

**CENTER OF APPLIED RESEARCH  
FOR NONPROFIT ORGANIZATIONS**

**Parent Child Center of Tulsa Report:  
Program Evaluation**

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*\*Note not all programs within PCCT were evaluated in this report, but plans are being developed to evaluate them in the future.*

### **Mission of The Parent Child Center of Tulsa (PCCT)**

The mission of PCCT is to prevent child abuse and neglect through education, treatment, and advocacy. Ultimately, PCCT works to PREVENT abuse and neglect through parent, child and community education, PROTECT children at risk through family safety & support services, and HEAL the harmed through parent & child treatment. All of PCCT's education and prevention programs are voluntary. Physicians, hospital social workers, and other human service agencies refer parents or children. DHS, courts, or private attorneys refer adults in our treatment programs.

This mission is accomplished on three levels: primary, secondary, and tertiary. Primary prevention consists of education in order to prevent child abuse before it has occurred. Secondary prevention also attempts to prevent child abuse before it has happened, but its focus is on families identified as "at risk" of child abuse and neglect. Tertiary prevention is concerned with preventing future incidences of child abuse in families where abuse has already occurred.

### **Mission of The Center of Applied Research for Nonprofit Organizations**

The mission of the University of Oklahoma is to provide the best possible educational experience for students through excellence in teaching, research, creative activity and service to the state and society. The Center of Applied Research for Nonprofit Organizations (Center) focus this mission by collaborating with community agencies to improve program services using sound scientific practice while simultaneously training graduate students in the application of quantitative and qualitative methodologies. Ultimately, nonprofit organizations share one common purpose. That is to give the individual's they serve hope. The purpose of the Center is the scientific study of optimum human functioning. Its goal is to identify and enhance the human strengths and virtues that make life worth living for all members of our community. The specifics of particular programs will be elaborated on within this report.

## **History**

The Parent-Child Center of Tulsa and The Center of Applied Research for Nonprofit Organizations began collaborating in mid-2010. The goal of this collaboration was to develop with PCCT a global assessment on the impact of services on parent-child relationship quality as well as the formation of hope. Furthermore, the purpose was to focus on predictor's of the parent-child relationship as well as the predictors and indicators of hope among clients. This assessment ultimately discovered the services provided by PCCT alleviated the negative affects of parental stress on the parent-child relationship. Also, PCCT services were found to be significant predictors of hope, and these services not only increased the pathways to goal attainment as well as the motivation to pursue the pathways. The next step in the collaboration was program specific assessment, which this report contains. The following phases of evaluation specify the focus of the relationship.

- Phase I: Hope, Parenting Stress and the Parent-Child Relationship (2010).
- Phase II: Evaluation of existing programs, their outcomes, and data collection processes. We also focused on discussing how hope can be integrated in program evaluations where appropriate.
- Phase III: Streamlined evaluation outcomes with a fully integrated foundation of promoting hope.

## **Purpose**

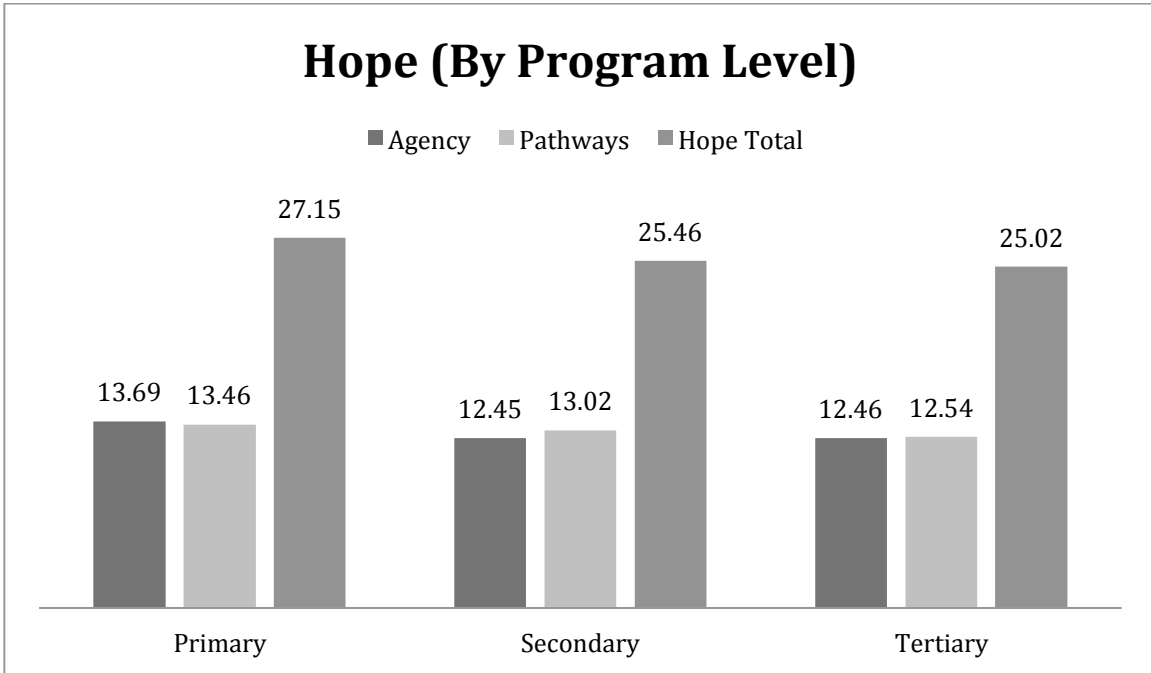
The purpose of research being conducted within PCCT is to determine both the effectiveness of outcome based programs, such as Adult Treatment, as well as help develop new ways to conduct outcome-based research.

## **Nonprofits and Hope**

Nonprofits exist to bring about optimize functioning in the clients they serve. These clients are often characterized as living in high stress environments that leave them at a greater risk for such things as poverty, substance abuse, intimate partner abuse, child abuse, etc. Indeed, nonprofits maintain a pro social concern for others and see their purpose as a “safety net” for our communities. Nonprofit organizations provide services for their clients through specialized programs relative to the mission of the agency and the specific client populations they serve. While matriculating through these programs, the client and agency staff establishes client outcomes (goals) that are believed to enhance optimum functioning of the client given their psychological, social, and demographic means. Of particular interest is the pathway towards goal attainment and the important mental processes that are impacted. One important mental process that has received prominence in the positive psychology literature is the cognitive construct of hope (Snyder, 2002). We argue that these program services are pathways of hope for the client as a precursor to goal attainment (cf. Feldman, Rand, & Kahle-Wroblewski, 2009).

## **Hope Theory**

Approximately twenty years ago, C. R. Snyder introduced his theoretical framework of hope along with a measure of dispositional hope (cf. Snyder, 1989; Snyder, Irving, & Anderson, 1991). Snyder defined hope as the positive interaction between mental agency and pathway thinking toward goal attainment. Thus, the basic assumption of hope is that purposeful human behavior is based upon an expectation of reaching a desired goal (cf. Locke & Latham, 2002). It follows then, that hope is a cognitive process that is grounded in the interrelated trilogy of future goals, pathway thinking and human agency. Further, high hope individuals can articulate very specifically their desirable goals. High hope people can identify detailed strategies toward attaining these goals as well as their positive mental energy in pursuing these pathways. High hope individuals have confidence in their pathways and can often find alternative pathways when they experience barriers in their goal pursuit (Irving, Snyder, & Crowson, 1998; Snyder, 1994; Snyder, 1995; Snyder, 1996; Snyder, 2000; Snyder, 2002; Snyder, Lapointe, Crowson, & Early, 1998).



Primary N= 61  
 Secondary N= 56  
 Tertiary N= 48  
 Total N= 165

The above graph illustrates the three aspects of hope measured in the Trait Hope Scale. In this case, primary prevention hope scores only include the Never Shake a Baby program. Perhaps the most interesting aspect of this graph is the difference between primary prevention and the other two program levels. Primary level hope scores are higher than those in both secondary and tertiary, indicating the general population, which in this case includes respondents from Never Shake a Baby, has higher hope than those who are actual clients of PCCT.

## **Executive Summary**

One of the goals of this evaluation was to examine the data already being collected by PCCT, determine its efficacy toward assessing program outcomes and, where appropriate incorporate the concept of hope into the program evaluation activities.

- 1. Six of Eight programs were evaluated.**
- 2. Evaluation occurred across Primary, Secondary, and Tertiary programs.**
- 3. Primary Prevention: Kids on The Block**
  - a. Qualitative analysis was used to assess letters written by children to determine if knowledge transfer of targeted themes was successful.
  - b. 52% of children mentioned “telling someone if you are being abused.”
  - c. 34% of children learned what abuse was.
  - d. While historically children have disclosed abuse to a teacher or counselor after the program, no children in this sample reported the experience of abuse.
- 4. Primary Prevention: Never Shake a Baby**
  - a. Hope scores were relatively high for parent(s) of newborns.
  - b. Hope scores were higher in this program compared to previous data (2010) collected from secondary and tertiary programs.
  - c. In a follow up survey (N=66), 39.4% of parents reported having watched the video. 36.4% reported having shared the video with another caregiver.
  - d. If a parent watched the video, 61.5% shared the video compared to 20.0% of those who did not watch the video. This suggest that if a parent watches the video they are much more likely to share the video.
- 5. Secondary Prevention: Great Beginnings**
  - a. Across time primary caregivers and family support workers were congruent on their assessment on the ability to manage a child’s behavior and the home environment was safe.
  - b. 52.3% of the primary caregivers showed improvement in the ability to manage the child’s behavior; and 69.2% showed improvement in the ability to maintain a safe environment as measured by the family support worker.

## **6. Secondary Prevention: SafeCare**

- a. Positive changes were observed for most of the subscales on the Healthy Families Parenting Inventory. More specifically, 62.6% improved in personal care, 56.6% improved in depression, 53.3% improved in parenting efficacy, and 50.2% improved in social support.

## **7. Tertiary Prevention: Adult Treatment**

- a. This evaluation concerned the Adult-Adolescent Parenting Inventory. The findings of this evaluation across time showed a statistically significant reduced risk of child abuse and neglect from the beginning of the program to the end.
- b. 64.7% of caregivers showed improvement in compassion.
- c. 76.0% of caregivers showed improvement in responsibility.

## **8. Tertiary Prevention: Child Therapy**

- a. Much of the work this year was the development of a behavior based observation measure of hope of caregiver toward the child and hope of the child toward the caregiver. These measures are provided by therapist observations.
- b. Our interest is the impact of therapy on the improvement of hope, the congruence of hope, and the impact of hope on the parent-child interaction.
- c. Across time, both caregivers and children showed a marked increase in their hope related behaviors.
- d. These hope scores are correlation (statistically significant) with the parent-child interaction. For example, higher hope is associated with improved positive affect, anger/hostility, compliance, parent responsiveness, and child's withdrawn behavior.
- e. Improving hope for a caregiver and child is associated with improved parent-child interaction.



## **Kids on the Block**

### **Goal**

The mission of the Kids on the Block program is to provide children of various ages the knowledge needed to deal with tough situations and the motivation to pursue help when necessary. The program achieves these goals through the use of puppetry in the Japanese Bunraku style, and currently focus on five main themes: bullying, divorce, stranger danger, physical abuse and sexual abuse. KOTB also has clear messages that it is attempting to communicate, such as “tell an adult and keep telling”, or “abuse is not your fault”.

### **Purpose**

The aim of research within this program is to ascertain the increase in knowledge in the aforementioned themes as well as determine other important factors being learned by children during the presentation.

### **Procedure**

The Parent-Child Center currently collects letters from students in grades 2-5 in which students are instructed to report on what they learned from the show. Using a stratification sampling method, the letters were presorted into grades 2-5, and up to 25 letters were randomly selected for each grade. Also, 25 letters were chosen at random from those letters where grade was not reported. Using NVivo, a qualitative research software, these letters were then analyzed in order to search for both themes the program purports to teach as well as other themes arising as a natural result of the program, such as disclosures of abuse.

### **Themes**

Kids on the Block focuses on nine main ideas within the physical/sexual abuse theme. The initial data analysis focused on identifying children who mentioned these ideas in their letters, while later analysis attempted to discover other important ideas that children mentioned.

- Abuse Is Not Your Fault
- Adults Are The Ones Who Can Help You
- Don't Keep A Secret
- Solving Problems
- Abusers Are Often People You Know
- No One Has The Right To Abuse You
- Parents Can Get Help
- Tell An Adult And Keep Telling
- The Uh-Oh Feeling

## Brief Summary

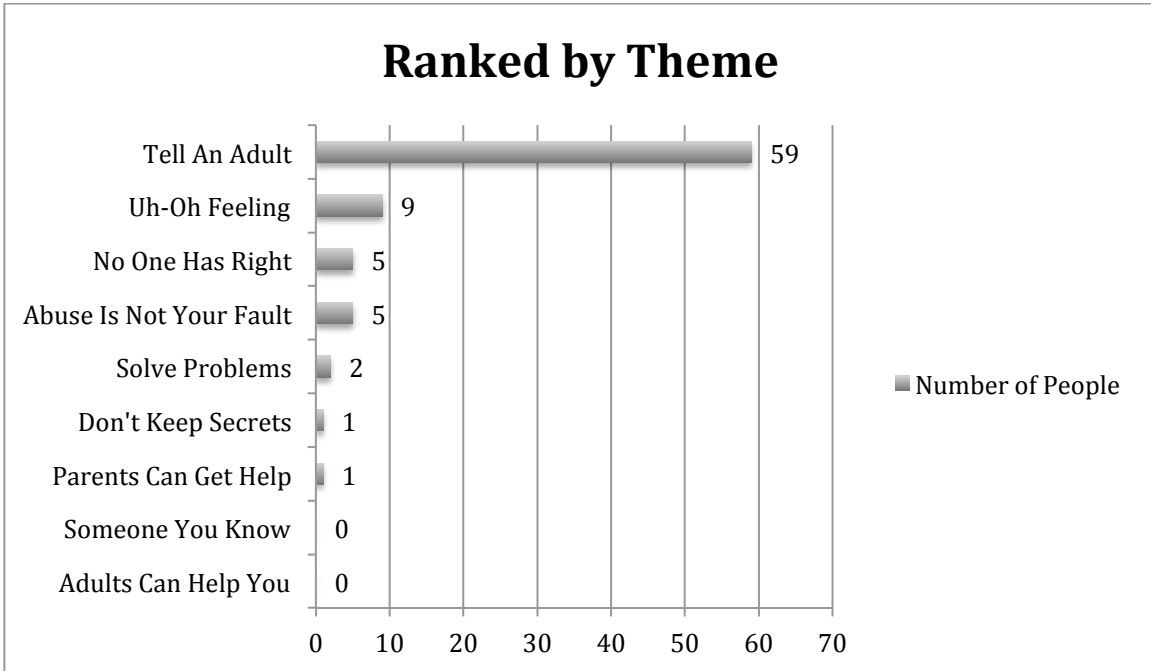
Perhaps the most important message in the show is to “tell an adult and keep telling”. For the current sample of 112 letters, 58 (52%) of them mentioned this theme of telling someone if you are being abused. For example, one 2<sup>nd</sup> grader wrote “that I shod tall win someting bad happ and if some one bad tohis me some war” (that I should tell when something bad happens and if someone bad touches me somewhere). A 5<sup>th</sup> grader wrote, “that if somebody tried to abuse me I tell right away to anybody that will believe me”, noting that not only should they tell, but also they should tell until someone believes them. It is impossible to help children being abused if no one knows it is happening, and this message gives children the knowledge and permission to tell someone.

