HEALTHY OUTCOMES THROUGH PREVENTION & EARLY SUPPORT

Final Evaluation Report

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The University of Texas at Austin
Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work
HEALTHY OUTCOMES THROUGH PREVENTION & EARLY SUPPORT

FINAL EVALUATION REPORT

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SPONSOR/FUNDER

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ACKNOWLEDGEMENTS

The evaluation team would like to thank HOPES program administrators, parent educators and caregivers who took time to share their personal experiences with us.

RECOMMENDED CITATION

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EXECUTIVE SUMMARY

Project 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). This report covers 22 HOPES programs sites from September 1, 2014, to August 31, 2018, covering four fiscal years (FY2015 to FY2018).

HOPES is implemented by a two-pronged approach of:

1. Providing evidence-based parenting programming to families at no cost. Families are eligible to participate if they have at least one child who is five years old or younger and have at least two risk factors that impact family functioning, mental health, and parenting.

2. Supporting child welfare and/or early childhood welfare community coalitions to increase community knowledge and capacity for child maltreatment prevention programming.

In addition to evidence-based programming, HOPES participants gain access to a variety of services through the participating HOPES agencies. Some examples of the types of services offered include basic needs assistance (e.g., accessing food, transportation), case management, therapeutic counseling, or childcare services. This coordination of services allows for families to be supported in a systems-based approach to address multiple factors to prevent child maltreatment.

A mixed-methods approach for data collection was used to gather information for this evaluation that included: online surveys completed by HOPES staff and community members; interviews and focus groups with caregivers and HOPES staff; administrative data from the PEI database; quarterly reports submitted by program sites; survey data collected by the Texas Institute for Child & Family Wellbeing; publicly available county-level demographic data; and administrative data about substantiated cases of child maltreatment.

This mixed-methods evaluation is guided by the Centers for Disease Control’s model of community-based child maltreatment prevention that focuses on three tenets of promoting safety, stability, and nurturing within a child’s environment (individual level, family level, and community level).

REPORT HIGHLIGHTS AND TAKE-AWAYS

The vast majority of families who participated in HOPES programming did not have a substantiated case of child maltreatment during their time in HOPES, which remained consistent up to 3 years after exiting programming.

- 99.2% of families who participated in HOPES programming did not have a new substantiated case of child maltreatment while participating in HOPES.
  - 98% of families who participated in HOPES programming did not have a new substantiated case of child maltreatment after 1 year of exiting HOPES.
  - 96.4% of families who participated in HOPES programming did not have a new substantiated case of child maltreatment after 2 years of exiting HOPES.
  - 93.6% of families who participated in HOPES programming did not have a new substantiated case of child maltreatment after 3 years of exiting HOPES.

- From 2010 to 2018, substantiated cases of child maltreatment among children ages 5 and younger decreased by a small but statistically significant number in counties served by HOPES compared to counties who were not served by HOPES. Continued funding and programming for child maltreatment prevention will build on progress made towards strengthening families and communities.

- From FY2015-FY2018, there were a total of 56 different agencies and 21 different coalitions
serving 31 Texas counties and implementing 21 different evidence-based programs in HOPES.

- 28,489 individuals participated in evidence-based programs. These individuals include primary caregivers, target children, secondary caregivers, and other family members.
- A total of 12,477 families participated in evidence-based programs and the average length a family participated in programs was approximately 7 months.
- HOPES programming reached families who were at risk of child maltreatment.
  - 50% of caregivers indicate a concern for mental health
  - 32% of caregivers had 4 or more adverse childhood experiences, a measure of a person’s history of childhood trauma.
- HOPES programming strengthened families and mitigated risk factors.
  - On average, families have improved protective factors related to family functioning, social support, parenting knowledge on child development, and parent-child interactions.
  - On average, primary caregivers who have exited programming decreased their risk for mental health concerns when comparing their mental health concerns to their responses recorded at the beginning of the program.
- Evidence-based programs were well-liked by HOPES staff, however, the strong relationships between parent educators and caregivers were the most important factor for families to stay in the program.
- Offering HOPES programming to families with current CPS involvement was beneficial for families, however, greater assistance is needed for HOPES parent educators and CPS caseworkers to support that collaboration.
- Approximately 1,029,261 individuals were reached through community collaboration outreach activities aimed to increase awareness about child maltreatment prevention and support for families.

RECOMMENDATIONS

Based on this evaluation and data analyzed, the Texas Institute for Child & Family Wellbeing advises the following recommendations for PEI and Project HOPES. Below are highlights of our recommendations, more detail on these recommendations are throughout the report and in the conclusion section.

1. Continue funding for child maltreatment prevention to build on progress implemented by Project HOPES.

- After adjusting for already existing trends in child maltreatment rates, counties that have implemented HOPES programming from 2015 –2018 have seen a decrease in child maltreatment among children ages five and younger by a small but statistically significant percent compared to counties that have not implemented HOPES during the same period.
- Continuing child maltreatment prevention programming in counties already implementing HOPES will positively impact county-level child maltreatment rates across Texas. The longer HOPES is implemented in counties, the greater the likelihood is that counties will see decreases in their child maltreatment rates.

2. Support evidence-informed programming, rather than strict adherence to evidence-based protocols, to encourage staff to tailor services and the delivery of the curriculum in order to
holistically support the diversity of families who participate in HOPES.

- Many evidence-based programs are not evaluated in diverse populations. In this case, “diversity” refers to cultural diversity, range of risk factors, and family structures, and home environments. Families experiencing immediate crises cannot complete the curriculum as intended resulting in visits not being counted although services are being delivered.
- In addition to implementing evidence-based approaches, PEI should encourage agencies to tailor the delivery and content of the curriculum and in order to ensure families are getting their needs met.

3. Encourage agencies to support case management.

- HOPES staff discussed challenges in balancing case management with funding constraints and curriculum requirements.
- The majority of HOPES participants noted that parent educators’ time providing case management services to support basic needs and crisis intervention was instrumental in securing trust their parent educators. This trust was then discussed by participants as the most important factor for families to stay in the program until completion and ultimately their success in the program and positive family impact.

4. Strengthen training and resources for direct service staff on how to discuss substance use, domestic violence, and mental health with families.

- Families served in HOPES show a higher risk of mental health issues and history of trauma higher than the national averages. Staff also indicate that domestic violence is a pervasive issue in communities they serve.
- Both agencies and staff should be equipped with the resources necessary to help families address these risk factors that have been empirically linked to child maltreatment. PEI should increase funding for agencies to encourage them to hire licensed mental health professionals to address mental health and substance use for caregivers and improve trainings for parent educators to know the risk factor signs and navigate systems.

5. Establish consistency in data collection policies, practices, and training and promote collaboration across multiple data systems to better understand the impacts of services and needs among HOPES families.

- PEI should ensure consistency in the types of data collected in multi-year programming and on-going quality assurance on how sites are collecting data.
- PEI and other state agencies should collaborate to share information across systems such as Medicaid databases to better understand the needs and long-term impacts of programming and services for families.

6. PEI should provide additional guidance to HOPES sites who partner with subcontractors to implement HOPES programs and services.

- Staff implementing HOPES in collaboration with other contractors discussed collaboration challenges that often stemmed from competition to meet contracting numbers and allocation of funding that prevented agencies to collaboratively serve families.
- PEI should help establish collaborative communication among agencies contracted in HOPES to ensure roles and responsibilities are transparent to ensure the sustainability of partnerships.
INTRODUCTION

Project 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 to prevent child abuse and neglect in Texas. Throughout this report, Project HOPES will be referred to as HOPES.

The ultimate goal of HOPES is to reduce the incidence of child abuse and neglect in Texas.

HOPES is implemented by a two-pronged approach of:

- Providing evidence-based parenting programming to families at no cost. Families are eligible to participate if they have at least one child who is five years old or younger and have at least two risk factors that impact family functioning, mental health, and parenting.
- Supporting child welfare and/or early childhood education community coalitions to increase community knowledge and building capacity for child maltreatment prevention programming.

In addition to participating in evidence-based programs, HOPES participants also gain access to a variety of services available at participating agencies, such as basic needs assistance, case management, therapeutic counseling, and childcare services, among many other services. This coordination of services allows for families to be supported in a systems-based approach that is designed to address multiple factors in order to prevent child maltreatment.

OVERVIEW OF HOPES

Project HOPES (referred to as HOPES in this report) was rolled out in three phases, known as HOPES I, HOPES II, and HOPES III. Each phase contains several primary counties and secondary counties. Primary counties are counties where the lead agency is located and where most HOPES participants receive services. Secondary counties are counties neighboring the primary county that also provide services to families. Each HOPES contract details which counties agencies will provide HOPES services, depending on their capacity and community needs. This report references HOPES sites based on the primary county. The list of primary and secondary counties served by HOPES is located in Appendix C: HOPES Site Information.
HOPES FINAL EVALUATION REPORT

Figure 1. Three Phases of HOPES Implementation


HOPES I

HOPES II

HOPES III

Note: The counties highlighted in the maps are the primary counties implementing HOPES. The list of all counties that are served by HOPES is included in Appendix C: HOPES Site Information

About the HOPES Evaluation

PEI has contracted with the Texas Institute for Child & Family Wellbeing (TXICFW) at The University of Texas at Austin’s Steve Hicks School of Social Work to conduct an independent evaluation of HOPES. TXICFW is responsible for developing the evaluation plan, conducting evaluation research activities, and reporting findings.

This report is the final HOPES Evaluation report published by TXICFW that covers September 1, 2014, to August 31, 2018, of four fiscal years of HOPES I, HOPES II and HOPES III sites. This report also explores various DFPS data to identify substantiated cases of child maltreatment among families who participated in HOPES. The data in this report show compelling evidence that HOPES programming has strengthened protective factors and mitigated certain risk factors. Additionally, the data has shown significant decreases in primary counties served by HOPES programming compared to other counties in Texas during the implementation of HOPES (FY2015 to FY2018). While the changes to county-level rates of child maltreatment cannot be attributed to HOPES programming alone, in conjunction with intermediate outcome of strengthening protective factors and mitigating risk factors, there is evidence that HOPES programming is helping communities preventing child maltreatment. For information on previous evaluation reports, visit https://txicfw.socialwork.utexas.edu/research/project/project-hopes-evaluation/.

CONCEPTUAL FRAMEWORK

In order to effectively prevent child maltreatment in the community, interventions that promote and create safe, stable, and nurturing relationships in a child’s life have been shown to be the most effective at preventing and reducing the incidence of child maltreatment.¹

The characteristics of safety, stability, and nurturing operate on multiple levels within a child’s system and should be addressed at the child level, family level, community level, and policy level. The conceptual framework on the following page describes some of the factors related to these three tenets and how they serve as protective factors to prevent child maltreatment. An overview of the supporting research behind each element of the conceptual framework is provided in the figure below. This conceptual framework serves as a guide for our HOPES evaluation in addressing child maltreatment prevention from an evidence-based and holistic systems perspective to improve the lives of children and families.
**Building Blocks for Community-based Child Maltreatment Prevention**

How to create **healthy families** through **safe, stable & nurturing** relationships

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<th>Safety</th>
<th>Stability</th>
<th>Nurturing</th>
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<tr>
<td><strong>Child</strong></td>
<td><strong>Caregiver</strong></td>
<td><strong>Community</strong></td>
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<tr>
<td>Children receive regular well-checks &amp; are in a safe environment.</td>
<td>Children have consistent caregivers.</td>
<td>Children have positive interactions with their caregivers.</td>
</tr>
<tr>
<td>Caregivers are physically &amp; mentally well &amp; have healthy relationships &amp; support systems</td>
<td>Families are able to meet their basic needs.</td>
<td>Parents know child development &amp; discipline strategies.</td>
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<td>The neighborhood is safe &amp; the family has access to the resources they need.</td>
<td>There are adequate employment opportunities &amp; affordable housing.</td>
<td>Communities collaborate to reduce stigma around families seeking help.</td>
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<td>Federal &amp; state laws ensure safety of ALL people.</td>
<td>Funding adequately provides resources to address risk factors.</td>
<td>Program policies are able to meet the needs of families in crisis.</td>
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**Child Maltreatment is prevented.**
SAFETY

Child receives regular wellness checks & is in a safe environment.

Pediatric and family health professionals are in a unique position to screen for and address potential child abuse, as they usually have regular contact with women throughout pregnancy and see families for regular check-ups. Missing regular well-child exams increases the likelihood that child maltreatment will go undetected, particularly for young children.²

Research has demonstrated a strong correlation between children witnessing familial partner violence and several forms of child maltreatment including physical, emotional, and sexual abuse, as well as neglect. In a study containing data from more than 4,500 youth between the ages of 0-17, more than one-third of youth who witnessed partner violence experienced maltreatment within the past year, and more than half experienced maltreatment within their lifetime.³ Youth who witnessed partner violence were three to nine times more likely to be maltreated as youth compared to those did not witness partner violence.³ These findings indicate that ensuring a child is in a safe environment may prevent child maltreatment.

Caregiver(s) are physically and mentally well and have healthy relationships.

There is a strong correlation between parental substance use and child maltreatment. In FY2016, 51% of fatalities due to child maltreatment included a caregiver actively using a substance or were reported as being under the influence of one or more substances, which affected the caregiver’s ability to safely care for the child.⁴ In addition, substance abuse is a significant predictor for recurrent child maltreatment.⁵ In another study regarding mothers who were involved in the child welfare system, 30.2% of mothers had met criteria for alcohol or drug abuse/dependence, and 22.6% met criteria for co-occurring substance abuse and mental health disorder.

Research has also linked parental mental health to child maltreatment. Maternal depression is associated with an increased risk for child maltreatment.⁷ One study suggests that 57.4% of mothers involved with the child welfare system met the clinical criteria for one or more mental health disorders; the most prevalent being depression (47%) and anxiety (39.6%).⁸

Research has also demonstrated that caregivers who experience high levels of conflict within their relationship with their partner are at high risk for engaging in child maltreatment.⁹ In an analysis of the National Survey of Child and Adolescent Well-Being containing data from 5,501 children ages 0-14, nearly half of the mothers who had been reported to Child Protective Services for child maltreatment experienced intimate partner violence.¹⁰ In addition, mothers who experienced intimate partner violence were at greater risk of engaging in child maltreatment.¹⁰

Neighborhoods are safe and the family has access to resources they need.

The 5-year Fragile Families and Child Wellbeing Study analyzing the relationship between neighborhood factors and child maltreatment found that negative neighborhood structural factors were consistently associated with child maltreatment.¹¹ Some examples of structural factors are social and economic deprivation, unemployment, residential turnover, vacant housing, overcrowding, and the number of alcohol outlets per capita.¹¹

Federal & state laws ensure the safety of ALL people.

While many federal and state policies impact the safety of various populations, research suggests that punitive immigration policies create high levels of fear and stress among families, which negatively impact the safety of children and families.¹² Some examples of how the safety of children may be compromised include families becoming too fearful to seek medical attention for their children or seek assistance in fleeing abuse, for fear of deportation. This fear creates a barrier to seeking support, which contributes to child maltreatment.¹²
STABILITY

**Children have consistent caregivers.**

Research shows that complex caregiver networks (i.e. multiple-segmented caregivers) are related to child maltreatment outcomes. A high number of inconsistent caregivers could mean that the child is experiencing instability in the home. These caregivers often do not have the same attachment to the child and vice versa, which has been associated with an increased risk for child maltreatment.

**Families are able to meet their basic needs.**

Research has shown that food insecurity has a harmful physiological impact on child development. Poverty and food insecurity also lead to high parental stress, which has been shown to be associated with child maltreatment. In a study analyzing predictors of parenting stress among two groups of families who were in the child welfare system (children removed from the home and children remained in the home), researchers found that one-third of both groups experienced food insecurity. Food insecurity was a significant predictor for increased parenting stress for families who had children removed from their home.

**Adequate employment opportunities and affordable housing.**

Lack of employment opportunities or the inability to gain employment both impact a family’s ability to meet their basic needs, thus contributing to parental stress. Several studies have investigated the levels and causes of parental stress among a sample of families involved in the child welfare system. One study found that over half of the families with an open child welfare case experienced housing instability. Researchers analyzing data from the longitudinal cohort study, the Fragile Families and Child Well-Being Study, found that housing instability and housing unaffordability are indirectly linked to child maltreatment by maternal stress.

**Funding to adequately provide resources to address risk factors.**

A study analyzing the relationship between the availability of social services and child maltreatment among 1,050 parents in Ohio found that greater access to social services is associated with lower levels of child maltreatment. This study also concluded that the availability of resources moderates the relationship between social support and child maltreatment, with the greater availability of resources showing higher social support and lower child maltreatment in neighborhoods. This suggests improved funding for social services will improve the community’s access to receiving services that may lead to lower incidences of child maltreatment.

NURTURING

**Children have positive interactions with their caregivers.**

Child-caregiver attachment is an extremely important factor in child development. Forming and maintaining a secure attachment provides a child with a foundation to integrate cognitive, emotional, and behavioral functioning that influences the understanding of self and the ability to form and maintain a future interpersonal relationship. Children develop internal relationship models for all future relationships based on their interactions with their primary caregiver(s). Research has shown that children who have experienced maltreatment are significantly more likely to have an insecure or disorganized attachment, which can result in fear, hostility, affect dysregulation, and disengagement.

**Caregivers are educated regarding child development and effective discipline strategies.**

Research has demonstrated regarding the lack of knowledge regarding normal child development, as well as limited parenting competence, including harsh, inattentive, or inconsistent parenting, are all risk factors for child maltreatment. One researcher suggested that guidance and education regarding developmental issues and discipline practices are opportunities to prevent child maltreatment in
pediatric practices.\textsuperscript{21}

\textbf{Communities collaborate to reduce stigma around families seeking help.}

The manner in which caregivers interact within their community can contribute to the level of risk for child maltreatment. One study revealed that mothers who did not participate in social groups and/or neighborhood functions displayed an 80-90\% increase in the possibility of psychological aggression and were 60\% more likely to neglect their child.\textsuperscript{22} In contrast, when parents and caregivers reside in communities where they feel connected and supported by neighbors and community events, the risk of child maltreatment decreases.\textsuperscript{22} Researchers suggest that this is because active community members may have access to more resources and parenting advice. Parents may learn positive parenting behaviors from the modeling of other parents in the community. Moreover, community activities provide a social outlet, which can help to reduce the stress some families may experience in the home.

\textbf{Program policies are flexible to be able to support families in crisis.}

In a study analyzing retention of 2,357 families participating in two national home-visiting models (Nurse-Family Partnership and Healthy Families America), researchers concluded that supportive administration policies and organizational structures streamline referrals to better support families and their ability to follow through recommendations from the program model.\textsuperscript{23} This research study supports tailoring of program models and policies to best support families’ needs.\textsuperscript{23}
The logic model presented below describes the activities, short-term outcomes, and long-term outcomes for HOPES.

**Figure 3. HOPES Logic Model**

**Healthy Outcomes through Prevention and Early Support (HOPES)**

Goal: Reduce the incidence of child maltreatment through community-based prevention and evidence-based interventions

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding from DFPS</td>
<td>Deliver evidence-based interventions to families</td>
<td># of families recruited, participating, and completing interventions across 22 sites</td>
<td>Increased child emotional and cognitive well-being</td>
</tr>
<tr>
<td>Database system</td>
<td>Provide case management</td>
<td># of sessions; # of hours of services provided; other fidelity measures</td>
<td>Increased parental protective factors</td>
</tr>
<tr>
<td>Provide programming</td>
<td>Deliver other programming to meet family needs</td>
<td>Support &amp; maintain coalitions</td>
<td>Increased Safety</td>
</tr>
<tr>
<td>Local agencies</td>
<td></td>
<td>Community Awareness Campaigns/ Presentations</td>
<td>Reduction in child maltreatment cases</td>
</tr>
<tr>
<td>Evidence-based interventions</td>
<td></td>
<td>Coordinate events and activities to promote professional development</td>
<td>Prevention of child maltreatment</td>
</tr>
<tr>
<td>Support community coalitions</td>
<td></td>
<td>Improved referral process/systems across agencies</td>
<td>Increased Nurturing</td>
</tr>
<tr>
<td>Existing/new community collaborations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family-serving professionals</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Short-term Outcomes**
- Increased child emotional and cognitive well-being
- Increased parental protective factors
  - nurturing/attachment
  - knowledge of child development
  - parental resilience
  - social connections
  - concrete supports
  - economic self-sufficiency
- Reduction of risk factors
  - parental substance use
  - parental mental illness
  - exposure to family conflict

**Intermediate/Long-term Outcomes**
- Increased collaboration and communication between agencies
- Increased knowledge of child maltreatment
- Increased access and use of services
Research Questions

1. What are the programs and services provided under HOPES from FY2015-FY2018? How many families participated in programs and services, what type of programs did families participate in, and how long did families engage in these programs?

2. To what extent have HOPES programs impacted families and communities in supporting and improving safety, stability, and nurturing, the building blocks for community-based child maltreatment prevention?

3. What are the strengths in the implementation of HOPES and what are some areas of improvement?

4. How many families who participated in HOPES did not experience a new CPS case? Can the data provide any valuable information on families who had a CPS case during HOPES programming or after exiting HOPES programming?
THE COMMUNITIES SERVED BY HOPES
THE COMMUNITIES SERVED IN HOPES

In designing HOPES, PEI sought to identify communities of greatest risk for child maltreatment to target prevention funding in order to show the greatest impact. Thirty-three Texas counties were identified based on their high rates of domestic violence, substance abuse, teen pregnancy, child poverty, and child abuse fatalities. Of those 33 counties, thirty-two counties were chosen for participation in either phase of HOPES I, HOPES II, or HOPES III.

This section provides a brief demographic overview of primary counties served in HOPES and how HOPES staff and community members perceive resource needs and risk factors related to child maltreatment in their communities.

