CENTER OF APPLIED RESEARCH FOR NONPROFIT ORGANIZATIONS

The Parent Child Center of Tulsa

2016 Final Report

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Table of Contents

Executive Summary

Adult Treatment is a tertiary prevention program whose goal is to break the cycle of child abuse and neglect. The Adult Treatment program has shown consistently throughout 6 years to be effective in reducing the risk of child abuse and neglect. The paired samples t-test demonstrated positive change for empathy, corporal punishment, and oppression as evidence by statistical significance. Examining the different risk categories also showed a movement towards lower risk for those in high and moderate risk categories. Compassion Workshop, Responsibility Processing, and Nurturing Parenting all displayed an increase in knowledge gained through the program on the part of the participants, and that change was statistically significant. Overall, the program has shown remarkably consistent results throughout the years.

Child Therapy has a goal of improving the parent-child relationship, and providing the parent with strategies for dealing with their children's behaviors. Hope scores were not statistically significant. Using the Crowell assessment allows the team to observe the parent and child and provide suggestions on how to improve that relationship. Results from the Crowell Assessment showed some positive change, particularly with such variables as positive affect, intrusiveness, enthusiasm, and emotional responsiveness. There were several variables that were not statistically significant. With regards to the TSCYC, 1 out of 11 scales was statistically significant. Generally speaking, the number of those individuals in the clinical and problematic range on the TSCYC decreased. Overall, there are some positive outcomes with regards to the Child Therapy programs.

Healthy Families and Safe Care are a home visiting program that enrolls pregnant women and families with children up to one year old who are at moderate to high risk for abuse and neglect due to circumstances such as teen mother, single head of household, unemployment, lack of support system, or poverty. The goal of the Child Well-Being Scale is to measure a variety of areas related to child safety and protective factors. Note that because data was interpreted differently with regards to time points, that Healthy Families data is not comparable to SafeCare Data. With regards to Healthy Families on household sanitation, at baseline the majority of respondents were in the baseline time point with the majority (71%) having *appropriate* household sanitation. SafeCare found that 53% had *appropriate* household sanitation. Regarding Healthy Families on physical health care, at baseline 94% had *appropriate* care. SafeCare found that 87% had *appropriate* basic care. With regards to parental expectations of children in Healthy Families, 61% had *very realistic* expectations. SafeCare found that 38% had *very realistic* expectations.

Kids on the Block program has a goal to provide children of various ages the knowledge needed to deal with tough situations and the motivation to seek help when necessary. The results for the Kids on the Block program were consistently positive. Of all teaches who responded, 87% agreed that they would recommend the program to others. And 81% agreed that the performance was interesting while 83% agreed that it was developmentally appropriate. Teacher comments were also positive towards the program, both in terms of content of the program as well as the presentation itself. Overall, Kids on the Block received positive feedback from teachers.

Adult Treatment

Goal

Adult Treatment is a tertiary prevention program whose 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 future child abuse and neglect through parenting education.

Purpose

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

Procedure

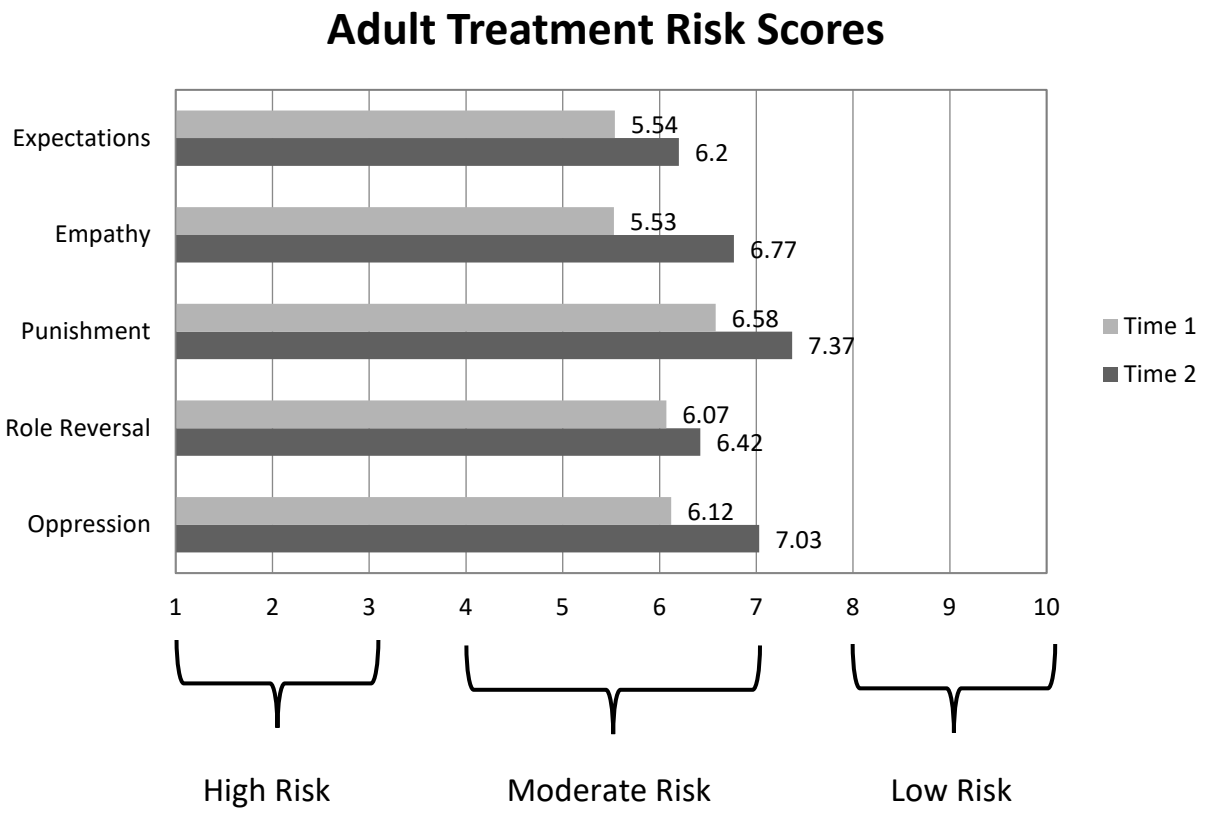
Upon entrance to the adult treatment program, participants are put in either the Compassion Workshop or the Responsibility Processing Group. Upon completion, participants will enter the Nurturing Parenting program, and when completed, will fill out the Adult-Adolescent Parenting Inventory (AAPI), which was also filled out upon entrance to the program. For this report, all of the data on the AAPI was collected in 2016 and analyzed to determine the effectiveness of the program over a longer period of time.

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. Risk scores of 1-3 are considered high risk, 4-7 are moderate risk, and 8-10 are low risk.

Knowledge Quizzes - The Parent Child Center also developed a knowledge quiz for both Compassion Workshop and Responsibility Processing. These quizzes are administered before the program begins and immediately after. The results are then analyzed to determine whether the change in correct scores was significant.

Graph 1: Adult Treatment Risk Scores



N= 137

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. 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 at time 1 are in the moderate risk category and show 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 Adult Adolescent Parenting Inventory (AAPI)

Table 1: What is the level of risk?

Construct	Time 1: Percentage of Clients in High or Moderate Risk Group	Time 2: Percentage of Clients in High or Moderate Risk Group	Time 1: Percentage of Clients in Low Risk Group	Time 2: Percentage of Clients in Low Risk Group
STEN A: Expectations of Children	82.5%	76.6%	17.5%	23.4%
STEN B: Empathy Towards Children's Needs	86.2%	53.3%	13.9%	46.7%
STEN C: Use of Corporeal Punishment as a Means of Discipline	67.9%	54.0%	23.6%	46.0%
STEN D: Parent-Child Role Responsibilities	70.8%	71.6%	29.2%	28.5%
STEN E: Children's Power and Independence	54.0%	72.2%	27.7%	46.0%

N=137

The preceding table examines what percentage of individuals moved from one risk category to another. 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, 86.2% of respondents at time 1 were considered high or moderate risk regarding empathy towards child's needs (construct B), but that percentage dropped to 53.3% at time 2. In addition, at time 1 only 13.9% of people were in the low risk group for use of corporeal punishment, while at time 2, that percentage rose to 46.7%. The only STEN that observed no positive change was the parent child role responsibilities (construct D).

Summary of Adult Adolescent Parenting Inventory (AAPI)

Table 2: Number of respondents in risk categories from time 1 to time 2

	High 1	High 2	Mod 1	Mod 2	Low 1	Low 2
Expectations	20	17	93	88	24	32
Empathy	22	12	96	61	19	64
Punishment	9	1	84	73	44	63
Role	18	16	79	82	40	39
Oppression	18	10	81	64	38	63

N=137

The above table displays the actual number of people in the high, moderate, and low risk groups at time 1 and time 2. For the high and moderate risk categories, the total number of respondents in each group decreased. The low risk group increased in total numbers from time 1 to time 2 in all categories except expectations, where it remained the same.

Summary of Adult Adolescent Parenting Inventory (AAPI)

How has risk changed across time? The following provides specifics of direction of change based upon their rating at time 1 to time 2 (N=137).

Construct A: Expectations of Children
High Risk (n=20): 50% improved to moderate or low risk, 50% stayed the same.
Moderate (n=93): 20% improved, 72% stayed the same, 8% moved to high risk.
Low (n=24): 46% stayed the same and 54% moved to moderate risk.

Construct B: Empathy Towards Children's Needs
High Risk (n=22): 59% improved to moderate or low risk, 41% stayed the same.
Moderate (n=96): 46% improved, 51% stayed the same, 3% moved to high risk.
Low (n=19): 84% stayed the same, 16% moved to moderate risk.

Construct C: Use of Corporal Punishment as a Means of Discipline
High Risk (n=9): 78% improved to moderate risk; 22% improved to low risk.
Moderate (n=79): 37% improved, 62% stayed the same, 1% moved to high risk.
Low (n=40): 68% stayed the same, 32% moved to moderate risk.

Construct D: Parent-Child Role Responsibilities
High Risk (n=18): 50% improved to moderate or low risk, 50% stayed the same.
Moderate (n=79): 21% improved, 70% stayed the same, 9% moved to high risk.
Low (n=40): 55% stayed the same, 45% moved to moderate risk.

Construct E: Children's Power and Independence
High Risk (n=18): 67% improved to moderate risk or low risk, 33% stayed the same.
Moderate (n=81): 43% improved, 52% stayed the same, 5% moved to high risk.
Low (n=38): 46% stayed the same, 47% moved to moderate, 7% moved to high risk

Thus, for Construct A, of those identified as high risk, 50% improved to the moderate or low risk group, and of those in the low-risk category, 46% stayed the same and 54% moved to moderate risk. For Construct C, 100% of those identified as high-risk improved, while 37% of those in the moderate group improved, and of those identified as low-risk, 68% stayed the same and 32% moved to moderate risk. Construct E also showed improvement, with 67% of those in the high-risk group moving to the moderate or low risk group, while 43% 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. 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 time 1 to time 2 is statistically significant. As the table below displays, positive change was seen in all categories, which was statistically significant. See the table below for further description.

Table 3: Significance of mean change from time 1 to time 2

	Variable	N	Mean 1	Mean 2	t	Sig.
Construct A	Expectations	137	5.54	6.20	-3.86	.000***
Construct B	Empathy	137	5.53	6.77	-6.27	.000***
Construct C	Punishment	137	6.58	7.37	-5.17	.000***
Construct D	Role Reversal	137	6.07	6.42	-2.06	.04*
Construct E	Oppression	137	6.12	7.03	-4.51	.000***

Levels of significance:
*p < .05, ** p < .01, *** p < .001

The goal of adult treatment is to decrease caregiver risk. The data presented for AAPI scores show that this goal is being achieved for those in the high risk and moderate risk categories. The next page displays the paired-samples t-test for each year from 2009-2015.

Paired Samples T-Test (split by year)

The following tables show the results of the paired-samples t-test for each year from 2009-2015. The year 2009 only has nine individuals in the sample, which reduces the likelihood of significance from the start.

Table 4.1: Significance of mean change from time 1 to time 2 **(2009)**

	Variable	N	Mean 1	Mean 2	Difference	Sig.
Construct A	Expectations	9	6.67	7.89	1.222	.023*
Construct B	Empathy	9	5.11	6.11	3.082	.359
Construct C	Punishment	9	6.00	6.22	1.394	.645
Construct D	Role Reversal	9	6.00	6.67	1.936	.332
Construct E	Oppression	9	5.89	6.22	2.739	.724

Table 4.2: Significance of mean change from time 1 to time 2 **(2010)**

	Variable	N	Mean 1	Mean 2	Difference	Sig.
Construct A	Expectations	150	5.22	6.04	.820	.000*
Construct B	Empathy	150	4.80	6.37	1.573	.000*
Construct C	Punishment	150	5.98	7.01	1.033	.000*
Construct D	Role Reversal	150	5.71	6.39	.687	.000*
Construct E	Oppression	150	5.55	6.43	873	.000*

Table 4.3: Significance of mean change from time 1 to time 2 **(2011)**

	Variable	N	Mean 1	Mean 2	Difference	Sig.
Construct A	Expectations	172	5.27	6.08	.808	.000*
Construct B	Empathy	172	5.21	6.93	1.721	.000*
Construct C	Punishment	172	6.01	7.38	1.378	.000*
Construct D	Role Reversal	172	5.90	6.63	.733	.000*
Construct E	Oppression	172	5.65	6.90	1.256	.000*

Table 4.4: Significance of mean change from time 1 to time 2 **(2012)**

	Variable	N	Mean 1	Mean 2	Difference	Sig.
Construct A	Expectations	129	5.60	6.29	.690	.001*
Construct B	Empathy	129	5.49	6.83	1.341	.000*
Construct C	Punishment	129	6.60	7.47	.876	.000*
Construct D	Role Reversal	129	6.12	6.68	.558	.002*
Construct E	Oppression	129	6.21	7.03	.822	.000*

Table 4.5: Significance of mean change from time 1 to time 2 **(2013)**

	Variable	N	Mean 1	Mean 2	Difference	Sig.
Construct A	Expectations	96	5.24	6.05	.813	.000*
Construct B	Empathy	96	5.09	6.31	1.219	.000*
Construct C	Punishment	96	6.13	7.20	1.073	.000*
Construct D	Role Reversal	96	5.81	6.30	.490	.021*
Construct E	Oppression	96	6.08	6.50	.417	.109

Table 4.6: Significance of mean change from time 1 to time 2 **(2014)**

	Variable	N	Mean 1	Mean 2	Difference	Sig.
Construct A	Expectations	172	5.28	5.88	0.6	.000***
Construct B	Empathy	172	5.24	6.34	1.10	.000***
Construct C	Punishment	172	6.28	7.30	0.98	.000***
Construct D	Role Reversal	172	5.70	6.20	0.50	.000***
Construct E	Oppression	172	6.28	6.68	0.40	.052

Table 4.7: Significant of mean change from time 1 to time 2 **(2015)**

	Variable	N	Mean 1	Mean 2	t	Sig.
Construct A	Expectations	178	5.67	5.90	-1.57	.12
Construct B	Empathy	178	5.31	6.56	-7.891	.000***
Construct C	Punishment	178	6.30	7.33	-8.36	.000***
Construct D	Role Reversal	178	6.24	6.41	-1.30	.194
Construct E	Oppression	178	6.08	6.56	-2.69	.008**

As the above tables illustrate, and with the exception of the year 2009, there is statistically significant change consistently throughout the last 6 years. Oppression scores in 2013 and 2014 were not statistically significant. In 2015, expectations and role reversal were not statistically significant. Overall, the program has been consistent on an annual basis in reducing risk scores as evidenced by the paired samples analyses.

