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Table of Contents

| | |
|---|----|
| Program Description | 1 |
| Assessment and Instruments | 2 |
| Assignment to Therapy | 2 |
| Service Schedule and Post-Assessment..... | 4 |
| Data Recording and Confidentiality | 5 |
| Timeline and Staffing | 5 |
| Evaluation and Continuous Improvement..... | 6 |
| Results..... | 8 |
| Implementation Fidelity..... | 8 |
| Child and Family Social and Demographic Characteristics | 11 |
| Aim 1: Child and Mother-Child Relationship Status at Entry | 12 |
| Aim 2: Participation in Treatment..... | 20 |
| Aim 3: Treatment Outcomes..... | 21 |
| Outcome of Randomized Treatment Groups | 24 |
| Maternal Satisfaction | 24 |
| Conclusions and Interpretations..... | 25 |
| Recommendations | 28 |
| Appendices | 30 |
| A. Staff Titles, Effort, Qualifications, and Duties..... | 30 |
| B. Interim Report Year II: Non-Attendance | 30 |
| C. Interim Report Year II: Lotus House Staff Satisfaction Survey..... | 32 |

Program Description

This report summarizes a Program funded by two grants¹ awarded to the Lotus House Women's Shelter (LH) for the provision of therapeutic services for mothers and their children. Because the aims and objectives of the two grants were complimentary, LH staff incorporated these into a single service-driven research Program. The aims, objectives, and activities designed to attain the grants' objectives are presented in Table 1.

Table 1. Aims and Objectives of the Lotus House Therapeutic Mother-Child Program.

| Aims | Objectives | Activities |
|---|---|--|
| Increase current understanding of the status of homeless mothers and their children | Determine the children's developmental status | Screen for developmental delays with a standardized and normed instrument. |
| | Determine children's mental health status | Collect demographic, experiential, and contextual data on mothers and their children through and child self-report. |
| | Quantify mental health domains and the quality of maternal-child interactions | Use established scales to collect data on. Mothers <ul style="list-style-type: none"> a. parenting stress, b. parent child relationships, c. children's behavior, d. children's trauma experiences, and e. symptoms of posttraumatic stress Children (7 and older) <ul style="list-style-type: none"> a. trauma experiences b. symptoms of post-traumatic stress Use established observational protocol to rate maternal-child interactions. |
| Improve child mental health status with therapeutic services for mothers and children | Provide therapeutic child-focused services to dyads and/or children. Adapt modalities to enhance appropriateness to the population. | Provide therapy to families in need: <ul style="list-style-type: none"> a. psychotherapy (<i>Child-Parent Psychotherapy</i>), b. parenting (<i>Parent-Child Interaction Therapy</i>), or c. trauma focused therapy (<i>Trauma Focused Cognitive Behavior Therapy</i>) |
| Evaluate the effectiveness of services provided | Improve services on the basis of treatment outcomes | Establish and maintain an electronic data collection system |
| | | Re-assess families in treatment at 4 months post- assignment. |
| | | Analyze service provision, assessment results, and provide feedback |
| | | Staff undertakes corrections, adaptations, or improvements to services if/as necessary |

¹ Funds were awarded by The Children's Trust for services that commenced in 2017.

| Aims | Objectives | Activities |
|---------------|--|---|
| Dissemination | Make results available to other shelters nationwide and other relevant stakeholders. | Publish results in the LH website, present at conferences, and publish in academic journals |

Assessment and Instruments

As part of the intake procedure to the LH, all families were assessed by specially trained assessment specialists and coders to determine family status and needs². Assessments typically took one hour and a half with some of it occurring concurrently. A coder read out the rating instruments to the mother while the assessment specialist conducted the developmental screening of the young children or interviewed the older children. Generally, in families with multiple siblings, assessments were conducted in order of maternal concern, else in descending age order, with older siblings scheduled first and generally, assessments were completed in the first two weeks post entry to the LH.

The instruments, which included rating scales read to mothers, structured interviews, and structured observations, focused on five aspects of functioning: young children's development, child behavior, maternal stress, parenting, and trauma experiences with subsequent post-traumatic symptoms. Specifically, interviews provided demographic and contextual information according to maternal and child report. The child interview administered to children and youth ages 8 and older, provided information on childhood experiences and on children's self-reported concerns. Children up to age 8 were screened for developmental delays. Mother-child interactions of dyads with children ages 6 months to 13 years of age were assessed with a protocol that requested that mothers play with their children for 15 minutes during 3 specified conditions while the session was recorded for subsequent coding. Table 2 specifies the instrument used, the age ranges of children with which they were used, the domains or scales generated, and an approximate time for administration. Copies of the interview protocols are available from the LH and all others are established instruments that are available online.

Subsequent participation in therapy and the availability of assessment results for analyses depended on maternal informed consent. Families already in-residence at the beginning of the Program were also assessed and invited to participate in relevant services.

Assignment to Therapy

Mothers and children who needed therapy, as determined by the assessment battery, were offered therapy in the following manner. Mothers who agreed to participate in one of the service modalities and agreed for their results to be available for research purposes signed informed consent forms that had been cleared by the Florida International University IRB.

- a. Mothers of children under age 2 were offered 10 or more sessions of the *Child-Parent Psychotherapy (CPP_10+)*. The aim of this modality is to help young children and their families recover from stressful and traumatic events. Therapeutic stages

² Assessment specialists had master's level clinical degrees. Coders, who might administer the ECBI, SIPA, or PRQ, had bachelor's degrees in psychology. Both received specialized training as necessary for the protocol.

include: getting to know the family, addressing the families' needs, and planning for the future. Sessions include toys, helping parents and children understand each other, talk and play about difficult experiences, respond to difficult feelings and behaviors, and create a family story that leads to healing. With very young children, sessions focus on helping parents understand the effects of experiences on their relationship and ways to strengthen the parent-child relationship. Therapy is intended to extend over 30 to 50 sessions. But, in this Program it generally included 10 to 14 sessions that in some cases extended to over 30 sessions.

Table 2. Assessment Instruments.

| Instrument | Abbreviation | Ages | Topics/Scales | Duration |
|--|---------------------|--------------------|---|-------------------------|
| Lotus House Child Clinical Assessment | LHCC | all | Demographics and child clinical history | 20 min. |
| Parenting Stress Index IV-Short Form | PSI-IV SF | Birth to age 13 | Subscales: 1) parental distress, 2) parent-child dysfunctional interaction, 3) difficult child, and 4) total score (36 items) | 15 min. |
| Stress Index for Parents of Adolescents | SIPA | 13 to 21 | Sub-scales: 1) adolescent, 2) parent, 3) adolescent-parent relationship, 4) life stress scale, and 5) total parenting stress (111 items) | 30 min. |
| Eyberg-Child Behavior Inventory | ECBI | 6 months to age 13 | Subscales: 1) intensity of behavior problems, 2) problem score (36 items) | 15 min. |
| Parenting Relationship Questionnaire | PRQ | 13 to 21 | Subscales: 1) attachment, 2) communication, 3) discipline practices, 4) involvement, 5) parenting confidence, 5) satisfaction with school, 7) relational frustration (71 items) | 25 min. |
| Dyadic Parent-Child Coding System | DPICS | 2 to 13 | Subscales: 1) Do statements (labeled praises, reflections, and descriptions, 2) Don't statements | 20 min. |
| Child and Adolescent Trauma Screener-Caregiver | CATS - C | 3 to 8 | Measures: 1) list and count of child traumatic events, 2) child PTSD score | 20 min. |
| Battelle Developmental Screener (v2) | Battelle | 6 months to age 8 | Sub-scales: 1) fine and gross motor, 2) adaptive, 3) personal-social, 3) receptive and expressive language, 4) cognitive skills, and 5) total score | 30 minutes (concurrent) |
| LH Child Clinical Interview -self report | LHCC | | Child's report of mood, desires, problems | 20 minutes |

| Instrument | Abbreviation | Ages | Topics/Scales | Duration |
|---|--------------|------|--|--------------------------------------|
| Child and Adolescent Trauma Screener -Self-Report | CATS | | Measures: 1) list and count of child traumatic events, 2) child PTSD score | (concurrent with maternal interview) |

Note. Duration times varied depending on the number of children in a family.

- b. Mothers of children ages 2 to 5'11", at random, were offered either CPP_10+ or *Parent Child Interaction Therapy (PCIT)*. The aim of this modality is to address the needs of families with children ages 2 to 7 with disruptive behavior problems. The focus of treatment, which is to improve the quality of the parent-child relationship by changing the parent-child interaction patterns has a two-phase implementation: child-directed interaction in which the parent follows the child's lead in play and parent-directed interaction in which the parent is taught to lead play with appropriate use of commands and consistent and positive discipline. Intervention was designed to be 10 to 14 sessions.
- c. Mothers of children 6'0" to 6'11" year of age were offered PCIT or *Trauma Focused Cognitive Behavior Therapy (TF-CBT)* depending on clinical need. Like the CPP_10+, the aim of this modality is to help children and adolescents recover from trauma. It addresses the effects of trauma such as affective or behavioral problems and supports effective parenting. But, whereas the CPP_10+ is psychotherapeutic in its orientation and delivered over a period of a year or more, the TF-CBT is based on cognitive behavioral principles and is designed to be provided over a period of 12 to 16 sessions.
- d. Mothers of youth ages 7'0" and above were offered *TF-CBT* for their children.

