Submitted to the members of the Violence Against Women Service System Capacity and Implementation Team Central West Region
(a sub-committee of the Central West Region VAW Forum)

Child Witness Program Effective Practices Project: Central West Region of Ontario

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EXECUTIVE SUMMARY:

Building upon a previous research program dedicated to domestic violence issues, members of the Violence Against Women Service System Capacity and Implementation Team, Central West Region (VAWSSCIT-CWR), a sub-committee of the Central West Region VAW forum, engaged an ongoing research collaboration with the Faculty of Social Work at Wilfrid Laurier to conduct an assessment of programs for children exposed to domestic violence/intimate partner violence (DV/IPV) in the CWR. This project was a follow-up to an earlier exploration of VAW services across the CWR, *Enhancing VAW Service System Delivery in the Central West Region of Ontario: Building Bridges between Theory, Practice and Action*, completed by Dr. Lafrenière and her research team from Laurier and submitted to the committee in December 2009.

Over the course of January – March 2010, a literature review on effective practices in child witness programs (CWPs) was completed and 23 interviews were conducted with group facilitators, program coordinators, senior staff and partner agencies affiliated with these programs from all regions within the Central West Region of Ontario. The interviews were guided by a questionnaire developed by the VAWSSCIT-CWR and were conducted by members of the research team.

Key Findings:

The CWPs across the Region form an integral part of the continuum of VAW services offered to women who have experienced DV/IPV and their children. They are successfully meeting the needs of the women and children they serve, providing them

with safe spaces to share experiences, helping mothers respond effectively to their children's needs and providing opportunities to strengthen family relationships.

There is strong collaboration in many communities across agencies and sectors which provide diversity of expertise, and continuity of care. CWPs benefit from committed, dynamic, resourceful, and creative staff who are skilled at engaging and supporting families.

The original curriculum designed at the Ministry has provided a strong foundation for the CWPs and has been adapted and modified (to a greater or lesser extent) in order to tailor it to the needs of each community and group context. Significant enhancements have been made in several agencies to ensure it meets the needs of participants and remains current with emerging research and knowledge.

However, gaps in service remain for youth, who may be more difficult to engage in the CWP model, and for fathers who have engaged violence within their intimate relationships but who continue to be involved in their children's lives. Access to services for cultural communities remains uneven across the CWR. Some programs offer groups in different languages or are targeted at particular ethnic/cultural groups, but most CWPs have relied on interpreters when necessary or have referred families to individual/family counseling as an alternative. Finally, there is a significant gap in service for members of the LGBTQtranstwo-spirited, and [dis]abled communities.

Issues of parental consent constitute a challenge for many CWPs and there is no consistent response across programs in addressing this obstacle to participation.

Collaboration with child and family service agencies has been an important element of many CWPs with significant benefits to the programs. However, tensions may exist within that collaboration, including difficulties relative to voluntary vs. mandated participation in the CWPs and different philosophical frameworks informing practice.

There is a need for ongoing research, resource development and more systematic evaluation to demonstrate program successes and challenges. Ongoing training was also identified as necessary as well as opportunities for networking and interaction for staff of CWPs across the Central West Region of Ontario.

Recommended next steps for the VAW Forum to consider:

- That continued dialogue occurs between providers of CWPs and their local child and family service agency in order to clarify relationships, the impact of mandated participation in a program designed for voluntary participation, etc. Additional training for CAS staff in VAW issues may be required to facilitate this dialogue.

- That spaces be created in order to bring practitioners involved in the CWP to come together to share knowledge and experiences, learn about new and emerging research and exchange resources. The VAW forum is uniquely situated to provide the necessary leadership to ensure this collaborative spirit is maintained and strengthened.

- That attention be paid to developing a more uniform evaluation strategy for the CWP which to date is significantly absent. A standardized, coordinated information gathering strategy for research should be developed – not one which is onerous but that would allow for a more effective planning and monitoring program across the CWR and would allow for an assessment of resource needs.

- That continued dialogue occurs between mainstream and culturally-specific agencies to ensure a meaningful collaboration that recognizes the strengths and contributions of each and honors the philosophy of inclusivity when serving women and children.

- That resources be allocated to all CWPs in order that they may provide the child care services that currently constitute a barrier to access for some families. Additional resources may also be required to ensure agencies have the necessary age-appropriate toys, games and activities for children across the age spectrum.

- That a recognition of the context of women's lives including the impact of poverty be at the centre of any provincial strategy for addressing DV/IPV for women and their children.

- That specific attention is paid to the needs of immigrant and refugee families, including survivors of war and torture, who have unique needs and trauma histories.

- That an inclusivity analysis be undertaken of the child witness programs across the CWR to develop an action plan to address the particular realities and service needs members of LGBTQtrans/two-spirited, (dis)abled, cultural and First Nation communities.

- That increased emphasis on funding and research is attributed to programming for fathers who have used violence in their intimate relationships (e.g. Caring Dads) in recognition of the ongoing relationship they have in the lives of their children.

- That additional planning, resources and training be put in place to ensure that older children and youth are engaged and involved in the CWPs, through group sessions and/or through alternative measures.

- That a more detailed assessment of training needs is undertaken, with the goal of developing an introductory training course for all new facilitators in order to ensure a basic standard of knowledge regarding DV/IPV and childhood exposure, as well as skill-based knowledge about group facilitation, particularly with children. Further professional development training should be offered periodically to address emerging issues, new interventions and other areas identified by CWP facilitators.

- That women have access to ongoing supports following involvement in the CWPs, including follow-up and referral to additional services, as required. This recognizes that CWPs are only one component of a comprehensive system of services required to support families which should include access to individual and family counseling, children's mental health services, programs for men who have used violence within intimate relationships, etc.

INTRODUCTION:

In December 2009, the Violence against Women Service System Capacity and Implementation Team, Central West Region (VAWSSCIT-CWR) undertook the initiative to explore in more detail the work currently underway in the CWR with respect to children exposed to domestic violence/intimate partner violence (DV/IPV). In particular, the focus of the project was to study the ways in which agencies across the CWR were implementing, experiencing and evaluating the group model that has been in place across the province for the past decade. The growing awareness of the potential long-term impact of DV/IPV on children and recognition of the importance of developing a comprehensive response to families that have experienced DV/IPV informed this study.

METHODOLOGY:

A literature review was undertaken to assess the current scholarship relative to the needs of children and families who have experienced DV/IPV. This review details the growing body of literature regarding the myriad of ways in which the experience of being exposed to DV/IPV can manifest in children, the emerging research on effective interventions with this population, particular issues and tensions that underlie service delivery to these families and contextual factors that may affect the effectiveness of existing interventions. It also identifies areas that require additional study. A recent Ontario Association of Children's Aid Societies (OACAS) conference, held in March 2010 points to the growing community response to children who have been exposed to DV/IPV and the attempts to determine how best to serve these families. It also highlights many of the tensions that will be discussed in this report, not least of which is the

increasing coordination between services for women who have experienced DV/IPV delivered through the traditional VAW sector and the growing authority/involvement of the child welfare system. This has significant implications for service delivery including increased opportunities for integrated, comprehensive services to families who have experienced violence and the need for thoughtful, deliberative dialogue in order to ensure that both women and their children are effectively served within that collaboration.

A questionnaire was initially developed by the Violence against Women Service System Capacity and Implementation Team - Central West Region for distribution but it was determined that interviews would more effectively gather the necessary information. With slight modifications, the questionnaire formed the basis of interviews conducted by Laurier researchers. Questions focused on the structure and process of delivering child witness programs and allowed for a broader exploration of the context of service delivery as well as the strengths, challenges and opportunities for enhancement within existing programs.

