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Development and Testing of the Home Safety and Beautification Checklist with Mothers Referred for Child Neglect and Substance Abuse

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DEVELOPMENT AND TESTING OF THE HOME SAFETY AND
BEAUTIFICATION CHECKLIST WITH MOTHERS REFERRED
FOR CHILD NEGELCT AND SUBSTANCE ABUSE

By

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Bachelor of Arts in Psychology
University of California, Santa Barbara
2008

A thesis submitted in partial fulfillment of the requirements for the

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ABSTRACT

Development and testing of the Home Safety and Beautification Checklist with mothers referred for child neglect and substance abuse

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Unintentional injury is the leading cause of death among children in the United States accounting for nearly 40 percent of deaths in this age group (CDC, 2012a).

Approximately 50 percent of nonfatal injuries, and 40 percent of fatalities, occur in and around the home (Safe Kids Worldwide, 2004). Elevated rates of child injury in the home environment are associated with parental substance abuse and neglectful behaviors.

Childhood injuries are preventable, yet practical and cost-effective measures to identify child home safety risks are limited. This study involved a retrospective preliminary examination of the Home Safety and Beautification Checklist (HSBC) in a sample of drug-abusing mothers referred by Child Protective Services for child neglect (N = 77).

The HSBC assesses child safety hazards and cleanliness and aesthetic problems in the home, and was implemented by trained assessors as part of a baseline assessment in a larger treatment outcome study. In doing so, assessors rate rooms in the home on nine categories designed to evaluate safety (toxins, electrical, sharp objects, food and nutrition needs, home access/security, heavy/tipsy objects, small objects, problems with air quality, and other), and two categories designed to evaluate cleanliness (needs clean-up and aesthetic needs). The participants also provide ratings of the safety and appearance of each room in their homes. This study was conducted to expand the current literature on

practical measures to identify child home safety and appearance problems. Specifically, it examined the psychometric properties of the HSBC utilized to detect the severity of child safety hazards and aesthetic concerns when implemented in the at-risk homes of mothers referred for substance abuse and child neglect. Overall, it was determined that the HSBC had good psychometric properties and its development is a particularly useful outcome of this research.

TABLE OF CONTENTS

ABSTRACT.....	iii
LIST OF TABLES.....	vi
CHAPTER 1: BACKGROUND.....	1
Relationship Between Child Neglect and Unintentional Injuries.....	1
Purpose of the Present Study.....	4
CHAPTER 2: LITERATURE REVIEW.....	6
CHAPTER 3: METHODS.....	16
Participants.....	16
Measures.....	17
Procedures.....	21
CHAPTER 4: RESULTS.....	22
Phase 1.....	22
Phase 2.....	25
Phase 3.....	29
Phase 4.....	30
CHAPTER 5: DISCUSSION.....	34
Conclusions.....	39
Study Implications.....	41
Limitations and Future Directions.....	42
APPENDIX A: Assessment of Home Safety and Beautification Procedure.....	52
FORM A: Assessor Prompting List for Home Safety and Beautification Tour....	69
FORM B: Home Safety and Beautification Profile Form.....	75
FORM C: HSBC Rating Form and “Other Room” Rating Form.....	76
FORM D: Common Home Safety and Beautification Problems and Solutions...	82
REFERENCES.....	87
CIRRICULUM VITAE.....	98

LIST OF TABLES

Table 1. <i>Exploratory Factor Analysis Results for Room Safety and Appearance Item</i>	43
Table 2. <i>Room Safety and Appearance Correlations</i>	44
Table 3. <i>Room Safety Multiple Regression</i>	45
Table 4. <i>Room Appearance Multiple Regression</i>	46
Table 5. <i>Correlations Between Assessor and Participant Room Safety Ratings</i>	47
Table 6. <i>Correlations Between Assessor and Participant Room Appearance Ratings</i>	48
Table 7. <i>Correlations with CAPI Abuse</i>	49
Table 8. <i>Multiple Regression for Safety Subscale</i>	50
Table 9. <i>Multiple Regression for Appearance Subscale</i>	51

Development and testing of the Home Safety and Beautification Checklist with mothers referred for child neglect and substance abuse

CHAPTER 1

BACKGROUND

Relationship Between Child Neglect and Unintentional Injuries

Historically, studies specific to “child neglect” and “unintentional injuries” were conducted in separate disciplines with different construct conceptualizations and little overlap (Liller, 2001). However, during the past several decades these research areas have benefited by a more unified approach as a result of evidenced parallels between both forms of harm (Peterson & Brown, 1994). The unique relationship between child neglect and unintentional injuries is best understood through research illuminating that the majority of child fatalities officially recorded as injury, are actually the result of neglect (Ewigman, Kivlahan, & Land, 1993; Landen, Bauer, & Kohn, 2003). Extreme neglect by the caregiver contributes to unintentional deaths, including fire risks, drowning, and poisonings. Additionally, 9% of admissions to pediatric burn units are estimated to be a result of neglect (Chester, Jose, Aldlyami, King, & Moiemmen, 2006). Childhood injury as a function of child neglect is most commonly evidenced in the homes of victimized children (DePanfilis, 2006; DHHS, 2012, Metchikian, Mink, Bigelow, Lutzker, & Doctor, 1999). Regardless of intentionality, physical neglect is often indicated if a child sustains an injury as the result of a hazardous home environment (Watson-Percel, Lutzker, Greene, & McGimpsey, 1988) because caregivers are assumed to have failed to use available devices to protect their children (DePanfilis, 2006). For instance, the basis for referring parents for services for child neglect is often the result of poorly kept home

environments with various child safety hazards (Tertinger, Greene, & Lutzker, 1984). For instance, one study revealed several home factors directly indicative of child neglect: an unsafe environment, human and animal excrement in the home, and little availability of food (Lewin & Herron, 2007).

Notably, parental substance abuse and misuse is one of the most consistent predictors of childhood injury as a function of child neglect, aside from poverty. In fact, there is a direct association between parental substance use disorders and child neglect (Dunn et al., 2002; Tyler, Allison, & Winsler, 2006). Studies estimate between 40% and 80% of substantiated maltreatment cases involve children of substance-abusing parents, with the chance of neglect at 4.2 times more likely if the parent abuses drugs or alcohol (Young, Gardner, & Dennis, 1998). Low-income families, whom are already at higher risk, have a concomitant risk for neglectful behaviors if there is substance use exposure within the family (Ondersma, 2002). In a study by Merikangas, Rounsville, & Brusoff (1992), the association between parental substance use and child neglect remained strong even after controlling for social support, depression, and antisocial personality disorder, factors frequently observed in conjunction with a substance use disorder. Children of adult substance abusers are at a four times greater risk for child neglect (Reid, Macchetto, & Foster, 1999), and seven out of ten cases of child abuse and neglect are exacerbated by parental substance abuse.

In a study by Schnitzer and Ewigman (2008), most fatal child injuries were sustained as a result of a lack of adult supervision in the home or placement in an unsafe sleeping environment. Parental substance abuse increases risk of child injury through inadequate supervision and care. As a result of increasing concerns about the negative

effects of parental substance use on a child's well-being, virtually all states have expanded their child protection statutes to include child exposure to illegal drug activity in the home environment as a form of maltreatment (Young et al., 2009). Additionally, many state statutes dictate that the possession of any controlled substance while in the presence of a child is a felony (DHHS, 2011b).

It is clear that parental negligence in protecting children from unsafe environments is exacerbated by parental substance abuse. The development of a comprehensive safety program for families at risk for CAN has been recommended for almost three decades (Tertinger et al., 1984). Furthermore, there is great consensus among researchers that evidence-based approaches for child neglect are greatly lacking as compared to other forms of maltreatment (Chaffin & Friedrich, 2004). There is a great need for development and evaluation of screening measures to identify unsafe homes and contribute directly to the prevention of deleterious injuries (Towner & Mytton, 2009; Schnitzer & Ewigman, 2008). Barth et al. (2008) assert research on 'best practices' could help identify innovations in areas such as screening and assessment for use between services such as CPS, the courts, and other social services or treatment agencies. Best practices are also a key aspect of a public health approach to the endemic of childhood injuries and with the intention of suitability for widespread adoption (CDC, 2012a). Identification of child safety risks in the home will also increase recognition of these injuries as preventable, and will likely lead to increased use of child safety devices in homes (CDC, 2012a).

Programs intended to prevent CAN have developed screening methods to identify parents at high risk of maltreating their children through identified risk factors, such as

income level, substance abuse, readiness or motivation to change (Gelles, 2001), and other demographic criteria. However, their poor specificity and low positive predictive value, combined with the potential stigmatizing effects of false-positive identifications greatly restrict their application (Peters & Barlow, 2005). Nonetheless, hazard observations collected while assessing a home provide a proxy of parental safety behaviors (Glik, Greaves, Kronenfeld, & Jackson, 1993). To more efficiently prevent unintentional childhood injuries, directly assessing existing and potential safety hazards in the home is a necessary step in the determination of appropriate services (Gilbert et al., 2009a).

Purpose of the Present Study

The proposed study will initially examine the psychometric properties of a child home hazard and appearance checklist for use in the homes of mothers evidenced to neglect their children and abuse illicit substances. The Home Safety and Beautification Checklist (HSBC; Donohue, Miller, Van Hasselt, & Hersen, 1998) was originally developed to assess for child injury risks and appearance concerns in the home, and will be examined in the proposed study as an administered baseline assessment within a randomized controlled trial involving mothers recommended for treatment for child neglect and drug abuse. A trained assessor and participating mother, separately, rate each room of the home regarding its safety and appearance for children living in the home. Assessors are assisted in determining overall room ratings after a variety of HSBC categories are considered for each room (i.e. toxins, electrical hazards, sharp objects, adequate food & nutrition, home access/security, heavy/tipsy objects, small objects,

adequate temperature control, other risks, needs clean up, aesthetic needs). Although the HSBC appears to have good face validity, its validity and reliability remain untested.

Because of the high prevalence of unintentional childhood injuries in homes and an elevated risk of home hazards for parents referred for child neglect, particularly when parents use illicit drugs, the goal of this study is to examine the psychometric properties of a home safety identification checklist. To assist in real-world application, this measure was examined as a pre-treatment assessment within the context of a comprehensive evidence-based treatment program (e.g., six months of FBT or the control condition of treatment as usual). The following research questions (RQ) will be investigated in this study:

RQ1: What is the relationship between the scores on safety items and the room safety ratings, and the scores on appearance items and the room appearance ratings?

RQ2: What is the factor structure of the room ratings?

RQ3: What is the relationship among ratings of each room in the home?

RQ4: What is the relationship between room ratings and overall ratings of the home?

RQ5: How related are the assessor ratings with the participant ratings for safety and appearance of each room in the home?

RQ6: Is there a relationship between the safety and appearance of a home and the potential for child abuse or the type of perpetrated neglect?

RQ7: What is the relationship between frequency of drug or alcohol use and the safety or appearance of the home?

CHAPTER 2

LITERATURE REVIEW

In the United States alone, more than 3 million referrals of child maltreatment are received annually, amounting to nearly 6 referrals every minute (Department of Health and Human Services [DHHS], 2011b). However, the number of children affected by maltreatment and the extent of the impact on normal child development is largely unknown. The literature on child maltreatment consistently indicates child maltreatment is underreported (Fallon et al., 2010; Gilbert et al., 2009a; MacMillan, Jamieson, & Walsh, 2003). Estimates of official rates for substantiated maltreatment of children constitute less than a tenth of the actual burden (Gilbert et al., 2009b). Among the reasons for underreporting of the abuse and neglect of children is fear, stigma, lack of awareness of the signs of maltreatment and the processes for reporting to authorities, the perception that reporting may do more harm than good, and societal acceptance of this type of violence in many countries (Gilbert et al., 2009a; Pinheiro, 2006).

Child maltreatment is alternatively referred to as child abuse and neglect (CAN), and encompasses four main categories: physical abuse, emotional/psychological abuse, sexual abuse, and neglect or negligent treatment of children with the potential to result in harm (Butchart, Phinney, Kahane, Mian, & Furniss, 2006; DHHS, 2011b; Tyler et al., 2006). These categories are defined by state legislation and are based on minimum standards set forth by federal law. The Child Abuse Prevention and Treatment Act (CAPTA), reauthorized in 2010, defines child abuse and neglect at a minimum: “Any recent act or failure to act on the part of a parent or caretaker which results in death,

serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm.”

The categories comprising CAN are frequently treated as separate entities in the literature. Separately, child neglect is defined as a failure by the parent or caretaker to provide food, clothing, shelter, medical care, or appropriate supervision to such a degree that the safety, health, and general well-being of the child is threatened (DHHS, 2011b). Physical abuse is defined as any unintentional physical injury or any action towards the child that results in physical impairment (e.g., kicking, striking, burning, and biting). The definition of this type of abuse in approximately 38 States also includes circumstances that threaten harm or create substantial risk of harm to the child. All States have some definition of sexual abuse as child abuse, with some States using general terms while others specify sexual acts that constitute abuse. Additionally, most jurisdictions include sexual exploitation as one element of the definition of sexual abuse, referring to allowing or coercing a child to engage in the production of pornography or in prostitution (CAPTA Reauthorization Act of 2010). Nearly all States include language defining emotional injury to a child as abuse. Typical language for emotional abuse includes, “injury to the emotional stability of the child as evidenced by an observable or substantial change in behavior, emotional response, or cognition,” and injury as “withdrawal, depression, anxiety, or aggressive behavior” (DHHS, 2011b).

Each year among high-income countries, approximately 4% to 16% of children are physically abused, 10% are psychologically abused, 1% to 15% are neglected (Gilbert et al., 2009b), and reported childhood sexual abuse ranges tremendously from 2% to 62% (Butchart et al., 2006). Reported incidences of maltreatment can be broken down

categorically, for instance in the year 2011 more than 75% suffered from neglect (78.5%), followed by physical abuse (17.6%), then sexual abuse (9.1%).

One consequence of CAN is the significant economic cost incurred for society, with immediate costs (e.g., trauma treatment) and long-term costs (e.g., mental health care) estimated at over \$80 billion annually in the United States alone (Gelles & Perlman, 2012). One analysis (Rovi, Chen, & Johnson, 2004) demonstrated that financial costs for children hospitalized as a result of CAN incurred considerable costs in comparison to that of other children. The average cost was estimated at \$10,000 more per hospitalization for the abused or neglected group. Individual economic costs are incurred by adults with a history of CAN as they are 14% less likely to be employed and significantly less likely to have a bank account, a vehicle, or a home (Currie & Widom, 2010).

Child maltreatment substantially contributes to child mortality and morbidity and has immediate and enduring effects on physical health, mental health, and social and behavioral functioning for victims of CAN (Gilbert et al., 2009b). In 2011, 1,570 children reportedly died due to child abuse and neglect, with an overall rate of 2.10 deaths per 100,000 children (DHHS, 2012). These children are also nearly 9 times more likely to die during hospitalization (Rovi, et al., 2004). The exposure to maltreatment in childhood is a risk factor for a range of behaviors or disorders that, in turn, are related to other major health problems (e.g., smoking, obesity, risky sexual behavior, depression; Felitti et al., 1998; Gilbert et al., 2009b).

Additionally, exposure to CAN has significant effects on children that persist into adulthood. In one long-term study, Silverman, Reinherz, and Giaconia (1996) found that nearly 80 percent of young adults that were abused in childhood met diagnostic criteria

for one or more psychiatric disorders by age 21. The problems experienced include antisocial and borderline personality traits, anxiety, eating disorders, depression, criminal behavior, risky sexual behavior, drug and alcohol misuse (Gilbert et al., 2009b), suicide attempts, and violent behaviors (Schore, 2003). Additionally, early maltreatment experiences may alter a child's ability to interact positively in interpersonal relationships due to changes in the brain's neurochemical balance. More immediate psychological consequences of CAN include anger, attention-deficit hyperactivity disorder, depression, dissociative disorders, panic disorder, posttraumatic stress disorder, and reactive attachment disorder (De Bellis & Thomas, 2003; Springer, Sheridan, Kuo, & Carnes, 2007; Teicher, 2000). The high burden and deleterious long-term consequences of maltreatment warrant increased investment in preventative strategies from early childhood (Gilbert et al., 2009b).

Child neglect has consistently been the most frequently indicated form of child maltreatment (HHS, 2012) with 531,413 cases of neglect reported in a single year (i.e., 2011). Physical neglect is the most prevalent form of child neglect accounting for up to 57% of neglect (Sedlak & Broakhurst, 1996), and impacting an estimated seven of every 1,000 children in the U.S. (DePanfilis, 2006). The most common categories of neglect include physical (inadequate supervision, household safety, nutrition, clothing), medical (lack of appropriate medical care), educational (failure to provide academic materials or attendance to school), and emotional (failure to provide adequate support and affection; see Cowen, 1999; Scannapieco & Connell-Carrick, 2002). Given the high prevalence of neglect as a type of maltreatment, it is imperative for research to continue to illuminate the many factors associated with the identification and prevention of child neglect.

Child neglect is at least as damaging as physical or sexual abuse in the long term, but has received the least scientific and public attention (Gilbert et al., 2009b). Fatal injury is the most tragic consequence of child neglect, with a variety of non-fatal health detriments as a more common outcome of this type of maltreatment (DePanfilis, 2006; DHHS, 2012, Metchikian et al., 1999). For instance, there is a higher likelihood to suffer from physical ailments in adulthood such as allergies, arthritis, asthma, bronchitis, high blood pressure, and ulcers (Springer et al., 2007). Additionally, neglect in early childhood may cause brain regions to form and function improperly with long-lasting consequences on cognitive, language, social, and emotional mental health (DHHS, 2009). Research by Healy (2004) indicated that children who suffered severe neglect may experience permanent alterations in the way serotonin functions in the brain. Some regions of the brain are chronically stimulated as a result of a child's fear and stress response. Meanwhile, other brain regions involved in abstraction and complex thought are less frequently activated, consequently a child may become less competent in processing with abstract cognitions (Perry & Pollard, 1998). These alterations in brain functioning can have life-long consequences for academic, cognitive, and language abilities (Watts-English, Fortson, Gibler, Hooper, & De Bellis, 2006).

The literature reveals a variety of characteristics that are often present among individuals identified for neglectful treatment of a child. Neglect-related injuries in children are correlated with parental socioeconomic status, low educational achievement, younger age (Schnitzer & Ewigman, 2008), lack of parenting experience, lack of basic parenting knowledge and skills, lack positive social support (Palusci, 2011), mental illness, substance misuse and dependence, and violence between family members

(Butchart et al., 2006). In fact, poverty is a reliable predictor that is most frequently related to neglect (Ondersma, 2002; Sedlak & Broadhurst, 1996), and is considered a principal determinant of neglect (Garbarino & Collins, 1999).

