Manual for the Child Abuse Risk Evaluation (CARE)

Professional Guidelines for Assessing Risk of Physical Child Abuse and Neglect

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Introduction to the Problem

Although children have been the victims of abuse throughout history, the attention of society did not become focused on the problem of child maltreatment until the 1960s. Since then, reports of child abuse have continued to climb in North America, likely due to improved reporting procedures and increased awareness of abuse (Tzeng, Jackson, & Karlson, 1991). In Canada, the rate of substantiated physical child abuse was 2.47 per 1,000 children in 1998, while the incidence of neglect was 4.47 per 1,000 children (Trocme et al., 2001). In the United States, the overall incidence of physical child abuse was 2.5 per 1,000 in 1999. The reported incidence of neglect was 6.5 per 1,000 children (U.S. Department of Health & Human Services, 2001). In any case, as most abuse occurs in the privacy of the family home, the rate of officially verified child maltreatment likely underestimates the true incidence of this problem. A Gallup Poll in the United States puts the rate of physical child abuse at 16 times the official rate, based on parental self-reports (Gallup, 1995).

The impact of child maltreatment on individuals, families, and society is well established. The effects on the child may include intellectual and physical handicaps, impaired impulse control, poor self-esteem, affective problems, developmental problems, and problems in interpersonal relationships (Cicchetti & Toth, 1995; Herrenkohl & Herrenkohl, 1981; Salzinger, Feldman, Hammer, & Rosario, 1991). In addition, relationships have been found between childhood abuse and later criminal behaviour, mental illness, and alcoholism (Dutton & Hart, 1992; McCord, 1983). Arguably the most severe consequence of child abuse is the death of the child. In 1999, 1.68/100,000 children died from abuse or neglect in the United States (U.S. Department of Health and Human Services, 2001). Child maltreatment is clearly a widespread problem with many potentially harmful consequences.

Rationale for the Development of General Risk Assessment Guidelines for Physical Child Abuse and Neglect

Although there are many types of child maltreatment, physical abuse and neglect are the most commonly studied and reported forms of child abuse (Tzeng et al., 1991). They also commonly co-occur (Belsky, 1993; Mash & Wolfe, 1991; Tzeng et al., 1991). The first step in eliminating these two forms of child abuse is to identify the caregivers that are at risk for this behaviour. A formal, structured risk assessment is likely the most effective means of identifying those at risk for child abuse. Unfortunately, there are many problems with the risk assessment systems currently in use in North America. The main criticism involves the reliance on consensus rather than empirical evidence in the choice of risk factors (Wald & Woolverton, 1990). Many jurisdictions also apply these models inappropriately; for example, using the instruments to make decisions for which they were not designed (e.g., assessing whether to investigate a report of abuse; Pecora, 1991; Wald & Woolverton, 1990). Some of the systems have been criticized because they increase the workload for assessors due to the additional paperwork required (Doueck, Bronson, & Levine, 1992). The ability of the current systems to predict abuse and neglect is also fairly poor (English & Pecora, 1994; Lyons, Doueck, & Wodarski, 1996).

In addition to the significant problems with current instruments, most of the instruments were developed in the context of a specific child protection agency. Agencies vary with respect to mandate, documentation requirements, and a variety of other factors that impact on the design of a risk assessment system. Furthermore, it is possible that a risk assessment protocol developed for a specific population within a specific agency may not generalize to other 'at risk' populations.

Due to the agency-specific nature of many existing instruments, there is a need for general risk assessment guidelines for child abuse and neglect that would be useful for a variety of professionals including psychologists, correctional workers, social workers, and so forth. These professionals are involved in a number of activities that would benefit from a general risk assessment instrument. For example, social workers consider risk for child abuse and neglect when they make decisions such as whether a child should be removed from his or her home. Psychologists make recommendations concerning custody and access that should include an assessment of risk for child abuse and neglect. Corrections staff may need to consider risk for child abuse and neglect when making a number of decisions, such as whether an offender should be denied pre-trial release because he poses an imminent risk to his or her children. All of these professionals would be well served by general risk assessment guidelines for child abuse and neglect. In addition, a common instrument would enhance communication between professionals.

Introduction to the Child Abuse Risk Evaluation (CARE)

The CARE is a set of guidelines for assessing risk for child abuse and neglect. It was developed based on the general principles described below.

Development of the CARE

The first step in the development of the CARE was to conduct a survey of the literature on risk for physical child abuse and neglect. In addition, a survey was done of the literature on the prediction of risk for general violence and spousal violence, given the significant association between general violence, spousal abuse, and child abuse (Dinwiddie & Bucholz, 1993). This long list of risk factors was then condensed by removing overlapping or redundant factors. Based on the research literature, 14 factors have been identified that appear to be related to risk for physical child abuse and neglect. It should be noted that this list is not exhaustive. The decision to choose a small number of comprehensive and well-defined factors relates to the goal of keeping the risk assessment both accessible and time efficient (Webster, Douglas, Eaves, & Hart, 1997). Many risk factors mentioned in the literature were based on clinical experience but have not received any empirical validation. These factors were not included, as the mandate of the current project was to include only risk factors that have previously received empirical validation. However, individual assessors are encouraged to include risk factors that they believe are important based on their clinical experience, even if they have not yet been empirically validated.

Scope and Limitations of the CARE

To the extent that it is possible, the CARE attempts to be of general use to a variety of professions (i.e., psychologists, social workers, probation officers, police, etc.). The CARE also focuses on risk factors that appear to generalize across populations. In its current form, the CARE is appropriately used only as a checklist or guide to the professional decision-making of the assessor and not as a formal scale or psychological test. Given the current state of the literature, it would be inappropriate to use the CARE in an actuarial manner; for example, by adding up the number of risk factors or by using specific cutoff scores (Wald & Woolverton, 1990). There are also limitations to the actuarial approach, which assumes that overall risk increases with the number of risk factors present. Kropp, Webster, Hart, and Eaves (1999) point out that in some cases a rating of high risk may be based on the presence of only one risk factor (e.g., homicidal ideation). Alternately, a case may present a large number of risk factors and still be rated as low risk if all of the factors are well managed. Risk management also requires more complex and detailed information then is afforded by an actuarial model. For example, two individuals may have the same risk "score" but require completely different strategies to manage their risk. With these points in mind, the CARE is designed to act as a guide for professional decision-making and not as an actuarial instrument.

General Description of the CARE

There are four main sections to the CARE: **parental[1] factors**, which include the individual characteristics of the parent/caregiver that relate to risk for abuse, **parent-child factors**, which include parenting variables, **child vulnerability factors,** which include individual characteristics of the child and exposure to the maltreating parent, and **family factors**, which include features relating to the family environment. It should be noted that although the CARE includes individual characteristics of the child as a risk factor, there is mixed evidence concerning the role of child factors in the etiology of abuse. Researchers acknowledge that if child characteristics do play a role, it is a minor one (Ammerman, 1990; Dattalo, 1995, Kolko, 1996). More specifically, is a child "difficult" because he or she has been abused, or does a "difficult" child cause his or her own abuse? Some research suggests that the former is more likely (Hansen et al., 1989). Keeping these points in mind, characteristics of the child may be important in risk assessment insofar as they relate to increased parenting stress.

Definitions of Physical Child Abuse and Neglect

One of the major difficulties in this area relates to the use of different definitions for physical child abuse and neglect. Although it is important to define the behaviours that will be predicted in a risk assessment scheme, the research upon which this scheme is based will not have used exactly the same definitions for physical abuse and neglect. The definition proposed for physical child abuse in this manual is "non-accidental physical act(s) on the part of a caregiver that violate the community standards concerning the treatment of children and that cause or could cause physical injury." This definition includes references to the intentionality of the action, as well as relevant cultural norms. It expands on a research definition proposed by Parke and Colmer (1975) by including the endangerment of a child in the definition of physical abuse. This definition also makes it clear that children may suffer abuse from either parents or other caregivers, although the vast majority of abuse is committed by parents (Trocme et al., 2001; U.S. Department of Health & Human Services, 2001).

The definition proposed for neglect is "omission(s) on the part of a caregiver that violate the community standards concerning the treatment of children and that cause or could cause physical injury." The main difference between the definitions of physical abuse and neglect is the distinction between commission of an act versus omission of an act. Another important difference is that a parent's intentions are not considered relevant in the case of neglect. For example, an alcoholic mother who falls asleep and leaves her two-year-old unsupervised may not intend this omission, but in most jurisdictions it would be considered neglectful.

These definitions are intended to be fairly broad and inclusive yet specific enough to differentiate physical abuse and neglect from other types of child maltreatment.

For example, although threats of violence have been equated with acts of violence in other risk assessment schemes, such as the Sexual Violence Risk-20 (SVR-20; Boer, Hart, Kropp, & Web-

[1] The terms "parent" and "parental" are used interchangeably with "caregiver" throughout the CARE manual.

ster, 1997) and the Spousal Assault Risk Assessment guide (SARA; Kropp et al., 1999), in the child abuse and neglect field threats have historically been defined as psychological maltreatment (Hart, Brassard, & Karlson, 1996). As such, threats are not included in the definitions of physical abuse or neglect that are the basis for this manual. Nor is sexual child abuse included in these definitions, due to the very different risk factors associated with this form of child maltreatment (Berliner & Elliot, 1996; Boer et al., 1997).

There are obvious definitional differences between physical child abuse and neglect. These two types of child maltreatment have also been linked to differential outcomes for children (see Hillson & Kuiper, 1994) as well as different service needs for families (Dattalo, 1995). It has also been reported that neglect is much more common than physical abuse (Trocme et al., 2001; U.S. Department of Health & Human Services, 2001) and that neglect is responsible for half of reported child fatalities (see Pecora, 1991). Unfortunately, most of the current research has focused solely on physical abuse or has failed to differentiate between these two forms of child maltreatment. This is likely due to the difficulty in determining whether a child has suffered from physical abuse, neglect, or both, given the heterogeneous effects associated with the two types of maltreatment (Herron, Javier, & Cicone, 1992). Due to this limitation in the literature, the current manual will make no attempt to determine the differential risk factors for these two types of maltreatment. However, if differential risk factors are discovered in future research, the manual will be updated to reflect these findings.