Another key aim of this show is to educate children about what abuse is and how to recognize it. In this sample, 38 children (34%) mentioned that they learned about abuse and what constituted abuse. For example, one 2<sup>nd</sup> grader stated, “I learned that if your perents leave a brose on you that is abuse”, while a 3<sup>rd</sup> grader stated that “it should not be so bad that you have to go to the hospital”. Another child, perhaps displaying a deeper understanding of abuse, stated that “it dosint just hrte on your body it hrtes on your hart” (it doesn’t just hurt on your body it hurts on your heart). While telling is the first step to getting help, a child may never seek help if they do not know that it is wrong.

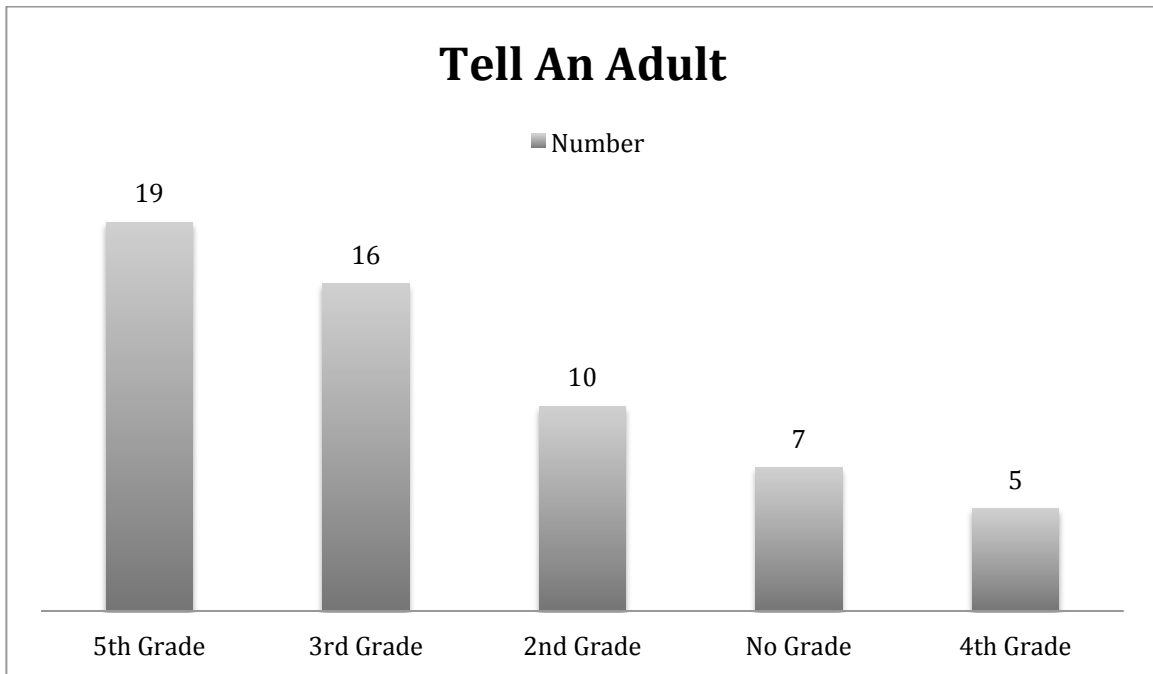
One of the other, and perhaps one of the more difficult aspects of the program, is the disclosure of abuse that can occur in the letters. While no student directly admitted to currently being abused, one student wrote, “My dad used to abuse me but he stopped when my mom caught him and said, ‘Either you can stop now or stop when we divorce and you never spend independent time with your kids again.’” In another case, a child alludes to her aunt being abused stating, “Very time I hear the word abuse it remember me what happen to my aunt. Her friend abuse. So my aunt haded to have a baby.” These children clearly received the messages conveyed in the program, as they were able to view the puppet show, connect the content to their personal experiences, and express that understanding in their letters. While the primary aim of the show is to help prevent abuse, in situations where abuse has already occurred, it provides a pathway for children to make a disclosure of current or past abuse. In these instances the KOB puppeteers and school counselors work to insure the child receives the appropriate services.

The current analysis indicates that PCCT’s Kids on the Block program is helping to prevent child abuse and neglect. It is obvious from the letters the children write, that they are receiving and remembering the messages of the ‘Kids On The Block’ show. Because of the information learned from viewing these puppet shows, children can better keep themselves safe, identify what abuse is, and more effectively seek help when necessary.

- *The following pages contain graphical representations of various themes*

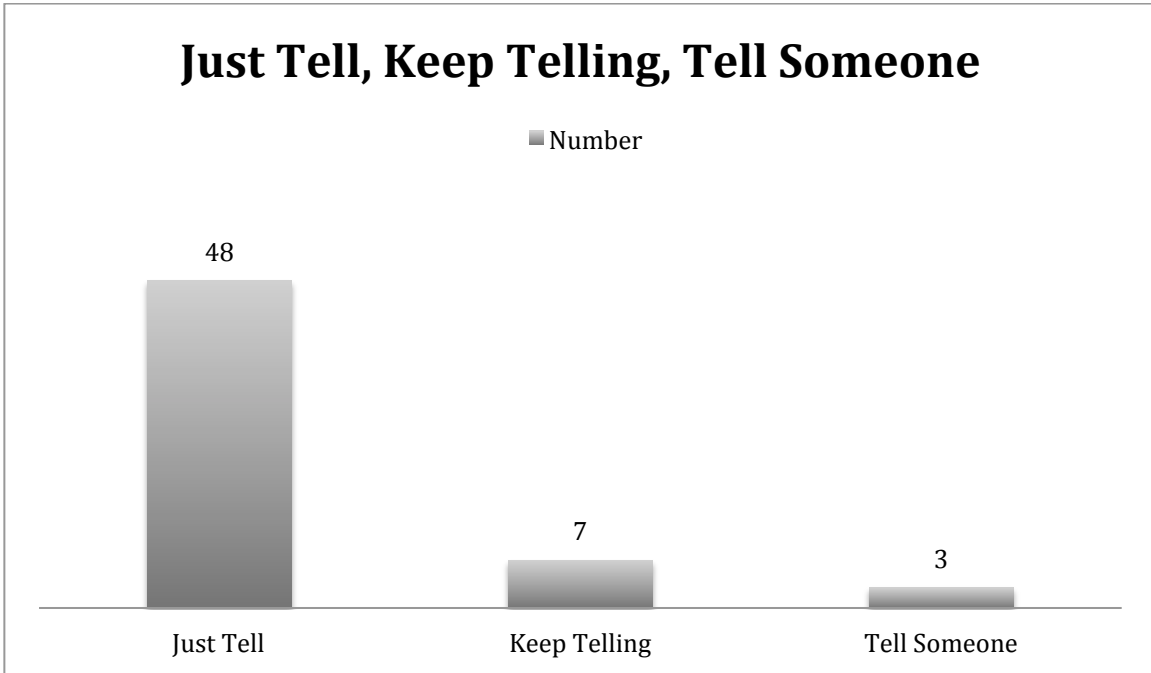


The above graph illustrates the number of people that mentioned each of the main themes. As can be seen, “tell an adult” was the most represented theme, with 59 individuals out of 112 mentioning it. 9 individuals mentioned the “uh-oh feeling”, while “no one has the right to abuse you” and “abuse is not your fault” both had 5. The themes, “the abuser is often someone you know” and “adults are the ones who can help you”, were not mentioned.

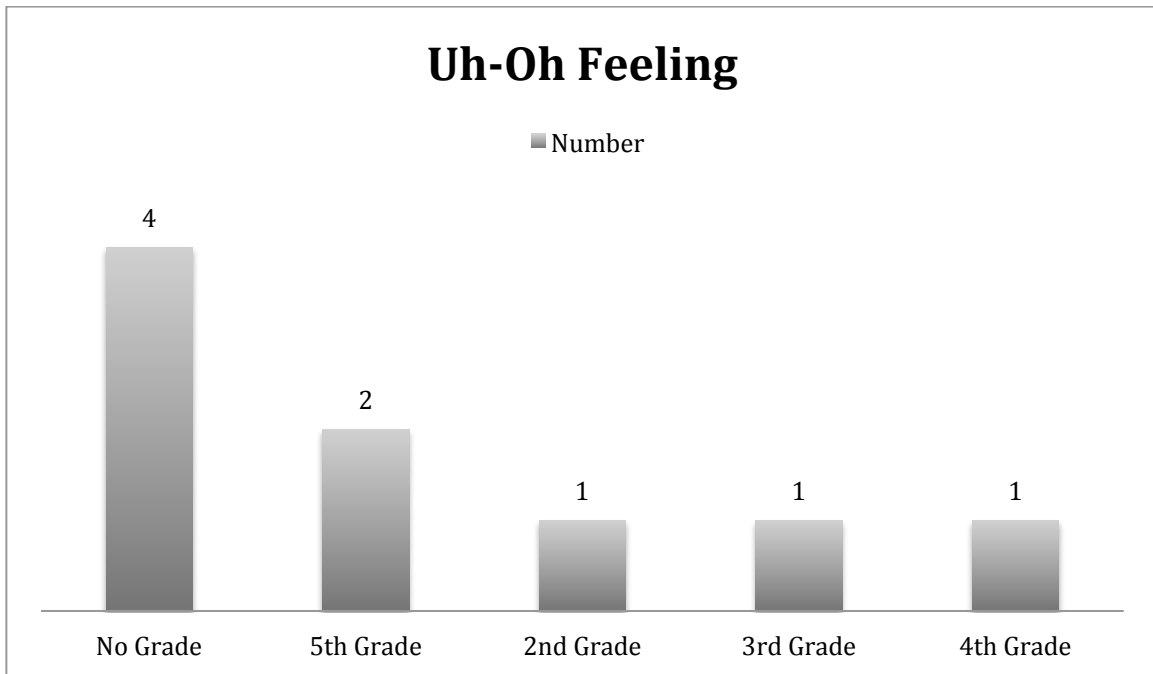


N = 57

The above graph illustrates the number of individuals who mentioned the theme “Tell an adult”. For example, 5<sup>th</sup> graders mentioned this theme the most, with 19 individuals, with 16 3<sup>rd</sup> graders being the second most. The least amount was 4<sup>th</sup> graders, which accounted for five individuals. Telling is such an important message for children to remember, and clearly, as the above graph illustrates, children are hearing that message loud and clear.

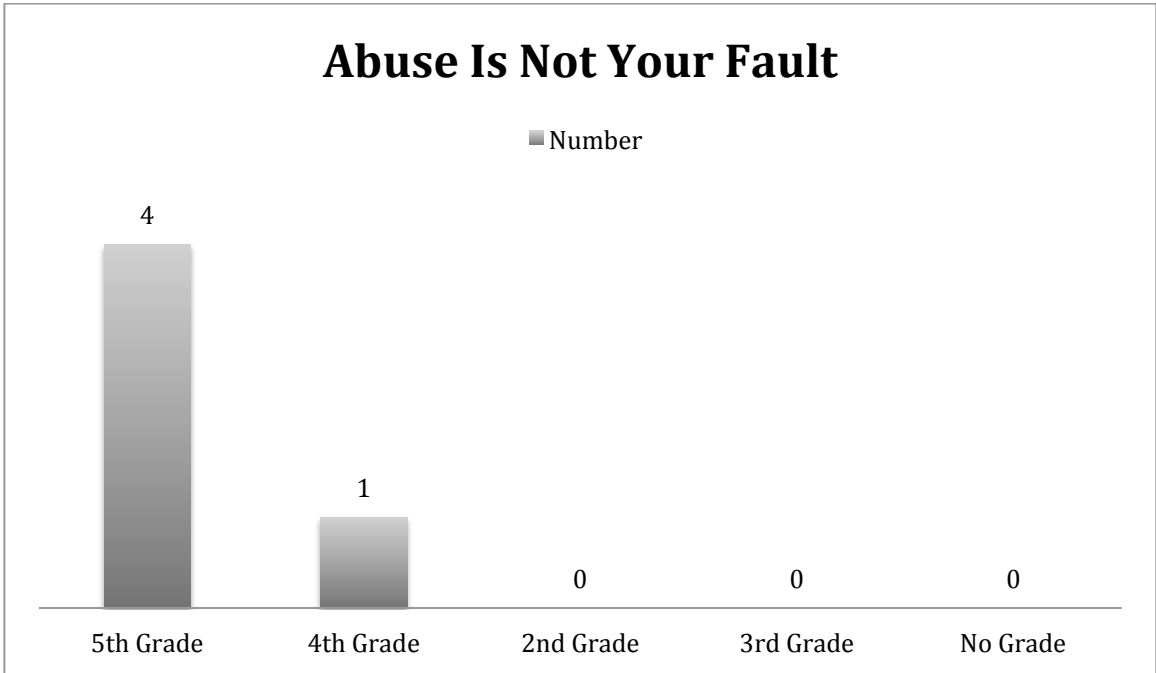


The above graph illustrates the sub themes within the main theme of “Tell an adult”. For example, while 48 of a total of 57 students simply stated that a person should tell an adult if abuse is occurring, 7 other students stated that they should keep telling until someone believes them. Three other students stated a specific person they would tell, which included “dad”, “mom”, and even “my aunt or my stepmom and my sister”.



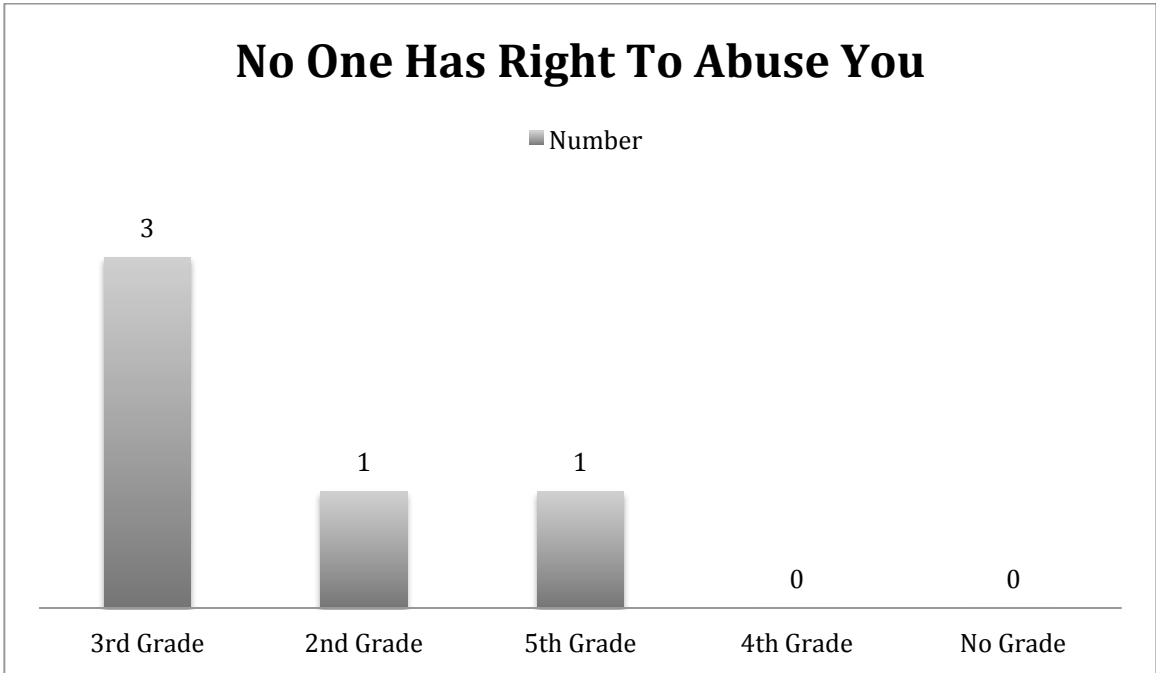
N = 9

In the graph above, it can be seen that four individuals in the no grade group mentioned the “Uh-oh feeling”, while two 5<sup>th</sup> graders mentioned it. 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> graders each mentioned it one time. Interesting to note that at least one person in every grade mentioned this theme, indicating that it is a theme that might transcend grade or intellectual level.



