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The Child Protection Center
Division of Community Pediatrics
Montefiore Medical Center

Final Report for OCAN Neglect Grantees

Submitted by Mary L. Pulido, MAT, CSW and W. Paul Kory, MD, MPH
Principal Investigators

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I. Introduction: Brief Description of the Project

The Child Protection Center (CPC) of the Division of Community Pediatrics at Montefiore Medical Center (MMC) in the Bronx of New York City, was a national recipient of a neglect prevention research demonstration award funded through the National Center of Child Abuse and Neglect (NCCAN) in September 1996. The Parent Empowerment Program (PEP) was created to engage socially isolated and resource poor teen mothers in a six-month parenting group, based in their community, with a special focus on accessing medical services and building a social support system.

The CPC initiated PEP in several community districts in the South Bronx. The South Bronx area of New York City is one of the most impoverished areas in the nation. This area has some of the highest rates for infant mortality, low birth weight, teen pregnancy, and asthma among children, reported cases of child abuse and neglect and children receiving welfare assistance. Raising children in this environment is very difficult. The assaults that poverty brings to the morale of a young family combined with socially isolating factors such as poor housing, drug dealing and fears of violence makes raising a healthy, happy child a substantial challenge.

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Conceptual Framework

Divorce, teen pregnancy, mental illness, a history of abuse and neglect, alcoholism, drug addiction, unemployment, financial distress and social isolation are important factors in the family structure of abusing or neglectful parents. Due to the complexity of the social, medical and mental health problems of the participants, to achieve any amount of success, programs on parenting and family care for special populations, with an emphasis on prevention and early detection must be developed by representatives of the medical-social disciplines responsible for child welfare.

The CPC utilized a social support educational intervention model as the foundation of the PEP program. This model draws upon cognitive and behavioral psychology approaches. Social support interventions are activities designed to alleviate stress and promote parental competencies and behaviors that will increase the ability of families to successfully nurture their children, enable families to use other resources and opportunities available in the community and create supportive networks to enhance child rearing abilities of parents and help compensate for the increased social isolation and vulnerability of families. Neglectful families report fewer formal and informal social ties and supports than their comparison groups, are able to identify fewer people to approach for practical or emotional support, and view their locales as less friendly and helpful.

The traumas of child neglect are exacerbated by poverty and single parenting. The South Bronx, the location for the initial PEP group model, is the poorest Congressional District in the nation. The effects of chronic poverty and its multiple elements have a stronger negative effect on individuals, families and the community, than the sum of the individual stresses. Chronic

poverty drains the emotional energy and coping capacity of parents. Parents confronting multiple stressors associated with poverty tend to be less emotionally available, less supportive and less able to use child management techniques requiring patience, negotiation and consistency. Poverty denies young children adequate housing, medical and mental health care, nutrition, safe environments in which to play and stimulating educational opportunities. Parents living in impoverished neighborhoods often are struggling with poverty-related stresses that undermine their ability to provide practical and emotional support for parenting. Low-income parents are three times more likely than other parents to begin child rearing during adolescence; thus they face unique challenges with very limited resources.

Program Model

PEP drew upon social support models and ACYF/OCAN recommendations to develop its curriculum and operating philosophy. The program combines aspects of a psycho-social parenting model with micro-level support/advocacy training. Initially, the program had established age requirements of 12 through 20, for young mothers who were either pregnant or parenting or both. In 1998, due to the combined demands of referral issues and recruitment/retention issues, the age limit was increased to 30 years of age.

PEP included two home-based family assessments (at enrollment and within one month of graduation), a six-month comprehensive parenting education series, a daycare component for the children, unique aftercare and tracking services for both crisis intervention and medical/social service referrals. It was anticipated that each year 50 mothers and their children would enroll in the program.

Collaborative Efforts

The success of PEP was due to the collaborative efforts of the Division of Community Pediatrics, Montefiore Medical Center and its 30 ambulatory sites and many other providers. The Parent Empowerment Program was well utilized by the Bronx community. Child Protective Services, foster care agencies and other social service providers who seek an intensive, therapeutic parenting education program for their clients, referred young mothers on a regular basis. As part of the excellent continuum of care at Montefiore Medical Center the CPC had the ability to reach and serve the neediest populations. Through our linkages with the NYC Administration for Children's Services (CPS), the Bronx Borough President's Child Welfare Advisory Council, the South Bronx Health Center for Children and Families, the District Attorney's Office, the Board of Education and the myriad of foster care and social service providers who refer clients to us, we were able to provide services for their referrals and coordinate the families ever-changing case management needs.

Special issues for consideration

The Bronx is composed of a diverse population that is primarily Latino (60%) African American (30%)and Caucasian (10%). Many of the Latino residents speak Spanish as their primary language. Therefore, it was necessary to recruit Spanish speaking clinicians, who were culturally competent in this capacity.

Funding information

The budget for the PEP program was approximately $200,000 on an annual basis. NCCAN/OCAN provided five years of funding at $150,000 per year. The CPC was responsible for raising the required match to these funds of $50,000. The required matching funds were

successfully raised through corporation and foundation grants for all five years of the project. The total project funds from September 30, 1996 through September 30, 2001 were $1,000,000. The CPC will continue to solicit funding for continuation of the PEP program.

Evaluation

The principal investigators on the project were Mary L. Pulido, MAT, CSW, Executive Director of the CPC and W. Paul Kory, MD, MPH, Director of Research and Evaluation for the Division of Community Pediatrics at Montefiore Medical Center. Dr. Kory relocated to Chicago, Illinois during the fifth year of the grant and continued to serve as the primary evaluator for the project through the final report period.

The principal investigators met with the PEP clinicians approximately twice a month during the grant period. After Dr. Kory relocated to Chicago, conference calls were held approximately every three weeks so that data issues could be discussed. The use of e-mail was extremely helpful to enhance communication and data access during the grant period. Mary L. Pulido and Dr. Kory held conference calls in between the research discussion meetings.

Mary L. Pulido provided weekly supervision for all clinical/programmatic issues for the PEP clinicians during the grant period. She also visited the PEP groups at all locations, accompanied the PEP clinicians on several home visits and attended the first PEP class and graduation ceremonies for all groups. It was very helpful to have this additional contact with the participants and also emphasized the CPC's commitment to the women enrolled in PEP.

Case Vignettes

The following case studies emphasize the complexity of the case management needs of the young women who utilized the PEP program at the CPC:

- A 22 year-old mother of four children, suffering from kidney failure, was diagnosed with HIV. The PEP clinicians provided psycho-social support and worked with the young mother and the foster care agency responsible for her children in determining future plans, legal guardianship issues, availability of home health aides, etc.
- A 17 year-old African American mother of eight month-old twins, was referred to the PEP program by the Administration for Children's Services, (CPS), during their investigation of possible child abuse. According to Juanita, her daughter sustained a broken femur after falling off of a bed. It was determined that the severity of the injury was not consistent with the story presented and she was mandated to attend a parenting group in order to retain possession of her children.
- A twenty-six year-old African American mother of four children was referred to PEP by the Lead Safe House at Montefiore Medical Center due to her children's ingestion of lead. This woman was overwhelmed by the needs of her four children, (two have ADHD). She was often exhausted, unable to attend to their needs and depressed. She expressed feelings of suicidal ideation to the PEP clinicians, who immediately had her evaluated at Montefiore Medical Center. She was placed on medication and is currently receiving outpatient therapy. She has since obtained adequate housing. In addition, her children were also referred for behavioral/family therapy through PEP.
- The South Bronx Health Center for Children and Families referred a 19 year-old mother of two children to PEP. She had a three year-old son and an 18 month-old daughter and appeared overwhelmed with this responsibility. She had a history of missing medical appointments for her children. The mother successfully graduated from PEP. She sought

additional help from the program due to financial distress which resulted in the electricity being turned off in her apartment and a lack of food and clothing for the children. She was also facing eviction. The PEP clinicians aided her in completing necessary documents needed by the housing court, showed the young mother how to access a local food pantry during emergencies and helped her get her electricity turned back on in her apartment.

II. Was the Project Successful In Its Implementation Objectives?

A. Statement of Project's Implementation Objectives As Provided In The Grant Application.

The program goals for PEP were as follows:

1. Identification and recruitment of 50 teen/young mothers considered "high risk" for neglect (due to factors of age, income, marital status and social isolation) who reside in the South Bronx.
2. Conducting an in-depth family strengths/stressors assessment in the home of the participant prior to the start of the PEP seminars.
3. Administration of the Child Abuse Potential Inventory (CAPI), the Social Support Questionnaire and the Knowledge of Behavior: Infancy to School-Age (KIDS) assessment tools.
4. Conducting two Parent Empowerment Program Seminar Series annually (each six months in duration with 25 sessions).
5. Conducting a play group/activity session for the children of the participants, which will be held concurrently with the PEP seminar.

6. Providing crisis counseling and on-going support mechanisms for aftercare services and referrals

7. Developing a Peer Parent Power Support Network

8. Scoring and Evaluating Data

Method, Work Plan and Target Population

Participants

Data was to be obtained on an annual basis, starting at the end of 1997 from 50 teenage pregnant or parenting teens. These women were recruited into the PEP program through a community-based pediatric care setting, the South Bronx Children's Health Project and through the Police Athletic League Center in the South Bronx of New York City and Montefiore Medical Center sites. It was assumed that these young women would fall into an "at-risk" category for neglect due to their age, the stressors associated with teen parenting, the poverty level of the catchment area, the infant mortality rate for the catchment area, lack of social support, lack of medical/mental health care, lack of social services, the high rates of child abuse and neglect reports and the high rate of secondary school drop out statistics for the area.