COMPARISON OF PRIMARY COUNTIES SERVED IN HOPES

The figure below compares county-level demographics of the percent of families or people in each county. These demographics include:

- Percent of families with a related child 5 years old and younger living in extreme poverty (below the poverty level), 2017\textsuperscript{24}
- Percent of households with children under 18 years old receiving food assistance (SNAP benefits), 2017\textsuperscript{25}
- Percent of families with children under 18 years old where everyone in the household is unemployed, 2017\textsuperscript{26}
- Teen birth rate (number of births per 1,000 females) between the ages of 15-19, 2010-2016\textsuperscript{27}
- Percent of households with children where everyone in the household is uninsured, 2013-2017\textsuperscript{28}
- Percent of all substantiated family violence incidents among all incidents in Texas, 2017\textsuperscript{29}
- Percent of all deaths due to drug use (substance use and alcohol use) among all deaths, 2017\textsuperscript{30}
Figure 4. County-level demographics of HOPES primary counties

<table>
<thead>
<tr>
<th>% OF FAMILIES WITH RELATED CHILD 5 AND YOUNGER LIVING BELOW FEDERAL POVERTY LEVEL (2017)</th>
<th>% OF HOUSEHOLDS RECEIVING SNAP WITH CHILDREN UNDER 18 YEARS OLD</th>
<th>PERCENT OF FAMILIES WITH CHILDREN WHO ARE UNEMPLOYED</th>
<th>TEEN BIRTH RATE (NUMBER OF BIRTHS PER 1,000 FEMALES AGES 15-19)</th>
<th>PERCENT OF FAMILY HOUSEHOLDS THAT ARE UNINSURED</th>
<th>% OF ALL FAMILY VIOLENCE INCIDENTS</th>
<th>% OF DRUG DEATHS (AMONG ALL DEATHS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>POTTER 13.1%</td>
<td>Hidalgo 44%</td>
<td>Webb 9%</td>
<td>Ector 76%</td>
<td>Hidalgo 32%</td>
<td>Harris 22%</td>
<td>Travis 4.48%</td>
</tr>
<tr>
<td>CAMERON 32.3%</td>
<td>Webb 40%</td>
<td>Jefferson 8%</td>
<td>Potter 79%</td>
<td>Cameron 30%</td>
<td>Dallas 11%</td>
<td>Webb 4.48%</td>
</tr>
<tr>
<td>HIDALGO 32.2%</td>
<td>Cameron 32%</td>
<td>Nueces 7%</td>
<td>Webb 71%</td>
<td>Webb 30%</td>
<td>Bexar 7%</td>
<td>Nueces 3.24%</td>
</tr>
<tr>
<td>WEBB 31.5%</td>
<td>Nueces 32%</td>
<td>Brazos 7%</td>
<td>Hidalgo 62%</td>
<td>Dallas 23%</td>
<td>Tarrant 7%</td>
<td>Bexar 3.72%</td>
</tr>
<tr>
<td>BRAZOS 26.1%</td>
<td>Taylor 31%</td>
<td>Wichita 7%</td>
<td>Cameron 61%</td>
<td>Ector 23%</td>
<td>Texas 7%</td>
<td>Bexar 3.39%</td>
</tr>
<tr>
<td>GREGG 25.5%</td>
<td>El Paso 29%</td>
<td>Hidalgo 7%</td>
<td>Gregg 59%</td>
<td>El Paso 22%</td>
<td>Travis 4%</td>
<td>Tarrant 3.32%</td>
</tr>
<tr>
<td>WICHITA 24.2%</td>
<td>Jefferson 28%</td>
<td>Bell 6%</td>
<td>El Paso 52%</td>
<td>Potter 22%</td>
<td>Harris 3%</td>
<td>Harris 3.22%</td>
</tr>
<tr>
<td>MCLENNAN 23.3%</td>
<td>Lubbock 26%</td>
<td>Bexar 6%</td>
<td>Bexar 49%</td>
<td>Bexar 21%</td>
<td>El Paso 3%</td>
<td>Lubbock 3.14%</td>
</tr>
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<td>JEFFERSON 21.9%</td>
<td>Gregg 25%</td>
<td>Cameron 5%</td>
<td>Cameron 47%</td>
<td>Jefferson 21%</td>
<td>Jefferson 3%</td>
<td>Bexar 3.11%</td>
</tr>
<tr>
<td>EL PASO 21.2%</td>
<td>Mclennan 25%</td>
<td>El Paso 5%</td>
<td>Nueces 48%</td>
<td>Texas 18%</td>
<td>Lubbock 2%</td>
<td>Bexar 3.05%</td>
</tr>
<tr>
<td>NUECES 20.9%</td>
<td>Potter 24%</td>
<td>Mclennan 5%</td>
<td>Hidalgo 47%</td>
<td>Nueces 12%</td>
<td>Nueces 2%</td>
<td>El Paso 2.87%</td>
</tr>
<tr>
<td>TAYLOR 19.2%</td>
<td>HARRIS 23%</td>
<td>Harris 4%</td>
<td>Dallas 46%</td>
<td>Bell 2%</td>
<td>Bell 2%</td>
<td>Galveston 2.86%</td>
</tr>
<tr>
<td>TEXAS 18.2%</td>
<td>Brazos 22%</td>
<td>Lubbock 4%</td>
<td>Taylor 44%</td>
<td>Tarrant 17%</td>
<td>Cameron 17%</td>
<td>Taylor 2.82%</td>
</tr>
<tr>
<td>LUBBOCK 18.1%</td>
<td>Dallas 22%</td>
<td>Montgomery 4%</td>
<td>Harris 41%</td>
<td>Mclennan 16%</td>
<td>Harris 16%</td>
<td>Texas 2.75%</td>
</tr>
<tr>
<td>BEXAR 17.3%</td>
<td>Bexar 21%</td>
<td>Taylor 4%</td>
<td>Bexar 40%</td>
<td>Bexar 16%</td>
<td>Potter 16%</td>
<td>Mclennan 2.72%</td>
</tr>
<tr>
<td>DALLAS 17.3%</td>
<td>WICHITA 21%</td>
<td>Texas 4%</td>
<td>Lubbock 39%</td>
<td>Bexar 16%</td>
<td>Bexar 16%</td>
<td>Mclennan 2.63%</td>
</tr>
<tr>
<td>HARRIS 17.3%</td>
<td>Texas 20%</td>
<td>Dallas 4%</td>
<td>Mclennan 39%</td>
<td>WICHITA 14%</td>
<td>Bexar 16%</td>
<td>Mclennan 1.99%</td>
</tr>
<tr>
<td>BELL 15.9%</td>
<td>Ector 20%</td>
<td>Tarrant 3%</td>
<td>Lubbock 39%</td>
<td>Tarrant 14%</td>
<td>Mclennan 16%</td>
<td>Mclennan 1.87%</td>
</tr>
<tr>
<td>TARRANT 13.9%</td>
<td>Bell 19%</td>
<td>Galveston 2%</td>
<td>Galveston 33%</td>
<td>Galveston 14%</td>
<td>Jeffeson 14%</td>
<td>Tarrant 1.80%</td>
</tr>
<tr>
<td>GALVESTON 13.3%</td>
<td>Galveston 15%</td>
<td>Potter 2%</td>
<td>Travis 41%</td>
<td>Travis 14%</td>
<td>Mclennan 14%</td>
<td>Galveston 1.69%</td>
</tr>
<tr>
<td>MONTGOMERY 11.0%</td>
<td>Tarrant 17%</td>
<td>Texas 2%</td>
<td>Texas 41%</td>
<td>Texas 14%</td>
<td>Travis 14%</td>
<td>Tarrant 1.63%</td>
</tr>
<tr>
<td>TRAVIS 10.8%</td>
<td>Travis 14%</td>
<td>Travis 2%</td>
<td>Tarrant 30%</td>
<td>Taylor 14%</td>
<td>Travis 14%</td>
<td>Travis 1.36%</td>
</tr>
<tr>
<td>ECTOR 9.8%</td>
<td>Montgomery 10%</td>
<td>Ector 2%</td>
<td>Montegomery 20%</td>
<td>Ector 12%</td>
<td>Gregg 12%</td>
<td>Gregg 0.96%</td>
</tr>
</tbody>
</table>
Poverty, Food Insecurity, & Unemployment

These county-level measures are a few indicators that give a glimpse about the financial stability of families with children in primary counties served by HOPES. Families experiencing extreme poverty, food insecurity, and unemployment may be in crises which negatively impact healthy family functioning and caregivers’ ability to nurture and focus on their child’s wellbeing and safety. In 2017, the federal poverty level is an annual income of $24,700 for a family of four.\(^{31}\) In order to qualify for SNAP benefits in 2017, a household size of four must make less than $31,596, which is approximately 128% of the federal poverty level.\(^ {32}\) In addition to income requirements, families must meet employment or job training requirements.

“...I see it as the economic issue as being one of the highest stressors just because we deal with that two or three times a week. Family of eight living in their car. Family of six living in a house with no electricity. You could understand where the parent’s head is, living in that situation and trying to care for a family and then living with multiple families in one household experiencing that.”

– HOPES Supervisor

Teen Birth, Uninsured Households

High rates of teen births may indicate families who are not able to earn a living wage based on their age. Families who do not have any health insurance coverage may not be able to address medical concerns or provide preventative care for themselves or their children, which can

“[We have] a mental health professional shortage in our area to start with. Unless you have enough mental health professionals to address it, there’s not a whole lot you can do. Especially if they don’t have insurance. If [families] don’t have private insurance or Medicaid, which a lot of them don’t qualify for Medicaid if they’re not pregnant, they have no way to pay for it. Nowhere to go. I’ve had a very hard time finding places for them to go to.”

– HOPES Staff

Domestic Violence, Substance Use

Domestic violence and substance use are risk factors are closely linked to child maltreatment. The incidence of domestic violence was likely higher in counties than in the data shown in Figure 4, since there were likely many domestic violence abuses that are not reported. In counties with greater populations, it is likely that there will be more cases of domestic violence reported. The data of family violence incidents are of reported cases among all reported incidents to police. The data on drug deaths are the percent of deaths that are due to drug use among all causes of death in counties, includes all ages of the county population.

“The demographics we have right now, a lot of one parent is dependent on the abuser, so they’re trying to do the best they can at home with the kids and are afraid to leave the situation. Because they’ve never had to do anything on their own or they have kids and they can’t do it by themselves financially, so they’re stuck”.

– HOPES Parent Educator

“Traditionally, 95 percent of our child maltreatment cases are drug-related and it’s opioid addiction. Meth is really prominent in our area. Meth having a 93 percent relapse rate. So, I think that’s what we’re seeing is the substance abuse.”

– HOPES Staff
In addition to county-level statistics on risk factors, this evaluation obtained HOPES staff and community stakeholders’ perceptions of resource needs and risk factors related to child maltreatment. The data below describes how HOPES staff and community stakeholders ranked resource needs and risk factors related to child maltreatment in communities they serve over three years of our evaluation. Survey responses were collected via online surveys from 2016, 2017, and 2018. In Figure 5 below, staff were asked to rank about available the following resources were in their community, by indicating if it was “generally available,” “sometimes available,” “rarely available,” or “unsure.” The majority response for each resource type is included in the figure below. Note: The data below may contain duplicates of the same respondents completing the survey from year to year.
Figure 5. HOPES staff & community members’ perceptions of resource needs over 3 years

<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESOURCES STAFF AND COMMUNITY MEMBERS INDICATED AS “GENERALLY AVAILABLE” IN THEIR COMMUNITIES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMERGENCY FOOD ASSISTANCE</td>
<td>62%</td>
<td>65%</td>
<td>59%</td>
</tr>
<tr>
<td>RESOURCES STAFF AND COMMUNITY MEMBERS INDICATED AS “SOMETIMES AVAILABLE” IN THEIR COMMUNITIES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JOB TRAINING</td>
<td>56%</td>
<td>52%</td>
<td>44%</td>
</tr>
<tr>
<td>WORK PAYING A LIVING WAGE</td>
<td>54%</td>
<td>55%</td>
<td>50%</td>
</tr>
<tr>
<td>ASSISTANCE WITH UTILITY SHUT-OFFS</td>
<td>51%</td>
<td>56%</td>
<td>63%</td>
</tr>
<tr>
<td>ASSISTANCE WITH RENT</td>
<td>49%</td>
<td>50%</td>
<td>54%</td>
</tr>
<tr>
<td>ACCESS TO AFFORDABLE HOUSING</td>
<td>45%</td>
<td>49%</td>
<td>50%</td>
</tr>
<tr>
<td>AFFORDABLE CHILD CARE</td>
<td>44%</td>
<td>53%</td>
<td>49%</td>
</tr>
<tr>
<td>ACCESS TO MEDICAL CARE</td>
<td>43%</td>
<td>44%</td>
<td>54%</td>
</tr>
<tr>
<td>ACCESS TO MENTAL HEALTH SERVICES</td>
<td>41%</td>
<td>41%</td>
<td>41%</td>
</tr>
<tr>
<td>ASSISTANCE WITH MEDICAL PRESCRIPTIONS</td>
<td>40%</td>
<td>49%</td>
<td>49%</td>
</tr>
<tr>
<td>RELIABLE PUBLIC TRANSPORTATION</td>
<td>37%</td>
<td>41%</td>
<td>44%</td>
</tr>
<tr>
<td>RESOURCES STAFF AND COMMUNITY MEMBERS INDICATED AS “RARELY AVAILABLE” IN THEIR COMMUNITIES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RESOURCES FOR FAMILIES IN RURAL AREAS</td>
<td>42%</td>
<td>44%</td>
<td>43%</td>
</tr>
<tr>
<td>RESOURCES FOR UNDOCUMENTED FAMILIES</td>
<td>40%</td>
<td>34%</td>
<td>39%</td>
</tr>
</tbody>
</table>
The majority of resources were indicated as sometimes available, with the exception of emergency food assistance and resources for families in rural areas. The availability and access to resources are important to be able to support families to gain healthy physical and emotional wellbeing that helps prevent child maltreatment. During interviews and focus groups with HOPES staff, 55% (n=140) of staff discussed a lack of resources and/or poor access to resources as an issue in their communities. The greatest discrepancy of high community need and poor accessibility of a resource was mental health services for families. Staff from all HOPES sites discussed the lack of affordable and accessible mental health providers in their communities.

“I think it all comes down to finances when you think about having the resources available for our clients. For example, I think it would be great if we had [a mental health] component being a part of HOPES where there was a good referral source to provide that service for our clients. That comes up quite often and it’s just like, ‘How can we do this?’ And of course it comes into it’s not within our budget or we don’t have the manpower to do it and these are the reasons why. So, I think with [domestic violence] we’re good, with substance abuse we’re good but mental health is just always that little ‘What are we doing? What can we do to make it better?’ And you always hear finances, budget, and manpower comes up.”

– HOPES Supervisor

In addition to resources, HOPES staff and community members were asked their perception of risk factors prevalent in their community. Survey responses were collected via online surveys from 2016, 2017, and 2018. Survey respondents were asked to indicate whether that risk factor was “an extreme problem,” “definitely a problem,” “a little bit of a problem,” “not at all problem,” or if they felt “unsure” in their community. The majority response for each risk factor is provided in the figure below. Note: The data below may contain duplicates of the same respondents completing the survey each year.
Figure 6. HOPES staff & community members’ perception of risk factor in HOPES communities

RISK FACTOR | 2016 252 STAFF | 2017 227 STAFF | 2018 271 STAFF
--- | --- | --- | ---
CHILDREN DO NOT RECEIVE REGULAR WELL-CHILD EXAMS | 52% | 59% | 44%
CHILDREN WITNESS VIOLENCE IN THEIR HOMES | 80% | 79% | 55%
PARENTS ABUSE DRUGS AND ALCOHOL | 74% | 73% | 67%
PARENTS HAVE MENTAL HEALTH ISSUES | 67% | 76% | 59%
CHILDREN HAVE MENTAL HEALTH ISSUES | 59% | 63% | 54%
PARENTS HAVE VIOLENCE RELATIONSHIPS | 73% | 77% | 55%
NEIGHBORHOOD HAVE VIOLENCE | 67% | 71% | 49%
CHILDREN HAVE INCONSISTENT CAREGIVERS | 65% | 69% | 56%
FAMILIES NEED FOOD | 67% | 77% | 66%
FAMILIES NEED HOUSING | 79% | 83% | 66%
FAMILIES ARE LIVING IN POVERTY | 88% | 90% | 73%
PARENTS DO NOT HAVE ACCESS TO EMPLOYMENT OPPORTUNITIES | 71% | 70% | 50%
LACK OF QUALITY, AFFORDABLE CHILDCARE | 80% | 82% | 64%
CHILDREN DO NOT HAVE STRONG RELATIONSHIPS WITH THEIR PARENTS | 64% | 66% | 50%
PARENTS LACK PARENTING SKILLS/CAPACITIES | 86% | 86% | 66%
PARENTS LACK CHILD DEVELOPMENT KNOWLEDGE | 87% | 92% | 71%
PARENTS LACK SOCIAL SUPPORT | 80% | 87% | 67%
LACK OF COMMUNITY SERVICES TO HELP FAMILIES | 57% | 62% | 54%
LACK OF PLACES TO REFER FAMILIES FOR HELP | 41% | 50% | 50%
PARENTS ABUSE NON-PRESCRIPTION DRUGS (STREET DRUGS) | | | 48%
PARENTS ABUSE OPIOIDS OR PRESCRIPTION DRUGS | | | 35%
PARENTS ABUSE ALCOHOL | | | 52%
FAMILIES ARE FEARFUL OF DEPORTATION OR HAVE IMMIGRATION CONCERNS | | | 60%

*For Year 3, the survey detailed the question about alcohol and drug abuse further and asked respondents to rate the risk of alcohol abuse, opioid abuse, and abuse of street drugs (non-opioids). An average of these three responses is the percentage included in this figure.
Over three years of this evaluation, HOPES staff indicated that they perceive their communities are experiencing moderate to extreme levels of risk factors that impact child maltreatment within a child’s environment.

“There’s some sort of trauma in almost every single home that we’re going into. So, I don’t have like, an actual statistic, but I if I were to guess, it would be like 95 percent of the homes there’s some sort of trauma. And we know how trauma affects the brain, and it can definitely affect your parenting. So, we are addressing trauma.”

– HOPES Supervisor

**Community Strengths & Capacity to Address Child Maltreatment Prevention**

Since the development of HOPES centered on community-based interventions, community cohesion and a community’s capacity for addressing child maltreatment prevention is necessary in order for HOPES programming to be successful. This evaluation sought to understand how community stakeholders working in child welfare perceived their community strength and capacity to address child maltreatment over three years of our evaluation. Responses below were collected from the online survey completed by community members during 2016 (n=134), 2017 (n=112), and 2018 (n=30). For 2018, only the newly implemented HOPES III sites were asked to complete these questions on community strengths, thus yielding a smaller sample size of responses. Across all three years, community stakeholders overwhelmingly rated their community strengths as very strong (69% and above). The areas that communities rated the least were the community’s self-reliance and amenability to change.

Community members were also confident that their communities were prepared to implement programming and had the capacity to prevent child maltreatment (70% -100% agree and strongly agree). Across all three years, community members indicated that their community had all the resources they need to address child maltreatment (50% - 67% agree and strongly agree). Community members’ and stakeholders’ perception of community strength and buy-in to address child maltreatment prevention at the community level is essential to mobilize sectors to collaborate and address systemic change in preventing child maltreatment.

**Agencies, Coalitions, and Programs in HOPES**

As a community-based program, HOPES encouraged grantees to choose their own organizational structure of agencies and programs they would like to implement under HOPES. In all three phases of HOPES, sites organized themselves into one of three organizational structures described below:

<table>
<thead>
<tr>
<th>Single Agency</th>
<th>Primary Agency &amp; Subcontractors</th>
<th>Primary Agency &amp; Subcontractors</th>
</tr>
</thead>
<tbody>
<tr>
<td>A single agency is the contractor who receives funding &amp; implements programming/services.</td>
<td>Primary agency manages the contract and does not implement programming/services. The primary agency manages other agencies that are the subcontractors who implement all programming/services.</td>
<td>All agencies provide programming/services, however one agency is designated as the primary contractor while all other agencies are the subcontractors.</td>
</tr>
</tbody>
</table>

| 12 HOPES sites | 3 HOPES sites | 7 HOPES sites |

From FY2015-FY2018, there were a total of 56 different agencies and 21 different coalitions serving 31 Texas counties and implementing 21 different evidence-based programs in HOPES. A table describing the types of counties, agencies, and programs implemented is located in Appendix C: HOPES Site Information.
FAMILIES SERVED BY HOPES
FAMILIES SERVED IN HOPES

This section of the report discusses HOPES program outputs, including the number of families served in each program, the demographics of families served in HOPES, and the types and amount of support services provided to participants. The data analyzed in this section includes administrative data from the PEI database covering FY2015 – FY2018 and the Caregiver Survey covering FY2016 – FY2018.

The figures below describe the number of families served in all long-term evidence-based programs implemented in HOPES from FY2015-FY2018. Since HOPES programming was implemented in phases, HOPES I has been serving families the longest for four fiscal years (FY2015-2018), HOPES II has been serving families for three fiscal years (FY2016-FY2018), and HOPES III has been serving families for the shortest period of time for two fiscal years (FY2017-FY2018). The scope, time frame, and service models implemented by each HOPES site were so different that the number of clients served is less of an indicator of success compared to client outcomes. To reiterate, the data below should not be used as a measure of success between different HOPES sites.
Figure 7. Total number of families served by HOPES site

This evaluation includes data from:

<table>
<thead>
<tr>
<th>Year</th>
<th>HOPES I = 6,438 Families Served from 2015-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td></td>
</tr>
</tbody>
</table>

HOPES II = 3,759 Families Served from 2016-2018

HOPES III = 2,280 Families Served from 2017-2018

A total of 12,477 families were served by HOPES programming from 2015-2018.
## Figure 8. Total number of families served by each evidence-based program and HOPES site

<table>
<thead>
<tr>
<th>EVIDENCE-BASED PROGRAM</th>
<th>TOTAL</th>
<th>TOTAL NUMBER OF FAMILIES SERVED AT EACH SITE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PARENTS AS TEACHERS</strong></td>
<td>4,605</td>
<td>Hidalgo: 583</td>
</tr>
<tr>
<td></td>
<td></td>
<td>El Paso: 497</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gregg: 416</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lubbock: 351</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Jefferson: 349</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Travis: 237</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Potter: 237</td>
</tr>
<tr>
<td></td>
<td></td>
<td>McCallen: 234</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Harris: 224</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ector: 154</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Montgomery: 104</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brazos: 87</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dallas: 75</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wichita: 66</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nueces: 41</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bexar: 33</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Galveston: 14</td>
</tr>
<tr>
<td><strong>TRIPLE P</strong></td>
<td>2,207</td>
<td>Travis: 622</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dallas: 367</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Harris: 79</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bexar: 79</td>
</tr>
<tr>
<td><strong>SAFECARE</strong></td>
<td>1,548</td>
<td>Cameron: 726</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Webb: 602</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Taylor: 219</td>
</tr>
<tr>
<td><strong>TRUST-BASED RELATIONAL INTERVENTION (TBRI)</strong></td>
<td>1,065</td>
<td>Tarrant: 1,065</td>
</tr>
<tr>
<td><strong>AVANCE PARENT-CHILD EDUCATION PROGRAM</strong></td>
<td>697</td>
<td>El Paso: 533</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dallas: 164</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Harris: 448</td>
</tr>
<tr>
<td><strong>NURTURING PARENTING PROGRAM</strong></td>
<td>492</td>
<td>Travis: 44</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nueces: 167</td>
</tr>
<tr>
<td><strong>HOME INSTRUCTION FOR PARENTS OF PRESCHOOL YOUNGSTERS (HIPPY)</strong></td>
<td>247</td>
<td>Wichita: 80</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ector: 82</td>
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<tr>
<td></td>
<td></td>
<td>Travis: 62</td>
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<td></td>
<td></td>
<td>Potter: 48</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gregg: 7</td>
</tr>
<tr>
<td><strong>24/7 DAD</strong></td>
<td>211</td>
<td>El Paso: 205</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bexar: 153</td>
</tr>
<tr>
<td><strong>INCREIBLE YEARS</strong></td>
<td>205</td>
<td>El Paso: 205</td>
</tr>
<tr>
<td><strong>SYSTEMIC TRAINING FOR EFFECTIVE PARENTING (STEP)</strong></td>
<td>153</td>
<td>Bexar: 153</td>
</tr>
<tr>
<td><strong>AGGRESSION REPLACEMENT THERAPY/SKILLSTREAMING</strong></td>
<td>83</td>
<td>Bexar: 83</td>
</tr>
<tr>
<td><strong>NURSE-FAMILY PARTNERSHIP</strong></td>
<td>81</td>
<td>Dallas: 81</td>
</tr>
<tr>
<td><strong>ABRENDIO PUERTAS</strong></td>
<td>65</td>
<td>Harris: 65</td>
</tr>
<tr>
<td><strong>CENTERING PREGNANCY</strong></td>
<td>61</td>
<td>Harris: 61</td>
</tr>
<tr>
<td><strong>EXCHANGE FAMILY AIDE</strong></td>
<td>52</td>
<td>Harris: 52</td>
</tr>
<tr>
<td><strong>NURTURING FATHERS PROGRAM</strong></td>
<td>44</td>
<td>Travis: 44</td>
</tr>
<tr>
<td><strong>BARKLEY’S DEFIANT CHILD</strong></td>
<td>27</td>
<td>Bexar: 27</td>
</tr>
</tbody>
</table>

**11,830 FAMILIES SERVED IN EVIDENCE-BASED PROGRAMS**

*Data included in this table are from long-term evidence-based programs, with the exception of Triple P. Administrative data did not delineate what level of Triple P families participated in, therefore this data may include families who participated in Triple P-Level 2, one-time group parent education session.*
The long-term evidence-based programs that served the most families were Parents as Teachers offered by 17 HOPES sites (4,605 families served), Triple P offered by 4 HOPES sites (2,207 families served), and SafeCare offered by 3 HOPES sites (1,548 families served). While most of the programs were offered by sites for the entirety of HOPES programming, some sites adjusted their contracts to change programs or change their goals for the number of target families to serve. For the Harris HOPES site, Family Connections implemented by Arrow Child and Family Ministries and Centering Pregnancy implemented by the Baylor Teen Health Clinic only participated in HOPES in FY2016, during its first fiscal year of programming. For the remaining fiscal years covered by this evaluation (FY2017 –FY2018), DePelchin Children’s Center increased its capacity to implement Triple P and offered Nurturing Parenting in lieu of Family Connections and Centering Pregnancy. Similarly, the Nueces HOPES site gradually phased out Parents as Teachers as part of HOPES and instead increased the number of families served in HIPPY. One of the subcontractors in Dallas, Dallas Child Advocacy Center, also decided to withdraw from the HOPES contract after FY2016 and the other subcontractors increased the number of families served to maintain their contracting requirements.