Applications

The CARE was developed for use in assessing risk for child abuse and neglect in either criminal or civil forensic settings. Given the tendency in North America to view violence against children as a child protection or civil forensic issue, it is likely that the CARE will be most often used in these contexts. The CARE may also be used for purposes of education, training, quality assurance, and critical incident reviews.

Child protection. Risk assessments can be helpful to social workers when making a variety of decisions. These include whether a child should be removed from a parent, the amount and type of access a parent should have to a child, whether and under what conditions a child should be returned to a parent, and which risk management activities will be most likely to manage risk.

Custody and access evaluations. In some cases, a risk assessment for child abuse and neglect may be necessary in the context of a custody and access evaluation. The decision to include a risk assessment should be based on appropriate screening criteria, which will be discussed later in the CARE manual. Risk for future abuse and neglect should inform any recommendations made concerning custody and access.

Duty to report. In many North American jurisdictions, all persons who have reason to suspect that a child has been or is likely to be abused or neglected are required by law to report their suspicions to child protective services (Melton, Petrila, Poythress, & Slobogin, 1997). Although these laws apply broadly to the general population, a subset of professionals (e.g., those who work with children and families, in forensic settings, or in mental health settings) will be more likely to encounter situations where mandatory reporting applies. Knowledge of the CARE factors may sensitize these professionals to cases in which an abusive or neglectful incident is imminent and serve as reasonable and probable grounds to report.

Criminal forensic contexts. Child maltreatment is rarely the main reason for involvement in a criminal forensic proceeding. However, risk for child abuse and neglect may be a secondary consideration with many violent offenders, given the overlap in risk for general violence, spousal violence, and child abuse (Dinwiddie & Bucholz, 1993). The CARE might be used to make important decisions concerning pretrial release, suitability/conditions for family visits, conditional release, etc.

Quality assurance. Child abuse and neglect risk assessments and the decisions that are based on these assessments are often scrutinized by other mental health professionals, lawyers, and victim's advocates. This scrutiny might occur, for example, when a child is harmed while under the protection of the social services system. Because the CARE represents a distillation of scientific knowledge in this area, it may be used as a check on the thoroughness and quality of a risk assessment. For example, did the evaluator adequately consider all of the risk factors described in the CARE? Did the evaluator have adequate information to rate the risk factors? Did the evaluator note other risk factors that were considered in addition to those mentioned in the CARE? Was the risk message communicated appropriately? In these situations, the CARE could contribute to a critical incident review to determine if important risk management opportunities were missed.

Administration of the CARE

The current section will discuss general assessment issues that are applicable to the administration of the CARE. In addition, specific guidelines are discussed for rating the individual risk factors described in the CARE as well as the overall level of risk.

User Qualifications

The qualifications necessary to use these guidelines will depend upon the specific context. If the CARE is used for purposes of education (e.g., teaching social workers about risk assessment), consultation (e.g., a lawyer uses the CARE to prepare her case), or evaluative research (e.g., a therapist uses the CARE to plan an intervention program for abusers) then no special qualifications are necessary.

In some situations, the CARE may be used to evaluate and make decisions about an individual or a family (e.g., whether a child should be apprehended from the abuser). In these situations, assessors are responsible for ensuring that their assessment conforms to relevant laws, regulations, and policies. These assessors must also have knowledge of individual assessment techniques and have expertise in the area of child abuse and neglect. This may include formal training or work experience in the fields of psychology, psychiatry, social work, nursing, or corrections.

Mental health judgments are required in order to rate some of the parental risk factors in these guidelines (i.e., Items 3, 4, 5, and 6). Judgments about the physical and mental health of the child/children are also required (i.e., Item 11). These tasks may be beyond the professional training of some assessors. If these assessors suspect that these issues are a concern, then the relevant professionals should be consulted. The assessor could also review existing psychological/psychiatric reports. If this is not possible, the assessor might make a provisional coding of the item. Alternately, the item could be omitted from the assessment. In either case, the resulting limitations should be noted in the summary risk judgment.

Screening Criteria for Potential Risk Assessments

It is not appropriate to conduct a risk assessment for child abuse and neglect unless the results of the assessment can be considered reasonably valid and reliable. If the base rate of physical abuse and neglect in a certain population is quite low, then it will be extremely difficult to predict the occurrence of physical abuse and neglect in that population, and any predictions will tend to be unreliable. The base rate of physical child abuse and neglect in the general population is reported to be a low frequency occurrence (e.g., Murphy-Berman, 1994)[2]. This means that any predictions made about a person from the general population will tend to overestimate his or her risk. In contrast, there are other populations for which a risk assessment for child abuse and neglect will likely be much more reliable and valid.

[2] The base rate in the general population for officially verified child abusive behaviour is not clear. Self-reports indicate that 3.6% of parents commit an abusive act of violence in a given year (Gelles & Strauss, 1988).

Known or suspected physical child abuse/neglect. The base rate of recidivistic physical child abuse/neglect in previously identified abusers is reported to be in the range of 30% to 50% (Baird, 1988; Wald & Woolverton, 1990). A person who has a history of physically abusing or neglecting a child is thus a prime candidate for a risk assessment.

Known or suspected child maltreatment of other types (i.e., sexual abuse, emotional abuse). There is a high rate of co-occurrence among all the forms of child maltreatment (Trocme et al., 2001; U.S. Department of Health & Human Services, 2001). It is therefore reasonable to conduct a risk assessment for physical child abuse and neglect if one of these other conditions is present.

Known or suspected spousal abuse. The relationship between abuse in the spousal relationship and child abuse is well established (Bowker, Arbitell, & McFerron, 1988; Carlson, 1984; Shipman, Rossman, & West, 1999). It is therefore reasonable to conduct a risk assessment for physical child abuse and neglect if there is evidence that spousal violence is occurring in the family.

Other reasonable grounds for a risk assessment. There may be situations in which a risk assessment is appropriate even with no evidence of previous child maltreatment or family violence. To cite an obvious example, it would be reasonable to perform a risk assessment on a pregnant, drug-addicted teenager who expresses negative views of the impending birth. Other indicators for a risk assessment may include a significant history of general violence or severe mental illness (i.e., psychosis, severe depression).

Conducting Risk Assessments for Physical Child Abuse and Neglect

The following procedural guidelines are based on the most current knowledge and practice in the field of child protection (e.g., B.C. Ministry for Children & Families, 1996; De Panfilis & Salus, 1992; Dubowitz & DePanfilis, 2000; Reid, Sigurson, Christianson-Wood, & Wright, 1995) and violence risk assessment (e.g., Boer et al., 1997; Kropp et al., 1999; Webster et al., 1997; Webster, Harris, Rice, Cormier, & Quinsey; 1994). Both the practice guidelines and the risk assessment systems are centred on a multi-trait, multi-method approach to risk evaluation (see Tables 1 & 2).

Cover multiple areas of functioning. In order to accurately assess the risk variables, a number of areas should be covered with respect to the abuser and the child victim(s).

An assessment of the abuser should include:

- History of abusing/neglecting children
- History of being abused or neglected as a child
- Current and past mental health functioning
- Parenting ability
- Relationship with the abused child

- Attitudes towards the abused child
- Attitudes towards risk management
- Current parenting and family stressors
- Coping skills and other strengths
- Current social support network
- Marital relationship

Areas that may be relevant to an assessment of the child victim(s) include:

- History of being abused or neglected
- Developmental status
- Current and past mental health functioning
- Current and past physical health functioning
- Educational functioning
- Social functioning
- Relationship with the abuser
- Coping skills and other strengths
- Current social support network

Obtain information from multiple sources. Assessors should collect information from a variety of sources, including the abuser, the victim, the nonabusing parent, siblings, other family members, the abuser's friends and coworkers, and law enforcement or mental health professionals that have been in contact with the abuser. Information concerning the child victim can be obtained from teachers, social workers, childcare workers, the nonabusing parent, other family members, or healthcare professionals that have been in contact with the child. An interview with the child may provide useful information; however, depending on the age of the child, this information may vary with respect to its reliability (Melton et al., 1997).

Attempt to verify the accuracy of important information. Forensic assessments should always involve the collection of collateral information in order to assess the credibility of sources, to reconcile contradictory information, and to determine whether there is sufficient information for valid decision-making. Concerns about the validity of information should be included in oral and written reports (e.g., Committee on Ethical Guidelines for Forensic Psychologists, 1991).

Use multiple types of information gathering. All risk assessments should involve an interview with the abuser. Due to the possibility that the abuser will present himself/herself in an overly positive light, it is important to be alert for inconsistencies in self - report information. Information should also be obtained through behavioural observation of the parent and child and a review of relevant file information. This may include reports or notes by psychologists, social workers, psychiatrists, police, medical professionals, etc. The use of standardized psychological measures may also be useful (see Tables 1 & 2).

Be aware of cultural issues. Raters must be sensitive to differences in parenting attitudes and practices across cultures. If a rater is unsure of the practices in a specific culture, the rater should become familiar with the relevant practices through research or through communication with other members of the culture. The level of acculturation of the individual should also be considered. If an individual is highly acculturated, then it may be appropriate to use the standards of the dominant culture in assessing his or her behaviour. Although it is very important to be culturally sensitive, the safety of the child is of paramount concern.

Perform reassessments of risk at regular intervals. Risk status varies over time due to fluctuations in the risk factors themselves. As such, the validity and usefulness of any given risk assessment is time limited. It is necessary to repeat a risk assessment at regular intervals (i.e., every 6-12 months) or when there has been an important change in a case (e.g., successful alcohol and drug treatment).

