The tool would also prompt the worker to note behavioural indicators associated with a child's response to trauma.

5.2.2. Need for knowledgeable child welfare professionals

In order to effectively implement the tool noted above, an adequate and consistent knowledge level (pertaining to the impact of trauma on child development, including behavioural indicators according to age and developmental stage) would need to exist within the population of child welfare professionals.

While many professionals enter the field of child welfare with a university degree in social work, others enter the field from diverse educational backgrounds. The equalizing factor is the mandatory training required for new child protection workers in Ontario. The current mandatory training curriculum does not provide specialized training for professionals who will be working with a traumatized clientele. One module reviews the impact of abuse and neglect on child development, with a very brief mention of the impact on brain development. Another module provides a brief section on the impact of

domestic violence. There is not one module that makes the links between the traumatic experience of abuse and neglect, including witnessing/experiencing domestic violence, *and* the child symptoms *and* the need to fully document the child's experience in order to obtain an accurate and complete assessment.

At the present time, the knowledge level in the field, regarding trauma and its impact on children, is not known. When this knowledge is present, it is not known how consistently it is applied. Another improvement to service delivery, allowing for increased use of recent research findings, improved assessment processes and hopefully improved outcomes for children, would be the development and implementation of specialized curriculum in this area.

To compliment the type of training noted above, additional training for child protection workers regarding pertinent dynamic of providing services in cases of domestic violence (such as warning signs of extreme violence, increased knowledge of the mental health implications of domestic violence and increased ability for effective interaction with abusers, would hopefully facilitate an increase in the skill level of child welfare professionals and promote increased collaboration between the child welfare and domestic violence sectors.

5.2.3 Impact of current recording package

The Family Strengths and Needs Assessment (FSNA), completed once the file has transferred to ongoing services, is an actuarial-based instrument in which the child protection worker assigns ratings to nine areas of child functioning, based on the child's functioning at the time the assessment is completed. Each family member is assessed individually via a series of check boxes. There are no narrative fields to document

information that would justify the ratings and/or descriptors of current functioning for children and adults. Concerns exist with this type of instrument. Firstly, as it is numerically based, it may appear to indicate accuracy (in terms of assessment) when really it is only as reliable as the information utilized to determine the ratings. Secondly, the instrument requires that social workers record specific information needed to complete the assessment, which may result in other pertinent information not being included in the assessment process.

In the present study, it was noted that the child as client, did not appear to be prioritized within the recording package. Information about the child was not readily available, nor easy to locate within the recording database. One immediate improvement would be the addition of a narrative field at the conclusion of each child portion within the FSNA. This would allow the child protection worker to document information, descriptors of functioning and other justification of ratings. It would also provide clarification for the reader in some instances. For example, in File 29 an infant was rated high, in terms of substance use. As no details were available, it was not known from the computerized recording whether the infant tested positive at birth for substances, or if it was a data entry error.

It was noted in the present study that documentation was not consistently completed within the computerized recording package. This is problematic in terms of the vulnerable clientele served within the field, as well as the integrity of staff and quality of service offered by the agency.

5.2.4 Lack of assessment framework

Although the Ministry of Children & Youth Services supports the use of ecological theory in assessing families receiving child welfare services in Ontario, there is no specific assessment framework identified to guide child protection workers in a consistent information-gathering process and subsequent analysis of family functioning. The areas to be considered within each layer in ecological theory, in order to produce a complete and comprehensive assessment, are not routinely outlined to child protection workers for consideration during the assessment process. Without an assessment framework, there is nothing to prompt the social worker to ensure that broader information is considered and/or to identify all areas of functioning to be included in the assessment process.

Similar to adequate and effective training, an assessment framework is especially pertinent for social workers who are new to the field, or who may be from varying educational backgrounds. Without an assessment framework, there is no unifying lens to ensure that child welfare workers are approaching this task, central to the profession, in a consistent manner, from one family to another.

As identified within the 2003 Canadian Incidence Study,

> "Although child welfare workers assess the safety of the child, they do not routinely conduct a detailed assessment of child functioning. Items on the checklist included only issues that workers happened to become aware of during their investigation. A more systematic assessment would therefore likely lead to the identification of more issues than noted by workers during the CIS" (Trocmé et al., 2005, p. 66).

Holland (2004) presents a new assessment framework adopted in the UK since 2000 (the Framework for the Assessment of Children in Need and their Families or, more simply, the Assessment Framework), is illustrated in Figure 3 below.

Figure 3
The Assessment Framework
(Holland, 2004, p. 21)

This assessment framework is comprised of three main domains allowing for analysis of the child's developmental progress, parental capacity of caregivers as well as any other family and/or environmental factors (such as domestic violence). The increased engagement of fathers and children during the assessment process is emphasized within this assessment framework. This is aligned with the current practice shift in Ontario towards increased client engagement as well as with the literature regarding the impact on domestic violence on children. Holt, Buckley and Whelan (2008) state that one impact of domestic violence on parental ability can be parental dissociation on the part of both parents. This can result "…in a lack of empathy with the child's experience, where the child is not helped to deal with and integrate the impact of family violence…" (Holt,

Buckley & Whelan, 2008, p. 802). An intentional focus on engagement with fathers may improve the outcome for the child.