While this flexibility in amending contracts is appreciated by both PEI and contracting agencies, it was difficult to discern whether changes in programming were instituted because of the programs’ poor fit for families or if it was due to contracting requirements. During interviews and focus groups with primary agencies and subcontracting agencies, it was expressed that strict contracting requirements and pressure to meet quotas sometimes took precedence over which program best fit the needs of families. For example, Family Connections is an intensive case management program and Centering Pregnancy specifically served teen mothers in Harris County. Both of these programs focused on families that would be considered “high needs,” which may have made meeting quotas of families served more challenging. While the details of the primary contractor and subcontractor relationship are not fully known to the evaluation team, our discussions with staff suggested that the priority on meeting contracting requirements may have impacted which programs are pursued by HOPES versus which programs may have been the most impactful towards helping families.

The evaluation team also analyzed the average length of time participants participate in each program. For primary caregivers who had a start date and end date (n=8,676), the average length of time caregivers stayed in programs was 7.4 months (222 days). The shortest program length observed was 2 days and the longest program length observed was 3.8 years (1,381 days). The figure below presents the average length of time HOPES participants spent in each evidence-based program, from the shortest average program length to the longest average program length. This figures also includes the recommended program length by the program developers.
Figure 9. The average length of time families participated in each evidence-based program

- **Systematic Training for Effective Parenting (STEP)**: 2.3 Months, 3.5 Months
- **Abriendo Puertas**: 2.5 Months, 2.4 Months
- **Nurturing Fathers Program**: 3.2 Months, 3.5 Months
- **Nurturing Parents Program**: 2.5 Months, 3.75 - 6.75 Months
- **Family Connections**: 4 Months, 3.7 Months
- **Barkley’s Defiant Child**: 2.5 Months, 3.9 Months
- **TRIPLE P (Positive Parenting Program)**: 4 Months, 1 Session - 5 Months
- **Parent Aide**: 4.5 Months, 9 - 12 Months
- **Safe Care**: 5 Months, 4.75 Months
- **Incredible Years**: 3.5 Months, 5.5 Months
- **Aggression Replacement Therapy/ Skillstreaming**: 5 Months, 5.9 Months
- **Trust-Based Relational Intervention (TBRI) for Home Visitors, 10 Session Model**: 3 Months, 6 Months
- **Centering Pregnancy**: 4.1 Months, 5 Months
- **24/7 Dad**: 3 Months, 7 Months
- **Avance Parent-Child Education Program**: 6.5 Months, 8.5 Months
- **Home Instruction for Parents of Preschool Youngsters (HIPPY)**: 9.1 Months, 24 - 36 Months
- **Parents as Teachers (PAT)**: At least 24 Months, 12.8 Months

Note: Nurse-Family Partnership is omitted from this figure due to database issues that did not capture data for all primary caregivers participating in Nurse-Family Partnership.
In general, HOPES families who participated in a shorter length program were able to meet the intended program length. This suggests that on average, families who participated in those programs had high program retention, which indicates that families who participated in these shorter length programs often finished them to completion. The two longer programs, HIPPY and Parents as Teachers, have program lengths of 2 years or longer but both had families participate for less than 1 year. Program retention is still quite high in these programs, despite the intended length of the program is a minimum of 2 years. Overall, this data suggests that HOPES families who participated in evidence-based programs remained in for the intended program length.

In order to participate in HOPES, families must have had at least one child who was 5 years old or younger, which included families who were pregnant. The figure below describes the distribution of ages of target children served in HOPES. Although families were required to have one child, many HOPES families had several children who would benefit from programming, particularly from families with multiple children under 5 years old.

Figure 10. Distribution of ages of target children served in HOPES

Note: Ages of target children who were above 5 years old were excluded from this report. Errors in data collection may have resulted in showing target children who were enrolled in programming older than 5 years old.

In addition to evidence-based programs, families who participated in HOPES also accessed other supportive services such as basic need fulfillment (e.g., food, clothing, assistance with bills), childcare and/or counseling services, among many others. The types of services available to families varied for each HOPES site and were either provided by the agency implementing programming or by the coordination of services that exist in communities served by HOPES. The figure below describes the percent of HOPES families who received each type of service above 1%. The services of “Home Visiting and Parent Education & Training” refer to the evidence-based program and number of sessions families received. It is important to note that there is some variability in how each HOPES site collected and reported services provided to families. For example, some HOPES sites that most likely provided basic needs services did not have any service units for basic needs listed in the database. Thus, the data listed below should be interpreted with caution and may not be representative of all the services provided.
Figure 11. Percent of services received by primary caregivers & target children in HOPES

* Counseling included services of counseling, individual counseling, group counseling, and therapeutic counseling as denoted in administrative PEI data.

Service Coordination includes services identified as “case management” and “service coordination and planning services.” “Converted Services” was provided to 3.1% of HOPES families but the definition of Converted Services could not be confirmed by PEI, therefore it is omitted from the figure above. The following services were provided to less than 1% of primary caregivers and target children: Career Exploration (0.5%), Health Screenings (0.5%), Fatherhood Services (0.4%), Parent Education-Domestic Violence (0.2%), Early Childhood Development (0.2%), Respite Care (0.2%), Therapeutic Early Childhood Classroom Services (0.2%), Academic Support (0.1%), Parent Leadership (0.1%), Group Prenatal Parenting (0.1%), Family Focused Service (0.01%), Child Education (0.01%).
CHARACTERISTICS OF FAMILIES SERVED IN HOPES

The PEI database relies on the identification of a primary caregiver, who is the main recipient of the evidence-based program and all data is then tracked through that individual. The figure below describes the typical primary caregiver who participated in HOPES programming.

**Figure 12. Demographics of a typical primary caregiver in HOPES**

**TYPICAL HOPES CAREGIVER:**
- 27 years old mother, child is 2 years old
- 39% are married, 36% are single or were never married
- 37% Hispanic, White
- 55% primary language is English
- 25% lack a high school diploma
- 48% have an annual income of less than $10,000
- Participated in programs for 7 months

In order to qualify for PEI services, families must report having two of the following risk factors. The percentages of caregivers indicating each risk factor at intake is described below.

**Figure 13. Type of risk factors & number of risk factors among HOPES caregivers at intake**

**RISK FACTORS OF PRIMARY CAREGIVERS**

- **HIGH STRESS LEVEL:** 72%
- **CAREGIVER HAS INNACURATE EXPECTATIONS:** 50%
- **NON-TRADITIONAL FAMILY STRUCTURE:** 30%
- **POOR PARENT/CHILD INTERACTION:** 27%
- **SOCIAL ISOLATION:** 25%
- **CAREGIVER HAS NEGATIVE ATTITUDES ABOUT CHILD BEHAVIOR:** 21%
- **HIGH PARENTAL CONFLICT:** 16%
- **TEEN PARENT:** 13%
- **CAREGIVER/CHILD HAS DEPRESSION/ANXIETY:** 9%
- **CAREGIVER MENTAL ILLNESS:** 6%
- **HOMELESSNESS:** 5%

15% had 4+ risk factors
22% had 3 risk factors
38% had 2 risk factors
3% had 1 risk factor

Non-traditional family structure is defined as a family structure of a single parent with a lack of support system and/or a family with a high number of children.

The data on the number of risk factors should be interpreted with caution. At the beginning of HOPES implementation, some HOPES staff would stop collecting risk factors after caregivers indicated two risk factors, instead of listing all the risk factors they identified at intake. Thus, the number of risk factors may be higher than the data shows and the type of risk factors collected may not accurately represent all the families served in HOPES.
In addition to the risk factors collected by PEI, the evaluation team collected data on risk factors that are more closely linked to child maltreatment from program participants. These risk factors include risk of mental health concern, alcohol abuse/misuse, substance use/misuse, domestic violence, and history of childhood trauma. The scales used to collect these risk factors are validated measures. DePelchin Children’s Center in Harris HOPES sites also collected the same types of risk factors from all of their HOPES participants. Instead of requiring participants to fill additional paperwork, DePelchin provided their data to the TXICFW evaluation team to include in this report. Although TXICFW and DePelchin collected the same type of risk factors from program participants, some of the scales are different. For more information on these measures, refer to Appendix B.

The figure below provides an overview of risk factors among HOPES caregivers who completed the Pre-Caregiver Survey or DePelchin’s risk assessment and compares this percentage to the general population in the United States. Note: The Caregiver Survey is voluntary and was intended for families who participated in long-term evidence-based programming. Not all families who participated in long-term programming completed it.

Figure 14. Risk factors collected by the Caregiver Survey & comparison with the general population

![Risk Factors Chart]

Note: Data above reflects the percent of families who met the cut-off score indicating a positive screen for that risk factor. The survey questions used by TXICFW and DePelchin to assess risk factors are located in Appendix G.

Among HOPES caregivers who completed the Pre-Caregiver Survey or DePelchin’s risk assessment, there is a larger percentage of caregivers who indicated that they may be at risk of a mental health concern and have a history of childhood trauma compared to the general population. This suggests that HOPES is reaching families who may be at risk of child maltreatment and/or families who would benefit from additional support. The risk factors of domestic violence, alcohol abuse/misuse, and substance abuse/misuse are lower among HOPES caregivers compared to the general population. This data contradicts the qualitative data collected and online survey responses from staff and community members on domestic violence and alcohol/drug abuse, which suggests that these issues are likely prevalent in the families being served.

There are two explanations for this discrepancy: 1) social desirability bias resulted in caregivers being fearful of answering these questions honestly for fear of system involvement, and/or 2) HOPES did not engage with families who are at risk/experiencing domestic violence and alcohol/drug abuse even though these are consistently the biggest risk factors for child maltreatment.

Social Desirability Bias

Social desirability bias is a type of response bias that occurs when the respondent answers
questions to be perceived as favorable or less “bad.” It’s typical and reasonable for caregivers to be wary to reveal negative or dangerous behaviors for fear of repercussions or negative judgment by the parent educator, with whom they have just met. Although the Caregiver Survey emphasizes all responses are anonymous and confidential, there may be a lack of trust among caregivers that results in social desirability bias.

**Difficult Engaging High-Risk Families**

Another reason for the small percentage of caregivers experiencing domestic violence and alcohol/drug abuse may be the fact that these families are more difficult to engage in HOPES programming. As discussed before in the Community Served in HOPES section, PEI selected HOPES sites based on high rates of these risk factors, thus there is a prevalence of families experiencing these risk factors in communities but they are not participating in HOPES programs. Since the majority of long-term evidence-based programs are focused on parenting, high-risk families experiencing domestic violence and alcohol/drug abuse may not feel prepared to engage with agencies to address their parenting skills while currently experiencing more severe stressors. Likewise, evidence-based program requirements may inadvertently pressure staff to engage with families who are more stable, thus preventing parent educators from recruiting and engaging with families who are of higher-risk. Greater discussion on evidence-based programs and high-risk populations will be discussed in the Implementation of HOPES Programming section of this report.

**COMMUNITY COALITIONS & OUTREACH**

The second prong of the HOPES grant was focused on improving community collaboration and increasing community awareness of child maltreatment and child maltreatment prevention services/resources. HOPES sites were required to engage in community collaboration, referred in this report as a coalition, which addressed early childhood and/or child maltreatment prevention. The purpose of such coalitions was to strengthen the partnership across various sectors within communities to raise awareness about child maltreatment and outreach to families who would benefit from additional support. This section will discuss the process outcomes gathered from coalitions who were part of HOPES, including characteristics of coalitions and the total reach of individuals through community events. Data used to analyze collaborations include Quarterly Reports from FY2015-FY2018 that were submitted by HOPES sites to PEI and a voluntary online survey completed by coalition members and community stakeholders.

**Figure 15. Community members’ perception of sectors involved in coalitions**

<table>
<thead>
<tr>
<th>Very Engaged</th>
<th>Somewhat Engaged</th>
<th>Not Engaged</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Non-profit agencies</td>
<td>• Medical community</td>
<td>• Parents</td>
</tr>
<tr>
<td>• Child Protective Services (CPS)</td>
<td>• Law enforcement</td>
<td>• Business community</td>
</tr>
<tr>
<td>• Schools</td>
<td>• Childcare facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Legal/court system</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• City/State governments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Faith-based organizations</td>
<td></td>
</tr>
</tbody>
</table>

Data was collected from the 2018 online survey completed by community members (n=82).
As expected, the sectors most engaged in the coalitions are those in the field of child and family wellbeing. A sector that should be more engaged in coalitions is caregivers themselves. Gaining input from a diverse group of parents in communities would be beneficial in tailoring services and understanding gaps in outreach.

The majority of HOPES coalitions participated in or hosted family-friendly community events that encouraged caregivers to interact with their children. Some of these included events at the local park encouraging parents and children to play together, literacy events hosted at local libraries, or events in collaboration with schools. Some HOPES sites hosted professional development opportunities and trainings for child welfare professionals. **Across all HOPES sites, there were approximately 1,029,261 individuals reached through community events, as estimated by the quarterly reports for FY2015-FY2018.** This data likely includes duplicated individuals and the evaluation team computed the average “reach” when the quarterly report listed a range of individuals reached. Note: The data does not include individuals reached through media campaigns or social media campaigns.

Figure 16. Total estimates of outreach by HOPES site

“As it relates to coalition work, I think that it gives us a collective voice when can speak out to our stakeholders and people of influence and start really addressing the transit system in our local community because of the program that we’ve had. So, we’ve been able to bring a lot of people to the table there and I think when you have a series of community – of social service agencies and those who work with families in crisis coming together to really advocate on behalf of changing our transit system, that’s really going make huge impact as well.”

– HOPES Staff & Coalition Member
IMPLEMENTATION OF HOPES

Since HOPES programming was implemented in three phases, the implementation experience was different for each phase of HOPES (HOPES I, HOPES II, and HOPES III). The online survey asked administrators and program managers about the start-up experience during the first year of implementing HOPES. The data describing the start-up experience should be interpreted with caution, as there are many factors impacting start-up experience that could not be captured. Additionally, each HOPES site is comprised of a variety of agencies with different organizational structures, capacities, and who are implementing different programs.

Figure 17. Start-up experience for each HOPES phase across three years, percent of HOPES staff responses

In general, a majority of HOPES staff in HOPES I and HOPES III indicated that they would have benefitted from more time during start-up because they experienced issues of not having all partners or subcontracting agencies on board to implement HOPES. One issue that impacted all HOPES programs was the implementation of a new database beginning in FY2017. The new database was a challenge for all HOPES sites but may have been a particular issue for HOPES III sites who had the additional challenge of being new contractors. During interviews and focus groups with supervisors, 18 supervisors discussed challenges with the grant requirements of HOPES. Specifically, some of the grant issues discussed were multiple changes in the paperwork required by either PEI or the primary agency, changes in partnerships, and challenges in meeting target numbers of families served. Another start-up challenge discussed was limited time to recruit families, hire and train staff, and provide programming for families, particularly for agencies who are implementing the evidence-based program for the first time.

“I think really vetting forms, processes and what’s going be handed down as the tool and the model would be helpful. That way there’s not so many changes. And I think having just a really good scope of what an organization has to do to build capacity to adopt these types of initiative requirements first and then understanding that what’s building that capacity means...when those things change, it can get a little messy.”

– HOPES Staff
Figure 18. Sectors involved during start-up during each HOPES phase over three years, HOPES staff responses

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>COMMUNITY SERVICES (E.G. POLICE, HOSPITAL, SCHOOLS, OTHER LOCAL AGENCIES)</td>
<td>74%</td>
<td>67%</td>
<td>53%</td>
</tr>
<tr>
<td>PARTICIPANTS/FAMILIES</td>
<td>74%</td>
<td>72%</td>
<td>63%</td>
</tr>
<tr>
<td>KEY PERSONS WITHIN ORGANIZATION (E.G. AGENCY DIRECTOR, PROGRAM MANAGERS)</td>
<td>78%</td>
<td>72%</td>
<td>95%</td>
</tr>
<tr>
<td>DIRECT SERVICE STAFF</td>
<td>85%</td>
<td>78%</td>
<td>95%</td>
</tr>
<tr>
<td>EBP DEVELOPER (E.G. IN PROVIDING TRAINING, TECHNICAL ASSISTANCE)</td>
<td>89%</td>
<td>67%</td>
<td>79%</td>
</tr>
<tr>
<td>FUNDING AGENCY</td>
<td>71%</td>
<td>72%</td>
<td>89%</td>
</tr>
</tbody>
</table>

Overall, most HOPES supervisors implementing programming described that they were well supported during the implementation of HOPES. Starting a new collaboration, hiring staff, and implementing programs is a challenging process. In spite of certain unique circumstances, such as the implementation of the new database or change in partners, the majority of HOPES managers reported that they were well-supported during the start-up process.

STAFFING & WORKPLACE SUPPORT

Some consistent themes in the implementation of HOPES are the strengths and challenges of hiring staff and staff turnover. In contrast to the online survey that suggests that staff turnover is not a major issue, interviews and focus groups with HOPES staff and program managers often discussed staff turnover as an issue impacting their ability to serve families. Particular challenges discussed during interviews and focus groups were hiring bi-lingual staff (n=12 interviews/focus groups). A lack of funding or scarcity of funding was also cited as an issue for some agencies who could not offer competitive salaries.
Direct service staff who completed the online survey also indicated the level of support they felt at their workplace. This evaluation sought to understand how supported and respected direct staff felt at their workplace, which has been shown to be a factor in fostering a positive work environment and minimizing staff turnover.

Overwhelmingly, HOPES staff felt very supported at their workplace, which suggested that agencies are promoting healthy, positive work environments. During interviews and focus groups with HOPES staff, 21 supervisors and parent educators specifically discussed the value of reflective supervision sessions as crucial to ensure parent educators are supported both professionally and personally. Reflective supervision was scheduled through one-on-one time between parent educators and supervisors to discuss cases, brainstorm solutions, and check-in on the personal wellbeing/self-care for parent educators.

“I feel like we do have a good amount of support. We have reflective (supervision) two times a month with our supervisor, so we’re able to voice out our concerns with having to do with our caseload, and are able to guide us during that time of reflection with the parent educators. And it also helps us to stay mentally well, because they ask us how’s our stress doing, are we feeling okay, we can just let out our feelings during our reflections.”

-HOPES Parent Educator
COLLABORATION AMONG PARTNER AGENCIES IN HOPES

As briefly discussed in the Introduction section, there are several HOPES sites that have decided to implement programming using a primary contractor and subcontractor structure. During interviews and focus groups with HOPES staff, 30 parent educators and supervisors discussed challenges and how that collaboration can be improved. Some consistent themes discussed among staff members included:

1. Subcontractors were not receiving referrals from other partner agencies participating in HOPES as was originally intended by the contract.

2. There was a sense of competition among the different partner agencies to meet quotas of families served in their own programs, which impeded effective collaboration.

3. Direct service staff were unfamiliar with staff from partner agencies and unsure of who to communicate to about referring families to programs. This was often due to staff turnover, inconsistent communication, and changing roles of staff at partner agencies.

“...I feel like most of our parent educators are getting a little overwhelmed and not being able to focus on the families and they’re trying to focus more on the assessments and having their numbers and I feel like it’s become more of a number game instead of helping families. Quantity, not quality it seems like.”

– HOPES Staff

The three concerns outlined above were the most common issues discussed in interviews and focus groups when staff members were asked about a collaboration among partner agencies who were part of the same HOPES grant. Staff recommended improvements in relationship building among all agencies and consistent communication among direct service staff are necessary for improving the collaboration of subcontractors.

In contrast, when asked about collaboration among partner agencies in the online survey, the majority of staff indicated that the partner agencies were collaborating well. The data below was collected from 96 staff who participated in a HOPES site that had a multiple agency structure.

Figure 21. Collaboration among partner agencies, average percent of HOPES staff responses

- 85% of respondents indicated they meet with staff from partner agencies who are implementing HOPES.
- 75% of respondents indicated that even after the HOPES contracts end, they feel their organization would continue to work together with the partner agencies that participated in HOPES.
- 73% of respondents indicated that being part of HOPES has improved their agency’s relationship with all the partner agencies.
- 58% of respondents indicated that all partner agencies were involved in discussions to address issues/problems related to the HOPES grant.
- 56% of respondents indicated that all partner agencies were involved in decision making about HOPES.
The online survey also aimed to learn about the types of collaboration activities that partner agencies would work together on. The responses below are gathered from 95 HOPES staff.

**Figure 22. Types of collaboration activities among partner agencies, average percent of HOPES staff responses**

- **77%** of respondents indicated they refer families to different partner agencies. 
  *Referals depended on location of agencies, needs of families, and capacity of agencies.*

- **68%** of respondents indicated that they collaborate with partner agencies on outreach events to promote child abuse prevention awareness.

- **47%** of respondents indicated that they collaborate with partner agencies on staffing cases (consulting with each other on how best to serve a specific family).

- **39%** of respondents indicated that they collaborate together with partner agencies on recruiting families into programming.

Consistent with data collected from interviews and focus groups, respondents of the online survey stated that they collaborated with partner agencies most frequently during community outreach events. The community outreach events were primarily about raising awareness about child maltreatment prevention and recruiting families into HOPES programming.