Coding

Presence of individual items. All the items in the CARE are rated based on a 3 - point response format on the summary form (see Appendix A). A rating of "Y" indicates that the risk factor is definitely present, a "?" indicates that the factor is possibly or partially present, and a "N" indicates that there is no evidence that the risk factor is present. If insufficient information is available to code an item, it can be omitted from the risk assessment. This omission should be noted when making a summary risk judgment and when communicating the risk assessment.

Presence of critical items. A rater may decide that there are certain risk factors are of particular importance in a certain case. These critical items are noted on the summary form. This indicates that the item was given more weight than other factors in making the summary risk decision. As stated previously, a rating of high risk may be made based solely on the presence of one critical item. These items should also be most heavily targeted in terms of risk management (see Table 3).

Description of Risk Scenarios

In chart format (see Appendix A), raters are asked to describe all 6 aspects of risk in a particular case (i.e., nature, likelihood, imminence, frequency/duration, physical severity, and emotional severity). They are further asked to indicate factors that will increase or decrease the risk for the target individual. If a rater is unable to describe an aspect of risk due to lack of information or

other limitations, this should also be indicated on the chart (e.g., indicate "unknown" or "unclear").

Nature. Raters should describe the most likely forms of future child abuse and neglect. The assumption in most cases is that any future maltreatment will mirror previous acts of abuse/neglect. However, this assumption may be untenable if the individual has committed multiple types of maltreatment in the past, or if the risk assessment gives good reason to believe that the individual's "trajectory" of child abuse/neglect may be changing (Greenland, 1985). Perhaps most important to consider is the possibility that the individual will commit acts of multiple or extreme (i.e., life-threatening) violence.

Likelihood. This refers to the probability that abuse or neglect will occur in the future. The 14 risk factors described in the CARE have been found to be related to the likelihood of future maltreatment, and should be considered when making this rating. If possible, assessors should indicate whether the absolute likelihood that the subject will commit each act of abuse or neglect is low, moderate, or high. Alternatively, assessors can rank order the scenarios in terms of relative likelihood.

Imminence. Imminence refers to the length of time until the next episode of physical abuse or neglect. When evaluating imminence, raters should consider the triggers of previous maltreatment and how soon these triggers are likely to recur. On the chart, assessors may wish to describe the imminence of the abuse or neglect as low, moderate, or high; alternately, they may choose to indicate when the next episode of maltreatment is likely to occur (e.g., in the next week, month, or year). Imminence may not be applicable in cases where the maltreatment is chronic and stable in nature (i.e., some forms of neglect). This should also be indicated on the chart (e.g., indicate "not applicable").

Frequency/duration. This refers to how often the maltreatment is likely to occur or how long the maltreatment will last. Some types of maltreatment are more likely to be low frequency events (e.g., child homicide) whereas other types may occur quite frequently (e.g., slapping a child on the face). Some forms of maltreatment (i.e., neglect) do not involve discrete events; instead, they represent stable episodes of maltreatment. In these cases, the likely duration of the episode should be described.

It is important to consider the pattern of previous abuse or neglect when rating the frequency/duration of future maltreatment. In addition, a recent escalation in the frequency of maltreatment may reflect a trajectory of violence that is increasing across time. When completing the chart, assessors may choose to indicate whether the frequency/duration of the maltreatment is likely to be low, moderate, or high. Alternately, they may specifically describe the likely frequency of the maltreatment (e.g., daily, monthly, a few times a year) or the likely duration of the episode (e.g., a week, a month, 6 months, chronic).

Severity (Physical). The physical severity of the abuse or neglect refers to the extent of the potential physical harm caused to the child. This might entail physical injury (e.g., bruises, broken bones, burns) or even death. There is a small research literature on the predictors of severity of physical injury that may be helpful to assessors (Hegar, Zuravin, & Orme, 1994). Higher severity of physical injury has been associated with younger children (e.g., Daley & Piliavin, 1982,

Sabotta & Davis, 1992), male perpetrators (e.g., Bergman, Larson, & Mueller, 1986), and low socioeconomic status (e.g., Gil, 1970). When a parent is homicidal or suicidal, future abuse may be more severe, given the risk that the parent may deliberately attempt to kill the child (Wilson & Daly, 1988b; Wilson, Daly, & Daniele, 1995). There is also a positive relationship between the severity of spousal abuse and the severity of child abuse in a family (Bowker et al., 1988).

The severity of previous maltreatment is also an important predictor of future severity. In addition, a recent escalation in the severity of abuse may reflect a trajectory of violence that is increasing across time. This pattern is demonstrated in the child maltreatment literature, which shows that the majority of filicides were preceded by at least one officially verified incident of physical abuse (Sabotta & Davis, 1992; Wilczynski, 1997).

On the chart, raters should indicate whether the physical severity of future maltreatment is likely to be low, moderate, or high. Alternately, they may wish to specifically describe the physical outcomes for the child (will require medical attention, life threatening, minor bruising, etc.).

Severity (Emotional). Physical abuse and neglect also have emotional consequences for children (Cicchetti & Toth, 1995; Herrenkohl & Herrenkohl, 1981; McCord, 1983; Salzinger et al., 1991). The emotional severity of the abuse or neglect refers to the extent of the potential emotional harm caused to the child. This harm can be manifested in emotional problems, developmental problems, problems in interpersonal relationships, and/or behavioural problems.

Although all children will potentially be impacted by abuse or neglect, some children will be more severely affected than others. The extent to which the child will be affected depends on a variety of factors including individual differences in temperament, intelligence, access to other supportive adults, and a variety of other considerations (see Luthar & Cicchetti, 2000; Masten, Hubbard, Gest, et al., 1999). It is also important to consider the emotional impact of previous physical abuse or neglect when making this rating, as this may be an indication of how the child will react to maltreatment in the future.

When filling out the chart, raters should indicate whether the emotional impact of future maltreatment is likely to be low, moderate, or high. Alternately, raters may wish to indicate the specific emotional outcomes for the children (e.g., increase in acting out, poor school performance, mood problems, etc.).

Factors that will increase or decrease risk. Fluctuations in risk factors over time will lead to changes in overall risk. Raters are asked to indicate the factors that may be particularly important to fluctuations in risk for a specific case. For example, a mother in remission from an episode of depression may be at higher risk if her depression recurs.

Summary Risk Judgments

Assessors are required to make an overall rating of the risk for child abuse/neglect. This rating should be made based on the professional experience of the evaluator, taking into consideration the presence of relevant risk factors and all of the aspects of risk (i.e., nature, imminence, physical severity, emotional severity, frequency/duration, and likelihood). The summary risk judg-

ments are recorded on the summary form using a 3-point response format. These ratings should be a rough indication of the need for intervention in a case: **"high"** is an indication for intervention with high priority, **"moderate"** is an indication for monitoring and intervention as necessary, and **"low"** is an indication that intervention is not necessary. The summary risk judgments may be based wholly or in part on the presence of risk factors not considered in the CARE, but which, in the professional opinion of the assessor, are critical to the specific case. This information should be noted on the summary form under "Other Considerations".

Multiple Children in the Household

If an individual acts as a caregiver for more than one child, rating of the CARE factors may vary depending on which of the children is considered. This is especially true with respect to the section of the CARE that focuses on parent-child characteristics and child vulnerability factors. If there is more than one child in a family, separate ratings should be done for each child in these sections. This may lead to different summary risk judgments and different recommendations for risk management depending on which child is under consideration.

Communicating Findings

Unless risk assessment results are communicated effectively in written reports and oral testimony, they may have little or no impact on decisions made by others. The following basic questions should be addressed in any communication about risk. They are based on a review of relevant child protection guidelines (e.g., B.C. Ministry for Children & Families, 1996; De Panfilis & Salus, 1992; Dubowitz & DePanfilis, 2000; Reid et al., 1995) and violence risk assessment manuals (e.g., Boer et al., 1997; Kropp et al., 1999; Webster et al., 1997; Webster et al., 1994).

Risk Assessment

The first set of questions that should be addressed involves the assessment of risk status given no efforts at additional intervention.

What was the nature, frequency/duration, physical severity and emotional severity of the previous physical abuse or neglect? The subject's previous history of physical abuse and neglect should be described as this is an important indicator of future risk, unless there has been a significant change in key risk factors or the perpetrator's behaviour or circumstances. The pattern of previous abuse or neglect may be important, especially if there has been a recent escalation in the frequency or severity of the maltreatment.

What is the probable nature, likelihood, imminence, frequency/duration, physical severity and emotional severity of future physical abuse or neglect? It is important to be as specific as possible about the nature of the risks posed by an individual. All six aspects of risk that were described in chart format on the CARE rating form should be mentioned in the risk message. It is also recommended that the overall likelihood of abuse or neglect be compared to some specific group of parents/caregivers (Boer et al., 1997; Kropp et al., 1999). It may also be helpful to provide information concerning the base rate of recidivism over specific time periods in that comparison group (if this information is available). The likelihood of risk should be justified by referring to the presence or absence of various risk factors in the case at hand.

What is the current status of the variable risk factors? Risk factors may be defined as *fixed* or *variable* (Kraemer et al., 1997). A fixed risk factor is one that cannot change (i.e., a history of being abused or neglected as a child). In contrast, a variable risk factor can change spontaneously or as a result of intervention (i.e., suicidal ideation, major mental illness). Although fixed factors are the best long-term predictors of violence, variable factors are associated with short-term fluctuations in risk status.

Who are the likely victims of any future child abuse/neglect? Although potential victims are often obvious because they are under the care of the parent, any child who has contact with the individual is potentially at risk.

What circumstances might exacerbate or reduce the individual's risk for child abuse/neglect? The risk factors present in a given case may allow the evaluator to identify some "warning signs" that, if they occur, should prompt the parent or case management professionals

to consider a formal re-assessment of risk. Positive changes in risk factors may also indicate that a re-assessment is necessary.

Are there additional risk factors not included in the CARE that are relevant to this case? The CARE includes a basic set of risk factors that should be considered based on current empirical evidence. Evaluators are encouraged to identify other risk factors that they believe to be important in a specific case. These factors may include a history of violence outside of the family, a history of criminal activity, and so forth.

