Lotus House Prenatal and Early Childhood Research Project Annual Research and Evaluation Report

October 1st, 2023, to September 30th, 2024

This report outlines significant program and administrative activities that occurred during the reporting period, positively impacting progress toward the program outcomes, as well as challenges that affected the progress toward the program outcomes.

PROJECT OVERVIEW

The Children First – Lotus House Prenatal and Early Childhood Development Research Project utilizes a community-academic partnership to implement and evaluate an intervention to provide evidence-based therapeutic practices to support early childhood development, well-being, and school readiness within Lotus House shelter. The shelter supports a high-need community of children and families who are mostly racial and ethnic minorities, who often face social and gender-based inequities, and are experiencing homelessness. Using a randomized control trial design, the study compares four therapeutic modalities: Child Parent Psychotherapy (CPP), Parent Child Intervention Therapy (PCIT), Perinatal Child Parent Psychotherapy (P-CPP) with adaptations, and Video Feedback Intervention for Positive Parenting–Sensitive Discipline (VIPP). Additionally, therapeutic interventions, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is provided for children 6 years and older. Family Check-Up/Everyday Parenting (FCU-EP), introduced last year, is designed to help parents identify and address potential behavioral and emotional challenges in children before they become significant problems, with a strong emphasis on early intervention and prevention. FCU-EP is offered to mothers of children aged 0-5 who are not in the clinical range for trauma or behavioral problems. It is also provided to mothers of children aged 6-18 years who are not in the clinical range for trauma or behavioral problems **and** do not have clinically elevated scores in other domains. The project includes the following aims:

- Increase current understanding of the developmental, social and emotional wellbeing (mental

health), and trauma of homeless children, birth to 5.11 months, and their mothers (including expecting mothers).

- Improve child developmental status and social and emotional well-being, reduce impacts of trauma, and improve mother-child relationships by providing services.
- Evaluate the effectiveness of services provided to optimally support sheltered children experiencing homelessness and their service providers.
- Raise public awareness of the developmental, social/emotional and trauma needs of sheltered children and the mental health and parenting needs of their mothers (including expecting mothers), and the value of evidence-based and promising practices to support early childhood development, well-being and school readiness and improve the lives of children and families disproportionately impacted by racial, ethnic, gender (including intergenerational trauma and maternal victimization), health, educational and social/economic inequities and further marginalized by homelessness.

The current research project builds off prior work conducted by Lotus House and Florida International University. The current findings indicate children in the shelter are experiencing developmental delays and social-emotional deficits; caregivers are at risk for child maltreatment; and both caregivers and expectant mothers are experiencing trauma-related symptoms. This research contributes to evidence of the need for clinical support for sheltered children and their mothers.

METHODS

Randomization

During intake, all mothers are informed of Lotus House requirements that children participate in therapy. Mothers are also offered the option to participate in the randomized control trial. Mothers who agree to participate sign an informed consent form, per the protocol approved by the Florida International University IRB. Upon receipt of the signed informed consent form, the mothers are randomized into one of the appropriate therapeutic modalities, based on the age of their children. Families are generally kept in the same therapeutic modality, to avoid contamination of results of children in the same family participating in different modalities. Thus, the unit of randomization is at the mother- child(ren) level. Additionally, clinical needs also take priority over randomization; therefore, if a clinical modality that the family is not randomized to is a better fit to meet their clinical needs, they are placed in that modality rather than being randomized.

Service provision and fidelity monitoring

After randomization, the mother and child(ren) are assigned a Lotus House staff therapist. Each therapist has completed extensive training in the modalities for which they provide services. Services are offered for 12 weeks or sessions. Staff are monitored for fidelity to modality implementation through videotaped sessions, which are reviewed by the supervisor. Consent is obtained prior to videotaping participants. Upon completion of the intervention, participants are reassessed. These assessments are a second-time point. Post-intervention assessments are matched with pre-intervention assessment data.

Assessments

All mothers and children are assessed as part of the Lotus House intake procedure. Before the delivery of the therapeutic modality, sociodemographic data is collected (**Tables 1-2**), and the Lotus House Caregiver/Youth Clinical Assessment is administered. Trained Lotus House staff conduct the assessments and record the data. In addition, parenting, family interactions, and child behavior are assessed from rating scales and structured observations. The clinical rating scale assessments (**Appendix A**) are administered to participants before the therapy modality is delivered, serving as baseline analysis, and again upon completion of therapy (10-12 sessions).

Analyses

Baseline assessment data was analyzed to increase current understanding of the developmental, social, and emotional well-being (mental health), and trauma of homeless children (N=1,206), their caregivers (N=776), and expectant mothers (N=76). Furthermore, an analysis was conducted using matched pre-intervention and post-intervention assessment data from 470 participants who completed the assigned therapy modalities: Child-Parent Psychotherapy (CPP, N=150); Family Check Up/Everyday Parenting (FCU-EP, N=22); Perinatal Child-Parent Psychotherapy for expectant mothers (P-CPP, N=27); Parent Child-Interaction Training (PCIT, N= 60); Video Feedback Intervention for Positive Parenting-Sensitive Discipline (VIPP, N=56); and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT, N=155). The analysis includes the outcomes of the scales as well as a comparison of the percentage of participants who improved in child social and emotional well-being, mother-child relationships, and reduced impacts of trauma among the different therapy modalities. Outcomes from the assessments were interpreted by scores categorized as normal, borderline, and clinically significant. **Appendix A** has brief descriptions of each assessment, the number of completed assessments at baseline, and the number of

individuals who successfully completed each assigned therapy modality with baseline and follow-up assessments.

Limitations

Currently, there have been three years of data collection for this five-year study. At the end of the study, there will be sufficient matched assessment data from participants who completed different therapy modalities for inferential statistics to be conducted.

PRELIMINARY RESEARCH RESULTS - QUANTITATIVE

Child and family sociodemographic characteristics

A total of 1,206 children from 774 unique households received services. More than half of the children (67.1%) were 0 to 5 years old, with an average age of 5 years. Children's gender was evenly split between female (49.2%) and male (50.2%); most children were Black or African American (64.2%) and more than one-third were Hispanic (41.9%). Nearly half of the children were not yet enrolled in daycare or school (45.4%). Comparatively, demographic trends were similar among participants who completed therapy and those interviewed at pre-intervention (Table 1), apart from a slightly lower proportion of younger children, ages 0 to 5 years who completed the therapy modalities (59.8%) compared to those assessed at baseline (67.1%).

Table 1. Child demographics for children interviewed at baseline (N=1,206) and for those who completed the assigned therapy modality (N=443).

	Baseline (N=1,206)	Therapy Completed (N=443)
	N (%)	N (%)
Gender		
Female	601 (49.8)	214 (48.3)
Male	605 (50.2)	229 (51.7)
Ethnicity		
Haitian	109 (9.0)	36 (8.1)
Hispanic	505 (41.9)	201 (45.4)
Non-Hispanic	581 (48.2)	203 (45.8)

	Baseline (N=1,206)	Therapy Completed (N=443)
	N (%)	N (%)
Another ethnicity	11 (0.9)	3 (0.7)
Race		
American Indian or Alaskan	1 (0.1)	-
Asian	3 (0.2)	-
Black or African American	774 (64.2)	261 (58.9)
Multiracial	50 (4.1)	21 (4.7)
White	369 (30.6)	158 (35.7)
Another race	8 (0.7)	3 (0.7)
Age (years)		
Mean (*SD*)	5.0 (*4.23*)	5.6 (*4.41*)
Age Groups (years)		
0 - 2	489 (40.5)	165 (37.2)
3 - 5	321 (26.6)	100 (22.6)
6 - 8	183 (15.2)	78 (17.6)

Of caregivers assessed at baseline (N=776), most identified as Black or African American (61.2%), 41.6% identified as Hispanic, and more than half of caregivers (59.7%) had one child in the household. Of expectant mothers (N=76), 65.8% identified as Black or African American, 34.2% identified as Hispanic, and the average age was 27.3 years. Of caregivers and expectant mothers, most spoke English (79.4% - 86.8%), followed by Spanish (27.6-39.8%), and Haitian Creole (6.6%-7.5%). Sociodemographic trends were similar among caregivers and expectant mothers who were interviewed pre-intervention and who completed the therapy modality (Table 2).