N = 5

The above graph displays the number of individuals who mentioned the theme “Abuse is not your fault” in their letter, by grade. In this case, four 5<sup>th</sup> graders mentioned this theme while one 4<sup>th</sup> grader mentioned it.



N = 5

In terms of “No one has the right to abuse you”, three 3<sup>rd</sup> graders reported this tem, while one 2<sup>nd</sup> grader and one 5<sup>th</sup> grader also mentioned this theme.



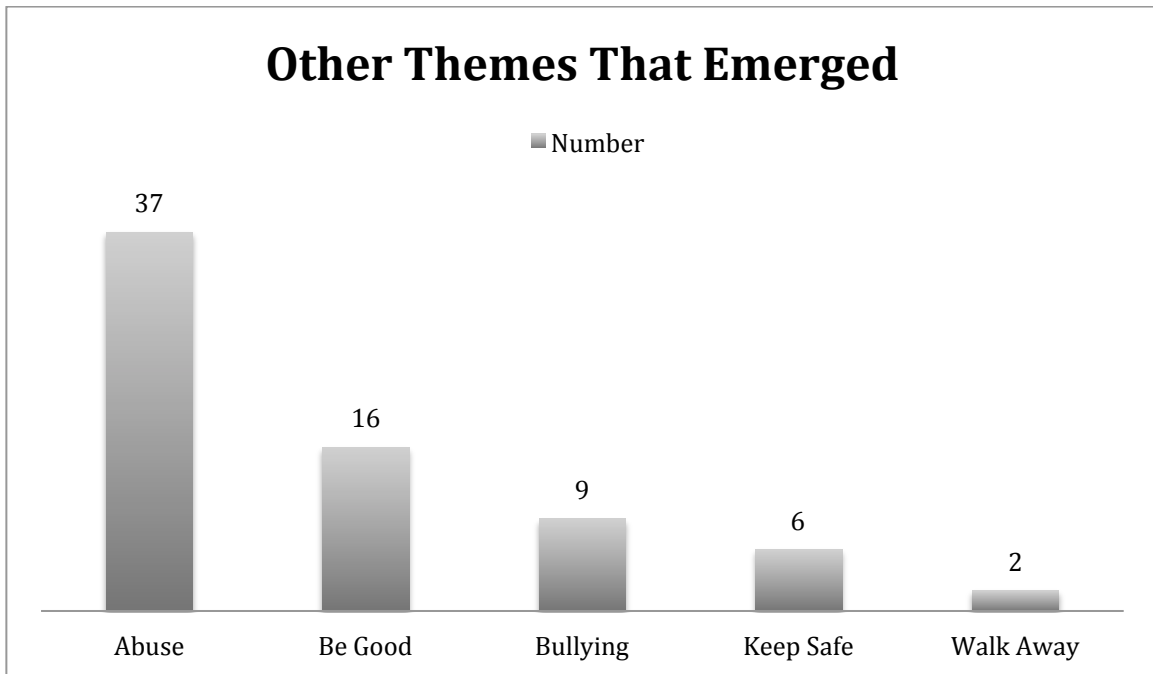
## Brief Explanation

As for the main themes, the graphs above display that the most prevalent was “tell an adult”. While some of the themes attempt to dispel the notion of fault and rights, this theme of telling an adult is particularly important, and it is good that it is mentioned more than any other theme. Telling an adult is the first step for children to get help. However, respondents also remembered a number of other themes.

- Don't Keep A Secret: one 2<sup>nd</sup> grader commented about the puppet, stating “She did not keep secret”.
- How To Solve Problems: two students mentioned solving problems, a 2<sup>nd</sup> grader and a 5<sup>th</sup> grader. While the younger student explicitly mentions problems and “how to solve them”, the older student states “what to do if something ever happen like that to us”.
- Parents Can Get Help: a 3<sup>rd</sup> grade student mentions that her aunt had been abused in the past and indicates that she will “talk with my aunt and maybe she may go parent services so she can know about it”.

While respondents touched on most of the themes, two themes were not mentioned. “Adults are the ones who can help you” and “The abuser is often someone you know” were not mentioned explicitly. However, the former theme might have been overshadowed by the theme “Tell and adult”, because of their similarity.

*\* The following page contains a graph of other themes that emerged in the letters*



The above graph illustrates other themes that emerged from the response letters. As can be seen, many children mentioned abuse even if not in the form of one of the main themes. For example, one child wrote, “I didn’t know about child abuse or the other things that you taught me”. Just the awareness of what abuse is can be the first step in the recognition and disclosure of it to adults.

As for the other themes, one student wrote, “How to deal with bullies”, while another wrote “How to be safe”. Another student wrote, “and if you have a bad feeling about something then walk away or run”. While these may not be the most prevalent themes that occurred in the letters, these are important themes of the program and indicate retention one of the main points of the program, which is how to keep children safe.

## **Never Shake a Baby**

### **Goal**

Never Shake a Baby hopes to decrease incidences of Shaken Baby Syndrome (SBS) through hospital outreach to parents of newborns, teaching them about normal infant behaviors, techniques to calm a crying baby and the dangers of shaking a baby. Never Shake a Baby provides education in the form of both videos and pamphlets for parents of newborns about how to safely respond to challenging infant behaviors such as inconsolable crying.

### **Purpose**

Research within this program is meant to demonstrate the program's usefulness in not only providing the parent with information, but also to determine whether this information is being shared with other caregivers.

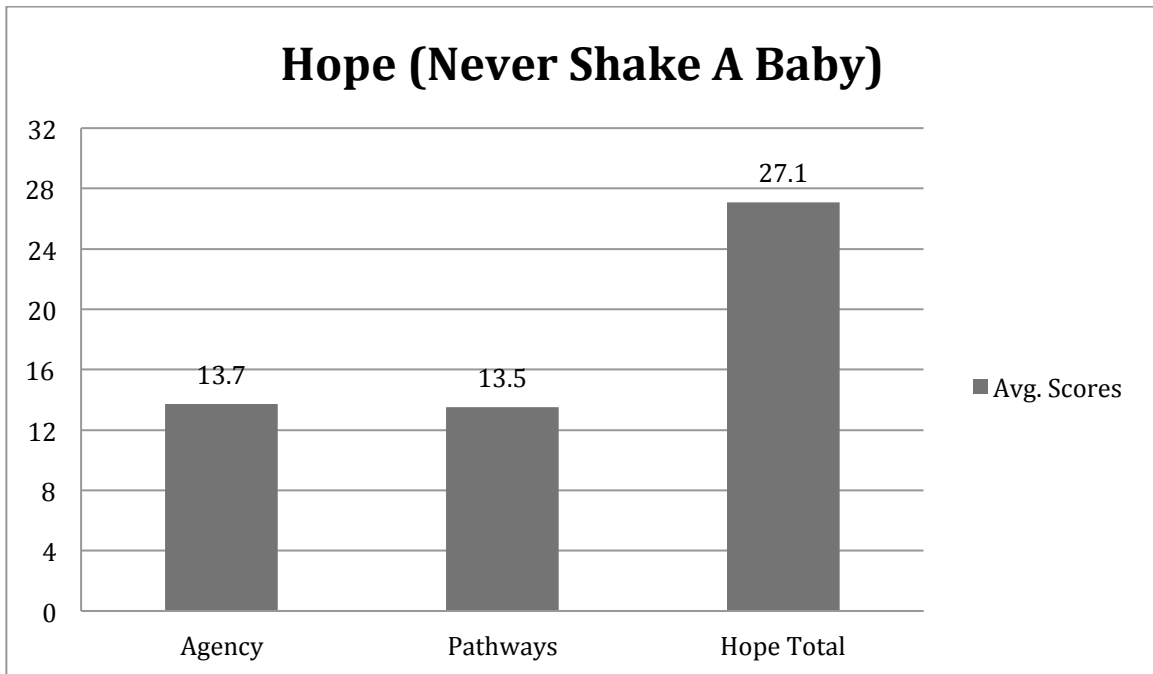
### **Procedure**

Using a questionnaire designed by individuals within the program, a PCCT representative visits parents in a hospital setting and presents the Never Shake a Baby literature and video. Individuals are then asked to complete a questionnaire and, if consent is given, a follow-up questionnaire is also completed within 4 weeks of initial contact.

### **Instruments**

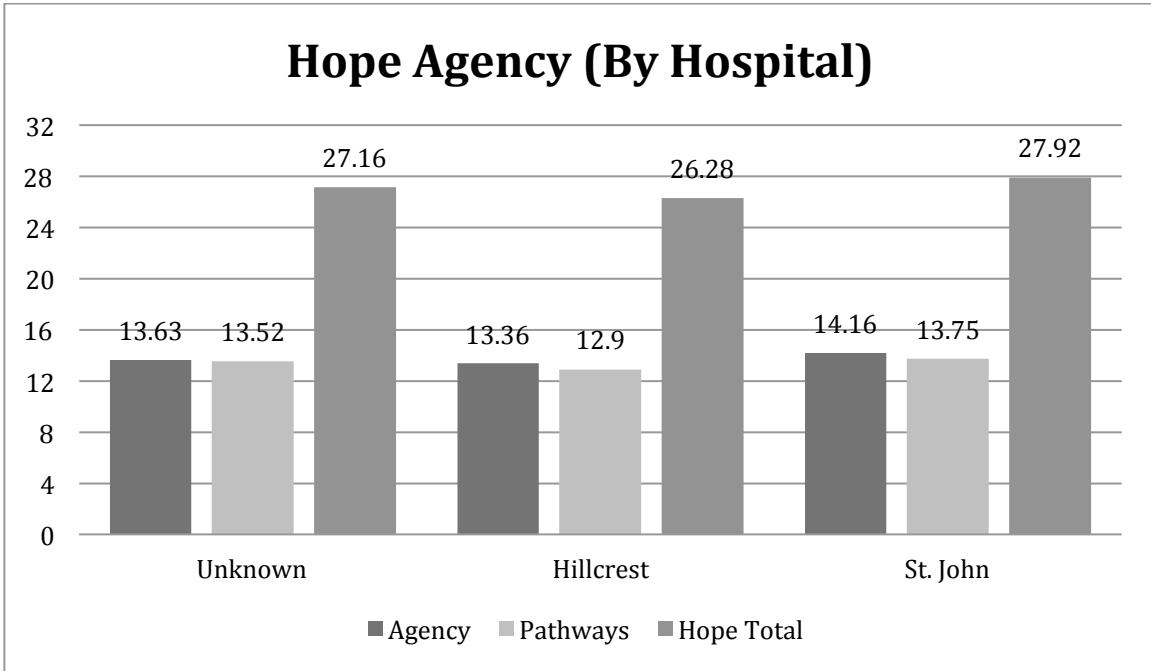
*Trait Hope Scale* - In conjunction with a questionnaire developed by PCCT, the Trait Hope Scale was administered during the follow-up period. The Trait Hope Scale was modified to include only the eight questions used for scoring. This instrument is used to determine three aspects of hope: agency, pathways, and total hope. Four of the questions deal with agency, four with pathways, and total hope is calculated by summing the two subscales. For the Hope Scale, higher scores indicate higher hope.

*\*The following pages contain graphical representations of data collected during the pre and post periods.*



N = 61

The above graph depicts mean hope scores only for respondents of the Never Shake a Baby program. Agency was 13.7, pathways were 13.5 and the total hope score was 27.1. Being that the highest score achievable for each scale is 16, 16, and 32, respectively, this group could be considered to have high hope scores.



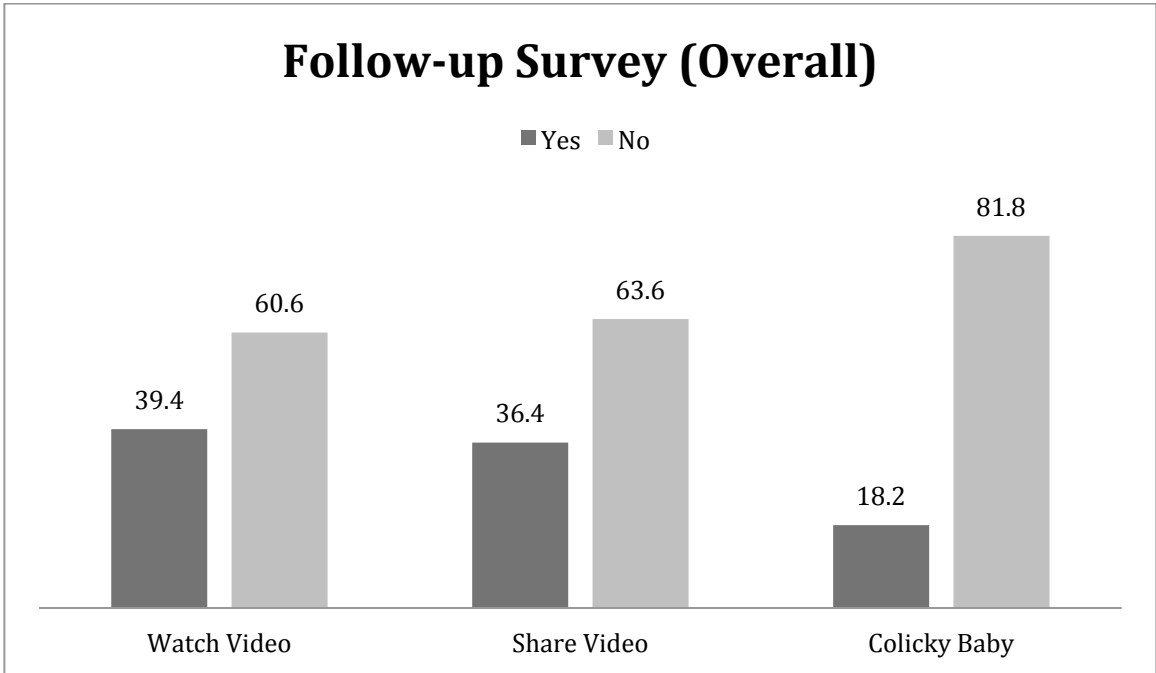
Unknown N= 38

Hillcrest N= 11

St. John N= 12

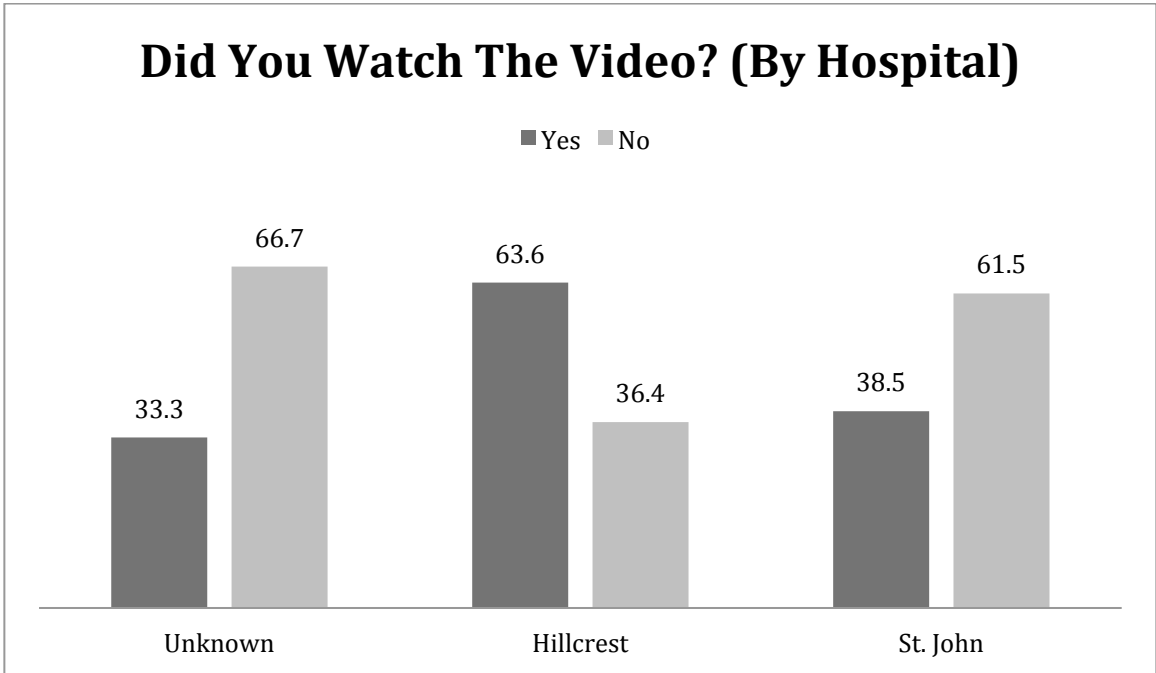
Total N= 61

The above graph displays hope scores separated by hospital. As can be seen, St. John had the highest total hope scores, with a score of 27.92, versus 26.28 for Hillcrest. Pathways scores for St. John were 13.75 and agency scores were 14.16; however, for Hillcrest, pathways were 12.9 and agency scores were 13.36.