Risk Management

The implicit goal of risk assessment is not only to predict, but also to manage risk. When communicating assessment information, there are a number of risk management issues that should be considered. Given the current paucity of information concerning the effectiveness of programming for child abusers (Azar & Wolfe, 1998; Corcoran, 2000; Lutzker, Van Hasselt, Bigelow, et al., 1998), evaluators are cautioned against making explicit or implicit promises that the recommended interventions will *reduce*, rather than simply *manage*, risk.

Which risk variables are amenable to intervention? Evaluators should keep the distinction between fixed and variable risk factors in mind when making concrete and practical suggestions for risk management (Kraemer et al., 1997). In particular, knowledge of variable risk factors is crucial to develop appropriate intervention strategies (see Table 3).

What is the likely success of specific interventions? Previous interventions aimed at managing the risk factor should be considered in making current recommendations for risk management. An individual's attitude towards intervention, insight into his or her risk and any noncompliance with previous interventions may be particularly important.

Which factor(s) should be targeted as critical to risk management? Certain risk factors may be more important to risk management than others. These factors will likely vary from case to case. Intervention with critical risk factors should be given priority.

What level of access does the individual have to the child/children at risk? Different levels and types of risk management activity may be necessary depending on the amount of time spent with the child, whether the child is alone with the individual, and so forth. The presence of another adult who can protect the child is also an important consideration.

How is the individual or family currently managing risk? There may already be strategies in place that manage risk for an individual/family. For example, the psychotic symptoms of a schizophrenic parent may be well managed with appropriate anti-psychotic medication.

What are the strengths of this individual or family that may help to manage risk in the future? An individual/family may have strengths that can be built upon to manage risk in the future. These may include individual factors (e.g., high self-esteem, good interpersonal skills), family factors (e.g., strong bonds among family members, supportive extended family) or community/other supports (e.g., religious affiliation, close attachment to ethnic community).

What is the current level of functioning of the child(ren) in the family? The current functioning of the children will be important in deciding how best to intervene in a particular family. For example, a child who develops significant mood problems related to abuse or neglect may necessitate a more intensive level of intervention than a child that is more psychologically resilient. In addition, different interventions may be necessary for different children within the same family. However, it should be noted that no matter how well a child may appear to be coping with maltreatment, it is ethically and legally necessary to intervene if abuse or neglect is occurring.

What are the links between risk management and family outcomes? If possible, the assessor should make explicit links between risk management progress and family outcomes. For example, it could be recommended that a parent be stable on anti-depressant medication for 6 months before a child is returned to his or her care.

A sample risk assessment is provided in Appendix B. It includes all a completed CARE as well as a sample report.

1. History of physical abuse or neglect of a child

Rationale

The literature suggests that parents who have previously abused or neglected their children will be at a higher risk for future child maltreatment than parents who have never maltreated their children (Fryer & Miyoshi, 1994). Indeed, recidivism rates of 30% to 50% have been reported for physical child abuse and neglect (Baird, 1988; Wald & Woolverton, 1990). This is much higher than self-reported child abuse rates in the general population (Gelles & Straus, 1988).

Coding

Y	Definite evidence that the individual has a history of physical abuse or neglect of a child.
?	Possible/partial evidence that the individual has a history of physical abuse or neglect of a child.
N	No evidence that the individual has a history of physical abuse or neglect of a child.

2. Victim of physical abuse or neglect as a child

Rationale

Childhood history of abuse is perhaps the most cited parental risk factor for child maltreatment (see Belsky, 1993; Caliso & Milner, 1992; Kolko, 1996; Milner, 1994). After a review of existing evidence, Kaufman and Zigler (1987) concluded that one-third of adults who were abused or neglected as children will go on to maltreat their own children. This relationship may be due to the learning of maladaptive parenting strategies (McCord, 1983; Widom, 1989) or may be indirectly explained by the myriad of intra- and interpersonal problems that are the result of maltreatment (Briere, 1992). Given the empirical evidence, parental history of being abused or neglected should be considered as a risk factor for physical child abuse and neglect.

Coding

Y	Definite evidence that the individual was a victim of physical abuse or neglect or neglect as a child.
?	Possible/partial evidence that the individual was a victim of physical abuse or neglect as a child.
N	No evidence that the individual was a victim of physical abuse or neglect as a child.

3. Major mental illness

Rationale

There is significant evidence that major mental illnesses (i.e., those that seriously impair cognition and affect) are linked to increased risk for violence (Monahan, 1992). This may be especially true with respect to psychotic and/or manic symptoms (e.g., Binder & McNeil, 1988; Link & Stueve, 1994; Taylor, Norman, Murphy, et al., 1991). It is also commonly found that physically abusive and/or neglectful parents exhibit symptoms of depression (Belsky, 1993; Kolko, 1996; Milner, Charlesworth, Gold, Gold, & Friesen, 1988; Milner, Halsey & Fultz, 1994; Roberts, 1988; Robertson & Milner, 1983; Taylor et al., 1991; Wolfe, 1985). Research has confirmed that depression is an important risk factor for physical child abuse and neglect (e.g., Chaffin, Kelleher, & Hollenberg, 1996; Kelleher, Chaffin, Hollenberg, & Fischer, 1994; Kotch, Browne, Dufour, Winsor, & Catellier, 1999; Kotch et al., 1995). These findings are consistent with general research on the effects of depression on parenting, which links this affective state/trait to detached and unresponsive caregiving as well as rejecting, hostile, and intrusive parenting styles (Gelfand & Teti, 1990).

Coding

Y	Definite evidence that the individual has, at any time in his or her life, suffered from a major mental illness.
?	Possible/partial evidence that the individual has, at any time in his or her life, suffered from a major mental illness.
N	No evidence that the individual has, at any time in his or her life, suffered from a major mental illness.

Notes

"Major mental illness" includes serious cognitive or intellectual impairment (e.g., dementia, mental retardation); psychotic disorders (e.g., schizophrenia, delusional disorder); and major mood disorders (e.g., major depression, bipolar mood disorder). Diagnoses should be made according to standardized criteria (e.g., those in the *DSM-IV*). Provisional diagnoses should be coded as "?" and explained in the risk message.

4. Suicidal or violent/aggressive ideation

Rationale

The relationship between violent/aggressive ideation and risk for violence is obvious. This factor has been cited as a risk factor for spousal abuse (Kropp et al., 1999), and it seems clear that a parent experiencing violent/aggressive ideation is at higher risk for maltreating a child. There is also a general link between dangerousness to self and dangerousness to others (e.g., Convit, Jaeger, Lin, Meisner, & Volavka, 1988; Menzies, Webster, & Sepejak, 1985). Suicidal ideation/intent has been cited as a risk factor for spousal abuse (Kropp et al., 1999) because suicidality is often a sign of crisis for the individual. There is also an association between suicidality and child maltreatment. For example, there is evidence that men who kill their families are at increased risk for suicide (Cooper & Eaves, 1996; Wilson et al., 1995). Women who kill their own non-infant children are also at high risk for suicide (Wilson & Daly, 1988b). These murder suicides may reflect a despondent parent's attempt to 'save' his or her children from a dismal future (Daly & Wilson, 1994b; Wilson et al., 1995).

Coding

Y	Definite evidence that the individual has, at any time in his or her life, experienced problems with violent/aggressive or suicidal ideation.
?	Possible/partial evidence that the individual has, at any time in his or her life, experienced problems with violent/aggressive or suicidal ideation.
N	No evidence that the individual has, at any time in his or her life, experienced problems with violent/aggressive or suicidal ideation.

Notes

"Suicidal or violent/aggressive ideation" includes thoughts, impulses, and fantasies about causing — as well as intent or attempts to cause — serious harm or death to self or others. The child may or may not be the main target of this ideation.

Suicidal or violent/aggressive ideation can be inferred from behavior. Such inferences are more likely to be accurate when based on a pattern of behavior, rather than a single act.

5. Substance use problems

Rationale

Substance misuse is one of the most commonly investigated risk factors in the child maltreatment literature. There is significant evidence that substance abuse problems are linked to risk for child abuse/neglect (Baird, 1988; Bath & Haapala, 1993; Brown, Cohen, Johnson, & Salzinger, 1998; Chaffin et al., 1994; Kelleher et al., 1996; Kolko, 1996). One large prospective study found that substance abusers were 2.9 times more likely to physically abuse their children and 3.24 times more likely to neglect their children than a control sample (Chaffin et al., 1994).

Coding

Y	Definite evidence that the individual has, at any time in his or her life, experienced problems related to substance use.
?	Possible/partial evidence that the individual has, at any time in his or her life, experienced problems related to substance use.
N	No evidence that the individual has, at any time in his or her life, experienced problems related to substance use.

Notes

"Substance use" includes use of illicit drugs, as well as misuse of licit drugs (e.g., alcohol, prescribed medications).

"Problems" include substance abuse and dependence; that is, substance use resulting in impairment of the individual's health or social functioning (e.g., overdose, physical illness, arrest, employment problems, marital problems).

6. Personality disorder with anger, impulsivity, or behavioural instability

Rationale

Personality disorders characterized by anger, impulsivity, or behavioural instability are related to an increased risk for violence and violent recidivism (Hare, 1991; Harris et al., 1995; Sonkin, 1987), and have been linked to family violence (Hamberger & Hastings, 1988; Hart, Dutton, & Newlove, 1993; Saunders, 1993). The specific disorders in question include antisocial/psychopathic, borderline, narcissistic, or histrionic personality disorders. With respect to child maltreatment, physical child abusers have been shown to be significantly more likely to meet criteria for personality disorders, including narcissistic personality disorder (Miller, Fox, & Garcia-Beckwith, 1999), antisocial personality disorder (Dinwiddie & Bucholz, 1993), as well as histrionic and borderline personality disorders (Bools, Neale, & Meadow, 1994).

