

HELPING HANDS



2012

Final Report for the Stollery Foundation

Helping Hands was a two-year project carried out by the Alberta Council of Women's Shelters, in partnership with the Edmonton Family Centre and four ACWS members in the Edmonton-area. The goal of the project was to provide an enhanced level of support for young children in shelters in order to build their resilience after exposure to domestic violence. The final report discusses the results of the project, the achievement of project objectives, and lessons learned for future initiatives.

Helping Hands

FINAL REPORT FOR THE STOLLERY FOUNDATION

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BACKGROUND INFORMATION

Organization: Alberta Council of Women's Shelters (ACWS)

Project: *Helping Hands*

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PROJECT PARTNERS

Alberta Council of Women's Shelters

The Alberta Council of Women's Shelters (ACWS) is the unified voice of 43 member sheltering agencies. As a province-wide voluntary organization, the Alberta Council of Women's Shelters supports member agencies and leverages collective knowledge to inform solutions to end domestic violence. The focus of ACWS is on issues of family violence and breaking the cycle of inter-generational violence. To this end ACWS:

- Serves as the unified voice of member organizations;
- Fosters networking and information sharing;
- Assists in acquiring adequate resources for member shelters and ACWS;
- Influences public policy and systems;
- Increases public awareness of issues related to family violence; and
- Fosters professional development within Alberta's sheltering movement.

Most of the ACWS member organizations are registered charities. . All member organizations receive funding from various levels of government, many for over 25 years. Shelter practice is informed by the ACWS Ethical Moral Framework with associated practice standards.

The Family Centre

The Family Centre strives to build healthy families, healthy communities and healthy workplaces. The Centre does this by providing a variety of services designed to help individuals, couples, families, groups and workplaces to achieve wellness and to reach their full potential. The Family Centre assists over 15,000 families annually. Its 400 staff includes social workers, family counsellors and therapists, psychologists, workplace support specialists, family life educators, interpreters, youth workers, family aides, crisis intervention workers, family support workers, home support aides, mediators, nutritionists, and financial counselors. The Family Centre offers a wide range of programs and services to individuals, families and workplaces. Programs are provided on a fee for service basis. Many of our services are subsidized and we are pleased to offer sliding scale options for those who qualify.

The Helping Hands Project, with its goal of working with mothers and young children in Edmonton area shelters, recognized that it would be important to offer support to mothers and their young children after they left the shelters. The Family Centre is in the position to continue providing sliding scale fee services to these families as they move on with their lives.

Participating Shelters

La Salle

La Salle is a second stage women's shelter for mothers and their children who have left abuse and are transitioning from a front-line crisis agency. The program provides accommodation in nine furnished suites for up to a year. During that time clients receive support and counselling as they access educational, employment and training opportunities. While at La Salle, women and their children are provided with group workshops, one on one counselling, childcare, aboriginal support, and outreach services. The program offers a safe place for women and their children to help break the cycle of violence. La Salle exposes its residents to a wide support network which breaks the cycle of isolation and offers the potential to make new friendships.

Wings of Providence

WINGS of Providence is a non-profit organization whose mission is to provide comprehensive transitional programs and independent living in a safe, secure, supportive and healthy environment for women with children who have experienced family violence. WINGS has been providing long term accommodation and accompanying support services for women with their children for twenty five years.

Lurana

Lurana Shelter is a first-stage emergency shelter for women and children fleeing domestic violence. It provides safe shelter in a confidential location, immediate crisis intervention, food, clothing, transportation and child support. The main objective of the shelter is to facilitate empowerment of the women and children they serve. The shelter seeks to empower by encouraging information based decision-making; by increasing awareness of the cycle of violence and the effects of abuse; by working to reduce the problematic symptoms experienced by child witnesses; by strengthening the relationship between the child and the non-abusive parent; by encouraging positive behaviour patterns and attitudes in the children; and by helping mothers attain the tools that will enable her to build a safe, nurturing environment for her children.

A Safe Place

A Safe Place is a first-stage shelter operating in Sherwood Park, Alberta since 1984. The Strathcona Shelter Society Ltd. is chartered under the Companies Act solely for the purpose of operating "A Safe Place", a shelter for abused women and their children. Under contract with Alberta Family and Social Services, and under the direction of a full time Executive Director, the Society oversees the operation of the 35-bed shelter for abused women and their children.

PROJECT DESCRIPTION

Brief Summary of the work completed

The Helping Hands project was met with staff change-over during Year 2. The original therapist from the Family Centre left the project in June of 2011 and was replaced by a new therapist. Due to the unexpected leave of the first therapist, ACWS undertook the data organization, analysis and drafting of the mid-term report, which was submitted January 24, 2012. A project newsletter was sent out to shelters in February 2012 (appendix A) and September 2012 (Appendix B). An evaluation framework was developed in February 2012 in collaboration with the therapist from The Family Centre. A meeting was held on February 13, 2012 with ACWS, The Family Centre and representatives from each of the four participating shelters. The purpose of the meeting was to review the mid-term report, achieve consensus on the evaluation framework and discuss next steps as we headed into the final months of the project.

The Helping Hands project was carried out in two women's emergency shelters (Lurana and A Safe Place) and two second stage shelters (La Salle and Wings of Providence). The context of project delivery was different for each shelter type given the difference in the two programmes. Specifically, women in emergency shelters are offered short term residential services in a communal living environment (with an average length of stay of 12 days) while those in second stage shelters have a longer stay in self contained apartments; this resulted in women and children from emergency shelters receiving a lower number of sessions.

Over the last 8 months (October 2011- June 2012), the therapist conducted three-hour weekly visits at each shelter and provided attachment-based interventions to mothers and children (see Appendix D for breakdown of the therapists' hours). The nature of the services delivered by the therapist for Year 2 varied from year one. In year two, the therapist focused on engaging and supporting mothers in understanding the impact of domestic violence on their children and improving their parenting techniques in order to achieve healthy attachment with their children. The therapist also provided mentorship to shelter staff and made an effort to help staff integrate the project into shelter programming. In Year 2, the therapist collected and analyzed data from participating children, mothers and shelter staff to evaluate the impact of the project on participants. ACWS collected data from shelter executives and staff in order to evaluate the overall impact of the project from the shelters' perspective. See the Project Results section for a summary of findings.

As a result of the therapists' differing data collection and analysis, data and results for the two years could not be combined. Accordingly, the final report is a summary of Year 2 while a summary for Year 1 can be found in the Med-term Report.

Achievement of desired Results, Goals, and Objectives

Overall, Helping Hands project objectives were successfully met. Project objectives included:

1. Provide access to a child psychologist for pre-school children in Edmonton's women's shelters.
 - See Project Results section for a summary of the number of families that attended therapy sessions and the overall number of sessions that were provided to the four participating emergency and second stage shelters.
2. Improve Edmonton shelter worker capacity to:
 - quickly and accurately identify children for referral to a psychologist
 - implement effective early interventions
 - support mothers in shelter in addressing their child's exposure to domestic violence
 - See Part II: Shelter Evaluation in the Project Results section for a summary of feedback from shelter executives and staff regarding the project's ability to improve shelter capacity.
3. Establish a program model to be support and inform practice across Alberta.
 - See Lessons Learned section for recommendations for a program model or similar initiative.

Overview of the roles and responsibilities of any partners involved

ACWS's roles and responsibilities were as follows:

- Provide project management and coordination including organizing, chairing and reporting on project meetings.
- Support the finalization of the project implementation and evaluation plan, associated outcomes and measurement tools.
- Provide two project updates/newsletter to all staff involved in the project and other member shelters (see appendix A and B).
- Provide ongoing project support with respect to implementation and monitoring.
- Support the development of the evaluation framework and project evaluation.
- Support Family Centre with data analysis and manuscript draft for Year 2.

- Conduct interviews with shelter staff and organize and analyze subsequent data in collaboration with Family Centre.
- Interface and report to funders.
- Write the interim and final reports.
- Finalize dissemination plan and disseminate project results

The Family Centre's roles and responsibilities were as follows:

- Retain a Child Psychologist that specializes in children under the age of 6, with a particular emphasis on the 0-4 age group.
- Provide supervision of the Child Psychologist.
- Child Psychologist to provide services at Lurana, La Salle, WINGS, and A Safe Place.
 - This would involve weekly shelter visits, with a total weekly commitment of 15 hours per week until May 31, 2012.
 - Child Psychologist to mentor staff on interventions; develop a roster of services (see appendix C); and provide a report at the end of the year on recommended next steps.
- Execute ongoing monitoring and evaluation of the project including:
 - Number of families served at each shelter per month.
 - Hours spent at each shelter (see appendix D) with a breakdown on individual services provided which includes:
 - Individual counseling sessions.
 - Staff mentorship.
 - Documenting Outcome Rating Scales for the project.
- Work with ACWS in the development of the evaluation framework and execution of the final evaluation and report to be provided by August 31, 2012
- Attend project planning meetings.
- Plan and schedule case consultations and other project related tasks with each shelter, according to shelters' time, needs, and resources.
- Complete PRQ data analysis for year 1
- Take principle investigator role in terms of organizing data, analyzing data and drafting manuscript for Year 2 evaluation.

The shelters' roles and responsibilities were as follows:

- Provide space on-site for therapist visits.
- Work with therapist to organize appropriate time for visits.
- Facilitate the attendance of shelter staff at interdisciplinary training on interventions for children.
- Refer children to program (based on consultation with therapist).
- Facilitate the involvement of mothers in the Helping Hands Project.
- Participate in case consultation as necessary.
- Provide information to The Family Centre on existing shelter programs and supports.
- Ensure that a mentoring relationship/process is developed between shelter staff and The Family Centre.
- Assist in project evaluation, which will include data collection, participation in qualitative interviews, one post-project debrief, and a review of reports produced.
- Ensure appropriate consent from women using shelter services are obtained for Helping Hands.
- Attend project planning meetings.
- If desired, to contribute to the writing of the final report.

PROJECT EVALUATION

Client Population and Service Delivery

A total of 103 sessions were carried out in both the emergency and second stage shelters. 20 sessions were carried out in the emergency shelters and 83 sessions were carried out in the second stage shelters. In emergency shelter I, the therapist provided attachment-based therapy to 10 mothers with focus on 10 children. A total of 11 sessions were carried out. The developmental ages of the children ranged from 1 to 4 years. The mean of the developmental ages of the target children was 2.45 years. Transfer of knowledge is assumed to reach 21 children totaling the number of children within the targeted family. In emergency shelter II, therapist provided attachment-based therapy to 9 mothers with focus on 9 children. In second stage shelters, a total of 83 sessions were carried out with 7 families. The number of sessions each family received ranged from 2 to 20 and on average the family attended 12 sessions.

Treatment Packages

The therapist provided three treatment packages geared at enhancing quality interactions and attachment between caregiver/parent-child dyads based on need assessment conducted on each and every parent-child dyad. Treatment package I is an ICDP (International Child Development Program) intervention program focusing on eight guiding themes of positive interactions. The program, based on its notion of applying recent knowledge from scientific research in child development, aims at providing human care by activating empathy and education of both parents/caregivers and their children. The program, as well, laid its foundation on the principles that are laid down in the UN Convention on the Rights of the Child. Accordingly, in Geneva in 1993, the ICDP psychosocial intervention program was evaluated by the Mental Health Division of the World Health Organization and was adopted and published its manual as a WHO document. The aim of the program is to promote the optimum psychosocial development of children by improving the interaction between children and their caregivers (Kebede-Tekle, 2004; Rye & Hundeide, 2005). The program is geared towards sensitizing caregivers to gradually develop a strong emotional attachment to their children which again strengthens their sensitivity to the children's needs and initiatives.

