


**A STUDY OF PARENTING AND FAMILY CHARACTERISTICS
OF FAMILIES PARTICIPATING IN THE
COMPREHENSIVE HEALTH INVESTMENT PROJECT**

by


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(ABSTRACT)

The Comprehensive Health Investment Project is a community health project operating in Roanoke, Virginia that is designed to address the needs of families and their children who do not have access to continuous health services. This study examined parental characteristics of those parents participating in the Comprehensive Health Investment Project.

Five surveys, which assess parental satisfaction, parental skills, parental comfort, sense of community, and safety practices were administered to parents and subsequently collected for analysis. It is the data from these surveys which provide invaluable descriptions of these parents and family dynamics. Results indicate that the participating parents have high levels of parenting satisfaction and a high level of involvement with their children. The parents had a low sense of community. Overall, parents followed good safety practices with their children. Some questions, when cross

tabbed with demographic variables, demonstrated an interaction between the response and the selected variable. However, there was no apparent trend for the interaction to be true for all questions.

A description of the method of data analysis and the parenting characteristics exhibited by these parents is included. Recommendations and suggestions are also provided to better assist the CHIP staff in service provision.

This research will assist providers in measuring parental program effectiveness and will expand existing knowledge regarding parental practices and satisfaction.

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CHAPTER I

Introduction

Today, many American children and families are faced with a crisis: domestic poverty. Over 34 million Americans fall below the level of poverty and almost 70% of those people are minorities (Washington, 1985). Millions of children are affected by their parent's level of income and overall socioeconomic status. Those children born to low-income families are faced with adversity and difficulties that are unique to low-income groups. One disadvantage is the lack of accessible and affordable health and medical promotion services which can greatly influence a child's overall well-being and success in society as an adult and future parent.

Child and infant mortality rates for low-income groups are indicative of the link between income and access to health care. The chances of infants dying during their first year of life is two-thirds greater for the poor than non-poor (Keniston, 1977). While the poor are four times as likely to be in poor or fair health than children from families with incomes over \$15,000, they are only one-half as likely to have seen a doctor in the last year (Keniston, 1977). Factors associated with poverty that contribute to poor health include poor housing, poor sanitary facilities, inadequate food supplies, and little or no pre- and postnatal care. These factors accumulate as a child develops. Those children born to

low-income families endure higher rates of severe health problems and higher rates of disabling handicaps (Nugent, Brykczynski, Crawford, Fuller, and Riggs, 1988) than children of other economic groups. Health problems of children may include dental carries, lead poisoning, visual and hearing impairments, and incomplete immunizations. These problems are exaggerated in low income families if they are unable to receive proper care. In addition, low-income groups must often deal with the effects of high crime rates, drug abuse, few male-headed households, and a large number of adolescent pregnancies, all of which can become barriers to achieving adequate health care.

All children should have proper health care and the opportunity to incorporate positive health behaviors as a part of their lives. Having access and the means to obtain care would be one way to help reduce the risk of illness and disease for children by ensuring preventive care during critical developmental years. It would enable many families to get care that they are unable to get because of financial constraints. This could ultimately help break the cycle of deprivation that exists among generations of disadvantaged parents and children. What can be done to address the needs of children to ensure that they no longer fall below the health status achieved by children of wealthier families?

The solution does not lie within the expectation that

infants and children exercise responsibility for their own motivations toward better health care. Instead, researchers must engage in a holistic approach by directing efforts at both children and their parents. A preoccupation with children's needs should not exist to the degree that researchers lose sight of the interrelated, comprehensive needs of high risk families and the role that parents and families play in the health status of children (Travers and Light, 1982; Gortmaker, 1979). Family dynamics and the relationship between parenting and health status must be evaluated if we are to achieve a goal of continuous health care to all children.

A child's health is, in part, determined by his family's attitude towards health and the family's strengths and weaknesses which are determined by social and economic environments in which the family operates (De'Ath, 1982). Children do not exist in isolation and their problems should not be viewed in such a manner. Children and their health status are influenced by their families, communities, other persons in the community, and the relationship between the three. Thus, to assist in improving children's health, the child and his health must be viewed from a holistic perspective, acknowledging and examining the social and economic system influences as they relate to what is experienced by the family.

A move towards a broader understanding of parenting, the family, and the way economic barriers are mediated in the home is necessary in order to help children. According to Richards (1989), an understanding of a parent's view of the world is essential in knowing the ecology in which the child is raised. Comprehending children and their health problems requires an understanding of parents. To reach this understanding, researchers must not focus solely on children without respect for their families and the environment in which they function. The way a family operates is vital to the health of the family, community, and society. Because a parent is a child's first and most influential teacher, how a father and/or mother raise their children, how much parents are involved with their children, how confident they are in their parenting abilities, their competency in parenting skills, and their sense of community all influence children. Some researchers believe that families are the most critical factors in determining children's fate (Keniston, 1977) with parents' well-being directly related to children's development.

Statement of Importance

The purpose of this study was to describe and illustrate the parental dimensions of those parents participating in the Comprehensive Health Investment Project (CHIP). Characterizing parents' satisfaction, involvement with their children, parental skill, sense of community, and home safety practices provides a clear picture of the family dynamics exhibited among parents and children participating in CHIP. Results will enable providers to assess the current effectiveness of the parental program component. The study will provide a base upon which providers can modify services or add to existing ones, better filling existing parental deficits. In addition, the paper will add to the existing base of knowledge regarding family characteristics of low income groups living at the poverty level or below and who would otherwise have no access to medical care.

Justification

Program evaluation is a responsibility underlying the delivery of all human service programs. Researchers must continually evaluate to ensure program effectiveness and progress. It is essential to ascertain whether a program is meeting its short and long term goals and objectives. Once this information is derived, programs can be varied or expanded as necessary. In addition, accountability is often demanded by program funders and administrators in order to guarantee the continuation of projects. Thus, program measurement is an integral part of community health education programs such as CHIP.

Evaluation of the CHIP parental surveys is required to better understand the CHIP family's parenting satisfaction and sense of community. The results of data analysis will help determine whether several objectives set forth for CHIP are being met, specifically the objectives of (1) enhancing the participants' quality of life via educational programs and improved parent-child interaction and (2) determining CHIP clients' comfort in parenting skills, family relations and adequacy of socialization skills. Uncovering the effects of CHIP on parents is important so that current programs may be modified, enhanced, or eliminated. This will assure that CHIP is appropriately addressing and meeting the needs of its

clients. Finally, the surveys, which primarily collect attitudinal data can provide researchers with indications on participant's parenting knowledge and behavior. This information will also help CHIP workers better serve and assist their clients. Analysis of the questionnaires is an unobtrusive means for better understanding these parents and ultimately improving the programming for these families.

Limitations

There are inherent limitations of this study which are beyond this researcher's control. These limitations must be set forth so that additional work may be continued with the data or so that the study may be replicated at a future time.

These surveys were not created or administered by this researcher. Thus, any problems observed with survey question clarity have not been corrected in this study. However, difficult questions and confusion about procedures for scaling one's responses can influence results.

In addition, no clear standards are followed in questionnaire administration and regulation by the CHIP staff. Some outreach workers mail the questionnaires to their clients while others distribute the questionnaires during home visits. Some outreach works assist in question clarification and others refuse to provide this assistance.

The very nature of the clientele often prevents unfailing response and return of the surveys. Many respondents have education levels below high school graduation and are unable to read or understand all of the material. Augmenting this problem is the fact that many of the participants are transient and can be difficult locate. This population faces many demands (financial, social, and psychological) and

responding to a questionnaire can not always be a priority. Frequently, a natural parent, who may or may not be the head of the household, responds to the questionnaires and often a guardian who has assumed custody of the child enrolled in CHIP will respond. In addition, the surveys should be distributed at enrollment and one year later during the recertification phase. However, the surveys may get lost or misplaced by clients, some clients may move out of the area or drop out of the program, outreach workers may fail to administer the survey at the appropriate time, and some clients may refuse to complete the information. Thus, complete data are not available on all families. Finally, some participants may not realize the value of their responses and may arbitrarily mark answers.

All of these limitations certainly influence the accuracy of this research. But, while these problems may appear overwhelming they do not detract from the necessity or validity of the study. Indeed, the very limitations of this study help by providing a clearer picture of the population being studied. CHIP outreach workers and clients live and function in a natural setting and are influenced by many natural occurrences previously mentioned (economic barriers, low education levels, transiency, and a high caseload). These natural influences, or limitations, provide us with an understanding of the conditions and constraints under which

these people must operate. If our goal is to understand these people so that we might help them, then we must understand these constraints. In fact, despite the aforementioned drawbacks, questionnaires are widely used in educational research and continue to be a very cost-effective and fairly fast method for measurement and evaluation. They can also be used with large groups of people, are objective, and can be easily duplicated.

In addition to inherent limitations, some restrictions have been purposefully set forth for this research. Family files for all CHIP outreach workers were obtained and examined on two separate occasions to determine if the files contained all or a portion of the needed questionnaires. The two dates for data collection were established as September, 1991 and January, 1992.

In September, all family files were gathered and all questionnaires were collected. In January, 1992 the same files were again examined to ascertain if new surveys or missing parts of surveys had been completed during the interim between the September and January collection dates. It was hoped that the two data collection dates would increase the sample size and increase the number of respondents who had enrollment/certification (pre/post) data. No surveys were collected after January, 1992.

While all surveys were collected from the family files

(those entirely complete, those with only part 1, and those with only part 2), only those questionnaire packets that were complete, containing all five required surveys, were used in this analysis. To be considered for analysis, queried demographic data had to be available on the respondents who had completed packets. In sum, the research examined only those survey packets which contained all five questionnaires and on which family demographic data could be obtained. In addition, only those surveys located at the CHIP facility were used. It was not the intent of this study to contact those parents who had completed only portions of the survey packet.

CHAPTER II

Literature Review

This review of literature explores the dynamics involved in parenting, particularly in low-income groups and describes several programs designed to enhance children's health through improvement of the family system. Also described are the characteristics of families and parental patterns of those families participating in CHIP.

Parenting Styles

Baumrind (1966) developed one of the earliest theoretical models to describe parenting styles. The model is based upon the degree of control parents have over their children and includes the following: permissive, authoritarian, and authoritative. Permissive parents leave decisions about what to do up to the child. The child must decide what is best and is free to choose unless his behavior interferes with the parent's or child's safety. The child is free to regulate his own behavior. An authoritarian parent believes his role is to make decisions for the child, thus teaching the child the desired behavior. However, there is no input from the child as to what the behavior might be, and should conflict arise, harsh discipline may be used as obedience is considered a virtue. Finally, the authoritative parent cooperates with his child, providing reassurance and guidance in order to arrive at choices and decisions. The child is allowed input toward

family decisions and consultation with the child is always made before finalizing plans.

The significance of parenting styles on children can be documented in Baumrind's (1967) study of parent-child interactions. Observations of preschool children identified several patterns of child behavior: competent, withdrawn, and immature. Baumrind also observed family interaction through home visits. Through these observations, parents were rated on dimensions of control, maturity demands, communication, and nurturance. High parental control was indicative of parental influence and dominance while those scoring high on the maturity demand scale were parents who pressured their children to perform beyond normal expectations. These parents also allowed their children independence. Parents who communicated well with one another used reasoning skills with their children. Parents who rated high on the nurturance scale expressed a great deal of love and affection for their children. In comparing the two observation sets, results show that parents of competent children scored high on all parenting dimensions while those children who were withdrawn had parents who scored lower on the nurturant scales and were more controlling than the other parents (Groves, 1987). Thus, parenting styles can have outcomes on a child's behavior and socialization process and are worthy of evaluating when concern for a child's welfare exists.