Families with more than one child with clinical need were assigned to the age category (0 to 2, 2 to 6, 6 to 13, and 13 up) of the child with the most pressing need. In Year I it was planned that only one child would be served at a time. However, that practice would leave siblings without needed services. Thus, starting in Year II, families with multiple children had two children assigned at a time as appropriate, both to the same modality, or to the TF-CBT and one of the other two modalities except that mothers were not assigned to CPP_10+ and PCIT concurrently. In some cases, two different modalities were provided consecutively and in a few cases, dyads were re-assigned if new needs or previously unperceived needs emerged.

Service Schedule and Post-Assessment

Therapeutic services were scheduled weekly for 45 to 60 minutes for the CPP_10+, 60 minutes for the PCIT, and 30 to 45 minutes for the TF-CBT. To ensure fidelity to the treatment protocols, each modality included supervision and recorded checks on fidelity.

Participants were considered to be fully engaged if they completed at least 3 sessions per month. Re-assessments were undertaken 4 months after the first assessment, earlier if at least 12 sessions had been completed, or after completing 10 sessions if the clinician deemed that the guest had attained treatment goals. Mothers who required additional support continued in therapy after the re-assessment. Service goals were 400 children, youths, and their mothers per year.

The post intervention assessment protocol was the same as the pre-intervention assessment with the exclusion of demographic questions and the Battelle Screener. It also included questions on perceived improvements on child behavior, child trauma symptoms, parenting relationship as well as Program satisfaction.

Subsequent treatment options depended on the results obtained. Specifically,

- a. Families who completed therapy, at least 10 sessions of their treatment, and their assessment results did not suggest continued need, discontinued therapy.
- b. Families continued in the same modality if assessment results suggested substantial progress, assessment suggested continued need, and their clinicians considered that additional sessions were potentially beneficial. For instance, CPP_10+ included some dyads who had over 30 sessions. Without perfect attendance, TF-CBT treatment goals modality might not have been completed by 4 months and required one or more sessions.
- c. Mothers were offered an additional modality for additional needs of the same or another child.

Data Recording and Confidentiality

Two electronic data systems were used to record data. An electronic health record was used for clinical data such as session attendance and clinical notes, i.e. what would be kept in a paper chart. Results of assessments were kept in the LH Research Electronic Data Capture (REDCap). Each system used numeric unique identifiers for each child and mother. To ensure confidentiality a very limited number of authorized staff had access to each depending on need. Paper records were in locked drawers within locked offices, uploaded, and then shredded. Transfers between Staff and the Evaluator/Researcher were encrypted prior to transfer. The Evaluator/Researcher maintained the same confidentiality procedures with all data received.

Timeline and Staffing

Implementation schedule was as follows. During the first quarter of the Program, staff was hired, an application for IRB approval was submitted, the assessment protocol was established, staff was trained on assessments and treatment modalities, a data entry protocol was determined, and fidelity protocols for each modality were developed. During the second quarter, protocols were pilot tested and full implementation was commenced. Process evaluation commenced during the first quarter and continued throughout. Reliability and fidelity checks were started with full implementation. Clinical staff met weekly to review attendance and guest progress. The research team, composed of clinical directors, administrators, researcher, and evaluator met monthly to ensure adherence to protocol, monitor progress towards service goals, troubleshoot, and make programmatic decisions. Service use and therapeutic outcomes were evaluated yearly.

Staffing at the end of Year III included administration (10% FTE), Clinical Program Director (100% FTE), Assessment specialists (200% FTE), Coders & Data Management (300% FTE), Counselor/Therapists (6.25% FTE), Engagement Specialist (100% FTE), and the contracted services of a researcher and an evaluator. Detailed information on staff qualifications and duties

are available in Appendix A. A major change in staffing that occurred since the Program was implemented was to hire a Clinical Program Director that could oversee operations and provide clinical supervision instead of having separate positions for the two roles.

Evaluation and Continuous Improvement

The evaluation, conducted on a continuous basis since the beginning of the Program, had the formative functions of providing feedback to Program staff so that corrective action and/or adaptations could be undertaken if necessary. It also had the summative function of documenting attainments for reporting to LH administration and to the funding agency. Summative evaluation measured the extent to which the Program was carried out as proposed and attained its objectives. Overarching evaluation questions were as follows.

1. Were Program activities conducted as planned, in a timely and efficient manner?
2. Did Program activities contribute to the desired outcomes?
3. Were mothers, staff, and administration satisfied with the process and outcomes?
4. Might activities and outcomes be improved?

Sources of data included observations, results of mother and child assessments, as well as interviews, focus groups, and surveys of staff. To ensure data quality and the fidelity of the implementation plan such as timely assessments and assignment to treatment modalities, the Evaluator helped to set up data entry and in the first year of operation reviewed the data and implementation first weekly and then monthly. Quarterly review of data quality and procedures began in the middle of the second year.

Interviews and focus groups of mothers and staff along with staff surveys were conducted as needed, roughly twice a year. The focus of these varied depending on need. For instance, in the first year, the aim of data gathering was to understand the reasons for maternal attrition from the service programs and to collect staff ideas for improvements. In the second year, the focus was on staff attrition and re-engaging with new staff. In the third year the focus was on adaptations to the Covid-19 pandemic. These efforts provided a qualitative context for interpretation of quantitative results.

Client-based outcomes identified by the funder, the Children's Trust, as meaningful improvement. are presented in Table 3. Results were measured against the targets displayed in the Table.

Table 3. Contracted Client-Based Outcomes: Meaningful Improvements.

| Outcome & Target % | Data Source/ Measurement Tool(s) | Meaningful Improvement | Associated Activity & Service Component |
|---|---|---|--|
| 75% of parents/primary caregivers increase positive parent/child interactions | <p>DPICSIV, Dyadic Parent-Child Interaction Coding System (DPICS-IV)- Child Directed Interaction (for children ages 5-12 years)</p> <p>Scoring: 5-minute CDI coding periods</p> <ul style="list-style-type: none"> ·Total # of labeled praises ·Total # of reflections ·Total # of behavioral descriptions | A total increase of 10 or more positive parent-child interactions (labeled praises, reflections, or behavioral descriptions) from pre- to post-intervention | Parenting Consultation Behavioral/Mental Health Intervention Weekly |
| | <p>Parenting Relationship Questionnaire (PRQ-CA) (for children ages 13 and above)</p> <p>71 items Scoring: t-scores (M=50, SD=10). Range: 0-100 Clinically significant scores on the following 6 out of the 7 subscales are indicated by $t \leq 40$:</p> <ul style="list-style-type: none"> ·Attachment ·Communication ·Discipline Practices ·Involvement ·Parenting Confidence ·Satisfaction with school <p>Clinically significant scores on the Relational Frustration subscale is indicated by $t \geq 60$</p> | The following condition must be met for at least 5 out of the following 7 subscales: <ul style="list-style-type: none"> ·Attachment ·Communication ·Discipline Practices ·Involvement Parenting ·Confidence ·Satisfaction with school If pretest t score is in the lower extreme range (0-30), then posttest must be t score > 30 OR if pretest t score > 30 then posttest must be t score > 40. For the Relational Frustration subscale, if pretest t score is in the upper extreme range (70-100), then posttest must be t score < 70 OR if pretest t score < 70 then posttest must be t score < 60. | |
| 75% of parents/primary caregivers decrease parenting stress | <p>PSI4, Parenting Stress Index (PSI-4) (for parents of children ages 0-12 years)</p> <p>36 items Scoring: Percentile Range: 16 - 99 Scoring ranges: 16-80 = normal, 81-84 = borderline, 85-99 = clinically significant. Only use Adolescent Domain</p> | A post-intervention percentile total score of 84 or lower | Parenting Consultation Behavioral/Mental Health Intervention Weekly |
| | <p>Stress Index for Parents of Adolescents (SIPA): (13 and above)</p> <p>112 items; percentile scores from 0 to 99; scoring ranges: 0 to 84th percentiles is normal, 85th to 89th is borderline, 90th</p> | A post-intervention assessment total score below the 85 th percentile | |

| Outcome & Target % | Data Source/ Measurement Tool(s) | Meaningful Improvement | Associated Activity & Service Component |
|---|--|--|--|
| | to 94 th percentile is clinically significant, and 95 th to 99 th percentile is clinically severe. | | |
| 75% of children/youth decrease problem behavior | <p>ECBI, Eyberg Child Behavior Inventory (ECBI) (children 2-16)</p> <p>36 items Scoring: Sum of scaled Intensity items Range: 36-252 Scoring ranges: 36-130 = normative, greater than or equal to 131 = clinically significant.</p> | A post-intervention intensity score equal or lower than 130 | Parenting Consultation Behavioral/Mental Health Intervention Weekly |
| | <p>Child and Adolescent Trauma Screener (Caregiver ages 3 to 7'11' and self-repot ages 8'0" and above)</p> | A post-intervention decrease of 20% in total PTSD symptom score. | |

Results

Implementation Fidelity

This section examines the evidence available on the fidelity of Program implementations; a precondition to considering whether or not treatment outcomes were attained. Implementation was determined from the quantitative data as well as from regular conversations with the Clinical Program Director, monthly team meetings, and staff interviews, surveys, and focus groups.

As can be seen from the following indicators of implementation in the majority of instances, the Program was implemented as designed. All mothers on whom data were provided to the Evaluator had signed informed consent. By the end of Year III, the Program was only 94 children short of the projected 1,212 that would be evaluated. Eighty-two percent (82%) of mothers had their first assessment within a week of entry as planned and an additional 10% had their first assessment within 2 weeks. Pre- to post-intervention occurred within 3 to 5 months as planned in 69% of cases, with 22% being assessed between 6 to 14 months, and 9% being assessed at 2 months. The major barrier to completing post-assessments at 4 months was staff

attrition, i.e. leaving the LH and maternity leave, and the non-availability of CPP_10+ trained clinicians which delayed beginning of therapy.