Knowledge Quizzes

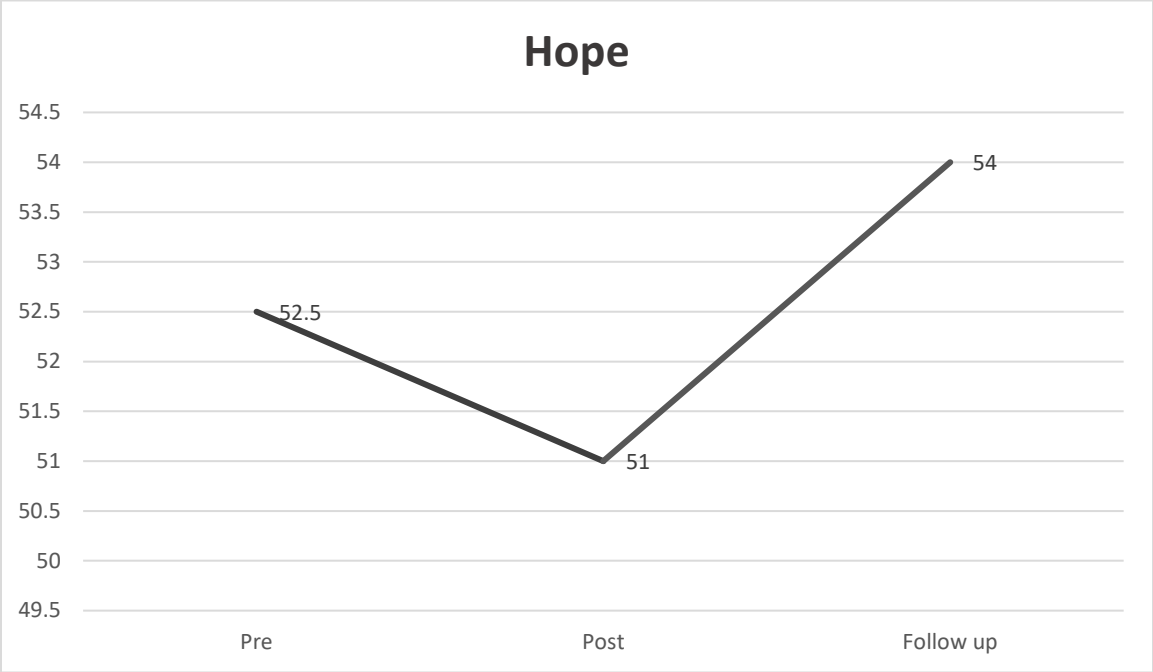
Participants in the adult treatment program go through one of two initial groups, Compassion Workshop or Responsibility Processing, and then continue on to the Nurturing Parenting group. The t-test analysis examined the correct responses at time 1 with time 2 to determine whether the increase in correct responses was significant and indicative of an increase in knowledge. The table below is similar to the tables from the previous pages, which show the mean score pre and post, the change in the mean scores, and whether this change was significant. The sample for the quizzes only includes participants from 2016.

Table 5: Significance of mean change from time 1 to time 2 for all three groups

Variable	N	Mean 1	Mean 2	Difference	Sig.
Compassion Workshop	76	20.43	22.64	-2.21	.000*
Responsibility Processing	121	21.43	22.93	-1.50	.000*
Nurturing Parenting	99	18.08	21.31	-3.23	.000*

Table 5 presents findings from the t-test analyses. As can be seen, the number of correct responses from time 1 to time 2 changed in a statistically significant way, indicating that those going through the program are displaying an increase in knowledge of the presented material.

Graph 2: Adult Hope Means



N=23

The preceding graph shows Hope scores for pre, post, and follow up after participating in parenting classes. Between pre and posttests, scores decreased; however, they increased again at follow up to higher than the pre-test. None of the changes between time points were statistically significant [$F(2, 22) = 2.67$; $p > .05$].

Summary

The Adult Treatment program has shown consistently throughout 6 years to be effective in reducing the risk of child abuse and neglect. The paired samples t-test demonstrated positive change for empathy, corporal punishment, expectations, role reversal, and oppression as evidenced by statistical significance. Examining the different risk categories also showed a movement towards lower risk for those who had scored as high risk during time 1; however, people who were low risk during time 1 sometimes moved into the moderate risk category during time 2. Compassion Workshop, Responsibility Processing, and Nurturing Parenting all displayed an increase in knowledge gained through the program on the part of the participants, and that change was statistically significant. Overall, the program has demonstrated positive results this year and throughout the years studied.

Child Therapy

Goal

The Parent Child Center of Tulsa 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, 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. For the latter, the child therapy services for children age 6-12 include a combination of individual and family therapy interventions to help children and families heal and improve their relationships with one another. PCCT 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 parent and child.

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 is administered every six months, as is the Hope Scale.

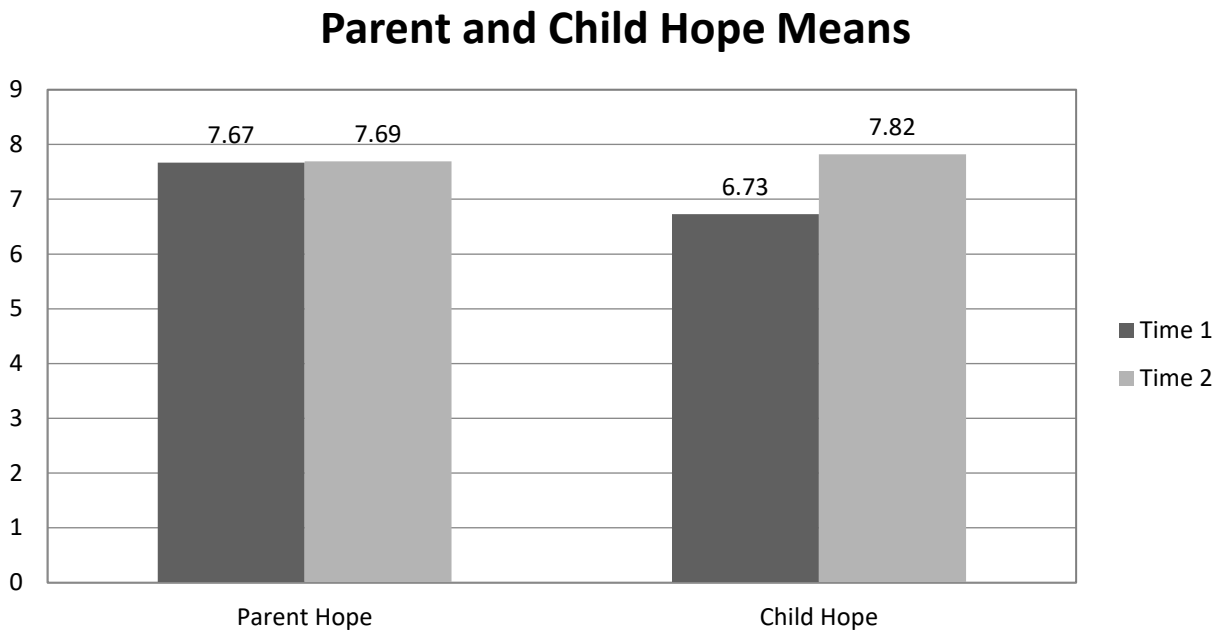
Instruments

Hope Scale – The Hope scale was designed by Snyder (2002) and consists of eight items and has two subscales (pathways and agency). A total score is also calculated. It is administered every 6 months.

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 assessment observations are videotaped and scored by trained staff at PCCT. The Crowell is designed for use with children aged 0-5.

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. This measurement is used with children aged 6-12.

Graph 3: Parent and Child Hope Means



The above graph illustrates the mean scores for parent and child hope. Parent hope increased slightly from 7.67 to 7.69, while child hope increased from 6.73 to 7.82. Higher scores indicate higher total hope. T-test were used to compare differences in mean scores for measurement one and measurement two. The change in scores for Child Hope was significant. The table below presents data with regards to the t-tests.

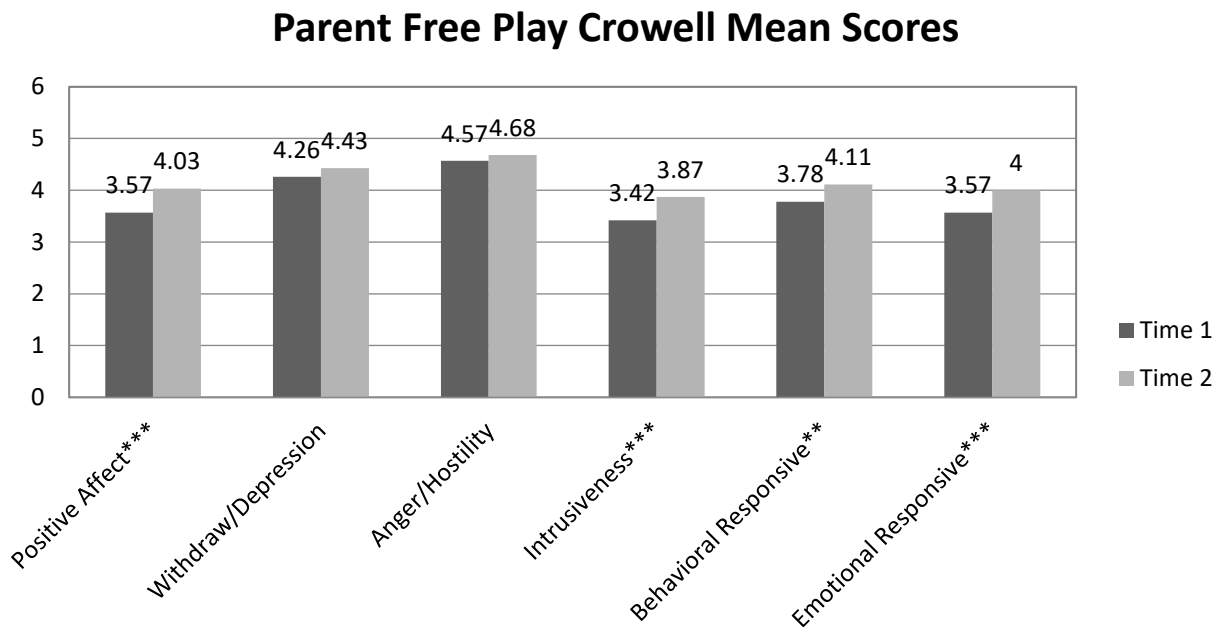
Parent and Child Hope Paired-Samples T-Test

Table 6: One-Sample T-Test Statistics

Quiz	N	Mean 1	Mean 2	Difference	Sig.
Parent Hope	51	7.67	7.69	.02	.923
Child Hope	51	6.73	7.82	1.09	.000*

As can be seen in the above table, the differences in parent hope from time 1 to time 2 was *not* statistically significant, but the differences between child hope was **statistically significant.**

Graph 4: Parent Free Play Crowell Mean Scores



n=76

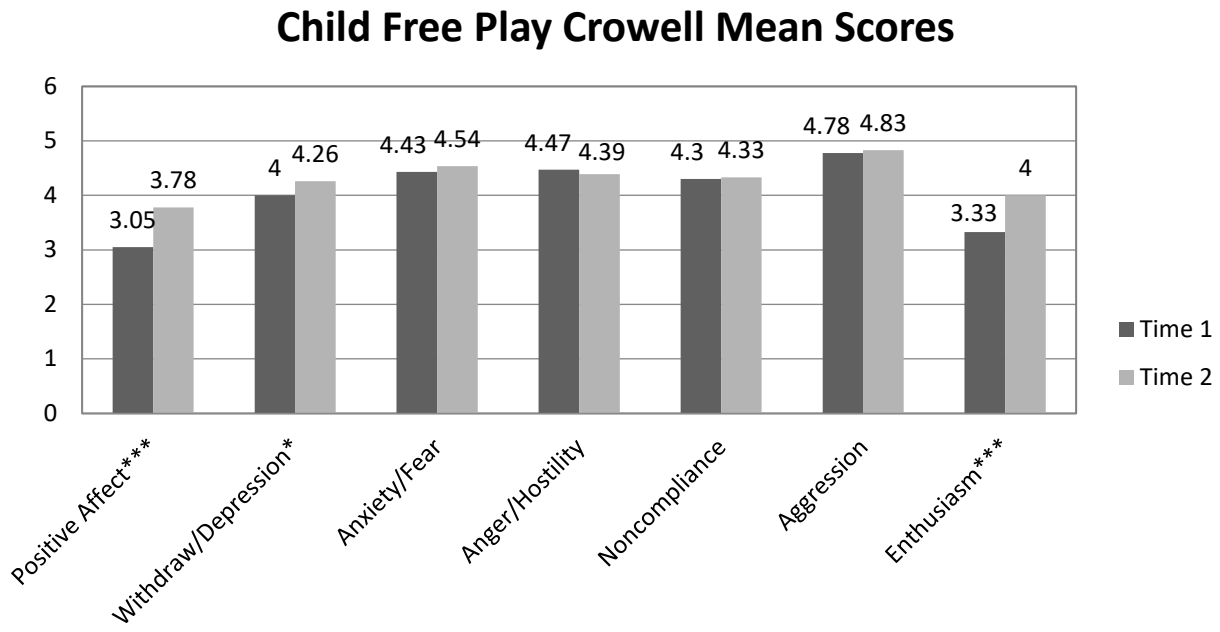
The preceding graph presents mean scores for the Parent Free Play/Reunion on the Crowell assessment. T-test analyses were used to compare differences in mean scores for measurement one and measurement two. There was a statistically significant difference between Crowell scores for Positive Affect, Intrusiveness, Behavioral Responsiveness, and Emotional Responsiveness. See Table 8 for additional quantitative information.