Utilizing three assessment domains, this framework is similar to the Looking After Children framework, currently utilized in Ontario for the assessment of children in care. The introduction and implementation of this framework would be an improvement to the current practice situation, hopefully facilitating broader information gathering, and potentially allowing for consistent and accurate documentation of child symptoms of trauma.

5.3 Pertinent Areas for Future Research

Research that would further inform this topic could include:

a) The literature suggests that children who experience both child abuse and exposure to domestic violence are at greater risk for both externalizing and internalizing symptoms, physical and mental health issues and later difficulties in adult relationships (Herrenkohl, et al., 2008; Holt, Buckley & Whelan, 2008). Further study, differentiating between children in the sample who have been solely exposed to domestic violence from those who have also experienced other forms of abuse, in order to examine the impact on the type and number of symptoms, would be pertinent.

b) As the findings of the present study suggest a difference in the type of symptoms exhibited by gender, a longitudinal study examining potential gender differences in the number and type of symptom, would be pertinent.

c) Quality assurance studies to examine: (a) the quality of written assessment with respect to the identification of symptoms by child welfare workers and (b) the extent to which subsequent services address the documented child symptoms.

d) In order to improve the training and skill level of professionals interacting with a vulnerable population, studies that gathered data about the population of child welfare staff, (i.e., their knowledge level regarding the impact of trauma and potential child symptoms), taking into consideration years of experience in the field and educational background, would be pertinent.

e) Similarly, studies that examined the training available to child welfare professionals and how they subsequently integrate the curriculum content, would be pertinent. Does specialized training regarding trauma and the impact on child development impact the rate of symptoms documented, treatment options implemented, service delivery, client outcomes?

f) A pilot project, implementing the Child Welfare Trauma Tool (Taylor, Steinberg & Wilson, 2006), would also be pertinent. This may determine if rates of documented symptoms increase or change, if there is an increase in symptoms being reflected in service delivery and if assessment practices are impacted by screening for the child's experience of trauma.

5.3 Limitations of the study

There were limitations to the present study. The sample size, at 70 files, was small. More extensive file reviews may provide additional insight into the current findings.

As the current computerized recording package was introduced in the agency during the fall of 2007, it was still relatively new in 2008 and this may have impacted the social workers' facility in utilizing the recording program.

In other review processes at the agency, it has been determined that, although some aspects of service delivery are not recorded in the computerized program, the information *is* documented in hand-written case notes. Thus, more behavioural descriptors of child symptoms may have been located in case notes. However, a physical file review was beyond the scope of the present study, in terms of the time factor involved.

Due to the eligibility codes of the files reviewed, service for some files was likely provided by the co-located VAW teams. This may have contributed to an increased focus on the adult victim. Further research would need to be undertaken, randomly examining files from all eligibility codes, to determine whether symptoms are documented for the child and if the child's experience is reflected in service planning.

As noted above, the literature suggests that children who experience both child abuse and exposure to domestic violence experience greater difficulties as a consequence. In the data collection process for the present study, no differentiation was made between children who experienced both child abuse and exposure to domestic violence and those

who were exposed to domestic violence, but not abused (i.e., in terms of the number of symptoms documented).

6. CONCLUSION

The findings from the present study indicate that children who have been exposed to domestic violence continue to exhibit symptoms indicative of problematic functioning, during the post-investigative stage of child welfare service delivery. The findings suggest that child protection workers need to pay particular attention to the chronicity of the violence within the caregivers' relationship, as this appears to directly impact the child's level of functioning. In addition, both the gender and age of the child need to be considered, in terms of accurately assessing risk and determining appropriate service options.

The findings also suggest a lapse in the quality of service being provided to a vulnerable clientele, as evidenced by:

- The majority of children not being included in the family's Plan of Service, including one third of children with documented symptoms (22 children, 33%).
- Symptoms were not documented for most children in the sample, even though it appeared that some children without documented symptoms experienced challenges in some areas of functioning (according to other documentation on file).
- Multiple incidents of incomplete or absent documentation on file.

The quality and effectiveness of service delivery would be improved with the development of pertinent training (regarding the impact of trauma as well as key issues related to domestic violence service provision) in addition to the implementation of an in-depth trauma screening process. With these supports, child protection workers would hopefully be more aware and sensitized to behavioural indicators in general, as well as those which are more difficult to discern, i.e. internalizing symptoms. This could result

in a more systematic and consistent approach to assessment, thereby positively impacting outcomes for children.

Adoption of a pertinent assessment framework, such as the Assessment Framework (Holland, 2004) would further assist child protection workers in compiling and analyzing client information in a consistent and complete manner. This would hopefully increase effective service delivery, including appropriate treatment options, and lead to improved client outcomes.

As a profession mandated by provincial legislation, it is essential that child welfare professionals ensure that documentation is completed and on file for each child in the family, as they provide service to an at-risk and vulnerable clientele. Documentation is the only way to track the service provided and client progress (or lack thereof). Adjusting the computerized recording package to allow documentation to be created sequentially and allowing for professional input via narrative-based fields, would hopefully enrich the information documented for each child and thereby contribute to improved client service and outcomes.

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APPENDIX A

Child Exposure to Partner Violence
(Child & Family Services Act References)

Clause 37 (2)
A child is in need of protection where:

(a) The child has suffered physical harm, inflicted by the person having charge of the child or caused by or resulting from that person's,

(i) failure to adequately care for, provide for, supervise or protect the child, or
(ii) pattern of neglect in caring for, providing for, supervising or protecting the child.