Table 2. Sociodemographic characteristics for caregivers and expectant mothers interviewed at baseline and for those who completed the assigned therapy modality.

	Caregiver		Expectant Mother	
	Baseline (N=776)	Therapy Completed (N=286)	Baseline (N=76)	Therapy Completed (N=27)
	N (%)	N (%)	N (%)	N (%)
Ethnicity				
Haitian	63 (8.1)	21 (7.3)	4 (5.3)	2 (7.4)
Hispanic	323 (41.6)	130 (45.5)	26 (34.2)	9 (33.3)
Non-Hispanic	384 (49.5)	134 (46.9)	43 (56.6)	16 (59.3)
Another race	6 (0.8)	1 (0.3)	3 (3.9)	-
Race				
American Indian or Alaskan	4 (0.5)	1 (0.3)	-	-
Asian	2 (0.3)	1 (0.3)	-	
Black or African American	475 (61.2)	160 (55.9)	50 (65.8)	19 (70.4)
Multiracial	13 (1.7)	6 (2.1)	2 (2.6)	-
White	274 (35.3)	116 (40.6)	24 (31.6)	8 (29.6)
Another race	8 (1.0)	2 (0.7)	-	-
Age (years)				
Mean (*SD*)	-	-	27.3 (*6.4*)	26.9 (*5.6*)
Education				
Less than HS Diploma	251 (32.3)	78 (27.3)	29 (38.2)	9 (33.3)
HS Diploma/GED	323 (41.6)	126 (44.1)	35 (46.1)	13 (48.1)
Some College/Technical College	129 (16.6)	54 (18.9)	9 (11.8)	4 (14.8)
Graduate degree	7 (0.9)	2 (0.7)	-	-
Associate degree	32 (4.1)	14 (4.9)	2 (2.6)	1 (3.7)
Bachelor's degree	34 (4.4)	12 (4.2)	1 (1.3)	-
Languages Spoken				
English	616 (79.4)	223 (78.0)	66 (86.8)	23 (85.2)
Spanish	309 (39.8)	116 (40.6)	21 (27.6)	8 (29.6)
Haitian Creole	58 (7.5)	18 (6.3)	5 (6.6)	2 (7.4)

	Caregiver		Expectant Mother	
	Baseline (N=776)	Therapy Completed (N=286)	Baseline (N=76)	Therapy Completed (N=27)
	N (%)	N (%)	N (%)	N (%)
Other	15 (1.9)	6 (2.1)	4 (5.3)	2 (7.4)
Number of Children in Household				
0	-	-	70 (92.1)	24 (88.9)
1	463 (59.7)	178 (62.2)	5 (6.6)	3 (11.1)
2	213 (27.4)	78 (27.3)	1 (1.3)	-
3	82 (10.6)	27 (9.4)	-	-
4 or more	18 (2.3)	3 (1.0)	-	-

Status at entry

One project aim is to increase current understanding of the developmental, social, and emotional well-being (mental health), and trauma of homeless children, their mothers, and expectant mothers. The following analysis seeks to expand understanding in the aforementioned areas and is representative of all children, caregivers, and expectant mothers before participating in an assigned therapy modality. Among children aged 0 to 5.11 years, 738 children (91.1%) were identified as being in the high-risk category for at least one domain. For children aged 6 years and older, 318 children (80.3%) were similarly classified. These high-risk designations were based on assessments across multiple domains, including low-quality parent-child interactions, potential deficits in competence, social, behavioral, and emotional difficulties, severity of PTSD symptoms, and the need for referrals for developmental skills prior to treatment.

Developmental and behavioral status of children

Developmental status was assessed for children 6 months to 8 years of age using the **Battelle Developmental Screener (BDI)**. More than half of all children (64.9%) required a referral for further assessment in one or more developmental domains. One-third or more of children required further assessment for developmental delays in cognitive skills (42.7%) and communication skills (35.1%). The cognitive domain measures those skills and abilities most commonly thought of as "mental" or "intellectual," with the exception of language and communication skills; the communication domain

measures how effectively a child receives and expresses information and ideas through verbal and nonverbal means. Referrals were more frequent for communication (10.7%) and cognitive skills (9.7%) among younger children aged 6 to 36 months compared to older children aged 3 to 8 years. In contrast, older children had higher referral rates for adaptive skills (9.5%) and motor skills (3.2%). Despite these differences, the overall screening referral rate was similar across the two age groups. Referral rates using BDI scores were calculated for younger, older children, and all children (Table 3).

Table 3. Children's Development Status at Entry as Assessed by BDI: Referral Rates (%)

	6 to 36 mos. (N=355)	3 to 8 years (N=453)	All (N=808)
	%	%	%
Adaptive	23.4	32.9	28.7
Social-Emotional	19.2	19.2	19.2
Communication	40.6	30.9	35.1
Motor	25.9	29.1	27.7
Cognitive	48.7	38.0	42.7
Total Screening Score	31.3	30.9	31.1

The **Brief Infant Toddler Social Emotional Assessment (BITSEA)** is used to assess social-emotional problems and deficits in competencies among children ages 12 months to 35 months. The BITSEA has items that measure certain areas such as externalizing problems, internalizing problems, dysregulation, maladaptive behaviors, and atypical behaviors as well as competence. There was a high need for referrals for social and emotional problems for children before treatment (51.1%). Referrals for potential deficits in competence among children pre-intervention were comparatively lower (27.2%).

There are two versions of the **Child Behavior Checklist (CBCL)**: one for use with children ages 1.5-5 years, and children 6-18 years. The Total Problems scale measures the following syndromes: anxious/depressed, withdrawn/depressed, somatic complaints, rule-breaking behavior, aggressive behavior, social problems, thought problems, and attention problems. Of children ages 1.5-5 years assessed by the CBCL, 21.6% fell into the clinical range for total problems, and 24.8% of older children assessed fell into the clinical range for total problems. Before the intervention, most children aged 1.5–5 years (70.0%) and 6–18 years (62.5%) were assessed as being in the normal range according to the CBCL.

Traumatic events and symptoms

The **Caregiver Child Adolescent Trauma Screen (C-CATS)** was administered to caregivers of youth ages 3-17 years, and the **Youth Child Adolescent Trauma Screen (Y-CATS)** was self-administered to youth ages eight years and older. The total PTSD Severity score is used to interpret the severity of trauma (**Table 4**). Most caregivers reported that their child or adolescent (78.9%) had experienced at least one traumatic event. There was a similar rate of probable PTSD reported by caregivers among younger children aged 3 to 6 years (22.4%) and older children aged 7 to 17 years (23.2%). However, a higher rate of probable PTSD (34.8%) was observed among youths aged 8 to 17 years based on their self-reported trauma symptoms.

Table 4. Severity of Trauma Symptoms as Assessed by the C-CATS and Y-CATS among Children and Adolescents.

	C-CATS (3-6 years) N=406	C-CATS (7-17 years) N=310	Y-CATS (8+ years) N=253
	%	%	%
Normal	71.2	61.0	48.2
Moderate trauma-related distress	6.4	15.8	17.0
Probable PTSD	22.4	23.2	34.8

At baseline, nearly half of the children and adolescents met DSM-5 criteria for trauma-related symptoms as assessed by the C-CATS instrument, including re-experiencing (47.8%), functional impairment (44.7%), arousal (40.4%), and avoidance (32.5%).

In addition, the **PTSD Checklist-5 (PCL-5)** was used to assess the 20 DSM-5 symptoms of PTSD for caregivers and expectant mothers. The PCL-5 Severity Score was used to interpret the severity of trauma symptoms. As seen in **Table 5**, there was a high prevalence of probable PTSD among both expectant mothers (46.1%) and caregivers (35.6%) at baseline.

Table 5. Severity of Trauma Symptoms as Assessed by the PCL-5 among Caregivers and Expectant Mothers.