Treatment package II is an MLE (Mediated Learning Experience) intervention program, otherwise known as the MISC (Mediational Interactions for Sensitizing Caregivers) program. MLE is a conscious attempt of an adult interposing him/herself between the child and the environment. Feuerstein defines human mediation as a conscious attempt of an adult to adjust his or her behaviour and modify the environment in a way that will ensure that the child can benefit from it, that is, focus on it, perceive, or understand and respond (Klein, 2003). MLE is a way of looking at the quality of interaction and is not specifically related to content. There are five parameters of quality interaction of MLE and the MISC program has been developed as an early intervention program to enhance these quality interaction parameters. The MISC program is a developmental approach to early intervention involving the identification and the attempt to enhance the mediational components in a caregiver-child interaction in a developmentally appropriate manner. It aims at improving the quality of caregiver-child interaction without any specificity in language, content or materials employed in the interactions.

Treatment package III is an adaptation of the CPRT (child-parent relationship therapy) which is an approach to train parents to be therapeutic agents with their own children. They are taught basic child-centered play therapy principles and skills including reflective listening, recognizing and responding to children's feelings, therapeutic limit setting, building children's self-esteem and structuring required weekly play sessions with their children using a special kit of selected toys. Through CPRT, the parent-child relationship is enhanced thus facilitating personal growth and change for both child and parent. The focus is on the importance of the child-parent relationship (Landreth & Bratton, 2006).

Project Results

The Helping Hands evaluation was comprised of two parts. The first was evaluation undertaken by the project therapist to assess the impact of the project on individual participants. The second part was evaluation undertaken by ACWS to assess the overall impact of the project, from the perspective of shelter executives and staff.

Part I: Participant Evaluation

By Edna Legesse Wakene, PhD., Therapist, The Family Centre

EMERGENCY SHELTERS QUALITATIVE ANALYSIS

Approaches in women's emergency shelters needed to differ from long-term shelters due to the nature of the shelters themselves. As the women's stay in emergency shelters is short-term, basically for about 21 days before they leave the shelter¹, scheduling appointments for therapy can be challenging. As the women come from a crisis situation; needing to settle down in their new environment and feeling the pressure of making decisions about their lives before they leave the shelters, scheduling appointments for therapy can be pushed aside to make room for their present, basic and pressing needs.

The approach that fitted best the emergency shelter was for the therapist to be available and accessible during the time set for the specific shelter. For example in Lurana shelter, the therapist was physically present in the dining room where women came to have their meals and feed their children. Informal conversations were carried out and certain women either made appointments for the coming week or requested to go to the confidential room for more formal therapy. Building relationships with shelter staff was a key to carry out the attachment-based work with clients; as clients had already established rapport with shelter staff and, through that trust, the therapist was able to access the clients. This flexible arrangement seemed to work best due to the nature of the emergency shelters because everything was novel to clients, the shelter itself, and the therapist as well.

In emergency shelters, qualitative data was collected from three different data sources namely, the therapist's observational data, shelter staff observational data and participating mothers' satisfaction index. The therapeutic intervention was focused on providing psycho-education on the importance of special play time from CPRT, The importance of mediation from MLE and the importance of attunement from ICDP.

The therapist's logbook revealed that the engagement of the mothers during the individual sessions was found to be high and referring to curiosity; the mothers were engaged in probing and seeking more information concerning the treatment packages. Mothers, in addition, have expressed their satisfaction with the information they were provided.

Mothers' feedback data in the emergency shelters revealed that mothers found the sessions to be helpful and gave them confidence to activate their potentials of caring skills in their interactions with their children. They have expressed that they have been given the chance to realize that they can reclaim their power as a parent and caregiver that was once taken away from them in the abusive environment that they were in and that they recently escaped. They further shared that the sessions helped them recognize how important their role as a mother and parent is in the development of their children.

[Mothers] expressed that they have been given the chance to realize that they can reclaim their power as a parent and caregiver that was once taken away from them in the abusive environment that they were in and that they recently escaped.

¹ The Government of Alberta's guideline for women's emergency shelters length of stay is 21 days, however the length of stay varies depending upon a woman's needs and circumstances.

In emergency shelter I, staff observational data revealed that mothers showed increased involvement with their children. They engaged in setting structure and understanding better the effect of domestic violence on both their children and themselves. Mothers showed an increase in self-assurance as a parent, spent more quality time with their children as opposed to quantity, the children's acting out behaviours showed a decrease and mothers displayed a shift in attitude as in replacing the provision of negative attitude by a more positive and healthy one. Mothers' interactional behaviours with their children were enhanced. They were observed engaging with their children in specific activities and tried to convey the "I hear you and I understand you" attitude to their children.

Emergency shelter I Mothers' satisfaction index revealed that mothers' level of satisfaction of the sessions was 95.5 % and they were assessed based on the perceived relationship with the therapist, the goals and topics addressed, the approach or method of the therapist and their overall feeling about the session. Table 1 below presents mothers' satisfaction index.

Table 1: Mothers' satisfaction index (emergency shelter I)

Participant mother	Actual score out of 40	Percentage (%)
1	35.8	89.5
2	39.3	98.25
3	37.6	94
4	40	100
5	35.4	88.5
6	39.2	98
7	39.2	98
8	39.6	99
9	37	92.5
10	39	97.5
Mean	38.21	95.5

Emergency shelter II Mothers' satisfaction index revealed that mothers' level of satisfaction of the sessions was 91.8 % and they were assessed based on the perceived relationship with the therapist, the goals and topics addressed, the approach or method of the therapist and their overall feeling about the session. Table 2 below presents mothers' satisfaction index.

Table 2: Mothers' satisfaction index (emergency shelter II)

Participant mother	Actual score out of 40	Percentage (%)
1	37.5	93.75
2	37.5	93.75
3	34.9	87.25
4	38.9	97.25
5	38.8	97
6	36	90
7	37.8	94.5
8	37.4	93.5
9	31.7	79.25
Mean	36.72	91.80

SECOND STAGE SHELTERS | QUALITATIVE ANALYSIS

Women and their families reside in second stage shelters from 6 months to up to 1 year. As they participate in diverse programming and have settled in the shelters, scheduling appointments for therapy was less challenging than in the emergency shelters. The approach was to build sound relationships with shelter staff who already had relationships with clients and accessing the clients through this relationship.

The evaluation of second stage shelters is presented in a case by case basis as women participated in the attachment-based sessions. Pseudonyms have been used to ensure confidentiality of the individual women in presenting the results. Following the qualitative analysis of the data, a quantitative analysis is presented to highlight statistically significant changes. Statistical methods have several advantages. They can be used with unstable baseline data and they have the ability to detect small, but consistent, treatment effects. The statistical analysis of the data was based on the convention for analyzing Single-case data using statistics. Simplified time series analysis was employed to statistically analyze the data. The simplified time series analysis made use of the C-statistic producing z value which was interpreted using the normal probability table for z scores. The C statistic is a simple, yet elegant, method for quantitatively evaluating the presence of changes due to treatment interventions in serially dependent time-series data. The C statistic is used initially to evaluate baseline data. Autocorrelation was run to detect if the data were serially dependent. The form of autocorrelation used here is a lag-1 correlation. A non-significant result would yield a $p > .05$ and a significant result would yield $p < .05$.

Jane R and her child A.M.

The therapist’s logbook revealed that 12 sessions were carried out with Jane R and her toddler A.M. In all of the 12 sessions, Jane R was motivated and engaged and attended all of her sessions. The treatment package made in effect with Jane R was the MLE intervention, otherwise known as the MISC program. The baseline phase of the treatment delivery consisted of providing psycho-education and observation of the parent-child interaction and lasted for 4 sessions. The next 8 sessions were dedicated to the practical aspect of the treatment delivery. Through the 12 sessions, A.M’s mood improved from being agitated when mother could not physically be perceived to being calm and cheerful. Behaviour has improved from being agitated in the absence of Jane R to cooperative, relaxed and open. A.M was observed to be highly responsive in participating in the activities with Jane R and has improved in behaviour from being monopolizing to sharing. Staff observational data revealed that A.M struggled with being left in child care and there seemed to be a noticeable attachment issues. As treatment progressed, A.M’s separation anxiety decreased as A.M was being dropped in child care. Jane R was observed implementing what she has learnt in her interactions with her child and was more playful.

Mother’s feedback data revealed that she found the therapy useful and that she has learnt new strategies on how to affect her relationship to her child and A.M’s development. Jane R’s satisfaction index revealed that her level of satisfaction of the sessions was 97.5 % and she was assessed based on the perceived relationship with the therapist, the goals and topics addressed, the approach or method of the therapist and her overall feeling about the session. Table 3 below presents Jane R’ satisfaction index.

Table 3: Jane R’s satisfaction index

Session	Actual score out of 40	Percentage (%)
1	37.9	94.75
2	39	97.5
3	37.8	94.5
4	39.6	99
5	39.5	98.75
6	38.9	97.25
7	39	97.5

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8	39.5	98.75
9	39	97.5
10	39	97.5
11	39.5	98.75
12	39.6	99
Mean	39.02	97.55

Statistical analysis of Jane R's data

A visual data of Jane R's treatment is presented below followed by the statistical analysis of the data.
 Simple Time Series Analysis

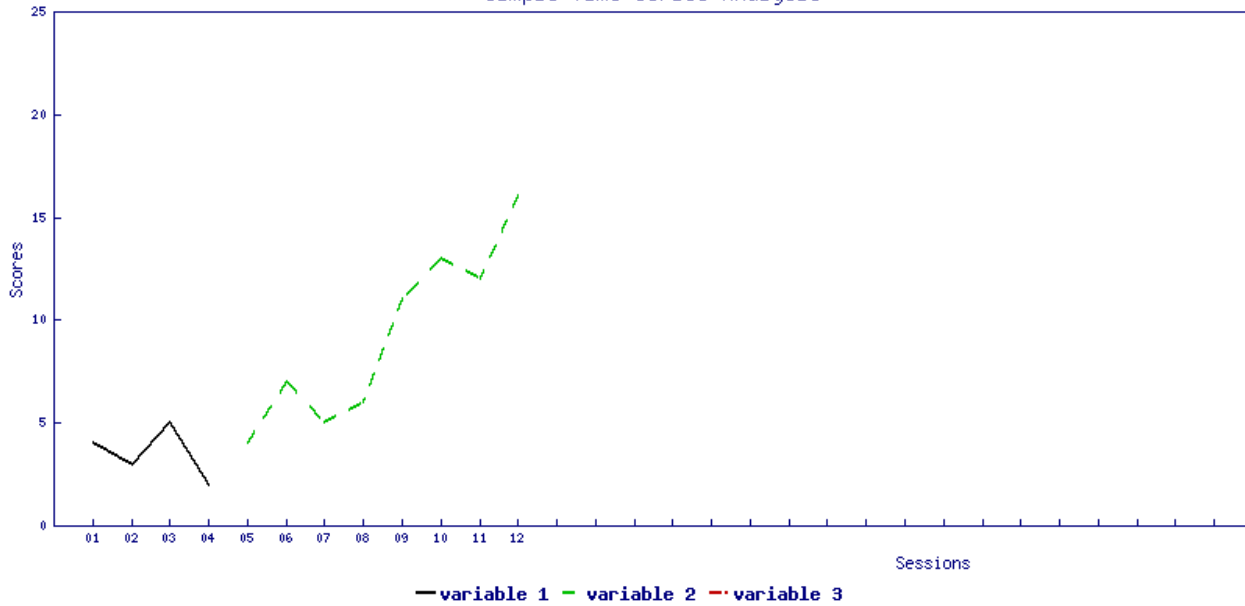


Figure 1: Jane R's baseline and treatment phase

Jane R's treatment data was statistically analyzed and is presented as follows.