(b) there is a risk that the child is likely to suffer physical harm inflicted by the person having charge of the child or caused by or resulting from that person's,

(i) failure to adequately care for, provide for, supervise or protect the child, or
(ii) pattern of neglect in caring for, providing for, supervising or protecting the child.

(f) the child has suffered emotional harm, demonstrated by serious:

(i)anxiety, (ii) depression, (iii) withdrawal, (iv) self-destructive or aggressive behaviour, or (v) delayed development and, there are reasonable grounds to believe that the emotional harm suffered by the child results from the actions, failure to act, or pattern of neglect on the part of the child's parent or the person having charge of the child.

(f.1) the child has suffered emotional harm of the kind described in sub clause (f) (i), (ii), (iii), (iv) or (v) and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to remedy or alleviate the harm.

(g) there is a risk that the child is likely to suffer emotional harm of the kind described in sub clause (f) (I), (ii), (iii), (iv) or (v) resulting from the actions, failure to act, or pattern of neglect on the part of the child's parent or the person having charge of the child.

(g.1) there is a risk that the child is likely to suffer emotional harm of the kind described in sub clause (f) (i), (ii), (iii), (iv) or (v) and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to prevent the harm.

(Eligibilty Spectrum, 2006, p. 61)

APPENDIX B
LEVEL OF RISK

Eligibility Spectrum: Rating Scale for Child Exposure to Partner Violence
(Section 3, Scale 3)

EXTREMELY SEVERE		
A	**Physical Harm**	
B	**Neglect of Child's Basic Needs**	
C	**Mental/Emotional Harm Results from Exposure to Partner Violence**	
D	**Mental/Emotional Harm or Developmental Condition Results from Significant Conflict Regarding Custody of Child**	
E	**Serious Violent Incident/Threat**	
MODERATELY SEVERE		
F	**Risk of Physical Harm**	
G	**Neglect of Child's Basic Needs**	
H	**Risk to Child of Mental/Emotional Harm or Developmental Condition Resulting from Exposure to Domestic Violence**	
I	**Risk of Mental/Emotional Harm or Developmental Condition due to Significant Conflict over Custody**	
I N T E R V E N T I O N L I N E		
MINIMALLY SEVERE		
J	**No Evidence of Harm or Mild Evidence of Harm**	
K	**Minimal Partner Violence**	

(Eligibility Spectrum, 2006, p.62-66)

APPENDIX C

Child Symptom Coding

Characteristics from CIS (2003)	Codes used in this study
1. Depression/anxiety	1. Depression/anxiety
2.ADD/ADHD	2.ADD/ADHD
3.Negative peer involvement	3.Negative peer involvement
4. Alcohol abuse	4. Substance abuse (CIS 4 + 5)
5. Drug/solvent abuse	5. Self-harming behaviour
6. Self-harming behaviour	6. Violence towards others
7. Violence towards others	7. Running (CIS 8 + 9)
8. Running (one incident)	8. Inappropriate sexual behaviours
9. Running (multiple incidents)	9. Other behavioural/emotional problems
10. Inappropriate sexual behaviours	10. Learning disability
11. Other behavioural/emotional problems	11. Special education services
12. Learning disability	12. Irregular school attendance
13. Special education services	13. Developmental delay
14.Irregular school attendance	14. Physical disability
15. Developmental delay	15. Positive toxicology at birth (CIS 17 + 18)
16. Physical disability	16. Other health conditions
17. Substance abuse related birth defects	17. Psychiatric disorder
18. Positive toxicology at birth	18. Youth Criminal Justice Act involvement
19. Other health conditions	19. PTSD Symptoms – Cluster A (re-experiencing symptoms)**
20. Psychiatric disorder	20. PTSD Symptoms – Cluster B (avoidance-numbing symptoms)**
21. Youth Criminal Justice Act involvement	21. PTSD Symptoms – Cluster B (avoidance-numbing symptoms)**

** Symptoms 19 - 21: PTSD Symptoms from DSM-IV as interpreted by Kerig, Fedorowicz, et al (2000) found in 'Children Exposed to Domestic Violence' (2000), p. 165 – 169)

APPENDIX D

Developmental Differences in Post Traumatic Stress Symptoms

Table 1: DSM-IV Cluster A Symptoms: Re-Experiencing

Adult	Adolescent	School-age	Preschool
1. Recurrent recollections	recurrent revenge/rescue fantasies	recurrent revenge/rescue fantasies	repetitive play
2. Distressing dreams	**nightmares**	**nightmares** **night terrors**	**nightmares** **night terrors**
3. Feeling that event is recurring	**Feeling that event is recurring**	intrusive sounds, images, trauma re-enactment	intrusive sounds, images, trauma re-enactment
4. Distress when exposed to traumatic cues	trauma-specific and mundane fears	trauma-specific and mundane fears	separation anxiety, stranger anxiety, regressive fears
5. Physiological reactivity upon exposure	reactivity and somatic complaints	reactivity and somatic complaints	eating problems, sensitivity to loud noises

Note: Bold represents DSM-IV criteria.