N = 66

The above graph displays percentages of those who watched and shared the video as well as the percentage of those who had a colicky baby. 39.4% of respondents stated they watched the video, and 36.4% of respondents stated they shared the video. Only 18.2% of individuals reported having a colicky baby.

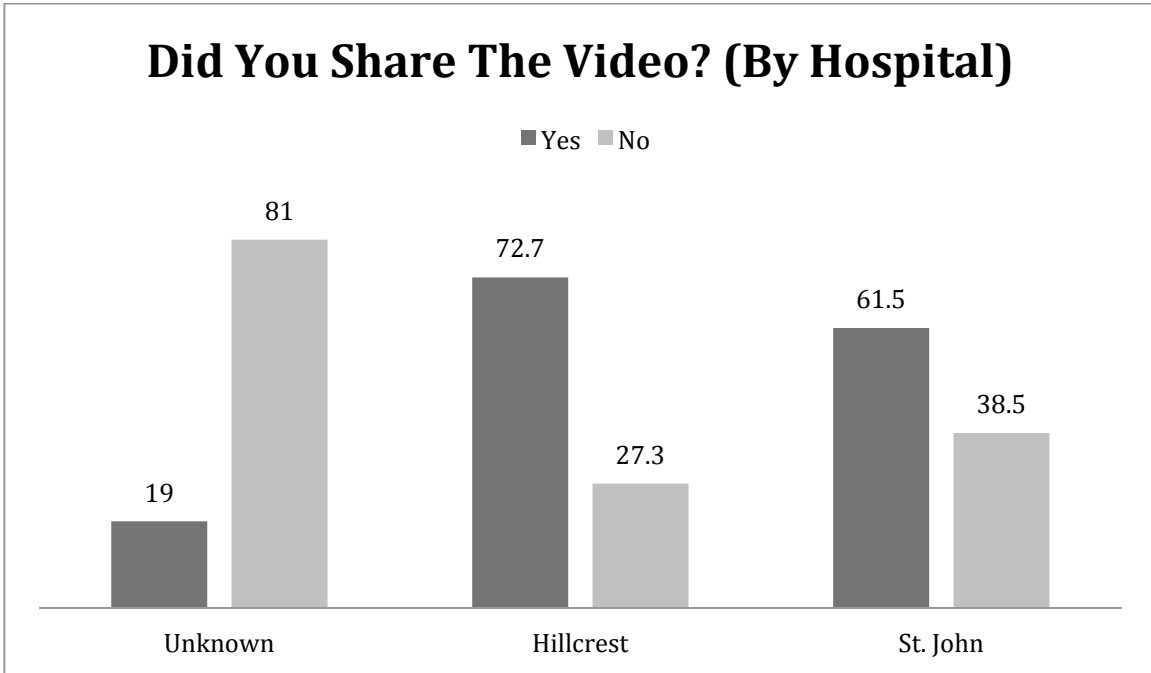


Unknown N= 42

Hillcrest N= 11

St. John N= 13

In the above graph, it can be seen that more individuals at Hillcrest (63.6%) watched the video than at St. John (38.5%). In the unknown category, 33.3% watched the video.



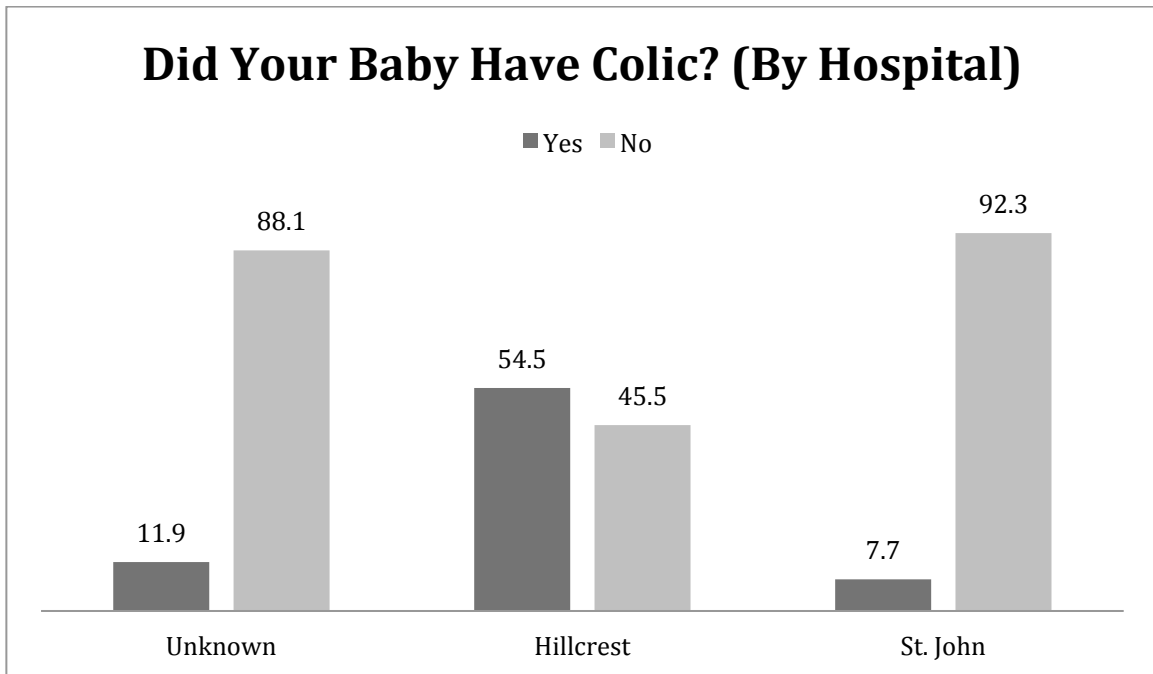
Unknown N= 42

Hillcrest N= 11

St. John N= 13

The above graph illustrates the percentage of those from each hospital who shared the video with others. Interestingly, Hillcrest, which had the highest percentage of those who watched the video, also had the highest percentage of individuals who shared the video (72.7%). Of those at St. John, 61.5% shared the video.





Unknown N= 42

Hillcrest N= 11

St. John N= 13

As can be seen in the above graph, 54.5% of those individuals at Hillcrest had a baby who was colicky. This is interesting, because Hillcrest also had the highest percentage of people who watched and shared the video, as previously mentioned. St. John reported 7.7% had colic, while another 11.9% reported colicky babies in the unknown category.

## Crosstabs

Running a crosstab analysis of the variables “Watched Video” and “Shared Video” allows one to see the relationship between the two variables. In this case, it allows one to see the percentage of people who shared the video from the number of people who actually watched. This is relevant because only 36.4% of the total respondents stated that they shared the video, and 39.4% stated they watched the video. However, the cross tabulation revealed that of the 39.4% who watched it, 61.5% also shared the video. This indicates that the sharing of the video is increased when the video is watched in the first place. Comparatively, of the 60.6% who did not watch the video, only 20% shared it.

### Crosstabs Numbers

		Did you share		Total
		No	Yes	
Did you watch	No	32	8	40
	Yes	10	16	26
Total		42	24	66

The above table displays the actual numbers for those that watched and shared the video. 40 people stated that they *did not* watch the video, but eight of those 40 stated that they shared the video (highlighted in yellow). However, of the 26 people who stated they watched the video, 16 also shared it (highlighted in blue). The table below displays the associated percentages.

### Crosstabs Percentages

			Did you share		Total
			No	Yes	
Did you watch	No	Count	32	8	40
		% within Did you watch	80.0%	20.0%	100.0%
		% within Did you share	76.2%	33.3%	60.6%
	Yes	Count	10	16	26
		% within Did you watch	38.5%	61.5%	100.0%
		% within Did you share	23.8%	66.7%	39.4%
Total	Count	42	24	66	
	% within Did you watch	63.6%	36.4%	100.0%	
	% within Did you share	100.0%	100.0%	100.0%	

## **Great Beginnings**

### **Goal**

Great Beginnings enrolls pregnant women and families with children up to one year old who are at moderate to high risk for abuse & neglect due to circumstances such as teen mother, single head of household, unemployment, lack of support system, or poverty. The mission is to provide these families with the tools necessary to prevent child abuse and neglect.

### **Purpose**

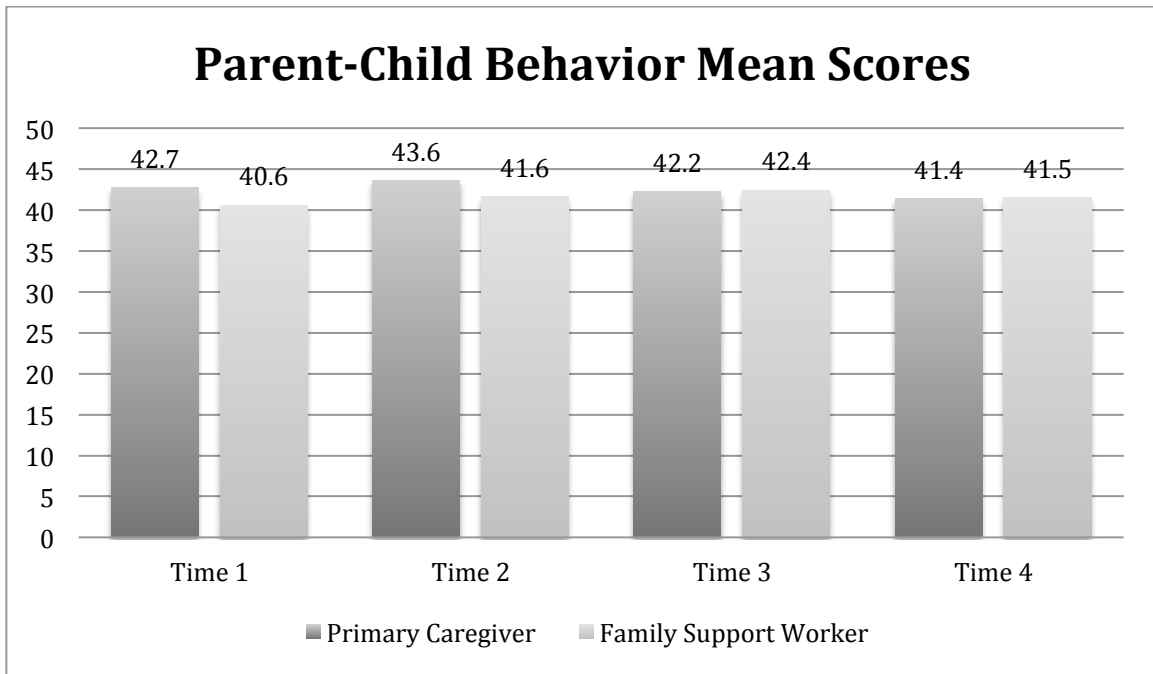
The purpose of research within Great Beginnings is to display the progress that parents and families are showing due to PCCT involvement.

### **Procedure**

Great Beginnings uses many different instruments to measure progress and success. For this report, only the Healthy Families Parenting Inventory (HFPI) was analyzed. Both the primary caregiver and the family support worker fill out two scales on the HFPI, the Parent-Child Behavior scale and the Home Environment Scale. This scale was completed up to four times, with the goal of bringing the caregiver and support worker's scores closer together.

### **Instruments**

*Health Families Parenting Inventory (HFPI)* – The HFPI is a self-report measure completed by the primary caregiver; however, PCC augmented the limitations of a self-report measure by also having the Family Support Worker complete ratings for the selected scales. Two subscales, Parent/Child Behavior and Home Environment, were selected for comparison. The Parent/Child Behavior subscale includes items that assess for how well the parent is able to manage the child's behavior, while the Home Environment subscale includes items that assess for whether the parent has structured the home environment and routines to be safe and nurturing. These subscales were selected because they were observable on behalf of the Family Support Worker rather than requiring assumption or inference and should hopefully lead to more valid and meaningful results. Higher scores are better for each subscale.



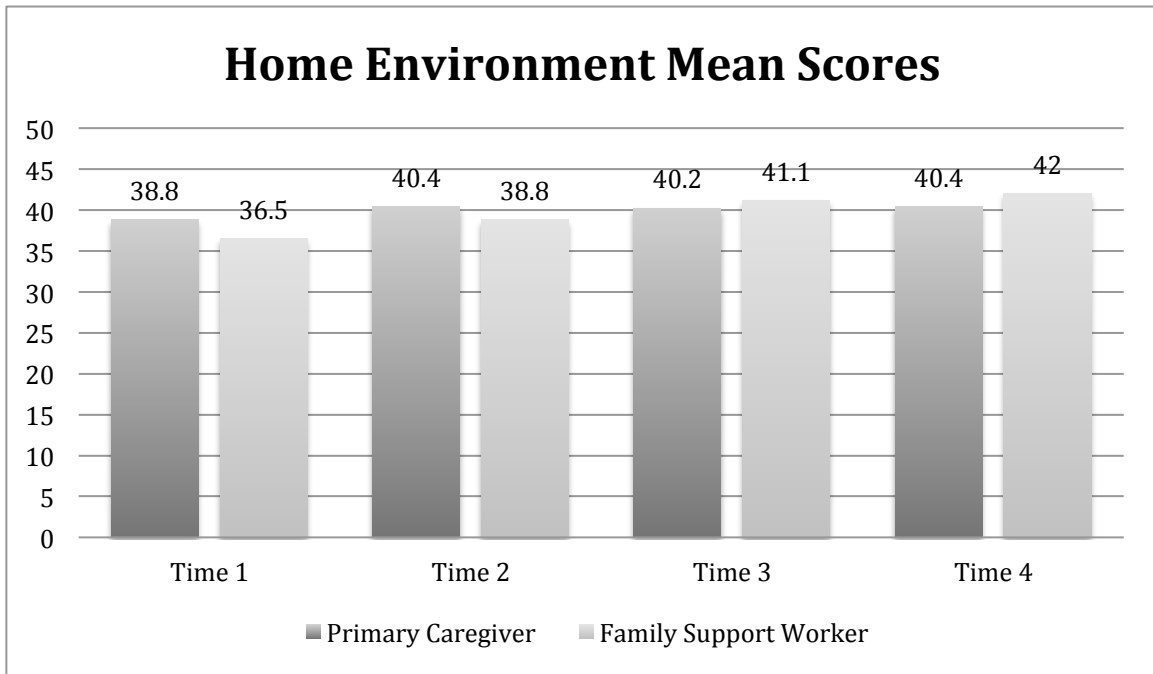
PCG(Bx): Time 1 N=66, Time 2 N=66, Time 3 N= 22, Time 4 N=8

FSW(Bx): Time 1 N=65, Time 2 N=66, Time 3 N= 22, Time 4 N=8

PCG(Home\_Env): Time 1 N=66, Time 2 N=66, Time 3 N= 22, Time 4 N=8

FSW(Home\_Env): Time 1 N=65, Time 2 N=66, Time 3 N= 22, Time 4 N=8

The above graph illustrates the change in mean scores from Time 1 through Time 4. As can be seen, the Primary Caregivers' (PCG) scores rise at first, but then drop to a mean of 41.4 at Time 4. The Family Support Workers' (FSW) scores increase through Time 3 but then decrease to a mean of 41.5 at Time 4. Perhaps most interesting is that the mean scores are almost identical by the third and fourth series, indicating that the perception of the parent-child behavior has aligned.