A total of 77% of staff respondents indicated that they referred families to partner organizations, which conflicted with the responses of staff during interviews and focus groups that there have been issues in getting referrals from agencies that were set up to refer families to each other. In the online survey completed by staff, 38% of respondents discussed that referrals were made depending on the initial assessment for the family and then determining which agency/program would be the best fit. Thirty percent of respondents indicated that referrals were dependent on capacity where their agency would sometimes refer families to the other partner agencies if their caseloads were full. Twenty-seven percent of respondents indicated that referrals sometimes depended on the transportation or location needs of the family being served. The evaluation team recommends that PEI provide technical assistance to help troubleshoot collaboration issues among all partner agencies, to ensure collaborations are productive and help serve families.

When asked about some of the barriers that prevent HOPES staff from collaborating with partner agencies, the majority of respondents did not indicate significant barriers. The types of barriers cited as hindering collaboration are described below collected from the online survey completed by 93 staff.

“...we do have a lot of successful partnerships and support for this program. We’re not a hidden resource anymore because you really know what everybody’s doing in this – in this town. So, we have appreciated the fact that it’s got a lot of attention on child abuse efforts and to address them in a more long-term primary prevention effort. That’s been extremely exciting to be a part of those endeavors.”

– HOPES Staff
of respondents indicated that time constraints prevented them from connecting with staff from partner agencies.

7% of respondents indicated that the lack of leadership from management prevents them from collaborating with staff from partner agencies.

2% of respondents indicated that previous attempts to collaborate with partner agencies were unsuccessful, thus hindering them from trying to build that relationship.

“...there are other agencies that are part of [HOPES]. But because it’s hard to find out what they do and we know that the families that we work with can’t benefit from their programs, because it would be double-dipping. So, [other programs] exist, but I’m not going to necessarily spend a lot of effort and time figuring out all of what their services encompass. Because I know that I can’t access it anyway.”

–HOPES Staff

**EVIDENCE-BASED PROGRAMS**

Evidence-based programs are one of the main components of the HOPES grant. At least one type of evidence-based program must be implemented in each HOPES site as part of the funding requirements. While the grant requirements did not specifically require agencies to implement evidence-based parenting programs, all HOPES sites have implemented evidence-based parenting programs. Over the years, each HOPES phase has included a greater diversity of evidence-based programs that target unique populations and/or addresses specific issues related to parenting. Program participants and HOPES sites have often expressed that the curriculum of evidence-based programs is one of the greatest strengths of the programs. During interviews and focus groups with HOPES staff and program participants, the topics that were the most useful and liked by staff and program participants respectively.
Figure 24. Staff and caregivers’ opinions on topics liked in the evidence-based programs from interviews and focus groups

- **64%** of participants interviewed valued the support from parent educators.
- **53%** of HOPES staff stated that parent-child interaction activities are the most useful.
- **38%** of HOPES staff stated information about discipline techniques & strategies.
- **52%** of participants interviewed valued parent-child interaction activities.
- **46%** of participants interviewed valued the techniques and modeling of activities.
- **38%** of HOPES staff stated information about child development and milestones are the most useful.

However, not all evidence-based programs are a good fit for families, particularly when faced with diverse cultural needs or families experiencing multiple crises. Often, evidence-based programs are piloted and tested in one type of population which may not be similar to the populations and families as those served by HOPES, who are typically facing higher risk of mental health and instability or who are of different cultural background. However, some evidence-based programs such as AVANCE Parent-Child Education Program and Abriendo Puertas have been piloted in Latino communities and are specific in targeting Hispanic families to participate in programming.

Each evidence-based program has its own flexibility and guidance on how to address these issues, with some programs having a very flexible curriculum structure and other programs having very rigid curriculum, requiring staff to seek guidance from the evidence-based program developers on how to tailor it for specific circumstances. When trying to adapt some curricula for HOPES program participants, staff indicated that they struggled to get timely responses from program developers or that there was no guidance on how to address certain topics. In these scenarios, staff would have to change the evidence-based program delivery at their own discretion or with support from their supervisor, whether that be to change the order of curriculum topics or supplementing the curriculum with information from resources found outside the evidence-based program. The figure below describes the various changes made to the program as indicated by 67 HOPES staff.
Of the HOPES staff that indicated that they make changes to the evidence-based program, 22% said changes were made due to the difficulty in retaining or engaging participants in the program. During interviews and focus groups, staff and participants expressed that spending time on case management to help families access resources for food, clothing, medical care, mental health care, or job/career assistance was extremely valuable for families to stay in the evidence-based program for the entire program duration. Many participants who were interviewed stated that their parent educators’ willingness and time to help provide case management was crucial for participants to trust parent educators. Participants often noted that the act of helping participants with case management outside of the curriculum proved that HOPES staff were committed to the wellbeing of the family and not simply trying to deliver the program. Many evidence-based programs have a case management component as part of the curriculum, however, during interviews/focus groups many HOPES staff noted that family needs required much more time for case management than what could be completed within the scheduled time with the family. Several HOPES sites discussed challenges and frustration with the lack of Spanish translated curriculum materials. Specific issues were the delay in getting appropriately translated materials from the evidence-based program developers, updates to program materials would often not include updates to the material in Spanish, and media materials with translations dubbed in Spanish over the English audio, making it very difficult for participants to understand. Some HOPES sites served refugee families who spoke languages other than Spanish, such as Vietnamese, Somali, and Nepali. For these sites, staff did not expect curriculum materials to be translated to these languages, but parent educators or translators did take time to translate materials themselves to deliver programming to families. For recruiting families into programming, HOPES sites had many different ways of marketing HOPES and enrolling families into programs. Some HOPES sites had discussed using incentives such as providing books for children or first aid kits to families who enrolled in programs, which may not have been something required by the evidence-based program.

This evaluation also gained insight from staff who implemented programming about their opinions regarding the delivery of evidence-based models. The online survey asked select questions from the 50-item Evidence-based Practice Attitudes (EBPAS) scale, which is a validated scale that measures a practitioner’s attitudes toward adopting and implementing new evidence-based interventions and practices. The full scale consists of twelve domains, however, this survey chose to include three of the twelve domains: monitoring, limitation, and balance. Responses in the data below was collected from 114 HOPES staff through the online survey.
The majority of HOPES staff supported the use of evidence-based programs and did not find that using evidence-based programs was a limitation in their work. A noteworthy result from this assessment was that 62% of respondents felt that a positive outcome from the evidence-based curriculum from the program was more of an art than a science. This suggests that while evidence-based programs are models aimed to be replicated and produce the same positive outcomes, there is an acknowledgement that it is not the curriculum alone that produces the desired outcomes, but more how the program is delivered. Particularly in parenting programs where staff are working individually with families, the intuition of parent educators and ability of parent educators to connect with families are important to tailoring activities and topics to address specific needs. When asked about the content of the evidence-based program, 25% of the respondents indicated that the curriculum is too narrowly focused. During interview and focus groups, HOPES staff often mentioned that there is lack of information on addressing mental health, domestic violence, and substance use in the curriculum and they would have to seek guidance outside of the training materials for the program.

“I think it’s very focused on just preventing neglect, preventing physical abuse. I would like for it to include more towards other types of traumas. For example, we have gone into some homes and we’ve learned that there is domestic violence in the home, and how that might impact a child. So, I would just maybe like to see [the curriculum] to be expanded a little bit more. However, those are things that we can address as we do our crisis intervention and our prevention counseling.”

– HOPES Supervisor

CASE MANAGEMENT & STRONG RELATIONSHIP BETWEEN FAMILIES AND PARENT EDUCATORS

During interviews and focus groups, the evaluation team asked HOPES staff what component of HOPES programming and services was the greatest strength. Case management was the service discussed as the most important component of HOPES programming by 15% of staff interviewed (n=39). Staff often discussed that case management was important to not only help address the underlying stressors to stabilize families but also as a way to build trust between staff and families. The majority of HOPES staff discussed that a focus on addressing basic needs, education/career training, and addressing crises were necessary to even begin to engage the family in the evidence-based parenting program. While some evidence-based programs had a case management component, many parent educators discussed that they needed to devote more time than what the curriculum allocated for.
“So, that’s why this program does not work unless we can provide some sort of case management service. If we’re only going in and we’re reading this scripted, evidence-based curriculum, and then we’re saying, “See ya,” they’re really never going to make progress to be the best parents they can be. You have to have both. You have to have the parent education and the case management to be able to serve them the way they need to be served.”

– HOPES Staff

When program participants were asked what was most useful from all the services they received from HOPES, half of the respondents (50%, n=25) stated that the supportive and trusting relationship between the parent educator and family was the most useful, regardless of the topics covered in the curriculum. This support was often expressed not only through parent educators’ empathy by listening and connection with families, but also through the parent educator’s ability to help families gain resources, navigate healthcare systems, and access therapy. Participants often noted that the act of parent educators to take time to help them with an issue outside of the curriculum proved that the parent educator was committed to the wellbeing of the family and not simply trying to deliver the program. While parent educators were very adept in building authentic relationships with families, many staff discussed the value of case management to reaffirm staffs’ commitment to families, securing their trust in HOPES programming, and destigmatizing the experience of seeking support.

“[My parent educator] just being there and [knowing] that I had support right there, it’s just a phone call away. Because during the time I was in the program I separated from my child’s father. And so, going through all that she was right there. I knew if I needed help or needed something I could always call her. And it was just anybody in the program really. If she wasn’t available somebody else was.”

– HOPES program participant

“Knowing that some of our moms, they’re out there all alone and we’re literally their only circle of support, realizing that. I had a mom the other day called me and had testing that her son needed done and she didn’t have anybody to go with her, so I went with her. So just knowing that we’re there for them in those times is important to me. You know, it’s hard being by yourself when you don’t have someone to help you parent.”

– HOPES Parent Educator

While case management was seen as a program strength of HOPES programming, 23% (n=57) of HOPES staff interviewed also discussed the challenge in balancing case management with funding constraints and curriculum requirements. Additionally, some parent educators discussed not being equipped to address crises with families, since the majority of their training was focused on how to deliver the evidence-based program.

Overall, evidence-based programs are useful and well-liked by HOPES staff when they are also adapted depending on family needs. With HOPES programming serving families of higher risk and who experience greater challenges in accessing resources, it is important to take in consideration the additional case management and basic needs assistance needed to ensure families are stable for them to be able to gain the benefits from evidence-based programs. For this reason, the evaluation team encourages PEI to adopt evidence-informed program framework, which encourages families to use the foundational curriculum of the evidence-based programs but to also encourage flexibility in program delivery in order to best fit family needs.
“I think a lot of the time the role that we have to fill is less of an educator and more of a case manager. The curriculum doesn’t really allow us to do the case management that’s sometimes necessary. Because if you don’t deliver the curriculum and a visit it doesn’t count as a visit. So, we may get there and our poor parent is just in tears, not able to even remotely function on it. It’s not something that we can deliver, we can’t deliver a curriculum while she’s just in distress. And so, it doesn’t count as a visit for us but then starts counting against us if we aren’t getting all those in”.

– HOPES Staff

BARRIERS IN ENGAGING FAMILIES INTO HOPES PROGRAMMING

Over the course of this evaluation, online surveys collected staff opinions on the types of barriers that prevent families from engaging in HOPES programs and services. The figure below describes the types of barriers.

Figure 27. Average percent of HOPES staff that said these barriers generally impacted families’ participation

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>CANNOT IDENTIFY OR REACH FAMILIES THAT NEED HELP</td>
<td>9%</td>
<td>14%</td>
<td>3%</td>
</tr>
<tr>
<td>CULTURAL BARRIERS PREVENT FAMILIES FROM ACCESSING HELP</td>
<td>15%</td>
<td>24%</td>
<td>7%</td>
</tr>
<tr>
<td>FAMILIES ARE UNWILLING TO ACCEPT HELP</td>
<td>12%</td>
<td>31%</td>
<td>15%</td>
</tr>
<tr>
<td>TRANSPORTATION</td>
<td>N/A</td>
<td>44%</td>
<td>24%</td>
</tr>
<tr>
<td>AVAILABILITY OF TIMES SERVICES ARE BEING OFFERED</td>
<td>N/A</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>PERCEPTION THAT THE AGENCY IS AFFILIATED WITH CPS</td>
<td>N/A</td>
<td>26%</td>
<td>17%</td>
</tr>
<tr>
<td>CONCERN REGARDING IMMIGRATION</td>
<td>N/A</td>
<td>36%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Note: n/a indicates that this question was not asked in the survey that year, thus there is no data collected for that barrier topic. With each subsequent year, our evaluation learned of barriers that were impacting programming and included these in online surveys.

During interviews and focus groups with HOPES staff, 82% (n=207) of staff interviewed discussed the lack of transportation as a barrier preventing families from seeking services, particularly in rural counties. While the many of the evidence-based programs have a home visiting component where staff met families at their home to deliver programming, nearly all other support services, such as doctor’s appointments or job training, required caregivers to travel in communities with poor public transportation systems. Immigration concerns were another major barrier discussed
by 54% (n=136) of all staff interviewed. The national political climate around immigration intensified during the implementation of HOPES programming and many HOPES staff discussed challenges in serving Hispanic communities, despite families being of legal residency status. Cultural and language barriers were also discussed as another barrier that prevented families from engaging in service discussed by 47% (n=118) of all staff interviewed. Seeking outside help is often stigmatized in many different cultures, particularly in seeking parenting support and mental health. To help mitigate this barrier, many agencies prioritized hiring parent educators from the same cultural backgrounds and communities as the families in order to help gain trust and improve cultural competency in delivering the program. Affordable and safe childcare was also a major barrier preventing caregivers form seeking therapy, education/employment, and other services, discussed by 31% (n=79) staff.

“I’ve got a mom that needs drug treatment and—it’s one of those things that’s like she needs to be in a facility and so we try to get her connected. We don’t have one here in town that we connect her to. The closest one which is an hour away so, transportation is an issue. But, even to get her in it they said it’s a wait and they couldn’t even give us a clear view of what that looked like.”

— HOPES Staff

A unique barrier that negatively impacted HOPES program implementation was the hurricane in August 2017, known as Hurricane Harvey, which heavily impacted southeast and coastal cities in Texas. The Texas cities that were greatly impacted included Houston, Beaumont, and Corpus Christi. Twenty-three percent of HOPES staff who completed the survey indicated that Hurricane Harvey impacted HOPES programming and/or their community. The responses on how programming was impacted are described below collected from 40 HOPES staff through the online survey.

Figure 28. Hurricane impacts to HOPES programming, average percent of HOPES staff responses

This hurricane resulted in many families being displaced, losing their home and belongings due to flooding, and anxiety and trauma experienced by children and caregivers. While the impacts of the hurricane were devastating, families who were already connected to HOPES were able to get some support during this crisis.
Families’ Motivation to Participate

While there are barriers that make it difficult for families to participate in HOPES programming, the evaluation team also gained insight from families on their motivation to participate in programming and their initial reaction when they first learned of HOPES programming. A question was asked to ascertain hesitation felt by caregivers to participating in HOPES. This question was asked to participants who were at different lengths of time in HOPES and who were participating in different programs.

Figure 29. Participants’ motivation to participate & initial reactions, from interviews

- **44%** of participants interviewed said they had no hesitation in their initial reaction to HOPES.
- **36%** of participants interviewed said they had some hesitation in their initial reaction to HOPES.
- **14%** of participants interviewed said they were very hesitant in their initial reaction to HOPES.

The majority of participants interviewed described that they were motivated to participate in HOPES because of its help with parenting, how to appropriately discipline children, and address child behavior/development issues. Some other factors that influenced their motivation to participate included that the program was free, positive impressions from staff and parent educators and that parent educators would come to the participant’s home. Note: Not all programs in HOPES are home visiting programs, but the majority of programs have a home visiting component.

When the evaluation team asked participants to recall their initial impression of HOPES when they first learned about it, there were mixed responses on how hesitant they were to participate. Only
one caregiver interviewed by our evaluation team discussed that their hesitation was due to fear of CPS, which is much lower than expected since the issue of families being fearful of CPS was indicated as a barrier by HOPES staff. While the evaluation team tried to interview a random sample of program participants, it is likely families who are less fearful of outside organizations participated agreed to be interviewed by our evaluation team thus showing higher perceived trust in organizations than all program participants in HOPES.

Since all programs implemented in HOPES have a parenting component and/or focus, the evaluation team also gained insight from participants on what were some of the main challenges that make parenting difficult for them or families in their community. The figure below describes the types of issues HOPES participants explained to be the most challenging when parenting. Note: These interviews were completed among 12 HOPES participants. Responses and opinions may vary among families who have not participated in HOPES programming.

**Figure 30. Participant opinions on the challenges of parenting, from interviews**

Appropriate discipline for children, lack of knowledge about child development and parenting techniques, and stress were the top issues that participants discussed as being the most challenging part about parenting young children. Some caregivers discussed that they did not want to repeat the harsh discipline they experienced with their own children, but they also discussed that they were unaware of other strategies. Lack of knowledge of child development and parenting techniques were also discussed as difficult components of parenting. Some participants often discussed that after participating in HOPES they learned how valuable child development is in understanding their child’s behavior. Stress often encompasses an umbrella of issues, but many participants noted that compounding issues such as medical needs and the lack of financial resources exacerbated their stress levels which make parenting even more difficult.

**THE COLLABORATION WITH CHILD PROTECTIVE SERVICE AGENCIES**

The history of collaboration efforts between HOPES and CPS is complicated. At the beginning of the implementation of HOPES, families with a history of CPS involvement could not participate in HOPES programming because the intention was to serve families before maltreatment occurred. HOPES sites expressed their dissatisfaction with this policy, as many felt they were turning away
families who would benefit from HOPES programming and further stigmatize families with a CPS case. In the second year of HOPES implementation, PEI allowed for HOPES sites to serve families with a past or current CPS case but expressed that only some of the caseload could be families with a prior or current CPS case. During interviews and focus groups with HOPES staff, there was confusion on how much of their caseload could be families with a CPS case. Some HOPES staff discussed that PEI stated that 10% of their caseload could be families with a current CPS case and others said they were not given a specific percentage, but that it could not be a “majority” of the families they serve. As HOPES began collaborating with CPS through coalitions and serving families with an open CPS case, it became evident that HOPES has potential to be a valuable program to help families who are the most at-risk of child maltreatment and to strengthen families to prevent future CPS involvement. During interviews and focus groups with HOPES staff, 5 HOPES sites did not have any formal collaboration process or communication with CPS, 9 HOPES sites had at least one agency with an existing collaboration with CPS, and 20 HOPES sites have at least one agency that was currently collaborating with CPS in providing HOPES programming.

Figure 31. HOPES collaboration with CPS, average percent of HOPES staff responses

These responses indicated that HOPES and CPS were collaborating, however, the effectiveness of that collaboration may need some attention. To understand more about the respondents’ experience in collaborating with CPS to support families, the survey also asked for an open-ended response to describe some of the strengths and challenges in collaborating with CPS. There were several themes identified that are highlighted below.

Strengths in the collaboration between HOPES Programs & CPS

- HOPES staff stated they were serving higher-risk populations when they collaborated with CPS in gaining referrals of families to participate in HOPES programming. HOPES staff felt that families who needed services and support were gaining it through the collaboration on referrals between HOPES and CPS.
- HOPES staff stated that the collaboration between the HOPES parent educator and the
CPS caseworker was effective because this alliance of care was beneficial for the wellbeing of the family.

- HOPES staff felt that families who participated in HOPES with a current involvement with CPS had enabled families to stay together while families gained support, instead of removing children from families as that can cause more distress for families.
- When working to access resources for families, HOPES staff stated that the collaboration with CPS helped expedite the process to receive resources that would typically take longer or be more burdensome without the help of CPS.
- The collaboration with CPS has brought steady referrals for HOPES staff, so they can focus on serving families rather than spending time marketing and recruiting families.

“Helping [families] and guiding them to break that stigma that reaching out for assistance, especially within the community, is not something that everybody can obtain or should obtain, especially if it’s somebody that’s already involved with CPS. And depending on prior experiences they’ll be a little bit more hesitant to reach out. So, that’s something that I always touch on, on my last group is that ‘I hope that you enjoyed this experience, and I hope that this experience helps you see that we are here to help you regardless of your situation.’”

– HOPES Staff

**Challenges in the collaboration between HOPES Programs & CPS**

- The high staff turnover at CPS made collaboration on a family between the HOPES parent educator and CPS caseworker challenging.
- The poor communication between HOPES staff and CPS caseworkers led to parent educators receiving incorrect information about families.
- HOPES staff discussed that certain levels of bureaucracy at CPS hindered collaboration between HOPES staff and CPS caseworkers when working with a family.
- The policies of required participation on behalf of CPS and voluntary participation on behalf of HOPES created confusion for families. Thus some families may have been participating out of fear of removal of their children.
- HOPES staff expressed that CPS caseworkers would overstep boundaries and use parent educators as an extension to follow up their CPS visits. For example, several HOPES staff noted that CPS caseworkers would ask about whether HOPES parent educators saw any drugs at the families’ homes, rather than the CPS worker visiting the family’s home.

This data suggests that the collaboration between HOPES programming and CPS is valuable for families, but there needs to be more structure and clarity among both HOPES and CPS with regards to roles and responsibilities. With greater support from PEI to help bridge the gap between prevention and intervention of child maltreatment, this collaboration has the potential to positively impact families.

**TRAININGS REQUESTED BY HOPES STAFF**

Over the years of implementing HOPES, PEI has improved access to trainings by providing access to webinars and implementing regional trainings. The data in the figure below describe trainings requested by 264 HOPES staff from the online survey completed by staff in 2018. These training topics may have already been provided to HOPES staff or staff may be interested in gaining a deeper understanding or skillset in the following topics.
The topics that staff requested more training on included addressing mental health issues, parenting for special needs/disabled children, and family violence. Although parent educators followed the program model and cover topics/lessons determined by the curriculum, they were in a unique position to help families address personal issues/concerns beyond the curriculum. Ensuring that staff were equipped to know how to approach these topics and support families in seeking support is valuable to help prevent child maltreatment.

HOPES staff indicated that there were not major barriers preventing them from participating in training opportunities. The responses from 103 HOPES staff from this question on the online survey question are provided below.

The ability to attend trainings and professional development opportunities is often impacted by the location of the training (e.g., if staff must travel out of town to attend), the availability (e.g., how often the training is provided), and the cost (e.g., cost of attendance, including travel and lodging). Slightly less than half of the respondents stated that the location and availability of trainings were an issue in accessing trainings. The issue of location was particularly an issue for the staff of HOPES sites in rural counties who had to travel long distances to attend training opportunities. PEI has worked to
provide webinar and regional training to all HOPES sites, including rural counties to help mitigate this issue.

“...I think if you’re going to have a visitation program and educators are going to be put in these circumstances, I absolutely think there needs to be more training in recognizing abuse and broaching the top of abuse.”

– HOPES Parent Educator

DATA COLLECTION & DATABASE ISSUES

An issue that was expressed by all HOPES staff during interviews and focus groups was the process of switching to a new PEI database. At the end of FY2016, PEI implemented a new database where all HOPES contractors were required to input data into a newly developed database. During interviews and focus groups, 39 HOPES staff across 17 interviews and focus groups discussed that issues with the new database were the primary challenges during program implementation. Specifically, staff discussed that functionality issues of the database (e.g., inability to input/retrieve data as intended), the poor roll-out of database training, and staff turnover at PEI to help troubleshooting database issues. Due to these database issues, HOPES staff were given several changes in procedures regarding data collection and input processes, which greatly strained administrative staff. However, in 9 of the 17 interviews and focus groups HOPES staff discussed that the PEI database issues have been resolved and data collection and input process have been improved.