Coding

Y	Definite evidence for a personality disorder characterized by problems with anger, impulsivity, or behavioural instability.
?	Possible/partial evidence for a personality disorder characterized by problems with anger, impulsivity, or behavioural instability.
N	No evidence for a personality disorder characterized by problems with anger, impulsivity, or behavioural instability.

Notes

"Personality disorder" indicates a persistent, pervasive, and problematic manner of interacting with others. Diagnoses should be made according to standardized criteria (e.g., those in the DSM-IV). Provisional diagnoses should be coded as "?" and explained in the risk message.

"Problems" means that the behaviour resulted in inpatient or outpatient psychiatric treatment, or that they substantially impaired social functioning.

7. Barriers to risk management

Rationale

There are a number of parental characteristics that may present barriers to risk management activities. If risk management is ineffective, there is an increased risk for future abuse or neglect. In the child maltreatment literature, the recurrence of neglect has been associated with poor motivation for change on the part of the parent (Baird, 1988). Similarly, the recurrence of physical abuse has been linked to a lack of cooperation with child protection agencies (Baird, 1988; Weedon, Torti & Zunder, 1988). The inability of the parent to make use of child protection agency resources has also been shown to predict the recurrence of physical abuse (Johnson & L'Esperance, 1984; Weedon et al., 1988). In the family violence literature, extreme minimization or denial of previous violence has been linked to recidivism, through its impact on the offender's motivation to engage in risk management activities (Dutton, 1988; Sonkin, 1987). These characteristics appear to reflect either an inability or an unwillingness on the part of the perpetrator to engage in interventions that might manage risk.

Coding

Y	Definite evidence for serious barriers to risk management at any time in the individual's life.
?	Possible/partial evidence for serious barriers to risk management at any time in the individual's life.
N	No evidence of barriers to risk management at any time in the individual's life.

Notes

"Serious" means that the barriers are likely to interfere significantly with the management of critical risk factors.

Indicators for serious barriers to risk management may include: poor motivation to change, lack of cooperation with intervention, poor response to previous interventions, lack of insight into the need for intervention/the seriousness of the problem, minimization or denial of the abuse or neglect, or a refusal to accept responsibility for the abuse/neglect (BC Ministry for Children & Families, 1996; Kropp et al., 1999).

8. Problems in parenting knowledge, skills, and/or attitudes

Rationale

It is not surprising that maltreating parents demonstrate generally inadequate parenting skills. Maltreating parents have been found to be deficient with respect to child management, anger and stress control, and problem solving (Hansen & MacMillan, 1990; Kolko, 1996; Milner, 1994; Wolfe, 1985). Abusive parents also tend to use more harsh, punitive, and authoritarian child rearing strategies than nonabusive parents do (Belsky, 1993; Chilamkurti & Milner, 1993; Milner, 1994; Trickett, Aber, Carlson, & Cicchetti, 1991) and tend to hold attitudes that support the use of these punishment strategies (Arnold, O'Leary, Wolff, & Acker, 1993). Poor knowledge of child development and unrealistic expectations of children have also been associated with child maltreatment (Azar & Rohrbeck, 1986; Egeland, 1979, Johnson & L'Esperance, 1984; Stern & Azar, 1998). Deficient parenting skills may lead to child behaviour problems, increased child-parent conflict, inappropriate discipline strategies, and subsequent physical abuse (Belsky, 1993). Problems in parenting may lead to neglectful behaviour on the part of the parent if age inappropriate responsibilities are shouldered by the child.

Coding

Y	Definite evidence for serious problems with respect to parenting knowledge, skills, and/or attitudes at any time in the individual's life.
?	Possible/partial evidence for serious problems with respect to parenting knowledge, skills, and/or attitudes at any time in the individual's life.
N	No evidence of problems with respect to parenting knowledge skills, and/or attitudes at any time in the individual's life.

Notes

"Serious" means that the parenting deficits have resulted in serious psychological or behavioural problems in the child or that the parenting deficits would merit substantial professional intervention even without evidence of abuse/neglect. Indicators for serious deficits in parenting may include: a history of child maltreatment other than physical abuse or neglect (e.g., emotional maltreatment, sexual abuse), age-inappropriate expectations (e.g., expecting a 6 year old to watch over a younger sibling), frequent corporal punishment, frequent loss of temper, frequent use of threats to obtain compliance (B.C. Ministry for Children & Families, 1996; Kropp et al., 1999).

9. Distorted attitudes towards child

Rationale

Abusive parents tend to have distorted attitudes towards their children. For example, a number of studies indicate that abusive mothers perceive the children that they abuse as more difficult than other children. However, independent ratings of the children's behaviour indicate that these perceptions are negatively biased (Chilamkurti & Milner, 1993; Mash, Johnson, & Kovitz, 1983; Reid, Kavanagh, & Baldwin, 1987; Schellenbach, Monroe, & Merluzzi, 1991; Stern & Azar, 1998; Stringer & LaGreca, 1985; Wood-Shuman & Cone, 1986). Abusive parents also demonstrate attributional biases concerning the intentions of the child when he or she misbehaves (Azar, 1991; Belsky, 1993; Hansen & MacMillan, 1990; Kolko, 1996; Wolfe, 1985). A parent's tendency to perceive a child negatively and attribute malicious intent to the child may lead to increased frustration with the child and subsequent abuse/neglect.

Coding

Y	Definite evidence for serious distortions in the individual's attitudes towards his or her child at any time in the individual's life.
?	Possible/partial evidence for serious distortions in the individual's attitudes towards his or her child at any time in the individual's life.
N	No evidence for distortions in the individual's attitudes towards his or her child at any time in the individual's life.

Notes

"Serious" means that the distortions are pervasive (i.e., occur across a number of situations) and persistent (i.e., stable across time).

10. Problems in parent-child interactions

Rationale

The quality of parent-child interactions is markedly dysfunctional in abusive/neglectful families (see Belsky, 1993; Kolko, 1996; Milner, 1994, Wolfe, 1985). Abusive and neglectful families exhibit lower rates of overall parent-child interactions, lower rates of positive interactions, and higher rates of negative interactions (Bousha & Twentyman, 1984; Burgess & Conger, 1978; Mollerstrom, Patchner & Milner, 1992; Tuteur, Ewigman, Peterson, & Hosokawa, 1995). Studies show that coercive parent-child interactions frequently escalate into abuse (Oldershaw, Walters, & Hall, 1989; Stringer & LaGreca, 1985; Trickett & Kuczynski, 1986). There is evidence that disturbances in parent-child interaction may be present very early in a child's life (i.e., at one month of age; Vietze, O'Connor, Hopkins, Sandler, & Altemeier, 1982), and therefore may have a causal relationship with maltreatment.

Coding

Y	Evidence for serious problems in parent-child interactions at any time in the relationship.
?	Possible/partial evidence for serious problems in parent-child interactions at any time in the relationship.
N	No evidence for serious problems in parent-child interactions at any time in the relationship.

Notes

"Serious" means that the relationship problems have resulted in significant psychological or behavioural problems in the child or that the parent-child relationship would merit significant professional intervention even without evidence of abuse/neglect.

Indicators for problems in parent-child interactions may include: infrequent interaction between parent and child, high levels of hostile interaction (i.e., yelling, shouting, pejorative language), infrequent demonstrations of verbal or physical affection between parent and child (i.e., praise, hugging, sharing a joke) (B.C. Ministry for Children & Families, 1996).

11. Child characteristics that increase vulnerability

Rationale

It appears that some children are more vulnerable to maltreatment. Various child characteristics (e.g., disabilities, behavioural problems, etc.) may create challenges not experienced by the average parent. The impact of these child characteristics on risk is likely indirect through the increased stress that is created for the parents (Ammerman, 1990; Dattalo, 1995; Kolko, 1996). Children under the age of six are also more vulnerable to maltreatment because they often spend extended periods of time alone with a parent, are completely dependent on the parent for their basic needs, and are more vulnerable to physical injury than older children (Depanfilis & Zuravin, 1999, Fryer & Miyoshi, 1994; Jones & McCurdy, 1992; McDonald & Marks, 1991, U.S. Department of Health & Human Services, 2001). Children who are abused also tend to demonstrate higher rates of misbehaviour which then contributes to the maintenance of preexisting abusive relationships (Ammerman, 1990).

Coding

Y	Evidence for child characteristics that increase vulnerability at any time in the child's life.
?	Possible/partial evidence for child characteristics that increase vulnerability at any time in the child's life.
N	No evidence for child characteristics that increase vulnerability at any time in the child's life.

Notes

Indicators for child characteristics that may increase vulnerability include: child under the age of six, born premature, seriously or chronically ill, born unwanted, hyperactive, physically or mentally disabled, or significant behaviour problems (i.e., requiring professional intervention; B.C. Ministry for Children & Families, 1996).

12. Family stressors

Rationale

In general, the research shows that the higher the level of stress that a family is enduring, the higher the risk for both physical abuse and neglect (see Ammerman, 1990; Kolko, 1996; Milner, 1994; Wolfe, 1985). In particular, socioeconomic stressors such as poverty and unemployment have been identified as important risk factors for both types of child maltreatment (Brown et al., 1998; Krugman, Lenherr, Betz, & Fryer, 1986; Kruttschnitt, McLeod, & Dornfeld, 1994). Other stressors such as the number of children in the home (Baird, 1988; Brown et al., 1998; Johnson & L'Esperance, 1984) and the level of disruption due to illegitimacy, divorce, separation, and the presence of a step-parent/co-habitee (Baird, 1988; Martin & Walters, 1982) have also been associated with increased risk for child abuse/neglect. Even positive life events (i.e., getting a promotion, getting married, the birth of a child) should be considered as they can create significant stress for a family. The total number of stressful life events has been linked to increased risk for child maltreatment (Gelles & Straus, 1988; Herrenkohl & Herrenkohl, 1981).