Aside from childhood injuries as a function of neglect, physical hazards in the home in themselves pose a significant threat to the safety of children and can lead to unintentional injuries. Unintentional injury is the leading cause of death among children 1 to 19 years of age in the U.S., accounting for nearly 40 percent of deaths in this age group (CDC, 2012a; Safe Kids Worldwide, 2008). Many of the unintentional injuries leading to death or causing serious and permanent disabilities are preventable (CDC, 2012a), yet each year almost nine million children and teenagers are treated in emergency departments for unintentional injuries, 225,000 are hospitalized, and 9,000 of these injuries prove fatal (CDC, 2012a). The U.S. ranks among the worst of all high-income countries for child injury death rates, with a rate of four times that of countries with the lowest rates, and two times that with the highest rates (CDC, 2012b). Unintentional fatal injuries have not declined at the same rate as other health conditions affecting children in the U.S., and resources to address fatal injuries are not commensurate with the burden it poses to society (CDC, 2012a).

The resulting cost of unintentional injuries to society is estimated at \$87 billion each year (CDC, 2012a). For instance, children playing with fires caused an estimated \$279 million in direct damages in one year (2008), with fire and burn injuries costing society a total of \$7.5 billion each year. Significant financial savings are associated with the use of safety products (CDC, 2012a), for example it is estimated that the installation

and maintenance of smoke alarms in the home could save society \$770 per alarm (Safe Kids Worldwide, 2011).

The treatment of unintentional injuries resulting from a hazardous environment is the leading cause of medical expenses in children. For instance, unintentional poisonings in children under the age of 19 years lead to 300 emergency department visits and two deaths per day in the U.S. (CDC, 2012b). Additionally, 1 out of every 180 two-year-olds is poisoned from improperly secured household medications (Schillie, Shehab, Thomas, & Budnitz, 2009).

The safety of a child's home environment is critically important as the majority of unintentional injuries occur in the home (CDC, 2012a; Danseco, Miller, & Spicer, 2000; Nagaraja et al., 2005; Phelan, Khoury, Kalkwarf, & Lanphear, 2005). Approximately 40 percent of deaths and 50 percent of nonfatal unintentional injuries among children under age 14 years occur in, or in close proximity, to the home (Safe Kids Worldwide, 2004). Between 1992 and 1999, it is estimated that 2,100 children under age 15 died as a result of unintentional injuries occurring in the home (Runyon & Casteel, 2004). The most common injury risks for children in the home environment include suffocation, drowning, poisoning, fires/burns, and falls (CDC, 2012b; Glik et al., 1993; Safe Kids Worldwide, 2004; 2008).

Various factors are associated with an increased likelihood of childhood injuries as a result of home hazards. As anticipated, factors that increase the likelihood of child injury are many of the same factors denoted as contributors to neglectful behaviors. Low socio-economic status is the most reliable predictor of unintentional injury. Disproportionate rates of childhood injury are found among lower-income families as a

result of economic and social reasons including: less economic resources, difficulty obtaining lifesaving medical care, residences in more hazardous environments, lower rates of use of safety devices due to finances or access to devices, and perceived lack of control over living conditions (Miller, Romano, & Spicer, 2000; Safe Kids Worldwide, 2004). Children from low-income families are at four times the risk to drown and five times the risk to die in a fire (Safe Kids Worldwide, 2004). Twenty percent of parents with a yearly household income below \$25,000 cited cost as an obstacle in making the home environment safe for children, while only nine percent of parents with higher incomes cited finances as an obstacle (Safe Kids Worldwide, 2008). Additionally, substandard housing, lack of safe play facilities, exposure to physical home hazards, and limited access to healthcare when injury occurs are subsumed by the aforementioned risk factors (Safe Kids Worldwide, 2004). Other risk factors include residences in rural areas, lack of supervision (Safe Kids Worldwide, 2004), lower maternal age, increased number of persons residing in one household, increased number of children in one household, and single-parenting (CDC, 2012a).

The literature reveals extant formal home hazard assessment measures (Tertinger et al., 1984), with only two of the existing standardized home safety measures demonstrating psychometric support. The Home Accident Prevention Inventory – Revised (HAPI-R; Lutzker, Bigelow, Doctor, & Kessler, 1998) may be utilized to assess hazards in the home environment as part of a home accident prevention program service. The HAPI-R is a comprehensive assessment tool, for use in families evidencing child maltreatment. This measure may be utilized to identify the type, quantity, and child accessibility of hazards identified as leading causes of death in young children (Barone,

Green, & Lutzker, 1986). The HAPI-R is a checklist comprised of 10 categories of common household hazards (e.g., choke, electrical, suffocation). Tertinger et al. (1984) indicated that the HAPI program is impractical for wide-spread use as only highly trained counseling professionals are able to administer the program with families. However, Barone et al. (1986) found trained graduate students were able to employ the HAPI (a predecessor to the HAPI-R) assessment with empirical success in homes that are in need of safety hazard reduction and removal (Lutzker et al., 1998). It was concluded that future research is needed to refine home safety assessment techniques (Barone et al., 1986).

The Home Inventory of Dangers and Safety Precautions – 2 (HIDSP-2; Tymchuk, Lang, Dolyniuk, Berney-Ficklin, & Spitz, 1999) is a validated scale designed to assess frequency of dangers in homes, as well as associated safety precautions. This inventory contains both common dangers accounting for unintentional childhood injuries within the home, and the recommended precautions for use in the remediation of such dangers. The scale is arranged into 14 categories including: fire, electrical, suffocation by ingested object, suffocation by mechanical object, fire arm/weapon, solid/liquid poisons, heavy object, sharp/pointed object, clutter, inappropriate edible, toy/animal, cooking, yard/outdoors, and general dangers. A copy of this inventory was unable to be located in the literature and the author was unresponsive to requests for information on locating it.

A reliable and valid home hazard assessment is a prerequisite in addressing problems in home safety for children. Tymchuk et al. (1999) indicate, “There is a critical need for standardized methods for use in the assessment of home dangers and precautions within healthcare, parenting, and child care.” To design effective intervention or

prevention programs, it is suggested that a functionally operationalized assessment is optimal (Mandel, Bigelow, & Lutzker, 1998; Tymchuk et al., 1999). If specific dangers in the home are identified, then specific prevention and remediation techniques can be provided in a prescriptive manner (Tymchuk et al., 1999). For instance, the HAPI-R is a good example of a standardized home safety assessment measure as it contains 10 hazard categories with one to seven potential items contributing to the risk to child safety. The evaluator then records the number of violations of each safety hazard item and records notes relevant to the hazard. However, this measure falls short of providing any information about the level of severity to child safety afforded by the presence of this hazard. Additionally, there is no standardized information about the presence of such concerns within specific rooms in the home. Lastly, this measure lacks overall scores that provide conclusive information relevant to the overall safety of the home, as well as the safety level of each room in the home. Given the limitations of such available measures, the creation and validation of a home safety assessment would be beneficial, particularly in light of a lapse in research on this type of assessment despite confirmations that this research is of importance.

CHAPTER 3

METHODS

Participants

Participants include 77 adult females referred for treatment of substance abuse and child neglect by the County's Department of Family Services (DFS) after being identified to use illicit drug use within four months prior to the referral date and a documented incident of child neglect. Inclusionary criteria include evidencing a diagnosis of Substance Abuse or Dependence according to results obtained from the Structured Clinical Interview for DSM-IV (SCID-IV; First, Spitzer, Gibbon, & Williams, 1996) administered during baseline assessment, residing with, or the intention to reside with, the neglected child at the time of treatment initiation.

Of the mothers who completed the baseline assessment and qualified for the study, 39 (50.6%) self-identified as Caucasian, 16 (20.8%) as African American, 9 (11.7%) as Hispanic, 3 (3.9%) as American Indian, 2 (2.6%) as Asian American, 2 (2.6%) as Pacific Islander, and 6 (7.8%) as other. Average age was 29 years ($SD = 7.9$ years, range = 18 to 49 years). Marital status was reported as 35 (45.5%) single, 26 (33.8%) cohabitating, and 15 (19.5%) married. The mean for the highest grade achieved was 11.34 ($SD = 1.88$, range = 5 to 16). Reported monthly incomes of the mothers ranged from \$0.00 to \$60,000, with the median income at \$1,150 and the average income at \$2,649. On average, 1.57 minors resided in the home with the average age of the child being 3.79 years. Forty participants (52%) evidenced a SCID-IV diagnosis of current alcohol or drug dependence and 31 participants (40%) evidenced a diagnosis of current alcohol or drug abuse. Fifty-seven participants (74%) evidenced a SCID-IV diagnosis of lifetime alcohol

or drug dependence and 42 participants (55%) evidenced a diagnosis of lifetime alcohol or drug abuse. Thirteen participants (16.8%) evidenced a current dual-diagnosis with the presence of more than one current substance use diagnosis. The most common current SCID-IV substance use disorder diagnosed was Stimulant Dependence (N = 27). The type of substantiated neglect included 35 participants (45.5%) who used drugs while pregnant, 11 participants (14.3%) were found to evidence multiple neglect types, 10 participants (13%) evidenced lack of supervision of the child(ren), 4 participants (5.2%) were cited for physical neglect, three participants (3.9%) for environmental neglect, three participants (3.9%) for exposing the child to drugs after birth, 1 participant (1.3%) for emotional neglect, 1 participant (1.3%) for medical neglect, and three (3.9%) evidenced neglect that was not clear enough for categorization in the other available categories.

Measures

After referral and study consent was obtained, demographic questionnaires and a comprehensive battery of standardized assessments was administered in the homes of participating mothers. For the current study, a smaller battery of standardized assessment measures was selected (see below). A structured interview was utilized to obtain demographic information from participants, including age, ethnicity, income, employment status, educational level, and number and ages of children.

Timeline Followback (TLFB; Sobell, Brown, Leo, & Sobell, 1996; Sobell, Sobell, Klajner, Paven, & Basian, 1986) assesses daily patterns and frequency of use of alcohol, marijuana, and other illicit substances for the preceding 4 months. Memorable events (e.g., holidays, birthdays, work schedules) are marked on month-by-month calendars to facilitate recall of the days in which substances were used. After calendars are

constructed, participants indicate on the calendar which days illicit drugs or alcohol were used, including the specific drug(s) used and the amount. The TLFB has excellent psychometric support (see Carey, 1997). The variables used in this study include number of days using marijuana (Marijuana Use), number of days using hard drugs (illicit drugs other than marijuana; Hard Drug Use), and number days of self-reported alcohol intoxication (Alcohol Intoxication).

The Structured Clinical Interview for DSM-IV (SCID-IV; First et al., 1996) is a semi-structured diagnostic interview instrument to determine DSM-IV-TR Axis I diagnoses. Only the substance abuse and dependence module of the SCID-IV was administered in this study. The substance abuse and dependence module permits diagnosis of substance use disorders associated with a variety of psychoactive substances (e.g., marijuana, methamphetamine, cocaine, PCP). The SCID-IV is designed to be administered in an interview format by a trained mental health professional or assessment technician, and incorporates questions with operational definitions of symptoms corresponding to categorical diagnoses contained in the DSM-IV-TR. For all symptoms queried, the assessor determines whether the symptom is present, sub-threshold, or absent and an algorithm is used to arrive at a final diagnosis. Administrations of this test yield good validity and reliability (Spitzer, Williams, Gibbon, & First, 1992), and it has demonstrated clinical utility in controlled outcome studies involving drug abuse (e.g., Azrin et al., 2001).

The Child Abuse Potential Inventory (CAPI; Milner, Gold, Ayoub, Jacewitz, 1984; Milner, 2006) is a 160-item, forced-choice, agree-disagree format screening measure to assess the potential of a parent to neglect and physically abuse their children.

The measure contains an Abuse Potential scale and six factor scales: Distress, Unhappiness, Rigidity, Problems with Child and Self, Problems with Family, and Problems from Others. Three validity scales detect response distortions: Lie scale, Random Response scale, and Inconsistency scale, and are paired to form validity indexes of Faking-Good, Faking-Bad, and Random Response. If elevations in any of the validity indexes are observed, the abuse score may not accurately represent the behavior it is intended to measure. Abuse Potential scale scores are weighted, and range from 0 to 486, with higher scores indicating greater abuse potential and scores at or above 166 are capable of detecting abuse. Additionally, the CAPI yields factor scores assessing areas known to be closely related to child abuse and neglect (i.e., Unhappiness, Loneliness, Problems with Others, Distress, Rigidity; Milner, 2006). This Inventory is able to discriminate among mothers know to neglect or abuse their children from those who do not (Lutzker et al., 1998; Milner et al., 1984) and has demonstrated extensive psychometric support (Walker & Davies, 2010).

The Home Safety Beatification Checklist (HSBC) was inspired from the Home Accident Prevention Inventory (HAPI: Tertinger et al., 1988). A series of focus groups convened to initially generate of list of potential home safety hazards and factors that would negatively affect the home appearance. All focus groups emphasized a brainstorming analysis, allowing group members the opportunity to reflect and refine their opinions based on discussion and feedback from other group members (Ritchie & Lewis, 2003). A moderator with experience in child neglect assessment and treatment directed discussion and kept conversation flowing to identify key ideas (Krueger & Casey, 2000). An assistant moderator was responsible for recording comprehensive notes

of the focus groups, and utilizing a process facilitation approach in which there was low content control and high process control (Millward, 1995).

Using this method, a pool of items was generated for the kitchen, bedrooms, bathrooms, and family room, and a response format was created. An administration manual was developed for the Home Safety and Beautification Checklist (HSBC; see appendix B), and reliability procedures were established and implemented. Along this vein, each room corresponds to a separate screening checklist, which varies slightly depending on the function of the room (e.g. the kitchen includes items to screen for the presence of an adequate amount of nutritional food while the bathroom includes an item on the presence of razors in reach of the child). Additionally, a pool of items was generated to assess aesthetics of the rooms (referred to as appearance items) utilizing similar procedures.

Trained assessors tour each room in the home and record any hazards or aesthetic concerns present in various safety hazard and aesthetic categories. All safety hazard and aesthetic problem items were rated on a scale that corresponds to the level of priority for remediation. This scale ranges from 0 to 4 (0 = *not present*, 1 = *present, no priority*, 2 = *present, minimal priority*, 3 = *present, moderate priority*, and 4 = *present, high priority*). Assessors also provide two overall ratings for each room (one safety rating and one appearance rating), and overall ratings for the entire home using the same categories and rating scale.

The participant (i.e., caregiver) is instructed to independently provide overall safety and appearance self-ratings on the Client Safety and Appearance Rating Form. For each assessed room in the home, the participant provides a rating on a scale from 1 to 6.

The participant is given verbal directions on how to rate each room in regards to level of safety (1 = *extremely safe*, 2 = *very unsafe*, 3 = *somewhat unsafe*, 4 = *somewhat safe*, 5 = *very safe*, 6 = *extremely safe*) and level of attractiveness (1 = *extremely unattractive*, 2 = *very unattractive*, 3 = *somewhat unattractive*, 4 = *somewhat attractive*, 5 = *very attractive*, 6 = *extremely attractive*). To ensure independent ratings are provided, the participant is instructed to place the completed rating form in an envelope without revealing scores to the assessor.

The initial step in screening living conditions of the home is to orient the participant to the home tour procedure. Next, the participant is provided instruction to provide self-ratings of the living spaces in their home, and, in turn, the assessor rates the living conditions of the home utilizing the HSBC (see appendix B).

Procedures

Upon referral to the treatment program from a Department of Family Services caseworker, participants were contacted by phone and screened for inclusionary/exclusionary criteria. If all criteria were met, eligible participants were scheduled for an in-home pretreatment assessment in which they provided informed consent and underwent a standardized battery of assessments by trained technicians approximately one week prior to treatment initiation. The university's Institutional Review Board approved all study procedures, and no adverse events were determined.

CHAPTER 4

RESULTS

The statistical approach occurred in phases. First, the relationship between safety hazard items and room safety ratings, and aesthetic items and room appearance ratings was explored. The factorial validity of the measure was examined for the room ratings of the homes. Internal consistency reliabilities were then performed for each resulting factor. Second, the relationship among room ratings, and the relationship between room ratings and home ratings were examined. Third, the relation between assessor ratings and participant ratings for each room was analyzed. Fourth, the relationship of the measure with other variables was examined. The concurrent validity of the measure was examined by correlating scores on the Child Abuse Potential Inventory (CAPI) Abuse subscale with the measure. It was anticipated that the aforementioned relationships would be statistically significant, thus demonstrating acceptable psychometric support. The relationship between frequency of maternal drug and alcohol use and overall home ratings was explored. It was hypothesized that the latter relationship would be statistically significant, showing a positive relationship between home safety and substance use.

Phase 1

The relationship between scores on safety hazard items for each room and the overall room safety ratings; and scores on aesthetic items for each room and the overall room appearance ratings were explored using bi-variate correlations. In doing so, for each room the items representing potential safety concerns were summed into a single composite score. Likewise, in each room the items representing aesthetic concerns were summed into a single composite score. Bivariate correlations were conducted between

Kitchen Safety Sum (40 hazard items) and the Kitchen Safety rating, Kitchen Appearance Sum (16 aesthetic items) and Kitchen Appearance rating, Bathroom Safety Sum (37 hazard items) and Bathroom Safety rating, Bathroom Appearance Sum (16 aesthetic items) and Bathroom Appearance rating, Bedroom Safety Sum (40 hazard items) and Bedroom Safety rating, Bedroom Appearance Sum (14 aesthetic items) and Bedroom Appearance rating, and Family Room Safety Sum (40 hazard items) and Family Room Safety rating, and Family Room Appearance Sum (14 aesthetic items) and Family Room Appearance rating.

The bi-variate correlation between Kitchen Safety and the 40-item Kitchen Safety Sum was $r = .63$ ($p < .001$), Kitchen Appearance and the 16-item Kitchen Appearance Sum was $r = .79$ ($p < .001$), Bathroom Safety and the 37-item Bathroom Safety Sum was $r = .61$ ($p < .001$), Bathroom Appearance and the 16-item Bathroom Appearance Sum was $r = .77$ ($p < .001$), Bedroom Safety and the 40-item Bedroom Safety Sum was $r = .57$ ($p < .001$), Bedroom Appearance and the 14-item Bedroom Appearance Sum was $r = .82$ ($p < .001$), Family Room Safety and the 40-item Family Room Safety Sum was $r = .48$ ($p < .001$), and Family Room Appearance and the 14-item Family Room Appearance Sum was $r = .57$ ($p < .001$). These results indicate that the safety hazard and aesthetic items present in each room rating form were indeed utilized to inform the room safety and appearance ratings. Additionally, the appearance items were generally more correlated with the room appearance ratings, relative to the safety items.