Interviews, many of them building on initial questions from the VAW study conducted in the Fall of 2009, were conducted over the course of January through March 2010 with 23 individuals from agencies across the CWR. Participants were identified through lists solicited by committee members. Participants were primarily facilitators of groups offered for mothers and their children, along with several program coordinators and a small number of senior staff working within agencies providing VAW services. Staff members from community partner agencies, including Child and Family Services

were also interviewed. Interviews were then transcribed and data analysis was conducted by members of the research team in order to identify key themes and inform recommendations.

Research Limitations:

Facilitators involved in delivering Child Witness Programs (CWPs) are most often part-time workers and take on this role in addition to full-time work in other agencies. Finding opportunities to connect for a fairly lengthy interview (often over an hour) was sometimes challenging. Interviews with several participants were conducted in the evenings and on weekends on their own time rather than within a context of paid work. Given the geographic area covered by the CWR, a phone interview format was used which necessarily sacrificed some of the richness of data that is often gathered within the context of face-to-face interviews. Finally, given the limits to the scope of the project, a comprehensive environmental scan of effective programs was not possible but would be an initiative that would complement the work completed to date. Finally, again due to the scope of the research, the voices of program participants themselves are missing from this report and would certainly enrich the understanding of strengths of the programs and areas for further enhancement.

LITERATURE REVIEW:

The literature review which follows explores best practices for social service practitioners working with children who have been exposed to domestic violence (DV)/intimate partner violence (IPV). The review surveys several studies and practice guides that suggest methods and frameworks to inform practice with these children. Further, it provides some contextual information regarding the ways in which the lives of women and children are affected by DV/IPV more broadly, in order to ensure that interventions targeting them integrate into a systemic, structural analysis. Finally, some emerging research regarding the ways in which the child welfare and violence against women sectors intersect in ways that may inform Child Witness Programs (CWPs) will be outlined.

Use of the term 'children exposed to DV/IPV' allows for a definition that encompasses the diverse ways in which a child may experience and/or witness domestic violence/intimate partner violence; "this includes directly viewing the violence, hearing it, being used as a tool or shield of the perpetrator, and experiencing the aftermath" (Ernst, Weiss, Enright-Smith & Hansen, 2008, p. 393). Canadian estimates suggest that up to 80% of incidents of DV/IPV are witnessed by children (Tutty, 2010). Although at one time there was much scholarly debate about whether or not child witnesses are affected by exposure to DV/IPV there is now a "wealth of clinical evidence that indicates that they do" (Gibson, p. 3, 2008). Studies show that exposure to DV/IPV can have consequences in 2 major areas: behavioural and emotional functioning, as well as attitudinal and cognitive functioning (Ernst et al. 2008).

Researchers have documented a range of difficulties that children who witness DV/IPV are at risk of experiencing, including aggressive behaviour, anxiety, excessive crying, depression, difficulty sleeping, nightmares, anger, low-self esteem, fear, poor school performance, temperament problems, cognitive dysfunction, difficulty with peers, argumentativeness and an increased likelihood of engaging in abusive behaviours themselves (Gibson, 2008; Jaffe, 2005; Borrego, Gutow, Reicher & Barker, 2008; Baker& Jaffe, 2007). Without effective supports and interventions, these difficulties may continue into adulthood and can result in depression, low self-esteem, violence-tolerance and violence in adult relationships (Ernst et al., 2008). Investments in programs and services to encourage resiliency and healthy development in children exposed to DV/IPV and to provide families with adequate education and supports is an aspect of VAW services that is still in its infancy and there remains much to be learned about how best to achieve these outcomes. A more recent development in understanding the impact of childhood exposure to DV/IPV is a recognition of the symptoms as being trauma-related (and in some cases, children may be experiencing post-traumatic stress disorder). (Adams, 2006 as quoted in Tutty, 2010).

The issue of DV/IPV is not new to the realm of social work intervention and research, however, the emphasis on children exposed to violence has been given increasing importance and focus within the research, literature, and theorizing about DV/IPV over the last decade or two (Holt, Buckley & Whelan, 2008; Gibson, 2008). As awareness regarding the potential effects of exposure to DV/IPV on child development has grown, little is in fact known about effective or 'best' practices in serving this population. The lack of strong professional knowledge is endemic in all key sectors

involved in serving families in which DV/IPV has occurred - health, social, legal and educational systems. (Gibson, 2008). Professionals have had difficulty in identifying signs pointing to exposure to DV/IPV in children and have also had trouble recognizing the multiplicity and complexity of children's unique needs and deciphering how to translate this complexity into effective interventions (Holt, Buckley & Whelan, 2008).

The information provided in the following pages aims to highlight effective treatments and interventions for children exposed to DV/IPV. However, it is important to acknowledge the interconnectedness between the experiences of, and responses to, children exposed to DV/IPV and children who are themselves victims of other forms of abuse. Studies show that about one-third of children exposed to DV/IPV are also victims of other forms of direct child abuse (Ernst, Weiss, Enright-Smith & Hansen, 2008). Children who have experienced both forms of violence may have additional difficulties and issues and may, therefore, need interventions that have not been explored in this review.

Identified Deficits in Knowledge of Effective Interventions:

There is a growing body of knowledge that directly relates to children exposed to DV/IPV and interventions for this population, however, as noted, it is still an emerging field of research. Prior to a recognition regarding the particular issues involved in the context of childhood exposure to DV/IPV, treatment for these children was either embedded within the larger treatment approaches for child abuse and neglect or ignored altogether. For those children who received traditional interventions, the question was posed whether such treatment was effective for circumstances of exposure to DV/IPV

and for those children who did not receive treatment, questions began to be raised about the need for specific, tailored interventions addressing this gap. These questions began to be seen most clearly within the context of child welfare interventions and the inclusion of exposure to DV/IPV as a category of child abuse in and of itself in recent years.

Inclusion of this criterion within the child protection mandate has dramatically increased reporting to child welfare agencies. Across Canada in 2003, there were 50,000 cases of DV/IPV investigated by child protective services and of these investigations, almost half were due to children exposed to violence (without having experienced the violence directly themselves) (Trocme et al, 2005). Holt, Buckley & Whelan (2008) suggest that the current child welfare services mandate and discourse is 'child-focused' and is therefore hasty in defining and responding to children's exposure to violence as a form of child abuse. Furthermore, Holt et al. (2008) draw on scholarship suggesting that child welfare services are "punitively responsive to women, simultaneously holding them responsible for their children's protection while ignoring their attempts to keep their children safe" (p. 21). Instead of the focus remaining on the violent partner, mothers often become the focus of the child welfare intervention and face both regulation and sanctions for not cooperating with agency requirements. Holt et al. go on to discourage child protection responses, encouraging a community-based response in the majority of cases, and relegating child protection to severe cases of abuse and child exposure.

This argument highlights a key area of tension within collaborations between the VAW sector and child welfare services, particularly within the context of CWPs. The need to reconcile child-focused and woman-focused paradigms can lead to conflict and values-based struggles. An exclusive focus on a narrow interpretation of child protection may

create circumstances which overly pathologize mothers who are parenting in the context of DV/IPV even when they are no longer living within these relationships. (Tutty, 2010). It can also shift the focus and supports away from women, who remain the primary victims of DV/IPV. Finally, it denies the growing body of literature and research demonstrating that many abused women are excellent mothers and that many children exposed to DV/IPV are enormously resilient and grow up with few of the symptoms reported in earlier literature (Casaneuva et al, 2008; Tutty, 2008).