Table 2: DSM-IV Cluster B Symptoms: Avoidance/Numbing

Adult	Adolescent	School-age	Preschool
1.Avoidance of thoughts or feelings about event	"spacing out"	"spacing out"	"spacing out"
2. Avoidance of people, places or activities	phobic behaviour	phobic behaviour	phobic behaviour
3. Inability to recall event	time skew, omen formation	time skew, omen formation	cognitive confusion
4. Diminished interest in activities	truancy	school refusal	regressive behaviours
5. Detachment from others	isolation, acting out against others	withdrawal from peers, lack of interest in play	anxious attachment
6. Restricted range of affect	sadness, guilt	sadness, guilt, sense of aloneness	sadness, helplessness
7. Sense of foreshortened future	**Sense of foreshortened future**	**Sense of foreshortened future**	**Sense of foreshortened future**

Note: Bold represents DSM-IV criteria.

Table 3: DSM-IV Cluster C Symptoms: Increased Arousal

Adult	Adolescent	School-age	Preschool
1. Difficulty sleeping	insomnia or withdrawal into heavy sleep	difficulty falling asleep	difficulty falling asleep
2. Irritability/anger	angry or aggressive behaviour	oppositionally acting out	tantrums, acting out
3. Difficulty concentrating	academic difficulties	academic difficulties	inattention to instructions
4. Hypervigilence	Hypervigilence	obsession with trauma details	sensitivity to auditory stimuli
5. Exaggerated startle response	**Exaggerated startle response**	**Exaggerated startle response**	**Exaggerated startle response**

Note: Bold represents DSM-IV criteria.

Kerig, Fedorowicz, et al (2000) found in 'Children Exposed to Domestic Violence' (2000), p. 165 – 169.

APPENDIX E

RECODED STUDY DATA		
ID #	**Documented Symptoms**	**Coded As:**
1.1	Medically fragile, FTT, dev. disability	13, 16
2.1	None documented	0
3.1	None documented	0
3.2	Very quiet, teary-eyed	9, 20
3.3	None documented	0
4.1	Crying, visibly upset, impacted by ongoing exp to DV	9
5.1	Refuses to attend school, academic difficulty, untreated m.h. needs; chronic truancy, severe anxiety, acting out beh.	1, 7,11, 12, 21
6.1	Challenging beh; typical teen beh	9
6.2	ADHD, OCD, aggressive beh	2, 17, 21
7.1	None documented	0
7.2	Sleep disturbances, tantrums, unable to settle	19, 21
8.1	Beh. Issues - not specific; assessed at CHEO, OCTC involved; speech delay	9, 13
9.1	Timid, w/drawn; obsessive beh;l nervous ticks; assmt done = high anxiety due to adult conflict	1, 20
9.2	None documented	0
10.1	None documented	0
11.1	None documented	0
11.2	Gross & fine motor delays; OCTC involved	13
11.3	None documented	0
12.1	None documented	0
12.2	Academic difficulties	11
12.3	Language delays; serious academic difficulties	11, 13
12.4	Academic difficulties	11
12.5	Difficulties in social relationships	20
13.1	None documented	0
14.1	None documented	0

15.1	Unlawful behaviour YCJA - no documentation	18
15.2	None documented	0
15.3	None documented	0
15.4	Violent at school with peers	6, 21
16.1	None documented	0
17.1	Fearful, sad, reserved, wakes up scared	19, 20
17.2	Sad, difficulty to focus, wakes up scared, very energetic	19, 20
18.1	Verbally abusive to mom; verbal aggression	21
19.1	None documented	0
19.2	None documented	0
20.1	None documented	0
21.1	Anxiety, stomach pains, interrupted sleep	1, 19
22.1	None documented	0
23.1	None documented	0
23.2	None documented	0
24.1	None documented	0
25.1	Interrupted sleep, awake and disruptive at night	19, 21
25.2	Partially collapsed lung	16
25.3	None documented	0
26.1	Speaks negatively of mother; medical cond: diabetes	16
26.2	Speaks negatively of mother	Could not code
27.1	Fear, aggression, eager to please	20, 21
27.2	Fear, aggression, eager to please	20, 21
28.1	Uncommunicative	19
28.2	None documented	0
28.3	None documented	0
29.1	Nightmares	19
29.2	None documented	0
30.1	None documented	0
31.1	ADHD	2
31.2	Physical aggression with sibling; acting out	21

32.1	None documented	0
32.2	None documented	0
32.3	None documented	0
33.1	None documented	0
33.2	None documented	0
34.1	None documented	0
34.2	Unexplained skull fracture;	16
35.1	None documented	0
35.2	None documented	0
35.3	None documented	0
36.1	ADHD	2
36.2	Language delays	13
36.3	Speech delays	13
37.1	None documented	0
37.2	None documented	0
37.3	None documented	0
37.4	None documented	0
38.1	None documented	0
39.1	Aggressive behaviour; acting out	21
39.2	Insecure, aggressive	21
40.1	None documented	0
40.2	None documented	0
41.1	Rigid, obsessive, angry	21
41.2	Detached from relationship with father	20
41.3	Fearful, feels unsafe	20
42.1	None documented	0
42.2	None documented	0
42.3	None documented	0
43.1	None documented	0
43.2	None documented	0
44.1	None documented	0