The UT evaluation team learned that the switch to a new database also changed the types of data collected by PEI. In order to consistently analyze data across fiscal years, changes in the types of data collected heavily impacts the quality of data and impedes the ability to conduct valuable analyses due to smaller samples sizes. The implementation of a new system of IDs, the lack of certain demographic and risk factor information makes it difficult to link together the data for all participants and results in large amounts of missing data.

COALITION FUNCTIONING

Through the online survey, data was also collected regarding how well the community coalitions are functioning in meeting their intended goals. To assess this, the online survey asked coalition members to complete the Wilder Collaboration Factors Inventory Survey that is comprised of 19 factors found to be critical for successful collaborations. Over the three years, a total of 317 coalition members completed the Wilder Collaboration Factors Inventory Survey, which may include duplicated individuals since many of the coalition members participated in coalitions multiple years during this evaluation. Since this was a voluntary survey, not all coalitions are represented in the data we collected. The figure below describes the total coalition functioning score for each of the coalition. Scores range from 1 to 5, with 1 indicating poor coalition functioning and 5 indicating a productive, effective coalition. 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.
Figure 34. Wilder Collaboration Index scores by each coalition in HOPES

<table>
<thead>
<tr>
<th>HOPES SITE</th>
<th>COALITION NAME</th>
<th>YEAR 1 SCORE</th>
<th>YEAR 2 SCORE</th>
<th>YEAR 3 SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMERON/HIDALGO</td>
<td>MAKE THE FIRST 5 COUNT</td>
<td>4.0 (n=34)</td>
<td>4.2 (n=14)</td>
<td>2.0 (n=13)</td>
</tr>
<tr>
<td>ECTOR</td>
<td>EARLY CHILDHOOD COALITION</td>
<td>4.1 (n=34)</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>EL PASO</td>
<td>PROJECT LAUNCH</td>
<td>4.1</td>
<td>3.9</td>
<td>n/a</td>
</tr>
<tr>
<td>GREGG</td>
<td>FAMILY BRIDGE / BRIDGES OUT OF POVERTY</td>
<td>4.2 (n=11)</td>
<td>4.1 (n=7)</td>
<td>n/a</td>
</tr>
<tr>
<td>POTTER</td>
<td>HOME VISITING STAKEHOLDER’S GROUP</td>
<td>3.9 (n=36)</td>
<td>3.9 (n=7)</td>
<td>n/a</td>
</tr>
<tr>
<td>TRAVIS</td>
<td>FAMILY SUPPORT NETWORK</td>
<td>4.1 (n=17)</td>
<td>4.0 (n=7)</td>
<td>n/a</td>
</tr>
<tr>
<td>WEBB</td>
<td>PROJECT HOPES STAKEHOLDER GROUP</td>
<td>4.3 (n=15)</td>
<td>4.5 (n=10)</td>
<td>n/a</td>
</tr>
<tr>
<td>HARRIS</td>
<td>PARENTING HELP COALITION</td>
<td>n/a</td>
<td>4.1 (n=11)</td>
<td>2.2 (n=7)</td>
</tr>
<tr>
<td>JEFFERSON</td>
<td>COMMUNITY RESOURCE COORDINATION GROUP</td>
<td>n/a</td>
<td>4.9 (n=5)</td>
<td>n/a</td>
</tr>
<tr>
<td>LUBBOCK</td>
<td>SOUTH PLAINS COALITION FOR CHILD ABUSE PREVENTION</td>
<td>n/a</td>
<td>4.3 (n=14)</td>
<td>1.6 (n=7)</td>
</tr>
<tr>
<td>MCLENNAN</td>
<td>MCLENNAN COUNTRY HOPES COALITION</td>
<td>n/a</td>
<td>4.3 (n=14)</td>
<td>n/a</td>
</tr>
<tr>
<td>NUECES</td>
<td>SUCCESS BY 6 COASTAL BEND EARLY CHILDHOOD COALITION</td>
<td>n/a</td>
<td>4.1 (n=8)</td>
<td>n/a</td>
</tr>
<tr>
<td>TAYLOR</td>
<td>HOPES COALITION</td>
<td>n/a</td>
<td>n/a</td>
<td>2.4</td>
</tr>
<tr>
<td>WICHITA</td>
<td>EARLY CHILDHOOD COALITION OF NORTH TEXAS</td>
<td>n/a</td>
<td>3.9 (n=13)</td>
<td>n/a</td>
</tr>
<tr>
<td>BEXAR</td>
<td>READY KIDS SA</td>
<td>n/a</td>
<td>n/a</td>
<td>2.0 (n=12)</td>
</tr>
<tr>
<td>GALVESTON</td>
<td>COMMUNITY RESOURCE COORDINATION GROUP (CRCG)</td>
<td>n/a</td>
<td>n/a</td>
<td>2.0 (n=7)</td>
</tr>
</tbody>
</table>

Note: n/a indicates that there is no data collected for those years. No coalition members completed Wilder Collaboration Index scores for Bell, Brazos, Montgomery, or Tarrant HOPES sites. Coalitions included in the table above are from coalitions who had at least 5 responses.

The responses collected from the online survey may not represent all coalition members since this survey is optional. From the responses collected, the data suggests that most coalitions have been functioning poorly compared to previous years, for HOPES sites that have data. In contrast
to the low Wilder Collaboration Index scores, respondents described many of the successes and accomplishments of their coalitions. The online survey collected open-ended responses on strengths and challenges of coalitions, organized in themes below.

Across all coalitions, the majority of respondents described some of the strengths of the coalitions:

- Coalition meetings have been an opportunity to bring different sectors and organizations together to best address the needs in the community;
- Coalitions have been useful in developing a more standardized referral system to best support families; and
- Coalitions have been useful to strategically address family and community needs by conducting needs assessments.

Some continued challenges include:

- The need for consistent communication and stability among leadership in coalitions;
- The feeling of competition for funding and resources hinders collaboration; and
- The lack of involvement in certain sectors in order to more effectively address community issues.

Since HOPES is focused on community-based changes to address prevent child maltreatment, PEI should help troubleshoot issues experienced by coalitions to ensure that collaborations are functioning well and are sustainable.
IMPACT OF PROGRAMMING ON FAMILIES
IMPACT OF HOPES PROGRAMMING ON FAMILIES

This section of the report addresses the research question, “To what extent have HOPES programs impacted families and communities in supporting safety, stability, and nurturing, the building blocks for community-based child maltreatment prevention?” This section of the report evaluates the impact on families from data collected by the Protective Factor Survey, Caregiver Survey, and interviews/focus groups from staff and program participants.

PROTECTIVE FACTORS SURVEY ASSESSMENT

HOPES, like all PEI programs, used the Protective Factors Survey (PFS) to measure changes in protective and risk factors in caregivers 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 G. The subscales of the PFS are detailed in the figure below. Note: The developers of the PFS recently released an updated version of the PFS, called PFS-2 that has been revised. The data collected in this report used the older version of the PFS that is in Appendix G of this report.

Figure 35. Protective Factor Survey Subscales

<table>
<thead>
<tr>
<th>PROTECTIVE FACTORS</th>
<th>DESCRIPTION</th>
<th>SCORING</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAMILY FUNCTIONING/ RESILIENCY</td>
<td>Having adaptive skills and strategies to persevere in times of crisis. A family’s ability to openly share positive and negative experiences and to accept, solve, and manage problems.</td>
<td>If 4 or more items completed, take average of item responses</td>
</tr>
<tr>
<td>SOCIAL SUPPORT</td>
<td>Perceived information support (from family, friends, and neighbors) that helps provide for emotional needs.</td>
<td>If 2 or more items completed, take average of item responses.</td>
</tr>
<tr>
<td>CONCRETE SUPPORT</td>
<td>Perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.</td>
<td>Reverse score all items. If 2 or more items completed, take average of item responses.</td>
</tr>
<tr>
<td>CHILD DEVELOPMENT &amp; KNOWLEDGE OF PARENTING</td>
<td>Understanding and using effective child management techniques and having age-appropriate expectations for children’s abilities.</td>
<td>Reverse score 12, 14, 16. Because of the nature of these items, calculation of a subscale score is not recommended.</td>
</tr>
<tr>
<td>NURTURING &amp; ATTACHMENT</td>
<td>The emotional tie along with a pattern of positive interaction between the parent and child that develops over time.</td>
<td>If 3 or more items were completed sum the items responses and divide by the number of items completed.</td>
</tr>
</tbody>
</table>


The PFS is administered when a caregiver starts and ends services, resulting in a pre-PFS at the beginning of services and a post-PFS at the end of services. For programs that lasted longer than one year, PEI required sites to administer the survey at one year after the beginning of services. Participants who stopped services prior to completing the program also completed post-PFS surveys. Of the 12,478 primary caregivers who received services from FY2015-FY2018, 4,350 completed a pre-PFS and post-PFS (34.9%). Thus, the analyses and information in this section only include those 4,350 primary caregivers.

In the sample of PFS survey scores at the end of FY2018, the number of days between pre- and post-surveys ranged from 0 to 1,260 days, or approximately 3.5 years. The average time between a pre-PFS and post-PFS is 6.9 months. The figure below shows the average change in PFS scores for primary caregivers who exited the program from FY2015 – FY2018 (n=4,350). All changes in PFS subscales scores were statically significant (p< 0.05). The figure below presents the change in PFS subscales score among HOPES participants with a pre-PFS and post-PFS.
Overall, all HOPES caregivers with a pre- and post-PFS strengthened the protective factors that were collected by the PFS. The subscales that had the greatest improvement is the Child Development & Knowledge of Parenting item of “I know how to help my child learn” by almost one point. Since many of the HOPES programs focused on child development and parenting skills, it was expected that these areas were where the most improvement occurred. The subscale that had the least improvement was concrete support. This was also a reasonable outcome since the improvement in concrete support was often related to income. While some HOPES programming supported families with job or career goals, it was difficult to improve concrete supports within a year or less time. The figure below examine the change of PFS subscale scores by the evidence-based program.
The programs that showed the greatest change across the different PFS subscales were: Incredible Years, AVANCE Parent Child Education Program, Safe Care, and Family Connections. Caution should be exercised when interpreting PFS subscale change scores. Negative change scores should not be interpreted as the program negatively impacting that subscale. Reasons for negative change score could be due to: 1) social desirability bias during the pre-survey and subsequent lack of bias at the time of the post-survey or 2) caregiver was not aware of issues or challenges at the beginning of the program that were later discovered to address during the program. Additionally,
programs with small change scores may suggest that families already had strong protective factors, thus improvements were minimal since families were already at a high protective factor baseline score.

**Associations of Change in PFS scores & PEI Risk Factors**

When examining the relationship of PFS subscale scores and PEI risk factors collected at intake, the data showed that there were several significant associations between PFS subscale change score and the type of PFS risk factor, however, all the associations showed very weak correlations (Pearson’s r correlations of less than 0.01). Thus, data could not confidently see any correlation if the presence of certain risk factors had impacted any change in PFS subscale score. Note: Pearson’s r correlations of 1 indicated a strong positive correlation, -1 indicate a strong negative correlation. Pearson’s r correlation of the absolute value of 0.5 indicates a moderate association.

The evaluation team also analyzed whether there is a trend in the number of risk factors indicated by caregivers and PFS subscale changes. The figure below number of risk factors and the change of PFS subscale scores.

**Figure 38. Change in PFS Subscale Scores by the Number Risk Factor at Intake**
In general, caregivers with a greater number of risk factors experienced the greatest change in PFS. This confirms the assumption that caregivers experiencing more risk factors have the opportunity to gain the most out of the program evaluated here by the PFS subscale change. Again, data here should be taken with caution and the number of risk factors does not take into consideration the scope or severity of risk factors present.

**Program Length & Changes in PFS Subscale Scores**

While each evidence-based program has determined its own model including program length, it is valuable to assess how a family’s length in HOPES programming may have impacted changes in their protective factors, as assessed by the PFS. It is important to note that this analysis does not take into account the types of support/resources received during program participation or the level of program participation, which may contribute to improving protective factors.

The range of time that HOPES participants with a start date and end date participated in programming lasted from 2 days to 3.8 years. Our analyses separated this range into quartiles, described in the table below. The figure below describes the average change in PFS subscales by...
program length, defined by these quartiles.

<table>
<thead>
<tr>
<th>QUARTILE</th>
<th>APPROXIMATE LENGTH OF TIME IN PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2 days - 2.83 months</td>
</tr>
<tr>
<td>2</td>
<td>2.86 months – 5 months</td>
</tr>
<tr>
<td>3</td>
<td>5 months – 9 months</td>
</tr>
<tr>
<td>4</td>
<td>9 months – 3.8 years</td>
</tr>
</tbody>
</table>

Figure 39. Change in PFS subscale score by average length in program

- Average change score of family functioning by program (N=3,839)
- Average change score of social support by program (N=3,851)
- Average change score of concrete support by program (N=3,804)
Program participants who participated in HOPES from 5 months to 9 months experienced the greatest improvement across all PFS subscales compared to participants who participated in HOPES less than 5 months and participants who participated in programming for more than 9 months. The reason for the smaller improvement in PFS subscales scores for families participating in HOPES for longer than 9 months may be due to the higher pre-PFS scores for these families who are able to attend programming consistently for over 9 months.

ABOUT THE CAREGIVER SURVEY

The Caregiver Survey was developed by the TXICFW evaluation team and was implemented from January 2016 to February 2019 for HOPES program participants. The Caregiver Survey includes validated measures on indicators that are empirically linked to child maltreatment, such as the caregiver’s history of trauma, mental health, domestic violence, and substance abuse, as well as an assessment of protective factors related to family’s stability and the caregivers’ nurturing capacities that are a key component in strengthening families. The aim of the Caregiver Survey is to gain a better understanding of families participating in HOPES and ultimately help screen families who are at risk of child maltreatment. The description of the scales used in the Caregiver Survey is located in Appendix B.
The Caregiver Survey is a voluntary survey completed by the primary caregiver participating in long-term evidence-based programs in HOPES. The pre-Caregiver Survey is offered at the beginning of services, between the first and fifth session/home visit and the post-Caregiver Survey is offered when the primary caregiver exits services or is nearing the end of the program. Due to various paperwork and competing deadlines required by the HOPES program and evidence-based program, the Caregiver Survey offered flexibility on when to implement the pre- and post-surveys.

The evaluation team collected a total of 1,858 pre-Caregiver Surveys, 808 post-Caregiver Surveys, and 535 primary caregivers completing both the pre and post-Caregiver Surveys.

OUTCOMES OF CAREGIVER SURVEY

The figure below describes the average Pre-Caregiver Survey scores and Post-Caregiver Survey scales assessing risk factors, family stability and nurturing from 535 primary caregivers who completed both the pre-Caregiver Survey and post-Caregiver Survey.

Figure 40. Percent of caregivers with a risk factor, Pre and Post Caregiver Survey

Note: Due to the small number of respondents who indicated alcohol abuse/misuse (less than 5 caregivers), this risk factor is omitted from this table. History of childhood trauma captured by the number of ACEs is only collected once in the pre-Caregiver Survey.

Based on the data collected, the risk factors of mental health and domestic violence, and substance use/misuse were all mitigated from pre- to post-survey, indicating that these risk factors improved since the caregiver participated in programming. Interestingly, the percent of substance abuse/misuse in the post-Caregiver Survey was higher than that of the pre-Caregiver Survey. As discussed before, social desirability bias may influence caregivers to answer substance use questions in a more “favorable” manner since they have not yet built trust with their parent educator and were unsure of the consequences. While we do not have the data on all of the types of support services these caregivers participated in during HOPES programming (e.g., access to counseling), with the data provided the evaluation team can state that HOPES program participation helped mitigate or address these risk factors for these caregivers.

The figure below describes the percent of caregivers at each subscale score of low, moderate, and high. Low indicates a poor level of the protective factor, moderate indicates a moderate level of the protective factor, and high indicates a high level of strength in the protective factor. Scores of maximum indicate that caregivers responded with the highest score for all questions.
Overall, the majority of caregivers who completed the pre- and post-Caregiver Survey had moderate to high nurturing and stability subscale scores and improved slightly after program completion, with the exception of family resources. Similar to the Protective Factor Survey, and any survey assessing risk and protective factors, the Caregiver Survey is also subject to social desirability bias when respondents complete the pre-survey at the beginning of the program. Alternatively, this data could also suggest that the majority of families served in HOPES programming already have strong nurturing and parenting capabilities.
Figure 42. Participants’ responses on program impact, from interviews

The topics that participants discussed as having the most impact were improved parenting behavior and positive changes in their child’s behavior. Additionally, many participants mentioned that parent educators were the most impactful because they empowered the family and caregiver. Examples of empowerment were building their confidence as a caregiver or giving them the confidence to seek support or apply for a job. These acts of encouragement and support provided by the parent educator are not often part of the curriculum, but their impacts are profound and lasting to many of these families.

This evaluation also aimed to understand HOPES staff opinions on how effective HOPES programming is at helping families mitigate risk factors and strengthen protective factors. The results of this survey question are presented in the figure below.

Figure 43. Usefulness of HOPES services in helping families address risk and protective factors, average percent of HOPES staff responses

The majority of HOPES staff felt that HOPES programming was effective in helping families build protective factors related to strengthening parenting and access to resources and also risk factors related to mental health and domestic violence. Helping families address issues of substance
use was indicated as less effective. This finding is expected since there seems to be a low percentage of families participating in HOPES programming who are currently struggling with substance abuse. Additionally, not all HOPES sites have access to substance abuse counselors or have the capacity to help families seek help due to a lack of resources and/or providers in the community.

The Caregiver Survey implemented by the evaluation team also collected participants’ opinions on program impact. The figure below describes how caregivers who completed the post Caregiver Survey described the program impact.

Figure 44. Participant survey responses of program experience, post-Caregiver Survey

The responses from the post-Caregiver Survey were from program participants from different HOPES sites who participated in different programs. Overwhelmingly, the majority of survey respondents (over 95%) were satisfied with their program experience on how services were delivered to them. While survey respondents participated in different evidence-based programs, the majority (84%) indicated that the program length was appropriate, not too long or too short. Similarly, program participants described that since starting HOPES programming the majority have had positive impacts...
in various areas of their personal and family life. The two areas that the majority of survey respondents experienced an improvement were being able to better address crises (92%) and improving in their housing situation (91%). Although not all HOPES programming offer services to help families with housing, this suggests that case management services provided by parent educators were valuable in securing stability for families.

“I know a lot of other programs, they tend to focus more on the child, not so much the parent. And that’s something that I’ve really seen is great about our program is that we go in and we help the parent so that they can help their child. And I think that makes it very unique compared to other services that are offered in our community. And I honestly think that’s why a lot of parents like our program: that we come to them and we go to help them out, and in turn that helps them support their child.”

– HOPES Staff

CAREGIVERS’ OPINIONS ON IMPROVING HOPES

When asking families for suggestions to improve programming, many families did not have any suggestions and noted that the way the structure of the program was implemented was valuable. However, some families discussed recommendations to make the programming better and to improve recruitment into HOPES programming. The data below describes the type of suggestions recommended by participants interviewed.

Figure 45. Program suggestions from participants interviewed

Because of how valuable the program was for their families, many participants discussed that HOPES programming was not well advertised or known about in their community. Thus, many participants interviewed reiterated that there is a need for this program in their communities and suggested to have more advertisements to promote HOPES. Some of the participants enjoyed the program so much that they were disappointed when the program ended and wished the program was longer.

“I feel like being able to teach the parents or to educate on those types of strategies because I never learned as a kid how to cope with things, and eventually that’s why I turned to drugs. So, when you’re trying to break a cycle but you don’t know how, that information has become huge. If I would’ve known this when [my daughter] was 2 or 3 months old, the change that could’ve probably happened. I just wish that information was available to all moms that had kids.”

– HOPES Program Participant
IMPACT OF HOPES ON CHILD MALTREATMENT
IMPACT ON CHILD MALTREATMENT

This section of the report addresses the last research question, “How many families who participated in HOPES did not experience a new CPS case? Can the data provide any valuable information on families who had a CPS case during HOPES programming or after exiting HOPES programming?” This section will use data provided from the PEI database, CPS database, and publicly available county-level data on substantiated cases of child maltreatment in Texas.

HOPES PARTICIPANTS & INVOLVEMENT WITH CPS

PEI collected data on the number of caregivers served in HOPES and identifies whether the caregiver had a CPS case since enrolling into HOPES programming. That data presented in the figures below is from matching PEI administrative data from program participants with CPS administrative data. Note: the PEI program data is from FY2015-FY2018 and the CPS administrative data is from FY2010 – FY2017.

The figure below describes the number of HOPES participants who have had a CPS case before they started HOPES programming, during HOPES programming, and after they exited HOPES programming.

Figure 46. HOPES participants with a CPS case opened

<table>
<thead>
<tr>
<th></th>
<th>CPS CASE OPENED BEFORE, DURING &amp; AFTER HOPES PARTICIPATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BEFORE</td>
</tr>
<tr>
<td>ALL HOPES WITH CPS CASES</td>
<td>3,927</td>
</tr>
<tr>
<td>PERCENT WITH CPS INVOLVEMENT AMONG ALL HOPES PARTICIPANTS</td>
<td>31.15%</td>
</tr>
<tr>
<td>WHEN CASES OCCURRED</td>
<td>2 days to 3378 days (9.25 years), average was 2057 days (5.6 years) before starting the program</td>
</tr>
</tbody>
</table>

Note: CPS intake date is defined as the date when a CPS investigation was opened for the family. An opening of the CPS investigation does not necessarily indicate the child was a victim of child maltreatment.

Based on this data match linking PEI program data to CPS administrative data, 33% HOPES participants (4,154 HOPES participants) have had a CPS case opened either prior to HOPES, during HOPES, or after exiting HOPES. Of the 33% of HOPES participants who have had a CPS case, nearly all of them (31.2%) experienced the CPS case prior to their enrollment in HOPES programming. Since HOPES agencies collaborated with CPS in receiving referrals, there were HOPES participants who were enrolled in HOPES in order to resolve their CPS case. There were 64 HOPES participants who had a CPS case opened 30 days prior to their HOPES start date, which suggests that these families may have been referred to HOPES by CPS. Due to the limitations of the data received, the evaluation team could not determine the exact number of referrals from CPS to HOPES.

The range of time that CPS cases occurred prior to their enrollment into HOPES spanned a wide range, from 2 days prior to HOPES enrollment date to 9.25 years, with the average time of when the CPS case was opened to be 5.6 years prior to their HOPES start date. While this data is of HOPES participants with an opened CPS case, it does not necessarily indicate that child maltreatment was confirmed for the child. This data match shows that nearly one-third of HOPES participants have had past CPS involvement which suggests that HOPES programming is reaching families who are in need of additional support to help keep their children safe from maltreatment.

The figure below describes the disposition of the CPS cases among HOPES participants with a CPS involvement. There are four types of disposition results based on the investigation conducted by
CPS caseworkers that are defined in the table below.