Baumrind's later research (1973) further supports this concept. Her study revealed that authoritarian parents fulfilled their own needs before those of their children which hindered the social development of their children, while permissive parents failed to promote social responsibility among their children (Groves, 1987).

A second model of parenting styles was developed by Maccoby and Martin (1983). The two dimensions of their model are (1) parental responsiveness which ranges from accepting and responsive to unresponsive and parent-centered and (2) parental demandingness which ranges from high demand to low control. The two dimensions produce four parenting styles very similar to Baumrind's styles. The four styles are authoritative-reciprocal, authoritarian, indulgent, and neglecting-uninvolved. While both models appear straightforward and clear, parenting is not. It is difficult to place a parent in one specific category.

Several studies intimate the complexity in placing a parent in a parenting style category. Ross, Hall, and Demus (1990) gathered data on 21 lower class mothers who lived without a spouse or family member. The mothers were asked both open and close-ended questions regarding their parenting behaviors in order to determine what style of parenting they exhibited most often. A classification system was devised in which eight of ten similar responses resulted in being placed

in a particular category. Overall, authoritative style was chosen most frequently (47% of the time) with authoritarian and permissive styles chosen 32% and 21% of the time respectively. However, only two mothers could be classified as authoritative (eight of ten authoritative responses) and one as authoritarian (eight of ten authoritarian responses). This investigation revealed that parents were not consistent with their parenting styles.

A similar study by Grusec and Kuczynski (1980) indicated the same pattern. The mother's disciplining patterns were determined more by what the child did than by a consistent pattern of child rearing approaches.

Carter and Welch (1981) studied 178 married and single subjects who were asked to respond to vignettes describing normal behaviors of preschool children. The researchers found that females and singles were more likely to exhibit authoritative responses. However, as the age of the subject increased, so did the authoritarian and permissive responses. And, while the literature reports a large percentage of children growing up in near-equalitarian or authoritative style families (Ingersoll, 1948) many mothers and fathers are still likely to slap or hit their children or confine them to their room when they misbehave which is an authoritarian style (Pratt, 1976).

It is difficult to draw generalizations about the complex

area of parenting styles and family behavior. In a study of parents' values concerning qualities desired in their children, both mothers and fathers valued independence (self-reliance and freedom to make choices) but also valued obedience (respect for elders and authority figures) almost as much as independence (Pratt, 1976). A combination of parents wanting to protect their children, wanting appropriate behavior, and believing that parents know best affects and complicates a parent's parenting style, making it difficult to categorize any one family or any one socioeconomic group into one particular parenting category. Instead, the categories provide researchers with a general overview of parenting styles that might assist in analyzing parent behavior. One must remember however, that parenting is highly situational and dependent upon a variety of factors including individual differences in philosophies, needs, goals, and the child's age.

While many studies recognize the situational nature of parenting, researchers have drawn conclusions about what is necessary to have a healthy family. Stinnett (1980) found healthy families to have a sense of purpose, to support one another, to have a high level of communication and to use a team approach for problem solving. Other researchers have made efforts at describing the "typical" good parent. Characteristics have included: a positive self-concept, at

least one close, meaningful relationship with another adult, an understanding of child development and learning, a high degree of verbal interaction with children, and social support links in the community (White and Kaban, 1979; Swick, 1984). Low income families may not exhibit or be able to exhibit all of these "typical" characteristics due to the economic and environmental constraints placed upon them.

Chilman (1968) cited some of the differences between poor and middle class families. She characterizes poor parents as inconsistent in their punishment, fatalistic, with a low self-esteem, granting early and abrupt independence to children, and having a strict, rigid family structure. She describes middle class parents as consistent in their discipline patterns, rationally objective, with a high self-esteem, utilizing gradual training for children's future independence, and having an equalitarian family structure.

Parental Demands

Raising the health status (physical, social, financial, and environmental) of a family as well as the standards of parenting to what researchers and practitioners consider appropriate or "typical" is not an easy task. It can mean encouraging children to communicate, making informed decisions, utilizing community resources, seeking out information, and being able to adequately meet daily demands. These tasks are particularly troublesome to families in low

socioeconomic groups that may not have adequate resources to meet financial needs, the skills or knowledge to perform some necessary parenting behaviors, or adequate knowledge about child development to be an effective parent. In addition, the multiplicity of external pressures and demands for this group plus a lack of readily available information and support systems may cause low-income parents to fail (Knight, 1979; Pugh 1980). Bricker, Seibert, and Casuso (1980) state that many low-income parents are forced to devote all their time to coping with environmental stressors leaving them little time to address their children's needs.

At least one in five children today live in a single-parent home (U.S. Bureau of the Census, 1988) which creates additional strain for both parent and child. Many of those born between 1970 and 1990 will likely spend a portion of their childhood in a female-headed household in which the mother is divorced, separated, widowed, or has never married (Bumpass, 1984; Norton & Glick, 1986). The consequences for children living in single-parent homes may include feelings of sadness, deprivation, or fear. Lowery and Settle (1985) noted that the effects of divorce on children under five can include depression, developmental disturbances, weight fluctuations, and physical complaints. Guidubaldi and Cleminshaw (1985) report that single parents rate their health and the health of their children significantly lower than do nuclear families.

Perhaps a decreased food purchasing power and a poorer health status for adults leads to inadequate diets for children and a perpetual poor health status for single families (Groves, 1987).

Of all poor families with children, almost 60% are headed by women (U.S. Bureau of the Census, 1988b) a trend called by some as the "feminization of poverty" (Pearce, 1978). Single women must try to combine attempts to maintain paid employment, perform suitable child care, and maintain a household. In a qualitative study by Richards (1989), of 43 single mothers interviewed, concerns of feeding, housing, and clothing children on a welfare income were all cited as overwhelming. And, in those poor families which are socially isolated, the stress of poverty and task overload has been associated with emotional disturbance for mothers and their children (Belle, 1980; Fine, et al., 1986).

Internal/External Support

In order to address multiple demands such as unemployment, a lack of education, poor housing, unaffordable health care or a lack of transportation, a supportive network of relationships is essential. This network which may include relationships with family, friends, neighbors, fellow workers, and schools, when present, enhances the family and its interaction (White, 1980; Bronfenbrenner, 1979). To be effective, parents must manage their families and believe

themselves to be in control of their environment; support can enhance parent effectiveness. Lefcourt (1976) and Partridge (1987) report that a feeling of mastery and social support is correlated with actual parent effectiveness and child rearing practices. It has been cited that those children living in supportive environments learn appropriate behaviors for school and family situations and have been assessed as more socially competent by teachers (Swick & Graves, 1986). Thus, a positive environment and a confident parent enhances not only a parent's well-being but that of the child as well. Those feelings of control and social support can serve to buffer some of the stress that low-income families often experience.

In Stevens' study (1988) of low-income black and white mothers, feelings of self-reliance, information and advice, and personal control were all correlated with and enhanced the mothers' parenting ability. However, internal and external support can often be absent in low-income families.

Parents who do not have internal and external support may create counterproductive family systems. Kempe and Kempe (1978) found that abusive parents are often deficient in meeting their own needs, and Gabarino and Gilliam (1980) report that isolated parents who have little exchange of information from support systems about parenting may become abusive. Those who find it difficult to respond to demands and family problems, of which low-income families face, may

end up blaming their children for their problems and may carry out antisocial acts in the community (Gabarino, 1982).

The apparent lack of support in low socioeconomic groups is documented in the literature. Allen, Affleck, McGrade, and McQueeny (1984) cite that lower socioeconomic parents have less support and less confidence in their own abilities which can be detrimental to family systems. A family pervaded by illness, lack of support, high demands and a lack of resources to meet those demands cannot support its family members; the family exhausts its time, money, energy, and other resources.

Interpersonal support is essential to family functioning and enables family management. In low socioeconomic groups, extended family members often provide intra-family support (Slaughter and Dilworth-Anderson, 1985; Wilson, 1986) which includes a base for exchange of knowledge about child development. These interpersonal relationships can influence an entire family by enhancing a parent's own strengths and validating a sense of being a good parent, resulting in positive outcomes in parenting behavior. A valued supporter reinforces parental identity and can strengthen environmental control (Swick and Graves, 1986). By strengthening one member of the family, the entire family is indirectly strengthened. But, if family members or a spouse are absent or unable to provide support, as is often the case in low-income families, child rearing may be difficult and self-confidence may be low.

Parenting with little support may have negative outcomes in child rearing. The effect of low support is evident in the failure-to-thrive syndrome seen in newborns (Stern, 1977).

External support is critical as well. Community isolation can make it nearly impossible for parents to perform their necessary roles (Swick, 1984). Lack of external support can reduce options for nurturing, impede personal development of self-image and self-confidence, and create the possibility of mental health problems (Bronfenbrenner, 1979). Support systems and a sense of community may influence the way a parent perceives his control and family management abilities. This in turn can either increase or decrease confidence in parenting abilities. Watson (1981) found that parents who perceived their neighborhood as supportive were also supportive of their children, but those who had inadequate neighborhood support systems were less effective at parental functioning. In a study by Brown and Swick (1981) the role of neighborhood support revealed interesting associations. One hundred sixty-four middle class professional educators were administered the Perception of Neighborhood Supportiveness Scale to determine the relationship between demographic information and perceived neighborhood support. Demographic information collected included information on: age, marital status, income, and educational level. Neighborhood support questions recorded on a likert scale ranging from strongly agree to strongly

disagree included: "If my car wouldn't start, I could count on a neighbor to give me a ride", and "If I had a marital problem, there are people in my neighborhood I could talk to about the problem". Other items included information on children's illnesses, school, work, and social activities.

Statistical analysis of the data revealed a positive relationship between perceived neighborhood support and demographic information. Those who scored high on the amount of play time with children, age of adults, housing, length of time in neighborhood, and frequency of social activities perceived their neighborhood as supportive. Specifically, those home owners with longevity in the neighborhood who also participated in frequent social activities perceived a supportive community environment. While this study focused on middle class families it has serious implications for low income families. The poor often can't afford to purchase homes; they are often forced to move frequently due to the instability of work; they can't afford to or have the time to participate in social activities or children's play time due to the multiple demands placed on them and the lack of support they have. Thus, based on the above cited research low income families are less likely to perceive their communities as supportive than middle or upper class families.

Social support systems at work can indirectly influence parenting style. Swick and Taylor (1982) hypothesized that

those parents unhappy at work were likely to lower their expectations as parents and become less involved at home. Low-income families, often struggling to find work or maintain paid employment, lack external support which may lead to little familial involvement. Role ambiguity, little control over the work process, and incompatible demands can all become significant strains on an individual; these strains may be transferred to the family and impede a person's parenting effort and negatively affect roles and relationships at home.

Parental Confidence

Ricks (1985) developed a model which posits that a person's self perception serves as an influence on how a person behaves. Utilizing this model, one would assume that the more positive a parent views himself as a parent, the greater success he will have in the role. Ricks (1985) supported this concept through her studies with infant- mother attachment and self-esteem. Others have linked role satisfaction, self-fulfillment, and general happiness to positive parenting outcomes for children (Lerner and Galumbos, 1985; Stuckey, McGhee and Beller, 1982; Warr and Parry, 1982). Researchers have found that well-adjusted parents have less difficulty with their parenting role which is reflected in parental behaviors (Maccoby and Martin, 1983; Pumroy 1966). Thus, a parent's negative attitude towards child rearing can have significant outcomes for children including reduced

health status, poor performance in school, and poor self-image.

