



HEALTHY OUTCOMES THROUGH PREVENTION AND EARLY SUPPORT  
**HOPES FY2015 EVALUATION FINDINGS**

December 2016



The University of Texas at Austin  
**Texas Institute for  
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*School of Social Work*

Healthy Outcomes through Prevention and Early Support  
**HOPES FY2015 Evaluation Findings**

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**RESEARCH TEAM**

Monica Faulkner, Ph.D., LMSW, Principal Investigator  
Beth Gerlach, Ph.D., LCSW, Co-Principal Investigator  
Tania Jordanova, MSPH, Lead Research Coordinator  
Patrick S. Tennant, Ph.D., Research Coordinator

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# EXECUTIVE SUMMARY

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## INTRODUCTION

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Healthy Outcomes through Prevention and Early Support (HOPES) is a program funded by the Prevention and Early Intervention Division (PEI) of the Texas Department of Family and Protective Services (DFPS). Its aim is to strengthen families with young children in order to prevent child abuse and neglect. Services are provided by program sites that use a variety of evidence-based parenting programs such as Parents as Teachers, SafeCare and Triple P. HOPES also requires collaborations at the local level to increase community awareness and capacity around child maltreatment prevention.

Project HOPES was rolled-out in three phases, known as HOPES I, HOPES II, and HOPES III. Under each phase, Texas contracted with eight communities, a total of 24. HOPES I contracts were executed in July 2014, with most sites starting work with clients in September 2014. This report covers the time period of September 1, 2014 to August 31, 2015 and only considers results from the first fiscal year, 2015 (i.e., FY2015), of HOPES.

The purpose of HOPES is to prevent child maltreatment through direct services to families, as well as community coalition efforts. Because this was the first year of collecting data for HOPES, community level child maltreatment rates cannot be included in this evaluation. Once more time has passed, an impact on the community rates of child maltreatment will be assessed and included in future annual reports.

A mixed-methods approach for data collection was used to gather information for this evaluation. Online surveys were completed by 110 staff and 132 community members across the eight HOPES I sites. Interviews and focus groups were conducted with 52 parents, 116 staff members and 42 coalition and/or community members. Administrative data from the PEI database was used to examine parent outcomes. Program sites' quarterly and annual reports were used to determine coalition involvement, specific event participation, and total number of clients served.

## RESULTS

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Findings suggest that HOPES I has been successful in increasing protective factors in families and assisting communities. HOPES sites reached an estimated 36,000 individuals through community programs, including community fairs, events at parks, libraries and children's museums, conferences and professional trainings and various other services. While this number may include some duplicated individuals, it suggests that sites were actively engaging their communities in child maltreatment prevention.

In FY2015, HOPES I served 2,803 individuals from 1,370 families, with direct services such as evidence-based parent education programs, counseling, child care, and case management. On average, families with closed cases saw an increase in protective factor scores on all subscales, suggesting that families increased protective factors that may ultimately reduce child

maltreatment. Qualitative data provide additional evidence that HOPES has reduced family stress, increased parental empowerment, and led to positive changes in parent and child interactions for participants.

Findings regarding coalition functioning indicate a high level of collaboration in the community and a clear commitment to continue to work together on issues related to child welfare. One area of growth for some coalitions is to develop a clearer vision and actionable strategy for child maltreatment prevention. For example, while 77% of community survey respondents believed their early childhood coalition was effective in mobilizing resources for general community programming, only 53% indicated the same for child maltreatment prevention programming.

The process evaluation of HOPES implementation revealed several program strengths: (1) parent education programs are well-liked by staff and clients, (2) staff have developed strong, trusting relationships with parents, and (3) supplemental services like case management and counseling are benefiting families. Along with these strengths are opportunities for growth. While there is considerable variability across the different sites, in general, implementation challenges suggest the need for: (1) improved program marketing, outreach, and engagement, especially of fathers and families with the highest needs, (2) assistance for staff on balancing evidence-based program fidelity with families' case management needs, (3) adjustment of agency flex time and caseload policies to reflect the realities of providing home visiting services to high needs families; and (4) staff training and professional development related to cultural competency, ethical boundaries and how to address crisis situations, especially for staff without a social work or counseling background.

## EXAMPLES OF PROGRAM IMPACT

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In interviews, parents, staff, and community members across the HOPES I sites gave examples of how they believed the program was strengthening families and preventing child maltreatment.

Parents reported that the programs educated them on proper discipline and positive ways to engage with their children, helped connect them to other parents, and provide them a trusted support network. One parent said the skills learned in the program, **“allowed me to develop a better relationship with my child. We’ve grown closer, I’m able to deal with him a lot better than I was when I first started, a year ago. I’ve come a long ways with my relationship with my son.”**

Program staff saw that the program was having a positive impact by the fact that parents were referring friends. One staff member who works with fathers said: **“One of the things we thought was a huge indicator [of success] was that the young men were bringing their friends in. Young men that the school didn’t realize had become dads.”**

A staff member at a different site recognized the same pattern of clients bringing their sisters, cousins and aunts to group activities. She stated: **“A lot of our referrals are coming from existing clients or clients who have completed the program. They are now**

**referring their neighbors, their friends, their relatives, and I just think that speaks to how successful the program has been.”**

Community members were grateful that HOPES sites could create programs that were meaningful for their specific community. One community member stated: **“I sing the praises [of the funders] for giving, allowing us the opportunity to create a program for our community that we live in, and I know and we feel like we have the right combination.”**

A staff member from a different site had similar feelings, stating: **“We’re delighted; we’re completely delighted that project HOPES identified [our] county as one of the eligible counties. I think the data definitely support the need for that kind of investment.”**

Another community member noted that HOPES was designed to have a long term impact: **“I think some of the best programs, sometimes you don't realize how good they were until ten, fifteen years later. Because – and that's what I would hope HOPES would be—that what's happening now, because it is helping that next generation.”**

## RECOMMENDATIONS

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Based on the findings from this evaluation, we make the following recommendations: seven related to programming, and five related to data collection.

## PROGRAM RECOMMENDATIONS

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- 1.** Preliminary findings suggest families are increasing protective factors that may prevent future child maltreatment. Thus, we recommend PEI **continue support of community-based child maltreatment prevention programs**. Participants in this evaluation were incredibly grateful that their community had been provided this support. Even without data to measure child maltreatment, there is an indication from survey and qualitative data that HOPES is helping families. However, there is not yet strong evidence that HOPES is serving the most at-risk families. Based on the demographics of parents being served, income and education levels are aligned with demographics of parents reported for child maltreatment. However, without more detailed information on risk factors that drive child maltreatment, including substance use, mental health, family violence and the parent’s history of trauma, it is difficult to say with certainty the risk level of families being served. We will be able to capture more of this information in FY2016.

**2.** We recommend PEI **shift to an evidence-informed framework to allow for increased flexibility in programming.** The general trend in policymaking is to fund evidence-based programs. The assumption is that funding should be provided to those programs that have research demonstrating that they ‘work.’ While policies should encourage research-based approaches, stringent requirements that a program must adhere to a specific evidence-based model should be balanced with the specific program and client needs. The standards for determining what is evidence-based are subjective, and programs designated with the label of evidence-based may not continue to produce evidence over time. Additionally, many programs are developed for a certain target population, and might not be best-suited for non-traditional participants with certain needs and risk factors. Furthermore, strong evidence-based models do not always exist for every issue and topic area. Thus, communities might be forced to select suboptimal models that are not tailored to their specific needs, in order to meet the evidence-based requirement.

A more rational approach is to ask programs to be evidence-informed, with a strong theoretical foundation and program guidelines that match that foundation. Evidence-informed approaches are suggested because they can borrow core components of evidenced-based programs while enjoying the flexibility of incorporating unique elements important to a particular community. In the case of HOPES, program staff and parents attest to the fact that case management is a crucial component of service delivery. However, concerns about sticking to evidence-based program models sometimes constrained parent educators from addressing real issues that families had, while others chose to make adaptations to the models to address client needs.

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**3.** We recommend PEI **adjust performance based contracting requirements.** Performance based contracting is another trend in policy making that attempts to hold grantees accountable to outcomes. With HOPES, outcomes are tied to whether a contractor can improve scores on at least one item on the Protective Factors Survey (PFS). In interviews with direct service staff and administrators at HOPES sites, concerns about the validity of PFS scores repeatedly came up. Concerns were raised about a lack of participant honesty in pre-tests due to social desirability bias, but increased honesty in post-tests, once a trusting relationship with the parent educator was established. Some sites experienced post-PFS scores that were lower than pre-PFS scores. Additionally, concerns were raised that the reading level, question wording, and seven-point agreement scale were confusing for some participants. Finally, the PFS was not developed to predict child maltreatment.

Since HOPES programs are tailored to community needs, we suggest that, in addition to a standardized measure, sites have the flexibility to develop their own logic models and site-specific measures with PEI oversight and approval. A statewide impact can still be demonstrated through a meta-analysis of the sites’ effect sizes. This would

allow communities to match their needs with outcomes and measures that best indicate their programming impact and success.

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**4.** We recommend PEI **maintain the community-based approach of HOPES**. The core idea with HOPES is that communities know best what they need for meaningful change. Many participants in this evaluation noted that they appreciated that aspect of HOPES. Communities have been able to provide wrap-around services, therapy and basic needs assistance that they would not have been able to provide if HOPES were only focused on home visiting. Additionally, some parents are more inclined to participate in group settings, while others prefer services in their homes. For those that prefer groups, certain evidence-based programs like Incredible Years and AVANCE offer avenues for parents to come together, and several mothers reported that they overcame experiences of isolation through these programs.

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**5.** We recommend PEI **dedicate time for programs to have a start-up period and to provide technical assistance regarding recruitment and operations planning** during this time. From the time this data was collected, PEI has already made adjustments to start-up time. In addition to time, technical assistance during the start-up period is important to help guide programs to a logic model and corresponding operations plan. Additionally, many sites struggled with recruitment during the first year of HOPES, especially with fathers. Recruitment can always be a challenge with a new program. PEI should provide guidance on marketing, outreach materials, strategies and best practices on how to engage traditionally hard-to-reach families.

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**6.** We recommend PEI **support staff through professional development, training and technical assistance and official guidance on program issues**. From the time this data was collected, PEI has already implemented trainings for parent educators. These efforts should continue and address topics requested by program staff such as boundaries and crisis intervention. Additionally, PEI should create official guidelines on caseloads for Texas programs utilizing evidence-based programs funded through HOPES. Such guidelines can be made in conjunction with a curriculum purveyor and should not alter fidelity. Guidelines could help sites adjust caseloads, since parent educators may also have case management roles. Similarly, guidelines should be established about supervision of direct service staff. Training can be provided on using social work supervising perspective, in which problems are discussed, staff are encouraged to challenge their own biases and limitations, and solutions are formulated. Such supervision is key to preventing staff burnout.

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**7.** We recommend PEI **provide guidance on how to incorporate child maltreatment prevention into community coalition goals and plans**. In order to reduce duplication of efforts, PEI allowed HOPES sites to join existing early childhood coalitions. The benefits of the existing coalitions is strong leadership, organization, and active membership. However, a drawback is an established vision and purpose, sometimes specifically focused on early education, poverty, or health. While these

focus areas are not mutually exclusive from preventing child maltreatment, coalitions did not often have objectives or actionable strategies specific to child maltreatment prevention. By including such objectives into a strategic plan, coalitions can measure progress made towards meeting those objectives and can hold themselves accountable and make course corrections if progress is not made. PEI can provide greater support and oversight in this area.

## DATA RECOMMENDATIONS

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**1.** We recommend an **expansion of data collection in order to better understand families being served**. There are several critical limitations of the available quantitative data collected in the PEI database that reduce the type of analysis possible, as well as the confidence with which inferences can be drawn. One limitation is a lack of data as to whether a given family qualifies as “high risk” based on evidence-based program standards. This reduces the understanding of the dosage and fidelity with which certain programs were implemented, and thus reduces the ability to determine program effectiveness. Also concerning is the lack of consistency with which “risk codes” are applied to families. A family qualifies for HOPES, because at least two risk factors are present. In general, “high stress level” is coded as one such risk factor. Risk factors used to screen families should be grounded in research linking them to child maltreatment. “High stress level” offers little to researchers. Important risk factors that have been shown through research to drive child maltreatment include substance use, mental health, family violence and a parent’s history of trauma.

**2.** We recommend PEI **clarify how programs enter services that a person received into the PEI database**. Because programs and implementation varied across HOPES sites, several programs include a combination of services being provided. At times, multiple service codes are listed for a single client under a single program. It is unclear whether those service codes represent unique 'visits' or a combination of services provided during one visit. This makes it impossible for a researcher to determine the number of times a client was served. This is additionally complicated by clients who were enrolled in multiple programs. Without clear data by site, program, type of services provided, and number of times a client was served, it is not possible to assign responsibility for outcomes (such as change in PFS score) to any of those potential sources. Finally, reporting errors may also be present in the data. It is difficult to determine the legitimacy of data that differs from expectations (such as an indication that a client has received the minimum dosage, when other data in the database suggest that same client does not have the requisite number of sessions for minimum dosage). It is likely that these conflicting data are due to reporting error, program idiosyncrasies, or both.

**3.** We recommend PEI **provide guidance on recording minimum dosage**. Data reporting should be standardized and mandated across all HOPES sites. Received minimum dosage should be a really important variable, but it is only reported once in the database, without a specific date of attainment, even for clients enrolled in multiple programs or receiving multiple services. This makes the current minimum dosage variable very hard to use for data analysis.

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**4.** We recommend PEI **create a standardized format for sites' quarterly and annual reports**. The quality of quarterly reports varies widely by site. Additionally, because these reports determine program reach beyond direct services, such as during community events, sites need to keep careful track of event attendance to identify those who have already been counted as receiving services in order to avoid duplication of counting.

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**5.** We recommend PEI **manage expectations about what data analysis is able to show about successful implementation of a prevention program**. Prevention is incredibly difficult to measure because a researcher is tasked with measuring something that has not happened, but might have happened, if not for a prevention intervention. On a community level, PEI expects to see a reduction in child maltreatment rates. While community-level analysis will be conducted, it is difficult to attribute change directly to HOPES programs. Intermediate measures are important to consider when looking at program success. For example, measuring change in known risk factors for child abuse helps determine the likelihood of a future reduction in child abuse instances.

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# INTRODUCTION

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Healthy Outcomes through Prevention and Early Support (HOPES) is a program funded by the Prevention and Early Intervention Division (PEI) of the Texas Department of Family and Protective Services (DFPS). Its aim is to strengthen families and prevent child abuse and neglect. Services are targeted towards families with children aged zero to five and are provided through community-based organizations contracted under Project HOPES. The program sites use a variety of evidence-based programs (EBPs), including home-visiting programs. In addition to EBPs, sites provide basic needs support, case management, and other supplementary services. HOPES also requires collaborations between child welfare, early childhood education, and various other community agencies, to increase community awareness and capacity to prevent child maltreatment.

Project HOPES was rolled out in three phases, known as HOPES I, HOPES II, and HOPES III. Under each phase, Texas contracted with eight communities, totaling 24. HOPES I contracts were executed in July 2014, with most sites requiring start up time before service provision could begin. Most sites saw their first clients in September 2014. This report covers the time period of September 1, 2014 to August 31, 2015, and only focuses on results from the first fiscal year, FY2015, of HOPES I.

## HOPES SITE PROJECT DESCRIPTIONS

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The eight communities selected for HOPES I are outlined in Tables 1 and 2. The HOPES contract encouraged communities to conduct needs assessments to identify local strategies for child maltreatment prevention. Thus, each site's program differs in content and structure in order to meet the needs of each unique community. Many sites selected the Parents as Teachers (PAT) evidence-based home visiting curriculum, while some selected other EBPs. Some sites partnered with multiple sub-contracting agencies, while others did not. Detailed summaries of each site are available in Appendix C.

This diversity of programs is intentional in the design of HOPES in order to produce locally-supported programs that match the needs of a particular community. However, this diversity in programs creates challenges for measurement and cross-site evaluation. Ideally, evaluations seek to measure changes in participants which is usually in the form of a pre-test/post-test research design. Some measures, such as the Protective Factors Survey (PFS) are common across all sites. However, some components of each program require unique measures. For example, some sites have one-time parenting seminars or workshops that provide training for professionals, but not directly to parents (e.g. Stewards of Children). Other programs have one-time training events (e.g. Period of Purple Crying) when parents receive a short training, and some programs use non-evidence-based programs (e.g. Saturday Morning Club). The structure of these programs did not necessarily fit within a research design that could measure change in participants. Thus, the evaluation is focused on common program elements across sites.

**TABLE 1: HOPES I EVIDENCE-BASED PROGRAMS BY SITE**

HOPES I County	PAT	SafeCare	Triple P	24/7 Dad	AVANCE	Other
<b>Cameron</b>		X				Counseling
<b>Ector</b>	X			X		Stewards of Children; Saturday Morning Club
<b>El Paso</b>	X				X	Incredible Years; Wrap Around
<b>Gregg</b>	X					Counseling
<b>Hidalgo</b>	X					Child Care; Counseling
<b>Potter</b>	X			X		Equine Therapy; School Social Workers
<b>Travis</b>	X		X	X		Support Services; Counseling; Period of Purple Crying
<b>Webb</b>		X				CHOICES; Counseling

**TABLE 2: HOPES I SITE SUBCONTRACTORS AND COALITIONS**

HOPES I County	Prime Contractor	Subcontractors	Coalition
<b>Cameron</b>	BCFS Health and Human Services		Make the First 5 Count (Hidalgo)
<b>Ector</b>	UTPB: First 5 Permian Basin	Boys & Girls Club of Odessa Harmony Home	Early Childhood Coalition (MIECHV)
<b>El Paso</b>	El Paso Center for Children	Child Crisis Center United Way of El Paso AVANCE – El Paso Paso Del Norte Children's Development Center	Project Launch Young Child Wellness Council
<b>Gregg</b>	Buckner Children and Family Services		Family Bridge (MIECHV)
<b>Hidalgo</b>	Easter Seals Rio Grande Valley		Make the First 5 Count (MIECHV)
<b>Potter</b>	Family Support Services of Amarillo	Mesquite Ranch	Home Visiting Stakeholders' Group (MIECHV)
<b>Travis</b>	Austin Children's Shelter	Any Baby Can Safe Place Easter Seals United Way for Greater Austin CommunitySync	Family Support Network
<b>Webb</b>	Serving Children and Adults in Need		Project HOPES Stakeholder Group

## GOALS & THEORY OF CHANGE

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The ultimate goal of HOPES is to reduce the incidence of child abuse and neglect through community-based prevention and evidence-based interventions. These goals are to be achieved through a two-pronged approach of: (1) providing programming directly to families, especially families with certain risk factors, and (2) supporting community coalitions to increase community knowledge and capacity in providing prevention programming.

The short-term outcomes of interest at the family level include increased child emotional and cognitive well-being; increased parental protective factors such as: nurturing and attachment, knowledge of child development, resilience, social connection, concrete support, and economic self-sufficiency; and decreased parental risk factors such as substance abuse, untreated mental illness, and intimate partner or other family violence. The short-term outcomes for the community coalitions include an increased collaboration and communication between agencies, increased knowledge and awareness about child maltreatment, increased cross-referrals and access to services, and increased training and capacity building of agency staff. For a summary of short- and long-term outcomes of Project HOPES, refer to the logic model in Appendix B.

## EVALUATION DESIGN

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The purpose of the evaluation is to understand the degree to which HOPES program goals were met and to identify strengths and areas for improvement. A detailed evaluation plan, which carefully outlines the program objectives and measurement methods is available online at Texas Institute for Child and Family Wellbeing's website.<sup>1</sup>

As this report specifically covers only the first year of Project HOPES, it primarily focuses on evaluating program implementation and processes and short-term goals, as opposed to long-term outcomes. While the ultimate goal of Project HOPES is to prevent child maltreatment, not enough time has passed to allow for an analysis of program impact on community-level rates of child maltreatment. Community-level impacts often do not appear until years after a program has been established, implementation problems are worked out, and a larger portion of the population is reached. Thus, analysis of community-level child maltreatment rates is not included in this report. These analyses will be included in subsequent reports.

This report addresses five research questions, and the remainder of the report is structured around these questions.

## RESEARCH QUESTIONS

1. What are the child maltreatment prevention needs in the HOPES communities?
2. What services were provided by HOPES, and what was program reach?
3. To what extent have HOPES programs impacted families?
4. To what extent have HOPES programs impacted community collaboration?
5. What are the strengths of the HOPES programs, and what are opportunities for growth?

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<sup>1</sup> <https://txicfw.socialwork.utexas.edu/>

A mixed-methods approach utilizing multiple forms of data collection was used to collect data for this evaluation. These methods included individual interviews, focus groups, two online surveys, and data from the PEI database and quarterly reports. In-person interviews and focus groups with staff, program participants, and coalition members were conducted between April and June, 2016. Those who were interviewed were not selected randomly. Rather, they were identified as available during site visits made by the evaluation team. On average, we spoke to about six coalition members per HOPES site. As part of the qualitative data collection, 22 focus groups and 14 individual interviews were conducted with staff funded through HOPES. In total, 30 administrators and 86 direct service staff members across the eight sites participated, which includes representation from all subcontractors. Additionally, a total of 52 HOPES participants took part in 27 interviews and eight focus group conducted across all eight communities.

In April and May 2016, links to the two online surveys were distributed. A staff survey was sent out to all HOPES I program staff, while a separate link to a community survey was sent to HOPES I coalition members and other stakeholders in the community. Data from the PEI database covered the period of September 1, 2014 to August 31, 2015, which was the first fiscal year of HOPES I. Quarterly reports submitted by HOPES sites to PEI for FY2015 were also examined.

See Appendix A for a more detailed discussion of data collection and analysis methods.

## **REPORT STRUCTURE OVERVIEW**

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The report has five main sections corresponding to the five research questions stated above. The first section summarizes the characteristics of the HOPES communities and includes information on community needs surrounding child abuse prevention identified in staff and community online surveys. The second section summarizes services provided and how many families were served by HOPES in the first year. Participant demographics and family risk factors are also discussed.

The third section considers what impact Project HOPES has had on families in the first year of implementation. It first summarizes changes to family risk and protective factors associated with child maltreatment prevention as measured by the PFS, and then highlights findings from the qualitative interviews and focus groups with caregivers, staff, and community members on their perceptions of program effectiveness and participant satisfaction.

The fourth section reviews the impact of HOPES on increased community collaboration around child maltreatment prevention. This relates directly to the requirements of HOPES that communities initiate a new, or join an existing, community coalition to increase agency collaboration, professional development, and public awareness about child maltreatment prevention.

The fifth section of the report identifies the strengths and opportunities for growth within the HOPES contracting agencies with a specific focus on the implementation challenges and successes in the first year of the contract. This section also explores fidelity and adaptation of evidence-based practices as well as professional development needs. Finally, the report concludes with a summary of main findings and next steps in the conclusion.

## HOPES SUCCESS STORY

A former foster youth's  
journey to break the cycle of  
child maltreatment

Laura<sup>2</sup>, a 19 year-old mother, recently completed the SafeCare program provided by a HOPES program site. Laura gave birth to her daughter one month after she left the foster care system. Laura's primary concern is breaking the cycle of child maltreatment; she said that she never wanted her daughter to enter the foster care system. Even though Laura has multiple responsibilities as a wife, mother of an infant and full-time college student, she enrolled in Project HOPES and worked out a home visit schedule around her class and work schedules. Through the SafeCare lessons, she learned how to care for and bond with her infant, how to child-proof her home, and how to care for a sick infant. With her home visitor, she was able to honestly address her concerns about raising a child appropriately since she had never had a strong parental role model. She developed a plan for managing stressors associated with being a young working mother with a full schedule. Laura is now thriving with the tools and support she needs to parent her daughter and break the cycle of child maltreatment.

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<sup>2</sup> In order to protect the identity and confidentiality of HOPES participants, names and minor story details have been changed. Pictures are not of HOPES clients

# COMMUNITY NEEDS

In designing Project HOPES, PEI sought to identify a few select communities with demonstrated need to target with prevention funding for greatest impact. Thirty-three counties were identified based on their rates of domestic violence, substance abuse, teen pregnancy, child poverty, and child abuse fatalities. Of those 33, eight counties were chosen for participation in HOPES I.

In the first year of HOPES not enough time has passed to confidently measure change in child maltreatment rates at the county-level and to be able to attribute those changes to HOPES programming. Evaluations in future years will have additional analyses comparing child maltreatment rates. Instead of looking at community level-change, this section provides a brief demographic overview of communities and discusses information about community needs obtained from a survey of community members and HOPES program staff.

## CHARACTERISTICS OF COMMUNITIES

To get a better idea of the context of the HOPES programs, some demographic data for each community is presented here. Table 3 provides contextual information about each county. Data are from the 2010-2014 American Community Survey 5-Year Estimates.

**TABLE 3. COUNTY DEMOGRAPHICS**

	Population	Child population	Living in families receiving public assistance	At or below poverty	Living with bio, step or adopted parent	Living with grandparent	Living with relatives	Living with foster parent
<b>Texas</b>	25.14 million	6.97 million	36.0%	25.0%	87.0%	8.9%	2.8%	1.3%
<b>Cameron</b>	422,156	133,456	54.7%	48.1%	81.4%	13.7%	3.4%	1.5%
<b>Ector</b>	137,130	42,449	30.1%	20.0%	83.0%	12.5%	2.4%	2.1%
<b>El Paso</b>	800,647	239,540	42.6%	32.2%	83.6%	12.2%	3.2%	0.9%
<b>Gregg</b>	121,730	31,342	34.9%	29.4%	86.4%	9.8%	2.7%	1.2%
<b>Hidalgo</b>	774,769	274,584	55.2%	46.4%	82.9%	13.1%	3.2%	0.9%
<b>Potter</b>	121,073	33,786	37.3%	68.0%	85.5%	9.4%	3.1%	2.0%
<b>Travis</b>	1.2 million	255,598	28.0%	23.9%	90.2%	5.6%	2.9%	1.2%
<b>Webb</b>	250,304	89,346	54.0%	43.1%	80.3%	14.9%	3.4%	1.4%

Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates. Table S0901 - Children Characteristics.

Poverty is highly correlated with child maltreatment. In Texas, 25.3% of children lived below the poverty line and 30.6% of children live in families that receive some form of public assistance (SSI, TANF or SNAP). For HOPES I sites, six of the eight counties had poverty rates higher than the state average. Six of eight counties also had higher rates than the state average of children living in families receiving public assistance.

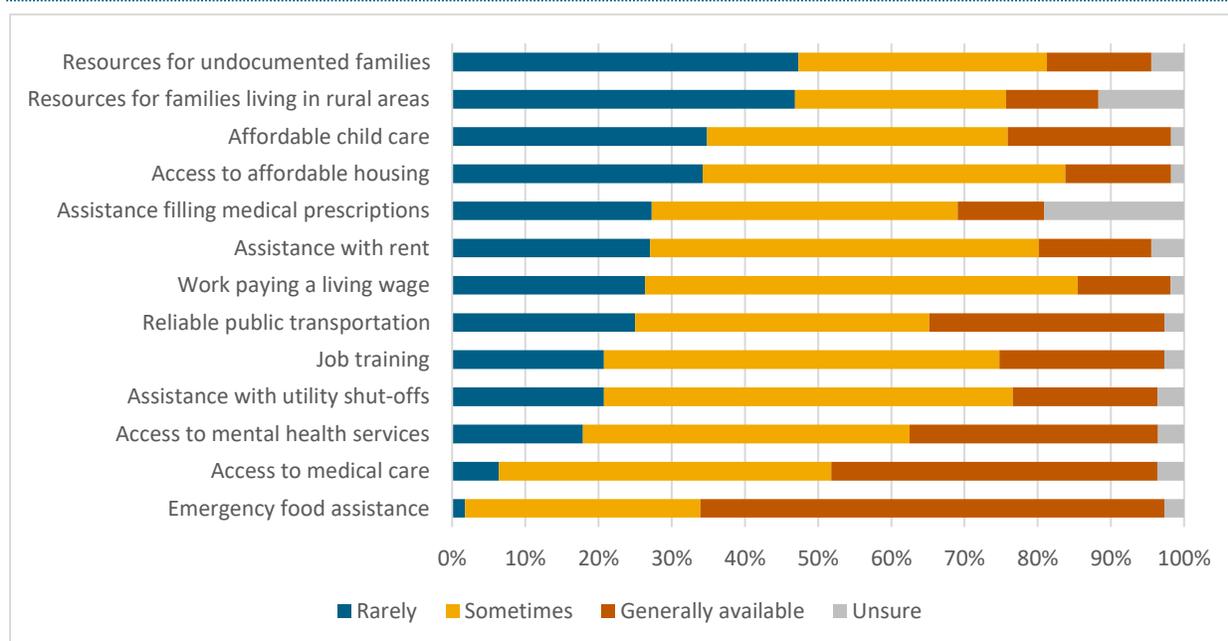
Another telling indicator of family well-being is where children are living. In Texas, 87% of children live with their biological, step or adopted parents, 8.9% with grandparents, 2.8% with other relatives and 1.3% with foster parents or other caregivers. While not an exact indicator, living with caregivers other than parents suggest instability in family settings. In seven of the eight sites, the percent of children not living with parents was higher than the average for the state.

## GENERAL COMMUNITY RESOURCE NEEDS

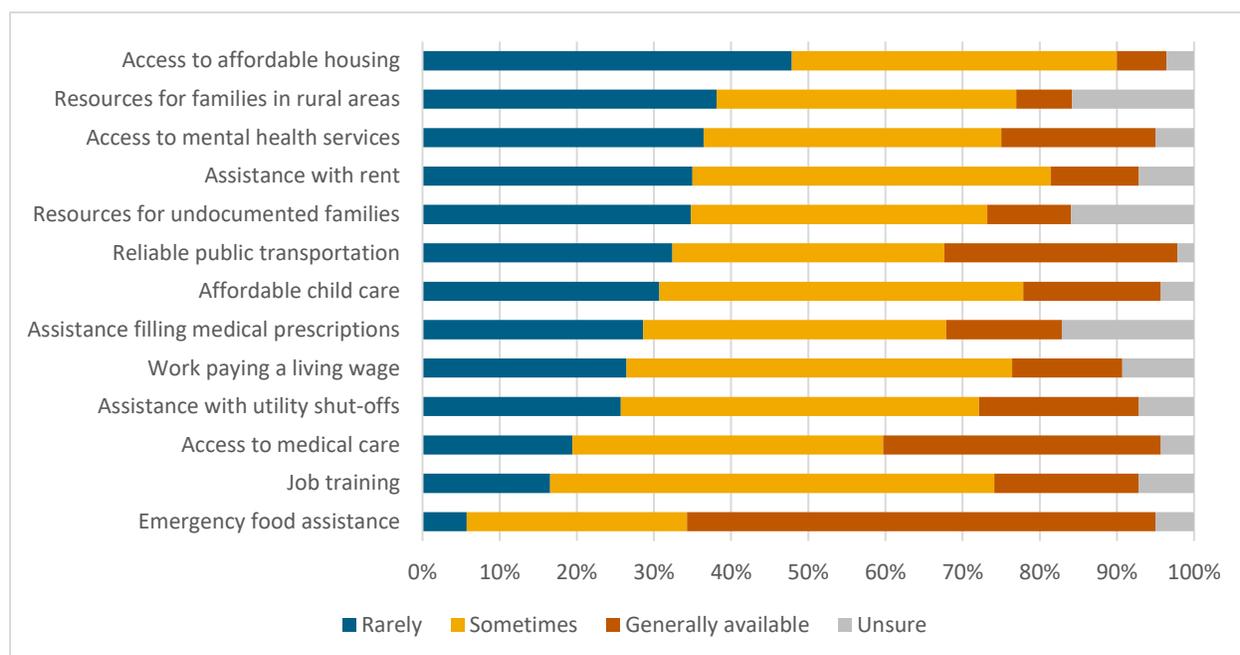
Staff and community members were asked to complete a survey to identify the availability of general resources in their community. As shown in Figure 1, staff identified the community resources that were most rarely available as: (1) resources for undocumented families, (2) resources for families in rural areas, (3) affordable childcare, and (4) access to affordable housing. Figure 3 on the following page shows that community members identified many of the same community resources as least available in their communities, with the top three being: (1) access to affordable housing, (2) resources for families in rural areas, and (3) access to mental health services.

Interestingly, in contrast to community members, HOPES staff did not rank mental health services as being rarely available. This might be because the agencies where staff work provide mental health services, or because a larger percentage of staff survey respondents were from more urban areas, whereas a larger percentage of community survey respondents were from more rural areas.

**FIGURE 1. PERCENT OF STAFF MEMBERS INDICATING COMMUNITY RESOURCE AVAILABILITY**



**FIGURE 2. PERCENT OF COMMUNITY MEMBERS INDICATING COMMUNITY RESOURCE AVAILABILITY**



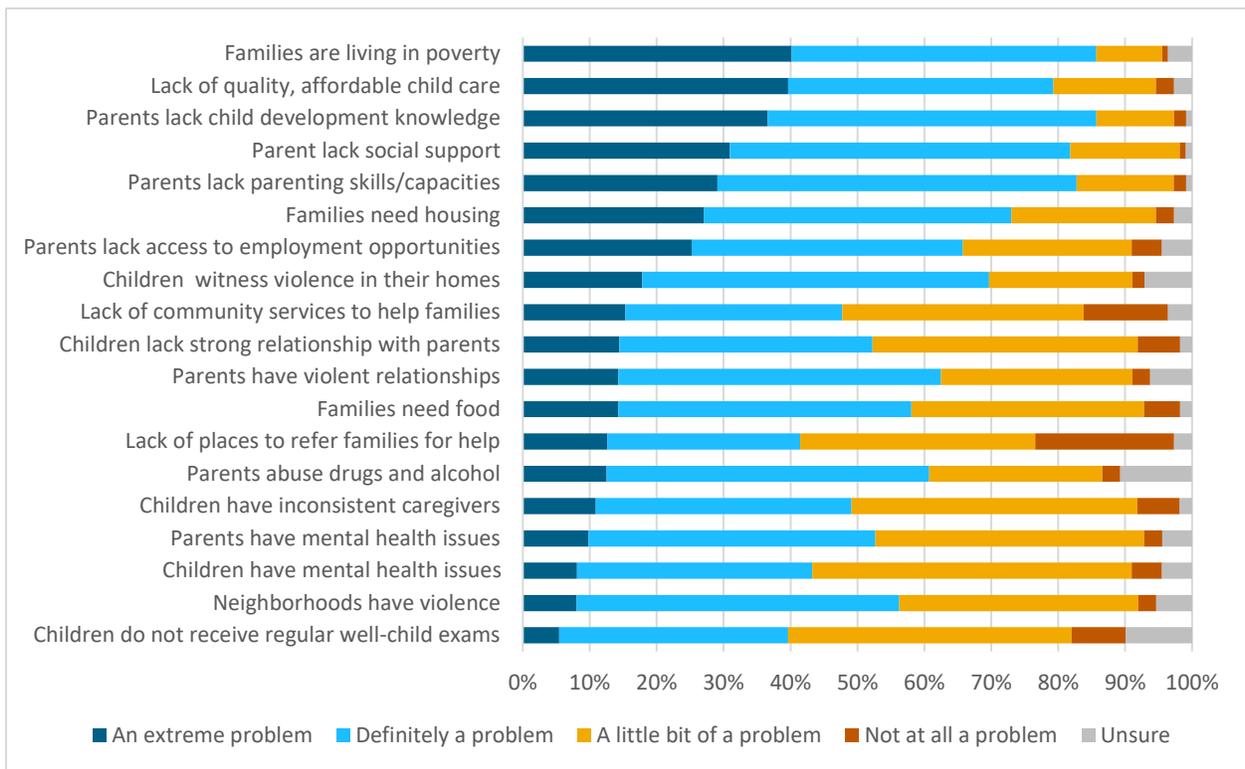
## COMMUNITY RISK FACTORS FOR CHILD MALTREATMENT

In addition to general community resources, the surveys also asked staff and community members to provide feedback on risk factors for child maltreatment. Figures 3 and 4 display the level that risk factors related to child maltreatment are a problem in the community, as identified by staff and community members. Both groups identified families living in poverty as an extreme problem in their community. In interviews, parents tied many of their parenting challenges to issues related to poverty. Parents discussed their lack of income and housing issues as major sources of parental stress. One community member explained: “In this community we have a lot of people who are in poverty. Our percentile is very high and we have a lot of the same percentile that’s uninsured. So programs like [HOPES] are very essential, and I think it’s very beneficial support-wise – I know moneys are hard to get nowadays but if at all possible and if there were to be some additional support then that would be something that would benefit this type of program in these type of communities that really need the services.”