Staffing

The CPC received funding to hire two full-time staff for this project. A Program Coordinator (MSW-level social worker) and a Case Manager (BSW-level) were hired. It was desirable to have the staff members bi-lingual (Spanish/English) and to have familiarity with the South Bronx catchment area. Mary L. Pulido,MAT, CSW, the Executive Director of the CPC, provided direct supervision to this team. W. Paul Kory, MD, MPH, served as the principal

investigator and primary evaluator. Linda Cahill, MD, assisted the team with curriculum development, outreach efforts and medical interventions/referrals. Carol Perlman, CSW, aided the PEP clinicians with aftercare efforts and assistance in curriculum development.

Procedure

The first PEP group began in April 1997. All participants received a written overview of the program, and were asked to participate in a voluntary research project involving parent education for young mothers investigating the relationship between the PEP program and neglect prevention.

The participants were assured confidentiality and anonymity. The CAP test was self-administered on an individual basis in the private office of the Program Coordinator. The Social Support Questionnaire was self-administered in the participants' home (if feasible). The Knowledge Inventory of Child Development and Behavior was administered in a group setting during the PEP module dealing with child development.

In the introduction to the questionnaires, honesty in answering questions was stressed and voluntary participation was emphasized.

Informed Consent Procedures Utilized

In February, 1997, the Child Abuse Potential Inventory (CAP), the Knowledge Inventory of Development and Behavior (KIDS) and the Social Support Questionnaire were reviewed by the Institutional Review Board for the Protection of Human Subjects of the Office of Research and Sponsored Programs at Montefiore Medical Center. It was determined that a general informed consent form for minimum risk protocols would be utilized for the PEP program which would cover these three research assessment tools. The consent form was reviewed by the IRB

and approved. Subsequently, all participants in the program, including those in on-going PEP Seminar series signed an informed consent form.

Instruments

▪The Child Abuse Potential Inventory (CAP) was administered at the beginning of the PEP seminar and upon completion of the PEP series. The 160-item CAP was designed to measure elements of individual pathology and interactional problems related to physical child abuse and neglect. The CAP measures variables predictive of abuse behavior. Factors measured on CAP include: parent's rigidity, distress, loneliness, problems within the family, depression and negative concept of the child and of self. In February 1997, Mary L. Pulido conferred with Dr. J.S. Milner, Department of Psychology, Northern Illinois University in Dekalb Wisconsin, the author of CAP and obtained his permission to use the tool.

▪The Knowledge Inventory of Child Development and Behavior was administered as a pre and post test during the PEP program module entitled "Maintaining developmentally appropriate expectations of the child". The pre and post test design of this tool was used to measure changes in self-esteem, knowledge of child development and tendencies toward inappropriate interactions with children. In February 1997, Mary L. Pulido conferred with Dr. Arlene M. Fulton, author of the Knowledge Inventory of Child Development and Behavior research tool. Dr. Fulton indicated that the PEP program would be a very appropriate study to utilize this tool. The tool takes approximately eight minutes to administer and is easily scored. Dr. Fulton forwarded the scoring key, other information on KIDS studies and information on the Maternal Support Index tool which she has found useful in her work with teenage mothers.

•The Social Support Questionnaire (SSQ) was initially considered for utilization. PEP clinicians administered this tool during the home assessment visit with the PEP participant. The questionnaire details the support system available to the young woman and her ability to access other support both from her family and the community. A goal of the PEP program is to increase social networks and support for the participants. The Social Support Questionnaire was to be administered at the beginning and upon completion of the PEP program. However, due to a recommendation from Dr. Arlene Fulton, author of the KIDS assessment tool, another instrument, the Maternal Social Support Index (MSSI) was substituted as a replacement for the SSQ. This instrument was easier to administer and better captured the concrete elements of social support applicable to our population.

B. Statement of Questions Related to Assessing Implementation Objectives.

The following questions will be addressed: How successful was PEP in meeting the eight implementation objectives? What implementation objectives were changed and why?

The PEP program was successful in achieving many of the objectives that were set forth in the initial application. Several were reevaluated over the first two years and either modified or changed due to the experiences of the PEP clinicians and Principal investigators.

The start-up phase of the project lasted approximately six months. Funding was designated to the CPC on 9/30/96; however, Mary L. Pulido, received the official announcement on 10/15/96. Although much preliminary work was performed prior to obtaining the grant, hiring the staff, identifying safe and adequate space, negotiating rent for the program

location, and obtaining office equipment took several months after the PEP program was funded. It was critical to identify the best qualified staff to orchestrate the program and to locate safe, accessible program space in the South Bronx. The first group was held in April 1997.

1. Recruitment of the Program Coordinator - Eneida Lopez Maydwell, CSW was recruited to implement the PEP seminars. Ms. Maydwell's experience included previous group therapy work with teenagers, intensive case management for children and families with multiple stressors and psycho-social counseling for the hearing impaired and children with developmental delays. She was tri-lingual (English, Spanish and Sign language). Lisa Raimundi, the case manager was also bi-lingual (Spanish/English). These two women remained at PEP for approximately two and a half years. Staffing was an issue throughout the five-year demonstration project as PEP had three different Program Coordinators and two different Case Managers. An extended maternity leave in the third year of the program, required hiring a temporary social worker. The stress of handling the complicated and serious case management problems of the young women who were PEP participants also played a major role in staff retention. The staff who resigned expressed a desire to work in a "less stressful" area of child welfare and the psychological demands of the work required frequent counseling of the PEP staff by Mary L. Pulido.

2. Site Location - The PEP program was held at the recently opened Police Athletic League South Bronx Community Center (PAL) located on Longwood Avenue in the South Bronx. A one-year, renewable lease was negotiated providing office space for the program coordinator, a classroom and playgroup area. The facility was designed to serve as a resource for the entire

South Bronx neighborhood. It offered recreational and educational programs for children in addition to activities for adults senior citizens and families. It has a Performing Arts Room, a gymnasium complex featuring regulation size basketball courts, a Fitness Room with cardio and weight equipment, a Game Room which serves as a teen lounge and an Educational Resource Center offering programs in Computers, Astronomy, Pottery, Horticulture, Public Speaking and Journalism. It was a social and educational resource for PEP participants.

The objective of identifying and recruiting 50 teen/young mothers considered at "high risk" for neglect on an annual basis was a challenge. The CPC received hundreds of referrals for PEP, however, the majority of the young women did not enroll in the program. There was significant difficulty contacting the young women due to the fact that they lived in transient living situations, did not have telephones or pagers, had scheduling conflicts, etc. In addition, some participants confused the "CPC" with "CPS" and were hesitant to establish contact initially. The CPC/PEP did significant outreach efforts throughout the five years that included local high schools in order to meet this goal. The CPC was able to enroll many young women in the program, but a large number of them failed to graduate. Recruitment and retention will be addressed in Section D. In the second year of the Program, the CPC extended the catchment area for recruitment to include a larger section of the Bronx. Eventually, it included the entire Bronx, since many referrals came from outside the catchment area. The CPC also decided to increase the age limit of the program. Pregnant and /or parenting women between the ages of 12-30 were admitted.

2. The CPC made home visits as frequently as allowed by the PEP participants. Pre and post group home visits were the goal of the PEP Program. The visits included the administration of the Child Well Being Check List (CWBCL). Home visits work. The CPC found that tremendous knowledge is gained during the initial home visit session. Besides aiding in recruitment, it allowed the PEP clinicians to aid the young mother in improving the living conditions of the household. However, home visits come with other sorts of issues, such as: demanding substantial time, last minute cancellations, "no-shows" by the mother, transportation difficulties and safety concerns. The PEP clinicians and the PI's feel that one home visit at the start of the program will produce greater returns as opposed to conducting two home visits (one at the start and one at the end of the program).

3. The administration of the CAPI, the MSSI, KIDS were conducted successfully in many instances. The data analysis section will address the Principal Investigators concerns with the implementation and analysis of these standardized measures. During the second year of the program, all OCAN grantees decided to utilize the Child Well Being Check List as a pre and post test measure during the home visitation process. In the third year of the program, all OCAN grantees agreed to develop and implement a tool that would capture the success of the participants in their respective programs that was not evidenced in the analysis of the data from the standardized instruments being used. The Principal Investigators and the PEP clinicians developed the Personal Goal Attainment Measure (PGAM). This has been effective in capturing changes in the PEP participants and will be described in the Data Analysis section.

4. The CPC quickly realized that the initial design of conducting four PEP groups a year would not be feasible. Due to the impact of scheduling issues, recruitment issues, space needs, geographic distance and age differences, it was decided that three groups would be conducted every six months, with smaller numbers of women and children in each group. At one point, the CPC experimented with "rolling admission" to the PEP groups in an attempt to increase enrollment. This was stopped after one year as it was deemed disruptive to the group process and resulted in even more administrative demands.

5. Childcare was provided for each PEP group to enable more mothers to participate. The PEP program tried many different strategies to ensure that this objective was met. Initially, volunteers were recruited to assist with the infants/children. However, this provided unreliable coverage. Therefore, the PEP program utilized MMC staff on a per diem basis and also hired childcare workers from a local temp agency to meet the on-going need.