The factor structure of the appearance room ratings (Kitchen Safety, Kitchen Appearance, Bathroom Safety, Bathroom Appearance, Bedroom Safety, Bedroom Appearance, Family Room Safety, and Family Room Appearance) was examined using

Exploratory Factor Analysis with principal axis factoring extraction and oblique rotation. Oblique (direct oblimin) rotation was utilized as the safety hazards and appearance concerns are conceptualized as related constructs. A Kaiser-Meyer-Olkin measure of sampling adequacy and Bartlett's test of sphericity was utilized to determine if that data meets minimum standards indicative of the ability for factor extraction. To determine the number of factors to retain several methods were utilized, including the Kaiser-Guttman Rule (i.e., eigenvalues greater than 1.0) and Scree test. Communalities were examined, with communalities of .40 to .70 considered low to moderate, and greater than .8 considered "high" (Velicer & Fava, 1998). The minimum factor loading considered was .32 (Tabachnick & Fidell, 2001). Items with cross-loadings of .32 or higher on two or more factors are noted and considered for item reduction. Factors with acceptable loadings (i.e., .32 or higher) of fewer than three items are considered unstable.

The factor structure of the safety room ratings (Kitchen Safety, Kitchen Appearance, Bathroom Safety, Bathroom Appearance, Bedroom Safety, Bedroom Appearance, Family Room Safety, and Family Room Appearance) was examined using Exploratory Factor Analysis with principal axis factoring extraction and oblique rotation. A Kaiser-Meyer-Olkin measure of sampling adequacy (.86) and Bartlett's test of sphericity ($p < .001$) met minimum standards indicative of the ability for factor extraction. The Kaiser criterion (eigenvalues greater than 1.0) and Scree plot examination substantiated two factors, with the first factor composed of the four safety ratings of each room (Kitchen Safety, Bathroom Safety, Bedroom Safety, and Family Room Safety), and the second factor composed of the four appearance ratings of each room (Kitchen Appearance, Bathroom Appearance, Bedroom Appearance, and Family Room

Appearance). The two factors accounted for 71% of the variance in the model. Factor 1 was named Appearance Subscale, and Factor 2 was named Safety Subscale.

Communalities were examined and all remained under .80 (Table 1). All item loadings exceeded the minimum of .32 with the lowest loading at .55 (Kitchen Safety). The Kitchen Safety item demonstrated some evidence of a cross-loading, with a loading of .32 on Factor 1 (Appearance Subscale) and a loading of .55 on the expected Factor 2 (Safety Subscale). All remaining items did not demonstrate cross-loadings. Internal consistency reliabilities using Cronbach's alpha were calculated for the Safety and Appearance Subscales. Cronbach's alpha was .81 for Factor 1 (Appearance Subscale) and .90 for Factor 2 (Safety Subscale), demonstrating a high level of internal consistency. The correlation between Appearance Subscale and Safety Subscale was $r = .61$ ($p < .001$). Results of the aforementioned analyses warrant the development of a 4-item subscale of home safety and a 4-item subscale of home appearance.

Phase 2

Relationships among safety and appearance ratings of each room in the home were examined. Bi-variate correlations were conducted to examine relationships among Kitchen Safety, Bathroom Safety, Bedroom Safety, Family Room Safety, Kitchen Appearance, Bathroom Appearance, Bedroom Appearance, and Family Room Appearance. This will help determine the extent to which safety and appearance ratings are distinct.

Relationships among safety and appearance ratings for each room in the home were examined. Bi-variate correlations were conducted to examine relationships among Kitchen Safety, Bathroom Safety, Bedroom Safety, Family Room Safety, Kitchen

Appearance, Bathroom Appearance, Bedroom Appearance, and Family Room Appearance (Table 2). Correlations among the Appearance of the rooms were largest, ranging from $r = .59$ to $r = .71$ ($p < .001$). The correlations among the Safety variables were smaller, ranging from $r = .41$ to $r = .57$ ($p < .001$), and indicating the Safety items have a lower association compared to the Appearance variables. The correlations of Safety and Appearance within each room ranged from $r = .41$ to $r = .58$ ($p < .001$), very similar to the range observed among the Safety variables and lower than the range of the Appearance variables. Lastly, the relationship between Safety and Appearance variables across rooms was examined, revealing correlations ranging from $r = .24$ to $r = .56$ ($p < .05$). Results of the pattern of correlations suggest that ratings of room appearance are distinct from ratings of room safety.

The relationships between the safety and appearance ratings of each room and the overall safety and appearance rating of the home were examined by conducting two multiple regression analyses to determine predictive validity of the HSBC. The first analysis involved regressing Home Safety Rating on Kitchen Safety, Bathroom Safety, Bedroom Safety, and Family Room Safety. The second analysis involved regressing the Home Appearance Rating on Kitchen Appearance, Bathroom Appearance, Bedroom Appearance, and Family Room Appearance. These analyses help determine the percentage of variance accounted for by rooms, as well as which rooms predict home safety and appearance.

The relationship between the room safety and room appearance ratings and the home safety and home appearance ratings were examined by conducting two multiple regression analyses to determine the predictive validity of the room ratings. The first

analysis involved regressing the Home Safety Rating on Kitchen Safety, Bathroom Safety, Bedroom Safety, and Family Room Safety. The second analysis involved regressing the Overall Home Appearance Rating on Kitchen Appearance, Bathroom Appearance, Bedroom Appearance, and Family Room Appearance.

For the Home Safety multiple regression analysis, the model was statistically significant, $F(4, 63) = 27.99, p < .001$. The four predictors explained 63.3% (Adjusted $R^2 = .610$) of the variance in Home Safety. Kitchen Safety ($\beta = .23, t = 2.47, p < .05$), Bedroom Safety ($\beta = .29, t = 3.04, p < .01$), and Family Room Safety ($\beta = .37, t = 3.82, p < .001$) were significant and positive predictors of Home Safety. Bathroom Safety was unrelated to Home Safety ($\beta = .12, t = 1.05, p = .30$). The multiple regression analysis revealed that the room safety ratings explained a high percentage of the variance, indicating that the Home Safety ratings were rated in a manner that was based on the room safety ratings. Participants who received higher remediation priority ratings for Kitchen Safety, Bedroom Safety, and Family Room Safety had higher Home Safety ratings. However, it is notable that Bathroom Safety was unrelated to the Home Safety rating, indicating that the bathroom did not significantly contribute to the rating the assessor gave for Home Safety. Scores are available in Table 3.

For the Home Appearance multiple regression analysis, the model was statistically significant, $F(4, 63) = 58.74, p < .001$. The four predictors explained 78.3% (Adjusted $R^2 = .770$) of the variance in Home Appearance rating. Kitchen Appearance ($\beta = .25, t = 2.82, p < .01$), Bathroom Appearance ($\beta = .26, t = 2.97, p < .01$), Bedroom Appearance ($\beta = .30, t = 3.07, p < .01$), and Family Room Appearance ($\beta = .21, t = 2.53, p < .05$) were significant and positive predictors of Home Appearance. The predictor

variables explained a high percentage of the variance, indicating that the Home Appearance ratings were rated in a manner that was based on the room appearance ratings. Participants who received higher priority Kitchen Appearance, Bathroom Appearance, Bedroom Appearance, and Family Room Appearance ratings had higher Home Appearance ratings. Room appearance ratings accounted for a higher proportion of the variance relative to the room safety ratings, indicating there is a stronger relative relationship between rating the appearance of the room and the appearance of the home. Scores are available in Table 4.

The Exploratory Factor Analysis (EFA) conducted in Phase 1 determined whether there are subscales of the HSBC. The subscale composite scores are calculated as the mean of the items composing each factor, and bi-variate correlations determined the relationship between the subscales and the home ratings (Home Safety and Home Appearance). This provided information on whether the room ratings assisted in deriving the home ratings.

Two subscales emerged from the EFA. The first subscale was comprised of 4 items and measured the level of aesthetic concerns present in the rooms of the homes (i.e., Appearance Subscale). The Appearance Subscale was derived by taking the mean of the room ratings of appearance (i.e., Kitchen Appearance, Bathroom Appearance, Bedroom Appearance, and Family Room Appearance). The second subscale was comprised of 4 items and measured the level of safety hazards present in the rooms of the homes (i.e., Safety Subscale). The Safety Subscale was derived by taking the mean of the room ratings of safety (i.e., Kitchen Safety, Bathroom Safety, Bedroom Safety, and Family Room Safety). The bi-variate correlation between the Safety Subscale and Home

Safety was $r = .76$ ($p < .001$), and between the Appearance Subscale and Home Appearance was $r = .87$ ($p < .001$). These results provide evidence that the assessors considered the ratings of each room when deriving the Home Safety and Home Appearance ratings. Consistent with the pattern emerging from previous analyses, appearance variables have a stronger relationship with each other when compared to safety variables.

Phase 3

The relation between assessor ratings and participant ratings of the safety and appearance of each room was examined. A series of correlations were calculated across rooms. First, the assessor ratings of Kitchen Safety, Bathroom Safety, Bedroom Safety, and Family Room Safety were examined with the corresponding participant ratings of safety for these rooms. Second, the assessor ratings of Kitchen Appearance, Bathroom Appearance, Bedroom Appearance, and Family Room Appearance were examined with the corresponding participant appearance ratings of these rooms. The assessor room ratings and the participant room ratings were scored using different scales. Assessors utilized a 5-point scale to determine room ratings (0 = *not present*, 1 = *present, no priority*, 2 = *present, minimal priority*, 3 = *present, moderate priority*, and 4 = *present, high priority*), and the participants utilized a 6-point scale to determine safety ratings (1 = *extremely unsafe*, 2 = *very unsafe*, 3 = *somewhat unsafe*, 4 = *somewhat safe*, 5 = *very safe*, 6 = *extremely safe*) and a 6-point scale to determine appearance ratings (1 = *extremely unattractive*, 2 = *very unattractive*, 3 = *somewhat unattractive*, 4 = *somewhat attractive*, 5 = *very attractive*, 6 = *extremely attractive*). It was hypothesized that there would be a strong negative relationship between assessor and participant raters.

First, the assessor ratings of Kitchen Safety, Bathroom Safety, Bedroom Safety, and Family Room Safety, were examined with the corresponding participant ratings of safety for the aforementioned rooms. The correlation coefficients are presented in Table 5. There were no significant relationships observed between assessor room safety and participant room safety ratings. Although the correlations were in the expected direction, the magnitude was negligible and the analyses lacked significance.

Second, the assessor ratings of Kitchen Appearance, Bathroom Appearance, Bedroom Appearance, and Family Room Appearance were examined with the corresponding participant appearance ratings of these rooms. The correlation coefficients are presented in Table 6. As previously noted, negative correlation coefficients are indicative of a stronger relationship between assessor and participant ratings. The assessor-rated appearance of the kitchen, bathroom, bedroom, and family room were significantly correlated with the participant-rated appearance of the same rooms. The magnitudes of the correlation coefficients (Kitchen Appearance, Bathroom Appearance, and Bedroom Appearance) fall within the range for the upper third of the distribution of correlation coefficients (Hemphill, 2003), providing evidence of a predictable relationship between the raters. Family Room Appearance is approaching the lower limit of magnitudes (i.e., .35) considered as the upper third of the distribution.

Phase 4

The relationship between the safety and appearance of the home and the potential for child neglect and type of substantiated neglect was examined. Correlation analyses examined the relationship between Home Safety and Home Appearance ratings and the Child Abuse Potential Inventory (CAPI) Abuse subscale to provide an estimate of the

HSBC's concurrent validity. A mean difference analysis was utilized between mothers cited for neglect due to exposure of their child to drugs and mothers cited for child neglect other than exposure of their child to drugs. Two regression analyses regressed the Safety Subscale and the Appearance Subscale, respectively, on the frequency of illicit drug or alcohol use by participants as measured by the TLFB (i.e., Marijuana Use days, Hard Drug Use days, and Alcohol Intoxication days).

Bi-variate correlations revealed no significant relationships between Home Safety and CAPI Abuse subscale, or between Home Appearance and CAPI Abuse subscale scores (see Table 7). These results provide evidence that the potential for child abuse, as measured by the CAPI Abuse subscale is not related to the safety or appearance of the homes for the mothers collectively, although the correlation with the Appearance Subscale approached significance. In addition, items for the Safety Subscale and Appearance Subscale were standardized using z-scores and then aggregated to form a subscale. Forming the subscales by utilizing z-scores, rather than taking the mean of the items, accounts for the differences in weights of each item within the subscales. The correlations between the subscales and the CAPI Abuse were examined again, resulting in nearly identical correlation coefficients.

An independent-samples t-test was conducted to determine whether there was a difference in home safety and appearance ratings between mothers who had been cited for child neglect due to exposure of their child to drugs and mothers who perpetrated non-drug related form of neglect (i.e., lack of supervision, physical neglect, environmental neglect, emotional neglect, and medical neglect). There were 36 mothers

cited for exposing their child to drugs and 33 mothers that were not determined to expose their child to drugs.

The t-test compared the Safety Subscale in Drug-Exposed Neglect Type homes and Non-Exposed Neglect Type homes. Levene's Test for Equality of Variances indicated equal variances assumed ($F = .56, p = .457$). There was a significant difference in the scores for Drug-Exposed Neglect Type homes ($M = 1.84, SD = 0.63$) and Non-Exposed Neglect Type homes ($M = 2.26, SD = 0.67$); $t(67) = -2.73, p < .01$. The Safety Subscale ratings of mothers with substantiated neglect cases that were a result of exposing their child to drugs evidenced less safety hazards than the homes of mothers with substantiated neglect cases where their child was not exposed to drugs.

An independent-samples t-test was conducted to compare the Appearance Subscale in Drug-Exposed Neglect Type homes and Non-Exposed Neglect Type homes. Levene's Test for Equality of Variances indicated equal variances assumed ($F = .011, p = .916$). There was a significant difference in the ratings for Drug-Exposed Neglect Type homes ($M = 1.42, SD = 0.89$) and Non-Exposed Neglect Type homes ($M = 2.16, SD = 0.91$); $t(67) = -3.44, p < .01$. The Appearance Subscale ratings of mothers with substantiated neglect cases that were a result of exposing the child to drugs had less aesthetic problems than the homes of mothers with substantiated neglect cases where their child was not exposed to drugs.

The first regression analysis examined the Safety Subscale with predictor variables Marijuana Use days, Hard Drug Use days, and Alcohol Intoxication days. The model was not statistically significant, $F(3, 72) = 1.15, p = .334$. The three predictors

explained 4.6% (Adjusted $R^2 = .006$) of the variance in the Safety Subscale. Scores are available in Table 8.

The second regression analysis examined the Appearance Subscale with predictor variables Marijuana Use days, Hard Drug Use days, and Alcohol Intoxication days. The model was statistically significant, $F(3, 72) = 3.16, p < .05$. The three predictors explained 11.6% (Adjusted $R^2 = .079$) of the variance in Appearance Subscale. Marijuana Use ($\beta = .24, t = 2.08, p < .05$) was a significant and positive predictor of the Safety Subscale. Alcohol Intoxication ($\beta = .21, t = 1.82, p$ a marginally significant and positive predictor of the Safety Subscale. Hard Drug Use was unrelated to the Safety Subscale ($\beta = -.06, t = -.54, p = .59$). The multiple regression analysis revealed that alcohol and drug use explain some of the variance in the appearance of the homes. This finding is consistent with the prior analyses finding relationships with the appearance ratings of the home but not safety ratings of the home. Participants who used marijuana and alcohol more frequently had higher Safety Subscale ratings (higher scores corresponded to higher remediation priority ratings). However, it is notable that Hard Drug Use was unrelated to the Safety Subscale, indicating that use of hard drugs did not significantly contribute to the subscale ratings the safety of the home. Scores are available in Table 9.

CHAPTER 5

DISCUSSION

This study was conducted to expand the current literature on practical measures to identify child home safety and appearance problems. Specifically, it examined the psychometric properties of the Home Safety and Beautification Checklist (HSBC) utilized to detect the severity of child safety hazards and aesthetic concerns when implemented in at-risk homes of mothers referred for substance abuse and child neglect. Overall, it was determined that the HSBC had good initial psychometric properties and its development is a particularly useful outcome of this research.

The HSBC is formatted in such a way that during the tour of a home the assessor will collect a variety of molecular hazard and aesthetic ratings specific to each room, while also providing an overall room rating pertaining to the safety and the appearance, and lastly, ratings of the entire home's safety and appearance. Therefore, it would be expected that the home ratings should be derived from the room ratings, and the room ratings should be derived from the operationally defined safety hazards and aesthetic concerns within each room. The relationships among these levels of ratings were examined. First, it was determined that the molecular ratings were significantly correlated with the respective ratings provided for the rooms. Safety hazard correlation coefficients ranged from $r = .48$ to $r = .63$, and appearance concerns correlation coefficients ranged from $r = .57$ to $r = .82$, providing evidence of strong positive relationships between the specific hazards and aesthetic problems and the room rating of safety and room rating of appearance determined by the assessor. Therefore, the specific hazards and aesthetic problems available for each room of the home are essential for deriving accurate and

informed ratings of the rooms. Notably, some hazard items and some aesthetic items were never endorsed in this sample. Ideally, an exploratory factor analysis would be utilized for the items within each room, which would require the molecular items to be endorsed more or molecular items could be collapsed into more general items. Despite the absence endorsement of these items in the homes assessed, it is recommended that these items remain in the HSBC as the removal or collapsing of items may work well for research and measurement purposes, however, the practical implications of this type of change may result in oversight of safety hazard or appearance problems. This type of oversight poses potentially detrimental dangers to children. Additionally, the organization of the hazard and appearance items into categories (i.e., toxins) contributes to the ease of identifying potential problems within the rooms of the home.

The importance of the room ratings for the Home Safety and Home Appearance ratings were determined by several regression analyses. As expected, a high amount of the variance (63.3%) in the Home Safety rating was accounted for by the room safety ratings. However, Bathroom Safety was determined to not significantly contribute to the Home Safety rating. This was an unexpected result, but may be explained by the fact that bathrooms are very small relative to other rooms in the home and therefore there are fewer opportunities for problems, when compared to larger rooms containing more possessions. Also as expected, a very high amount of the variance (78.3%) in the Home Appearance rating was ascribed to the room appearance ratings. The appearance rating of all four rooms were found to significantly contribute to the model. Thus the ratings provided for each room were very influential in the home ratings.

An EFA was utilized for the room ratings and it revealed two factors: Safety Subscale and Appearance Subscale. The subscales are calculated by taking the average of the Room Safety ratings and the Room Appearance ratings. The internal consistency reliabilities were very high for each subscale: Safety Subscale ($\alpha = .90$) and Appearance Subscale ($\alpha = .81$). The subscales were then correlated with the assessor-rated Home Safety and Home Appearance, which determined that the assessors considered the ratings of each room when deriving the Home Safety and Home Appearance ratings, yet the magnitude of the correlations are not as high as might be expected ($r = .76$ for safety and $r = .87$ for appearance). These results underscore the utility of utilizing the Safety Subscale and Appearance Subscale rather than the Home Safety and Home Appearance ratings. It is suggested that the empirical scoring of the measure utilizing the subscales should replace the assessor determined Home Safety and Home Appearance ratings.