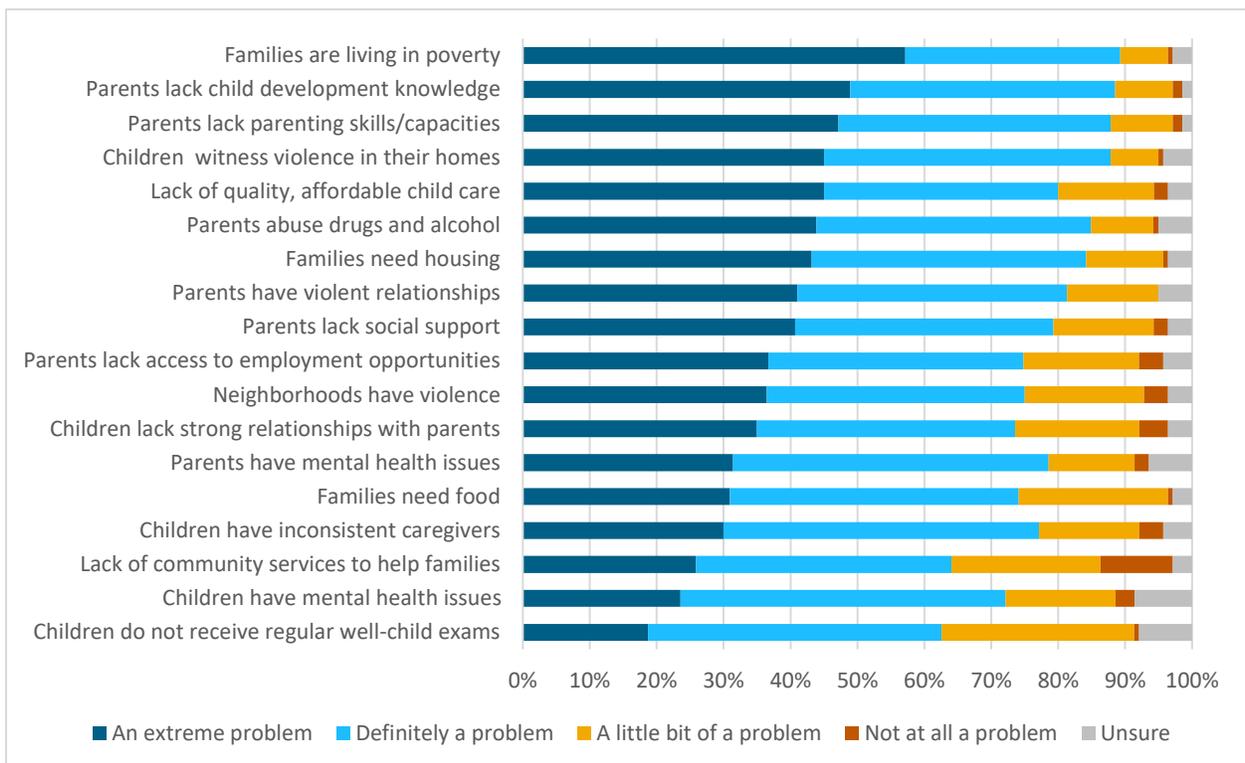
Lack of knowledge of child development and lack of parenting skills was also identified as an extreme problem by staff and community members in the survey. Parents expressed a desire for more information and more support. They readily acknowledged their lack of knowledge, particularly around behavior and discipline issues. One mom stated: “Since I’m a first-time mom, I really wanted to know stuff, because there were sometimes things that I would see my aunt do, and be like, ‘That’s not right’.”

Additional issues identified as problems in the community included lack of quality childcare, lack of social support for parents, children witnessing family violence, lack of housing options, parent substance use, and lack of jobs. In an interview, one parent stated: “So I think, yeah, childcare would probably be the worst thing in [our community].”

**FIGURE 3. PERCENT OF STAFF INDICATING RISK FACTOR IS A PROBLEM IN THE COMMUNITY THEY SERVE**



**FIGURE 4. PERCENT OF COMMUNITY MEMBERS INDICATING RISK FACTOR IS A PROBLEM IN THE COMMUNITY**

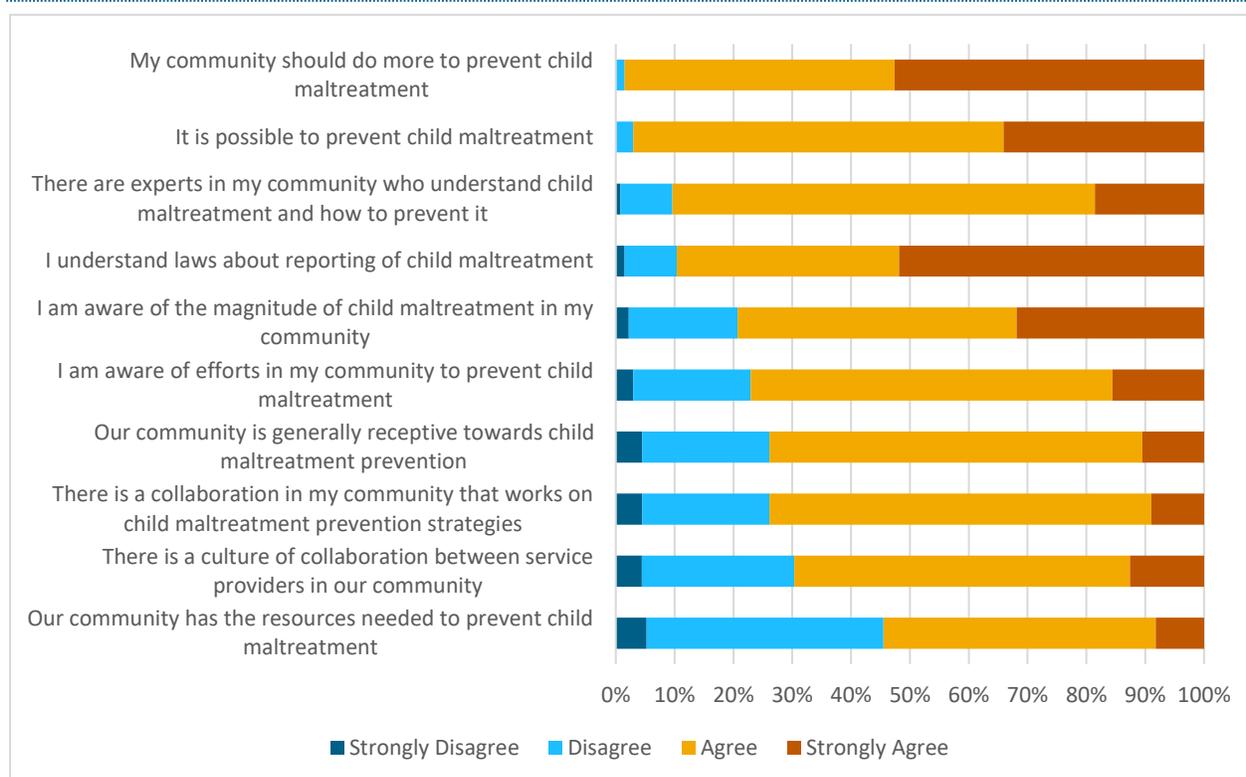


## COMMUNITY NEEDS FOR CHILD MALTREATMENT PREVENTION

In addition to asking community and coalition members about coalition functioning, we asked more general questions about community readiness for child maltreatment prevention. The results are shown in Figure 5. In terms of attitudes towards prevention, the vast majority of respondents (99%), stated that they “agreed” or “strongly agreed” that their community should do more to prevent child maltreatment. Additionally, 97% of respondents “agreed” or “strongly agreed” that it is possible to prevent child maltreatment. However, only 55% of respondents “agreed” or “strongly agreed” that their community had the resources needed to prevent child maltreatment.

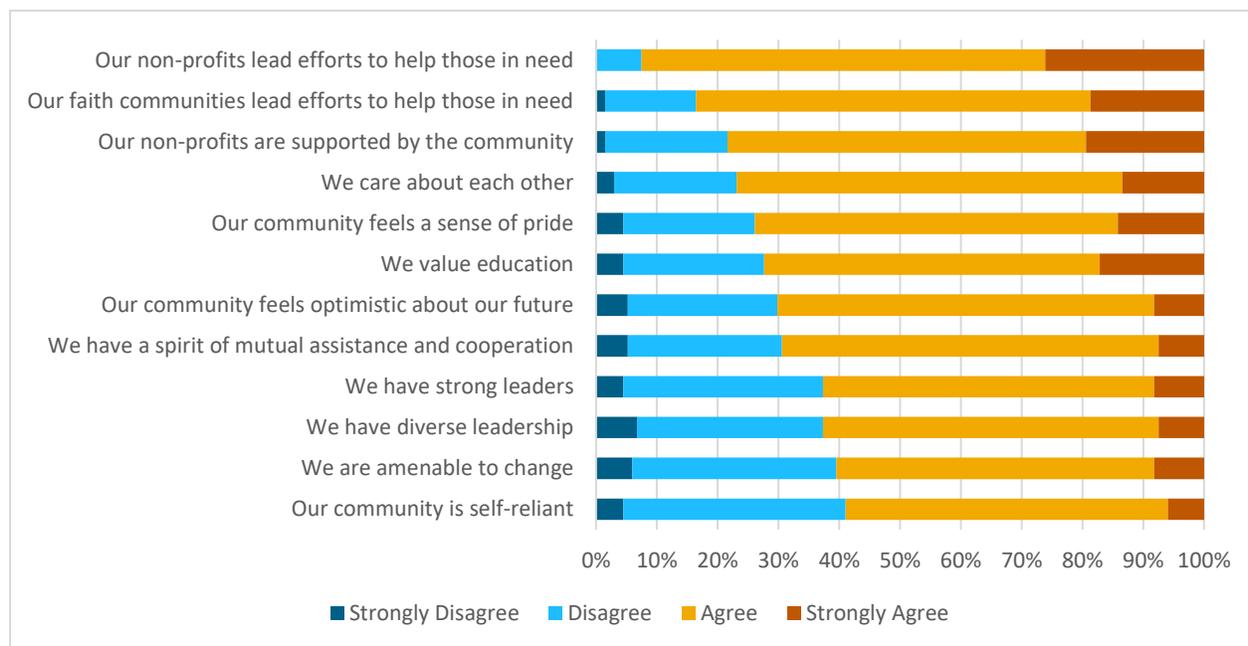
Furthermore, 30% of respondents “disagreed” or “strongly disagreed” that there is a culture of collaboration between service providers in their community, and 26% of respondents “disagreed” or “strongly disagreed” that there is a collaboration in their community focused specifically on child maltreatment prevention strategies. Thus, there is still some work for the coalitions supported through HOPES to do to improve awareness and collaboration in this sector.

**FIGURE 5. PREVENTION ATTITUDES AND COMMUNITY READINESS**



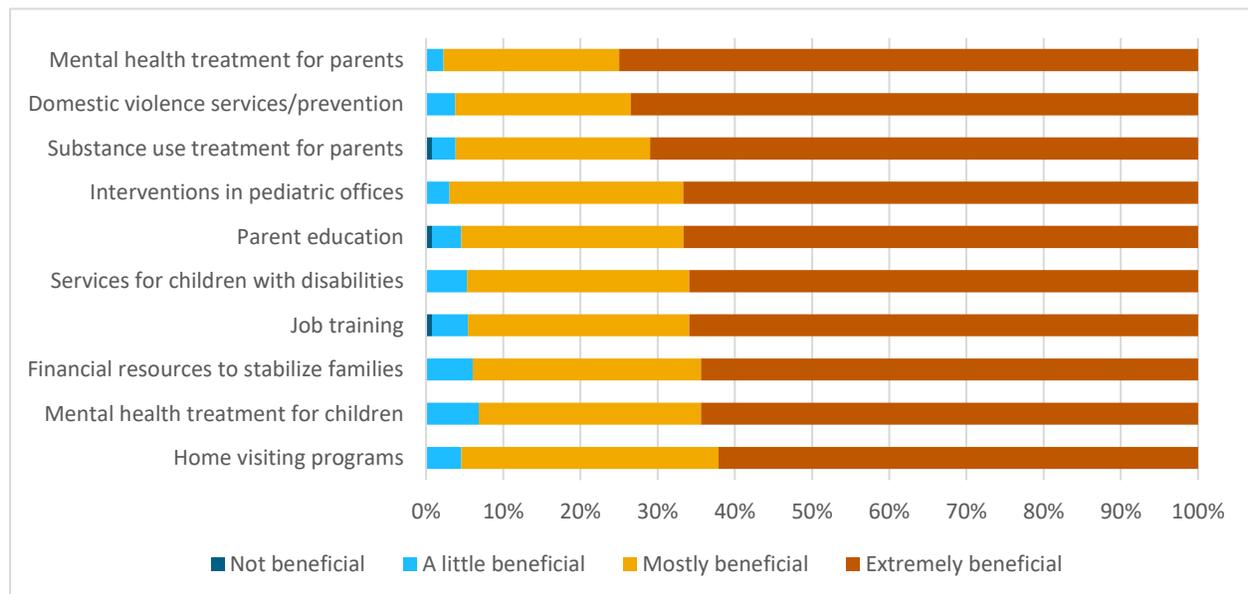
As seen in Figure 6 on the next page, the top community strengths identified by survey respondents were that non-profits and faith-based organizations led efforts to help community members in need, and that non-profits were supported by the community. The areas that scored lowest in terms of community strengths were that the community was self-reliant, that the community was amenable to change, and that there were diverse and strong leaders in the community.

**FIGURE 6. COMMUNITY STRENGTHS**



Survey respondents were also asked to rank how beneficial different services were preventing child maltreatment. In general, survey respondents rated all services listed in the survey as being “mostly” or “extremely” beneficial to reducing child maltreatment in the community, and any differences between options are not statistically significant. Still, as Figure 7 demonstrates, the three categories with the highest percentage of “extremely beneficial” responses were: 1) mental health treatment for parents, 2) domestic violence services/prevention, and 3) substance use treatment for parents. Finally, 94% of survey respondents indicated that the community use of evidence-based strategies was “extremely” or “very” important.

**FIGURE 7. SERVICES RATED AS MOST BENEFICIAL TO REDUCE CHILD MALTREATMENT IN THE COMMUNITY**



# HOPES SERVICES & PARTICIPANT CHARACTERISTICS

The next research question within this report considers the types of services provided by HOPES and overall program reach. In addition to the number of parents receiving services, characteristics of the families who participated in the program are also described. In this section, we use administrative data from the PEI database and qualitative data from interviews and focus groups.

## EVIDENCE-BASED PROGRAMS

Data collection in the PEI database relies on the identification of a primary caregiver. Data is then tracked through the primary caregiver. The primary caregiver is the main recipient of the evidence-based parent education program. Primary caregivers may have more than one child, but one child is identified as the target child. The target child must be within the range of zero to age five. Additionally, families might have a secondary caregiver or other children or family members who also receives services. Thus, the number of families served by the program is equal to the number of primary caregivers, while the total number of individuals served is larger. Most of the available demographic data in the PEI database is related to the primary caregiver and is reported as such unless otherwise specified.

HOPES I contractors were required to implement at least one evidence-based program. Sites chose home visiting and parent education programs, including: Triple P, 24/7 Dad, Parents as Teachers (PAT), SafeCare and AVANCE Parent-Child Education Program (PCEP). In most cases, these programs required extensive training to ensure that facilitators could implement the program with fidelity. Thus, there was a significant start-up period in FY2015 in which staff were trained and site-specific recruitment strategies were developed. As a result, the number of families served in the first year will be lower than in subsequent years.

**TABLE 4. EVIDENCE-BASED PROGRAMS PROVIDED TO FAMILIES IN FY2015, BY HOPES I COUNTY**

County	Total Families	Triple P	24/7 Dad	Parents as Teachers	Safe Care	AVANCE	Other <sup>1</sup>
Travis	220	118	5	86	0	0	11
Webb	135	0	0	0	135	0	0
Cameron	174	0	0	0	167	0	7
Ector	79	0	38	41	0	0	0
El Paso	405	0	0	244	0	60	101
Gregg	143	0	0	143	0	0	0
Hidalgo	168	0	0	166	0	0	2
Potter <sup>2</sup>	46	0	0	46	0	0	0
<b>Total</b>	<b>1370</b>	<b>118</b>	<b>43</b>	<b>726</b>	<b>302</b>	<b>60</b>	<b>121</b>

<sup>1</sup> Other includes: 9 families in the Nurturing Parenting Program, and 112 families who received Basic Needs Support, Case Management, Crisis Intervention, or Incredible Years, without receiving a primary parenting program.

<sup>2</sup> Includes Potter and Randall counties.

As shown in Table 4, 1,370 primary caregivers were served by evidence-based parent education programs during FY2015 of HOPES I. However, when taking into consideration other family members who received services, the total number of individuals reached by these evidence-based programs was 2,803. Most primary caregivers (n=726) received the Parents as Teachers program.

### DOSAGE

Minimum dosage is important to track, because even if families do not complete an intervention, receiving minimum dosage should create an impact. Different evidence-based programs vary in terms of protocol and minimum dosage. For example, the SafeCare program considers 18-20 weekly sessions the minimum dosage, while Parents as Teachers considers 2 years of 1 or 2 monthly visits (depending on family risk factors) the minimum dosage. The designation of whether a client received minimum dosage is left to the discretion of each site and staff member. Thus, there is a chance that clients may have been assigned as receiving or not receiving minimum dosage based on the opinion of staff, and not in accordance with standards defined by the EBP.

In the first year of HOPES, 36% of caregivers (n=491) exited services. Of those caregivers that exited services, 35% (n=174) received minimum dosage. There may be multiple explanations for this finding. First, HOPES is attempting to reach high risk populations which may not be stable enough to complete an evidence-based intervention. Second, during this first year, most families had just begun long-term programs like Parents as Teachers. Over time it may be that as more families exit the program, the percentage of parents receiving the minimum dosage increases. Finally, the recording of minimum dosage is done by sites likely needing more guidance around what is considered minimum dosage.

### SUPPLEMENTAL SERVICES PROVIDED

HOPES I sites had the opportunity to propose and provide supplemental services that matched the needs of their community. These services ranged from traditional case management to innovative therapeutic approaches such as equine therapy. Table 5 details the distribution of all services provided by HOPES in FY2015, including evidence-based programs and supplemental services. This table shows that a total of **7,515 service provisions occurred in the first year of HOPES**. It should be noted that this is not an unduplicated number of individuals served.

The most common type of service received was evidence-based home visiting; which was received by 93% of individuals. Parent education and training came in second, reaching 62% of HOPES participants. Case management was provided to 52% of HOPES participants, while basic needs support was provided to 21% participants. A further 19% took part in support groups. The remaining services reached a smaller percentage of participants, often because they were provided by only a few sites.

**TABLE 5. TYPES OF SERVICES RECEIVED BY PARTICIPANTS THROUGH HOPES IN FY2015**

	Number of individuals who received service	% of all individuals who received service
Evidence-based Home Visitation Programs	2613	93.2%
Parent Education & Training	1734	61.9%
Case Management	1444	51.5%
Basic Needs Support	582	20.8%
Support Groups	526	18.8%
Transportation	151	5.4%
Child Care	117	4.2%
Individual Counseling	114	4.1%
Crisis Intervention	82	2.9%
Therapeutic Early Childhood Classroom	41	1.5%
Therapeutic Counseling	40	1.4%
Equine Assisted Psychotherapy	27	1.0%
Parent Education & Training-Domestic Violence	22	0.8%
Fatherhood Services <sup>1</sup>	17	0.6%
Family Counseling	11	0.4%
Parent Leadership	11	0.4%
<b>TOTAL SERVICE PROVISIONS<sup>2</sup></b>	<b>7,515</b>	

<sup>1</sup>HOPES sites determined their own methods for assigning services received by clients. Thus, fatherhood services provided by some sites were coded under the “Support Groups” category, since it was a group-based fatherhood intervention, instead of under “Fatherhood Services.” Thus, the number of individuals receiving Fatherhood Services is actually greater.

<sup>2</sup>This table does not provide an unduplicated number of individuals receiving services. The number of unduplicated individuals served was 2,803. The table shows total number of individuals receiving each type of service, and thus includes duplication of individuals who received multiple services.

In addition to direct services to individuals, HOPES sites were encouraged to develop community-level activities that filled gaps in services and knowledge and/or raised the community’s awareness of child maltreatment. According to information provided by HOPES contractors in Quarterly Reports during FY2015, **over 36,475 individuals were reached by HOPES programing in the community.**<sup>3</sup>

Figure 8 on the next page provides examples of various activities. These included community events, professional development workshops, conferences and other activities. In many cases, these activities provided a means to identify and recruit families for the evidence-based home visitation programs or other services. For example, many sites hosted library reading programs, outings at the community parks, or activities at a local children’s museum where hundreds of families received information and were referred to services.

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<sup>3</sup> This number likely includes some duplicate individuals who received multiple services or attended multiple outreach events.

**FIGURE 8. EXAMPLES OF HOPES PROGRAM REACH**



Several sites focused on engaging populations that are not typically receiving parenting supports. One site worked diligently to provide relevant outreach to a local tribe and military base in the area and has now successfully forged relationships with these entities. Sites also chose to focus on engaging fathers in parenting. One site hosted a “Day in the Park with Dad” that was attended by 750 participants. Another site hosted a more intimate bonding experience with a Lego building workshop attended by 20 dads and their children.

Communities also used resources to train professionals. One community identified a need for child sexual abuse prevention and trained over 2,000 professionals using the Stewards for Children Sexual Abuse Training Curriculum. Another community provided training to professionals on the Period of PURPLE Crying, while others held conferences on child maltreatment for professionals.

**CHARACTERISTICS OF FAMILIES SERVED**

Although over 36,000 individuals were reached through HOPES in FY2015, data were primarily collected from parents who received evidence-based programs. One-time events and/or short-term interventions do not provide the same opportunities for in-depth data collection. Thus, this section uses information only from the 1,370 primary caregivers who received evidence-based parenting programs. In considering the multitude of services offered through HOPES, these

families would likely be the most 'at risk.' This section provides an overview of demographics, risk factors and common parenting challenges of participants.

### DEMOGRAPHIC CHARACTERISTICS

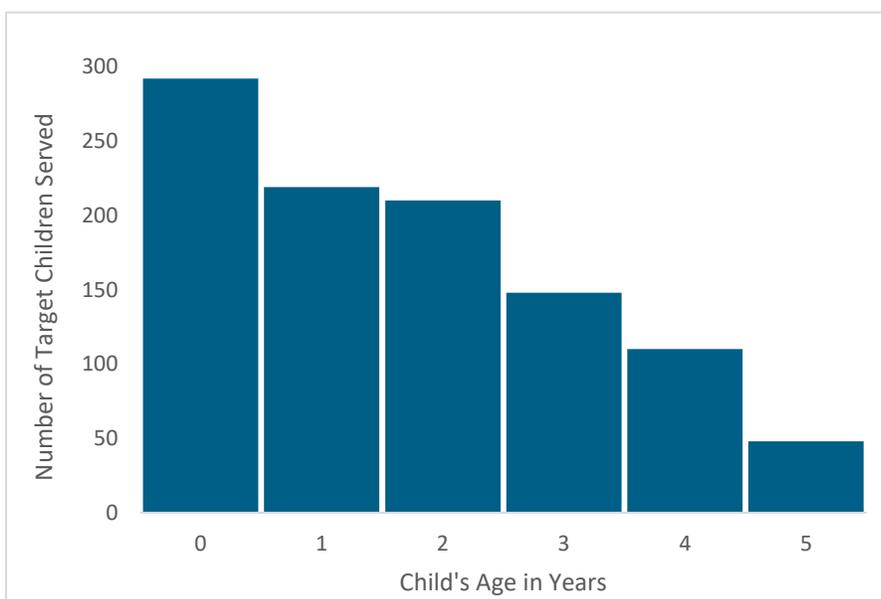
Figure 10 on the following page details caregiver demographics. In FY2015 of HOPES I, 93.6% of primary caregivers were female, while 6.4% were male. The predominant relationship of primary caregivers to target child was that of mother (88.8%), followed by father (5.9%), and grandmother (1.9%).

In terms of ethnicity, 82.6% of primary caregivers were Hispanic. In terms of race, 88.2% of primary caregivers were white (9% were white non-Hispanic), 7.2% were black, 1.7% were of multiple races, and less than one percent were Asian or American Indian or Alaska Native. Additionally, 49.1% of primary caregivers spoke English as their primary language, while 44.5% spoke Spanish as their primary language, and less than one percent spoke another language.

The average age of primary caregivers was 28.2 years (median = 27), with a range of 13 to 68 years. The average age for the target child was 1.7 years (median = 2).

All target children ranged from zero to five years, except for one child who was 6 and another who was 11 years old. The two children outside the 0-5 age range were excluded from analysis, as they may have resulted from data entry error. Figure 9 shows the age distribution of the target children. To simplify data collection, a target child is identified, but in the qualitative portion of this evaluation 82% of caregivers reported having more than one child. While the caregivers interviewed for the qualitative component are not representative of all caregivers interviewed, it does imply a likelihood that most HOPES parents have more than one child.

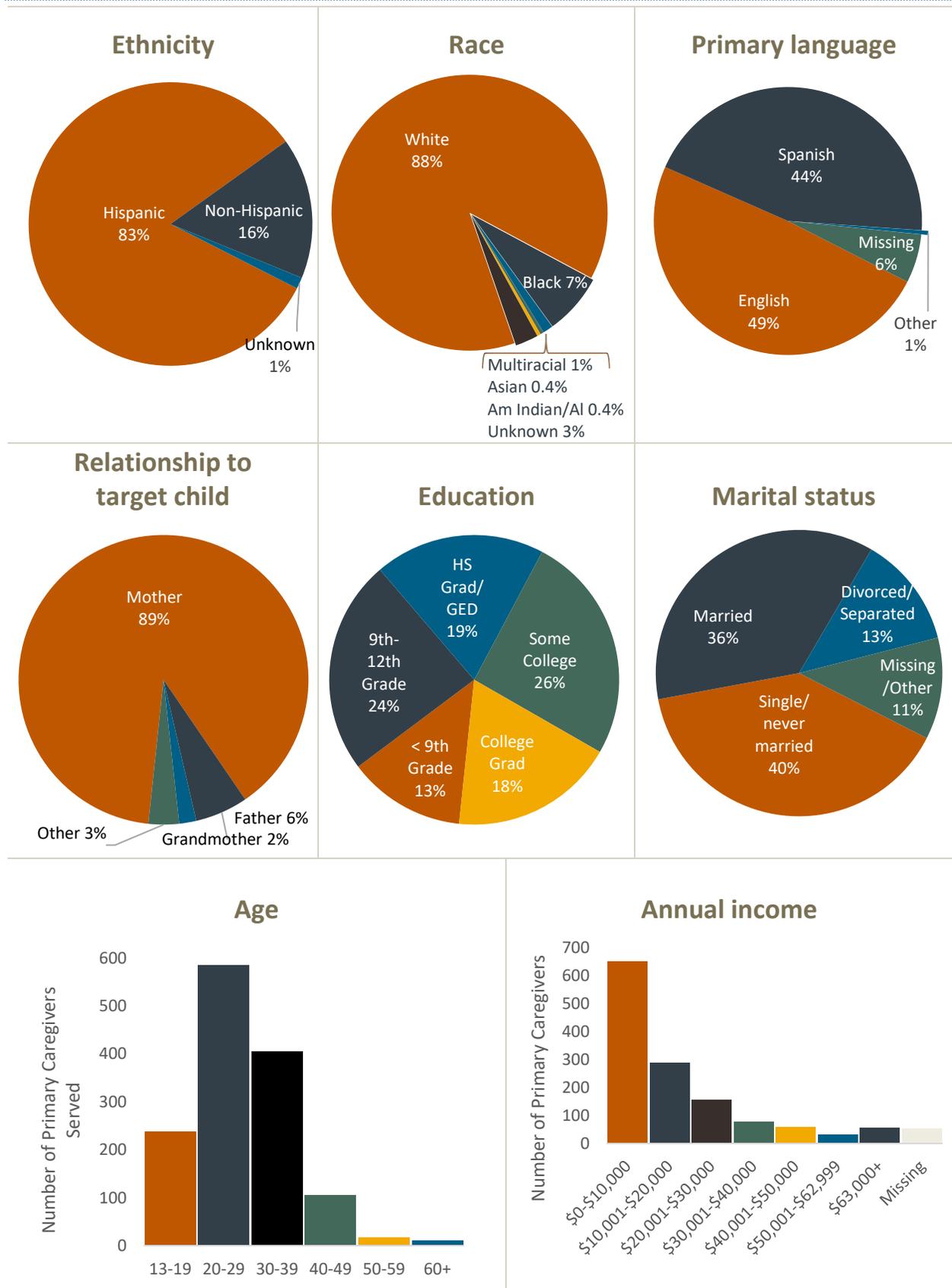
**FIGURE 9. AGE OF TARGET CHILDREN SERVED BY HOPES IN FY2015**



[The home visitors] don't make you feel weird if you're not doing something right. They're trying to help us while we're helping our kids.

*-Mother of 5 and Grandmother of 3 on why she is involved in a home visiting program after raising multiple children*

**FIGURE 10. PRIMARY CAREGIVER CHARACTERISTICS**



FY2015, HOPES I served 237 primary caregivers who were under 18 years old, which is reflected in the number of primary caregivers without high school degrees, since many teenage primary caregivers are likely still in high school. Thus, to understand the education level of the adult population served by HOPES, educational attainment for the population 25 and older was calculated. This 25 and older age range is also used by the U.S. Census Bureau when calculating educational attainment.. About 34% of HOPES primary caregivers aged 25 and older had an educational attainment of “less than high school diploma.” As a comparison, only 17.6% of individuals in Texas age 25 and older had a less than high school diploma level of education in 2015.<sup>4</sup>

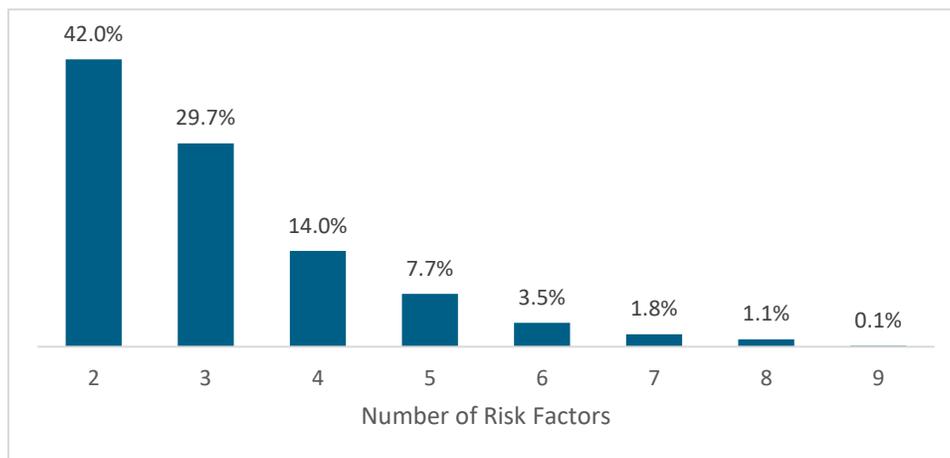
Nearly half (47.5%) of primary caregivers served by HOPES I in FY2015 had an annual income of \$10,000 or less. More than two thirds (68.6%) of primary caregivers had an annual income of \$20,000 or less. By comparison, the median household income in Texas in 2015 was \$55,653.<sup>4</sup>

### RISK FACTORS EXPERIENCED BY FAMILIES

While HOPES programs provided a variety of community services, data in the PEI database was only collected for those families receiving core services. For HOPES I, core services were evidenced-based parenting programs. In order to be eligible for services, primary caregivers must indicate that they have at least two risk factors present in their family.

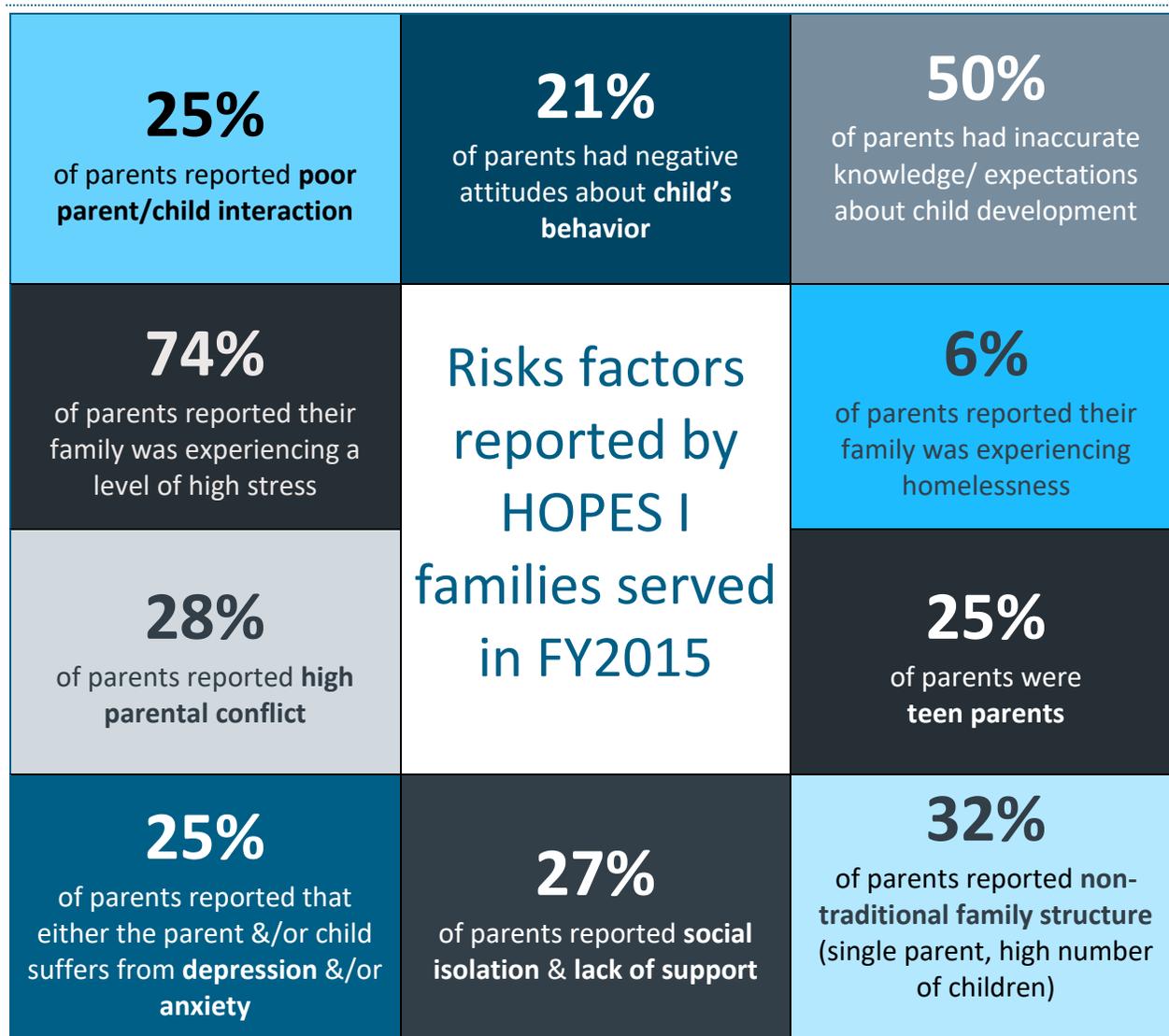
Forty-two percent of caregivers reported two risk factors present, 29.7% reported three risk factors, 14% reported four risk factors and 15% of families reported four or more risk factors. The most common risk factor was high levels of family stress (75% of primary caregivers), followed by lack of knowledge of child development (50% of primary caregivers), and then non-traditional family structure, such as single parent without social support and/or a high number of children (32% of primary caregivers). The least common risk factor was homelessness, reported by 6% of primary caregivers. Figure 12 on the next page details the percent of parents reporting various risk factors.

**FIGURE 11. PERCENT OF PRIMARY CAREGIVERS WITH NUMBER OF RISK FACTORS**



<sup>4</sup> U.S. Census Bureau, 2015 American Community Survey 1-Year Estimates

**FIGURE 12. PERCENT OF PARENTS REPORTING SPECIFIC RISK FACTORS**



**COMMON PARENTING CHALLENGES ACCORDING TO HOPES PARTICIPANTS**

In addition to risk factors from PEI data, qualitative interviews and focus groups with 52 caregivers provided additional information about the challenges experienced by their families.

**Child behavior challenges.** One of the most common challenges faced by families enrolled in HOPES I was having a child with a disability and/or behavior difficulties that parents were not sure how to handle. This was mentioned as a challenge across 15 out of 35 interviews and across all eight HOPES I sites. For example, one parent said, “I have two children with disabilities. And so, here we are, working hard with the kids, because it really isn't easy having two children with disabilities. Sometimes they get restless, one cries and one walks off, one runs, the other jumps.”<sup>5</sup>

<sup>5</sup> Original Spanish quote: “Tengo dos niños con deshabilidad. Y pues, aquí estamos, trabajando duro con los niños, porque no, no es fácil con dos niños con deshabilidad. A veces se ponen inquietos, llora uno, y anda, uno anda corriendo, otro brinca.”

Not surprisingly, managing children’s behavior with appropriate discipline was also one of the things participants struggled with: “The most difficult for me is to discipline them [my children]. How to use discipline correctly, that’s something I should do, and for me that is the hardest.”<sup>6</sup> About 6 out of 35 parent interviews mentioned that discipline and managing children’s behavior was the most challenging aspect of parenting for them, and 19 parent interviews listed education on discipline and parent-child interaction as one of the most beneficial aspects of HOPES.

**Lack of social support and income.** The next two most common challenges mentioned by families were lacking a social support network and lacking income. Both of these themes were mentioned in 13 interviews at six HOPES I sites. Having family, friends, or some other support system is vital when raising children. These networks provide parents with advice, free or affordable child care and moral or emotional support. One participant stated, “I don’t have family. I mean I have family here, but they’re not supportive. They’re expecting me to mess up, so I beat the odds and I have to keep proving myself. But I’m not doing it for them. I’m doing it for my babies.” Some participants interviewed also reported feeling isolated, overwhelmed, the inability to manage time, and lack of time for oneself were the hardest things about being a parent. One said, “It’s just too much for me, sometimes. It’s overwhelming. Just those days. Or, what I found, too, people do stereotype moms that are single, especially in school and stuff like that – or my church. They think that I did something wrong to be alone.”

Many participants gave examples of one or more family members losing their jobs and the struggle that caused. For example, one participant said: “My husband’s work has gone down, and a couple of days ago, they cut off our gas...We’re barely making it. Right now, we’re behind on our house payment, and our truck payment.” Additionally, a few parents mentioned that one of the hardest things about being a parent was not being able to provide for their children at a level that they would like. One parent stated, “I am kind of scared because I start thinking what if I don’t have enough money to pay bills...That is the main thing that I am worried about.” A related theme was struggles with housing, reported in seven interviews, across five HOPES I sites. Some participants reported being homeless, while others felt stressed about increasing rents, or had to live in crowded conditions with multiple families in single dwellings.

**Additional family challenges.** Parents also discussed challenges with: (1) **domestic violence** (nine interviews across six sites), (2) **immigration** (six interviews at five sites), (3) **mental health** (four interviews at four sites), and (4) **substance use** (three interviews at three sites). One participant stated needed counseling, but struggling to get it before enrolling in HOPES: “I was in prison for eight years; I went in when I was 17, I got out when I was 25. Now, I know they say the prison system is to rehabilitate you, but I really didn’t get the counseling that I needed even then.”

**Co-parenting.** Finally, a challenge some parents had was a difficult time co-parenting. This was one of the most common challenges reported by the two focus groups with teen fathers that were conducted. One father said, “It’s so hard getting on the same page as far as what you wanna do with children because me and my girlfriend came from two different styles of parenting.”

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<sup>6</sup> Original Spanish quote: “Y lo difícil para mí es disciplinarlos. Como usar la disciplina correcta, qué es lo que uno debe de hacer, para mí eso es lo difícil.”