Correlation Coefficients- Product-Moment lag-1 for variables 1 and 2 was run to detect autocorrelation. The autocorrelation check is presented in table 4 below.

Table 4: Autocorrelation check for Jane R

Variable 1	Variable 2
r = -0.981	r = 0.785
p = 0.12104	p = 0.03635

The autocorrelation result shows that there was serial dependency in the data. Therefore, the statistic run to detect change was the simplified time series statistics.

The simplified time series analysis run for Jane R is presented in table 5 below.

Table 5: Simplified time series for Jane R

Variables	C	Z	P	Result
Variable 1	-0.399	-1.095	0.863	Random Variation
Variable 2	0.771	2.501	0.006	Non-random variation
Variable 1+2	0.826	3.125	0.001	Non-random Variation

Table 5 shows that there was a stable trend in the above series and an unstable trend in the following series and the C statistic showed that these differences indicated a *non-random* variation through the series. Treatment resulted in significant change when the sequence was combined. There was a non-random variation suggesting that there was change. The change was statistically significant ($p = 0.001$).

Jane H and her child E.F.

The therapist’s logbook revealed that 6 sessions were carried out with Jane H and her toddler E.F. In all of the 6 sessions, Jane H was motivated and engaged and attended all of her sessions. The treatment package made in effect with Jane H was the ICDP intervention program. The baseline phase of the treatment delivery consisted of providing psycho-education and observation of the parent-child interaction and lasted for 2 sessions. The following 4 sessions were dedicated to the practical aspect of the treatment delivery. Through the 6 sessions, E.F’s mood improved from being angry and agitated when E.F doesn’t get his/her way to being cheerful. Behaviour has improved from being hyperactive to open and cooperative. E.F was observed to be highly responsive in participating in the activities with Jane H and has improved in behaviour from being intrusive to being attentive and sharing. Staff observational data revealed that Jane H was observed in playing more with her child and that their quality interactions increased. Mother’s feedback data revealed that she found the therapy helpful as she was separated from her child due to extenuating circumstances and she felt that she “missed out” in her child’s development. She shared that she realized that the possibility was there to affect her child’s development and that they could still ‘bond’ as mother and child. Jane H’s satisfaction index revealed that her level of satisfaction of the sessions was 97.37 % and she was assessed based on the perceived relationship with the therapist, the goals and topics addressed, the approach or method of the therapist and her overall feeling about the session. Table 6 below presents Jane H’ satisfaction index.

Table 6: Jane H’s satisfaction index

Session	Actual score out of 40	Percentage (%)
1	38.4	96
2	37.8	94.5
3	39.1	97.75
4	40	100
5	39.1	97.75
6	39.3	98.25
Mean	38.95	97.37

Statistical analysis of Jane H’s data

A visual data of Jane H’s treatment is presented below followed by the statistical analysis of the data.

Simple Time Series Analysis

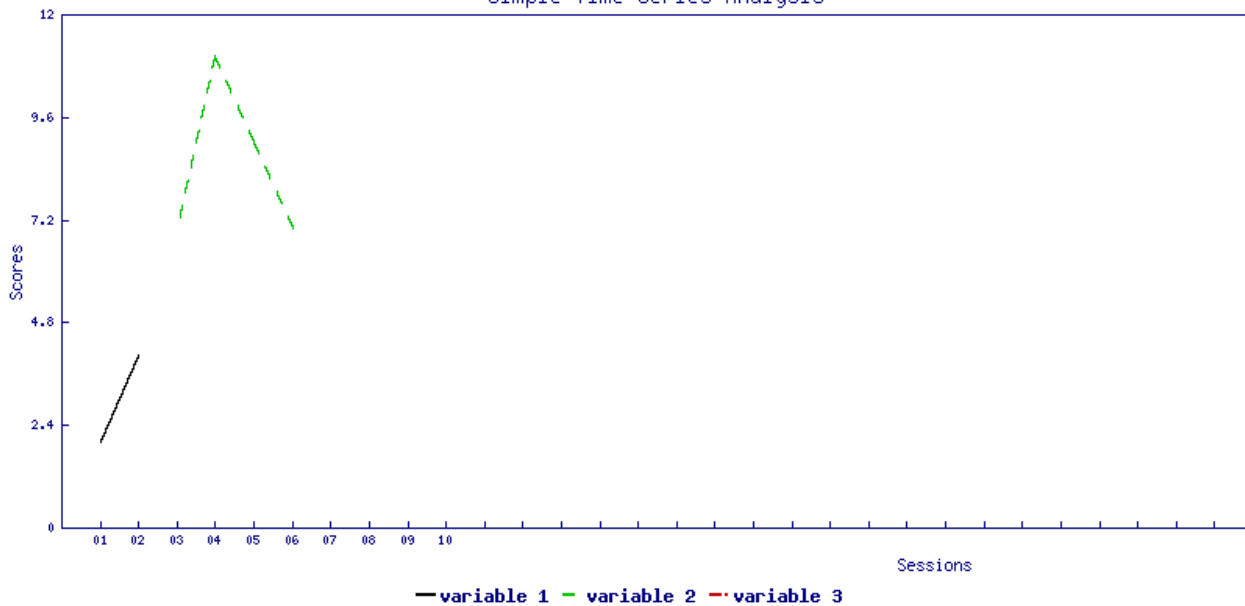


Figure 2: Jane H's baseline and treatment phase

Jane H's treatment data was statistically analyzed and is presented as follows. Autocorrelation check could not be computed as there were few data points in the baseline phase. The simplified time series analysis run for Jane H is presented in table 7 below.

Table 7: Simplified time series for Jane H

Variables	C	Z	P	Result
Variable 1	0.000	0.000	0.000	Non-random Variation
Variable 2	-0.090	-0.248	0.598	Random variation
Variable 1+2	0.653	1.931	0.026	Non-random Variation

Table 7 shows that there was an unstable trend in the above series and a clear trend in the following series. The C statistic showed that these differences indicated a *non-random* variation through the series. Treatment resulted in significant change when the sequence was combined. There was a *non-random* variation suggesting that there was change. The change was statistically significant ($p = 0.026$).

Jane A and her child E.F.2

The therapist's logbook revealed that 8 sessions were carried out with Jane A and her pre-schooler E.F.2. In all of the 8 sessions, Jane A was motivated and engaged and attended all of her sessions. The treatment package made in effect with Jane A was the MLE intervention program, otherwise known as the MISC. The baseline phase of the treatment delivery consisted of providing psycho-education and observation of the parent-child interaction and lasted for 3 sessions. The following 5 sessions were dedicated to the practical aspect of the treatment delivery. Through the 8 sessions, E.F.2's mood improved from being anxious when E.F.2 was not the center of attention to being calm. Behaviour has improved from being uncooperative to cooperative. E.F.2 was observed to be highly responsive to Jane A and has improved in behaviour from being unexpected to being attentive.

[The mother] expressed that therapy not only was benefitting her in her interactions with her child but was a personal healing process for her as well.

Staff observational data revealed that Jane A struggled with implementing routines but was observed in consistently attending to her child’s needs and engaging in play. Mother-child interaction was enhanced considerably. Mother’s feedback data revealed that she found the therapy helpful as she needed guidance in implementing routines. She shared that she struggled with following through with routines but felt that there was a considerable difference as therapy progressed. She expressed that therapy not only was benefitting her in her interactions with her child but was a personal healing process for her as well.

Jane A’s satisfaction index revealed that her level of satisfaction of the sessions was 97.71 % and she was assessed based on the perceived relationship with the therapist, the goals and topics addressed, the approach or method of the therapist and her overall feeling about the session.

Table 8 below presents Jane A’ satisfaction index.

Table 8: Jane A’s satisfaction index

Session	Actual score out of 40	Percentage (%)
1	36.6	91.5
2	39.4	98.5
3	39.2	98
4	39.2	98
5	39.6	99
6	39.5	98.75
7	39.6	99
8	39.6	99
Mean	39.08	97.71

Statistical analysis of Jane A’s data

A visual data of Jane A’s treatment is presented below followed by the statistical analysis of the data.

Simple Time Series Analysis

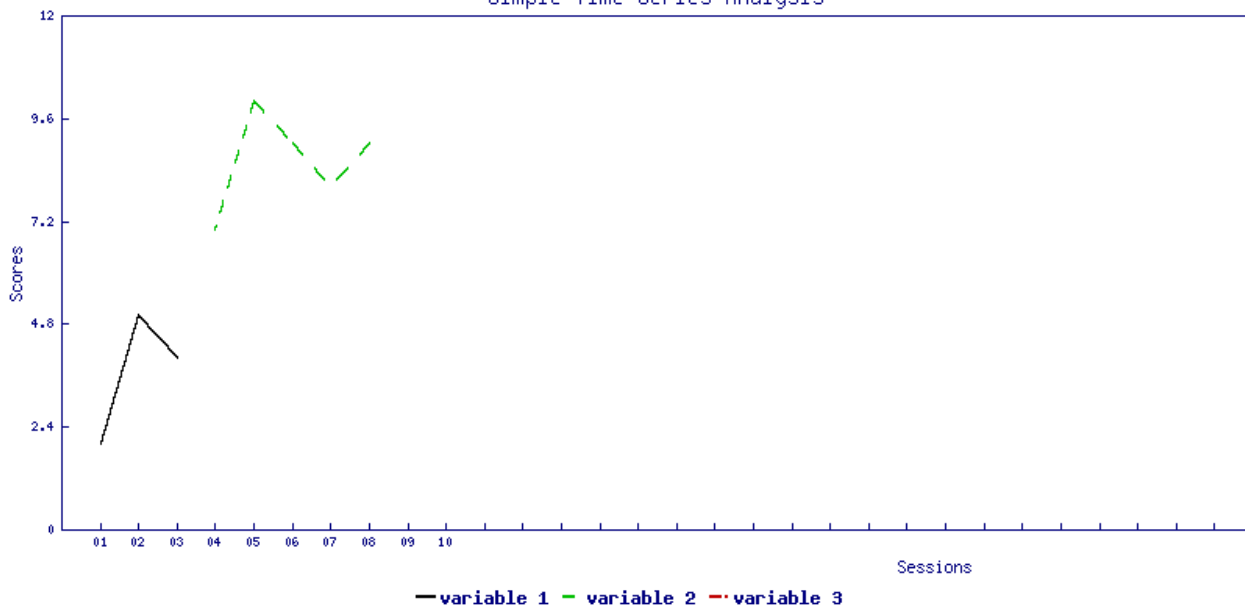


Figure 3: Jane A’s baseline and treatment phase

Jane A’s treatment data was statistically analyzed and is presented as follows. Autocorrelation check could not be computed as there were few data points in the baseline phase.