Correlational analyses determined there was largely no relationship between the room safety ratings by the assessors and the room safety ratings by the participants. In contrast, the room appearance ratings by the assessors and by the participants were significantly related. The relationships between the two raters on room appearances were predictable with correlation coefficients between $r = -.31$ and $r = -.44$. One interpretation of this outcome is that the participants have less insight into what hazards may be present in their homes, and tend to underreport potential hazards compared with the objective scoring provided by the assessors. However, the cleanliness of the home is more apparent due to the obviousness of messes when compared to, for example, what represents a choking hazard, as this is also dependent on the age of the child. One weakness is regarding the use of different scales for the assessor form and for the participant form. In

the future, the same scale should be used for both raters, therefore enabling an intra-class correlation to determine the consistency between the raters.

Notably, a pattern emerged where appearance variables have a stronger relationship with each other when compared to the safety variables. This would be predicted by the nature of the constructs being measured. Problems with aesthetic and cleanliness would be much more apparent when compared to safety hazards. This would be especially descriptive of at-risk populations that have evidenced neglect or substance abuse, where the identification of more nebulous concerns such as specific hazards to the child is much more difficult than determining the appearance/cleanliness. Additionally, given the number of safety hazard checklist items were often twice that of the appearance checklist items, there is more room for variance between raters or the introduction of random error into the equation.

It was hypothesized that the safety and appearance of the home would be related to the potential for child abuse, however, this relationship was not found. This result is not surprising given the variety of abuse types and related attitudes measured by the CAPI, many of which manifest in a variety of areas aside from safety and aesthetics of the home.

Based upon the relationship between child neglect and parental substance abuse revealed in the extant literature, it was hypothesized that the Safety Subscale and Appearance Subscale would be predicted by maternal alcohol or drug use. Contrary to expectations, the regression analyses indicated no such relationship for the Safety Subscale. However, as predicted the model for the Appearance Subscale was significant and the predictors explained an adequate (11.6%) amount of the variance. Marijuana use

was found to significantly predict home cleanliness and aesthetics, while alcohol use was marginally significant ($p = .07$). Unexpectedly, maternal use of other drugs was found to be unrelated to home appearance. It is unclear why only the home appearance model was significant and why not all of the predictors in the home appearance were related. This pattern of results may, again, be associated with the nature of the safety concerns as more vague than appearance of the home. Regarding the appearance model, it is hypothesized that the lack of relationship between other drug use and home appearance could be a result of the variety of drugs that are encapsulated by this variable. A difference in behavioral outcomes of different categories of drugs is well known in the literature. For example, cocaine use is associated with increased activity whereas tranquilizer use is associated with increased muscle relaxation and sleep. By compiling all drug use, aside from marijuana, into a single category it is likely that a relationship could not be reliably detected given the vast differences in expected behavioral outcomes of the drugs.

It was hypothesized that the type of child neglect that lead to referral to the treatment program would be associated with home safety and appearance, specifically substantiated neglect involving environmental exposure to drugs or maternal drug use while pregnant would be related to homes that were more unsafe and had more aesthetic problems. T-tests indicated significant differences between neglect groups (drug-exposed neglect vs. non-exposed neglect), however the differences were opposite the hypothesized direction. Mothers referred for non-drug exposed neglect had unsafe and more appearance problems compared with the mothers referred for drug-exposed neglect. The differences in means between groups appeared pronounced, with the non-drug exposed neglect type exhibiting higher use in each category: Marijuana ($M = 13.68$, $M =$

23.03), other drugs ($M = 12.74$, $M = 16.27$), and alcohol ($M = 0.16$, $M = 4.39$), respectively.¹ Thus, use of alcohol and other drugs is an explanation as to why the drug-exposed neglect group had less safety hazards in their homes, because this group was using substances less. Future research may endeavor to understand why certain types of child neglectful behaviors are associated with differing levels of maternal substance use.

Conclusions

The available child home safety and appearance checklists and assessment protocols are typically restricted to assessing broad and rather undefined categories of hazards (i.e., toxins), but lack defined safety hazards and aesthetic concerns that may be encountered in the home and that are specific to each room. The HSBC builds upon previous measures by including potential hazards and aesthetic concerns of each type of room within the checklist. The more comprehensiveness of the HSBC may therefore be instrumental in the prevention and identification of a wider range of hazards to children. As evidenced by the analyses, this type of information was utilized when rating the safety and appearance of each room. Given the relatively low magnitude correlations ($r = .11$ to $r = .16$) between room safety ratings of the assessor and that of the participant, it is likely that the at-risk mothers in this study lacked the knowledge base to identify potential child safety hazards in their homes. Notably, the correlation coefficients of the relationship between the two raters for the appearance variables were highly significant and had higher magnitudes ($r = .31$ to $r = .44$) than the safety variables, providing evidence that the participants were more capable of identifying appearance problems. This result makes sense when considering the straight forward nature of appearance when compared to

¹ A MANOVA was not statistically significant. The mean differences appear rather large; therefore it is likely the model lacked power (.454) to detect the group differences.

safety hazards which are also dependent on age and ability of the children present in the home. In the future, the safety items that were included in the assessor's HSBC form can serve as a learning tool for at-risk mothers to assist in the identification of a variety of child safety and aesthetic concerns within each room of the home.

The context in which HSBC was developed and utilized represented only one aspect of a larger assessment battery and subsequent treatment program that frequently included other services such as job placement, child management, relationship enhancement, and management of impulsive behaviors. The highly structured nature of the assessment and treatment processes are warranted in order to adequately correct the conditions associated with child neglect and disordered parental drug use. All of the mothers who participated in this research were referred by CPS, and because neglect charges are frequently brought against parents as a result of conspicuous safety hazards that may catch the attention of case workers, reducing these hazards in the home assists in remitting the cycle of problems. Additionally, due to the nature of the HSBC as a learning tool for mothers, it is likely that the home environment changes would be sustained rather than temporary fixes that can just as quickly revert.

Contrary to experimental expectations, the relationship between potential for child abuse (i.e., CAPI Abuse subscale), days of marijuana use, days of hard drug use, and days of alcohol intoxication were not related to Home Safety, and only in certain circumstances were related to Home Appearance. This was a surprising result considering the amount of information available in the scientific literature drawing connections between environmental hazards, child neglect, and parental substance abuse. In large part, this may be due to the restricted sample utilized for this study. A more generalizable

sample would have assessed the homes of mothers referred for neglect, without inclusionary criteria of a substance abuse diagnosis. It could be hypothesized that home safety and cleanliness may be related to the presence of maternal substance abuse, rather than the quantity and frequency of maternal substance abuse. Future research could examine this relationship by utilizing the HSBC with mothers referred for neglect but do not evidence ongoing substance abuse problems.

Study Implications

The data developed regarding the HSBC illuminates the utility of the instrument in regards to identifying environments that may pose a risk to children, particularly children that are already at increased risk for unintentional injuries such as those residing with a parent with a substance use disorder. Most importantly, information gathered through the HSBC may prove useful to social workers, counselors, and the court system by helping to understand the extent of hazards to children in the home and the relationship between home safety and appearance and substance use and the potential for neglect of mothers involved with CPS. The measure may even prove useful in helping identify some children who could profit from services to prevent unintentional injuries or other neglectful behaviors at home. Overall, the present study aligns well with the current direction of the child maltreatment field. Recent literature indicates that a comprehensive assessment measure for examining hazards to child safety in the home be prioritized. An assessment to identify hazards is the first step in remediation of hazards, especially for high-risk groups such as victims of neglect living with substance-abusing mothers. Thus, information provided as a result the present study should be utilized to inform researchers

committed to the development and evaluation of screening measures for child safety hazards in child welfare populations.

Limitations and Future Directions

Like all research this study had limitations. The analyses conducted in this research excluded Exploratory Factor Analysis of items within each room due to a restricted number of participants. A larger sample size would enable analysis of the items within each room to determine potential factors that may differ from the current organization of the safety and aesthetic items into face-valid categorical groupings.

To accurately determine the generalizability of the results, it is necessary to test the HSBC in the homes of a more diverse representation of at-risk groups such as parents with intellectual disabilities and neglectful or substance-abusing fathers, to name a few. Future research is also necessary for the refinement of the techniques used in this study. Namely, the participant was provided with an abbreviated home safety and appearance rating form compared with the assessor. This may have impacted the ability of the participant to provide accurate ratings on par with that of the assessor. Further research can experimentally manipulate this aspect and determine whether this increases reliability between the two raters.

Taken as a whole, the current study sheds important information on the structure of a measure that can not only screen for hazardous and cleanliness issues to prevent injury in the homes where formerly neglected children reside, but as a learning tool for mothers to readily identify these issues.

Table 1

Exploratory Factor Analysis Results for Room Safety and Appearance Items

Item	Factor		h ²
	1	2	
Bedroom Appearance	.93	-.07	.79
Family Room Appearance	.82	-.02	.65
Kitchen Appearance	.80	.03	.67
Bathroom Appearance	.71	.14	.65
Family Room Safety	-.09	.82	.59
Bedroom Safety	-.00	.67	.45
Bathroom Safety	.07	.67	.51
Kitchen Safety	.32	.55	.62

Notes. h² = communality. Salient factor pattern matrix coefficients are in boldface. Factor 1 = Appearance Subscale (presence and priority for remediation of aesthetic concerns). Factor 2 = Safety Subscale (presence and priority for remediation of safety hazards).

Table 2

Room Safety and Appearance Correlations

Variable	1	2	3	4	5	6	7	8
1 Kitchen Safety	-							
2 Bedroom Safety	.41**	-						
3 Bathroom Safety	.57**	.51**	-					
4 Family Room Safety	.43**	.56**	.51**	-				
5 Kitchen Appearance	.58**	.24*	.48**	.32**	-			
6 Bedroom Appearance	.56**	.41**	.36**	.33**	.70**	-		
7 Bathroom Appearance	.51**	.39**	.53**	.37**	.67**	.71**	-	
8 Family Room Appearance	.42**	.31**	.34**	.37**	.61**	.69**	.59**	-
Mean	2.16	2.03	1.99	1.99	1.72	2.01	1.76	1.50
Standard Deviation	.94	.87	.96	.89	1.13	1.18	1.13	1.17

Note. * $p < .05$. ** $p < .001$.

Table 3

Room Safety Multiple Regression

Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>
Kitchen Safety	.20	.08	.23	2.47**
Bathroom Safety	.09	.09	.11	1.05
Bedroom Safety	.28	.09	.29	3.04**
Family Room Safety	.34	.09	.37	3.82**

Notes. $R^2 = .63$ ($p < .001$). * $p < .05$. ** $p < .01$.

Table 4

Room Appearance Multiple Regression

Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>
Kitchen Appearance	.26	.93	.25	2.82**
Bathroom Appearance	.28	.93	.26	2.97**
Bedroom Appearance	.31	.10	.30	3.07**
Family Room Appearance	.21	.09	.21	2.53*

Notes. $R^2 = .79$ ($p < .001$). * $p < .05$. ** $p < .01$.

Table 5

Correlations Between Assessor and Participant Room Safety Ratings

Variable	<i>r</i>	<i>p</i>
Kitchen Safety	-.15	.19
Bathroom Safety	-.16	.17
Bedroom Safety	-.11	.35
Family Room Safety	-.13	.28

Table 6

Correlations Between Assessor and Participant Room Appearance Ratings

Variable	<i>r</i>	<i>p</i>
Kitchen Appearance	-.44	< .001
Bathroom Appearance	-.41	< .001
Bedroom Appearance	-.42	< .001
Family Room Appearance	-.31	< .01

Table 7

Correlations with CAPI Abuse

Variable	CAPI Abuse	<i>p</i>
Safety Subscale	.16	.16
Appearance Subscale	.21	.07

Note. Child Abuse Potential Inventory (CAPI) abuse subscale.

Table 8

Multiple Regression for Safety Subscale

Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>
Marijuana Use	.000	.003	-.014	-.116
Hard Drug Use	.001	.004	.018	.152
Alcohol Intoxication	.019	.010	.212	1.78

Note. $R^2 = .006$ ($p = .334$). * $p < .05$. ** $p < .01$.

Table 9

Multiple Regression for Appearance Subscale

Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>
Marijuana Use	.007	.003	.235	2.08*
Hard Drug Use	-.003	.005	-.062	-.54
Alcohol Intoxication	.026	.014	.209	1.82

Note. $R^2 = .079$ ($p < .05$). * $p < .05$. ** $p < .01$.

APPENDIX A

ASSESSMENT OF HOME SAFETY AND BEAUTIFICATION PROCEDURE

RATIONALE FOR THE HOME SAFETY AND BEAUTIFICATION ASSESSMENT

Accidents around the home are a leading cause of death and injury among children. In homes where child maltreatment occurs, there is increased incidence of environmental hazards. Caregivers of neglected children are often unaware of potential home hazards that may harm or create an unsafe environment for their children. The homes of neglectful parents are often messy and may have household items that need to be replaced or repaired. Thus, it is important to help parents recognize the importance of maintaining a safe and clean home. The first step in assuring a safe and clean home is to conduct a home inspection that identifies areas of need with regard to safety, cleanliness and attractiveness. The Home Safety and Beautification Assessment is designed specifically for this task.

MATERIALS NEEDED TO COMPLETE THE ASSESSMENT

- a. Assessor Prompting List for Home Safety and Beautification Tour (Form A)
- b. HOME SAFETY AND BEAUTIFICATION PROFILE FORM (Form B)
- c. HSB RATING FORM and "OTHER ROOM" ASSESSMENT FORM (Form C)
- d. Common Home Safety and Beautification Problems and Solutions (Form D)

OVERVIEW

STEPS INVOLVED IN COMPLETING THE HSB ASSESSMENT

Present Rationale for the Home Safety and Beautification Tour to the Client and Significant Others

A rationale is provided before the tour begins in order to orient the client to the home tour procedure. Because most clients have not participated in a home tour evaluation or have only done so in the context of an investigation for child neglect or abuse, it is not uncommon for clients to be uncomfortable or defensive when informed that their home will be inspected. Often times, clients will object because they have not had an opportunity to clean their homes or feel that the tour is an invasion of privacy. It may also be the case that they would feel embarrassed if the evaluator were to find personal items such as financial information, sex toys, or drug paraphernalia. These are all valid concerns. Thus, it is critical to present a rationale for the home tour that emphasizes its potential benefits (safer home for client and family) and decreases defensiveness and discomfort.

To accomplish this, introduce the SAFETY AND APPEARANCE RATING FORM and the HSBC RATING FORM to the client and significant other using to the following guidelines:

- a. Tell client you will conduct the safety and appearance tour
- b. Explain tour designed to identify home hazards (objects/physical situations that could cause harm)

- c. State that all households contain potential hazards
- d. Tell client that hazards can cause home accidents
- e. State that home accidents are a leading cause of death and injury for children.
- f. Explain that tour designed to help identify home hazards.
- g. Explain tour involves touring each room in home and completing forms
- h. Forms include types of home hazards common in most homes
- i. As we look, if there is any room you don't want me to enter, tell me.
- j. At times I will need to look in closed places.
- k. I will ask your permission to do this.
- l. Standard part of tour to identify hazards that might be present in closed places
- m. We will be examining the family area, kitchen, main bath, and child's bedroom
- n. Explain that client will also rate attractiveness and safety of each room.

For example, you may provide this rationale by saying: “(a) The next thing we are going to do is conduct a safety and appearance tour of your home. (b) This tour is designed to identify home hazards, which are objects or physical situations that could cause someone to get hurt. (c) All households contain potential hazards that are sometimes overlooked. (d) These hazards can cause home accidents and (e) home accidents are a leading cause of death and injury for children. (f) This tour is designed to help identify hazards that might have been overlooked in your home. (g) It involves you and me going through each room in your house and completing these forms (point to the forms but do not show them to the clients or allow client to see items that will be rated). (h) These forms tell me the types of home hazards I need to look for that are common in most homes. (i) As we look through your home, if there is any room you don't want me to enter, tell me. (j) At times I will need to look in closed places. (k) I will ask your permission to do this. (l) This is standard part of tour, and is necessary to identify hazard that might be present in these closed places. (m) Today we will be examining the family area, kitchen, main bath, and your child's bedroom. (n) However, before we do the tour I also want you to rate how attractive and safe each of these rooms is before I do my ratings.”

Prepare the CLIENT SAFETY AND APPEARANCE RATING FORM and the HSBC RATING FORM

Two forms are used for the home safety and beautification tour. The first is the CLIENT SAFETY AND APPEARANCE RATING FORM, which is completed by clients and elicits their opinions regarding the safety and appearance of their homes. The second form is the Home Safety and Beautification Checklist Rating Form (HSBC Rating Form), which is completed by the evaluator. There are a number of features common to both forms. First, both forms provide the opportunity to rate each room in the home. The client form requires one safety and appearance rating for each room, while the evaluator form allows individual item ratings and general ratings for each room, as well as overall ratings for the entire home. Second, both forms include a number of specified rooms, such as the Kitchen, Family Room, Dining Room, 3 Bedrooms, and 3 Bathrooms, as these rooms are contained in most homes. However, there are also places to record “Other Rooms” so that rooms that occur less frequently in most households (e.g., den, office, sun room) can also be rated when appropriate. Third, both forms allow ratings for Outside Play Areas and Automobiles. A fourth feature common to both forms is that they have places to record

identifying information for each room. This identifying information is critical for rooms that appear more than once in most homes (bedrooms, bathrooms). Identifying information should be simple but descriptive and may include a unique feature of the room (color of paint, location in house), or a unique use of the room (girls bedroom, master bathroom). When identifying information has been obtained for all rooms, cross out those rooms that are not present in the home in order to avoid confusion as the client completes the tour. For example, if there were only two bedrooms in the home, then the space to record rating for Bedroom 3 would be crossed out.

***Note: Although the above procedure is typically utilized when conducting home tours. The following procedure can be utilized as a more parsimonious tour. In this tour the assessor will be touring the main family living area, kitchen, main bathroom, and identified child's room. If the identified child is sharing a room with an adult caregiver, the room should not be rated. Therefore, the only times the identified child's room will be rated is when they reside in their own room or with another minor child. The assessor will follow the procedure below to prepare the forms for these rooms. During the home tour, the assessor will place a check mark next to each heading for the hazard category and only provide an overall room rating for each room. The individual risk items will not be scored.*

After the rationale for the home tour has been presented, the two forms are prepared according to the following procedures. These steps allow the evaluation to obtain identifying information for each room that will be rated. They also orient the client to the CLIENT SAFETY AND APPEARANCE RATING FORM so that they understand their task and thus are able to provide consistent and valid ratings.