Coding

Y	Evidence that the family has experienced serious stressors within the past year.
?	Possible/partial evidence that the family has experienced serious stressors within the past year.
N	No evidence that the family has experienced serious stressors within the past year.

Notes

"Serious" means that the stressor resulted in significant problems in family functioning or would merit significant professional intervention or support for the family even without evidence of abuse/neglect.

Indicators for family stressors may include: poverty, unemployment, chronic illness of parent, divorce/separation, remarriage, moving, large family (i.e., 3 or more children).

13. Deficient social support

Rationale

One of the most common coping resources investigated in the child maltreatment literature is social support. Level of social support has been linked to risk for child maltreatment in a number of studies (see Azar, 1991; Belsky, 1993; Hansen & MacMillan, 1990; Milner, 1994). Social support is likely an important factor in determining a parent's ability to cope with stress, and in this way, it likely impacts on the parent's risk for child abuse and neglect. Access to respite childcare and emotional support may be particularly important in relation to risk for child maltreatment (Cooey, 1996). The relationship between social support and risk for child abuse and neglect is complex, and the ability of the person to access social networks as well as the quality of those networks must be considered. Some social contacts may in fact increase risk if they lead to increased stress for the parent (Hansen & MacMillan, 1990; Seagull, 1987).

Coding

Y	Evidence for serious deficits in the family's level of social support in the past year.
?	Possible/partial evidence for serious deficits in the family's level of social support in the past year.
N	No evidence of serious deficits in the family's level of social support in the past year.

Notes

"Serious" means that the family has less than two sources of social support (e.g., to provide respite childcare, information concerning parenting, emotional support, etc.) or is unable/ unwilling to use existing social support. Social support may include both formal (i.e., professional) and informal (i.e., family and friends) resources.

14. Spousal abuse

Rationale

One of the most consistent risk factors for physical child abuse relates to conflict and/or violence in the marital relationship. There is much evidence supporting the relationship between conflict in the marital relationship and child abuse (Bowker et al., 1988; Herrenkohl & Herrenkohl, 1981; Hilberman & Munson, 1977-78; Salzinger et al., 1991; Shipman et al., 1999). It is estimated that child abuse occurs in 40-60% of wife-abusive families (Carlson, 1984). There are a variety of theoretical explanations for this link. Belsky (1980) hypothesizes that spousal abuse creates an increased tolerance for violence in the family, which leads to increased physical child abuse. Parke (1980) characterizes physical child abuse as an outlet for the aggression of the abused spouse. In any case, there appears to be a 'climate of violence' created in homes with multiple abusive relationships (Straus, Gelles, & Steinmetz, 1980).

Coding

Y	Definite evidence for spousal abuse at any time in the couple's relationship.
?	Possible/partial evidence for spousal abuse at any time in the couple's relationship.
N	No evidence for spousal abuse at any time in the couple's relationship.

Notes

"Spousal abuse" is defined as any actual, attempted or threatened physical harm perpetrated by a man or woman against someone with whom he or she has, or has had, an intimate, sexual relationship (Kropp et al., 1999).

"Couple" refers to the primary caregiver and his or her intimate partner. The couple may or may not currently be co-habitating. If the primary caregiver is not currently in a relationship, any history of spousal abuse should be coded "Y".

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Table 1

Assessment of Parental Risk Factors

Factor	Sources of Information	Assessment Instruments
History of abuse or neglect of a child **Victim of physical abuse or neglect as a child**	Interviews Collateral interviews Child protection records Criminal records	
Major mental illness	Semi-structured interview Collateral interviews Medical or therapy records Psychiatric/psychological reports	Structured Clinical Interview for DSM-IV (SCID-IV; Spitzer, Gibbon, & Williams, 1996) Beck Depression Inventory II (BDI-II; Beck, Steer, Ball, & Ranieri, 1996)
Suicidal or violent/ aggressive ideation	Semi-structured interview Collateral interviews Medical or therapy records Psychiatric/psychological reports	SCID-IV
Substance use problems	Semi-structured interview Collateral interviews Medical or therapy records Psychiatric/psychological reports	SCID-IV Screening instruments (e.g., see Selzer, 1971; Skinner, 1982)
Personality disorder	Semi-structured interview Collateral interviews Therapy records Psychiatric/psychological reports	Personality Assessment Inventory (PAI; Morey, 1991) Personality Disorders Interview for DSM-IV (PDI-IV; Widiger, Mangine, Corbitt, Ellis, & Thomas, 1995) Psychopathy Checklist -Revised (PCL-R; Hare, 1991)
Barriers to risk management	Interviews Collateral interviews Child protection records Medical or therapy records	

Table 2

Assessment of Parent-Child, Child Vulnerability, and Family Risk Factors

Factor	Sources of Information	Assessment Instruments
Problems in parenting **Distorted attitude towards child** **Problems in parent-child relationship**	Interviews Collateral interviews Behavioural observation Child protection records	Adult-Adolescent Parenting Inventory-2 (Bavolek & Keene, 1999) Parenting Stress Index (PSI; Abidin, 1986, 1990) Home Observation for the Measure of the Environment (HOME; Caldwell and Bradley, 1984)
Child vulnerability	Interviews Collateral interviews School and medical records Child protection records Home visits	Child Behavior Checklist (CBCL; Achenbach, 1991, 1992) Conners' Parent Rating Scale - Revised (Conners, Sitarenios, Parker, & Epstein, 1998a) Conners' Teacher Rating Scale - Revised (Conners, Sitarenios, Parker, & Epstein, 1998b)
Family stressors	Interviews Collateral interviews Child protection records	PSI Life Events Questionnaire (Garmezy, Masten, & Tellegen, 1984)
Deficient social support	Interviews Collateral interviews Child protection records	Perceived Social Support Questionnaire (PSSQ; Procidano & Heller, 1983)
Spousal violence	Interviews Collateral interviews Child protection records	Conflict Tactics Scale 2 (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996)

Table 3

Management of Risk Factors

Factor	Risk Management
History of abuse or neglect of a child	Monitoring Supervised access to child
Victim of abuse or neglect as a child	Individual counseling/psychotherapy
Major mental illness	Individual psychotherapy Psychotropic medication Hospitalization
Suicidal or violent/ aggressive ideation	Intensive supervision Individual psychotherapy Crisis counseling Hospitalization
Substance use problems	Substance abuse treatment Court-ordered abstinence Urine screens
Personality disorder	Long-term individual psychotherapy Group psychotherapy
Barriers to risk manage-ment	Monitoring Supervised access to child
Problems in parenting	Parenting training Psychoeducational groups Family therapy Social service programs
Distorted attitude towards child	
Problems in parent-child relationship	
Child vulnerability	Medical treatment (for child) Individual therapy (for child) Support groups Social service programs
Family stressors	Social service programs Individual or family therapy Stress management
Deficient social support	Interpersonal therapy Social skills training Community supports
Spousal violence	Spousal assault treatment Individual therapy

APPENDIX A

The Child Abuse Risk Evaluation

Name of Parent: _____ Parent's Date of Birth: _____

Name of Child A: _____ Child A's Date of Birth: _____

Name of Child B: _____ Child B's Date of Birth: _____

Name of Child C: _____ Child C's Date of Birth: _____

Other persons living in the home (specify relationship to parent or children):

_____

_____

_____

Reason for Referral:_____

_____

_____

_____

Name of Assessor: _____ Title: _____

Signature: _____ Date: _____

LIST OF SOURCES

Interviews

TYPE	SUBJECT NAME(S)	DATE	LENGTH
Subject of risk assessment			
Child/children at risk			
Other parent/adults living in home			
Other family members			
Other collaterals			
Health care professionals			
Social workers			
Teachers			
Childcare workers			
Law enforcement officers			
Parole officers			
Other interviews			

File Reviews

TYPE	SUBJECT OF FILE	DATE REVIEWED
Social service records		
Criminal records		
Court documents		
School records		
Medical records		
Mental health records		
Other records		

Psychological Tests

NAME OF TEST	SUBJECT OF TEST	DATE

Other Sources

TYPE	SUBJECT OF ASSESSMENT	DATE
Behavioural observation		
Home visit		

RATINGS OF INDIVIDUAL RISK FACTORS

	Factor Present (Y, ?, N)	***Critical Item (check)***
Parental Factors		
1. History of physical abuse or neglect of a child	☐	☐
2. Victim of physical abuse or neglect as a child	☐	☐
3. Major mental illness	☐	☐
4. Suicidal or violent/aggressive ideation	☐	☐
5. Substance use problems	☐	☐
6. Personality disorder with anger, impulsivity, or behavioural instability	☐	☐
7. Barriers to risk management	☐	☐
Parent-Child Factors		
8. Problems in parenting knowledge, skills, and/or attitudes	☐	☐
9. Distorted attitude towards child		
Child A	☐	☐
Child B	☐	☐
Child C	☐	☐
10. Problems in parent-child interactions		
Child A	☐	☐
Child B	☐	☐
Child C	☐	☐

	Factor Present (Y, ?, N)	***Critical Item (check)***
Child Vulnerability Factors		
11. Child characteristics that increase vulnerability		
Child A	☐	☐
Child B	☐	☐
Child C	☐	☐
Family Factors		
12. Family stressors	☐	☐
13. Deficient social support	☐	☐
14.Spousal abuse	☐	☐
Other Considerations		
• _____	☐	☐
• _____	☐	☐
• _____	☐	☐

DESCRIPTION OF POTENTIAL RISK SCENARIOS

Nature	Likelihood	Imminence	Frequency/ Duration	Severity (Physical)	Severity (Emotional)	Factors that Increase Risk	Factors that Decrease Risk

SUMMARY RISK RATINGS

	Low	Moderate	High
Child A	☐	☐	☐
Child B	☐	☐	☐
Child C	☐	☐	☐

APPENDIX B

The Child Abuse Risk Evaluation

Name of Parent: Donna Harris Parent's Date of Birth: May 17, 1970

Name of Child A: Alex Harris Child A's Date of Birth: Sept. 12, 1992

Name of Child B: _____ Child B's Date of Birth: _____

Name of Child C: _____ Child C's Date of Birth: _____

Other persons living in the home (specify relationship to parent or children):