Table 8: Significance of mean change from time 1 to time 2

	Subject	Variable	N	Mean 1	Mean 2	t	Sig.
Free Play	Parent	Positive Affect	76	3.57	4.03	-4.189	.000***
Free Play	Parent	Withdraw/Depression	76	4.26	4.43	-1.778	.080
Free Play	Parent	Anger/Hostility	76	4.57	4.68	-1.217	.227
Free Play	Parent	Intrusiveness	76	3.42	3.87	-3.906	.000***
Free Play	Parent	Behavioral Responsive	76	3.78	4.11	-3.039	.003**
Free Play	Parent	Emotional Responsive	76	3.57	4	-3.900	.000***

Levels of significance:
*p < .05
** p < .01
*** p < .001

Graph 5: Child Free Play Crowell Mean Scores



n = 76

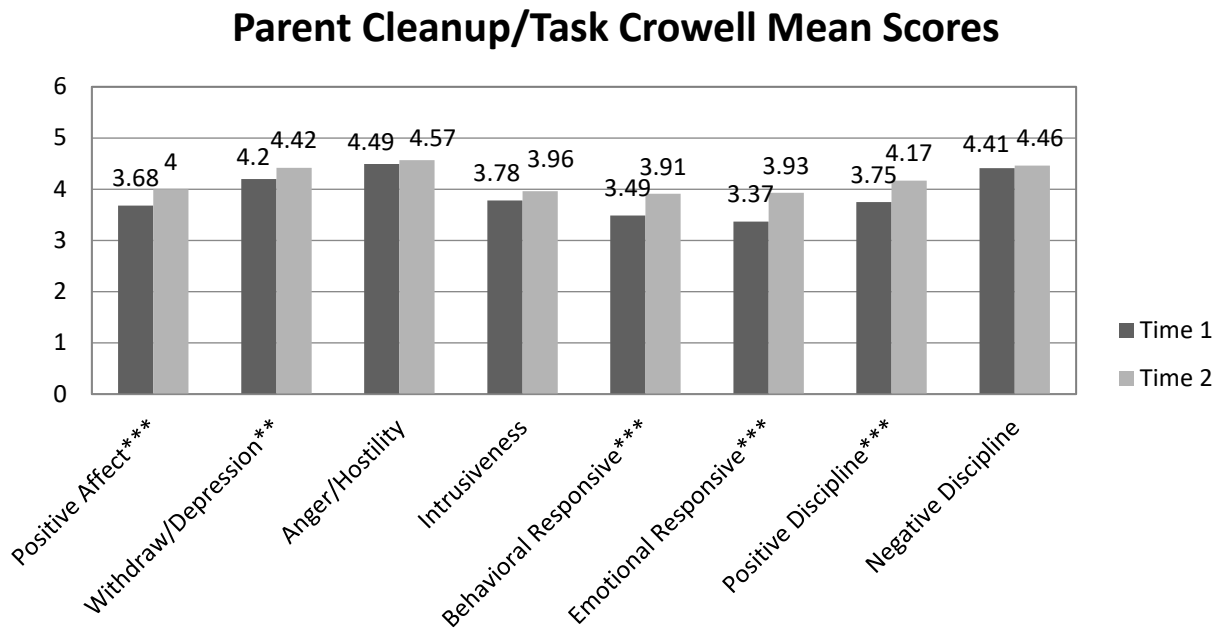
The above graph presents mean scores for the Child Free Play on the Crowell assessment. T-test analyses were used to compare differences in mean scores for measurement one and measurement two. There was a statistically significant difference between Crowell scores for Positive Affect, Withdraw/Depression, and Enthusiasm. Positive change was observed for all statistically significant findings. See Table 9 for additional quantitative information.

Table 9: Significance of mean change from time 1 to time 2

	Subject	Variable	N	Mean 1	Mean 2	T	Sig.
Free Play	Child	Positive Affect	76	3.05	3.78	-6.301	.000***
Free Play	Child	Withdraw/Depression	76	4.00	4.26	-2.432	.017*
Free Play	Child	Anxiety/Fear	76	4.43	4.54	-1.033	.305
Free Play	Child	Anger/Hostility	76	4.47	4.39	.800	.426
Free Play	Child	Noncompliance	76	4.30	4.33	-.238	.813
Free Play	Child	Aggression	76	4.78	4.83	-.705	.483
Free Play	Child	Enthusiasm	76	3.33	4.00	-6.394	.000***

Levels of significance:
*p < .05
** p < .01
*** p < .001

Graph 6: Parent Task Crowell Mean Scores



n = 76

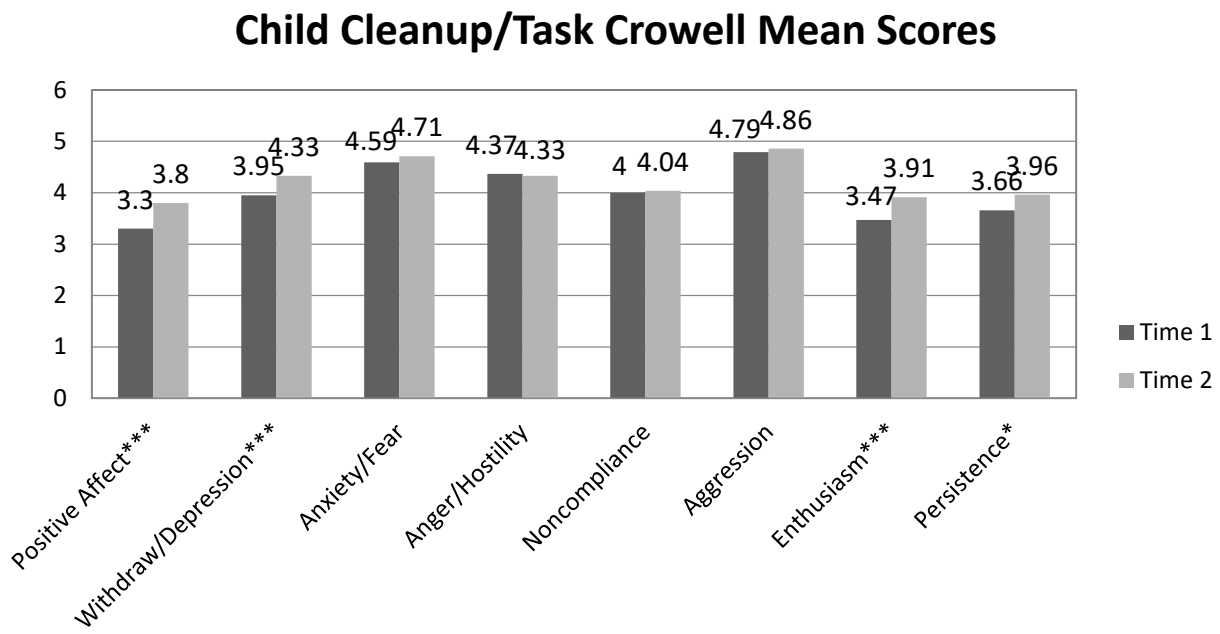
The above graph presents mean scores for the Parent Cleanup/Task on the Crowell assessment. T-test analyses were used to compare differences in mean scores for measurement one and measurement two. There was a statistically significant difference between Crowell scores for Positive Affect, Withdraw/Depression, Behavioral Responsiveness, Emotional Responsiveness, and Positive Discipline. See Table 10 for additional quantitative information.

Table 10: Significance of mean change from time 1 to time 2

	Subject	Variable	N	Mean 1	Mean 2	t	Sig.
Free Play	Parent	Positive Affect	76	3.68	4.00	-3.845	.000**
Free Play	Parent	Withdraw/Depression	76	4.20	4.42	-2.847	.009*
Free Play	Parent	Anger/Hostility	76	4.49	4.57	-.830	.330
Free Play	Parent	Intrusiveness	76	3.78	3.96	-1.505	.230
Free Play	Parent	Behavioral Responsive	76	3.49	3.91	-3.957	.000***
Free Play	Parent	Emotional Responsive	76	3.37	3.93	-5.484	.000***
Free Play	Parent	Positive Discipline	76	3.75	4.17	-3.957	.000***
Free Play	Parent	Negative Discipline	76	4.41	4.46	-.587	.559

Levels of significance:
*p < .05
** p < .01
*** p < .001

Graph 7: Child Task Crowell Mean Scores



n = 73

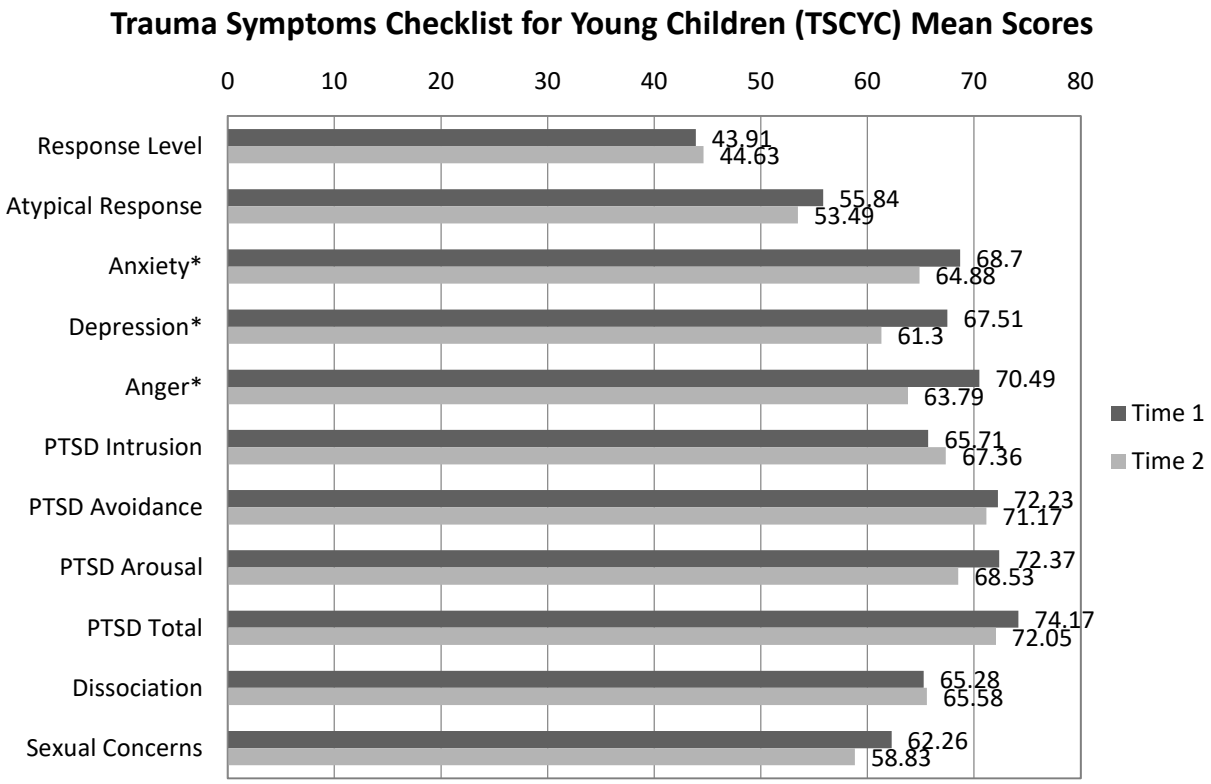
The above graph presents mean scores for the Child Cleanup/Task on the Crowell assessment. T-test analyses were used to compare differences in mean scores for measurement one and measurement two. There was a statistically significant difference between Crowell scores for Positive Affect, Withdraw/Depression, Enthusiasm, and Persistence. Positive change was observed for all statistically significant findings. See Table 10 for additional quantitative information.

Table 11: Significance of mean change from time 1 to time 2

	Subject	Variable	N	Mean 1	Mean 2	T	Sig.
Free Play	Child	Positive Affect	76	3.30	3.80	-4.302	.000***
Free Play	Child	Withdraw/Depression	76	3.95	4.33	-3.661	.000***
Free Play	Child	Anxiety/Fear	76	4.59	4.71	-1.452	.151
Free Play	Child	Anger/Hostility	76	4.37	4.33	.340	.735
Free Play	Child	Noncompliance	76	4.00	4.04	-.344	.732
Free Play	Child	Aggression	76	4.79	4.86	-.820	.415
Free Play	Child	Enthusiasm	76	3.47	3.91	-4.141	.000***
Free Play	Child	Persistence	76	3.66	3.96	-2.492	.015*

Levels of significance:
*p < .05
** p < .01
*** p < .001

Graph 8: Trauma Symptoms Checklist



n = 42-43

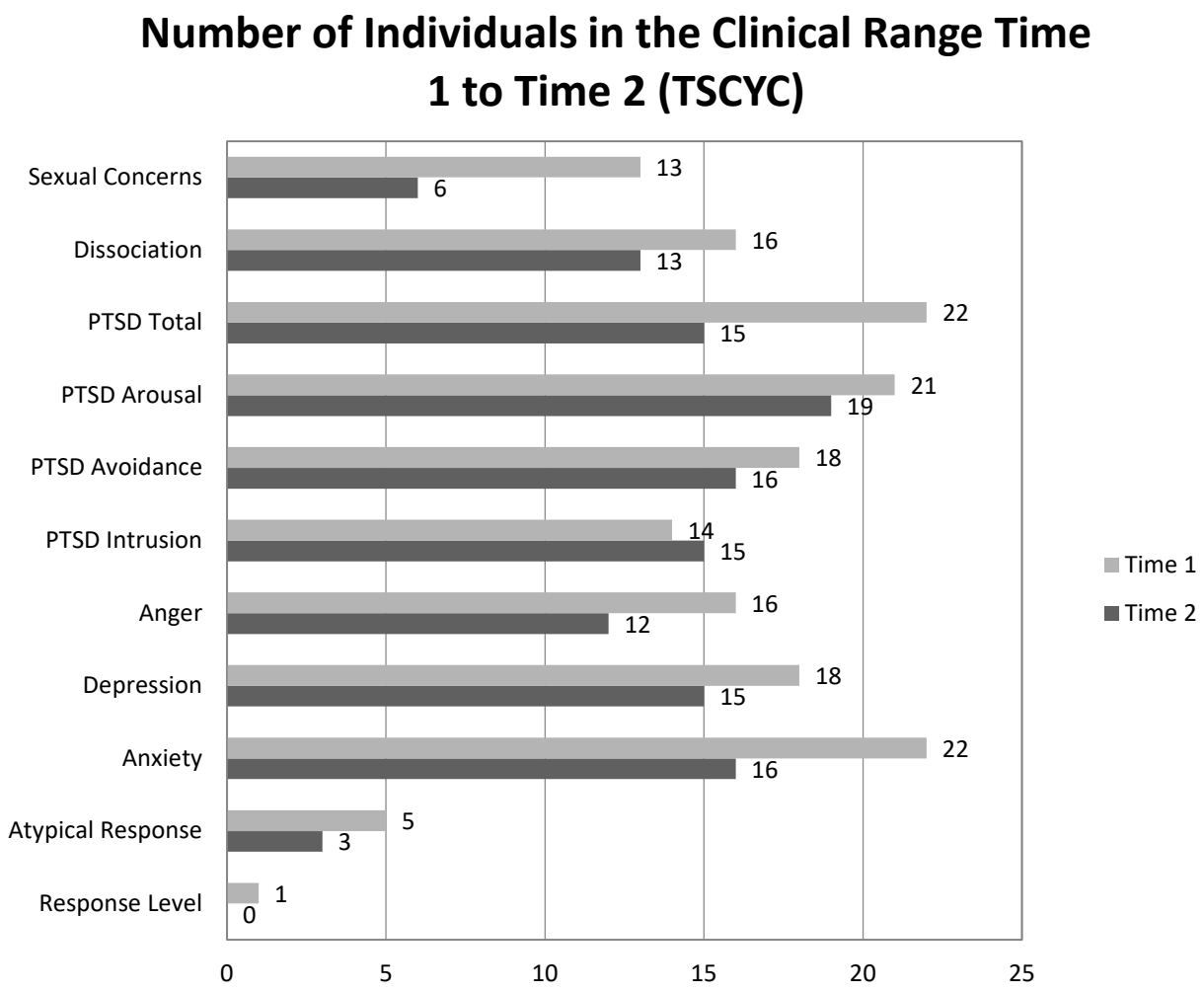
Graph 7 presents scores for the TSCYC. The TSCYC has 11 subscales that are scored to determine whether an individual falls into a clinical range. T-test analyses were used to compare differences in mean scores for time 1 and time 2. There was a statistically significant difference between scores for Anxiety, Depression, and Anger. See Table 12 for additional information.