The simplified time series analysis run for Jane H is presented in table 9 below.

Table 9: Simplified time series for Jane A

Variables	C	Z	P	Result
Variable 1	-0.071	-0.202	0.580	Random variation
Variable 2	-0.153	-0.435	0.668	Random variation
Variable 1+2	0.720	2.335	0.009	Non-random variation

Table 9 shows that there was a clear trend in the above series. The C statistic showed that these differences indicated a *non-random* variation through the series.

Treatment resulted in significant change when the sequence was combined. There was a *non-random* variation suggesting that there was change. The change was statistically significant ($p = 0.009$).

Jane P and her child M.M

The therapist’s logbooks revealed that 5 sessions were carried out with Jane P and her toddler M.M. In all of the 5 sessions, Jane P was motivated and engaged and attended all of her sessions. The treatment package made in effect with Jane P was an integrative approach consisting of the MLE and the ICDP intervention program. The baseline phase of the treatment delivery consisted of providing psycho-education and observation of the parent-child interaction and lasted for 2 sessions. The following 3 sessions were dedicated to the practical aspect of the treatment delivery. Through the 5 sessions, M.M’s mood improved from being apathetic to being cheerful. Behaviour has improved from being detached to open. M.M was observed to be highly responsive with Jane P in the last 3 sessions and has improved in behaviour from being unexpected to being attentive.

Staff observational data revealed that Jane P struggled with showing affect to her child but improved in providing individualized attention to her children. Mother-child interaction was enhanced considerably.

[The mother] shared that she realized how her own attachment issues could affect her child and that she wanted 'things' to be different for her and her children.

Mother's feedback data revealed that she found the therapy helpful especially that she was struggling with unresolved childhood attachment issues. She shared that she realized how her own attachment issues could affect her child and that she wanted 'things' to be different for her and her children.

Jane P's satisfaction index revealed that her level of satisfaction of the sessions was 92.7 % and she was assessed based on the perceived relationship with the therapist, the goals and topics addressed, the approach or method of the therapist and her overall feeling about the session. Table 10 below presents Jane P' satisfaction index.

Table 10: Jane P's satisfaction index

Session	Actual score out of 40	Percentage (%)
1	31.4	78.5
2	36.6	91.5
3	38.8	97
4	39.4	98.5
5	39.2	98
Mean	37.07	92.7

Statistical analysis of Jane P's data

A visual data of Jane P's treatment is presented below followed by the statistical analysis of the data.

Simple Time Series Analysis

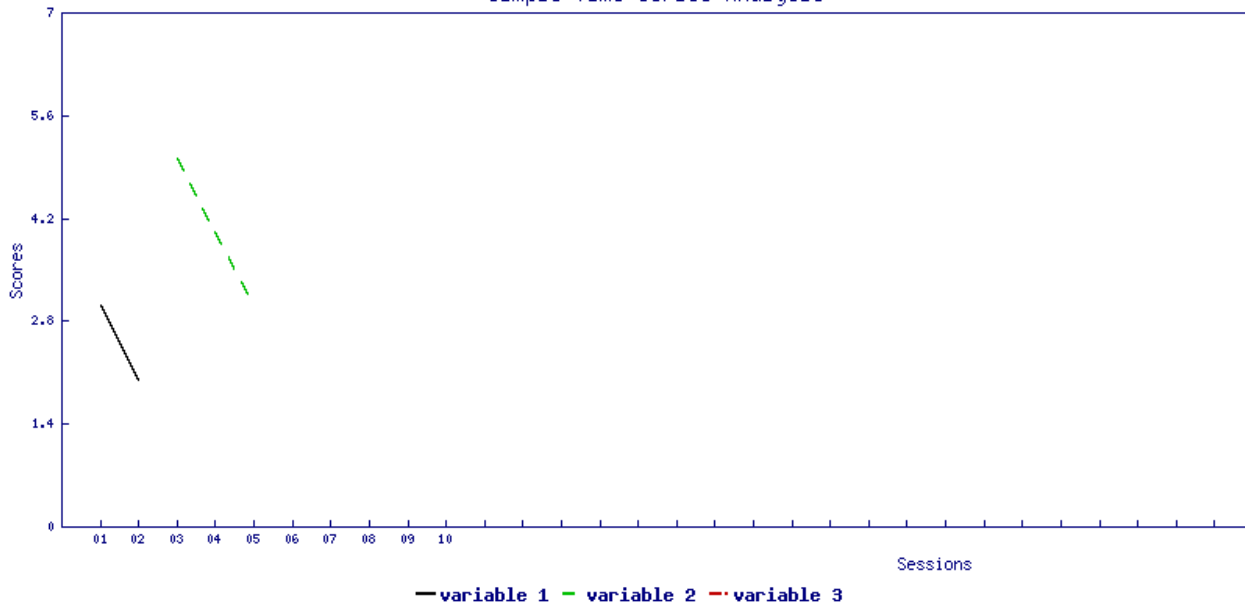


Figure 4: Jane P's baseline and treatment phase

Jane P's treatment data was statistically analyzed and is presented as follows. Autocorrelation check could not be computed as there were few data points in the baseline phase. The simplified time series analysis run for Jane P is presented in table 11 below.

Table 11: Simplified time series for Jane P

Variables	C	Z	P	Result
Variable 1	0.000	0.000	0.000	Non-random variation
Variable 2	0.500	1.414	0.078	Random variation
Variable 1+2	-0.153	-0.435	0.668	Random variation

Table 11 shows that there was an unstable trend in the above series and a clear trend in the following series. The C statistic showed that these differences indicated a *random* variation through the series. Treatment resulted in a non-significant change when the sequence was combined. There was a *random* variation suggesting that the change was statistically non-significant ($p = 0.668$).

Jane T and her child T.F

The therapist's logbook revealed that 20 sessions were carried out with Jane T and her baby T.F. In all of the 20 sessions, Jane T was motivated and engaged and attended all of her sessions. The treatment package made in effect with Jane T was the ICDP intervention program. The baseline phase of the treatment delivery consisted of providing psycho-education and observation of the parent-child interaction and lasted for 4 sessions. The next 16 sessions were dedicated to the practical aspect of the treatment delivery. Through the 20 sessions, T.F's mood has been calm and cheerful. Behaviour has been open and relaxed and T.F was observed to be highly responsive in participating in the activities with Jane T.

Staff observational data revealed that Jane T engaged in talking, singing and providing a lot of affection to T.F as therapy progressed. T.F's language development was enhanced as well, as T.F increased in babbling and vocalizing using tones and patterns similar to the ones Jane T used. The data revealed additionally that Jane T's interactional behaviours with her other children was altered as therapy progressed. She engaged in setting routines for her children and increased in nurturing behaviour and displayed affect in her interactions.

Mother's feedback data revealed that she found the therapy useful, not solely directed to her baby but to her other children as well. She shared that she felt more confident in her role as a mother and felt 'in control' of her children's development.

Jane T's satisfaction index revealed that her level of satisfaction of the sessions was 98.13 % and she was assessed based on the perceived relationship with the therapist, the goals and topics addressed, the approach or method of the therapist and her overall feeling about the session. Table 12 below presents Jane T's satisfaction index.

Table 12: Jane T's satisfaction index

Session	Actual score out of 40	Percentage (%)
1	32.6	81.5
2	33.6	84
3	40	100
4	39.5	98.75
5	39.6	99
6	39.8	99.5
7	40	100
8	40	100
9	40	100
10	40	100
11	40	100
12	40	100
13	40	100
14	40	100
15	40	100
16	40	100
17	40	100
18	40	100
19	40	100
20	40	100
Mean	39.25	98.13

Statistical analysis of Jane T's data

A visual data of Jane T's treatment is presented below followed by the statistical analysis of the data.

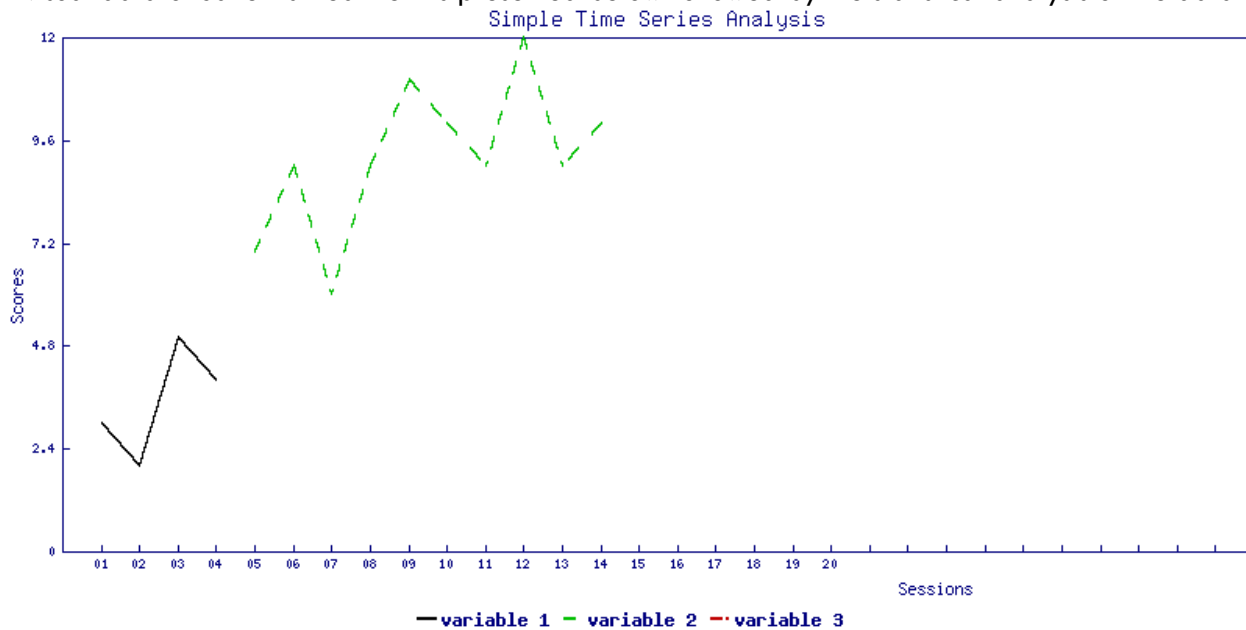


Figure 5: Jane T's baseline and treatment phase

Jane T's treatment data was statistically analyzed and is presented as follows. Correlation Coefficients- Product-Moment lag-1 for variables 1 and 2 was run to detect autocorrelation. The autocorrelation check is presented in table 13 below.

Table 13: Autocorrelation check for Jane T

Variable 1	Variable 2
r = -0.142	r = -0.001
p = 0.90874	p = 0.99549

The autocorrelation result shows that there was no serial dependency in the data. The statistic run to detect change was the simplified time series statistics. The simplified time series analysis run for Jane T is presented in table 14 below.

Table 14: Simplified time series for Jane T

Variables	C	Z	P	Result
Variable 1	-0.100	-0.273	0.607	Random Variation
Variable 2	0.164	0.700	0.242	Random variation
Variable 1+2	0.703	3.313	0.001	Non-random Variation

Table 14 shows that there was a clear trend in the above series. The C statistic showed that these differences indicated a *non-random* variation through the series. Treatment resulted in significant change when the sequence was combined. There was a *non-random* variation suggesting that there was change. The change was statistically significant (p = 0.001).

