

CONNECTIONS FOR BREAKING THE CYCLE OF VIOLENCE

Promising Practices and Path Forward 2022–2026



“It’s all about connection. When women feel connected, peer learning flourishes, friendships develop, and requests for additional programs ensue. They feel empowered to want better lives for themselves and their children. And they feel the need and strength to make changes in their lives, to live lives free from IPV.”

—Connections facilitator

Acknowledgements

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We extend our sincere appreciation to the pregnant people and mothers who participated in *Connections* and generously shared their experiences and stories as part of this evaluation. Their strength, insight, and wisdom will continue to support learning and contribute to the well-being of other children and families.

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Connections for Breaking the Cycle of Violence:
Promising Practices and Path Forward 2022–2026

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Who We Are and What We Do

Connections for Breaking the Cycle of Violence (C-BTC) is an initiative of Breaking the Cycle, a program of Canadian Mothercraft Society. Mothercraft has delivered Breaking the Cycle since 1995. We are one of Canada's first prevention and early intervention programs for pregnant and parenting women who use substances and their children aged 0 to 6. Breaking the Cycle is funded by the Public Health Agency of Canada (PHAC) through their Community Action Program for Children (CAPC) and Canada Prenatal Nutrition Program (CPNP). Additional funding is provided by the Province of Ontario through the Ministry of Children, Community

and Social Services. We operate through a formal partnership of nine agencies representing:

- child protection
- addiction treatment
- public health
- addictions medicine
- corrections and probation
- obstetrics
- mental health
- developmental paediatrics
- childcare
- Fetal Alcohol Spectrum Disorder (FASD) assessment and diagnosis
- children's mental health, and
- infant/child development

BTC Services in 2026

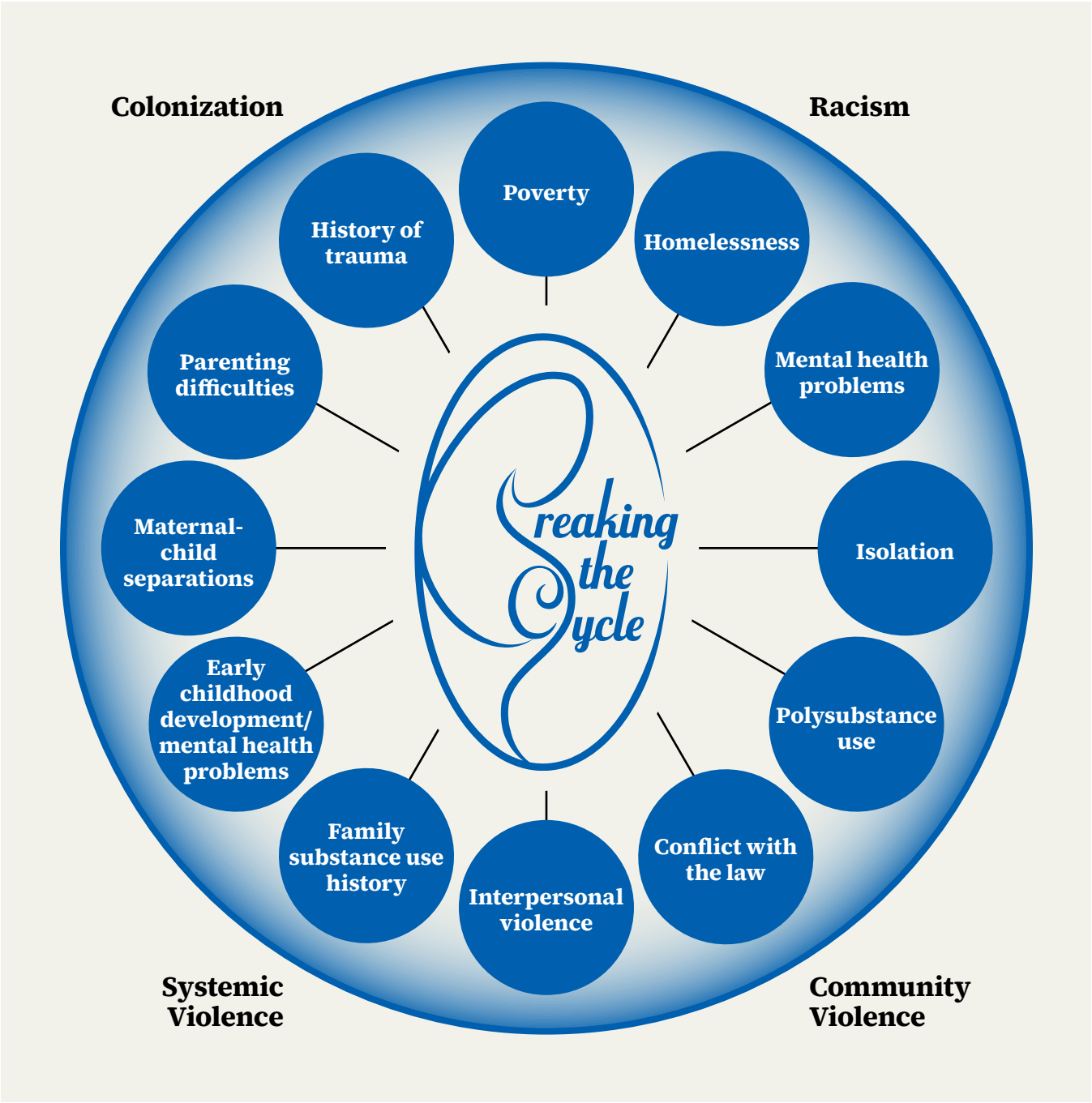
Our services are delivered through a single access model with home visitation and street outreach components. We operate on frameworks of relational, attachment, developmental, and trauma theories. These approaches inform our understanding of women, mothers, and children, and guide all our programs and approaches. Our aim is to decrease barriers and promote engagement for women and mothers who typically have complex life

circumstances and difficult past experiences in relationships. This makes it difficult for them to feel safe to access services for themselves and their children. We offer a range of programs designed to foster healthy relationships between mothers and their children. All BTC services are offered within the context of a safe environment and safe relationships with service providers. We offer:



Profile of BTC Families

BTC engages with and serves an extremely high-risk population of families. Their context of risk is illustrated in the figure below.





Fundamental Principles of BTC

We focus on three main approaches to service delivery:

A **trauma-informed approach** helps mothers understand how their own trauma histories have impacted their current behaviour and functioning; and helps service providers recognize signs of trauma, understand the impact of trauma, and know how to support mothers who are experiencing, or have experienced, trauma. Trauma-informed practices are recognized as a best practice approach for working with mothers and children who live with Intimate Partner Violence (IPV).

A **relational approach** means the mother-child relationship is explicitly supported through information about positive parenting and the impacts of IPV on children's development & well-being. From the outset, BTC defined two clients:

women and children. BTC's priorities, philosophy, and programs were developed in consideration of the healthy development of the mother, child, and the mother-child relationship. All aspects of BTC services reflect the fact that both mother and child are affected by a woman's substance use and related conditions, that the care of substance-involved mothers and their young children requires attention to each, and to the relationship between them. In fact, the primary focus of all services delivered at BTC is the relationship between the mother and child.

A **community-based approach** supports these services for mothers & children which often act as an entry point to connect with health and social supports within their communities. Integrating IPV strategies into community-based services decreases barriers to engagement and attendance.

Treatment Approaches at BTC

Several theoretical frameworks inform our work at Breaking the Cycle (BTC). These include:

Relational Theory

The central principle of relational theory is that people, institutions, and systems grow through relationships with others. Growth fostering relationships are a central human necessity and disconnection from healthy relationships is the source of many psychological problems. Relational theory also calls for attention to larger system changes, including reduction of service fragmentation and access issues as part of the solution for families and children.

Attachment Theory

This approach proposes that the young child's cognitive and emotional sense of self and others is developed within the emotional relationship between infants and their primary caregivers. This relationship has a critical influence on the infant's perception of the environment and of others, as well as on later personality development, social functioning, and learning.

Developmental Theory

Children's development is seen as a product of the combination of their inborn qualities and the contributions from their experiences. Developmental theory calls for the consideration of the combined contributions of both the prenatal and postnatal environments. This allows us to understand and respond to every child based on his/her unique strengths and vulnerabilities, and to tailor our programs and services appropriately.

Trauma Theory

People who experience trauma, either in childhood or as adults, are profoundly impacted by those experiences and exhibit the impacts in neurological and psychosocial development and behaviours. Trauma can be the result of many things, but is often the result of violence, abuse, or in the case of children, neglect. Indigenous people are likely to have increased levels of trauma through their experiences of historical trauma.

Historical trauma theory proposes that populations historically subjected to long term, mass trauma (colonialism, war, genocide) exhibit a higher prevalence of physical and emotional problems even several generations after the original trauma occurred. It relates to the cumulative emotional and psychological wounding across generations and provides a framework for understanding the intergenerational trauma resulting from cultural, geographic, social, and economic destabilization.

Harm Reduction Strategies

These public health policies and approaches aim to reduce negative social and/or physical consequences associated with substance use. At BTC, harm reduction is applied to both mothers and children impacted by substance use. We consider ways to reduce harms to mothers as a result of their substance use; and we also consider ways to reduce harms to children exposed to the substance use of their parents/caregivers.

The need to address IPV and its links with trauma

Throughout our 30-year history, we have recognized the importance of addressing IPV with the mothers and children in our programs. We also came to a clear understanding that IPV and trauma are strongly linked. The mothers and children who have attended BTC over the years showed us that:

Most mothers involved with BTC have experienced high rates of abuse and IPV

Many mothers at BTC report extensive histories of maltreatment, which often started when they were young children: 89% report physical abuse, 87% report emotional abuse, and 67% report sexual abuse. Abuse as a child and IPV in current relationships are linked. Women with histories of childhood abuse are more likely to be re-victimized in intimate relationships in adulthood than women who do not have trauma experiences.

IPV is one kind of trauma

Experiences of trauma are more than merely stressful. They can be shocking, terrifying, and destabilizing. And they can result in profound feelings of terror, shame, helplessness, and powerlessness. A traumatic event can involve a single experience. Or it can be repeated experiences that completely overwhelm a person's ability to cope. Trauma can also be historical and intergenerational. This means that the psychological or emotional effects of trauma are felt by people who live with trauma survivors, even when they have not directly experienced the trauma themselves. The way people cope and adapt in response to trauma can be passed from one generation to the next.



The experiences and effects of trauma are wide ranging

Women and children can be affected by experiences of trauma that have occurred in childhood or adulthood. They can include a range of adverse experiences in childhood and in adulthood, such as physical and sexual violence, emotional abuse, neglect, and witnessing violence. Children can also experience trauma from disrupted attachment. Both children and adults can be traumatized by accidents, natural disaster, war, dislocation, and events that result in other sudden or unexpected losses. Some traumatic events are so profound that they can change the way children and adults see themselves and the world. Sometimes the impact of the trauma is not felt until weeks, months, or even years after the traumatic event.

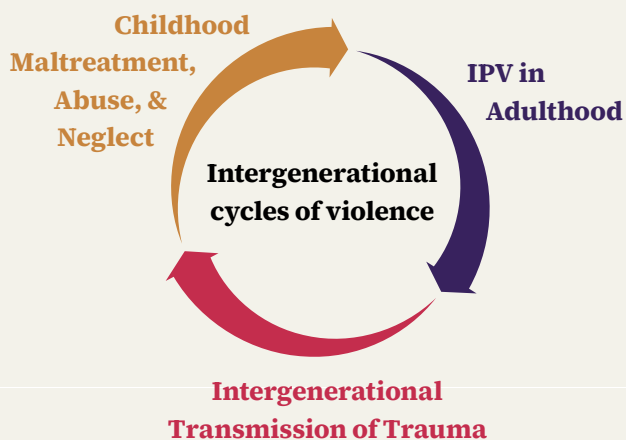
Trauma impacts on substance use and mothering

Most substance involved women have significant trauma histories, which impact the mother-child relationship and the way women nurture their children. When their trauma is not healed or resolved before they become mothers, their view of parenting relationships is often based on their own early experiences of the care they received from their caregivers.

Children of BTC mothers also have very high rates of trauma

Many children at BTC have lived with domestic violence, neglect, or maltreatment, and have witnessed their mothers' substance use relapses, which can lead to trauma responses.

Intergenerational cycles of violence are the result of: childhood maltreatment, abuse, and neglect; leading to IPV in adulthood; leading to intergenerational transmission of trauma.

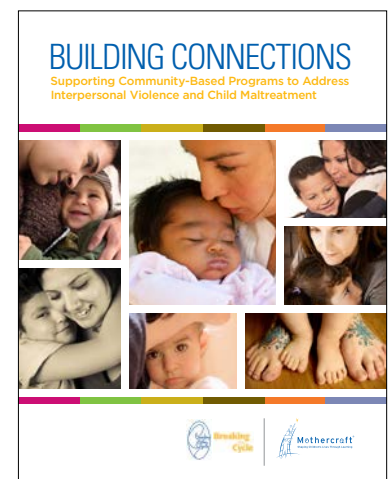


At BTC, we recognize the following considerations for ending or preventing intergenerational cycles of violence:

Recognizing that the prenatal period and the early years of mothering are windows of opportunity for women affected by IPV. Mothers are more likely to make changes at these times through a desire to protect their children

Supporting mothers to heal from IPV, through understanding that this healing helps them protect their children, which in turn can break the cycle of violence across generations. The first years of life are critical periods for intervention and prevention to break the cycle of violence in relationships across the lifespan. Supporting mothers' healing from IPV helps them protect their infants and young children from the experiences that caused their own pain, thereby breaking the cycle of violence

Enhancing healthy relationships between mothers and their children with community-based programs that engage in trauma-informed and relational approaches to care using evidence-based supports. To find out more about evidence-based, trauma-informed supports, refer to: [Building Connections: Supporting Community-Based Programs to Address Interpersonal Violence and Child Maltreatment.](#)







The *Connections* Story: The Evolution of *Connections*

Rationale for the need for *Connections*

Substance use interferes with the capacity for healthy, positive relationships. In addition, exposure to IPV may create significant long-term harm to positive parenting. Because many of the mothers at BTC experience IPV, we understood the need to create an opportunity for them to explore these issues as a key component of their recovery process. Given our focus on supporting parenting, we wanted

to assist mothers to consider the potential impact of IPV not only on their own healing and recovery, but also to consider the impacts of IPV on their children. For mothers struggling with substance use problems, parenting presents many challenges. When these mothers also live with IPV, the challenges are magnified and the potentially negative impacts on them and on their children are dramatically increased.

Our evaluations have shown that mothers who attend our programs have high rates of maltreatment and trauma that began in their own early childhoods. Most have significant histories of substance use in their families of origin. The disruptions in many of their relationships began at an early age, including multiple caregivers and foster care placements. Most mothers who come to BTC have histories of physical, sexual, and/or emotional abuse dating back to early childhood. Almost half of mothers also say that their current partner relationships involve IPV. Overall, mothers at BTC have high rates of mental health issues and other stressful experiences including:

- depression
- suicide attempts
- eating disorders
- compromised health
- low levels of education
- poverty
- high rates of IPV, and
- loss of custody of children



We developed *Connections* in response to these findings. *Connections* helps mothers learn about how their experiences of traumatic relationships and IPV have affected:

- the development of their own sense of self
- the relationships they have established in their lives, and
- the relationships they create with their own children.