One strategy in place in several communities across the United States and Canada is a differential response model in responding to child maltreatment in all forms. This model has been endorsed by many researchers as a more effective way to manage cases involving DV/IPV as it allows for a more effective identification and allows for the provision of supportive services while avoiding the more punitive response that can occur through the formal child protection systems (Edleson, 2004; Waldfogel, 1998).

Differential response approaches are based on the belief that voluntary community-based services may be more appropriate for some families, while others will require more formal interventions. Given women's fears of child welfare involvement, including the risk of apprehension of their children, a DR approach may offer a useful alternative that can more effectively serve both women and their children (Devoe & Smith, 2003; Jenney, Alaggia, Mazzuca & Redmond, 2007). The challenge of such an approach is the reality that voluntary services within the community are often underfunded, or may not exist at all, and therefore cannot always meet the demand for service that this approach

creates. A greater investment in these resources is needed for optimal implementation of these models (Edelson, 2010).

Considerable research suggests that social workers and other practitioners interacting with children exposed to DV/IPV often feel ill-prepared to counsel and/or intervene with them. Reasons cited include a lack of awareness and understanding of DV/IPV dynamics and implications for children, a lack of knowledge, training and appropriate skills to successfully work with this population including the tensions between woman-focused and child-focused approaches highlighted above (Holt et al., 2008). Further, Ernst, Weiss, Enright-Smith & Hansen (2008), highlight the fact that intervention programs for children who witness DV/IPV have yet to be adequately evaluated. This lack of structured evaluations not only leads to challenges in designing and implementing new interventions but also means that those innovative programs that are in place in many places across the country are not able to provide the necessary 'proof' that they are models of good practice. This is creating missed opportunities for agencies and social service providers to learn from one another.

Other issues causing delays and difficulty in intervening with children exposed to DV/IPV is the fact that, until very recently, little research on this subject has been conducted in Canada. Many interventions used in American, UK or Australian studies are not easily accessible or culturally relevant to the Canadian context. In these other countries there does not appear to be any national comprehensive strategies of support for children exposed to DV/IPV and research on therapeutic approaches remains sparse (Dodd, 2009). The lack of empirical knowledge is seen as a result of the complexities of

intervening with children who have been exposed to domestic violence (Borrego, Gutow, Reicher & Barker, 2008). Few researchers have been able to contribute empirically sound methods of intervention owing to issues such as small sample size, lack of control groups, untested measures and little follow-up (Borrego et al., 2008). What has been examined in other populations have been studies which find that domestic violence is an environmental influence on children's behaviour (Foster et al., 2009). Holt, Buckley & Whelan (2008) argue that the recent academic push to address the current lack of methods and frameworks for intervention with this population is a sign of greater acknowledgement of the complexities that have been overlooked for those affected by domestic violence.

The recent Ontario Association of Children's Aid Societies' (OACAS) conference, *Critical Connections: Where Woman Abuse and Child Safety Intersect*, held in March 2010, is a significant step forward in providing important research and promising approaches to working with children and families within the Canadian context. However, it must be acknowledged that this conference is focused on child and family service providers and thus the types of interventions implicated in those systems were given primary attention and other programs may have been overlooked.

Gibson (2009) expresses that "there is a wealth of clinical evidence" (p. 2) demonstrating that children exposed to DV/IPV suffer "real and significant consequences as the result of their experiences" (p. 2), although Borrego et al. (2008) question the efficacy of the limited intervention models and point out the lack of "systematic evaluation of effectiveness" within the field (p. 497; see also Ernst et al. (2008). She

believes the real issue is not whether or not these children have experienced trauma, but whether existing therapeutic models are beneficial and provide the tools needed to overcome said trauma. Further, Gibson (2009) posits that although there is an eclectic ensemble of methodologies that currently informs professionals within the realm of social work, there remains a lack of attention to the fundamental values inherent in each process as well as how a particular process might contribute to the child's sense-of-self throughout the course of intervention.

As practitioners attempt to capture the diverse range of experiences and responses of these children into a single category, Holt et al., (2008) argue that the issue requires individualized responses, an approach they believe the child protection system is structurally unable to do. Dodd (2009) calls for broad multi-agency preventative programs to raise awareness and to change attitudes surrounding violence. She also emphasises the need for specialisation within those preventative programs for children exposed to DV/ IPV. Examples of broad education and awareness campaigns include school-based programs addressing violence within IPV such as In Love and in Danger and the Friends, Families and Neighbours program in place in many communities in Ontario.

Best Practices:

According to Linda Baker and Peter Jaffe (2007), one-half of the women who transitioned into a shelter with their children in Canada did so to protect the children from witnessing their abuse. Therefore designing interventions for children exposed to violence are important within transition institutions and shelters as frontline workers in

these venues will come into contact with the child at the earliest point. Indeed, the Task Force on Community Preventative Services (2008) insists that early interventions are most beneficial when administered quickly and appropriately. Early intervention refers to intervention occurring less than a month after disclosure of abuse (Task Force, 2008). Speedy and intensive intervention is the most effective tool when dealing with children exposed to domestic violence (Holt et al., 2008), however, recklessness in hastily administering an intervention is not recommended. Due to the lack of developed scholarship in effectiveness of treatment, there are a multitude of models that are currently in use to treat DV/IPV witnesses. These models range from clinical models, individual and group approaches, to school and community programs, multidisciplinary teams, play and art therapy and combinations of all the above (Holt, Buckley & Whelan, 2008). However, before an early intervention can take place, there must be an assessment.

In terms of best practices, assessments must be holistic and consider the unique dynamics of protective and risk factors that exist in every family previous to assuming what harm or risk there is to a specific case and what interventions are needed (Holt et al., 2008). Holt et al. (2008) emphasize the necessity of including the child in the assessment process, when and where appropriate, as children will self-identify those areas in their lives that are most problematic for them, and a detailed plan can emerge from this consultative method. There is much emphasis on the idea that interventions must be individualized, detailed, multilayered and flexible (Borrego et al, 2008; Holt et al., 2008).

The types of interventions utilized can be placed anywhere on a spectrum of primary, secondary and tertiary interventions (Holt et al., 2008) and may be short or long-term, involve the entire family or simply the child, and incorporate the surrounding community and other informal networks. The assessment should be based on the child's immediate and future needs and should take into account the child's resiliency and strengths. In fact, at times a sound assessment concludes that the child does not need direct intervention and will focus aid in the direction of the non-abusing and abusing parents (Holt et al., 2008). This is an ecological model that shows how the child will benefit from those around him or her receiving services and improving the home environment. Borrego, Gutow, Reicher & Barker's (2008) study states that the modality should be dependent on factors that take into account the child's presenting symptoms, the family's safety and the "practitioner's conceptualization of family violence" (p. 496) and are most often goal and objective specific with a structured curriculum.

Common Threads:

Although research illustrates that modes of intervention can and do vary from case to case, it is important to note several interconnecting themes, which seem to span the array of literature on children exposed to DV/IPV. These include mother-child relationship dyads, cognitive-behavioural learning and expressive/communicative techniques. These themes often overlap and intertwine in a single intervention tool.