Jane D and her child H.F

The therapist's logbook revealed that 11 sessions were carried out with Jane D and her pre-schooler H.F. In all of the 11 sessions, Jane D was motivated and engaged and attended all of her sessions. The treatment package made in effect with Jane D was an adaptation of the CPRT. The baseline phase of the treatment delivery consisted of providing psycho-education and observation of the parent-child interaction and lasted for 3 sessions. The following 8 sessions were dedicated to the practical aspect of the treatment delivery. Through the 11 sessions, H.F's mood improved from being apathetic to cheerful. Behaviour improved from detached to open. H.F was observed to be highly responsive in participating in the activities with Jane D and improved from being monopolizing to sharing.

Staff observational data revealed that Jane D was open and motivated to engage in attachment work with her child. H.F was observed to be unhappy and as therapy progressed, H.F. became more relaxed, happy and began to engage with and approach Jane D frequently.

[The mother] shared that as therapy progressed, she realized how attachment issues can be handed down trans generationally and that she was motivated to make the changes necessary to spare her child from 'feeling' the way she was 'feeling' as a child herself.

Mother's feedback data revealed that she found the therapy helpful especially that she, herself, was dealing with unresolved childhood attachment issues. She shared that the process was not only a healing journey for her child but for her as well. She shared that as therapy progressed, she realized how attachment issues can

be handed down trans generationally and that she was motivated to make the changes necessary to spare her child from ‘feeling’ the way she was ‘feeling’ as a child herself.

Jane D’s satisfaction index revealed that her level of satisfaction of the sessions was 93.9 % and she was assessed based on the perceived relationship with the therapist, the goals and topics addressed, the approach or method of the therapist and her overall feeling about the session. Table 15 below presents Jane D’ satisfaction index.

Table 15: Jane D’s satisfaction index

Session	Actual score out of 40	Percentage (%)
1	37	92.5
2	36.2	90.5
3	36	90
4	38.1	95.25
5	36.9	92.25
6	36.2	90.5
7	36.9	92.25
8	40	100
9	38.3	95.75
10	38.2	95.5
11	39.4	98.5
Mean	37.52	93.9

Statistical analysis of Jane D’s data

A visual data of Jane D’s treatment is presented below followed by the statistical analysis of the data.

Simple Time Series Analysis

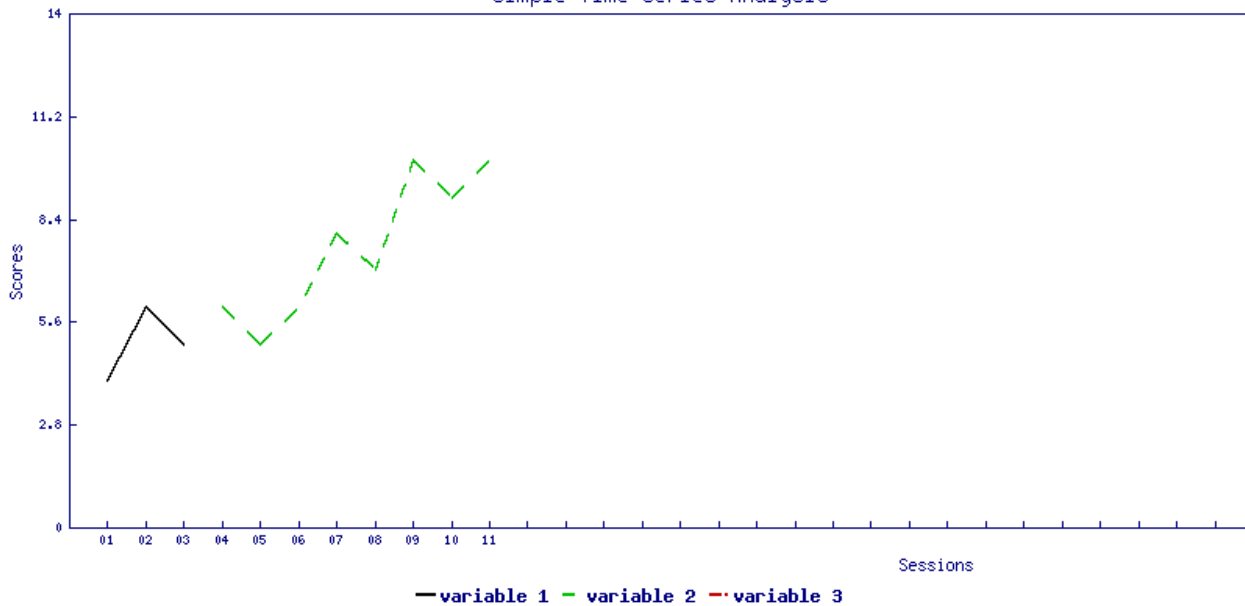


Figure 6: Jane D’s baseline and treatment phase

Jane D’s treatment data was statistically analyzed and is presented as follows. Autocorrelation check could not be computed as there were few data points in the baseline phase.

The simplified time series analysis run for Jane D is presented in table 16 below.

Table 16: Simplified time series for Jane D

Variables	C	Z	P	Result
Variable 1	-0.250	-0.707	0.760	Random Variation
Variable 2	0.652	2.113	0.017	Non-random variation
Variable 1+2	0.720	2.630	0.004	Non-random Variation

Table 16 shows that there was a clear trend in the above series and an unstable trend in the following series. The C statistic showed that these differences indicated a *non-random* variation through the series. Treatment resulted in significant change when the sequence was combined. There was a *non-random* variation suggesting that there was change. The change was statistically significant ($p = 0.004$).

Jane W and her child R.M.

The therapist’s logbook revealed that 13 sessions were carried out with Jane W and her pre-schooler R.M. In all of the 13 sessions, Jane W was motivated and engaged and attended all of her sessions. The treatment package made in effect with Jane W was an adaptation of the CPRT. The baseline phase of the treatment delivery consisted of providing psycho-education and observation of the parent-child interaction and lasted for 5 sessions. The following 8 sessions were dedicated to the practical aspect of the treatment delivery. Through the 13 sessions, R.M’s mood improved from being agitated to cheerful. Behaviour improved from being agitated to relaxed. R.M was observed to be highly responsive in participating in the activities with Jane W and improved from being unexpected to attentive.

Staff observational data revealed that Jane W’s identity as a parent boosted as therapy progressed. Jane W initially had difficulties anticipating herself as a single parent and gradually developed confidence in parenting her children on her own. She became more conscious of the parent-child relationship and as a result became more relaxed and trusting. R.M was observed craving for attention and crying inconsolably and as therapy progressed, these behaviours decreased and R.M. became more relaxed and happy.

Mother’s feedback data revealed that she found the therapy helpful not only for her and her child but for her and her other children as well. She shared that she felt that she was more equipped to handle emerging behavioural issues and setting routines.

Jane W’s satisfaction index revealed that her level of satisfaction of the sessions was 90.34 % and she was assessed based on the perceived relationship with the therapist, the goals and topics addressed, the approach or method of the therapist and her overall feeling about the session. Table 17 below presents Jane W’ satisfaction index.

Table 17: Jane W’s satisfaction index

Session	Actual score out of 40	Percentage (%)
1	36.5	91.25
2	34.3	85.75
3	36.3	90.75
4	36.6	91.5
5	36.1	90.25
6	33.4	83.5
7	35.5	88.75
8	37.7	94.25
9	36	90
10	36.4	91

11	36.4	91
12	37.1	92.75
13	37.5	93.75
Mean	36.13	90.34

Statistical analysis of Jane W's data

A visual data of Jane W's treatment is presented below followed by the statistical analysis of the data.

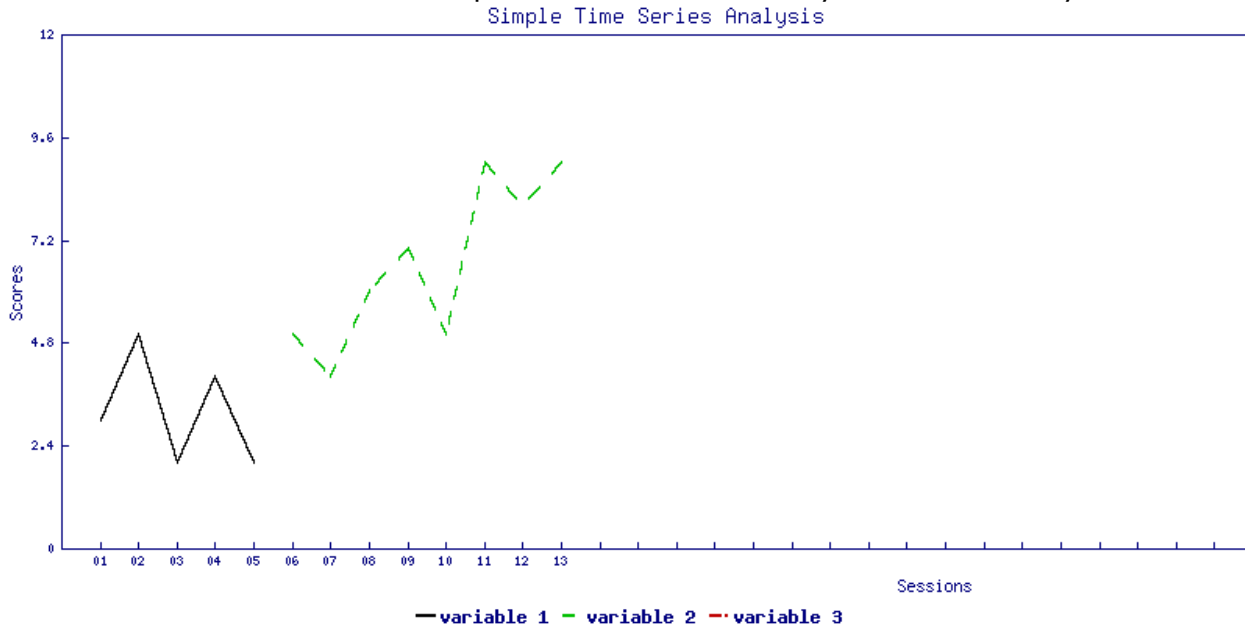


Figure 7: Jane W's baseline and treatment phase

Jane W's treatment data was statistically analyzed and is presented as follows.

Correlation Coefficients- Product-Moment lag-1 for variables 1 and 2 was run to detect autocorrelation. The autocorrelation check is presented in table 18 below.

Table 18: Autocorrelation check for Jane W

Variable 1	Variable 2
r = -0.774	r = 0.393
p = 0.2254	p = 0.38288

The autocorrelation result shows that there was no serial dependency in variable 2 data but that the data in variable 1 were serially dependent. The statistic run to detect change was the simplified time series statistics. The simplified time series analysis run for Jane W is presented in table 19 below.

Table 19: Simplified time series for Jane W

Variables	C	Z	P	Result
Variable 1	-0.544	-1.538	0.937	Random Variation
Variable 2	0.458	1.487	0.068	Random variation
Variable 1+2	0.578	2.260	0.012	Non-random Variation

Table 19 shows that there was a clear trend in the above series. The C statistic showed that these differences indicated a non- random variation through the series.

Treatment resulted in significant change when the sequence was combined. There was a *non-random* variation suggesting that there was change. The change was statistically significant ($p = 0.012$).