Childhood Injuries and Accidents

Injury is a public health problem, particularly for children. For those children ages one through four, injuries cause almost half of all deaths and three times as many deaths as the next leading cause (Rivara and Mueller, 1987). In addition to fatalities, non-fatal injuries occur often as well. Each year there are about 200 emergency room visits per 1000 children for injury related reasons (Galagher, Finson, Guyer and Goodenough, 1984). Childhood injuries include motor vehicle accidents, falls, burns, drownings, and injury from furniture and recreational activities. Some of these show a trend across age groups (Gallagher et al., 1984). Why are there so many childhood injuries? The old myth of "accident prone" children has been dismissed. However, there are some dimensions which researchers believe contribute to the high injury rate.

Maternal age and marital status are often associated with the risk of injury (Rivara and Mueller, 1987). In a longitudinal study by Wadsworth and Butler (1987), the researchers found that children of teenage mothers were more likely to be admitted to a hospital after accidents than children of older mothers. Those accidents reported by the teenage mothers in the study included poisoning, burns, and

lacerations. Perhaps young, single mothers lack knowledge about child development and have no support network to provide the information, making their child rearing inadequate and leaving their children at a greater risk for injury.

Children of single-parent families and step families are also likely to be injured more often than children who live with both of their natural parents (Rivara and Mueller, 1987). This research has direct meaning for the poor, for it is the poor who have high rates of both teenage pregnancy and single parenthood.

Low socioeconomic status can certainly be associated with high injury rates just as it is associated with high mortality rates. In a study by Nersesian, Petit, Shaper, Lemieux, and Naor (1985) of child deaths in Maine, children of low-income families were over two times as likely to die from accidents than children from non-poor families. This was true for motor vehicle collisions, drownings, and fires. Non-fatal injuries are common among low income groups. Rivara and Barber (1985) found in Memphis that child pedestrian injuries occur most often in families whose income falls below the poverty level, in female-headed households, and in crowded neighborhoods. Poor parenting knowledge, insufficient parent supervision, inadequate housing, inadequate financial resources, hazardous environments, all of which are linked to poverty, may thus be linked to high injury rates among low-income families.

Injuries among low socioeconomic groups have created an interest and concern among health educators and others engaged in promoting the welfare of America's children.

Health Promotion

Concern for child care and a focus on the quality of family life and parent-child relationships has resulted in the formation of numerous programs designed to provide family support and parent training. These programs are generally proactive and are directed at increasing the level of family wellness and aiding families to reach their health potential. These health promotion programs take on any combination of services to achieve a behavior that is conducive to maintaining or improving a family's health and can include educational, organizational, economic, and environmental support. The programs attempt to empower a family by addressing community-wide problems which community members have identified. To be successful, these interventions are sensitive to the beliefs and values of the population served (Nugent et al., 1988). The community based programs are multi-directional and serve as an attempt to encourage social awareness and social change.

Such community based programs originated in the 1960's when neighborhood health centers were established by the federal government to serve the needs of the indigent and minorities who fell under medicaid guidelines (Williams,

1990). Today there are a variety of community programs operating in a wide range of settings which are tailored to a particular community's needs. The programs however, are faced with barriers. Because the population being served has competing needs, health promotion is often a low priority. Williams (1990) cites the following as potential program barriers: limited resources, limited providers and volunteers, difficulty defining the populations in need, and difficulty in evaluating program effectiveness. Despite these difficulties, programs continue to function successfully and make a difference in the lives of children and their parents.

Comprehensive Health Investment Program (CHIP)

CHIP is an example of a public/private program designed to aid low income families which last year served nearly 1,000 children (CHIP, 1990) ages 0-8 living in the Roanoke Standard Metropolitan Statistical Area (cities of Roanoke and Salem, counties of Roanoke, Craig, and Botetourt). The children served are at or below 150% of the poverty level and have no regular health care. The program seeks to provide quality medical care to those children who have little health care continuity. The CHIP team is composed of physicians, nurses, social service personnel, health department employees, and community business persons who can maximize appropriate use of community resources.

Services provided include care coordination,

immunization, nutrition education, parent education, and pharmacy and laboratory services. All of these services are categorized into four program areas: outreach and enrollment, primary health care and supportive services, care coordination, and parent involvement (Williams, 1990).

The outreach and enrollment phase generally begins with a referral from a local social service agency which identifies an eligible child. Once eligibility requirements are confirmed, the family is guided by a nurse or outreach worker through completion of family intake forms, eligibility forms, and health history questionnaires. Parents also participate in an orientation session in which CHIP services are described. A medical record release and patient provider contract are drawn up and signed by the participating family (Williams, 1990).

A needs assessment identifies a child's deficiencies so an individual care plan can be developed and the child is assigned to a participating physician. A nurse serves as the family coordinator monitoring the child's progress, ensuring that medical appointments are kept, scheduling necessary follow-ups, and making appropriate referrals.

Parents also complete a series of parental surveys which assess: parenting satisfaction, parental involvement and skill, sense of community, and safety in the home. The surveys provide a means to assess family dynamics and provide a basis

for development of family programs that may include providing information on job training, helping a parent get a high school equivalency diploma, making a referral for substance abuse, assisting in housing needs, or help in finding suitable and affordable day care. By enhancing the family systems, CHIP hopes to have positive and long-term effects on the children (Pierce, 1990).

A study by Williams (1990) provides an overview of demographic characteristics of the CHIP families. Most family heads (55.4%) are between 22 and 30 years old; 19.8% are 15 to 21 years old and 24.2 % are 31 to 45 years old. Forty-one percent of family heads are female. While few family heads completed college, most family heads completed high school. Fifty-three percent completed the 12th grade or obtained their equivalency diploma. Yet, as many as 42% are unemployed and are supporting two to three children on a welfare income. CHIP families depend on a variety of assistance including Medicaid, food stamps, and Women, Infants and Children (WIC). A majority of the families Williams studied indicated a need for financial assistance, adequate housing, and 33.6% specified a need in assistance with family relationships and parenting skills.

Related Programs

The following programs are a sample of interventions which are similar to the Comprehensive Health Investment

Project. While not all of them provide the same medical care that CHIP does, each is community-based with the purpose of empowering the family and improving the quality of life for both children and their parents.

■Washington's Can Do Kids

Washington's Office of Community Development created the Early Childhood Education & Assistance Program (ECEAP) to address the needs of pre-school children who, without assistance, would be at risk for failure in the formal educational system (Washington State Office of Community Development, 1989). The goal of the program is to mobilize local service personnel to strengthen families and the community. The program is considered a whole-child intervention and is operated through local organizations which contract with the state to provide management and services.

The program focuses on social and cognitive education with an emphasis on language development and parenting skills training. The program provides medical, dental, mental health, and nutritional services as well as referrals to social services throughout the community.

ECEAP is funded by the local government, school districts, non-profit groups, and community colleges. The population served is predominantly white (49%) with 3/4 of

the participant's income below 75% of poverty guidelines. More than 1/2 are single-parent families.

■The Center for Successful Child Development

The Center for Successful Child Development was created to provide primary prevention services to children living in the six buildings of the Robert Taylor Homes in Chicago, Illinois (Mclaughlin and Bowie, 1987). These subsidized homes, serving 20,000 predominantly black, poor families, are the catchment area for a local elementary school. The program provides services to those born after January, 1987 and is designed to operate through January 1992. The program addresses families' needs before children are born then follows the families until the children reach the age of 5 and enter elementary school.

The Center for Successful Child Development provides a wide range of aid including health care (pre/postnatal, pediatric care, parent health, nutrition, infant screening), a family drop-in center, community information, home visits, referrals, child development/parenting information, and networking of social services.

Funding is derived from the United States Department of Health and Human Services and the local Harris Foundation.

■St. Columbia Ministries

The St. Columbia Ministries serve a population of low income families residing in the Norfolk, Virginia area (Kotler, 1986). The purpose of the program is to enable poor residents to meet material needs through a program of emergency services. The program provides emergency assistance for rent, utility, and medical bills. In addition, arrangements are made with local professionals so that free medical and dental care as well as legal advice can be obtained. The program makes necessary referrals to various social service agencies and provides assistance with transportation needs. Funding is derived from private donors and contributions from churches.

■Maternal Infant Health Outreach Worker (MIHOW)

MIHOW serves 4 sites in Appalachia and a fifth site in rural Tennessee; all sites are impoverished areas. The program is community-based and provides health interventions to women living in the designated areas (Clinton, Elwood, Parks & Soraci, 1988). The goal of the program is to assist in the improvement of the quality of the home environment of rural, low income children, to teach families what to do to become successful parents, and to teach families to become actively involved in their child's development.

Services include prenatal care and child development instruction. The program is operated by outreach workers and

"natural helpers" or women indigenous to the area and who are very similar to the population they serve. Home visits are regularly conducted and an effort is made to link women with the medical care system. The program follows children from birth until the age of two.

Approximately 2/3 of the population served are white. Forty-three percent are married and most have not finished high school. All participants are at or below the poverty level.

Funding is derived from the state and federal governments as well as private corporations.

■ Little Sisters of the Assumption

This program focuses its efforts on high-risk families living in the east Harlem community of New York (Gordon, 1985). It attempts to break the cycle of deprivation for community members who face a high percentage of teenage pregnancies, drug dependency, accidents, and a high percentage of uneducated, unemployed persons. A team of medical workers, physical therapists and home health aides try to "re-parent" the parents in an effort to address family problems.

The work begins primarily in the families' homes where the isolation experienced by these women can be broken and a relationship developed between the workers and families. After a secure relationship is established the families are

encouraged to participate in center-based programs where children can play, GED classes are taught, and recreational activities occur. The program combines nursing, social, welfare, and educational components to provide integrated services. These services attempt to create an extended family that helps with illness, isolation, and poverty of which all participants are affected.

Summary

In sum, parenting is a difficult and challenging responsibility. This can be particularly true for single-parent families and those families with limited incomes or financial resources. In addition, a lack of social support and self-confidence can make the job of parenting even more difficult.

Many health promotion programs do exist, however, which assist parents in improving their family's well-being. These programs include educational, environmental, organizational, and economic components. One such program, CHIP, operates in Roanoke, Virginia. The program, like other similar ones throughout the country, attempts to both provide continuous health care to children in need and to empower parents in improving their parenting skills.

CHAPTER III

Methodology

This study used five parental surveys as follows: (1) Parenting Satisfaction, (2) Parental Involvement, (3) Parental Skills Inventory, (4) Sense of Community, and (5) Framingham Safety Survey (see Appendix A). The surveys, administered to clients upon enrollment and at the one year recertification period, assist staff members in determining parenting and family characteristics of those participating in CHIP.

The Parenting Satisfaction survey is composed of six questions; five questions ask parents to assess and place their level of comfort in their parenting currently, one year ago, three years ago, and in five years. Questions are recorded on a likert scale ranging from 1 (worst) to 9 (best). Parents also record their satisfaction about being a parent on a scale ranging from 5 (very satisfied) to 1 (very dissatisfied).

The Parental Involvement inventory is composed of 15 questions, which ask parents to record how often they spend time with their son or daughter engaged in various activities such as: walks, sports, vacations, talking, eating, reading, attending church, and playing games. Answers are recorded on

a scale which includes the following options: 1 (never), 2 (once a year), 3 (monthly), 4 (weekly), and 5 (daily).