Several researchers have stressed the importance of the mother-child relationship in healing victims and witnesses of domestic violence (Dodd, 2009; Borrego et al., 2008; Gibson, 2009). It is advised that parental involvement is vital in any child intervention

process (Dodd, 2009; Borrego et al., 2008) as it enables parents to recognise the effect that violence has on their child. Although many interventions continue to concentrate on the mother or child individually, failing to fully acknowledge the importance of this key relationship and the interdependence of healing, there is a growing emphasis on integrated interventions. This may be accomplished through various methods of family counselling or, increasingly, through the use of group supports that provide opportunities for both individual learning, peer support and mother-child dyad activities. Dodd (2009) describes good parenting and secure attachments as "one of the protective factors for children which enables them to overcome and cope with the adverse and damaging effects of living with domestic abuse" (p. 34). If a mother is able to work through her trauma while remaining an attentive parent, it is seen as strength of the child's and will benefit them in their journey of healthy development.

Research suggests that tensions can develop within the relationships of women who have experienced abuse and their children, due in part to the challenges of parenting created within the context of an abusive relationship, and the impact of witnessing abuse on children's behaviour and emotions (Borrego et al., 2008). An issue that receives less attention but requires additional study is the contextual realities of the lives of women and children following the end of an abusive relationship – this might include isolation, a lack of access to formal and informal social supports, financial difficulties, a lack of access to appropriate housing, a lack of appropriate employment opportunities and challenges in accessing child care to name only a few. This can be exacerbated for women who belong to marginalized communities such as the LGBTQtrans/two-spirited, newcomers and First Nations women, who may face additional discrimination and fear of

accessing services. This context must be acknowledged and helps to broaden thinking and planning about effective interventions for children who witness DV/IPV. Individual interventions are critical but must be designed in a way that acknowledges the broader social challenges affecting many families who have experienced DV/IPV.

A further area requiring additional study is the delivery of services to these children in a way that includes the abusive parent. Baker, Jaffe, Ashbourne & Carter (2002) state that "children may experience strong ambivalence toward their violent parent: affection coexists with feelings of resentment and disappointment" (p.7), suggesting that parents who have been perpetrators should be engaged, where appropriate, in holistic programs that recognize the ongoing role that many of these abusive parents continue to play in their children's lives. Traditionally, programs for abusive men did not integrate significant content regarding parenting or the impact of violence on their children (in programs such as Partner Assault Response). More recently, programs have been developed such as Caring Dads, the My Dad's group (a partnership between the Children's Aid Society of Owen Sound and the County of Grey and the Children's Aid Society of the County of Bruce), as well as partnerships aimed at supporting families when parents have reconciled and want to ensure violence does not re-occur within the relationship such as the Partners for Healthy Relationships program run by Family and Children's Services of Waterloo Region and the John Howard Society of Waterloo-Wellington.

The recent exploration into mother-child relationship counselling has brought forth a host of therapies and intervention methodologies from around the world, the most

empirically supported is Child-Parent Psychotherapy for Family Violence (CPP-FV; Borrego et al., 2008). The intervention is based on psychodynamic, attachment, cognitive-behavioural and social learning theories; an amalgamation of the 3 pillars discussed above. The therapy is geared towards children in pre-school and below who have witnessed domestic violence or who seem to be exhibiting traumatic symptoms from exposure to IPV. Mothers are encouraged to develop emotional bonds and foster child development through supportive play, communication and physical contact activities. The end result is to create a secure attachment for the mother-child dyad. Another intervention that is gaining some recognition within domestic violence research is Parent-Child Interaction Therapy (PCIT). This evidence-based behavioural intervention therapy is parent-focused and focuses on disruptive/maladaptive behaviours in children from 2-7 years-old. This is yet another intervention that focuses on the parent-child dyad as the locus of change and by utilizing the tenets of the authoritative parenting style (Borrego et al., 2008).

In Dodd's (2009) study, an intervention method whose aim was to augment positive relationships between mother and child and promote parental sensitivity and secure attachments was used. "Theraplay" is a form of play therapy that emphasises the relationship between the mother and child and uses specific play activities to reinforce secure attachments, such as "eye contact, touch, closeness, physical proximity, sensory motor stimulation and rhythmic movements" (p. 28). This approach seemed most effective with younger children and children with anxious-avoidant and disruptive attachment styles.

Cognitive-behavioural learning is most commonly used to treat children with ‘behavioural problems’. The supporting theory espouses that behaviour is “learned social responses modeled by violent caretakers and peers” (Borrego et al., 2008, p.496). Most often Cognitive-Behavioural Therapy, or some derivation of that intervention, is used with positive results. Ensuring a safe and nurturing environment from which to conduct these activities is paramount, as well as having a safe place for children to continue to learn after leaving a session. Dodd’s (2009) findings from her study suggest that “all children develop and learn holistically and their emotional and social development…form[s] the bedrock of other developmental areas” (p. 27).

Both group and individual Cognitive-Behavioural Therapy (CBT) are recommended for use in treating traumatized children. CBT is a trauma-focused therapy created to alleviate symptoms of post-traumatic stress disorder (PTSD), along with depression and anxiety. Therapies based on the CBT model should include the ‘strengths based’ model and aim to create a positive and therapeutic environment. As previously stated, treatment plans should be individualized and child input must be sought out when possible. Safety plans should be developed in case of future violence and discussions about where and how to seek assistance if violence were to reoccur. This procedure helps children to feel in control in a situation where they may normally feel powerless (Ernst, Weiss, Enright-Smith & Hansen, 2008). Essentially, the purpose of therapy is to “teach children that violence in their family is not their fault or responsibility” (Ernst et al., 2008, p.391). Interventions also aim to educate the child to end the cycle of domestic violence in their current and future lives.

Play, art and animal therapy are all expressive/communicative interventions that work best with younger children who have limited vocabulary to express how they feel. Each one of these therapies has difficulties in being empirically evaluated because their components vary by practitioner as well as what kind of games, art or animals are introduced for therapy. However, that does not mean that these modalities should not be used, simply that they should be used in conjunction with a more measurable methodology. In fact, Dodd's (2009) study showed that play therapy was a huge factor in cognitive development and that it could also be used in a therapeutic way by enabling young children with the ability to fantasize and project their inner feelings. Also, Dodd (2009) believes that "children, particularly younger ones, may also communicate through drawings and painting" (p. 27) thus it may be a worthy activity.

The Task Force on Community Preventative Services (2008) also discourages practitioners from using pharmacological therapies, as most drug therapies have not been extensively tested on children and there is little proof that these synthetic substitutes provide more good than harm.

More and more research suggests exposure to domestic violence can cause damage to children's development, psychological well-being, safety and self-esteem. Each child exposed to DV/IPV is unique, as is their situation and the methods and theories used to help them should always take this into consideration. Practitioners should also take note that because of this uniqueness, not every child who has witnessed domestic violence will be in need of services (Dodd, 2008). For those that do, the goal

must be to provide these children with stability, safety and trust, which starts in their own homes.

The question remains: what can we do to support child witnesses of domestic violence? Baker and Jaffe (2007) encourage the community and agencies within it to help by providing children exposed to domestic violence and their families with accessible services that provide safe, nurturing spaces and encourage the emotional well-being of all family members. They also believe that it is the community's responsibility to hold aggressors accountable in a legal manner while also providing rehabilitative services to perpetrators of domestic violence in their areas.

For young children exposed to domestic violence, programs of intervention that give support should respond to the child on an individual basis; provide stable, nurturing environments; promote safe, healthy relationships and give guidance during possible transitions occurring in their lives. Healthy familial relationships and community bonds are also important for children in this tumultuous time. Encouraging extended family members and friends to whom the child is close is an important step towards creating safe places and normalcy in new environments (Baker & Jaffe, 2007). A study by Foster and Brooks–Gunn (2009) found that "socially supportive processes and perceived safety in family, school, and neighbourhood…hold particular promise for interventions with poly-victimized youth" (p. 87).