45.1	None documented	0
45.2	None documented	0
45.3	None documented	0
46.1	Anxiety, fear	1, 20
47.1	“Child has been traumatized” - no descriptors	Could not code
48.1	None documented	0
49.1	Night terrors; difficulty potty training, difficulty eating/finishing meals; anxious, defiant	1, 19, 20, 21
50.1	ADHD, Asperger symptoms, tantrums	2, 21
50.2	None documented	0
51.1	Symptoms of autism - OCTC involved; developmental delay	13
52.1	Sad, angry at mother	20, 21
52.2	ADHD, behavioural issues, mild developmental delay; difficulties with peers; violent behaviour at school and in community; “borderline mentally retarded” (functioning at Gr 2 level)	2, 9, 13, 21
53.1	None documented	0
54.1	Anger, anxiety	1, 21
55.1	“emotionally affected”	9
55.2	“emotionally affected”	9
56.1	Short temper; short attention span; aggressive with peers; language delay; growls when upset; yelling; hitting; defiant	13, 21
56.2	Cries, anxious, clingy with mother	1, 19
57.1	Language delay	13
57.2	Language delay; cognitive limitation; behavioural issues	9, 13
57.3	Language delay	13
58.1	None documented	0
58.2	None documented	0
58.3	None documented	0
59.1	None documented	0
60.1	None documented	0
60.2	None documented	0
61.1	Defiant, aggressive, angry, difficulty with social interactions; anxiety; ADD tendencies	1, 2, 21

61.2	None documented	0
62.1	Acting out	21
62.2	Acting out	21
63.1	Aggressive, ADHD, speech problems	2, 13, 21
63.2	None documented	0
64.1	None documented	0
65.1	Shy, reserved	Could not code
66.1	Fearful	20
67.1	None documented	0
67.2	None documented	0
68.1	None documented	0
68.2	Behavioural issues	9
69.1	None documented	0
69.2	None documented	0
69.3	None documented	0
70.1	Speech delay	13

APPENDIX F

Family and Child Strengths and Needs Assessment Tool – Child Portion

B. CHILD - Rate each child according to the current level of functioning					
Child's Name (Insert one name in each column)		1	2	3	4
		Score	Score	Score	Score
CSN1. Emotional/ Behavioural					
a. Strong emotional adjustment	+3				
b. Adequate emotional adjustment	0				
c. Limited emotional adjustment	-3				
d. Severely limited emotional adjustment	-5				
CSN2. Family Relationships					
a. Nurturing/supportive relationships	+3				
b. Adequate relationship	0				
c. Strained relationship	-3				
d. Harmful relationship	-5				
CSN3. Medical/ Physical					
a. Preventative health care is practiced	+2				
b. Medical needs met	0				
c. Medical needs impair functioning	-2				
d. Medical needs severely impair functioning	-4				
CSN4. Child Development					
a. Advanced development	+2				
b. Age-appropriate development	0				
c. Limited development	-2				
d. Severely limited development	-4				
CSN5. Cultural/Community Identity					
a. Strong cultural/community identity	+1				
b. Adequate cultural/community identity	0				
c. Limited cultural/community identity	-1				
d. Disconnected from cultural/community identity	-3				
CSN6. Alcohol, Drug, Substance Use					
a. No alcohol, drug, substance use	+1				
b. Experimentation/use	0				
c. Alcohol, drug or substance use	-1				
d. Chronic alcohol, drug or substance use	-3				
CSN7. Education					
Does child have a special education placement or an Individual Education Plan? _____No _____Yes, describe:_____					
a. Outstanding academic achievement	+1				
b. Satisfactory academic achievement	0				
c. Academic difficulty	-1				
d. Severe academic difficulty	-3				
CSN8. Peer/Adult Social Relationships					
a. Strong social relationships	+1				
b. Adequate social relationships	0				
c. Limited social relationships	-1				
d. Poor social relationships	-2				
CSN9. Unlawful Behaviour					
a. Preventative activities	+1				
b. No unlawful behaviour	0				
c. Occasional unlawful behaviour	-1				
d. Significant unlawful behaviour	-2				

(Ontario Child Protection Tools Manual (2006), p. 52)

APPENDIX I

Data Transformation :

The behavioural descriptors recorded by child protection workers were coded as per the list of symptoms noted in Appendix C. Data were entered into SPSS with "1" if the symptom was documented and "0" if the symptom was not present.

For purposes of analysis, these were recoded as follows:

Externalizing symptoms: Some documented symptoms could be categorized as externalizing behaviours (ADD/ADHD, other behavioural/emotional, violence towards others, running, Youth Criminal Justice Act involvement, etc.). The data collected under variables CS2 to CS18 plus CS21, were collapsed into one variable renamed Externalizing Symptoms.

Internalizing Symptoms: Symptoms that could be categorized as internalizing behaviours included depression/anxiety, PTSS-A (re-experiencing symptoms) and PTSS-B (avoidance-numbing symptoms). The data collected under variables CS1, plus CS19 (PTSS-A) and CS20 (PTSS-B), were collapsed into one variable renamed Internalizing Symptoms.

Post-Traumatic Stress Symptoms: Data that could be categorized as Post Traumatic Stress symptoms were also recorded under variables CS19, CS20 and CS21. These were collapsed into one variable renamed PTSS Symptoms.

The SPSS COUNT procedure was used to get the number of recorded symptoms for each client.