<table>
<thead>
<tr>
<th>CPS CASE DISPOSITION</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>REASON TO BELIEVE</td>
<td>Child maltreatment occurred</td>
</tr>
<tr>
<td>RULED OUT</td>
<td>Child maltreatment did not occur</td>
</tr>
<tr>
<td>UNABLE TO DETERMINE</td>
<td>Unable to determine is assigned if there is either:</td>
</tr>
<tr>
<td></td>
<td>1. Not enough evidence to support whether the maltreatment occurred, or</td>
</tr>
<tr>
<td></td>
<td>2. There is enough information that the maltreatment occurred, however there is not enough information to determine in the alleged perpetrator is responsible.</td>
</tr>
<tr>
<td>UNABLE TO COMPLETE</td>
<td>Unable to complete the investigation because the family could not be located to complete the investigation or the family was unwilling to cooperate with the investigation.</td>
</tr>
</tbody>
</table>

Definition of CPS disposition DFPS Child Protective Services Handbook, Section 2281.2 – 2281.5 [https://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_2200.asp](https://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_2200.asp)

For the purposes of this report, designation of the CPS disposition of “unable to determine” will be included as part of the confirmed child maltreatment counts since the CPS data does not delineate whether the “unable to determine” dispositions were due to the fact that there was not enough evidence to confirm maltreatment or whether the maltreatment was confirmed but unconfirmed whether the alleged perpetrator was responsible for the maltreatment.

Figure 47. Confirmed disposition of CPS cases among HOPES participants

<table>
<thead>
<tr>
<th></th>
<th>CPS CASE OPENED BEFORE HOPES</th>
<th>CPS CASE OPENED DURING HOPES</th>
<th>CPS CASE OPENED AFTER HOPES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmed maltreatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reason to believe (n)</td>
<td>1,227</td>
<td>33</td>
<td>21</td>
</tr>
<tr>
<td>Reason to believe (% of</td>
<td>9.7%</td>
<td>0.3%</td>
<td>0.2%</td>
</tr>
<tr>
<td>all HOPES participants)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confirmed maltreatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to determine (n)</td>
<td>528</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Unable to determine (%</td>
<td>4.2%</td>
<td>0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>of all HOPES participants)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confirmed maltreatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ruled out (n)</td>
<td>2,117</td>
<td>84</td>
<td>76</td>
</tr>
<tr>
<td>Ruled out (% of all</td>
<td>16.8%</td>
<td>0.7%</td>
<td>0.6%</td>
</tr>
<tr>
<td>HOPES participants)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confirmed maltreatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to confirm (n)</td>
<td>55</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unable to confirm (% of</td>
<td>0.4%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>all HOPES participants)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Among all HOPES participants, 13.9% had a confirmed case of child maltreatment either before, during or after their participation in HOPES, while 86.1% did not have any CPS involvement based on this data match. Of the 4,154 HOPES participants with a CPS case opened, 43.9% (1,822 HOPES participants) resulted in a confirmed case of child maltreatment. Looking specifically at confirmed maltreatment after exiting HOPES, there were 28 HOPES participants (0.2%) who had a confirmed case of child maltreatment after exiting HOPES. There was only 1 HOPES participant who had a CPS case opened prior to HOPES and a CPS case opened after exiting HOPES.

While the evaluation team could not determine that HOPES programming alone prevented families from experiencing CPS involvement after exiting HOPES, the evidence-based programs and support services provided to families during their participation in HOPES is likely to have been a factor in strengthening families and protecting children from having a CPS investigation.

The figure below describes the type of abuse among confirmed cases of child maltreatment. The CPS data provided to the evaluation team had significant missing data about the allegation type data. The figure below describes the allegation type based on the data provided to the evaluation team.

**Figure 48. Type of child maltreatment allegation among cases with confirmed child maltreatment**

<table>
<thead>
<tr>
<th>TYPE OF ALLEGATION</th>
<th>CPS CASE OPENED BEFORE, DURING &amp; AFTER HOPES PARTICIPATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BEFORE</td>
</tr>
<tr>
<td>ABANDONMENT</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>EMOTIONAL ABUSE</td>
<td>2 (0%)</td>
</tr>
<tr>
<td>MEDICAL NEGLECT</td>
<td>23 (0%)</td>
</tr>
<tr>
<td>NEGLECT SUPERVISION</td>
<td>394 (3%)</td>
</tr>
<tr>
<td>PHYSICAL ABUSE</td>
<td>182 (1%)</td>
</tr>
<tr>
<td>PHYSICAL NEGLECT</td>
<td>36 (0%)</td>
</tr>
<tr>
<td>REFUSAL TO ACCEPT PARENTING RESPONSIBILITY</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>SEXUAL ABUSE</td>
<td>19 (0%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>657</strong></td>
</tr>
</tbody>
</table>

Neglectful supervision of children was the most common type of child maltreatment as the majority of all child maltreatment cases are neglectful supervision. This CPS administrative data covering 2010 – 2017 shows that 71% (n=545,223) of all confirmed abuse allegations were neglectful supervision. In a Texans Care for Children report using Texas DFPS data, it was reported that in 94% of all neglectful supervision cases, parental substance abuse was a factor. The next most prevalent abuse type was physical abuse that made up 13% (n=96778) of all confirmed child abuse cases.

The figure below describes the average age of the victim and the child’s relationship to the perpetrator for all HOPES participants who have had a CPS case opened.
Figure 49. Average age of victim & victim’s relationship to the perpetrator

<table>
<thead>
<tr>
<th></th>
<th>CPS CASE OPENED BEFORE, DURING &amp; AFTER HOPES PARTICIPATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BEFORE</td>
</tr>
<tr>
<td><strong>AVERAGE AGE</strong></td>
<td>• 5 years old</td>
</tr>
<tr>
<td></td>
<td>• Ranged from 0 – 18 years old</td>
</tr>
<tr>
<td></td>
<td>• 61% are 5 and younger</td>
</tr>
<tr>
<td><strong>RELATIONSHIP TO</strong></td>
<td>• 64% not recorded</td>
</tr>
<tr>
<td><strong>PERPETRATOR</strong></td>
<td>• 32% Parent</td>
</tr>
<tr>
<td></td>
<td>• 1% and less other</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Other includes Aunt/Uncle, Grandparents, Adoptive Parent/Foster Parent, Step-parents, Guardian, Partners of Parents, Cousin, Unrelated Person, Cousins, Siblings, Friend, Unknown Person

The majority of the child victims were 5 years old and younger and the most common perpetrator was identified as the victim’s parent. This confirms that HOPES programming is targeting the correct population to address child maltreatment by offering services to families with at least one child 5 years old or younger.

The figure below describes the type of programs families participated in based on when they had a CPS investigation opened (before HOPES, during HOPES, or after HOPES).
The evidence-based programs completed by HOPES participants with a CPS case opened were the programs that also served the most people, which were Parents as Teachers, SafeCare, and Triple P. The data did not clearly show a tendency of a certain group to participate in a specific evidence-based program based on whether they had a CPS case.
The figure below describes the average length of time and range of time families with a CPS case participated in HOPES compared to average program length among families without a CPS case.

**Figure 51. Average length in the program among HOPES participants with a CPS case**

- 3,158 HOPES Caregivers had a CPS case before entering the program. 6.9 Months
- 123 HOPES Caregivers had a CPS case during entering the program. 12.1 Months
- 103 HOPES Caregivers had a CPS case after entering the program. 6.8 Months

These HOPES Caregivers were in the program a minimum of 2 days to 3.6 years.

On average, the majority of HOPES participants who did have a CPS case were in HOPES programming approximately the same amount of time as families without a CPS case. For primary caregivers who had a program start date and end date and who did not have confirmed CPS case (n=3,384), the average length of time caregivers would stay in programs was 7.1 months (213 days).

The figure below describes the percent of families who remain safe, which is defined as the percent of caregivers who did not have a substantiated CPS case recorded in Texas. There is a discrepancy of the number of caregivers analyzed in this data compared to the total number of families served by HOPES sites since there were families still in programming at the time this data was provided to the evaluation team.

**Figure 52. Percent of HOPES families without a new CPS case**

- 99.2% did not have a new CPS case during services.
- 98.0% did not have a CPS case 1 year after services.
- 96.4% did not have a CPS case 2 years after services.
- 93.6% did not have a CPS case 3 years after services.

Data on the percent of families in HOPES without a CPS case was provided by PEI from FY2010-2018.

Overwhelmingly, all HOPES sites had a very high percentage of families who remained safe as most HOPES families did not have a new CPS case during services or after they exited programming. There was a total of 263 HOPES participants (2.1%) from FY2015-FY2018 who had a substantiated child maltreatment case either during services or up to 3 years after they exited services. For all
HOPES sites, the percentages of families who were safe decreased after each subsequent year from when the family exited services, which suggests that the number of substantiated CPS cases did increase slightly after each following year after the family exited services. Since we did not have a control group of families who did not participate in HOPES programming and we did not track all the interventions and lifestyle changes families experienced during or after HOPES programming, we cannot confidently attribute HOPES programming to the prevention of a substantiated CPS case.

Because the number of substantiated cases of child maltreatment among families who participated in HOPES is small, it is difficult to assess significance in predicting whether certain risk factors or PFS scores could predict a future child maltreatment case. However, the section below describes administrative data collected on families who participated in HOPES programming and had a substantiated case of child maltreatment either during or after exiting HOPES programming.

**Predictability of the PFS Scores to a Future CPS Case**

An important part of this evaluation was analyzing whether the data collected from families at the start of HOPES programming can predict a future case of child maltreatment. Although there were many different circumstances and factors that may have resulted in a CPS case being opened for a family, the purpose of collecting information related to child maltreatment from families was to: 1) identify families who are in need of programming to prevent child maltreatment and 2) identify which services are needed to support families during programming. The information presented below is from the data analyses conducted of HOPES participants with a CPS case opened after exiting HOPES compared to HOPES participants without a match to the CPS case. It is important to note that CPS administrative data may have been updated since the data was provided to the evaluation team.

As discussed throughout this report, risk factors and protective factors impacting the child’s environment have been shown to be closely linked to child maltreatment. While the data we were provided showed that there were 28 HOPES participants who had a substantiated CPS case after exiting HOPES, only 5 of those participants had complete risk factor data and Protective Factor Survey data. Thus, this is not enough of a sample size to confidently analyze the predictability of risk factors.

Due to low number of confirmed cases of child maltreatment among HOPES participants after exiting HOPES, the evaluation team could not confidently assess the predictability of risk factors or survey data. The evaluation recommends that another data match and analyses be completed with more complete data on HOPES participants and after a longer period of time after families have exiting programming.

It is ultimately a positive outcome that there was a low number of substantiated cases of child maltreatment. Furthermore, this community-based model of child maltreatment prevention of assessing safety, stability, and nurturing in a child’s environment has shown to positively impact families by mitigating risk factors and strengthening protective factors, thus preventing child maltreatment.
From 2010 to 2018 the child maltreatment rate:

Decreased in 38.2% (97) of Texas counties
Increased in 42.1% (107) of Texas counties
Stayed the same in 2% (5) of Texas counties stayed the same

Note: 27.7% (n=45) had no data or a very low range of number of victims of child maltreatment, reported in the administrative data as "1 to 5"
Analysis of County-level Changes in Child Maltreatment

During the time frame that HOPES was implemented (FY2015-FY2018), the primary counties served in HOPES showed a significant but small decrease in the percent of child maltreatment cases among children ages 5 and younger by 0.23% (p = 0.032), compared to the other counties in Texas. In fact, during this period from FY2015-FY2016 counties not served by HOPES had an increase in child maltreatment rates among children ages 5 and younger. There were no significant differences the percent of child maltreatment among HOPES primary counties and all other Texas counties from the
time frame of FY2010 to FY2018 (p = 0.81).

Although the majority of HOPES programming was provided to families in primary counties, families were served in the HOPES secondary counties. For a list of the secondary counties see Appendix C: HOPES Site Information. When comparing all HOPES counties (HOPES primary and secondary counties) to non-HOPES counties, there was no significant difference in the average change of the percentages of child maltreatment in either time frame, from FY2010 to FY2018 (p=0.255) or FY2015 to FY2018 (p=0.541).

This data also showed a significant change in the average child maltreatment rates among primary and secondary HOPES counties by HOPES phase (HOPES I, HOPES II, and HOPES III), which was the length of time counties have been implementing HOPES. Primary and secondary counties served in HOPES I, HOPES II, and non-HOPES serving counties all have a statistically significant decrease in their rates in child maltreatment between FY2015 to FY2018 compared to HOPES III. Counties served in HOPES III are showing the greatest increase in child maltreatment rates (more children are victims to maltreatment). After adjusting for already-existing trends in child maltreatment rates, primary and secondary counties served in HOPES were statistically significant in having a 0.156% lower percentage of substantiated child maltreatment among children ages 5 and younger compared to counties not served by HOPES.

It is important to note that county-level child maltreatment rates are influenced by a multitude of factors, including changes in reporting abuse. Though decreasing rates of child maltreatment may indicate child maltreatment is being prevented, it may also mean the reporting child abuse may be decreasing. Likewise, increasing rates of child maltreatment may also indicate that a heightened community awareness about child maltreatment, thus a higher rate of child maltreatment.

Additionally, this analysis cannot empirically link HOPES programming to county-level child maltreatment rates, since there are many different factors in the community that may impact maltreatment rates. However, taking together the intermediate outcomes of HOPES programming improving a child’s environment on improving safety, stability, and nurturing across the individual, family and community level, it is evidence that HOPES has positively impacted communities in helping to prevent child maltreatment.
RECOMMENDATIONS

Based on the data collected and analyzed for the evaluation of Project HOPES, the Texas Institute for Child & Family Wellbeing presents the following recommendation for PEI:

1. Continue funding for child maltreatment prevention.
   - Counties who have implemented HOPES programming have seen a significant decrease in child maltreatment rates compared to counties who have not implemented HOPES. After adjusting for already existing trends in child maltreatment rates, counties that have implemented HOPES programming from 2015 – 2018 have seen a decrease in child maltreatment among children ages 5 and younger by a small but statistically significant percent of 0.156% compared to counties that have not implemented HOPES during the same period. Additionally, 94.3% did not have a new CPS case 3 years after exiting HOPES programming.
   - HOPES programming has made significant improvements to strengthening families and communities that should continue to serve more families and communities to further impact county-level child maltreatment rates. The longer HOPES is implemented in counties, the greater the likelihood will be that counties will see decreases in their child maltreatment rates.

2. Support evidence-informed implementation of programs to be able to holistically assist the diversity of families who participate in HOPES.
   - Many evidence-based programs are not evaluated in diverse populations. In this case, “diversity” refers to cultural diversity and the many different types of risk factors or family structures. Offering flexibility for parent educators to address the diversity of family needs, in addition to offering evidence-based approaches, will ensure families are getting their needs met.
   - 25% of staff stated that evidence-based programs are too narrowly focused and 22% of staff discussed that they made changes to evidence-based curriculum due to the difficulty in engaging and retaining families.
   - During interviews and focus groups, a consistent theme of staff implementing evidence-based programs was the difficulty in balancing curriculum/fidelity requirements with addressing immediate needs or concerns for families.

3. Encourage agencies to support case management.
   - 23% of staff interviewed discussed the challenge in balancing case management with curriculum and funding constraints. During interviews with participants, many discussed that staff’s time spent on case management helped build trust between their family and HOPES staff.
   - 50% of participants interviewed stated that this trust between the caregiver and HOPES staff was crucial for families to be engaged in the program.

4. Strengthen training and resources for direct service staff on how to discuss substance use, domestic violence, and mental health with families.
   - Staff indicated that they need more training to address risk factors among families they serve:
     - 43% of staff indicated that they needed more training & support on addressing mental health;
     - 41% of staff indicated that they needed more training & support on addressing domestic violence
○ 33% of staff indicated that they need more training & support in addressing substance use.

- Both agencies and staff should be equipped with the resources necessary to help families address these risk factors that have been empirically linked to child maltreatment. Improving funding in these areas will help fill resource gaps in communities.

5. Improve database and establish consistency in data collection.

- PEI should establish policies, practices, and training to ensure consistency in the types of data collected in multi-year programming and on-going quality assurance on how sites are collecting data.
- PEI and other state agencies should collaborates their database such as Medicaid databases to better understand the needs and long-term impacts of programming and services for families.

6. PEI should provide additional guidance to HOPES sites who partner with subcontractors to implement HOPES programs and services.

- Additional guidance is needed for HOPES sites who partner with subcontractors to implement HOPES programs and services and community collaborations.
- For agencies offering HOPES services, clarity in roles in a collaboration between primary contractors and subcontractors is important to ensure the sustainability of partnerships.

CONCLUSION

The purpose of this evaluation report was to detail the outcomes of HOPES activities from FY2015 to FY2018 and to examine the impact of programming on preventing child maltreatment by supporting safety, stability and nurturing across children, families, and communities. The data collected and analyzed for this evaluation suggests that HOPES programming has been effective at strengthening families and mitigating risk factors that have been shown to help prevent child maltreatment. While this evaluation cannot link community-level changes of child maltreatment to the impact of HOPES programming alone, the data provided evidence from multiple data sources that the services, programs, and collaborations implemented as part of HOPES was successful in supporting families that help keep children safe from abuse and neglect.

The evaluation findings also suggest how resilient families were even more successful when sectors collaborated to support families together. For families with a history of involvement with CPS, whether that was a substantiated child maltreatment case or a potential risk for child maltreatment, HOPES enabled sectors to come together to help fill gaps by encouraging the collaboration between HOPES programming and CPS. This evaluation has shown how resilient families are when compassionate and individualized programming is prioritized.

“They are giving the families the opportunity to address some of the needs they have that sometimes cause them stress to where they lose patience with the children because they have so much going on. They get overwhelmed and it gets challenging between the finances, children, and parenting and everything the families encounter. I feel like we’re definitely working towards that goal. The stability that is provided to these families is what prevents any type of future for child abuse.”

– HOPES Staff
At the time of this evaluation, HOPES contracts were renewed for some communities and PEI was continually improving implementation processes and database issues. With each passing year of HOPES, programming and services has become more streamlined as communities and families interact with agencies supported by HOPES. As reiterated throughout this report, community-level changes, especially changes in societal norms, take time. Agencies implementing programming have consistently worked towards improving service delivery to families and the coordination of services among partner agencies to help fill in the gaps for children and families. Robust data on the types of services utilized by families and fidelity measures will more comprehensively assess the impact of programs and services on families. Additionally, many counties served in HOPES are receiving other types of child maltreatment prevention programs. Understanding the impacts of saturation of child maltreatment programs in counties including HOPES will better assess the holistic impact of programming in counties. With a continued focus on improvement and collaboration to address systems-level changes across the individual, family, and community, the lasting impacts of HOPES programming will be seen in communities for future generations.
REFERENCES


24. U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates; Table S1702, Poverty Status in the Past 12 months of families

25. U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates, Table S2201, Food Stamps/Supplemental Nutrition Assistance Program (SNAP)

26. U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates; Table S2302, Employment Characteristics of Families


42. https://www.statisticssolutions.com/mental-health-inventory-mhi/


APPENDIX A: SITE PROFILES
HOPES HAS PROMOTED NURTURING ENVIRONMENTS

Average scores before and after HOPES participation:

**CHILD DEVELOPMENT & KNOWLEDGE OF PARENTING**

<table>
<thead>
<tr>
<th>BEFORE</th>
<th>AFTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.0</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Increase in understanding and use of effective child management techniques and having age-appropriate expectations for children’s abilities.

**NURTURING & ATTACHMENT**

<table>
<thead>
<tr>
<th>BEFORE</th>
<th>AFTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.9</td>
<td>6.7</td>
</tr>
</tbody>
</table>

Increase in perceived emotional tie along with a pattern of positive interaction between the parent and child that develops over time.

---

**HOPES HAS INCREASED FAMILY STABILITY**

Average scores before and after HOPES participation:

**CONCRETE SUPPORT**

<table>
<thead>
<tr>
<th>BEFORE</th>
<th>AFTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.7</td>
<td>5.1</td>
</tr>
</tbody>
</table>

Increase in perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.

**SOCIAL EMOTIONAL SUPPORT**

<table>
<thead>
<tr>
<th>BEFORE</th>
<th>AFTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2</td>
<td>6.1</td>
</tr>
</tbody>
</table>

Increase in perceived informal support (e.g., family, friends, neighbors) who help provide emotional needs.

**FAMILY FUNCTIONING/RESILIENCY**

<table>
<thead>
<tr>
<th>BEFORE</th>
<th>AFTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.0</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Increase in perceived adaptive skills and strategies to persevere in times of crisis, openly share positive and negative experiences and mobilize to accept solve and manage problems.

---

**ALL SITES 1,041,738** Individuals reached in HOPES from FY2015-2018

From 2010 - 2018 the child maltreatment rate among children 5 years old and younger decreased by 0.16% in counties served by HOPES compared to counties without HOPES.

**HOPES HAS KEPT FAMILIES SAFE**

99.2% of program participants did not have a new CPS case since receiving HOPES services.

**MISSING**

- <= 0.01% RATE DECREASED OVER TIME
- 0.01% TO 0.12% RATE STAYED THE SAME OVER TIME
- >=0.12% RATE INCREASED OVER TIME

---

**HOPES HAS KEPT FAMILIES SAFE**

- 92.0% DID NOT HAVE CPS CASE
- 96.4% DID NOT HAVE CPS CASE
- 98.0% DID NOT HAVE CPS CASE
- 98.3% DID NOT HAVE CPS CASE
- 99.2% DID NOT HAVE CPS CASE

---

**HOPES**

The most [HOPES] did was give me another chance. The fact that I say anybody and everybody is not shutting you down because of what you’re going through with CPS and whatever the case may be. It’s more of somebody is there and they’re not judging you just like everybody else.

— Parent, HOPES Participant

---

**MISSING**

- <= 0.01% RATE DECREASED OVER TIME
- 0.01% TO 0.12% RATE STAYED THE SAME OVER TIME
- >=0.12% RATE INCREASED OVER TIME

---

**MISSING**

- <= 0.01% RATE DECREASED OVER TIME
- 0.01% TO 0.12% RATE STAYED THE SAME OVER TIME
- >=0.12% RATE INCREASED OVER TIME

---

**MISSING**

- <= 0.01% RATE DECREASED OVER TIME
- 0.01% TO 0.12% RATE STAYED THE SAME OVER TIME
- >=0.12% RATE INCREASED OVER TIME

---

**MISSING**

- <= 0.01% RATE DECREASED OVER TIME
- 0.01% TO 0.12% RATE STAYED THE SAME OVER TIME
- >=0.12% RATE INCREASED OVER TIME
HOPES HAS REACHED FAMILIES AT RISK

Typical HOPES caregiver in 31 counties:
- Married mother, 27 years old
- 2 year old child
- White, Hispanic
- English-speaking
- No High School Diploma
- Annual income is $0-$10,000
- Average time in program is 7 months

Risk factors HOPES caregivers in 31 counties are experiencing:
- 32% had 4 or more Adverse Childhood Experiences
- 50% had a positive screen for a mental health concern
- 7% had a positive screen for substance use
- 7% had a positive screen for domestic violence
- 13% said they felt their neighborhood was unsafe

FROM 2015-2018:

1,029,261 individuals reached at community events
*may include duplicated individuals

Number of families who participated in evidence-based programs:
- 21 different EBPs
- 11,830 families

Collaboration of HOPES Partnerships

Coalitions have an opportunity to improve collaboration among all coalition members.