SECOND STAGESHELTER II QUALITATIVE ANALYSIS

As the number of sessions carried out with 4 mothers in the second stage shelter II was 3 and below, a quantitative analysis could not be performed.

A total of 8 sessions were carried out with 4 mothers namely, Jane L, Jane J, Jane B and Jane A. The children in focus were all in the early childhood age. Transfer of knowledge is assumed to reach 13 children totaling the number of children within the targeted family.

Qualitative data was collected from three different data sources namely, the therapist's observational data, Shelter staff observational data and participating mothers' satisfaction index.

The therapeutic intervention was focused on providing psycho education on the importance of special play time from CPRT, the importance of mediation from MLE and the importance of attunement from ICDP. The therapist's logbook revealed that the engagement of the mothers during the individual sessions was found to be high to moderate and referring to curiosity, 3 mothers were engaged in probing and seeking more information concerning the treatment packages. Mothers' have also expressed their satisfaction with the information they were provided.

Mothers' feedback data revealed that mothers' found the sessions to be helpful especially in terms of managing the behaviours of their children and acquiring invaluable information they can use as they parent their children.

Staff observational data revealed that mothers' shared that they had a positive experience with therapy. Staff revealed that a seed was planted for some of the mothers and others experienced attitude change with regards to parenting.

Mothers' satisfaction index revealed that mothers' level of satisfaction of the sessions was 92 % and they were assessed based on the perceived relationship with the therapist, the goals and topics addressed, the approach or method of the therapist and their overall feeling about the session. Table 20 below presents mothers' satisfaction index.

Table 20: Mothers' satisfaction index (4 mothers in second stage shelter II)

Participant mother	Actual score out of 40	Percentage (%)
1	30.6	76.5
2	31.9	79.75
3	37.1	92.75
4	36.7	91.75
5	39.7	99.25
6	38.4	96
7	40	100
8	40	100
Mean	36.8	92

MENTORING

The mentoring activities in all of the shelters appeared to be similar. However, in the emergency shelters there were opportunities for mentoring child care staff while they were on duty and working with children actively. These incidents provided opportunities for therapist to observe interactions between staff and children and that information was incorporated in the subsequent mentoring sessions. Though this opportunity was found to be helpful, it was found challenging as well to have full attention from staff during the mentoring sessions as staff were actively working with the children.

The approach used and found to be helpful during the mentoring sessions was an informal approach, semi-structured to provide the opportunity for staff to relate to their experiences and challenges in their respective fields and work environment. A round table format was used, group numbers were few and everyone had the opportunity to participate in each and every discussion during the mentoring sessions. The therapist took into consideration the wealth of experiences and training staff had and connected it to current theory and practices and built on the knowledge reservoir that staff already possessed. This approach proved to be very helpful, participant-centered and differed from the traditional approaches of implementing workshops or courses.

RECOMMENDATIONS

The Helping Hands project was found to be an interesting and valuable project in terms of empowering women and children exposed to domestic violence. The key strategy that was found helpful was the relationship building between the therapist who was an external staff and the shelter staff; and the capacity and willingness of the therapist to adjust to the shelters' structures, routines and systems of functioning. As the project expands and moves forward, it would be helpful to have case consults for referral purposes with the therapist helping to prioritize the need of attachment-based work and subsequent support the client may need. Discussions need to continue with shelter staff as they were found helpful in addressing the needs of the women through the life span of the project. Through and between the sessions that a client receives, it would be helpful to update therapist and vice versa of significant incidents that have happened or have been happening in the client's life to strategize and be effective in implementing the attachment-based work in the subsequent sessions and to address the needs of the client as they arise.

Part II: Project Impact on Shelters

By Amy Mercure, MA, Research and Evaluation Specialist, Alberta Council of Women's Shelters

In Part II of the project evaluation, two shelter executives and six staff from the four participating shelters were interviewed to assess the overall success of the project from the shelter's perspective. The interviews consisted of four closed-ended questions and seven open-ended questions. The questions assessed the project impact, successes and challenges. Responses to interview questions were analyzed for emerging themes and grouped by project outcomes, as summarized below.

DISCUSSION OF PROJECT OUTCOMES

Increased attachment and engagement between mother and child

Shelters reported seeing a transformation in the relationship between mothers and children as a result of working with the therapist. This transformation was described as instantaneous by both an emergency and second stage shelter. Child care staff reported children's behaviour improved, children were calmer, mothers started initiating activities with their children and interacted differently with their children after sessions with the therapist. Shelter staff reported seeing a huge improvement in communication, play and attachment for mothers and children participating in the project. After working with the therapist, staff reported mothers' and children's stress was reduced, mothers were more affectionate towards their children, were more secure in their parenting and had a greater piece of mind knowing their children were getting help. All shelters reported mothers felt good after the therapist's sessions. Working with the therapist to improve their relationship with their children gave mothers an opportunity to learn about attachment and a safe place to explore parenting strategies—two opportunities they never had in the past. Profoundly important, the therapist was able to help mothers see how domestic violence has affected their children and helped mothers experience what it is like to live a violence-free life with their children. The therapist helped mothers see the strength of their children's resilience and the promising possibility that their children's wellbeing and relationship can improve once they stop the exposure to violence.

Profoundly important, the therapist was able to help mothers see how domestic violence has affected their children and experience what it is like to live a violence-free life with their children.

The majority of shelters agreed that the project had a significant impact on participating families. One shelter said they were unable to say if the project had a significant impact because families only had one session, but other shelters reported seeing a significant difference after just one session. One shelter reported some families that were recruited in the project weren't ready to fully participate, but the shelter reported the project still had an impact on these families wherein it planted the seed that it's so important for mothers to have a relationship with their children.

Children received an enhanced level of service in order to help build their resiliency after exposure to domestic violence.

The project therapist provided 103 attachment-based therapy sessions to 29 families in emergency and second stage shelters. The majority of shelters found it very valuable to have an external therapist working with families and internal staff. Staff thought an external therapist brought a fresh or different perspective that both supported and validated the work of the shelter. Staff thought the external therapist provided an opportunity for mothers to learn to not just depend on the shelter but experience support from another agency and hopefully initiate contact with them in the future. Staff reported that mothers valued the therapist's expertise and felt privileged to be working with her. Staff reported mothers responded to the therapist differently than internal staff, confiding more in her. This was due to a combination of her external position, level of education and experience.

One staff member described the greatest benefit of the project as helping women who felt helpless feel hopeful again.

All shelters reported families liked the therapist and had very positive feedback in general. In many shelters, mothers reported to shelter staff that they were using the techniques the therapist taught them, were eager to follow the therapist's guidance and took very seriously the therapist's suggestions. Mothers reported that sessions with the therapist were uplifting, non-judgmental and helped with stress, parenting, and their children's behaviour. One staff member described the greatest benefit of the project as helping women who felt hopeless feel hopeful again.

Increased shelter worker capacity to:

- **Quickly and accurately identify children for referral to a therapist.**
- **Implement effective early interventions.**
- **Support mothers in shelter in addressing their child's exposure to domestic violence.**

Each shelter developed a selection process and protocol to help staff identify the mothers and children who would benefit most from participating in the project. The selection process complimented shelters' already established assessment and referral practices which further enhanced their ability to refer children to proper services and/or interventions when necessary.

Two shelters felt the project increased staff's ability to quickly and accurately identify children for referral to a therapist, while two felt it did not increase staff ability to do so. The two shelters that *did* find the project increased staff capacity to quickly and accurately identify children for referral to a psychologist said their engagement in the project and more specifically their mentoring from the therapist gave them a greater awareness of attachment issues and an increased ability to identify said issues. Staff reported their increased knowledge gave them a new perspective on the mother-child dyad. The two shelters that said the project *did not* increase staff capacity to quickly and accurately identify children for referral to a psychologist either said their staff already had the background knowledge to do so or referral to a psychologist was not within child care staff's roles or responsibilities.

Throughout year two, the therapist provided ongoing mentorship to shelter staff. All staff members reported the mentoring was helpful and valuable. The therapist helped staff connect past experience with current theory and practice, making the mentoring directly applicable to the work shelter staff do with mothers and children. The therapist was highly regarded by shelter staff and her mentoring was described as educational, eye-opening, inspirational and amazing. Some highlights of mentoring included helping staff see the big picture, reflect on their work, have 'ah-ha' moments and see how they can work together to better meet the needs of mothers and children.

Shelter staff found the project gave them a broader perspective of the impact of domestic violence and increased their ability to pick up on issues rooted in attachment, which better enabled them to support mothers in improving their relationship with their child.

All shelters agreed this project increased staff capacity to support mothers in shelter in addressing their child's exposure to domestic violence. The majority of shelters reported the project made their programming stronger and increased shelter support for mothers and children. Having an extremely skilled external therapist that taught transferrable concepts and skills better equipped shelter staff to work with mothers and children. Shelter staff found the project gave them a broader perspective of the impact of domestic violence and increased their ability to pick up on issues rooted in attachment, which better enabled them to support mothers in improving their relationship with their child. One shelter reported the project brought to light that staff were already doing attachment activities with mothers and children, which bolstered their confidence in their work. In general, staff feedback on the project was very positive. Staff reported being excited to see the interaction between mothers and children and happier with the therapist's input and support. Shelter staff found an external perspective particularly valuable; staff were open to the therapist's mentoring and in turn acquired new skills that enabled them to move forward with attachment work in shelter with mothers and children. Shelters also reported the project made their work easier, as opposed to increasing their workload.

Overall success of the project

Overall, shelters said the main successes of the program were the skills that staff learned and were able to directly apply to their work with mothers and children; mothers and children repeating the exercises they learned with the therapist outside of sessions; mothers focusing more on their parent-child relationship in general and as the therapist provided a non-judgmental safe space for mothers to explore their parenting. Shelters also provided specific stories of success in their shelter:

Story 1: The child was violent towards his mom, hitting her and yelling at her. After mom and child saw the therapist there was improvement in his behaviour and staff saw mom spending more quality time with her child. Mom requested to continue seeing the therapist as they moved onto a second stage shelter. At the end of their stay at the emergency shelter, mom and child were much more in touch and their communication had improved.

Story 2: Mom was angry and wanted a break from her kids when she came to the therapist. After just one session with the therapist, staff reported that mom seemed calmer and her confidence had significantly increased. After working with the therapist, the mom said she was having fun and enjoying her kids; mom said she couldn't remember last time she had fun with her kids.

After working with the therapist, the mom said she was having fun and enjoying her kids; mom said she couldn't remember last time she had fun with her kids.

Story 3: The child was so attached to mom that he had trouble transitioning to child support. He was pulling mothers hair to keep her physically close. Mom also didn't know how to play with her child. Mom met with the therapist, who taught her specific strategies to establish secure attachment, which mom took very seriously. Staff reported mom using the therapist's techniques to play with her child as well as the therapist's specific steps for leaving the child with child care in a healthy manner. Staff reported that mom always prioritized the therapist's sessions over everything else and that her child was more secure after working with the therapist.

Story 4: Mother's relationship with her daughter wasn't great. After working with the therapist mom realized what the problem was and what was keeping her from bonding with that child. Mom also had a little boy that she paid far more attention to. After working with the therapist mom showed much more interest in her daughter and treated her children equally. The family came back after leaving the shelter and mom was still using positive parenting. This was wonderful as staff could see that working with the therapist made a long-term difference for this family.