Focus Groups and Interviews

Each year, focus groups, interviews, and/or surveys were conducted as necessary with mothers and staff in accordance to what was relevant and appropriate at the time. In Years I and II, the main foci of data collection were on issues related to fine-tuning implementation and on program non-completers and staff attrition, respectively. In Year III, the focus was on program implementation in the face of the Covid-19 pandemic and on maternal stress.

Year I. Two focus groups five months apart were conducted with all clinical staff as well as a survey of clinical staff including supervisors ($n = 13$). Focus groups or interviews were also conducted with mothers ($n = 17$). Because procuring attendance at focus groups was challenging, the evaluator moved to one-on-one interviews and because it was not possible to procure participation from more than a handful of non-completers, feedback can be assumed to be biased.

Findings and recommendations arising from these were summarized and shared with staff. Key findings included: a) some small program features were not understood (such as why in the Battelle children were asked to perform tasks that were too difficult for them) and explanations or adaptations for new participants were undertaken; b) mothers of children who had undergone trauma understood the need and the benefit of therapy; c) for other mothers, before commencing treatment, it was not clear why play is important for children or for dyads; d) many mothers felt awkward playing with their children; e) some mothers were surprised when strategies taught them improved children's behavior; and f) even when strategies obviously worked, it was challenging to implement them on a regular basis. The latter seemed to be an issue of lack of habit, of not having practiced them enough.

Year II. Interviews with non-completers were sought unsuccessfully in Year II. Mothers who had left the LH did not respond to phone calls or begged off the phone promising to speak at a later, more convenient time, but would never make themselves available. From responses to a hasty question on the part of the evaluator akin to, '*...but did anything happen to make you unhappy or displease you.*' The Evaluator developed the impression that reasons for attrition were not related to the services received, but instead were based on women's desire to move on with their lives. However, that impression must be interpreted with caution because it was based on only a handful of mothers.

Year III. The beginning of Year III had a very promising start with a Clinical Program Director who had been in place for almost one year and with the recruitment and training of new staff to replace counseling staff that had left or filled in for staff on maternity leave so that families could be moved from the waiting list into active participation. But, shortly after mid-year, the Covid-19 epidemic broke out and Administration and staff had to develop new procedures that would be maximally protective while at the same time continue to provide services. Without childcare the pandemic increased the challenge of providing sessions. The question arose as to whether sessions that were provided with physical distance and masks or virtually could be used to

measure treatment effects. In effect, most sessions continued to be offered in-person because Administration deemed that the level of needs and stressors for the families as well as the importance of personal engagement, mitigated in favor of in-person sessions whenever possible and safe. Hence, the evaluator surveyed clinicians who unanimously reported that although, particularly at the beginning of the pandemic, some therapy time was taken to address concerns related to the pandemic, they felt confident that treatment goals for all sessions were being attained.

Barriers to Implementation. Missed appointments were common, a major barrier to implementation, and an issue that according to staff, was not limited to counseling sessions. The reasons for no-shows were many; some clearly reasonable and/or associated with low income such as having a family member in the hospital, delayed public transportation, or a cell phone not working. Others such as “forgetting” were not as easily explained. Hence, staff undertook a series of strategies aimed at improving regular attendance that included: voice and/or text reminders the day before the appointment, an hour or so before the appointment, and a “you must be on your way” text 5 minutes before the scheduled appointment.

By the end of Year I, as a matter of routine, staff met weekly to review attendance, no-shows, and reasons for no-shows to identify barriers to attendance and address those on a case by case basis. A first “no-show” or occasional missed appointments were addressed by the clinician assigned to the family. Repeated missed appointments were addressed by the supervising clinician because repeated missed appointments might signal a problem in the mothers’ lives that might need to be addressed or it might signal a problem with the treatment itself. At the end of Year I, when treatment issues were ruled out and it was observed that the major reason for non-attendance was maternal difficulty with planning and organizing, a staff member skilled in motivational strategies was charged with the responsibility of reminding mothers, encouraging them, and helping them address barriers to attendance. When possible this “engagement specialist” was introduced to mothers during the pre-intervention assessment. According to clinician report, in the process of engaging mothers with the therapeutic modality, the first session might have been critical towards completion because in the first session, the therapist had an opportunity to put forth to mothers the benefits of participation and that play is children’s work. In Year III, lack of childcare during the pandemic added one more reason for missed appointments. Nonetheless, to the immense credit of staff, the fourth quarter of Year III evidenced more sessions than the first three and attendance levels attained in Year II were maintained.

Implementation benefitted from the following features or **adaptations**: 1) food and drink available at assessments, which depending on the length of the session were provided during a break or after the session; 2) translation/interpretation of items for Creole speaking families; 3) a standardized re-phrasing of rating items, such as “dawdles,” “sasses,” “lingers” and “acts defiant,” that proved incomprehensible to many mothers; 4) deletion of rating items that refer to a spouse; 5) administration of the most intrusive rating scale at the end of the assessment to give the assessment clinician a chance to establish rapport; 6) selecting as assessment clinician a person whose manner was markedly friendly and who was very skilled at putting mothers at ease; 7) providing rewards; 8) allowing in-room time-out for mothers who expressed concern

about their children's wellbeing if out of sight; 9) adding a depression screener for mothers of infants under 6 months of age; and 10) regular attendance reminders.

The use of **rewards and reinforcers** to motivate attendance was always used but its nature and schedule shifted and adapted multiple times depending on the clinicians' sense of what schedule was most effective and most desirable. Some of the change reflected the Clinical Program Director's philosophy towards the use of extrinsic motivators. At one point, mothers received a reward after each session. By Year III, mothers received a reward after each assessment, at the mid-point of the Program, and if they finished their modality within 4 months. This completion reward might be a gift card to a national chain store, generally of \$20, but possibly more for large families. At the other time points children received toys and mothers received a beauty product or costume jewelry of their choice. Families who had left the LH and needed to return to complete a modality or a post-assessment were offered an additional incentive. By the end of Year III, staff felt that this schedule worked well and no immediate plans for change.

Evaluations undertaken in Year II (see Appendix B) suggested two **additional strategies** to consider in order to increase attendance. One was a response cost program for missing sessions whereby some small privilege would be lost for non-attendance. However, administration felt that it would not be beneficial for Program participants to have additional losses in lives that were already characterized by loss. A second strategy was for clinicians to emphasize children's needs and how the sessions would address those needs. The aim of this strategy was to cause a shift in maternal priorities. Administration opted in favor of the latter strategy.

Child and Family Social and Demographic Characteristics

This section examines whether child and family characteristics were sufficiently consistent across years to allow the data to be collapsed across years. In other words, was LH serving the same population across all years? The advantage of collapsing data across years is that statistics based on larger numbers are more stable and more likely to reflect true population values than statistics based on fewer observations. It also presents the demographic information on participating families.

Table 4. Demographic Characteristics of Participants.

| Year | | I | II | III |
|-----------------------|---------------|---------------|-----------|------------|
| Children | | <i>n=</i> 378 | 350 | 390 |
| Children's Ages | | | | |
| | 0 to 3 | 54% | 53% | 50% |
| | 4 to 12 | 41% | 38% | 41% |
| | 13 up | 5% | 9% | 9% |
| Gender | | | | |
| | female | 48% | 49% | 50% |
| | male | 52% | 51% | 50% |
| Single-child family | | | | |
| | | 34% | 34% | 24% |
| Child's race | | | | |
| | Black | 74% | 73% | 74% |
| | White/mixed | 26% | 27% | 26% |
| Mothers | | <i>n=</i> 218 | 202 | 198 |
| Maternal Ethnicity | | | | |
| | Hispanic | 27% | 33% | 29% |
| | Non-Hispanic | 73% | 67% | 70% |
| Maternal Civil Status | | | | |
| | Never married | 82% | 86% | 84% |
| | Married | 9% | 3% | 4% |
| | Other | 9% | 11% | 12% |
| Maternal Employment | | | | |
| | Employed | 27% | 25% | 18% |

A total of 1,118 children and their mothers ($n = 618$) were assessed in Years I through III of the Program (see Table 4). In Year III, as compared to the other years, there was a decrease in the percentage of children without siblings and in the percentage of mothers who were employed. Other than that, demographics were comparable across the three years of services. Across years, roughly half the children were under 4 years of age; only one-quarter to one-third of the children arrived without siblings; and roughly three-quarters of the children were Black. Most mothers had never married, and roughly one-quarter was employed. This pattern of results suggests that the population served across the years was consistent in their characteristics.

Aim 1: Child and Mother-Child Relationship Status at Entry

This section addresses the Program objectives that were specified to achieve the first aim, that of increasing current understanding of the status of mothers and children experiencing homelessness. Specifically, the objectives were to: a) determine the developmental status of all young children entering the LH, b) determine children's mental health status, and quantify mental health domains and the quality of maternal-child interactions. (See Table 1).

Children's **developmental status** was screened with the *Battelle Developmental Screener*. Results on this screener identify children who need a full developmental evaluation. These are children whose scores are 1.5 standard deviation below the average score for their ages. As can be seen from Table 5 below, the major findings of the assessment were as follows.

1. The need for referral increased with age. Whereas 19% of children under 3 scored in the referral range, referrals were indicated for 47% of children above 3.
2. With increase in age, there was also a higher percentage of children with at least one developmental area at risk; 51% of children under 3 and 74% of children from 3 to 8 years of age.
3. With increase in age, the domains most at risk changed. Communication was the domain most at risk among the younger children, 27%. For the older children the Personal Social domain was most at risk, 57%.