# IMPACT OF HOPES ON FAMILIES

Since the primary focus of the HOPES program is to reduce child maltreatment, an understanding of how the program impacts families is essential. In this first year evaluation, measurement of community-wide maltreatment rates is not possible since not enough time has passed to see impacts on a community scale. This section provides a summary of program impact on parental Protective Factors Survey (PFS) scores, data from staff surveys, and qualitative data from interviews and focus groups with parents, staff, and community members on their perceptions of program impact.

## PROGRAM IMPACT ON RISK AND PROTECTIVE FACTORS ASSOCIATED WITH CHILD MALTREATMENT

Project HOPES, like all PEI programs uses the Protective Factors Survey (PFS) to measure changes in protective and risk factors in parents for continuous improvement and evaluation purposes. The PFS is a 20-item measure designed for use with program participants receiving child maltreatment prevention services, including home visits, parental education, and family support. The PFS was designed to help identify areas where families need assistance. A copy of the PFS is provided in Appendix E. The subscales of the PFS are detailed in Table 6 below.

**TABLE 6. SUBSCALES OF THE PROTECTIVE FACTORS SURVEY**

Protective Factors	Description	Survey Items	Scoring
Family Functioning/ Resiliency	Having adaptive skills and strategies to persevere in times of crisis. Family's ability to openly share positive and negative experiences and to accept, solve, and manage problems.	1-5	If 4 or more items completed, take the average of item responses.
Social Support	Perceived informal support (from family, friends, and neighbors) that helps provide for emotional needs.	6,7,10	If 2 or more items completed, take the average of item responses.
Concrete Support	Perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.	8,9,11	Reverse score all items. If 2 or more items completed, take the average of item responses.
Child Development & Knowledge of Parenting	Understanding and using effective child management techniques and having age-appropriate expectations for children's abilities.	12-16	Reverse score 12, 14, and 16.
Nurturing & Attachment	The emotional tie along with a pattern of positive interaction between the parent and child that develops over time.	17-20	If 3 or more items were completed, take the average of item responses.

Source: *The Protective Factors Survey User's Manual Revised, October, 2011. Retrieved from: [http://friendsnrc.org/jdownloads/attachments/pfs\\_user\\_manual\\_revised\\_2012.pdf](http://friendsnrc.org/jdownloads/attachments/pfs_user_manual_revised_2012.pdf)*

PEI requires that the PFS be administered when a client starts and ends services. For programs that last longer than one year, HOPES requires sites to administer the survey at one year after the beginning of services. Some sites decided to implement a post-PFS at the six-month mark as well to gather additional data. Clients who stop services prior to completing the program also complete post-PFS surveys.

Of the 1,370 primary caregivers who received services, 491 exited services within FY2015. Of the 491, 235 completed a post-test (48%). Thus, the analyses and information in this section only include those 235 primary caregivers who completed a pre- and post-PFS survey.

In the sample of PFS survey scores from FY2015 of HOPES I, the number of days between pre- and post-surveys ranged from 12 to 310 days, or less than a month to 10 months. Additionally, the dosage of services received varied. Dosage was measured using two different measures. One measure was provided in the PEI database. For this measure, agency staff entered “yes” or “no” under a “minimum dosage received” field. This variable may be unreliable, as it is not clear how staff made this determination. There is a chance that staff did not use EBP guidelines.

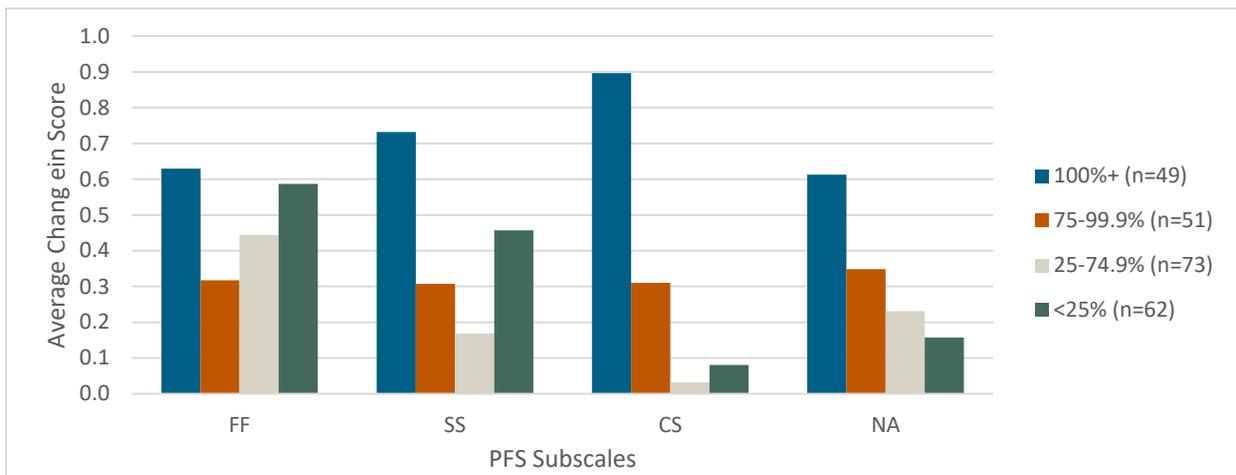
The other measure of minimum dosage was calculated by the research team, based on the number of times primary caregivers received an EBP service, using the minimum dosage standards for each type of EBP. This variable is in the form of a percentage (“percent of program complete”) as opposed to a yes or no binary variable. This calculated dosage measure was based on many assumptions from the research team, and is also unreliable. Comparison of the “minimum dosage received” variable in the PEI database to the one calculated by the research team showed a discrepancy in about half of the data points. **Considering the unreliability of variables, data for both is presented in this report. Data should be interpreted with caution.**

Using the calculated dosage variable, in FY2015, nearly half of participants who exited services received less than 50% of the EBP, while the other half received 75% or more of the dosage. Based on the “minimum dosage” variable in the database, 36% of participants who exited services had received the minimum dosage, while 64% did not.

Figures 13 and 14 on the next page show the average change in PFS subscale scores for primary caregivers who exited the program in FY2015, based on the two different dosage measures. Additionally, Figure 15 provides average change in scores to the five questions in the Child Development & Parenting Knowledge subscale based on minimum dosage received. The items in this subscale must be reported separately and cannot be aggregated into a single subscale score. Greater improvement is represented by greater average change scores (higher bars).

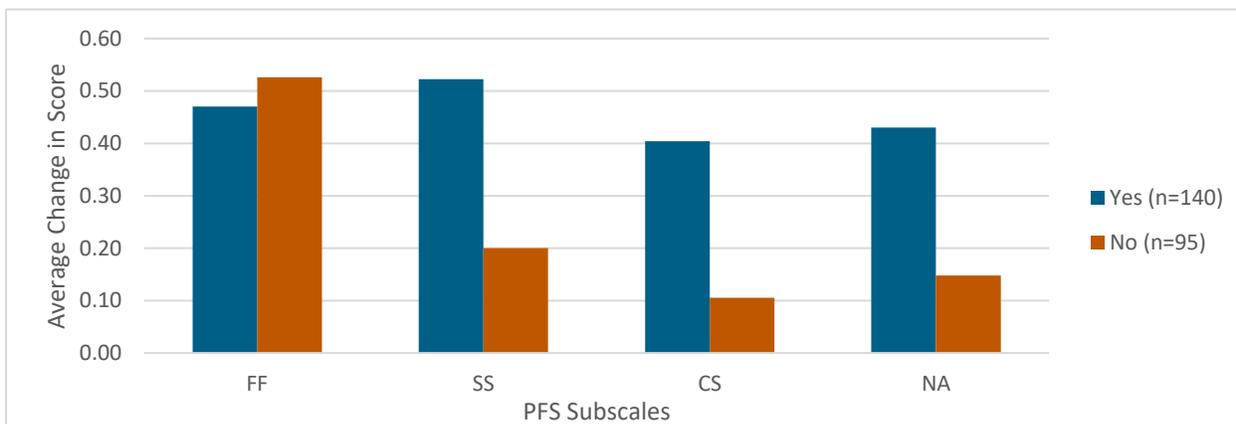
The charts which use the “minimum dosage received” variable show that for three of the four PFS subscales, participants who received the minimum dosage had higher changes in scores than those who did not. The exception is the family functioning scale, though the difference in means was not significant ( $p = 0.705$ ). The difference in means was only significant for the Nurturing and Attachment subscale ( $p = 0.046$ ). The charts which use the “percent program complete” variable indicate that participants who completed 100% of the program had the highest increases in scores. However, the family functioning scale has a counter-intuitive distribution of scores.

**FIGURE 13. AVERAGE CHANGE IN PFS SUBSCALES FOR HOPES PARTICIPANTS WITH CASE CLOSED, BY % PROGRAM COMPLETED**



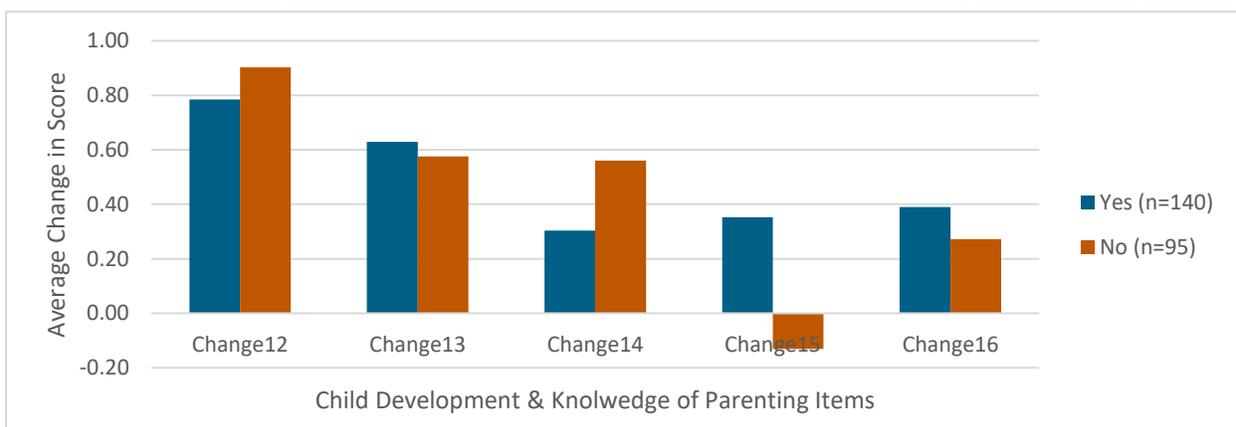
Note: FF = Family Functioning; SS = Social Support; CS = Concrete Support; NA = Nurturing and Attachment

**FIGURE 14. AVERAGE CHANGE IN PFS SUBSCALES FOR HOPES PARTICIPANTS WITH CASE CLOSED, BY MINIMUM DOSAGE RECEIVED**



Note: FF = Family Functioning; SS = Social Support; CS = Concrete Support; NA = Nurturing and Attachment

**FIGURE 15. AVERAGE CHANGE IN CHILD DEVELOPMENT & KNOWLEDGE OF PARENTING FOR HOPES PARTICIPANTS WITH CASE CLOSED, BY MIN DOSAGE**



Note: See questions 12-16 of the PFS in Appendix E for individual item definitions.

Family functioning appears to have improved for families regardless of whether they completed the program. Family functioning refers to the family's ability to openly share positive and negative experiences and to accept, solve, and manage problems. Primary caregivers who completed 100% of the program reported an average of .63 points improvement on this subscale. In terms of improvement on this subscale for families who did not complete the program, caregivers who completed over 75% of the program reported an average of .32 points increase in family functioning, while those who completed 25 to 75% of the program reported an average of .44 points increase. Those primary caregivers who completed less than 25% of the program had a .59 point increase in this subscale.

Social support also appears to have improved for families regardless of whether they completed the program. Social support refers to the perceived informal support (from family, friends, and neighbors) that meets emotional needs. Primary caregivers who completed 100% of the program reported an average of .73 points improvement on this subscale. In terms of improvement on this subscale for families who did not complete the program, caregivers who completed over 75% of the program reported an average of a .31 point increase in family functioning, while those who completed 25 to 75% of the program reported a .17 points increase. Those primary caregivers who completed less than 25% of the program had a .46 point increase in this subscale.

Concrete supports appear to have improved for families regardless of whether they completed the program, but those who completed the program had much higher change scores. Primary caregivers who completed 100% of the program reported an average of a .90 points improvement on this subscale. In terms of improvement for families who did not complete the program, caregivers who completed over 75% of the program reported an average of a .31 points increase in family functioning, while those who completed 25 to 75% reported a .03 points increase. Those primary caregivers who completed less than 25% of the program had a .08 point increase in this subscale.

Nurturing and attachment appears to increase based on the percentage of the program that primary caregivers complete. Nurturing and attachment refers to the pattern of positive interaction between the parent and child. Primary caregivers who completed 100% of the program reported an average of a .61 point improvement on this subscale. In terms of improvement on this subscale for families who did not complete the program, caregivers who completed over 75% of the program reported an average of a .35 point increase in family functioning, while those who completed 25 to 75% of the program reported a .23 point increase. Those primary caregivers who completed less than 25% of the program had a .16 point increase in this subscale.

Child development and knowledge of parenting is the primary focus of evidence-based programs used by sites. With the exception of question 15 ("I praise my child when s/he behaves well"), the items in this subscale appear to have improved for families regardless of whether they completed the program. Item 15 is the only one where those who did not receive the minimum dosage scored lower in the post-PFS, and the difference in means between the two groups was significant ( $p = 0.012$ ). As the items in this subscale must be reviewed on an individual basis, it is more difficult to make reliable conclusions.

Taken together, the changes in these subscales are positive. However, there are limitations when interpreting the subscale changes. First, sample sizes are small and outliers may have dramatic effects on the average change rate. With increased data in subsequent years, these average change rates should be more stable and better representative of program impact. Additionally, when looking at the data in terms of percent program complete, only the nurturing and attachment subscales follows the expected pattern where more programming increases change while less programming decreases change. Given the fact that participants who completed the program and those who left with completing less than 25% of the program had similar change scores, questions exist as to the true effectiveness of programs. It may be that the minimum dosage of these programs is not needed to create change, or it may mean that these subscales are not a good representation of client change. Indeed, many programs expressed concerns about the utility of the PFS to accurately measure change.

## **PROGRAM IMPACT ON FAMILIES BASED ON CAREGIVER PERCEPTIONS**

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Interviews indicate that HOPES is reaching families who need and appreciate the services. The qualitative interviews and focus groups with 52 caregivers described how gaining abilities to address these challenges made the HOPES program appealing to participants. This section describes reasons parents participated and their satisfaction with the program.

### **WHY CAREGIVERS PARTICIPATED IN THE PROGRAM**

Many parents stated that they wanted do things differently compared to how they were raised. Mentioned in seven interviews across five HOPES sites was the desire not to repeat a cycle of abuse. Those parents who disclosed being abused as children stated that they wanted to do things differently with their children. “I was abused as a child...I’ve changed everything. I don’t spank, because I was spanked. I feel like it made me an aggressive person, more than I should be, because of the spanking. And, angry, too, I feel like it made me angry and aggressive. Something that I always struggled with. That I don’t spank, I separate myself. I do time out.” Parents expressed desire to learn about how to discipline and communicate effectively with their children, and in general how to be better parents. One participant described the most important thing she gained from the program as understanding that “people can change – especially parents need to change for these kids, because they deserve something better – at least than I what I had.”

Additionally, as discussed in six interviews across four HOPES sites, parents wanted to be more present and involved in their children’s lives. This was especially true for fathers. One teen dad said, “I think my favorite part is just, I learned so much stuff that I wouldn’t have learned before. I couldn’t have a conversation with my dad about parenting; my dad has never really been a parent.”

Another appealing aspect to the HOPES I program for parents was the additional social connection and support that the program provided. This was mentioned in at least six interviews across five HOPES sites. One parent said, “I think it’s a perfect program, the way it is. If I have any kind of questions about something, or I’m curious about something, the [home visitor] always brings me literature about what I have questions about, or I’m concerned about. She’s really good with my son, my son loves her, he always looks forward to it.”

A final benefit of the program, considering the financial struggles faced by families, was that the program was free. One participant explained that she had tried to find help elsewhere, but did not have the funds to pay: “So, everybody else had a long wait program. They wanted to know if I had Medicaid, or – basically, they wanted to know who was gonna pay for it, if I couldn't pay for it. That's what it all boiled down to.”

### CAREGIVER SATISFACTION WITH SERVICES

**Program curriculum.** Parent education and associated materials was one of the most liked parts of the program (mentioned in 30/35 interviews across all eight HOPES sites). In particular, activities that demonstrated parent-child interaction were highly valued (mentioned in 19 interviews across all eight sites). Through the various curricula parents reported changing their behavior (mentioned in 28 interviews across all eight sites) and improvements in their children's behavior (mentioned in 15 interviews across all eight sites). One parent stated, “They gave us many strategies about how, specifically in many difficult situations, like when you should leave or should stay and work with the children, because many times you don't know, no one teaches you how to be a mother. These strategies they gave us, this kind of information you don't get in books, or in church, or from grandmothers, or with mothers—none of them have this information.”<sup>7</sup>

**Parent educator relationship.** The relationship and support provided by the parent educator was also a part of the program that participants mentioned over and over as one of the best aspects (29/35 interviews across all eight sites). Quotes from parents included feeling like the parent educator was part of the family and that they could ask them for any type of help or advice they needed. One participant said, “I liked that my [home visitor] is very helpful. She's very supportive. She has nothing but positive things to say to me. Even when I'm being negative to myself, she's very positive. She's very supportive – like a friend. She's very helpful, friendly, and, if I don't have a solution, she has one.”

**Tailored services.** Home visitation (mentioned in 20 interviews at all eight sites) and the flexibility of the program to tailor to the family's needs (mentioned in 19 interviews at all eight sites) were also highly valued by program participants. Services like text message responses to participants' questions were greatly appreciated. Transportation was also noted as a barrier that would have prevented families from services if home visitation was not an option.

**Holistic nature.** Another key component of the HOPES program participants appreciated was its holistic structure. In addition to parent education, parent educators provided social support, case management and assistance improving parents' personal lives (mentioned in 17 interviews at six sites). One parent said, “I go to [my parent educator] for almost everything that I need... I know [her and] most of all the ladies that I've met up there; I text [her] and I'm like, hey, I need prayers. We got a family problem. And they've always called me and asked ‘Hey, are you okay? Are you doing fine now?’”

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<sup>7</sup> Original Spanish quote: “Nos dijeron muchas estrategias de cómo, precisamente en muchas situaciones difíciles como uno puede salir o puede trabajar con los niños, porque muchas veces no sabes, nadie te enseña a ser mamá. [...] Esas estrategias que nos dieron pues, ese tipo de información que no consigues en libros, o en iglesias, o con abuelas, o con mamás--uno no tiene información.”

**Counseling.** Beyond parent education and case management, some HOPES programs also provided supplemental counseling and therapies that participants found very beneficial. One parent said, “that’s another huge part I love about the program, that they have a counselor, and I get to see her every other week, and she’s helped me with a lot of my issues... She’s helped me to see that I’m pretty hard on myself, a lot harder than I should be, and that I am a good mom, and I’m not doing anything wrong... I’ve come a long way, so I’m proud about that.”

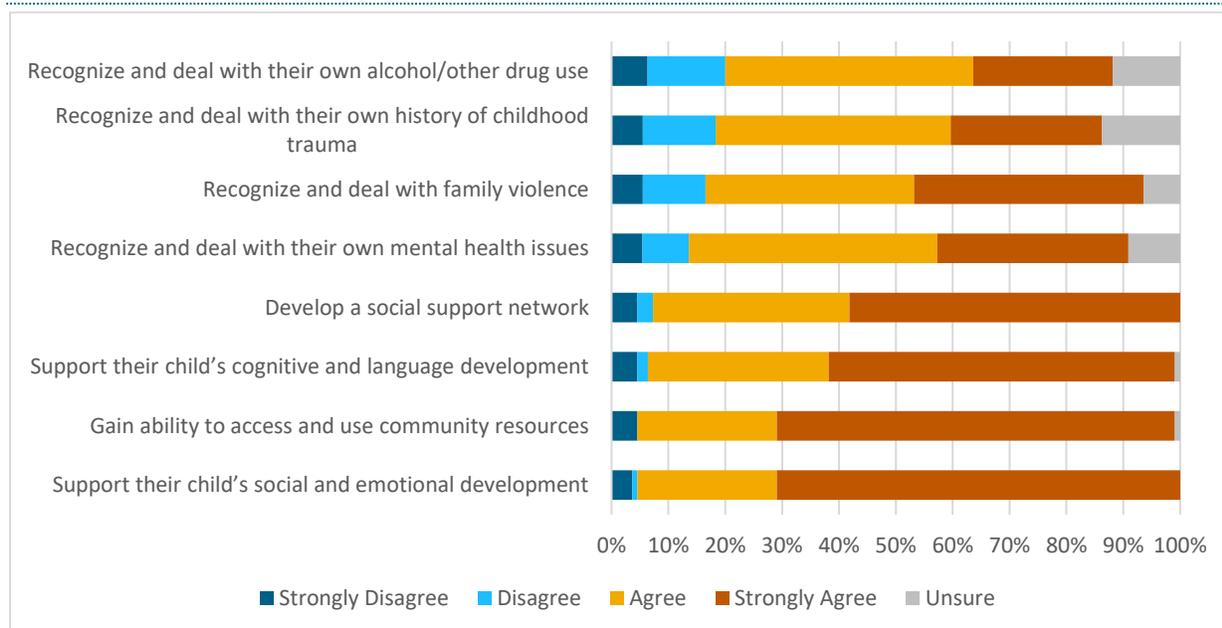
**Recommend others.** Finally, a huge testament to participant satisfaction is recommending the program to others. Many of the parents interviewed said they did that, or that another parent had recommend the program to them (mentioned in 15 interviews at six sites). Multiple participants indicated mentioning the program to their family members who were now also participating.

## PROGRAM IMPACT ON FAMILIES BASED ON STAFF PERCEPTIONS

In this section, we present information from staff surveys and interviews that address their perceptions of program impact. According to the staff survey, the majority of staff believe the HOPES program is effective and provides participating families with many useful tools. Over 90% of respondents “agreed” or “strongly agreed” that HOPES helps caregivers support his/her child’s social and emotional development and cognitive and language development, gain access to community resources, and develop a social support network.

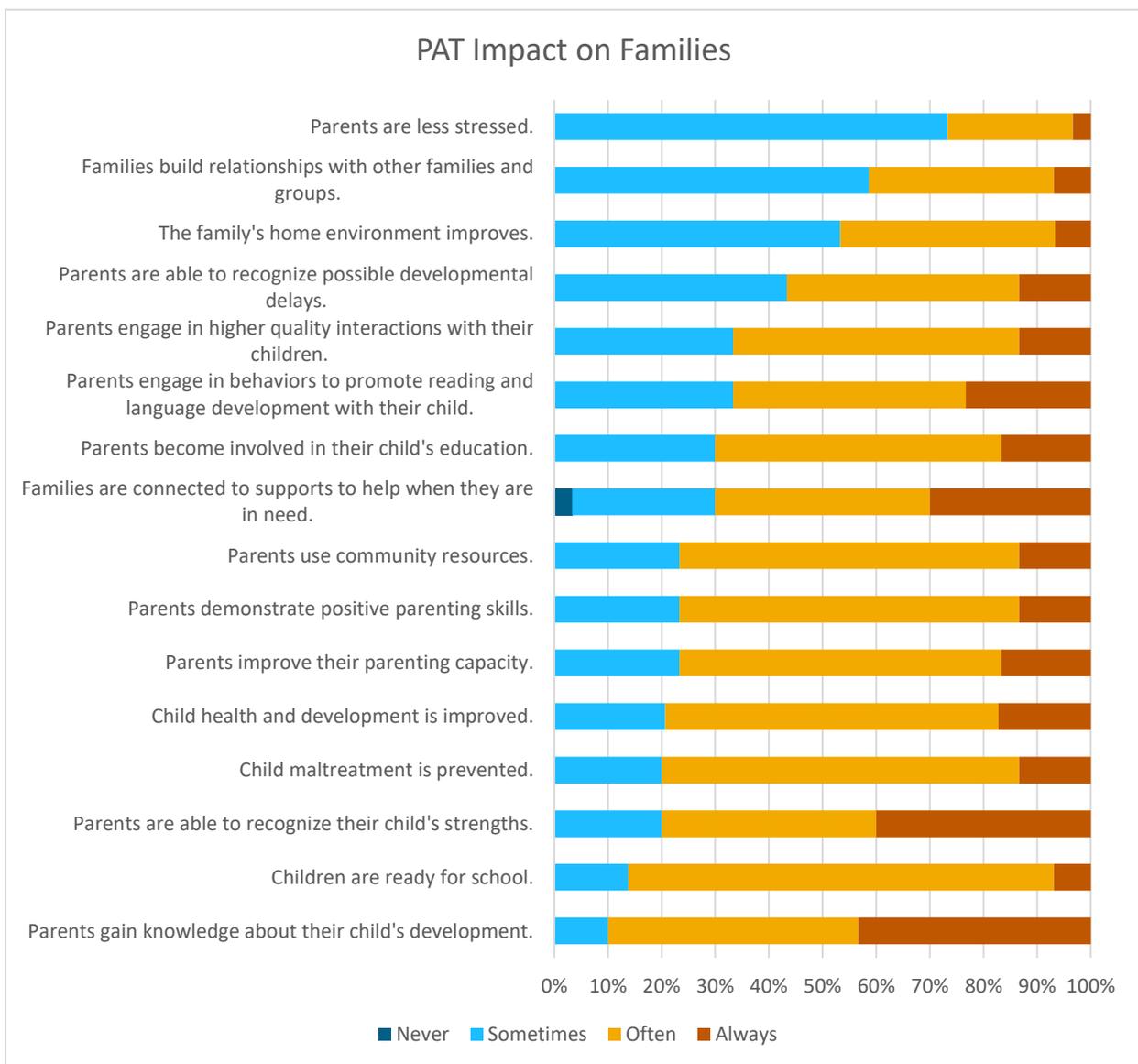
The areas that had the highest responses of “disagree” or “strongly disagree” were in helping parents deal with other significant factors driving child maltreatment: parents’ own substance use (20%), parents’ history of trauma (19%), family violence situations (17%), and parents’ own mental health issues (13%). Figure 16 details these findings. It should be noted that these responses vary by HOPES site. Some sites provide supplemental counseling in addition to parent education that directly targets risk factors such as substance abuse and domestic violence. See pages 30-34 of this report for examples provided by staff on the impact of HOPES on clients with such risk factors.

**FIGURE 16. HELP PROVIDED BY HOPES TO PROGRAM PARTICIPANTS**



Additionally, staff members who offered the Parents as Teachers (PAT) program were asked to evaluate the impact of PAT specifically, relevant to six out of the eight HOPES I sites. The results are presented in Figure 17. The greatest positive impact of PAT based on staff perceptions were in the areas of parents gaining knowledge on child development (90% “often” and “always” responses), and children being ready for school (86% “often” and “always” responses). The areas that had the largest percentage of responses of “sometimes” impactful to families were: parents are less stressed (73% “sometimes” response), families build relationships with other families (59% “sometimes” response), and family’s home environment improves (53% “sometimes” response).

**FIGURE 17. PARENTS AS TEACHERS (PAT) STAFF PERCEPTIONS ON THE IMPACT OF PAT ON HOPES FAMILIES**



## STAFF PERCEPTIONS FROM INTERVIEWS AND FOCUS GROUPS

As with parents, we asked staff during interviews and focus groups for their opinions on whether the HOPES programs they provided were effective. While staff did cite some challenges in engaging some families, the overwhelming response was that they could see many examples of how programs were benefiting families they work with. They discussed how programs could reduce child abuse and neglect by: (1) educating and empowering parents, (2) shifting cultural perspectives, (3) stopping cycles of violence, (4) encouraging parental behavior changes, and (5) addressing risk factors for neglect through counseling, case management, basic needs assistance and social support. A secondary impact of the HOPES program is improving school readiness in children. Many of the program successes and strengths given by staff are similar to those shared by the families interviewed.

**Parent education.** Examples of educating parents on a variety of topics and skills were mentioned 57 times in 28 interviews/focus groups across all eight program sites. For example, one parent educator described how the main benefit for parents participating in HOPES is an understanding of the reasons why children misbehave being tied to the parent's actions. The parent educator explained that parents began to recognize areas of improvement for their child and to say things like, "Oh, I do that all the time," or "I don't praise my child." Parent educators tended to believe that proper discipline discussed in the home visiting sessions was very important to parents, as well as "how to use quiet time and time out, because they just think they know how to use it, and they just use it as a threat [...] So I think once they learn how to use it or how not to use it, that's when they realize, oh, I've been doing it wrong."

Staff at one site shared an example of a teen mother who had very low self-esteem before entering the program. After participating in the program, staff saw a big change in her: "She's now (a success). She comes with the teen group and she's like a leader in that group now. She's one that's helping the other ones that were where she was when she first started. But the confidence level in her and the fact that she's been coming so long, the principles that we've been teaching about helping her with her children are solidified in her mind where she feels better about being a parent because she knows what to do when something happens." In another focus group, a participant gave the following example of the impact of parent education: "[This] dad is very shy in the home visits. He'll just kind of linger and be there, but as of lately, it's a whole different dad. I feel honestly it's because of these [parenting sessions]. He even told me, 'I'm learning a lot. I really like it.'"

**Empowerment.** In addition to parent education, different ways project HOPES empowers families were highlighted by participants 64 times in 27 interviews/focus groups across seven sites. One staff member said the program "builds their confidence. So once they're building their confidence then they will feel that importance to further succeed."

Many staff interviewed described the importance of empowering families who often had not heard anyone give them encouragement to build their self-esteem and confidence. One staff member said, "And we're able to come in, and I try to encourage them as much as I can no matter what they're facing. Whatever their home life looks like, I try my hardest to try to encourage these parents, and some of them do say like, 'Oh, yo, thank you.' You tell them, 'Man, you do good. That's great.' They're just like, they don't hear that sometimes, so I'm thankful for this

program and that we're able to come in here and go into those homes, connect them to resources, make an impact in their life, and I think as a parent educator, you can make that change if you really, really put your work into it and you really care about your families. **It will change their lives.**"

Another program staff member discussed how having a role model and support from a parent educator empowers parents in regards to finding a job/education, bonding with their child, and stopping intergenerational cycles of abuse: "We have some moms that didn't even think about getting their GED are now taking classes to get their GED. Or didn't even think that they could work are now working. Seeing where their child is now, just more interaction with their child. Bonding. You know, how important that is from such a young age. We just see as a family as a whole that they're growing. I just love to see that. I just feel that's so important. **That first five, that zero to five, those beginning years is very crucial. Sometimes certain families don't realize that because of generations of how they lived. Come from a broken family.** Didn't see that. So once we're introduced to them, I feel that they connect with a parent educator, can see how important it is to bond with their baby to help them learn."

**Cultural shifts.** Some sites also mentioned examples of how they see the program having impact on cultural shifts, such as parents adopting different discipline techniques than what they experienced as children, or from what is considered appropriate in their culture, and less stigma around accessing mental health services. This was discussed in five interviews/focus groups, across four sites. For example, one program staff member said, "I hope to see less stigma with taking parent education classes or seeking mental health for moms, that's what I hope to see within the Hispanic community." Another said: "I want [parents] to feel that it's a strength to ask for help and to seek services, because in our culture you know especially when it comes to mental health it's like no, only crazy people go ask for therapy... So, we want them to feel that it's okay. That it's not looked upon as negative."

## CHILD ABUSE PREVENTION

Thirty-two specific examples of how HOPES acts to reduce child abuse and neglect were given in 20 interviews/focus groups across six sites. Additionally, how the programs reduce parental stress and other risk factors for abuse, like domestic violence, were provided 13 times in 10 interviews/focus groups across six sites. As an overall example of success, one program staff stated: "**We have not, up to this point, we have not had a single family that we have worked with be referred to CPS.** So I think that's probably the biggest success as far as benefits to the families."

As already mentioned in the previous section, many staff participants discussed how HOPES helps **stop intergenerational cycles of child maltreatment.** For example, one program staff member stated: "You're creating better people by the way they treat their children, then these children they're gonna treat good – like the next generation and the next generation and it's like a chain. That's what we're hoping, to change a little bit. We're not gonna change the world but at least we're doing a little." In another focus group, a program staff member said, "We've had parents that once we start with talking about the different strategies and how children learn, and grow, and play, and all that, I mean, we've had parents crying in the room and saying, 'I never got any

of that. I was raised in a home where I was never praised, I never did anything right.’ I mean, it’s like a healing process for them, and then they say, ‘Oh my god, I don’t want my child to go through that. I’ve never talked about it with anyone, but now that I see how important all of this is, I wanna change. I wanna provide a better home for my kid.’”

Another staff member gave an example of how the program has helped a parent who was suffering from **domestic violence** in the home and how that has increased child safety: “She thought that [the violence] was acceptable. With this program and the guidance that she got and the one-on-ones with her family, she left him. Now, she is really working two jobs and is providing for her baby. It’s just been very empowering to see how strong she has been to get away from that and kind of better her baby’s life and hers. So that’s what the program is all about.”

**Parent behavior change.** Program staff also noted that programs are providing tools to parents to help them manage their emotions. One program staff discussed how the program gives families useful tools to reduce stress in the household that can ultimately lead to reduced instances of child maltreatment: “I think that we give good tools to the parents and good resources and good information. A lot of things that they use that will help them when they get into stressful situations or where they’ve got four kids and three of them are crying and screaming and they don’t know what to do. I think there are some very useful things that we are helping them with that will help them in those situations. So yeah, I think that what we’re doing is **laying a good ground work for child abuse prevention.**”

While discipline and child behavior are important components of the home visiting and other evidence-based curriculums, another important component noted by staff are the tools provided to parents to be aware of and improve their own behavior. One program staff gave an example of how **parents improved awareness and self-control**: “The parents say: ‘Wow. It was a great program. You make me think now of how I behave with my kids, how I react to their behavior, so I can control myself more.’” Another said, “Some of the things that parents said at the end of our last group class...the parents report feeling more patient and less agitated or aggravated. They were able to stay calm more. They were able to understand their child more and feel less stressed about things. And **I could definitely see all of that directly related to preventing abuse and neglect.**”

These behavioral changes, such as **improved patience** were also often mentioned by parents in interviews and focus groups. Staff members offered further evidence: “They’ll tell you, ‘You know I used to yell at them all the time and I used to call them names, and I don’t do that anymore.’ Because one of the things that they tell you is that, ‘I want to learn patience, I wanna learn to be patient.’ And they’re working on it.” Another staff member said the most effective part of the program is when parents learn “coping skills when they’re stressed. It’s normal to be stressed out. There are other avenues besides taking it out on your children to help relieve your stress.”

### **REDUCING RISK FACTORS OF NEGLECT**

While education on child development, parent-child interaction and discipline techniques is valuable in reducing physical abuse, the majority of child maltreatment cases in Texas are related to neglect as opposed to physical abuse. Neglect can occur due to a family’s lack of knowledge about home safety, lack of resources, such as adequate housing, lack of support network or child

care, as well as untreated parental mental health and substance use conditions which impact a parent's ability to provide supervision. In the next few subsections, program staff identified ways in which some HOPES programs tackle some of these risk factors of neglect.

**Home safety education and materials.** Staff members using one evidence-based program discussed its focus on home safety and the impact on families: "We're seeing some change. We're in a lot of homes and we're in there asking all kinds of questions and going through these safety checklists." Another staff member said, "I've noticed that the stuff that we've given them, like the [home safety] incentives, and that we help them and we tell them how to apply it, it's helped. They do use them. The next visit that you go, they have their little latches, they have the stove covers, they have their fire extinguisher where they're supposed to have it."

At another site, staff members discussed how being in the home allows them to discuss important child maltreatment prevention information, such as on safe sleep: "with our program, I think when you go in, and you let that person talk to you, tell you what's really going on, and then, you give them support, then we can keep them from child abuse. The safe sleep – she said, I've been letting him sleep with me. Oh, no, baby. Do you know how many people rolled over on their baby by accident last year? She was like, really?"

**Counseling and mental health services.** Mental health is a key risk factor to child abuse and neglect, and 12 interviews/focus groups at five HOPES sites discussed the provision of counseling services. For example, one staff member said, "So besides the [EBP] curriculum, we do prevention counseling, so any issues that they identify or that we pick up on during our visits that we feel need to be addressed because it affects their ability to parent." At another site, a staff member said, "What we have seen lately is a growth in our counseling. So that is definitely a service that's becoming well known and that's being requested by the families. So that's really wonderful to see and I love seeing the families come into counseling because again, you truly do see families who are in a not so good situation."

At one site, staff would like to add a counseling position to their team, in addition to the one they currently contract with, due to the need that they have seen with their families: "[a request] for next year is maybe having our own counselor because this has come up so often. Or a counselor that can [specifically] work on... grief and maternal depression." At another site, a staff member gave an example of how just a home visit and the social support from a parent educator has counseling benefits: "There's a lot of stay at home moms and I think that there's a lot of depression in the [community]. And the fact that there's someone coming in every week to see them and provide support. I think that's one of the reasons that they stay [in the program]."

**Case management and basic needs assistance.** Program staff noted that while the evidence-based curricula were useful, other aspects of HOPES were impactful. In focus groups and interviews, staff were asked what parts of the HOPES program was most effective or impactful to families. The top response was **the added case management and basic needs assistance in addition to parenting education**. These supplemental services directly relate to preventing neglect. This was mentioned 68 times in 27 interviews/focus groups across all eight sites. When asked whether case management plays an important role in parent engagement in HOPES, one focus group participant responded, "If we were just trying to provide the parenting [education],

I think that [parents wouldn't] be able to focus.” Another continued, “They wouldn’t be in it one hundred percent because in the back of their mind they are gonna think, ‘How am I going to get dinner for my kids tonight?’ They have ripped up shoes and kids are making fun of my children and things like that.” In another focus group, a staff member said, “I remember when we first started, our director described our program as [parent education EBP] on steroids. At first I didn’t know what she meant, but I know what she means now. We’re filling in the little holes that the other program was having. With that being said, it’s also a lot more stress because not only do we have to focus on the curriculum, but there’s also all this case management on the side.”