Connections has been delivered at BTC since 2005 when funding for the initial pilot project was received and has been implemented nationally since 2016. *Connections* has gone through several iterations in scope, although its content and delivery have been consistent. From the beginning, *Connections* has been a six-week group program using trauma-informed and relational approaches designed to interrupt the intergenerational transmission of IPV. *Connections* promotes mothers' understanding of:

- healthy interpersonal relationships
- the importance of healthy relationships to their children's development
- the ways that IPV interferes with healthy relationships and child development

Like all programs at BTC, *Connections* is based on our foundational principles of trauma-informed, relational, and attachment-based approaches.



Phase 1: *Connections* Beginnings and Curriculum Development

The *Connections* group was developed as a pilot project beginning in 2005 based on the high rates of IPV experienced by mothers at BTC. This led to a qualitative examination of mothers' experiences, with funding provided by Ontario's Ministry of the Attorney General (Ontario Victims Service Secretariat), that enabled BTC to develop, deliver, evaluate, and disseminate the results of a "two-generation" approach. A two-generation approach simultaneously addresses the needs of both BTC mothers and their children for whom IPV co-exists with substance use and related challenges.

As we developed the pilot project, it became evident that *Connections* should be delivered in a group format for mothers struggling with problems of substance misuse, who are also experiencing IPV. The aim of *Connections* also became clear: it is essential to provide information, increase awareness, and create a safe opportunity for mothers to explore their

experiences of IPV in relationships, and examine its impact on their parenting, their substance use recovery, and their children's development.

Connections was also designed to be delivered concurrently with other programs available at BTC for mothers and their young children, including substance use treatment, mental health counselling, childcare, early intervention services, parenting services, advocacy, and instrumental supports. The primary activities of the initial pilot project included:

- a needs assessment, including literature review and focus group interviews with BTC mothers
- the development of a *Connections* group curriculum
- the delivery of the *Connections* group, and
- revision of the curriculum based on feedback from participants and facilitators

The group curriculum was designed to be delivered in six sessions with topics based on trauma-informed, attachment, child development, and relational approaches. It was intended to interrupt the intergenerational transmission of IPV and to increase understanding of healthy interpersonal relationships and their importance to child development for mothers who have experienced IPV.

Development of pilot curriculum and delivery of the *Connections* group

The literature synopsis, focus group data, and additional background information collected for the pilot study were used to develop a pilot curriculum, which was delivered as six-week group series for the first time in the spring of 2006. Mothers from BTC attended each weekly session regularly and participated in ongoing evaluation of the sessions. The focus groups were co-facilitated by a psychologist and an addiction counsellor at BTC. These clinicians were known to most of the participants, which accelerated establishing trust and comfort in discussing the sensitive and difficult material that this group covered. Since all mothers were active clients at BTC, they had access to individual counsellors regarding any residual feelings stemming from the discussions in the group. Childcare was provided by trained early childhood educators who were known to the children. The project consultant was an “observer” of the group sessions. Modifications to the pilot curriculum content were made on a week-by-week basis in response to the needs of the women participating in the group and the weekly participant feedback.

The group facilitators identified this as a pilot and helped the mothers understand that their feedback was extremely important as the group unfolded. Participants were asked for specific feedback about what was interesting and/or helpful, what was uninteresting or not helpful and what, if anything,

they would change. In response to direct feedback from participants, changes were made in the curriculum for the following week. Participants were pleased to be asked to provide feedback. At the conclusion of the final week, additional time was devoted to an evaluation of the entire six sessions.

Participant feedback on the pilot *Connections* group

The overall response to the pilot program was extremely positive. Participants stated that the information was valuable and they perceived their ability to recognize healthy, supportive relationships had increased. All participants identified that they had a better understanding of the potentially negative impact of unhealthy relationships on their young children. All participants confirmed that the information discussed in the group was relevant and applicable to their own relationships. When participants were asked which topics or areas could have been more emphasized, the responses included:

- more information about how to make changes in their own behaviour
- more information about how to relate to others because “this sends messages to our children”
- more handouts and written material

All the participants were unequivocal about their interest in participating in this group again and all asked if it would be offered again soon.

Development of the final *Connections* curriculum

The *Connections* curriculum was revised based on the participant feedback and reflection by the group facilitators. The development and revision of the curriculum relied heavily on participant input in both the needs assessment and evaluation phases of the pilot. Following completion of the pilot, *Connections* was granted ongoing funding by Ontario’s Ministry of Children and Youth Services.

The integrated framework of *Connections* aligned with the Ministry's policy at the time of identifying IPV, substance abuse, and children's mental health as priority areas for community capacity building within the children's service system. The *Connections* program highlighted the need for primary research about the interface between IPV, substance abuse, child maltreatment, and healthy child development.

The six key messages of the *Connections* curriculum were revised and determined to be:

1. Learning about healthy relationships
2. What happened when we were kids matters now
3. Recovering from my past – building healthy relationships for me and my child
4. Child development and behaviour
5. Building self-esteem
6. Positive Parenting: building self-esteem in children

The six key messages build on each other over the six weekly group meetings.

Evaluation of the *Connections* pilot project

Our evaluations of *Connections* confirmed that there were positive outcomes for the mother, the child, and the mother-child relationship. Following participation in *Connections*, we found that women had:

- more confidence to resist substance use
- less anxiety and depression
- greater ability to develop positive relationships with their children
- increased social support
- more appropriate expectations in their parenting roles
- increased empathy
- decreased parenting stress, and
- children's development tended to be within the average range

Other evaluations showed us that mothers who participated in *Connections* had:

- enhanced their ability to reflect on their past experiences in order to make changes in their current relationships
- gained an understanding of the cycle of unhealthy relationships, and
- increased their understanding of the impact of unhealthy relationships on their children and on their parenting

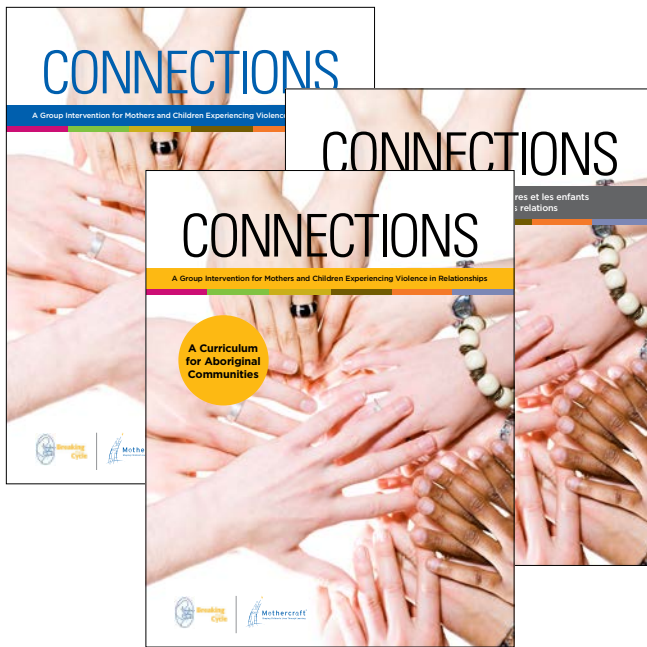
Phase 2: The *Connections* Manuals

Based on our evaluations and the excellent participant and community uptake of *Connections*, BTC applied for funding to the Public Health Agency of Canada for support to develop and disseminate *Connections* in the form of an explanatory, how-to manuals in three versions (English, French, and an Indigenous adaptation). The manuals describe the history of, rationale for, and implementation of *Connections* within community-based programs. The manuals were distributed across Ontario, primarily to CAPC, CPNP, and Aboriginal Head Start in Urban and Northern Communities (AHSUNC) projects.

Known as ***Connections: A Group Intervention for Mothers and Children Experiencing Violence in Relationships***, the project was funded by PHAC for five years. Project activities included a literature review, focus group interviews, and key informant interviews, culminating in the development of manuals in the three formats.

The manuals provide information about:

- the BTC program and the mothers who are its participants
- the background to *Connections* and the program's development to 2014



- linking *Connections* with the research literature
- making *Connections* by linking research and practice
- the results of focus groups conducted during this project, amplifying the voices of mothers who live with IPV and have been involved with the *Connections* group
- an overview of the development and delivery of the pilot version of the *Connections* curriculum
- an overview of the development of the final *Connections* curriculum
- Key Messages contained within the *Connections* curriculum
- practical considerations for facilitating the *Connections* group

The manuals also provide the necessary tools for delivering *Connections* for each of the six sessions, including:

- key messages
- overview of the session
- background/research information specific to each session for facilitators
- session content – check-in, information sharing/teaching component, and wrap-up
- all materials/handouts needed for participants

The *Connections* manuals are available at mothercraft.ca.

Phase 3: *Building Connections*

Based on the successes we had in delivering *Connections* and the uptake from the distribution of the *Connections* manuals, Mothercraft launched the *Building Connections* initiative in 2016. The Public Health Agency of Canada (through the Supporting the Health of Survivors of Intimate Partner Violence and Child Maltreatment through Community Programs initiative) provided financial support for a five-year national project. Our overall goal was to enhance the capacity of service providers working in CAPC, CPNP, and AHSUNC projects to identify and respond to mothers and young children impacted by IPV and child maltreatment. This national initiative emphasized the importance of systematically engaging community partners across Canada with the necessary capacity, resources, and support systems to safely deliver and evaluate *Connections*.

In addition to IPV awareness and skills, *Building Connections* was also intended to help service providers and organizations to work within a trauma-informed perspective and develop trauma-informed relationships that cultivate safety, trust, and compassion.

***Building Connections* activities**

Several activities were undertaken during the *Building Connections* project, including:

Development and distribution of a resource manual called *Building Connections: Supporting Community Based Programs to Address Interpersonal Violence and Child Maltreatment*. In addition to promoting understanding of IPV, the resource manual was intended to help service providers and organizations work from a trauma-informed perspective and develop trauma-informed relationships that cultivate safety, trust, and compassion. It was distributed to

all 800+ CAPC, CPNP, and AHSUNC projects across Canada. The *Building Connections* resource manual is available at mothercraft.ca.



Delivery of a live National Training Webinar. The webinar was based on the content of the *Building Connections* resource manual. The webinar was offered to community-based staff from CAPC, CPNP, and AHSUNC projects, as well as to interested service providers from other community organizations.

Selection process. This was undertaken to determine which CAPC and CPNP projects had the resources and partnerships to safely implement *Connections* within their existing programs. It also helped CAPC and CPNP project staff reflect on their own readiness to implement *Connections* within their programs. Based on the selection process, 30 CAPC and CPNP projects were invited to attend the *Connections* Certified Training.

Adapting *Building Connections* for AHSUNC projects.

The adaptation was undertaken in consultation with Indigenous leaders and experts. An Indigenous adaptation of the *Connections* group program,

based on Anishnabek traditions, already existed, having been developed during the previous manual development project. For the *Building Connections* project, we adapted the readiness assessment tool, training for AHSUNC facilitators, and individualized evaluation plans for each community.

Pre-training site visits. *Building Connections* team members from BTC visited each project selected for certified training, delivery, and evaluation of *Connections*. These visits strengthened the relationships between community projects and the BTC team of staff and researchers.

Training and certifying *Connections* facilitators. The CAPC, CPNP, and AHSUNC projects selected to partner in the *Building Connections* initiative attended three and a half days of intensive training at BTC. These trained staff became *Connections* Certified Training Facilitators who were able to provide *Connections* within their own communities.

Implementing the *Connections* group within their communities.

Establishing a *Connections* Community of Practice and an online platform. *Connections* Certified Facilitators were invited to attend the *Connections* Community of Practice (CoP), which enabled them to share updates from their project, hear how other projects were delivering the group, and discuss any barriers to delivery that had arisen.

Conducting ongoing research and evaluation. We developed and implemented a variety of research and evaluation instruments with strong ethical considerations for these community programs.



Evaluation of *Building Connections*

The evaluation reports for *Building Connections* are available in two versions—the technical report (*Building Connections to Support Mothers and Children Affected by Interpersonal Violence: The Evaluation Report*) and the Plain Language version of the Evaluation Report (*Building Connections for Healthy Relationship: What We Learned*). Both reports are available at mothercraft.ca.

Phase 4: *Connections for Breaking the Cycle of Violence (C-BTC)*

BTC was invited by the Public Health Agency of Canada (PHAC) to apply for funding under the Preventing and Addressing Family Violence: The Health Perspective initiative. Funding was subsequently received for this four-year national project aimed at enhancing community capacity to identify and respond to IPV affecting mothers and young children. The C-BTC project emphasized the importance of engaging community partners in CAPC, CPNP, and AHSUNC projects with the necessary capacity, resources, and support systems to safely deliver and evaluate *Connections*.

C-BTC activities

The C-BTC project included numerous activities including:

- C-BTC training on evidence-based practices and approaches through a series of community **webinars**, designed to encourage and support behaviour changes in the daily work of service providers, increase sharing with colleagues, and influence practices and policies of organizations.
- C-BTC *Connections* **certified training**, which would enable *Connections* facilitators to confidently and safely deliver and evaluate *Connections* within their projects and communities.
- C-BTC **Community of Practice** was established to promote fidelity (which means encouraging and ensuring consistency with the goals, philosophy, and delivery of *Connections* among facilitators), knowledge sharing, and support among certified facilitators across Canada.
- **Delivery of the *Connections* group** at CAPC, CPNP, and AHSUNC partner sites in 14 communities across Canada, and
- **Evaluation** of the overall project.

Since its inception, BTC has modified *Connections* with extensive participant and facilitator engagement in the development, testing, and confirmation of its curriculum. Over the years of implementation, BTC has encouraged adaptations to the curriculum in response to the wisdom of participants, facilitators, and communities to reflect culture, geography, and other unique features that make *Connections* meaningful for specific groups, while maintaining fidelity.

3



What We Learned From *Connections* Evaluations Over the Years

Early evaluations of the *Connections* group delivered at BTC confirmed positive outcomes for the mother, the child, and the mother-child relationship. Using quantitative measures for evaluation, we learned that mothers had:

- increased confidence to resist substance use
- decreased anxiety and depression
- enhanced relationship capacity with their children
- increased social support

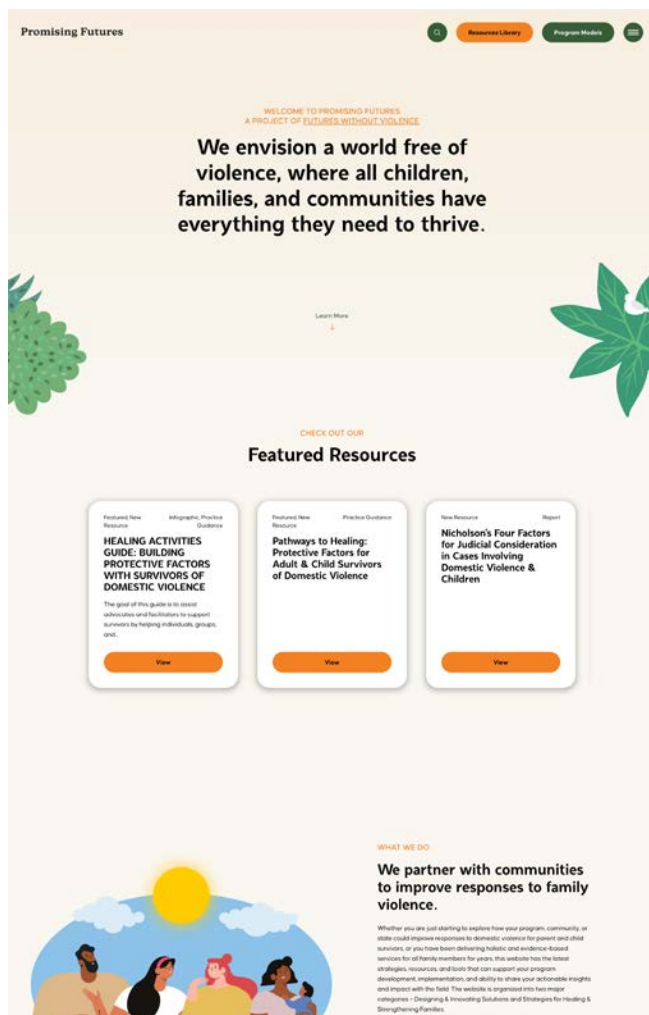
- more appropriate expectations in the parenting role
- increased empathy for their children, and
- decreased parenting stress

This research also showed that children's development was within the average range on standardized assessments.