Table 5. Children's Development Status at Entry: Referral Rates.

| | 6 to 36 mos. | 36 mos. up | All |
|---|--------------|------------|-----|
| <i>n</i> = | 439 | 364 | 803 |
| Adaptive | 19% | 41% | 29% |
| Personal Social | 16% | 57% | 35% |
| Communication | 27% | 31% | 29% |
| Motor | 19% | 10% | 15% |
| Cognitive | 19% | 31% | 24% |
| Total Referral Rate | 19% | 47% | 31% |
| Children with 1 or more referral category | 51% | 74% | 62% |

Note. Excludes children less than 6 months of age.

These results might indicate a relationship between delayed communication in the first three years of life and delayed personal social relationships among the 3-to-8-years-olds. In other words, do children with early delays in communication become children who later are likely to have delays in social skills? Do early delays in communication signal an environment that is lacking in interaction, hence an environment where it is also difficult to learn social skills?

Traumatic events and the severity of symptoms associated with their occurrence were assessed with the CATS-Caregiver and the CATS-Youth. As can be seen from Table 7, the results of assessment with these instruments indicated high rates of traumatic events and of PTSD symptoms and that children tended to be affected in one or more functional areas. Findings also indicate that children reported considerably more traumatic events and more symptomatology than mothers did on their behalf. Specific findings were as follows.

1. In addition to experiencing homelessness, almost all children had experienced one or more traumatic event. The percentages as reported by the mothers and by the children were 89% and 96% respectively.
2. Children tended to experience multiple traumatic events. The average number of traumatic events were 2.4 ($SD = 1.7, n = 588$) as reported by the mothers, and 3.9 ($SD = 2.0, n = 254$) as reported by the children.
3. As reported by mothers and children respectively, the average PTSD scores were at or above the threshold that indicates the possibility of PTSD, i.e., scores of 15 or above ($mean = 15.0, SD = 9.7, n = 588; mean = 21.3 SD = 11.8, n = 254$).
4. From caregiver and youth report, from 42% to 72% of children met DSM-V criteria associated with PTSD: re-experiencing (58% & 76%), avoidance (42% & 63%), negative mood/cognition (46% & 63%), and arousal (54% & 72%). Percentages listed in parenthesis are from caregiver and youth reports respectively.
5. Impairment in one or more area of children's functioning was reported by 55% of mothers and by 63% of youths.

Child behavior was assessed with the ECBI, a maternal rating scale in which scores above the 85th percentile are deemed of clinical concern. Overall, 34% of mothers reported their children's behavior to be of concern to them and rated 30% of children in the clinical range on the intensity of their behavior ($mean T Intensity score = 53.4, SD = 12.3 n = 736$). Because the population norm for clinical concern is 15% (100 - the 85th percentile threshold), these results indicate that roughly twice as many children were rated in the clinical range as one would expect from a general population sample. See Table 7.

Parenting stress was measured with the PSI-4 SF for mothers of children under 13 years of age and with the SIPA for mothers of adolescents. Both instruments have clinical cut-offs at the 85th percentile. On the SIPA, only the Adolescent Domain was used because the Parent Domain had multiple questions that assume the presence of a spouse and these questions in addition to not being appropriate, were coded by interviewers as "strongly disagree."

Parenting stress totals in the clinical range as measured by the inventories were evident among 15% of mothers of children ($mean percentile score = 58.5, SD = 25.1, n = 1,031$) and among 16% of mothers of adolescents ($mean percentile score = 59.2, SD = 21.9, n = 86$). Thus, the percentages of mothers who rated their stress at the clinical level was comparable to what one would expect to find in the general population. See Table 7.

Subscales of the PSI-4 SF indicated that the percentages of mothers who considered themselves to be stressed, as measured by the Parental Distress subscale (25%), and the percentages of mothers who considered their children to be difficult, as measured by Difficult

Child (23%), were higher than what one would expect to find in the general population (15%). Notwithstanding its relatively elevated rate, the Parental Distress subscale rate appeared modest relative to the results expected by clinicians and administrative staff who had spent years working with the population and were well acquainted with the mothers' lives and day-to-day behavior such that it was possible that these levels under-reported the mothers' actual stress status. Hence, to examine the issue at greater length, the evaluator conducted interviews with the Clinical Program Director and administrative staff. Also, clinicians were asked to provide a vignette that portrayed maternal stress at whichever level they wished; low, average, or high levels of stress. After these were provided, the mothers' stress scores were identified to look for apparent concurrence between the vignettes and the scores. See summary in Table 6.

Thematic analyses of the interviews and vignettes yielded the following interpretation. The stress instruments were primarily sensitive to situational stress, i.e., the level of stress experienced by mothers at the time of the interview that was above and beyond their typical stress levels. However, the instrument failed to account for chronic stress, in other words, whether the mother's typical level of stress was low, average, elevated, or high. Clinicians on the other hand were sensitive to both types of maternal stress.

The failure of the instrument to pick up chronic stress is exemplified in synthesis #1, the case of a mother who still as an adult had a problem with bedwetting yet scored in the 12th percentile. The instrument's sensitivity to situational stress can be seen in synthesis #2. In this case the mother came in at a relatively low level of situational stress, had a number of very distressing life events, and even though when she left she was well enough to do so, her stress score at post-intervention was still elevated relative to her entry score. Mothers #3, #4, and #5 had the chronic stressors of high risk pregnancy, childhood history of sexual abuse, and domestic violence which at pre-assessment registered as stress in the average range, from the 44th to the 64th percentile because the burden of these experiences were part of the fiber of their lives. They were events that the mothers lived with daily and their levels of stress only heightened after the pre-assessment when the pandemic limited one mother's ability to find a job and help her child and during therapy when the other mother re-visited issues of sexual abuse. But, their stress levels were not measured at those times. Syntheses #6 and #7 show elevated levels that were consistent with punitive childrearing and shutting herself away. The last two cases, clearly show maternal distress during the pre-assessment which were indeed picked up by the instrument, as reflected in the fact that they both scored in the 99th percentile. This pattern of findings was interpreted to be consistent with the conclusion that the instrument was sensitive to situational stress and not particularly sensitive to chronic stress possibly because for mothers their high levels of chronic stress were normal.

Table 6. Stress Vignettes and Percentile Score on Stress Instrument.

| Synthesis | Score(s) |
|--|---|
| 1. Mother related that her 7-year-old was bedwetting, her 17-year old still occasionally had the same problem and that she herself had a history of bedwetting that persisted into adulthood, even to the date. Mother attributed the bedwetting to stress. | 12th percentile |
| 2. Pregnant mother had 3 children. Inconsistent attendance at therapy sessions became worse with closing of day care because of the pandemic. Telehealth sessions did not work for her because she and therapist could not hear each other due to children's noise. She was hospitalized, suffered a miscarriage, and at a subsequent in-person session endorsed and presented with depressive symptoms. | 26th and 42nd percentile on pre- and on post- |
| 3. Pregnant mother had one child. During the pandemic she reported that with a high-risk pregnancy that required regular doctors' visits, and with schools being closed she could not get a job. Reported concern for her situation and for not being able to adequately support her child's distance learning. | 44th percentile |
| 4. Mother blamed herself more than typical and had crying spells during therapy when she recounted her brother's sexual abuse of her daughter; that "she should have known better." | 46th percentile |
| 5. Mother fled from a situation of domestic violence which she left after her boyfriend physically attacked her while pregnant which resulted in early labor. She was hyper-vigilant, constantly looking out the window during assessment. | 64th percentile |
| 6. Mother withdrew to her room and would not come out after the daycare closed. She became more irritable with her child, struggled to attend services for herself and her child, and take care of herself. "This response to stress is typical." | 74th percentile |
| 7. Mother, who had fled domestic violence was extremely irritable, harsh, and negative towards her children while simultaneously being overprotective of her children and other children at the shelter. "Her behavior is typical of mothers at the shelter." | 74th percentile |
| 8. In session mother discussed that while walking out of the shelter a man tried to approach her daughter and made inappropriate comments to her. This event re-traumatized her own history of abuse. | |
| 9. While responding to the PSI questions, mother seemed to be reflecting on the questions for the first time and started weeping. Said she tended to prioritize her child's needs and not think about herself. It is unusual for mothers to weep during assessment. | 99th percentile |
| 10. At pre-assessment, mother of 3 children expressed feeling extremely overwhelmed at having the sole responsibility of wage earning plus childcare. Prior to leaving her spouse because of domestic violence, she had been the family's wage earner and the father had cared for the children. | 99th percentile |

The question remains why mothers scored so much below the norm on Parent-Child Functional Interaction, 92% in the non-clinical range. Two interpretations have been offered for this finding. One is that relative to the other stressors that mothers have, they are not stressed by their relationship with their children unless it is an unusual case such as the mother who blamed herself for not realizing that her daughter was at risk of sexual abuse. The second interpretation is that mothers are guarded in reporting problems in this arena lest they compromise themselves and expose themselves to investigation by protective services.

Parenting relationship for dyads with children under age 13 was measured by the sum of positive parental statements expressed by mothers during the DPICS-IV five-minute observational protocol, i.e., the sum of labeled praises, reflections, and behavioral descriptions. The sums indicated that 52% of mothers made 0 or 1 positive statement to their children during the five-minute interaction (*mean statements = 2.6, SD = 3.6, n = 875*). Thus, half the mothers offered no positive verbal communication to their children during the five-minute interaction and the average was fewer than 3 statements in five minutes. See Table 7.