	Caregivers (N=592)	Expectant Mothers (N=76)
	%	%
Normal	47.8	39.5

Moderate trauma-related distress	16.6	14.5
Probable PTSD	35.6	46.1

The following outcomes are from an analysis of matched participants (N=470) who completed their therapy modality. Participants who completed therapy were assigned to the following therapy modalities: **CPP,** N=150 (31.9%); **FCU/EP**, N=22 (4.7%); **P-CPP**, N=27 (5.7%); **PCIT**, N=60 (12.8%); **TF-CBT**, N=155 (33.0%); and **VIPP**; N=56 (11.9%). The following assessment results are grouped by the following constructs: trauma, parent stress, child social-emotional and behavioral problems, and parenting practices. The analysis reflects how the therapy modalities compare in effectiveness, although the results are subject to change as further data is collected over the next two years.

Traumatic events and symptoms

The highest rate of improvement in trauma symptoms among children aged 3-6 years was seen in participants who completed **TF-CBT (38.1%)**, although other therapies, such as **CPP, VIPP, and PCIT**, also demonstrated notable improvements. Prior to intervention, approximately one-third of children in this age group exhibited moderate trauma-related distress and probable PTSD across most modalities, except for those who received **FCU-EP**.

For older children (ages 7-17), **41.8%** were reported by caregivers to have clinically elevated trauma symptoms prior to the intervention, while **51.4%** self-reported elevated symptoms based on the **Y-CATS assessment**. **TF-CBT (78.9%)** demonstrated a notably high rate of improvement in reducing trauma severity for this age group, as measured by the **C-CATS**. Additionally, **TF-CBT** led to improvements in **32.7%** of cases as assessed by the **Y-CATS**.

Additionally, improvements in trauma symptoms were observed among **expectant mothers (37.0%)** and caregivers **(34.6%-38.5%)** as assessed by the **PCL-5**.

Below is the percentage of participants who have moderate trauma-related distress and probable PTSD pre- and post-intervention (**Table 6**) and the percentage of participants who reduced traumatic symptoms from pre-intervention to post-intervention across therapy modalities (**Figure 1**).

Table 6. Pre- and Post-Intervention Comparison of Trauma Symptoms (% Moderate Trauma-Related Distress and Probable PTSD) among Children, Adolescents, Caregivers, and Expectant Mothers by Therapy Modality.

	CPP		FCU-EP		PCIT		TF-CBT		VIPP		P-CPP	
Assessment	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
C-CATS (3-6 years)	31.3	12.5	11.1	11.1	31.3	16.7	47.6	38.1	27.3	4.5	-	-
C-CATS (7-17 years)	-	-	16.7	8.3	-	-	41.8	23.3	-	-	-	-
Y-CATS (8+ years)	-	-	12.5	12.5	-	-	51.4	30.0	-	-	-	-
PCL-5	51.7	28.9	-	-	61.5	38.5	-	-	44..2	26.9	66.7	51.9

Note: Expectant mothers participated in the P-CPP modality.

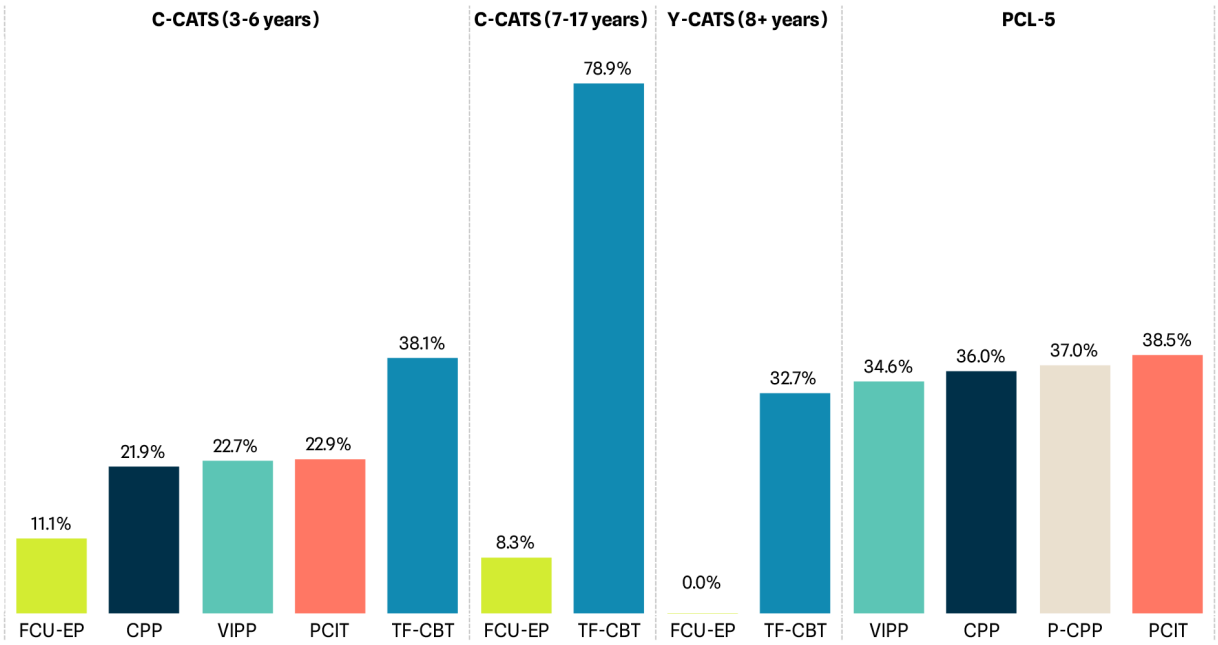

Figure 1. Improvement in traumatic symptoms among children, adolescents, caregivers, and expectant mothers by therapy modality.

Parent stress

The **Parenting Stress Index v.4 Short Form (PSI-4)** is designed to identify parent-child systems under

stress and at risk for developing dysfunctional parenting behaviors or behavior problems in children. At baseline, nearly half or more of parents reported stress levels within the borderline to clinical range **(42.7%-56.7%)** as assessed by the PSI-4 (Table 7).

As shown in Figure 2, the greatest improvements in reducing the risk of developing dysfunctional parenting behaviors were observed among caregivers who participated in **PCIT (43.3%)** and **VIPP (26.8%)**. The **Stress Index for Parents of Adolescents (SIPA)**, which evaluates stress levels among parents of adolescents, found that only a small percentage of caregivers **(14.7%)** were in the borderline to clinical range pre-intervention. Among those who received **TF-CBT**, **18.2%** experienced reductions in stress as measured by the SIPA.

These results highlight that **PCIT** is the most effective intervention for reducing parenting stress, while **FCU-EP** may require reconsideration or adjustments when applied in contexts focused on alleviating caregiver stress.

Table 7. Pre- and Post-Intervention Comparison of Stress (% within Borderline and Clinical Range) among Caregivers as Assessed using the Total Percentile Scores.

	CPP		FCU-EP		PCIT		TF-CBT		VIPP	
Assessment	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
PSI-4	42.7	35.1	30.0	50.0	56.7	21.7	43.8	35.8	46.4	28.6
SIPA	-	-	-	-	-	-	14.7	6.0	-	-