Table 12: Significance of mean change from time 1 to time 2

Variable	N	Mean 1	Mean 2	t	Sig.
Response Level	43	43.91	44.63	-.819	.418
Atypical Response	43	55.84	53.49	1.232	.225
Anxiety	43	68.7	64.88	2.058	.046*
Depression	43	67.51	61.3	3.463	.001*
Anger	43	70.49	63.79	2.877	.006*
PTSD Intrusion	42	65.71	67.36	-.636	.528
PTSD Avoidance	42	72.05	71.17	.303	.763
PTSD Arousal	43	72.37	68.53	1.901	.064
PTSD Total	42	74.17	72.05	1.078	.287
Dissociation	43	65.28	65.58	-.106	.916
Sexual Concerns	42	62.26	58.83	1.605	.116

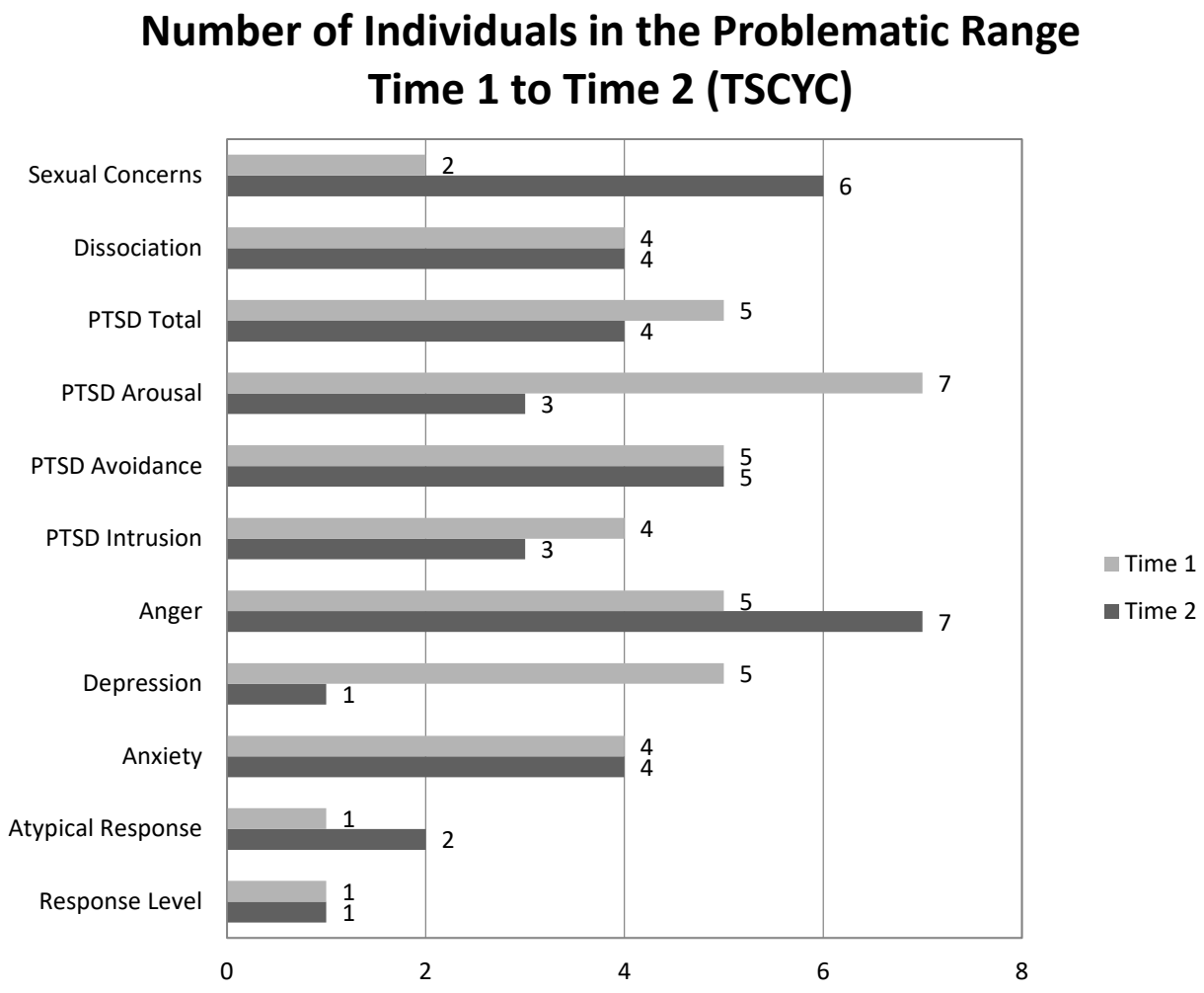
Levels of significance: *p < .05

Graph 9: Number of Individuals in the Clinical Range



As presented in Graph 8, 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. Scores can range from 35 to 110. The above graph displays the number of individuals with scores in the clinical (70 or greater) at time 1 and time 2. All scales saw a decrease in the number of individuals meeting a clinical score except for PTSD Intrusion, which increased by one person.

Graph 10: Number of Individuals in the Problematic Range



The above graph displays the number of individuals with scores in the TSCYC problematic (65-69) range at time 1 to time 2. A few scales saw an increase in individuals in the problematic range: Sexual concerns, Anger, and Atypical response.

Summary

Child Therapy has a goal of improving the parent-child relationship, and providing the parent with strategies for dealing with their children's behaviors. Using the Crowell assessment allows the team to observe the parent and child and provide suggestions on how to improve that relationship. Results from the Crowell Assessment showed some positive change, particularly with such variables as withdrawn/depression, positive effect, emotional responsiveness, behavioral responsiveness, and enthusiasm. There were several variables that were not statistically significant. With regards to the TSCYC, 3 out of 11 scales was statistically significant (anxiety, depression, and anger). Generally speaking, the number of those individuals in the clinical and problematic range on the TSCYC decreased. Overall, there are some positive outcomes with regards to the Child Therapy programs.

Healthy Families and Safecare

Goal

Healthy Families (HF) enrolls pregnant women and families with children up to one year old who are at moderate to high risk for abuse and 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.

SafeCare (SC) is a program for high-risk families that 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 these departments is to determine the degree to which individuals progressed every six months on a number of different skill sets.

Procedure

Primary caregivers complete all ten subscales on the HFPI every six months. The family support worker also fills out two scales on the HFPI, the Parent-Child Behavior scale and the Home Environment Scale, every six months. These scores are entered into a database that is then transferred to SPSS, quantitative data software, for analysis.

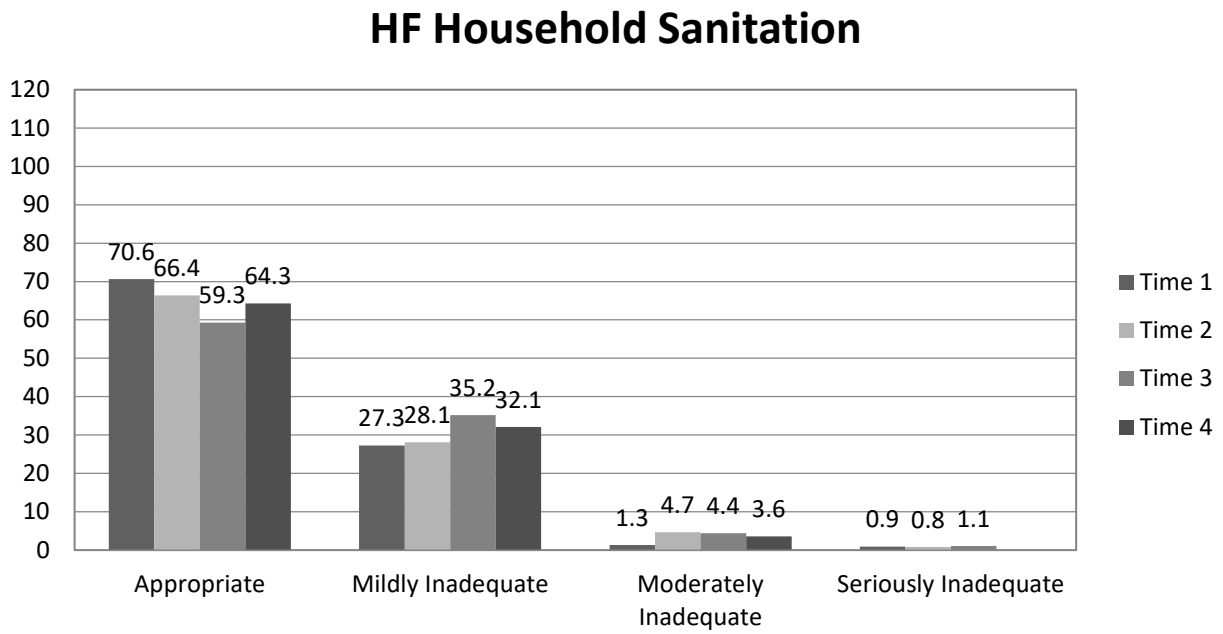
Instruments

Child Well-Being Scales (CWBS) – The CWBS is comprised of multiple variables. For purpose of this report, 6 will be reported. Its goal is to measure a variety of areas related to child safety and protective factors. Healthy Families administered the CWBS at the given chronological age of the child (i.e. infant, 6 months, 12 months, 18 months, etc.). SafeCare administered the CWBS at intake, then every 6 months. Thus, data is presented separately since time points are interpreted differently for each program.

Hope Scale – The Hope scale was designed by Snyder (2002) and consists of eight items and has two subscales (pathways and agency). A total score is also calculated.

The first set of graphs present CWBS findings from the Healthy Families (HF) program. SafeCare (SC) findings are presented thereafter.

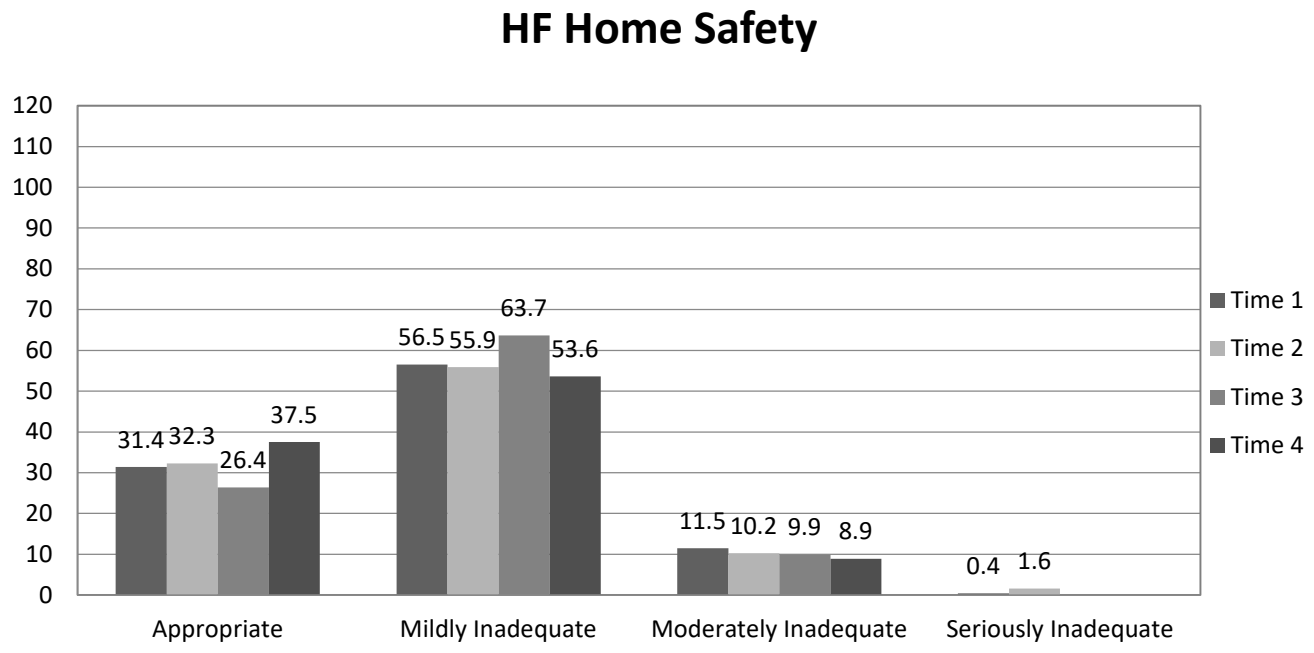
Graph 11: HF Household Sanitation



N=56-231

Graph 11 illustrates the number of respondents in each timeframe regarding household sanitation. The majority (71% time 1; 66% time 2; 59% time 3; 64% time 4) of respondents had appropriate household sanitation.

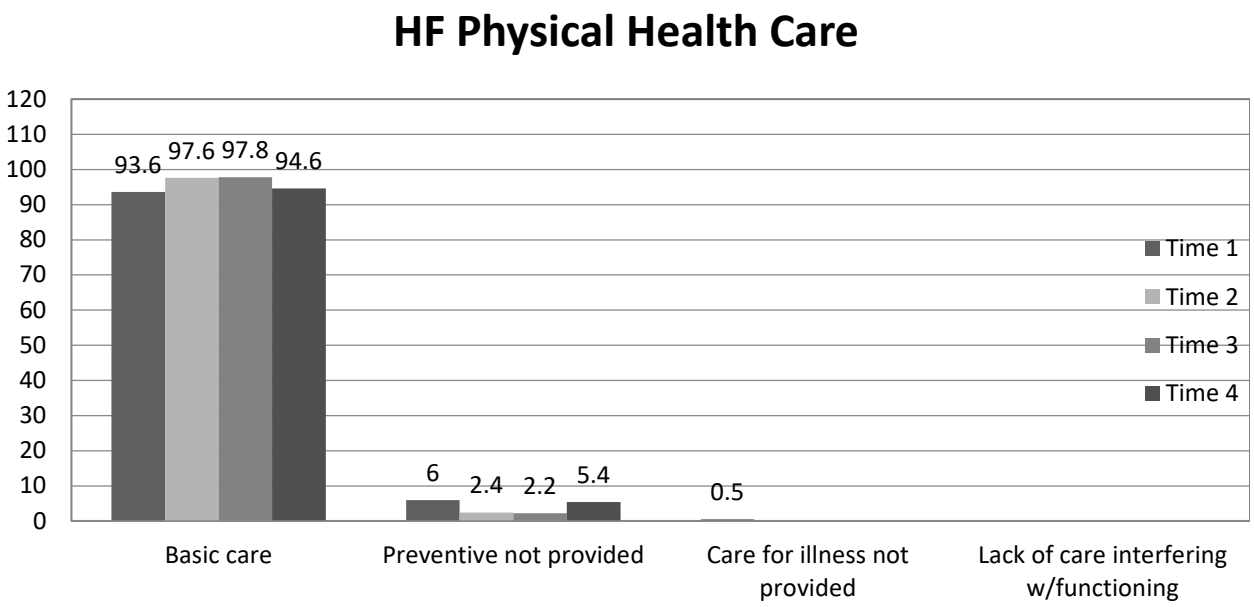
Graph 12: HF Home Safety



N=56-226

Graph 13 illustrates the number of respondents in each timeframe regarding home safety. The majority (57% time 1; 56% time 2; 64% time 3; and 54% time 4) of respondents had mildly inadequate home safety.