The Parental Skills inventory is composed of 12 total questions. The survey asks parents to rate their competency in abilities to: solve problems, provide their children time, provide family emotional support, give advice, make and keep rules, and provide good role models for children. The responses range from 1 (not at all comfortable) to 5 (very comfortable).

The Sense of Community inventory consists of 12 questions and assesses how each parent feels about his home and community. Parents rate their sense of community based upon statements in areas such as: feeling "at home," having influence in community decisions, sharing common values with community members, and longevity in the community. Scoring ranges from 1 (strongly agree) to 5 (strongly disagree).

The Framingham Safety survey is composed of 21 questions about parental safety practices in the home. Some of the questions include: "Do you know how to prevent your child from choking?," "Do you dispose of old medicines?," "Do you store household products in empty soda bottles, glasses or jars?," and "Is your child in the yard while the lawn mower is in use?"

The following demographic information was also collected on each family: single or two parent family, sex of family

head, age of family head, educational level of family head, employment status of family head, average family income level, number of children in family, and the number of years participating in the CHIP program (see Appendix B). All data were scored on a Virginia Tech Learning Resources Center opscan (see Appendix C).

Procedures

In September, 1991 and January, 1992, 533 client surveys were collected from the caseload of 12 outreach workers. All family files were examined to determine if they contained the parental surveys. All surveys were taken when found, and an indicator sheet was placed in each file clearly stating whether a survey packet had been removed or whether no survey packet was obtained (see Appendix D). Of those surveys obtained, 159 were incomplete and unacceptable for analysis. Thirty-five were complete, however, no demographic data could be obtained on those families, making these surveys also unacceptable for analysis. Fifty-two files contained no survey data at all. This left a total of 339 acceptable questionnaires.

All responses were recorded on the aforementioned opscan and analysis of the questionnaires was completed utilizing the Statistical Analysis System (SAS) package. Analysis includes frequency distributions for each question as well as percent, cumulative frequency, and cumulative percent. In addition,

total survey scores were tabulated for each respondent on each questionnaire. Reliability measurements were obtained on each questionnaire and paired t-tests were run on those individual's packets who completed the surveys both at enrollment and recertification. This was done to determine if scores varied after one year in the program. Cross tabulations were performed between demographic variables and selected question responses to ascertain if any significant interaction occurred between demographic variables and question responses.

This study characterized and described families at program enrollment and, for those meeting the time line requirements, after one year of participation. It was not the intent of the study to demonstrate cause and effect relationships between the program and family characteristics, but to describe the participating families, and determine if interactions existed between parents' demographic characteristics and identified survey responses.

CHAPTER IV

Results and Discussion

Analysis of demographic data showed that 57% of the families were headed by females and 43% were headed by males (n = 337) (see Figure 1.0). Fifty-two percent of the respondents were single-parent families and 48% were two-parent families (n = 339) (see Figure 1.0). Forty-three percent of the family heads ranged from 22 to 30 years in age (n = 320) (see Figure 2.0). Almost one-half of the parents graduated from high school or had their graduate equivalency diploma, and 39% do not have a high school diploma (n = 299) (see Figure 3.0). Sixty-six percent of the families had at least one member who was employed but family income levels still remained low with over 50% of the families earning less than \$11,000 (n = 289) (see Figure 4.0). Over one-half of the participants had two or more children and over 75% had been enrolled in the CHIP program between one and two years (n = 338) (see Figure 5.0).

Parenting Satisfaction

Parents rated themselves very high when asked about their comfort in parenting skills. When asked where they place their level of parenting comfort, 93% of respondents rated themselves "5" or better on a scale of 1 (worst) to 9 (best) (n = 333). The average response to this question was "7." As the number of years enrolled in CHIP increased, participants

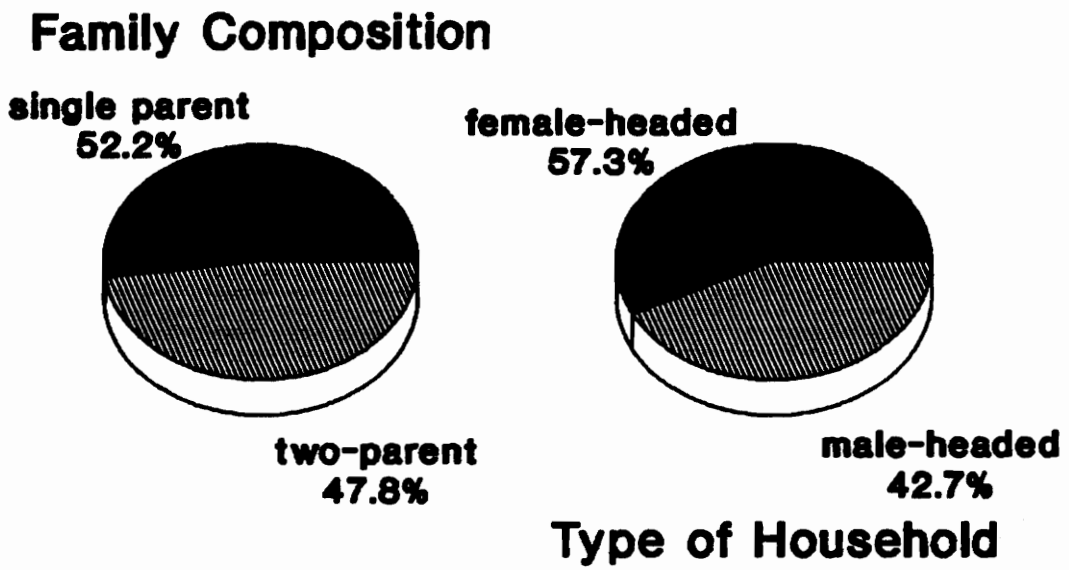
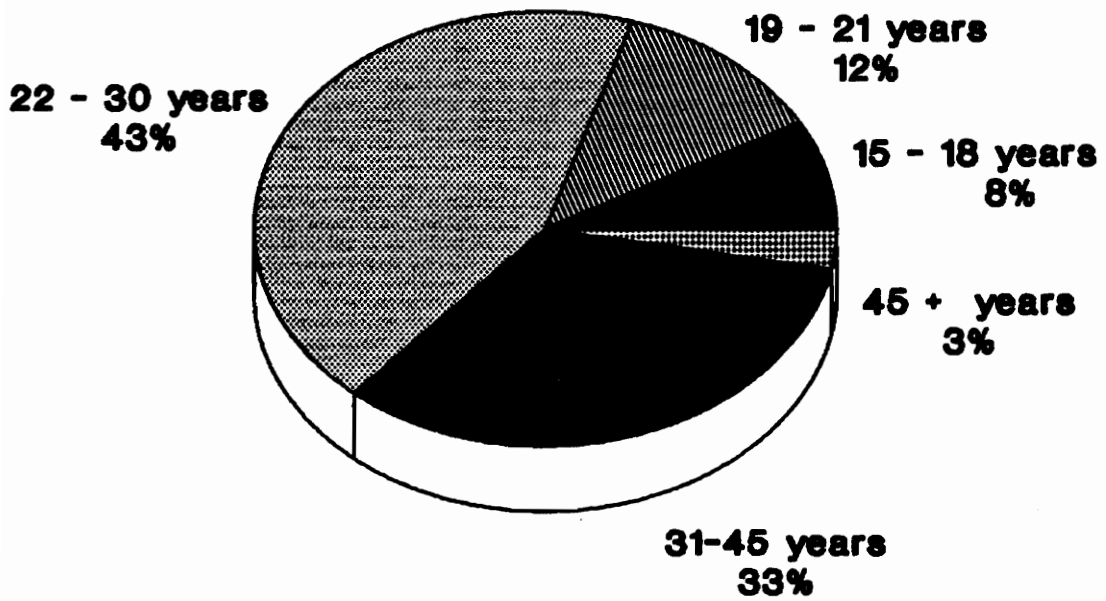
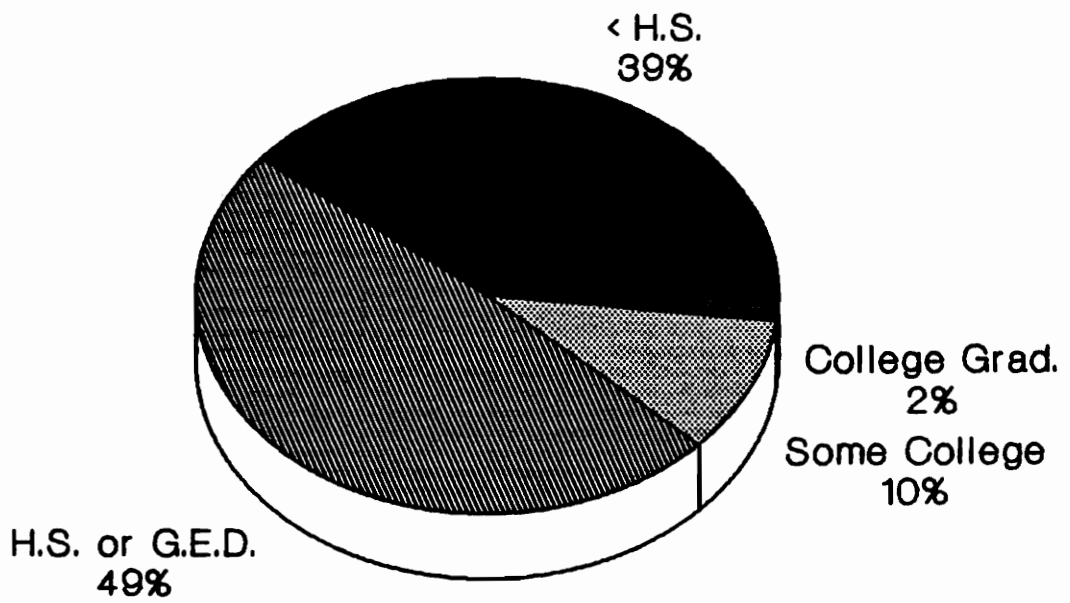