For dyads with children ages 13 and above, the parenting relationship was measured with the PRQ-CA. One third of respondents (33%) were not included in the statistics presented here because their F, D, Consistency Index, or Response Pattern Index was not "acceptable." T score averages of the seven scales for the remaining 57 mothers, ranged from a low of 46.8 for Satisfaction with School (SD = 10.7) to a high of 57.6 (SD = 10.5) for Involvement. In the clinical range were Satisfaction with School (25%), Communication (18%) and Attachment (16%). The high rate of unacceptable response patterns raises concern about the appropriateness of the instrument for this population. See Table 7.

Table 7. Trauma, Child Behavior, Parenting Stress, and Parenting Relationship: Averages, Percentage Occurrence and Percentages in the Clinical/Normal Range at Entry.

| Domain - Instrument, Measure | mean | S.D. | Percentages | | |
|--|------|------|-------------|--------|----------|
| | | | occurrence | normal | clinical |
| Trauma - CATS | | | | | |
| Potentially traumatic events-one or more | | | | | |
| Caregiver report | 2.4 | 1.7 | 86% | n/a | n/a |
| Youth report | 3.9 | 2.0 | 96% | n/a | n/a |
| Trauma symptom scores | | | | | |
| Caregiver report | 15.0 | 9.7 | -- | n/a | n/a |
| Youth report | 21.3 | 11.8 | -- | n/a | n/a |
| Meet DSM Criteria | | | | | |
| Caregiver report | | | | | |
| Re-experiencing | -- | -- | -- | 42% | 58% |
| Avoidance | -- | -- | -- | 58% | 42% |
| Negative mood/cognitive | -- | -- | -- | 54% | 46% |
| Arousal | -- | -- | -- | 46% | 54% |
| Youth report | | | | | |
| Re-experiencing | -- | -- | -- | 24% | 76% |
| Avoidance | -- | -- | -- | 27% | 73% |
| Negative mood/cognitive | -- | -- | -- | 37% | 63% |
| Arousal | -- | -- | -- | 28% | 72% |
| Functional Impairment | | | | | |
| Caregiver Report | -- | -- | -- | 45% | 55% |
| Youth report | -- | -- | -- | 37% | 63% |
| Child Behavior - ECBI | | | | | |
| Intensity T score | 53.4 | 12.3 | -- | 70% | 30% |
| Problem T score | 55.1 | 11.9 | -- | 66% | 34% |

| Domain - Instrument, Measure | mean | S.D. | Percentages | | |
|-------------------------------------|------|------|-------------|--------|----------|
| | | | occurrence | normal | clinical |
| Parenting Stress | | | | | |
| Children (PSI-4 SF) | | | | | |
| Parental Distress | 65.3 | 24.9 | -- | 75% | 25% |
| Parent Child Functional Interaction | 48.5 | 25.6 | -- | 92% | 8% |
| Difficult Child | 57.3 | 29.1 | -- | 77% | 23% |
| Total Stress | 58.5 | 25.1 | -- | 85% | 15% |
| Adolescents (SIPA) | | | | | |
| Adolescent Domain | 59.2 | 21.9 | -- | 84% | 16% |
| Parenting Relationship | | | | | |
| Children (DPICS) | | | | | |
| Positive statements | 2.6 | 3.6 | -- | n/a | n/a |
| 0 or 1 positive statement | -- | -- | 52% | n/a | n/a |
| Adolescents (PRQ) T Scores | | | | | |
| Attachment | 49.4 | 10.2 | -- | 84% | 16% |
| Communication | 50.5 | 10.5 | -- | 82% | 18% |
| Discipline Practices | 50.6 | 10.9 | -- | 86% | 14% |
| Involvement | 57.6 | 10.5 | -- | 93% | 7% |
| Parenting Confidence | 54.0 | 10.2 | -- | 89% | 11% |
| Satisfaction with School | 46.8 | 10.7 | -- | 75% | 25% |
| Relational Frustration | 47.2 | 11.8 | -- | 88% | 12% |

Note n/a = measure or indicator does not have normed clinical cutoffs.
 . Highlighted percentages indicate clinical rates above the 15% population norm.
 Counts for the statistics presented above are as follows:
 CATS Caregiver = 588; CATS Youth = 254
 ECBI = 736
 PSI-4 SF = 1,031
 SIPA = 86
 DPICS = 875
 PRQ = 57; excludes 29 respondents (33%) whose F, D, Consistency Index or Response Pattern was not "Acceptable"

Aim 2: Participation in Treatment

This section addresses the Program's second aim of improving child mental health status. The objective was to provide therapeutic services to mothers and children who reside in the shelter, adapting these as necessary.

Sessions. Since the beginning of Program implementation on August 1, 2018, 7,549 sessions were provided: 1,972, 2,900, and 2,677 in Years I, II and III, respectively. Thus, the number of sessions provided in Year II increased substantially and the level was maintained in Year III despite the Covid-19 pandemic. Percentages by modality were 39%, 34% and 27% for CPP_10+, PCIT, and TF-CBT, respectively. The maximum number of sessions by modality were 32, 16, and 19 for CPP_10+, PCIT, and TF-CBT, respectively.

Children. Table 8 presents the counts of children at various milestones of participation by treatment modality. Of 1,118 children assessed through the end of Year III, 833 (75%) had attended at least one session; 484 children (43%) had completed 10 or more sessions; and 481 children had completed post-assessments (43%). The average amount of time between sessions for children who had completed at least 3 sessions was 10.4 days ($SD = 5.1$). The average amount of time between sessions for children who had completed from 10 to 12 sessions was comparable, 10.2 days ($SD = 4.6$).

Table 8. Children Assessed, Attendees, and Completers.

| Service Milestones | CPP_10+ | PCIT | TF-CBT | Total |
|------------------------------|---------|------|--------|-------|
| Assessed | | | | 1118 |
| Attended 1 or more sessions | 328 | 231 | 274 | 833 |
| Attended 10 or more sessions | 184 | 128 | 172 | 484 |
| Completed Post-Assessment | 182 | 131 | 168 | 481 |

Children who had not attended at least one session ($n = 289$; 25%) included children who were waitlisted, had been assigned by the end of Year III but had not yet begun therapy, and children who were not assigned for various reasons. Reasons for non-assignment included: having moved out right away, having a sibling in therapy, receiving treatment outside of Lotus House, or having a member of the dyad unsuitable for therapy due to a health or developmental condition.

A key indicator of adequate service coverage is the total percentage of participants who completed treatment. Of 526 children who entered in Year I or II and had attended at least one therapy session, 57% completed at least 10 sessions and 67% completed a post-assessment. More children had completed post-assessments than the 10 sessions because in Year I and part of Year

II a concerted effort was made to assess families who were planning to move out even though they had not completed the sessions,

The Covid-19 Pandemic broke out eight months into the third year of services and a series of adaptations were made to continue to serve Program participants. A procedural manual was developed and revised multiple times as understanding increased on how to prevent transmission. Social distancing was practiced as much as possible, masks were used, and when necessary, sessions moved from in-person to a virtual delivery mode although most services were delivered in person. Breakdown by quarter of the services provided in Year III indicated that the very slight decrease in services from Year II to Year III, 223 sessions fewer, which was less than 10% of the sessions provided in Year II was not due to the Covid-19 pandemic. The slight decrease in services occurred in the first quarter of the year for reasons of staffing; staff on maternity leave, and staff turned over. The number of sessions provided in the first quarter of Year III and in the last quarter under Covid-19 conditions were 18% and 29% respectively of the total number of sessions for the year. Thus, the number of sessions provided in the fourth quarter, which was during the pandemic, was higher than the 25% that one would expect and shows excellent ability to deliver services..

The key findings on analyses of participation in therapy were:

1. An increase in services in Year II with respect to Year I was maintained in Year III
2. Substantial numbers of families were in the service pipeline
3. Average 10-session attainment was within 4 months
4. 57% completion rate was attained for families who began services in Years I or III

Aim 3: Treatment Outcomes

This section addresses the third aim of the Program, to evaluate the effectiveness of services provided. It includes the effects obtained from improving services on the basis of feedback obtained from analyses conducted throughout the life of the Program (See Tables 1 for aims, objectives and activities and table and Table 3 for the targets set by the Children's Trust for meaningful improvement).

Treatment results that occurred after the pandemic and include the effects of services provided during this period when session time was also allocated to pandemic-related stress and some sessions were conducted through Telehealth are included in analyses because a survey of clinicians, described below, indicated that they judged the sessions since the outbreak of the pandemic to be productive. Analyses to compare in-person and virtual sessions will be conducted in Year IV if there are sufficient virtual sessions for valid interpretation of results.

The section that follows provides statistics by treatment modality on the percentages of completers ($n = 484$) who met the meaningful improvement criteria established by the Children's Trust. Completers were families who had a post-intervention assessment, regardless of the number of

sessions they accomplished. These meaningful improvement criteria were as follows, each to be met by at least 75% of participants.

- a. A decrease of 20% or more from the pre-intervention symptom score on **trauma** symptoms.
- b. Score in the normal, non-clinical range on **child behavior**.
- c. Score in the normal, non-clinical range on **parenting stress**.
- d. For **dyadic interactions**:
 - a. Increase of 10 positive maternal statements from pre-intervention rate on observed interactions with children.
 - b. Movement towards or into the non-clinical range or staying in the non-clinical range on 5 of the 7 subscales of parenting relationships among mothers of adolescents.