- a. Present the CLIENT SAFETY AND APPEARANCE RATING FORM to the client
- b. Ask client to provide an identifier for each room on the client SAFETY AND APPEARANCE RATING FORM
 1. Use the CLIENT SAFETY AND APPEARANCE RATING FORM with the client to determine an identifier for each room that is named on the form (e.g., Kitchen).
 2. After completing all named rooms, ask if there are any additional rooms, closets, or storage areas not already covered (e.g., an additional 4th bedroom or bathroom, garage, study). Solicit and record identifying information for these rooms in the "Other Rooms" spaces that are provided at the end of the CLIENT SAFETY AND APPEARANCE RATING FORM. *(Note: if using the parsimonious procedure described above, only complete the descriptors for the kitchen, living area, main bathroom, and identified child's room).*
 3. Cross out rooms that are not present in the home.
- c. After the CLIENT SAFETY AND APPEARANCE RATING FORM is complete, transfer room identifying information to the respective HSBC RATING FORM.
 1. Use the "OTHER ROOM" ASSESSMENT FORM as needed.

For example, the following instruction may be used when preparing the forms: "(a) I have this form for you to complete on each of the rooms in your home (present client with the CLIENT SAFETY AND APPEARANCE RATING FORM). (b) However, before you

start completing the form, I just need you to tell me what color these rooms are, or maybe something else that will help us to tell them apart from each other. This is most important for rooms like bedrooms and bathrooms, where there may be more than one of the rooms in your home. (Client provides descriptors and clinician records these descriptors on the CLIENT SAFETY AND APPEARANCE RATING FORM.) Once all the rooms have been identified on the CLIENT SAFETY AND APPEARANCE RATING FORM, the rate should transfer the room identifying information to each respective HSBC RATING FORM) (c) Now that we have identified all of the rooms that are contained on this form (point to CLIENT SAFETY AND APPEARANCE RATING FORM), I wonder if there are any other rooms, large closets, or maybe storage areas that were not on this form but that are in your home? (Client indicates a garage, and clinician indicates “garage” as an “Other Room” room on the CLIENT SAFETY AND APPEARANCE RATING FORM.) Since these rooms will not be rated, we can cross them out.”

Conduct Client Self-Rating Tour

After the forms have been prepared and the client understands how they are to rate each room. Figure 1 contains the ratings for Kitchen from the CLIENT SAFETY AND APPEARANCE RATING FORM. As can be seen from the Figure, each room is labeled at the top with a space to record a brief description of the room. There is also a place for the client to record the Safety rating and an Appearance rating. Both ratings range from 1 to 6 and allow for ratings reflecting a room that is “Extremely Unsafe” or “Extremely Unattractive” (rating = 1) to “Extremely Safe” or “Extremely Attractive” (rating = 6).

Figure 1. One room from the CLIENT SAFETY AND APPEARANCE RATING FORM

	Kitchen			Description: _____		
Safety rating:	1 Extremely Unsafe	2 Very Unsafe	3 Somewhat Unsafe	4 Somewhat Safe	5 Very Safe	6 Extremely Safe
Appearance rating:	1 Extremely Unattractive	2 Very Unattractive	3 Somewhat Unattractive	4 Somewhat Attractive	5 Very Attractive	6 Extremely Attractive

Use the following guidelines to conduct the client safety and appearance rating tour. (Note that we have specified that an individual other than the main evaluator will accompany the client on this part of the tour, so as not to bias the ratings of the main evaluator.)

- a. Provide client with CLIENT SAFETY AND APPEARANCE RATING FORM
- b. Instruct client to provide safety and appearance ratings for each room
- c. Explain that there is a place on the form to provide ratings for each room
 1. Explain the safety rating
 - a. 1 = extremely unsafe
 - b. 6 = extremely safe

2. Explain the appearance rating
 - a. 1 = extremely unattractive
 - b. 6 = extremely attractive
- d. Tell clients to rate the rooms as they wish
- e. Instruct clients to place ratings in envelope when finished to keep them private
- f. Have child specialist or other person who will not complete the HSB RATING FORM escort client through home to complete client safety and appearance tour
- g. If client asks for advice on ratings, respond in a nondirective manner

For example, the following instructions may be used: “(a) Here is a form that you can use to rate each room in your home (show client the form and point to the title of each of the first few rooms, e.g., “Kitchen”, “Dining Room”, etc., so the client understands). (b) For each room there is a place for you to make a safety and an appearance rating (point to the spot for the Safety and Appearance rating for the first room “Kitchen”). (c) The first rating is on safety with a “1” (point to the “1”) indicating the room is extremely unsafe and a “6” (point to the “6”) indicating the room is extremely safe. The next rating is an appearance rating (point to the rating). I want you to look at the appearance of each room and rate it with a “1” indicating extremely unattractive and a “6” indicating extremely attractive (point to the “1” and “6”). You indicate your rating by circling the number that you think best describes the room. For example, if you thought this room was very attractive you would circle the number 5, right here (point to the number 5 on the form) or if you thought it was very unattractive, you would circle the number 2 here (point to the number 2 on the form). (d) We are most interested in your impressions of the safety and appearance of each room in your home, so go ahead and rate the rooms as you wish. Do you have any questions?”

“(e) I will need to make my own ratings of the rooms after you are finished, so I do not want to know your ratings. To keep your ratings private, please place them in this envelope when you finish so I can’t read them (hand client the envelope). (f) _____ (child management specialist) will go with you as you rate your rooms so if you have any questions about how to fill out the form, _____ can help answer them for you. This will help make sure that I do not know how you rate the rooms.”

(g) If client asks for advice on ratings, respond in a nondirective manner, e.g., “I know this is new for you and that you have not done it before, but there are no right or wrong answers. We are most interested in what you think so go ahead and rate the room as you see fit.”

Conduct HSBC Tour of Home with the Client

After the client has completed the tour of the home and placed their ratings in an envelope, follow the procedures below to complete the HSBC tour of the home:

- a. For each room mark the appropriate checkbox at the top HSBC RATING FORM
 1. Rated = room is present and was reviewed

2. Self-Report = client did not allow tour but self-reported the contents of the room to the evaluator
 3. Not Rated = room is present but client did not allow tour and refused to provide a self-report of the room contents
 4. NA = the room is absent
- b. Provide **item** ratings and **overall** ratings for each room
1. Use the following rating scale for Safety and Appearance ratings
 - 0 or blank = absent
 - 1 = present, no priority
 - 2 = present, minimal priority
 - 3 = present, moderate priority
 - 4 = present, high priority
 2. For each room, examine the following:
 - a. Floor
 - b. Ceiling
 - c. Walls
 - d. Any enclosures present (i.e., cupboards, dressers, etc.)
 - e. Objects listed on home assessment form
 3. Provide individual ratings for each item in each room using the following guidelines:
 - a. Consider the most vulnerable child in the home
 - b. Consider the developmental age of all children in home
 - c. Accessibility of item to children in home
 - d. Extenuating circumstances for the family
 - e. If potential hazard is to be treated, it must have a rating of 2 or greater
 - f. If the item does not “fit” into one particular rating (i.e., falls between 2 and 3) assign the higher of the two ratings
 - g. Rate each item only once
 4. Write notes for each item that is rated
 5. Provide an overall safety rating and appearance rating for each room

***Note: The parsimonious tour, omit the steps concerning the individual ratings for the rooms. Although the assessor should place a check mark next to each risk category indicating that they did look for these items when arriving at an overall room rating.*

- c. Provide Overall Ratings for home for the following areas
 1. Overall Home Safety Rating
 2. Overall Home Appearance Rating

The following sections elaborate on the guidelines presented above.

a. For each room mark the appropriate checkbox at the top HSBC RATING FORM
 At the top of each room form contained in the HSBC RATING FORM there are four check

boxes where the rater can indicate either: 1) Rated, 2) Self-report, 3) Not Rated, or 4) NA. These checkboxes should be marked according to the following guidelines.

1. The “Rated” checkbox is marked when the examiner is allowed to inspect the room, even if the client does not allow inspection of some enclosures within the room. For example, the rater may be allowed to inspect Bedroom 1, but the client may refuse to allow inspection of the dresser drawers in that room. In this case, the rater would check “Rated” for Bedroom 1, and indicate in the appropriate place on the HSBC RATING FORM one of two options. An SR (self-report) should be written if the dresser drawers were not directly examined but that client described their contents to the rater. Alternatively, a NR (not rated) should be written next to item if the client refused direct inspection and also refused to report the contents of the dresser.
2. The “Self-Report: checkbox is marked when the examiner is not allowed to inspect the room, but the client does report the contents of the room when queried by the rater. The procedure for querying the contents of the room is described in the **Procedures to Use When Clients Refuses to Allow Inspection of Rooms or Enclosures** section of the manual.
3. The “Not Rated” checkbox is marked in instances where the client refuses to allow direct inspection of a room and also refuses to report the contents of the room when the rater requests this information. Instances in which the client refuses both direct inspection and self-report are unusual. A rating of “Not Rated” often reflects a more general lack of cooperation on the client's part with the home tour.
4. The “NA” checkbox is marked when the room is absent from the home. For example, in home that has two bedrooms, the NA checkbox would be marked on the “Bedroom 3” form. NA is used so that it is clear that, in this example, Bedroom 3 was absent from the home rather than simply not rated.

b. Provide a rating for each item on HSBC RATING FORM using the following ratings:

1. Use the following rating scale for Safety and Appearance ratings

0 or blank = absent

1 = present, no priority for treatment

2 = present, minimal priority for treatment

3 = present, moderate priority for treatment

4 = present, high priority for treatment

Some HSBC require a Safety rating and others require an Appearance rating, but the same scale is used for both types of items.

Safety items pertain to environmental factors in the home that pose a risk of physical injury to children, whereas Appearance items pertain to objects or situations that require clean up or aesthetic improvements in order to aid in the

social and cognitive development of the children.

Safety categories include the following:

- a. Toxins (e.g., detergents, paints, medications, pesticides)
- b. Electrical Hazards (e.g., exposed wires, electrical appliances by water, exposed light sockets)
- c. Sharp Objects (e.g., kitchen knives, scissors, tools)
- d. Food and Nutrition Needs (e.g., 1 of the 4 food groups absent, spoiled foods)
- e. Home Access/Security (e.g., windows broken, doors won't lock)
- f. Heavy/Unstable Objects (e.g., furniture, tools, boxes)
- g. Small Objects that could be swallowed or tripped on (e.g., marbles)
- h. Problems with Air Quality (e.g., poor ventilation, mildew, excessive dust)
- i. Other Risks (e.g., holes in the floor, access to pornography)

Safety categories are generally consistent across all rooms in the HSBC RATING FORM, although there is some variability between the rooms for items that are not applicable from one room to another. For example, toilets pertain to bathrooms and are rarely found in the kitchen. The COMMON HOME SAFETY AND BEAUTIFICATION PROBLEMS AND SOLUTIONS FORM provides descriptions and helpful examples of these categories and so is a valuable tool in understanding these categories.

Appearance ratings fall into two general categories. One of these categories assists in the identification of Clean-up needs (e.g., bug infestations, clothing is dirty, carpet is soiled) and the other with the identification of Aesthetic Needs (e.g., worn carpet, unpainted walls).

Appearance ratings are also similar across rooms on the HSBC RATING FORM, although there are some differences across rooms (e.g., bedrooms do not have a prompt for stacked dishes in the sink). Appearance needs are generally detrimental to cognitive and social development in children. For instance, rooms with no decorations and worn furniture may interfere with the development of creativity, or potentially foster acquiescence to standards of cleanliness that are less than optimal.

Whether a Safety or Appearance rating is required for an item, the HSBC RATING FORM provides a standard format for recording the ratings. As Figure 2 illustrates, there are three columns dedicated to each category that is rated. The first column will always contain a general category title (e.g., TOXINS), underneath which are listed the specific category items (e.g., Medications, Cleaning Supplies). The second column, which is denoted with either an "S" or "A" (for Safety or Appearance) contains a space to record ratings for the category items. The third column provides a space for notes. Notes are used to assist the treatment clinicians in understanding the hazard by providing more specific information about the category items that are present (e.g., pesticide under sink) or to identify any extenuating circumstances (e.g., medication with child-proof cap).

Figure 2. HSB rating system

TOXINS	S	Notes
Medications		
Cleaning supplies		
Detergents		
Paint/solvent/thinner		
Alcohol or Drugs		
Pesticides		
Others:		

As indicated in Figure 2, the specific category items (e.g., medications, cleaning supplies) are usually self-explanatory and mutually exclusive, although in some cases a particular item can be classified into more than one category. To assist in decision making, specific examples of items that make up each category are provided in the Common Home Safety and Beautification Problems and Solutions section of this manual (Form E). Also, while the list of category items is intended to be comprehensive, for practical reasons it is not exhaustive. That is, there may be hazards or appearance needs in the home that are not explicitly included in the HSB RATING FORM. Consequently, each category includes an item denoted “Other,” so that items that are not included on the form can be recorded and a treatment priority rating can be assigned. Furthermore, potential hazards or appearance needs that do not fit into any particular Category can be listed and rated in the category denoted “Other Risks.”

Priority ratings are assigned to all Safety, Clean-up Needs, and Aesthetic Needs items. Safety items are biased to reflect risk due to physical harm, whereas Aesthetic Need items, and to a lesser extent Clean-up Need items, also reflect non-physical harm (e.g., interfere with the child’s development, foster acquiescence to poverty).

The following scale, which is provided at the top of each HSB form, provides these rating options:

- a. A blank or rating of “0” reflects that the item is absent. For safety items, this rating is assigned when the hazard is not present in the room, e.g., there are no medications present in Bathroom 1. For Appearance ratings, this ratings is given where there are no clean-up needs or Aesthetic needs in the room
- b. A rating of “1” indicates that the item is present, but does not require intervention because it poses no risk of harm to children living in the home, or because it is not anticipated to result in cognitive or social developmental delays. For example, in a home where the youngest child is a normally developed 10 year old, uncovered outlets would result in a rating of 1 because although present, they do not pose a risk of harm.
- c. A rating of “2” reflects that the item is a “Minimal Priority” for intervention. For Safety ratings, a 2 indicates the item poses very little risk of harm to children living in the home. For Appearance, it is unlikely that a developmental delay would be caused by the item.
- d. A rating of “3” reflects that the item is a “Moderate Priority” for intervention.

Safety items rated a “3” are those that must be addressed in treatment because they pose a threat to the welfare of the child, but do not pose an imminent threat. Appearance items rated a “3” require remediation because if left in their current condition are expected to result in a social or cognitive developmental delay over the long term.

- e. A rating of “4” reflects that the item is a “High Priority” for intervention. All Safety items receiving a rating of 4 pose an imminent threat to children living in the home and require immediate intervention to correct the hazard and protect the health and welfare of the children in the home. Items rated a 4 would include a loaded gun that is accessible to the child, a balcony with no railing that the child could fall from, or an exposed gas or electric heater that could cause serious burns. Appearance items rated a “4” are a high priority for treatment but may not require immediate intervention because they do not pose an imminent risk of harm to the child. Appearance items rated a “4” would receive top priority in treatment.

2. For each room, examine the following:

When touring each room in the home, examine each of the following:

- a. Floor
- b. Ceiling
- c. Walls
- d. Any enclosures present (i.e., cupboards, dressers, etc.)
- e. Objects listed on home assessment form

Visual inspection of the ceiling, walls, and floors is particularly important because these can sometimes be overlooked as the home tour progresses. For example, cracks in the ceiling and walls that are dirty or in need of repainting would result in a rating for appearance. Carpet and linoleum that is badly worn or dirty would also result in an appearance rating but may be a safety issue as well, if there are tears that could increase the risk of tripping and falling. It is recommended that the rater adopt a standard procedure for inspecting the rooms. For example, the ceiling floors and walls may be rated first, followed by inspection of open places (counter tops, tables, etc.), and then inspection of enclosed places. A standard procedure will ensure that each room is evaluated in a systematic manner and that none of the major items are inadvertently skipped.

It is also important to take adequate precautions with conducting home tours. We do not recommend wearing protective gloves when conducting the tour, because clients may take offense. However, when inspecting enclosed spaces, such as drawers, ask the client whether there is anything sharp such as needles or knives.

3. Provide individual ratings for each item in each room using the following guidelines

- a. Consider the most vulnerable child in the home
- b. Developmental age of all children in home
- c. Accessibility of item to children in home

- d. Extenuating circumstances for the family
- e. If potential hazard is to be treated, it must have a rating of 2 or greater
- f. If the item does not “fit” into one particular rating (i.e., falls between 2 and 3) assign the higher of the two ratings
- g. Rate each item only once

The guidelines (a – g) are intended to help guide the rater as they determine the ratings that are most appropriate for the individual items. They include considerations that are specific to the child (a. most vulnerable child; b. developmental age), that are specific to the home (c. accessibility of the items; d. extenuating circumstances), that include treatment considerations (e. rating of “2” for treatment), as well as more general procedures that may assist in assigning ratings when there is lack of clarity (f. g.). The following sections elaborate on each of these guidelines and provide examples for each.

- a. First, consider the most vulnerable child in the home. Although all youth living in the home should be considered when conducting the ratings, the underlying content reflected in each item is prioritized according to its likelihood of causing potential harm to the most vulnerable child living in the home (e.g., an infant child would probably be more vulnerable to dog feces in the kitchen than a 7-year old).
- b. Second, consider the developmental age of all children living in the home. In general, younger children are more likely to be harmed from home accidents and lack of stimulation in the home than their older counterparts. For instance, cleaning supplies that are stored under the kitchen sink pose minimal risk of harm to a 4-year old child who knows the dangers of ingesting these products (i.e., “2” rating), and Moderate to High risk to a toddler who can’t appreciate poisons can cause harm (i.e., probably receive a “3” or “4” rating). A penny on the ground poses no or very little risk for a 6 year-old (i.e., probably a 0 or 1 on the rating scale), and high risk for an infant (i.e., 3 or 4 rating). Similarly, developmental limitations (e.g., mental retardation, victims of head trauma, severe learning disabilities) should be considered, as potential for harm increases as developmental limitations become more severe.
- c. Third, consider accessibility of the item’s content to all children living in the home. Items are hazardous only to the extent that children have access to them. For instance, medications that are placed high on a shelf, pose little risk to an infant who is unable to walk, even if these medications are in an unlocked medicine cabinet (i.e., receive “1” or “2” rating). However, medications are potentially lethal for ambulatory children who have discovered how to use chairs to gain access to bathroom cabinets (i.e., 3 or 4 rating). Safety precautions may also decrease risk of harm. For example, medications with childproof caps on containers, cleaning supplies that are stored in cabinets with safety locks, and moving furniture in front of dangerous equipment, all decrease the potential risk of harm for toddlers and infants (i.e., rating of 1 or 2).