Qualitative evaluation data confirmed that, as a result of their participation in *Connections*, mothers experienced:

- enhanced capacity to reflect on their past experiences in order to make changes in their current relationships
- increased understanding of the cycle of unhealthy relationships, and
- increased understanding of the impact of unhealthy relationships on their children and on their parenting.

These findings led to the identification of *Connections* as a best practice project at [Promising Futures: Best Practices for Serving Children, Youth and Parents Experiencing Family Violence](#).



Recently, *Connections* was evaluated with a national sample of 400 participants through the *Building Connections* project. The overarching goal of *Building Connections* was to enhance the capacity of service providers working in CAPC, CPNP, and AHSUNC projects to identify and respond to mothers and young children impacted by IPV and child maltreatment. With *Building Connections*, we disseminated trauma-informed resources (a resource manual and webinar specifically developed during the *Building Connections* project) to all 800+ CPAC, CPNP, and AHSUNC projects; delivered certified training for *Connections* to a subset of 34 specially selected CPAC, CPNP, and AHSUNC projects; provided a Community of Practice to support communication and fidelity; and facilitated the delivery of the *Connections* group by partner projects.

What is fidelity and why is it important?

Comprehensive research and evaluation in an initiative like *Building Connections* is necessary because we need to ensure that all participating projects are delivering the core components of *Connections* as intended. This research requirement is known as fidelity. One of the goals of *Building Connections* was to confirm the feasibility of replicating the *Connections* group in 34 communities across Canada. We were able to ensure that each of the participating CAPC, CPNP, and AHSUNC community partners received consistent information, training, and level of support throughout the *Building Connections* initiative, and were able to deliver *Connections* in a consistent manner.



Concurrently, we found significant decreases on measures of mothers' anxiety in relationships and parenting stress.

During the national delivery of *Building Connections*, we understood the need to strike a balance between the research requirement of fidelity and respecting community wisdom. For example, in the *Connections* curriculum, BTC trainers emphasized and supported adaptation of the group's activities and delivery by CAPC, CPNP, and AHSUNC facilitators based on the needs of individual women and their broader communities. The content topics of the six-week curriculum needed to remain consistent across all projects, but the ways in which the information was delivered could be adapted to suit local needs.

Over the course of *Building Connections*, certified *Connections* group facilitators were able to reflect on changes in four key areas related to trauma-informed practice:

- awareness (e.g. attitudes toward IPV)
- competency (e.g. application of trauma-informed knowledge)
- collaboration (e.g. working with other organizations to provide service to children and families), and
- safety (e.g. organizational policies to ensure safe, welcoming spaces).

Evaluation of outcomes for mothers who participated in the *Connections* group during the *Building Connections* initiative confirmed significant increases in:

- self-esteem
- self-efficacy (a belief in their ability to make positive changes)
- ability to feel closeness in relationships
- ability to depend on others in relationship
- knowledge of community services, and
- understanding of *Connections* concepts

Building Connections demonstrated that there was a high level of consistency in the evaluation outcomes for both facilitators and participants across Canada, despite the variations in geographic region, population centre, and setting of the CAPC, CPNP, and AHSUNC project. This highlights the strength of *Connections*, its adaptability, and its ability to be delivered through community-based projects. Also, the results indicate that the training was delivered with fidelity. It was implemented in 34 different projects according to consistent guidelines. At the same time, the facilitators had a strong capacity to use the supports that were provided to adapt *Connections* effectively based on the needs of their community.



4



Connections for Breaking the Cycle of Violence (C-BTC)

I. Overview of C-BTC

In 2021, BTC was invited by the Public Health Agency of Canada to apply for funding under the Preventing and Addressing Family Violence: The Health Perspective initiative. In 2022, funding was received and the four-year national project, known as **Connections for Breaking the Cycle of Violence (C-BTC)**, was implemented from 2022 to 2026.

The **overall goal** of C-BTC was to promote and expand upon the national implementation of **Connections: A Group Intervention for Mothers and Children Experiencing Violence in Relationships**, a trauma-informed program designed to interrupt intergenerational transmission of IPV. C-BTC was directed to pregnant people and mothers of young children (from birth to six years of age) attending CAPC, CPNP, or AHSUNC projects in 14 communities across Canada.

The **foundational principles** of C-BTC were to:

- provide an opportunity for pregnant people and mothers to explore their past and present experiences of IPV in relationships
- consider the potential impact of IPV on their parenting and their children's development

Connections supports these foundational principles through its design, which includes the concepts of:

- providing a **two-generation trauma-informed group support** intended to interrupt intergenerational transmission of IPV by:
 - » supporting the health and healing of mothers affected by IPV, and
 - » preventing the transmission of IPV through the parenting relationship
- **enhancing mothers' capabilities** in their adult and parenting relationships, which helps prevent child maltreatment
- **prioritizing delivery in community-based settings** like CAPC, CPNP, and AHSUNC projects that offer additional supports including parenting supports, childcare/respite services, and instrumental supports (such as food supplementation) which combine with the *Connections* messaging to increase the important positive impacts on mothers and children

Most women and children who experience IPV are not connected to specialized IPV services. However, they are connected to community-based projects where they feel safe and can access a range of supports. The importance of CAPC, CPNP, and AHSUNC projects as the setting for *Connections* cannot be underestimated. These PHAC-funded community-based projects promote non-judgemental and culturally sensitive environments, which are fundamental to engage and support women and children who experience IPV. Thanks to PHAC, these projects are embedded in communities

across Canada. They often act as an entry point for families who are geographically or socially isolated. They also connect families to health and social supports within their communities.

The C-BTC project had four main **objectives** designed to support the overall goal of national implementation and expansion of *Connections* and enhancement of its evidence base. The objectives included:

- **promoting access** to the *Connections* group for women who attend CAPC, CPNP, and/or AHSUNC projects
- **strengthening and expanding** a national network of certified *Connections* facilitators able to respond safely and effectively to women and children living with IPV in communities across Canada
- **conducting intervention research** that:
 - » evaluated the impact of the *Connections* group on mothers and certified *Connections* facilitators
 - » built an understanding of when, how, and why changes occur (the “underlying mechanisms of change”), and
 - » analyzed moderating factors that identified for whom *Connections* is most effective
- **translating and disseminating the knowledge** developed by C-BTC broadly and to a wide range of audiences including project participants, the larger network of CAPC, CPNP, and AHSUNC service providers, allied community service providers, researchers, and policy makers.

The project objectives were founded on trauma-informed approaches, which were developed in the *Building Connections* project, and tailored to the needs of mothers who have experienced, are experiencing, or are at-risk of experiencing IPV. The C-BTC Community of Practice and annual training sessions promoted fidelity in the delivery and evaluation of the *Connections* groups by strengthening and supporting the trauma- and IPV-informed practice and relational approaches that are embedded in the *Connections* group content.

II. C-BTC project activities

We developed C-BTC based on fundamental principles applied by BTC in all its work. The main activities we took to share *Connections* through the C-BTC initiative included:

Activity 1: Community Webinars

C-BTC provided community training on evidence-based practices and approaches through a series of community webinars. Certified *Connections* facilitators from partnered sites, along with service providers from community-based programs, attended. The C-BTC project invited experts with specialized skills to host virtual community webinars on a variety of topics related to supporting the mental health of mothers from diverse groups. The aim of the webinars was to encourage and support behaviour changes in the daily work of service providers, increase sharing with colleagues, and influence practices and policies of organizations. We delivered eight webinars, each approximately one and a half hours long. Each webinar was evaluated with a focus on supporting community service providers to improve their understanding, knowledge, and skills in relation to diverse populations of women. The webinars began in January 2023 and continued to February 2026; topics included were:

- Promoting Readiness for Change in Mothers Experiencing IPV (April 2023, presented by Margaret Leslie)
- Unresolved Trauma Impacts on Caregiving (November 2023, presented by Margaret Leslie)
- Supporting Parenting in the Digital Age (June 2024, presented by Dr. Nicole Racine and Hannah McDowell)
- The Complex Art of Working with Black Families Understanding Their History and Trauma (October 2024, presented by Kafui Sawyer)
- Engaging South Asian Families (February 2025, presented by Bhupinder Heer)

- The Many Uses of Harm Reduction in Addiction Counselling, Pregnancy, and Parenting Support (May 2025, presented by Nerina Chiodo)
- Integrating Social Prescribing into Clinical Practice: Tools for Better Supporting Families (October 2025, presented by Cynthia Côté)
- *Connections* for Breaking the Cycle of Violence Evaluation (February 2026, presented by Dr. Naomi Andrews, Dr. Mary Motz, and Gloria Lee)

A total of 369 service providers attended webinar trainings.

Activity 2: Certified Training

The *Connections* group was delivered by certified facilitators in the 14 partner CAPC, CPNP, and AHSUNC sites. To gain the certification we deemed necessary to deliver the groups, *Connections* facilitators participated in virtual certified training, held over three sessions. The purpose of the training was to enable the facilitators to confidently deliver and evaluate the *Connections* group in the partner communities across Canada.

Training certification has been deemed necessary by BTC in both the *Building Connections* and the C-BTC projects. Certification enhances facilitator knowledge and understanding of IPV and trauma-informed approaches. It also builds commitment and fidelity to group goals, objectives, and program delivery in its intended form. Regardless of where the group is delivered, the *Connections* group delivery will then be consistent across settings. Certification also builds confidence in the capacity of facilitators to make adaptations to *Connections* that are important for local communities while still maintaining fidelity.

Pre- & post-training surveys examined facilitator awareness, confidence, and capability related to IPV and child maltreatment. Five training events consisting of three sessions each were delivered, with a total of 46 facilitators completing the certification. Feedback from the *Connections* Certified Training surveys indicated a high satisfaction rate of 93%, along with significant improvements in awareness, capability, and confidence, ranging from 67% to 93% among participants.

Activity 3: Community of Practice

A Community of Practice (CoP) was established to promote fidelity, knowledge sharing, and support among certified facilitators across Canada. The CoP met bi-weekly from January 2023 onward with regularly contributing participants from the 14 partner communities. A virtual platform was used for sharing resources. Community partners continued to gain knowledge and insights about ways to effectively support the IPV-affected mothers, children, and families they work with. The CoP meetings also provided the opportunity for *Connections* facilitators to discuss effective strategies in the group process to support mothers experiencing IPV to achieve resilience and empowerment.

Feedback given by partners was evaluated and shared to ensure the needs of facilitators were being met. C-BTC project staff noted highlights from each CoP meeting and regularly evaluated the needs of the *Connections* group facilitators based on their feedback in the CoP meetings.

Topics discussed by the *Connections* group facilitators in the CoP meetings throughout the C-BTC project included:

Participant recruitment and group facilitation skills

Connections group facilitators and C-BTC staff discussed the importance of ensuring that mothers who attended the *Connections* groups would be able to maximize the benefits from it. Facilitators also shared their strategies for facilitating group sessions and supported each other to learn new skills and approaches. Topics of discussion included:

Group readiness and eligibility

- how to understand a participant's history or current situation/status (e.g., IPV and/or intergenerational trauma)
- how to recognize a participant's stage of change

Advertising *Connections*

- how to create and disseminate flyers promoting the *Connections* group
- sharing ideas and strategies for community outreach and providing information about the *Connections* group

Careful word choice

- emphasize the importance of using non-authoritative and supportive words (e.g., refer to "group guidelines" rather than "group rules")

Socialization

- ideas for creating comfort among group participants such as having lunch together after each group session
- cooking/baking or having a celebration lunch together when the group is completed

Skills for group sessions

- emphasize the need to pay attention to participants' words and behaviours
- how to capture participants' "lightbulb" moments of discovering their patterns in unhealthy relationships



- provide an activity for participants to complete during group discussion to cope with a discomfort level when discussing difficult subjects (e.g., replacing phones with colouring books)

Follow up with participants

- encourage participants to give “thumbs up” to represent their emotional states when leaving the group for a break (i.e., thumbs up means “I’m ok”)
- phone participants to check in after the group, especially to those who showed any distress with the subject matter

Barrier assessment

- communicate understanding of a participant’s current physical and environmental barriers to group attendance
- connect participants with any available resources or community supports that can help reduce the barriers

Psychoeducational intervention

- *Connections* is a psychoeducational rather than therapeutic group, so it may be important to help participants to be focused on the present since facilitators may not be confident or skilled in dealing with past distress
- always follow up with participants who indicated emotional distress during the group

Organizational practice and policy

Organizations who agree to implement *Connections* within their programming can employ practices and policies to enhance and support the group’s success. Suggestions from *Connections* facilitators were focussed on:

Organizational practices

Certified facilitators exchanged ideas or opinions on how participants can be more effectively supported from an organizational perspective to increase empowerment and resilience. For example, delivering a variety of programs, including *Connections*, to participants is helpful. Here are some that may work well alongside *Connections* based on the experiences of BTC:

- Make the Connection
- Community Kitchen – Cooking Healthy Together
- Circle of Security – Parenting (COS-P)
- Triple P – Positive Parenting
- Maternal Mental Health Toolkit
- Relapse Prevention Group

The facilitators suggested that delivering a combination of programs with *Connections* increased mothers’ motivation to change and strengthened the facilitators’ relationships with mothers.

Organizational policies

The CoP meetings enabled certified facilitators to widen their viewpoints on working with mothers, allowing them to share new, updated policies with other staff within their organizations. Some examples of updates that could be incorporated into organizational policy are:

- use of respectful, non-authoritative, and inclusive language
- promoting an egalitarian, non-judgemental, and supportive stance

In addition, certified facilitators suggested that participating in the C-BTC initiative helped them to increase funding opportunities for their programs.

Community capacity building and partnership

Certified facilitators explored ideas at CoP meetings for connecting with other organizations in their communities. Active community outreach and collaboration provided the facilitators with numerous benefits, including:

- **Diversity:** the opportunity to recruit *Connections* participants from diverse backgrounds beyond those women who might be participants in their own programs
- **Collaboration:** the opportunity to engage in more effective collaboration and communication with other organizations
- **Innovation:** the opportunity to develop and share with other service providers innovative ideas and approaches that improve outcomes for IPV-affected families

Some innovative ways for increasing community capacity building and expanding partnership suggested were:

- **Community kitchens:** Make food with women; then, instead of eating it at the centre, encourage them to take it home to enjoy with their family
- **Social media:** Utilize social media to promote an organization's programs and services, as well as to share helpful information with women and communities
- **Resource folder:** provide a resource folder that women can freely access at a centre, so that they can obtain relevant resources or connect with other organizations to seek help

We also facilitated introductions between partner organizations to support certified facilitators to respond to changing community needs.