_____

_____

_____

Reason for Referral: Ministry of Children and Families has requested an assessment of risk for child abuse and neglect to aid in long-term planning for Alex Harris

_____

_____

_____

Name of Assessor: Chris Wilson, Ph.D., R.Psych. Title: Registered Psychologist

Signature: _____ Date: January 18, 2002

LIST OF SOURCES

Interviews

TYPE	SUBJECT NAME(S)	DATE	LENGTH
Subject of risk assessment	Donna Harris	10/01/00 10/10/00	2 hours 3 hours
Child/children at risk	Alex Harris	10/02/00	30 minutes
Other parent/adults living in home			
Other family members			
Other collaterals	Helen Smith (friend of Donna)	10/03/00	20 minutes
Health care professionals			
Social workers			
Teachers	Penny Brightman	10/04/00	20 minutes
Childcare workers			
Law enforcement officers			
Parole officers			

File Reviews

TYPE	SUBJECT OF FILE	DATE REVIEWED
Social service records	Donna Harris	09/27/00
Court documents		
School records		
Criminal records		
Medical records		
Mental health records		
Other records		

Psychological Tests

NAME OF TEST	SUBJECT OF TEST	DATE
MMPI-II	Donna Harris	10/01/00
PSI	Donna Harris	10/10/00
CAPI	Donna Harris	10/10/00

Other Sources

TYPE	SUBJECT OF ASSESSMENT	DATE
Behavioural observation		
Home visit		

RATINGS OF INDIVIDUAL RISK FACTORS

	Factor Present (Y, ?, N)	*Critical Item (check)*
Parental Factors		
1. History of physical abuse or neglect of a child	**Y**	
2. Victim of physical abuse or neglect as a child	**Y**	
3. Major mental illness	**Y**	**X**
4. Suicidal or violent/aggressive ideation	**Y**	
5. Substance use problems	**N**	
6. Personality disorder with anger, impulsivity, or behavioural instability	**N**	
7. Barriers to risk management	**Y**	**X**
Parent-Child Factors		
8. Problems in parenting knowledge, skills, and/or attitudes	**Y**	
9. Distorted attitude towards child		
Child A	**N**	
Child B		
Child C		
10. Problems in parent-child interactions		
Child A	**Y**	
Child B		
Child C		

	Factor Present (Y, ?, N)	***Critical Item (check)***
Child Vulnerability Factors		
Child characteristics that increase vulnerability		
Child A	**Y**	**X**
Child B		
Child C		
Family Factors		
11. Family stressors	**Y**	
12. Deficient social support	**N**	
14.Spousal abuse	**Y**	
Other Considerations		
• _____		
• _____		
• _____		

DESCRIPTION OF POTENTIAL RISK SCENARIOS

Nature	Overall Likelihood	Imminence	Frequency/ Duration	Severity (Physical)	Severity (Emotional)	Factors that Increase Risk	Factors that Decrease Risk
Alex is improperly fed and/or clothed	High	N/A	Chronic	Moderate	High		Ms. Harris' mood improves
Alex is improperly monitored and engages in antisocial activities (e.g., firesetting)	High	High	Moderate	High	High		Ms. Harris' mood improves
Alex is physically abused by Ms. Harris (e.g., slapped, pushed)	Moderate	Moderate	Low	Low - Moderate	Moderate	Alex's disruptive behaviour escalates	
Alex is physically abused by Ms. Harris' partner	Low	Low	Low	Unknown	Unknown		Ms. Harris not in a relationship

SUMMARY RISK RATINGS

	Low	Moderate	High
Child A	☐	☐	X
Child B	☐	☐	☐
Child C	☐	☐	☐

SAMPLE REPORT

PRIVATE AND CONFIDENTIAL

RE: Ms. Harris

AGE: 29

REASON FOR REFERRAL

The Ministry of Children and Families has requested an assessment of Ms. Harris's risk for abuse and neglect towards her son, Alex Harris (age 7).

SOURCES USED FOR THIS REPORT

This report is based on a review of the following information:

1. A review of the child protection records for this family.
2. One 2 hour and one 3 hour interview with Ms. Harris on October 1, 2000 and October 10, 2000 respectively.
3. A 30 minute interview with Alex Harris on October 2, 2000.
4. A 20 minute interview with Ms. Smith (friend of Ms. Harris) on October 3, 2000.
5. A 20 minute interview with Penny Brightman (Alex's teacher) on October 4, 2000.
6. Questionnaires completed by Ms. Harris on October 1, 2000 and October 10, 2000.

INFORMED CONSENT

At the outset of the interview the purpose of the assessment and limits of confidentiality were explained to Ms. Harris. She stated that she understood these issues as explained to her and consented to the interview.

SUMMARY OF CHILD PROTECTION RECORDS

The involvement of this family with child protective services dates back to 1986 when Ms. Harris gave birth to her first child at the age of 15. Due to Ms. Harris' young age, this child was removed from her custody and adopted out at birth.

Since the birth of her second child, Alex, there have been 3 reports involving neglect and one report involving physical abuse. The first neglect report occurred in 1995 and came from a former partner of Ms. Harris. He alleged that Ms. Harris sometimes left Alex (age 2) alone in the apartment while she went to the corner store. An investigation was inconclusive. Ms. Harris denied these allegations and refused to attend parenting classes.

The second report of neglect came from Alex's Grade 1 teacher in January 1999. She reported that Alex (age 6) often came to school hungry and inappropriately dressed (e.g., wearing sandals in December). Upon investigation, social workers found little or no food in the apartment. Ms. Harris denied all allegations. As a result of the investigation, Alex was enrolled in the school lunch program. Ms. Harris refused to engage in parenting classes. She accepted the services of a homemaker for a number of months before abruptly refusing this service in March 1999. The file notes that Alex appeared to be eating breakfast and was properly clothed during the period of time that the homemaker was visiting the home.

The homemaker's reports indicate that Ms. Harris appears largely indifferent to the care of Alex. Alex is often unsupervised and his meals frequently consist of sandwiches or cereal. The homemaker further noted that Ms Harris typically ignores Alex until Alex misbehaves, at which point Ms. Harris yells at him.

The only reported physical abuse incident occurred in February 1999 and involved Ms. Harris's then live-in partner, Mr. McGee. Ms. Harris left Alex (age 6) in the care of Mr. McGee while she was out with friends. When she returned

home, she found Alex crying in his bedroom with contusions on his back and buttocks. Alex reported that Mr. McGee had become angry with him for having the TV too loud, and when he refused to turn it down, he began to beat him with an extension cord as punishment. Alex's injuries were reported to the Ministry of Children and Families by his Grade One teacher the following day.

The most recent child protection report occurred in September 2000. Alex's grade 2 teacher reported that Alex (age 7) was often late for school and often complained that he was hungry. She stated that Alex's concentration in class suffered as a result. She further reported that Alex was frequently dirty and unkempt. Investigation revealed inadequate food in the Harris's apartment. The apartment was in a state of chaos and several bags of garbage were piled in the front entrance. Ms. Harris denied all allegations and stated that she was just about to go food shopping when the social worker arrived.

INTERVIEW WITH MS. HARRIS

Background

Ms. Harris was raised by her biological parents in New Westminster, BC. She is the middle of three children. By her account, she was subjected to physical abuse, sexual abuse, and neglect throughout her childhood. Ms. Harris was frequently beaten by her father for minor infractions or "whenever he felt like it". Her mother was an alcoholic who was generally too inebriated to parent Ms. Harris. At the age of 11, Ms. Harris met Bill Harris, a 41 year old man who lived next door. Mr. Harris began sexually abusing Ms. Harris when she was 13 years of age. A discussion of their relationship will follow.

Ms. Harris left school when she was 14 years of age. Over the years, she has held jobs cleaning hotel rooms and as a clerk in a convenience store. Since the birth of her son Alex, Ms. Harris has been supported on social assistance.

Spousal Relationship History

When Ms. Harris was 15 years old she became pregnant by Mr. Harris. The child was taken into care immediately after birth and adopted out. Subsequent to the baby's birth, Mr. Harris was convicted of sexual interference with a minor and forbidden to have contact with Ms. Harris. In spite of this, their relationship continued, and Ms. Harris married Mr. Harris at the age of 19. Ms. Harris denied the occurrence of any spousal violence in this relationship.

Ms. Harris ended her relationship with Mr. Harris shortly after the birth of Alex Harris in 1992. Ms. Harris has had little or no contact with Mr. Harris since that time. Since 1992, Ms. Harris has had a number of intimate relationships. On 3 or 4 occasions, these men have moved in with Ms. Harris to share household expenses. A number of these relationships have involved high levels of conflict and physical abuse. She reported that none of these men were physically assaultive towards her son with the exception of her most recent partner, Mr. McGee.

Ms. Harris met Mr. McGee in 1998. He moved in with her after 3 months of dating. Ms. Harris described their relationship as "up and down" and indicated that they broke up and reunited on a number of occasions. Their break ups were usually precipitated by violent conflicts. The worst of these conflicts left Ms. Harris with a broken arm. She obtained a restraining order against Mr. McGee at that time but they subsequently reunited.

In February 1999, Mr. McGee assaulted Alex while Ms. Harris was out. Mr. McGee apparently whipped Alex with an electrical cord leaving serious contusions on his legs and buttocks. Ms. Harris subsequently asked him to move out. She stated that she has not had any contact with Mr. McGee for the past

year. Ms. Harris stated that the assault on Alex was "the last straw" and that she does not plan on reinitiating a relationship with Mr. McGee.

Ms. Harris is not currently in a relationship. She is supported by social assistance and stated that she finds it difficult to survive on the money that is allotted to her. Although her current housing is unacceptable (i.e.. drug dealers in the stairwells, heating frequently doesn't work) Ms. Harris cannot afford to move elsewhere.