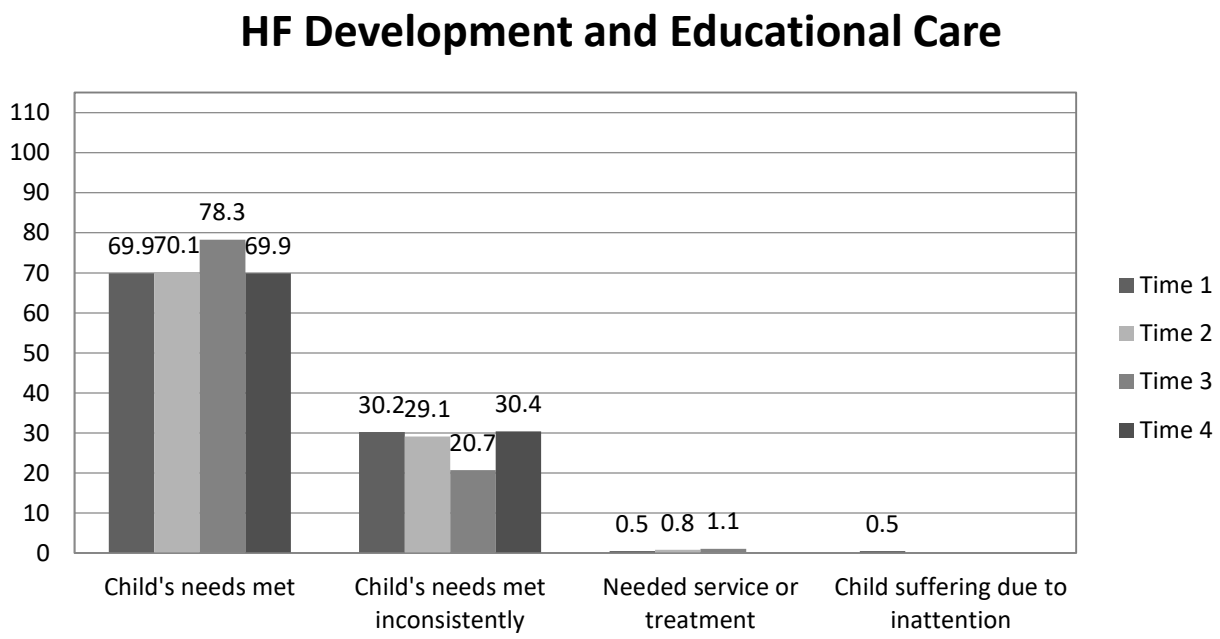
Graph 13: HF Physical Health Care



N=56-218

Graph 13 illustrates the number of respondents in each timeframe regarding physical health care. The majority (94% time 1; 98% time 2; 98% time 3; and 95% time 4) of respondents had appropriate physical health care.

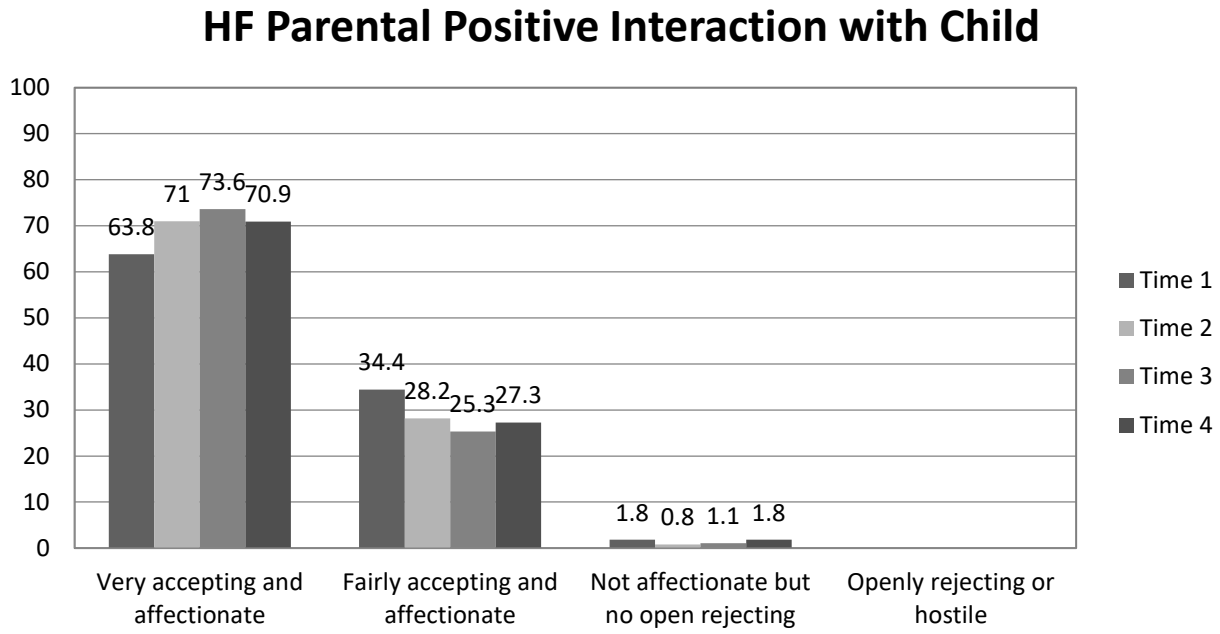
Graph 14: HF Development and Educational Care



N=56-212

The above graph illustrates the number of respondents in each timeframe regarding developmental and educational care. The majority (70% time 1; 70% time 2; 78% time 3; and 70% time 4) of respondents were meeting their child's developmental and educational needs.

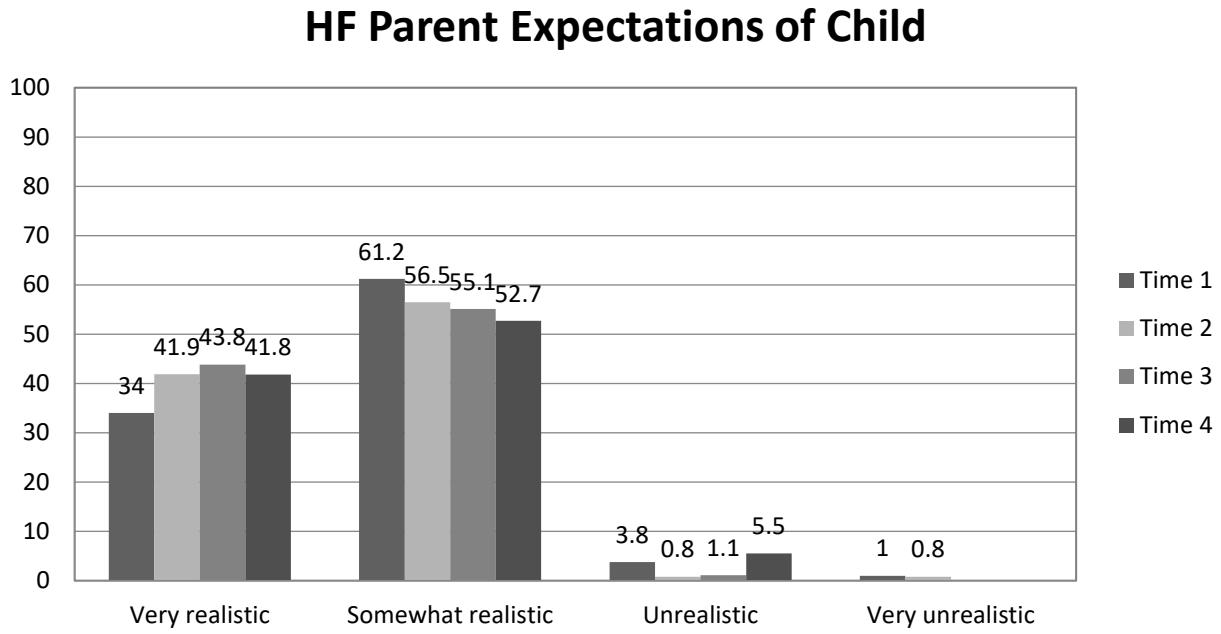
Graph 15: HF Parental Positive Interaction with Child



N=55-218

Graph 15 illustrates the number of respondents in each timeframe regarding parental positive interaction with child. The majority (64% time 1; 71% time 2; 74% time 3; and 71% time 4) of respondents had very accepting and affections interactions with their child.

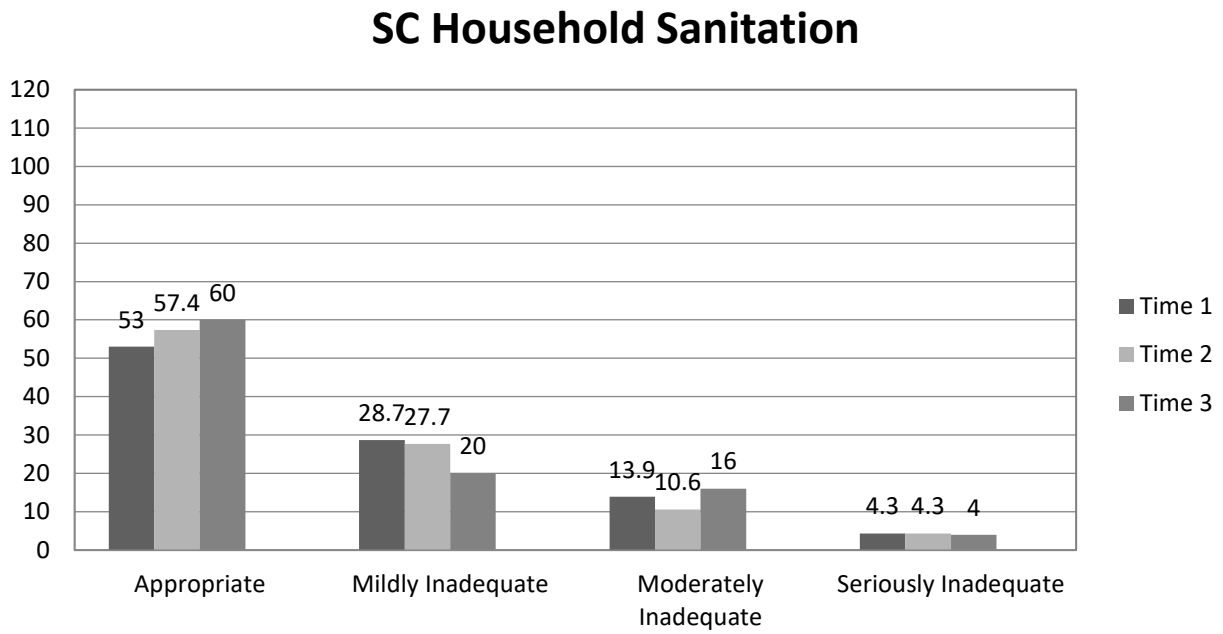
Graph 16: HF Parent Expectations of Child



N=55-209

The above graph illustrates the number of respondents in each timeframe regarding parent expectations of child. The majority or a little more than half of parents had somewhat realistic expectations for their child (61% time 1; 57% time 2; 55% time 3; and 53% time 4)

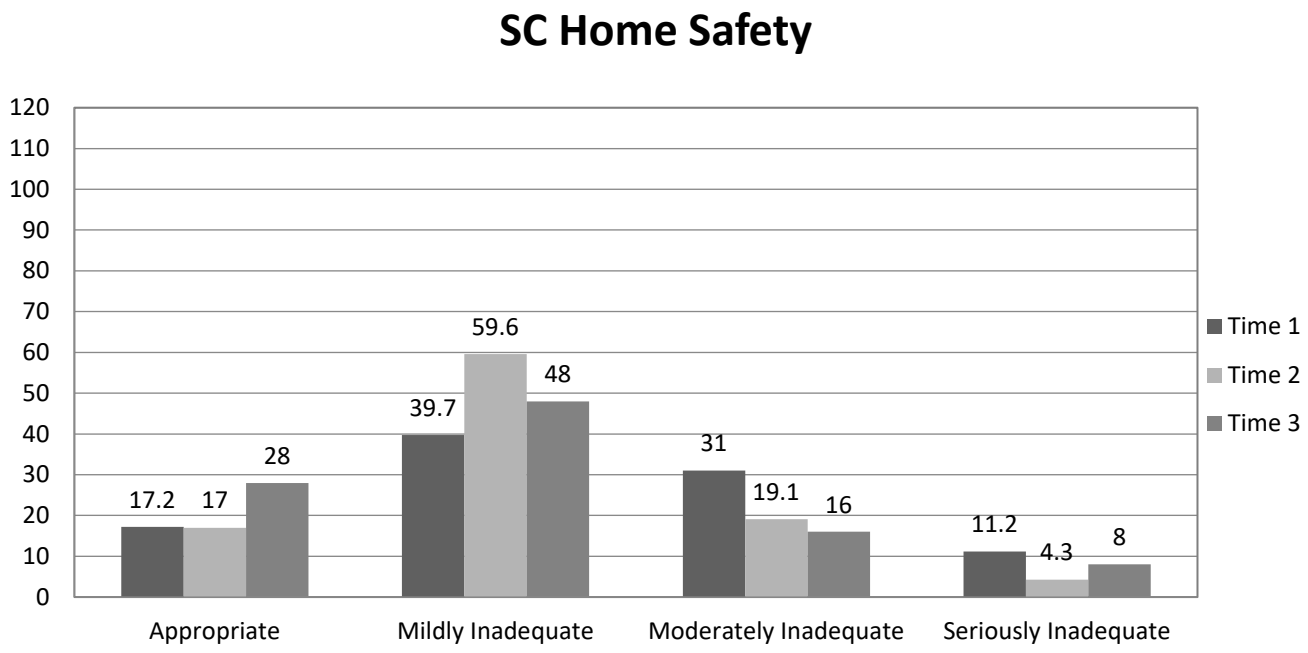
Graph 17: SC Household Sanitation



N=25-115

Graph 17 illustrates the number of respondents in each timeframe regarding household sanitation. The majority (53% time 1; 57% time 2; 60% time 3) of respondents had appropriate household sanitation.

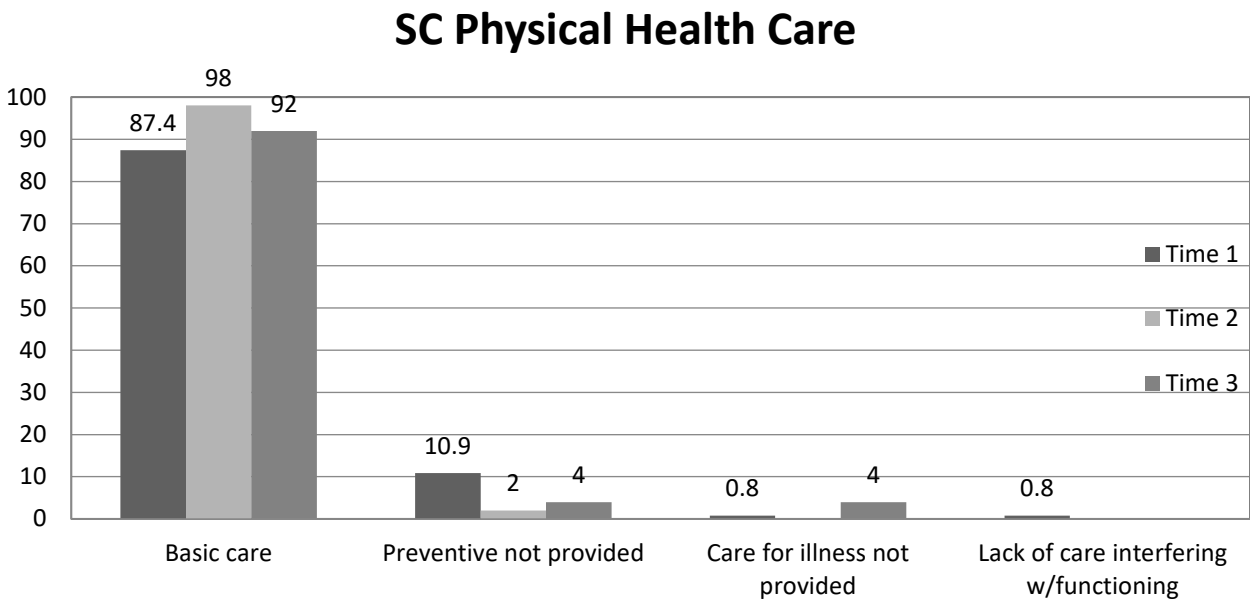
Graph 18: SC Home Safety



N=25-116

Graph 18 illustrates the number of respondents in each timeframe regarding home safety. There were improvements in those respondents who had appropriate or mildly inadequate home safety. Time 1 showed only 17.2% of respondents had appropriate home safety; at Time 3, that number rose to 28%.