6. The CPC provided crisis counseling and on-going support to the best of our ability to all PEP participants. Hundreds of referrals to mental health services, medical services, housing, public assistance, domestic violence, legal aid, etc. were made over the years. Since this population was fraught with complex, often life-threatening problems, the PEP program staff often handled their case management issues. At times, other members of the CPC team were also needed to handle crisis issues involving PEP participants. Staff were also directly involved with providing aid and helping PEP women access resources. For example, CPC/PEP staff accompanied women to court to obtain orders of protection, escorted suicidal/homicidal women to the

emergency room for psychiatric evaluations and escorted them to their public assistance meetings if their benefits were in jeopardy.

Examples of the complexity of medical and mental health needs of the PEP participants include:

- A 16 year-old Caucasian mother of a six-month-old boy was referred to PEP by a local foster care agency. She and her son were placed in foster care due to her mother's substance abuse history and for allegations of sexual abuse by her brother. A serious, aggressive behavioral change was noted by PEP clinicians as the months progressed and they recommended that the young mother be psychiatrically evaluated for depression and screened for substance abuse. The PEP clinicians worked with the foster care agency to arrange these services. The mother was placed in a substance abuse detoxification program.
- A 21 year-old Latina mother was referred to PEP after her three year-old son was placed in foster care, due to the drowning of her one-year-old son. The mother had left the children unattended in a bathtub, due to a domestic dispute in the home. The mother was mandated to receive parenting counseling and enrolled in PEP. The case regarding the death of her son proceeded through the court system and the mother was incarcerated. The CPC/PEP will continue to follow the mother and offer support/assistance to her in the future when she is released.

7. After the second year of PEP, the CPC decided not to develop a Peer Parent Support Network as originally outlined in the proposal. This was due primarily to the following reasons: many PEP mothers exhibited a high level of personal dysfunction, others had time pressures, TANF requirements for workfare, mental health issues, serious medical issues, open CPS cases,

transient living conditions, etc. The Principal Investigators and the PEP clinicians did not feel that even selected young women could adequately serve as resources for each other in times of crisis due to their own overwhelming demands. However, several PEP graduates were willing to fulfill a modified role and acted as "greeters" for young women entering the PEP groups. Many others agreed to spread the word about PEP to their friends, neighbors and acquaintances so that PEP could reach/engage additional women.

8. The Principal Investigators and the PEP clinicians initially developed and implemented eight data sets for this project, derived from the basic data collected from existing paper forms. It was determined in the fourth year that the majority of the research effort would focus on the intensive evaluation of three of these sets. They included: the Registration data set, the Test data set and the Personal Goal Achievement Measure data set.

The PEP clinicians entered all of the data on each PEP participant on a regular basis. A personal file with all intake, registration and test data was also maintained for each participant. In addition, each young women had a computer file so that progress notes on group attendance and issues of case management could be noted. The PEP clinicians shared this information with the Principal Investigators on a routine basis.

B. Methods Used For Data Collection and Data Analysis.

Initially, seven major data sets were utilized to gather information on the Parent Empowerment Program. Later, an eighth data set was created for data derived from the PGAM tool. The initial set of databases captured approximately 800 variables; these were explicitly defined in a variable list and linked data set templates. It was composed of a variable list and linked data set template files. The template files, which provided the framework for the data sets, included the following information:

1. Recruitment information on all clients referred to the PEP and registration information on all those who express interest in the program regardless of whether they enroll in a PEP group.
2. Outcome related information relating to the participants enrolled in the PEP program, their children and the fathers of their children. This included data on: health status, involvement with the Administration for Children's Services, school attendance, substance abuse, public assistance status, domestic violence living situations, etc.
3. Test result information collected in the context of the PEP program from the enrolled participants and from visits to the homes of the participants including: the Maternal Social Support Index (MSSI), the Child Abuse Potential Inventory (CAPI), the Knowledge of Infant and Child Development Scale (KIDS) and the Child Well Being Check List (CWBCL).
4. Information related to the homes of the PEP clients including data on persons living with them and the client's children.
5. Information on the marketing/outreach efforts for the PEP program.
6. Information on the Tracking Data Set which is composed of questions that are asked to the PEP participants after their departure from the program. It monitored goal progress, Child Protective Service involvement, employment, education, health factors, etc.

7. Subject Data which included 170 variables on the participants themselves.

The Principal Investigators added the eighth data set for the Personal Goal Attainment Measures (PGAM) in the third year of the program. Due to the overwhelming demands on time of the PEP clinicians and the inability to obtain consistent information for all data sets, it was decided that PEP would focus on the Registration, Test, and Personal Goal Attainment Measure data sets for this project.

Data was gathered on the PEP participants from several sources. They included: face-to-face interviews with the PEP participants, their children and their family members, professional staff who had either referred the PEP participant or who were involved with their on-going case management needs; Child Protective Service workers, legal aid attorneys, etc. Information was collected during the home visits and group sessions through the use of the CWBCL, MSSI, CAPI, KIDS and the PGAM. The PEP clinicians also filled out detailed intake registration information on each client. Attendance logs were also kept to monitor participation. In each case, the PEP clinicians attempted to complete all of this information on every PEP participant. The PEP clinicians each had a personal computer for data entry and case management purposes. Individual CPC computerized medical records were created and maintained for the PEP members. The young women also completed a consumer satisfaction survey upon graduation from the program.

On a monthly basis, Dr. Kory would review the data and discuss any data collection/entry issues with the PEP clinicians so that all problems were addressed on a timely basis. On an annual basis the Principal Investigators would conduct a complete data analysis of the groups that were held since the initiation of the program.

C. Findings Regarding the Implementation-related questions.

The Principal Investigators feel that a tremendous amount of knowledge about the implementation of neglect prevention demonstration programs for young mothers deemed "at risk" for abuse and neglect has been realized during the course of this grant period. Some of the "lessons learned" include:

- The Child Protection Center (CPC) is an advocate for substantial funding to provide services to mothers and their children at risk for abuse and neglect. The CPC, through the Parent Empowerment Program (PEP) and its other programs, has learned that there is an overwhelming need for services for this population that is not currently being met in the Bronx of New York City.
- The Principal Investigators feel that the initial methodology of the research component was inadequate to accurately measure performance and outcomes. Most of the standardized instruments have limited utility with this type of program and the measurement of outcomes is a very complex process. The creation and development of a measure of Personal Goal Achievement (Pulido, Kory, 2000) aided the PEP program in capturing gains realized by the participants.
- The CPC learned that this type of parenting skills program for high-risk families needs to be integrated (both physically and programmatically) into a larger spectrum of care model. The participants presented daily with overwhelming problems, such as: illness, severe mental health issues, domestic violence,

substance abuse, homelessness, financial distress, etc. The CPC was well situated to handle these issues with the support of Montefiore Medical Center, strong linkages to government agencies and the foster care system. A program as a "stand-alone" would be hard pressed to handle these types of concerns effectively.

- Recruitment and Retention require constant vigilance. The CPC found that the provision of a meal at every session, metro cards for transportation and childcare during group sessions substantially aided group participation. Other types of incentives (books, child safety items, toys, CD's for the mothers, etc.) did not appear to have a significant impact on retention, but were appreciated. The CPC received a significant number of referrals from the MMC medical provider community - another advantage of being linked to a larger agency setting.
- The provision of childcare during PEP sessions was more complicated than originally anticipated. The CPC learned that it is critical to have adequate, safe play space for the children and infants. It is important to note that initially we thought that PEP would be utilized by pregnant and parenting teens that did not have many children. We underestimated how many children that the mothers would have, as well as the types of emotional and developmental problems that PEP would encounter in the children. The use of volunteers to provide babysitting services was not successful. The volunteers were not dependable, many did not want to travel to the South Bronx and they often cancelled with short notice. Paid childcare staff is essential for these types of services.

- The selection of appropriate staff is critical for program success. For PEP, it was essential that at least one of the two PEP clinicians be bi-lingual (Spanish). It was also necessary to recruit clinicians who had experience with, or were willing to learn how to implement research protocols and administer standardized tests to the group.
- Tracking of participants was not feasible due to the tremendous amount of resources that would need to be invested to monitor their whereabouts. It was difficult to maintain contact with them after graduation due to: lack of telephones, changes of address, etc. A full-time staff person would need to be assigned to work full-time on this assignment in order to track participants effectively. It might also be necessary to provide incentives to participants to maintain contact with the program.

What works and for whom?

- The CPC found that the PEP participants enjoyed interactive group sessions that utilized role-playing activities, videos, games and outside speakers/presentations. These activities, combined with didactic sessions kept interest levels high. It was also helpful to be able to deviate from the curriculum when needed to have a "rap" session on pressing issues, i.e.: domestic violence, postpartum depression, childcare, TANF, relationships with boyfriends and family members, etc.

- Home visits work. The CPC found that tremendous knowledge is gained during the initial home visit session. Besides aiding in recruitment, it allowed the PEP clinicians to aid the young mother in improving the living conditions of the household. However, home visits come with other sorts of issues, such as: demanding substantial time, last minute cancellations, "no-shows" by the mother, transportation difficulties and safety concerns. The PEP clinicians and the PI's feel that one home visit at the start of the program will produce greater returns as opposed to conducting two home visits (one at the start and one at the end of the program).
- Regular six-month PEP groups were more successful than the school based program model regarding retention and participation levels. The school participants often did not show up for classes, the school often inserted new students into the class several months after the group started and many students dropped out. In contrast to the non-school based groups, the school-based groups had a majority of participants who were neither pregnant nor parenting. In addition, there were males in the group that changed the group dynamic and for whom the curriculum was much less applicable. The young mothers in the other groups had agreed to participate and consequently were more committed to the PEP program.