- d. Fourth, consider other extenuating circumstances. Indeed, situational contexts greatly influence hazardous conditions. For instance, prescribed medications in an unlocked medicine cabinet or an open bar may not be risks for typical teenagers (i.e., receive rating of “1”), but be a high treatment priority for depressed substance abusing teenagers (i.e., rating of “4”). Other extenuating circumstances include the child’s inquisitiveness, activity level, and special needs (e.g., handicaps).
- e. Fifth, remember that if the potential hazard is to be treated, it must have a rating of 2 or greater. Because ratings of “0” and “1” are not priorities for treatment, it is helpful to consider whether or not the safety or appearance need should be remediated. Thus, safety items that are clearly low risk but that should be addressed at some point during treatment must be rated with a “2”, which indicates that they are a priority for treatment, even though they are a low priority.
- f. Sixth, when rating a potential hazard, it may be that it does not clearly “fit” into one particular rating. For example, it may be that you judge an item to be somewhere between a rating of “2” which indicates minimal priority for treatment, and a “3” which indicates a moderate priority for treatment. In these instances, always assign the higher of the two ratings (in this example, a “3” rather than a “2”). The rationale for this procedure is that assigning a higher rating will result in a higher likelihood that the safety or attractiveness item will be addressed in treatment, which in questionable cases is the best approach to ensure the safety of the child.
- g. Seventh, an attempt should be made to rate each item only once. For example, tacks on the floor could be included in the category “Small Objects” or the category “Sharp Objects”. In these cases, it is recommended that the item be rated in the one category in which it would receive its highest treatment priority rating.

4. Write notes for each item that is rated

Each item in the HSBC RATING FORM has a space to record notes of pertinent information regarding each of the respective hazards that are identified, including location and description of the hazard (particularly when “Other” hazards are identified). Evaluators are encouraged to take detailed notes, as therapists will often utilize the notes to guide intervention.

5. Provide overall safety and appearance ratings for each room

At the bottom of each room rating form, there is a place to record an overall Safety and Appearance rating for the entire room (see Figure 3). The overall Safety and Appearance ratings for each room are made on the same scale that was used for rating individual items in the room. Unlike the individual ratings, the overall rating reflect a combination of the number of items rated in the room, as well as the severity of any particular item that was rated. Because of this, the overall ratings are not simply an average of the number of items that were rated. For example, with regard to the Safety rating, it may be that only one item in the room was rated, but that item was a loaded handgun that was accessible to the

children. In this case, a rating of “4” for the item and “4” for the room is appropriate because of the extreme danger posed by the handgun. Alternatively, a room may have received many item ratings of “2” with no items rated “4”. A room rating of “4” might also be appropriate in this case because the sheer number of items the are present in the room pose a serious risk of harm to the child, even though no item in and of itself is considered an imminent threat.

Figure 3. Room Safety and Appearance Ratings

OVERALL ROOM RATINGS									
Safety (S)					Appearance (A)				
0	1	2	3	4	0	1	2	3	4

d. Provide Overall Ratings for home

Record on the Home Safety and Beautification Profile Form, the 5-point intervention priority ratings for Overall Home’s Safety and Appearance. Use the following scales to make these rating.

1. Overall Home Safety Rating

- 0 = not present
- 1 = present, no priority
- 2 = present, minimal priority,
- 3 = present, moderate priority
- 4 = present, high priority

2. Overall Home Appearance Rating

- 0 = not present
- 1 = present, no priority
- 2 = present, minimal priority,
- 3 = present, moderate priority
- 4 = present, high priority

Procedures to Use When Clients Refuse to Allow Inspection of Rooms or Enclosures

It is not uncommon for clients to be initially uncomfortable with the idea of allowing the assessor to inspect each room in their home. Sometimes, even after providing the initial rationale that emphasizes the benefits of the home safety tour and attempts to ally concerns, clients will refuse to allow inspection of a room. It is also the case that clients may be hesitant to allow the rater to inspect enclosed spaces, such as cupboards and drawers, because these often contain personal items.

When clients refuse to allow inspection a room or enclosed space, use the following procedures. The procedures are designed to optimize the chances of being able to inspect a room or enclosure after the client has refused, which is the primary objective. However, if the client does not provide permission, the guidelines also allow for a standardized approach to guide the client in self-reporting the contents of the room or enclosure. The procedures for rooms and enclosure are essentially the same. An outline of the entire procedure is provided below, followed by an explanation of key points and examples.

- a. Rooms: If the client indicates that a room is off-limits, do the following:

1. attempt to determine why client does not wish to tour room
 2. empathize or normalize concerns
 3. attempt to resolve issues that may prevent tour of room, including:
 - a. For concerns regarding the purpose of the tour, reiterate the rationale that was initially provided
 - b. Disclose positive aspects of the tour including (Note: This step should not be used for clients who are in the randomized controlled trial.)
 - i. an attempt will be made to correct significant hazards and improve attractiveness.
 - ii. greater leverage with landlords and potential public assistance to correct any problems that are identified.
 - c. report assessor will keep information from tour confidential, while telling the caseworker how open the client was to the assessment in general
 4. If client still refuses entry to room, have client self-report room contents as follows:
 - a. Indicate that the whole room was self-report in the appropriate checkbox at the top of the rating form for that room.
 - b. Query client about room content and read list of hazards to the client asking if each item is present or absent in the room
 - c. Indicate this information on assessment form
 5. After self-report is complete, assure children have no access to hazards in the room that was refused.
 - a. Ask client if child has access to the room
 - i. If client gives vague response ask if there are any measures in place to keep child from accessing room
 - ii. If the child has access to the room, ask if the child might have access to any of the hazards identified in the self-report
 - b. If the room is locked ask if child has access to the key
- b. Enclosures: For any enclosures (i.e., locked rooms or closed cabinets/drawers) that the client says are off limits, do the following:
1. attempt to determine why client does not wish to look in the enclosure
 2. empathize with and normalize concerns
 - a. For concerns regarding the purpose of the tour, reiterate the rationale that was initially provided
 - b. Disclose positive aspects of the tour including (Note: This step should not be used for clients who are in the randomized controlled trial.)
 - i. an attempt will be made to correct significant hazards and improve attractiveness.
 - ii. greater leverage with landlords and potential public assistance to correct any problems that are identified.
 - c. report assessor will keep information from tour confidential, while telling the caseworker how open the client was to the assessment in general
 3. If examination of enclosure is still refused have client self-report content of enclosure as follows:
 - a. Indicate that the enclosure was self-report in the appropriate space next to

- the item that was in the enclosure
- b. Query client about enclosure content and read list of hazards to the client asking if each item is present or absent in the enclosure
- c. Indicate this information on assessment form
- 4. Assure children have no access to hazards in the enclosure that was refused.
 - a. Ask client if child has access to the enclosure
 - i. If client gives vague response ask if there are any measures in place to keep child from accessing enclosure
 - b. If the enclosure is locked ask if child has access to the key

a. Rooms: If the client indicates that a room is off-limits, do the following:

1. Attempt to determine why client does not wish to tour room

When clients refuse entry into a room, it is often for a valid reason. It is vitally important to determine the nature of their concern so that the rater can allay the concern and gain permission to inspect the room. To obtain this information, the assessor might say “Can you tell me a little more about why you do not want me to inspect this room?”

2. Empathize with and normalize concerns

As the client discusses her concerns, make empathic statements and normalize the concerns to the extent possible. Again, two major areas of concern involve being unprepared to have their house toured and invasion of personal space. Statement such as, “I understand why you are concerned about that” will help clients feel validated and that their concerns are understood.

3. Attempt to resolve issues that may prevent tour of room, including:

a. For concerns regarding the purpose of the tour, reiterate the rationale that was originally provided

b. Disclosing positive aspects of the tour including (Note: This step should not be used for clients who are in the randomized controlled trial.)

i. an attempt will be made to correct significant hazards and improve attractiveness.

ii. greater leverage with landlords and potential public assistance to correct any problems that are identified.

c. Report assessor will keep information from tour confidential, while telling the caseworker how open the client was to the assessment in general

Clients may be concerned that information obtained on the tour will be shared with a caseworker. In these cases, reaffirming the confidentiality of the evaluation with reference to the certificate of confidentiality, along with the assurance that the caseworker will be informed of the client’s cooperativeness, may help allay this concern.

The following example represents a typical exchange between a client and assessor when inspection of a room is initially refused but after following the procedures, permission is then granted:

Client: “I don’t want you to go in my bedroom.”

Assessor: (a) “While we can exclude your bedroom from the tour today, I’d prefer that we tour all rooms. Are there concerns that you have with me going into your bedroom?”

Client: “I didn’t have a chance to clean the house, so it will be a mess. Especially my bedroom. I didn’t know you’d be going around my house.”

Assessor: (a1) “I understand. It might be helpful to stress that the home tour might help to identify things that can be used to motivate your landlord to update the quality of your apartment. For instance, you mentioned that I should be careful about the ants when we first sat down. Results of this tour might give you the professional backing you need to suggest your landlord needs to take care of this problem for you. My program has supported other parents this way. I should also stress all information will be strictly confidential. In fact, if we discover a significant hazard, I’ll help you to get rid of it right away.”

Client: “That sounds great, but can we exclude my bedroom?”

Assessor: “Yes, as long as children don’t have access to hazards in your room. However, could you tell me what you are uncomfortable about regarding a tour of your room?”

Client: “Well, I told you it’s a mess. My bed isn’t made and all my stuff is just piled up on the floor of my closet.”

Assessor: “I didn’t make my bed today either. What if we just skip your closet? I doubt your children would want to go in there anyway. I’ll even make a note in my records about how open and cooperative you were with me in my assessment. Later, if you want your caseworker to know how cooperative you were in the assessment process, I can provide this information, and still keep the results of this tour completely confidential.”

Client: “That’s fine.”

4. *If client still refuses entry to room have client self-report room contents as follows:*
 - a. *Indicate that the whole room was self-report in the appropriate checkbox at the top of the rating form for that room.*
 - b. *Query client about room content and read list of hazards to the client*

- asking if each item is present or absent in the room*
- c. *Indicate this information on assessment form***

For enclosures such as cupboards, dresser drawers, closets, clients may be hesitant to allow you to inspect these areas. Assure the client that you do not have to look in the enclosures but that it would be helpful for the assessment, and that it is a standard part of the assessment process that everyone goes through. In cases when they still refuse, ask the client why they do not want you to look in the enclosure. They may say “because there are personal items in there.” Try to get a sense of what the personal items are. For example, you may say, “can you tell me a little more about the personal items?” or “are they items that have to do with intimacy?” Once the item is described, ask them what else is in the enclosure other than the personal item. Once all the items have been described, follow up by asking if there is anything else in the enclosure that could be a hazard for their child. Make sure to rate each item described on the rating sheet. For all items that are not directly observed, indicate that they were self-reported by the client by writing “SR” next to the item.

- 5. *After self-report is complete, assure children have no access to hazards in the room that was refused.***
- a. *Ask client if child has access to the room***
- i. *If client gives vague response ask if there are any measures in place to keep child from accessing room***
- ii. *If the child has access to the room, ask if the child might have access to any of the hazards identified in the self-report***
- b. *If the room is locked ask if child has access to the key***

**FORM A: ASSESSOR PROMPTING LIST FOR HOME SAFETY AND
BEAUTIFICATION TOUR**

Client ID#: _____

Date: _____

Start Time _____

Present Rationale to Client and Significant Others

- ___ a. Tell client the assessor will conduct a safety and appearance tour
- ___ b. Explain that tour is designed to identify home hazards (objects/physical situations that could cause harm)
- ___ c. State that all households contain potential hazards
- ___ d. Tell client that hazards can cause home accidents
- ___ e. State that home accidents are a leading cause of death and injury for children.
- ___ f. Explain that tour designed to help identify home hazards
- ___ g. Tour involves touring each room in home and completing forms.
- ___ h. Forms include types of home hazards common in most homes.
- ___ i. As the assessor looks, if there is any room you don't want the assessor to enter, say so.
- ___ j. At times the assessor will need to look in closed places.
- ___ k. The assessor will ask your permission to do this.
- ___ l. Standard part of tour to identify hazards that might be present in closed places.
- ___ m. We will tour the kitchen, living area, main bathroom, and your child's room.
- ___ n. Explain that client will also rate attractiveness and safety of each of these rooms.

Prepare The HSBC Rating Form and client Safety and Appearance Rating Form

- ___ a. Present CLIENT SAFETY AND APPEARANCE RATING FORM to client (Form A)
- ___ b. Ask client to provide an identifier for each room listed on the form
 - ___ 1. Use the CLIENT SAFETY AND APPEARANCE RATING FORM with the client to determine an identifier for each room.
 - ___ 2. Cross out rooms that are not present in the home.
- ___ c. After the CLIENT SAFETY AND APPEARANCE RATING FORM is complete, transfer room identifying information to each respective HSBC RATING FORM

Conduct the client Safety and Appearance tour

- ___ a. Provide client with CLIENT SAFETY AND APPEARANCE RATING FORM
- ___ b. Instruct client to provide safety and appearance ratings for each room listed
- ___ c. Explain that there is a place on the form to provide ratings for each room
 - ___ 1. Explain the safety rating
 - a. 1 = extremely unsafe
 - b. 6 = extremely safe
 - ___ 2. Explain the appearance rating
 - a. 1 = extremely unattractive
 - b. 6 = extremely attractive
- ___ d. Tell clients to rate the rooms as they wish
- ___ e. Instruct client to fold the paper their ratings are written on when finished to keep

- them private
- ___f. Have child specialist or other person who will not complete the HSBC RATING FORM escort client through home to complete Safety and Appearance tour
 - ___g. If client asks for advice on ratings, respond in a nondirective manner

Conduct the HSBC Tour of Home with Client

- ___a. For each room mark the appropriate checkbox at the top HSBC RATING FORM
 - Rated = room is present and was reviewed
 - Self-Report = client did not allow tour but self-reported the contents of the room to the evaluator
 - Not Rated = room is present but client did not allow tour and refused to provide a self-report of the room contents
 - NA = the room is absent
- ___b. Check each risk category listed on the HSBC RATING FORM for each room toured in the home
 - ___1. Use the following rating scale for Safety and Appearance:
 - 0 or blank = absent
 - 1 = present, no priority
 - 2 = present, minimal priority
 - 3 = present, moderate priority
 - 4 = present, high priority
 - ___2. For each room, examine the following:
 - Floor
 - Ceiling
 - Walls
 - Any enclosures present (i.e., cupboards, dressers, etc.)
 - Objects listed on home assessment form
 - ___3. Place a check mark next to each risk category in each room indicating that you examined that risk category.
 - ___4. Provide overall safety and appearance ratings for each **room** using the following guidelines
 - Developmental age of all children in home (most vulnerable child)
 - Accessibility of item to children in home
 - Extenuating circumstances for the family
 - Rating of 2 or greater required for treatment
 - When item falls between 2 ratings assign the higher rating
- ___c. Provide Overall Home Assessment Ratings for the following areas
 - ___1. Use the following rating scale for **Overall Home Safety**:
 - 0 = not present
 - 1 = present, no priority
 - 2 = present, minimal priority,
 - 3 = present, moderate priority
 - 4 = present, high priority
 - ___2. Use the following rating scale for **Overall Home Appearance**:
 - 0 = not present

- 1 = present, no priority
- 2 = present, minimal priority,
- 3 = present, moderate priority
- 4 = present, high priority

Procedures to Use When Clients Refuses to Allow Inspection of Rooms or Enclosures

- ___ a. Rooms: If the client indicates that a room is off-limits, do the following:
 - ___ 1. attempt to determine why client does not wish to tour room
 - ___ 2. empathize with and normalize concerns
 - ___ 3. attempt to resolve issues that may prevent tour of room, including:
 - a. For concerns regarding the purpose of the tour, reiterate the rationale that was initially provided
 - b. Disclose positive aspects of the tour including (Note: This step should not be used for clients who are in the randomized controlled trial.)
 - i. an attempt will be made to correct significant hazards and improve attractiveness.
 - ii. greater leverage with landlords and potential public assistance to correct any problems that are identified.
 - c. report assessor will keep information from tour confidential, while telling the caseworker how open the client was to the assessment in general
 - ___ 4. If client still refuses entry to room have client self-report room contents as follows:
 - ___ a. Indicate that the whole room was self-report in the appropriate checkbox at the top of the rating form for that room.
 - ___ b. Query client about room content and read list of hazards to the client asking if each item is present or absent in the room
 - ___ c. Indicate this information on assessment form
 - ___ 5. After self-report is complete, assure children have no access to hazards in the room that was refused.
 - ___ a. Ask client if child has access to the room
 - i. If client gives vague response ask if there are any measures in place to keep child from accessing room
 - ii. If the child has access to the room, ask if the child might have access to any of the hazards identified in the self-report
 - ___ b. If the room is locked ask if child has access to the key
- ___ b. Enclosures: For any enclosures (i.e., locked rooms or closed cabinets/drawers) that the client says are off limits, do the following:
 - ___ 1. attempt to determine why client does not wish to look in the enclosure
 - ___ 2. empathize or normalize concerns
 - ___ 3. attempt to resolve issues that may prevent examination of the enclosure, including:
 - a. For concerns regarding the purpose of the tour, reiterate the rationale that was initially provided
 - b. Disclose positive aspects of the tour including (Note: This step should

not be used for clients who are in the randomized controlled trial.)

- i. an attempt will be made to correct significant hazards and improve attractiveness.
 - ii. greater leverage with landlords and potential public assistance to correct any problems that are identified.
 - c. report assessor will keep information from tour confidential, while telling the caseworker how open the client was to the assessment in general
- ___4. If examination of enclosure is still refused have client self-report content of enclosure as follows:
- ___a. Indicate that the enclosure was self-report in the appropriate
 - ___b. Query client about room content and read list of hazards to the client asking if each item is present or absent in the room
 - ___c. Indicate this information on assessment form
- ___5. Assure children have no access to hazards in the enclosure that was refused.
- ___a. Ask client if child has access to the enclosure
 - i. If client gives vague response ask if there are any measures in place to keep child from accessing enclosure
 - ___b. If the enclosure is locked ask if child has access to the key

End Time: _____

Instructions to be verbally presented to the client:

Now I would like you to provide a rating for the safety and appearance of each room in your home. On this form, there is a place for you to provide a rating for each room. The first rating is a safety rating with a "1" indicating that the room is "Extremely Unsafe" and a "6" indicating that the room is "Extremely Safe". The second rating for each room is an appearance rating. A "1" indicates that the room is "Extremely Unattractive" and a "6" indicates the room is "Extremely Attractive." Go ahead and rate the rooms how you see fit -- there are no right or wrong answers. However, since I will be rating each room later, I would ask that you keep your ratings private and do not share them with me. In fact, to keep your ratings private, please place them in this envelope when they are completed. Do you have any questions?

HSB Client Safety and Appearance Rating Form

Instructions: Please provide a rating for the safety and appearance of each room by circling a number from 1 to 6 on the scales provided below.