PCG(Bx): Time 1 N=66, Time 2 N=66, Time 3 N= 22, Time 4 N=8

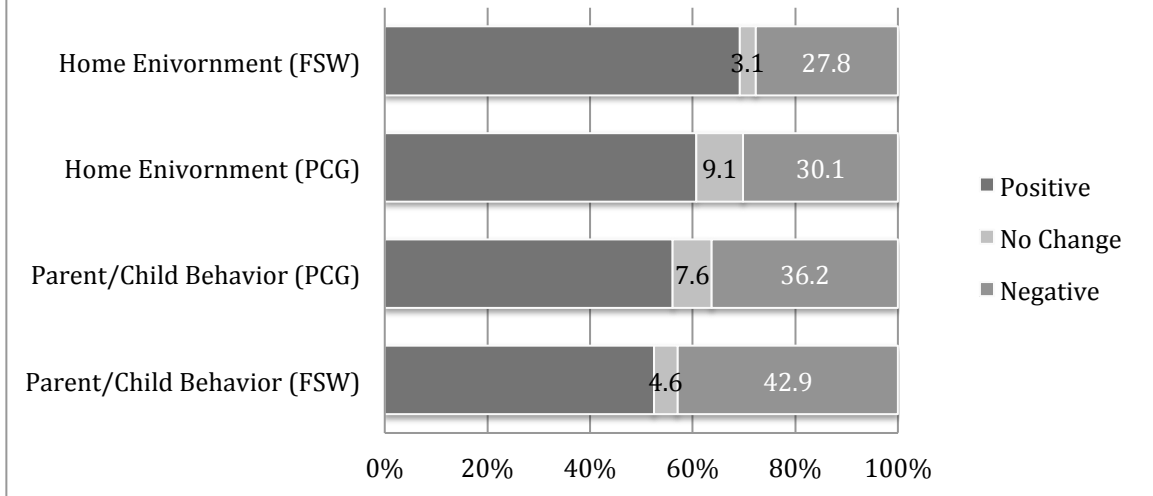
FSW(Bx): Time 1 N=65, Time 2 N=66, Time 3 N= 22, Time 4 N=8

PCG(Home\_Env): Time 1 N=66, Time 2 N=66, Time 3 N= 22, Time 4 N=8

FSW(Home\_Env): Time 1 N=65, Time 2 N=66, Time 3 N= 22, Time 4 N=8

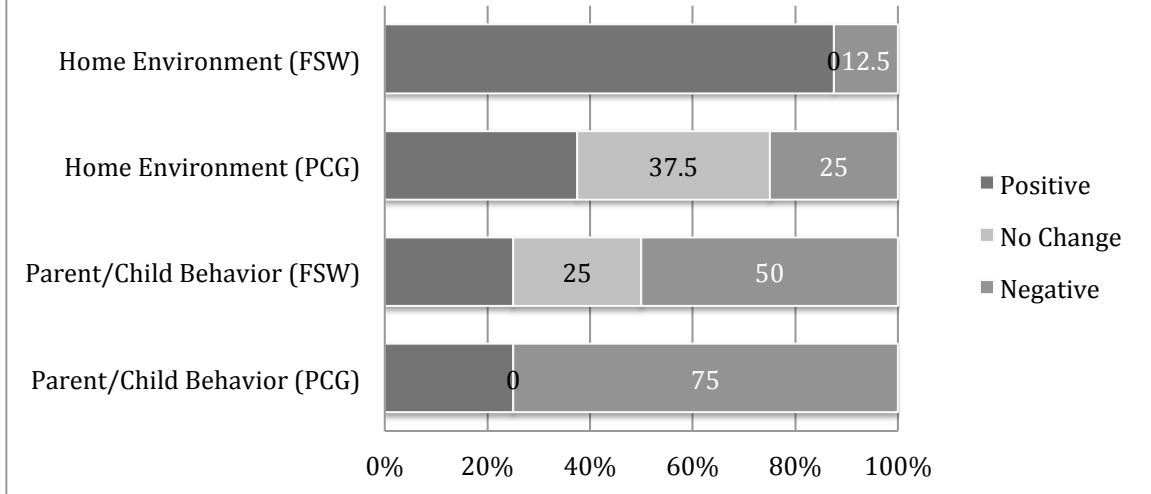
In the above graph, the PCGs' scores increase from Time 1 to Time 2, but then level off at a mean of 40.4 by Time 4. However, the FSWs' scores increase throughout the four series, ending at a mean of 42, indicating the FSWs' perception of the Home Environment is, in fact, better than the PCGs'.

## Great Beginnings HFPI Percentages (Time 1 to Time 2)

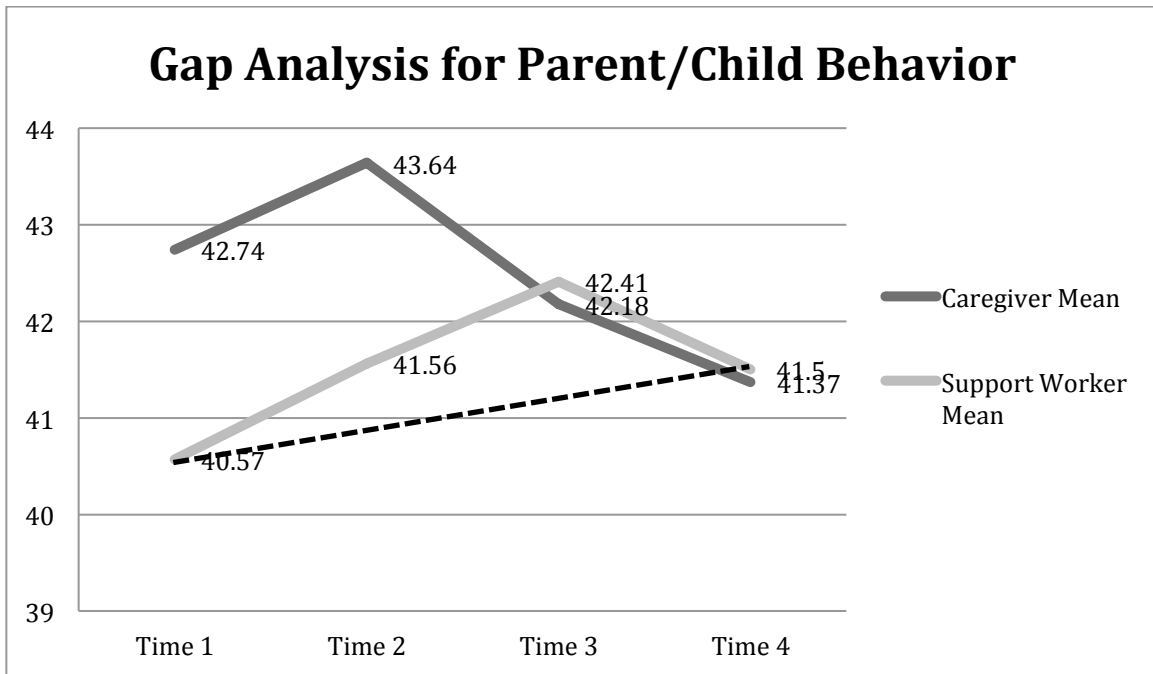


Directly related to the mean scores is the percent that actually changed. For example, in regards to Parent-Child Behavior, 56% of primary caregivers showed positive change. In terms of Home Environment, 69.2% of family support workers reported positive change, with only 27.8% negative change. What this table ultimately shows is that from Time 1 to Time 2, over 50% showed positive change on each variable.

## Great Beginnings HFPI Percentages (Time 1 to Time 4)

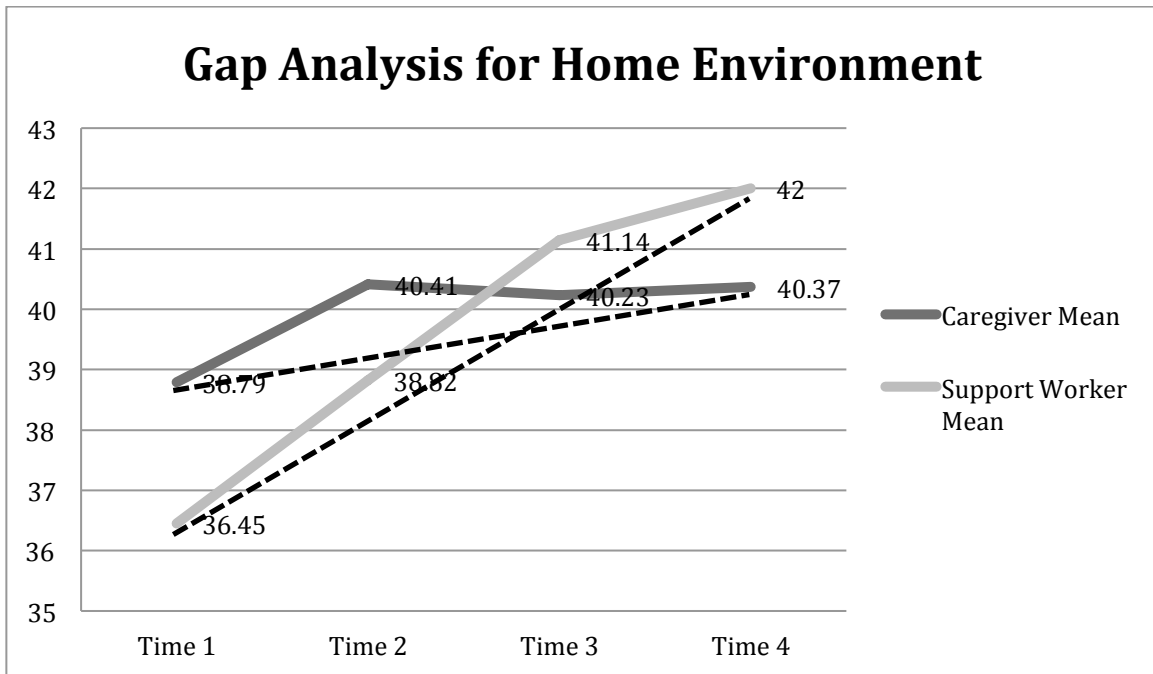


The above graph displays percent of change between time 1 and time 4. Unlike the first previous table, scores do not improve quite as much from time 1 to time 4. However, it should be noted there were only 8 total responses at time 4, compared to 66 for time 1 and time 2.



The above graph illustrates that from time 1 to time 2 the difference between the caregiver scores and family support worker scores steadily decreases. That is, the gap between the mean scores gets smaller. For example, the gap between time 1 and time 2 is 2.11, while the gap at time 4 is -.23. Despite higher scores being better and the scores decreasing at time four, what is more important is how the scores are aligned, indicating congruence with the perceptions of both the caregiver and the support worker. Again, at time 4 there were only 8 responses, thus, it could be that the decrease in mean scores is more a product of a low response rate as opposed to worsening of the respondents' behavior.





The above graph shows, again, that as time passes the gap between the caregiver and support worker's scores decreases. However, in this graph, the time when the scores are closest is at time 3, and by time 4, it is clear that the support worker is beginning to see more progress in home environment than the caregiver.

**Gap Analysis Table**

	N	Minimum	Maximum	Mean Dif.
Behavior 1	<b>65</b>	<b>-11.00</b>	<b>18.00</b>	<b>2.11</b>
Behavior 2	<b>66</b>	<b>-10.00</b>	<b>18.00</b>	<b>2.08</b>
Behavior 3	<b>22</b>	<b>-20.00</b>	<b>19.00</b>	<b>-.23</b>
Behavior 4	<b>8</b>	<b>-6.00</b>	<b>10.00</b>	<b>-.13</b>
Environment 1	<b>65</b>	<b>-17.00</b>	<b>21.00</b>	<b>2.22</b>
Environment 2	<b>66</b>	<b>-16.00</b>	<b>25.00</b>	<b>1.59</b>
Environment 3	<b>22</b>	<b>-18.00</b>	<b>6.00</b>	<b>-.91</b>
Environment 4	<b>8</b>	<b>-14.00</b>	<b>5.00</b>	<b>-1.63</b>

The above graph illustrates the gap between the caregiver and support worker's scores from time 1 through time 4 for both parent/child behavior and home environment. By subtracting the caregiver score from the support worker score, it is possible to see the actual mean gap score. The minimum and maximum scores represent the smallest and largest difference between the mean scores, and in this case, a smaller mean difference indicates that the support worker and the caregiver are rating the caregiver similarly. Thus, for Behavior, the difference between the caregivers and support workers' mean scores at time 1 was 2.11, whereas at time 4 the difference was -.13. The negative simply means the support worker's scores were higher than the caregiver's, which was the case at time 3 and 4 for both variables.

## Cohen's D

Statistical significance does not necessarily address clinical significance. Therefore, effect size estimates are useful in describing how different two groups are on a given measure (e.g., parent's ability to manage child's behavior). A large effect size indicates there is difference, and many times this difference could be considered clinically significant. In this case, the means between the caregiver and support worker were compared, and what one would expect is to see a small or negligible effect by time 4, indicating that the means are not different. This lack of effect size by time 4 would show that the caregivers' perception of themselves has begun to align with that of the family support worker. A small effect size would have a value of + or - .20, medium + or - .50, and a large effect size would be + or - .80. Again, time 1 is the difference between the Caregiver and Support Worker means for either Parent/Child Behavior or Home Environment using Cohen's D to determine the effect size.

Cohen's D

	Time 1 D	Time 2 D	Time 3 D	Time 4 D
Parent/Child Behavior	.40	.40	-.04	-.02
Home Environment	.41	.24	-.13	-.34

As the above table illustrates, the effect size between the means decreases for both variables through time 3, at which point the difference becomes negligible. Only home environment increases again to a small effect size at time 4, whereas parent/child behavior continues to decrease. However, the increase in effect size on time 4 of home environment is the result of the support worker rating the caregiver higher than the caregivers rated themselves.