Number of families served:
- 2015: 0
- 2016: 4.1
- 2017: 2.0

ABOUT THIS SITE

31 counties County is a HOPES I - III Site (2015-2021)

Primary Agency:
22 primary agencies

Subcontractor:
34 subcontractors

Coalition:
21 community coalitions

Evidence-Based Programs:
21 evidence-based programs

31 counties County completed 1,858 pre-caregiver surveys, 808 post-caregiver surveys, 518 online staff surveys, 442 online community surveys, 581 staff interviews and focus groups, 165 client interviews, and 99 coalition member interviews and focus groups throughout our 4 year evaluation. Thank you for your cooperation & time!

Project Healthy Outcomes through Prevention and Early Support is funded by the Prevention and Early Intervention division of the Texas Department of Family and Protective Services. This evaluation is by:

The University of Texas at Austin
Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work
HOPES HAS KEPT FAMILIES SAFE

99.4% of program participants did not have a new CPS case while receiving HOPES services.

HOPES HAS INCORPORATED FAMILIES STABILITY

Average scores before and after HOPES participation:

**CONCRETE SUPPORT**

BEFORE: 4.3
AFTER: 5.0

Increase in perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.

**SOCIAL EMOTIONAL SUPPORT**

BEFORE: 4.8
AFTER: 6.0

Increase in perceived informal support (e.g., family, friends, neighbors) who help provide emotional needs.

**FAMILY FUNCTIONING/RESILIENCY**

BEFORE: 4.8
AFTER: 6.0

Increase in perceived adaptive skills and strategies to persevere in times of crisis, openly share positive and negative experiences and mobilize to accept, solve and manage problems.

Average scores are from the Protective Factors Survey data (n=411)

HOPES HAS PROMOTED NURTURING ENVIRONMENTS

Average scores before and after HOPES participation:

**CHILD DEVELOPMENT & KNOWLEDGE OF PARENTING**

BEFORE: 4.8
AFTER: 5.9

Increase in perceived understanding and use of effective child management techniques and having age-appropriate expectations for children’s abilities.

**NURTURING & ATTACHMENT**

BEFORE: 5.9
AFTER: 6.6

Increase in perceived emotional tie along with a pattern of positive interaction between the parent and child that develops over time.

From 2010 - 2018 the child maltreatment rate among children 5 years old and younger decreased by 0.96% in Cameron County.

From 2010 - 2018 the child maltreatment rate among children 5 years old and younger decreased by 0.96% in Cameron County.

99.4% of program participants did not have a new CPS case while receiving HOPES services.

Average scores before and after HOPES participation:

**CONCRETE SUPPORT**

BEFORE: 4.3
AFTER: 5.0

Increase in perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.

**SOCIAL EMOTIONAL SUPPORT**

BEFORE: 4.8
AFTER: 6.0

Increase in perceived informal support (e.g., family, friends, neighbors) who help provide emotional needs.

**FAMILY FUNCTIONING/RESILIENCY**

BEFORE: 4.8
AFTER: 6.0

Increase in perceived adaptive skills and strategies to persevere in times of crisis, openly share positive and negative experiences and mobilize to accept, solve and manage problems.

Average scores are from the Protective Factors Survey data (n=411)
Typical HOPES caregiver in Cameron County:

- Married mother, 31 years old
- 2 year old child
- White, Hispanic
- Spanish-speaking
- No High School Diploma
- Annual income is $0-$10,000
- Average time in program is 5.4 months

FROM 2015-2018:

24,250 individuals reached at community events

*may include duplicated individuals

Number of families who participated in evidence-based programs:

Cameron County is a HOPES I Site (2015-2019)

PRIMARY AGENCY:
BCFS Health & Human Services

COALITION:
Make the First Five Count

EVIDENCE-BASED PROGRAMS:
SafeCare

Risk factors HOPES caregivers in Cameron County are experiencing:

- 33% had 4 or more Adverse Childhood Experiences
- 61% had a positive screen for a mental health concern
- 0% had a positive screen for substance use
- 0% had a positive screen for domestic violence
- 46% said they felt their neighborhood was unsafe

Addressing these factors are known to prevent child maltreatment.

Make the First Five Count has opportunity to improve collaboration among all coalition members.

Project Healthy Outcomes through Prevention and Early Support is funded by the Prevention and Early Intervention division of The Texas Department of Family and Protective Services. This evaluation is by:

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Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work
**ECTOR** 41,014 Individuals reached in HOPES from FY2015-2018

From 2010 - 2018 the child maltreatment rate among children 5 years old and younger **decreased** by **1.36%** in Ector County.

**HOPES HAS KEPT FAMILIES SAFE**

99.6% of program participants did not have a new CPS case while receiving HOPES services.

**HOPES HAS INCREASED FAMILY STABILITY**

Average scores before and after HOPES participation:

**CONCRETE SUPPORT**

BEFORE: 5.5
AFTER: 6.0

Increase in perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.

**SOCIAL EMOTIONAL SUPPORT**

BEFORE: 5.9
AFTER: 6.3

Increase in perceived informal support (e.g., family, friends, neighbors) who help provide emotional needs.

**FAMILY FUNCTIONING/RESILIENCY**

BEFORE: 5.4
AFTER: 5.8

Increase in perceived adaptive skills and strategies to persevere in times of crisis, openly share positive and negative experiences and mobilize to accept, solve and manage problems.

Average scores are from the Protective Factors Survey data (n=115)

**HOPES HAS PROMOTED NURTURING ENVIRONMENTS**

Average scores before and after HOPES participation:

**CHILD DEVELOPMENT & KNOWLEDGE OF PARENTING**

BEFORE: 5.5
AFTER: 6.1

Increase in perceived understanding and use of effective child management techniques and having age-appropriate expectations for children’s abilities.

**NURTURING & ATTACHMENT**

BEFORE: 6.1
AFTER: 6.3

Increase in perceived emotional tie along with a pattern of positive interaction between the parent and child that develops over time.

"The most useful thing I’ve gotten out [HOPES] is all the paperwork [on child development] she’s given me after every session... I could see the changes in my son even though it was a few months earlier when [I learned about it]. [Understanding child development] has been one of the things I feel is most useful."

—Parent, Cameron County HOPES Participant
FROM 2015-2018:

35,789 individuals reached at community events
*may include duplicated individuals

Number of families who participated in evidence-based programs:

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<thead>
<tr>
<th>Program</th>
<th>Number of Families Served</th>
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<tbody>
<tr>
<td>PARENTS AS TEACHERS</td>
<td>154</td>
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<tr>
<td>24/7 DAD</td>
<td>82</td>
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</table>

HOPES HAS REACHED FAMILIES AT RISK

Typical HOPES caregiver in Ector County:

- Married mother, 23 years old
- 1 year old child
- White, Hispanic
- English-speaking
- No High School Diploma
- Annual income is $20,001-$30,000
- Average time in program is 17.3 months

Risk factors HOPES caregivers in Ector County are experiencing:

- 64% experienced high stress
- 60% had inaccurate child development knowledge
- 37% were teen parents
- 24% experienced social isolation
- 21% had a non-traditional family structure

Collaboration of HOPES Partnerships

Early Childhood Coalition had a high level of collaboration in 2015.

Level of Collaboration: 4.1

Number of families who participated in evidence-based programs:

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<tr>
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Ecton County is a HOPES I Site (2015-2019)

**PRIMARY AGENCY:**
University of Texas Permian Basin

**SUBCONTRACTORS:**
Boys & Girls Club, Harmony Home

**COALITION:**
Early Childhood Coalition

**EVIDENCE-BASED PROGRAMS:**
24/7 Dad, Parents as Teachers, Stewards of Children

Ector County completed 10 pre-caregiver surveys, 0 post-caregiver surveys, 21 online staff surveys, 36 online community surveys, 37 staff interviews and focus groups, 26 client interviews, and 15 coalition member interviews and focus groups throughout our 4 year evaluation. Thank you for your cooperation & time!

Project Healthy Outcomes through Prevention and Early Support is funded by the Prevention and Early Intervention division of The Texas Department of Family and Protective Services. This evaluation is by:

The University of Texas at Austin
Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work
From 2010 - 2018 the child maltreatment rate among children 5 years old and younger decreased by -1.96% in El Paso County.

HOPES HAS KEPT FAMILIES SAFE

99.3% of program participants did not have a new CPS case while receiving HOPES services.

HOPES HAS INCREASED FAMILY STABILITY

Average scores before and after HOPES participation:

**SOCIAL SUPPORT**

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Increase in perceived social support from family, friends, and peers to help address child needs or caregiver’s own emotional needs.

**FAMILY RESOURCES**

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Increase in perceived available resources to assess family concerns and priorities based on the hierarchy of needs.

**CONCRETE SUPPORT IN TIMES OF NEED**

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Increase in perceived ability to identify, seek, access quality services to preserve caregiver’s dignity and promote healthy family development.

Average scores are from the Caregiver Survey data (pre-survey n=311, post-survey n =147)

HOPES HAS PROMOTED NURTURING ENVIRONMENTS

Average scores before and after HOPES participation:

**PARENTAL RESILIENCE**

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Increase in perceived ability to manage stress and function well when faced with stressors, challenges, or adversity.

**SOCIAL CONNECTIONS**

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Increase in perceived healthy, sustained relationships with people, institutions, the community, or a force greater than oneself that forge a sense of belonging, attachment, reciprocal positive regard, and a feeling that one matters.

**SOCIAL & EMOTIONAL COMPETENCE OF CHILDREN**

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Increase in perceived ability to provide an environment and experiences that enable children to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.
HOPES HAS REACHED FAMILIES AT RISK

Typical HOPES caregiver in El Paso County:

- Married mother, 32 years old
- 2 year old child
- White, Hispanic
- Spanish-speaking
- No High School Diploma
- Annual income is $0-$10,000
- Average time in program is 10.8 months

FROM 2015-2018:

22,791 individuals reached at community events

*may include duplicated individuals

Number of families who participated in evidence-based programs:

- Parents as Teachers: 583
- AVANCE: 533
- Incredible Years: 205

El Paso County is a HOPES I Site (2015-2019)

PRIMARY AGENCY:
El Paso Center for Children

SUBCONTRACTOR:
AVANCE, Child Crisis Center, Paso Del Norte Children’s Development Center, United Way of El Paso

COALITION:
Project LAUNCH

EVIDENCE-BASED PROGRAMS:
AVANCE Parent-Child Education Program, Incredible Years, Parents as Teachers, Wrap Around

El Paso County completed 311 pre-caregiver surveys, 147 post-caregiver surveys, 55 online staff surveys, 22 online community surveys, 84 staff interviews and focus groups, 26 client interviews, and 6 coalition member interviews and focus groups throughout our 4 year evaluation. Thank you for your cooperation & time!
From 2010 - 2018 the child maltreatment rate among children 5 years old and younger increased by 1.39% in Gregg County.

97.5% of program participants did not have a new CPS case while receiving HOPES services.

**HOPES HAS KEPT FAMILIES SAFE**

**HOPES HAS INCREASED FAMILY STABILITY**

Average scores before and after HOPES participation:

**CONCRETE SUPPORT**

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Increase in perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.

**SOCIAL EMOTIONAL SUPPORT**

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Increase in perceived informal support (e.g., family, friends, neighbors) who help provide emotional needs.

**FAMILY FUNCTIONING/RESILIENCY**

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Increase in perceived adaptive skills and strategies to persevere in times of crisis, openly share positive and negative experiences and mobilize to accept, solve and manage problems.

Average scores are from the Protective Factors Survey data (n=294)

**HOPES HAS PROMOTED NURTURING ENVIRONMENTS**

Average scores before and after HOPES participation:

**CHILD DEVELOPMENT & KNOWLEDGE OF PARENTING**

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Increase in perceived understanding and use of effective child management techniques and having age-appropriate expectations for children's abilities.

**NURTURING & ATTACHMENT**

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Increase in perceived emotional tie along with a pattern of positive interaction between the parent and child that develops over time.

...the biggest thing that has been [useful has been] the TBRI classes and counseling and getting [my daughter] evaluated [by] the psychologist. Just having an answer as to why she has been the way she is and then what to do to help her.

— Parent, Gregg County HOPES Participant
HOPES HAS REACHED FAMILIES AT RISK

Typical HOPES caregiver in Gregg County:

- Single mother, 28 years old
- 1 year old child
- White, Non-Hispanic
- English-speaking
- No High School Diploma
- Annual income is $0-$10,000
- Average time in program is 14 months

FROM 2015-2018:

10,134 individuals reached at community events

*may include duplicated individuals

Number of families who participated in evidence-based programs:

- PARENTS AS TEACHERS: 497
- 24/7 DAD: 7

PROJECT STATUS:
Gregg County is a HOPES I Site (2015-2019)

PRIMARY AGENCY:
Buckner Children & Family Services

COALITION:
Bridges out of Poverty

EVIDENCE-BASED PROGRAM:
Parents as Teachers

Risk factors HOPES caregivers in Gregg County are experiencing:

- 12% had 4 or more Adverse Childhood Experiences
- 56% had a positive screen for a mental health concern
- 0% had a positive screen for substance use
- 0% had a positive screen for domestic violence
- 33% said they felt their neighborhood was unsafe

ADDRESSING RISK FACTORS:
Addressing these factors are known to prevent child maltreatment.

LEVEL OF COLLABORATION:

Bridges out of Poverty shows a high level of collaboration that has maintained from 2015 to 2016.

ABOUT THIS SITE

Gregg County completed 41 pre-caregiver surveys, 3 post-caregiver surveys, 16 online staff surveys, 45 online community surveys, 27 staff interviews and focus groups, 10 client interviews, and 3 coalition member interviews and focus groups throughout our 4 year evaluation. Thank you for your cooperation & time!

Project Healthy Outcomes through Prevention and Early Support is funded by the Prevention and Early Intervention division of The Texas Department of Family and Protective Services. This evaluation is by:

The University of Texas at Austin
Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work
From 2010 - 2018 the child maltreatment rate among children 5 years old and younger decreased by 0.39% in Hidalgo County.

**HOPES HAS KEPT FAMILIES SAFE**

99.1% of program participants did not have a new CPS case while receiving HOPES services.

**HOPES HAS INCREASED FAMILY STABILITY**

Average scores before and after HOPES participation:

**CONCRETE SUPPORT**

BEFORE: 5.1
AFTER: 5.4

Increase in perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.

**SOCIAL EMOTIONAL SUPPORT**

BEFORE: 5.2
AFTER: 5.9

Increase in perceived informal support (e.g., family, friends, neighbors) who help provide emotional needs.

**FAMILY FUNCTIONING/RESILIENCY**

BEFORE: 5.3
AFTER: 5.7

Increase in perceived adaptive skills and strategies to persevere in times of crisis, openly share positive and negative experiences and mobilize to accept solve and manage problems.

**HOPES HAS PROMOTED NURTURING ENVIRONMENTS**

Average scores before and after HOPES participation:

**CHILD DEVELOPMENT & KNOWLEDGE OF PARENTING**

BEFORE: 5.3
AFTER: 5.7

Increase in perceived understanding and use of effective child management techniques and having age-appropriate expectations for children’s abilities.

**NURTURING & ATTACHMENT**

BEFORE: 6.3
AFTER: 6.4

Increase in perceived emotional tie along with a pattern of positive interaction between the parent and child that develops over time.

The most useful [part of HOPES] is all the information [my parent educator] brings me. She always gives me handouts, she’ll tell me about a certain topic. Or if I’m concerned about something, she’ll write it down and bring me the papers and all that information that I need.

— Parent, Hidalgo County HOPES Participant
HOPES HAS REACHED FAMILIES AT RISK

Typical HOPES caregiver in Hidalgo County:

- Single mother, 28 years old
- 2 year old child
- White, Hispanic
- Spanish-speaking
- No High School Diploma
- Annual income is $0-$10,000
- Average time in program is 12.8 months

HOPES HAS PROMOTED NURTURING ENVIRONMENTS FROM 2015-2018:

Number of families who participated in evidence-based programs:

- HOPES I

20,579 individuals reached at community events
*may include duplicated individuals

FROM 2015-2018:

Number of families who participated in evidence-based programs:

- Parents as Teachers
  - 1,140

PROJECTED LEVEL OF COLLABORATION

Risk factors HOPES caregivers in Hidalgo County are experiencing:

- 51% experienced high stress
- 50% had inaccurate child development knowledge
- 49% had a non-traditional family structure
- 26% experienced social isolation
- 20% experienced high parental conflict

These risk factors were collected at intake from primary caregivers.

Collaboration of HOPES Partnerships

Make the First Five Count has opportunity to improve collaboration among all coalition members.

Hidalgo County is a HOPES I Site (2015-2019)

PRIMARY AGENCY:
Easter Seals of Rio Grande Valley

COALITION:
Make the First Five Count

EVIDENCE-BASED PROGRAM:
Parents as Teachers

Hidalgo County completed 6 pre-caregiver surveys, 0 post-caregiver surveys, 43 online staff surveys, 61 online community surveys, 28 staff interviews and focus groups, 6 client interviews, and 5 coalition member interviews and focus groups throughout our 4 year evaluation. Thank you for your cooperation & time!

ABOUT THIS SITE

The University of Texas at Austin
Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work
HOPES HAS KEPT FAMILIES SAFE

95.0% of program participants did not have a new CPS case while receiving HOPES services.

HOPES HAS INCREASED FAMILY STABILITY

Average scores before and after HOPES participation:

**CONCRETE SUPPORT**

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Increase in perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.

**SOCIAL EMOTIONAL SUPPORT**

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Increase in perceived informal support (e.g., family, friends, neighbors) who help provide emotional needs.

**FAMILY FUNCTIONING/RESILIENCY**

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Increase in perceived adaptive skills and strategies to persevere in times of crisis, openly share positive and negative experiences and mobilize to accept solve and manage problems.

HOPES HAS PROMOTED NURTURING ENVIRONMENTS

Average scores before and after HOPES participation:

**CHILD DEVELOPMENT & KNOWLEDGE OF PARENTING**

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Increase in perceived understanding and use of effective child management techniques and having age-appropriate expectations for children’s abilities.

**NURTURING & ATTACHMENT**

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Increase in perceived emotional tie along with a pattern of positive interaction between the parent and child that develops over time.

“...lot of the [Hispanic] families we’re serving have a lot of concerns with the new law changes. There’s a lot of fear. I think just us being present in their lives and using the support can ease them at least have someone who can actually connect them to the right resources and get them the support they need through this difficult time.”

— Potter County HOPES Staff Member
**Typical HOPES caregiver in Potter County:**

- Single mother, 27 years old
- 1 year old child
- White, Hispanic
- English-speaking
- No High School Diploma
- Annual income is $0-$10,000
- Average time in program is 13.8 months

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**FROM 2015-2018:**

15,476 individuals reached at community events

*may include duplicated individuals

**Number of families who participated in evidence-based programs:**

- Parents as Teachers: 237
- 24/7 Dad: 12

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**COLLABORATION OF HOPES PARTNERSHIPS**

- Level of collaboration: 3.9 (2015) vs 3.9 (2016)
- Operation First Five has maintained the level of collaboration among coalition members from 2015 to 2016.

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**ABOUT THIS SITE**

**Potter County** is a HOPES I Site (2015-2019)

**PRIMARY AGENCY:**
Family Support Services

**SUBCONTRACTOR:**
Amarillo Independent School District, Mesquite Ranch

**COALITION:**
Operation First Five

**EVIDENCE-BASED PROGRAM:**
Parents as Teachers

Potter County completed 9 pre-caregiver surveys, 0 post-caregiver surveys, 31 online staff surveys, 59 online community surveys, 25 staff interviews and focus groups, 7 client interviews, and 3 coalition member interviews and focus groups throughout our 4 year evaluation. Thank you for your cooperation & time!
From 2010 - 2018 the child maltreatment rate among children 5 years old and younger increased by 0.18% in Travis County.

Average scores before and after HOPES participation:

**SOCIAL SUPPORT**

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Increase in perceived social support from family, friends, and peers to help address child needs or caregiver’s own emotional needs.

**FAMILY RESOURCES**

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Increase in perceived available resources to assess family concerns and priorities based on the hierarchy of needs.

**CONCRETE SUPPORT IN TIMES OF NEED**

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Increase in perceived ability to identify, seek, access quality services to preserve caregiver’s dignity and promote healthy family development.

Average scores before and after HOPES participation: Average scores are from the Caregiver Survey data (pre-survey n=63, post-survey n=16)
HOPES HAS REACHED FAMILIES AT RISK

Typical HOPES caregiver in Travis County:

- Single mother, 30 years old
- 2 year old child
- White, Hispanic
- Spanish-speaking
- No High School Diploma
- Annual income is $0-$10,000
- Average time in program is 7.4 months

FROM 2015-2018:

109,180 individuals reached at community events
*may include duplicated individuals

Number of families who participated in evidence-based programs:

- TRIPLE P: 1,064
- PARENTS AS TEACHERS: 349
- 24/7 DAD: 62
- NURTURING FATHERS: 44
- NURTURING PARENTING: 44

COLLABORATION OF HOPES PARTNERSHIPS

Success by 6, Family Support Network shows a high level of collaboration that has maintained from 2015 to 2016.

Risk factors HOPES caregivers in Travis County are experiencing:

- 49% had 4 or more Adverse Childhood Experiences
- 72% had a positive screen for a mental health concern
- 7% had a positive screen for substance use
- 12% had a positive screen for domestic violence
- 51% said they felt their neighborhood was unsafe

ADDRESSING THESE FACTORS ARE KNOWN TO PREVENT CHILD MALTRATION

PROJECT HEALTHY OUTCOMES THROUGH PREVENTION AND EARLY SUPPORT is funded by the Prevention and Early Intervention division of The Texas Department of Family and Protective Services. This evaluation is by:

The University of Texas at Austin
Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work

Travis County is a HOPES I Site (2015-2019)

PRIMARY AGENCY:
SAFE Alliance

SUBCONTRACTORS:
Any Baby Can, Easter Seals of Central Texas

COALITION:
Success by 6, Family Support Network

EVIDENCE-BASED PROGRAMS:
24/7 Dad, Nurturing Fathers, Nurturing Parenting, Parents as Teachers, Triple P

Travis County completed 63 pre-caregiver surveys, 16 post-caregiver surveys, 65 online staff surveys, 27 online community surveys, 71 staff interviews and focus groups, 12 client interviews, and 8 coalition member interviews and focus groups throughout our 4 year evaluation. Thank you for your cooperation & time!
From 2010 - 2018 the child maltreatment rate among children 5 years old and younger decreased by **0.62%** in Webb County.

**HOPES HAS_kept families safe**

99.8% of program participants did not have a new CPS case while receiving HOPES services.

**HOPES HAS INCREASED FAMILY STABILITY**

**Average scores before and after HOPES participation:**

**SOCIAL SUPPORT**

Before: 2.9
After: 3.2

Increase in perceived social support from family, friends, and peers to help address child needs or caregiver's own emotional needs.

**FAMILY RESOURCES**

Before: 2.0
After: 2.0

Increase in perceived available resources to assess family concerns and priorities based on the hierarchy of needs.