Reductions in **trauma symptoms** were assessed among children who had pre-intervention scores above the clinical threshold of 15. As can be seen in Table 9, reductions of 20% or more on scores derived from maternal report were evident in: 67% of CPP_10+, 82% of PCIT, and 80% of TFCBT completers. Meaningful improvement was also observed on youth self-report by 81% of TF-CBT completers. Hence completers of two modalities, PCIT and TF-CBT, met the meaningful improvement criteria.

On **child behavior** ratings derived from maternal report, both PCIT and TF-CBT completers (85%) met the meaningful improvement criteria. CPP_10+ completers did not meet the 75% criteria but the percentage that met it was close, with 70% meeting the criteria.

In **parenting stress**, completers of all modalities met the outcome criteria of scores in the non-clinical range; 96%, 92% and 97% among mothers of children who participated in CPP_10+, PCIT, and TF-CBT respectively. For mothers of adolescents, 84% of TF-CBT completers likewise scored in the non-clinical range.

Because at pre-intervention the percentage of mothers whose overall **stress** scores was not elevated relative to the general population norms, the stress score might not be a good indicator of program effectiveness. Thus, analyses were conducted on the two domains that were elevated at entry and included only mothers who had scored in the clinical range at pre-intervention. Of 39, 45, and 35 mothers who had scored in the clinical range on the Parental Domain at entry and had completed the CPP_10+, PCIT, and TF-CBT respectively, 87%, 78% and 69% scored below the clinical threshold post-intervention. Of 30, 42, and 38 mothers who at entry had rated their children in the clinical range on the Difficult Child domain and had completed the CPP_10+, PCIT, and TF-CBT respectively, 63%, 76%, and 93% scored below the clinical threshold post-intervention. Hence, it would appear that for mothers who are particularly stressed, the CPP-10+ was marginally more successful in reducing stress than the other two modalities and that for mothers who were particularly stressed about their children, the TF-CBT was marginally more successful in reducing stress than the other two modalities.

On **positive maternal interactions**, the target was to increase these by 10 from pre-treatment levels. This target was met by 2%, 47%, and 3% of CPP_10+, PCIT, and TF-CBT completers, respectively. In addition to this target, the percentages of mothers who made only 0 or 1 positive statement was also examined. PCIT completers had substantially lower rates (9%) than CPP_10+

completers (45%) of post-intervention observations in which they expressed 0 or only 1 positive statement. This statistic is quite possibly the most meaningful indicator of improvement, because at entry, regardless of subsequent assignment, 52% of mothers made no positive statement to their children during the observed play session. Thus, a reduction to 9% among the PCIT group can be considered quite meaningful.

Parenting relationship in adolescents could be examined in 25 of 47 completers (53%) who had acceptable F, D, Consistency indices, and Pattern of Responses. Of these 25 completers who had participated in the TF-CBT, 72% improved or stayed in the non-clinical range in at least five of seven scales. Although the percentage fell short of the 75% criteria, the number of completers is quite modest. A more robust sample might attain the desired percentage.

Table 9. Percentages of Children/Mothers who Met the Meaningful Improvement Criteria by Modality.

| Construct | CPP % | PCIT % | TF-CBT % |
|---|------------------|-------------------|---------------------|
| Trauma symptom decrease: Caregiver (CATS) | 67% | 82% * | 80% * |
| Baseline scores of 15 or more | <i>n</i> = 15 | 17 | 90 |
| Trauma symptom decrease: Youth (CATS) | -- | -- | 81% * |
| Baseline scores of 15 or more | <i>n</i> = -- | -- | 86 |
| Child behavior non-clinical (ECBI) | 70% | 85% * | 85% * |
| | <i>n</i> = 64 | 116 | 163 |
| Parenting stress non-clinical: Children (PSI4-SF) | 96% * | 92% * | 97% * |
| | <i>n</i> = 182 | 132 | 168 |
| Parenting stress non-clinical: Adolescents (SIPA) | -- | -- | 84% * |
| | <i>n</i> = -- | -- | 45 |
| Positive relationship: Children (DPICS) | 2% | 47% | 3% |
| | <i>n</i> = 133 | 132 | 120 |
| Positive relationship: Adolescents (PRQ) | | | 72% |
| | <i>n</i> = | | 25 |

Note. *n* indicates the count of responses on which statistics are based.

Values marked with * indicate that the met the following meaningful improvement criteria.

Outcome of Randomized Treatment Groups

In Year III enough dyads randomized to the CPP_10+ and the PCIT modalities completed interventions to allow analyses of results. Consistent with the findings from non-randomized families these indicated that families who participated in the PCIT showed significantly higher levels of improvements than families randomized to the CPP_10+. As of the writing of this report, LH staff, Dr. Paulo Graziano and colleagues are preparing a manuscript for publication in a peer reviewed research journal.

Maternal Satisfaction

Using a 5-point scale, mothers were asked to rate their satisfaction with the modality in which they had participated, the degree to which they would recommend the program, and the quality of the relationship with their children. Depending on whether children had presented with trauma or behavior problems and had been assigned to the corresponding modality, mothers were asked to rate the children's behavior and trauma symptom improvement. Favorable ratings were considered those to which mothers had chosen 'better' or 'much better.' Table 10 below provides the percentages of favorable responses by modality.

Table 10. Maternal Satisfaction Ratings by Therapeutic Modality

| | Therapeutic Modality | | |
|--------------------------------|----------------------|------|--------|
| | CPP_10+ | PCIT | TF-CBT |
| The mother-child relationship | 63% | 78% | 70% |
| Improvement in child behavior | 71% | 82% | 74% |
| Improvement in trauma symptoms | 70% | 70% | 80% |
| The Lotus House Program | 92% | 86% | 90% |
| Likely to recommend Program | 91% | 82% | 90% |

Maternal ratings indicated a good to high degree of satisfaction. Mothers who participated in the CPP_10+ program had lower ratings of satisfaction with regards to improvement in the mother-child relationship, than did mothers who participated in the other two modalities. Mothers who participated in the PCIT had higher satisfaction with improvements in their children's behavior than did participants in other modalities and mothers who participated in the TF-CBT had higher satisfaction in improvements of trauma symptoms than did other mothers. Thus, satisfaction ratings reflected the aims of the specific therapeutic modalities. Interestingly, although mothers who

participated in the CPP_10+ modality had relatively lower satisfaction with regards to their relationship with their children and with improvements in child behavior and trauma symptoms, they had the highest ratings on their overall satisfaction. This suggests that mothers benefited from the CPP_10+ in ways that are not assessed by the other three questions.

Conclusions and Interpretations

A substantial number of families were served in the three years of implementation. Most of the children were quite young; infants and preschoolers. Mothers had very low levels of income, education, and a high proportion of the mothers were unmarried. Children's histories indicated very high rates of potentially traumatic events and elevated symptomatology possibly indicative of PTSD. Children's status at entry clearly indicated a portrayal of a population that was fragile, at high risk of developing developmental delays, particularly in social-emotional development.

Implementation demonstrated three major challenges to services as planned: 1) engaging families to keep them attending sessions regularly, 2) preventing staff turnover, and 3) a pandemic which made physical proximity a health risk. Staff turnover evidenced in Year I continued in Year II despite staff's high ratings of program features (See Appendix). In response, administration hired clinicians with more experience working with special needs populations and added increases in compensation including increases when staff attains professional markers such as becoming licensed. Although administration should continue to explore strategies to promote staff retention, it is recognized that the working conditions are challenging. Clients are difficult to engage and few clients reward clinicians by showing appreciation for their efforts. In addition, services must be provided over the weekend. Thus, a certain level of staff turnover might be unavoidable.

The **viability of the program** has been most evident by the fact that it continued to provide services through the pandemic that started in February of 2020. In addition to the fact that measures were taken to screen LH guests, to implement and teach best practices to reduce the possibility of transmission, it should be noted that from the outset, the Lotus House President moved into the shelter for three months. When challenged by the evaluator, she responded to the effect that, 'I can't ask people to do what I am not willing to do. I must show them that it is safe.'

As with any Program, it was important to monitor activities closely, including **data entry**, to prevent drift that can occur over time, particularly with changes in personnel. It is advisable that staff who maintain the database have experience in data management rather than a background in psychology. In a community setting where conditions are not controlled, for instance families leave and re-enter a shelter, or have several children all of whom need services, the realities of life can be

at odds with the consistency necessary for data analyses. Experience with data management allows staff to structure datasets in ways that allow for clinical and for research needs.

Families' Status. Findings indicated that children's risk of **developmental delay** and of **potential PTSD** increased with age. These findings are consistent with the fact that development is cumulative and other than motor development, which is relatively more "hard-wired" in the early years, it is also transactional. Abilities build over time through experience and interaction.

Across years, the percentage of mothers who rated their **children's behavior** in the clinical range was 30%, twice the 15% percentage that would be expected from the ECBI's norms. However, it has been suspected by clinicians and administrative staff since the beginning of this Program that the actual rate of disruptive behavior problems among children might have been higher than reported by mothers.

The results of the PSI returned rates of total **parenting stress** in the clinical range equal to that of the general population, 15%. This percentage included the following percentages in the clinical range, 25% for Parental Distress, 23% for Difficult Child, and 8% for Parent Child Functional Interaction. Results of qualitative analyses of clinical reports on maternal stress were interpreted to suggest that the PSI-IV SF measured maternal stress above and beyond what was typical for the mother. As such, it measured situational stress and did not account for chronic stress because the mothers had normalized the experience of being stressed. Clinicians also drew a link between chronic stress, maternal irritability with their children, and punitive parenting. The typical mother was characterized as highly stressed. The research literature on the relationship between punitive parenting and subsequent disruptive and aggressive behavior in children is well developed. As such, it is recommended that subsequent studies aim to improve our understanding of maternal stress in this population, how it is related to dyadic interactions, and how to affect both in a positive manner.