## SafeCare

### **Goal**

SafeCare provides broad-based, individualized parenting support and education to families with children ages 0-5. It is a voluntary, home-based program designed to strengthen parent/child relationships and enhance home safety and child-well being. SafeCare enrolls pregnant women and families with at least one child under the age of 5 who are interested in improving their parenting skills and/or their ability to nurture and care for their child.

### **Purpose**

The purpose of research in this department is to determine the degree to which individuals progressed during each visit on a number of different skill sets.

### **Procedure**

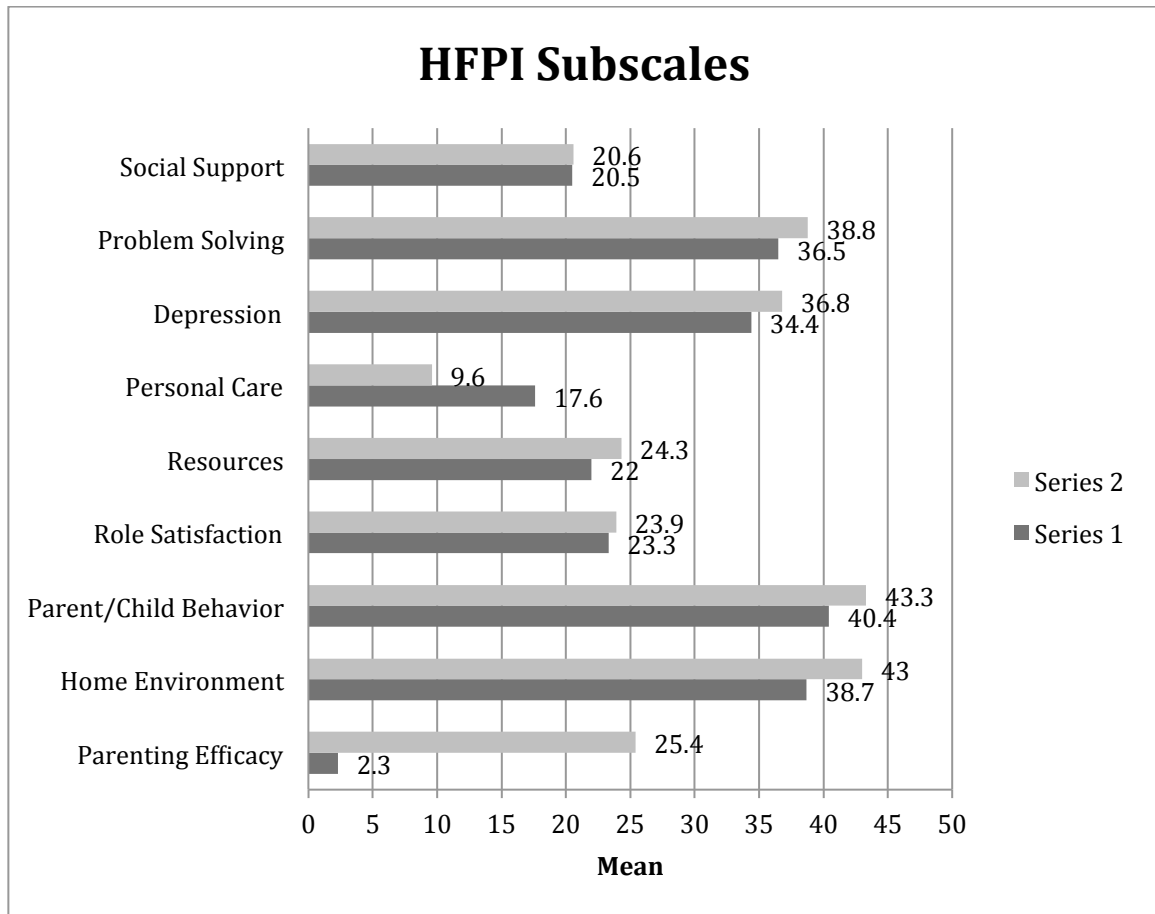
Family support workers complete all ten subscales on the HFPI for each client during each visit. These scores are entered into a database that is then transferred to SPSS, quantitative data software, for analysis.

### **Instruments**

*The Health Families Parenting Inventory (HFPI)* – The HFPI is a self-report measurement that examines 9 different subscale, of which the sum of these nine yield a total score. Ultimately, its goal is to measure a variety of areas related to child safety and protective factors, such as home environment, parenting skills, and parent-child interaction. In clinical practice, the HFPI can assess severity, identify strengths or critical needs, and identify targets for treatment. Again, higher scores are better, just as within the Great Beginnings program, and responses are on a 5-point Likert format.

HFPI Subscales:

- Social Support
- Problem Solving/Coping
- Depression
- Personal Care
- Mobilizing Resources
- Role Satisfaction
- Parent/Child Interaction
- Home Environment
- Parenting Efficacy

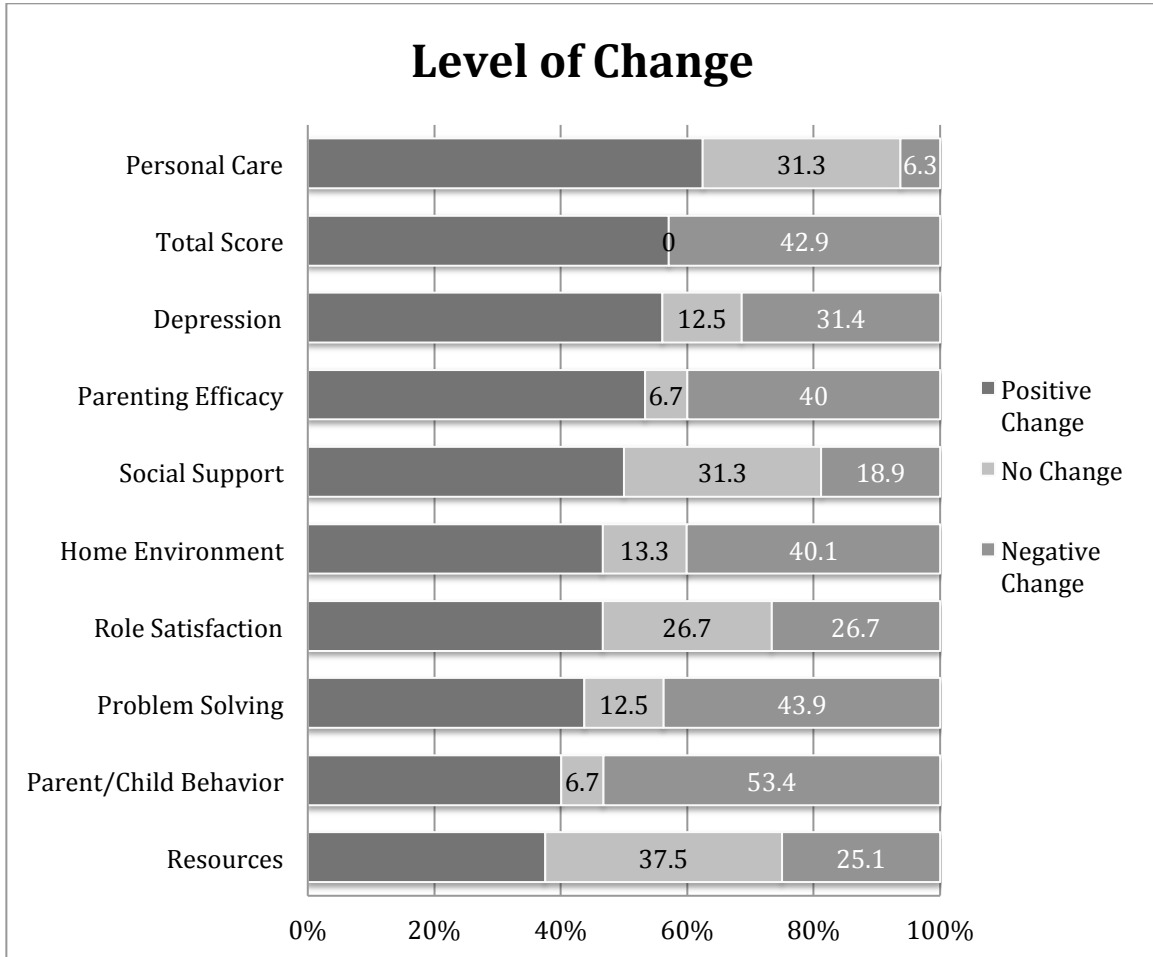


Social Support Time 1: N = 57; Time 2: N = 16 Range: 5-25  
 Problem Solving Time 1: N = 57; Time 2: N = 16 Range: 6-30  
 Depression Time 1: N = 57; Time 2: N = 16 Range: 9-45  
 Personal Care Time 1: N = 57; Time 2: N = 16 Range: 5-25  
 Mobilizing Resources Time 1: N = 57; Time 2: N = 16 Range: 6-30  
 Role Satisfaction Time 1: N = 52; Time 2: N = 16 Range: 6-30  
 Parent/Child Behavior Time 1: N = 51; Time 2: N = 16 Range: 10-50  
 Home Environment Time 1: N = 51; Time 2: N = 16 Range: 10-50  
 Parenting Efficacy Time 1: N = 51; Time 2: N = 16 Range: 6-30  
 Total Score Time 1: N = 51; Time 2: N = 15 Range: 63-315

The above graph is a display of the means for the nine subscales of the HFPI for time 1 to time 2. Generally speaking, the means all increased, with Problem Solving increasing by 2.3, Depression 2.4, and Personal Care 2.0. Social Support also increased, although minimally, by .1. Home Environment increased by 4.3, while Parenting Efficacy increased by 2.1. Improvement was also seen with the Total Score, with scores increasing from 240 to 260.7. The question is what is the percentage of those that changed from time 1 to time 2, and was this change significant.

### SafeCare Percentages (Time 1 to Time 2)

The table below displays the level of change from time 1 to time 2 for each subscale of the HFPI, including the total score.



The above table displays the percent of individuals who changed from time 1 to time 2. All variables showed improvement, with Personal Care having 62.6% improvement, and Depression displaying 56.5% improvement. The two variables that had the lowest percentage of change were Mobilizing Resources (37.6%) and Parent/Child Behavior (40.2%). Interestingly, it was Parent/Child Behavior that also had the highest percentage of negative change at 53.4% as well as the lowest percent of those that stayed the same.

### One-Sample T-Test

The one-sample t-test was run to help determine how those remaining in services compare to all who started. A one-sample t-test compares a population mean to a sample mean to determine if differences between the two means are significant. Due to the small number of paired samples, a one-sample t-test was used for the HFPI data, using time 1 scores as the population mean, which allowed for the mean of all the scores from time 1 to be used as a comparison.

<b>Variable</b>	<b>Test Mean</b>	<b>Post Mean</b>	<b>Sig.</b>
<b>Social Support</b>	20.51	20.63	.898
<b>Problem Solving</b>	20.42	22.19	.039*
<b>Depression</b>	34.42	36.75	.116
<b>Personal Care</b>	17.63	19.56	.088
<b>Mobilizing Resources</b>	22.00	24.25	.053
<b>Role Satisfaction</b>	23.25	23.88	.488
<b>Parent/Child Behavior</b>	40.39	43.25	.025*
<b>Home Environment</b>	38.69	43.00	.008*
<b>Parenting Efficacy</b>	23.27	25.44	.066
<b>Total Score</b>	239.96	260.67	.009*

*\*Denotes statistical significance*

As the above table illustrates, four of the 10 variables proved to be significantly different from time 1 to time 2. These were problem solving, parent/child behavior, home environment, and the total score. However, two other variables, mobilizing resources and parenting efficacy, also approached significance, in which the significance score was close to but not less than the .05 needed to prove significance. While all the scores increased, as described previously, the change was not statistically significant for all of them.

## **Adult Treatment**

### **Goal**

Adult Treatment is a tertiary program and the goal is to break the cycle of child abuse or neglect. The objective of the first phase is to assist parents in taking responsibility for court involvement and to assist them in understanding what changes they need to make in their life to break the cycle of abuse and neglect. The objective of the second phase is to reduce the risk of child abuse and neglect through parenting education.

### **Purpose**

The goal of research within Adult Treatment was twofold: first, analyzing the current data being collected to determine improvement from pre to post; secondly to determine improvements that can be made in both data collection and use of instruments.

### **Procedure**

Upon entrance to the adult treatment program, participants are put in either the Compassion Workshop or the Responsibility Processing Group. Participants take a pre- and post-test to assess for knowledge gained during this process. Upon completion, participants will enter the Nurturing Parenting program, and when completed will fill out the Adult-Adolescent Parenting Inventory (AAPI), which was also filled out upon entrance to the program.

### **Instruments**

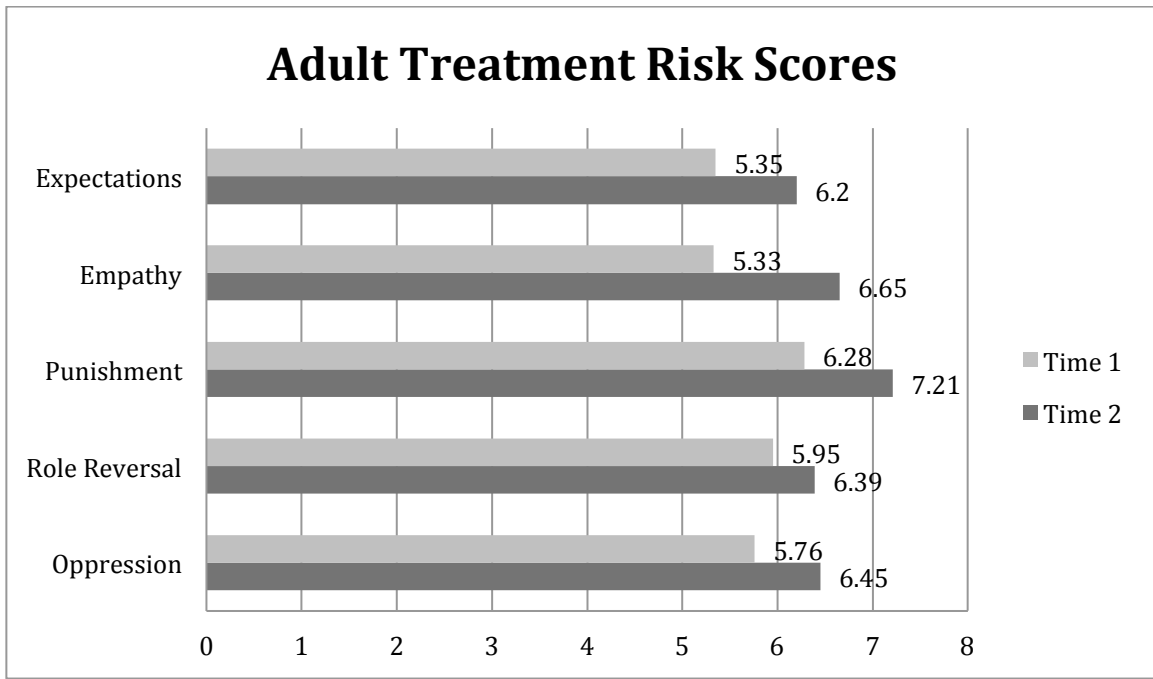
*Adult-Adolescent Parenting Inventory (AAPI-2)* – The AAPI-2 is comprised of 40 items that measure parenting attitudes and child rearing practices of both adults and adolescents. The goal of the AAPI-2 is to ascertain the level of risk of child abuse and neglect based upon 5 constructs: parental expectations, empathy, corporal punishment, family roles, and oppression of child's independence. The AAPI-2 has a Form A and Form B as a pre-test and post-test, respectively. The AAPI-2 has been normalized to the general population. Individuals' raw scores are converted to sten scores, or risk scores, in order to compare their scores with that of the general population. Risk scores are best used to determine where an individual stands in relation to a normal distribution of scores, and in this case, is used to determine risk of child abuse or neglect.