Figure 1.0



Ages of CHIP Parents

Figure 2.0



Education Level
of Parents

Figure 3.0

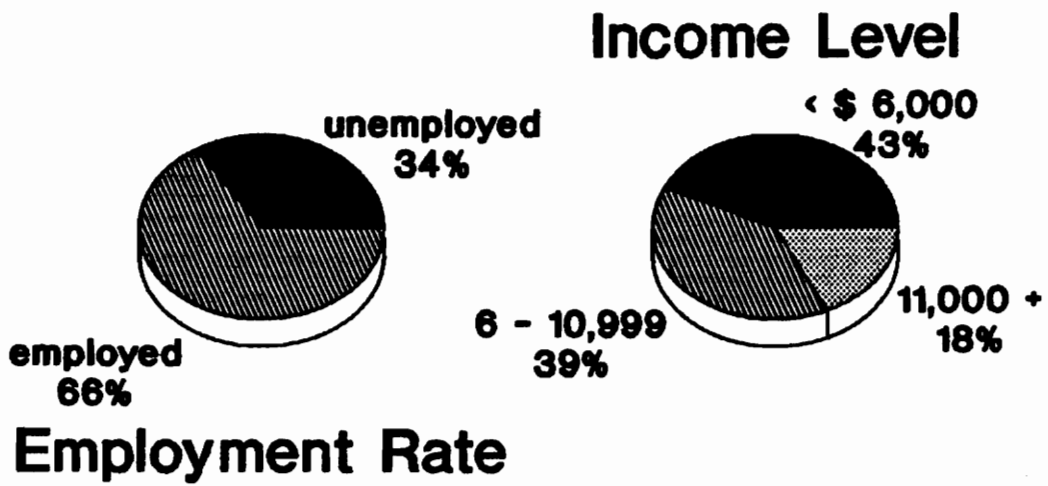


Figure 4.0

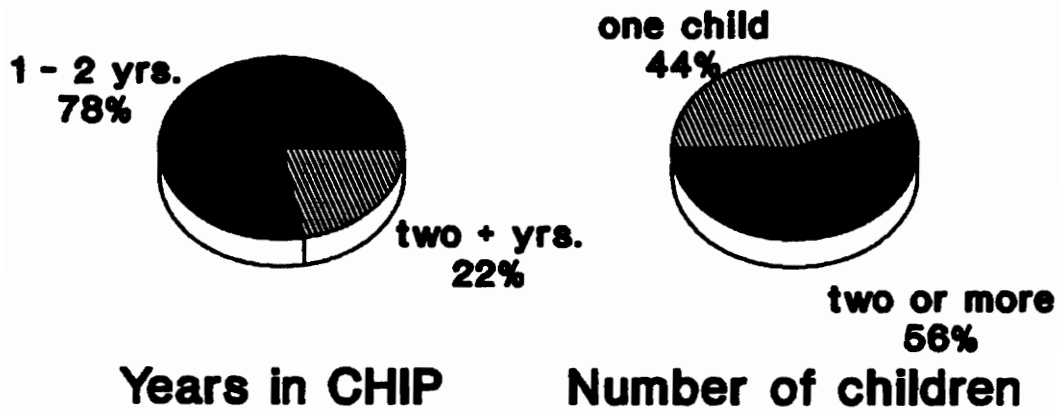


Figure 5.0

tended to rate themselves slightly higher, with 93% of those in the program one to two years rating themselves "5" or better and 96% of those in program two to three years rating themselves "5" or better. A three percent increase is noted and, thus, a slight improvement in perceived level of comfort. This may suggest that the longer parents are enrolled in CHIP, the more likely they are to feel comfortable with their parenting skills and the more likely they are to experience an enhanced sense of overall well-being which could be reflected in the improved self-reported rating. The improved rating could also be a response to the increased attention that parents receive and not to the interventions themselves. In addition, the children are getting older which may mean an improved sense of self-confidence or changed parental demands. There was also a subtle improvement for those participants who were employed. Eighty-five percent of those employed rated themselves "6" or better while only 80% of those unemployed rated themselves "6" or better ($n = 285$). Hence, there was a slight decrease (5%) in self-rating as employment status changed from employed to unemployed. The effects of unemployment on family systems is documented in the literature and has been reported to result in lower self-expectations and little family involvement (Swick and Taylor, 1982).

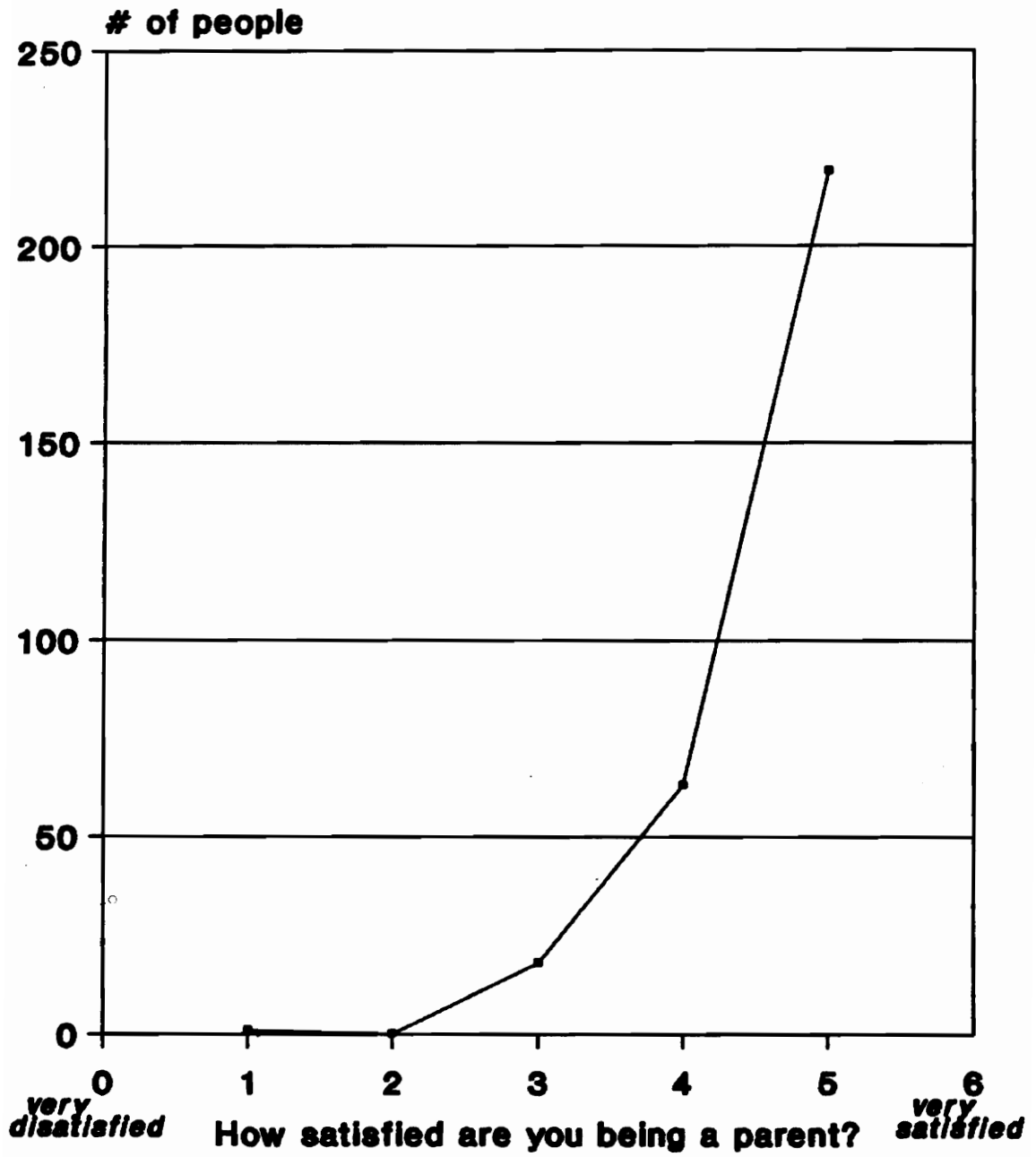
This instrument also asked participants to predict their level of parenting comfort in five years. Of those in the

program one to two years, 74% predicted themselves to be at "8" or "9" (on the same scale of 1 {worst} to 9 {best}) and of those in program two to three years, 79% rated themselves "8" or "9" (n = 325). This depicts a slight improvement in predicted self-comfort (a 5% difference) as the participant's time in CHIP increases.

When asked how satisfied they were with being a parent, 72% of the respondents replied "5" or very satisfied (n = 303) (see Figure 6.0). This is a significant number of very satisfied respondents and may be an indication of the benefits of CHIP enrollment. However, it is not known whether CHIP actually causes the parents to respond highly or whether the parents would have responded similarly had they not been enrolled in the program.

Finally, reliability for this questionnaire (and the remaining four) was determined using Cronbach's Alpha coefficient. For the Parenting Satisfaction inventory an alpha coefficient of .74 was obtained indicating a reliable instrument.

In sum, parents tended to rate themselves as being very satisfied with their level of parenting comfort with parenting skills now and their predicted comfort in the future. There was also a trend towards improvement in self-reported rating as the number of years enrolled in the program increased and for those respondents who were employed.

**Figure 6.0**

Parental Involvement

This survey instrument's reliability coefficient was .61 indicating a reliable instrument. Complete frequencies for each question can be found in Table 1.0. The following ranges

were established for total scores on this questionnaire:

total score of 1 - 38.9 = low involvement

total score of 39 - 53.9 = moderate involvement

total score of 54 - 75 = high involvement

Ninety-one percent of the respondents fell into the "moderate to high involvement" range ($n = 339$). Eighty-eight percent of respondents fell into the "high involvement" range indicating a group of CHIP parents who are very involved with their children (see Table 1.1). Of this 88%, 52% had a high school diploma or graduate equivalency diploma while 36% had less than a high school diploma. This 88% consisted of male-headed households (45%) and female-headed households (55%) respectively. Thus, involvement is apparently greater among females and those with a higher education level. Both single and two-parent families shared a "high involvement" rating. Fifty-two percent of one-parent families and 48% of two-parent families fell into the "high involvement" range. Twelve percent of the respondents fell into "the low to moderately involved" range.

When asked, "How often do you and your child talk about day-to-day things?," 79% of those with less than a high school

TABLE 1.0
Parental Involvement Inventory Results
(frequency of response to each category)

<i>how often do you:</i>	<u>never</u>	<u>once/yr.</u>	<u>monthly</u>	<u>weekly</u>	<u>daily</u>
spend with your your child in athletics (n=323)	32	9	46	133	103
and your child go for a walk (n=338)	8	8	36	172	114
and your child do outdoor activities together (n=335)	8	3	36	142	146
and your child go on vacations (n=331)	110	181	29	4	7
and your child visit relatives (n=336)	7	20	51	158	100
instruct your child in some skill/activity (n=336)	5	1	143	132	23
and your child participate in purchased activities together (N=337)	21	18	143	132	23
and your child talk about day-to-day things (n=329)	9	0	7	28	285
and your child eat together (n=338)	1	0	2	21	314
and your child watch TV together (n=338)	2	0	5	20	311
read a book with your child (n=337)	5	4	29	116	183
play a game with your (n=335)	2	3	22	120	188
go to the store with your child (n=334)	1	0	28	197	108
involve your child in church activities (n=334)	65	24	60	151	34
tell your child safety rules (n=330)	6	2	20	83	219

TABLE 1.1
CHIP Parents' Level of Involvement

Parental Involvement	Frequency	Percent
low involvement	2	.6
moderate involvement	39	11.5
high involvement	298	87.9

diploma said "daily," 89% of those with a high school diploma said "daily," and 96% of those with some college reported "daily" (n = 291). These responses indicate that talking to children about day-to-day things increases as education level increases (see Table 1.2). There was no evident difference between the responses of one and two-parent families, male-headed households and female-headed households, or those respondents who were employed or unemployed.

When asked "How often do you read a book with your child?," 47% of those with less than a high school degree reported "daily," 58% of those with a high school degree said "daily," and of those with some college, 67% said "daily" (n = 297). So, as education level increased, so too did reported daily reading (see Table 1.3).

When asked, "How often do you tell your child safety rules?," an increase was visible with education level. Sixty-four percent of those with less than a high school degree reported "daily" while 66% of those with a high school diploma said "daily" and of those with some college, 76% said "daily" (n = 290) (see Table 1.4).

In sum, these data suggest that the education level of the participants influences the amount they read and talk with their children on a daily basis. However, 91% of all respondents fell into the "high to moderately involved" range.