Regardless of which approach or approaches taken when assessing and intervening with domestic violence child witnesses, it is essential that practitioners keep

in mind that the goal is to increase stability and routines in the lives of these children and create strategies that help children cope (Dodd, 2009) with their unique issues.

DATA ANALYSIS

From January to March 2010, 23 interviews were conducted with service providers across the CWR including program coordinators, group facilitators, individual clinicians, senior staff and community partners. The focus of the interviews was to gain a detailed overview of how children exposed to DV/IPV are currently being served, with a particular emphasis on group approaches providing psycho-educational and therapeutic support to mothers and children. The interviews explored how programs have been implemented in each agency, what innovations are occurring in order to address the particular needs of each community, the necessary ingredients for a successful program and challenges and tensions in doing work with families who have experienced DV/IPV. A final goal of the interviews was to assess needs (such as training and resource-sharing) that could be addressed collectively and gauge participant interest in ongoing collaboration and information-sharing opportunities.

Themes emerging from the interviews were consistent with many of those identified in the literature and several mirrored those uncovered within the VAW project completed this Fall. In exploring these themes, the more concrete issues of program structure will be presented, followed by the strengths and challenges within the programs and finally the interest expressed regarding continued networking and collaborative opportunities.

The structure of Child Witness Programs:

Most CWPs discussed with respondents were adapted versions of the Ministry-designed group program based on the curriculum conceptualized almost 10 years ago. All but one agency offered a group model that involved weekly sessions with mothers and their children, either on an evening or weekend. Groups ranged from 6 to 12 weeks in length, with individual sessions ranging from 1.5 to 3 hours in total. Groups are run, on average, two or three times a year depending on the available funding at each respective agency. All programs involved a shared meal (whether that be pizza ordered in or involve a collective-cooking type of situation), a brief family activity that allowed mothers and children to interact and learn together, and a time for moms and children who have separate time to learn in groups, co-facilitated by two staff members.

The children's groups were divided by age, although the specific age range divisions depended on the make-up of each cohort and also depended not only on chronological age but on an assessment of the children's developmental and emotional stages. Most programs had children participate in curriculum-based activities from the age of 4 or 5, although several were able to offer a 0-5 group that was primarily child care for those families that had younger children as well as school-aged ones. The majority of the CWPs were designed to include teenagers up to age 16, although given challenges in engaging older children/youth (to be discussed in more detail later in the report), most children participating are under the age of 13. In all CWPs, the children's groups are mixed-gender.

While the groups are primarily psycho-educational in design, most agencies have included a range of more therapeutic interventions from art and play therapy and in some programs, undertake a more detailed exploration of the impact of trauma on families.

The primary goal of the program is to allow children to identify and express their feelings and experiences in a safe environment and to provide mothers with tools to better understand and respond to her children's needs. Therefore, the focus of the work completed in the mothers' groups is less on her own emotional healing, than on her ability to relate to and support the healing of her children. Helping mothers to recognize and understand the impact of the violence on their children can be a challenging process, according to some respondents, as often women may feel that they have kept the violence hidden and/or underestimate the degree of exposure that the children have had and the resulting trauma experienced. Coming to this realization is often an extremely painful and difficult journey for participants. In practice, most respondents pointed to the need for an integrated approach that recognizes the ongoing need to support mothers in their own well-being – as an end in and of itself and as a way to support her in her role as a parent.

In general, families participate in CWPs only once, given its psycho-educational framework, although in certain agencies there is flexibility for those that want to re-enroll. Often these families would be asked to skip the next cycle, and then they could take it again later in the year. Others might be re-referred several years later if the mother

had been in another relationship that involved DV/IPV or if some of her children had been too young to fully benefit from the program the first time around. In most cases, however, if families required continued supports they would be referred to family counseling services, or to another community agency for further follow-up. However, the dearth of effective mental health supports for children in some communities (and in particular for mental health assessments) means that referrals can sometimes be challenging and families may continue to rely on VAW/CWP services in the absence of other supports. Often, CWP staff are also taking on unfunded case management responsibilities in order to attempt to link families to other, often scarce, resources.

Criteria for Participation:

Many respondents spoke of the detailed family assessments done by program coordinators prior to accepting them into the groups, in order to understand their unique needs (as individuals and as families). Each agency had specific criteria for participation, however, the majority of respondents highlighted the following issues: that families should not be in a state of acute crisis (they should not be living within the context of the violent relationship, should have stable housing, should not be constantly in and out of courts, and the mother should have done some of her own initial healing work and be motivated to participate); and that the children should be able to benefit from the program. Therefore, in several programs, children with severe behavioral or mental health issues would often be referred to individual counseling supports instead, while the other members of the family participated in the group program. The family's willingness

to commit to participate in the full program was assessed and weekly participation was strongly encouraged in all agencies to ensure continuity and safety for participants, particularly children who might be disclosing their feelings or experiences for the first time. Although cut-offs varied, and there was a commitment to as much flexibility as possible, in most cases families could miss no more than 2 sessions before being asked to re-enroll in a future cohort. Parental consent was also an important criterion for eligibility identified by respondents, although the complexities of this issue require it to be dealt separately. There were some programs that took a broader approach, with fewer restrictions on participant eligibility (including current involvement in a relationship in which DV/IPV was occurring).

In a small number of programs, the coordinator was able to assess families and match participants to try to ensure the right 'fit' of families for best program outcomes (whether by age of the children, family history, etc.), but primarily eligible families were selected from waiting lists or as referrals came in. In some communities, ensuring access required an assessment of language and cultural identity. While only a small number of programs offered culturally-specific groups, often through partnerships with culturally-specific agencies in their community, several spoke of having co-facilitators that spoke a range of languages to facilitate access to families that may not have English fluency. Others suggested that translators were occasionally hired to provide assistance to families within the program. Overall, however, with a few exceptions for agencies serving particularly diverse populations, the programs are largely framed within an English, mainstream lens. When asked about LGBTQtrans/two-spirited families, none of the

participants could recall having members of that community participate in group programs, although several mentioned that it was a topic of discussion at their agencies. When asked about services for women in same sex relationships, one respondent acknowledged that "we haven't had any in 8 years. It's not that we turn them away, we're not even reaching that population."

Similarly, although there were several programs offered through the agencies to support fathers such as Caring Dads and the Partner Assault Response program, there were no services offered to men and their children who were survivors of DV/IPV. Men who had used violence in their relationships were not involved in any way in the child witness programs discussed by respondents, although some might be receiving individual services. One respondent noted that the lack of services for men is a "huge gap", noting that "these men, these fathers are still in their children's lives. There have to be supports. We need to start looking at this seriously."

Challenges in Access to CWPs:

In addition to parental consent and language/cultural barriers, challenges in access were consistent with earlier findings from the VAW project and included transportation, child care and other resources. Providing transportation, whether in the form of bus tickets or taxi vouchers, went a long way in addressing this issue, as did holding the groups in a central, accessible location so families were not forced to travel for too long to attend. For those agencies that did not offer programming for the 0-4 age group, subsidizing private child care was helpful in reducing barriers to participation. However,

given that these families are often isolated, sometimes accessing private child care remained challenging even with the resources provided. Having on-site care was an enormous benefit for ensuring access for all eligible families, and those agencies not resourced to provide that recognized it as a significant barrier to some participants.