A second category of data that required recoding was the child ratings within the Family Strength and Needs Assessment (FSNA) (see Appendix F). Each of the nine domains were initially rated along a 4-point scale (a,b,c,d responses). The FSNA letter

ratings were re-coded to numerals using SPSS AUTORECODE procedure (a = 1, b = 2, c = 3, d = 4) followed directly by the COMPUTE procedure for calculating the FSNA score.

Utilizing the TRANSFORM function within the SPSS computer program, the following variables were recoded:

a) Children's age at the time of file opening: The raw data were collected in months. These data were recoded into the following age categories: Preschool (0 to 60 months), School-age (61 to 144 months) and Adolescent (145 to 192 months).

b) Level of Risk (Eligibility Code): The raw data were entered as per the eligibility code on the file (Eligibility Spectrum - see Appendix B). In order to reduce eleven categories into three categories pertaining to level of risk, these were recoded as follows: 1 = severe (33A to 33E), 2 = moderately severe (33F to 33I), and 3 = minimally severe (33J to 33K).

APPENDIX J

Results for Child Functioning Ratings (Family Strength and Needs Assessment)

Factor	Rating Scores	All n=131	All with DS (n=59)	DS + POS (n=37)	DS, no POS (n=22)	All, no DS (n=72)	No DS + POS (n= 27)	No DS, no POS (n= 45)
CSN1	a) strong	17	2	2	0	16	8	7
Emotional/Beh	b) adequate	84	38	22	16	46	15	31
	c) limited	20	17	13	**4**	**3**	**1**	**2**
	d) severely lim.	0	0	0	0	0	0	0
	Not doc.	10	2	0	3	8	5	5
CSN2	a) nurturing	28	9	5	4	19	9	23
Family Rel.	b) adequate	64	31	20	11	33	14	17
	c) strained	28	16	11	**5**	**12**	**1**	0
	d) harmful	1	1	1	0	0	0	0
	Not doc.	10	2	0	3	8	5	5
CSN3	a) preventative	67	29	18	11	38	15	23
Medical/phys.	b) needs met	51	25	16	9	26	9	17
	c) impair func.	3	3	3	0	0	0	0
	d)severely impair	0	0	0	0	0	0	0
	Not doc.	10	2	0	3	8	3	5

Factor	**Rating Scores**	**All n=131**	**All with DS (n=59)**	DS + POS **(n=37)**	DS, no POS **(n=22)**	**All, no DS (n=72)**	**No DS + POS (n= 27)**	**No DS, no POS (n= 45)**
CSN4	a) advanced	7	3	3	**0**	4	2	2
Child Dev	b) age-approp.	100	41	25	16	59	21	38
	c) limited	11	10	7	**3**	**1**	**1**	0
	d) severely lim.	3	3	2	**1**	0	0	0
	Not doc.	10	2	0	3	8	3	5
CSN5	a) strong	15	5	4	1	10	8	2
Cul./Comm	b) adequate	78	41	30	11	37	11	26
	c) limited	27	11	3	**8**	**16**	**5**	**11**
	d) disconnect	0	0	0	0	0	0	0
	Not doc	11	2	0	3	9	3	6
CSN6	a) none	109	54	35	19	55	18	37
Substance Use	b) experimental	9	2	2	0	7	5	2
	c) use	0	0	0	0	**1**	0	**1**
	d) chronic use	0	0	0	0	0	0	0
	Not doc.	12	3	0	4	9	4	5
CSN7	a) outstanding	11	3	3	0	8	3	5
Education	b) satisfactory	88	38	24	14	30	19	31
	c) academic difficulty	11	10	7	**3**	**1**	**1**	0
	d) severe difficulty	3	3	3	0	0	0	0
	Not Doc.	18	5	0	18	13	4	9

Factor	**Rating Scores**	**All n=131**	**All with DS (n=59)**	DS + POS **(n=37)**	DS, no POS **(n=22)**	**All, no DS (n=72)**	**No DS + POS (n= 27)**	**No DS, no POS (n=45)**
IEP	Yes	11	10	9	**1**	**1**	**1**	0
	No	85	42	28	14	14	17	26
	Not doc.	35	7	0	8	8	9	19
CSN8	a) strong	15	3	2	1	12	7	5
Peer/Social	b) adequate	91	45	29	16	46	16	30
	c) limited	11	9	6	**3**	**2**	0	**2**
	d) poor	0	0	0	0	0	0	0
	Not doc.	14	2	0	3	12	4	8
CSN9	a) preventative	51	23	14	9	28	7	21
Unlawful Beh.	b) none	61	32	22	10	29	13	16
	c) occasional	1	1	1	0	0	0	0
	d) significant	1	1	0	**1**	0	0	0
	Not doc.	17	2	0	3	15	7	8

APPENDIX K

Child Welfare Trauma Referral Tool

Module 4, Activity 4F; Module 4, Activity 4G

Child Welfare Trauma Referral Tool

This measure is designed to help child welfare workers make more trauma-informed decisions about the need for referral to trauma-specific and general mental health services. It is to be completed by the child welfare worker through record review and key informants (i.e., natural parent, foster parent, child therapist, school-aged children or adolescents if appropriate, and other significant individuals in the child's life).