TABLE 1.2
Percentage of Respondents Who Talk About
Day-To-Day Things With Their Child "Daily"

Education Level	Percent	Total Respondents
< High School	79.46	112
Diploma or GED	89.04	146
Some college	96.30	27

TABLE 1.3
Percentage of Respondents Who Read A
Book With Their Child "Daily"

Education Level	Percent	Total Respondents
< High School	47.37	114
Diploma or GED	57.82	147
Some college	66.67	30

TABLE 1.4
Percentage of Respondents Who Tell Their Child
Safety Rules "Daily"

Education Level	Percent	Total Respondents
< High School	64.29	112
Diploma or GED	65.73	143
Some college	75.86	29

Parental Skills Inventory

Complete frequency responses for this questionnaire can be found in Table 2.0. A range for parental comfortability was developed for total involvement scores and is as follows:

total score of 1 - 31.1 = uncomfortable

total score of 31.2 - 43.1 = moderately comfortable

total score of 43.2 - 60 = very comfortable

Ninety-one percent of all respondents scored in the "very comfortable" range of parenting skills while 9% fell into the "moderately comfortable" range ($n = 339$) (see Table 2.1). This comfortability with parenting skills may be due, in part, to the assistance the families receive from CHIP outreach workers. Ninety-two percent of those employed respondents fell into the "very comfortable" range, while 91% of unemployed fell into "very comfortable" range ($n = 289$). Accordingly, little interaction between employment status and the level of comfort in parenting skill was observed.

In responding to the question, "How comfortable do you feel helping your child solve problems?," 60% of respondents with some college reported feeling "very comfortable"; 49% of those parents with a high school diploma or graduate equivalency diploma answered "very comfortable," and 48% of those with less than a high school diploma responded "very comfortable" ($n = 297$) (see Table 2.2). Thus, a decrease in comfortability was observed as one's education level decreases.

TABLE 2.0
Parental Skills Inventory Results
(frequency of response to each category)

How <u>comfortable</u> do you feel about your ability to...	<u>not at all</u>	<u>not very</u>	<u>somewhat</u>	<u>fairly</u>	<u>very</u>
care for your children when they are sick or upset (n=338)	1	4	15	76	242
help your children solve problems (n=335)	0	5	28	131	171
provide adequate time for your children (n=339)	1	10	39	106	183
be a good parent (n=338)	0	1	29	108	200
provide emotional support for your children (n=336)	0	2	24	97	212
maintain a close relation- ship with your children (n=338)	0	2	16	58	262
provide a good role model for your children (N=339)	1	8	29	128	173
discipline your children (n=338)	2	7	42	121	166
give advice to your children (n=332)	1	2	29	91	209
meet the needs of your children (n=339)	0	5	41	104	189
make & keep rules for your children's behavior (n=339)	4	4	55	107	169
be able to get needed resources for your children (n=335)	2	7	49	101	176

TABLE 2.1
Respondents' Levels of Comfortability

Level of Comfort	Frequency	Percent
Moderately Comfortable	29	8.6
Very Comfortable	310	91.4

TABLE 2.2
Respondents Who Feel "Very Comfortable"
Helping Their Child Solve Problems

Education Level	Percent	Total Respondents
< High School	46.96	115
Diploma or GED	48.63	146
Some college	60.00	30

When parents were asked, "How comfortable do you feel about meeting the needs of your children?," the percentage of one-parent families who responded "very comfortable" (55%) surpassed the percentage of two-parent families (46%) responding "very comfortable" (n = 339). This is surprising, as one would expect one-parent families to be less comfortable than two-parent families due to the multiple demands, lack of spousal support, and overwhelming concerns that are cited for one-parent households (Richards, 1989). Of the 187 "very comfortable" respondents, 61% were female-headed households and 39% male-headed households demonstrating a relationship between level of comfortability and male or female-headed households (n = 337).

Parents were also asked, "How comfortable do you feel in getting resources for your child?." Of the 174 who responded "very comfortable," 61% were female-headed households, 39% male-headed households, 63% employed, 37% unemployed. Thus, it appears that women and those employed felt more comfortable at getting resources for their children than men or the unemployed. One would expect those employed and earning an income to feel more capable of obtaining resources.

When asked, "How comfortable do you feel maintaining a close relationship with your children?," 38% of male-headed household respondents reported "very comfortable," while 62% of female-headed households reported "very comfortable" (n =

336). Of the respondents without a diploma ($n = 116$), 80% reported feeling "very comfortable" maintaining a close relationship with their child and of the respondents with a diploma ($n = 146$), 75% felt "very comfortable" maintaining this relationship.

Finally, when asked, "How comfortable do you feel disciplining your children?," of the 263 respondents who were in the program one to two years, 52% reported feeling "very comfortable" and 34% reported feeling "fairly comfortable." Of the 164 persons who responded "very comfortable," 39% were male-headed households and 61% female-headed households.

The alpha coefficient for reliability was .89.

Sense of Community

Reliability measurements provided an alpha coefficient of .89 on this instrument. Again, this suggests a reliable instrument. Complete responses to this inventory are found in Table 3.0. A range for sense of community was established based on total possible questionnaire scores as follows:

total score of 15 - 27 = strong sense of community
total score of 28 - 45 = moderate sense of community
total score of 46 - 56 = weak/low sense of community

Results of the Sense of Community inventory show that as many as 94% of the respondents fell into the "low to moderate" sense of community range ($n = 328$) (see Table 3.1). This indicates that a large percentage of CHIP participants do not

TABLE 3.0
Sense of Community Inventory Results
 (frequency of response to each category)

	<u>strongly agree</u>	<u>agree</u>	<u>don't agree or disagree</u>	<u>disagree</u>	<u>strongly disagree</u>
My community is a good place to live (n=338)	91	144	54	32	17
People in my community share the same values (n=335)	34	137	95	49	20
My neighbors & I want the same things from this community (n=334)	49	141	85	42	17
I can recognize most of the people who live in my community (n=336)	80	164	46	37	9
I feel at home in this community (n=338)	94	158	41	28	17
Very few of my neighbors know me (n=335)	36	130	60	75	34
I care about what my neighbors think of my actions (n=337)	73	136	81	28	19
I have influence over what this community is like (n=335)	19	91	145	57	25
If there is a problem in this community people who live here can get it solved (n=335)	34	134	97	38	32
It is important to me to live in this community (n=336)	48	114	78	65	30
People in this community get along with each other (n=336)	44	146	79	44	23
I expect to live in this community for a long time	71	100	67	50	48

TABLE 3.1
Respondents' Level of Sense of Community

Sense of Community	Frequency	Percent
Strong	21	6.4
Moderate	180	54.9
Low	127	38.7

have a positive sense of community. Perhaps CHIP home visits and a high client-to-outreach worker ratio do not permit interventions which are comprehensive enough to modify one's sense of community. Of the 6% who fell into the "strong" sense of community range, 71% were employed and 29% were unemployed indicating an interaction between one's sense of community and employment status. Most important to note, however, is the fact that so few fell into the "strong" sense of community range.

Of the 38% of respondents who fell into the "low sense of community" range, only 38% were one-parent families illustrating a greater sense of community among one-parent families. This contradicts much of what can be found in the literature, as most research points to single-parent families as having a poor sense of community (Brown and Swick, 1981).

When parents were asked to respond to the statement, "I think my community is a good place to live," 70% of respondents strongly agreed and agreed ($n = 338$). Of those who strongly agreed, 37% were one-parent families and 63% were two-parent families. Fifty-four percent were male-headed households and 46% were female-headed households. This suggests that two-parent families and males have higher levels of agreement. Of those with less than a high school diploma, 31% strongly agreed; of those with a high school diploma, 22%

strongly agreed; of those with some college, 23% strongly agreed; and of those with a college degree, 20% strongly agreed ($n = 298$) (see Table 3.2). Hence, a decrease occurred in strong agreement regarding the community as a good place to live as one's education level rose. Of those in program less than one year, 67% strongly agreed that the community is a good place to live; of those in program one to two years, 26% strongly agreed, and of those in program two to three years, 29% strongly agreed that the community is a good place to live. Thus, there was a trend for decreasing agreement that the community is a good place to live as the number of years participants are enrolled in CHIP increased. This may be because of a heightened awareness regarding the community and potential services and benefits it should provide.

When asked to agree or disagree with the statement, "I have influence over what my community is like," only 6% of respondents strongly agreed ($n = 337$). Eleven percent of male-headed households disagreed, while 21% of female-headed households disagreed. Response to this statement indicates that few CHIP parents felt as if they have community influence and this was true for more female than male-headed households.

Finally, when provided the statement, "If there is a problem in the community, people in the community can get it solved," 51% of the respondents agreed or strongly agreed and

TABLE 3.2
Respondents Who "Strongly Agree" That Their
Community Is A Good Place To Live

Education Level	Percent	Total Respondents
< High School	31.03	116
Diploma or GED	21.92	146
Some college	23.33	30
College Grad.	20.00	5

21% disagreed or strongly disagreed (n = 335) suggesting that over one-half of the CHIP participants believe they have the power to solve community problems.

Framingham Safety Survey

The Framingham Safety survey has a reliability score of .43. When questions 8, 10, 20, and 21 (see Appendix A) were eliminated due to a lack of appropriate response categories, reliability remained low at .42. These are low scores and suggest flaws in the survey and imply caution when interpreting these results.

When parents were asked, "Do you keep small objects out of your children's reach?," 33% of those in program less than one year responded "always" and 33% responded "never"; of those in the program one to two years, 66% responded "always" and 23% responded "never"; of those in program two to three years, 74% responded "always" and 13% responded "never" (n = 335) (see Table 4.0). This illustrates a positive relationship between years in the program and positive safety behavior among the parents. As the number of years in CHIP increased, the more objects were reportedly kept out of children's reach.

When parents were asked if they knew how to keep their child from choking 84% of respondents said "yes" and 16% said "no" (n = 336) (see Figure 7.0). Both one parent and two-parent families responded alike, as did males and females. No apparent interaction existed in this case. However, when asked

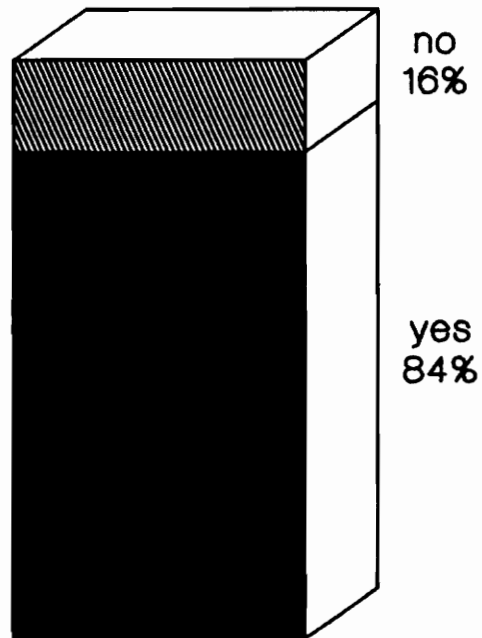
TABLE 4.0

Respondents Who "Always", "Never" &

"Sometimes Keep Small

Objects Out Of Their Child's Reach

Years in CHIP	% who respond "never"	% who respond "sometimes"	% who respond "always"	Total
Less than one year	33.33	33.33	33.33	3
one-two years	22.52	11.45	66.03	262
two-three years	12.86	12.86	74.29	70



Do you know how to keep your
child from choking?

Figure 7.0

if guns or air rifles were kept in the house, there was an interaction among one and two-parent families as well as between male and female-headed households. More female-headed households and one-parent families responded "no." Eighty-nine percent of one-parent families responded "no," while 61% of two-parent families responded "no." Fifty-nine percent of male-headed households responded "no" and 88% of female-headed households responded "no" (n = 338).

When asked, "Has your child had an accident requiring a visit to the doctor or hospital?" 37% of one-parent families said "yes" and 59% said "no." The two-parent families responded 50% ("yes") and 43% ("no") respectively.