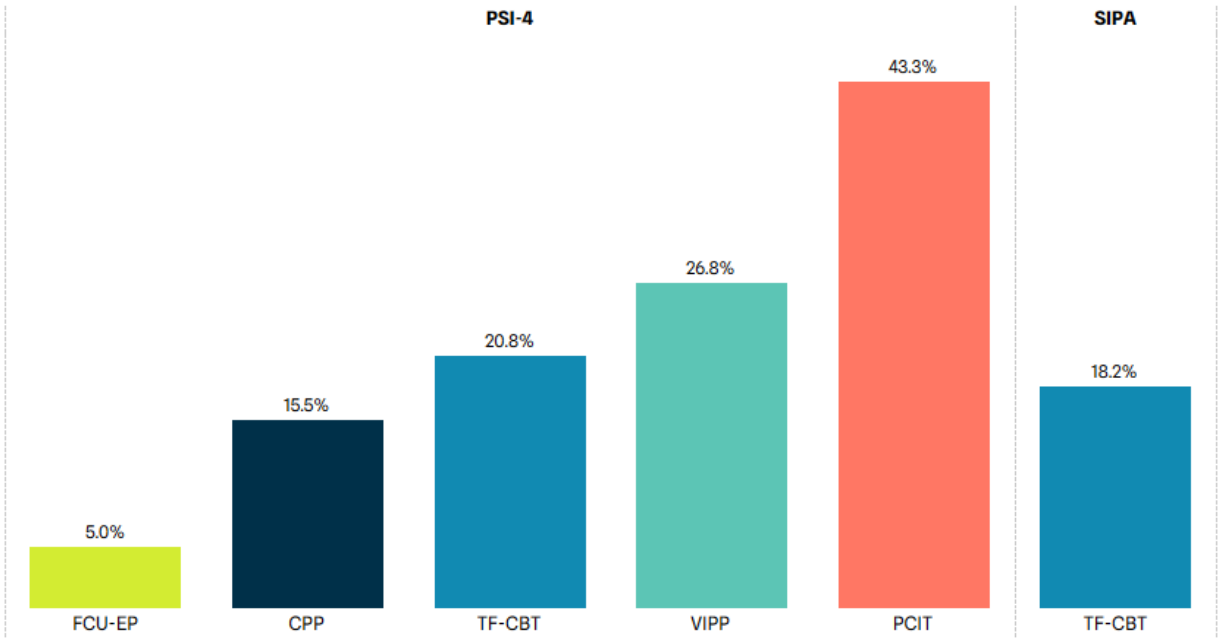

Figure 2. Improvement in parent-child systems that are under stress and stress levels among parents of adolescents.

Child social emotional and behavioral problems

At baseline, at least one-third of children (**31.3%-34.1%**) aged 1.5-5 years participating in **CPP** and **PCIT** were in the borderline to clinical range for behavioral and social-emotional problems, compared to **VIPP (22.7%)** as assessed by the **CBCL** (Table 8). Additionally, across all modalities, most children (**46.9%-75.0%**) were within the borderline to clinical range for social-emotional problems, as indicated by the **BITSEA**.

Among children aged 1.5 to 5 years, the greatest improvements in behavioral problems and competence were observed in those receiving **PCIT (22.0%-33.3%)** and **CPP (14.8%-20.4%)**, based on assessments from the **CBCL** and **BITSEA** (Figure 3). It is notable that the BITSEA, which is primarily used to assess younger children aged 12 to 36 months, included considerably more participants in the CPP (N=54) and VIPP (N=32) modalities compared to PCIT (N=12), reflecting the tendency to assign children aged 2.9 years or younger to CPP or VIPP due to their developmental focus on early childhood. For older children (ages 6-18), **PCIT (57.1%)** demonstrated the most substantial improvement in reducing behavioral and social-emotional symptoms. In contrast, **FCU-EP (0%)** showed no measurable improvement. However, it is important to note that the baseline rates of children in the borderline to

clinical range for FCU-EP were relatively low compared to other modalities. As a preventative intervention, FCU-EP is specifically designed to prevent the escalation of behavioral and emotional problems in children. Additionally, as a brief intervention, it focuses on helping parents identify their parenting goals and develop actionable plans to achieve them, which may limit its immediate impact on measurable child outcomes.

Overall, **PCIT** consistently shows the highest rates of improvement across assessments, particularly in reducing behavioral problems, enhancing social-emotional well-being, and increasing competence.

Table 8. Pre- and Post-Intervention Comparison (% within Borderline and Clinical Range) of Behavioral and Social-Emotional (SE) Problems by Therapy Modality.

	CPP		FCU-EP		PCIT		TF-CBT		VIPP	
Assessment	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
CBCL 1.5-5 years	31.3	21.9	-	-	34.1	22.0	-	-	22.7	18.2
CBCL 6-18 years	-	-	16.7	22.2	57.1	42.9	36.6	28.5	-	-
BITSEA:										
SE Problems	53.7	14.0	-	-	75.0	8.3	-	-	46.9	17.9
Deficits in Competence	25.9	18.5	-	-	41.7	33.3	-	-	12.5	6.3

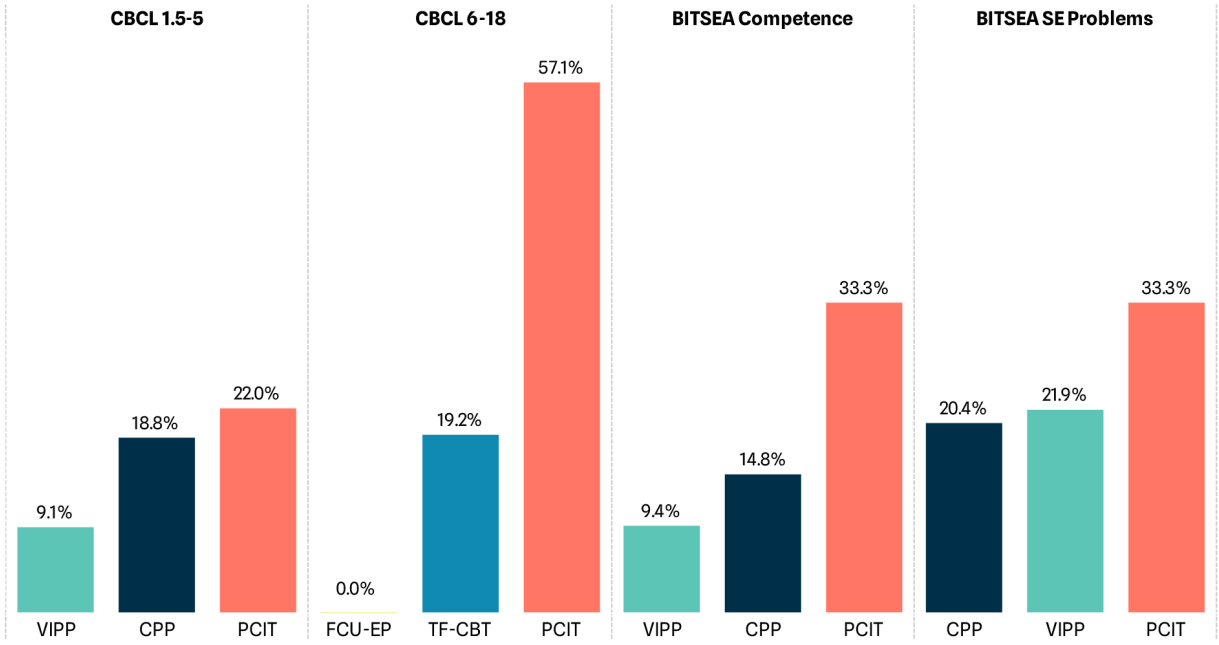

Figure 3. Improvement in behavioral and social-emotional (SE) problems among children and adolescents by therapy modality.

Parenting practices

The **Keys to Interactive Parenting Scale (KIPS)** mean score is the average of items rated on a 1 to 5 scale and indicates the quality of parenting, which includes such constructs as building the parent-child relationship, promoting learning and development, supporting confidence, understanding their child's developmental and behavioral needs, and responsive parenting behavior in relation to the child's needs. To make sense of the changes in scores for program evaluation, the KIPS behavioral descriptors allow the scores to be categorized as low quality, moderate quality, and high quality. Nearly a third of caregivers (29.4% to 32.6%) were in the low-quality parenting category pre-intervention across all modalities (**Table 9**). In addition, as seen in **Figure 4** an impressive 54.0% of caregivers improved in quality of parenting who were assigned to the PCIT modality, followed by caregivers assigned to CPP (41.1%) and VIPP (37.0%).

The **Adult Adolescent Parenting Inventory v. 2 (AAPI)** assesses parenting and child-rearing attitudes. The following constructs are assessed: expectations of children (APPI-A), empathy towards children's needs (APPI-B), use of corporal punishment as a means of discipline (APPI-C), parent-child role responsibilities (APPI-D), and children's power and independence (APPI-E). The scores are

categorized by risk (low-risk, moderate-risk, and high-risk) for child maltreatment. The following (Table 9) includes the percentage of caregivers and expectant mothers who are at high risk for maltreatment. Across the constructs, on average, the following percentage of caregivers were in the high- risk category for child maltreatment pre-intervention: 29.8% assigned to CPP; 37.5% assigned to FCU-EP; 35.7% assigned to PCIT; 40.0% assigned to TF-CBT; 31.5% assigned to VIPP; and 35.6% assigned to P-CPP.