Activity 4: Delivery of the *Connections* Group

The *Connections* group was implemented at the 14 partner CAPC, CPNP, and AHSUNC partner sites across Canada. A total of 182 mothers attended *Connections* groups, with 139 mothers completing all six sessions of the *Connections* groups during the four-year project.



5



Evaluation of C-BTC

Highlights of the C-BTC Evaluation

As *Connections* has evolved over the years, so have its evaluations. The earliest *Connections* projects were evaluated to assess the group's impacts on participants, facilitators, and communities. *Building Connections* expanded the evaluation to connect trauma-informed approaches to the delivery of an IPV program.

C-BTC expanded the evaluation further and conducted intervention research that not only evaluated the impact of the *Connections* group on

participants exposed to IPV and on certified *Connections* facilitators, but also:

- **enhanced the evidence base for *Connections*** by assessing its long-term impact on families, facilitators, and communities which will support its adaptation
- **built an understanding of the underlying mechanisms of change** – when, how, and why changes occur, and
- **analyzed moderating factors** that identified for whom *Connections* is most effective

I. Evaluation Instruments

In addition to several standard and widely available evaluation instruments, we developed evaluation instruments specific to our needs. One is called the *Connections* Knowledge and Satisfaction for Participants (CKS-P) Tool.

Participants also completed a series of online surveys, including pre-group, weekly, and post-group questionnaires. These were completed on a tablet, then sent electronically from the tablet directly to the research team. This strategy protected participants' privacy and helped to keep both mothers and facilitators safe from the potential risks of living with IPV.

The pre- and post-group surveys included the CKS-P tool. This measure examines a range of items, including:

- mothers' satisfaction with the *Connections* group experience
- knowledge of available community services
- knowledge of *Connections* concepts, and
- changes in parenting behaviour, relationship capacity, self-esteem, self-efficacy, and self-compassion

We also developed and used:

- the Awareness, Capacity, Confidence, and Satisfaction – Training Version (ACCS-T). The ACCS-T was developed for the prior *Building Connections* initiative to evaluate the effectiveness of the *Connections* Certified Training
- the Awareness, Capacity, Confidence, and Satisfaction – Webinar Version (ACCS-W). ACCS-W was also developed for *Building Connections* to evaluate the impact of the community webinar training

II. Evaluating the Underlying Mechanisms of Change

As noted above, the C-BTC project evaluated *Connections* for its impacts on mothers of children from birth to six years of age who have been exposed to IPV. The evaluation also enhanced the evidence base for *Connections* by assessing its long-term impact, which encourages its implementation by communities across Canada.

However, the evaluation was taken a step further in identifying when, how, and why changes occur (the “underlying mechanisms of change”). This also encourages the overall implementation of *Connections* by communities. And it supports ways to implement *Connections* more effectively for the individual needs of different communities.

We looked at the mechanisms of change from the perspective of the mothers who participated in *Connections* in several ways, including:

- how, following their participation in *Connections*, mothers became aware of changes in their thinking and behaviours about themselves, their relationships, and their parenting
- how mothers recognized the associations between their experiences in *Connections* and the changes they reported in their lives – how they saw that their participation in *Connections* shaped a new understanding of IPV and altered how they conducted themselves and changed in their day-to-day lives

III. The Follow-Up Connections Evaluation

For the C-BTC evaluation process, we incorporated a follow-up evaluation. When participants completed the post-Connections survey, the C-BTC researchers asked if they would be interested in participating in a follow-up evaluation. If they agreed, six months after participants had completed the Connections group, they were contacted again by researchers who conducted a follow-up survey, an individual interview, or both. Participants were thanked for completing the follow-up evaluation with a \$25 online gift card for each evaluation completed.

Evaluation of the C-BTC Project Components

Complete quantitative evaluation results for the C-BTC project are included in the [Appendix](#). For detailed evaluation results, please refer to the [Appendix](#).

a. Evaluating Connections Certified Training

The certified training, provided online in three sessions, prepared facilitators to deliver Connections and support its evaluation with confidence and fidelity. The virtual trainings consisted of a variety of presentations and activities. Over the course of the initiative, four virtual certified training sessions were delivered. In the final year of the project, based on feedback from facilitators, a one-day, accelerated training was delivered to five facilitators. These were facilitators who had baseline knowledge of group delivery; they had acted as co-facilitators of a Connections group with certified facilitators who had received the certified training in the traditional format. A total of 46 service providers were trained to become Certified Connections Facilitators.

Participants who attended the certified training were service providers from CAPC, CPNP, and AHSUNC partner sites from 14 communities across Canada. Participants for training were chosen internally from within their CAPC, CPNP, and AHSUNC projects. At the beginning and end of each Connections certified training session, facilitators were asked to complete the Awareness, Capacity, Confidence, and Satisfaction – Training Version (ACCS-T). This online questionnaire took approximately 15 minutes to complete. Of these, 39 participants completed a pre-training questionnaire, and 33 participants completed a post-training questionnaire, with full pre-training and post-training data available from 25 participants.

The ACCS-T was developed for the previous *Building Connections* project to evaluate the effectiveness of the Connections certified training. For the C-BTC project, we were interested in measuring:

- **awareness** (e.g., “How aware are you of the ways to enhance relationship capacity of the families with whom you work?”)
- **capacity** (e.g., “How capable do you feel to safely deliver an IPV intervention?”), and
- **confidence** (e.g., “How confident do you feel in your ability to build partnerships and collaborate with other community organizations?”)

Five training sessions were delivered, with a total of 46 facilitators completing the certification. Initial findings from the Connections Certified Training surveys indicated a high satisfaction rate of 93%, along with significant improvements in awareness, capability, and confidence, ranging from 67% to 93% among participants.

Facilitators were also asked to share any additional comments or suggestions they might have had about their experience in the training.

The facilitators reported significant increases in awareness, capacity, and confidence after their participation in the Connections training. All the trained facilitators reported positive satisfaction with the training itself. Some of their comments include:

“Thank you so much for providing this opportunity to learn and bring a much-needed intervention to our program. As we have benefitted from your immense knowledge base, so will our program participants. Your training was easy to understand and very relevant. Your passions shine. Thank you again for your time and knowledge sharing. We look forward to bringing this to the women we support.”

“I enjoyed the training. It was comprehensive. I look forward to delivering the program and building my confidence to support women and families.”

The primary concern some community staff members had with the training was its online delivery format. In the earlier training sessions in particular, some participants found this to be a bit of a challenge:

“I would have like to see some more faces and make a few more connections with the other participants. I know the presenters did ask people to have their cameras on so that is not something they can control but perhaps practicing a few ice-breakers with the use of break out rooms or some other interactive approach.”

Another participant similarly struggled with the online format, though also found the training overall helpful:

“Having it online can be a bit discouraging as a group. I think maybe having a different approach or having people who are doing it online, do it separately as opposed to a whole group in the room... I feel in person would have a more powerful impact as opposed to online where you cannot see anyone and not truly know if everyone is actively listening... Other than that I truly enjoyed it. I loved listening to all the speakers and the knowledge they carry, as well as the guidance everyone shared. I did take lots of knew info from it all and truly grateful for everyone’s time and knowledge.”

b. Evaluating *Connections* Webinars

We provided community webinar training on evidence-based practices and approaches for supporting mothers experiencing IPV and substance abuse, and their children affected by FASD. The webinars were open to certified *Connections* facilitators and to community-based service providers who were invited to participate by the CAPC, CPNP, and AHSUNC projects. The community-based service providers were invited in order to support the capacity building phase of C-BTC. A total of eight webinars were delivered over the course of the C-BTC project, each lasting approximately 2 hours.

We used email addresses (provided by participants to register for the training) to send a link to an online questionnaire at the end of each webinar. Participants were asked to measure their satisfaction with the training. The questionnaire took approximately 10 minutes to complete. A total of 369 service providers attended webinar trainings, with survey data available from 134.

The Awareness, Capacity, Confidence, Satisfaction – Webinar version (ACCS-W) was developed for *Building Connections* to evaluate the impact of the community webinar training. For the C-BTC project, we were interested in measuring:

- **awareness** (e.g., “How aware are you of the impact of [webinar topic] on women and children in your community?”)
- **capacity** (e.g., “How capable do you feel to respond to [webinar topic] in your program?”), and
- **confidence** (e.g., “How confident do you feel in your ability to address the issue of [webinar topic] with women in a sensitive manner?”)
- **satisfaction** (e.g., “How satisfied were you with the relevance of the information in the webinar to your program?”)

A total of 369 participants attended a total of 8 webinars delivered during the C-BTC project. 98% of participants reported high satisfaction. Results indicated that information from the training would be used to change behaviour; specifically, the information would be:

- reflected in day-to-day work (82%)
- shared with colleagues (74%), and
- considered in developing practices and policies (47%)

The post-webinar survey also asked participants how the information might be reflected in their work and shared with others. Webinar participants were also asked to share any additional comments they might have had about the webinar trainings. Feedback was overwhelmingly positive, though some participants noted the webinars could have been longer to allow for more discussion and interaction:

*“Fantastic webinar thank you!
A full day one where we can discuss
‘situations’ would be helpful.”*

Others noted that they felt better prepared to work with diverse families in their communities:

*“I left feeling better prepared to work
with Black clients and would absolutely
attend more webinars like this.”*

*“I feel I have a better understanding of
South Asian community and culture.”*

Several participants appreciated the personal experiences shared and passion demonstrated by webinar presenters:

“I really enjoyed the presenter, she shared about her own experience and was very personable.”

“Presenter was very engaging and passionate about her work and discussed tangible ways we can practice social prescribing in real life with clients/patients.”

Finally, several participants spoke about how they would use information presented to shape their own work:

“Thank you for providing this resource. It has truly helped me rethink how I can more effectively integrate recruitment, promotion, and community linkages.”

“I believe I am better prepared and capable of asking questions, being open and sensitive to the community.”

c. Evaluating the Connections Community of Practice

At the mid-way point of the C-BTC project, and again at the end of the project, facilitators from the Community of Practice (CoP) were asked to complete a short online survey. In the survey, we asked about their experiences related to the community training webinars, their participation in the CoP, and their experience delivering the Connections group.

Eighteen facilitators completed the mid-way point survey (the survey was sent to 39 facilitators, though this number likely includes some people no longer with their organizations). Facilitators had positive feedback about the webinars. Many CoP participants shared the webinar content with others in their organizations or in the wider community. They also suggested several topics that they would be interested to see in future webinars. These included:

- supporting young parents with mental health difficulties
- forming relationships with other organizations
- cultural competence for families experiencing IPV
- delivering IPV programs to transient populations, and
- current information on substance misuse

From this mid-way point information, we were able to adapt upcoming community training webinars to accommodate some of these interests (e.g., Engaging South Asian Families; The Many Uses of Harm Reduction in Addiction Counselling, Pregnancy, and Parenting Support; and Integrating Social Prescribing into Clinical Practice: Tools for Better Supporting Families).

Facilitators were also asked about their participation in the CoP itself. In terms of barriers to attending CoP, facilitators noted not being available at the scheduled meeting time or not having enough time in their work schedule to meet.

Several facilitators felt that an accelerated training for new staff would be helpful, a Connections evaluation refresher would be helpful, and that receiving reminders during Connections delivery (e.g., evaluation reminders) is helpful. Based on this feedback, we were able to offer an accelerated training to service providers who had already delivered Connections with a certified facilitator but had not yet received training.

At the end of the C-BTC project, 11 facilitators completed the survey (19% of total). Facilitators noted topics of community training webinars that they found particularly helpful, including:

- social prescribing
- harm reduction, and
- supporting individuals from diverse cultural backgrounds

One noted how helpful it was for webinar recordings to be available for those who were not able to attend.

Overall, facilitators found the webinars helpful for their work, with one noting:

“The info gives me extra confidence in my ability to assist these clients to the best of my ability.”

Another highlighted how learnings helped her gain perspective on her work with families:

“The content of the courses and materials remind us that relationships are very complicated...We cannot tell anyone what to do with their relationships, we can only support, guide, and keep having conversations with individuals to help them gain greater understanding of themselves, their children, and situations.”

Facilitators were asked to reflect on their experiences in the CoP, though only a few provided feedback regarding potential changes to the structure and content of CoP meetings. One facilitator appreciated when there was a specific topic question or two provided by the hosts and found that this encouraged “genuine learning and reflection.” Another suggested occasional 15-minute learnings or informal presentations on topics such as addictions,

mental health, or IPV. Finally, a facilitator highlighted the relationship-building component of the CoP:

“I did like hearing from other projects, about the types of agencies offering the program. Welcome and introductions by the hosts made it a safe place to share and learn from each other.”

Facilitators were also asked to reflect on their experiences delivering the Connections group. In terms of barriers to delivery, facilitators noted difficulties with:

- client engagement
- insufficient resources
- distance and transportation for participants
- timing/workload, and
- staff changes/turnover

More than one facilitator noted the small number of service providers at their program and the difficulty in finding a co-facilitator, as well as someone to support childcare, despite partnering with other organizations.

When asked if facilitators had made any adaptations or modifications when delivering Connections, several discussed changes they had made. Some made changes to the time and length of delivery, including:

- offering Connections biweekly
- having shorter sessions to account for school pick-up times, and
- adding extra sessions (e.g., self-care, coping strategies, child nutrition)

Two facilitators described changing written materials based on clients’ language and literacy, including:

- translating materials for non-English speaking clients
- adding art-based activities, and
- giving information verbally due to concerns about literacy level).

All facilitators found reminders about the evaluation component of the initiative to be helpful. When asked if there were additional supports that we could have provided, most indicated that the level of support was sufficient and appreciated:

“I think your support was outstanding. Always there to support and encourage with positive feedback. I learned from other group members as well—new ideas, new ways of doing things.”

Some noted that funding remained the biggest issue, as programs wanted to be able to offer transportation, childcare, and food to Connections participants. One facilitator suggested a package of promotional materials might be helpful to advertise in the community.

Finally, facilitators were asked to point to any specific positive changes observed among the Connections participants; all facilitators noted positive changes. A few facilitators highlighted the importance of having a safe space to discuss and process experiences, and the positive relationships formed during the Connections group. In one location, facilitators started a new group so that women from the Connections group could remain connected:

“The participants became very close and continued to ask to meet because it supported their mental wellness, which in turn prompted our agency to create a [mother’s group] so those members could still meet, but with their kids present.”



Several facilitators felt that the largest impact on the participants was their ability to connect the experiences they had in the past to their current relationships and parenting, leading to a better awareness and understanding:

“They made connections as to why they accept and maintain the relationships they do.”

One facilitator specifically noted that this led to women leaving unhealthy relationships. Facilitators also pointed to empowerment as a key factor leading to change:

“Participants gained in their ability to share in giving and receiving social support, found the script to tell their stories and to validate others based on their own experiences. They lost (at least some of) the shame attached to being mistreated and became more hopeful.”

Overall, and despite noting some barriers to attending CoP and Connections delivery, facilitators seemed to have a very positive view on the CoP and the C-BTC project as a whole. As one facilitator writes:

“Thanks again for treating me like a learner and contributor. It has been a rewarding personal and professional experience.”