What can the CPC/PEP tell others not to try?

- Peer mentoring was not feasible. The principal investigators and the PEP clinicians realized that the high levels of stress and dysfunction among the women precluded them from providing peer mentoring to others. Several attempts to utilize peer-led activities were unsuccessful due to the competing demands of childcare, TANF regulations, medical/mental health issues, work demands, insecure housing and family conflict, etc.
- The PEP staff felt more supported when their office was relocated from the South Bronx Police Athletic League to the Child Protection Center. The PEP staff stress could be better assessed and managed within the CPC itself. The initial geographical isolation produced many problems with referral accessibility, office coverage, security concerns and space issues. Relocating the staff in the main program also strengthened supervision sessions. The CPC continued to rent space at the PAL for group sessions which worked out quite well.
- Standardized testing as a stand-alone measure for program evaluation is not recommended. Due to the level of literacy, test anxiety, occasional absenteeism, the mechanics of administering four different tools and participant hostility to this form of testing, it is difficult to obtain valid and reliable pre and posttest scores. The Principal Investigators feel that the employed assessment tools do not adequately measure the progress of the participants. The PI's recommend the addition of the Personal Goal Achievement Measure to assess outcomes more accurately and meaningfully.

- Data sets need to be streamlined from the start of the project. The PEP program initially created eight datasets with several hundred variables. The program currently utilizes three major data sets, (registration, test and Personal Goals). Transferring all of the forms used in the PEP into data points created an unreasonable burden for the staff due to the need for double data entry. Since the primary staff are not researchers, parsimony in data collection is vital.
- Rolling admission to this type of program is not recommended. It resulted in less group cohesiveness and more administrative work.

What aspects of the program are you ready to "roll out" to others?

- The CPC is ready to rollout the PEP curriculum. Over the last two years the CPC has produced an extensive parenting skills curriculum in two versions. The first version is formatted for six-month groups that meet every week. The second version is targeted for classroom teaching, with daily 45-minute sessions, over the course of a 3-month semester. The curriculum is divided into group modules that cover the areas of: self esteem building, domestic violence assessment and intervention, substance abuse prevention, well baby care, health and nutrition, effective discipline techniques and stress management. The CPC also incorporated a section on independent living skills and interviewing techniques into the school-based curriculum. (Please refer to Appendix 1 for an overview of the PEP curriculum).
- The CPC can provide the field with the Personal Goal Achievement Measure (PGAM) that was developed by the Principal Investigators. Mary L. Pulido,

MAT, CSW and W. Paul Kory, MD, MPH are in the process of writing an article for publication describing this tool. (Please refer to Appendix 2 for overview of PGAM).

- The CPC could provide the field with the datasets' frameworks, variable lists and the plan for the analysis of the data.

What can we now say about measuring neglect?

- The CPC is a certified child advocacy center. It has tremendous expertise in identifying and providing services to families that have been reported to CPS for child sexual abuse, physical abuse and neglect. The CPC staff teaches the mandated course in child abuse maltreatment identification and treatment. In our implementation of the PEP program, the clinicians followed the basic guidelines regarding reporting issues. "Measuring" neglect was not the issue that was problematic, rather, it was the fact that PEP spent very limited time with each family and often could not accurately assess all potential neglect factors that needed to be taken into consideration. The PEP clinicians spoke regularly with other agencies involved with the participants to help resolve CPS-related issues. They also had to make several CPS reports to ensure the safety of the child. It is also important to note that many mothers had never received any type of preventive services; therefore the PEP clinicians connected these families with neighborhood providers.

It was helpful that the clinicians met regularly with the Executive Director of the CPC for supervision. All potential cases that were going to be reported were discussed in these meetings.

Can anything be reported about the neglect and poverty relationship?

- The CPC feels that the definition of "poverty" that is used must be significantly broadened in regards to this question. Poverty is not solely financial. The young mothers in the PEP program endured poverty in many spectrums. They were impoverished in their housing, social support systems, lack of medical and mental health services, education. They were also assaulted with constant threats of violence, both personally and in their communities. The CPC has found that the availability of resources to aid these women is extremely limited. Demand exceeds capacity in many areas of New York City.

What would grantees like to try next?

- The CPC anticipates continuing the PEP program after the termination of this grant. Recently, the CPC applied for funding through the Administration for Children, Youth and Families for funding for PEP2, an enhanced PEP model with significant mental health service provision for participants. The PI's and PEP clinicians identified significant and serious mental health problems in the young mothers and in their children in the current PEP program that needed various levels of treatment. Depression and anxiety were pervasive among the women and their children in PEP. These interventions included: psychiatric evaluation,

emergency room treatment, short-stay hospitalization, long-term hospitalization and on-going therapy.

- The CPC is in the process of renovating a new facility, which will house its prevention efforts. The new PEP program will be one of several MMC programs operating from this site. This new building has space that is specially designed to meet PEP needs. This should have a positive impact on program effectiveness.

III. Was the program successful in attaining its participant outcome objectives?

A. Statement of Participants Outcome Objectives As Stated in the Grant Application.

The CPC developed the PEP program with an objective of empowering parents to create nurturing homes for their children. The program was designed as a "strengths-based" initiative, emphasizing the parents' strengths rather than deficits. The original application stated that this type of program could also have a positive impact on the participants' self-esteem and trust in their own parenting skills – items which are impossible to assign a value. By empowering parents through the educational PEP curriculum, referring them to needed medical and mental health services and by providing crisis intervention, it was posited that children would experience less neglect and abuse. The CPC utilized four standardized assessment measures, administered during different phases of the PEP curriculum to attempt to measure the degrees of maternal social support, child abuse potential, knowledge of infant development and home environment safety in the lives of the young women.

As the program progressed, the OCAN grantees felt that an additional measure was needed to capture improvements not captured through the use of standardized tools. Therefore, the principal investigators of PEP developed and implemented the Personal Goal Achievement

Measure (PGAM) as another gauge of participant outcomes. This measure would aid the PEP program in evaluating whether certain concepts of "empowerment" were realized in the lives of the participants.

B. Questions Related to Assessing Participant Outcome Objectives, Expectations for Change and Definitions.

1. How effective was the project in empowering young mothers and strengthening their parenting skills and social support systems as measured by the standardized assessment tools?
2. How effective was the project in assessing the personal goal achievement of the young women?
3. How flexible was the program/curriculum to accommodate the needs of the young women so that these objectives could be realized?

C. Methods used to answer each outcome-related question.

Assessment Issues and Evaluation Challenges in Family-Based Services

The Parent Empowerment Program has had a dramatic impact on the lives of many of the young families that it has engaged since its beginning in 1997. Many of the changes and outcomes cannot be measured effectively by the use of rigorous, standardized assessment tools. Measurement of change is multi-dimensional and is more complicated than simple affirmation or denial of an attribute before or after intervention. Although standardized instruments may have

good psychometric properties, the tools may have low clinical sensitivity and be difficult to employ in a clinical setting involving special populations. Further, the relationship of standardized test scores to the actual outcomes of interest, such as reduced child abuse and neglect, is often tenuous.

The investigators of the PEP program are also aware that the data collection environment varies from group to group. Often the young women are in crisis and have trouble focusing on the assessment; reading and comprehension issues may also be substantial (the majority of the participants who are included in this analysis had not completed high school/GED).
The investigators also realize that developmental outcomes are not linear, rather they are transactional in nature, the result of dynamic and continuing interactions and processes. There are ups and downs, progress and set backs and then more progress. Most standardized instruments do not capture the transactional nature of family and child development. Standardized tests are generally used to support a diagnosis, condition or trait rather than to devise a service plan. Therefore, researchers need more than just assessment instruments to capture fully the changes sought by the Parent Empowerment Program. However, the PEP investigators feel that the standardized assessment tools can be used to support both practice and research if employed as part of a multidimensional assessment and treatment plan.

Data Collected, Methods and Sources

The PEP program clinicians administered the Maternal Social Support Index (MSSI), the Child Well Being Check List (CWBCL) , the Child Abuse Potential Index (CAPI)and the Knowledge of Infant Development Scales (KIDS) to each participant enrolled in the program, as

pre and post test measures. The MSSI was completed during the initial home visit. The CWBCL was completed by the clinicians following the home visit. The CAPI and KIDS was completed during group sessions. If a home visit was not feasible/allowed, the participants completed the MSSI prior to a group session. Due to the issues of attrition, missed group sessions, inability to conduct two home visits for each participants, etc. due to these issues, gaps in the data for these measures were inevitable.

After scoring these tests, the PEP clinicians entered the data into one of the PEP data sets designed for this project. This database was designed by the principal investigator, Dr. Kory. Dr. Kory monitored the data entry issues and met regularly with Mary L. Pulido and the PEP clinicians to discuss the data collection and analysis. The collected data for the Registration, Test and PGAM data sets were analyzed formally at years three, four and five of the program.

Introducing the Personal Goal Achievement Measure (PGAM).

The PEP evaluation started to use a quantifiable measure of personal goal attainment data during 1998-1999. This type of performance assessment may prove to be a more sensitive and comprehensive method of capturing the transactional change occurring in the lives of the PEP participants. It may also inform the program about the effectiveness of its intervention strategies, as well as being an intervention itself.