With mothers who are experiencing homelessness, **instruments** that require maternal report might not be particularly appropriate. Differences between this population and the general population in education and in experiences, as well as in the thresholds of what is considered normal and acceptable may hamper the ability of self-report instruments to measure accurately. The finding that children self-report more trauma symptoms than their mothers and more higher levels of PTSD symptoms, as well as the fact that on the SIPA only 53% of respondents had response patterns deemed acceptable, is an indicator that maternal responses in other instruments might likewise suffer from low levels of validity and reliability. Observational ratings of behaviors in naturalistic settings and situations are advisable.

Specifically, staff and maternal **feedback on instruments** suggested that some items were difficult to understand, some mothers felt that the questions were not appropriate to their children, and others took offense at some items. For instance, one mother reported that acknowledging some of her daughter's behavior felt like a betrayal to her love for her daughter and that a good mother would not feel negatively about her children's behaviors. In addition, requesting that mothers rate item after item, at a time when mothers were facing being homeless, might have been taxing and might have appeared irrelevant to them.

Notwithstanding difficulties in procuring regular attendance, a major **program attainment** was that 57% of mothers who had commenced services in Year I or II had completed at least 10 sessions and a post-assessment by the end of Year II. This is an impressive figure for this population. One study that used a similarly time-limited version of PCIT with parents who had or were at high risk of maltreating their children found an attrition rate of 32%. Hence, retention of 68%³.

Program Effectiveness. By the end of Year III, the number of completers in each modality was large enough to provide confidence in the findings. From these completers, it was evident that the PCIT was **particularly successful** at improving mothers' interactive behavior; that the PCIT and the TF-CBT were successful at reducing trauma symptoms; and that the CPP_10+ was valued by mothers, possibly by decreasing, more than the other two programs, the percentage of mothers whose stress placed them in the clinical range.

By the end of Year III, it was also evident that the percentages of dyads expected to make **meaningful improvement** or the meaningful improvement level itself on dyadic interaction as measured by the DPICS was too high for this population. Specifically, with a population that tends to make no positive statements in interacting with their children, it may be more reasonable to expect mothers to increase the number of positive statements by 5 rather than the currently expected 10 statements. In other words, whereas for most mothers, successful participation in the PCIT might imply an increase in the frequency of behavior that already exists, for these mothers implementing what they have learned in the PCIT requires two paradigm shifts. One is to be open to playing with their children and two, is to make positive statements. Thus, even a very modest increase from 0 might be an indicator of meaningful change. A follow-up study might examine the sustainability of gains.

The lack of performance of **the CPP_10+** on the measures of interest has been evident since the end of Year I. It could very well be that 10 to 12 sessions of the CPP_10+ is insufficient to show treatment effects. However, the reality of working with the population of families experiencing homelessness is that courses of treatment must be effective in as few sessions as possible. A modality that requires 40 to 50 sessions⁴, as does the CPP, is a challenge to implement for families experiencing homelessness and might not remain in a shelter for over a year. There is also a serious shortage of clinicians trained in the CPP_10+ modality. In Year I administration at the Lotus House tried for over a year to hire a trained clinician by posting on commercial hiring sites and industry job postings that historically have yielded results for other clinical positions, as well as by reaching out to agencies specializing in child therapy, specifically the CPP_10+. During that time, administration was unable to identify and hence hire one clinician who had completed the CPP_10+ training. Hence, to fill the position, the LH had to host its own CPP training. In addition training is expensive and extensive, lasting 18 months. On the other hand, completers endorsed the

³ R. Thomas, M.J. Zimmer-Gembeck. Parent-child interaction therapy: An evidence-based treatment for child maltreatment. *Child Maltreatment*, 17 (2012), pp. 253-266.

⁴ Lieberman, A. F., Ippen, C. G., & Van Horn, P. (2006). Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(8), 913-918.

CPP_10+ and appeared to feel supported by it. Besides being much briefer than intended to be, perhaps the assessment protocol fails to measure what mothers find beneficial.

The findings of engagement, however difficult it was to procure, and the favorable outcomes obtained have implications for the service community. In Year IV LH staff and consultants will undertake dissemination efforts.

Recommendations

With respect to the mother-child dyads, there are three major areas that the Program addressed for healing and preparing families for a successful life. Childhood trauma was addressed successfully by TF-CBT. Parenting strategies to increase positive mother-child interactions was addressed successfully by the PCIT, and the CPP_10+ appears to have had some effect on maternal stress, but the effect does not translate into more positive mother-child interactions as measured by our instruments. Possibly mothers felt better but still lacked the parenting strategies that the PCIT provides. Thus, the Program as it stood at the end of Year III still searches for an intervention that fully addresses parenting and maternal stress needs of children younger than 2 and older than 8 years of age. The recommendations that follow aim to lay the groundwork for identifying and procuring services for these gaps and needs.

1. Continue to take steps to improve attendance.
2. Continue to explore why, with this population, the instruments used failed to have the validity and reliability for which they are known. Hence, debrief mothers at/after post assessment to review pre- and post-intervention results with mothers, if/when there were discrepant results between:
 - a. maternal report on instruments and clinical impressions;
 - b. maternal report on instruments and maternal satisfaction;
 - c. substantial improvement at post-assessment for children who at pre-assessment mothers had reported as not having problems, and
 - d. worsening of child status.
3. In the Program, all assessments of children's behavior were derived from maternal report and findings show that these might lack validity and reliability. Hence, it is suggested that a subsequent Program add an independent measure of child behavior. To this end, consider a rating scale of children' behavior that could be coded from videotapes.
4. If Administration is not ready to replace the CPP_10+ and desires to explore it further,

- a. To see if the CPP_10+ has a positive effect that is being missed by current instruments, code maternal bonding and child attachment from existing DPICS videotapes.
 - b. Run a comparison study between the CPP_10+ and another empirically supported short-duration program that:
 - i. Has received high levels of maternal satisfaction ratings,
 - ii. Has had a significant positive effect on maternal-infant interaction, and
 - iii. Has available trained personnel that can be hired or conditions for training current personnel in a reasonable time frame and at a reasonable cost.
5. Test the association between maternal chronic stress with the quality of dyadic interaction and improvement in interaction with decreases in stress.
- a. Pilot test instruments designed to assess chronic stress.
 - b. Test an adjunct therapy to the PCIT, Triple P, and TF-CBT that focuses on maternal stress. Cognitive and dialectic behavioral therapy programs have garnered evidence of effectiveness and improving the effectiveness of conjoint modalities.
6. Procure additional funding as necessary to carry out coding of existing video tapes and subsequent service-driven research.

Appendices

A. Staff Titles, Effort, Qualifications, and Duties: End of Year III

| Title | # | % Effort | Position Type | Qualifications | Duties |
|------------------------------|------|-------------|---------------|---|---|
| President/Executive Director | 1 | 10% In-kind | Employee | Juris Doctorate | Overall project direction, program supervision, reporting, writing, and dissemination |
| Clinical Program Director | 1 | 100% | Employee | Psychology Doctor or PhD in relevant field preferred and research experience. Else Master's degree in relevant field and 10 years of research management experience | Oversee all operations: assessment, clinical services, data management, ensure clinical and data fidelity, serve as liaison with consultants, prepare reports, assist in program development, co-author research articles, attend required training and meetings. |
| Assessment Specialist | 2 | 100% | Employee | Bachelor in relevant field and research experience | Coordinate and conduct assessments, transcribe videotapes, code, enter data, track and monitor data. |
| Coders & Data Management | 3 | 100% | Employee | Bachelor's degree + experience in data management | Enter data, score and verify coding, ensure fidelity, manage database. |
| Counselor/Therapist | 6.25 | 100% | Employee | Masters' degree in psychology or related field, licensure or registered intern, 1 year of experience | Deliver CCP, PCIT, or TF-CBT, complete fidelity checks appropriate for the treatment modality, attend training and meetings. Two counselors have caseloads and supervisory responsibilities. |
| Engagement Specialist | 1 | | Employee | Bachelor in related field | Engage mothers, assist operations |
| Researcher | 1 | N/A | Consultant | Ph.D. in Psychology or relevant field | Train staff on PCIT model, monitor delivery of the PCIT to ensure fidelity. Write research articles. |
| Evaluator | 1 | N/A | Consultant | Ph.D. in evaluation or relevant field | Evaluate program effects: acceptability of treatment modalities, absolute and relative effectiveness of services, conduct statistical analyses, write reports and dissemination material on methods and findings. |

B. Interim Report Year II: Non-Attendance

This report addresses the intent expressed in the *Year I Evaluation Report* of focusing in Year II on maternal attendance and completion rates. Specifically, the recommendation in the end-of-the year report was to deepen the understanding of maternal reasons for no-show to develop strategies additional to those currently in use that will prevent no-shows.

Methods. The Evaluator conducted loosely structured interviews that on average lasted one hour each. Questions were adapted to the staff person's role. Core questions asked of therapists included:

1. What changes have come about since we spoke at the last focus group?
2. Tell me about "no-shows".
 - a. What do you do to prevent them?
 - b. What do you do when they happen?
3. Have personnel changes affected the work that you do?
 - a. How?
 - b. How is the counselors' mood?
4. What additional needs do children and mothers have that the Program might be able to meet?
5. Do you have any suggestions?
6. Do you have any questions?