The C-BTC Community of Practice met bi-weekly from January 2023 to the end of the project. The 14 community partners contributed to the CoP regularly. Feedback given by partners was evaluated and shared to ensure the needs of facilitators were being met. Changes to topic delivery and delivery method were made based on the facilitators’ feedback.

d. Evaluating the *Connections* Group and Participants

Participants included mothers who attended *Connections* groups at one of the CAPC, CPNP, and AHSUNC projects from the 14 C-BTC partner sites across Canada. Certified facilitators within the CAPC, CPNP, and AHSUNC projects recruited mothers from their communities, and decided through discussion with the mothers whether the *Connections* group would be a good fit.

Prior to starting the *Connections* group, mothers were asked to complete a series of online surveys (*Connections* Knowledge and Satisfaction for Participants [CKS-P] Tool) on a tablet computer. Surveys were sent electronically from the tablet directly to the research team as a means to protect participants’ privacy and keep both mothers and facilitators safe. The CKS-P took approximately half an hour, with facilitators available to assist. After the final group session (approximately 6-8 weeks later), mothers were asked to complete another set of surveys (similar to the pre-*Connections* CKS-P), again taking approximately half an hour to complete.

In 10 CAPC and CPNP projects, the *Connections* group was delivered 38 times, with group size ranging from one to nine participants. A total of 182 women attended *Connections* and 139 completed the group (76% completion rate). The pre-*Connections* CKS-P

tool was completed by 162 women, and the post-*Connections* CKS-P was completed by 113 women. 17 women participated in an interview and 27 completed a follow-up *Connections* CKS-P.

The CKS-P was designed to increase our understanding of the participants' family context and demographics as well as to measure participants' changes in:

- sense of self
- relationship capacity
- parenting capacity
- knowledge of, and comfort with, community services, and
- knowledge of *Connections*-related concepts

The post CKS-P measure also asked participants to provide feedback on their satisfaction with the *Connections* group.

Demographics

Women were asked about a variety of socio-demographic characteristics, including their age, nationality, preferred language, ethnic heritage, education, employment, income, housing status, relationship status, and number of children.

Self-esteem

Women answered 10 items related to positive and negative feelings about the self (e.g., "I am satisfied with myself").

Self-efficacy

Self-efficacy was measured using an 8-item scale that assessed women's beliefs about their ability to accomplish certain tasks/goals (e.g., "I will be able to achieve most of the goals that I have set for myself").

Self-compassion

Self-compassion was measured using 12 items that assessed women's ability to be kind and understanding toward themselves (e.g., "When I'm

going through a very hard time, I give myself the caring and tenderness I need").

Relationship capacity

Relationship capacity was measured using 18 items consisting of three subscales (6 items each). The subscales measured:

- a woman's ability to feel close to others in relationships (e.g., "I find it relatively easy to get close to others")
- her ability to depend on others (e.g., "I know that people will be there when I need them"), and
- any anxiety in relationships (e.g., "I often wonder whether romantic partners really care about me").

Parenting efficacy and satisfaction

Parenting efficacy and satisfaction was measured using 12 items assessing parenting efficacy (e.g., "I feel like I am doing a good job as a parent") and parenting satisfaction (e.g., "Being a parent makes me tense and anxious").

Parenting stress

The measurement used to assess parental stress contains 36 items. These items assess a mother's stress with respect to:

- her parenting role
- perceptions of the quality of and satisfaction with her interactions with her child, and
- the children's behavioural characteristics that may lead mothers to perceive them as difficult to manage

Knowledge of services

The extent to which women had knowledge of and felt connected to community services was measured using seven items (e.g., "I feel connected with programs I can use;" "I am able to get help from other organizations and agencies").

Understanding of Connections concepts

Women completed a 9-item measure that assessed their knowledge and understanding of *Connections*-related concepts (e.g., “Unhealthy relationships between parents can affect a child’s development, even if they do not witness violence”).

Satisfaction (post-Connections)

Following the final *Connections* group session, women reported on their overall satisfaction using an 8-item measure (e.g., “How satisfied are you... with the extent to which the information helped you think differently about healthy relationships,” “... with the amount of information you received about parenting,” “... with the *Connections* program overall.”).

In 10 CAPC and CPNP projects, the *Connections* group was delivered 38 times, with group size ranging from one to nine participants. A total of 182 women attended *Connections* and 139 completed the group (76% completion rate). The results of this component of the C-BTC evaluation of the *Connections* group showed that:

- mothers who participated in *Connections* expressed high levels of satisfaction with the group, with a majority of participants reporting complete satisfaction
- there were significant increases in knowledge of available community services and knowledge of *Connections* concepts
- there were positive changes in parenting behaviour and relationship capacity
- there were significantly improved outcomes based on self-esteem, self-efficacy, and self-compassion

Based on the responses of the women who participated in the *Connections* groups, we had several evaluation questions.

Evaluation Question #1: Who were the women who completed the *Connections* group?

We examined the sociodemographic characteristics for the 205 women who participated in *Connections*.

We found that:

- the **average age** of the women participating in the group was 32.90 years, with a range of 17 to 62 years old
- 53% of participants had received previous **support or counselling** related to IPV and healthy relationships
- when asked about **place of birth and preferred language**, 83% of the women were born in Canada and 94% reported English as their preferred language
- women reported that their **ethnic heritage** was 44% North American, 26% European, 16% Indigenous, 5% South Asian, and 11% other (note that women were invited to select more than one option)
- **education levels** of the participants showed that 82% of women had completed high school with almost 25% achieving some trade or technical education, and 68% had some post-secondary education
- **employment status** showed that 74% of women were not currently employed outside the home
- **source of income** was varied, with the most prevalent being social assistance, disability benefits, maternity/child tax benefits, employment insurance, or some combination of those
- **actual income** varied, but almost half of the women (46%) reported a gross income of less than \$1,500/month or less than \$18,000/year

- **living situations** varied, with many living in a house (35%), apartment (38%), or shelter (16%)
- most women reported that their **marital status** was single (51%) or married/common law (24%)
- when asked about **living arrangements**, responses showed that 52% of women lived only with their child or children, while 26% lived with a partner and their child or children, and 9% lived alone
- the **number of children** women had was between 1 and 9, with a mean of 2.36 children

Evaluation Question #2: Did women who attended *Connections* change over time?

We examined the following variables which helped us to understand ways in which change occurred for the women who participated in the *Connections* group. The variables were:

- self-esteem
- self-efficacy
- self-compassion
- relationship capacity including closeness, ability to depend on others, and anxiety in relationships
- parenting efficacy
- parenting satisfaction
- parenting stress
- knowledge of community services
- understanding of *Connections* concepts

With two exceptions, women showed significant change in positive directions. That is, women reported higher self-esteem, self-efficacy, and self-compassion after participating in *Connections* compared to before. They also reported feeling more closeness in relationships, higher ability to depend on others in relationships, and lower anxiety in relationships after *Connections* compared to before. Contrary to expectations, women reported lower parenting efficacy and satisfaction after *Connections* compared to before. However, women also reported lower overall

parenting stress, higher knowledge of available services, and a greater understanding of *Connections* concepts after *Connections* compared to before.

Women also reported very high satisfaction with the *Connections* group. 99% of participants reported positive satisfaction, with two thirds reporting complete satisfaction.

Evaluation Question #3: Does change happen more for some women than for others?

We were very interested to discover and understand if some mothers changed more during their participation in the *Connections* group than others. To deepen our understanding, we first created a way to measure vulnerability based on each woman's demographic status (called the "demographic cumulative risk index").

This included six demographic variables: age, education, employment status, income, current housing status, and number of children. We then determined lower and higher risk levels for each variable. Next, we assigned a value of zero or one for every risk indicator reported by each *Connections* group participant. Finally, we calculated a percentage risk score for every individual woman. We found that the risk level and percentage of participants for each variable was:

- **age**—13% of women were in the higher risk category of 17 to 24 years old and 87% of women were in the lower risk category of 25 years old or older
- **education level**—18% were in the higher risk category of less than Grade 12 education and 82% were in the lower risk category of Grade 12 completed
- **employment status**—80% were in the higher risk category of not currently employed and 20% were in the lower risk category of part or full-time employed

- **income**—53% were in the higher risk category of under \$18,000 per year and 47% were in the lower risk category of over \$18,000 per year
- **housing status**—21% were in the higher risk category of no stable housing and 79% were in the lower risk category of housed
- **number of children**—34% were in the higher risk category of three or more children and 66% were in the lower risk category of two or fewer children



We were interested in how these demographic risks impacted any changes women made. Once again, we examined the key variables of self-esteem, self-efficacy, self-compassion, relationship capacity (including closeness, ability to depend on others, and anxiety in relationships), parenting efficacy, parenting satisfaction, parenting stress, knowledge of community services, and understanding of *Connections* concepts. We found that:

- with respect to **self-esteem**, women who had higher levels of demographic risk had higher self-esteem after their participation in the *Connections* group
- in terms of **self-efficacy and self-compassion**, the same pattern was found, indicating that women with higher levels of demographic risk increased more in self-efficacy and self-compassion following *Connections* relative to those with lower levels of demographic risk
- levels of demographic risk did not seem to be related to **relationship capacity, parenting efficacy, satisfaction, or stress, or knowledge of community services**
- levels of demographic risk were significantly related to women's **understanding of *Connections* concepts**, in that women with higher levels of demographic risk also had higher knowledge of *Connections* concepts after they completed the group

This suggests that *Connections* works particularly well for mothers who are more vulnerable. This includes mothers whose conditions of risk range across several realms, including women who are younger and who have lower education and employment/income levels, unstable housing, and more children. The positive impacts of *Connections* on self-esteem, self-efficacy, self-compassion, and knowledge of *Connections* concepts seem to be greater for women who are more vulnerable at the beginning of the process and have more to gain through participation in *Connections*.

Evaluation Question #4: How does change happen?

Our goal was to gain an understanding of when, how, and why change happens (the “theorized mechanisms of change”) for women living with IPV. To do this, we examined the voices of mothers from our previous *Building Connections* project. This enabled us to explore the ways change occurs in women who participate in *Connections*. From the mothers’ own perspectives, we were able to discover the mechanisms of change through the processes they experienced, including:

- how mothers became aware of changes in their thinking and behaviours following their participation in *Connections* across three realms of self, relationships, and parenting, and
- how mothers recognized the associations between their experiences in *Connections* and the changes reported in their lives

Most notably, the key mechanisms of change for mothers included increases in their capacity for:

- self-care and compassion,
- forgiveness and healing, and
- reflection

These shifts combined to form increases in self-esteem and empowerment, and ultimately affected positive changes in mothers’ well-being, relationships, and parenting.

Evaluation Question #5: What are the effects of increased self-compassion?

Moving beyond the women who were participants in the *Building Connections* project, we examined the group of mothers who completed the C-BTC *Connections* group. We further tested the mechanisms of change. We were especially interested in exploring self-compassion as a key mechanism of change. Our research question was: Do larger changes in self-compassion predict changes in the other outcomes of interest to us? That is, is increased self-compassion linked to self-esteem, self-efficacy, relationship capacity, and parenting?

We found that change in self-compassion predicted post-*Connections* self-esteem, though the reverse was also true; that is, increased self-esteem could predict higher levels of self-compassion. The same general pattern was found with self-efficacy. This again indicates that self-compassion may increase self-efficacy, but the reverse may also be true.

When we looked at relationship capacity, (including closeness, ability to depend on others, and anxiety in relationships), we found that increases in self-compassion predicted:

- higher post-*Connections* closeness,
- higher dependence on others, and
- lower anxiety in relationships,

However, in this case, the reverse did not seem to apply. That is, changes in closeness and dependence did not predict post-*Connections* self-compassion. Taken overall, results indicate that mothers who had increased more in self-compassion after *Connections* also had higher relationship capacity after participation in *Connections*.

When we looked at self-compassion and parenting (including parenting efficacy, satisfaction, and stress), the results were mixed. Here, when participants reached higher levels of self-compassion, we found lower parenting stress, though there was some evidence for the reverse as well. But contrary to expectations, we found that increases in self-compassion predicted lower, not higher, parenting efficacy and parenting satisfaction. However, given generally ill-fitting models, we caution interpretation of these results.

Increasing self-compassion appears to be an important mechanism of change for increasing self-esteem and self-efficacy of women living with IPV. These changes might occur mutually (reciprocally) or one leading to the other (in tandem). Increasing self-compassion also appears to be important in changing relationship capacity, but not the reverse. Finally, self-compassion may play a functional role in parenting attitudes and thinking, though these results are less clear.

e. Analyzing the Mechanisms of Change

As noted previously, a research focus for the C-BTC project was an analysis of the mechanisms of change – we wanted to build an understanding of when, how, and why changes occur for women living with IPV. The qualitative analysis of the mechanisms of change involved interviews with 17 women approximately 11.3 months (range from 3 to 28 months) after completing *Connections*. In these semi-structured interviews, women were asked open-ended questions about their experiences with the *Connections* group and any changes they had experienced since completing it. Responses were analyzed with the intention of identifying mechanisms of change.

Observation #1: There are cascading processes of change in women’s relationships

Women were able to describe how change occurred for them as a “cascade” – one change would lead to another. Changes began from specific things they learned in *Connections*, which led to positive changes in their lives. First, women described that one of the initial things they learned was how to identify healthy relationships. Their participation in *Connections* led women to understand what is and what is not a healthy relationship. From there, they developed an increased awareness of healthy and safe relationship patterns. This included women who were supported to connect their own histories of trauma to their current life circumstances:

“[Connections] definitely brought up some stuff from the past, and my childhood, and stuff like that kind of made me maybe realize some different things and not be so hard on myself.”

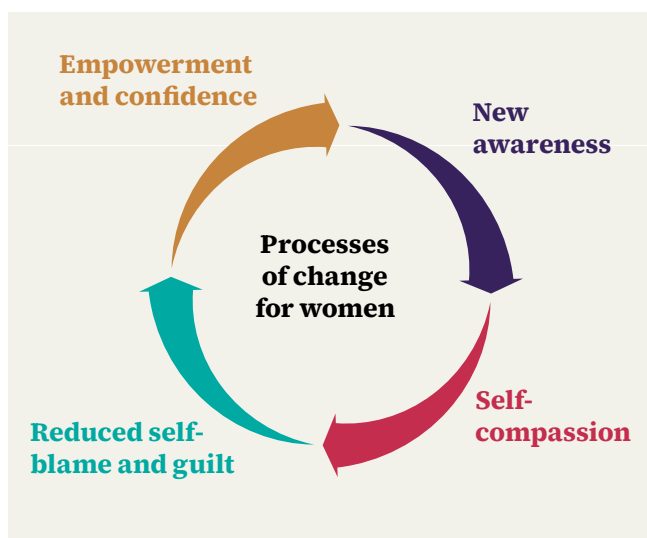
This increased awareness led women to understand that their current unhealthy relationships were ‘not their fault.’ In fact, those relationships made sense given their childhood experiences. Subsequently, they had increased compassion for themselves as a result of being able to make sense of their experiences within this new awareness:

“And I – we just look at our lives now and we just laugh about it because it’s like, if we didn’t have what had happened to us, we would not be the way we are now. And yes, we are very strong and resilient and independent, but we’re also that little girl hiding in the corner”.