Parent-Child Relationship and Parenting Skills

When asked about her involvement with Child Protective Services, Ms. Harris stated that the allegations of neglect are false. When asked about Alex, Ms. Harris stated that her son is very moody and often difficult to manage (e.g., refusing to comply with requests, frequent temper outbursts). She reported that Alex has been lying a lot lately and has been caught shoplifting on 2 occasions.

With respect to discipline, Ms. Harris described taking away privileges as punishment for misbehaviour. She generally avoids spanking Alex but stated that she resorts to this form of punishment 3-4 times a year. Ms. Harris could not report a schedule of care for Alex; for example, she was not sure when Alex should be awakened for school.

When asked about her refusal to attend parenting classes, Ms. Harris stated that she would have attended but that social services never followed through and enrolled her. When asked why she discontinued homemaker services, Ms. Harris stated that the homemaker was "too nosey".

Social Support Network

Ms. Harris's main sources of social support are 2 female friends that live nearby. She talks with on a weekly basis and they occasionally take care of Alex for her. Ms. Harris has limited contact with her family.

Physical and Mental Health History

Ms. Harris denied any past or current manic or psychotic symptoms. She appears to meet criteria for Dysthymia. She stated that she currently experiences low mood, lack of appetite, low self-esteem, and delayed sleep onset. It appears that she has a history of suicide attempts as a child (overdosing on medication at age 10 and attempting to slit her wrists at age 12). Ms. Harris denied any current suicidal ideation/intent and does not have a suicide plan.

Ms. Harris began drinking and using marijuana at the age of 10. She stated that Mr. Harris was instrumental in helping her to overcome her addiction problems while they were married. She denied any current problems with substance use. The subject reported that she consumes a few beers every 2-4 weeks.

Ms. Harris denied any other chronic or acute physical problems.

Current Mental Status

Ms. Harris presented as a casually dressed and groomed woman who appeared older than her stated age. She was moderately defensive with the interview and assessment procedures, although she became more open as the assessment progressed. Ms. Harris expressed frequent distress concerning her interactions with the Ministry of Children and Families and did not appear to appreciate their ongoing concerns about Alex's safety.

Ms. Harris's affect was generally dysthymic and she became tearful at various points in the interview. There did not appear to be any distortions either in the form or content of her thinking that would indicate the presence of a psychotic disorder. Her memory for recent and remote events was adequate. Attention and concentration also appeared to be within normal limits.

INTERVIEW WITH ALEX HARRIS

Alex Harris presents as a dishevelled young boy who rarely made eye contact and who appeared younger than his stated age. He was generally uncooperative with the interview process and generally answered in monosyllables. He denied that his mother had ever done anything to frighten or hurt him but acknowledged that he sometimes did not get enough to eat for breakfast. He further stated that his mother is much better at providing meals when she is not depressed.

INTERVIEW WITH MS. SMITH (FRIEND OF MS. HARRIS')

Ms. Smith has been a friend of Ms. Harris' for 12 years and visits her once or twice a month. She reported that Ms. Harris "does a good job with Alex". She denied any impairment of Ms. Harris' parenting secondary to Ms. Harris' mood problems. She initially indicated that Ms. Harris never consumed alcohol, but later in the interview stated that Ms. Harris has the occasional drink. She denied any knowledge of corporal punishment, child abuse, or child neglect on the part of Ms. Harris. Ms. Smith stated that Ms. Harris is no longer in touch with Mr. McGee and that she has not seen him around the house since the abuse incident one year ago.

INTERVIEW WITH MS. BRIGHTMAN (ANNE'S TEACHER)

Ms. Brightman is Alex's Grade 2 teacher. She stated that she has ongoing concerns about Alex's care at home. Alex is late for school about half of the time and frequently appears not to have eaten breakfast. On a number of occasions Alex has arrived at school inadequately dressed for the weather. Ms. Brightman stated that Alex has significant conduct problems in the classroom and is quite disruptive. She also stated that Alex's misbehaviour has been escalating in the past few months and he was recently expelled for lighting a fire in the school yard with a group of older children.

QUESTIONNAIRES COMPLETED BY MS. HARRIS

Three questionnaires were administered to Ms. Harris. The questionnaires are intended to measure:

- patterns of personality and emotional disorders;
- risk for child abuse/neglect; and
- stress in the parent-child relationship.

On a questionnaire designed to measure patterns of personality and emotional disorders, Ms. Harris responded in a valid and open manner, freely admitting to faults and psychological difficulties. Ms. Harris's results are consistent with someone who is very distressed and who likely blames others for her problems. Individuals with this profile may also have some impaired reality testing.

Another questionnaire indicated that Ms. Harris is at significant risk for child abuse/neglect. Her results indicate that she perceives Alex in a very negative light and does not feel capable of parenting Alex. Ms. Harris appears to have rigid standards with respect to children's behaviour. Her responses also indicate that she is unhappy with her life.

With respect to stress in the parent-child relationship, Ms. Harris indicated that she does not find interaction with Alex reinforcing, and that Alex does not match her hoped-for child. These results may indicate difficulties in the parent-child relationship, or the emotional unavailability of the parent. Ms. Harris also appears to be experiencing symptoms of depression that may interfere with her ability to parent. She is also experiencing a number of life stressors that may also impact on her parenting. With respect to child behaviour prob-

lems, Ms. Harris rated Alex as having significant conduct problems.

CONCLUSIONS AND RECOMMENDATIONS

Ms. Harris presents with a number of risk factors deemed by the literature to be related to child abuse and neglect. The principal risk factors that I currently have concern about are her past history of neglect, her own history of being maltreated, her mood problems, her deficient parenting skills, her inability/unwillingness to engage in risk management, her tendency to choose violent partners, the current stresses in her life and the level of conflict in her relationship with her son. In addition, Alex's ongoing behaviour problems are an important factor. These risk factors will be discussed below.

According to the available information, Ms. Harris has a longstanding history of neglecting her son, including inadequate supervision, poor nutrition and clothing, an inadequate level of household hygiene, and on at least one occasion, a failure to protect Alex from her violent partners. Ms. Harris herself was a victim of serious maltreatment as a child, which likely contributes to her current level of distress as well as to her deficient ability to parent her own child.

Ms. Harris's mood problems appear to be a critical factor in the neglect of her son. She does not appear to have the motivation or energy to engage in basic childcare activities such as providing meals and making sure he attends school. Her poor parenting and child management skills are also a major concern. Ms. Harris' difficulties are compounded by her lack of financial resources and inadequate housing, which create additional stress.

With respect to child-related factors, Alex's antisocial behaviour appears to be escalating in the past few months. His behaviour problems at home and at school likely reflect the serious emotional impact of being abused and neglected. At this point, he has become a very difficult child to parent, which further increases the challenge for Ms. Harris.

Ms. Harris' main strength is that she appears to have a decent social support network that provides respite childcare on occasion. She was also able to protect Alex from further physical abuse by ending her relationship with Mr. McGee.

It should be noted that due to time constraints, behavioural observation of Ms. Harris and her son was not possible. This may reduce the validity of conclusions made about the quality of their relationship and Ms. Harris' parenting skills.

It is my opinion that overall, Ms. Harris poses a *high* risk for child abuse and neglect towards her son. I believe that the *probability* of future neglect is *high*. The recidivism rate for identified child abusers is estimated to be between 30 and 50%. I believe that Ms. Harris' risk for recidivism is significantly higher than this estimate.

I believe that Ms. Harris' neglect of her son will continue to be *chronic,* and any act should it occur, will likely be of *moderate severity* with respect to physical consequences. The most likely form of this neglect will be inadequate nutrition and clothing and poor household hygiene. In addition, there is a *high* probability that Alex will not be monitored properly. If Alex engages in more fire setting, the physical consequences could be of *high severity.* Should this chronic neglect continue, the emotional and behavioural consequences for Alex with respect to peer relationships, school performance and overall adjustment will likely be of *high severity.*

With respect to physical abuse, given the problems in Ms. Harris's relationship with her son, her poor child management skills, and Alex's increasingly disruptive behavior, there is a *moderate*

likelihood that Ms. Harris will physically abuse Alex in the future in the context of a parent-child conflict. In addition, if one of Ms. Harris's partners moves into the home in the future, then it is likely that Alex will be at risk for physical abuse from her partner, given Ms. Harris' tendency to choose violent partners. Alex may be injured while intervening to protect his mother, or he may become the target of violence.

Managing Ms. Harris's risk will be a challenge, given that compliance with previous interventions has been sporadic at best. She has not cooperated with agency interventions in the past and has no insight into her neglectful behaviour and its serious impact on her son. In fact, Ms. Harris denies and minimizes her responsibility for Alex's difficulties. These factors are all related to poor outcomes with respect to risk management.

In terms of risk management options, Ms. Harris's risk could be partially managed by treating her mood problems, either through medication or psychotherapy. It appears that homemaker services were effective in the past and this could be attempted again. Increased financial aid and more suitable living conditions would also likely decrease the stress on this family.

Ms. Harris is also in need of intensive training in basic parenting skills, however, it is doubtful that she would be receptive to this intervention. Parenting training will be most successful if it involves home visits, lasts for longer than 6 months, and involves specific behavioural interventions.

With respect to Alex, individual therapy may be helpful with for his anger and conduct-disordered behaviour. A youth worker might provide a positive role model, as well as providing support and encouraging more constructive behaviour. Family therapy may also be helpful in improving the relationship between Alex and his mother.

In addition to regular monitoring of this difficult case, reassessments of Ms. Harris' risk should be undertaken on a regular basis (i.e., every 6 months) or earlier if there is a significant change in the case (i.e., Ms. Harris' mood worsens, Alex's antisocial behaviour escalates, or if one of Ms. Harris' romantic partners moves into the household). If no significant improvement in Ms. Harris' parenting occurs in the next 6 months, it may be necessary to consider out of home placement for Alex, given the high risk of serious physical and emotional outcomes for this 7 year old.