Kitchen

Safety rating:	1 Extremely Unsafe	2 Very Unsafe	3 Somewhat Unsafe	4 Somewhat Safe	5 Very Safe	6 Extremely Safe
Appearance rating:	1 Extremely Unattractive	2 Very Unattractive	3 Somewhat Unattractive	4 Somewhat Attractive	5 Very Attractive	6 Extremely Attractive

Main Bathroom

Description: _____

Safety rating:	1 Extremely Unsafe	2 Very Unsafe	3 Somewhat Unsafe	4 Somewhat Safe	5 Very Safe	6 Extremely Safe
Appearance rating:	1 Extremely Unattractive	2 Very Unattractive	3 Somewhat Unattractive	4 Somewhat Attractive	5 Very Attractive	6 Extremely Attractive

Family Room

Description: _____

Safety rating:	1 Extremely Unsafe	2 Very Unsafe	3 Somewhat Unsafe	4 Somewhat Safe	5 Very Safe	6 Extremely Safe
Appearance rating:	1 Extremely Unattractive	2 Very Unattractive	3 Somewhat Unattractive	4 Somewhat Attractive	5 Very Attractive	6 Extremely Attractive

Child's Bedroom

Description: _____

Safety rating:	1 Extremely Unsafe	2 Very Unsafe	3 Somewhat Unsafe	4 Somewhat Safe	5 Very Safe	6 Extremely Safe
Appearance rating:	1 Extremely Unattractive	2 Very Unattractive	3 Somewhat Unattractive	4 Somewhat Attractive	5 Very Attractive	6 Extremely Attractive

FORM B: HOME SAFETY AND BEAUTIFICATION PROFILE FORM

Overall Home Assessment Ratings Form

To be completed by assessor.

1. Overall Home Safety Rating

0 = not present

1 = present, no priority

2 = present, minimal priority,

3 = present, moderate priority

4 = present, high priority

2. Overall Home Appearance Rating

0 = not present

1 = present, no priority

2 = present, minimal priority,

3 = present, moderate priority

4 = present, high priority

FORM C: HSBC RATING FORM AND "OTHER ROOM" RATING FORM

KITCHEN Applicable		<input type="checkbox"/> Rated <input type="checkbox"/> Not Rated <input type="checkbox"/> Self Report <input type="checkbox"/> Not E/ID # _____							
Treatment Priority Ratings:									
Safety (S): 0 = not present, 1 = present, no priority, 2 = present, minimal priority, 3 = present, moderate priority, 4 = present, high priority Appearance (A): 0 = not present, 1 = present, no priority, 2 = present, minimal priority, 3 = present, moderate priority, 4 = present, high priority									
Toxins	S	Notes	Heavy/Tipsy Objects	S	Notes	Needs Clean Up	A	Notes	
1. Medications			25. Furniture			41. Clothes			
2. Cleaning supplies			26. Boxes			42. Counters/Tables			
3. Detergents			27. Appliances (blender)			43. Floor/Wall/ Ceiling			
4. Paint, solvents			28. Artwork			44. Dog feces			
5. Alcohol or Drugs			29. Other:			45. Bug infestation			
6. Pesticides						46. Food left out			
7. Other:						47. Clutter			
Electrical Hazards	S	Notes				48. Dishes in sink			
8. Outlets exposed						49. Other:			
9. Appliances and tools						Aesthetic Needs	A	Notes	
10. Empty light sockets			Small Objects	S	Notes	50. Furniture is worn/ torn			
11. Exposed/frayed wires			30. List:			51. Appliances are malfunctioning			
12. Other:						52. Carpet, Rug, or floor worn			
Sharp Objects	S	Notes	Probs. w/ Air Quality	S	Notes	53. Light bulbs missing or burnt out			
13. Knives/skewers, pins, scissors, needles			31. Poor ventilation			54. Decor absent			
14. Corners			32. Too hot			55. Walls unpainted			
15. Tools			33. Too cold			56. Other:			
16. Nails/splinters			34. Mildew/mold						
17. Other:			35. Doors/windows drafty						
Food & Nutrition Needs	S	Notes	36. Other:						
18. 4 food groups absent									
19. Food is spoiled									
20. Junk food accessible									
21. Other:			Other Risks	S	Notes				
Home Access/Security	S	Notes	37. Floor/wall/ceiling in disrepair/holes						
22. Windows won't lock/ broken			38. Weapons (gun, p. spray)						
23. Doors won't lock / broken			39. Porn or sex toys						
24. Other:			40. Other:						
OVERALL ROOM RATINGS									
# 57. Safety (S)					# 58. Appearance (A)				
0	1	2	3	4	0	1	2	3	4

BATHROOM : Description _____ Applicable	<input type="checkbox"/> Rated <input type="checkbox"/> Not Rated <input type="checkbox"/> Self Report <input type="checkbox"/> Not # _____
Treatment Priority Ratings:	

Safety (S): 0 = not present, 1 = present, no priority, 2 = present, minimal priority, 3 = present, moderate priority, 4 = present, high priority
Appearance (A): 0 = not present, 1 = present, no priority, 2 = present, minimal priority, 3 = present, moderate priority, 4 = present, high priority

Toxins	S	Notes	Heavy/Tipsy Objects	S	Notes	Needs Clean Up	A	Notes	
1. Medications			21. Furniture			38. Tub/shower/toilet			
2. Cleaning supplies			22. Boxes			39. Clothes			
3. Detergents			23. Appliances (iron)			40. Counters			
4. Paint, solvents			24. Artwork			41. Floor/ Wall/ Ceiling			
5. Alcohol or Drugs			25. Other:			42. Dog Feces			
6. Pesticides						43. Bug Infestation			
7. Other:						44. Food Left Out			
						45. Clutter			
						46. Other:			
Electrical Hazards	S	Notes				Aesthetic Needs	A	Notes	
8. Outlets						47. Furniture worn/torn			
9. Appliances (blow dryer, curling iron, radio)			Small Objects	S	Notes	48. Appliances are malfunctioning			
10. Empty light sockets			26. List:			49. Carpet, rug, or flooring is worn			
11. Exposed/frayed wires						50. Light bulbs missing or burnt out			
12. Other:						51. Decorations absent			
			Air Quality	S	Notes	52. Walls unpainted			
			27. Poor ventilation			53. Other:			
			28. Too hot						
			29. Too cold						
			30. Mildew/mold						
			31. Doors/windows drafty						
			32. Other:						
Sharp Objects	S	Notes							
13. Razors, hair pins, scissors, needles									
14. Corners									
15. Tools									
16. Nails/splinters									
17. Other:									
Home Access & Security	S	Notes	Other Risks	S	Notes				
18. Windows won't lock/broken			33. Floor/wall/ ceiling in disrepair/holes						
19. Doors won't lock/broken			34. Weapons (gun, p. spray)						
20. Other:			35. Porn or sex toys						
			36. Plumbing (problem)						
			37. Other:						
OVERALL ROOM RATINGS									
#54. Safety (S)					#55. Appearance (A)				
0	1	2	3	4	0	1	2	3	4

FAMILY ROOM : Description _____		<input type="checkbox"/> Rated <input type="checkbox"/> Not Rated <input type="checkbox"/> Self Report <input type="checkbox"/> Not Applicable						
		# _____						
Treatment Priority Ratings:								
Safety (S): 0 = not present, 1 = present, no priority, 2 = present, minimal priority, 3 = present, moderate priority, 4 = present, high priority Appearance (A): 0 = not present, 1 = present, no priority, 2 = present, minimal priority, 3 = present, moderate priority, 4 = present, high priority								
Toxins	S	Notes	Heavy/Tipsy Objects	S	Notes	Needs Clean Up	A	Notes
1. Medications			25. Furniture			41. Clothes		
2. Cleaning supplies			26. Boxes			42. Counters/Tables		

3. Detergents			27. Appliances (stereo)			43. Floor/Wall/ Ceiling			
4. Paint, solvents			28. Artwork			44. Dog feces			
5. Alcohol or Drugs			29. Other:			45. Bug infestation			
6. Pesticides						46. Clutter			
7. Other:						47. Other:			
Electrical Hazards	S	Notes							
8. Outlets exposed									
9. Appliances and tools									
10. Empty light sockets									
11. Exposed/frayed wires			Small Objects	S	Notes	Aesthetic Needs	A	Notes	
12. Other:			30. List:			48. Furniture worn/ torn			
						49. Appliances are malfunctioning			
Sharp Objects	S	Notes				50. Carpet, Rug, or floor worn			
13. Knives, pins, scissors, needles			Probs. w/ Air Quality	S	Notes	51. Light bulbs missing or burnt out			
14. Corners			31. Poor ventilation			52. Décor absent			
			32. Too hot			53. Walls unpainted			
15. Tools			33. Too cold			54. Other:			
16. Nails/splinters			34. Mildew/mold						
17. Other:			35. Doors/windows drafty						
Food & Nutrition Needs	S	Notes	36. Other:						
18. 4 food groups absent									
19. Food is spoiled									
20. Junk food accessible									
21. Other:			Other Risks	S	Notes				
Home Access/Security	S	Notes	37. Floor/walls/ceiling in disrepair/holes						
22. Windows won't lock/ broken			38. Weapons (gun, p. spray)						
23. Doors won't lock / broken			39. Porn or sex toys						
24. Other:			40. Other:						
OVERALL ROOM RATINGS									
#55. Safety (S)					#56. Appearance (A)				
0	1	2	3	4	0	1	2	3	4

CHILD'S BEDROOM: Description _____						<input type="checkbox"/> Rated <input type="checkbox"/> Not Rated <input type="checkbox"/> Self Report <input type="checkbox"/> Not		
Applicable						E/ID # _____		
Treatment Priority Ratings:								
Safety (S): 0 = not present, 1 = present, no priority, 2 = present, minimal priority, 3 = present, moderate priority, 4 = present, high priority								
Appearance (A): 0 = not present, 1 = present, no priority, 2 = present, minimal priority, 3 = present, moderate priority, 4 = present, high priority								
Toxins	S	Notes	Heavy/Tipsy Objects	S	Notes	Needs Clean Up	A	Notes
1. Medications			25. Furniture			41. Clothes		
2. Cleaning supplies			26. Boxes			42. Counters/Tables		
3. Detergents			27. Appliances			43. Floor/Wall/ Ceiling		
4. Paint, solvents			28. Artwork			44. Dog feces		
5. Alcohol or Drugs			29. Other:			45. Bug infestation		
6. Pesticides						46. Clutter		
7. Other:								

Electrical Hazards	S	Notes				47. Other:			
8. Outlets exposed									
9. Appliances and tools									
10. Empty light sockets									
11. Exposed/frayed wires									
12. Other:									
Sharp Objects	S	Notes				Aesthetic Needs	A	Notes	
13. Knives, pins, scissors, needles			Small Objects	S	Notes	48. Furniture worn/torn			
14. Corners			30. List:			49. Appliances are malfunctioning			
15. Tools									
16. Nails/splinters			Probs. w/ Air Quality	S	Notes	50. Carpet, Rug, or floor worn			
17. Other:			31. Poor ventilation			51. Light bulbs missing or burnt out			
Food & Nutrition Needs	S	Notes	32. Too hot			52. Decor absent			
18. 4 food groups absent			33. Too cold			53. Walls unpainted			
19. Food is spoiled			34. Mildew/mold			54. Other:			
20. Junk food accessible			35. Doors/windows drafty						
21. Other:			36. Other:						
Home Access/Security	S	Notes	Other Risks	S	Notes				
22. Windows won't lock/broken			37. Floor/wall/ceiling in disrepair/holes						
23. Doors won't lock/broken			38. Weapons (gun, p. spray)						
24. Other:			39. Porn or sex toys						
			40. Other:						
OVERALL ROOM RATINGS									
#55. Safety (S)					#56. Appearance (A)				
0	1	2	3	4	0	1	2	3	4

OTHER									<input type="checkbox"/> Rated	<input type="checkbox"/> Not Rated	<input type="checkbox"/> Not Applicable
Treatment Priority Ratings:											
Safety (S): 0 = not present, 1 = present, no priority, 2 = present, minimal priority, 3 = present, moderate priority, 4 = present, high priority											
Appearance (A): 0 = not present, 1 = present, no priority, 2 = present, minimal priority, 3 = present, moderate priority, 4 = present, high priority											
Toxins	S	Notes	Heavy/Tipsy Objects	S	Notes	Needs Clean Up	A	Notes			
1. Medications			25. Furniture			41. Tub/shower/toilet					
2. Cleaning supplies			26. Boxes			42. Clothes					
3. Detergents			27. Appliances			43. Counters/Tables					
4. Paint, solvents			28. Artwork			44. Floor/Wall/ Ceiling					
5. Alcohol or Drugs			29. Other:			45. Dog feces					
6. Pesticides						46. Bug infestation					
7. Other:						47. Clutter					
Electrical Hazards	S	Notes				48. Other:					
8. Outlets exposed											
9. Appliances and tools											
10. Empty light sockets											
11. Exposed/frayed wires			Small Objects	S	Notes	Aesthetic Needs	A	Notes			
12. Other:			30. List:			49. Furniture worn/ torn					
Sharp Objects	S	Notes				50. Appliances are malfunctioning					

13. Knives/skewers, pins, scissors, needles			Probs. w/ Air Quality	S	Notes	51. Carpet, Rug, or			
14. Corners			31. Poor ventilation			floor worn			
15. Tools			32. Too hot			52. Light bulbs			
16. Nails/splinters			33. Too cold			missing or burnt out			
17. Other:			34. Mildew/mold			53. Decor absent			
			35. Doors/windows			54. Walls unpainted			
			36. Other:			55. Other:			
Food & Nutrition Needs	S	Notes	Other Risks	S	Notes				
18. 4 food groups absent			37. Floor/wall/ceiling						
19. Food is spoiled			in disrepair/holes						
20. Junk food accessible			38. Weapons						
21. Other:			(gun, p. spray)						
Home Access/Security	S	Notes	39. Porn or sex toys						
22. Windows won't lock/ broken			40. Other:						
23. Doors won't lock/ broken									
24. Other:									
OVERALL ROOM RATINGS									
#56 Safety (S)				#57 Appearance (A)					
0	1	2	3	4	0	1	2	3	4

OTHER									<input type="checkbox"/> Rated <input type="checkbox"/> Not Rated <input type="checkbox"/> Not Applicable		
<i>Treatment Priority Ratings:</i>											
Safety (S): 0 = not present, 1 = present, no priority, 2 = present, minimal priority, 3 = present, moderate priority, 4 = present, high priority											
Appearance (A): 0 = not present, 1 = present, no priority, 2 = present, minimal priority, 3 = present, moderate priority, 4 = present, high priority											
Toxins	S	Notes	Heavy/Tipsy Objects	S	Notes	Needs Clean Up	A	Notes			
1. Medications			25. Furniture			41. Tub/shower/toilet					
2. Cleaning supplies			26. Boxes			42. Clothes					
3. Detergents			27. Appliances			43. Counters/Tables					
4. Paint, solvents			28. Artwork			44. Floor/Wall/ Ceiling					
5. Alcohol or Drugs			29. Other:			45. Dog feces					
6. Pesticides						46. Bug infestation					
7. Other:						47. Clutter					
Electrical Hazards	S	Notes				48. Other:					
8. Outlets exposed											
9. Appliances and tools											
10. Empty light sockets											
11. Exposed/frayed wires			Small Objects	S	Notes	Aesthetic Needs	A	Notes			
12. Other:			30. List:			49. Furniture worn/ torn					
						50. Appliances are malfunctioning					
Sharp Objects	S	Notes	Probs. w/ Air Quality	S	Notes	51. Carpet, Rug, or					
13. Knives/skewers, pins, scissors, needles			31. Poor ventilation			floor worn					
14. Corners			32. Too hot			52. Light bulbs					
15. Tools			33. Too cold			missing or burnt out					
16. Nails/splinters			34. Mildew/mold			53. Decor absent					
17. Other:											

			35. Doors/windows drafty			54. Walls unpainted		
Food & Nutrition Needs	S	Notes				55. Other:		
18. 4 food groups absent			36. Other:					
19. Food is spoiled								
20. Junk food accessible								
21. Other:								
Home Access/Security	S	Notes	Other Risks	S	Notes			
22. Windows won't lock/ broken			37. Floor/wall/ceiling in disrepair/holes					
23. Doors won't lock/ broken			38. Weapons (gun, p. spray)					
24. Other:			39. Porn or sex toys					
			40. Other:					
OVERALL ROOM RATINGS								
#56 Safety (S)					#57 Appearance (A)			
0	1	2	3	4	0	1	2	3

FORM D: COMMON HOME SAFETY AND BEAUTIFICATION PROBLEMS AND SOLUTIONS

TOXINS (safety)

Potential Hazard: Toxins are chemicals or substances that when ingested or rubbed on the body may cause bodily harm or death. Toxins are present in most homes, and fine to have around as long as children or adolescents do not have access to them. Toxic hazards usually occur in small children because children are curious to discover what they taste like, particularly in infants who have a tendency to explore by putting things in their mouths. Older children and adolescents are also at-risk to overdose on particular types of toxins, such as illicit and prescribed drugs and alcohol. Adolescents may be unable to appreciate the importance of being consistent with prescriptions.

Examples. Children eating medications that are left on kitchen or bathroom counters in non-childproof containers. Young children drinking cleaning detergents left under kitchen and bathroom sinks. Children drinking pesticide or paint left on garage floors or closets. Adolescents drinking toxic amounts of alcohol left in kitchen cabinets. Children getting ill from illicit drugs found in dresser drawers of their caregivers. Babies eating paint chips on walls or ceilings. Adolescents spraying toxic pesticides on plants without wearing protective gloves or masks.

Solutions. Install safety latches on cabinets or drawers that contain toxins. Restrict toxins to childproof containers. Place toxins in inconspicuous areas that are inaccessible to at-risk children (e.g., garage shelf, locked box). Instruct at-risk children to draw frown faces (or anything that represents danger) on containers that contain toxins. Scrape paint chips off ceilings and walls. Remove flammable toxins from heat sources. Review dangerous consequences of prescription abuse.

Special considerations. The family should be taught to implement the most convenient solution possible to prevent each potential hazard (e.g., toxins may be left in cabinets if safety latches are installed or children are able to demonstrate that toxins are harmful). It may be necessary to provide non-motivated caregivers with safety latches, and assist with installation of safety latches during home tours. Ropes may be used to tie cabinets together in easy to open bows if safety latches are unavailable when infants or very young toddlers are in the home.

ELECTRICAL HAZARDS (safety)

Potential Hazard: Human contact with electric, particularly electric and water or metal, may be potentially lethal.

Examples. Young children sticking their hands or metal objects into electrical appliances (e.g., toasters), electrical sockets or electrical outlets that do not have plugs, cover plates, light bulbs or switch plates. Touching exposed wires (e.g., spliced stereo wires). Hair dryers and radios falling into bathtubs or sinks.