Increased self-compassion led women to want to defend and stand up for themselves. They began to feel a sense of pride and esteem in their own strength and resilience. They could acknowledge and take pride in their ability to persevere, despite their strained relationships in both childhood and adulthood. The initial awareness about healthy relationships followed a certain pattern that:

- led to gentleness for themselves
- then, to a grieving for what they hadn't had, and
- finally, to confidence in affirming and accepting that they have a human right to dignity and safety in relationships

“Because I think that our partners had made us feel so ashamed about what was happening that I didn’t want to talk about it. But until I was able to start talking about it, then I was able to start forgiving myself ... I forgive myself, for the guilt, for the things. I didn’t do anything wrong. But I’m forgiving myself for what’s happened so I can let it go.”



Observation #2: There are also cascading processes of change in women’s parenting

There was a parallel cascading process related to women’s parenting. That is, the cascade described above, where women gained new awareness, increased self-compassion, reduced self-blame and guilt, and moved toward empowerment and confidence, also motivated them to create a similar environment for their children. In fact, making those connections between their own histories of trauma and their own and their children’s current experiences was a motivator to make change for their children. They shifted their approaches to parenting in a positive way, leading them to act protectively and proactively for their children’s wellbeing. Women were gentle with, protective of, tried to educate, and empowered their children more when they were aware, self-compassionate, and confident. This brought a sense of parenting competence and confidence, as well as hope.

“I can recognize some things that took place or whatever in my past that may be affecting me in the future. And I can try and be, like, more aware so I can have, a better and really good, healthy relationship for my daughter, and moving forward for her relationships as she, you know, goes on in the future.”

“I’m a little bit nicer to myself, and I’m a little bit more forgiving with myself, which means I get to be a better mom and more forgiving with my children, because I’m understanding that we’re all just the same.”

Equipped with these tools, women reported feeling less fear about unconsciously repeating cycles. Instead, they felt confident and empowered. They came to believe that they had the skills to address risks and bolster protective factors in their lives and the lives of their children. For some women, these skills were grounded in their increased ability to regulate themselves and their emotions. Women reported looking toward the future and having hope:

“And, you know, so it’s like, it’s just everything is kind of coming into place now. Like I’m starting to feel more like, okay, this is manageable. I can do this.”

Observation #3: There are additional factors that support change

We identified several additional themes that women talked about as being important factors in their ability to make positive changes. Broadly, this included:

- the new safety they felt within the *Connections* group and relationships
- their new ability to view themselves and their basic needs and resources objectively as a step toward change, and
- having access to the time and ongoing supports needed for meaningful change

Factor #1: Safety within the *Connections* group.

The nature of the *Connections* group itself enabled women to make changes. Women described how facilitators created a space that was safe enough to allow them to process their experiences of IPV without judgement or the fear of their privacy being violated. Facilitators recognized the women’s complex circumstances and were able to work with them using patience, awareness, and providing resources that ‘met them where they were at’

(including providing transportation, food, and childcare). When facilitators first created that sense of safety and care, women were able to take steps to make changes.

Factor #2: Safety within relationships.

The *Connections* group format provided a caring setting. Women felt seen and heard by others who had been through similar experiences. When women spoke about their experiences in *Connections*, they revealed how they were able to use the group as a support – as a new way to rethink their expectations about relationships and “internal working models” that they had not been previously able to develop given their life experiences and relationships. That is, through their relationships with facilitators and peers in the group, women felt more emotionally regulated and therefore ready for change:

*“And to have [the *Connections* facilitator] that I just felt like was a person that I could confide in her. She had a little bit of an idea of my situation and who I was...it was the fact that somebody took the time to talk to me and gave me their time and, that respect, just... I respect her so much for that. And I’m so grateful, for her doing that. And it helped me. It really, really helped me.”*

The internal working model of attachment is a cognitive framework that children develop in early childhood based on their interactions with primary caregivers. It shapes expectations, self-worth, and behaviours in future relationships. The internal working model:



- dictates how people perceive themselves and others, and
- influences emotional regulation and social interactions throughout life

Factor #3: The impacts of relationships on women's health.

Women grew to understand that the quality of their relationships influences their health. They were able to recognize the importance of their relationships. And they grew to understand how the relationships in their lives support health outcomes (in both negative and positive ways).

“I could name two people right now. If I did not have those two women in my life, I would not have my child to be with. And I would not be where I’m at.”

Women spoke about practicing a balanced view of themselves and their relationships, and how this perspective supported them in making positive changes. That is, women explained how they learned to view both the good and the challenging aspects of their lives objectively. They were able to develop a balanced viewpoint that allowed them to scrutinize

their identity, relationships, and life events. When they were able to dispel negative views of their own and their children's experiences, growth occurred.

“So just because we missed a few years of [our children’s] lives because we had a bad moment in our past, does not mean that we are going to do it again. And so what if we relapse? There is a reason why we relapsed. So to get back up on our feet and crawl out of that hole... that just makes us stronger than we were, again!”

Women acknowledged the many practical steps they needed to make change in their lives and the lives of their children. They understood that women who had access to sufficient resources in their support network (e.g., housing, income, food, childcare, transportation, emotional support) were more able to address, reduce, or remove stressors from their own and their child's lives. Practical supports are critical:

“There are people that are still trying to get better, but there’s also people that can’t get better because they don’t have the supports in their lives.”



For some, this understanding allowed for further healing and growth. For example, hypervigilance (constantly scanning for threats) is common among women who live with IPV. One woman talked about the changes she was able to make once she was able to detach from her hypervigilance. In her case, this meant constantly managing safety concerns in her living situation. The physical and emotional

resources she had previously spent on monitoring and managing her own behaviour were freed up. She was then able to devote her physical and emotional resources to self-care and forward movement (including a focus on job applications and finances).

Hypervigilance is a state of extreme, chronic alertness and sensory sensitivity due to IPV, trauma, PTSD, or anxiety. It involves constantly scanning for, and reacting to, perceived dangers, leading to exhaustion, irritability, and social withdrawal.

Some women spoke about how change is an ongoing process. These women explained that, given the complexities of their lives and circumstances, the time required to make change can be lengthy. They acknowledged the need for an extended period of time to fully process the information, awareness, and tools they learned through the *Connections* group. Change requires more processing, organization, and periods of rest and resource gathering than can be measured or accomplished within the weeks that the group is running.

Several women noted the importance of pursuing ongoing supports following *Connections*, as well as maintaining the supportive relationships they formed within the group. Many women completed the group multiple times. These women noted that it was only after two or more rounds of participation in the group that they could slowly overcome the barriers standing between them and the changes they wanted to make. For instance, one woman described being recently able to end an unhealthy relationship. She had participated in *Connections* twice and received other ongoing parenting support through a community-based program:

“I actually recently ended a relationship just due to like, we dated for four years, but I did Connections twice. I did Circle of Security [parenting group] three times now, like I’m in the middle of doing it my third time. And it just kind of like doesn’t match, like the relationship doesn’t fit in with my parenting. There’s some traits where like this person reminds me of the past and when I try to address that with them, they just gaslight me. So I got to a point where I was like, okay, well, I know that I went through these things and these things like harmed me and having someone constantly tell me that like that’s not the case. I just kind of had to let that go. So that’s been really hard because that person and I were – we dated for four years.”

f. The Follow-up Evaluation

A total of 27 women completed a follow-up survey, on average of just over 9 months after completing the Connections group. We examined their risk levels (the demographic cumulative risk index) based on what they told us before participating in the Connections group compared with what they told us at follow-up. On average, women had a slightly lower overall risk at follow-up than before Connections.

We also compared women’s responses to the question “What is your current living arrangement?” Only five respondents changed their living arrangement from before their participation in Connections and follow-up. But in all cases, responses indicated parenting success or lower risk in parenting abilities. Specifically, two women gained access to their children – both had reported living alone prior to participating in Connections but lived

with children or a partner and children at follow-up. One woman changed from a group or shared living environment to living with children and a partner. Another changed from living only with children to living with children and other family members. Finally, one woman reported no longer living with a partner (changing from living with a partner and children to only living with children) who, given the context of the group, could have been living with IPV.

We found four general patterns for the women who completed the follow-up survey:

- women showed improvements in self-esteem, self-efficacy, self-compassion, and parenting stresses
- although still showing improvements compared to their pre-Connections scores, at follow-up compared to their post-Connections scores, women declined in their ability to depend on others in relationships, anxiety in relationships, and knowledge of services
- in the case of closeness and understanding of Connections concepts, women’s scores were lower (closeness) or virtually the same (understanding of Connections concepts) at follow-up than they were before Connections
- both parenting efficacy and satisfaction initially decreased between pre- and post- Connections, but both showed increases at follow-up (though not to initial levels)



What We Learned and the Future of C-BTC

Lesson Learned #1

There is cumulative evidence of efficacy for *Connections*.

We continue to see support for the efficacy of *Connections*. Women reported increases in self-esteem, self-efficacy, self-compassion, relationship capacity, knowledge of community services, and understanding of *Connections* concepts, as well as decreases in parenting stress, after *Connections* compared to before. Unexpectedly, women also reported decreases in parenting efficacy

and satisfaction. It may be that, after better understanding the impact of IPV on children's brain development and increasing parenting challenges as children age, mothers were struggling to feel confident in their parenting. Qualitative analysis, however, indicates that mothers did speak about positive changes in their parenting confidence, competence, and improved relationships with their children in follow-up (approximately 11 months following *Connections*). Thus, it appears that *Connections* is successful in supporting positive changes in the lives of these mothers and children experiencing IPV.

Lesson Learned #2

***Connections* seems to have a more positive impact on mothers who live in greater conditions of risk (based on age, employment, income, housing, and number of children).**

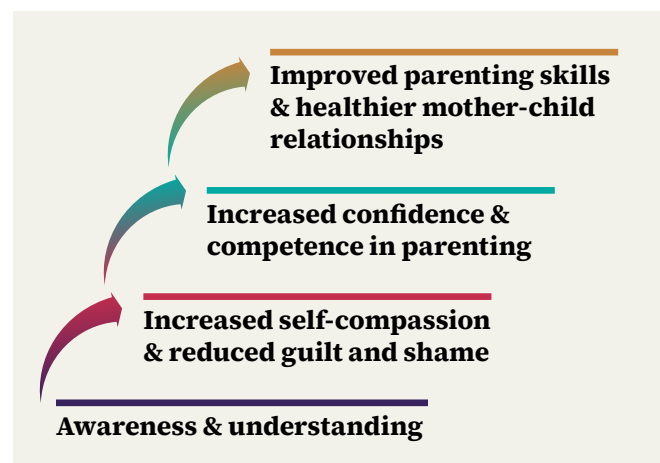
We learned that some women change more than others. In our previous project, *Building Connections*, we found that mothers who were unable to complete the *Connections* group were more likely to have less education, lower income, and have no stable housing. *Building Connections* showed us that for women to successfully complete a six to eight week group, they need a base level of stability to successfully commit to and engage in it. However, C-BTC showed us that, for women in the highest risk groups who **are** able to complete the group, there is more opportunity for growth, even though they live in conditions of risk. This was also mentioned in interviews – mothers spoke about the necessity of sufficient resources. Women who have access to housing, income, food, and other basic needs are able to spend more time and energy on personal and parenting growth.

When we support families who live in conditions of risk, we support their ability to attain basic needs. And we also establish a crucial foundation for women to reduce their exposure to IPV, unhealthy relationships, and parenting problems.

Lesson Learned #3

Self-compassion is an important route to change.

Both quantitative and qualitative data pointed to the importance of self-compassion as a pathway of change. Our evaluation indicated that when women increase in self-compassion, their relationships are enhanced. Self-compassion appeared to play an important role in changing relationship capacity. Higher levels of self-compassion were also related to higher levels of self-esteem and self-efficacy (though this may be reciprocal rather than one leading directly to the other). Qualitative findings supported this: women discussed a cascade of changes that flowed from learning and awareness, to self-compassion and self-forgiveness, to empowerment and change. This cascade was also reflected in their parenting; women described moving from awareness and understanding (including understanding the potential for change through brain plasticity and protective factors), to increased self-compassion and reduced guilt and shame, to increased confidence and competence in parenting, to improved parenting skills and healthier mother-child relationships. Both mothers and facilitators spoke about mothers now feeling hope for the future.



Lesson Learned #4

It has been difficult to re-engage with many families after COVID-19.

The COVID-19 pandemic brought with it many challenges for families at risk for experiencing IPV. Isolation, lack of access to supports for social determinants of health (e.g., food insecurity, unemployment, inadequate housing), and limited service provision during the pandemic put mothers and children at increased risk for IPV. In addition, it has become increasingly difficult to re-engage vulnerable families in community and health services. These effects were seen in the C-BTC project; facilitators noted difficulties in engaging families in service. Rates of attendance in *Connections* were lower than anticipated. Much of this may be due to difficulties in encouraging women to re-engage with in-person services.

Lesson Learned #5

There are benefits and drawbacks in online relationship building.

Our re-engagement with community partners was also challenging. The previous *Building Connections* project involved in-person site visits to all 30+ community partner sites and in-person week-long training for facilitators at the BTC location. The C-BTC project opted for online facilitator training because it increased the feasibility of C-BTC in several ways. In addition to substantial cost savings, some people continued to avoid travel due to health concerns even after lockdowns were over and regular travel had resumed. By offering the training online, we could train more facilitators, at reduced cost, with fewer life disruptions, and with fewer potential issues with health and safety related to travel. However, online training for facilitators was a challenge. From the perspective of relationship

building, it is much more difficult to form and foster relationships online. Facilitators commented on their wish for more connection, particularly with the other service providers receiving the training. In the *Building Connections* project, we found that the initial in-person relationship building was crucial. Our relationships with our community partners were then bolstered by the CoP meetings. These provided ongoing opportunities for connection and communication. Without the opportunity to build strong face-to-face relationships at the beginning of the project, online gatherings were not able to offer the same level of connection.

Lesson Learned #6

Organizational instability creates obstacles.

Staff retention in small community-based projects has always been a challenge. This has continued to be a challenge in the current C-BTC initiative. Organizations with small budgets and funding reductions must sometimes resort to cutting staff positions. For the C-BTC project, this means that staff who were trained as Certified Facilitators are no longer employed by the organization. These are staff who hold knowledge, information, and experience facilitating the *Connections* group. They also understand and know how to support evaluation data collection. This loss of staff creates instability for C-BTC, the families being served, and the mothers participating in *Connections*. In addition, women living with IPV understandably take a long time to build trust with service providers. Frequent staff turnover can be a barrier to their willingness to access services. During the C-BTC project, the sites experienced on-going challenges with staff stability and retention, even among higher-level (e.g., executive directors) positions.

We continued to work on engagement with staff at CAPC, CPNP, and AHSUNC to ensure as much consistency and continuity of *Connections* facilitation as possible. Based on facilitator feedback, we offered an accelerated training for facilitators who had previously partnered with a certified facilitator to deliver the *Connections* group but had not formally been trained themselves. This allowed informal training knowledge shared between facilitators to be solidified and expanded upon by our C-BTC training staff. The biweekly Community of Practice also allowed us to continue to engage staff who had delivered *Connections*, including new staff not previously involved in the project. Nonetheless, we recognize the ongoing challenge of staff retention and problems this can create for women and children who require support related to IPV and additional services.

Lesson Learned #7

There are increasing levels of distress among participating families.