Issues identified in Year 2

EMERGENCY SHELTERS

Level of crisis for mothers

Women come into shelter in a state of crisis as a result of the domestic violence they have experienced. Children exposed to domestic violence also enter the shelter in a state of disequilibrium and express behaviour that is commonly associated with their internal needs of safety. Understandably, mothers and children are not always ready for therapeutic intervention; this has been evident in the occurrence of last minute cancellations of appointments, the ending of treatment during a session or abruptly, or mothers being disengaged/distracted from the therapeutic process. Shelters and the therapist both described mothers that were unable or unwilling to engage because they weren't ready to accept the effect of domestic violence on their children; some mothers even thought their children's exposure to domestic violence had no impact on their children.

Basic needs

In emergency shelters, a significant barrier to project participation was the priority of basic needs. Many mothers couldn't participate because they need to attend to their basic needs such as housing, financial support, employment and legal issues with their abuser. Efforts to meet these needs require a significant amount of time and energy, thus leaving mothers unable to participate in Helping Hands sessions or fully engage. A recent pilot project in rural Alberta shelters indicated a dearth of financial support to meet the basic needs of women and children fleeing domestic violence, especially for the most vulnerable of this population such as the disabled, immigrants, and those with mental and physical health issues. Urban emergency shelters such as those that participated in the Helping Hands project likely face similar challenges to meeting women and children's basic needs.

Scheduling

Regular participation in sessions has not been easy to implement in emergency shelters. Having a set appointment with an external therapist, (as opposed to shelter staff working with mothers and children when available) proved difficult as apparent by mothers' cancellations or failure to show up at appointments.

Length of stay

A standardized assessment (i.e., a pre and post-test) to measure attachment was not possible as there was much variety in women's length of stay; this impacted the number of sessions women and children were able to participate in. Such variety in number of sessions completed limited the use of standardized tools because analysis required two elements - analysis required that a certain number of sessions be completed by clients and that a certain number of clients complete the same number of sessions. The use of standardized tools is further complicated because it is not always known when women will leave, especially those who access emergency shelters. In particular, it is difficult to conduct a standardized assessment when women and children receive only 1 or 2 sessions.

Limited space

Providing space for the therapist to work with mothers and children was a challenge for emergency shelters. Although second stage shelters found it a challenge as well, they were able to make modifications such that the therapist would go to the families' apartment rather than meet in a shelter room.

SECOND STAGE SHELTERS

Level of crisis for mothers

Although mothers in second stage shelters have a lower level of crisis than those in emergency shelters, there were still mothers that were unable or unwilling to engage because they weren't ready to accept the effect of domestic violence on their children.

Limited number of clients that could be taken on at one time

The therapist was only able to take on three clients at a time, due to workload. Second stage shelters found they had more demand for participating in the project than they could fulfill. Shelter staff found it difficult to determine who should participate in the project, as families had similar levels of need.

Frequency of sessions

Second stage shelters expressed a desire to have sessions at a greater frequency (i.e. more than once a week). They found if sessions were cancelled or missed for a week, the two week span between sessions was too long for clients.

Case conferencing

Second stage shelters found it challenging to find the time to do case conferencing or discuss clients' progress with the therapist.

Child care

The therapist only worked with one child at a time therefore mothers with more than one child were forced to find child care for their other children while they attended sessions. Second stage shelters expressed a desire to have the therapist work with more than one sibling at a time if possible.

LESSONS LEARNED

Helping Hands provided important lessons to inform the development of a program model for shelters to implement interventions for young children in shelter.

Lesson 1: Each shelter context is different and therefore a 'one size fits all' model is not appropriate for early childhood interventions. A model must be flexible in order to be effectively integrated into shelters.

Lesson 2: Having an external therapist delivering interventions appears to be more effective than only training shelter staff to deliver therapies. The expertise that a therapist brings to intervention is invaluable and cannot be taught to shelter staff through in-services. Further, shelter staff are already working at full capacity, making it very difficult to add another role to their work. Having an external therapist come and work with mothers appeared to be an important aspect of the success of the project.

Lesson 3: For successful integration into shelter work, shelter staff require training and mentorship from the acting therapist. This training and mentorship allows shelter staff to provide more seamless support to mothers and children while in shelter. Case conferencing is also an important aspect to successful integration of shelter services for mothers and children. When staff are both aware of the work the therapist is doing and understand this work, they are able to better support the therapists' work and continue it when the therapist is gone or sessions have ended.

Lesson 4: In order to engage in therapy, mothers and children need to have their basic needs met. Shelters should continue to advocate for funding such as Making Amends, that provide financial support to meet the immediate needs of women and children fleeing domestic violence.

Lesson 5: External therapists need to recognize the often chaotic nature of communal living in a women's emergency shelter and adjust the activities accordingly. Lack of space in women's shelters compounds this difficulty. In one emergency shelter, in year 2, the therapist engaged women in the eating area, which reduced perceived barriers of approaching a therapist.

Lesson 6: The Interdisciplinary Training sessions that were held to acquaint the Family Centre and shelters with their respective work was very helpful in establishing an appreciation and shared understanding for the work of the respective organizations.

Lesson 7: The amount of staff time and ACWS support was greater than anticipated and not budgeted.

Lesson 8: Families that had seen the therapist in an Emergency shelter were asking to see the therapist once they came to a Second Stage shelter. Unfortunately, these families were not always able to access the service due to the high demand for the therapists' services. An increase in funding is needed to enable the therapist to provide a continuum of services as families' transition through Emergency and Second Stage shelters.

NEXT STEPS

Based on the learnings from this pilot project and the dearth of intervention services available for young children in shelter, we are recommending the project be continued and be used a program model to deliver similar services across the province. Three out of the four participating shelters would like to continue with the project, requesting the therapist's services for a cumulative three days a week. For an investment of approximately \$60,000 a year this would be possible. Accordingly, ACWS, the Family Centre and the three shelters will be looking for sustainable funding to continue the project. We will also be making a presentation to the Alberta Government to bring to their attention the success of the project in beginning to address the absence of services available to young children in shelter and the myriad of research that has found early interventions for children fleeing domestic violence is the most effective approach to mitigating the impact of abuse on children's development and ending the cycle of domestic violence.

RECOGNITION OF THE STOLLERY CHARITABLE FOUNDATION

ACWS continues to appreciate the support of our financial sponsors, and acknowledges them whenever possible. This includes on our website, in our newsletters, on our donor wall, and in connection with this project whenever its findings are presented.

APPENDIX A: NEWSLETTER 1

HELPING HANDS

NEWSLETTER 1
February 2012
By Joy Medori



Helping Hands is a 2 year project funded by the Stollery Charitable Foundation. The project aimed to provide young children in shelter with an enhanced level of support as well as integrate, develop, and evaluate promising child support practices that focused on pre-school children. The project was carried out and delivered by the following organizations: The Family Centre, ACWS, LaSalle, Lurana, WINGS, and A Safe Place.

The project focused on the provision of attachment based interventions by a Child Therapist to children and their mothers in the participating shelters. The Child Therapist and Child Care staff also worked together and engaged in knowledge transfer. It is hoped that as a result of this project, children will be better supported and mothers better informed and equipped to mitigate the impact of abuse on their children.

The content of this newsletter contains the results of the evaluation for Year 1 (November 2010 – September 2011).

Helping Hands, Newsletter 1, February 2012 1

Overview of Participation and Sessions Provided

Second Stage Shelters:

- The Child Therapist provided therapy to 17 mothers and 17 target children. Overall, 83 sessions were conducted with mothers and children.
- On average, each mother and child received 4.9 sessions.

Emergency Shelters:

- The Child Therapist provided Therapy to 18 mothers and 23 target children. Overall, 26 sessions were conducted with mothers and children.
- On average, each mother and child received 1.4 sessions of therapy.

Project Outcomes and Results

Increased attachment and engagement between mother and child.

- Mothers and children generally showed increased attachment as treatment progressed; mothers were observed to be more regulated in the 4 dimensions of attachment (i.e., nurturing, engaging, challenging, and structuring).
- Interventions reinforced existing attachment practices employed by Mom and its benefits to the developing child; moms and children showed increased engagement and calmness during the intervention and activities.

Children received an enhanced level of services in order to help build their resiliency after exposure to domestic violence.

- Access to a Therapist was provided and children received timely intervention services.
- Mothers felt more confident in their parenting role which increased their ability to utilize resources and gain additional coping skills.
- Children seemed more content and happy when compared to pre-treatment.

Increased shelter worker capacity.

- Knowledge transfer between Therapist and Child Care staff occurred in an informal and formal basis.
- Staff felt that knowledge transfer provided new ways of meeting the needs of children and offered mothers with practical activities that can be used once they left shelter.


Benefitted shelters and the wider community.

- The project informed a community organization of the impact of domestic violence on children as well as informed mothers' understanding of how domestic violence impacted their developing child.
- Shelters benefitted from the consistency and reinforcement of the messages mother received from the project and the messages received in shelter programming.

APPENDIX B: NEWSLETTER 2


HELPING HANDS

NEWSLETTER 2
September 2012



Helping Hands is a 2 year project funded by the Stollery Charitable Foundation. The project aimed to provide young children in shelter with an enhanced level of support as well as integrate, develop, and evaluate promising child support practices that focused on pre-school children. The project was carried out and delivered by the following organizations: The Family Centre, ACWS, LaSalle, Lurana, WINGS, and A Safe Place.

The project focused on the provision of attachment based interventions by a Child Therapist to children and their mothers in the participating shelters. The Child Therapist and Child Care staff also worked together and engaged in knowledge transfer. It is hoped that as a result of this project, children will be better supported and mothers better informed and equipped to mitigate the impact of abuse on their children.



Overview of Participation and Knowledge Transfer

Work with families:

- In emergency shelters, 20 attachment-based therapy sessions were carried out with 19 families for an average of one session per family.
- In second stage shelters, 83 attachment-based therapy sessions were carried out with 11 families with a range of two to 20 sessions per family.

Work with shelter staff:

- In emergency shelters, the therapist provided 25.75 hours of mentoring and spent 25.25 hours with shelter staff on collaborative discussion of clients and practice.
- In second stage shelters, the therapist provided 13.5 hours of mentoring and spent 26.75 hours with shelter staff on collaborative discussion of clients and practice.

Overview of Therapy

The Therapist provided three treatment packages geared at enhancing quality interactions and attachment between mother and child based on a needs assessment conducted with each.

1. **International Child Development Program:** based on the idea that the best way to help children is by helping the children's caregivers. There is a focus on eight guiding themes of positive interactions
2. **Mediated Learning Experience:** a conscious attempt of an adult to adjust their behaviour and modify the environment in a way that will ensure a benefit to the child. This approach is aimed at improving the quality of parent-child interaction without any specific language, content or materials employed in the interactions.
3. **Child-Parent Relationship Therapy:** an approach to train parents to be therapeutic agents with their own children through child-centred play.

Overview of Year 2 Evaluation

The evaluation of Year 2 assessed the impact of the project on individual participants and participating shelter.

The **individual evaluation** was undertaken by the project therapist to assess the impact of the project on individual participants through:

- therapists' observations
- shelter staff's observations
- mothers' feedback

The **shelter evaluation** undertaken by ACWS to assess the overall impact of the project, from the perspective of the shelters. Two shelter executives and six staff from the four participating shelters provided interviews.