Also, given the fact that some participating families live in difficult financial circumstances, the sharing of a meal was seen as an important way to engage and to offer additional support to them – a point was made in several agencies to ensure that there were always lots of leftovers so that families could be sent home with food for the week. In fact, some respondents identified poverty as a significant factor in the lives of many families they served. For example, one facilitator reported children sharing within the group context that they had insufficient food, bedding or warm jackets for the winter. In some agencies, ensuring that these basic necessities were provided to families wherever possible in a way that did not shame or pathologize the mothers was an integral part of serving families. The context of poverty is a factor that is not formally addressed within CWPs but certainly informs the needs of the families served and should be considered in any analysis of program effectiveness. As the literature points out, poverty is a considerable factor affecting how women are able to respond to the violence in their lives and that it is an issue that often continues after the relationship has ended.
CWPs are attempting to find creative, respectful ways to respond to families facing financial difficulties. One respondent explained their process in this way:

> We found that in some families, kids were talking about not having enough food….or for example, one child when talking about self-soothing expressed that he did not have a pillow so we'll get bedding together. The challenge is doing it while still allowing mom to feel capable - like one child came to group with no appropriate jacket, and miraculously we had another jacket lying around. Or the food piece – these families need leftovers to send home so there is always an abundance of food. At one point we got snipped back budget-wise and there was not enough food and then families don't eat. Therapeutically it's powerful to send families home with a care package…we insist they take it home, 'please take it home, we have no where to store it'. This helps them to maintain their dignity…so we are always listening to families about what they are not getting, what they don't have – like one girl's grade 8 graduation prom – we accessed the dress exchange program….we do what we can…

<u>CWPs are an important component of a continuum of service for DV/IPV:</u>

The child witness group model was presented by respondents as merely one of the services offered to families who have experienced DV/IPV. Many of the families participating would be receiving a range of other services, either concurrently or consecutively – these might include group programs for mothers, individual and family counseling sessions, etc. A large number of referrals to the CWGs were internal to the agencies delivering the programs (or community partner agencies with ongoing connections to the families) and allowed for comprehensive supports to these families. Often, if families could not access the group program right away, they would be referred to counseling services in the meantime to ensure they did not 'fall off the radar' of the agency or that they did not lose their commitment to the process. Strong collaboration across agencies helped to keep families from falling through the cracks. However, it was noted that increased funding was needed for individual and family counseling in order to meet family needs. Further, the full range of supports were not always available within a community (such as mental health assessments and services for children, relevant youth programming, or addictions support).

Parental Consent:

The challenge of securing parental consent from fathers in order to allow children to participate in CWPs was a topic discussed by almost all respondents as a barrier to access and to effective program implementation. There is no consensus among agencies about how best to address this issue. Recent changes in custody and access policy were cited by some respondents as facilitating their role, in that responsibility for securing consent (in cases where a joint custody order was in place) was left to the mother. In some programs, an honor system was in place so that if she expressed that she had obtained consent, the program coordinator took her word for it. Others required written proof of consent by the non-custodial parent and had a form developed to that end. Several agencies working very closely with the local child and family service agency relied heavily on that agency for securing consent. One agency had what amounts to a 'Don't Ask, Don't Tell' policy, which resulted in what one respondent called an 'ethical grey area':

> We don't ask about legal custody - if mom's signing them up, we start from assumption they have the right to do so. That's where it's uncomfortable, where we bounce up to ethical questions…. there's going to be a day when it backfires... it doesn't feel good but that's what we do…

For some agencies, a failure to secure consent would result in families being turned away from the program (often referred to other services) and this was seen as a serious concern by respondents. Others had devised systems with a default consent clause in which they did outreach to these parents and in the absence of a response refusing

consent, consent was implied. In some cases, families were able to begin the program but could not continue unless consent was secured within first sessions. Agencies seemed to be getting different legal advice about their accountability for ensuring parental consent was secured before providing service. In only one program, the issue of consent by a parent other than the mother was seen as irrelevant, and not a barrier to service delivery.

When doing outreach to fathers in order to attempt to secure consent for their children to participate in the program, staff reported framing CWPs in more neutral terms - as dealing with conflict in families, or helping children deal with divorce, etc. They further reported making it clear to the men that the purpose of the program is not to 'trash talk' the father or to turn his children against him, but simply to help them to heal. While fathers are often resistant at first, according to respondents, they generally do ultimately provide consent. However, there are instances in which participation in the program becomes another tool of manipulation and abuse by men over their ex-partners and this is an ongoing concern expressed by some respondents.

Given that many of the respondents suggested that the optimal timing of participation in the program was not until families had moved out of the crisis period (including ongoing fractious legal proceedings), parental consent was seen as less of an obstacle by many respondents. In those programs that accepted a broader range of families at different stages of the separation process or those who remained within relationships, this issue was a more common concern. In cases in which fathers are involved, strict confidentiality is maintained. Unless it has been determined ahead of time, no disclosure

will occur regarding the participation of a family in the program. In cases of joint custody where a father has given consent and contacts staff for updates, only the most basic information is shared.

Ensuring Participant Safety:

Despite the criteria informing most of the programs that families should be out of 'crisis' by the time they participate, according to respondents, safety remains an issue of concern. Therefore, a safety assessment is completed as a part of the broader eligibility assessment prior to enrolling a family in the program. In some agencies, the detailed safety assessment and planning are done by partner agencies (particularly the children's aid society) when a referral is made and this safety plan is shared. In others, it is the role of the coordinator to ensure a safety plan is in place where it is warranted. Safety planning is also a part of the program curriculum for all participants.

In addition to safety planning, all groups are held within secure locations, whether that be at the host agency or in a local community building (such as a church or community centre). The outside doors are locked after participants arrive and procedures are in place to respond to situations in which an abusive partner arrives on the premises. While it is not unheard of in some agencies, it is extremely rare, and has been effectively managed when the circumstance has arisen.

The Role of Child and Family Services:

As the emotional and psychological impact of exposure to DV/IPV has increasingly been understood based on the growing body of literature and experiential knowledge within the service provider community, VAW has increasingly been framed/recognized as a child protection issue. Strong partnerships have been developed in many communities between service providers working with children who have been exposed to DV/IPV and local child and family service agencies. In many circumstances this includes co-facilitation of groups with staff of child and family service agencies (whether as a function of their existing work or as separate contracts). This relationship has provided a strong source of referrals through CAS caseloads, has helped in establishing clarity regarding legal responsibility for reporting in cases of disclosure and helped families to receive supportive services in the face of often fractious relationships with child protection agencies. However, this relationship is also a source of tension for many agencies, and reflects some of the larger questions often posed within certain feminist VAW sectors regarding how mothers who have experienced violence are pathologized. As was noted in the literature review, Dr. Leslie Tutty at the University of Calgary has completed some important work regarding the assumptions of the parenting capacity of mothers who have experienced violence that may not be supported by the evidence and that can lead to an over-regulation of these families.

Further, CWPs varied greatly in how they understood and framed the issue of voluntary vs. mandatory attendance in the program. While respondents confirmed that the program was voluntary from the point of view of the delivering agency, in almost all of the programs, some families participating were involved with the local children's aid society and had been, at the very least, 'encouraged' to participate in the groups. One respondent reported that up to 1/3rd of all participating families were mandated CAS referrals. Some respondents noted the challenges that could arise from this tension, stating that families who felt they were mandated to be there (whether this was officially the case or not) were often less engaged and motivated, were more likely to miss sessions, and often mothers had difficulties in trusting program staff (particularly when co-facilitators were staff of the child and family service agency, even when they were not participating in that capacity). Another concern raised was that during the assessment/screening phase of the program, women who were mandated to participate in the program might fear being rejected and therefore leave out important information (including safety issues and children's behavioral needs). This concern was addressed in part by ensuring a thorough assessment process in order to ensure that referred families were, in fact, 'group ready'.