Through C-BTC, we were able to better understand that families accessing our partner projects and participating in the *Connections* group were in more precarious situations and experiencing more challenges than families seen in the past. For instance, we found that over half (53%) of mothers in *Connections* reported a gross income of less than \$1,500/month (\$18,000/year), indicating high levels of poverty. This annual income is much lower than Canada's official poverty line. Assuming mothers only have one child, low-income cut-offs for a family of two is between \$26,161 and \$38,003 (based on 2023 values; cut-offs are even higher using different methods, including the Market Basket Measure). Among our *Connections* participants, 72% report an income below \$24,000/year, and 88% report an income below \$36,000/year. We also know that 33%

of mothers have only one child. The overwhelming majority of *Connections* participants live in conditions of deep poverty. In coming to a full understanding of IPV, it must be acknowledged that poverty, unstable housing, and caring for children make it exponentially more difficult for women to leave unsafe relationships.

Facilitators were also impacted by the increasing distress among families they serve. They expressed significant personal suffering and vicarious trauma in their roles working to support these vulnerable families. They also talked about compassion fatigue and feeling burn out due to competing demands, high caseloads, and limited staff, funds, and supports.

Mothers and facilitators both mentioned how transformative the *Connections* group was. Mothers were provided with a caring setting to learn and process their experiences with other women who had been through similar experiences. The relationships and friendships built among mothers in the *Connections* group were powerful. Women often requested that facilitators offer additional groups. They wanted to continue to be supported and build relationships with the other mothers in their *Connections* group, which decreased isolation and built a sense of community. Some of our CAPC, CPNP, and AHSUNC partners were able to develop additional programming (e.g., running a parenting group) which continued to support, maintain connections, and foster on-going relationships among women. Other partners, however, were eager to offer additional services, but often did not have the capacity due to time, funding, and staffing.

We have learned the importance of embedding *Connections* within ongoing, consistent service offerings, allowing families to maintain engagement with service providers and continue to build relationships with other families accessing that service.

Lessons Learned In Summary

C-BTC reinforced several key lessons for community-based prevention of family and IPV. Trauma-informed, relational interventions embedded in trusted settings are critical for engaging mothers affected by IPV. Reducing practical barriers supports participation and completion, particularly for women facing high levels of risk. Self-compassion emerged as a central pathway to healing, empowerment, and improved parenting. The project also highlighted the importance of workforce stability, ongoing training, peer support, and attention to service provider wellbeing in sustaining effective implementation.

The Future of C-BTC: It's all about connection

Now at the end of the C-BTC project, we have been partnered with CAPC, CPNP, and AHSUNC projects for ten years. We have learned together through:

- conversations during and feedback from the training
- CoP surveys conducted at two different points, showing us topics to address, barriers to engagement, and challenges
- conversations with organizational leaders
- bi-monthly CoP meetings from which a core group developed

Our conversations went beyond *Connections*. We learned about:

- the impacts of the COVID-19 pandemic
- the increased demand for basic needs and the reduced capacity to access services among families, which increases risk factors for IPV and the likelihood of staying in violent relationships
- the extent of compassion fatigue and moral distress among service providers, who are



working harder and holding the suffering of their participants

- the challenges organizations have with engaging and retaining families
- the challenges organizations also have with staff turnover at all levels, leading to instability in service delivery
- the precarious nature of funding for CAPC, CPNP, and AHSUNC projects

Our project partners know they are doing the right thing and the best they can for their families. But maintaining a sense of connectedness and stability is more difficult than it has been previously. All our beliefs and practices are in line with relational theory. That is, as service providers, we need to work hard, work together, and be connected to provide the best outcomes for families. Working in isolation or at cross purposes is counterproductive.

When participants feel connected, peer learning flourishes, friendships develop, and requests for additional programs ensue. Women who participate feel a stronger connection to their organization and community. They feel empowered to want better lives for themselves and their children. And they feel the need and strength to make changes in their lives, to live lives free from IPV. The impacts of this on the next generation are immeasurable.

The Legacy of C-BTC

Our goal is to make sure that after ten years of partnership with both the *Building Connections* and the C-BTC projects, we can continue to support women and children experiencing IPV. In part, this can be accomplished through:

- a multitude of *Connections* resources that live on the Mothercraft website, including the *Connections* manuals, reports and publications, and videos of community webinars
- service providers now knowing there is a network of other service providers doing this work – those connections between organizations can lead to future collaborations, which is especially important given funding challenges

Building Connections and C-BTC have demonstrated the ability to build capacity within CAPC, CPNP, and AHSUNC projects to meet the complex needs of families, especially those living with IPV, in our communities.

CAPC, CPNP, and AHSUNC projects are small, community-based services. But these projects are doing the most important work. They work with families experiencing violence, trauma, and marginalization; the projects are accepted within their communities and have long histories of community involvement. During the pandemic, these projects were the ones that women and families stayed connected to. And families trust these projects when families need information and support for their children, and when they need help with their families.

Beyond financial stability, our hope is that our funders will prioritize the expansion of existing, proven initiatives rather than seeking to create new ones. There are highly effective organizations already deeply embedded in their communities

and successfully providing services to families. We believe investing in these established programs represents the most impactful opportunity for growth and support.

The enduring impact of C-BTC includes strengthened community capacity, a national network of trained facilitators, and increased access to effective IPV prevention. Sustained components include continued delivery of *Connections* with CAPC, CPNP, and AHSUNC programming; ongoing access to manuals, reports, and recorded webinars; and strengthened relationships among service providers. Exploring future funding opportunities will support continued training, evaluation, and program delivery. Embedding *Connections* with ongoing, consistent community services remains essential to supporting women and children affected by IPV and preventing intergenerational harm.



Appendix

Connections for Breaking the Cycle of Violence Quantitative Outcomes

I. Connections Certified Training

This three-session certified training prepared facilitators to deliver and support evaluation of the *Connections* intervention with confidence and fidelity. These virtual trainings consist of presentations and activities related to delivery and evaluation of the *Connections* intervention. Over the course of the initiative, four virtual certified training sessions were delivered. In the final year of project activities,

based on feedback from facilitators, a one-day, accelerated training was delivered to five facilitators. These were facilitators who had baseline knowledge of group delivery; they had acted as co-facilitators of a *Connections* group with certified facilitators who had received the certified training in the traditional format.

Participants who attended training were service providers from CAPC, CPNP, and AHSUNC partner sites from 14 communities across Canada. Participants for training were chosen internally within their CAPC,

CPNP, and AHSUNC projects. At the beginning and end of each *Connections* Certified Training Session, facilitators were asked to complete the Awareness, Capacity, Confidence, and Satisfaction – Training Version (ACCS-T). This online questionnaire took approximately 15 minutes to complete. A total of 46 professionals were trained to become Certified *Connections* Facilitators. Of these, 39 completed a pre-training questionnaire and 33 completed a post-training questionnaire, with full pre-post data available from 25.

The Awareness, Capacity, Confidence, and Satisfaction – Training Version (ACCS-T) was developed for the prior *Building Connections* project to evaluate the effectiveness of the *Connections* Certified Training. Awareness (e.g., “How aware are you of the ways to enhance relationship capacity of the families with whom you work?”), capacity (e.g., “How capable do you feel to safely deliver an IPV intervention?”), and confidence (e.g., “How confident do you feel in your ability to build partnerships and collaborate with other community organizations?”) were each measured with 8 items each.

Four-point Likert scales were used, ranging from 1 = Not at All Aware/Capable/Confident to 4 = Very Aware/Capable/Confident. Responses across the 8 items were averaged to create pre- and post-training scores for awareness ($\alpha_{pre} = .81$, $\alpha_{post} = .92$), capacity ($\alpha_{pre} = .91$, $\alpha_{post} = .92$), and confidence ($\alpha_{pre} = .92$, $\alpha_{post} = .95$). The post-training survey included an additional 12-item measure of satisfaction with the training (e.g., “How satisfied were you with the content of the *Connections* training curriculum?”), with responses ranging from 1 = Not at All Satisfied to 4 = Very Satisfied. Responses were averaged to create a total satisfaction score ($\alpha = .93$). Facilitators were also asked to share any additional comments or suggestions they might have had about their experience in the training.

On the ACCS-T, facilitators reported statistically significant increases in awareness ($F[1, 23] = 51.25$, $p < .001$, $\eta^2 = .69$), capacity ($F[1, 23] = 38.35$, $p < .001$, $\eta^2 = .63$), and confidence ($F[1, 23] = 16.81$, $p < .001$, $\eta^2 = .42$) following, compared to before, the *Connections* training. Eta squared (η^2) effect sizes greater than .25 are considered large; thus effect sizes for these comparisons are very large. Facilitators also reported high satisfaction with the training; on average, facilitators reported satisfaction of 3.52 (SD = .43), on the 1-4 scale. It should be noted that 100% of trained facilitators reported positive satisfaction (min-max = 2.67-4.00).

TABLE 1

	Pre-Training		Post-Training	
	M	SD	M	SD
Awareness	2.76	.51	3.47	.49
Capability	2.87	.66	3.53	.47
Confidence	2.98	.66	3.39	.54

II. *Connections* Webinars

C-BTC Community Training on Evidenced-Based Practices and Approaches

The Awareness, Capacity, Confidence, Satisfaction – Webinar version (ACCS-W) was developed for the prior *Building Connections* initiative to evaluate the impact of the community webinar training. Awareness (e.g., “How aware are you of the impact of [webinar topic] on women and children in your community?”), capacity (e.g., “How capable do you feel to respond to [webinar topic] in your program?”), and confidence (e.g., “How confident do you feel in your ability to address the issue of [webinar topic] with women in a sensitive manner?”) were each measured with 7 items, using 3-point Likert scales, ranging from 1 = Not Aware/Capable/Confident to 3 = Very Aware/Capable/ Confident. Responses across the 7 items

were averaged to create post-webinar scores for awareness ($\alpha = .88$), capacity ($\alpha = .91$), and confidence ($\alpha = .94$). The survey also included a 7-item measure of satisfaction with the webinar (e.g., “How satisfied were you with the relevance of the information in the webinar to your program?”). Responses ranged from 1 = Not Satisfied to 3 = Very Satisfied and were averaged to create a total satisfaction score ($\alpha = .93$). Other items in the post-webinar survey assessed how the information in the webinar might be reflected in community project staff members’ work and shared with others. Community project staff were also asked to share any additional comments they might have had about the webinar trainings.

Findings indicated very high levels of awareness ($M = 2.65$, $SD = .38$, on a 1-3 scale), capacity ($M = 2.52$, $SD = .43$), confidence ($M = 2.51$, $SD = .47$), and satisfaction ($M = 2.90$, $SD = .29$) with the webinar trainings. It should be noted that 98% (scores of 2 and above) of participants reported positive satisfaction (min-max = 1.00 – 3.00). Results indicated that information from the training would be used to change behaviour, specifically that the information would be reflected in day-to-day work (82%), shared with colleagues (74%), and considered in developing practices and policies (47%).

III. The *Connections* Group Intervention and Participants

Participants included mothers who attend CAPC, CPNP, and AHSUNC partner sites from 14 communities across Canada and attend the *Connections* intervention. Certified facilitators within the CAPC, CPNP, and AHSUNC projects recruited mothers within their own communities, and decided through discussion with the mothers whether the intervention would be a good fit. Prior to starting

the *Connections* intervention, mothers were asked to complete a series of online surveys (*Connections* Knowledge and Satisfaction for Participants [CKS-P] Tool) on a tablet computer. Surveys were sent electronically from the tablet directly to the research team as a means to protect participants’ privacy and keep both mothers and facilitators safe. The CKS-P took approximately half an hour, with facilitators available to assist. After the final intervention session (approximately 6-8 weeks later), mothers were asked to complete another set of surveys (similar to the pre-*Connections* CKS-P), again taking approximately half an hour to complete. At the end of the post-*Connections* CKS-P, women were asked whether they were interested in participating in follow-up research and provided their email address. Approximately 3-6 months after their *Connections* intervention ended, women who had provided email addresses were contacted to enquire about follow-up research. Women were asked to participate in an interview and/or complete a follow-up CKS-P survey.

In 10 CAPC and CPNP projects, the *Connections* intervention was delivered 38 times (group size ranged from 1 to 9 participants, $M = 5.24$, $SD = 2.21$). A total of 182 women attended *Connections* and 139 completed the group (76% completion rate). The pre-*Connections* CKS-P tool was completed by 162 women and the post-*Connections* CKS-P was completed by 113 women ($N = 103$ with both pre- and post-surveys). 17 women participated in an interview and 27 completed a follow-up *Connections* CKS-P.

The CKS-P comprised both selected standardized measures as well as modified and locally-developed measurement tools. It was designed to support understanding of women’s family context and demographics, as well as to measure change in women’s sense of self, relationship capacity, parenting capacity, knowledge/comfort with community services, and knowledge of *Connections*-related constructs over the period of time that they participated in the

Connections intervention. The post CKS-P measure also elicits satisfaction with the *Connections* intervention. See details on each measure below.

Demographics

Women were asked about a variety of socio-demographic characteristics, including their age, nationality, preferred language, ethnic heritage, education, employment, income, housing status, relationship status, and number of children.

Self-esteem

Self-esteem was measured using the Rosenberg Self Esteem Scale (Rosenberg, 1979). Women answered 10 items related to positive and negative feelings about the self (e.g., “I am satisfied with myself”) on a 4-point scale from 1 = Strongly Disagree to 4 = Strongly Agree (5 items were reverse coded). Responses were averaged to create a total self-esteem score ($\alpha_{pre} = .90$, $\alpha_{post} = .84$).

Self-efficacy

Self-efficacy was measured using an 8-item scale (Chen et al., 2001). Items assessed women’s beliefs that they were able to successfully accomplish certain tasks/goals (e.g., I will be able to achieve most of the goals that I have set for myself). Items were rated on a 5-point scale from 1 = Strongly Disagree to 5 = Strongly Agree. Responses averaged to create a total self-efficacy score ($\alpha_{pre} = .93$, $\alpha_{post} = .91$).

Self-compassion

Self-compassion was measured using a the 12-item Self-Compassion Scale – Short Form (Raes et al., 2011). Items assessed women’s ability to be kind and understanding toward themselves (e.g., “When I’m going through a very hard time, I give myself the caring and tenderness I need”) on a 5-point scale from 1 = Almost Never to 5 = Almost Always. Responses were averaged to create a total self-compassion score ($\alpha_{pre} = .84$, $\alpha_{post} = .87$).

Relationship capacity

The Adult Attachment Scale was used to assess women’s relationship capacity (Collins & Read, 1990). This is an 18-item scale consisting of three subscales (6 items each): one’s ability to feel close to others in relationships (e.g., “I find it relatively easy to get close to others”), one’s ability to depend on others (e.g., “I know that people will be there when I need them”), and one’s anxiety in relationships (e.g., “I often wonder whether romantic partners really care about me”). Items were rated on a 5-point scale from 1 = Not at All Like Me to 5 = Very Much Like Me (7 items were reverse coded). Responses to each of the 3 subscales were averaged to create total scores for closeness, depend, and anxiety ($\alpha_{pre} = .60$, $.74$, and $.89$; $\alpha_{post} = .66$, $.70$, $.90$, respectively).

Parenting Efficacy and Satisfaction

Parenting efficacy and satisfaction was assessed using the Being A Parent Scale (BAP; Gibaud-Wallston & Wandersman, 1978). This 12-item scale includes 6 items each assessing parenting efficacy (e.g., “I feel like I am doing a good job as a parent”) and parenting satisfaction (e.g., “Being a parent makes me tense and anxious” [reverse coded]). Items were rated on a 5-point scale from 1 = Strongly Disagree to 5 = Strongly Agree. Six (6) items were reverse coded prior to averaging items within each subscale to create scores for parenting efficacy ($\alpha_{pre} = .77$, $\alpha_{post} = .76$) and satisfaction ($\alpha_{pre} = .63$, $\alpha_{post} = .69$).