In addition, research studies have noted that group outcomes are not necessarily reflective of a program intervention's impact on the population in the group. In any group setting, participants may experience dramatic gains or setbacks, which are inevitably lost when an average score is taken to measure the effectiveness of the intervention. Knowing this

information, the standardized tests utilized in PEP will also be evaluated on an individual basis as a substantial number of young women showed positive increases, which are not reflected in the averaging of test score data. (Note: Before/after individual measures showed less improvement than grouped scores). ***Please refer to Appendix 3 for the test data analysis and PGAM results.***

Elements of the PEP curriculum

An important aspect of the PEP program was its ability to meet the ever-changing demands and challenges encountered by the young families. Since the program model utilized a group sessions that were not exclusively didactic in nature, the PEP clinicians had the advantage of incorporating topics of concern/interest into the modules to address the young mothers' needs.

For example, during the third year of PEP, the clinicians and the principal investigators realized that dating and domestic violence permeated the majority of the young women's relationships. The CPC was able to develop a four week module on domestic violence issues. Since many of the young families felt that violence was "a fact of life", it provided PEP an opportunity to share information on definitions, resources, the impact on children, legal rights, etc.

Case examples illustrate the pervasiveness of domestic violence in the lives of the PEP participants:

- A 19 year-old mother was referred to PEP by a foster care agency after her two children, ages 18 months and three months were removed due to inconsistent and unexplained injuries sustained by the infant. The baby was burned on the foot and upon examination

a healing skull fracture was identified. The mother missed a PEP group due to an emergency room visit warranted by a domestic dispute in which her boyfriend punched her in the face. The PEP clinicians are working with her on the domestic violence issues, parenting skills, her impending case in criminal court regarding her child and referrals for on-going psychological counseling.

- A 19 year-old Latina mother of two children was mandated to PEP by the court system. Both of her children are not in her custody at the present time. Her son had been removed for excessive corporal punishment and her daughter was placed in the custody of her grandmother. She was a victim of domestic violence. Her ex-husband is currently incarcerated. The CPC was informed that the police were looking for this mother due to the fact that she had witnessed a murder that had occurred in her apartment. The PEP clinicians attempted to contact the mother. The mother turned herself into the police and described the death of one of her friends due to Russian roulette. Her current boyfriend had fired the gun. She eventually turned him into the police and is staying with her mother at the present time.
- A 23 year-old Latina female with a seven year-old son, a six year-old son and a one year-old daughter was referred to PEP by a friend. She was mandated by the Administration of Children's Services to receive parenting education as part of her plan to reobtain custody of her daughter. Her daughter was removed due to a suspicious spiral fracture of her leg. She faithfully attends every PEP session and has followed through on all court expectations. The PEP clinicians are working closely with her regarding child

supervision, safety and discipline techniques. While in PEP, she disclosed domestic violence. She was supported while she received an order of protection. Recently, her boyfriend attacked her and she called the police. While a police chase ensued, he jumped from one building to another and fell to his death. This mother was with him when he died and consequently experienced severe depression, placing herself and her children at risk of neglect. The PEP clinicians brought her into Montefiore Medical Center for psychiatric evaluation. She is on medication and was enrolled in a crisis therapy program. Her mother is helping her watch her two boys during this stressful time.

D. Findings regarding Each of the Outcome-related Questions.

Registration Data Set

The following data set contains information on the PEP participants for 18 groups. It is representative of all groups held from the start of the program through August 2001. The registration data set currently contains information on 438 women. This data set includes young women who were referred to the program and the reasons why they were able or unable to successfully complete the program. The subjects included represent the following constituencies:

- Participants who enrolled (IE. Signed an informed consent) but failed to start the program. (N=55).
- Participants who started the program but did not complete the program. (N=90).
- Participants who graduated. (N=87).

Those who graduated were required to attend at least 80 percent of the sessions.

Group Characteristics from the Registration Data Set - Table 1

This overview consists of information gathered on participants of 18 PEP groups that were held from the period of 5/22/97 through 2/1/01. A total of 438 young women were referred to the program. (This number includes 28 women who were re-referred). Of these, 250 women enrolled in PEP of which 195 actually started the program (This includes 24 re-referrals). Of these 195 women 87 (including 6 re-referrals) have completed the requirements for graduation; however 17 of the 195 women who started the program are in groups that began late in 2000.

The following information focuses on those 195 women who enrolled in and started the program.

The average group size was 10.2 women, the groups ranged in size from 5 to 17 participants.

The average age of the young women in PEP was 20.5 years old. The women ranged in age from 12 to 33 years. The women were predominantly Hispanic (N = 112). There were 79 African American women and 4 Caucasian women enrolled. The majority of the women were parenting (N = 146). Thirty-three young women were pregnant and eight were both pregnant and parenting. Of those with children, the average number of children per woman was 1.52. Nearly 97% of the young women were single mothers (N =176).

Approximately 32% of the young women were mandated by the Administration for Children's Services (ACS/CPS) to attend the program (N = 45). Over 15%of these participants (N = 22) had their children removed and placed in foster care. Forty-nine of the young mothers (36.6%) had an open case with ACS, but retained custody of their children.

The Maternal Social Support Index – Preliminary Analysis

The Maternal Social Support Index (MSSI) is a 21-item questionnaire designed to quickly assess qualitative and quantitative aspects of a mother's social support. It is administered during the first home visit (or office visit if the clinicians are unable to gain access to the home).

For the first eighteen PEP groups, data for the pre test was obtained for 234 of the 253 women who enrolled. The average score on the pre test was 20.8. For the 77 of the 183 participants completing the program who took the post-test, the average score was 20.0. Comparing only the 75 pre-test and post-test scores of those taking the test twice and completing the program, the principal investigators found negligible change +0.79 However, from an individual case analysis, 38 young women's scores increased, nine remained the same and 28 went down slightly. (The maximum score on this test is 39).

Although the cumulative test scores difference indicates little change (the range of scores at the program start was 4 to 36, the range of scores at program finish was 2 to 33), the principal investigators feel that this tool may not adequately capture the dynamics present in the lives of these participants. Several participants moved out of their homes due to issues of domestic violence and substance abuse and therefore may have felt more isolated and less supported, while actually bettering their living condition. On the reverse side, several women became homeless, experienced death in their families, had complex health issues arise ranging from HIV to suicidiality. The MSSI captures these women at two distinct stages of their life and do not necessarily reflect the program's parenting intervention.

The PEP program may have also allowed the participants to explore options/feelings regarding empowerment/change of their daily living situations that now made them dissatisfied with their present living situation. Therefore progress may have been made, but it was not reflected in the test scores.

Finally, there was a persistent and pervasive problem with the administration and collection of data with this population due to absences from the group, clients missing scheduled home visits, reading and comprehension problems, fears of and hostility toward testing, general depression and anxiety, and stresses of daily survival.

The Child Well Being Scales (CWBCL) Preliminary Analysis

As requested at the NCCAN conference in April 1997, the PEP program began to utilize the Child Well Being Scales as an additional assessment tool. The Child Well Being Scales are a set of standardized client outcome measures specifically designed to meet the needs of a program evaluation in child welfare services. The evaluation needs to be completed in the participants' home. Some of the dimensions covered include: physical safety in the home, availability of utilities, security of residence, household sanitation, overcrowding, clothing, household furnishings, etc. The PEP investigators feel that this tool may be more useful in mandated child protective service agencies as it can only be administered once access is gained to the dwelling.

The PEP clinicians were allowed to make home visits to 129 of the participants at the start of the program. Forty-three home visits were completed at the end of the program. Data for 32 participants was gathered as both a pre and post-test measure. For these participants there

appeared to be a slight increase in the test scores overall (+ .90). The average score at the start of the program was 92.7. The average score at the end of the program was 94.4. The maximum score is 100. Of the 32 women where PEP was able to obtain both pre and post-test scores, 17 scores went up, nine scores went down and six remained the same. The range of scores at the start of the program was 73.9 to 100. The range of scores at the end of the program was 79.6 to 100. The difference in the test scores for those PEP participants who had pre and post-test scores, fell within a range of –12.8 to +12.1.

Data collection was limited due to the fact that over 70% of the young women for whom pretest data was collected did not complete the program or allow a home visit at the end of the program. Some participants may have been afraid to allow the clinicians into their homes due to: substandard living conditions, overcrowding, domestic violence and drug dealing activities. The participants who let PEP clinicians enter their homes were self selected and presumably had fewer concerns of the latter type. It should also be noted that many of these young mothers live with their mothers or other family members. Thus, they were not free to invite the PEP clinicians into their living situations due to the mandates of the person supporting the household. Scheduling issues were a substantial problem due to the many demands on the participants' and PEP clinicians' time. In addition, for safety reasons, the CPC did not allow the PEP to conduct home visits at night, further complicating the scheduling process.

Knowledge of Infant Development Scales – Preliminary Analysis

The Knowledge Inventory of Development and Behavior: Infancy to School-age (KIDS) was developed to measure what people know about how children grow and change. A total

score and four subscale scores are possible when reviewing responses to the Inventory. Scores on each of the subscales can indicate areas of strength/weakness in the understanding of how children grow and behave during specific developmental periods.

In the literature on child abuse and neglect, adolescent parents have been characterized as impatient, insensitive, irritable and prone to use physical punishment with their children. Teen mothers are often coping with frustrations which include low income, low education level, inability to access health care, forced early maturity, low self-esteem, limited social support and family expectations. Unrealistic expectations of behavior and development by the teen parent toward her child can lead to impatience resulting in the abuse or neglect of the child. Young mothers enrolled in the PEP program were not well informed about child development and growth.