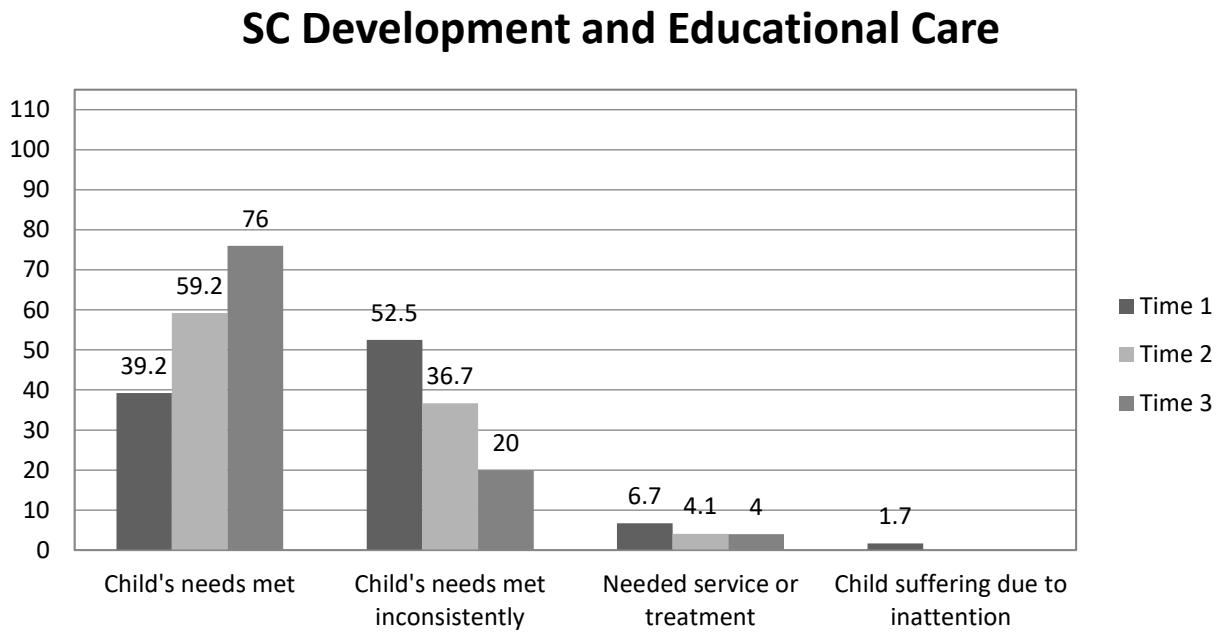
Graph 19: SC Physical Health Care



N=25-119

Graph 19 illustrates the number of respondents in each timeframe regarding physical health care. The majority (87% time 1; 98% time 2; and 92% time 3) of respondents provided appropriate physical health care.

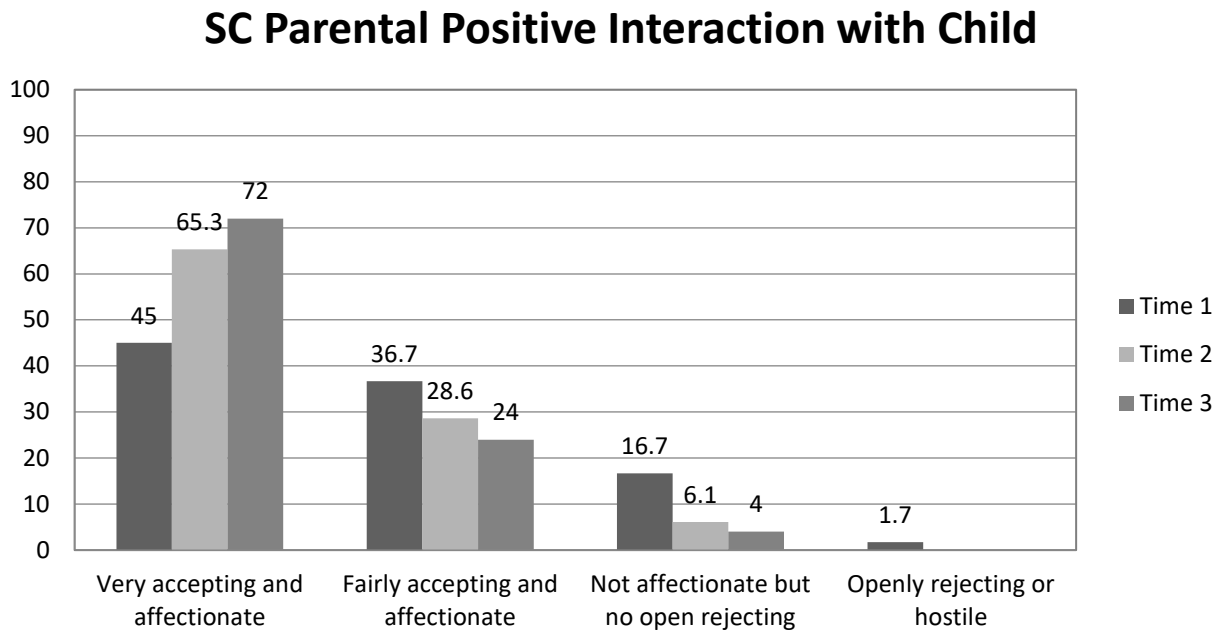
Graph 20: SC Development and Educational Care



N=25-120

The above graph illustrates the number of respondents in each timeframe regarding developmental and educational care. There were improvements in those respondents who were meeting their child's needs. Time 1 showed only 39.2% of respondents were meeting their child's needs; at Time 3, that number rose to 76%.

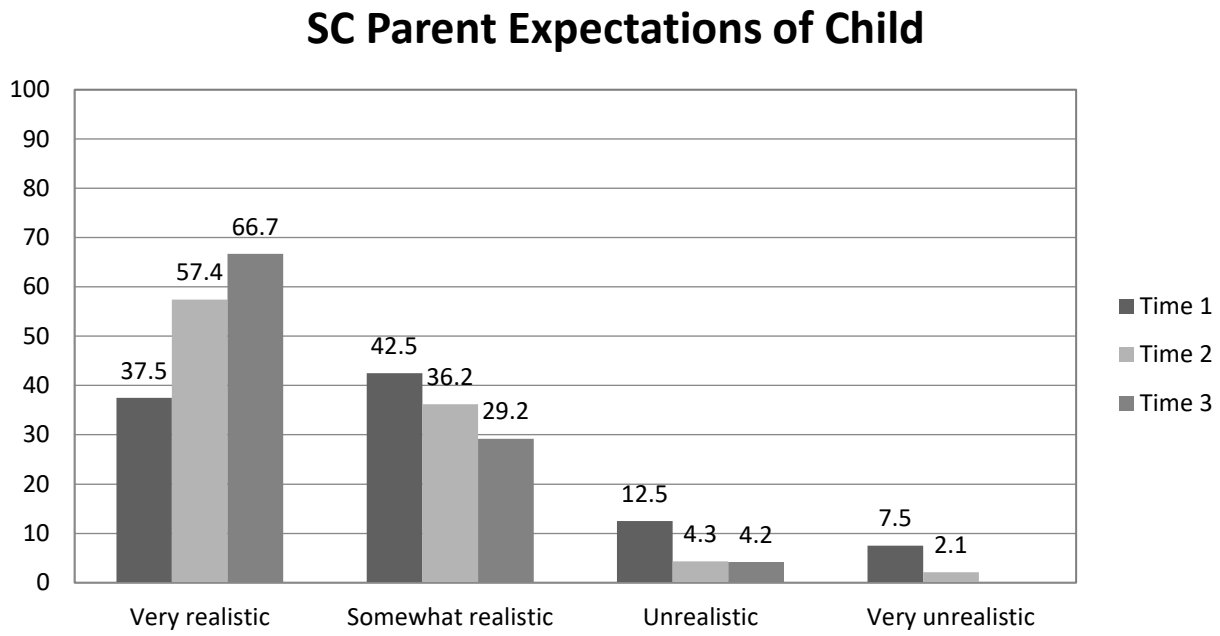
Graph 21: SC Parental Positive Interaction with Child



N=25-120

Graph 21 illustrates the number of respondents in each timeframe regarding parental positive interaction with child. There were improvements in those respondents who had very accepting and affectionate interactions with their child. Time 1 showed only 45% of respondents had very accepting and affectionate interactions; at Time 3, that number rose to 72%.

Graph 22: SC Parent Expectations of Child



N=24-120

The above graph illustrates the number of respondents in each timeframe regarding parent expectations of child. There were improvements in those respondents who had very realistic expectations of their child. Time 1 showed only 38% of respondents had very realistic expectations; at Time 3, that number rose to 67%.

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. KOB 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 determine the effectiveness of Kids on the Block in educating children in various concepts related to abuse and bullying as well as determine whether a change in behavior is likely.

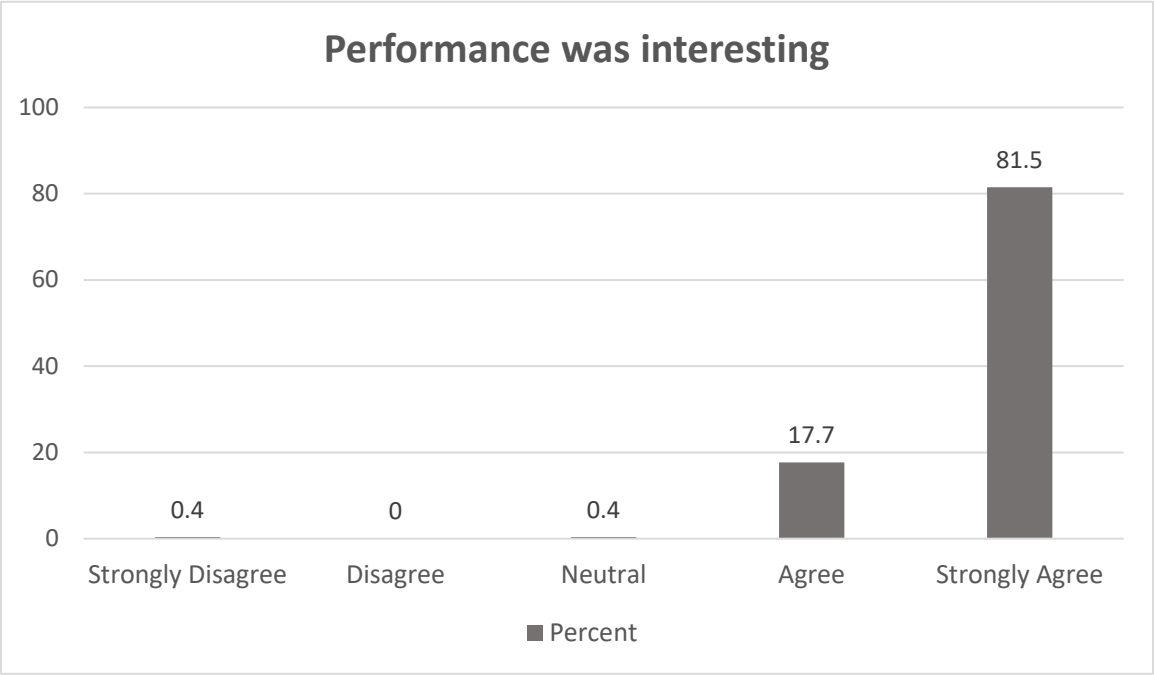
Procedure and Instrument

The Kids on the Block program was evaluated using self-report questionnaires for the children who attended the presentation. Teachers responded to the self-report measures. The self-report consists of six Likert-type questions and four open-ended items. PCCT staff in conjunction with OU developed the scale so that questions would be directly related to the content being presented to the children.

Teacher Evaluations

Teachers were given a questionnaire to address four main variables, including puppeteer performance, audience reaction, developmental appropriateness, and increase of awareness. The following graphs display the responses to each of these variables in percent form.

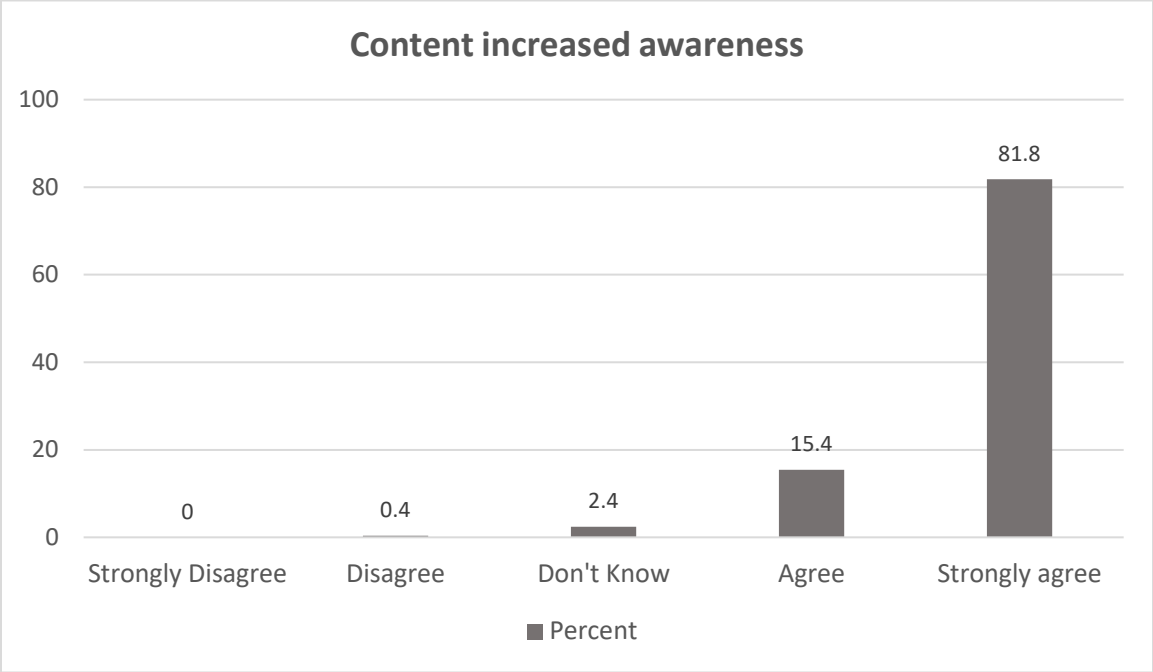
Graph 23: Puppeteer Performance



N=248

The above graph displays the overwhelmingly positive responses to the item, “The performance was interesting and engaging for the students.” As reviewed by teachers, 81.5% of teachers “strongly agreed” with this statement.