Another staff member provided an example of hearing how the program through case management and other support helped move some participants out of **homelessness**: “Starting from a parent educator and hearing the stories of the original group that got hired from the beginning of time and when I came in, just how my mouth dropped in hearing success stories at our staff meetings, and I was like, “What? They helped? This program helped somebody go from homeless to home?” How many times do you get to hear [that]? Especially in the social work, case management field.”

**Relationship with parent educator.** Related to case management, another component of the HOPES program seen as impactful for families was the relationship developed with the parent educator, and the support the educator was able to give to the family. This was especially true for families that were more socially isolated, missing a support network. For example, a program staff said, “We have some families kind of, like, outside of city limits, in the rural areas. So they rarely ever see any people. So then they look forward to seeing us because that’s their one hour or hour-and-a-half that they have to talk to somebody about what’s going on during the week.” The relationship between program participant and parent educator was mentioned 51 times in 23 interviews/focus groups across all eight sites, and general support the educator and program provide to the family was mentioned 35 times in 20 interviews/focus groups across seven sites.

As to why families appreciated the parent educator relationships, a staff member explained that parents feel that “**I’ve got somebody on my side.** I’ve got somebody on my team that’s advocating for me and that’s helping me and that believes in me to do these things and to make changes and to be better.” Or, “I’m having a really bad day and I just need to vent to someone.” Parents who participated in interviews and focus groups also mentioned how much they enjoyed the relationship with the parent educator and appreciated that they offered nonjudgmental support. A program administrator echoed this sentiment when stating, “Parents talk really good about [the parent educators], and they have that bond with them. It’s really neat to hear that. I think they get that also from the home visiting. The ones who have started coming to counseling too, we’re able to see that. So, they have not just one person, but they’ve developed multiple people to trust and count on.”

Parents also mentioned they felt the parent educator was like an **extended part of their family**, and staff members offered similar experiences. One parent educator gave this example about what parents who graduate from the program like the most: “I don’t think it’s so much the curriculum they miss. I think it’s just the rapport that we build... We become part of their family, you know the siblings, the kids, everybody that’s there. And they get used to it. They like us...” Another staff member put it this way: “Well, I think you have to look to the relationships of the

families. And I think it's a lot about trust. So, by doing the home visits, I feel that we are becoming like part, to a certain degree, a part of their circle. And the trust is there. So, I feel that sometimes when we go in versus maybe a total stranger it's more beneficial. Because the trust is there."

Staff gave examples of how parents gained **social support systems** not only through home visitation, but also in programs that offered group classes. For example, "An amazing thing too is as years go by [the parents in the parenting class] become a support group for each other. They form a very strong relationship. Because you know I still have heard, you know they sent pictures where they got taken to Peter Piper or a baby shower for somebody and you know after all these years, they still have that. That support for each other. Very strong relationships, very strong friendships. And then say for example if somebody doesn't call, they'll call, 'Hey, what happened?' They encourage each other. Or 'I'll come pick you up,' and yeah, they look after each other."

Once that close relationship was developed, staff members felt more comfortable **discussing sensitive topics** with parents. For example, one staff member said, "I start with the families and then really when they feel comfortable with me, then I can be more open to talk about topics, more direct and maybe be more pushy. But when you can push a little bit to help the family, we make changes. I love that, I really believe in the program. I believe in our program, I believe that we really, we have different degrees but we are really impact their lives."

Beyond assisting in developing a close relationship, the **benefits of home visitation** that staff members mentioned were being able to better see and understand the needs of the families they worked with, as well as it being more convenient for parents who lacked transportation or had other challenges. For example, one staff member who also provided group classes said, "It's very different when they're in the home environment. When they're in their environment...you learn a lot from going to that home." Another staff member said, "I like going into their home because it gives you a clear picture – I feel like if we met somewhere, you wouldn't really know what their needs are like...I feel that it bonds us. You are building relationships. I like meeting in the home." In terms of transportation and convenience, one staff member said, "You're meeting them where they're at. A lot of our families do not have transportation...There's no way that you would've been able to get them to come to a classroom setting." Home visitation as a program strength was mentioned 35 times in 20 focus groups, across all eight sites.

**Improved school readiness.** Another commonly mentioned positive outcome of the program was improved school readiness for children, since more attentive, educated, and empowered parents will have positive influences on their children's development and wellbeing. This was mentioned in seven interviews/focus groups across five sites. For example, "Project HOPES is able to provide that opportunity within the family to focus all their attention on their child. And we think it should come naturally to families on what they should do with their child to help promote child development, but it doesn't. When you have so many of these stressors just piled and piled and piled, our families can't see past tomorrow let alone two years down the road when their child starts school and they're going to be behind developmentally...And so when we were able to really provide that information for families, we saw that is really the lightbulb moment that was going off in a lot of families' lives in terms of the whole structure. The curriculum is strength-based and so it's empowering."

## PROGRAM IMPACT ON FAMILIES BASED ON COMMUNITY PERCEPTIONS

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During focus groups, community coalition members across all sites also offered observations about the positive impact of the HOPES program in the community and why they were excited to get the contract in their community. One community member stated, “[The community] began talking about the grant that they hoped to get and what they were gonna be doing. And we just said, “Yes, yes, yes, yes.” Because we need so many services surrounding at-risk children. Just in [our area] and all our outlying counties. And the programs that they were interested in – that they wanted to get started and all that, it could have been beneficial to every child.”

Once HOPES programming began, community member noted positive aspects about programs including the fact that the services were free and that they were designed to meet the unique needs of the community. One participant explained that her community had identified case management as a need because it was not being provided elsewhere for high risk families: “HOPES has sometimes also identified some of the higher needs families because they’ll get the wraparound case management to better help support the family.”

Other community members noted that the parent connections that were being made seemed impactful because parents were engaging with others to break down feelings of isolation. One community member noted, “I think the family connections that they do, they’re helping families become advocates for themselves and getting out and learning about their community. They’re teaching families how to become self-reliant so that the day that they do walk away a parent knows how to pick up the telephone and say, ‘I need help’ for whatever reason.”

**Because they felt the HOPES programs were helping their communities lead efforts to prevent child maltreatment and fill gaps in services, many community members addressed concern about funding for HOPES ending.** One community member stated, “We want funding for it [as well as to be able to build on the folks that we already have. We need more clinicians in our community... There's a lot of services that are missing and you have to go outside the area to get the service for your family.”

# IMPACT OF HOPES ON COMMUNITY COLLABORATION

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All HOPES sites were required to build or engage in a community collaboration addressing the needs of children. The purpose of such collaboration is to enhance public and private collaboration to reach more children, youth, and families. To learn about the characteristics and functioning of the early childhood coalitions supported through HOPES funding, several data sources were used. In addition to data provided by agencies through quarterly reports, a voluntary online survey was sent to coalition email listservs and coalition members at each program site were interviewed (N=42).

Of the community survey respondents, 52% had participated in a HOPES coalition in the past year. On average, a representative from the survey respondents' agencies attended six coalition meetings in the previous year. Additionally, many had been members of the coalition in their community for over 2 years (41%).

The findings specific to community collaboration are presented in this section beginning with the characteristics of coalitions.

## CHARACTERISTICS OF COALITIONS

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Rather than requiring the establishment of new coalitions, HOPES allowed grantees to join forces with existing coalitions that had a focus on early childhood issues in the community. Thus, six of the seven coalitions supported through HOPES I had a community presence prior to HOPES. Four were established through support from a Texas Home Visiting program/MIECHV. One of the other pre-established coalitions was through a federal Project LAUNCH grant, while the other was part of a local United Way coalition. One site formed a stakeholder group as their coalition. One site that had difficulty joining or establishing a coalition on early childhood joined another HOPES coalition from an adjoining community in order to avoid duplication of meetings. In terms of membership, 267 organizations participated in local coalitions in HOPES project sites in FY2015, according to data from quarterly reports. A complete list of those organizations is provided in the HOPES site profiles in Appendix C.

## GOALS & PURPOSE OF COALITIONS

Every coalition focus group mentioned an overarching goal of increased collaboration across agencies and sectors to improve linkages across services for families. For example, one coalition member said, "I see as one of the goals...keeping us as professionals connected, and our agencies connected. But ultimately, it's connecting families to each other, and keeping children safe, preventing bad things from happening, preventing child abuse. And as we network with each other, then we're able to help our families make those connections."

Coalitions also provided a variety of specific focus area goals. The most common coalition goals mentioned were school readiness and early childhood education (mentioned in five out of seven coalitions). For example, one focus group member stated the main goal of the coalition was

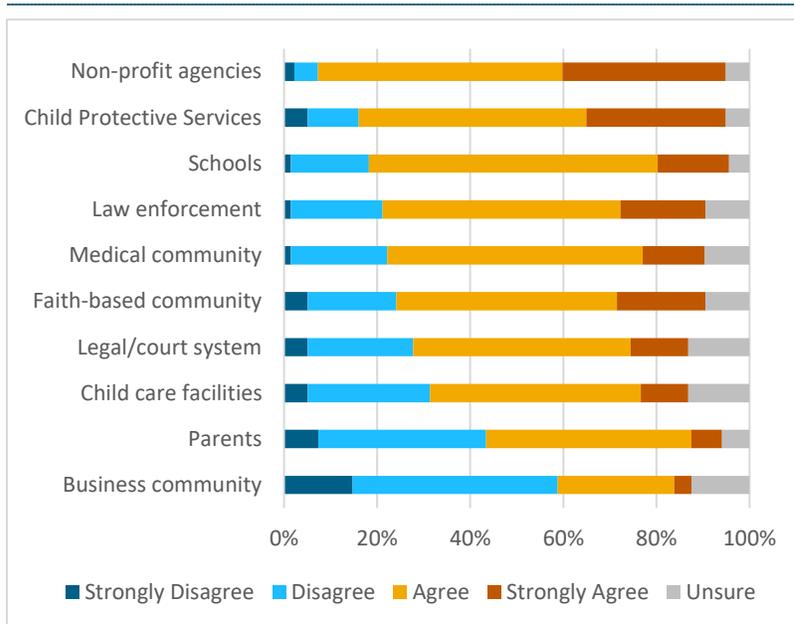
“working at early childhood so that children are ready for kindergarten. So we’ve kind of just shown ourselves as a resource for the school district versus leaving the burden of education on them. Because education doesn’t start at five years old.” Five coalitions also mentioned or implied the prevention of child maltreatment as a goal. A coalition member said, “I think a coalition like this...would prevent child abuse – So I think there’s, it’s implied that that obviously is a goal, and it’s through the connections and education of the community and parents that you do see it change.” Other goals included the reduction of poverty and improved public health. “And that’s really been one of our main goals with [the coalition], is to have the holistic approach and be able to reach everyone in the family and connect them to the things that they needed, and reduce poverty, and get these families out of that cycle.”

### COALITION MEMBERSHIP

Based on survey findings, non-profits, child protective services (CPS) and schools were the top three sectors most engaged in the coalitions. On the other hand, the business community, parents, and child care facilities were the top three sectors that were missing from the community conversation about child maltreatment prevention.

Interestingly, CPS also had a higher “strongly disagree” contingent. This may indicate that CPS is an active participant in some communities and not in others. Variations in coalition membership are likely across the different HOPES sites.

**FIGURE 18. SECTORS ENGAGED IN COMMUNITY CONVERSATION ABOUT CHILD MALTREATMENT PREVENTION**



In focus groups with coalition members, participants also listed a variety of sectors from the community involved in coalitions. These often involved social service agencies. For example, one participant said coalition members included: “healthcare – we have our Medicaid help plans at the table. We have social services, domestic violence, child abuse prevention services and we have education. Lots of education at the table. City government has gotten involved. County government. They’ve given us funding.” A member of another coalition stated, “The representation of agencies has been very strong. And then, anytime that we’ve been able to reach out to other sectors and get their buy-in, they’re always very helpful. And so our community is very connected in that way.”

**Sectors Not at the Table.** There were several sectors identified as more difficult to engage in the focus groups. Three out of seven coalitions listed the business community as not being involved in the community: “Well, it is hard, sometimes, with those business sectors because they don't really see a buy-in into an early childhood coalition. So, sometimes, they don't feel like that could be a part of their work, and so we've struggled with that.” In another focus group, a participant explained the importance of engaging this group: “Even things that maybe might not make sense from the outside, like the banking industry. You know, we've talked about where families – where they like to bank; that's the business community, banking, or Wal-Mart, or wherever might be a part of this. But that's where it goes – to really go into that private sector and the business community; because everybody [should have] an investment in what this coalition is trying to do, and the services that everybody offers.”

Additionally, while some communities were able to get government and healthcare involvement, two of the seven coalitions mentioned difficulty getting those sectors to participate. In terms of government officials, one coalition member expressed that “in some of our coalition meetings, we talked about wanting to bring this up more at council meetings and trying to get more awareness within the community itself. So I think maybe politicians and newspaper outlets are where we struggled.” In another coalition, a member mentioned, “We also had some struggle with city officials that haven't been represented. And then we do have representation in the faith basis partners but, actually, their involvement directly with the coalition has been a struggle at times as well.”

A few coalitions had initial difficulty with engaging health systems: “Even on our board – the Coalition of Health Services – our board members, they had a hard time buying into home visiting to take the grant on when we first started because they saw it as just education...They didn't see it as health-related, and we're a coalition of health. But, after about the second or third year, we were able to expand and then they saw so much success with our families – and they're all hospital administrators in rural communities – and they're like, ‘How do we get this program here?’” In another coalition, a participant further pointed out the need to include the medical community in the conversation: “The hospital [needs to be involved], like nurses, because we get victims that have been raped or sexual assaulted...So maybe if a nurse is knowledgeable about the resources that HOPES and all these other resources in the community [they can help those patients].”

## COALITION FUNCTIONING

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The Wilder Collaboration Index was used to evaluate coalition functioning in the community survey. This is a 40-item scale made up of 19 Factors. Factor scores of 4.0 or higher show strength in the coalition, scores between 3.0 and 3.9 are borderline and may require attention, while scores of 2.9 or lower indicate concern that should be addressed. Based on survey responses, all coalitions are functioning very well, with 13 out of 19 factors scoring a 4.0 or higher, and the remaining six factors scoring in the range of 3.5-3.9. The factor with the lowest score (3.54) assessed whether the coalition had sufficient funds, staff, materials, and time. The next lowest score of 3.83 was for the factor measuring whether the coalition had developed clear roles and policy guidelines. Finally, the factor that received the third lowest score of 3.89 measured

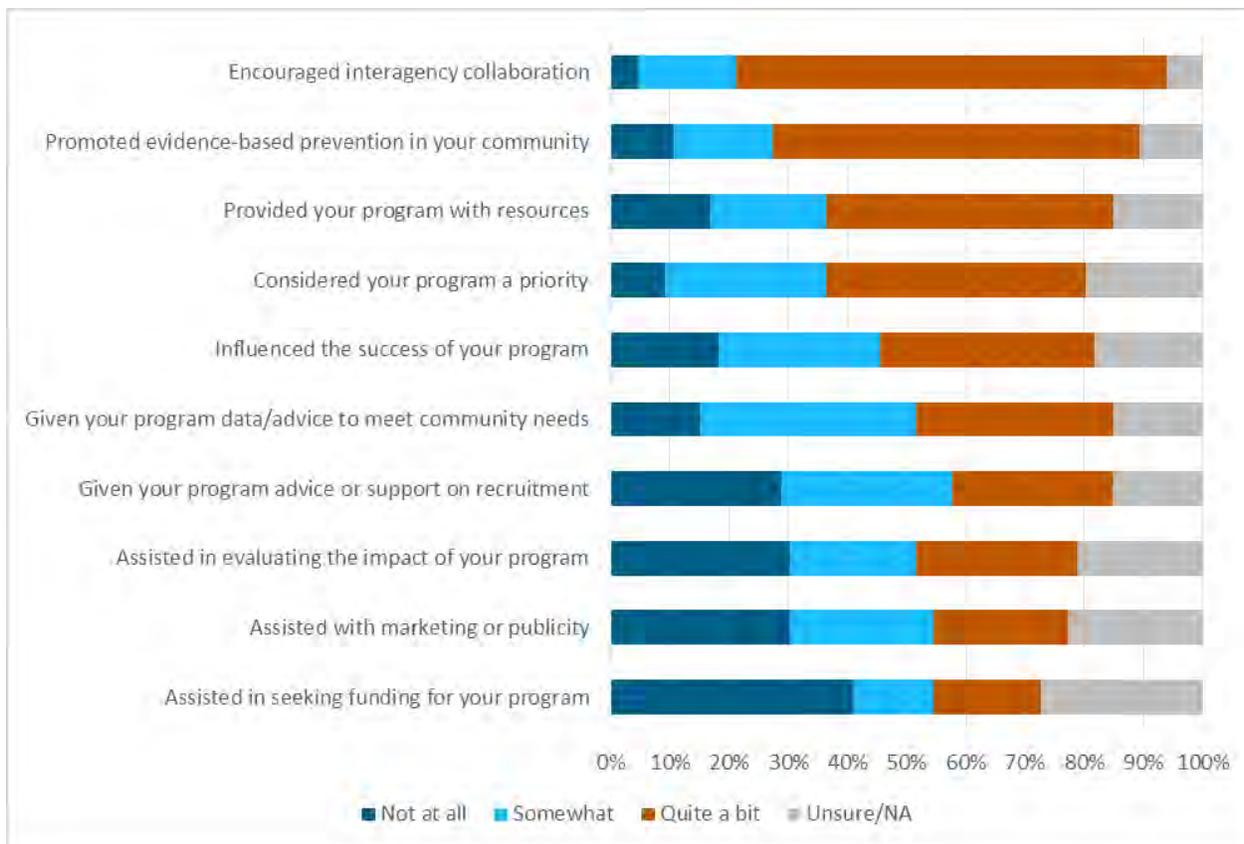
whether there was a history of collaboration or cooperation in the community prior to the coalition. The factors and scores are summarized in Figure 19. For a detailed breakout of factor scores by coalition, please refer to Appendix D.

**FIGURE 19. SURVEY RESPONSES FOR THE FACTORS OF THE WILDER COLLABORATION INDEX ACROSS ALL SITES**

Factor	Mean	SD	Min	Max	Range & Mean				
					1	2	3	4	5
History of collaboration or cooperation in the community	3.89	0.81	1.00	5.00					
Collaborative group seen as a legitimate leader in the community	3.96	0.77	2.00	5.00					
Favorable political and social climate for collaboration	4.34	0.62	2.50	5.00					
Mutual respect, understanding and trust among collaboration members	4.22	0.66	3.00	5.00					
Appropriate cross section of members involved in collaboration	3.94	0.75	2.00	5.00					
Members see collaboration as in their self interest	4.49	0.70	2.00	5.00					
Ability to compromise among collaboration members	4.05	0.80	2.00	5.00					
Members share a stake in both process and outcome	4.15	0.64	2.67	5.00					
Flexibility of collaboration members	4.24	0.61	3.00	5.00					
Development of clear roles and policy guidelines by collaboration	3.83	0.88	1.00	5.00					
Adaptability of collaboration to changes	4.00	0.60	2.50	5.00					
Appropriate pace of development for collaboration	3.99	0.65	2.50	5.00					
Open and frequent communication among collaboration members	4.27	0.61	2.67	5.00					
Established informal relationships and communication links	4.13	0.70	2.50	5.00					
Concrete, attainable goals and objectives for collaboration	4.14	0.78	1.00	5.00					
Shared vision among collaboration members	4.22	0.59	2.50	5.00					
Collaboration serves a unique purpose for community	4.19	0.74	2.50	5.00					
Sufficient funds, staff, materials and time devoted to collaboration	3.54	0.84	1.00	5.00					
Skilled leadership involved in collaboration	4.27	0.72	2.00	5.00					

As shown in Figure 20, the top three areas in which survey respondents stated coalitions assisted agencies “quite a bit” was through: (1) increased interagency collaboration (73%), (2) promotion of evidence-based programs (62%), and (3) provision of resources for agency programs (48%). The areas where coalitions were less successful were: (1) the assistance of agencies with seeking funding opportunities, (2) marketing of agency programs, and (3) recruitment to participating agency programs and assistance with evaluating the impact of agency programs.

**FIGURE 20. EXTENT COALITION HAS ASSISTED PARTICIPATING AGENCIES IN CATEGORY IN THE PAST YEAR**



## COALITION ACCOMPLISHMENTS

The number one accomplishment given by all seven coalitions in focus groups, was the **increased inter-agency collaboration and sharing of information**. This was mentioned over 48 times throughout the focus groups. For example, one person listed the benefits of the coalition: “Just the collaboration, just the networking, and just making your net stronger through relationships that we developed through [the coalition] is a positive thing.” In another focus group, a coalition member provided the following example of the impact of the improved inter-agency collaboration: “This coalition – what I’m seeing it doing – it’s giving all the agencies whether profit or nonprofit, going ‘Oh, I didn’t know you existed. I didn’t know you did this. That’s exactly what I’ve been looking for.’ So we’re able to respond a little bit more appropriately [to family needs]... **And I think we’re starting to really [see] that ripple effect now. It’s starting to work.**”

In another focus group, a participant gave an example of a concrete outcome that resulted from the coalition. The participant described how the coalition instituted a warm hand off policy and developed an actual universal referral form across all collaborating agencies. According to the participant, this outcome came about, “Because we all admitted that while we do referrals, we don’t necessarily follow up on those referrals. Once they leave our office, we don’t necessarily have all of the background or do we remember to always – to double check. ‘Hey did you access the service? What was your experience?’ And so at the coalition’s request – and they actually helped build it – we came up with a referral form that each agency can customize to their use and then they keep a copy. And they call for the family or they make that connection for the family and the family takes a copy to their next stop – to wherever they’re being referred to.”

Related to **improving the inter-agency referral process**, several focus groups mentioned that their coalition specifically worked to referral resources, such as those offered through 2-1-1. For example, one coalition is working “to engage 2-1-1, which is one of the partners, so that [they] have better key words that can be used in the system that will create those matches right off the bat; because that’s where you get a better resource listing of what is available. And I think little efforts like that – I think, actually, are going to be a model for the state on how collaboration should work within the community.” Another coalition “took the resources that they had, took the resources listed from [a local university], and then 2-1-1, as well, and went through and made sure, from A to Z, every listing every kind of resource you need was listed and updated with correct phone numbers. And so [they] created resource binders that [they] gave out to all agencies in [the community].”

Another core accomplishment given in the focus groups was **training opportunities and capacity building through professional development**. This was mentioned at five of the seven coalitions. One coalition member was proud of the professional development the coalition brought to their community, stating, “We’ve used the resources that we had to kind of target areas that we knew needed some extra professional development. And all from the request of our providers that sit on the coalition as well as from the day that we collected [data] – when we did the early development instrument, one of the areas that showed vulnerability was social/emotional. And so last summer we brought in the conscious discipline training for two days. We did two sessions with almost 200 childcare providers each and that was something that the coalition sponsored.”

Another example given by one coalition was the Period of Purple Crying training. A focus group participant described how this staff training could then trickle down to clients: “So now we’ve got 40 additional staff members who are seeing families on a weekly basis, and whether that’s a – the child that’s enrolled in our program or anybody else. They’re able to now go and train that parent, or that parent-to-be. And then we’ve got...first aid training coming up that we’re gonna have almost 50 staff participate in that project HOPES helped organize for us. Really did everything for us. And as well as the prenatal and maternal depression training that’s coming up. **So for us, it’s increased our – the capacity of our workforce to make a difference in preventing child abuse and neglect for sure.**”

A final accomplishment mentioned by four of the more established coalitions was the ability to use data collected for the early development instrument (EDI) mapping, or for a community action plan, to leverage changes in the community. It is important to note that many of the data

collection efforts occurred through funding mechanisms in place prior to HOPES. A coalition member said, “Well, I know that large government funders, local government funders kind of adopted the [school readiness action plan] as one of their guiding philosophies behind how entities were going to be funded. So in order to apply for [a local] grant, you have to align – your work has to align with elements of the [action plan].”

## COALITION SUSTAINABILITY

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When asked whether the coalition would continue if funding from HOPES ended, coalition members offered mixed responses. In four of the seven focus groups, members felt hopeful that the coalition would find a way to remain. Some methods for sustainability included joining forces with other coalitions, or seeking local funding and support. For example, “The people are not going anywhere, and I still feel like [the coalition] would still fit in. It might be connected to another coalition...What we've found in [our community is that] we work well together, but the same people that you see at this coalition is the same that you see at another. And that's where now...we're able to say, ‘Okay, let's have a shared agenda instead of everybody having their own.’ And so, with collective impact, that just helps with the sustainability and that's why we want to go that path.” In another coalition, the answer was a bit more ambivalent, where one member said, “I don't know. If we can embed it in the regional strategic plan of [the local council of governments.]” Another continued, “Part of that plan is to ensure that this [coalition] now is ratcheted up to that higher level of county and regional governments – to ensure that it continues.”

In four of the focus groups, members expressed concern for the impact loss of funds would have on coalition sustainability: “We'd fall apart. We need the money. By now, I think we've grown connections and we would try our best. I think it would look different no doubt. But I think the good thing is that we built in a – relationships where we could try to – we could continue it. We just have to manage logistics and work a lot harder.”

One community offered this example of what lost funding did to the coalition prior to gaining support from HOPES: “I know there was a pediatrician [who] wanted to jump on board and wanted to see what else we could do for the community and how we could bring this in. But then the roadblocks [came] up and our grant terminated and then it took six months for it to come back up again. So some of the contacts were lost and some of the momentum that was moving forward kind of stopped a little.”

## COALITION STRENGTHS

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The strength listed by every coalition was the willingness of coalitions to collaborate in the community. For example, one focus group participant stated, “Collaboratively, we work really well together. We hear about these other agencies, cities that nonprofits aren't sharing information – they want to do it on their own. And I think that's a strength that we have here is that we have several nonprofit organizations and some coalitions but we all seem to work well together, I think, for the most part.” Another said, “people are very willing to network with each other and get ideas from one another about how to make it better. ‘Even if it doesn't benefit my agency, it might benefit theirs.’ And that's been really, really beneficial, I think.”

As mentioned previously, most of the coalitions joined by HOPES sites were pre-existing in the community. The benefit of older more established coalitions is that they often have important structures in place, such as a strategic plan and steering committee. Having a good leadership or organizational structure was mentioned as a strength by five of the seven coalitions. One focus group participant said an important tool of their coalition was “this whole process of the strategic plan and the whole – all of it. And then that has been essential because we’re – of course we’re always going back to it and going back to it and going back to it and referring to it all the time. And even when we’re in here at the coalition meeting or an extension of another meeting that’s tied to this.” In another focus group, a participant stated, “the leadership through this organization has been able to really bring us together with a passion, with a vision, and look forward to seeing each of us...That’s part of what – and I don’t know how I want to express that – but that gelling of a common vision.”

Having a vision that coalition members are passionate about was mentioned across many of the sites. For example, one member talked about how the coalition felt like a true collaboration where people worked together towards a common goal. “We don’t just come for free lunch. We’re actually working to – where we have a common agenda. I think that’s important. I don’t think we’ve ever really had some of the struggles that other communities say they have based on conflicting agendas. But I think that that stems from – not only the culture of our community, but I think that also stems from the original work that was done when the coalition was started. Because we did a lot of work on: “What does collective impact look like? What does it mean to collaborate?” All those things.”

## COALITION CHALLENGES

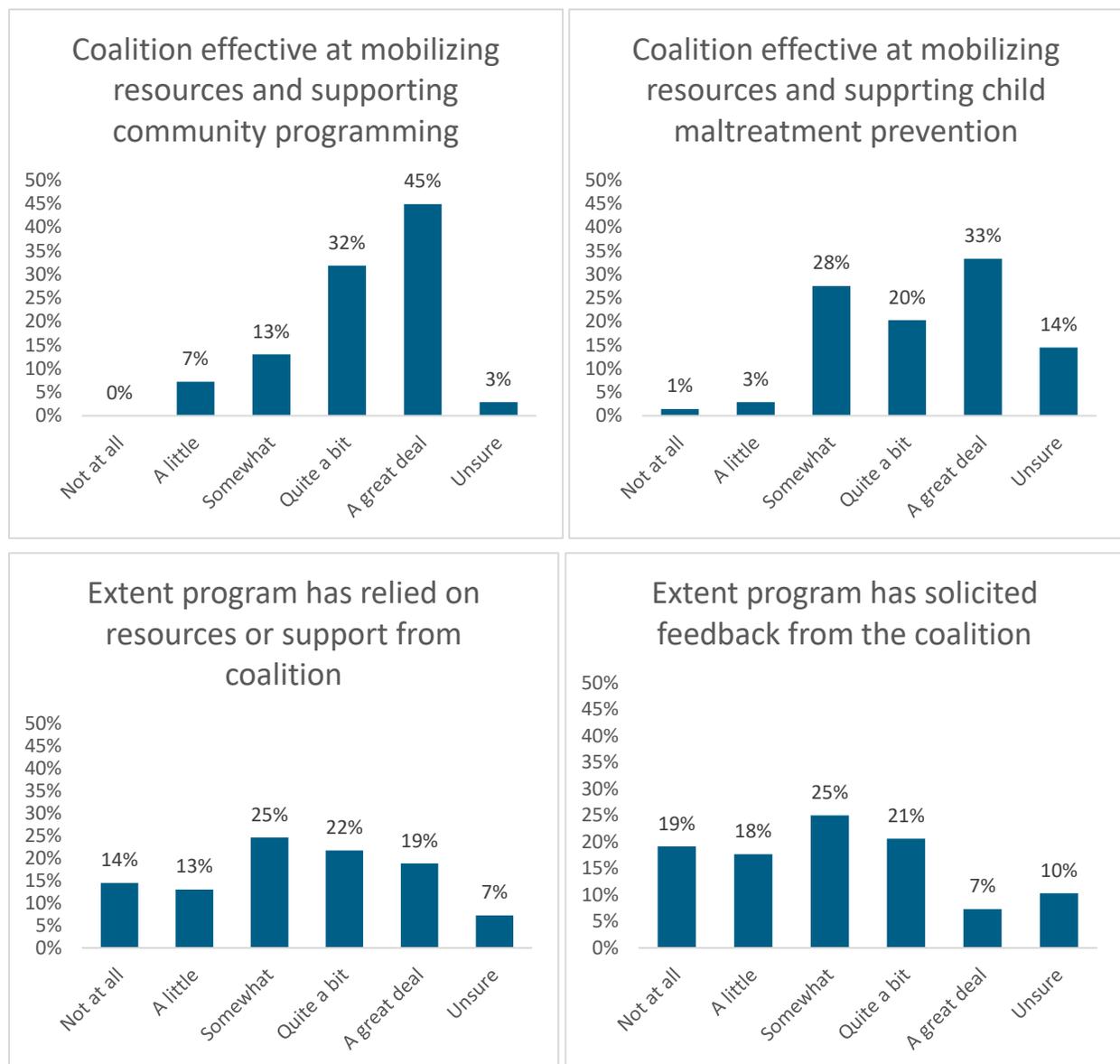
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The challenge for older coalitions is shifting goals, visions, and directions over time. For example: “Because of the HOPES Grant, the meeting – the collaboration has sort of morphed into – it started as [old coalition name]...and then it got called something else, and then something else. And so there was a little bit of confusion, like okay, who’s this group that’s meeting again?” At another coalition, a need to re-structure the coalition emerged: “We want every member to feel valued. Otherwise, why would you keep coming? We all have a lot to do so just to go to a meeting that’s not beneficial...So that’s something that I think had been lost six months or so before I came back aboard – it was starting to lose value and so we decided we need to revamp all of this. And that’s when the steering committee was formed and we were like, ‘Okay, what do we need to do to get everything back on track?’”

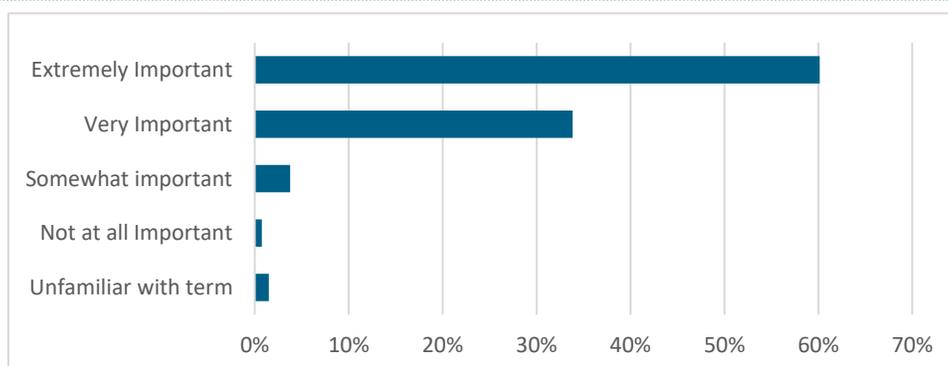
Additional coalition challenges related to changing membership and limited time to participate. “It seems like take three steps forward and two steps back, sometimes, because you constantly have to keep people engaged. And, if not, they’ll fall off and you have to pick up the pieces and start over.”

When asked about the coalitions’ abilities to mobilize community resources for community programs in general, 77% of community survey respondents indicated the coalition was effective at this “quite a bit” or “a great deal.” However, when asked about mobilizing resources for child maltreatment prevention, only 53% of respondents selected “quite a bit” or “a great deal.” Figure 19 on the next page shows these and other community survey results.

**FIGURE 21. SURVEY RESPONDENT RATINGS OF COALITION EFFECTIVENESS IN VARIOUS AREAS**



**FIGURE 22. IMPORTANCE FOR THE COMMUNITY TO USE EVIDENCE-BASED PREVENTION STRATEGIES**



# PROGRAM STRENGTHS, FUNCTIONING & OPPORTUNITIES FOR GROWTH

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Overall, parents, staff and community members who participated in interviews were extremely happy with the HOPES program. Many strengths have been highlighted in previous sections. These include: (1) provision of parent education, particularly on discipline and parent awareness, (2) flexibility in the programs to provide additional assistance, (3) strong relationships with parent educators that empower participants, and (4) established coalitions. One program staff member said, **“I sing the praises [of the funders] for allowing us the opportunity to create a program for our community that we live in and know, and we feel like we have the right combination. We’ve had some bumps on implementation but we’ve also had the support to see it through and have gotten nothing but support on that program implementation.”** Another participant noted that in her community, HOPES was providing something that did not previously exist: **“I think [HOPES] fills a great gap of nobody else addressing these type of needs in young children** because, if we intervene early and we’re able to work with the family early enough, we can prevent some later challenges that may end up in a mental health diagnosis.”

Despite the many strengths of the program, participants noted areas for additional growth. In some cases, these areas were already being addressed by the community and/or PEI staff. There is a general sense that successful program implementation is a joint learning process. The remainder of this section discusses implementation challenges, work environment and support, caseload challenges identified by staff, and professional development needs.

## IMPLEMENTATION CHALLENGES

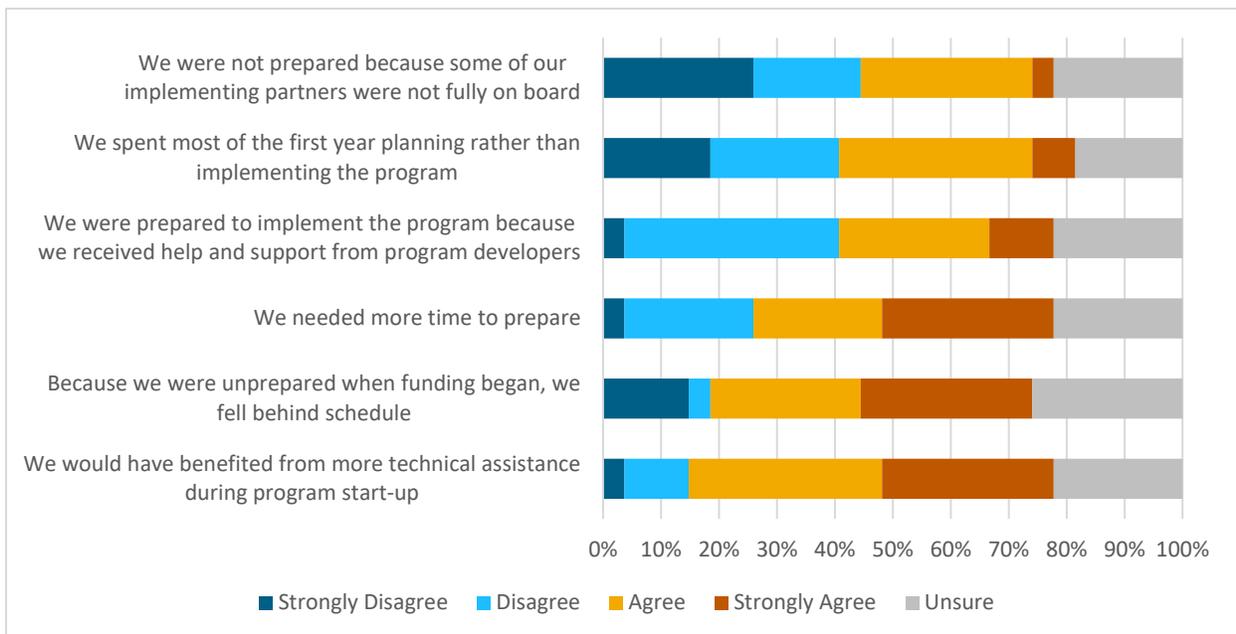
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### START-UP

HOPES I sites encountered challenges during start-up, since there was no built-in start-up time in the contract. This was a challenge mentioned by staff in 10 interviews across four HOPES sites. Many program administrators considered it one of the top challenges during the first year of the program. One stated: **“I’d say that the – if I had to pick one biggest struggle for all of HOPES... I’d say the fact that there was no built-in ramp up period was the hardest thing.** The fact that it was day one, spend the money, have to be fully staffed and have a full caseload, I think that was the hardest thing and it just set us up for failure in year one.”

Figure 23 on the next page shows that the implementation challenge during program initiation which had the most “agree” or “strongly agree” responses (63%) was: “We would have benefited from more technical assistance during program start-up.” Additionally, the next two most common start-up implementation issues were “Because we were unprepared when funding began, we fell behind schedule,” and “We needed more time to prepare,” with 56% and 52% of survey respondents stating “agree” or “strongly agree,” respectively.