Section A allows the child welfare worker to document history of exposure to a variety of types of trauma and indicate the age range over which the child experienced each trauma. Section B allows the child welfare worker to document the severity of the child's traumatic stress reactions. Section C allows the child welfare worker to document attachment problems. Section D allows the child welfare worker to document behaviors requiring immediate stabilization. Section E allows the child welfare worker to document the severity of the child's other reactions/behaviors/functioning. Section F provides strategies for making recommendations to general or trauma-specific mental health services by linking the child's experiences to their reactions.

Form Completed by (Name/Title/ID Code): _____ Date: _____

Child's Name: _____ Age: _____ Number of Months in Current Placement: _____

Reason for Current Evaluation (check all that apply):

☐ Baseline Assessment: New client ☐ New Trauma Reported ☐ Problematic Reactions/Behaviors Reported

☐ Change in Placement (Specify): _____ ☐ Other (Specify): _____

Instructions: Please fill out Sections A through E below by checking the box that corresponds to your answer:

- If there is absolutely NO information about the trauma factor in the vignette, you must answer **UNKNOWN**.
- If there is SOME information about the trauma factor in the vignette, you have three choices:
  - **YES**, if the information suggests that this trauma factor likely occurred,
  - **NO**, if the information suggests this trauma factor did not occur,
  - **SUSPECTED**, if the information suggests that this trauma factor could have occurred but more information is needed for a decision.

A. Trauma/Loss Exposure History

Trauma Type (Definitions attached)					Age(s) Experienced (Check each box as appropriate – example sexual abuse from ages 6–9 would check 6, 7, 8, and 9)
	Yes	Suspected	No	Unknown	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
1. Sexual Abuse or Assault/Rape	☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
2. Physical Abuse or Assault	☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
3. Emotional Abuse/Psychological Maltreatment	☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
4. Neglect	☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
5. Serious Accident or Illness/Medical Procedure	☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
6. Witness to Domestic Violence	☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
7. Victim/Witness to Community Violence	☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
8. Victim/Witness to School Violence	☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
9. Natural or Manmade Disasters	☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
10. Forced Displacement	☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
11. War/Terrorism/Political Violence	☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
12. Victim/Witness to Extreme Personal/ Interpersonal Violence	☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
13. Traumatic Grief/Separation (does not include placement in foster care)	☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
14. Systems-Induced Trauma	☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

B. Current Traumatic Stress Reactions (Answer questions B1–B4 in reference to the CURRENT situation only.)

	Yes	Suspected	No	Unknown	Definition (Check Yes if child presents with any of the descriptors listed below)
1. Re-experiencing	☐	☐	☐	☐	These symptoms consist of difficulties with intrusive memories or reminders of traumatic events, including nightmares, flashbacks, intense reliving of the events, and repetitive play with themes of specific traumatic experiences. Also included is pronounced reactivity to trauma or loss reminders. These symptoms are part of the DSM-IV criteria for PTSD.
2. Avoidance	☐	☐	☐	☐	These symptoms include efforts to avoid stimuli associated with traumatic experiences. The child may avoid certain places or people, or avoid discussing the specifics of the trauma. These symptoms are part of the DSM-IV criteria for PTSD.
3. Numbing	☐	☐	☐	☐	These symptoms include numbing responses that are part of the DSM-IV criteria for PTSD. These responses were not present before the trauma. Numbing symptoms include feelings of detachment or estrangement from others, restricted range of emotion (e.g., unable to have loving feelings), feeling out of sync with others, or having a sense of a foreshortened future.
4. Arousal	☐	☐	☐	☐	These symptoms consist of difficulties with hypervigilance (an exaggerated awareness of potential dangers), difficulty concentrating, exaggerated startle reactions, difficulties falling or staying asleep, and irritability or outbursts of anger. Children with these symptoms often seem distractible, impulsive and inattentive, leading to a common misdiagnosis of ADHD.

C. Attachment

	Yes	Suspected	No	Unknown	Definition (Check Yes if child presents with any of the descriptors listed below)
1. Attachment Difficulties	☐	☐	☐	☐	This category refers to a child's difficulty forming or maintaining relationships with significant parental or caregiver figures. It relates to the child's sense of security and trust in interacting with others. Often children with attachment difficulties interact with new acquaintances in unusual ways. They may bond too quickly (e.g., hugging strangers and climbing on their laps), or fail to engage in appropriate ways (e.g., avoid eye contact and fail to engage in appropriate conversations/ interactions).

D. Behaviors Requiring Immediate Stabilization

	Yes	Suspected	No	Unknown
1. Suicidal Intent	☐	☐	☐	☐
2. Active Substance Abuse	☐	☐	☐	☐
3. Eating Disorder	☐	☐	☐	☐
4. Serious Sleep Disturbance	☐	☐	☐	☐