Issues of confidentiality were raised by several respondents regarding disclosure of abuse, as well as sharing information with CAS case workers in cases of 'mandated' involvement with the program. In certain agencies, families complete consent forms prior to enrolling, allowing program staff to communicate directly with CAS staff

regarding the experience within the groups. Others have more restricted information-sharing practices.

Program Strengths:

When asked to outline the key strengths of the program, respondents were remarkably consistent. They spoke of the importance of working with mothers and children together, of providing opportunities for safe spaces for children to express themselves (often for the first time) and for mothers to learn how to respond to those needs in a non-judgmental environment. This focus on children's needs is at the core of all CWPs explored. The structure of the program – with shared dinner, focused time for family activities and the integration of play was seen as helping to engage children so that they became the motivators to ensure their families continued to participate. The parallel sessions for mothers and children were seen as very valuable for helping mothers to understand what their children were feeling and the peer model offered a significant source of support to the women. The integration of formal techniques of art and play therapies was viewed as very valuable in those CWPs that had access to that expertise.

One respondent shared her enthusiasm for the program in this way:

> It's a fabulous program! It helps kids to realize they are really not alone and that they have a voice. There are kids who come in and don't want to say a word at first, and then between groups they tell mom how they are feeling and they never have before – they are expressing what's inside, recognizing that they do have these rights and this is totally ok. We've seen changes in the relationship and role between mom and children, as small as it may seem at the time – it has been quite substantial.

The commitment and competence of the facilitators and the team approach to program delivery was also highlighted as a key strength. Facilitators were described as ‘real’, ‘authentic’, ‘nurturing and caring’ and their commitment to participants was seen as the foundation of the program. Respondents highlighted the strength of communication and collaboration between team members as inherent within the program. Many facilitators had been involved in the program for several years and the consistent relationships with other team members provided a level of confidence and trust that helped to strengthen the program for participants and allowed for effective problem-solving and responsive decision-making on the ground.

Another key strength was the flexibility within the program to tailor it to the needs of each family and group. While the curriculum provided gave a useful framework from which to launch, many agencies have made certain adaptations to the activities and content to make it more appropriate for their communities/families. The competence of the facilitation team allows for ongoing enhancements and ‘tweaking’ to ensure that the program is not a one-size-fits-all but can adapt to meet participant needs. While some agencies have simply integrated new activities and resources as they discover (or develop them), others have done more comprehensive reviews and restructuring of the curriculum. For example, one agency did a significant overhaul of the program several years ago to integrate a more comprehensive focus on the impact of trauma, attachment theory and the use of formal techniques of art and play therapy. Another agency has stretched the parameters of the program to broaden access to families that might not fit into the traditional model:

> It doesn't matter what the relationship is between the abuser and mom. In one situation, it involved an older brother so we have made some exceptions - if mom's older brother is the abuser, that's fine, we focus on the violence in the family context instead of just dad……and we haven't had any difficulty [with fulfilling Ministry requirements].

Enhancing Program Delivery:

When asked about what would enhance program delivery, several respondents highlighted the need for additional resources to expand the program and serve more families. One respondent explained that, "funding has not kept up with increasing demands. We could be running 3 times as many groups as we do now." The need for additional resources to allow for sessions to be held more often over the course of the year was raised by several respondents as a way to reduce waiting lists and to limit the loss of families for whom the program was no longer seen as a priority by the time CWP services were available. Several respondents recommended extending the sessions by several weeks, although others felt this would be a mistake and would be too long to keep children engaged in the process. Others suggested a series of follow-up sessions to be held 3-4 months later to provide additional support to families (particularly mothers) and to determine how effective the program is at making a lasting difference for families. Other respondents mentioned the need for new resource development that were age appropriate (activities, films, etc.), for the children's groups.

One participant suggested a much more significant change to the program structure, to accommodate the circumstances many families found themselves in:

> Ideally, we would look at making it more of an ongoing drop in approach, so women could come on nights that they are able, and it would be more open and flexible. We wouldn't have to say 'gee, if you miss more than two, you really should start over next time'. If it was run more continuously, which I recognize is a lot of money, but if it could be done, women could just jump back in when they are ready to get the content they missed. These families' lives don't always fit so easily into the appointment schedule model. Maybe this other approach wouldn't work, but we'd like to try it – it might be more friendly to the stage of life they are in….

The need to find ways to engage men was a common issue raised. Given the increasing focus on joint custody or continued paternal involvement in the children's lives, finding ways to engage fathers was seen as a missed opportunity thus far. Programs such as Caring Dads were seen as necessary but not a sufficient resource to ensure that the complex family issues facing children exposed to DV/IPV were addressed. While no respondent spoke of integrating fathers into the existing CWPs, they highlighted that this lack of service was a significant problem for many families.

The need for strategies to better engage youth was highlighted by several research participants who noted that CWPs have not had a tremendous amount of success in meeting the unique needs of adolescents exposed to DV/IPV. While some school-based programs are offered that address these issues, these models do not have a structure that allows for integrated dialogue with mothers and shared family activities. Several respondents suggested summer programming for families in order to better reach young people, while others recommended additional curriculum-development that would be better suited to this age group. The need to ensure that CWPs effectively address issues of dating violence and the particular gender dynamics within that age-group was highlighted by several participants.

When training was discussed, most respondents were enthusiastic about the possibility and had a range of topics they would like to explore. Interestingly, many of them suggested that training on basic skills would be very helpful – facilitation skills, working with children, and more training on VAW issues in general and the impact on children. Many of the facilitators came from other agencies/sectors and brought diverse strengths and competencies with them but may not have received training specific to the CWP and this was identified by some respondents as a gap. Many respondents spoke of the need to be trained to work with children with complex needs and/or severe behavioral issues, the effects of trauma, new effective caring intervention practices and the particular skills required for working in diverse communities. A further recommendation was for training in curriculum development so that facilitators/teams could more effectively adapt, update and enhance existing curriculums being used at their respective agencies.

Collaboration:

In general, respondents seemed to feel that there was strong collaboration happening between agencies, particularly when staff members from multiple agencies were involved in co-facilitating sessions. As noted, cooperation with local child and family service areas was seen as a real strength of the program, despite some of the tensions inherent in that relationship. In some communities, the relationships between agencies were largely informal, involving referrals from community agencies and

individual outreach. In others, formalized networks had been developed to ensure a comprehensive response to the needs of children exposed to DV/IPV. The one area of concern raised by participants was the lack of effective engagement with some cultural community agencies. One respondent noted that referrals made by her agency were often deemed ineligible but reasons were not provided, that staff felt devalued and frustrated as they did considerable preparatory work in helping families getting ready for the programs and were then turned away, and that participants did not always feel safe and comfortable within mainstream programs. A common thread to the VAW study conducted earlier was the reliance on staff members of culturally-specific agencies for translation, rather than relying on them for their other skills and engaging paid translators for that role. When sessions are co-facilitated by members of cultural communities that reflect the participants, however, it is seen as a real strength and helps to build cohesion across agencies and within participant groups.

Respondents also expressed an interest in ongoing collaboration with colleagues across the CWR. They expressed feeling disconnected at times from other people doing the work and felt that these connections were often rejuvenating and motivating. The sharing of ideas, of challenges and of resources, was seen as a very valuable role that could be facilitated by the VAW Forum. Some respondents spoke of participating in recent workshops and training sessions and how important they had found those and looked forward to future events. A few respondents also suggested that collaborating with university-based researchers could allow for better documentation of successful

models of practice and inform meaningful research to be undertaken to address emerging questions and issues that would be useful to practitioners.