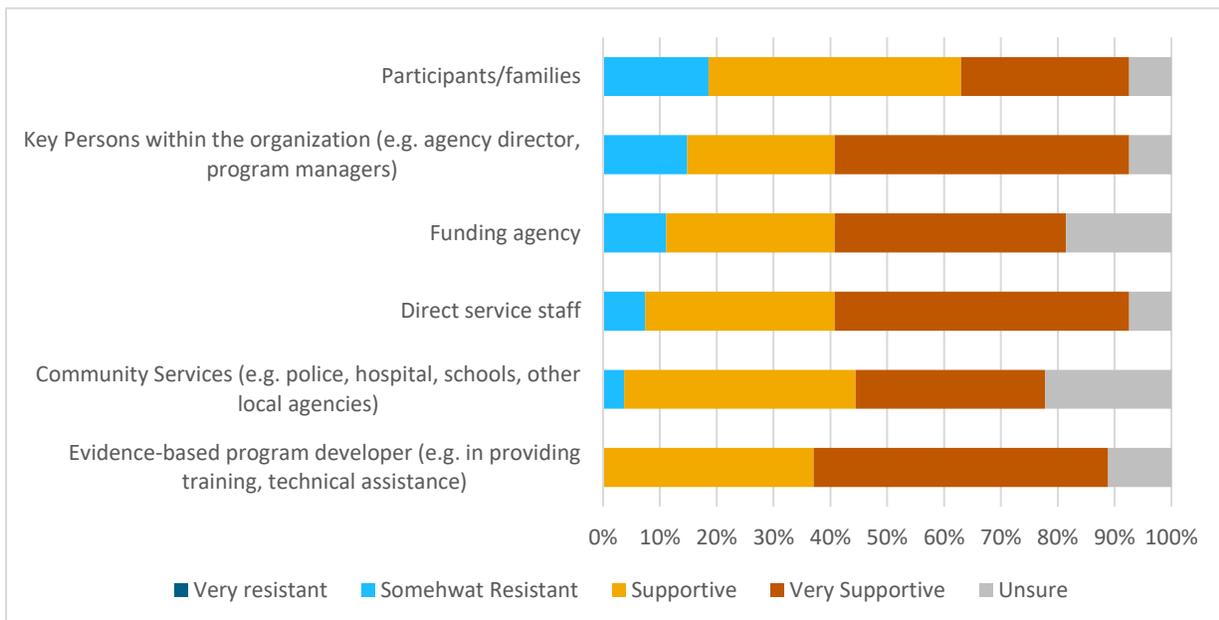
**FIGURE 23. STAFF OPINIONS ON PREPARATION FOR HOPES IMPLEMENTATION**



In terms of support received by various parties during implementation start-up, all administrators and managers rated the EBP developer and trainers as “supportive” or “very supportive.” While no parties received a vote of “very resistant,” the three parties which received the highest number of “somewhat resistant” responses were participants/families (19%), key persons within the contracting agency (15%), and the funding agency (11%).

It should be noted that the sample size for both of these questions was fairly small (n=27) as it was solely asked of staff members who identified themselves as program administrators or managers.

**FIGURE 24. SUPPORT OF HOPES BY VARIOUS PARTIES DURING START-UP**



## HIRING STAFF

Hiring staff and turnover was mentioned 43 times in 23 interviews/focus groups at eight sites. Many sites had turnover issues related to finding staff who were well suited for home visiting, stating that the reason for some turnover was the position was different from what staff anticipated. “It’s not what they thought and they wanna be in an office. So it does take a special kind of person that wants to do that home-based type intervention.”

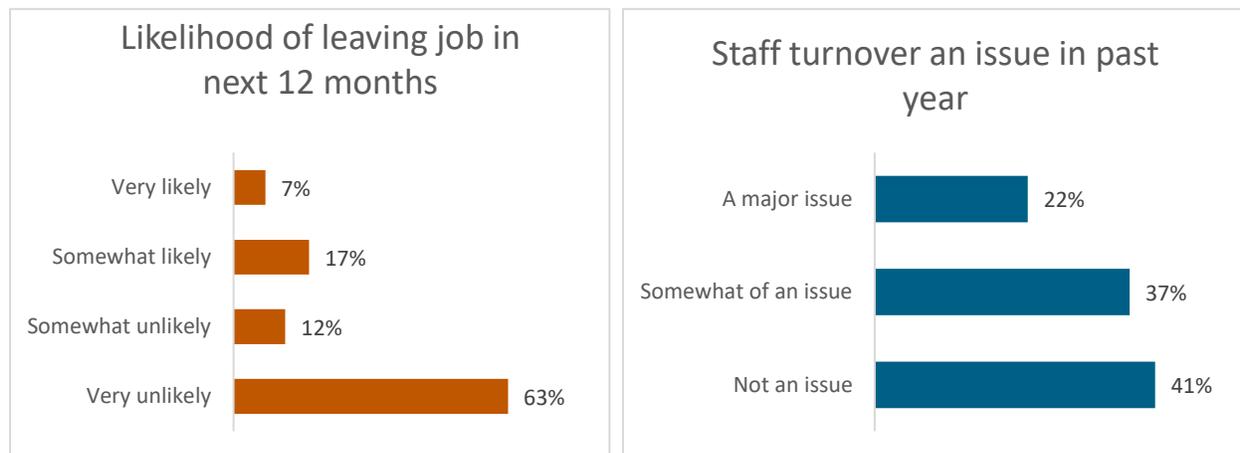
This has led some sites to shift from hiring staff with a social work or psychology background to those with an education background. “When we set out to do this journey, we really felt like of course somebody with a social work background, psychology, social services, the field of non-profit education, some sorta background where we knew that they could meet the families in crisis, while still communicating effectively a curriculum to them. So we had our assumptions and we quickly realized that this type of position would not satisfy for a length of time someone in that – with that background...but really you are professional curriculum development specialist.”

Another site had a similar issue: “We've had staff turnover – a lot of staff turnover. I think we've had challenges in differentiating between basic needs and parent ed, and how those two interplay with each other...It's a really unique position. You're not a case manager. So, you look at people who have Master's in Social Work, and while it sounds attractive, it's like they want to do case management. They want to do something different than what Parent Ed is.”

Other sites had difficulties finding counselors and professionals who required specific qualifications. For example, one site has a position that “requires a masters in a related field, a license of some form that’s related, and two years of supervisory experience. That one has always been a struggle. Do you know we’ve had six different people in those positions?”

Despite these challenges in hiring staff, there is evidence of only a small issue with staff turnover. Sixty-three percent of staff survey respondents noted they would not change job in the next year, and 41% of program staff said that turnover had not been an issue.

**FIGURE 25. STAFF SURVEY RESPONSES ABOUT TURNOVER**

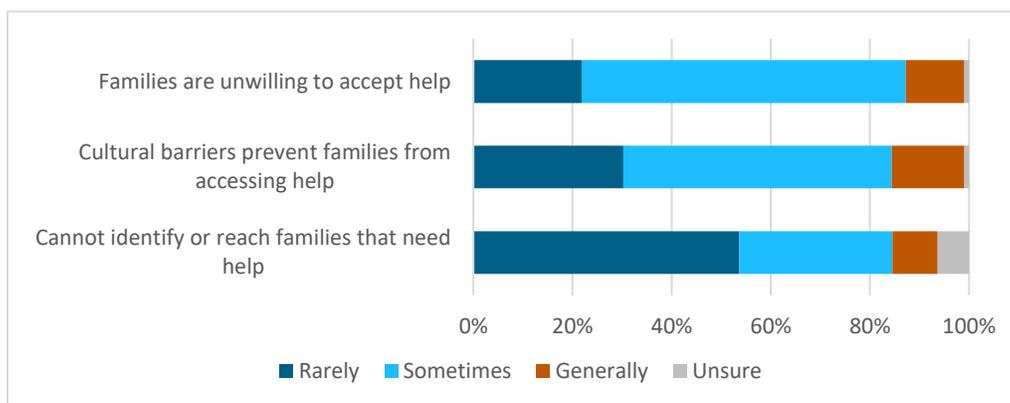


## RECRUITMENT

Recruitment of participants is crucial to any program, especially during the first year of implementation. The need for better outreach and to recruit more parents to the program was mentioned in 21 parent interviews across six HOPES I sites. Many parents who were interviewed discussed how the HOPES program was relatively unknown in their community, saying things like “a lot of people don’t know about the program.” Similarly, staff members also expressed issues with recruitment and outreach in 21 staff interviews/focus groups across six sites.

One site mentioned a challenge at the beginning of the contract, especially with no built-in startup time: “No one in the beginning planned on an outreach team or a PR team or a screening arm. And there was almost no administrative support...So all the infrastructure that makes a program effective just wasn’t there for these folks, and it was hard.” Another site had a similar problem, with a staff member saying, “We hadn’t had training in outreach. So I think year one was definitely a struggle to get numbers. I think now I know what to do and I’m taking charge of doing that outreach and building those relationships and having my staff work with the clients.”

**FIGURES 26. BARRIERS TO RECRUITING FAMILIES TO HOPES**



Figures 26 shows that 77% of staff survey respondents indicated that families being unwilling to accept help is “sometimes” or “generally” a barrier to engagement. Cultural barriers preventing families from accessing help were “sometimes” or “generally” a barrier to engagement according to 69% of staff respondents. Identifying or reaching families most at risk of child maltreatment was not rated as such a large barrier by staff, of which 54% of survey respondents reported that it was “rarely a barrier.” However, qualitative data from staff interviews suggest that it was challenging for some sites.

For example, agencies who typically get most of their referrals from CPS experienced difficulty in recruiting participants who were not involved in that system. One staff member explained, “Initially with [our HOPES program] when we had it here, there was a lot of challenges in regards to recruitment and outreach, because the people that come into our doors are typically the parents who have CPS history, and they're seeking support for that. And so, trying to figure out a way initially on how to target those parents who have the children with that age range that need additional support with parenting. Those are really challenging.” These issues were recognized by PEI staff and eligibility for services was changed to accommodate families who had been involved with CPS.

Additionally, another staff member described the general difficulty of finding the highest need families due to cultural and societal barriers: “I feel like our society...doesn't necessarily support the idea of...asking for help. [Families feel] like, 'no, no, no that's not my family.' ...Just not wanting to self-identify somebody who needs that support. So I think there's that issue, and then I think there's also, 'Okay, **so that's our job, we should be finding those families as people who want to support families holistically.**' And so knowing where to engage them is hard.”

On a positive note, many interviewed staff members discussed how they developed creative ways to recruit families into their programs as the year progressed. Yet many still felt that more could be done to recruit traditionally hard to reach families.

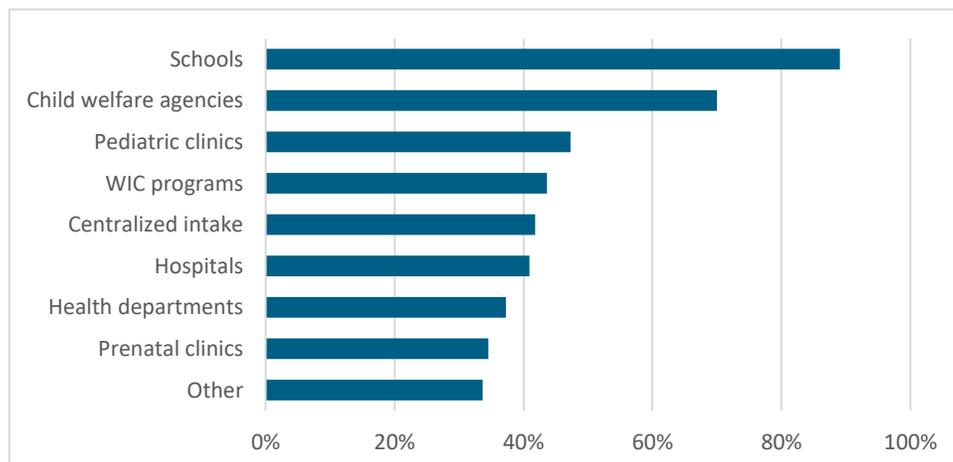
**Parent fear that HOPES is related to Child Protective Services Involvement.** Staff across five sites, mentioned that a recruitment challenge sometimes that families feared the program was either related to CPS or would lead to a report to CPS. For example, one staff member said, “My client, he was scared. I mean, he was asking a lot of questions, telling, ‘Please explain what the program is about because I’m so scared that you’re gonna call CPS because I dunno how to be a good parent.’ So it is kind of hard for them to understand what we do and to understand that we’re not here to get them in trouble. It’s, ‘We’re here to help you.’”

Another staff member stated, “I could hear her asking her in Spanish, ‘Well, but why are they gonna be at my home? And are they CPS?’ ...So when I went and I was asking the individual if they wanted to give me their information so we could give them more information, she just flat out said, ‘No, I don’t want you in my home.’ She basically said, ‘I don’t need somebody to call CPS on me.’ So for me, that was like, ‘Oh, my gosh. We need to be in this home.’”

### REFERRAL CHALLENGES

One source of recruitment of families into programs is through referrals. Based on staff survey responses, the most common referral sources to the HOPES programs were schools (89%), followed by child welfare agencies (70%). Less than 50% of respondents indicated referrals from clinics and other medical settings. These survey responses, as shown in Figure 27, do not add up to 100%, since respondents could select more than one option.

**FIGURE 27. REFERRAL SOURCES FOR HOPES PROGRAM**



*Note: Percentages do not add up to 100% because respondents could select more than one answer.*

Inter-agency partnerships for referrals were seen as a strength. However, at times, sites found issues with engaging parents in the program who were referred to HOPES from other agencies. Some sites found a high dropout rate for families referred from certain agencies and hypothesized it might have been due to false advertising. One staff member said, “We seem to get a lot of referrals in a lot of people who don’t even make it through their registration. Once the call is made to them, then they drop out. So I’m kind of trying to figure out...Looking at how probably we approach our outreach, and I’m wondering if the information that’s being shared is – there’s something wrong with the way it’s being shared. Maybe we need to look at that and kind of revise that and refine our message again.”

In another focus group, a staff member mentioned confusing marketing of the program as an issue. “I think, also, sometimes parents misunderstand what the program is going to be, and then misunderstand the commitment, or the fact that it's going to be in the home, or the fact that it's going to be something that they have to do some outside homework type stuff with.” Overall, instances of confusing program advertising were mentioned across six of the eight HOPES sites.

### PARENT ENGAGEMENT & RETENTION

**Self-motivation.** Self-motivation of the program participant is key to parent engagement, and was mentioned 35 times in 18 staff interviews/focus groups across all eight sites. One staff member provided this example about the importance of participant motivation: “We can think of families that have made huge growth and reached some really big milestones and things in their lives, and so that’s the nice thing...**It’s their commitment, their commitment to the program and to making changes in their lives, that’s where the success comes from.** Them being willing to change and them being open.”

When families are not motivated to participate, retention issues can result. One staff member described the following: “When I started, we were still kind of in that phase of we had to go out and recruit your families. And then sometimes you recruit a family that’s interested and then they kind of just drop the ball and you have to call and call and call them. And then there’s that whole struggle of are we engaging them enough? Are we doing everything humanly possible to pull them into this program?”

**Barriers faced by families.** Some families face certain barriers to participating in the program. For example, despite programs trying their best to be flexible and tailor services to family needs, scheduling still can pose a problem. One staff member described a barrier related to scheduling, stating, “I still don’t have a client, because I’ve gone through three already that have – they’ve just started school, working, have the kid, have a husband, have to go do this and go do that, and they’re like, ‘Would you be able to come at 8:00 or 9:00 and I’m like, ‘Uh, no. I can’t do 8:00 or 9:00.’ Like 6:00, but not 8:00 or 9:00. So I’ve encountered several that have multiple things going on and can’t actually fit into the schedule.”

Across six HOPES sites, staff shared another barrier faced by some families. They described instances where some families could not participate, because one member of the household wouldn’t allow it: “Her husband didn’t like the program. Or her boyfriend didn’t like the program and didn’t let her answer the door and didn’t let her continue. And we can’t continue with the program. We don’t have any ability to knock down the door and say she needs this program, she

needs to potentially leave you, all those kinds of things. So sometimes we lose families for that kind of reason.”

**Timeliness of engaging in parent education.** While HOPES does offer case management and basic needs assistance, it is primarily a parent education program. Thus, some families who sign up for the program might be harder to engage because they are not at a place where they are ready to receive and focus on parenting skills. This issue was discussed 28 times in 15 interviews/focus groups across six sites. For example, one staff member described the challenge these families faced in maintaining scheduled appointments: “That’s kinda – that’s been a battle for us, for those [clients] that are – that have more case management, getting them to where they’re a little bit more consistent with their appointments and understanding the educational component to the program.” A staff member at another site mentioned a similar problem in regards to retention and program completion for the highest need families. “I think I would say... that they recognize they need help in being a better parent, or a protective parent – as we phrase it. But, those factors, those basic needs, do get in the way sometimes in them being able to complete [the program] successfully, and they disengage.”

Some sites saw that families would sign up for the program to receive basic needs assistance, but then drop out after that immediate need was met and not continue with the parenting education. “The families, like the ones that I kind of shared with you, the ones that are not at a safe place themselves, where they’re still needing to get a lot of treatment, like if they’re going through some drug abuse or some alcohol abuse, if they’re worried about their immigration status, or they’re concerned, because they don’t have money to pay the rent next month, I mean, those families are not, probably, at a good place to really enjoy the benefits of the program because their concerns are somewhere else. Those that are very, very high-risk, very high-risk, may not.”

In response to these issues, HOPES agencies and community coalitions are working to develop holistic approaches to serving the highest risk clients, where parents who need additional support before they can engage and benefit from HOPES are connected to other specialized services first. Due to variability in available community resources, this may be more difficult in some communities. This evaluation did not explore in-depth the trajectories of families who were not ready to participate in HOPES, but will study this in future evaluations.

### DESIRE TO SERVE CPS POPULATION

In FY2015, HOPES I did not allow for caregivers with a substantiated case of child maltreatment or a current open CPS case to utilize HOPES services. When speaking to staff, a common complaint about the HOPES I contract was that it does not allow sites to serve parents with such a CPS history. This issue was mentioned 25 times in 17 interviews/focus groups across six sites. Even though HOPES is a primary prevention program, staff provided arguments for why they wished at least some proportion of clients could be those with CPS involvement.

One argument is for prevention of subsequent maltreatment: “One of the biggest issues that we’ve had in the beginning is that a disqualifier to be part of our program is that the family has an open case with CPS or has ever had a substantiated case. We have had referrals and we have had to turn them away because they have either a current or previous substantiated CPS case. We feel that those families would benefit from services because we want to prevent any future

occurrences.” In another interview, a staff member said, “We were all up in arms about being able to serve families that did have CPS history. It's not necessarily for those families that are currently involved with CPS, but it's more along the lines of those families who had reunification, had success, and now are really wanting to take some steps.”

Additionally, other staff members brought up an ethical issue in regards to turning away families who are seeking services: “I like that HOPES is prevention oriented and I like that this has designated money for that, but when it means turning families away, that’s really hard and not necessarily what we wanna do ethically and per climatically and aligning with our values.”

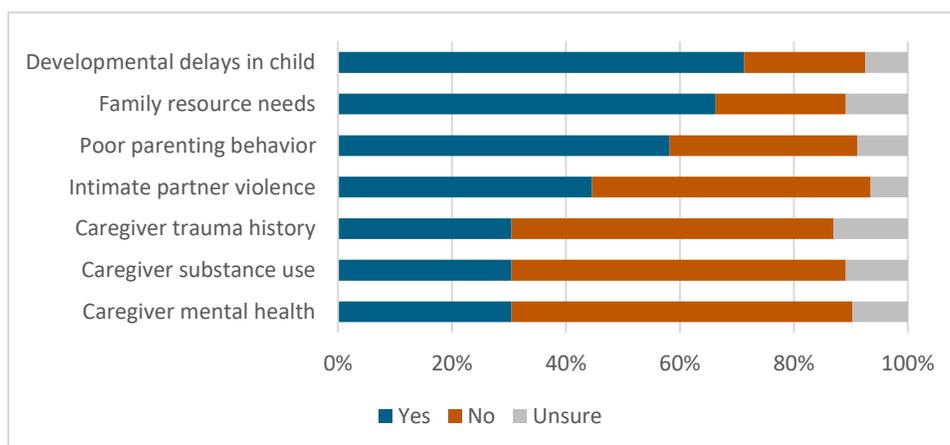
Finally, some staff explained a further issue with having to drop clients in the middle of services if they get an open CPS case: “The moment one of our families has an open CPS case, we have to drop them. And for me, that’s a problem because we’re mandated reporters. So you’re giving us incentive to not report because we don’t want to lose these families that we’re trying to help. And so I wish there was some part of the clause that if the family was already with us for a certain amount of time that we could stay with them and that we wouldn’t be punished for not preventing something that really is out of control.” However, this quote shows the goal of catching families before they get to CPS: “Because the other fatherhood programs in our community tend to be more dads who’ve gotten into trouble either through CPS or drug and alcohol issues. And so trying to catch these young men early and get them excited about being – taking care of themselves and then being good dads.”

## SCREENING

As discussed in the section on participant characteristics, the HOPES program serves families with multiple risk factors. However, based on survey responses, agencies and staff do not always use screens to identify major risk factors associated with child maltreatment.

According to staff survey responses, most staff (71%) reported that their agency required a screen for developmental delays of the target child served through HOPES. Additionally, 66% of staff reported that their agency required screening for family resource needs, and 58% for poor parenting behavior. Fewer staff members report that their agency required screens for caregiver trauma history (30%), substance use (30%), or mental health (30%).

**FIGURE 28. AGENCY REQUIRED SCREENS**

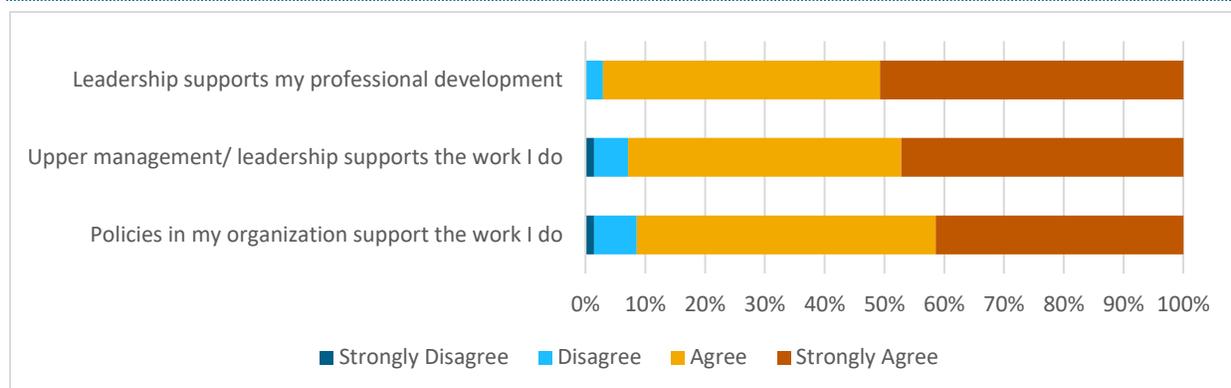


## WORK ENVIRONMENT & SUPPORT

Staff raised various issues related to their work environment and support. In general, there was variation across sites, where some things were experienced as strengths at some sites and challenges at others.

**SUPERVISION.** Issues related to supervision were discussed in nine interviews/focus groups across six sites. Some staff mentioned that they felt their supervisor was overworked, and thus was not as available to discuss self-care and reflective supervision as much as they would like. However, many others mentioned they felt they had the support and reflective supervision they needed. As demonstrated in Figure 29, the vast majority of direct service staff “agreed” or “strongly agreed” that agency leadership and program managers supported their work.

**FIGURE 29. SUPPORT AT THE WORKPLACE**



**FLEX TIME POLICIES.** In Figure 29 the category with the largest percentage of staff responding “disagree” or “strongly disagree,” though it was just 8%, was related to organizational policy. In six interviews/focus groups, issues regarding agency policies were also discussed. A few sites had issues with overtime and flex time policies that were not conducive to the requirements of a home visiting program. One program staff stated, “The biggest issue was the overtime. So it was like I have my 40 hours a week but I have this stuff to do, but I can’t go into overtime without asking if I can go into overtime. And so it’s like so if I ask and it doesn’t get approved then I’m not gonna meet this deadline.”

Another staff group stated, “If we come up with way too much flex, it’s like, well I was here, and I was doing what I needed to do, however, there’s just not enough time in the week to get everything done, and we’re reprimanded for that. And, we can only do [paperwork at home] for three hours, when really, we’re working at home almost eight hours out of our weekend.” At another site, staff provided another example: “It doesn’t help that we have very strict policy about our eight hours a day, and then let’s say that today I did eight-and-a-half; they don’t want for us to say, ‘Okay, so today I worked eight-and-a-half hours; tomorrow I’ll work seven-and-a-half.’” However, many other sites had more flexible policies, and staff did not have these issues.

**FOCUS ON NUMBERS.** Another issue mentioned by staff was the focus on outcomes and meeting numbers, which they felt could lead to policies creating higher worker stress and lower

quality services for families. For example, one staff member said, “You want the quality or you want the quantity? Because I feel like a lot of the time, that’s what we’re battling here because it’s like we have these families but it’s like the state’s like, ‘You don’t have enough. You need more. You need more.’ And it’s like you want me to get more, but do you want this to really be a quality program or you just want me to give you numbers? Because if you just want numbers, we can give you numbers but, what’s the impact on the family that you’re giving?” This topic was mentioned 29 times in 15 interviews/focus groups across seven sites.

As a result of numbers not being met, many programs have attempted to reduce the case management component and focus more on the EBP curriculum. For example, one staff member explained the questions received by supervisors when EBP delivery is not on schedule: “And when it looks on paper or [in the database], ‘Why did you spend three weeks, four weeks on this session? Why did you put crisis support over here?’ Well, because they were getting evicted and she was just sobbing the entire session. I can't say, ‘Okay, stop crying, please.’”

Program managers realize that this can be difficult for direct service staff, and it is also difficult for them. One supervisor said, “Working for a grant-funded position is a challenge. I've had multiple [parent educators] say, ‘I didn't realize we were going to have to be so focused on outcomes, and outputs, and assessments. I just want to help people. I just want to work with people.’ So, we feel like, as leaders of the program, it's like we're constantly saying, ‘Okay. We're not meeting our outputs. Okay. Your scores went down.’ So, I think that can be a challenge.”

## CASELOAD CHALLENGES IDENTIFIED BY STAFF

Issues with caseload size was one of the more common implementation challenges mentioned 35 times by staff in 18 interviews/focus groups at all eight sites. The staff survey asked about the number of home visits respondents made per month. For the 35 survey respondents who were home visitors and worked “full time,” between 38 and 45 hours per week, the minimum number of home visits was 8 and the maximum was 53, with an average of 26.8 and a median of 27 per month. As different EBPs have different designs and caseload requirements, we also broke out the statistics by EBP, as shown in Table 7. Only EBPs with more than five survey responses were included.

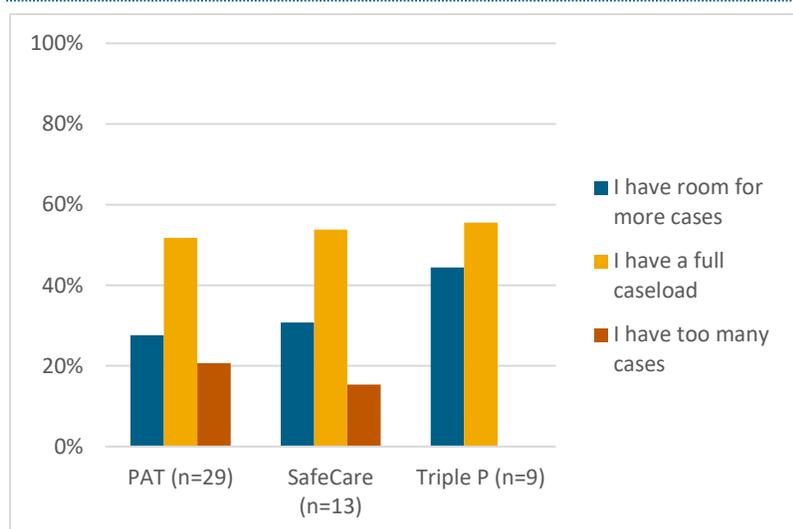
**TABLE 7. STAFF REPORTS OF HOME VISITS PER MONTH AND CASELOAD**

	Monthly Home Visits			Caseload Size		
	<i>Estimated number of home visits made per month by EBP</i>			<i>Home Visitor and Parent Educator caseload size by EBP</i>		
	PAT (N=19)	SafeCare (N=6)	Triple P (N=7)	PAT (N=28)	SafeCare (N=12)	Triple P (N= 9)
Mean	28.1	36.3	20.7	18.4	13.8	12.4
Median	30	37.5	20	18.5	15	9
Std Dev	7.4	11.1	7.2	4.2	5.0	5.5

In addition to home visits, direct service staff were asked about the number of cases on their caseload. A total of 70 staff responded to this question; however, outliers (one response of 0 and one response of 58) as well as respondents who worked less than 38 hours per week were excluded from analysis. The analysis was broken down by staff role. Parent educators and home visitors (n=55) had an average of 16.8 cases (median= 18). Again, these were broken down further by EBP, and the results for EBPs with more than five responses are presented in Table 7. Sample sizes for therapists (n=3) and case managers (n=6) were too small to be included in this report.

Caution should be taken when interpreting survey results on caseloads, since additional factors impact caseloads. For example, different EBPs require different frequencies of home visits, such as once or twice per month, to once or twice per week. The different EBPs also differ in their caseload recommendations. Also, some staff members might be assigned solely to work with clients one-on-one through home visits, while others might split their time doing home visits and teaching classes with caregivers or children. There was insufficient information in the survey data to better understand the impact of these different factors.

**FIGURE 30. CASELOAD PERCEPTION BY EBP TYPE**



The survey also asked direct service staff to rate their caseloads. Overall, 43% of respondents said they had room for more cases, 46% said they had a full caseload, while 12% stated that they had too many cases on their caseload. These data are broken down by EBP type in Figure 30.

In contrast to survey responses, parent educator focus groups revealed that at some sites, staff felt they had too many clients

on their caseload in relation to the amount of paperwork, large amounts of travel time to distant homes, and additional time needed to work with high risk families that needed case management and additional support beyond parent education. For example, a program staff stated, “I think too what’s unique with HOPES is the population we’re trying to reach, there are a lot of needs and so for us, the way our plan of operation was written, **I feel like the expectation of the caseload is very high for the needs and the intensity of the needs that the families have.** So really being able to meet their needs, do the curriculum and everything; that’s a lot.” Staff provided examples of how their caseloads were impacted by the following issues.

**Additional time needed.** Staff members at HOPES sites gave multiple examples of how their caseloads were impacted by various job requirements. For example, the need to spend additional time with high risk families was the number one issue mentioned 42 times in 17 interviews/focus groups across seven sites. One staff member gave this example: “Sometimes [teen parents] take

a little longer in visit, too. Like, I have one, she just had a baby, 15. And, she went through a depression state. And so I had to stay two and a half, three hours, because I was trying to show her how to hold the baby, how to connect. And even grandma, it'd been a while, and grandma would just take this baby. And, you could just see them frustrated. So, it took a little bit more time to stay, and I offered a little bit more of my time, that I would have been at home, but I felt that they needed somebody there."

**Transportation.** Driving time was mentioned as a barrier in managing caseloads 14 times in 10 interviews/focus groups across seven sites. Parent educators noted that many families lived in more rural areas and driving to them took a significant portion of their day. One program staff stated: "So, driving also takes a lot of time. We have a lot of families in [the outlying areas] and that's an hour. Going and coming, that's an hour. So, yesterday I had a visit in the morning and in the afternoon, so I spent two hours driving to these visits, and they weren't even home."

**More time for paperwork:** Program staff did raise concerns about the amount of paperwork they were completing. Staff at half the sites mentioned paperwork concerns; the other half felt that the paperwork was fine. One participant said, "I really believe in it, and I like what we're doing, but I think on our end, it could be better training, more time to get paperwork in, so that we can document it correctly. We don't miss the screenings, we don't – we just rush to do things, or oh, you got this other form you gotta start doing. And, we're having to throw it in, and make time for it, or we forget about it, or something. Just, not even on purpose, but just tired, you know?" Paperwork also increased in some programs if there was more than one child in the home. The duplication of having multiple children meant additional paperwork that added to the requirements for home visitors.

**Additional research to supplement curriculum to meet family needs.** Staff also discussed gaps in the curricula due to the narrow focus of the EBPs. They reported that families might have needs not addressed by the curricula such as talking with children about their bodies or managing sibling relationships. If educators wanted to provide information requested by families, they had to find resources on their own. One parent educator stated, "If you want to go over and above to find out, or say the curriculum isn't really covering exactly, so you need to add some stuff to it, that's not counting the research... So what happens is sometimes you don't get to that extra stuff when your caseload is big."

**Cancellations in relation to meeting monthly visit requirements.** Cancellations of appointments is common for families, which leaves workers struggling to maintain fidelity to some EBP models. One program administrator lamented, "We have so many families that will cancel. My parent educators are trying so hard to get that last second visit in [the month], because the family cancelled or rescheduled. Something happened with their baby which is all understandable reasons why to reschedule, but they are having at the very end to have four families in a day. Then, you've got to put in that documentation. It's just a lot. It can be a lot for [home visitors]."

**Lack of flexibility with work hours.** At some sites, program staff noted that the combination of travel time, cancellations and the numbers of families on their caseload might be manageable if they had more flexibility in their schedules. Several program staff described driving back to an office to check out of work for the day. They noted that if they could have checked out remotely,

they would not have had to work that additional hour and could have spent more of their 40 hours work seek with them. One program staff noted the pressure to not work more than their allotted time. “We do so much for these families, and we want to do that and more, but it’s hard when this is just one family, and I was only there an hour and ten minutes. I couldn’t be there much longer because I was, ‘I need to clock out. I need to leave. I’m not gonna have eight hours for Friday. I need to work eight hours on Friday.’ **It’s hard. Twenty-five families is wearing us out.**”

**Caseload Adjustments.** Some sites recognized these challenges and adjusted caseloads down to accommodate; staff members in 9 interviews/focus groups across five sites stated that their caseload and workload were fine. Because each EBP is different and has different requirements, caseloads should not be compared across EBPs, but should only be compared to the specific EBP expectations. For one EBP, the program administrator said, “I feel like that 12 to 15 range and the size of the caseloads that they have now is it allows them the opportunity to do some other things related to the casework should they choose.” For another EBP, the staff consulted the program developer and decided that with “the case management that’s been required for these families, we have seen that there’s just no way possible that we can do a case load more than 20.”

### **BALANCING EBP CURRICULUM WITH CASE MANAGEMENT**

As described above, one of the main issues related to caseload is the aspect of incorporating case management and other support into EBP curricula that may not have been designed to be implemented with high need families.

The difficulty balancing case management with parent education was mentioned 24 times in 13 interviews/focus groups across six sites. For example, a staff member described a common dilemma when serving high needs families: “They have all these needs, but it’s like sometimes I can’t even do a visit because I’m too busy doing case management. And sometimes it’s like, [how] do I decide what’s more important?” Furthermore, in one focus group, staff discussed how “[the program managers] told us that they want us to steer away from case management but, we all believe it’s very difficult because [the clients] are in active crises. So if we’re the only ones that are there to support them as a parent, case management is going to come up. So it’s hard to balance it sometimes.”

In another focus group, a staff member said: “The whole basis of the program is education and I think there’s so much power in education. And I can guarantee that probably everybody in here that’s worked with a family can tell you how a family has grown in some ways. And I feel like that is probably due first, trying to meet whatever basic needs that they need. **So trying their best to be a case manager and a parent educator.**” In another group, a participant stated, “I go to visits with the good intention of doing [the EBP] curriculum visit, but more times it’s a case management. It’s the ‘Miss, can I talk to you?’ ‘What’s going on?’ It’s always that. It’s ‘Can you help me with this? Can you help me with that?’”

A few sites have developed solutions to these challenges of balancing case management with parent education, in order to provide guidance and support for parent educators. One site restructured sessions so that the curriculum occurred in the first part of the visit while 10 to 15

minutes at the end of the visit was reserved for case management. If those case management needs went over the time limit, a referral was made to a different program.

A few other agencies hired a dedicated case manager or counselor to support the parent educators. A staff member from one agency stated that “the family well-being, we discovered, at least when I came on, that that's a huge chunk, really, of the families we serve. You can be there an hour and just spend it on family well-being, and still not help that family out to your full potential. So, it came to where the case manager, who is now a life coach – we would refer these families, or these parents, to her, as well, because she has all these other resources, and it gets them in the door with her, and to learn more about the [other programs at our agency]. Then it – I hate to say, it kind of alleviates stuff on us, but it really does, so that we can focus on the parenting, and the teaching with the parent.”

## **EVIDENCE-BASED PRACTICES**

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One requirement of HOPES programs is the use of an evidence-based curriculum. Both the qualitative interviews and the survey examined the pros and cons of using of evidence-based practices, as experienced by staff.

### **UNDERSTANDING & SUPPORT OF EBPs**

Of 68 direct service staff survey respondents, 60% indicated that they had previous experience implementing evidence-based programs, while 40% had not.