*Knowledge Quizzes* – The knowledge quizzes for Compassion Workshop and Responsibility Processing were developed by PCC staff to determine both the change in knowledge and the effectiveness of the program in disseminating information.



## Descriptive Statistics

- Gender: Of the 340 respondents, 42.6% (145) were male, and 57.4% (195) of them were female.
- Race: 64.1% were Caucasian, 16.8% Native American, 13.8% Black, 3.5% Hispanic, .9% Pacific Islander, .6% Unknown, and .3% Asian.
- Education: The majority of respondents had completed some college (27.4%) or was a high school graduate (26.2%). 13.2% completed 11<sup>th</sup> grade, 10.9% 10<sup>th</sup> grade, 9.1% 9<sup>th</sup> grade, 6.5% 8<sup>th</sup> grade, 1.8% 7<sup>th</sup> grade, and 1.5% completed grade school.
- Employment: 47.9% of respondents reported being unemployed, while 33.2% reported being employed. 9.7% stated they were employed part-time, 6.5% were not employed due to a disability, 2.4% employment was unknown, and .3% reported being retired.
- Income Level: The majority of respondents, 36.2%, stated they did not know how much they made per year, while 34.4% reported making under \$15,000. 16.8% made between \$15,001 and \$25,000, while 11.2% made \$25,001 to \$60,000. Only 1.5% reported making over \$60,001.
- Marital Status: The majority of respondents were either single (36.2%) or married (31.8%). 11.2% were unmarried partners, 11.5% separated, 7.6% divorced, and 1.8% widowed.
- Abuse Inside of Home: 32.6% of respondents indicated having experienced abuse within their family as a child while 61.5% had not. 5.9% did not know.
- Abuse Outside of Home: 20.3% reported experiencing abuse outside of their family while 69.7% did not. 10% did not know.



Time 1 N = 340

Time 2 N = 66

The above graph displays risk scores within the Adult Treatment program. Risk scores are measured on five constructs, including Expectations of Child, Empathy, Corporal Punishment, Role Reversal, and Oppression. Individuals are placed into a category of low, moderate, or high risk based upon these scores. High risk individuals fall between 1-3, moderate risk between 4-7, and low risk between 8-10. Thus, higher scores indicate lower risk, while lower scores indicate higher risk. In the graph above, the mean scores remain in the moderate risk category despite showing improvement from time 1 to time 2. However, the more important question is whether the change is significant change, as well as what percentage of individuals moved from one risk category to another. The following pages will answer that question.

## Summary of AAPI Treatment

The following table attempts to answer the question “What is the level of risk?”

<b>Construct</b>	<b>Time 1: Percentage of Clients in High or Moderate Risk Group</b>	<b>Time 2: Percentage of Clients in High or Moderate Risk Group</b>	<b>Time 2: Percentage of Clients in Low Risk Group</b>
<b>Construct A:</b> Expectations of Children	89.1	80.3	19.7
<b>Construct B:</b> Empathy Towards Children’s Needs	88.5	59.1	40.9
<b>Construct C:</b> Use of Corporal Punishment as a Means of Discipline	77.1	54.5	45.5
<b>Construct D:</b> Parent- Child Role Responsibilities	78.8	68.2	31.8
<b>Construct E:</b> Children’s Power and Independence	79.1	68.2	31.8

Time 1 N = 340

Time 2 N = 66

The goal of this program is to reduce risk to the lowest group. The above table illustrates the percentage of clients in the moderate to high risk group at time 1 and time 2 of analysis. For example, 88.5% of respondents at time 1 were considered high or moderate risk regarding empathy (construct B), but that percentage dropped to 59.1% at time 2.

## AAPI Summary

How has risk changed across time? Specifics of direction of change based upon their rating at time 1 (N=66).

### **Construct A: Expectations of Children**

High Risk: 71.4% improved to moderate or low risk, 28.6% stayed the same.  
Moderate: 21.6% improved, 68.6% stayed the same, 9.8% moved to high risk.  
Low: 12.5% stayed the same and 87.5% moved to moderate risk.

### **Construct B: Empathy Towards Children's Needs**

High Risk: 53.4% improved to moderate or low risk, 46.7% stayed the same.  
Moderate: 44.4% improved, 55.6% stayed the same.  
Low: 100% stayed the same.

### **Construct C: Use of Corporal Punishment as a Means of Discipline**

High Risk: 66.7% improved to moderate risk, 33.3% stayed same.  
Moderate: 43.5% improved, 54.3% stayed same, 2.2% moved to high risk.  
Low: 71.4% stayed the same, 28.6% moved to moderate.

### **Construct D: Parent-Child Role Responsibilities**

High Risk: 50% improved to moderate or low risk, 50% stayed the same.  
Moderate: 31.7% improved, 58.5% stayed the same, 9.8% moved to high risk.  
Low: 46.7% stayed the same, 53.3% moved to moderate risk.

### **Construct E: Children's Power and Independence**

High Risk: 72.7% improved to moderate risk, 27.3% stayed the same.  
Moderate: 37.0% improved, 58.7% stayed the same, 4.3% moved to high risk.  
Low: 44.4% stayed the same, 44.4% moved to moderate, 11.1% moved to high risk

Thus, for Construct A, of those identified as high risk, 71.4% improved moved to the moderate or low-risk group. For Construct C, 66.7% of those identified as high-risk improved, while 43.5% of those in the moderate group improved. Construct E also showed improvement, with 72.7% of those in the high risk group moving to the moderate risk group, while 37.0% of those in the moderate group improved to low risk.

### Paired Samples T-Test

The next goal was to determine whether this change across time was significant and to achieve this goal, a paired samples t-test was used. The purpose of a paired samples t-test is to determine whether the change in mean scores from pre- to post- are statistically significant. As the table below displays, all of the risk factors measured by the AAPI showed significant change from time 1 to time 2. This indicates that those in the Adult Treatment program showed a reduced risk of child abuse and neglect from the beginning of the program to the end. Therefore, not only were individuals showing movement from one risk group to another, or simply showing improvement in their risk scores, but also these changes were statistically significant.

	Variable	N	Mean 1	Mean 2	Difference	Sig.
<b>Construct A</b>	Expectations	66	5.41	6.20	.788	.005*
<b>Construct B</b>	Empathy	66	5.23	6.65	1.424	.000*
<b>Construct C</b>	Punishment	66	6.15	7.21	1.061	.000*
<b>Construct D</b>	Role Reversal	66	5.71	6.39	.682	.010*
<b>Construct E</b>	Oppression	66	5.32	6.45	1.136	.000*

The goal of adult treatment is to reduce caregiver risk. The data presented for AAPI scores show that this goal is being achieved across all constructs for those in the high risk and moderate risk categories, respectively.

### Adult Treatment Knowledge Quizzes

As previously stated, the knowledge quizzes were distributed to individuals in completing one of two groups: the Compassion Workshop or the Responsibility Processing group. The goal is to increase individuals' knowledge on a variety of areas having to do with parent-child relationship and empathy.

**Table: Percent of Change**

Type of Quiz	Positive	No Change	Negative
Compassion Workshop	64.7%	23.5%	11.7%
Responsibility Process	76%	7.4%	16.7%

As the table above illustrates, the majority of respondents showed positive change on the knowledge quizzes from time 1 to time 2. Compassion Workshop had a higher percentage of individuals that showed no change (23.5%) than Responsibility Processing (7.4%); however, the latter had a higher percentage of those showing negative change (16.7%) than the former (11.7%).

### Paired Samples T-Test

**Table: Statistical Significance**

Quiz	N	Mean 1	Mean 2	Difference	Sig.
<b>Compassion</b>	34	24.18	25.62	-1.44	.000*
<b>Responsibility</b>	66	22.19	23.89	-1.70	.000*

The above table displays the findings from a paired samples t-test from time 1 to time 2 with both the Compassion Workshop and Responsibility Processing knowledge quizzes. As can be seen, both showed significant change in mean scores, with Compassion showing an average difference of -1.44 and Responsibility an average of -1.70. This indicates that participants in both groups achieved an increase in knowledge that was not due to chance.

## **Child Therapy**

### **Goal**

The Parent Child Center of Tulsa's Children's Treatment Department offers a comprehensive range of services to children ages 0-12 and their families. Children of all ages, including infants and toddlers, can be impacted by traumatic events such as separation or loss of a caregiver, painful medical procedures, or frightening events that impact their world. Child Therapy uses two main treatment models: Child Parent Psychotherapy and Play Therapy. The former is used to help caregivers effectively manage infant/toddler behavior problems such as aggression, depression, and feeding and sleeping problems that may result from their exposure to traumatic experiences. The latter acknowledges that parents are the most effective agents of change for their children, and it is our goal to empower parent-child relationships to grow and become sources of stability for both partners.

### **Purpose**

The purpose of research within the Child Therapy program is to analyze current outcome measures being used by PCCT as well as examine the relationship between hope and parent-child behavior.

### **Procedure**

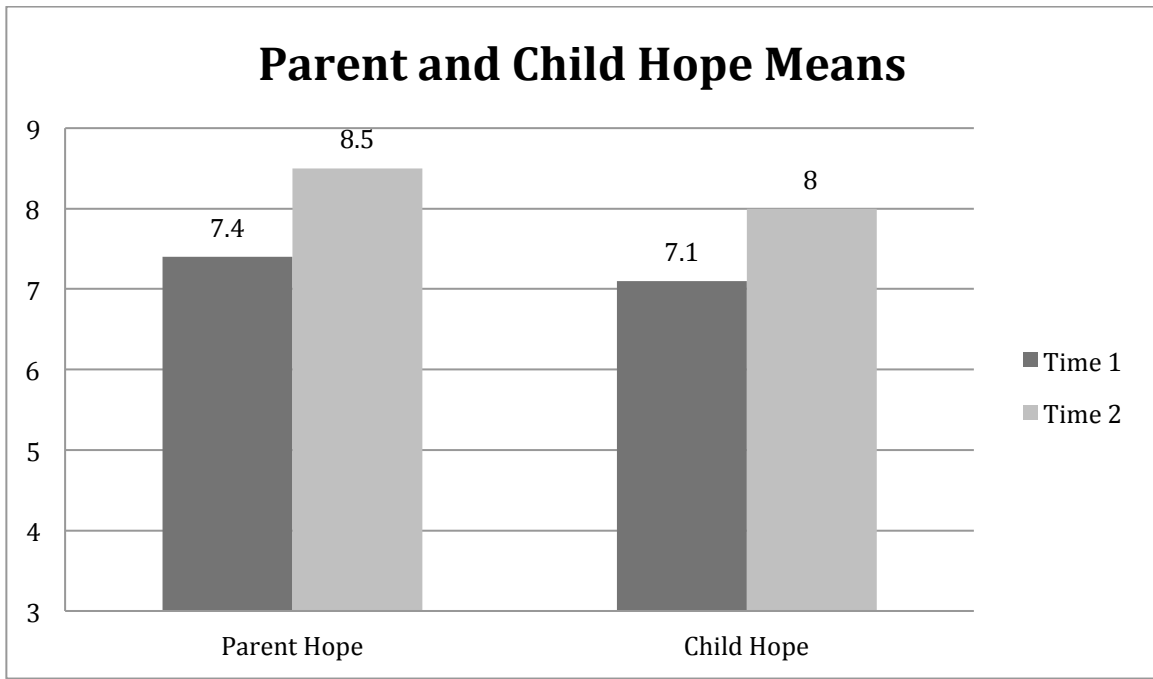
PCCT staff use a variety of instruments with the clients in their program and these clients fill them out upon entering the program. The scores from these assessments are entered into a database and used for analysis. The Crowell Assessment was administered twice for some participants, and a hope scale was developed to measure hope in terms of the parent/child relationship. The Trauma Symptoms Checklist for Young Children was only completed at intake, and thus has one set of scores.

### **Instruments**

*Hope Questionnaire* – this scale was developed by staff at PCCT and consists of questions regarding hope in the parent and hope in the child.

*Crowell Assessment* – the Crowell Assessment is a method for evaluating parent-child interaction within a variety of situations, including free play, clean up, and separation/reunion. The goal is to ascertain the quality of the parent-child relationship. All structured episodes are videotaped and scored by trained staff at PCCT.

*Trauma Symptoms Checklist for Young Children (TSCYC)* – the TSCYC is a 90-item caregiver report questionnaire designed to assess for trauma symptoms with their children. A variety of categories are measured, including posttraumatic stress, sexual concerns, anxiety, and depression.



The above graph illustrates the mean scores for parent and child hope. Parent hope increased from 7.4 to 8.5, while child hope increased from 7.1 to 8.0. Higher scores indicate higher hope.



## Parent and Child Hope One-Sample T-Test

**Table: One-Sample T-Test Statistics**

Quiz	N	Mean 1	Mean 2	Difference	Sig.
<b>Parent Hope</b>	6	7.45	8.5	1.05	.028*
<b>Child Hope</b>	6	7.14	8.0	.86	.157

As can be seen in the above table, the difference in caregiver hope from time 1 to time 2 *was* statistically significant. However, the difference in child hope scores from time 1 to time 2 *was not* statistically significant.

### Cohen's D Statistic

Further analysis using the Cohen's D statistic was used to measure the effect size between the parent and child hope scores. As previously mentioned, Cohen's D is a test designed to determine the effect size in a pre-post analysis. .20 would indicate a small effect size, .50 a moderate effect size, and .80 a large effect size. For caregiver hope, the effect size was found to be -.83, which indicates a large effect size. For child hope scores, the effect size was -.68, which is a moderate effect size. Ultimately, this means that both groups became more hopeful from pre to post, and because of the nature of Cohen's D, this change could be seen as clinically significant in regards to the parent/child relationship.

## Correlations

The table on the next page provides the correlation matrix for all the scales described above. A correlation represents the level of relationship between two variables. The interpretation is based upon the strength of the relationship as well as the direction. Strength of a correlation is based upon Cohen's (1990) effect size heuristic. More specifically, a correlation (+ or -) of .10 or higher is considered small; a correlation (+ or -) of .30 is considered moderate, and a correlation (+ or -) of .50 is considered strong. With regards to direction, a positive correlation indicates that higher scores on one variable are associated with higher scores on the other variable. A negative correlation indicates that higher scores on one variable are associated with lower scores on the other variable. Using a correlation matrix is a parsimonious way to present several correlations among multiple variables. Identifying a specific correlation is based upon matching a row to a particular column.