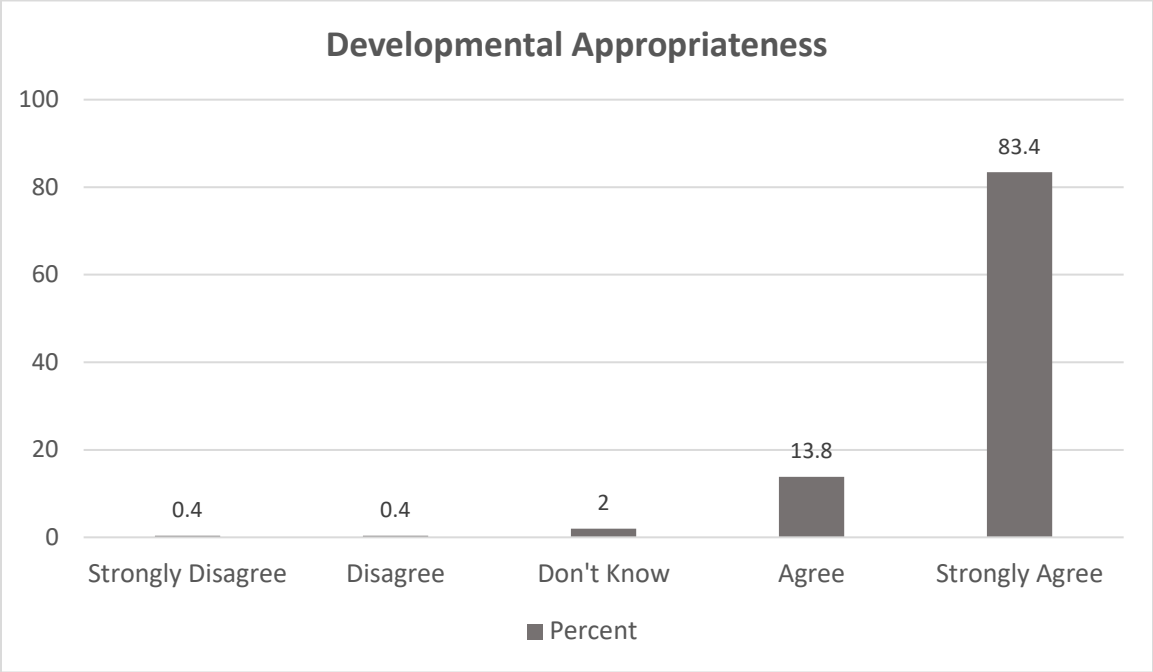
Graph 24: Content Increased Awareness



N= 247

Teachers responded to the question, “The content increased student awareness of the subject of all respondents, 81.8% of teachers stated they “strongly agreed.”

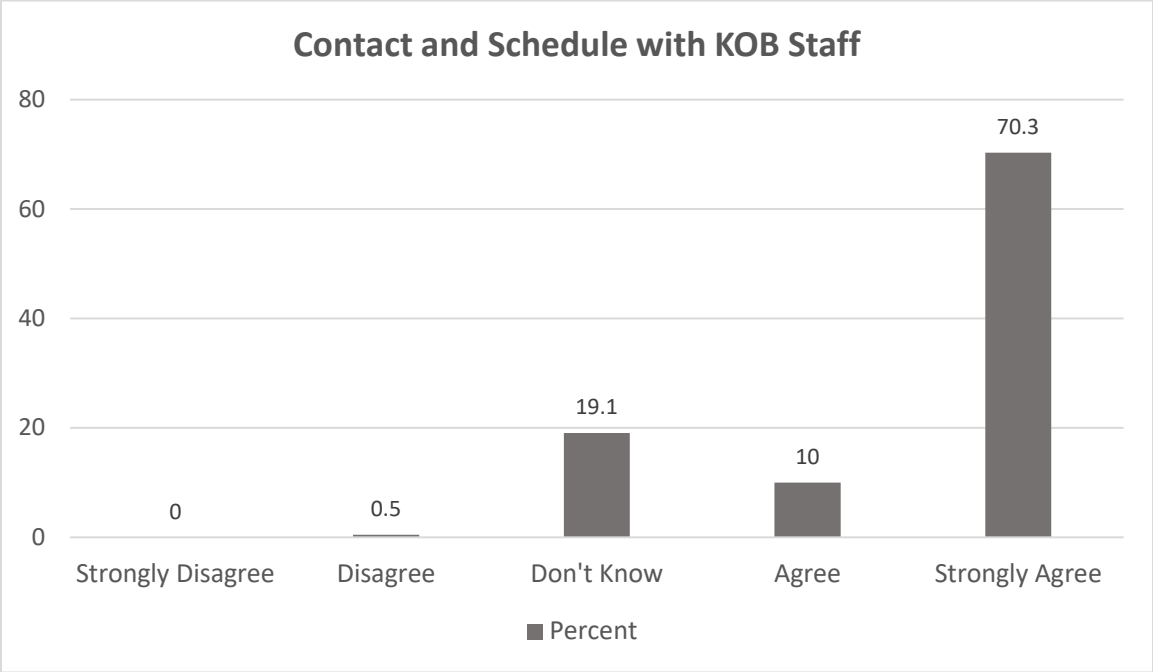
Graph 25: Developmental Appropriateness



N= 247

Teachers responded to the item, “The performance was developmentally appropriate.” Of all respondents, 83.4% indicated “strongly agree.”

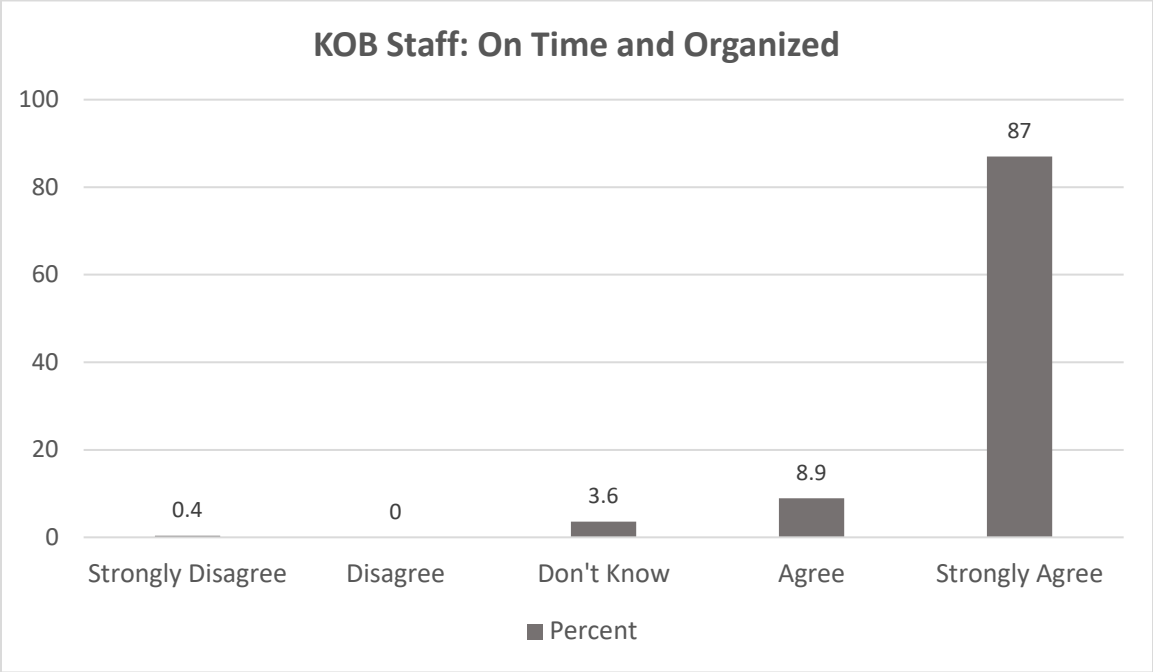
Graph 26: Contact and Schedule with KOB Staff



N= 209

Teachers responded to the item, “I was able to contact and schedule with KOB staff within a reasonable time frame.” Of all respondents, 70.3% indicated “strongly agree.”

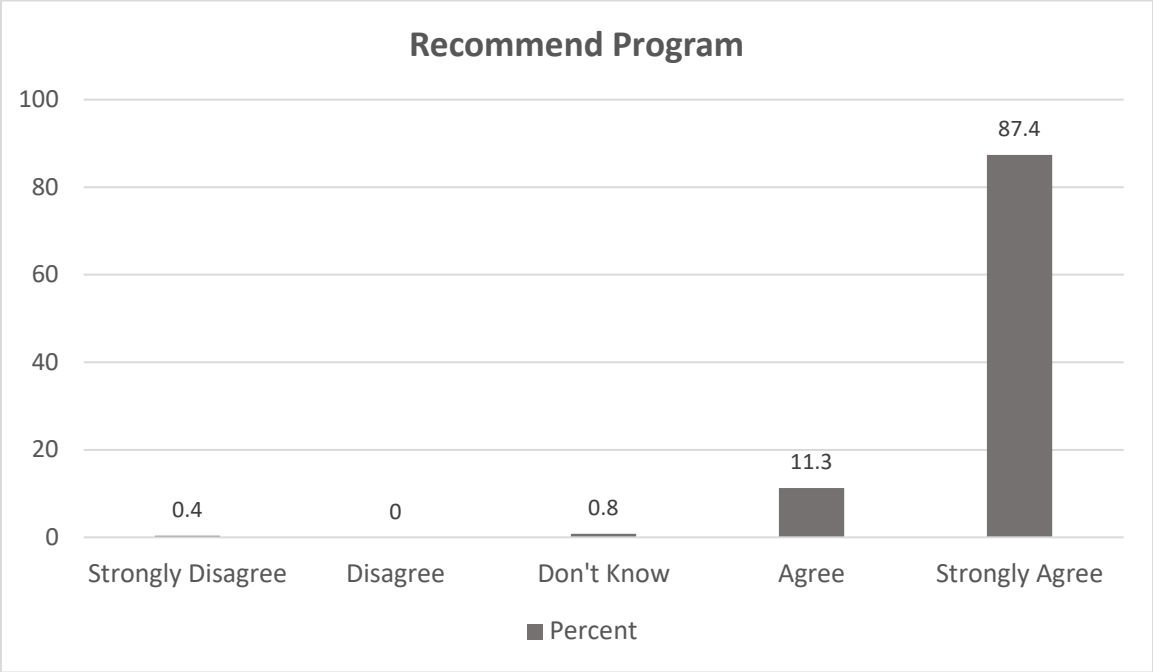
Graph 27: KOB Staff: On Time and Organized



N= 247

Teachers responded to the item, “KOB staff arrived on time and the presentation was well organized.” Of all respondents, 87% indicated “strongly agree.”

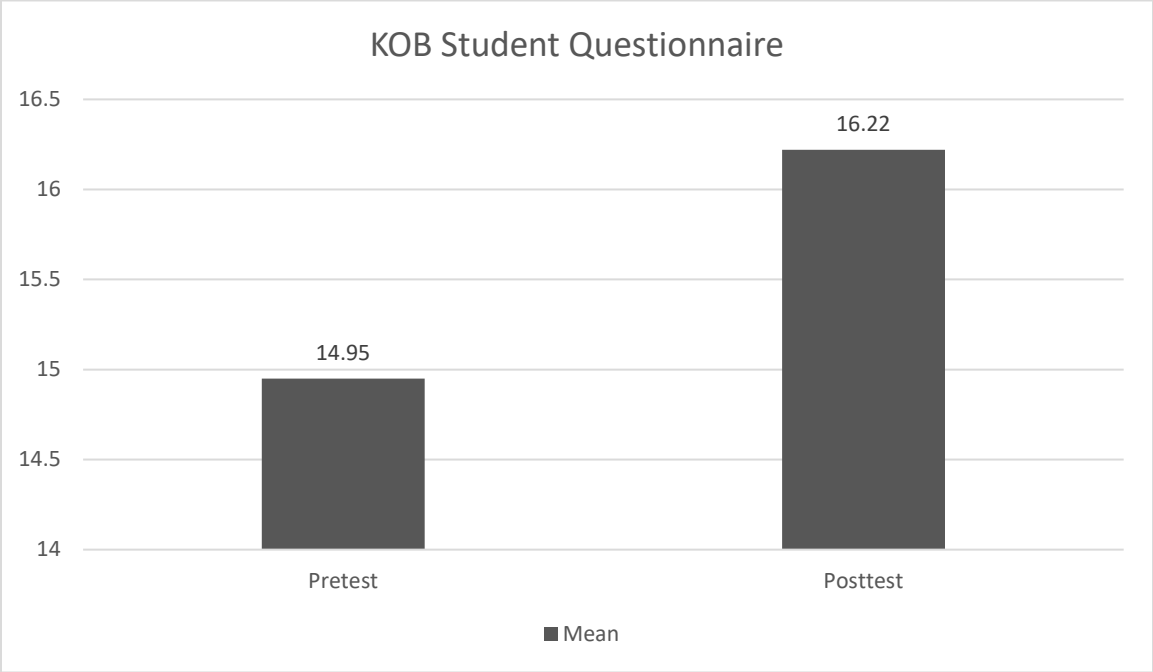
Graph 28: Recommend Program



N=247

Teachers responded to the item, “I would recommend this program to others.” Of all respondents, 87.4% indicated “strongly agree.”

Graph 29: KOB Student Questionnaire



N= 207

Graph 17 demonstrates the change in knowledge for students who participated in the KOB show. A paired samples t-test was computed to examine the differences in pre and posttest mean scores. There was a statistically significant difference in pre and posttests, indicating improvement. Total scores [t(206)= -6.01, p=.000] significantly increased.

Teacher Comments

The response to the following item, **"I expected:"**

Three themes emerged from the teachers' responses:

- A well done performance
- An informational show relevant to children's developmental age
- A puppet show that teaches kids needed life skills about bullying and stranger danger

The response to the following item: **"I received:"**

Three themes emerged from the teachers' responses:

- A puppet performance that was developmentally appropriate.
- A performance the students were actually engaged in.
- Tools to discuss with my students regarding bullying.

The response to the following item: **"I most valued:"**

Three themes emerged from the teachers' responses:

- The interaction and engagement of the students and the puppeteers' ability to hold the attention of the students.
- The content presented and the creativeness of the performance.
- The relevance of the information to their students.

The response to the following item, **"In the future I would like to see:"**

Three themes emerged from the teachers' responses:

- More shows, possibly with different skits about bullying.
- More of the same great performances.
- Different shows like the conflict resolution one.

Summary

The results for the Kids on the Block program were consistently positive. The teacher response to the program was positive. Of all respondents, 87.4% agreed that they would recommend the program to others. And 81.5% agreed that the performance was interesting while 83.4% agreed that it was developmentally appropriate. Teacher comments were also positive towards the program, both in terms of content of the program as well as the presentation itself. The student questionnaire showed an increase in knowledge about the covered topics, which was statistically significant. Overall, Kids on the Block received positive feedback from teachers.

Never Shake a Baby

The Never Shake a Baby program has drastically changed in the past year. Up until the end of 2014, the program focused solely on delivering the *Period of PURPLE Crying* curriculum via one Nurse Educator meeting with moms of newborns in local hospitals. The *Period of PURPLE Crying* is an evidence-based infant abuse prevention program which educates parents and caregivers about normal infant crying and the dangers of shaking an infant.