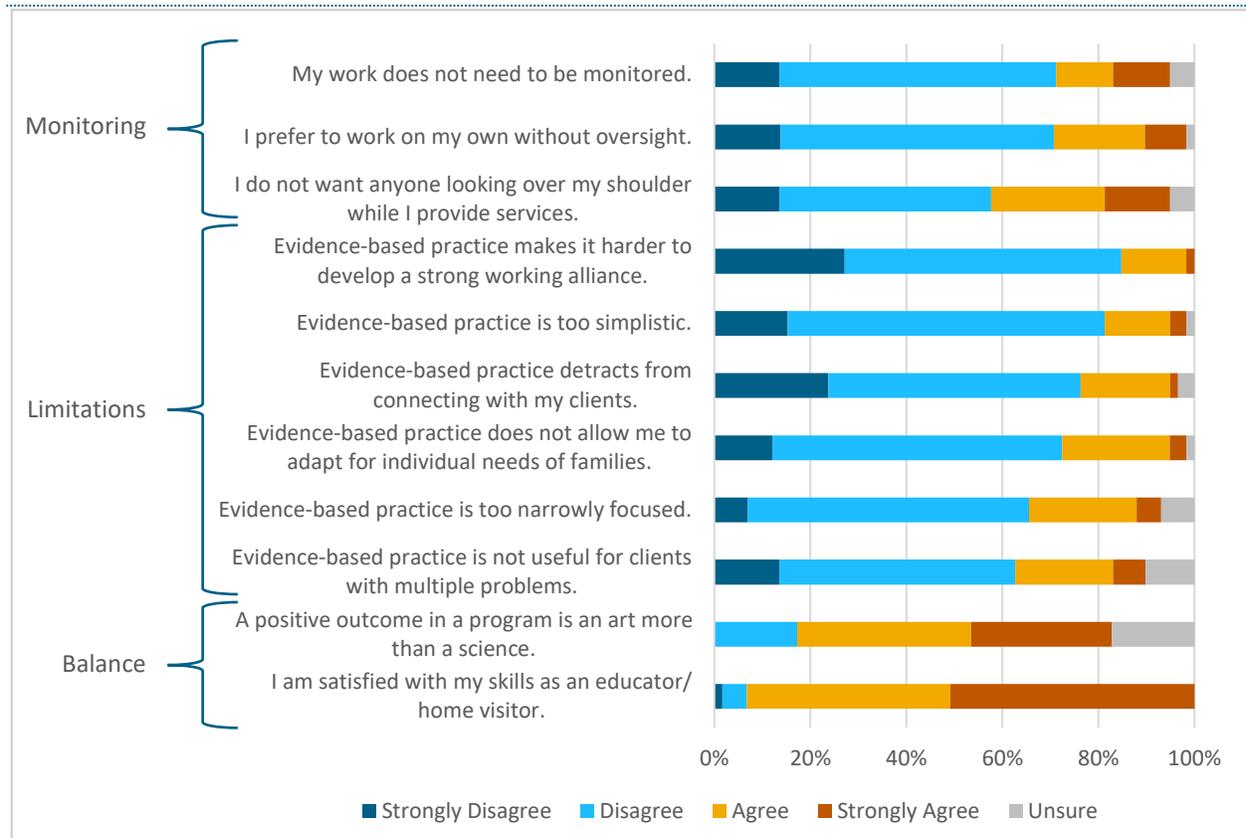
To better get an understanding on HOPES staff attitudes towards EBPs, the staff survey included 11 selected questions from the 50-item Evidence-Based Practice Attitude Scale (EBPAS). This scale measures a practitioner’s attitudes toward adopting and implementing new evidence-based interventions and practices, and consists of 12 domains, of which “monitoring,” “limitations,” and “balance” were considered in the staff survey. The monitoring domain measures whether staff have negative perceptions of oversight by supervisors, the limitations domain measures whether staff believe the EBP is limited in its ability to address client needs, and the balance domain measures staff perception that the EBP requires a balance between art and science.

The results are presented in Figure 31 on the next page. In terms of monitoring, the majority of survey respondents indicated that they did not have a problem having their work monitored. However, while 71% indicated that their work needed to be monitored and that they do not prefer to work without oversight, a lower percentage (58%) responded that they did not mind if someone was looking over their shoulder while providing services.

In terms of limitations, the majority of staff respondents did not find that EBPs were too limited in meeting client needs. However, 20% of respondents indicated that they “agreed” or “strongly agreed” with the statement that EBPs detract from connecting with clients. A further 26% indicated that EBPs don’t allow for adaptation for individual needs of families, 28% believed that EBPs are too narrowly focused, and 27% felt that EBPs are not useful for clients with multiple problems. While these responses were not the majority, they do indicate that about a quarter to a third of staff members found EBPs to be limited in their ability to address client needs. Perhaps this is even more the case for nontraditional and highest need families.

Finally, in terms of balance, 93% of respondents felt satisfied with their skills as a parent educator, while two-thirds (66%) believed that a positive outcome is an art more than a science. These responses could signify that staff believe that personal characteristics and skills are as important as scientifically-evaluated methods to achieve positive outcomes with clients.

**FIGURE 31. STAFF RESPONSES TO SELECT QUESTIONS FROM THE EBPAS-50**



To further explore staff perceptions of EBPs, the next few subsections summarize results from staff interviews and focus groups.

### EBP CURRICULA: STRENGTHS AND AREAS OF IMPROVEMENT

As outlined in the program strengths section, many staff interviewed believed the EBPs that they were implementing were effective with families. Staff thought that the EBP curricula and materials were a strength of Project HOPES. Specifically, parent-child interaction activities and education, including discipline, were mentioned 43 times in 20 interviews/focus groups at seven sites.

One administrator said, “I’ve read that on some of the surveys we’ve been getting back this year, is like, [parents] love the activities... And that probably has a lot to do with the risk of the child abuse and neglect as well, it’s just not being aware of child development, what they’re supposed to be doing at what age and how to help that along. We give them those tools, but it’s the activities that really draws them, because I don’t think they think of things. I went to a home, a visit observation a couple weeks ago with one of my parent educators and she taped toilet paper roles, it’s an activity in [the EBP]. And they rolled marbles down it, it was like a little tunnel. It looked awful, toilet paper rolls with tape, you know, painters tape on your wall, but the mom

wanted to leave it up till the dad got home, so that the baby could show him what she did, and it's as simple as that and they get so excited about that piece of it.”

Another staff member said, “We have that discipline book we've handed out to some of our parents. I've had them tell me, ‘I was spanked as a child. I was put in the corner as a child. I want new ways; different way.’ To hear that verbalized, and for them to feel comfortable saying that. Yes, the activities are great, watercolor learning, Play-dough, but that stuff really sets in with me.”

Another staff member also explained how they felt the program curriculum was effective in changing parents’ beliefs about discipline and interaction with their children: “I think it’s very effective. I think when parents first come in, you know, the first three weeks of class, they see that, you know, ‘Oh, I don’t do wrong. I’m the perfect parent.’ But as they get to the topics, they realize that ‘Oh, I don’t talk to my child about, you know, about feelings. I don’t praise my child as often as I should. I don’t set the rules that I should be setting.’ So I do see that there’s an effectiveness, you know, based on how the parents first start to how they finish.”

Yet another example from an interview with a fatherhood coordinator: “For some of our fathers, it was about I provide and pay the bills; but when it came to things like nurturing and being a role model, those things weren’t important. So I’ve noticed with my fathers that that’s some of the most eye opening [parts of the curriculum]. You’ll see a lot of self-revelation like, oh man, I’ve been doing this wrong. It’s not that you’ve been doing it wrong; it’s just another way of doing it. Discipline is another lesson that we do that’s...that’s kind of eye opening for them as well. I think the misconception of disciplining and punishment and how they’re not the same, but they can work together. I think that’s really a lesson for most of our fathers because of the type of home that they’ve come from and types of homes they live in now.”

**EBPs not designed for all clients & assume perfect situation.** Despite the strengths of the EBP curricula, staff also discussed drawbacks. Examples of how EBP curricula did not meet the needs of certain types of clients and scenarios were provided 28 times in 10 interviews/focus groups across six sites. Staff felt that EBPs were designed assuming the perfect situation, and did not consider nontraditional families or unexpected family situations.

For example, one staff person stated, “I think it would be very good to have some kind of training on nontraditional families because I feel like **the curriculum, it expects your families to be so traditional and it’s none of my families are traditional so a lot of this just doesn’t apply.**” In another focus group, a staff member explained that EBP curriculum was not well matched for certain types of clients: “we do have different kinds of clients. I know that – she had a client who did not know how to read or write whatsoever. So that’s also another challenge. We have clients, families who have children with special needs.”

In another focus group, staff felt the EBP training and curricula did not consider crisis situations: “**Different things that have happened that are crises, and I think that whenever we get the [EBP] training, none of that was even mentioned.** Like, ‘Oh, by the way, this might happen, or you might have to do crisis interventions, and things like that.’ We’ve had clients that had suicidal tendencies, so things that are major.” One staff member in another interview gave this example: “We also had to create a system for our case management. Of course, the curriculum doesn’t cover that. Curriculum is just straight up the developmental side but no family, you go in there

and **you're gonna try to do a little fun activity with a family on fine motor skills when they don't have electricity was ridiculous.**"

In cases where curricula did not cover the special needs of a particular family, parent educators gave examples of the additional research they had to do on their own. "We were trained with our curriculum, but **our curriculum was best case scenario, so perfect visit, this is what we're gonna do.** One of my main things with the curriculum is that there's no help for not being able to do something. So, we have information on temper tantrums, but what if this happens often or they're very aggressive? There's nothing to help or to provide for the family from the curriculum. **We always have to look for outside resources.**"

**EBPs designed for different stages of development.** An issue mentioned in several focus groups was that different EBP curricula are better suited for different ages of children. In particular, staff found the EBPs not as well suited for expectant mothers who do not yet have any children, or the parents of newborns and young infants. For example, "When it comes to the parent interaction, if they're teenagers and they're pregnant, the curriculum makes it very hard for them to practice. I had a teenager last week, she's like, 'Ma'am, are we going to do this role-play again? Really, I don't get a response. Really, you want me to do it again?' And I'm like, 'Well, it's going to be good practice for you.' 'Come on, ma'am. I'm talking to a teddy bear. This is not a life scenario. How am I going to learn this?'"

**Language of EBPs.** Additional issues with EBP curricula included translation and reading level of the materials. In terms of translation, there were some issues with materials not being readily available in languages other than English, or cases where, as one staff member put it, "Some of the Spanish is good. Some of the Spanish is very odd." One curriculum was noted as having very different dialects because it was developed in another county. For reading and comprehension level, one staff member gave the following example: "**I kinda feel like a parent educator is like a translator between whatever the curriculum says, which is insane and whatever fits.** You take little bits, like yesterday when I was trying to plan that visit, it was all about brain development and I'm trying to tell a woman who maybe has a high school level education if that about her two kids and how she's having trouble with discipline with them. So I was talking with [my supervisor] about what to do and she gave me some really helpful pointers about how to say the things that are in the curriculum, but at the same time why doesn't the curriculum just say that?"

**Program Duration.** An additional challenge to the program mentioned by staff was its duration (discussed 31 times in 18 interviews/focus groups across six sites). While many staff members felt that program length of each of their EBPs (which vary by EBP type) was good, some felt that duration should depend on family need. At some sites, staff felt that that they could not really alter duration too much. For example, one staff member stated, "One of my concerns is a lot of my parents are gonna be graduating...And sometimes I wonder in the future are they gonna be okay?"

On the other hand, some sites developed policies on how to tailor the program length based on family needs. For example, "in the first year we kept clients a long time. Then, when we reassessed whether we were meeting our outputs, we realized that we needed to be on more like a four to five month in order to turn over a caseload three times throughout the year to meet

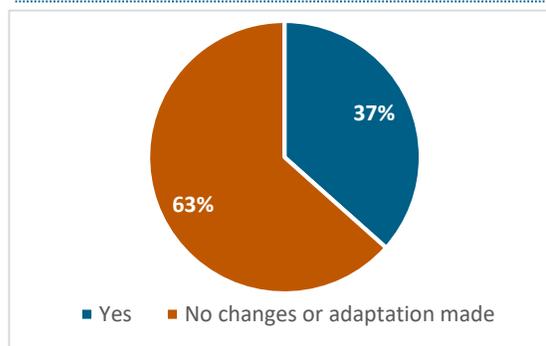
our output. I actually think it's been going well. It's much more clear to both the Parent Educator and the client, like this is a program. It's not this on-going service delivery. But, it's challenging. I would say like 90 percent in that box, and then we give a little grace to the 10 percent who need a little longer.” Another participant in the same focus group continued, saying some parents will say, “‘I need your help. I'm homeless again. I don't have a job, again.’ So, it's like starting all over again. You've already done the curriculum, so then that's not also how we're trained, but I think going in and saying, ‘I'm going to be with you for about six months.’”

**Participant Feedback.** Overall, as detailed in the section on program impact on families, parents expressed many positive feelings about the benefits of the HOPES program and EBP curricula and materials. When pressed for any suggestions for improvements, the most common critique from participants was that certain programs were too short in duration (mentioned in eight interviews at six sites). Other parents wished the program would extend to older children, and a few requested that program curriculum include more information and skill-building around finding jobs and assistance with becoming financially stable.

### ADAPTATIONS TO EBPs

The staff survey asked about adaptation of the evidence-based models used by the sites, since it is often unlikely that models can be followed with 100% fidelity in real-world settings. Based on survey responses, 63% of staff members reported not making modifications to the EBPs. However, qualitative interviews with staff highlighted ways that staff did make additions or modifications to the EBPs to tailor to the unique needs of the families served by HOPES.

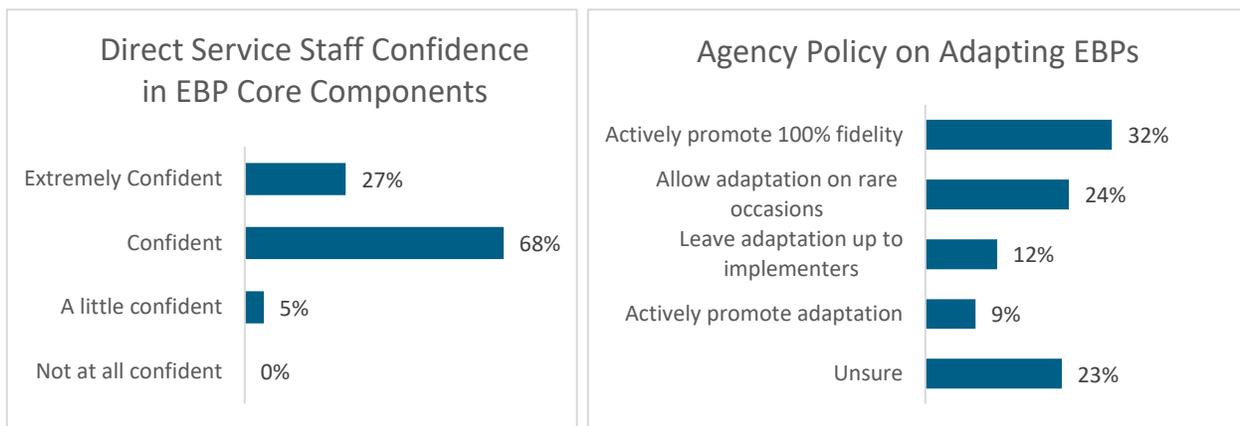
**FIGURE 32. ADAPTATION TO EBP**



Adaptation was discussed 35 times, in 18 interviews/focus groups across all eight sites. Certain types of adaptation can have a positive impact on outcomes, especially those done to improve cultural fit, planned ahead of time, and that preserve the EBP's core components.

As seen in Figure 33 on the following page, the vast majority of survey respondents (95%) reported being confident or extremely confident in the EBP core components. When staff are aware of a program's core components, then any adaptations they make are less likely to lead to negative outcomes. In terms of agency policy regarding adaptation of EBPs, only 32% of respondents stated that their agency actively promoted 100% fidelity to the model. Additionally, 23% of staff were unsure about the policy their agency had about adaptation of EBPs. This may indicate that some agencies have not discussed this yet or planned for the possibility of adaptation occurring.

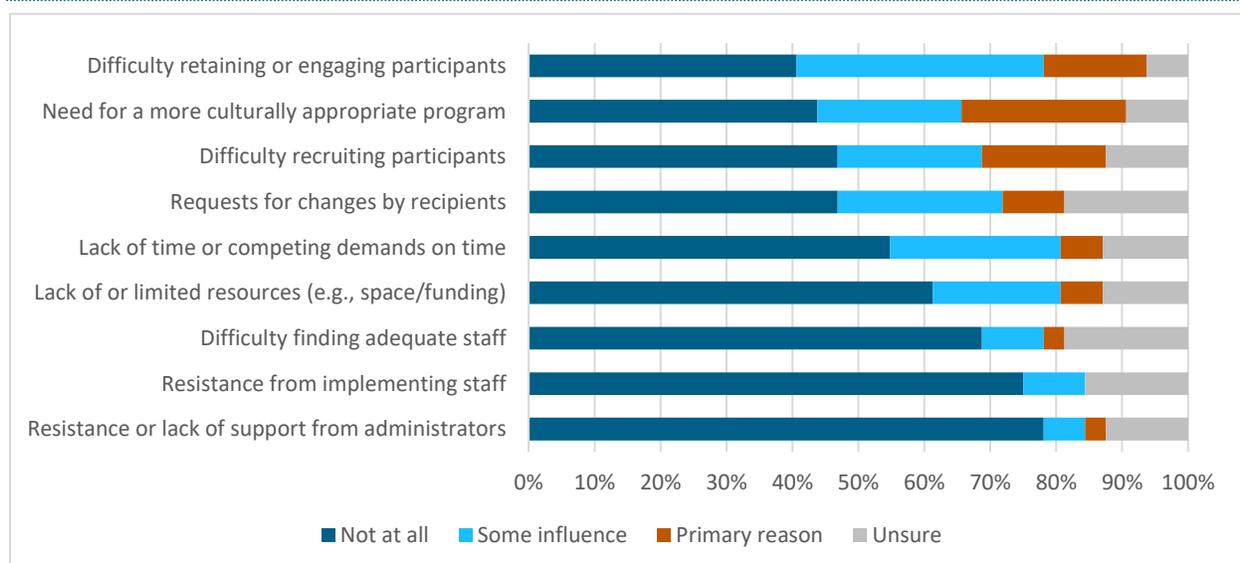
**FIGURE 33. STAFF KNOWLEDGE OF EBP CORE COMPONENTS & AGENCY POLICIES ON ADAPTING EBP**



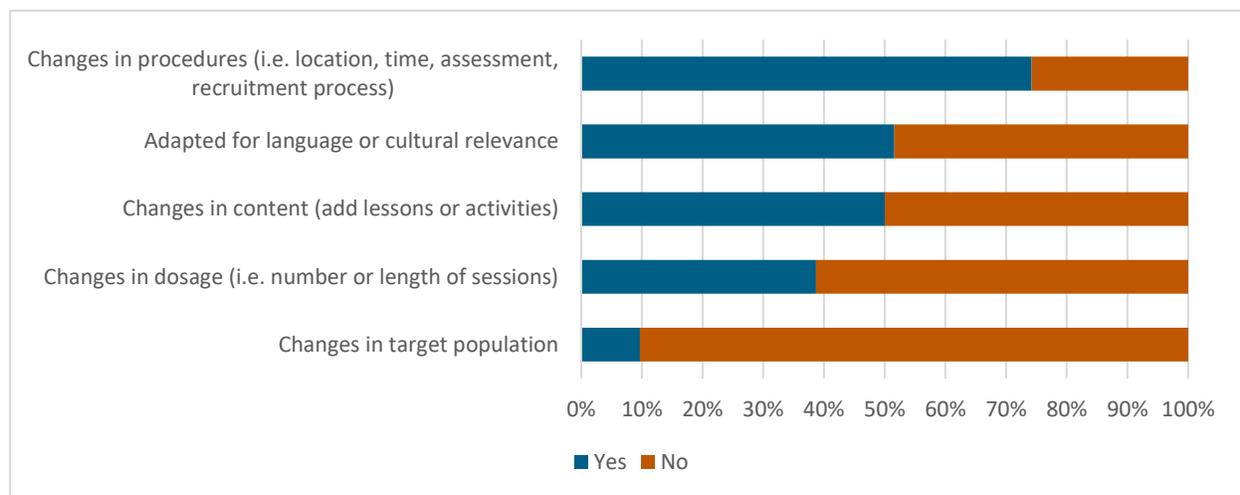
The staff survey sought to understand the reasons for adaptations, as well as what types of adaptations were most commonly made. Of the 30 individuals who responded that they had made adaptations, the top type of adaptation made was to procedure, including location, time, assessment, and recruitment process. Figure 35 shows that 75% percent of respondents made such a change. The next most common adaptation was for language or cultural relevance (52%), and changes in content, such as adding lessons that were not originally in the EBP (50%).

There were a variety of reasons for making adaptations to EBPs. The reason which received the most votes for “primary reason” was the need for a more culturally appropriate program (25%), followed by difficulty in recruiting participants (19%), and difficulty in retaining or engaging participants (16%). Figure 34 outlines the full list of reported reasons. While certain changes were planned in advance, others were made in reaction to something unexpected. The adaptation most planned for in advance was changes in procedures (48%), and the most common adaptation that was made in reaction to something unplanned was adaptation for language or cultural relevance (47%).

**FIGURE 34. REASON FOR EBP ADAPTATION**



**FIGURE 35. TYPES OF ADAPTATIONS MADE**



**Examples of adaptations made.** During interviews and focus groups, staff provided a multitude of examples of the types of modifications or additions to EBP curricula and materials that they had made. For example, we heard that parent educators often had to “translate” the information to match the reading and comprehension level of clients. One staff member said, **“If that’s what my family needs, that’s what I’m gonna do, even if the curriculum doesn’t allow me to.** If I know I have a family who’s not that in depth, I’m gonna work with what you give me but during my visit, I’m gonna do what I need to do to make sure that I get my point across in the way that you’re going to understand it and that you’re gonna use it. So technically, no, I can’t modify it, but I still do it in my visit the best that I can.” Similarly, some sites made adaptations to better suit a population of a different age group than what the curriculum was designed for. The EBP “can be for a 3-5 year old. So trying to make it fit with teens, I would say that’s the one where he had to add some things.”

Another common adaptation mentioned by staff members was supplementing the curricula with additional research done by the parent educator. One staff member said, “I use [the EBP], but I also bring them information that I found on the internet. Or, before, we used [another EBP], and I use that tool, sometimes. I shouldn't, I know, but I do.”

A further adaptation was shuffling the order that the lessons were presented. One staff administrator described how the agency supported staff in making this type of modification: “I think that's something we've learned also this year that helping [the parent educators] go in there and say, ‘Okay. It doesn't have to be like Chapter 2 this time.’ You can craft it to what they need as long as you stay within the dosage.”

Other sites have had to make adaptations due to time constraints, such as those at a school. “It’s been a challenge because that free period’s only 45 minutes. And to be true to the curricula, it should be an hour and a half to two hour sessions. So we’re having to break it up. Yeah. And I find to get someone for an hour and a half to two hours is a big ask so that’s what we’re doing, is we’re breaking it up how we can.”

## **PROFESSIONAL DEVELOPMENT NEEDS**

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Staff training requests varied by site, as different communities had different resources. Additionally, programs had staff members with different types of professional backgrounds. For example, staff members with a social work or counseling background had different training requests than those who lacked information on how to deal with family crises and sensitive topics. For example, one staff member said, “I feel like for us [the EBP] training was great but not to specifically address those families with those high needs. And so a lot of us have experience with mental health and case management and things like that but the curriculum itself didn’t prepare you for that. It’s kind of that pre knowledge that you had to have.” In another focus group, a staff member observed that one of her colleagues with a counseling background “brings a lot of what she knows already of her expertise into the session, and she says what would make a really good complete session. But it’s because of her and the knowledge that she brings.”

**EBP Training is not enough.** As discussed in the section on EBP strengths and areas of improvement, many staff felt the EBP curricula did not include guidance on what to do at home visits when crises situations occurred or when dealing with sensitive topics. Training requests focused on issues that high risk families faced beyond what was provided in the standard EBP curriculum. Such requests were mentioned 19 times in 14 interviews/focus groups at six sites.

One staff member gave a good summary of the various staff training needs: “I just think training wise, we need a lot of training on I wanna say everything like on child abuse, mental health dealing with the basic needs, domestic violence. Anything and everything that you can see when you go into a home, I think we need to be educated on that prior to going into that home, because it’s like you step into somebody else’s environment and you’re just blindsided and it’s like I’m here to do this visit but you’re about to get kicked out of your house. They’re about to turn off your electric bill. Your kid hasn’t been to the doctor in over a year. You don’t even have Medicaid. How do I do my visit when all these things are going on?”

### **SPECIFIC TOPICS REQUESTED**

Program staff had a list of training topics they felt were needed based on what they were seeing with families and what they felt that they personally needed. It should be noted that training requests varied by site and professional background. Overall, training requests on how to deal with a variety of sensitive topics was mentioned in 14 staff focus groups/interviews across six sites. Some of the topics discussed are described below.

**Children with special needs.** Staff members noted that they were serving parents who had one or more children with special needs. While some curricula accounted for special needs or was specifically designed to meet the needs of these families, parent educators using other EBPs wanted more training on what they should be providing to parents. One program staff explained, “We’re getting a lot of children referred – or parents referred to us who have children that have special needs. We’ve had about four or five referrals for parents whose children have down syndrome, several with autism, and of course a lot with ADHD. And that’s an area where I think our staff could use a little bit more training on how to help parents.”

**Pregnancy prevention and birth control.** Another issue that staff raised was their discomfort in discussing family planning with clients even though they felt that discussing child spacing, in particular, was important. A program staff explained, “That would be good, interesting, for there to be awareness or a push or program to promote birth control, because it's such a – for me it's really an uncomfortable conversation to have. How are you going to prevent your next pregnancy?”

**Suicide and mental health.** Mental health was a huge concern raised by program staff. Additional tools were needed to help screen for maternal depression and to conduct suicide risk assessments. In general, program staff expressed a need to understand how to reduce stigma for parents to get help and to provide emotional support within their professional relationship. For example, a program staff member at one site recalled showing up for a home visit right after a mom had a miscarriage. She felt unsure of how to help the mother manage that crisis and process those emotions. Another program staff member noted, “We came across a couple of instances of pretty severe mental health needs for families – for moms, especially, some maternal depression going on. One parent made a suicide declaration to one of the parent educators pretty early on which forced us to establish a policy and procedure which is good – unfortunate, but good. So, as a home visitor going into a home where that might be the case, there could definitely be some training around that.”

**Boundary setting and self-care.** In eight focus groups/interviews across seven sites, direct service staff members voiced uncertainty about how to set boundaries with clients, since home visiting does create strong bonds between parent educators and families. The need for this type of training was discussed in eight interviews/focus groups across seven sites. “One of the trainings that I think HOPES needs to improve is helping educators learn about the boundaries that social workers learn in school to develop. Because you're putting these caring educators into houses with families who are going through crisis and it's not always easy to have boundaries with those families. And I don't think we've had – well, we've had zero training from [the EBP] or from HOPES about how to establish boundaries especially when you invest in families. So I think HOPES needs to provide better training or better support for how to manage that dynamic which comes with that program and being in that house and being connected to the families.”

Another staff member further explained the uncertainty surrounding boundary setting in home visiting: “I have a complaint on that, because you know, we're told that we should become close to our families, but they shouldn't become friends. But then, you have ‘you're becoming a little too close, I might have to take this family away from you.’ It's like, well, which one is it? Which one do you want me to do? Because we're not their social worker, we're not their counselor, we're the child's teacher.”

Furthermore, this inability to set boundaries and take time for self-care can lead to burnout and turnover: “We had one educator that that was the ultimate reason why she left is because she wanted to take over everything – she wanted to do everything for the family – and that's not the model...She burned out. She wasn't able to regulate all of those emotions of this family being constantly in a cycle of crisis.”

**When to report child maltreatment.** Working in a family’s home environment, home visitors often saw family needs and challenges first-hand. At the same time, the role of the parent educator/home visitor is to help families improve their situation, partially by providing trusting social support and empowerment. In at least two focus groups, staff members indicated difficulties on deciding what to do when a situation they witnessed was something that perhaps should be reported to CPS, but such a report would break the trust built with the family, and the family would likely be dropped out of much needed services.

**Administering PFS and assessments.** In eleven focus groups/interviews across seven sites, staff also voiced a need for training related to EBP and HOPES-related paperwork and assessments. For example, one staff member said, “As far as the paperwork goes, I don’t feel like we got enough training at all. Like, because even still to this day, we’re like, when do we have to do this, or when do we have to do that? That type of thing.” Another staff member, in discussing administration of the PFS and other assessments said more training was needed, since “I think families are very suspicious– are we using this against them, is this possibly going to be for CPS. And if I don't understand it really well, it's real hard for me to convince or to share with them what it's all about, because they can see right through me that I'm not quite sure, but let's just fill it out.”

# CONCLUSION

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The purpose of this report is to detail the findings from the evaluation of the HOPES I activities in FY2015, its first year of programming. In this evaluation, a reduction of community-level child maltreatment rates was not measured because it would not accurately reflect the program's impact on child maltreatment. Such analysis will be conducted in future HOPES evaluation reports. During FY2015, HOPES programs were getting started and there was limited pre- and post-data available to understand program impact. Bringing programs to scale takes time; a similar analyses of home visiting programs in Texas concluded that it takes at least one year to bring a program to scale<sup>8</sup> due to inevitable issues with staffing, training, designing of protocols and recruitment of families.

This evaluation utilized a mixed methods design, collecting data from multiple sources, including: (1) parents who participated in programs, (2) staff who administered programs, (3) staff who worked directly with parents, (4) general community members, and (5) members of early childhood coalitions. All of these groups participated in interviews or focus groups, and all groups except parents received an online survey. The results from a parent-completed Protective Factors Survey (PFS) were also analyzed, as was information from staff-submitted quarterly reports.

## FINDINGS

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The FY2015 HOPES evaluation aimed to understand three specific elements of the program: (1) the impact on families participating the program, (2) the impact on community collaboration, and (3) implementation strengths and areas for growth. Findings relevant to each element are summarized below.

### TO WHAT EXTENT HAVE HOPES PROGRAMS IMPACTED FAMILIES?

In only its first year, Project HOPES reached parents through active programming. An estimated 36,000 individuals participated in various community programs provided by HOPES sites, such as community fairs, activities at parks and children's museums, professional trainings and various forms of case management services. While this number includes an unknown number of duplicated individuals, it suggests that sites were actively engaging their communities in child maltreatment prevention.

HOPES served 2,803 individuals with direct services such as counseling, child care and case management. Of those, 2,613 received evidence-based parent education programs. Considering those families who closed cases in FY2015, protective factor scores increased on all PFS subscales, suggesting that families increased protective factors that may ultimately reduce child maltreatment. Because these evidence-based curricula have a minimum dosage to create lasting impact, it is often assumed that the amount of the program completed corresponds to greater changes in protective factor scores. However, this pattern was not observed. In some cases, parents who completed only a small portion of the program reported improvements greater than

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<sup>8</sup> Osborne, C. (2013). *Texas Home Visiting Program Observations and Early Findings from the Evaluation of the First year of the Texas Home Visiting Program*. Child and Family Research Partnership, The University of Texas at Austin.

those who received more of the program. Thus, the protective factors analysis should be interpreted cautiously. While it appears that the protective factors are improving, it is not clear how consistent of a pattern this is.

Qualitative data and survey data strongly suggest that the programs are helping families. Parents reported that the programs educated them on proper discipline and positive ways to engage with their children, helped connect them to other parents and provided them a trusted support network. Program staff reported that they saw the impact of the program reflected in behavior changes they saw in parents. They also cited examples of parents referring their friends. One program staff member who works with fathers said, "One of the things we thought was a huge indicator [of success] was that the young men were bringing their friends in. Young men that the school didn't realize had become dads." Another program staff member stated, "One of the greatest indicators of how successful the program has been I think is that a lot of our referrals are coming from existing clients or clients who have completed the program. They are now referring their neighbors, their friends, their relatives, and I just think that speaks to how successful the program has been."

#### **HOW HAVE HOPES PROGRAMS IMPACTED COMMUNITY COLLABORATION?**

One factor mentioned by participants was that the communities were grateful to be able to design a program that fit their needs. In most cases, communities already had existing coalitions. Some communities already had early childhood coalitions because they had received prior funding supporting coalition development from Texas Home Visiting. In looking at scores from the survey of coalition members, there was a high level of collaboration in the community and a clear commitment to continue to work together on issues related to child welfare. One area of growth for some coalitions is to develop a clearer vision and actionable strategy for child maltreatment prevention.

#### **WHAT ARE THE STRENGTHS OF THE PROGRAM AND OPPORTUNITIES FOR GROWTH?**

There are several strengths of this project that emerged from the data: (1) parent education programs are well-liked by staff and clients, (2) staff have developed strong, trusting relationships with parents, and (3) supplemental services like case management are benefiting families.

Along with these strengths are opportunities for growth. First, some sites noted struggles related to consistent and effective marketing of the HOPES program in their community. Some sites had challenges recruiting particular groups of participants, such as fathers, or families with the highest needs who are not already involved in the CPS system. In some locations, qualitative data indicated some parents had hesitations to participating in HOPES and/or home visiting due to beliefs that is was associated with CPS.

Perhaps one of the most common concerns addressed by program staff was the difficulty of maintaining fidelity to an EBP while also addressing families' case management needs. There was tension between the realities of being in someone's home and providing appropriate support and being held to performance based contracting measures and/or fidelity requirements for a curriculum. As a result, many staff members reported making a variety of adaptations to EBPs. Some of these adaptations may have had positive or neutral effects on participant outcomes,

while others may have had negative effects. While this struggle is not new in social service provision, it is an important area for growth and guidance as programming grows.

There was also a need to examine staffing policies. For example, overtime pay, flexible work hours, paperwork and client meetings needed to be more balanced and fairer for staff. Caseloads appeared to be high for parent educators at some sites, and it was unclear what the curricula standards for caseloads were when serving high needs families.

A final area for growth related to professional development. Multiple topics for training were suggested by staff. Perhaps the most salient were related to cultural competency, ethical boundaries and how to address crisis situations, especially for staff without a social work or counseling background.

## **RECOMMENDATIONS**

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Based on the findings presented above and the experience of completing this evaluation, we offer the following recommendations on program issues and data collection issues.

### **PROGRAM RECOMMENDATIONS**

Our first recommendation is for PEI to **continue support of community-based child maltreatment prevention programs**. Participants in this evaluation were incredibly grateful that their community had been provided this support. Even without data to measure child maltreatment, there is an indication from survey and qualitative data that HOPES is helping families. However, there is not yet strong evidence that HOPES is serving the most at-risk families. Based on the demographics of parents being served, income and education levels are aligned with demographics of parents reported for child maltreatment. However, without more detailed information on risk factors that drive child maltreatment, including substance use, mental health, family violence and the parent's history of trauma, it is difficult to say with certainty the risk level of families being served. We will be able to capture more of this information in FY2016.

A second recommendation is to **shift to an evidence-informed framework to allow for increased flexibility in programming**. The general trend in policymaking is to fund evidence-based programs. The assumption is that funding should be provided to those programs that have research demonstrating that they 'work.' While policies should encourage research-based approaches, stringent requirements that a program must adhere to a specific evidence-based model should be balanced with the specific program and client needs. The standards for determining what is evidence-based are subjective, and programs designated with the label of evidence-based may not continue to produce evidence over time. Additionally, many programs are developed for a certain target population, and might not be best-suited for non-traditional participants with certain needs and risk factors. Furthermore, strong evidence-based models do not always exist for every issue and topic area. Thus, communities might be forced to select suboptimal models that are not tailored to their specific needs, just to meet the evidence-based requirement.

A more rational approach is to ask programs to be evidence-informed, with a strong theoretical foundation and program guidelines that match that foundation. Evidence-informed approaches

are suggested because they can borrow core components of evidenced-based programs while enjoying the flexibility of incorporating unique elements important to a particular community. In the case of HOPES, program staff and parents attest to the fact that case management is a crucial component of service delivery. However, concerns about sticking to evidence-based program modules sometimes constrained parent educators from addressing real issues that families had, while others chose to make adaptations to the models to address client needs.

A third recommendation is to **adjust performance based contracting requirements**. Performance based contracting is another trend in policy making that attempts to hold grantees accountable to outcomes. With HOPES, outcomes are tied to whether a contractor can improve scores on at least one item on the Protective Factors Survey (PFS). In interviews with direct service staff and administrators at HOPES sites, concerns about the validity of PFS scores repeatedly came up. Concerns were raised about a lack of participant honesty in pre-tests due to social desirability bias, but increased honesty in post-tests, once a trusting relationship with the parent educator was established. Some sites experienced post-PFS scores that were lower than pre-PFS scores. Additionally, concerns were raised that the reading level, question wording, and seven-point agreement scale were confusing for some participants. Finally, the PFS was not developed to predict child maltreatment.

Since HOPES programs are tailored to community needs, we suggest that, in addition to a standardized measure, sites have the flexibility to develop logic models and site-specific measures with PEI oversight and approval. A statewide impact can still be demonstrated through a meta-analysis of the sites' effect sizes. This would allow communities to match their needs with outcomes and measures that best indicate their programming impact and success.

A fourth recommendation is to **maintain the community-based approach of HOPES**. The core idea with HOPES is that communities know best what they need for meaningful change. Many participants in this evaluation noted that they appreciated that aspect of HOPES. Communities have been able to provide wrap-around services, therapy and basic needs assistance that they would not have been able to provide if HOPES were only focused on home visiting. Additionally, some parents are more inclined to participate in group settings, while others prefer services in their homes. For those that prefer groups, certain evidence-based programs like Incredible Years and AVANCE offer avenues for parents to come together, and several mothers reported that they overcame experiences of isolation through these programs.

A fifth recommendation is to **dedicate time for programs to have a start-up period and to provide technical assistance regarding recruitment and operations planning** during this time. From the time this data was collected, PEI has already made adjustments to start-up time. In addition to time, technical assistance during the start-up period is important to help guide programs to a logic model and corresponding operations plan. Additionally, many sites struggled with recruitment during the first year of HOPES, especially with fathers. Recruitment can always be a challenge with a new program. PEI should provide guidance on marketing, outreach materials, strategies and best practices on how to engage traditionally hard-to-reach families.

A sixth recommendation is to **support staff through professional development, training and technical assistance and official guidance on program issues**. From the time this data was

collected, PEI has already implemented trainings for parent educators. These efforts should continue and address topics requested by program staff such as boundaries and crisis intervention. Additionally, PEI should create official guidelines on caseloads for Texas programs utilizing evidence-based programs funded through HOPES. Such guidelines can be made in conjunction with a curriculum purveyor and should not alter fidelity. Guidelines could help sites adjust caseloads, since parent educators may also have case management roles. Similarly, guidelines should be established about supervision of direct service staff. Training can be provided on using social work supervising perspective, in which problems are discussed, staff are encouraged to challenge their own biases and limitations, and solutions are formulated. Such supervision is key to preventing staff burnout.

A final recommendation is to **provide guidance on how to incorporate child maltreatment prevention into community coalition goals and plans**. In order to reduce duplication of efforts, PEI allowed HOPES sites to join existing early childhood coalitions. The benefits of the existing coalitions is strong leadership, organization, and active membership. However, a drawback is an established vision and purpose, sometimes specifically focused on early education, poverty, or health. While these focus areas are not mutually exclusive from preventing child maltreatment, coalitions did not often have objectives or actionable strategies specific to child maltreatment prevention. By including such objectives into a strategic plan, coalitions can measure progress made towards meeting those objectives and can hold themselves accountable and make course corrections if progress is not made. PEI can provide greater support and oversight in this area.