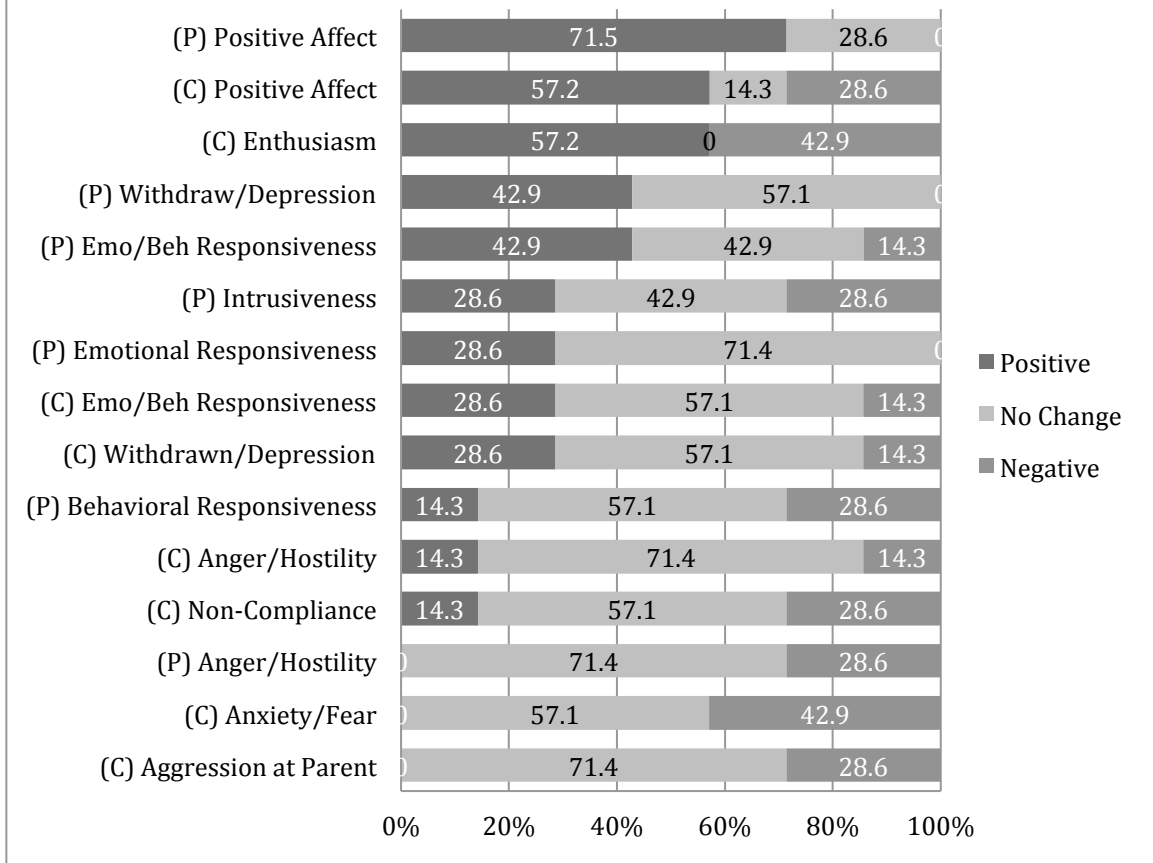
### Hope and Crowell Free Play Correlations

Table: Correlations Time 1

	Caregiver Hope (1)	Child Hope (1)	Hope Congruence (1)
<b>Caregiver Hope (1)</b>	1		
<b>Child Hope (1)</b>	.352	1	
<b>Hope Congruence (1)</b>	*.556	*-.582	1
<b>(P) Positive Affect</b>	*.627	*.512	.133
<b>(P) Withdraw/ Depression</b>	.314	*.470	-.125
<b>(P) Anger/Hostility</b>	*.458	.290	.172
<b>(P) Intrusiveness</b>	.361	*.445	-.058
<b>(P) Behavioral Responsiveness</b>	*.405	*.533	-.095
<b>(P) Emotional Responsiveness</b>	.376	*.462	-.060
<b>(C) Positive Affect</b>	*.465	*.529	-.035
<b>(C) Withdraw/ Depression</b>	.049	*.645	*-.532
<b>(C) Anxiety/Fear</b>	.093	.208	-.099
<b>(C) Anger/Hostility</b>	*.581	*.411	.179
<b>(C) Non-Compliance</b>	*.498	.354	.153
<b>(C) Aggression at Parent</b>	.184	.235	-.037
<b>(C) Enthusiasm</b>	.282	.330	-.030

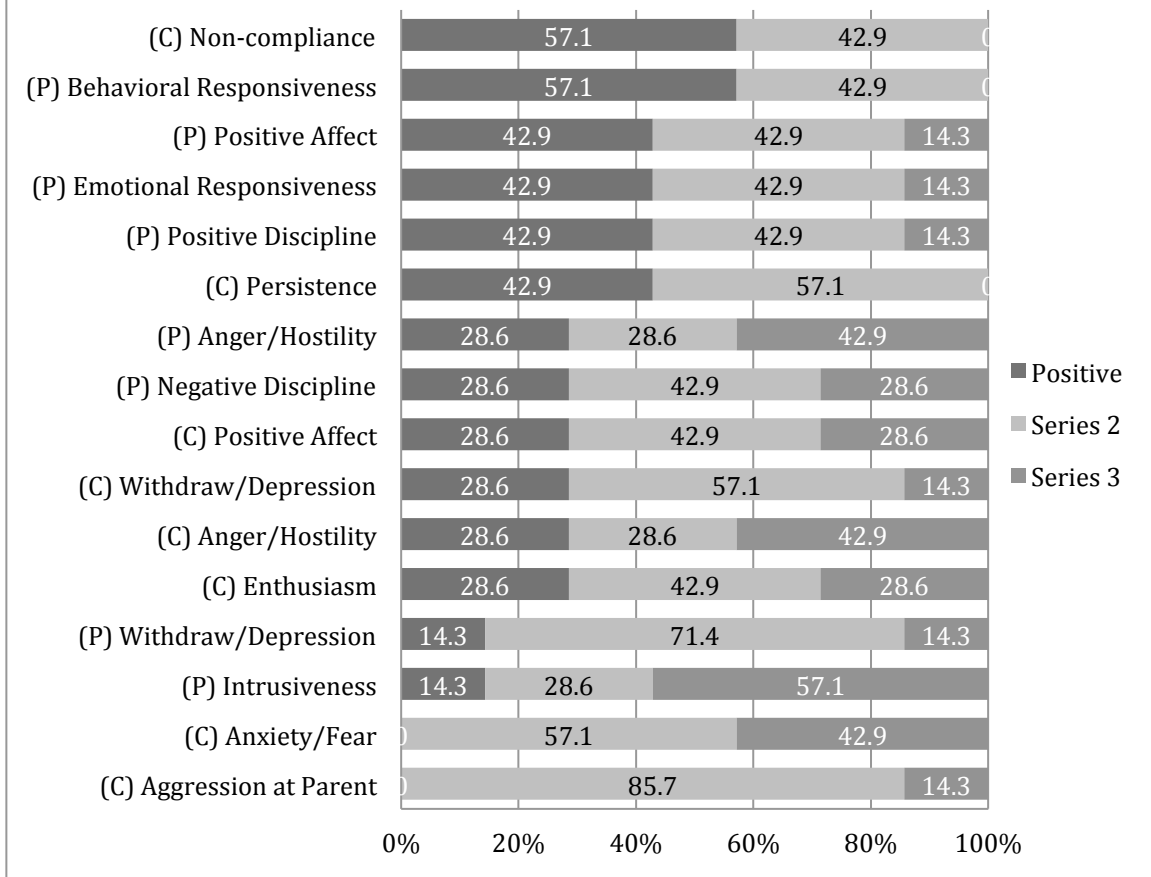
The above table displays correlations between hope scores of the parent and child with scores on the free play Crowell assessment. Correlations examine whether the relationship between two variables is significant. Those numbers with asterisks indicate significant correlations.

## Free Play and Reunion Percent of Change

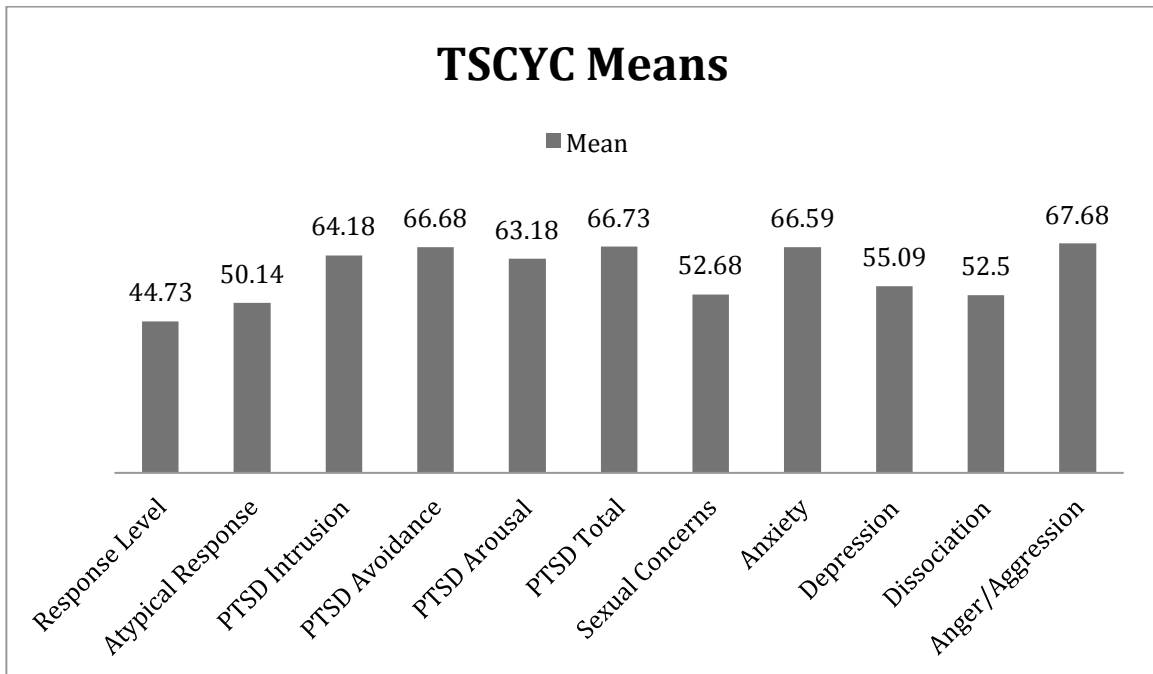


The above table displays the percentage of change for parent and child within the free play and reunion episodes of the Crowell Assessment. (P) Emo/Beh Responsiveness and (C) Emo/Beh Responsiveness are both part of the reunion, whereas the rest of the variables are from free play. For the most part, most individuals showed positive change on the various scales, including Parent Positive Affect (71.5%), Child Positive Affect (57.2%), and Child Enthusiasm (57.2%). However, there were three variables that showed no positive change, including Parent Anger/Hostility, Child Anxiety/Fear, and Child Aggression at Parent.

## Cleanup and Task Percent of Change



The above graph displays percentage of change for the cleanup and tasks episodes of the Crowell Assessment. Again, improvement was seen on many of the subscales, including Parent Behavioral Responsiveness (57.1%) and Child Non-Compliance (57.2%). Also again, improvement was not seen on a couple of subscales, including Child Anxiety and Fear and Child Aggression at Parent. However, in both cases, more individuals stayed that same (57.1% and 85.7%, respectively), than showed negative change (42.9% and 14.3%, respectively).



N = 22

The above graph displays the mean scores for the TSCYC. The TSCYC was implemented to assist in gaining a more detailed perspective of clinical trauma symptoms in children. The TSCYC has 11 subscales that are scored to determine whether an individual falls into a clinical range. Those scores that are greater than or equal to 70 are considered clinically significant. Those scales ranging from 65-69 are considered problematic.

## **Supervised Visitation**

### **Goal**

The goal of Supervised Visitation is to provide a safe place and a structured environment for children to visit and maintain a relationship with their non-custodial parent in a way that protects them from further abuse, neglect and conflict. Supervised Visitation is for families in which abuse or neglect has been alleged and there is a court order to conduct visits and exchanges under qualified supervision in a safe environment to protect children from further abuse or distress due to conflict in the family.

### **Purpose**

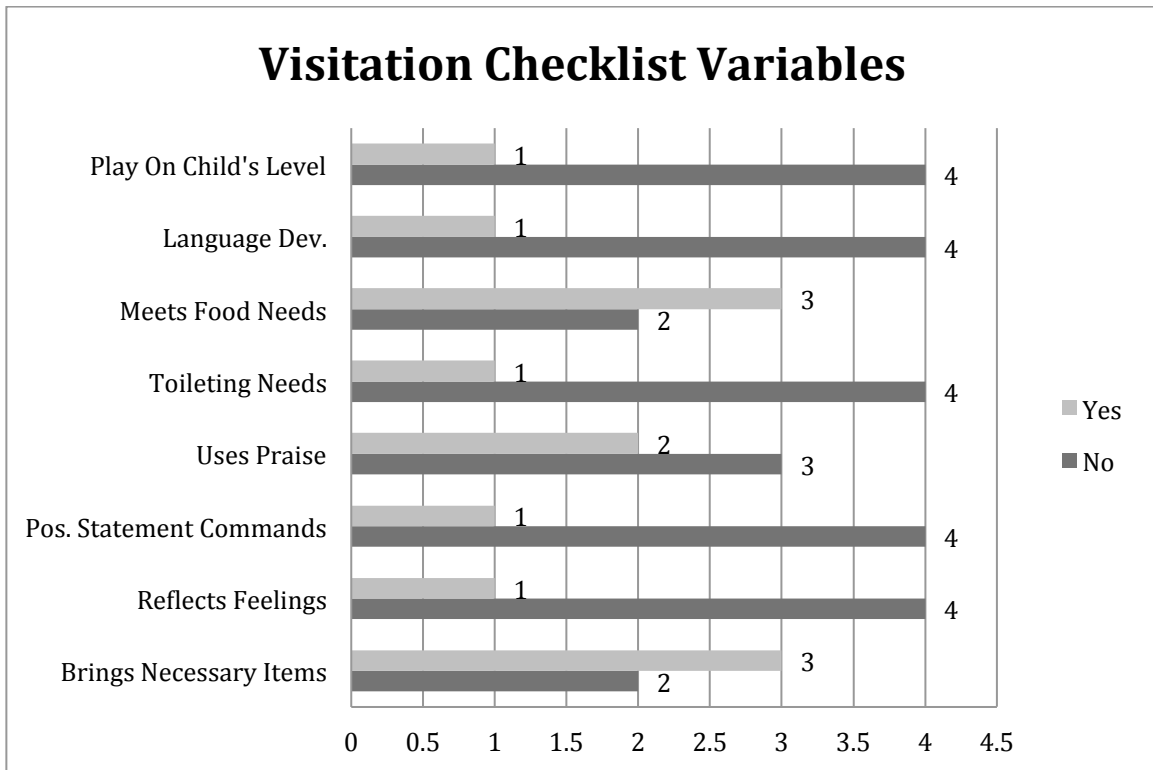
Supervised Visitation is in the preliminary stages of analysis. The purpose now and in the future will be to determine the usefulness of the current instruments being used and ways to improve data collection.

### **Procedure**

PCCT staff, when visiting families, fills out a Visitation Checklist, which contains a number of items concerned with the parent-child relationship and the ability of the parent to need the child's needs.

### **Instruments**

*Visitation Checklist* – The Visitation Checklist consists of two parts: a question concerning some aspect of the parent-child relationship and an indication as to who much intervention was needed to assist with that relationship.



N = 5 (number of people)

The above graph illustrates only those variables in which the specific behavior was not met 100% of the time. For the variable “Playing on the Child’s Level”, four out of five individuals demonstrated the identified target behavior. However, in terms of the variable “Meets Food Needs”, only two out of the five actually met this standard. Only three out of five were rated as using specific praise and two out of three bringing the necessary items to the visit.

#### Level of Involvement

Although there were times that individuals did not quite meet the objectives, the level of involvement needed to attain those goals never reached the intervention stage, in which the therapist would have to intervene between the parent and child. However, there were three times when the therapist had to facilitate. Once was for the Age-Appropriate Activities variable, while the other two were for “Meets Toileting Needs”. Overall, this can be considered to be successful, largely because the parents were displaying the behaviors the therapist was looking for and doing so without much involvement from the therapist.



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