Fifty-three percent of the males said "yes" and 37% of the females said "yes" (n = 335). In sum, more males and two-parent families reported having more accidents that required a visit to the doctor or hospital. This differs from other research which says that children of single-parent families are more likely to be injured than children living with both of their natural parents (Rivara and Mueller, 1987). Therefore, it may be questioned whether one-parent families had fewer accidents or whether the accidents actually went unreported.

When asked, "Do you keep household products, medicines and sharp objects out of reach and in locked cabinets?" no significant interaction was observed between one-parent and

two-parent families or male and female-headed households. Eighty-four percent of respondents reported that they have safety caps on all medicines (n = 337) and 87% said that they dispose of all medicines (n = 338) (see Figure 8.0).

Pre/Post Data

Two complete sets of data were obtained on 96 clients. One set of data was completed at program enrollment while the second set was completed during the client recertification phase, which occurs one year after client enrollment. It was hoped that these pre- and post-data would provide an indication of any changes that occur in clients' parenting skills and satisfaction, level of comfortability, safety practices and/or sense of community after being enrolled in the program for one year.

Each respondent's initial total questionnaire score was subtracted from each second total questionnaire score and a t-test was used to determine the probability of a difference between pre- and post scores. Results showed that only one survey's responses had changes at a significant level, falling below a p-value of .05, which allows rejection of the null hypothesis which states that the scores remain unchanged from initial response to post response.

The Framingham Safety survey had a t-score of 3.61 and a significant p-value of .0005. This allows rejection of the hypothesis that the scores did not change.

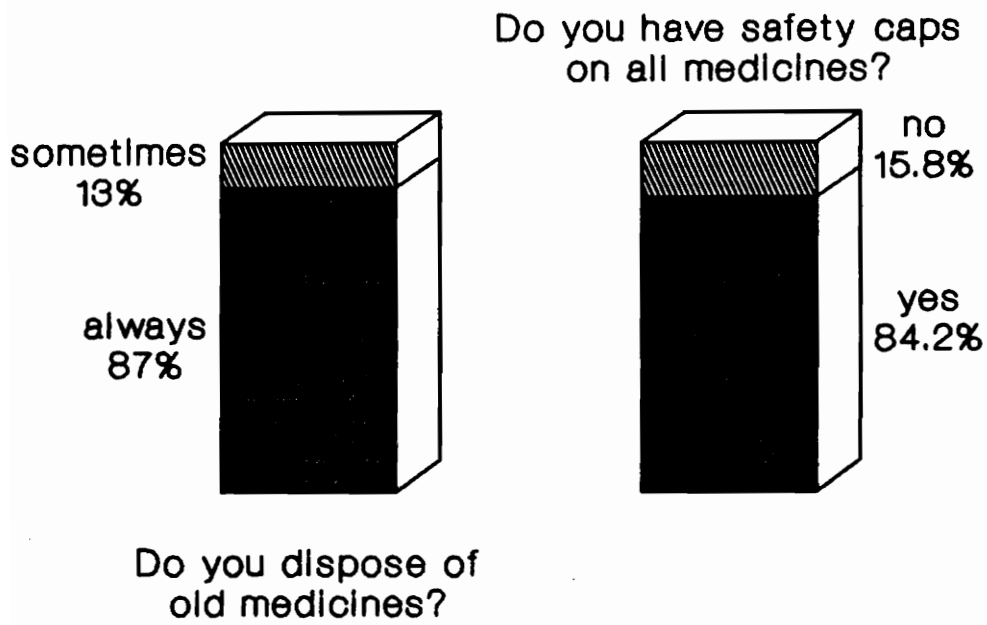


Figure 8.0

For this instrument, participant's scores from the initially administered questionnaire improved when the second (and identical) questionnaire was administered twelve months later.

The following are the respective t-scores and p-values for the remaining surveys: parenting satisfaction (t-score= 1.27; p=.2040), parental involvement (t-score= .41; p=.6795), parental skills (t-score = -.16; p=.8731), and sense of community (t-score = -.32; p=.7477). None of the p-values indicate an improvement or significant change in participant's scores from enrollment to recertification. This may suggest an inadequate offering of parenting services from CHIP, and thus, the lack of improvement. Or, it may point to the complexity of parenting behaviors, and as cited earlier the subjective, situational nature of parenting styles and abilities which makes it difficult to make permanent changes in large groups of parents.

In examining the five questionnaires in their entirety, both positive and negative parenting and family characteristics of the CHIP participants were observed.

Parents rated themselves very high in their parenting satisfaction and scored very high on their level of parenting comfortability. On the surface this may seem optimistic and could be a reflection of the interventions that families receive. However, discussions with CHIP outreach workers revealed that many parents who do a poor job of parenting tend

to believe themselves very capable and good parents and rate themselves very high on the instruments, while those parents who do a sound job of parenting tend to be more critical of themselves and rate themselves lower on the instrument scales. Thus, the high marks for parenting satisfaction and level of comfortability may be misleading. Self-reporting is one barrier with the use of surveys and may indicate the necessity for other methods of evaluation such as observation and qualitative studies.

The Sense of Community inventory revealed some meaningful data. It indicated that very few CHIP participants have a strong sense of community. As suggested earlier, perhaps CHIP is not comprehensive enough to alter sense of community, nor may this be a primary goal of the CHIP staff. Certainly, many factors including self-confidence, available community resources, housing, and neighborhood safety influence one's sense of community and CHIP staff may not have the manpower or resources to effectively address this need.

The Framingham Safety survey indicated that CHIP parents follow safe family practices. Results demonstrated that for many practices an improvement is seen the longer the client remains enrolled in CHIP. However, this questionnaire has the lowest reliability coefficient of all five instruments and its results should be reviewed with caution.

CHAPTER V

Conclusion and Recommendations

As stated earlier, evaluation is critical for CHIP's continued funding and for ensuring that the program is meeting clients' needs. Thus, examining the parental surveys is an invaluable means of determining how the parents perceive themselves as parents and for ascertaining their skill level and level of comfortability. The following represent this author's recommendations and conclusions and are based upon data analysis and work on this project over the course of one year.

The parenting surveys uncovered significant information about the parents in this program. The Parenting Satisfaction survey indicated that parents are extremely satisfied with being parents. The Parenting Skills and Involvement inventories also indicated that parents are comfortable in their parenting skills and have high levels of involvement with their children.

Some of the questions on the surveys can be isolated to demonstrate an interaction with demographic information. For example, the amount of time reading a book did decrease as the education level of the respondent decreased, as did parents' level of comfort with helping their children solve problems. However, this and other examples cited in the previous chapter

tend to be isolated and there was not an apparent trend for this to be true on all questions on all surveys as is suggested by Chilman's (1968) research. Parenting dynamics may be so situational, as suggested earlier, that trends associated with income levels, educational levels, or gender are non-existent (Grusec and Kuczynski, 1980) for this population. In addition, one might attribute CHIP's interventions and quality services for the overall positive results for all participants.

The Sense of Community survey indicated a poor sense of community for the parents. While it may not be in the scope of CHIP services to modify this dimension, the low overall scores should be a cause for concern. If CHIP staff do determine that this is an important program component, then new interventions should be implemented to address this apparent deficit.

The Framingham Safety survey indicated a very safe group of parents. This is expected from a group of older parents who are almost equally divided between one and two-parent families. However, the reliability on this scale was poor and these results should be considered with discretion.

Modification of Questionnaires

There were several questionnaire design problems that presented difficulty. The first being the ladder on the Parenting Satisfaction inventory (see Appendix A). Many participants were confused by the placement of this ladder on

the page and actually marked their responses on the ladder rather than beside the question as the directions indicate. I suggest eliminating the ladder and developing a likert-type scale for all five questions rather than two scales as currently exists. There would then be only one scale for this entire survey which would eliminate some confusion. I would also suggest a "not applicable" option for questions two and three which ask about parenting one and three years ago. Some parents are new parents and did not have children during the times put forth, thus making the questions inappropriate. This new option would allow those new parents to respond but not code an inaccurate response.

The second questionnaire which presented problems was the Framingham Safety survey. Not only is the reliability score low on this survey, but many questions are not suitable for CHIP clientele. Some questions include issues about yard safety with lawn mowers and wild plants, yet many of these parents live in city apartments and don't deal with this problem(s). Another similar question asks about safety practices at the entrance of stairways, yet it does not provide a place to respond if one does not have stairs. Some questions also refer to very small children, yet the CHIP program serves children up to the age of seven, making some of the questions inappropriate for those parents with older children. Unfortunately the survey does not offer an "other"

category to write in responses or a "not applicable" option. Thus, some participants fail to respond or just circle a category, believing they must answer, even if incorrectly. Perhaps CHIP staff could create an inventory that asks more suitable questions. I also suggest that this questionnaire be shorter. The participants are asked to respond to many questions and shortening this questionnaire might expedite the entire process and ensure the completion of all five questionnaires.

I also recommend the use of other techniques for the measurement of parental dimensions. As noted earlier, this population may have a tendency to "over rate" themselves on many of the questions which skews results. Also, some participants may arbitrarily mark responses. In addition, because a questionnaire is dependent upon self-rating, objectivity can be lost. Thus, supplementing the surveys with qualitative interviews or observations might provide a clearer, more accurate picture of the dynamics exhibited by these parents.

Establishing Administration Protocol

There is a great deal of confusion among outreach workers as to the proper administration of questionnaires and this confusion must be resolved. As cited earlier, some questionnaires are mailed and others distributed during home visits. While the distribution with home visits tends to

elicit the most responses, consistency using either pattern is essential. In addition, some outreach workers are providing assistance with question clarification and others are not. Again, this indicates the need for consistent procedures each time a questionnaire is distributed. I recommend the distribution of the questionnaires during home visits with the assistance of outreach workers. An illiterate parent does not imply a parent who doesn't put safety caps on medicines or one who doesn't know his neighbors. Since these are some of the dimensions that we are trying to ascertain, we wouldn't want to penalize those who have reading difficulties.

The questionnaires must also be given as close to the designated times as possible. One set of questionnaires should be distributed at enrollment and the same set given again during the one year recertification phase. This will ensure that evaluators have data on families before interventions begin and thereafter at one year intervals. This will assist future researchers in establishing cause and effect relationships between the program and parental behaviors.

Data Collection

It is important to obtain information on all families participating in the program. While the sample size for this study was fairly large ($n = 339$) there were 159 surveys that were incomplete and could not be used and 52 files which contained no surveys at all. In addition, for 35 participants,

no demographic information could be collected. CHIP staff need to update and obtain the demographic information regularly and work with clients to guarantee the completion of their surveys so that parts of the questionnaires are not left blank. Accurate and current record keeping would facilitate future work on this project and other projects which might require the demographic information on survey responses.

Future Studies

I would recommend that this study be replicated on an annual basis and data analysis conducted yearly. A longitudinal study is important in following the progress of families and it would be a means for determining direct links between parenting behaviors and enrollment in CHIP. A control group would also be essential for determining cause and effect relationships. As future analysis is completed, programs could be modified and new interventions introduced. Questionnaires could be refined and developed as the data indicated. As mentioned earlier, I would also recommend that future studies utilize other means of measurement such as observation or qualitative interviews to address some of the limitations that are encountered with the use of questionnaires.

Summary

In sum, the following highlight the conclusions and recommendations based on data collection and analysis.

Conclusions:

- Parents report a high level of satisfaction with their parenting skills.
- Parents report a total and overall low sense of community.
- Parents report being very involved with their children.
- Parents report that they follow good safety practices.
- All results should be interpreted cautiously as the information is self-reported.
- Some parents may have a tendency to overrate themselves.