## **DATA/EVALUATION RECOMMENDATIONS**

Through our work in analyzing PEI data, many limitations of the data became apparent. PEI is currently restructuring their database, and these recommendations are made with the intent to support that process.

We recommend an **expansion of data collected in order to better understand families being served**. There are several critical limitations of the available quantitative data collected in the PEI database that reduce the type of analysis possible, as well as the confidence with which inferences can be drawn. One limitation is a lack of data as to whether a given family qualifies as “high risk” based on evidence-based program standards. This reduces the understanding of the dosage and fidelity with which certain programs were implemented, and thus reduces the ability to determine program effectiveness. Also concerning is the lack of consistency with which “risk codes” are applied to families. A family qualifies for HOPES, because at least two risk factors are present. In general, “high stress level” is coded as one such risk factor. Risk factors used to screen families should be grounded in research linking them to child maltreatment. “High stress level” offers little to researchers. Important risk factors that have been shown through research to drive child maltreatment include substance use, mental health, family violence and a parent’s history of trauma.

A second recommendation for data is to **clarify how programs enter services that a person received in the PEI database**. Because programs and implementation varied across HOPES sites, several programs include a combination of services being provided. At times, multiple service codes are listed for a single client under a single program in the PEI database. It is unclear whether

those service codes represent unique 'visits' or a combination of services provided during one visit. This makes it impossible for a researcher to determine the number of times a client was served. This is additionally complicated by the many clients who were enrolled in multiple programs. Without clear data by site, program, type of services provided and number of times a client was served, it is not possible to assign responsibility for outcomes (such as change in PFS score) to any of those potential sources. Finally, reporting errors may also be present in the data. It is difficult to determine the legitimacy of data that differs from expectations (such as an indication that a client has received the minimum dosage, when other data in the database suggest that client does not have the requisite number of sessions for minimum dosage). It is likely that these conflicting data are due to reporting error, program idiosyncrasies, or both.

A third recommendation is that PEI **provide guidance on recording minimum dosage**. Data reporting should be standardized and mandated across all HOPES sites. Received minimum dosage should be a really important variable, but it is only reported once in the database, without a specific date of attainment, even for clients enrolled in multiple programs or receiving multiple services, making the minimum dosage variable very hard to use for data analysis.

A fourth recommendation is to **standardize quarterly and annual reports from sites**. The quality of quarterly reports varies widely by site. Additionally, because these reports determine program reach beyond direct services, such as during community events, sites need to keep careful track of event attendance to identify those who have already been counted as receiving services in order to avoid duplication of counting.

A fifth recommendation is to **manage expectations about what data analysis is able to show about successful implementation of a prevention program**. Prevention is incredibly difficult to measure because a researcher is tasked with measuring something that has not happened, but might have happened, if not for a prevention intervention. On a community level, PEI expects to see a reduction in child maltreatment rates. While such community-level analysis will be conducted, it is difficult to attribute change directly to HOPES programs. Intermediate measures are important to consider when looking at program success. For example, measuring change in known risk factors for child abuse helps determine the likelihood of a future reduction in child abuse instances.

## LOOKING FORWARD

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HOPES is a new and developing program, and since data collection for this evaluation, many changes have already been made. PEI has made changes in response to agency feedback to HOPES II and HOPES III contracts. Additionally, PEI is developing a new, more robust database system that will hopefully incorporate the data collection recommendations within this report.

HOPES program sites also have reported that they have learned from implementation challenges and are making changes to address them. Staff discussed changes to a variety of practices, with one staff member saying, "Honestly, as a program, I feel like we've been able to really kind of adapt once we've thought, 'Okay, this isn't working.'" The effects of these process changes from year to year will be evaluated in subsequent reports. Future evaluation reports will also include data from a caregiver survey designed by the research team. This survey will supplement data

from the PFS with information about additional risk and protective factors related to child maltreatment experienced by HOPES families.

Overall, those who were interviewed for this study were very supportive and hopeful about the long-term impact of the program. One community member said about HOPES: “The part that I'm excited and hopeful for is that it will also impact [participants'] neighbors, or their friends, and their family...I think **this is a long-term investment in this city, in the community.**”

As reiterated throughout this report, community-level changes, especially changes in societal norms, take time. With each passing year that Project HOPES is implemented and expanded, more information and evidence of its impact will become available.

# APPENDIX A: METHODS FOR HOPES CROSS-SITE EVALUATION

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## EVALUATION PURPOSE AND MIXED-METHOD DESIGN

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The purpose of this study was to examine process and outcome measures for the first year of HOPES I, during the time period of September 1, 2014 to August 31, 2015. While some preliminary outcome measures are reported, the evaluation is primarily focused on implementation challenges and successes in the first year of this new program.

The evaluation utilized qualitative and quantitative methods to gather and analyze information. Quantitative data were collected through two online surveys, as well as data from the PEI database. Qualitative methods included semi-structured in-person interviews and focus groups with staff, program participants, and coalition members at each of the eight HOPES I sites. Additionally, Quarterly Reports provided by HOPES contractors to PEI were also analyzed. The following sections describe the methods for these data collection activities in greater detail.

## SURVEY METHODS & SAMPLE SIZES

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Quantitative data were collected through online surveys, as well as data from the PEI database. In April and May of 2016, links to the two online surveys were distributed. A staff survey was sent via email to all HOPES I program staff, including direct service staff, supervisors, and supplemental service providers, while a separate link to a community survey targeted HOPES I coalition members and other stakeholders in the community. Both of these surveys were voluntary and confidential. The coalition survey offered participants the opportunity to enter a drawing to win a \$200 gift card.

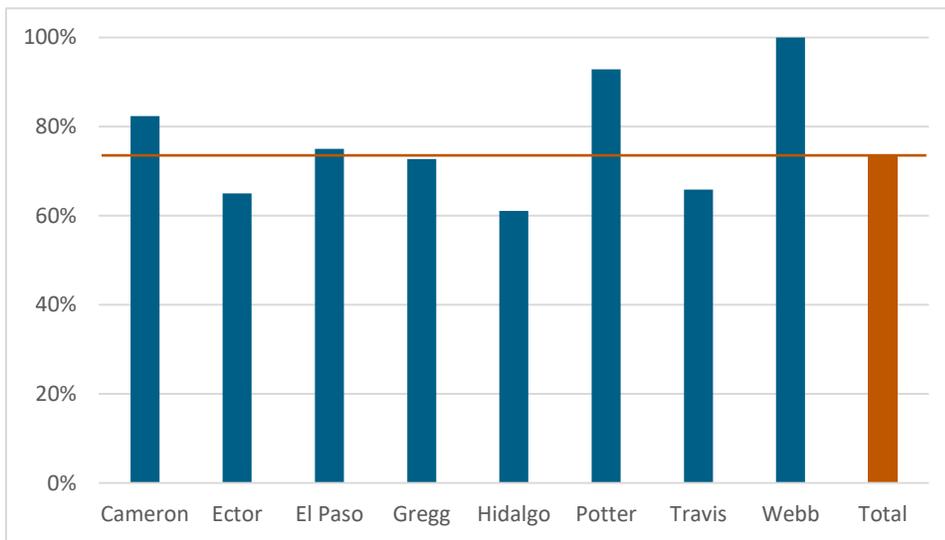
The surveys used a mixture of validated scales and questions developed by the research team. The staff survey provided contextual information about caseloads, perceptions of program success, staff demographics, and community level factors and challenges to service delivery. The survey items included: trauma-history questions from the ACEs study as modified by the Behavioral Risk Factor Surveillance System (BRFSS) Texas 2015 Survey. Additionally, the Patient Health Questionnaire-9 (PHQ-9) was used to measure caseworker strain (85-86). Certain EBP implementation questions (66-83) were taken, with permission and slight modifications, from the Annual Survey of Evidence-based Programs 2014, conducted by the Evidence-based Prevention and Intervention Support Center at Pennsylvania State University. Questions 55-65 were based on questions from the national Mother and Infant Home Visiting Program Evaluation (MIHOPE), led by MDRC. Question 15 was informed by the Implementation Leadership Scale (Aarons et al. 2014), and Question 17 used a modified subset of questions from the Evidence-Based Practice Attitude Scale-50 Item (Aarons, 2010). The remaining items in the staff survey were developed by the research team.

Community survey questions included a measure of collaboration for coalition members and questions about perceptions of the HOPES program and needs related to child abuse prevention in the community. The community survey used the freely available Wilder Collaboration Factors

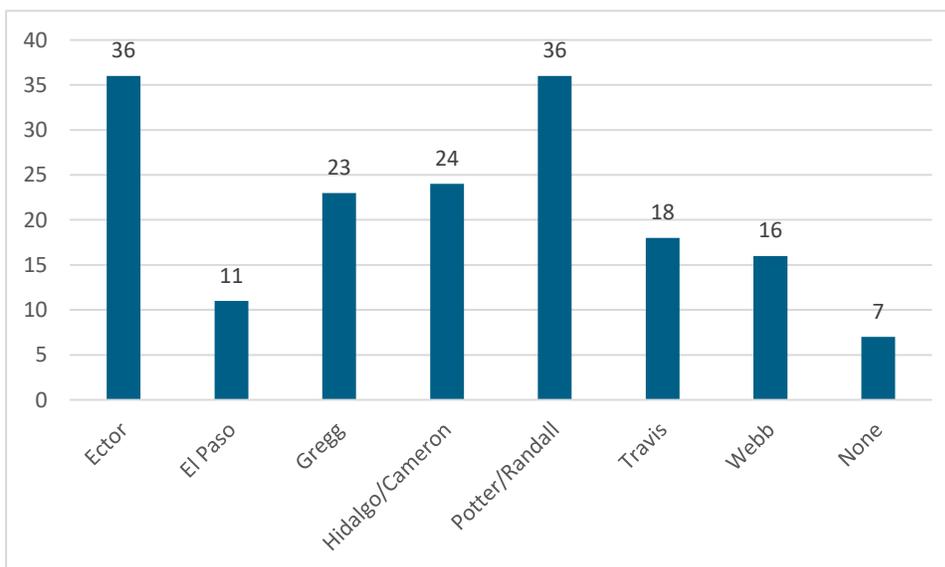
Inventory, which measures 20 collaboration factors with 40 questions. Additionally, questions 48-55 were adapted from the Annual Survey of Evidence-based Programs 2014. The remaining items in the community survey were developed by the research team.

The staff survey was initiated by 122 respondents, and completed in its entirety by 110. Response rates based on the number of staff members who received an email invitation to participate in the resurvey are presented in Figure A1. The community survey was initiated by 188 respondents, and completed in its entirety by 132. As this survey was forwarded to coalition members by coalition organizers through an anonymous link, there is no way to calculate response rates for this survey. However, Figure A2 does provide a summary of the number of respondents by HOPES community.

**FIGURE A1. STAFF SURVEY RESPONSE RATES BY COUNTY**



**FIGURE A2. COMMUNITY SURVEY RESPONSES BY COUNTY**



## FOCUS GROUP AND INTERVIEW METHODS & SAMPLE SIZES

Qualitative methods included semi-structured individual interviews and focus groups at each of the eight HOPES I sites. In-person interviews and focus groups with staff, program participants, and coalition members occurred between April and June of 2016. An effort was made to speak to representatives and participants from each contractor and subcontractor. Those who were interviewed were not selected randomly. Rather, they were identified as being available during site visits made by the evaluation team. On average, we spoke to about 15 staff members, six caregivers, and six coalition members per HOPES site. Table A1 provides the specific number of participants by site.

Each HOPES contractor assisted in coordinating and scheduling interviews and focus groups with staff, coalition members, and program participants. When possible, direct service staff were interviewed separately from managing and administrative staff. Excluding staff who did not receive compensation, interview and focus group participants were provided \$25 gift cards to cover their time and transportation costs.

Interview guides were developed to ensure consistency, though interviews were implemented in a semi-structured way to allow the interviewers flexibility to pursue particular themes or responses further. Interviews with program participants lasted about 20-30 minutes and were conducted either in the participant's home, or in a classroom or office setting. A team of bilingual researchers conducted 16 interviews in Spanish and 19 interviews in English. Interviews and focus groups with staff and coalition members typically lasted between 45 and 60 minutes, occurred at agency offices and were all conducted in English. All interviews and focus groups were audio-recorded and transcribed verbatim. Field notes were also taken and compared to transcriptions to ensure accuracy.

**TABLE A1. INTERVIEW/FOCUS GROUP PARTICIPANT TYPES AND COUNTS, BY HOPES SITE**

	Parents	Staff Members	Coalition Members	Interviews/focus groups
<b>Cameron</b>	4	11	-	5
<b>Ector</b>	11	11	8	11
<b>El Paso</b>	15	24	6	16
<b>Gregg</b>	4	10	3	7
<b>Hidalgo</b>	4	8	5	7
<b>Potter</b>	5	14	3	10
<b>Travis</b>	6	28	5	17
<b>Webb</b>	3	10	12	7
<b>Total</b>	52	116	42	80

### Administrative Data

Select data for fiscal year 2015 from the PEI database was used. These data were de-identified and provided to the research team by PEI through a DRIT. The data contain information on the number of target children, primary and secondary caregivers, and other participants served,

respective demographics and risk factors, and the types and quantities of services received. The data also include measures of dosage and the pre- and post-test scores for the Protective Factors Survey (PFS). PEI database limitations are described in the Limitations section.

PEI requires each HOPES contractor to submit quarterly reports summarizing program implementation. The topics covered in these reports include: (1) Collaboration with other agencies and/or community resources, (2) Outreach and awareness information, (3) Services available during the quarter, (4) Service delivery, including service provider activity, staffing and training, and resources and technical assistance, and (5) Volunteers. These reports were reviewed by a research assistant to identify pertinent information about coalition participation and program reach to community members who did not receive direct services, and thus were missing from the PEI database.

## Data Analysis

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Data from the online surveys were cleaned and consolidated to produce descriptive statistics. Data from the PEI database were also analyzed using R and Excel software to produce descriptive statistics. Certain assumptions were made due to the limitations in the data, which are described in the Limitations section.

Data from the focus groups, interviews and open-ended survey questions were analyzed using content analysis. The research team members who participated in the focus groups and interviews developed three separate coding schemes for program participants, staff, and coalition interviews/focus groups. One transcript of each type was coded by the lead researcher and five research assistants using the online software Dedoose. The coding team met to review each initial coding, and revised the coding scheme based on discussions.

Once coding schemes were finalized, two coders were assigned for each of the three interview/focus group types (parent, staff, or coalition). Each transcript was reviewed by two coders to ensure consistent application of codes. When coding was completed, all excerpts and codes were exported to Excel spreadsheets for additional summarization and organization of themes. Codes were further reviewed to identify quotes that provided good examples of themes.

## Limitations

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Limitations in the methods exist and should be considered when examining the findings presented in this report. Interview and focus group participants were not randomly selected and might not represent the views of any specific group. Both the online surveys and interviews/focus groups were voluntary; those who completed the surveys and attended the interviews/focus groups could potentially be unique from those that did not participate. The results cannot be generalized to the entire population of program participants (parents), staff or coalition members. Additionally, sample sizes, especially those of program participants, were small and might not be representative of the larger HOPES stakeholders.

Caution should also be taken when interpreting results from the Protective Factors Survey (PFS). There is a possibility of social desirability bias in pre-test scores. Additionally, question wording could have impacted comprehension for some participants. Finally, the PFS was not developed

to predict child maltreatment. Moreover, important risk factors that have been shown through research to drive child maltreatment are not currently collected by PEI and are missing from this report. These include substance use, mental health, family violence and caregiver trauma history.

Several critical limitations of the available quantitative data from the PEI database reduced the types of analyses possible as well as the confidence with which inferences can be drawn. These limitations are primarily due to: a lack of necessary data, idiosyncrasies in program implementation and participant utilization, and inconsistencies or errors in reporting data.

The lack of necessary data (e.g., whether a given family qualifies as 'high risk') results in a reduced understanding of the fidelity with which a given program was utilized, and thus a reduced ability to determine program effectiveness. Furthermore, because programs and implementation varied across HOPES sites, several programs include a combination of services being provided. At times multiple service codes are listed for a single client under a single program. It is unclear whether those service codes represent unique 'visits' or a combination of services provided during one visit, making it impossible for a researcher to determine the number of times a client was served. This is additionally complicated by the many clients who were enrolled in multiple programs. Without clear data by site, program, type of services provided and number of times a client was served, it is not possible to assign responsibility for outcomes (such as change in PFS score) to any of those potential sources. Finally, reporting errors may also be present in the data. It is difficult to determine the legitimacy of data that differs from expectations (such as an indication that a client has received the minimum dosage, when other data in the database suggest that client does not have the requisite number of sessions for minimum dosage). It is likely that these conflicting data are due to reporting error, program idiosyncrasies, or both.

## **Human Subjects' Protections**

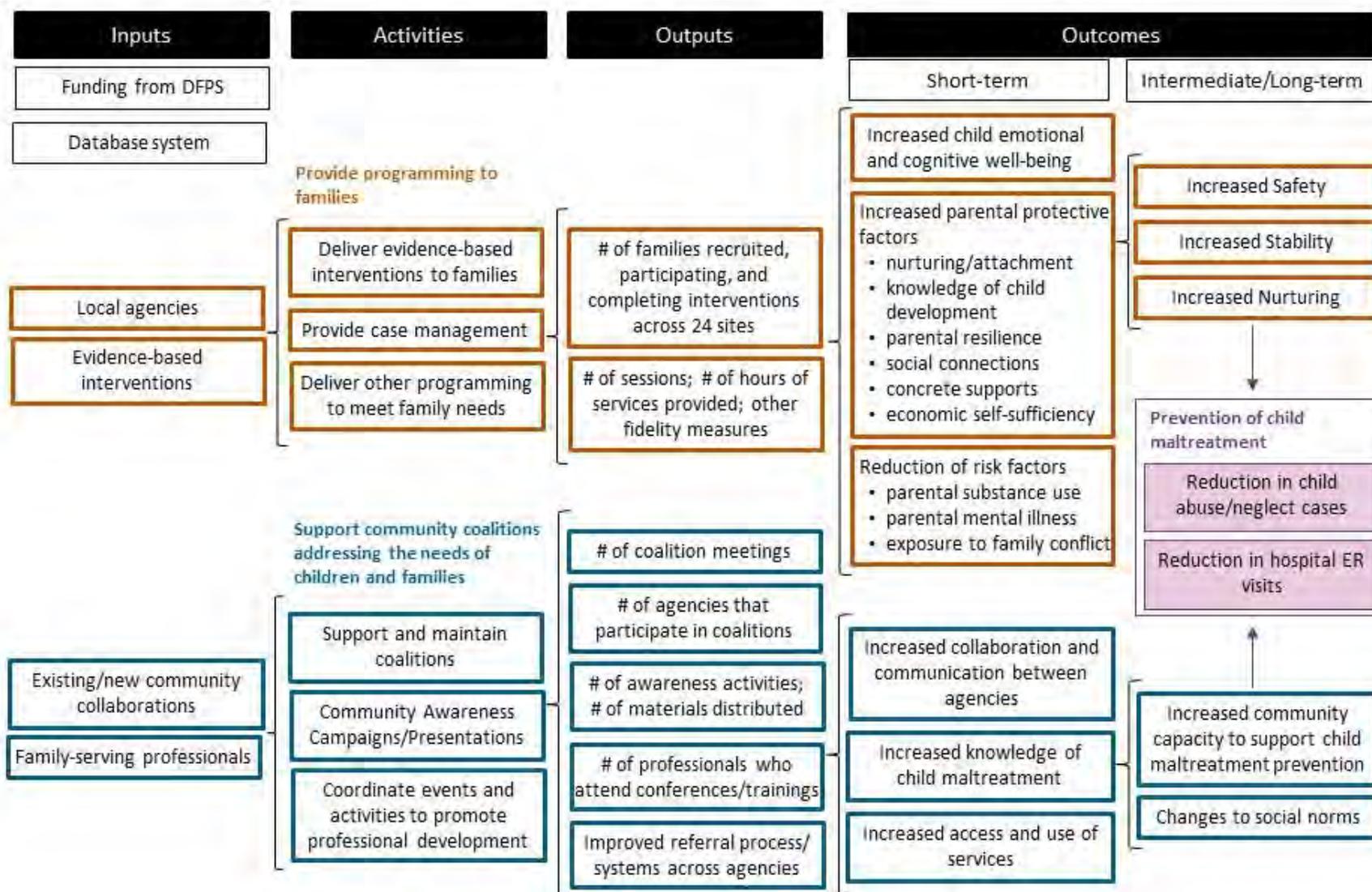
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Informed consent was obtained from all participants. Interview and focus groups participants provided written informed consent and were offered a copy of the consent form for their records. For the online survey, informed consent was obtained from the participant before they begin the survey and no documentation of informed consent was acquired to keep the survey anonymous.

Every effort was made to maintain the privacy and confidentiality of the participants. Participants were informed of how their privacy and confidentiality will be protected. The identities of interview and focus group participants are known to the UT research team. However, the only record of names is signatures on consent forms which are stored in a locked filing cabinet in a secure office. Audio files were transcribed. Audio files are labeled by date and sequence rather than more specific identifying information.

Survey participants were asked about their professional background and county. No other potentially identifiable information was recorded. Data from the online survey are anonymous. All survey and focus group results are reported in aggregate form to maintain confidentiality. All digital data will be stored on password and virus protected computers on a secure network for no longer than three years. Access to the network is granted by the principal investigator to study personnel. Only study personnel have access to identified data stored on the secure network.

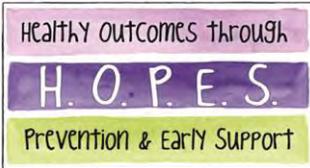
# APPENDIX B: HOPES LOGIC MODEL



# APPENDIX C: PROFILES OF HOPES PROGRAMS AND COMMUNITIES

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The following pages provide an overview of key components of the HOPES I sites.



# Cameron County

## Baptist Child & Family Services

### SERVICES

*Evidence based services:* SafeCare

*Support services:* basic needs assistance, case counseling, therapy, transportation, support groups

### BUILDING PROTECTIVE FACTORS

Carmen\*, a 45-year-old mother has a 4-year-old daughter with Down Syndrome. She began receiving in-home parenting education with the evidence-based curriculum SafeCare. Within the first month, a BCFS Parent Educator determined that the daughter could benefit from physical and speech therapy, and located a therapist in the community to provide the services. When the therapist identified some tools that would help the daughter improve her mobility, BCFS purchased the supplies and helped the daughter get the most out of her therapy sessions. When Carmen expressed an interest in counseling for her and her husband to learn more about what to expect related to the daughter's development, BCFS connected the family to a therapist specializing in working with children with developmental delays. BCFS Project HOPES has helped the family through direct counseling or referrals to other community resources that could meet the family's needs.

“So we wanted to make sure we were working with teen dads and **empowering them to really do what they want do in their hearts, which is be a good dad.** Our society kind of tends to let them off the hook and that isn't – that really isn't what they want to do.”

-HOPES Program staff

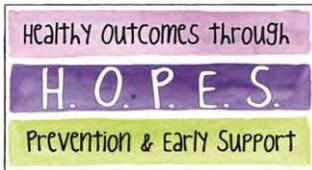


### COALITION MEMBERS

- APS
- Boys and Girls Club
- Brownsville Community Health Clinic
- Buckner Children and Family Services
- Cameron County Children's Advocacy
- Cameron County CPS
- Cameron County HHS
- Cameron County Juvenile Justice
- Cameron County Juvenile Probation
- Cameron County Mental Health Task Community Action Corporation of South Texas
- Easter Seals
- Educational Research Institute
- Friendship of Women
- Harlingen Consolidated ISD
- Harlingen Medical Center
- HeadStart
- Health and Human Services Commission
- Neighbors in Need of Services
- RGV Coalition
- Rio Grande Valley Council
- Rio Hondo ISD
- Santa Rose ISD
- Su Clinica Familiar
- Texas A&M Agri Life
- Texas Department of State Health Services
- Texas Southmost College
- Children's Museum of Brownsville
- Tropical Texas Behavioral Health
- University of Texas Brownsville
- Valley Baptist Health System
- Valley Primary Care Network
- Workforce Solutions



\*Names and minor details have been altered to protect confidentiality



# Ector County

## UTPB: First 5 Permain Basin

### SERVICES

*Evidence based services:* PAT, 24/7 Dad

*Support services:* Saturday Morning Club- recreation for families

*Professional development:* Stewards of Children sexual abuse training; Child maltreatment conference

### BUILDING PROTECTIVE FACTORS

After working with over 60 students from varying backgrounds participating in 24/7 Dad, one student, Mark\*, in particular stood out. He had a son, born two months early, who is facing a lifetime of health issues. The father has to travel to Dallas for his son to receive medical care. His son had not yet developed the back of his skull, he may not ever be able to walk on his own, and will certainly never be able to care for himself. When class was over, Mark would often vent his frustrations and fears. The 24/7 Dad instructor worked with Mark on becoming an advocate for his child in the medical setting. 24/7 Dad has given him the confidence and drive to never give up on his son, to find the positive and work on the influence he can have on his son.

“they help me learn to teach my child... which has allowed me to develop a **better relationship with my child**. We’ve grown closer, I’m able to deal with him a lot better than I was when I first started a year ago. I’ve come a long way with my relationship with my son. They work with you, and they work around your schedule, and they come to you whenever you’re available, and I like that.”

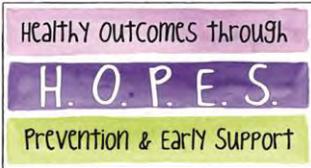


–HOPES Parent

\*Names and minor details have been altered to protect confidentiality

### COALITION MEMBERS (select)

- 211 WTB
- Boys and Girls Club
- Buckner Children and Family Services
- Caring for Children and Parents CASA
- Communication Access Ability Group
- Community Health Coalition
- Crisis Center/Angel House
- DentaQuest
- Department of State Health Services
- Eazy Rider
- EC ISD
- ECI
- Ector County Health Department
- Ector County Prevention Coalition
- Family Promise
- First Care Health
- Harmony Home CAC
- Head Start
- High Sky Children’s Ranch
- Hope Chest
- Junior League
- Juvenile Alt Ed Center
- March of Dimes
- Medical Center
- Midland Community Healthcare
- Odessa Chamber of Commerce
- Odessa college
- Odessa Parks Department
- Presbyterian Children’s Home
- ROPE Youth
- Safe Place
- Shalom Empowerment and Economic SHARE
- The Crisis Center
- The Genesis Center
- United Way
- UTPB College of Education
- UTPB Social Work
- Ventanilla de Salud
- West Texas Opportunities



# El Paso County

## El Paso Center for Children, Inc.

### SERVICES

*Evidence based services:* Incredible years, Parents as Teachers

*Promising practice:* AVANCE-PCEP

*Other services:* wrap-around services, basic needs support, case management

### BUILDING PROTECTIVE FACTORS

Carla\*, a young single mother of two, was diagnosed with cancer but still attended the Incredible Years classes every Thursday with no exception. In class she stated "it is very hard to start the day when you're feeling weak and sick; but I don't know how my mind always reminds me that I have to go to my Incredible Years classes, where since the first class has made me realize the importance of raising my two boys and create a very special relationship with them based on love, security, great adventures and positive discipline." She also participates in class with great enthusiasm and has found great support from other parents.

"My mom didn't raise me right. She didn't raise me period. And my dad's not around. I never met my dad. So **I've been learning a lot especially through the Parents as Teacher's program**"

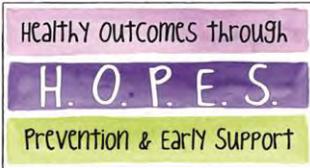
-HOPES Parent

### COALITION MEMBERS

- Aliviane
- AVANCE
- Child Crisis Center of El Paso
- Child Guidance Center
- City of El Paso Library
- Early Childhood Intervention
- El Paso Center for Children
- El Paso County Mental Health Support Services
- El Paso ISD
- Fort Bliss
- Lutheran Social Services
- NAMI El Paso
- Paso del Norte Child Development Center
- PAT Group Connections
- Project LAUNCH
- Region 10 CPS
- Region 19 ESC
- Texas DSHS
- Texas HHS
- Texas HHSC
- Texas Star Program
- United Way
- UTEP Social Work Department
- UTEP Speech-Language Pathology
- Ysleta del Sur Pueblo



\*Names and minor details have been altered to protect confidentiality



# Gregg County

## Buckner Children & Family Services

### SERVICES

*Evidence based services:* Parents as Teachers, 24/7 dad

*Support services:* case management, child care, transportation

### BUILDING PROTECTIVE FACTORS

Jennifer\*, a 16 year old client with a 3 month old baby, had dropped out of high school. During the first home visit, she explained she lived with 8 other people in a two bedroom trailer. Jennifer expressed a wish to be married, with more children and have a steady job and a loving home of her own. She has been actively working to achieve this goal. She has moved into her own apartment with her child and started a job that she was able to maintain longer than any other she had in the past. She has grown into an amazing mother and a responsible young adult. Over this period there have definitely been setbacks, many hard life lessons learned and mistakes made, but she has triumphed over each and every one. Jennifer recently graduated from the Kilgore College GED program.

“We’re trying to connect them to resources they may not know to better their family lifestyle. I feel **it’s a wonderful program for those families. I’ve seen such great success stories.** The only thing is still trying to get the word out there. We do hold new recruitment events. I’ve never heard of this. I’m like that’s why we’re here. So we’re just hoping to kind of spread that word of mouth to get more families. I think it’s a need out here. “

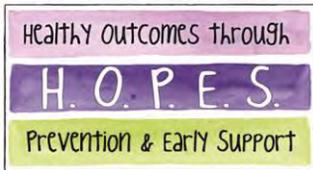
*-HOPES Program Staff*



### COALITION MEMBERS

City of Longview  
Community Healthcore  
Dream Center NPO  
East Texas Council on Drug and Alcohol Abuse  
ECI  
Epic Health Services  
Expectant Hearts Pregnancy Resource Center  
Family Bridge Coalition  
Family Summer Camp Buckner  
Good Shepherd Medical Center  
Head Start  
HWY 80 Women’s Center  
Innovative Health Solutions  
Kilgore ISD  
LeTourneau University  
Longview ISD  
Longview Public Library  
Longview Teen and Child Librarian  
MCNA Dental  
Nurse Family Partnership  
Partners in Prevention, City of Longview  
Pine Tree ISD  
Project Reach  
Sabine ISD  
School Supply Train  
Smith County Champions for Children  
The Rowe Boat Child Development Center  
United Way  
UT Tyler Nursing Department  
White Oak ISD  
WIC  
Women’s Center of East Texas





# Hidalgo County

## Easter Seals Rio Grande Valley

### SERVICES

*Evidence based services:* Parents as Teachers  
*Support services:* case management, child care, parent education, counseling, developmental and hearing screening

### BUILDING PROTECTIVE FACTORS

Juan and Elena\*, both 14 years old, found out rather unexpectedly they were going to be parents. Their baby was born prematurely, with a low birth weight and was diagnosed with Spina Bifida and Hydrocephalus that required surgery. At the time, Elena’s only support was Juan. She lived with him and his family. Her mother was incarcerated and her father was out of the country. The family was referred to Project HOPES in October 2014 by Early Childhood Intervention services. The family was provided daycare so the parents could focus on school. Through the developmental parenting curriculum, parenting seminars and extensive case management, they are overcoming the social stigma teen parents face and have demonstrated proactive parenting techniques and express an eagerness to learn more. Both parents are committed in continuing their education - dad aspires to attend college for a criminal justice degree and mom for a health science degree.

**“I sing the praises (of DFPS) giving, allowing us the opportunity to create a program for our community that we live in and know and we feel like we have the right combination. We’ve had some bumps on implementation but we’ve had also the support to see it through and have gotten nothing but support on that program implementation.”**

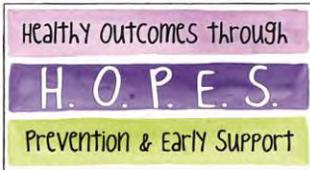
*-HOPES Program staff*

### COALITION MEMBERS

- Abundant Grace Community Church
- Aging and Disability Resources Center
- AVANCE
- BCFS HHS
- Big Brother Big Sister
- Boys and Girls Club
- Buckner Family Hope Center
- CASA Hidalgo
- Child Fund International
- City of Mission
- City of Weslaco
- CPS
- Easter Seals
- EDI
- Family Hope Center
- Hidalgo County Health Department
- Hidalgo County Probation
- Hidalgo HHS
- Home Health Nursing Care
- La Joya ISD
- Lutheran Social Services
- McAllen ISD
- McAllen Public Library
- Mujeres Unidas
- Nurse Family Partnership
- Palmer Drug Abuse Program
- PSJA ISD
- Salvation Army
- Southwest Keys
- Su Clinica Familiar
- Speer Public Library
- Tey Family Clinic
- Tropical Texas Behavioral Health
- Weslaco ISD
- WIC



\*Names and minor details have been altered to protect confidentiality



# Potter County

## Family Support Services of Amarillo

### SERVICES

*Evidence based services:* Parents as Teachers, 24/7 Dad

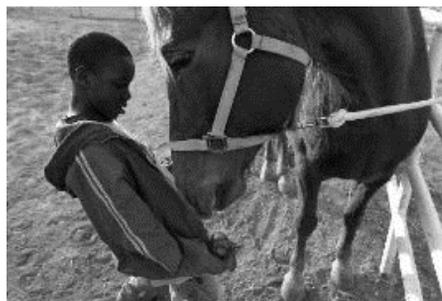
*Support services:* Fatherhood services, Equine therapy, Screenings (hearing, vision, developmental), Information and referral, Case management, Transportation, Child care

### BUILDING PROTECTIVE FACTORS

Jacob and Mary\* have custody of two nieces and a nephew along with their two biological children. They were referred to HOPES due to their non-traditional family structure and high general stress level. Mary stayed at home and struggled with depression, isolation and financial difficulties. ASQ assessments revealed one child had limited verbal skills and extreme shyness and another had discipline/attention issues. Since enrolling in the HOPES program, the children are improving and Mary started working a part-time job to help with her isolation and depression. Mary participated in our First Annual HOPES Luncheon and she was our representative for the program to come share her story to community representatives.

“I’m thankful for this program and that we’re able to come in here and go into those homes, connect them to resources, make an impact in their life. I think as a parent educator, you can make that change if you really, really put your work into it and you really care about your families. It will change their lives.”

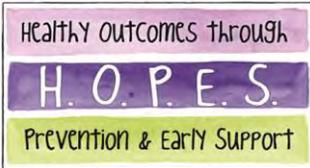
*-HOPES Program Staff*



### COALITION MEMBERS

Allstate Foundation  
Amarillo Area Foundation  
Amarillo College  
Amarillo CPS  
Amarillo ISD  
Amarillo Pediatric Center  
Amarillo Police Department  
Amarillo Probation Department  
Boys and Girls Club  
BSA  
Cal Farleys Boys Ranch  
CareNet Crisis Pregnancy Center  
City of Amarillo Public Health Management  
Coalition of Health Services  
DSHS  
Early Head Start  
ESC Region 16  
FSS Counseling Division  
Hillside Christian Church  
Laura W. Bush Women’s Health Science Center  
Managed Care Centers  
Maximus Health  
Mesquite Ranch  
Norse Family Partnership  
Northwest Texas Hospital  
Potter County Probation  
Refugee Services of Texas  
Texas Panhandlers Association  
Texas Tech Health Sciences  
Texas Tech School of Medicine  
The Haven Health Clinic  
The Pavilion NPTH  
United Way

\*Names and minor details have been altered to protect confidentiality



# Travis County

## Austin Children's Shelter

### SERVICES

*Evidence based services:* Triple P, PAT, 24/7 Dad

*Support services:* crisis support, basic needs assistance, case management, counseling, therapy, transportation, childcare, fatherhood support and support groups

### BUILDING PROTECTIVE FACTORS

Julia\* entered the HOPES program at 16 years old. She was pregnant and unsure how she would be able to stay in school.

Once the baby was born, she moved in with the father in a small town outside of Austin because one of her siblings was abusing drugs in her home. Once in the small town, she became isolated due to limited transportation and resources.

She was not able to work or to continue school. The father became verbally abusive to her. The Parent Educator assisted the mother in finding housing in Austin, after which Julia was able to find a job and finish high school. The Parent Educator also helped her to find child care and to obtain counseling to help her to learn about healthy relationships.

“[HOPES] is effective...It's hard but... it has worked. One thing that is great is that **these families haven't had an open CPS case.**”

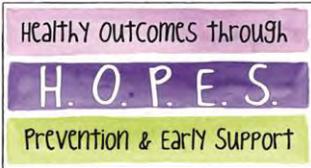
-HOPES Program Staff

### COALITION MEMBERS

Any Baby Can  
Austin Children's Services  
Austin Children's Shelter  
Austin ISD  
Austin Perinatal Coalition  
Austin Recovery  
AVANCE  
Bookspring  
Campfire  
Capital Area Foodbank  
Central Texas Perinatal Coalition  
Child Inc  
City of Austin WIC Clinics  
Communities in Schools  
Community Advancement Network  
CommunitySync  
Dell Children's Medical Center of Central Texas  
Easter Seals  
El Buen Samaritano  
Family Support Network (FSN)  
Foundation Communities  
Goodwill  
Integral Care  
KLRU  
LifeWorks  
Literacy Coalition of Texas  
Mainspring Schools  
Manor ISD  
Safe Place  
Trauma Informed Care  
Collaboration  
United Way/Success By 6's School  
Readiness Action Plan (SRAP)  
Workforce Solutions Capital Area



\*Names and minor details have been altered to protect confidentiality



# Webb County

## SCAN

### SERVICES

*Evidence based services:* SafeCare

*Support services:* crisis intervention, prevention counseling and case management

### BUILDING PROTECTIVE FACTORS

Carmen\* reported that she suffered from anxiety and depression and had high stress levels about properly caring for her children. She is a single mother with 3 children under the age of 5. Being enrolled in Project HOPES helped her not only cope with the anxiety of how to care for her children but allowed her to use the resources given to make proper health decisions. The safety module helped reduce her feelings of stress related to her children getting hurt. The PCI module helped her form a deeper bond with her children. She felt more comfortable playing with them and learned how to manage difficult behaviors. At the end of the program she was confident in her abilities as a mother; she became a volunteer in the parent school activities, started English classes, and obtained employment through case management provided.