CPP emerges as the most effective modality, demonstrating consistently high rates of improvement across most AAPI constructs. VIPP excels particularly in enhancing empathy (32.7%) and reducing beliefs in corporal punishment (19.2%). VIPP also had a significant impact on parent-child family roles (26.9%). FCU-EP is highly effective in fostering empathy (37.5%) but has limited impact on other parenting beliefs. TF-CBT is particularly effective in enhancing empathy (31.9%) and promoting children's independence (25.5%). PCIT has balanced but moderate improvements, particularly in fostering children's independence (26.2%). P-CPP is particularly effective in improving expectations of children (22.0%) and fostering children's independence (25.9%). It also shows notable effectiveness in enhancing parental empathy (25.9%), making it a strong intervention for expectant mothers aiming to adjust parenting beliefs before the child's birth.

Table 9. Pre- and Post-Intervention Comparison of Quality Parenting (% in the Low-Quality Range) and Parenting Beliefs/Practices (% in the High-Risk Range for Child Maltreatment) among Caregivers and Expectant Mothers.

	CPP		FCU-EP		PCIT		TF-CBT		VIPP		P-CPP	
Assessment	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
KIPS (Quality of Parenting-Low)	32.6	18.6	-	-	29.4	12.0	-	-	30.9	14.8	-	-
AAPI A. Expectations of Children	28.4	32.5	25.0	37.5	38.1	42.9	44.7	36.2	23.1	36.5	29.6	22.2
AAPI B. Parental Empathy Towards Children's Needs	44.8	43.0	75.0	37.5	57.1	50.0	61.7	38.3	51.9	40.3	51.9	40.7
AAPI C. Use of Corporal Punishment	12.1	12.3	37.5	25.0	9.5	16.7	17.0	19.1	17.3	11.5	11.1	11.1
AAPI D. Parent-Child Family Roles	31.9	25.4	12.5	12.5	35.7	26.2	51.1	34.0	34.6	23.1	29.6	25.9

AAPI E. Children's Power and Independence	31.9	21.9	37.5	25.0	38.1	23.8	25.5	19.1	30.8	21.2	55.6	37.0

	CPP	PCIT	VIPP	TF-CBT	P-CPP	FCU-EP
KIPS	41.1%	54.0%	37.0%			
AAPI-A	19.3%	11.9%	15.4%	19.1%	22.0%	12.5%
AAPI-B	28.1%	21.4%	32.7%	31.9%	25.9%	37.5%
AAPI-C	16.7%	14.3%	19.2%	12.8%	14.8%	12.5%
AAPI-D	25.4%	21.4%	26.9%	23.4%	14.8%	0.0%
AAPI-E	28.9%	26.2%	23.1%	25.5%	25.9%	25.0%

Figure 4. Improvement in quality parenting assessed by the KIPS and parenting beliefs/practices assessed by the AAPI by therapy modality.

Caregiver, expectant mother, and youth program satisfaction

More than half of the caregivers (79.9%) and youths (76.2%) reported being very satisfied or somewhat satisfied with improvements in trauma symptoms and behavior following the completion of treatment. Additionally, most caregivers, expectant mothers, and youths expressed a high level of satisfaction with the Lotus House Family Program (86.7%–93.3%) and indicated they would recommend it to others (81.3%–92.5%).

EVALUATION

In addition to the quantitative research outlined above, process and outcome evaluations are also being conducted to improve the implementation of the therapeutic modalities and research processes to best meet the needs of the participants. The evaluation uses the Consolidated Framework for Implementation Research (CFIR) to explore factors that promote or inhibit program implementation.[1]

Evaluation questions

[1] Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implement Sci. 2009;4(1):5

1. How did the Children's First project help to improve maternal and child relationships?
2. What are participants' perceptions of the utility of the therapeutic services and satisfaction with the services?
3. What are the participants' perceptions of changes/improvement to the following: reduction in trauma and social-emotional well-being?
4. How can the Children's First project enhance/augment services?

METHODS

Focus groups

Five focus groups were held, four with mothers who had completed therapy, stratified by therapeutic modality, and one with Lotus House counselors. BSRI led focus groups with support from Lotus House staff. One Lotus House staff member assisted with translation, as necessary, for Spanish-speaking participants. Participants were provided with light refreshments and personal care products as an incentive and all verbally reconsented to participate in this aspect of the research at the beginning of each group. Mom participants were also given $50 Amazon gift cards as an additional incentive. Focus groups were recorded and transcribed. The two BSRI staff who facilitated the focus groups performed a Rapid Qualitative Analysis shortly after the focus groups to examine the pros and cons of each modality and the benefits and suggestions for improvement of the overall program, consistent with the research questions.

Limitations

Focus groups took place during standard work hours, which may have affected who could participate. On a few occasions, moms had to leave during the focus group to attend other appointments or handle issues that arose. In addition, childcare could not be provided at one of the sessions, making it difficult to record the audio.

KEY FINDINGS

Over the past three years, both Parent-Child Interaction Therapy (PCIT) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) have been well-received by mothers in focus groups. Counselors echoed this sentiment, noting that PCIT is particularly effective in shelter settings. TF-CBT

was described as "old reliable," praised for its clarity and positive impact on both children and parents. Counselors consistently identified PCIT as the therapy modality that was most beneficial in the shelter context.

Child-Parent Psychotherapy (CPP) and Parent-Child Psychotherapy (P-CPP) also received positive feedback, but mothers expressed more concerns and suggestions for improvements regarding these modalities. Counselors acknowledged that while CPP and P-CPP are valuable, they presented challenges and required a higher skill set for effective administration.

In previous years, the Video Feedback Intervention for Positive Parenting-Sensitive Discipline (VIPP) garnered the fewest benefits and the most concerns from mothers. However, this year, VIPP was well-received, with few reported challenges. Counselors also found VIPP to be valuable and impactful, though they noted that it can be particularly difficult to implement at scale within a shelter setting.

Overall, counselors still found it challenging to answer the best-fit modality for shelter environments, as it depends on family and context. However, counselors resolved to rank **TF-CBT** and **PCIT** as the **best fit**. **CPP/P-CPP** was selected as a more **idealistic fit but unrealistic for the setting**, and **VIPP** was still ranked as the **worst fit** for the setting, although it is a valuable and impactful tool for promoting positive parenting behaviors.

MIXED METHODS SYNTHESIS OF KEY FINDINGS

Traumatic events and symptoms

A large majority of caregivers (78.9%) reported that their child or adolescent had experienced at least one traumatic event, with probable PTSD rates similar between younger children 3-6 years (22.4%) and older children 7-17 years (23.2%). However, youths aged 8-17 years self-reported a higher rate of probable PTSD (34.8%), suggesting that caregivers may be underreporting trauma symptoms. TF-CBT was especially effective across age groups, reducing trauma symptoms for 38.1% of younger children and achieving a 78.9% improvement rate among older youth. In focus groups, parents and counselors confirmed TF-CBT's value in facilitating emotional openness and processing, particularly for youth with emotional barriers. A mother in the TF-CBT modality shared regarding overcoming emotional barriers for her child: "Being that my son is very reserved emotionally, [the therapist] helps him to understand a lot emotionally and how to express his emotions."

A mother in the TF-CBT modality shared regarding overcoming emotional barriers for her child:

"Being that my son is very reserved emotionally, [the therapist] helps him to understand a lot emotionally and how to express his emotions."

- Mom Participant

In focus groups counselors described TF-CBT as,

"The old reliable"

"TF is clear and effective"

- Counselor Participants

Overall, TF-CBT showed the greatest improvements across trauma screens, even for younger children. This was echoed in the focus groups with counselors who described TF-CBT as "the old reliable" or "TF is clear and effective," highlighting its consistent effectiveness in the shelter setting.