Interviews also provided the opportunity to obtain narrative descriptions of the assessment procedure to compare it against the planned protocol and to assess the uniformity of strategies used across therapists. An interview of a therapist who facilitates all three modalities was also helpful for comparing the three modalities' benefits and drawbacks.

After each interview the Evaluator provided the interviewee with a written summary of their conversation so that staff could review it for validity and completeness. Once the interviews were completed, the Evaluator met with the researcher and with the clinical supervisor to obtain additional feedback and to review key points and interpretations drawn from the narratives.

Findings: No-Show. From mothers' pattern of participation, they could be classified into five types:

1. Non-compliers for reasons of oppositionality; tend to be non-compliers across the board;
2. Non-compliers for reasons of priority; other activities are deemed more important;
3. Difficulty complying because the mothers have difficulty functioning, organizing their lives;
4. Compliers of moderate ability;
5. Compliers who are highly motivated.

To the extent that mothers can accurately be classified in this manner, it is evident that the attendance strategies currently in use, which are reminding and finding the missing mothers, are best suited to type #3 above; mothers who have difficulty complying because they have difficulty organizing their lives. Additional strategies are needed for the other two types of non-compliers.

Mothers who are non-compliers for reasons of oppositionality tend to be non-compliers across the board, not just to child therapy sessions. For these mothers a response cost program might be effective (*to be discussed in person with the Research Team*). In this program, mothers would be allotted 8 "tickets" each month toward an end-of-the-month lottery. If mothers attend all sessions, at the end of the month, their

name gets put in the lottery 8 times, once for each ticket. Each session missed during the month, reduces the mother's allotted "tickets" by the count of 1 so that a mother who missed 1 session would have 7 "tickets" at the end of the month. To encourage mothers to return for a post-assessment session, these post-assessments could be worth 5 "tickets."

Mothers who are non-compliers because the treatment modalities are not a priority, need to have a strategy that aims to shift maternal priorities. The therapist should make a strong connection for mothers between observed or reported child behavior and why or how the treatment sessions will address the children's behaviors of concern. Given maternal understanding of play, as long as mothers see the sessions as "play" it may be difficult for mothers with competing demands to attend regularly. This issue might be most evident with the CPP_10+ which presents the sessions as play.

Emergent Issue: Children's Health. Children's poor health/hospitalization was mentioned several times as a reason for no-show. Lack of a primary health care provider might be leading to unnecessary hospitalizations or use of the emergency room. The social worker suggested she would look into health care practices and maternal choices for health care to see if hospitalizations could be diminished.

Emergent Issue: Staff Satisfaction. A considerable amount of training and supervision has been undertaken to ensure staff competence. Hence, it is important that the staff be retained. Although there was no specific expression of dissatisfaction, the reality is that the client population is challenging, crises occur frequently, the hours can be long, and the work schedule that includes evenings and weekend days is demanding. Prior suggestions to bolster staff's satisfaction and motivation are yet to be undertaken. As such, the next evaluative focus will be to see what perks or incentives might be put in place to maximize staff satisfaction.

Staff Suggestions. Staff suggested that the LH should have more programming for older children and teenagers. Programming ideas include entertainment, sports, clubs, and mental health groups.

Specific Suggestions for Implementation.

1. Verify that type #1 above are indeed non-compliers across the board.
 - a. At staff meeting therapists review caseload of the last 6 months and identify regular non-compliers.
 - b. At staff meeting of resource coordinators, resource coordinators review the therapists' whole client list and identify regular non-compliers.
 - c. What degree of overlap is there between the two lists of non-compliers?
2. Have assessment specialist write the script that she uses to explain difficult-to-understand items for mothers. Share the script with the new assessment specialist so that they can be consistent.
3. Continue to explore health care options and strategies designed to avoid unnecessary hospitalizations or use of emergency rooms. Revisit this issue at next interim report.
4. Evaluator to compare the results of the pre-intervention ECBI to the first intervention ECBI to look for increased disclosure on the second administration.
5. Have a reward system for staff that includes a salary increase with certification, switching out a weekend work day on a monthly basis or as a reward for surpassing expectations, and providing bonuses/treats such as haircare at an expensive salon, a massage, a plant, or flowers tied to excellent performance.

C. Interim Report Year II: Lotus House Staff Satisfaction Survey

{In Year II the Clinical Program Director resigned her position and a clinician who also had supervisory responsibilities for one of the modalities went on maternity leave. For a few months clinical staff did not have a Clinical Program Director followed by a few months with a temporary director. The staff survey reported below was undertaken 3 months after a replacement was hired. It should be noted that, as of the writing of this report, this individual continues to serve as Clinical Program Director and two layers of clinical supervision have been removed from the reporting hierarchy.}

Clinical, supervisory, assessment, and data entry staff members associated with the Program ($n = 11$) were asked to complete the 26-item satisfaction and feedback survey presented below. Anonymity was maximized by asking respondents to not include their names and by having each respondent fold the survey in half before placing it in a large manila envelope which was then sealed and signed before giving it to the Evaluator.

Nineteen (19) items were rated on a 5-point scale that ranged from “strongly disagree” (1) to “strongly agree” (5). Neither agree/disagree was given a value of 3. Hence, high scores indicate high levels of agreement and low scores indicate high levels of disagreement.

Results by individual suggested that 3 individuals were highly satisfied, average scores of 4.8 and 4.9, five individuals were satisfied, average scores of 4.1 to 4.6, and 3 individuals were mildly satisfied, average scores of 3.5 to 3.7. No individual expressed neutrality or dissatisfaction.

Results. Average responses by item are presented in Table 1, below. As can be seen from the table, it was unanimously felt that the mission of the Lotus House is important, and most items received high levels of endorsements. The lowest rated items were feeling valued by Program participants, 3.7, having the support and the resources necessary to do a good job, 3.6 and 3.7, respectively, as well as having an even distribution of work, 3.7. Open-ended responses suggested that time is the resource that was felt to be most lacking. No item received a rating of “1”.

Table 1. Summary of Item Responses.

| | |
|---|-----|
| 1. <i>The mission of the Lotus House is important.</i> | 4.8 |
| 2. <i>My job is important for Lotus House to accomplish its mission.</i> | 4.5 |
| 3. <i>I derive a sense of personal accomplishment from my work.</i> | 4.6 |
| 4. <i>I feel valued by Lotus House guests.</i> | 3.7 |
| 5. <i>I feel valued by Lotus House administration.</i> | 4.0 |
| 6. <i>I am clear on my job responsibilities.</i> | 4.1 |
| <i>I have the....</i> | |
| 7. <i>...skills necessary to do my job well.</i> | 4.6 |
| 8. <i>...motivation necessary to do my job well.</i> | 4.5 |
| 9. <i>...desire necessary to do my job well.</i> | 4.5 |
| 10. <i>...support necessary to do my job well.</i> | 3.6 |
| 11. <i>...resources (time/space/materials) necessary to do my job well.</i> | 3.7 |
| 12. <i>My feedback is valued by my supervisor.</i> | 4.0 |
| 13. <i>The staff members with whom I must interact are fun.</i> | 4.4 |
| 14. <i>The staff members with whom I must interact are supportive.</i> | 4.3 |
| 15. <i>Work is distributed fairly.</i> | 3.7 |
| 16. <i>I am doing a good job.</i> | 4.6 |
| 17. <i>My co-workers feel that I am doing a good job.</i> | 4.5 |
| 18. <i>My supervisor(s) feel that I am doing a good job.</i> | 4.4 |
| 19. <i>I want to stay at my job.</i> | 4.5 |

Fill in the blank for each item below. Feel free to write an extended response on the back of the paper.

At Lotus House...

20. *...my greatest source of satisfaction is*
21. *...my greatest source of dissatisfaction is*
22. *...my biggest skill challenge is*
23. *...I wish I knew how to ...*
24. *...the perk I most wish to have is ...*
25. *My suggestions...*
26. *If you gave any item a rating of "1" or "2", write in why*

The greatest source of satisfaction for respondents was helping families and/or feeling supported by co-workers. The biggest source of dissatisfaction was the workload, work schedule, working in a reporting hierarchy and the feeling that the team lacked unity, leadership and communication. The most cited skill challenge was engaging clients. Respondents wished they could meet all clients' needs, including transportation and childcare. The most frequently mentioned perks were a lighter workload in the form of fewer work hours, more vacation, and fewer work demands. Flexibility in work schedule, employee parking, trauma certification, and being part of the research meetings were also mentioned. Suggestions followed logically from the desired perks. Appreciative comments were also provided.

Recommendations/Comments.

1. Communicate to participants that staff's biggest motivation in their jobs is seeing the participants do well and having their assistance recognized by them.
2. Investigate what programs might be available to reflect guest appreciation. For instance, at exit mothers and older children could be asked if they would like to leave a "Thank You" to one or more employee that was particularly helpful to them. The "Thank you" could be a photograph of the child printed in a color printer on which the employee's name is written or a construction paper heart cut out by children on which the employee's name and the child's name is written.
3. Provide trauma training to all staff even if it is not directly associated with the person's job tasks.
4. It is understandable that some of the perks requested are impossible to provide because they require resources not readily available (employee parking lot, hiring more staff that would result in reduced workloads). However, greater flexibility in work schedules or a small increase in vacation time might be feasible.
5. The comments about communication and attendance at research meetings appeared linked. It is not clear what decisions staff thinks are being made at the research meetings that are not being communicated or to which it does not have input. Attendance by the whole team, even on a rotating basis, does not seem advisable given the comments on workload and the fact that procedures are set in place for the duration of the grant. Minutes from the research meetings could be communicated to the team at the subsequent staff meeting.