Parenting stress

The Parental Stress Index (PSI; Short Form, Fourth Edition; Abidin, 2012) is a 36-item scale. The items in the PSI assess women’s stress with respect to her parenting role, perceptions of the quality of and satisfaction with her interactions with her child, and the behavioural characteristics of the child that may lead parents to perceive them as difficult to manage. Items were rated on a 5-point scale from 1 = Strongly Disagree to 5 = Strongly Agree. A Parenting Stress Total Score was calculated by summing all items and

converting the score to a standardized percentile score ($\alpha_{pre} = .93$, $\alpha_{post} = .95$).

Knowledge of services

The extent to which women had knowledge of and felt connected to community services was measured using a 7-item measure (adapted from Centre for Research and Education in Human Services, 2005). Items were rated on a 5-point scale from 1 = Strongly Disagree to 5 = Strongly Agree (e.g., “I feel connected with programs I can use;” “I am able to get help from other organizations and agencies”). Items were averaged to create a total score for knowledge of services ($\alpha_{pre} = .83$, $\alpha_{post} = .86$).

Understanding of *Connections* concepts

Women completed a 9-item measure assessing their knowledge and understanding of *Connections*-related concepts (Motz et al., 2009; Andrews, N., Motz, M., Zuberi, S., Singh, C., Leslie, M., & Pepler, D. J. (2021). *Building Connections to Support Mothers and Young Children Affected by Interpersonal Violence: The Evaluation Report*. Toronto: Mothercraft Press.)

Items were rated on a 4-point scale from 1 = Strongly Disagree to 4 = Strongly Agree (e.g., “Unhealthy relationships between parents can affect a child’s development, even if they do not witness violence”). Items were averaged to create a total score for understanding of *Connections* concepts ($\alpha_{pre} = .67$, $\alpha_{post} = .68$).

Satisfaction (post-*Connections*)

Following the final *Connections* session, women reported on their overall satisfaction using an 8-item measure (Andrews et al., 2021). Items were rated on a 4-point scale from 1 = Not at All Satisfied to 4 = Very Satisfied (e.g., “How satisfied are you with...the extent to which the information helped you think differently about healthy relationships,” “...the amount of information you received about parenting,” “...the

Connections intervention overall.”). Responses were averaged to create a total satisfaction score ($\alpha = .95$).

IV. Who were the women who completed the *Connections* intervention?

Sociodemographic characteristics were examined for the 170 women who participated in the *Connections* intervention. Women were between 17 and 62 years old, with an average age of 32.90 years ($SD = 7.53$ years). Women were asked whether they had previously received support or counselling related to interpersonal violence and healthy relationships; 53% reported they had (5% preferred not to answer).

The large majority of women were born in Canada (83%) and reported English as their preferred language (94%). Most spoke English at home (81%), while many others spoke a mix of English and another language (10%; including French, Spanish, and ASL) or another language (7%; including Spanish, Hungarian, Tagalog, Tamil, Oromo, Farsi). Women were asked to identify their ethnic heritage (women were invited to select more than one option). Women reported their ethnic heritage primarily as North American (44%), European (26%), Indigenous (16%), South Asian (5%), and other (11%).

Most women (82%) had completed high school. Almost one quarter had some trade or technical education and 68 had some post-secondary education (including university or community college). Most women were not currently employed (74%). As expected, women’s source of income was varied, the most prevalent being social assistance, disability benefits, maternity/child tax benefits, employment insurance, or some combination of those. Women’s income varied, but over half (53%) reported a gross income of less than \$1,500/month (\$18,000/year).

Women's living situations varied, with many living in a house (35%), apartment (38%), or shelter (16%). Most women were single (51%) or married/common law (24%). Over half of women lived with only their child(ren) (52%), with most others reporting living with a partner and child(ren) (26%), or alone (9%). Women had between 1 and 9 children ($M = 2.36$ children, $SD = 1.59$).

V. Did women who attended *Connections* change over time?

With two exceptions, all variables indicated significant change in the expected direction. That is, women reported higher self-esteem, self-efficacy, and self-compassion after *Connections* compared to before. Women reported feeling more closeness in relationships (marginally significant), higher ability to depend on others in relationships, and lower anxiety in relationships

after *Connections* compared to before. Contrary to expectations, women reported lower parenting efficacy and satisfaction after *Connections* compared to before. However, women also reported lower overall parenting stress, higher knowledge of available services, and a greater understanding of *Connections* concepts after *Connections* compared to before. Eta squared (η^2) effect sizes are generally considered small, medium, and large at .02, .13, and .25, respectively; thus effect sizes for these comparisons are generally in the small to medium range, with the exception of self-esteem and self-compassion which can be considered relatively large effects.

Women also reported high satisfaction with the *Connections* intervention ($M = 3.83$, $SD = .35$, on the 1-4 scale). It should be noted that 99% of participants reported positive satisfaction (scores greater than 2.50), with 65% reporting complete satisfaction (scores of 4.00).

TABLE 2	Pre-Connections		Post-Connections		N	F	p	η^2
	M	SD	M	SD				
Self-Esteem	2.69	.67	3.07	.52	101	31.87	<.001	.24
Self-Efficacy	3.93	.80	4.26	.59	99	19.95	<.001	.17
Self-Compassion	2.81	.75	3.23	.71	96	34.30	<.001	.27
Relationship Capacity								
Closeness	3.01	.82	3.14	.74	94	3.49	.07	.04
Depend on Others	2.63	.69	2.83	.66	94	7.99	.01	.08
Anxiety in Relationships	3.63	1.17	3.34	1.13	94	8.25	.01	.08
Parenting Efficacy	2.31	.88	2.07	.75	89	7.14	.01	.08
Parenting Satisfaction	3.22	.74	3.01	.61	90	7.00	.01	.07
Parenting Stress	60.86	25.68	51.95	29.64	77	17.11	<.001	.18
Knowledge of Services	3.95	.71	4.25	.64	91	20.52	<.001	.19
Understanding of <i>Connections</i> Concepts	3.53	.34	3.67	.32	88	16.62	<.001	.16

Note. Self-Esteem and Understanding of *Connections* Concepts are measured on a 1-4 scale. Self-Efficacy, Self-Compassion, Relationship Capacity, Parenting Efficacy and Satisfaction, and Knowledge of Services are measured on a 1-5 scale. Parenting Stress is a percentile score (1-99).

VI. Does change happen more for some than others?

To understand whether some mothers changed more during the *Connections* intervention than others, we first created a demographic cumulative risk index. This included 6 demographic variables: age, education, employment status, income, current housing status, and number of children. Each of

these indicators was dichotomized as higher (1) or lower (0) risk. Categorizations were made consistent with prior literature (see Evans, 2004) or based on clinical expertise. See the Table below for details regarding the variables and how risk was categorized. Each participant received a 0 or 1 for each risk indicator they reported. A percentage risk score was then calculated by adding all indicators of high risk (scores of 1) and dividing by the total number of indicators with known information (to account for any missing data).

TABLE 3 Demographic Cumulative Risk Index

Indicator	Categories of Risk		Percent of Participants	
	Higher Risk	Lower Risk	Higher Risk	Lower Risk
Age	Age 17-24 years	Age 25+ years	13%	87%
Education	Completed < Grade 12	Completed Grade 12	18%	82%
Employment	Not currently employed	Part time or full time employed	80%	20%
Income	< \$18,000/year	> \$18,000/year	53%	47%
Housing	No stable housing (including shelter, residential program)	Housed	21%	79%
Number of Children	3+ children	2 or fewer children	34%	66%

To understand the impact of cumulative demographic risk on changes in key variables, we conducted a series of regression analyses predicting each post-*Connections* variable. In each, the corresponding pre-*Connections* variable was entered in the first step, and the percentage risk score was entered in the first step. Controlling for pre-*Connections* self-esteem, cumulative demographic risk predicted post-*Connections* self-esteem, such that those with more risk had higher self-esteem post-*Connections* ($b = .47, p = .045$). The same pattern was found for self-efficacy (marginally; $b = .48, p = .06$) and self-compassion (marginally; $b = .55, p = .07$), indicating that those with higher levels of cumulative risk increased more in self-efficacy and self-compassion following *Connections*

relative to those with lower levels of risk. Cumulative risk was not related to relationship capacity, parenting, or knowledge of community services. Cumulative was, however, significantly related to post-*Connections* knowledge of *Connections* constructs, such that after controlling for pre-*Connections* knowledge, those with higher cumulative risk also had higher knowledge of *Connections* constructs ($b = .36, p = .01$).

Together, this suggests that *Connections* works particularly well for mothers who are living in conditions of risk across multiple demographic domains, in terms of impacting self-esteem, self-efficacy, self-compassion, and knowledge of *Connections* constructs.

VII. How does change happen?

Using the voices of mothers from our prior *Building Connections* initiative, we explored the theorized mechanisms of change in *Connections* (MacAulay et al., 2025). From the mothers' own perspectives, we mapped the overarching mechanisms of change through several processes, including:

1. mothers becoming aware of changes in their cognitions and behaviours following their participation in *Connections* across three domains of self, relationships, and parenting;
2. mothers recognizing the associations between their experiences in *Connections* and the changes reported in their lives; and
3. integrating all addressed pathways to identify the key mechanisms of change experienced by mothers who participated in *Connections*.

Most critically, key mechanisms identified included shifts in mothers' capacity for self-care and compassion, forgiveness and healing, and reflection; all of which led to increases in self-esteem and empowerment, and ultimately affected changes in their well-being, relationships, and parenting.

Quantitative Analysis of Mechanisms of Change

Using the current sample of mothers who completed *Connections*, we further tested these mechanisms of change, first exploring self-compassion as a key mechanism of change. We used Mplus 8 to run a series of models exploring residualized change in self-compassion on changes in other variables of interest.

As an example, the model with self-esteem included autoregressive paths for self-compassion and self-esteem (pre to post), as well as the path of interest between self-compassion post-*Connections* predicting self-esteem post-*Connections*. Self-compassion and self-esteem pre-*Connections* were allowed to covary. This model tests whether those who change more in self-compassion (post-*Connections* self-compassion, controlling for pre-*Connections* self-compassion) also change more in post-*Connections* self-esteem (also accounting for pre-*Connections* levels of self-esteem). Or put more simply, do larger changes in self-compassion predict changes in self-esteem. We then compared that model to a reverse model wherein changes in self-esteem predicted post-*Connections* self-compassion (accounting for pre-*Connections* self-compassion), to provide support for our theorized direction of change.

The same set of models – A) the residualized change model and B) the reverse model – were run for 1) self-esteem, 2) self-efficacy, 3) relationship capacity (including closeness, dependency on others, and anxiety in relationships), 4) parenting capacity (including efficacy, satisfaction, and stress). For each set of models (residualized change model and reverse model), we compared fit indices including AIC, BIC, RMSEA, CFI, and SRMR to determine which model fit the data better. Model fit statistics showing these comparisons are in Table 4. We also compared the size of paths of interest and R² for each variable of interest, to again understand the direction of change.

TABLE 4 Global Fit Statistics for Models testing Changes in Self-Compassion as a Mechanism

	AIC	BIC	RMSEA	RMSEA 95% CI	CFI	SRMR
Self-Esteem						
Model A	919.27	956.90	.00	.00-.14	1.00	.02
Model B	922.68	960.31	.10	.00-.20	.97	.05
Self-Efficacy						
Model A	1089.86	1127.49	.06	.00-.18	.99	.06
Model B	1088.55	1126.18	.00	.00-.15	1.00	.04
Relationship Capacity						
Model A	2188.21	2288.18	.06	.00-.10	.98	.06
Model B	2239.59	2330.18	.16	.12-.19	.75	.10
Parenting						
Model A	3504.87	3605.02	.07	.02-.12	.94	.07
Model B	3530.47	3621.24	.13	.09-.16	.78	.12

Note. Good model fit is generally indicated by RMSEA and SRMR $\leq .05$ and CFI $\geq .95$. When comparing models, better fit is indicated by lower AIC and BIC, RMSEA and SRMR closer to 0, and CFI closer to 1.

In the model with self-esteem, the residualized change model (hereafter called Model A) fit better than the reverse model (hereafter called Model B), though both indicated relatively good fit. Change in self-compassion predicted post-Connections self-esteem, though the reverse was also true. Thus, results suggest there is evidence of self-compassion as a mechanisms impacting self-esteem, but the reverse may also be true such that there is bi-

directional association. The same general pattern was found in the model with self-efficacy. Both models fit well, though the Model B had better fit. Change was predicted in both directions, though the total variance accounted for (R²) in self-efficacy was larger in Model A. This again indicates that self-compassion may be a mechanism impacting self-efficacy, but the reverse may also be true.

TABLE 5 Paths of Interest for Models testing Changes in Self-Compassion as a Mechanism

	Model A			Model B		
	$SC_{post} \rightarrow Variable_{post}$		R^2	$Variable_{post} \rightarrow SC_{post}$		R^2
	b	p		b	P	
Self-Esteem	.49	<.001	.52	.78	<.001	.24
Self-Efficacy	.43	<.001	.44	.60	<.001	.25
Relationship Capacity						
Close	.29	<.001	.46	.11	.17	.40
Depend	.26	.001	.30	.09	.31	.22
Anxiety	-.71	<.001	.58	-.26	<.001	.39
Parenting						
Efficacy	-.37	<.001	.32	-.19	.03	.19
Satisfaction	-.20	.009	.21	-.03	.74	.16
Stress	-13.80	<.001	.29	-.01	.02	.37

Note. SC = Self-compassion

In the model with relationship capacity (including closeness, ability to depend on others, and anxiety in relationships), Model A fit well and fit better than Model B, which did not fit well. Change in self-compassion predicted higher post-Connections closeness, dependence on others, and lower anxiety in relationships, accounting for pre-Connections levels of each. Both b values and R² values for these paths in Model A were larger than the reverse. Indeed, in Model B, change in closeness and dependence did not predict post-Connections self-compassion. These results indicate that mothers whose self-compassion was higher post-Connections than expected (given pre-Connections self-compassion) also had higher post-Connections relationship capacity, controlling for pre-Connections relationship capacity.

In the parenting model (including parenting efficacy, satisfaction, and stress), neither Model A or B fit well, though comparatively Model A fit better. Here, more

change in self-compassion predicted lower parenting stress, though there was some evidence for the reverse as well. Contrary to expectations, more change in self-compassion predicted lower parenting efficacy and parenting satisfaction (with evidence of the reverse only for efficacy). However, given generally ill-fitting models, we caution interpretation of these results.

Taken together, increasing self-compassion appears to be an important mechanism in changing one's self-esteem and self-efficacy, though these may change reciprocally or in tandem. Increasing self-compassion also appears to be an important mechanism in changing relationship capacity, but not the reverse. Finally, self-compassion may play a mechanistic role in parenting attitudes and cognitions, though these results are less clear.

“The enduring impact of C-BTC includes strengthened community capacity, a national network of trained facilitators, and increased access to effective IPV prevention. Embedding Connections with ongoing, consistent community services remains essential to supporting women and children affected by IPV and preventing intergenerational harm.”

—Connections facilitator



For more information, please contact:

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