Parent Stress and Parenting Practices

PCIT emerged as the most effective intervention, reducing parenting stress by 43.3%, enhancing the quality of parenting by 54.0%, and improving social-emotional problems among children aged 1.5-5 years by 22.0%-33.3%, and among children aged 6-18 years by 57.1%. Its structured, hands-on approach enabled parents to reinforce positive behaviors and effectively manage challenging ones. Qualitative feedback from moms echoed these quantitative outcomes, with mothers reporting that PCIT made them "better parents by showing [them] how to reinforce good behavior and manage [their] child's tantrums effectively." While PCIT was beneficial, counselors noted engagement challenges as some parents found the structure too rigid, leading to early disengagement. As one counselor observed, "Some moms disconnect because the discipline application is structured.... So, by the middle session, they're like, 'Oh, I got everything I needed."

Qualitative feedback echoed quantitative outcomes of reduced parenting stress and improved behavioral practices, with Mom's reporting that PCIT made them

"better parents by showing [them] how to reinforce good behavior and manage [their] child's tantrums effectively."

- Mom Participant

Therapy Modality Effectiveness and Suitability

PCIT was found to be especially ***effective for younger children.***

TF-CBT provided ***significant trauma reduction for older youth.***

TF-CBT and PCIT were consistently ranked as the most effective modalities for shelter settings, with PCIT especially effective for younger children and TF-CBT providing significant trauma reduction for older youth. In contrast, CPP/P-CPP, while moderately effective, was perceived as less practical due to its complexity and the high level of skill required for effective implementation. The qualitative findings supported these observations, as counselors praised TF-CBT for its clarity and structure, describing it as "clear" and "effective." On the other hand, CPP/P-CPP was acknowledged as valuable but challenging, with one counselor noting, "CPP is harder... it requires more reflection and processing... that can be tricky sometimes."

Video Feedback Intervention for Positive Parenting-Sensitive Discipline (VIPP)

VIPP was initially met with mixed reviews in previous years, but it received more positive qualitative feedback by year three. Assessment results indicate that VIPP was effective in reducing parent stress, trauma symptoms, and child behavioral problems. It showed a comparable rate of enhancing parental empathy (32.7%) to that of TF-CBT and was the most effective intervention for reducing beliefs in corporal punishment (19.2%). While VIPP showed clear effectiveness, there is still room for continued refinement to optimize its impact. Counselors ranked **VIPP as the least ideal modality for shelter settings due to its time-intensive preparation and delivery requirements**. However, mothers found value in VIPP for fostering self-awareness and patience; as one participant reflected, "I learned to be more patient with my child and saw how my mood affects her." However, counselors expressed concerns about VIPP's feasibility, with one noting, "That's just not realistic. For [a] modality that requires you four hours to prep for a one-hour session… that's unrealistic."

Mother's apart of the VIPP therapeutic modality found value in VIPP for fostering **self-awareness** and **patience** in parenting. Alternatively, in focus groups, counselors *expressed concerns about VIPP's feasibility in a shelter setting.*

Program Satisfaction

Overall satisfaction with the Lotus House Family Program was high, with 86.7%-93.3% of caregivers, expectant mothers, and youths expressing satisfaction, and 81.3%-92.5% stating they would recommend the program to others. This positive feedback was supported by focus group discussions, where mothers highlighted improvements in their children's behavior, enhanced parenting skills, and the development of coping and emotional regulation techniques. Across modalities, caregivers frequently expressed gratitude for the program's support and its impact on family stability.

A caregiver expressed gratitude for the program's support and its impact on family stability,

"It taught me how to be a better mom, to have more patience, and to try not to worry so much."

– Mom Participant

Counselors observed that caregivers increasingly felt supported in managing their own and their children's emotions, leading to improved family interactions.

> "My daughter was very shut down... therapy helped her open up and to communicate more."
>
> – Mom Participant

Appendix B, Table 11 contains supporting quotations from both mother and counselor participants regarding each therapeutic modality.

PRELIMINARY EVALUATION DISCUSSION

How did the children's first project help to improve maternal and child relationships?

The Children's First Project significantly improved maternal and child relationships by equipping mothers with practical parenting skills and fostering deeper emotional connections. Through trauma-informed modalities like Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Child-Parent Psychotherapy (CPP), the project empowered mothers to respond to their children's needs with empathy and patience, creating a nurturing and stable environment. Interactive sessions, particularly within Parent-Child Interaction Therapy (PCIT) and Video Feedback Intervention for Positive Parenting-Sensitive Discipline (VIPP), emphasized positive reinforcement and effective communication, allowing mothers to develop a stronger bond with their children as they learned to understand and positively engage with each other. Mothers reported feeling closer to their children as they became more involved in their emotional and behavioral growth, learning techniques to manage stress and promote calm interactions. Strengthened mother and child attachment was further supported by therapeutic activities that encouraged quality time with their children, reinforcing trust and open communication. By providing these tools and insights, the Children's First Project helped mothers build lasting, supportive relationships with their children, laying the groundwork for continued positive dynamics beyond the shelter setting.

What are participants' perceptions of the utility of the therapeutic services and satisfaction with the services?

Moms' perceptions of the utility of therapeutic services and their satisfaction with them remained largely positive. Many mothers expressed initial hesitations about starting therapy. However, after engaging in the sessions, moms reported a significant increase in satisfaction. This satisfaction was mainly tied to the

supportive and understanding nature of the counselors, frequently described as "patient" and "professional." A recurring theme is the positive shift in attitudes towards therapy after participation. Mothers were willing to recommend these services to other parents, highlighting the perceived benefits and positive outcomes for themselves and their children. Across all modalities, mothers reported utilizing techniques learned during therapy daily. Techniques included behavioral techniques from PCIT and VIPP and self-care practices like breathing exercises from TFCBT and CPP/PCPP. These tools were credited with helping to improve parenting strategies and personal well-being. The relationship between mothers and counselors significantly influenced their satisfaction with the services. Many mothers appreciated the professionalism and empathy shown by the counselors, which helped to foster a trusting and supportive environment, with moms referring to counselors as "family" and "second parents."

What are the participants' perceptions of changes/improvement to the following: reduction in trauma, and social-emotional wellbeing?

Participants' perceptions of changes and improvements in trauma and social-emotional well-being continue to reflect positive outcomes across the various therapy modalities. Mothers in the TF-CBT and CPP/PCPP groups reported a heightened awareness of their trauma responses and the importance of self-care. This awareness helped them better manage their emotional reactions, positively affecting their children's social-emotional well-being. There was no specific mention of a reduction in trauma itself. However, participants observed a decrease in trauma-related responses, such as anxiety and behavioral issues, particularly in the PCIT, TFCBT, and CPP/PCPP groups. This reduction was linked to coping strategies learned in therapy, such as breathing exercises and other self-regulation techniques.

Across all therapy modalities, mothers reported improvements in their children's social-emotional well-being. They observed better communication, increased patience, and a deeper understanding of their children's emotional needs. In year three, there was a specific emphasis on recognizing and addressing children's emotional cues, which helped foster a supportive and nurturing family environment. A recurring theme is the consistent use of coping skills, such as those learned in PCIT and CPP/PCPP. Mothers reported that these skills were effective in managing their stress and their children's emotional outbursts. Feedback in year three indicated a continued reliance on these techniques, which helped stabilize the family environment and support emotional regulation. Mothers in the CPP/PCPP group better understood child behavior and developmental milestones. This knowledge empowered them to support their children's growth more effectively and to recognize the signs of trauma or emotional

distress early on.

How can the children's first project enhance/augment services?

Year three revealed that several key themes emerged on how the LH project can enhance and augment its services, focusing on the characteristics of the setting, population, and intervention:

Flexibility and Accessibility in Therapy Sessions Mothers value flexibility in scheduling therapy sessions. However, logistical challenges, such as coordinating appointments around work and other commitments, were noted as barriers. Mothers appreciated counselors providing flexible scheduling and rescheduling options, which helped them better manage their participation in therapy.