HELPING HANDS

"One mother shared that as therapy progressed, she realized how attachment issues can be handed down trans generationally and that she was motivated to make the changes necessary to spare her child from 'feeling' the way she was 'feeling' as a child herself."
-Project Therapist

"One staff member described the greatest benefit of the project as helping women who felt hopeless feel hopeful again."
-Helping Hands Final Report

"Mothers expressed that they have been given the chance to realize that they can reclaim their power as a parent and caregiver that was once taken away from them in the abusive environment that they were in and that they recently escaped."
-Project Therapist

For more information:
Amy.Gendron@acws.ca



Project Outcomes and Results

Increased attachment and engagement between mother and child

- During the individual sessions, mothers' engagement was found to be high. Mothers' reported the sessions to be helpful as it gave them:
 - the confidence to activate their caring skills in their interactions with their children;
 - the chance to realize they can reclaim their power as a caregiver that was once taken away from them through abuse; and
 - the opportunity to recognize how important their role as a parent is in the development of their child.
- Shelters reported seeing a transformation in the relationship between mothers and children as a result of working with the therapist.
- Child care staff reported children's behaviour improved, children were calmer, mothers started initiating activities with their children and mothers interacted differently with their children after sessions with the therapist.
- Shelter staff reported seeing a huge improvement in communication, play and attachment for mothers and children participating in the project.

Children received an enhanced level of services in order to help build their resiliency after exposure to domestic violence

- The project therapist provided 103 attachment-based therapy sessions to 29 families in emergency and second stage shelters.
- The majority of shelters found it very valuable to have an external therapist working with families and internal staff.

Increased shelter worker capacity

- Knowledge transfer between the therapist and child care staff occurred through mentoring and collaborative discussions.
- All staff interviewed reported the mentoring was helpful and valuable.
- Shelter staff found the project gave them a broader perspective of the impact of domestic violence and increased their ability to pick up on issues rooted in attachment, which better enabled them to support mothers in improving their relationship with their child.

Overall Success of Project

Shelters said the main successes of the project were:

- the skills that staff learned and were able to directly apply to their work with mothers and children;
- mothers and children repeating the exercises they learned with the therapist outside of sessions;
- mothers focusing more on their parent-child relationship; and
- mothers developing an openness to outside people discussing their parenting.

APPENDIX C: ROSTER OF SERVICES FROM THE FAMILY CENTRE

Resources for Women



Support Network
a program of

May 2012

(Please obtain a new copy from www.211Edmonton.com if more than 6 months old)

Basic Needs / Financial (also see Basic Needs list)

Alberta Employment & Immigration (AEI)	
Alberta Supports Contact Centre (Info. line)	780-644-9992
Income Support Contact Centre (24/7)	780-644-5135
Income Support / Employment Information	
City Centre (105th Street Office)	780-415-4900
North (Northgate Centre)	780-422-9440
South (Gateway Blvd.)	780-644-2888
West (Meadowlark)	780-415-8116
West (Westcore Building)	780-415-6500
Edmonton's Food Bank	780-425-4190
Hope Mission - Women's Emergency Shelter	780-422-2018
Money Matters	780-423-5265
WEAC (Women's Emergency Shelter, 18+yrs)	780-423-5302

Counselling (* no cost)

Catholic Social Services	780-420-1970
City of Edmonton Community Services	
*Assessment & Short – Term Counselling	780-496-4777
Cornerstone Counselling Centre (faith based)	780-482-6215
The Family Centre	780-424-5580
Jewish Family Services – Counselling	780-454-1194
Psychologists' Association of Alberta	
Referral Line Service	780-428-TALK(8255)
The Salvation Army (faith based)	780-412-2625
The Support Network	
Walk-in Counselling (call first)	780-482-0198
University of Alberta – Faculty of Education	
Counselling Centre	780-492-3746
YWCA of Edmonton – Counselling Centre	780-423-9922 x 222

Crisis (call 911 if in immediate danger)

AHS Addiction & Mental Health (FKA: AADAC)	
Addictions Helpline	1-866-332-2322
Child & Family Services	
Child Abuse Hotline (24/7)	1-800-387-5437
Sexual Assault Centre of Edmonton (24/7)	780-423-4121
The Support Network	
Distress Line (24/7)	780-482-HELP(4357)

Employment

Alberta Employment & Immigration (AEI)	
Career Information Hotline	780-422-4266
Elizabeth Fry Society	
Work for Women Employment Program	780-784-2207
Human Resources & Skills Development Canada	
Employment Insurance (EI)	1-800-206-7218
Women Building Futures – Trades Training	780-452-1200

Family Violence & Abuse (also see Family Violence list)

Aboriginal Consulting Services Association	
Circles of Safety	780-448-0378
City of Edmonton Community Services	
Assessment and Short Term Counselling	780-496-4777
(Individual counselling & various groups for abused women; childcare available; no cost)	
DECSA	
Opportunity Plus	780-474-2500
(employment program for women leaving abusive relationships)	
Edmonton John Howard Society	
Family Violence Prevention Centre	780-423-1635
Islamic Family and Social Services Association	
Serenity Group (for women)	780-462-0772
(verbal translation; transportation; child care available)	
Legal Aid Alberta	
Emergency Protection Order Program	780-423-1635
Lurana Shelter (women with or without children; 24/7)	780-424-5875
A Safe Place (Sherwood Park; 24/7)	780-464-7233
The TODAY Family Violence Help Centre	780-455-6880
WIN House (women with children; 24/7)	780-479-0058

Health and Sexuality

Alberta Health Services (AHS)	
Birth Control Centre (& pregnancy testing)	780-735-0010
Health Link Alberta (24/7)	780-408-LINK(5465)
Sexually Transmitted Infection Clinic	780-342-2300
Boyle McCauley Health Centre (inner city)	
Women's Health Promotion Clinic	780-422-7333
(women with/without children; low income; inner city)	
Multicultural Health Brokers Co-op	780-423-1973
OPTIONS Sexual Health Association	780-423-2300
Pride Centre of Edmonton	780-488-3234
Institute for Sexual Minority Studies and Services	780-492-0772

Legal Resources

Alberta Justice & Attorney General	
Family Law Information Centre	780-415-0404
Family Mediation Services	780-427-8343
Maintenance Enforcement Program	780-422-5555
Edmonton Community Legal Centre	780-702-1725
Law Society of Alberta - Lawyer Referral Service	1-800-661-1095
Legal Aid Alberta - Legal Service Centres	780-427-7575
Student Legal Services of Edmonton	780-492-2226
<u>Relationship / Support</u>	
Alberta Caregivers Association	780-453-5088
Mill Woods Family Resource Centre	
Women's Workshops	780-413-4521

For more information, or if you cannot find the particular service you are looking for dial 2-1-1 within Edmonton

If 211 is not yet available in your area call: 780-482-INFO (4636)

Inclusion of an agency or service on this list does not constitute an endorsement by 211.

For copies of this and other resource lists go to www.211edmonton.com and click on "Resource Lists".

The Support Network • Edmonton, Alberta • Phone: 780-482-0198 • Fax: 780-488-1495

Resources for Children



a program of **Support Network**

May 2012

(Please obtain a new copy from www.211Edmonton.com if more than 6 months old)

Counselling

Kids Help Phone (5-20yrs) 1-800-668-6868

Grief Counselling Programs

Starfish Family Resources Society 780-448-1180
 Kids on Track Association (5-15yrs) 780-481-2942
 Pilgrims Hospice Society (4-12yrs) 780-413-9801 x309
 West Edmonton Christian Assembly (5yrs) 780-489-2579
 YWCA of Edmonton (4-18yrs) 780-423-9922 x222

Play Therapy

Catholic Social Services (2-18yrs) 780-420-1970
 University of Alberta, Clinical Services 780-492-3746

Disabilities

Ability Society of Alberta
Early Birds (under 18yrs) 780-442-2740
 Alberta Health Services (AHS)
Early Intervention (0-3.5yrs) 780-342-1707
Social Skills Group (6-12yrs) 780-735-6068
 Centre for Autism Services 780-488-6600
 Connect Society
Early Intervention (deaf, 0-3.5yrs) 780-454-9581 x226
 Edmonton Down Syndrome Society
Play Group (0-5yrs) 780-944-4224
 Elves Special Needs Society
(severe developmental disabilities; 2-5yrs) 780-454-5310
 GRIT Program
Early Childhood Program (2.5-6yrs) 780-454-9910
 KARA Family Resource Centre
Developmental Screening for Children 780-478-5396
 The Steadward Centre for Personal and Physical Achievement
Motor Skill Development (4+yrs) 780-492-8269

Early Childhood Education

Alberta Health Services (AHS)
Pre-school Speech and Language (0-5yrs) 780-408-8793
 Mill Woods Family Resource Centre 780-413-4521
Head Start Programs
 ABC Head Start (3.5-5yrs) 780-461-5353
 Ben Calf Robe Society - *Mother Earth and Me* 780-477-6648
(Aboriginal, 3-4yrs, low income)
 E4C
Early Head Start (0-3yrs, low income) 780-426-3666 x221
Clairview Head Start (1-5yrs, low income) 780-475-1020
 Norwood Child and Family Resource Centre (3.5-6yrs)
 780-471-3737
 Oliver Centre Early Learning Programs (1-5yrs)
 780-482-2116 x233

Leisure / Recreation

A.C.T. Centre Drop In Programs
Indoor Playground 780-496-1494 (311)
 Boys & Girls Clubs of Edmonton 780-422-6038
 City of Edmonton Community Services 780-496-4999 (311)
Leisure Access Program (2-17yrs) 780-496-4918
City of Edmonton Recreation Facilities 311
 Edmonton Public Library
Children's Programs (general info. line) 780-496-7020
 Edmonton Sport Council (sport referrals) 780-497-7678
 Greater Edmonton and Area Parent Centre
Indoor Playground (0-5yrs) 780-465-3976
 Kids on Track Association
Monthly Rally (gr. 1-6) 780-481-2942
(entertainment, multimedia, object and interactive lessons, special events)
 KidSport (funding; under 18yrs) 1-888-914-5437
 Sport Central Association (no cost equipment) 780-477-1166
 YMCA of Edmonton - *Jumpstart (5-18yrs)* 780-429-9622
 Suggestions for parent-child or child activities 211

Mental Health

Alberta Health Services (AHS)
Child and Family Mental Health (5-18yrs) 780-735-7999
Children's Mental Health Community Response Team (under 18yrs) 780-342-2800
 Regional Children's Mental Health
Crisis Line (5-17yrs) 780-427-4491
Intake (5-17yrs) 780-342-2701

Mentoring Programs

Big Brothers Big Sisters of Edmonton 780-424-8181
 Uncles & Aunts at Large Society 780-452-5791
 United Way of the Alberta Capital Region
Partners for Kids 780-990-1000

Violence

Aboriginal Consulting Services Association of Alberta
Teaching Circles for Children Who Witness Abuse (6-17yrs) 780-448-0378
 Child and Family Services
Child Abuse Hotline (24/7) 1-800-387-5437
 Kids Help Phone (24/7; 5-20yrs) 1-800-668-6868
 Prevention of Family Violence & Bullying
Bullying Helpline (24/7) 1-888-456-2323
 Sexual Assault Centre of Edmonton
Counselling (3-17yrs) 780-423-4102

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