The project investigators believe that this lack of information can result in inappropriate interactions and unrealistic expectations regarding their children's abilities and behaviors. Such faulty expectations can increase the incidence of child abuse and neglect.

The KIDS assessment scale was administered to 141 participants as a pre-test and to 93 participants as a post-test; however, only 81 of these participants completed both the pre and post-test scales. When assessed as a group, there was negligible improvement in the overall scores. The average score at the start of the program was 26.5. The average score at the end of the program was 26.6. The maximum score for KIDS is 48. If this data is reviewed on an individual basis, positive gains were made by 37 women, 8 women's scores remained the same and 36 were lower at post-test.

The group subscale scores for the toddler, preschool and school age sections did not show significant improvement. ***However, the subscale scores for the infant section suggest substantive improvement overall.*** The score at the start of the program was 5.91; at the end of the program, it was 6.78. The PEP investigators believe that this may have been due to the fact that the majority of participants were young mothers with infants and were open to guidance on the "here and now" aspects of child development and growth. These participants were able to internalize, utilize and retain the information used in this section of the program since concrete needs/questions were being addressed. Although the main focus of the PEP program was educational, it was a process-based intervention that is memorizing specific information content was not stressed. Rather, an emphasis on expanding the participants' awareness of a range of issues was the predominant emphasis.

The Child Abuse Potential Index (CAPI) Preliminary Analysis

The CAP Inventory is a 160 item self-report questionnaire that is answered in an agree/disagree, forced-choice format. The questionnaire has a third grade readability level. The physical abuse scale contains six descriptive factor scales: distress, rigidity, unhappiness, problems with self/children, problems with family and problems with others.

One hundred and thirty-one young women completed CAPI at the beginning of the program. Eighty-five completed it at the end of the program. Seventy-nine young women completed CAPI as both a pre and post-test measure.

Overall the PEP participants were deemed at extremely high risk for abuse/neglect

potential according to their scores on this measure. The scale indicates that scores over 215 are considered extremely high risk for child abuse and neglect. The average score at the start of the program was 217.1. There was a range between 9 and 431. At the end of the program, the average score was 214.6 with a range of scores between 11 and 442. The downward trend is slight but encouraging since a large number of complex and distressing factors affect the participants in the program. If the 79 cases are reviewed on an individual basis, 39 women's scores were lower (improved), two young women had no change in their scores and 38 young women's scores increased.

The majority of the subscales indicated a slight downward trend (decreased risk) with the largest improvement noted in the rigidity and unhappiness scales. The three categories whereby more women showed increases were found in the following categories: problem with children and self, problem with others and problem with family. In the category, problem with children and self, at the start of the program the average score was 10.1; at the end of the program the average score was 13.5 an increase of +1.38 for those taking the pre and post-test. In the category of problem with self and others, at the start of the program the average score was 16.9. At the end of the program, the average score was 17.3, an increase of +0.911 for those taking the pre and post-test. In the category of problem with family the average score at the beginning of the program was 7.56, at the end of the program, it was 8.84 an increase of +2.00 for those taking the pre and post-test. The investigators think that these increases may be attributable to the young parents increased awareness of items that need to be changed in their life after participating in the program. Another factor adding to the prior increases may be related to their dissatisfaction with current living conditions and dysfunctional personal relationships with their

significant others and family members. These factors may be reflected most significantly in their relationship with their child and the people that they come in contact with on a daily basis. On an individual basis, 27 of the young women's scores increased, 25 decreased and 27 did not change.

Based on the literature reviewed by the PEP investigators and through research conducted by Joel S. Milner, the author of the CAPI, respondents with elevated abuse scores have an array of personal and interpersonal characteristics that are similar to characteristics found in identified physical child abusers. Those with elevated abuse scores are likely to report being abused and observing abuse as a child. They are less likely to report the existence of social supports, such as a caring adult or caring friend in their early environment or adult environment. Those with elevated scores are also more likely to be isolated and less likely to use community resources and be less likely to accept or remain in treatment.

Since the changes in some participants scores seemed excessive to us, we also examined in more detail the lying scales and faking good/faking bad scales. For example, one participant's pre and post-test scores increased over 200 points.

Reanalysis of CAPI Excluding CAPI's with Positive Faking Good Indices

As mentioned above, the principal investigators reanalyzed the CAPI data excluding these cases with positive faking good indices on cases where the CAPI score was less than 215. This reanalysis indicated that in the majority of categories, the young women's scores increased (more at-risk) with the exception of the category of rigidity, in which 24 women's scores improved (were lower), 18 scores increased and three did not change.

The principal investigators feel that the young women enrolled in PEP are at substantial risk for child abuse and neglect. Several theories should be considered regarding the results of the CAPI. First of all, the PEP program could be one of the few support systems available to them. Since PEP is not an intensive case management model, substantive changes in their overall risk factors should not be expected at the end of the program. The second factor to be considered is that for many of these young families, a new awareness of the responsibilities of parenting, understanding the need for additional medical and mental health services for themselves and their children, the recognition of domestic violence in their lives, the greater realization of living in precarious environments which may place their children at risk for neglect, may have increased their stress levels at this time. A third explanation which may be considered is that as the participants grew more comfortable and familiar with the PEP clinicians and other group members, their honesty in reporting may have increased, thereby producing more realistic scores.

Analysis of Personal Goal Data

During the OCAN Neglect Conference in June of 1998, grantees were encouraged to develop measures other than standardized tools for use in monitoring change/progress with the PEP participants. Since that time, the PEP clinicians and the Principal Investigators have worked with the young women to formulate a list of personal goals that were measurable. Currently, when the young women enroll in PEP, they are asked to select several goals from a list, which was derived from prior PEP participants' choices and options identified by the research team, that they would like to focus on during their six months in the program. In addition to the list of

goals, the PEP participants are given the criteria for successful achievement of the goals. These criteria define important steps that must be completed to achieve each overall goal. During the program orientation, the concepts of goal achievement and personal empowerment are discussed. The goals are reviewed with the young women periodically throughout the six-month cycle. After the young women graduate from the program, the aftercare/tracking component also monitors progress towards goal attainment, as many goals are not fully realized during the PEP program cycle. Thus, the goal selection process, the list of goals and the steps required to achieve them, may be considered part of the program intervention, as well as tools to evaluate overall program performance.

It is striking to note that many of the young women were not able to articulate their preference for goal selection, as this process was new to them. Many expressed serious doubt and reservation that they were capable of accomplishing any of the goals that were identified. The PEP clinicians reinforced personal goal achievement with the PEP participants throughout the program. Keeping these factors in mind makes the results of the goal data impressive. Significant levels of accomplishment were achieved by many of the young women

Goal achievement was defined initially by the following categories: not achieved, partially achieved, achieved and achieved beyond expectation. However, after the present analysis was completed, the Principal Investigators decided to collapse the "achieved and achieved beyond expectation categories" into one category, due to the PEP clinicians difficulties in differentiating these categories in actual use. The Principal Investigators worked with the PEP clinicians to develop a list of standards that needed to be accomplished for each goal in order to include them in one of the above-mentioned categories. This enabled the PEP clinicians to

systematically scorethe progress of the participants in respect to each goal selected. As evidenced in the Personal Goal table, a significant percentage of the goals were partially achieved (indicating that progress had been made and that the young woman could still be working on them as of her graduation from the program), achieved or achieved beyond expectation (meaning that the young women nearly met every standard listed for that particular goal). As researchers look for methods to capture accurately the outcomes that may be realized in the group work process, this type of performance measurement tool may hold promise.

Goal #1. To make progress toward regaining custody of their children or closing their ACS case. Sixteen clients selected this goal. PEP was able to report on the current progress of 13 of those women. Of the thirteen, one did not achieve the goal, four women partially achieved the goal, five achieved the goal and three achieved the goal beyond expectation.

Goal #2. To obtain mental health/developmental assessment and diagnosis for the client's children. Twenty-seven clients selected this goal. PEP was able to report on the progress of 14 of the young women. One client did not achieve the goal, three partially achieved the goal and 10 achieved this goal.

Goal #3. To make progress toward finishing high school or obtaining a GED. Fifty-three women selected this goal. PEP was able to report on the progress of 34 of those women. Of these, three did not achieve the goal, eleven partially achieved the goal, sixteen achieved the goal and four young women achieved the goal beyond expectation.

Goal #4. To enhance technical/vocational skills in a formal education setting. Thirty-four women selected this goal. PEP was able to report on the current progress of 18 young women. Of these, one did not achieve the goal, ten women partially achieved the goal, six achieved the goal, and one achieved beyond expectation.

Goal #5. To obtain part-time or full-time employment. Fifty-seven young women selected this goal. Thirty-two women were accounted for at the time of this report. Of these, two did not achieve the goal. Nineteen showed partial achievement, four achieved the goal and seven achieved beyond expectation.

Goal #6. To increase access to concrete resources-public assistance, food stamps, WIC and/or child support. Twenty women selected this goal. PEP was able to report on the progress of 10 young women. Of those, three did not achieve the goal, two partially achieved the goal, four achieved the goal and two women achieved the goal beyond expectation.

Goal #7. To increase access to concrete resources – medical benefits for child or parent (Medicaid/CHIP). Thirty-seven women selected this goal. PEP was able to report on the current progress of 21 of these women. Of these, two did not achieve the goal, six showed partial achievement, eleven achieved the goal and two achieved the goal beyond expectation.