Recommendations:

- Longitudinal studies with control groups should be conducted annually to demonstrate any cause and effect relationship that exists between parental behaviors and program enrollment.
- Data collection procedures by outreach workers should be refined and consistent.
- The Framingham Safety survey should be revised by CHIP staff who know key and pertinent safety questions to ask.
- Other measures should be implemented to determine parental behaviors. These may include observation or qualitative interviews.

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Appendix A - Questionnaires

Name of Family: _____

Parenting Satisfaction

Here is a picture of a ladder. At the bottom of the ladder represents the worst parent that you could expect to be. The top of the ladder is the best parent that you could expect to be. Most of us fall somewhere in between these extremes.

Best	9	
	8	
	7	
	6	
	5	
	4	
	3	
	2	
Worst	1	

Place a number to the left of each question below showing where on the ladder best answers the question.

_____ Where on the ladder would you place your parenting level of comfort in parenting skills at present.

_____ Where would you place your parenting a year ago?

_____ Where would you place your parenting 3 years ago?

_____ Where do you expect your parenting to be in 5 years?

Overall, how satisfied are you about being a parent?

5	4	3	2	1
Very				Very
Satisfied				Dissatisfied

Name of Family: _____

Parental Involvement Survey

Please answer the following questions with respect to your son or daughter.

The following questions should be answered with the following scale:

 1 = Never; 2 = Once a year; 3 = Monthly; 4 = Weekly; 5 = Daily.

- | | | | | | |
|--|---|---|---|---|---|
| 1. How often do you spend time with your child in sports or athletics? | 1 | 2 | 3 | 4 | 5 |
| 2. How often do you and your child go for a walk together? | 1 | 2 | 3 | 4 | 5 |
| 3. How often do you and your child do outdoor activities together? | 1 | 2 | 3 | 4 | 5 |
| 4. How often do you and your child go on vacations together? | 1 | 2 | 3 | 4 | 5 |
| 5. How often do you and your child visit relatives? | 1 | 2 | 3 | 4 | 5 |
| 6. How often do you instruct your child in some skill/activity? | 1 | 2 | 3 | 4 | 5 |
| 7. How often do you and your child participate in purchased activities (e.g. concerts, sporting events, going out to dinner) together? | 1 | 2 | 3 | 4 | 5 |
| 8. How often do you and your child talk about day-to-day things? | 1 | 2 | 3 | 4 | 5 |
| 9. How often do you and your child eat together at home? | 1 | 2 | 3 | 4 | 5 |
| 10. How often do you and your child watch TV together or engage in some other spontaneous activities at home? | 1 | 2 | 3 | 4 | 5 |
| 11. How often do you read a book with your child? | 1 | 2 | 3 | 4 | 5 |
| 12. How often do you play a game with your child? | 1 | 2 | 3 | 4 | 5 |
| 13. How often do you go to the store with your child? | 1 | 2 | 3 | 4 | 5 |
| 14. How often do you involve your child in church activities? | 1 | 2 | 3 | 4 | 5 |
| 15. How often do you tell your child safety rules? | 1 | 2 | 3 | 4 | 5 |

Name of Family: _____

Parental Skills Inventory

Please provide a rating for each of the items below, indicating how competent you feel about your abilities in these areas.

- 5 = very comfortable
- 4 = fairly comfortable
- 3 = somewhat comfortable
- 2 = not very comfortable
- 1 = not at all comfortable

How do you feel about your ability to . . .

1. care for your children when they are sick or upset?	5	4	3	2	1
2. help your children solve problems?	5	4	3	2	1
3. provide adequate time for your children?	5	4	3	2	1
4. be a good parent?	5	4	3	2	1
5. provide emotional support for your children?	5	4	3	2	1
6. maintain a close relationship with your children?	5	4	3	2	1
7. provide a good role model for your children?	5	4	3	2	1
8. discipline your children?	5	4	3	2	1
9. give advice to your children?	5	4	3	2	1
10. meet the needs of your children?	5	4	3	2	1
11. make and keep rules for your children's behavior?	5	4	3	2	1
12. be able to get needed resources for your children?	5	4	3	2	1

Family Name: _____

Sense of Community

For each of the following I'd like you to tell me how you feel about your home or community.

	<i>Strongly Agree</i>	<i>Agree</i>	<i>Don't Agree or Disagree</i>	<i>Disagree</i>	<i>Strongly Disagree</i>
1. I think my community is a good place for me to live	1	2	3	4	5
2. People in my community share the same values	1	2	3	4	5
3. My neighbors and I want the same things from this community	1	2	3	4	5
4. I can recognize most of the people who live in my community	1	2	3	4	5
5. I feel at home in this community	1	2	3	4	5
6. Very few of my neighbors know me	1	2	3	4	5
7. I care about what my neighbors think of my actions	1	2	3	4	5
8. I have influence over what this community is like	1	2	3	4	5
9. If there is a problem in this community people who live here can get it solved	1	2	3	4	5
10. It is very important to me to live in this particular community	1	2	3	4	5
11. People in this community get along with each other	1	2	3	4	5
12. I expect to live in this community for a long time	1	2	3	4	5

FRAMINGHAM SAFETY SURVEY From Toddlers through School (Part 1)



SAFETY IS YOUR BEST PRESCRIPTION

Name _____ Date _____

Please X through one answer

- | | | | |
|---|------------------------------|--------------------|-----------------|
| 1. Do you leave your child alone in the house? | Frequently | Occasionally | Never |
| 2. Are any of your babysitters less than 13 years old? | Yes | No | Don't know |
| 3. Do you keep plastic wrappers, bags and balloons, peanuts and other small objects out of the reach of your children? | Always | Sometimes | Never |
| 4. Do you know how to prevent your child from choking? | Yes | No | |
| 5. Do you have mechanical garage doors or hideaway beds? | Yes | No | |
| 6. Do you keep guns or air rifles in your house? | Yes | Don't know | No |
| 7. Are your window screens or guards in good condition? | All windows | Some windows | None |
| 8. Is your child in the yard while the lawn mower is in use? | Never | Sometimes | Have no mower |
| 9. Do you keep your child in an enclosed area when alone and not being watched by an adult? | Always | Sometimes | Never |
| 10. Do you place gates at the entrance to stairways?
(for children less than 3 years of age) | Always | Sometimes | Never |
| 11. Have any of your children ever had an accident requiring a visit to the doctor or hospital? | Yes _____
How many visits | Don't remember | No |
| 12. Do you check for safety hazards in homes of friends or relatives where your child may play? | Always | Sometimes | Never |
| 13. Do you keep household products, medicines (including aspirin and iron) and sharp objects out of reach and in locked cabinets? | Always | Sometimes | Never |
| 14. Do you dispose of old medicines? | Always | Sometimes | Never |
| 15. Do you store household products in empty soda bottles, glasses or jars? | Always | Sometimes | Never |
| 16. Do you have safety caps on all bottles of medicine? | Always | Sometimes | Never |
| 17. Does your child chew on paint chips or windowsills? | Frequently | Occasionally | Never |
| 18. Do you have Ipecac in the house? | Yes | Don't know | No |
| 19. Do you know how to use Ipecac? | Yes | No | |
| 20. Have you checked your yard and house for poisonous plants and wild mushrooms? | Yes | No | |
| 21. How frequently do you check the heating system in your home? | Never | At least once/year | Every few years |



American Academy of Pediatrics

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Appendix B - Demographic Collector Sheet

FAMILY NAME: _____

FAMILY # _____

SINGLE PARENT FAMILY: 1 TWO-PARENT FAMILY: 2

FAMILY HEAD: MALE: 1 FEMALE: 2

AGE OF FAMILY HEAD: 15-18 YRS: 1 19-21 YRS: 2
22-30 YRS: 3 31-45 YRS: 4
>45 YRS: 5

ED. LVL. FAMILY HEAD < HS GRAD: 1
HS GRD OR GED: 2
SOME COLLEGE: 3
COLLEGE GRAD: 4
POST GRAD: 5

EMPLOYED: 1
UNEMPLOYED: 2

AVERAGE INCOME LEVEL: < \$6,000: 1
\$6-10,999: 2
\$11-15,999: 3
\$16-20,999: 4
\$20-25,999: 5
\$>26,000: 6

OF CHILDREN IN FAMILY: 0-1: 1
2-3: 2
4-5: 3
5 OR > 4

YEARS IN CHIP: <1: 1
1-2: 2
2-3: 3

Appendix C - Opscan

VIRGINIA TECH

LEARNING RESOURCES CENTER

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	
3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	
4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	
5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	
6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	
7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	
8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	
9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

USE NO. 2 PENCIL ONLY

1	0	1	2	3	4	5	6	7	8	9
2	0	1	2	3	4	5	6	7	8	9
3	0	1	2	3	4	5	6	7	8	9
4	0	1	2	3	4	5	6	7	8	9
5	0	1	2	3	4	5	6	7	8	9
6	0	1	2	3	4	5	6	7	8	9
7	0	1	2	3	4	5	6	7	8	9
8	0	1	2	3	4	5	6	7	8	9
9	0	1	2	3	4	5	6	7	8	9
10	0	1	2	3	4	5	6	7	8	9
11	0	1	2	3	4	5	6	7	8	9
12	0	1	2	3	4	5	6	7	8	9
13	0	1	2	3	4	5	6	7	8	9
14	0	1	2	3	4	5	6	7	8	9
15	0	1	2	3	4	5	6	7	8	9
16	0	1	2	3	4	5	6	7	8	9
17	0	1	2	3	4	5	6	7	8	9
18	0	1	2	3	4	5	6	7	8	9
19	0	1	2	3	4	5	6	7	8	9
20	0	1	2	3	4	5	6	7	8	9
21	0	1	2	3	4	5	6	7	8	9
22	0	1	2	3	4	5	6	7	8	9
23	0	1	2	3	4	5	6	7	8	9
24	0	1	2	3	4	5	6	7	8	9
25	0	1	2	3	4	5	6	7	8	9
26	0	1	2	3	4	5	6	7	8	9
27	0	1	2	3	4	5	6	7	8	9
28	0	1	2	3	4	5	6	7	8	9
29	0	1	2	3	4	5	6	7	8	9
30	0	1	2	3	4	5	6	7	8	9
31	0	1	2							

Appendix D - Indicator Sheet

CHIP PARENTAL SURVEYS

	Yes or No	Date taken from folder
Completed at enrollment		
Completed at recertification 1		
Completed at recertification 2		
Completed at recertification 3		
Completed at recertification 4		
Completed at recertification 5		
Completed at recertification 6		
Completed at recertification 7		
Completed at recertification 8		

VITA

Tracy D. Mitchell was born September 3, 1965 in Charlottesville, Virginia to her parents Claude and Hattie Mitchell. She attended Western Albemarle High School and entered Virginia Tech in the fall of 1983 as an undergraduate. She received a Bachelor of Arts in Communication Studies in 1987. The following year she returned to Virginia Tech and earned secondary teaching endorsements in English, Theater Arts, Speech, and Drama. In the fall of 1990 she returned to Virginia Tech as a Graduate Student in Community Health Education. Her degree requirements were completed May, 1992. Her work experience includes a graduate teaching assistantship, public relations, and public service at various campus offices including the Department of Recreational Sports where she is most recently employed. Her interests include animals, hiking, and running.

A handwritten signature in cursive script that reads "Tracy D. Mitchell". The signature is written in dark ink and is positioned below the main body of text.