Program Evaluation:

Some form of evaluation was done in all the CWPs described by respondents. Most often this involved pre- and post-tests that were then either compiled for management use or simply filed (several facilitators expressed doubt that these tests were ever actually used for anything). The primary source of feedback for most agencies was informal discussions with program participants, questionnaires completed by mothers at the end of the final session and ongoing team meetings held following each session by co-facilitators and program coordinators.

One of the challenges raised by respondents was the difficulty in measuring success in the context of healing from the experience of DV/IPV. One respondent explained:

> I don't think I know what success is…is it that she doesn't return to an abusive partner or that she has additional knowledge? I don't think a 10 week group is going to necessarily make that shift…..I don't want to say that that's not successful…but the purpose of the group is really to help moms learn what their kids have experienced and not just focus on her individual issues…..

A few formal program evaluations were being undertaken in a small number of agencies, however, this was the exception to the rule. Primarily, statistics on participation were gathered and submitted to management, and informal feedback was being shared within the team but not always documented. An absence of documentation,

however, did not necessarily suggest a lack of program responsiveness to feedback. In most programs, this feedback has been used to enhance practice and modify program curriculum on an ongoing basis. The strength of the program coordinator was also mentioned by several respondents as key to ensuring the quality of the program by hiring qualified staff, doing effective family assessments and helping to ensure that families were referred to additional and ongoing supports as needed.

While various evaluation strategies are seen by many respondents as sufficient, it is executed on a per agency basis and is not uniform across CWPs. This is problematic as the information gathered is not consistent, sufficiently rigorous or comprehensive. This inhibits agencies from effectively demonstrating the success of their programs beyond anecdotal evidence and does not allow for a systematic review and enhancement of programs based on participant feedback.

CONCLUSION:

Although there is a significant body of literature outlining the impact and consequences of DV/IPV to children who have been exposed to it, we are still learning about how best to serve them. Still more challenging is ensuring that any response integrates mothers' and children's needs and allows them both space to heal without pathologizing women's parenting in the face of abuse or failing to recognize children's resilience.

The CWPs described by respondents seem to effectively respond to women's and children's needs when embedded in a larger system of services and supports, including strong VAW programs and an accessible children's mental health system (currently often difficult to access). The programs appear to offer women and their children real opportunities for shared healing, relationship-strengthening and safe and supportive environments to share their experiences with peers and skilled professionals. The Ministry has provided a strong basic framework for service delivery through the provincial curriculum and agencies providing CWPs appear to be largely successful in tailoring services to meet community and family needs (at least within the mainstream context). Flexibility is a central pillar of an effective approach.

One of the key strengths of this program is collaboration – with team members coming from a variety of backgrounds and with a range of expertise and a range of agencies working together to meet the needs of families. These relationships have led to strong referral sources, integration and continuity in service delivery, and greater understanding across agencies and sectors. This core strength can also create tensions; for example, the partnerships within CWPs with child and family service agencies may result in conflicts based on different approaches to issues of child protection and supporting mothers in their parenting roles.

There is a need to address significant gaps in service for a range of underserved populations including fathers, LGBTQtranstwo-spirited, cultural communities, newcomers and people with disabilities. While agencies are at different stages in their

thinking and implementation of more accessible services (particularly with respect to cultural communities), there remains a significant absence of diversity within programs to date. Programs are also required to meet the needs of young people who are falling through the cracks and may not be effectively served within the current model. While one-on-one counseling may provide some alternatives, the strengths of peer support for this age group should not be underestimated. Providing opportunities for older children and their mothers to share the process is also a very valuable component of current CWPs where effective engagement is done successfully.

Issues of parental consent to participation in CWPs are a growing issue given recent trends in custody and access and there is a need for dialogue among CWP providers about how best to address this challenge. There is currently a lack of consistency across agencies and while flexibility is necessary in order to meet the unique needs of each family, overarching policy may need to be developed to ensure that no family is denied service unnecessarily and strategies are developed in order to address certain barriers as highlighted above.

There is a significant need identified for ongoing training, and a more systematic approach to evaluation and research in order to demonstrate program success and to respond to emerging needs and issues. The need to continue to learn about new models of service delivery requires continued partnership between academics and practitioners. Ongoing university/community collaborations allow for the work to be developed and shared when resources and expertise are not always available in-house within agencies.

As the field grows at such a rapid rate and lessons are learned regarding effective practices, this partnership can help to foster continued learning and program enhancement.

The VAW Forum is well situated to provide leadership to the field in knowledge development and exchange. It can continue to provide opportunities for ongoing interaction, learning, resource-sharing and meaningful collaboration across the CWR and to facilitate dialogue on critical issues and tensions that are inherent in this work. It also has an important role to play in advocating for systemic changes that can reduce the vulnerability of women and children who have faced DV/IPV.

Based on the information which was collected for this research study, we believe that the following recommendations should be considered by the various stakeholders within the Violence Against Women Service System Capacity and Implementation Team (Central West Region) in order to nourish ongoing reflections and future directions for enhanced service system delivery:

RECOMMENDATIONS:

- That continued dialogue occurs between providers of CWPs and their local child and family service agency in order to clarify relationships, the impact of mandated participation in a program designed for voluntary participation, etc. Additional training for CAS staff in VAW issues may be required to facilitate this dialogue;

- That spaces be created in order to bring practitioners involved in the CWPs together to share knowledge and experiences, learn about new and emerging research and exchange resources. The VAW forum is uniquely situated to provide the necessary leadership to ensure this collaborative spirit is maintained and strengthened;

- That attention be paid to developing a more uniform evaluation strategy for the CWP which to date is significantly absent. A standardized, coordinated information gathering strategy for research should be developed – not one which is onerous but that would allow for a more effective planning and monitoring program across the CWR and would allow for an assessment of resource needs;

- That continued dialogue occurs between mainstream and culturally-specific agencies to ensure a meaningful collaboration that recognizes the strengths and contributions of each and honors the philosophy of inclusivity when serving women and children.

- That resources be allocated to all CWPs in order that they may provide the child care services that currently constitute a barrier to access for some families. Additional resources may also be required to ensure agencies have the necessary age-appropriate toys, games and activities for children across the age spectrum.

- That a recognition of the context of women's lives including the impact of poverty be at the centre of discussions relative to enhancing the CWPs;

- That specific attention be paid to the needs of immigrant and refugee families, including survivors of war and torture, as they have unique needs and trauma histories;

- That an inclusivity analysis and strategy be undertaken of the CWPs across the CWR to develop an action plan to address the particular realities and service needs of members of LGBTQtrans/two-spirited, (dis)abled, cultural, and First Nation communities.

- That increased emphasis on funding and research be attributed to programming for fathers who have used violence in their intimate relationships (e.g. Caring Dads) in recognition of the ongoing roles and relationships they have in the lives of their children;

- That additional planning, resources and training be put in place to ensure that older children and youth are engaged and involved in the CWPs, through group sessions and/or through alternative measures;

- That a more detailed assessment of training needs is undertaken, with the goal of developing an introductory training course for all new facilitators in order to ensure a basic standard of knowledge regarding DV/IPV and childhood exposure, as well as skill-based knowledge about group facilitation, particularly with children. Further professional development training should be offered periodically to address emerging issues, new interventions and other areas identified by CWP facilitators.

- That women have access to ongoing supports following involvement in the CWPs, including follow-up and referral to additional services, as required. This recognizes that CWPs are only one component of a comprehensive system of services required to support families which should include access to individual and family counseling, children's mental health services, programs for men who have used violence within intimate relationships, etc..

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