Goal #8. To increase access to concrete resources – housing. Forty-four women selected this

goal. PEP was able to report on the progress of 26 women. Of these, two did not achieve the goal. Thirteen women showed partial achievement, nine women achieved the goal and two achieved beyond expectation.

Goal #9. To improve parenting skills and knowledge (i.e. Decreasing use of corporal punishment, increasing understanding of child's needs). Sixty women selected this goal. PEP was able to report on the progress of 35 of these young women. Of these, three did not achieve the goal, seven showed partial achievement, sixteen achieved the goal and nine achieved the goal beyond expectation.

Goal #10. To improve participant's relationships with her children. Thirty-nine women selected this goal. PEP could report on the progress of 21 young women. Of these, one did not achieve this goal. Two showed partial achievement, thirteen young women achieved the goal and five achieved beyond expectation.

Goal #11. To improve participant's relationships with her own parents. Thirty-four young women selected this goal. PEP could report on the success of twenty young women. Of these, one did not achieve the goal. Seven showed partial achievement, eleven achieved the goal and one achieved the goal beyond expectation.

Goal #12. To improve participants relationships with the father(s) of her children. Thirty-four young women selected this goal. PEP was able to report on the current progress of 21 young

women. Of these, one did not achieve the goal. Seven showed partial achievement, eleven achieved the goal and one achieved the goal beyond expectation.

Goal #13. To increase number/strengthen relationships with other pregnant/parenting women. Twenty women selected this goal. PEP was able to report on the current progress of 10 of these young women. Of those, one showed partial achievement and nine women achieved the goal.

Goal #14. To make progress toward recognizing/ending relationship with domestic violence. Fifteen young women selected this goal. PEP could account for eight of the young women at this time. Of those, two showed partial achievement and six achieved the goal.

Goal #15. To obtain a mental health assessment and treatment for themselves. Sixteen women selected this goal. PEP could account for the progress of nine of these young women. Of these, one did not achieve the goal, one partially achieved the goal and seven achieved the goal.

Goal #16. To improve client's physical/psychological condition by weight loss, better grooming, more exercise, and higher self-esteem. Thirty-three young women selected this goal. PEP could report on 16 of these young women. Of these, two showed partial achievement, 12 achieved the goal and two women achieved beyond expectation.

Goal #17. To decrease licit and illicit drug use and /or obtaining drug treatment. Four young women selected this goal. PEP could report on two young women. Of these, one did not

achieve the goal and one showed partial achievement.

Goal #18. To better understand "welfare to work" requirements and resources. Twelve women selected this goal. PEP could account or seven women at the time of this report. Of these, two did not achieve the goal and five did achieve this goal.

Goal #19 and #20. PEP participants were encouraged to choose other goals that were not on this list if applicable. Twenty-one women identified other personal goals, such as: Opening their own business, moving to a different borough, owning their own apartment, changing/upgrading their jobs, etc. PEP was able to report on the progress of 11 of these women. Of these, two did not achieve their goals, three showed partial achievement, four achieved the goals and two achieved beyond expectation.

The principal investigators will continue to explore inferences that can be drawn between the methods utilized to assess the participants' progress while enrolled in PEP. In general terms, the standardized tests showed improvement in about 50% of the cases as a post test measure. Many of the young women did not show improvement as measured by these tests. ***In comparison, the measures of the personal goal data indicated that the majority of the women with whom both pre and post-test measures were available, did show substantial progress in achieving key goals.*** If total scores are examined, on 27 occasions, goals were not achieved. For 106 PEP participants, goals were partially achieved. In 156 instances, goals were fully achieved and in 39 cases goals were achieved beyond expectation.

IV. Discussion of Relationships Between Program Implementation and Participant Outcome Evaluation Results

The Principal Investigators and the PEP clinicians felt that certain policies, practices and procedures were very effective in fostering the attainment of desired participant outcomes. These included:

- The development and implementation of the Personal Goal Achievement Measure. Each participant was provided with a list of "steps" that they needed to address in order to meet their goals. PEP found that this type of concrete aid was very helpful to the participants in obtaining their desired goals.
- Home visitation was important to gaining insight into the lives of the young families. It provided a wealth of information to the PEP clinicians about the living arrangements, safety issues in the home, dangers in the neighborhood, etc. It also helped build the rapport between the clinicians and the young women. Although home visitation can be fraught with complications, it serves an invaluable purpose.
- A flexible parenting skills curriculum was important to addressing the needs of the young women. The Principal Investigators and the clinicians were able to modify the curriculum so that pressing needs of the young women were met. Domestic violence, postpartum depression, welfare-to-work issues are examples of subjects that required incorporation to meet the participants' needs.
- The support of a major medical center as a provider of immediate medical and mental health services was critical to the success of PEP. The overwhelming medical and mental health needs was much more serious than originally planned for in the grant application.

PEP is well ensconced in the Montefiore Medical Center Child Health Network and also had access to all adult services to aid these families.

- Weekly supervision sessions between the Executive Director of the CPC and the PEP clinicians were critical to addressing the complicated case needs of the participants. Many of the issues required involving other systems of care in an expeditious manner, such as the police, the district attorney's office, specialty medical providers, CPS staff, etc. These meetings were important for staff retention/support as well.
- It was very helpful to have an "outside" evaluator, who was also an "insider". W. Paul Kory, MD, MPH worked closely with the CPC/PEP, but was the Director of Research and Evaluation for the Division of Community Pediatrics at Montefiore Medical Center. His close proximity and availability to the CPC/PEP was extremely helpful in resolving the evaluation issues that confronted the program. He was also very knowledgeable about the population that PEP engaged and was able to offer sound programmatic advice regarding the curriculum development, test administration procedures, recruitment and retention strategies, etc.
- Providing incentives was important to maintaining the participation levels. Included in this category was metrocards/tokens for transportation, car service when needed, a meal at every group meeting and child care services for the infants/children while the mothers participated in the group. In addition to these routine incentives, child safety items, toys, videos, CD's, baby toys, etc. were distributed on a regular basis.
- A graduation ceremony at the successful completion was an important occasion for these young families. Often, the PEP certificate of completion was the only award that they

had ever received and it reinforced their ability to succeed. Immediate family and children were invited to the ceremony and celebratory dinner was held. Commencement speakers spoke volumes about the program in simple addresses to the graduates. During a recent PEP graduation, a 16 year-old mother, the valedictorian, delivered a stirring address. It included the following passage:

- "Let me start by expressing how gratifying and fulfilling this program has been for me and how it helped me when I learned that I was going to be a mother. I must admit, I wasn't prepared to assume such a big responsibility. For being a parent can be very fulfilling as well as stressful, but thanks to the PEP classes I learned how to cope and how to deal with my child at difficult times. I learned how to be patient, how to handle situations as they arose with clarity and using my better judgment. I acquired skills on how to be a good parent and how to make wise decisions concerning the welfare of my child. I was encouraged and shown that life doesn't end just because a baby was on the way. I shared experiences with other young mothers such as myself. We shared advice; we shared laughs and received much good advice and parenting tips from the excellent staff that supports this program. I really want to thank them...."

Staffing Characteristics and Considerations

Certain characteristics of the staff selected for this program that appeared to foster goal attainment. It was critical that at least staff were bi-lingual (English-Spanish) as the participants were predominantly Latina and often reverted to Spanish when they were in stressful situations. Knowledge of cultural issues such as - parenting expectations, family roles, discipline

techniques, etc. – was very helpful to the PEP clinicians. Throughout the five years of PEP at least one if not both of the PEP clinicians had the ability to communicate in Spanish.

It was also very helpful to recruit staff members who had knowledge of the Bronx community. The majority of the PEP clinicians lived or were born in the Bronx and were familiar with the resources, challenges and policy issues that impacted on service delivery to the PEP families. Familiarity with the area also aided in the home visitation efforts. During the recruiting process, many social workers were adverse to conducting home visits in the Bronx, consequently, they could not be considered for the position. It appeared that social workers who were familiar with the Bronx area were more at ease with this component of the program. Safety was always a concern. The CPC addressed these issues by providing secure transportation through a contracted car service company that waited for them to complete their home visit, cell phones and allowed home visits to be scheduled during the day work hours when two clinicians were available.

It was essential that the Program Coordinator have solid clinical skills. As noted, many of the young women and their children presented with multiple, serious medical/mental complex health issues that required diagnosis and referral. In some cases, immediate intervention was necessary for some participants and/or their children.

Finally, it was important that the staff be willing to implement an initiative with a formal research component. Most clinical social workers and case managers do not have a background or experience in the area of research. The majority of the candidates interviewed were reluctant to handle the responsibilities of test administration, scoring and data entry needs. The staff

members that were hired wanted to be involved in the development and assessment of research-based demonstration projects with at-risk populations.

There were many successes in the PEP program. These young women often struggled against overwhelming odds to provide a safe and secure home for their children. Examples of their success include the following vignettes:

- A 19 year-old African American mother of a two-year-old male, was referred to the PEP group by a local counseling center. She has experienced a recent death in her immediate family and the separation of her mother and stepfather. The family was in severe financial difficulty and she was struggling with not hitting her son during stressful times. She attended almost every PEP session faithfully and appeared to internalize the complex issues of child development stages and appropriate discipline techniques. Her relationship with her child flourished. She has developed friendships with other young mothers in the group and she feels that her self-esteem and confidence in her parenting abilities has improved. She was selected as a commencement speaker for a graduation ceremony.