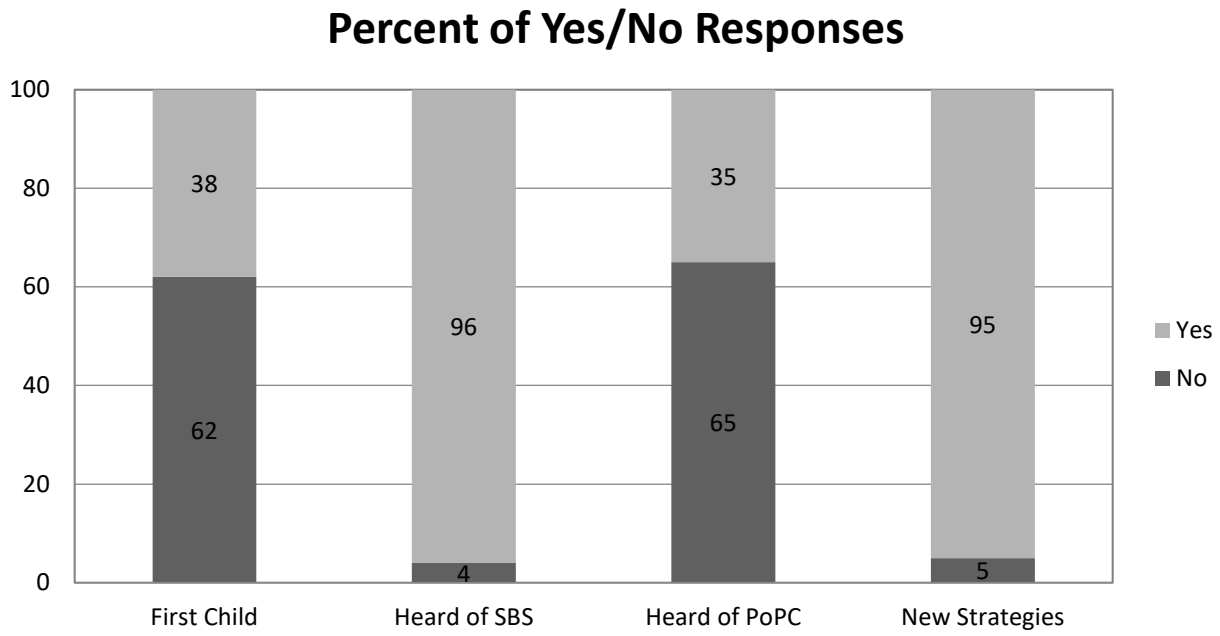
In 2015, PCCT integrated a new component into our hospital outreach called *Talking is Teaching,* which is presented alongside the *Period of PURPLE Crying* curriculum. Messages shared include the value of talking, storytelling, reading, and singing to babies which increases bonding and attachment while also serving as effective strategies for calming crying babies. The goal of *Talking is Teaching* is to build the earliest foundations of literacy. The program is based on the research of Betty Hart and Todd R. Risley who found that daily exchanges between parents and children shape language and vocabulary development.

The Parent Child Center of Tulsa currently employs five full time Nurse Educators who embed themselves into the six major hospitals in the Tulsa area. The Nurse Educators present the *Period of PURPLE Crying* and *Talking is Teaching* curricula to mom's and other caregivers of newborns prior to hospital discharge. The Nurse Educators also provide families with the *Period of PURPLE Crying* DVD and *Talking is Teaching* materials such as: tote bag, book, CD, DVD, booklet with important milestones, t-shirt, and other information.

Pre-Test Findings

The following are the findings from the initial questionnaire given to parents at the hospital. This questionnaire consisted of seven main questions, which centered on previous knowledge and knowledge gained. The table below displays the hospitals that were included in the program and how many people were served at each one.

Graph 30: Percent of Yes and No Reponses



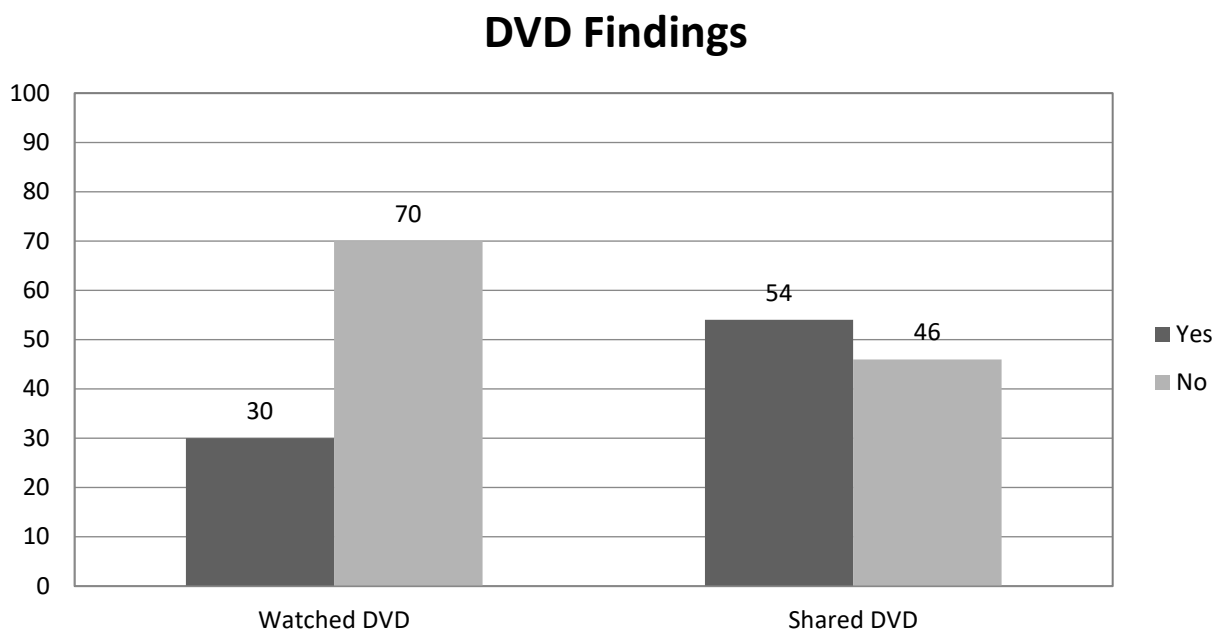
N = 742-857

The above graph displays the percent of "yes" and "no" responses to four of the pre-test questions. 38% of respondents indicated that this was their first child, while 62% stated it was not. While 96% of individuals had heard of Shaken Baby Syndrome, only 35% had heard of the Period of Purple Crying. 65% stated they had not heard of the Period of Purple Crying. 95% of individuals reported having learned a new strategy to help deal with a purple crying baby as a result of the presentation.

Post-Test Findings

The following pages contain information from the post-test. The goal of the post-test was to determine a number of things, including but not limited to, how the PoPC dvd was utilized by the parent, whether the parent had a purple crying baby, and how the parent was responding to moments of frustration with the new baby.

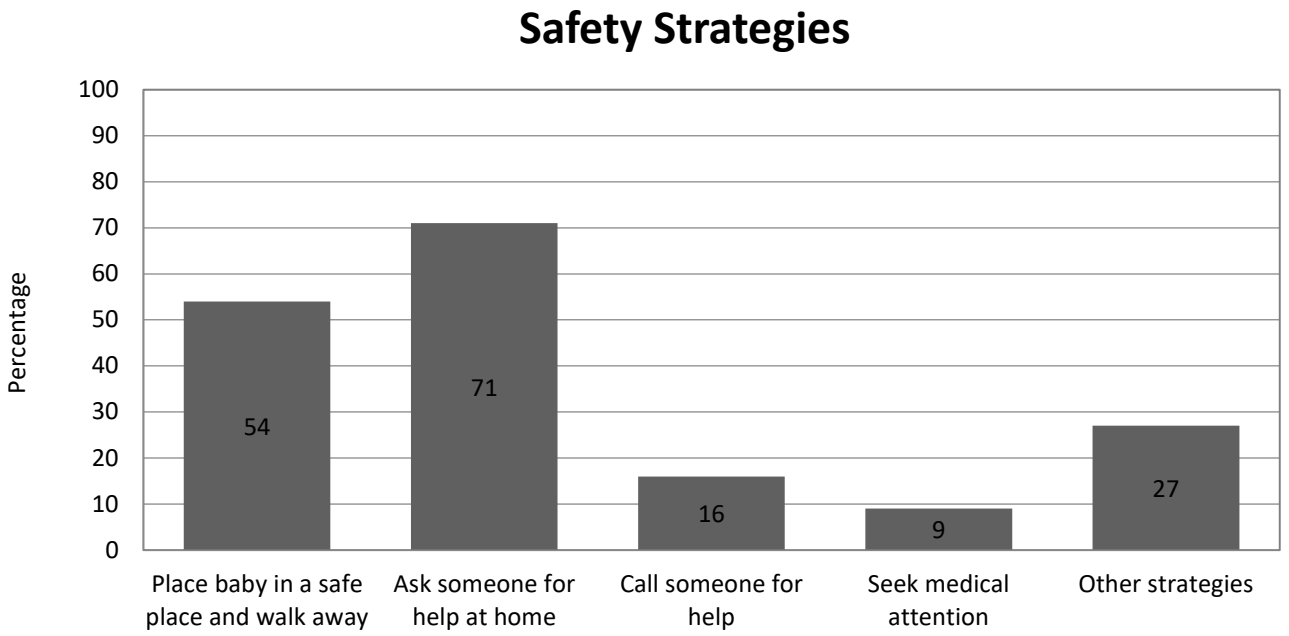
Graph 31: DVD Scores



N = 46-153

The above graph displays the percentage of individuals who watched and shared the DVD. As can be seen, more people didn't watched the DVD than did, with 70% not watching it. Of the 46 people who watched the video, 25 (54%) shared the video with someone else who is caring for their baby.

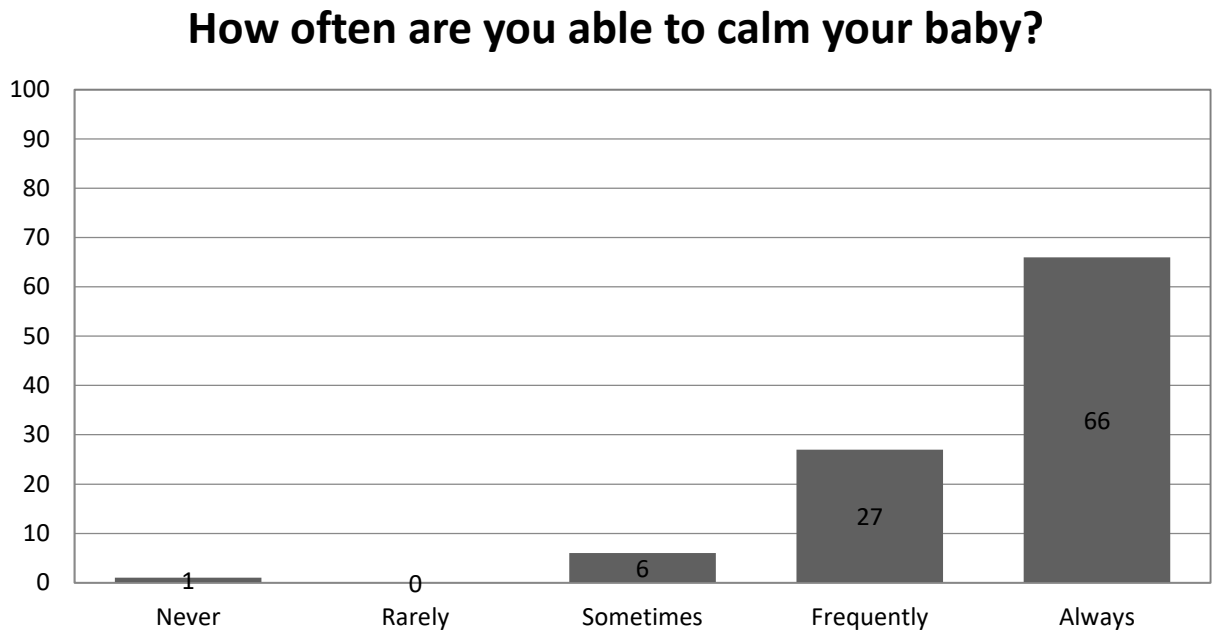
Graph 32: Parent Responses to Strategies to Calm Baby



N = 164

The above graph displays responses to the question, “In moments of frustration when your baby was crying, did you…?” Of all respondents 54% indicated that they “placed baby in a safe place and walk away, ” 71% “ask someone at home for help,” 16% indicated that they “called someone for help,” 9% “sought medical attention,” and 27% indicated that they used other strategies.

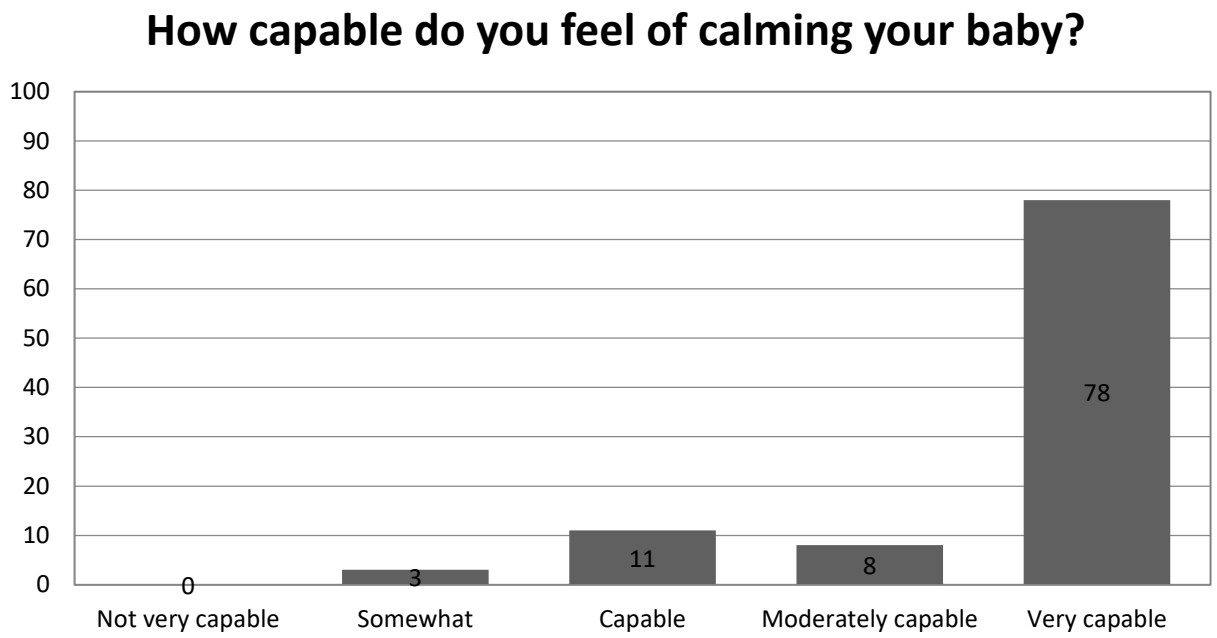
Graph 33: Parent Responses to Frequency of Calming Baby



N = 162

The above graph displays responses to the question, “How often are you able to calm your baby using the strategies listed above?” Of all respondents 66% indicated that they are always able to calm their baby. 27% reported frequently being able to; 6% reported sometimes; and 1% said they are never able to calm their baby.

Graph 34: Parent Responses to Capability of Calming Baby



N = 162

The above graph displays responses to the question, “How do you feel of calming your baby when he/she cries?” Of all respondents 78% indicated that they felt very capable. 8% reported feeling moderately capable; 11% reported feeling capable to calm their baby; and 3% said they felt somewhat capable.

Summary

The Never Shake a Baby program used the same survey as last year to focus on what was determined to be the most important aspects of the program. For the pre-test, the goal was to determine whether individuals already had knowledge of the concepts being presented in the program as well as determine whether individuals learned any new strategies for staying calm with their child. Perhaps most interesting in the pre-test was most people (96%) had heard of Shaken Baby Syndrome, but most had not (65%) heard of the Period of Purple Crying. Most people did not watch the DVD (70%), but a little over half (54%) of those who did shared it with someone else. The majority of parents felt they were capable of calming their baby and were able to do this most of the time, if not always. Overall, the program educates parents on effective ways to sooth their babies and helps them understand the period of purple crying.