Solutions. Cover all exposed electric wires with electrical tape (tape may be painted to

blend into background walls). In the homes of young or developmentally delayed children, insert safety plugs or night-lights into electrical outlets. Put cover plates on all electric outlets. Place switch plates on all electrical switches. Put electrical appliances in inconspicuous places that young or developmentally delayed children cannot reach. Remove electrical appliances from areas that contain water (baths, sinks, pools).

Special considerations. It is highly recommended that electricians or landlords be instructed to perform all electrical work when electricity may be live. It may be necessary to teach caregivers assertion skills specific to requesting electrical service from their landlords, or having a licensed electrician teach family to turn off all circuit breakers prior to initiation of electrical work.

SHARP OBJECTS (safety)

Potential Hazard: Sharp objects are hazardous when children touch or fall on objects that are sharp.

Examples. Children getting cut by knives that were left on kitchen counters. Children stubbing their toe on splinters that protrude from floors. Children cutting heads on sharp coffee table corners while wrestling. Poking eye on protruding curtain rods. Children cutting their mouths or fingers on razors that were left on bathroom counters or bathtubs. Stepping or bumping into nails that stick out of basement or garage walls or floors. Cutting fingers on electric can openers or electric saws.

Solutions. Place sharp objects in areas that are inaccessible to at-risk children (e.g., place knives in back of kitchen counter. Put new razors in medicine cabinets. Wrap old razors in electrical tape and throw away). Tape cloth, sponges or cardboard on sharp corners (e.g., table corners). Replace sharp objects with rounded pieces (e.g., sharp curtain rods may be replaced with rounded curtain rods). Use a hammer to remove protruding nails. Teach children to pick up glass with a paper towel or avoid broken glass.

FOOD AND NUTRITION NEEDS (kitchen only; safety)

Potential Hazard: Widespread accessibility to unhealthy foods (i.e., junk food), or inaccessibility to healthy foods (i.e., 4 food groups, i.e., meat, fish and poultry; milk and cheese; breads and cereals; vegetables and fruits), will inevitably lead to eating disorders and/or malnutrition.

Examples. It is very common to see children who have unlimited access to candies, cookies and other non-nutritious foods that are kept on kitchen counters or tables. Indeed, obese children are sometimes allowed to eat whenever and whatever they want. Perhaps even more frequently, rations from all four major food groups (fruits and vegetables, meat and poultry, breads and cereal, milk) may not be found in kitchens. In fact, caregivers often ask their children to fix their own lunches and dinners, which often results in unbalanced meals. Children sometimes get sick from eating spoiled foods.

Solutions. Hide or eliminate candies and other foods with high amounts of sugar, teach the caregivers to prepare meals that include each of the four major food groups. Check kitchen cupboards to make sure all food groups are present. Teach family members to serve appropriate

caloric amounts (calorie books are available at most grocery stores). Inspect refrigerators for spoiled foods.

Special considerations. Although the kitchen may be examined to see if foods are spoiled or to see if ample rations of the four major food groups are present, it will be necessary to ask the family about the type and amount of foods eaten. If the family cannot afford adequate foods, then food stamps may be requested at state welfare services. It is important to understand caregivers of low-income backgrounds may have long standing beliefs in the acceptance of non-nutritive, sugar-laden drinks and many African-Americans may be lactose intolerant (leading them to require dietary restrictions in lactose products, such as milk or cheeses).

HOME ACCESS & SECURITY (safety)

Examples. Homes that have broken windows or doors. Doors or windows that are broken or do not have locks installed. Homes that do not have exterior lights, and/or no alarm systems in dangerous neighborhoods. Cellar doors with no locks. Homes that have all windows either barred or “boarded” to prevent robbery, causing a potential fire hazards.

Solutions. Replace, add, or secure broken or absent windows and doors (windows may be “boarded” provided there are numerous alternative escape routes in the event of fire). Replace, repair, or add locks, exterior lights, or alarm systems when these are absent, broken, or insufficient. Create neighborhood watch programs, whereby neighbors look out for the homes of one another.

Special considerations. Most families cannot afford alarm systems. However, locks may be inexpensively purchased from hardware stores, garage sales, flea markets, auctions, Salvation Army, and so on. When renting apartments or homes, state laws may require landlords to repair or replace damaged locks, doors, or windows that threaten the welfare of the family. It may be necessary to teach caregivers assertion skills specific to requesting service from their landlords.

HEAVY/TIPSY OBJECTS (safety)

Examples. Young children pull chords, wires, and ropes that connect to heavy objects that can fall on them (e.g., iron, tools). Children pull handles of iron pans that extend over the floor when being used for cooking on stoves. Unfastened storage shelves fall on children who attempt to remove objects from the shelves. Fish aquariums with broken legs that can fall on children who attempt to touch the fish.

Solutions. Place heavy objects that are connected to chords, wires, and ropes in places that are inaccessible to children. When pans are on the stove, move pan handles towards the wall. Securely fasten heavy shelves against the wall with nails. Dismantle or remove heavy objects that may fall and cause injury (e.g., throw away a flimsy television stand and put the television on the floor until it is replaced). Put heavy stable furniture in front of flimsy objects or furniture to prevent child access.

SMALL OBJECTS (safety)

Examples. Pennies, rubber balls, screws, erasers, toys that have small pieces that are broken, and may be swallowed by small children.

Solutions. Keep small objects away from infants and young toddlers.

AIR QUALITY (safety)

Examples. Nonworking vents, fans, and air conditioners, poorly sealed windows and doors in tropical climates during summer. Doors and windows that are not sealed, lack of hot water, and heaters that do not work in polar climates during winter. Mold is present in airways where water has access, such as showers or under hot water heaters.

Solutions. Temperature is too hot: clean vents, buy fans, seal windows and doors from warm drafts, teach caregiver to assertively request landlord to fix or install air conditioner. Temperature is too cold: buy portable heaters, buy blankets or warm clothing, seal windows and doors from cold drafts, tape plastic over windows, teach caregiver to assertively request landlord to fix heater. Landlords are potentially liable for mold, and are usually very responsible in its removal by a licensed technician when asked to do so. When caregivers own their own home it is best to have them remove drywall with mold, although some professionals may recommend bleaching mold if it is not severe.

Special considerations. Often these families are not able to afford heating and cooling. In these cases, County resources should be informed of the hazardous conditions. Electric companies may be called to request emergency assistance. Cooling and heating equipment may be purchased inexpensively from the Salvation Army, garage sales, auctions, and flea markets. It may be necessary to teach caregivers assertion skills specific to requesting adequate temperature control from their landlords.

OTHER RISKS (safety)

Examples. Very young children falling down open staircases. Holes in walls or ceilings due to being punched or kicked, pornographic literature found under beds or x-rated movies left in video projectors. Toilets that do not flush or plumbing with no hot water. Children and adolescents shooting themselves with guns that were not locked in secure metal containers, children stabbing themselves with swords that were used for decoration, adolescents seriously injuring others in gang fights using brass knuckles or high-powered rifles that were stored in their room, shooting family members in the night due to mistaken identity, children being injured from explosives (e.g., firecrackers). Weapons hanging on walls for decorations.

Solutions. Block open staircases with furniture or ideally temporary plastic walls that are easily removed. Remove pornography from the home or put in locked compartments. Patch and repaint drywall where holes when holes are present. Get a licensed plumber to fix plumbing problems or teach caregivers to assertively request landlords to do so. Remove weapons (e.g., guns, brass knuckles, swords, combat knives, explosives) from the home. Dismantle/disengage guns that the caregiver refuses to remove from the home (assuming possession of firearm is legal). Lock all weapons in a metal box that is inaccessible to children and adolescents.

Special considerations. This is an extremely delicate topic, as caregivers may be vehement about keeping weapons for their personal safety, or argue weapons should be displayed to honor war veterans in the family. In such cases, it is most important to assure weapons are dismantled or inaccessible to the extent possible.

ACCESS TO WATER (safety)

Examples: One of the leading causes of death in small children is access of small children to pools, lakes, ponds, and other water areas. These deaths usually occur when children are not monitored, and have direct access to waterways.

Solutions. Install childproof doorknobs on exterior doors that permit access to water when small children live in the home. Instruct adolescents and older children to stay away from pools and other waterways unless adults are present. Install child safety retaining nets or ropes around waterways. Teach children to avoid water without the presence of adults.

Special considerations. Caregivers often believe their children know how to avoid waterways, and fail to take safety precautions. In such cases, it may be important to provide statistics that indicate high mortality rates for children due to drowning.

NEED CLEANUP (appearance)

Examples. Clogged toilets, unbathed children, children with dirty diapers, infants eating small infectious objects that are found on unswept floors, tripping on clothes during the night that are piled on the floor, roaches or other insects crawling in the ears of children whose bedding is on the floor, dirty dishes in sinks and around the house, used toothpaste on the bathroom sink, mildew stains on shower curtains; no toothbrushes, toothpaste, soap, shampoo, and so on.

Solutions. Set up contingency contracts for performance of chores and other cleaning behaviors. Encourage parents to descriptively praise children for their performance of chores and other cleaning behaviors. Encourage family members to flush toilets and not put hair and other objects in toilet that may act as clogging agents, wash dishes and laundry regularly, bathe with soap, clean bathrooms, make beds, vacuum, sweep, change dirty diapers, and brush the teeth of children at least 2 times a day. Encourage caregivers to buy toothbrushes, cleaning detergents, and brooms. Teach caregivers to assertively request insect pesticides from landlords. Involve children in painting walls and adding decorations.

AESTHETIC NEEDS (appearance)

Examples. Badly stained and worn carpets, sofas, and recliners; broken chairs, drawers, refrigerators, stoves, washing machines, closet doors, beds. Lack of wall decorations (e.g., family pictures, posters). Inappropriate pictures from the wall (e.g., nude pictures on bedroom ceilings and walls, satanic pictures). Outdated wallpaper that is peeling off the wall.

Solutions. Repair or replace broken items, whenever possible (e.g., use hammer and nail to fix broken drawer, fix hole in wall or put a picture in front of the hole). Assertively request landlord to repair or replace broken or worn appliances (e.g., refrigerators), rugs, and damaged property (e.g., holes in walls). Encourage family members to put decorations on the wall (e.g., good report cards, posters, family pictures). Encourage family members to remove inappropriate pictures on the wall. Encourage family members to tear off out-dated wallpaper and paint their home, when necessary. Encourage family members to grow plants in their home.

Special Concerns. When caregivers cannot repair broken or worn items, and new replacements are too costly, used replacements may be inexpensively purchased at garage sales, the Salvation Army, and flea markets. Relatives may also be sources from which to obtain used replacements.

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EDUCATION

- 2014 M.A. Clinical Psychology
University of Nevada, Las Vegas
Research Advisor: Brad Donohue, Ph.D.
- 2008 B.A. Psychology (*Cum Laude*)
University of California, Santa Barbara

RESEARCH AND GRANT EXPERIENCE

- 11/13-Present- Student Investigator, NCAA-funded study examining the influence of softball coach attitudes and behaviors regarding alcohol use of their players among 50 collegiate softball teams. *University of Nevada, Las Vegas, NV. Principal Investigator: Graig Chow, Ph.D.*
- 8/12-Present- NIDA Grant Coordinator, coordination of NIDA-funded R01 treatment outcome study of behavioral therapy with substance-abusing collegiate athletes. *University of Nevada, Las Vegas, NV. Principal Investigator: Brad Donohue, Ph.D.*
- 5/13-10/13 - Research Assistant, assistance for consultation project analyzing data of substance abuse and chronic pain treatment outcomes. *Central Recovery Services, Las Vegas, NV. Principal Investigator: Noelle Lefforge, Ph.D.*
- 8/11-8/12 - Graduate Research Assistant, NIDA-funded R01 outcomes study of efficacy of Family Behavior Therapy with substance abusing and child neglecting mothers. *Family Research and Services, University of Nevada, Las Vegas, NV. Research Advisor: Brad Donohue, Ph.D.*
- 11/10-8/11 - Research Assistant, data analysis and coding for study examining effectiveness of a college alcohol and substance education program. *Cosden Lab, University of California, Santa Barbara, CA. Research Advisor: Merith Cosden, Ph.D.*
- 4/09-10/09 - Grant Assistant, coordination of federally funded grant to implement alcohol and drug interventions for over 1,200 college students a year. *College Alcohol & Substance Education Office, University of California, Santa Barbara, CA. Principal Investigator: Ian Kaminsky, Ph.D.*
- 1/08-6/08 - Research Assistant, assisted in study that examined the impact of social support in romantic relationships on salivary cortisol. *Close Relationships Lab, University of California, Santa Barbara, CA. Research Advisor: Nancy Collins, Ph.D.*

CLINICAL EXPERIENCE

- 8/13-Present – Therapist, *VA Southern Nevada Healthcare System, Primary Care Mental Health, Las Vegas. Supervisors: Sarah Raymond, Ph.D. (primary); Jeffrey Wood, Ph.D. (secondary)*
- 8/12-Present - Performance Coach, *The Optimum Performance Program in Sports, University of Nevada, Las Vegas. Supervisor: Brad Donohue, Ph.D.*
- 8/12-8/13 - Doctoral Student Therapist, *Partnership for Research, Assessment, Counseling, Therapy and Innovative Clinical Education, University of*

Nevada, Las Vegas. Supervisors: Jason Holland, Ph.D; Noelle Lefforge, Ph.D.

EDITORIAL EXPERIENCE

5/12-9/13 Editorial Assistant, Journal of Child and Adolescent Substance Abuse

Ad Hoc Reviews

Clinical Case Studies (November, 2013)

Clinical Psychology Review (March, 2012; November, 2011)

Journal of Adolescent Health (January, 2012)

Journal of Child and Adolescent Substance Abuse (December, 2012)

Journal of Developmental and Physical Disabilities (February, 2012)

MANUSCRIPTS AND PUBLICATIONS

Donohue, B., Pitts, M., Gavrilova, Y., Ayarza, A., & Cintron, K. (2013). A culturally sensitive approach to treating substance abuse in athletes using evidence-supported methods. *Journal of Clinical Sport Psychology*, 7, 98-119.

WORKSHOPS

Donohue, B., Ayarza, A., Pitts, M., & Bradshaw, K. (2012, March). Family Behavior Therapy: An evidence-based approach for adolescent substance abuse and associated problems. Training conducted for the Nevada Psychological Association, Las Vegas, NV.

CONFERENCE PRESENTATIONS

Schubert, K., & Pitts, M. (April, 2014). Evidence-based substance abuse treatment tailored for the culture of college athletics. In B. Donohue (Chair), *Process of developing a non-stigmatizing, positive environmental context for the Optimum Performance Program in Sports (TOPPS): An alternative to the traditional campus counseling approach to addressing mental health with implications for non-athlete students*. Symposium conducted at the annual Convention of the Western Psychological Association, Portland, OR.

Pitts, M., & Urgelles, J. (2012, April). Initial evaluation of a standardized goals intervention in the treatment of mothers referred for substance abuse and child neglect. In J. Urgelles (Chair), *Behavioral treatment innovations in the treatment of concurrent substance abuse and child neglect*. Symposium presented at the annual convention of the Western Psychological Association, San Francisco, CA.

Lynch, S., Bradshaw, K., Pitts, M., & Donohue, B. (2012, April). *Family-supported contingency management*. Technical workshop conducted at the annual Joint Meeting on Adolescent Treatment Effectiveness (JMATE), Washington D.C.

Urgelles, J., Pitts, M., Wilks, C., Ayarza, A., & Donohue, B. (2012, August). *Integrating behavioral interventions in family therapy to manage triggers to drug use*. In M. Kenny & J. Urgelles (Chairs). Skills-building session conducted at the annual convention of the American Psychological Association, Orlando, FL.

POSTER PRESENTATIONS

Pitts, M., Chow G., Schubert, K., Soto-Nevarez, & Donohue, B. (2014, April). *The concordance among three measures of depression in college athletes*. Poster session presented at the annual convention of Western Psychological Association, Portland, OR.

Pitts, M., El Ansari, K., Schubert, K., Gavrilova, Y., & Donohue, B. (2014, April). *Are client preferences for intervention components consistent with treatment dosage?*

Results from an intervention outcome study in a sample of collegiate athletes.
Poster session presented at the annual convention of Western Psychological Association, Portland, OR.

- Brouwers, V.P., Diliberto, R., & **Pitts, M.**, & Barchard, K. (2014, April). *Examining the psychometric properties of the empathic concern scale.* Poster session presented at the annual convention of Western Psychological Association, Portland, OR.
- Soto-Nevarez, A., Dowd, A., Swarzman, E., **Pitts, M.**, Chow, G., & Donohue, B. (2014, April). *Examination of a home safety and home appearance scale in a sample of neglected children.* Poster session presented at the annual convention of Western Psychological Association, Portland, OR.
- Diaz, E., Kong, P., Swarzman, E. Holler, A., Gonzalez-Bueno, A., Gavriolova, Y. Loughran, T., Wrzeciona, K., **Pitts, M.**, Murrieta, V., Dunn, R., Chow, G., Kelleher, L., & Donohue, B. (2012, October). *Factors that interfere with sport performance and alcohol use among collegiate athletes.* Poster session presented at the annual conference of the Association for Applied Sport Psychology, New Orleans, LA.
- Urgelles, J., Wilks, C., **Pitts, M.**, & Donohue, B. (2012, April). *Factors associated with discontinuance of child custody in mothers referred by child protective services.* Poster session presented at the annual convention of the Western Psychological Association, San Francisco, CA.
- Urgelles, J., **Pitts, M.**, Wilks, C., & Donohue, B. (2012, April). *An empirically supported method for gaining employment within the context of adolescent drug abuse.* Poster session presented at the annual Joint Meeting on Adolescent Treatment Effectiveness (JMATE), Washington D.C.
- Sullivan, K., Cosden, M., **Pitts, M.**, & Tawalbeh, S. (2011, February). *High-school to college drinking trajectories: Risk factors and implications for intervention.* Poster presented at the National Association for School Psychologists convention, San Francisco, CA.
- Sullivan, K., **Pitts, M.T.**, Tawalbeh, S., & Cosden, M. (2011, August). *Web-based surveys, personal interview, or methods triangulation: What best measures college students' alcohol and drug use?* Poster presented at the American Psychological Association convention, Washington DC.

GRANTS

11/13 – 11/14 NCAA Graduate Student Research Grant (\$7,500), *The Influence of Collegiate Softball Coaches on the Alcohol Use of their Athletes*, awarded.

AWARDS AND SCHOLARSHIPS

2014 Summer Faculty Research Award (\$3,000), UNLV College of Liberal Arts
2013 The Patricia Sastaunik Scholarship (\$2,500), UNLV Graduate College
2013 The Summer Session Scholarship (\$2,000), UNLV Graduate College

SERVICE

3/14 – Present APA Graduate Students State Advocacy Coordinator
5/13 – Present APA Graduate Student Representative
2012 - Present UNLV Clinical Psychology Cohort Representative
2012 - Present UNLV Undergraduate Psychology Mentor
2008 UCSB Active Minds Mental Health Student Organization Secretary