- A twenty-three year-old mother of an 18 month-old female and a four month-old male, self-referred after reading an article about the PEP program in the local newspaper. The mother was severely depressed and expressed suicidal ideation after enrolling in the PEP group. The PEP clinicians and the CPC ensured that she received the appropriate medical, psychiatric and preventive services to enable her to keep her family intact and safe. Preventive services were engaged and she has a home care assistant helping her

through this time period. She made substantive progress and presents as less depressed and anxious at this time.

- An 18 year-old African American female with a one-year old daughter made momentous gains while in the PEP program. PEP clinicians provided family therapy during a tumultuous period in her life where she wanted to move out of her mother's home. The PEP participant and her mother fought constantly. Although she was a very good student and on the debate team, she stopped attending school. This change in living arrangements would have impacted her ability to continue school and she would have lost a valuable support system and daycare for her child. The family crisis was resolved. She went back to school, is working a part-time job and has been offered several college scholarships for her debate skills.

V. Recommendations to Program Administrators or Funders Regarding Future Program or Evaluation Initiatives

- The Principal Investigators feel that the methodology utilized to measure outcomes in child abuse and neglect prevention programs warrants more research. Our experience shows that the commonly utilized standardized assessment measures do not provide a thorough and meaningful understanding of the gains realized by the participants. Many assessment tools are designed for individual therapy sessions or for populations with less pervasive problems. Utilizing these tools in group settings has many complexities that undermine their usefulness.

- The impact on the TANF regulations on the young parents ability to access parenting groups and to continue in parenting groups warrants more research. Several participants in the program had to withdraw due to workfare regulations, consequently, they had trouble meeting the CPS requirements for parenting skills classes that they needed to retain or regain custody of their children.
- More demonstration projects are needed that explore the association of factors related to child neglect, such as mental health issues, domestic violence, substance abuse, insecure housing, etc. The relationship between domestic violence and child abuse should receive much more examination. Current research findings need to be translated into programmatic efforts in the field.
- Funding for additional educational resources that would supplement curriculum development to meet the needs of special populations is recommended. For example, the CPC developed a curriculum on domestic violence, postpartum depression and understanding CPS intervention.

Appendix 1 – Overview of the Parent Empowerment Program (PEP) Curriculum

The curriculum focuses on seven major areas: child development, well baby care and health/nutrition, substance abuse prevention, effective discipline techniques, managing personal stress, domestic violence awareness and intervention and building social support systems. Self-esteem enhancement exercises will be incorporated throughout the six-month curriculum.

Several early sessions focus on engagement and "icebreaker" activities so that the young women become more relaxed and comfortable with a group setting.

The ***Child Development*** Module covers the areas of conception, birth and child rearing issues up to five years of age. Videos, role playing, jeopardy-type question games serve as aids to learning about the female and male anatomy, what behaviors and milestones to look for as the child grows, teaching your child how to talk, playing with your child, how to handle a child saying "NO!" and temper tantrum resolution. Child safety items, books, and informational handouts are distributed to all participants throughout this series

The ***Well Baby Care*** Module covers issues such as bathing a baby, child-proofing your living environment, changing diapers and nutrition. A special emphasis is placed on medical issues such as Sudden Infant Death Syndrome, colic, otitis media, fevers, emergencies and how to interact with the pediatrician to ensure that the parents' questions/concerns are appropriately addressed. A section of this module addresses the mothers' health concerns regarding: sexually transmitted diseases, OB/GYN check-ups, breast vs. bottle-feeding, HIV/AIDS, post partum depression and birth control. Rap videos, role playing and guest speakers aid in the interactive classes.

Self-esteem, Empowerment and Building a Social Support System are covered. Defining self-esteem, how parents' actions and words reflect on their child and their child's self-esteem, tone of voice and language are covered. Discussion of how the participants' parents' behavior impacted on their self-esteem, communication techniques, building support systems between peers and the community are held. Role-play and video are utilized.

Stress Management focuses on the daily pressures encountered by PEP clients. Activities to relieve stress are discussed. Physical activities are utilized such as low impact aerobics, exercise videos and stretching techniques. Special focus is placed on the PEP clients engaging their children in play activities. PEP clinicians assist and guide the clients in play. Demonstrations are often needed for positive play activities.

Substance Abuse Prevention topics cover alcohol, tobacco, and other psychoactive drugs, consumption limits, peer pressures, how advertisements are targeted to youth, dangers of addiction, lung diseases and other long term effects. The effects of marijuana, its chemical ingredients, impairment of concentration, reaction time and lung damage are covered. Pros and cons of its use for medicinal purposes are discussed. The PEP participants receive an overview of how "gateway" drugs can lead to more damaging and addictive drugs. Other substances covered include: crack/cocaine, heroin, tranquilizers and inhalants such as glue, lacquer, paint thinner and acetone. Role-playing, outside speakers and handouts are used as educational aids.

Discussion regarding ***Appropriate Discipline Techniques*** is a critical module for PEP participants. The majority of the mothers have negative reference experiences and have internalized these interactions as standards of discipline. That is, most of the women were

subjected to corporal punishment within their own families. In addition to the group classes, the clinicians and the babysitters observe mother/child interactions, intervene when necessary and "model" appropriate alternative strategies for child discipline during the PEP sessions. The clinicians begin the module with a discussion of how the participants were disciplined as children; this often permits the clients to verbalize their feelings about prior abuse in their backgrounds. The PEP clinicians explore the meaning and reasons of discipline and options to use that are not inappropriate or abusive. Role-play is used in this module as members act out various domestic violence scenarios and then decide how the situation could have been handled in a non-confrontational manner. Recognizing the stress "breaking point", dealing with anger and education regarding domestic violence resources are covered. Positive discipline techniques, setting family rules, reinforcing the positive behaviors and setting limits with children are also presented.

The Child Protective Services (CPS) caseworker is an important guest speaker for this module. She explains the purpose of CPS, the reasons why children are removed, regaining custody and preventive services available to them. Many clients have prior experiences with foster care and often vent their frustrations with the "system" during these sessions. The CPS worker is based at the Child Protection Center and works closely with PEP clinicians to handle CPS issues that impact PEP clients.

Domestic Violence Assessment and Intervention. This module begins with a group discussion about creating a definition of domestic violence. Although the PEP clinicians have documented violent partner assault incidents among approximately 60% of the young mothers in past PEP groups; the young mothers do not consider themselves "victims". They have

expressed that this type of interaction is pervasive in all of their relationships and considered "the norm". The PEP clinicians introduce the concepts of different types of domestic violence, including the physical, sexual, emotional aspects of these interactions. The cycle of violence, current statistics and resources availability are discussed. The "It Ain't Love" video, which addresses teen domestic violence, will be used to generate a discussion group. A speaker from the District Attorney's office, Domestic Violence Bureau attends one session to answer questions about obtaining an order of protection, negotiating the court system and safety planning. A speaker from Safe Horizons, a domestic violence program in NYC, also addresses the group. The effect of domestic violence on the children is covered and parents receive information on how to protect them.

Appendix #2

Overview of the Personal Goal Attainment Measure (PGAM)

During the OCAN Neglect Conference in June of 1998, grantees were encouraged to develop measures other than standardized tools for use in monitoring change/progress with the PEP participants. Since that time, the PEP clinicians and the Principal Investigators have worked with the young women to formulate a list of personal goals that were measurable. Currently, when the young women enroll in PEP, they are asked to select several goals from a list, which was derived from prior PEP participants' choices and options identified by the research team that they would like to focus on during their six months in the program. In addition to the list of goals, the PEP participants are given the criteria for successful achievement of the goals. These criteria define important steps that must be completed to achieve each overall goal.

During the program orientation, the concepts of goal achievement and personal empowerment are discussed. The goals are reviewed with the young women periodically throughout the six-month cycle. After the young women graduate from the program, the aftercare/tracking component also monitors progress towards goal attainment, as many goals are not fully realized during the PEP program cycle. Thus, the goal selection process, the list of goals and the steps required to achieve them, may be considered part of the program intervention, as well as tools to evaluate overall program performance.

It is striking to note that many of the young women were not able to articulate their preference for goal selection, as this process was new to them. Many expressed serious doubt and reservation that they were capable of accomplishing any of the goals that were identified.

The PEP clinicians reinforced personal goal achievement with the PEP participants throughout the program. Keeping these factors in mind makes the results of the goal data impressive. Significant levels of accomplishment were achieved by many of the young women.

Parent Empowerment - Montfiore Med. Ctr.

THE NEW YORK SOCIETY FOR THE PREVENTION OF CRUELTY TO CHILDREN

December 1, 2001

p. 3? also titled ?

Ms. Suzanne Sparrow
Child Welfare Specialist
Administration on Children, Youth and Families
Children's Bureau
Division on Data, Research and Innovation
330 C Street, S.W. Room 2430
Washington DC 20201

Dear Sue:

On behalf of the Child Protection Center at Montefiore Medical Center, I am pleased to enclose the Final Report for OCAN Neglect Grantees for the Parent Empowerment Program.

Providing this service to the young families in the Bronx of New York City was a very rewarding experience. The impact of neglect prevention services is critical to preventing child abuse and neglect in this high risk population. More programs are needed.

It has been a pleasure working with you during the past five years. Please do not hesitate to call me if I can provide additional information on the enclosed report.

Sincerely,

Mary

Mary L. Pulido, MAT, CSW
Executive Director
Consultant to the Child Protection Center

C: W. Paul Kory, MD, MPH
Linda Cahill, MD
Karen Redlener
Theresa Epps
Elizabeth Lecher
Sofia Castro

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