E. Current Reactions/Behaviors/Functioning (Answer questions E1–E12 in reference to the current situation only)

	Does this interfere with child's daily functioning at home, in school or in the community?				How to Recognize Problem Behaviors (Check Yes if child presents with any of the descriptors listed below)
Regulation of Emotion	Yes	Suspected	No	Unknown	Definition (Check Yes if child presents with any of the descriptors listed below)
1. Anxiety	☐	☐	☐	☐	Anxious children often appear tense or uptight. Worries may interfere with activities and they may seek reassurance from others or be clingy. These children may be quiet, compliant and eager to please, so they may be overlooked. Anxious children may report phobias, panic symptoms, and report physical complaints, startle easily, or have repetitive unwanted thoughts or actions.
2. Depression	☐	☐	☐	☐	Depressed children may appear tearful/sad, show decreased interest in previous activities, have difficulty concentrating, or display irritability, They may present with depressed mood, social withdrawal, sleep disturbances, weight/eating disturbances, loss of motivation, verbal aggression, sullenness, grouchiness, hopelessness, or negativity. They may have frequent complaints of physical problems.
3. Affect Dysregulation	☐	☐	☐	☐	Children with affect dysregulation may have difficulty expressing specific feelings, whether positive or negative, and may have trouble fully engaging in activities. They may have problems modulating or expressing emotions, experience intense fear or helplessness, or have difficulties regulating sleep/wake cycle.
4. Dissociation	☐	☐	☐	☐	Children experiencing dissociation may daydream frequently. They may seem to be spacing out and be emotionally detached or numb. They are often forgetful and sometimes they experience rapid changes in personality often associated with traumatic experiences.
5. Somatization	☐	☐	☐	☐	Somatization is characterized by recurrent physical complaints without apparent physical cause. Children may report stomachaches or headaches, or on the more serious end of the spectrum, they may report blindness, pseudoseizures, or paralysis.

6. Attention/Concentration	☐	☐	☐	☐	Children with problems with attention, concentration and task completion often have difficulty completing schoolwork or may have difficulty forming strong peer relationships.
Regulation of Behavior	Yes	Suspected	No	Unknown	Definition (Includes risky behaviors) (Check Yes if child presents with any of the descriptors listed below)
7. Suicidal Behavior	☐	☐	☐	☐	Includes both superficial and more serious actions with potentially life-threatening consequences. Examples include overdosing, deliberately crashing a car, or slashing wrists.
8. Self-Harm	☐	☐	☐	☐	When someone deliberately harms him or herself. Includes cutting behaviors, punching oneself, pulling out hair or eyelashes, picking skin causing sores, burning, inhaling or overdosing on medications.
9. Regression	☐	☐	☐	☐	Child ceases using previously adaptive behaviors. Child may begin wetting or soiling themselves after they had been potty trained, and may begin using baby talk or refusing to sleep alone when these skills were previously mastered.
10. Impulsivity	☐	☐	☐	☐	Acting or speaking without first thinking of the consequences.
11. Oppositional Behaviors	☐	☐	☐	☐	Defined by negativistic, hostile and defiant behaviors. Child may lose temper frequently, argue with adults, and refuse to comply with adult rules. Child may deliberately annoy people and blame others for mistakes or misbehaviors.
12. Conduct Problems	☐	☐	☐	☐	Defined by a variety of different conduct problems. Child may be physically or verbally aggressive to other people or animals. Children with conduct problems may destroy property, steal, break the law, or start fires. They may run away from home or act in a sexually promiscuous or aggressive fashion.

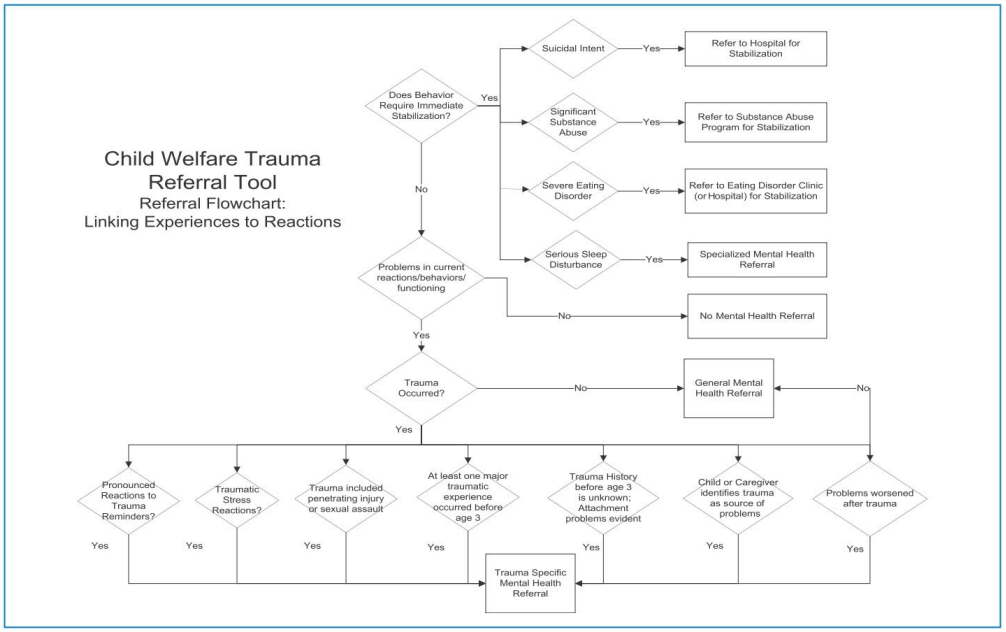
F. Given the information provided in the vignette, what is the appropriate next step? (Please circle one answer.)

a. Trauma-informed mental health referral

b. General mental health referral

c. Immediate stabilization mental health referral

d. No mental health referral



(Taylor, Steinberg & Wilson, 2006)
National Child Traumatic Stress Network
www.nctsnet.org