Cultural Sensitivity and Acceptability The need for cultural sensitivity was a prominent theme. Both caregivers and clinicians emphasized the importance of culturally sensitive approaches, particularly in understanding and respecting different parenting practices and cultural backgrounds. Some mothers initially hesitated to engage in therapy, but building rapport with families by acknowledging and integrating their cultural contexts into therapy was highlighted as essential for the success of therapy.

Therapeutic Modality Fit and Effectiveness Different modalities were received with varying levels of success, depending on the specific needs and contexts of the families. TF-CBT and PCIT continued to be well-received, particularly for addressing trauma responses and improving parent-child interactions. CPP/PCPP also received positive feedback, although some challenges and suggestions for improvement were noted, such as the readiness and engagement of mom, sensitive questioning for those of different cultural and contextual backgrounds, and the skilled nature it takes to administer CPP. VIPP had mixed reviews, with some mothers liking the modality and clinicians expressing concerns about its efficacy and fit for Lotus House guests.

Overall, counselors still found it challenging to answer the best-fit modality for shelter environments, as it depends on family and context. However, counselors resolved to rank TF-CBT and PCIT as the best fit. CPP was selected as a more idealistic fit but unrealistic for the setting, and VIPP was still ranked as the worst fit.

RECOMMENDATIONS

Recommendations stated below for the Children's First project came from moms and counselors involved in the four therapy modalities. The recommendations were organized into three categories: **programmatic, staffing and workflow,** and **administrative** recommendations.

Programmatic

1. Expand therapy services to involve non-custodial parents in sessions when appropriate and permitted to foster a comprehensive therapy approach.
2. Address practical barriers preventing consistent participation in therapy for moms, such as childcare and aftercare for various age groups.
3. Establish universal terminology around the word counselor/therapist and maintain consistency. Guests were confused about the interchangeability. In addition, developing a universal terminology may be better understood in other translated languages.
4. Fidelity monitoring- Counselors would like to revisit the 20% of sessions required for recording; as counselors agreed, "fidelity recordings are damaging to the therapeutic relationship."
5. Consider adding a peer to help with engagement at the beginning of therapy; this could be a Lotus House and therapy alumna who could share a positive experience about how the therapy helped them and what the process is like.

Staffing and workflow

6. Offering counselors more work-from-home days can enhance employee morale and productivity. This flexibility can give them a conducive environment to complete required work efficiently while contributing to a positive work-life balance. Such measures could also improve staff retention by fostering a more supportive and adaptable work environment. This protocol should be built into the hiring process to attract and retain high-quality staff.
7. Offer families and counselors a designated, private space for therapy sessions.
8. Establish a more inclusive protocol for families to inform them of a counselor's transition to ensure transparency and continuity of care.

Administrative

9. Balance funding guidelines with clinical needs to ensure the highest quality of care. While adhering to funding requirements is necessary, prioritizing clinical needs is crucial for delivering effective therapeutic outcomes. Address caseload limits to allow for the required sessions, ensuring that each client's unique therapeutic needs are fully met.
10. Condense or reduce assessments and/or move assessments to another day to allow the first couple of sessions to build rapport with moms and families.

APPENDIX A: QUANTITATIVE ASSESSMENTS

The following table includes the details of all assessments conducted as part of the research study. Expectant mothers participated in the P-CPP modality.

Table 10. Assessments in the research study.

Assessment	Topics/Scales	Baseline (N=1,282)	Matching Baseline and Post-Intervention Assessments Completed* (N=470)
The Battelle Developmental Inventory, Third Edition (BDI-3) (Baseline only)	An assessment for infants and children through age 7 and 11 months. Assesses the following domains: 1. Adaptive behavior; 2. Personal and social skills; 3. Motor skills; 4. Communication skills; 5. Cognitive skills. Any raw score at a or below the cut score value ascribed by the BDI indicates a potential referral for further assessment.	N=808	—
Adult Adolescent Parenting Inventory v. 2 (AAPI-2)	An inventory designed to assess the parenting and child rearing attitudes of adult and adolescent parent and pre-parent populations. Assesses for the following constructs: 1. Expectations of children; 2. Empathy towards children's needs; 3. Use of corporal punishment as a means of discipline; 4. Parent-child role responsibilities; 5. Children's power and independence. The scores are categorized by risk for child maltreatment: low risk (score of 8-10), moderate risk (score of 4-7) or high risk (score of 1-3).	Caregiver, N=722 Expectant mother, N= 76	Caregiver (N=265) CPP, N=116 FCU-EP, N=8 PCIT, N=42 TF-CBT, N=47 VIPP, N=52 Expectant mother (N=27) P-CPP, N= 27
Child Behavior Checklist (CBCL 1.5-5; CBCL 6 -18)	Used to detect behavioral and emotional problems in children and adolescents. There is a separate tool for each age groups: children ages 1.5- 5 years and youth ages 6 to 18 years. According to the normative data of the CBCL, a t-score ≤ 59 indicates non-clinical symptoms,	CBCL 1.5-5, N=320	CBCL 1.5-5 (N=95) CPP, N=32 PCIT, N=41 VIPP, N=22

Assessment	Topics/Scales	Baseline (N=1,282)	Matching Baseline and Post-Intervention Assessments Completed* (N=470)
	a t-score between 60 and 64 indicates that the child is at risk for problem behaviors, and a t-score ≥ 65 indicates clinical symptoms.	CBCL 6 -18 N=286	CBCL 6 -18 (N=176) FCU-EP, N=18 PCIT, N=7 TF-CBT, N=151
The Brief Infant-Toddler Social and Emotional Assessment (BITSEA)	Designed to assess the social emotional problems and competencies of children. Measures externalizing, internalizing, dysregulation and competence. These areas of assessment are combined to form two scales: Problems scale and Competencies scale; the assessment helps identify potential problems or deficits in competencies.	N=276	N=98 CPP, N=54 PCIT, N=12 VIPP, N=32
Keys to Interactive Parenting Scale (KIPS)	A structured observation tool to assess parent-child interaction during play. Key items assessed include: 1. Sensitivity of responses; 2. Supports emotions; 3. Physical interaction; 4. Involvement of child activities; 5. Open to child's agenda; 6. Engagement in language experiences; 7. Reasonable expectations; 8. Adapts strategies to child; 9. Limits & consequences; 10. Supportive directions; 11. Encouragement; 12. Promotes exploration and curiosity. The KIPS mean is categorized into three groups: low, moderate, and high-quality parenting.	N=714	N=233 CPP, N=129 PCIT, N=50 VIPP, N=54
The Parenting Stress Index v.4 Short Form (PSI-4 SF)	Measures parental stress focusing on three major domains: parental distress, difficult child, and parent-child dysfunctional interaction. These domains measure anxiety due to personal factors related to parenting,	N=1,118	N=407 CPP, N=150 FCU-EP, N=20 PCIT, N=60 TF-CBT, N=121

Assessment	Topics/Scales	Baseline (N=1,282)	Matching Baseline and Post-Intervention Assessments Completed* (N=470)
	assess how parents perceive their interactions with their children and the characteristics of child behavior and how difficult it can be to deal with such behavior. The PSI Total Stress Percentile Score is categorized as normal (16-80), borderline (81-85) or clinically significant (>86).		VIPP, N=56
PTSD Checklist for DSM-5 (PCL-5)	A 20-item measure that assesses the presence and severity of PTSD symptoms. A score of >20 is normal, 20-30 is mildly to moderately elevated, and a score between 31-33 is indicative of probable PTSD.	Caregiver, N=592 Expectant mother, N= 76	Caregiver, N=207 CPP, N=116 PCIT, N=39 VIPP, N=52 Expectant mother, P-CPP, N= 27
Symptom Checklist (SCL-27)	Designed to screen for psychiatric symptoms in patients presenting somatic complaints. It contains 6 subscales: depressive, dysthymic, vegetative, agoraphobic, sociophobic symptoms and symptoms of mistrust.	Caregiver, N=592 Expectant mother, N= 76	Caregiver, N=286 CPP, N=116 FCU-EP, N=10 PCIT, N=42 TF-CBT, N=66 VIPP, N=52 Expectant mother, P-CPP, N=27
Stress Index for Parents of Adolescents (SIPA)	The SIPA measures and interprets four levels of stress for parents of adolescents ages 11 to 19 years. The Total Parenting Stress score represents the composite of all items across domains. A percentile score >95% is clinically severe; 85%-94% is clinically significant; 85%-89% is borderline; and <85% is within normal limits.	N=87	Caregiver, N=36 TF-CBT, N=36