### COALITION MEMBERS

United ISD  
Laredo ISD  
HHS Commission  
Gateway Community Health Center  
Laredo Health Department  
Laredo Housing Authority  
111<sup>th</sup> District Court  
CPS  
Laredo Medical Center  
DISMAS  
Bethany House  
Head Start  
ECI  
BCFS  
Nurse Family Partnership  
Texas A&M Colonias Program  
CASA  
Wiggles Children's Rehab  
Children's Advocacy Center  
Casa de Misericordia Domestic Violence Shelter



“We usually struggle with new programs. We usually struggle with kind of getting it off the ground and we didn't with this one...I think that what stood out for me is that **the program obviously...it connected with the community.**”

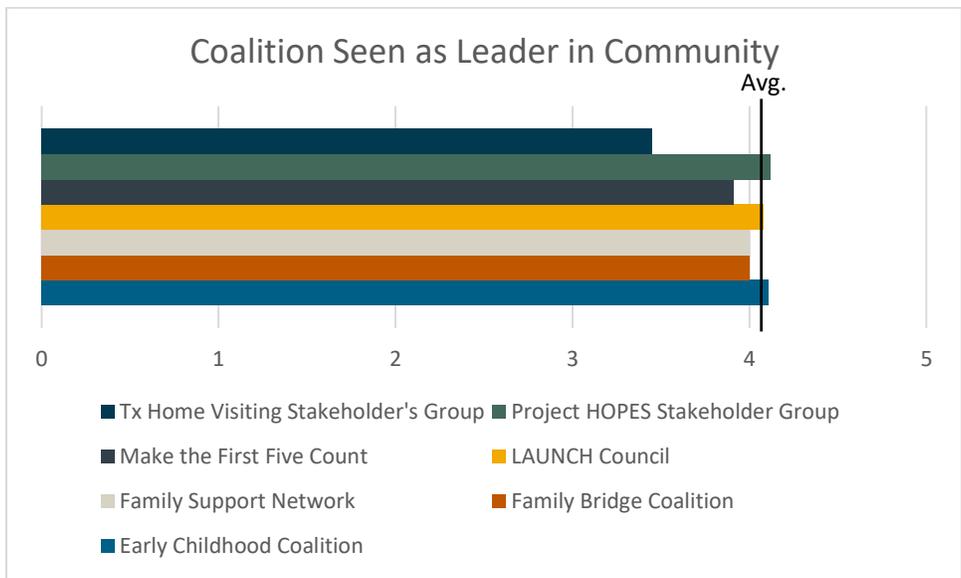
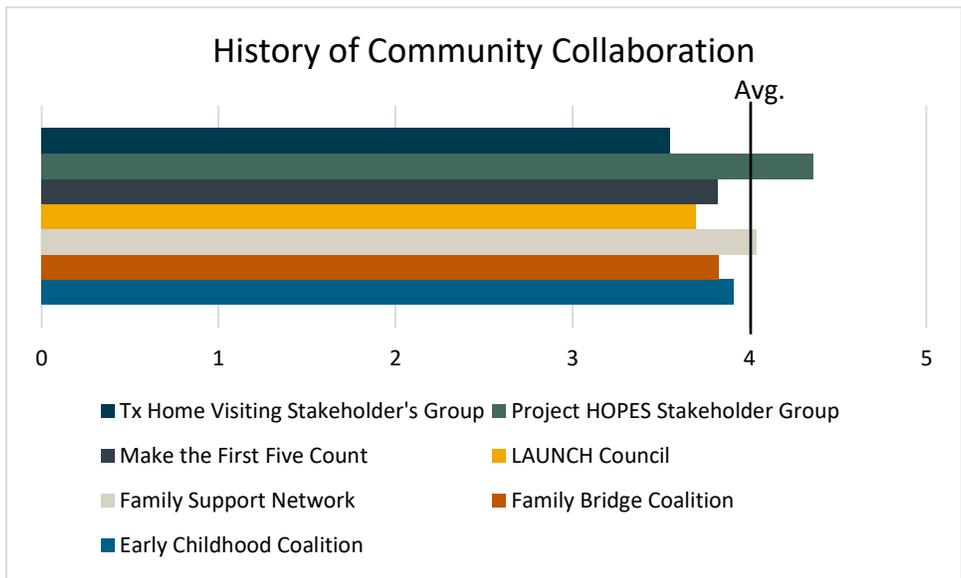
-HOPES Program Staff

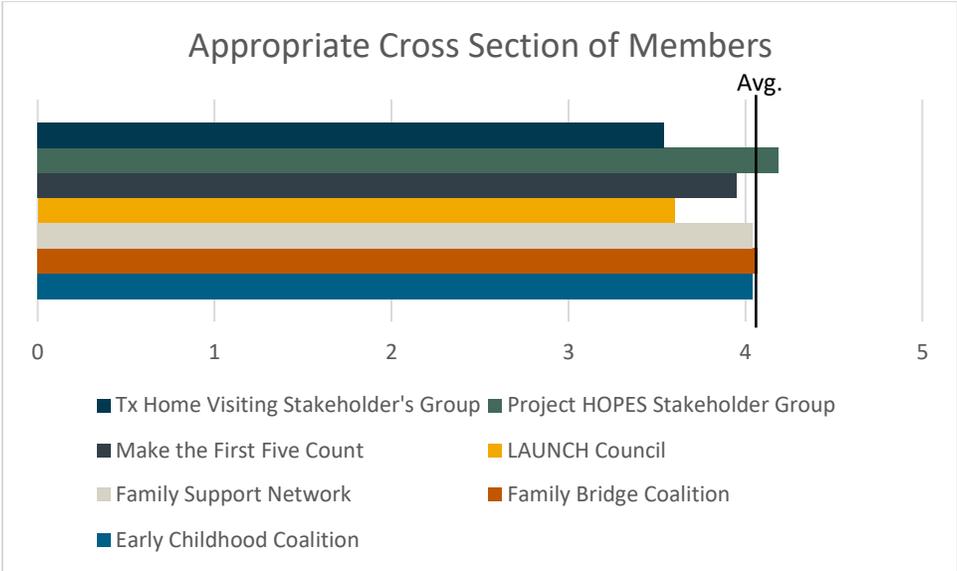
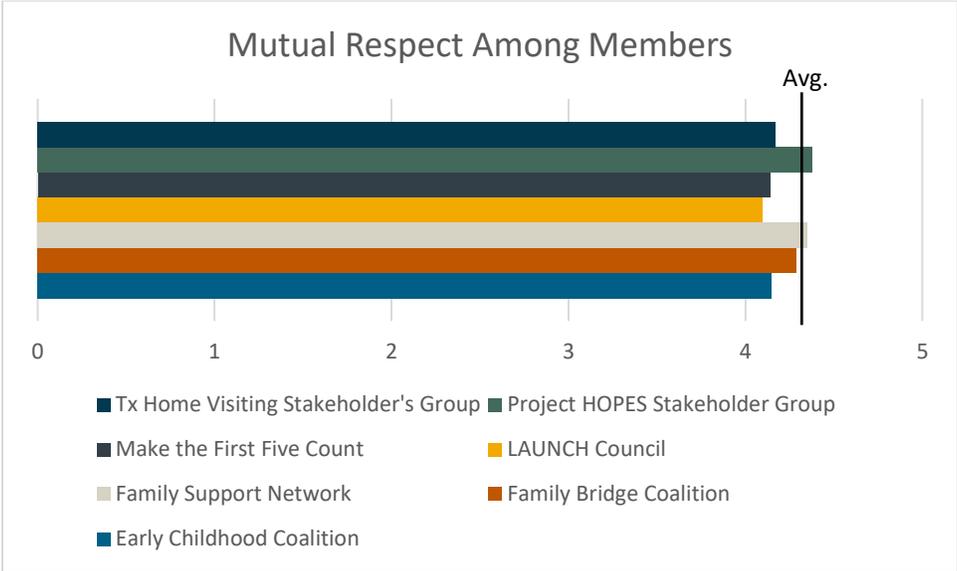
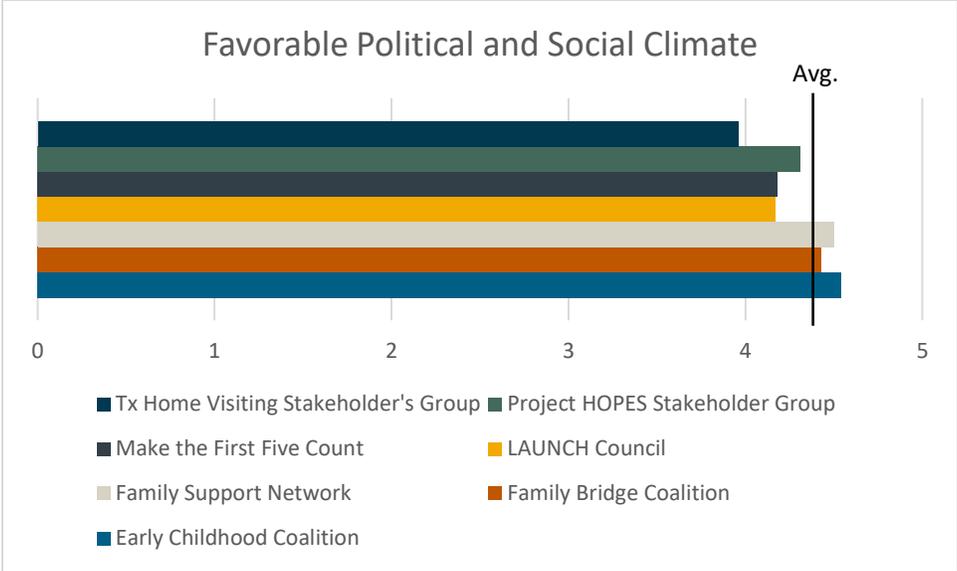


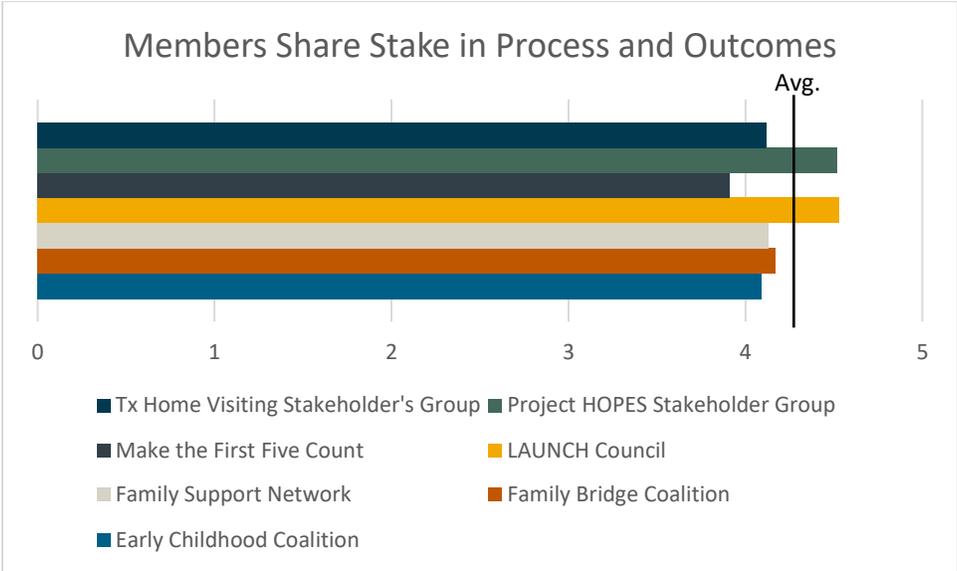
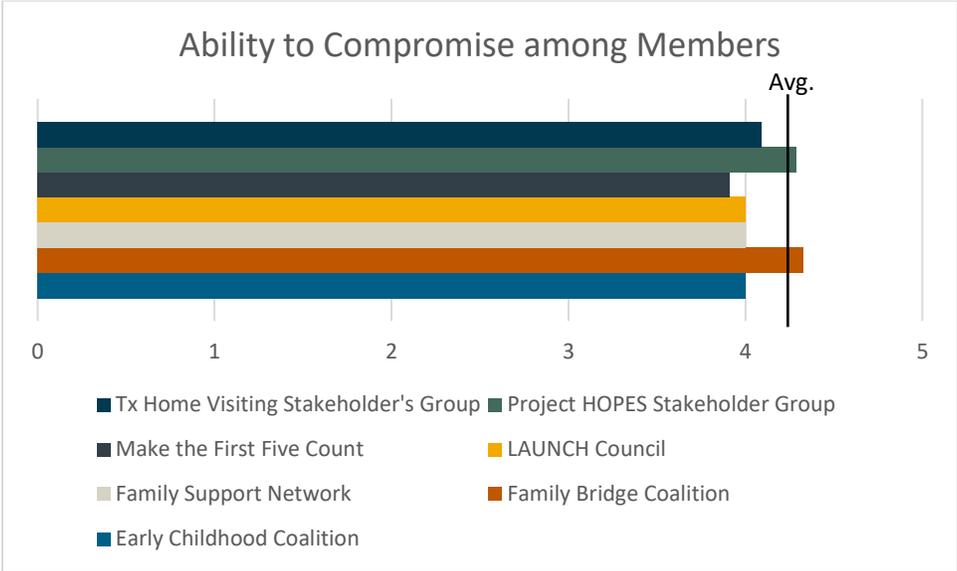
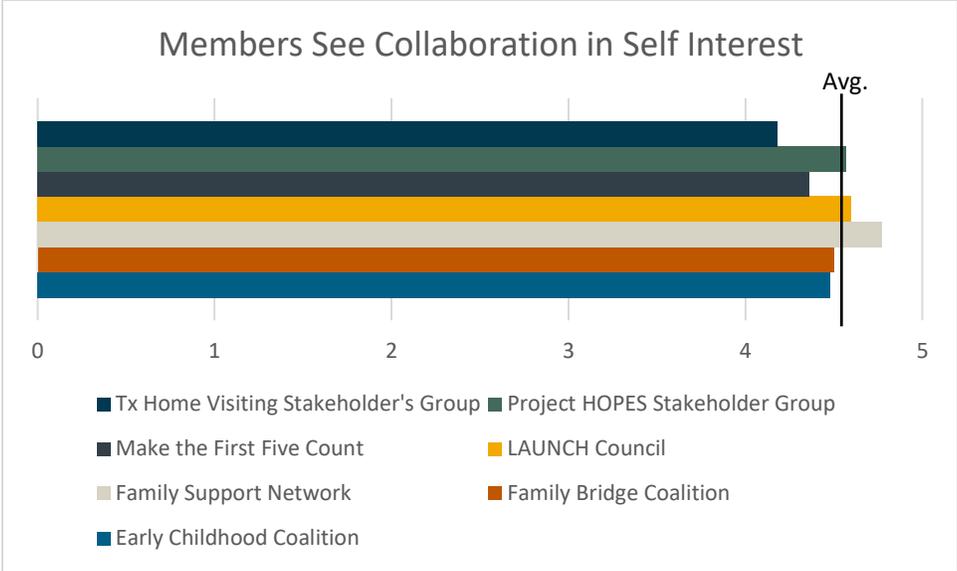
\*Names and minor details have been altered to protect confidentiality

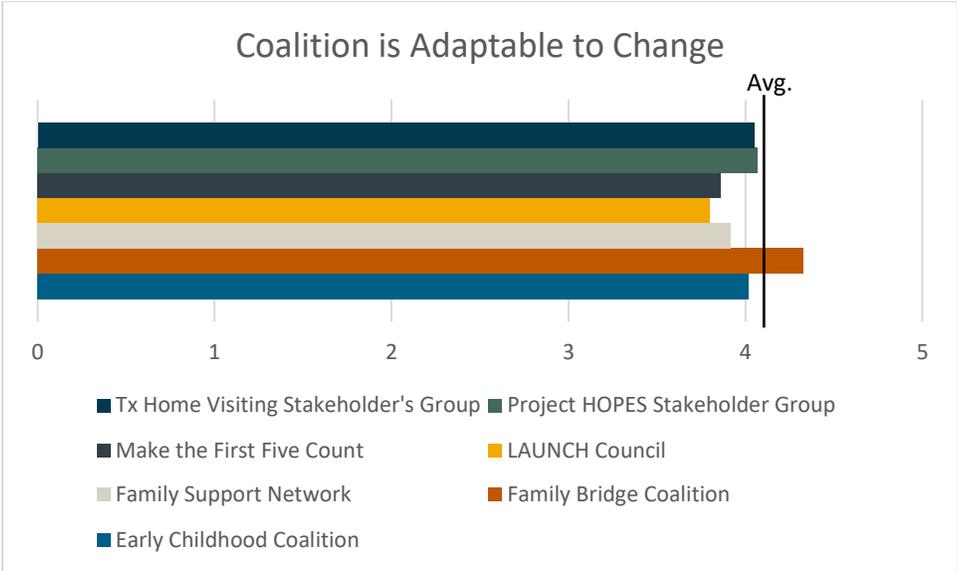
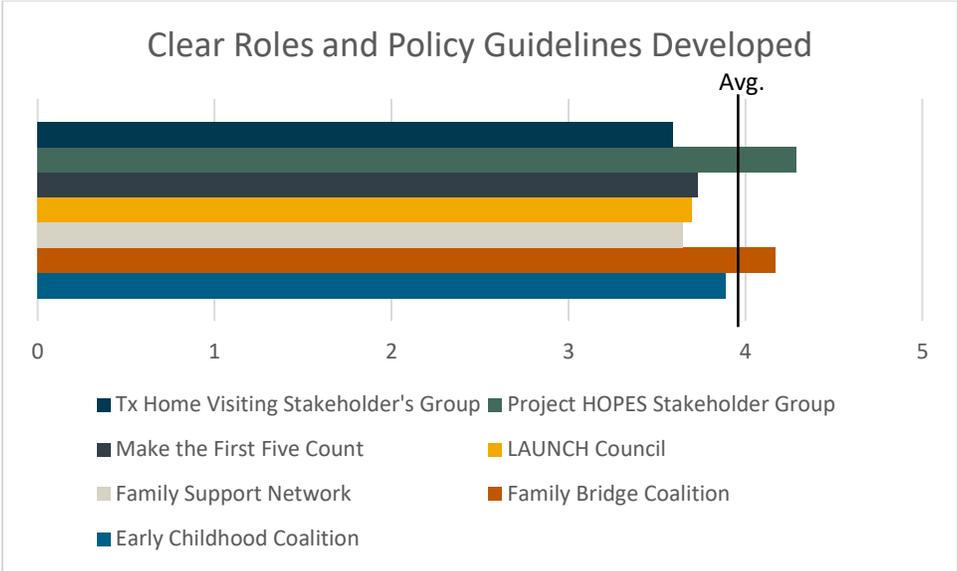
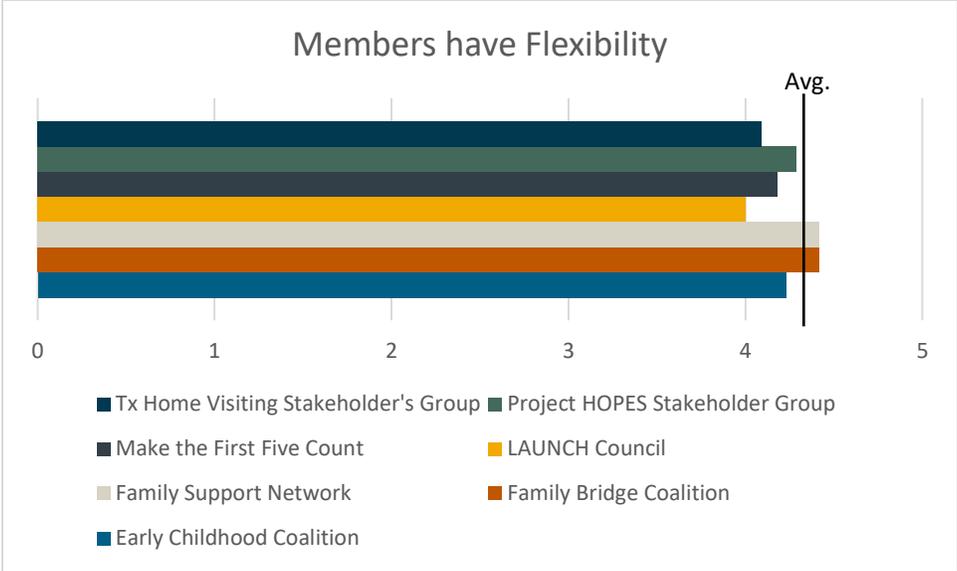
# APPENDIX D: WILDER INDEX SCORES BY COALITION

The charts below show the variations in Wilder Collaboration Index Scores for the 19 factors, as they varied by coalition. As can be seen, there is some variation in coalition strengths and weaknesses across sites, but overall, survey respondents scored all the coalitions highly. Few factors scored below 4, and none below 3. Factor scores of 4.0 or higher show strength in the coalition, scores between 3.0 and 3.9 are borderline and may require attention, while scores of 2.9 or lower indicate concern that should be addressed.

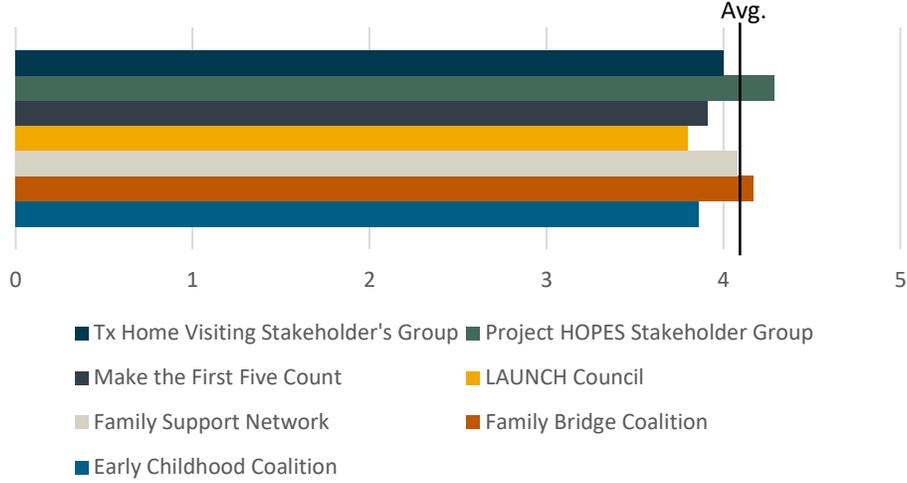




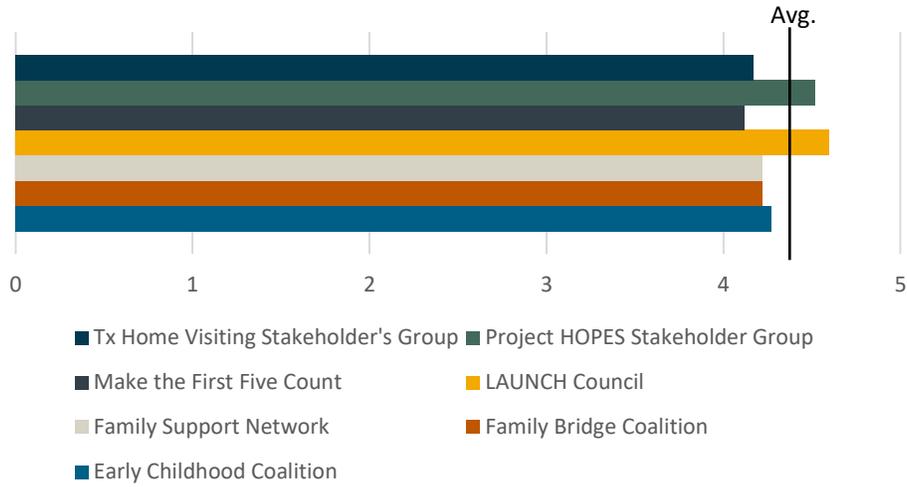




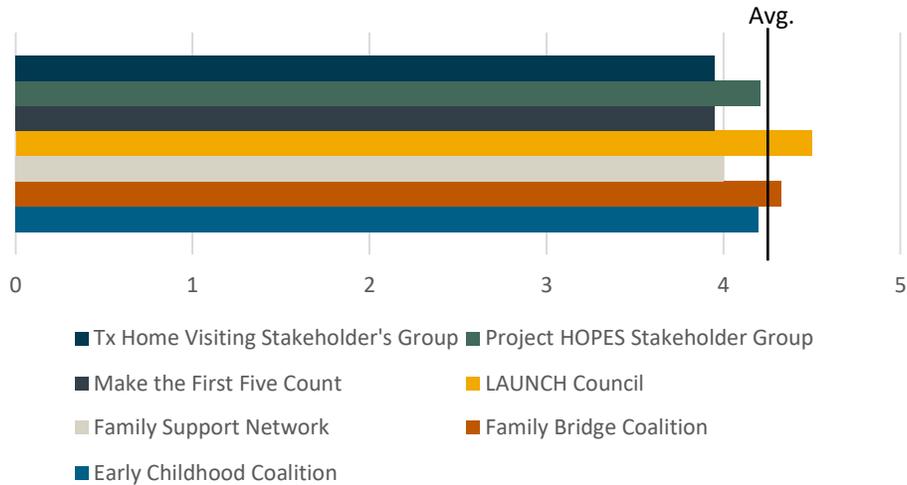
### Appropriate Pace of Development



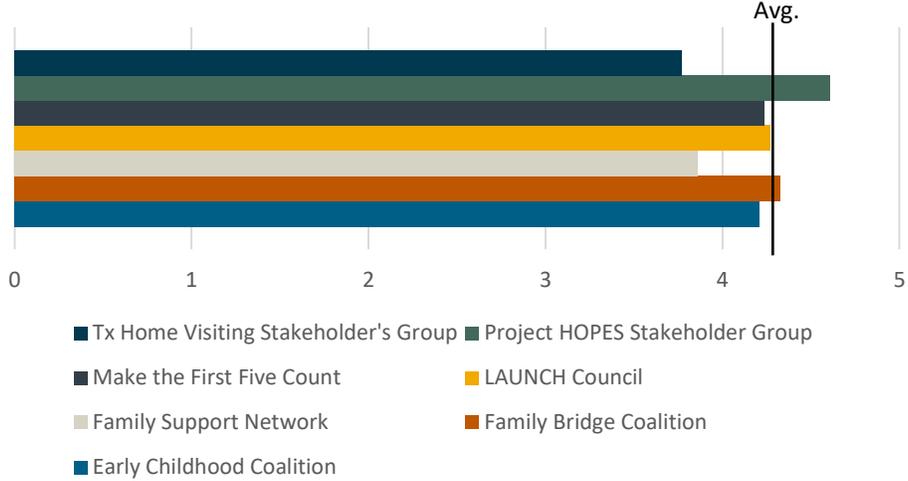
### Open/Frequent Communication among Members



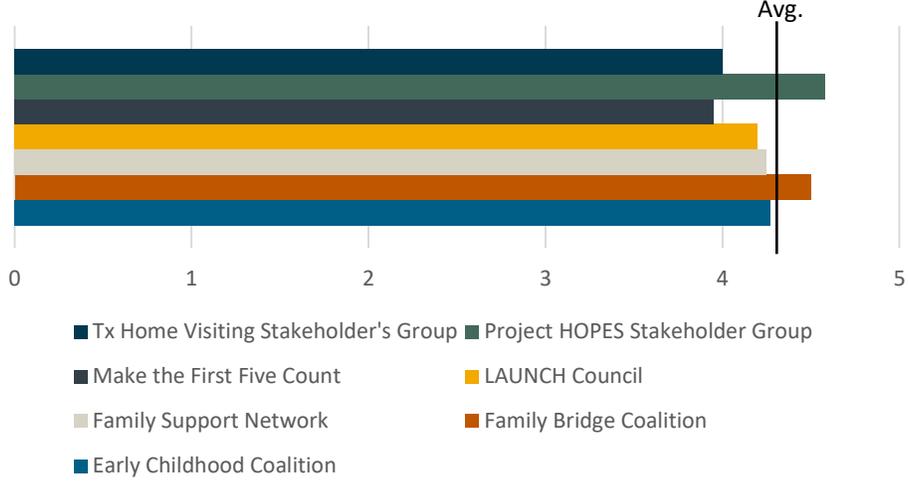
### Informal Relationships and Community Links



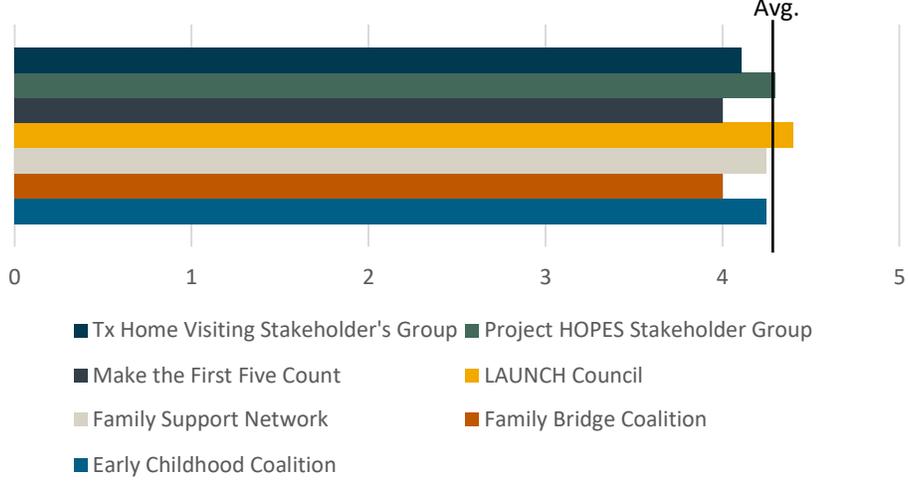
### Attainable Goals and Objectives Set

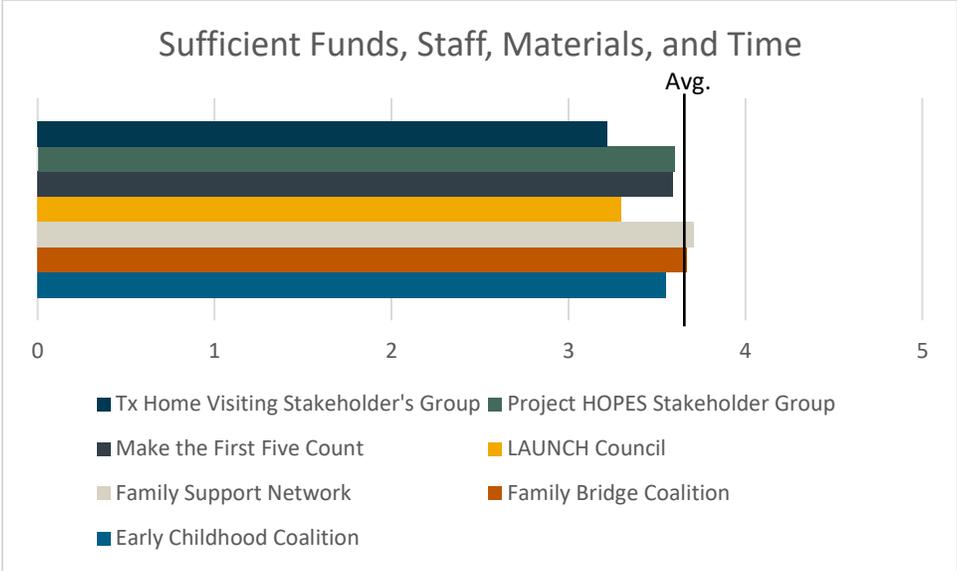


### Shared Vision among Members



### Collaboration Serves a Unique Purpose





# APPENDIX E: PROTECTIVE FACTORS SURVEY

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The 20 questions of the Protective Factors Survey (PFS) are provided on the following two pages. This tool, along with accompanying documentation is available at the FRIENDS National Resource Center website: <http://friendsnrc.org/protective-factors-survey>.

# PROTECTIVE FACTORS SURVEY

(Program Information-- For Staff Use Only)

Agency ID \_\_\_\_\_ Participant ID # \_\_\_\_\_

1. Date survey completed: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Pretest  Post test

2. How was the survey completed?

- Completed in face to face interview
- Completed by participant with program staff available to explain items as needed
- Completed by participant without program staff present

3. Has the participant had any involvement with Child Protective Services?

- NO
- YES
- NOT SURE

4.a. Date participant began program (complete for pretest) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

4.b. Date participant completed program (complete at post test) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

5. **Type of Services:** Select services that most accurately describe what the participant is receiving.

- Parent Education
- Parent Support Group
- Parent/Child Interaction
- Advocacy (self, community)
- Fatherhood Program
- Planned and/or Crisis Respite
- Homeless/Transitional Housing
- Resource and Referral
- Family Resource Center
- Skill Building/Ed for Children
- Adult Education (i.e. GED/Ed)
- Job Skills/Employment Prep
- Pre-Natal Class
- Family Literacy
- Marriage Strengthening/Prep
- Home Visiting
- Other (If you are using a specific curriculum, please name it here) \_\_\_\_\_

6.) **Participant's Attendance:** (Estimate if necessary)

A) **Answer at Pretest:** Number of hours of service offered to the consumer: \_\_\_\_\_

B) **Answer at Post-test:** Number of hours of service received by the consumer: \_\_\_\_\_



# PROTECTIVE FACTORS SURVEY

Agency ID \_\_\_\_\_

Participant ID # \_\_\_\_\_

1. Date Survey Completed: / /      2. Sex:  Male  Female      3. Age (in years): \_\_\_\_\_

**4. Race/Ethnicity: (Please choose the ONE that best describes what you consider yourself to be)**

- |  |   |
|--|---|
| <input type="checkbox"/> A Native American or Alaskan Native | <input type="checkbox"/> B Asian                                  |
| <input type="checkbox"/> C African American                  | <input type="checkbox"/> D African Nationals/Caribbean Islanders  |
| <input type="checkbox"/> E Hispanic or Latino                | <input type="checkbox"/> F Middle Eastern                         |
| <input type="checkbox"/> G Native Hawaiian/Pacific Islanders | <input type="checkbox"/> H White (Non Hispanic/European American) |
| <input type="checkbox"/> I. Multi-racial                     | <input type="checkbox"/> J Other _____                            |

**5. Marital Status:**

- A Married       B Partnered       C Single       D Divorced       E Widowed       F Separated

**6. Family Housing:**

- A Own       B Rent       C Shared housing with relatives/friends  
 D Temporary (shelter, temporary with friends/relatives)       E Homeless

**7. Family Income:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> A \$0-\$10,000      | <input type="checkbox"/> B \$10,001-\$20,000 | <input type="checkbox"/> C \$20,001-\$30,000 |
| <input type="checkbox"/> D \$30,001-\$40,000 | <input type="checkbox"/> E \$40,001-\$50,000 | <input type="checkbox"/> F more than 50,001  |

**8. Highest Level of Education:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> A Elementary or junior high school   | <input type="checkbox"/> B Some high school | <input type="checkbox"/> C High school diploma or GED          |
| <input type="checkbox"/> D Trade/Vocational Training          | <input type="checkbox"/> E Some college     | <input type="checkbox"/> F 2-year college degree (Associate's) |
| <input type="checkbox"/> G 4-year college degree (Bachelor's) | <input type="checkbox"/> H Master's degree  | <input type="checkbox"/> I PhD or other advanced degree        |

**9. Which, if any, of the following do you currently receive? (Check all that apply)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> A Food Stamps | <input type="checkbox"/> B Medicaid (State Health Insurance)    | <input type="checkbox"/> C Earned Income Tax Credit |
| <input type="checkbox"/> D TANF        | <input type="checkbox"/> E Head Start/Early Head Start Services | <input type="checkbox"/> F None of the above        |

**10. Please tell us about the children living in your household.**

	Gender		Birth Date (mm/dd/yy)	Your Relationship To Child (check one)						
	Male	Female		A Birth parent	B Adoptive parent	C Grand-parent	D-Sibling	E-Other relative	F-Foster Parent	Other
Child 1										
Child 2										
Child 3										
Child 4										

*If more than 4 children, please use space provided on the back of this sheet.*



# PROTECTIVE FACTORS SURVEY

**Part I.** Please **circle** the number that describes how often the statements are true for you or your family. The numbers represent a scale from 1 to 7 where each of the numbers represents a different amount of time. The number 4 means that the statement is true about half the time.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
1. In my family, we talk about problems.	1	2	3	4	5	6	7
2. When we argue, my family listens to "both sides of the story."	1	2	3	4	5	6	7
3. In my family, we take time to listen to each other.	1	2	3	4	5	6	7
4. My family pulls together when things are stressful.	1	2	3	4	5	6	7
5. My family is able to solve our problems.	1	2	3	4	5	6	7

**Part II.** Please **circle** the number that best describes how much you agree or disagree with the statement.

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
6. I have others who will listen when I need to talk about my problems.	1	2	3	4	5	6	7
7. When I am lonely, there are several people I can talk to.	1	2	3	4	5	6	7
8. I would have no idea where to turn if my family needed food or housing.	1	2	3	4	5	6	7
9. I wouldn't know where to go for help if I had trouble making ends meet.	1	2	3	4	5	6	7
10. If there is a crisis, I have others I can talk to.	1	2	3	4	5	6	7
11. If I needed help finding a job, I wouldn't know where to go for help.	1	2	3	4	5	6	7



# PROTECTIVE FACTORS SURVEY

**Part III.** This part of the survey asks about parenting and your relationship with your child. For this section, please focus on the child that you hope will benefit most from your participation in our services. Please write the child's age or date of birth and then answer questions with this child in mind.

Child's Age \_\_\_\_\_ or DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
12. There are many times when I don't know what to do as a parent.	1	2	3	4	5	6	7
13. I know how to help my child learn.	1	2	3	4	5	6	7
14. My child misbehaves just to upset me.	1	2	3	4	5	6	7

**Part IV.** Please tell us how often each of the following happens in your family.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
15. I praise my child when he/she behaves well.	1	2	3	4	5	6	7
16. When I discipline my child, I lose control.	1	2	3	4	5	6	7
17. I am happy being with my child.	1	2	3	4	5	6	7
18. My child and I are very close to each other.	1	2	3	4	5	6	7
19. I am able to soothe my child when he/she is upset.	1	2	3	4	5	6	7
20. I spend time with my child doing what he/she likes to do.	1	2	3	4	5	6	7