Assessment	Topics/Scales	Baseline (N=1,282)	Matching Baseline and Post-Intervention Assessments Completed* (N=470)
Youth Child Adolescent Trauma Screen (Y-CATS)	This is a self-report measure for youth ages 7-17 to evaluate the presence of two critical elements: (1) Exposure to potentially traumatic events/experiences, including traumatic loss, and (2) Traumatic stress symptoms/reactions. The total PTSD Severity score is used to interpret the severity of trauma; a score of 21+ indicates probable PTSD. The scores are categorized into normal-not clinically elevated, moderate trauma-related stress and probable PTSD.	N=253	Youth, N=119 FCU-EP, N=8 TF-CBT, N=111
Caregiver Child Adolescent Trauma Screen (C-CATS)	This is a measure administered to caregivers of youth ages 3-17 years to evaluate the presence of two critical elements: (1) Exposure to potentially traumatic events/experiences, including traumatic loss, and (2) Traumatic stress symptoms/reactions. The total PTSD Severity score is used to interpret the severity of trauma. For children ages 3-6 a score of 15+ indicates probable PTSD; and for ages 7-17 a score of 21+ indicates probable PTSD. The scores are categorized into normal-not clinically elevated, moderate trauma-related stress and probable PTSD.	C-CATS Ages 3-6, N=406 C-CATS Ages 7-17 N=310	C-CATS Ages 3-6 (N=132) CPP, N=32 FCU-EP, N=9 PCIT, N=48 TF-CBT, N=21 VIPP, N=22 C-CATS Ages 7-17 (N=145) FCU-EP, N=12 TF-CBT, N=133

***Note. The assessments included are for participants who completed their assigned therapy modality.**

APPENDIX B: SUPPORTING QUALITATIVE QUOTATIONS

Table 11. Supporting Qualitative Quotations by Modality.

Modality	Quotation
PCIT	"It made me a better parent by showing me how to reinforce good behavior and manage my child's tantrums effectively." - Mom Participant "I think it's very effective. Well, if they practice and do their homework, it can be very, very effective, but behavioral change is really quick, really good. Like, from one week of them actually practicing, there will be changes, so it's nice to have that shift."- Counselor Participant "I learned a lot about setting routines, which helped my child know what to expect and behave better." -Mom Participant "PCIT taught me how to praise my children more and not just give commands, which really made a difference" -Mom Participant "My son has his 'special time' and likes playing basketball playing soccer. He just want to throw stuff. It's not special to me. But it taught me to kind of like include myself..." -Mom Participant "The hands-on approach of PCIT is invaluable, but we do face challenges in keeping parents consistently engaged due to their busy schedules." - Counselor Participant "I felt like it was too much time consuming"- Mom Participant "Some moms disconnect because the discipline application is pretty structured... it might feel too rigid for some parents. So by the middle session, they're like, oh, I got everything I needed. So they tend to disengage around session after PDI [Parent-Directed Interaction], they tend to disengage a little bit" -Counselor Participant "...Consistency and follow through is difficult. So I think in PDI [Parent-Directed Interaction] sometimes they lose steam because of that or just they start working. There's just a lot of things that happen after six, seven, eight weeks of being in the shelter and then it's just they lose steam." - Counselor Participant

Modality	Quotation
TF-CBT	"I think that, being that my son is very reserved emotionally, she helps him to, open up. She helps him to understand a lot emotionally and like how to express his emotions and how to understand trauma and what trauma is and stuff. And that's something that's very important to me—So she kind of like helped me through what I do too." -Mom Participant "[My]daughter was very shut down when we entered the shelter. She was being very rude and condescending in general; therapy helped her open up and to communicate more and to be more understanding and have more patience." - Mom Participant "[Redacted] was kind of closed in a lot too. Didn't talk much. She was kind of like funny I think, but she got her to open up a lot as far as dealing with trauma." - Mom Participant "TF-CBT is the old Reliable"- Counselor Participant "TF is clear. It's effective."-Counselor Participant "So like you sometimes, like me, if I have a lot of stuff going on, I can't go 'cause I can't concentrate. So now I have a blockage. So now you trying to tell me what's going on, I'm shutting down 'cause I'm trying to figure out how to deal with all this stuff I'm going through mentally. So sometimes I can't handle it."- Mom Participant "I was mentally disturbed 'cause I'm not gonna go through the whole thing, right? But I was just mentally broken 'cause of the incident beforehand that got me into the predicament at the Lotus House." - Mom Participant "I think there's also difficulties when there's a parent that has multiple children, and they're in multiple assigned therapy modalities, that can feel very overwhelming. Sometimes, I think some parents can manage very well, but some parents have a hard time having many kids and sometimes their therapeutic services happening all at the same time. It's a lot to coordinate for them, and some of our parents have difficulties already with coordinating that calendars, that is tricky. It could get overwhelming where we get put in the bottom of the totem pole because there is other priorities and there's other things."- Counselor Participant "It is tricky at times, especially when moms have not been integrated with their own trauma or are not receiving proper services for their own experiences, like adult experiences. So makes it very difficult to support their child through trauma processing when they have not processed their own trauma or are not in the process of doing that. So that sometimes is a big barrier, but overall it's a very, I like the modality a lot. I enjoy TF-CBT." -Counselor Participant

Modality	Quotation
CPP /P-CPP	"I learned different ways to discipline other than 'beating' – it helped me find alternatives." Mom Participant The therapy has helped change how she sees father. And just taking into consideration the child's safety because her safety was in jeopardy with the father. Mom Participant "It taught me how to be a better mom, to have more patience, and to try not to worry so much." -Mom Participant "Like I said, it felt a little like interrogating in the beginning. But then after a while, when she got rid of the paper, we started communicating." -Mom Participant "Just let people be a little bit more, instead of just coming in head straight on with questions. Because their therapy is the parent first and then the child. So it's like just make them feel more comfortable at first to give them the opportunity to want to open up an event versus trying to poke it out of them." -Mom Participant "They need to open up like another section where people are able to drop their kids off that can't go to the aftercare or the daycare. There should be a spot for them, too, where they are able to go to work because my kids don't go to summer camp." -Mom Participant "CPP is harder... it requires more reflection and processing and inward-looking, which when people are still in difficult situations, that can be tricky sometimes."- Counselor Participant "I think it's an awesome modality, but it's tricky. It's kind of abstract. It's kind of hard to understand. But it's also tricky because we have guests that just came across the border, so it can feel a little bit intrusive. We have to be really careful the way it's presented and the way that questions are asked." -Counselor Participant

Modality	Quotation
VIPP	"I learned to be more patient with my child and saw how my mood affects her." -Mom Participant "So she's saying that she understands her mood impacts the child, and she tries to do something to have a neutral or happy mood so that way he can respond in a positive way."-Spanish Translator for Mom Participant "My child has like outbursts. If it doesn't get away, she just—I learn to be patient with her send her to the bathroom. Like we'll sit in the bathroom till you calm down, she'll come out. That made it so much easier." -Mom Participant

Modality	Quotation
	"I was just gonna add that the videos, I realized how much my son reacts or enjoys our interactions. Having a little conversation that we do, I realize even more, and listening to detail." -Mom Participant
	"I did learn those things about myself about parenting. So me communicating with him and graduate [sic] him, giving him that attention he could asked for, I learned that." -Mom Participant
	"The intervention is very powerful, even though our messaging is more passive, which I think is why people like it because it brings awareness to what's happening, where you cannot deny what you're seeing in the video." -Counselor Participant
	"It messes with overall productivity because you spend as many hours doing scripts, and then they don't come, and then you don't get to see people 'cause you were scriptwriting. It's hard to balance and organize your time."-Counselor Participant
	"That's just not realistic. For [a] modality, that requires you four hours to prep for a one-hour session. That's five hours per one session. That's unrealistic."-Counselor Participant