**CONCRETE SUPPORT IN TIMES OF NEED**

Before: 3.1
After: 3.2

Increase in perceived ability to identify, seek, access quality services to preserve caregiver’s dignity and promote healthy family development.

**HOPES HAS PROMOTED NURTURING ENVIRONMENTS**

**Average scores before and after HOPES participation:**

**PARENTAL RESILIENCE**

Before: 3.5
After: 3.6

Increase in perceived ability to manage stress and function well when faced with stressors, challenges, or adversity.

**SOCIAL CONNECTIONS**

Before: 3.0
After: 3.2

Increase in perceived healthy, sustained relationships with people, institutions, the community, or a force greater than oneself that forge a sense of belonging, attachment, reciprocal positive regard, and a feeling that one matters.

**SOCIAL & EMOTIONAL COMPETENCE OF CHILDREN**

Before: 3.4
After: 3.5

Increase in perceived ability to provide an environment and experiences that enable children to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.

Average scores are from the Caregiver Survey data (pre-survey n=123, post-survey n=73)
HOPES HAS REACHED FAMILIES AT RISK

Typical HOPES caregiver in Webb County:

- Married mother, 28 years old
- 2 year old child
- White, Hispanic
- Spanish-speaking
- No High School Diploma
- Annual income is $0-$10,000
- Average time in program is 4.8 months

HOPES HAS PROMOTED NURTURING ENVIRONMENTS FROM 2015-2018:

- Number of families who participated in evidence-based programs:
  - SAFECARE
  - 602

FROM 2015-2018:

4,661 individuals reached at community events
*may include duplicated individuals

Number of families who participated in evidence-based programs:

Collaboration of HOPES Partnerships

Project HOPES Stakeholder Group shows a high level of collaboration that has improved from 2015 to 2016.

About This Site

Webb County is a HOPES I Site (2015-2019)

**Primary Agency:**
Serving Children and Adults in Need (SCAN), Inc.

**Coalition:**
Project HOPES Stakeholder Group

**Evidence-Based Program:**
SafeCare

Webb County completed 123 pre-caregiver surveys, 73 post-caregiver surveys, 47 online staff surveys, 29 online community surveys, 30 staff interviews and focus groups, 8 client interviews, and 25 coalition member interviews and focus groups throughout our 4 year evaluation. Thank you for your cooperation & time!
HOPES HAS KEPT FAMILIES SAFE

99.9% of program participants did not have a new CPS case while receiving HOPES services.

HOPES HAS INCREASED FAMILY STABILITY

Average scores before and after HOPES participation:

**SOCIAL SUPPORT**

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Increase in perceived social support from family, friends, and peers to help address child needs or caregiver’s own emotional needs.

**FAMILY RESOURCES**

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Increase in perceived available resources to assess family concerns and priorities based on the hierarchy of needs.

**CONCRETE SUPPORT IN TIMES OF NEED**

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Increase in perceived ability to identify, seek, access quality services to preserve caregiver’s dignity and promote healthy family development.

Average scores are from the Caregiver Survey data (pre-survey n=37, post-survey n=24)

HOPES HAS PROMOTED NURTURING ENVIRONMENTS

Average scores before and after HOPES participation:

**PARENTAL RESILIENCE**

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Increase in perceived ability to manage stress and function well when faced with stressors, challenges, or adversity.

**SOCIAL CONNECTIONS**

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Increase in perceived healthy, sustained relationships with people, institutions, the community, or a force greater than oneself that forge a sense of belonging, attachment, reciprocal positive regard, and a feeling that one matters.

**SOCIAL & EMOTIONAL COMPETENCE OF CHILDREN**

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Increase in perceived ability to provide an environment and experiences that enable children to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.
HOPES II: Final Evaluation Report

HOPES HAS PROMOTED NURTURING ENVIRONMENTS FROM 2016-2018:

- Number of families who participated in evidence-based programs:
  - TRIPLE P: 622
  - AVANCE: 164
  - NURSE-FAMILY PARTNERSHIP: 81
  - PARENTS AS TEACHERS: 75

Typical HOPES caregiver in Dallas County:

- Married mother, 31 years old
- 2 year old child
- White, Hispanic
- Spanish-speaking
- No High School Diploma
- Annual income is $0-$10,000
- Average time in program is 3.5 months

HOPES HAS REACHED FAMILIES AT RISK

Number of families who participated in evidence-based programs:

- TRIPLE P: 622
- AVANCE: 164
- NURSE-FAMILY PARTNERSHIP: 81
- PARENTS AS TEACHERS: 75

Not enough responses were collected from the Child Abuse Prevention Coalition to assess collaboration. There is an opportunity for this coalition to assess their collaboration among coalition members.

FROM 2016-2018:

4,182 individuals reached at community events
*may include duplicated individuals

Risk factors HOPES caregivers in Dallas County are experiencing:

- 45% had 4 or more Adverse Childhood Experiences
- 55% had a positive screen for a mental health concern
- 41% had a positive screen for substance use
- 14% had a positive screen for domestic violence
- 39% said they felt their neighborhood was unsafe

ADDRESSING THESE FACTORS ARE KNOWN TO PREVENT CHILD MALTREATMENT.

Dallas County is a HOPES II Site (2016-2020)

PRIMARY AGENCY:
United Way of Metropolitan Dallas

SUBCONTRACTORS:
AVANCE, ChildCareGroup, Dallas Children Advocacy Center, Family Care Connection, Family Compass, Parkland Hospital

COALITION:
Child Abuse Prevention Coalition (CAPCO)

EVIDENCE-BASED PROGRAMS:
AVANCE Parent-Child Education Program, Nurse-Family Partnership, Parent as Teachers, Triple P

Dallas County completed 37 pre-caregiver surveys, 24 post-caregiver surveys, 33 online staff surveys, 11 online community surveys, 42 staff interviews and focus groups, and 6 client interviews throughout our 4 year evaluation. Thank you for your cooperation & time!
$HARRIS$ 185,171 Individuals reached in HOPES from FY2016-2018

From 2010 - 2018 the child maltreatment rate among children 5 years old and younger remained the same in Harris County.

HOPES HAS KEPT FAMILIES SAFE

99.3% of program participants did not have a new CPS case since receiving HOPES services.

HOPES HAS INCREASED FAMILY STABILITY

Average scores before and after HOPES participation:

**SOCIAL SUPPORT**

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Increase in perceived social support from family, friends, and peers to help address child needs or caregiver’s own emotional needs.

**FAMILY RESOURCES**

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Increase in perceived available resources to assess family concerns and priorities based on the hierarchy of needs.

**CONCRETE SUPPORT IN TIMES OF NEED**

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Increase in perceived ability to identify, seek, access quality services to preserve caregiver’s dignity and promote healthy family development.

Average scores are from the Caregiver Survey data (pre-survey n=412, post-survey n=227)

HOPES HAS PROMOTED NURTURING ENVIRONMENTS

Average scores before and after HOPES participation:

**PARENTAL RESILIENCE**

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Increase in perceived ability to manage stress and function well when faced with stressors, challenges, or adversity.

**SOCIAL CONNECTIONS**

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Increase in perceived healthy, sustained relationships with people, institutions, the community, or a force greater than oneself that forge a sense of belonging, attachment, reciprocal positive regard, and a feeling that one matters.

**SOCIAL & EMOTIONAL COMPETENCE OF CHILDREN**

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Increase in perceived ability to provide an environment and experiences that enable children to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.
HOPES HAS REACHED FAMILIES AT RISK

Typical HOPES caregiver in Harris County:

- Married mother, 32 years old
- 2 year old child
- White, Hispanic
- English-speaking
- No High School Diploma
- Annual income is $0-$10,000
- Average time in program is 4.7 months

FROM 2016-2018:

184,600 individuals reached at community events
*may include duplicated individuals

Number of families who participated in evidence-based programs:

- Nurturing Parenting: 448
- Triple P: 367
- Parents as Teachers: 224
- Family Connections: 62
- Centering Pregnancy: 61

HOPES II Site (2016-2020)

PRIMARY AGENCY:
DePelchin Children’s Center

SUBCONTRACTORS:
Collaborative for Children, Harris County Protective Services, UT Health Science Center

COALITION:
Parenting Help Coalition

EVIDENCE-BASED PROGRAMS:
Nurturing Parenting, Parents as Teachers, Triple P

Harris County completed 412 pre-caregiver surveys, 227 post-caregiver surveys, 32 online staff surveys, 9 online community surveys, 46 staff interviews and focus groups, and 10 client interviews throughout our 4 year evaluation. Thank you for your cooperation & time!
From 2010 - 2018 the child maltreatment rate among children 5 years old and younger increased by 0.14% in Jefferson County.

HOPES HAS KEPT FAMILIES SAFE

98.7% of program participants did not have a new CPS case while receiving HOPES services.

Average scores before and after HOPES participation:

**CONCRETE SUPPORT**

**BEFORE** | **AFTER**
---|---
5.4 | 5.7

*Increase in perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.

**SOCIAL EMOTIONAL SUPPORT**

**BEFORE** | **AFTER**
---|---
5.9 | 6.0

*Increase in perceived informal support (e.g., family, friends, neighbors) who help provide emotional needs.

**FAMILY FUNCTIONING/RESILIENCY**

**BEFORE** | **AFTER**
---|---
5.5 | 5.8

*Increase in perceived adaptive skills and strategies to persevere in times of crisis, openly share positive and negative experiences and mobilize to accept, solve and manage problems.

**CHILD DEVELOPMENT & KNOWLEDGE OF PARENTING**

**BEFORE** | **AFTER**
---|---
5.9 | 6.1

*Increase in perceived understanding and use of effective child management techniques and having age-appropriate expectations for children’s abilities.

**NURTURING & ATTACHMENT**

**BEFORE** | **AFTER**
---|---
6.5 | 6.4

*Increase in perceived emotional tie along with a pattern of positive interaction between the parent and child that develops over time.

I believe that the most useful thing was actually learning how to communicate at my child’s level and different ways to teaching him new things.

—Parent, Jefferson County HOPES Participant
HOPES HAS REACHED FAMILIES AT RISK

Typical HOPES caregiver in Jefferson County:

- Single mother, 27 years old
- 1 year old child
- Black, Non-Hispanic
- English-speaking
- Some College
- Annual income is $0-$10,000
- Average time in program is 8.4 months

FROM 2016-2018:

242,043 individuals reached at community events
*may include duplicated individuals

Number of families who participated in evidence-based programs:

Project Healthy Outcomes through Prevention and Early Support is funded by the Prevention and Early Intervention division of the Texas Department of Family and Protective Services. This evaluation is by:

The University of Texas at Austin
Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work

Risk factors HOPES caregivers in Jefferson County are experiencing:

- 55% experienced high stress
- 40% had inaccurate child development knowledge
- 35% had a non-traditional family structure
- 15% had poor parent-child interaction
- 15% had negative attitudes about child’s behavior

These risk factors were collected at intake from the primary caregiver.

Jefferson County is a HOPES II Site (2016-2020)

PRIMARY AGENCY:
Buckner Children & Family Services

COALITION:
Community Resource Coordination Group (CRCG)

EVIDENCE-BASED PROGRAM:
Parents as Teachers

Jefferson County completed 10 pre-caregiver surveys, 4 post-caregiver surveys, 6 online staff surveys, 1 online community surveys, 13 staff interviews and focus groups, 3 client interviews, and 1 coalition member interview throughout our 4 year evaluation. Thank you for your cooperation & time!
From 2010 - 2018 the child maltreatment rate among children 5 years old and younger **decreased** by **0.68%** in Lubbock County.

**HOPES HAS KEPT FAMILIES SAFE**

- **99.8%** of program participants did not have a new CPS case while receiving HOPES services.
- From 2010 - 2018 the child maltreatment rate among children 5 years old and younger **decreased** by **0.68%** in Lubbock County.

**HOPES HAS INCREASED FAMILY STABILITY**

Average scores before and after HOPES participation:

- **SOCIAL SUPPORT**
  - Before: **3.3**
  - After: **3.6**
  - Increase in perceived social support from family, friends, and peers to help address child needs or caregiver’s own emotional needs.

- **FAMILY RESOURCES**
  - Before: **2.7**
  - After: **2.8**
  - Increase in perceived available resources to assess family concerns and priorities based on the hierarchy of needs.

- **CONCRETE SUPPORT IN TIMES OF NEED**
  - Before: **3.2**
  - After: **3.5**
  - Increase in perceived ability to identify, seek, access quality services to preserve caregiver’s dignity and promote healthy family development.

**HOPES HAS PROMOTED NURTURING ENVIRONMENTS**

Average scores before and after HOPES participation:

- **PARENTAL RESILIENCE**
  - Before: **3.5**
  - After: **3.6**
  - Increase in perceived ability to manage stress and function well when faced with stressors, challenges, or adversity.

- **SOCIAL CONNECTIONS**
  - Before: **3.2**
  - After: **3.5**
  - Increase in perceived healthy, sustained relationships with people, institutions, the community, or a force greater than oneself that forge a sense of belonging, attachment, reciprocal positive regard, and a feeling that one matters.

- **SOCIAL & EMOTIONAL COMPETENCE OF CHILDREN**
  - Before: **3.5**
  - After: **3.6**
  - Increase in perceived ability to provide an environment and experiences that enable children to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.

Average scores are from the Caregiver Survey data (pre-survey n=198, post-survey n=93)
HOPES HAS REACHED FAMILIES AT RISK

Typical HOPES caregiver in Lubbock County:

- Married mother, 29 years old
- 1 year old child
- White, Non-Hispanic
- English-speaking
- Some College
- Annual income is $0-$10,000
- Average time in program is 7.1 months

FROM 2016-2018:

127,591 individuals reached at community events
*may include duplicated individuals

Number of families who participated in evidence-based programs:

- HOPES II

Risk factors HOPES caregivers in Lubbock County are experiencing:

- 30% had 4 or more Adverse Childhood Experiences
- 50% had a positive screen for a mental health concern
- 5% had a positive screen for substance use
- 4% had a positive screen for domestic violence
- 24% said they felt their neighborhood was unsafe

Addressing these factors are known to prevent child maltreatment.

COLLABORATION OF HOPES PARTNERSHIPS

South Plains Coalition for Child Abuse Prevention has opportunity to improve collaboration.

ABOUT THIS SITE

Lubbock County is a HOPES II Site (2016-2020)

PRIMARY AGENCY:
The Parenting Cottage

COALITION:
South Plains Coalition for Child Abuse Prevention

EVIDENCE-BASED PROGRAM:
Parents as Teachers

Lubbock County completed 198 pre-caregiver surveys, 93 post-caregiver surveys, 17 online staff surveys, 27 online community surveys, 13 staff interviews and focus groups, 3 client interviews, and 8 coalition member interviews and focus groups throughout our 4 year evaluation. Thank you for your cooperation & time!
HOPES HAS KEPT FAMILIES SAFE

99.7% of program participants did not have a new CPS case while receiving HOPES services.

HOPES HAS INCREASED FAMILY STABILITY

Average scores before and after HOPES participation:

**SOCIAL SUPPORT**

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Increase in perceived social support from family, friends, and peers to help address child needs or caregiver’s own emotional needs.

**FAMILY RESOURCES**

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Increase in perceived available resources to assess family concerns and priorities based on the hierarchy of needs.

**CONCRETE SUPPORT IN TIMES OF NEED**

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Increase in perceived ability to identify, seek, access quality services to preserve caregiver’s dignity and promote healthy family development.

HOPES II

**SOCIAL & EMOTIONAL COMPETENCE OF CHILDREN**

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Increase in perceived ability to provide an environment and experiences that enable children to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.

Average scores are from the Caregiver Survey data (pre-survey n=116, post-survey n=30)
HOPES HAS REACHED FAMILIES AT RISK

**Typical HOPES caregiver in McLennan County:**

- Single mother, 30 years old
- 2 year old child
- White, Hispanic
- English-speaking
- No High School Diploma
- Annual income is $10,001-$20,000
- Average time in program is 7 months

FROM 2016-2018:

30,508 individuals reached at community events

*may include duplicated individuals

**Number of families who participated in evidence-based programs:**

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<tr>
<th>Program</th>
<th>Number of Families Served</th>
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<tr>
<td>Parents as Teachers</td>
<td>234</td>
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**Risk factors HOPES caregivers in McLennan County are experiencing:**

- 25% had 4 or more Adverse Childhood Experiences
- 52% had a positive screen for a mental health concern
- 5% had a positive screen for substance use
- 4% had a positive screen for domestic violence
- 36% said they felt their neighborhood was unsafe

Addressing these factors are known to prevent child maltreatment.

COLLABORATION OF HOPES PARTNERSHIPS

**Alliance for Safe Children** had a high level of collaboration in 2016.

**LEVEL OF COLLABORATION**

0 1 2 3 4 5

**ABOUT THIS SITE**

McLennan County is a HOPES II Site (2016-2020)

**PRIMARY AGENCY:**
Family Abuse Center

**SUBCONTRACTOR:**
Waco Independent School District

**COALITION:**
Alliance for Safe Children

**EVIDENCE-BASED PROGRAM:**
Parents as Teachers

McLennan County completed 116 pre-caregiver surveys, 30 post-caregiver surveys, 11 online staff surveys, 21 online community surveys, 10 staff interviews and focus groups, 3 client interviews, and 2 coalition member interviews and focus groups throughout our 4 year evaluation. Thank you for your cooperation & time!
From 2010 - 2018 the child maltreatment rate among children 5 years old and younger increased by 0.09% in Nueces County.

HOPES HAS KEPT FAMILIES SAFE

98.7% of program participants did not have a new CPS case while receiving HOPES services.

HOPES HAS INCREASED FAMILY STABILITY

Average scores before and after HOPES participation:

**SOCIAL SUPPORT**

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Increase in perceived social support from family, friends, and peers to help address child needs or caregiver’s own emotional needs.

**FAMILY RESOURCES**

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Increase in perceived available resources to assess family concerns and priorities based on the hierarchy of needs.

**CONCRETE SUPPORT IN TIMES OF NEED**

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Increase in perceived ability to identify, seek, access quality services to preserve caregiver’s dignity and promote healthy family development.

Average scores are from the Caregiver Survey data (pre-survey n=174, post-survey n=64)

HOPES HAS PROMOTED NURTURING ENVIRONMENTS

Average scores before and after HOPES participation:

**PARENTAL RESILIENCE**

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Increase in perceived ability to manage stress and function well when faced with stressors, challenges, or adversity.

**SOCIAL CONNECTIONS**

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Increase in perceived healthy, sustained relationships with people, institutions, the community, or a force greater than oneself that forge a sense of belonging, attachment, reciprocal positive regard, and a feeling that one matters.

**SOCIAL & EMOTIONAL COMPETENCE OF CHILDREN**

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Increase in perceived ability to provide an environment and experiences that enable children to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.
Typical HOPES caregiver in Nueces County:

- Married mother, 31 years old
- 3 year old child
- White, Hispanic
- English-speaking
- Some College
- Annual income is $0-$10,000
- Average time in program is 10.3 months

FROM 2016-2018:

9,434 individuals reached at community events
*may include duplicated individuals

Number of families who participated in evidence-based programs:

- HIPPY: 167
- PARENTS AS TEACHERS: 41

Risk factors HOPES caregivers in Nueces County are experiencing:

- 36% had 4 or more Adverse Childhood Experiences
- 56% had a positive screen for a mental health concern
- 2% had a positive screen for substance use
- 6% had a positive screen for domestic violence
- 41% said they felt their neighborhood was unsafe

COLLABORATION OF HOPES PARTNERSHIPS

Success by 6 Coastal Bend Early Childhood Education had a high level of collaboration in 2016.

ABOUT THIS SITE

Nueces County is a HOPES II Site (2016-2020)

PRIMARY AGENCY:
Education Service Center, Region 2

COALITION:
Success by 6 Coastal Bend Early Childhood Coalition

EVIDENCE-BASED PROGRAMS:
Home Instruction for Parents of Preschool Youngsters, Parents as Teachers

Nueces County completed 174 pre-caregiver surveys, 64 post-caregiver surveys, 9 online staff surveys, 8 online community surveys, 19 staff interviews and focus groups, 6 client interviews, and 5 coalition member interviews and focus groups throughout our 4 year evaluation. Thank you for your cooperation & time!
HOPES HAS KEPT FAMILIES SAFE

98.8% of program participants did not have a new CPS case while receiving HOPES services.

HOPES HAS INCREASED FAMILY STABILITY

Average scores before and after HOPES participation:

CONCRETE SUPPORT

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Increase in perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.

SOCIAL EMOTIONAL SUPPORT

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Increase in perceived informal support (e.g., family, friends, neighbors) who help provide emotional needs.

FAMILY FUNCTIONING/RESILIENCY

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Increase in perceived adaptive skills and strategies to persevere in times of crisis, openly share positive and negative experiences and mobilize to accept solve and manage problems.

Average scores are from the Protective Factors Survey data (n=74)

HOPES HAS PROMOTED NURTURING ENVIRONMENTS

Average scores before and after HOPES participation:

CHILD DEVELOPMENT & KNOWLEDGE OF PARENTING

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Increase in perceived understanding and use of effective child management techniques and having age-appropriate expectations for children's abilities.

NURTURING & ATTACHMENT

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Increase in perceived emotional tie along with a pattern of positive interaction between the parent and child that develops over time.

From 2010 - 2018 the child maltreatment rate among children 5 years old and younger increased by 0.61% in Taylor County.

This program has done nothing but empowered me, and women. There are a few ladies that I know from my church that were actually in the program, too, and they all say the same thing, the program was a blessing.

—Parent, Taylor County HOPES Participant

TAYLOR COUNTY 0.61%

TAYLOR    6,409 Individuals reached in HOPES from FY2016-2018

From 2010 - 2018 the child maltreatment rate among children 5 years old and younger increased by 0.61% in Taylor County.

Average scores before and after HOPES participation:

ACROSS SUPPORT

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Increase in perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need.

SOCIAL EMOTIONAL SUPPORT

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Increase in perceived informal support (e.g., family, friends, neighbors) who help provide emotional needs.

FAMILY FUNCTIONING/RESILIENCY

<table>
<thead>
<tr>
<th>BEFORE</th>
<th>AFTER</th>
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<tbody>
<tr>
<td>5.2</td>
<td>5.7</td>
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</tbody>
</table>

Increase in perceived adaptive skills and strategies to persevere in times of crisis, openly share positive and negative experiences and mobilize to accept solve and manage problems.

Average scores are from the Protective Factors Survey data (n=74)

HOPES HAS PROMOTED NURTURING ENVIRONMENTS

Average scores before and after HOPES participation:

CHILD DEVELOPMENT & KNOWLEDGE OF PARENTING

<table>
<thead>
<tr>
<th>BEFORE</th>
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<tbody>
<tr>
<td>5.5</td>
<td>6.0</td>
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</table>

Increase in perceived understanding and use of effective child management techniques and having age-appropriate expectations for children's abilities.

NURTURING & ATTACHMENT

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<tr>
<th>BEFORE</th>
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<tr>
<td>6.2</td>
<td>6.6</td>
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</table>

Increase in perceived emotional tie along with a pattern of positive interaction between the parent and child that develops over time.

This program has done nothing but empowered me, and women. There are a few ladies that I know from my church that were actually in the program, too, and they all say the same thing, the program was a blessing.

—Parent, Taylor County HOPES Participant
HOPES HAS PROMOTED NURTURING ENVIRONMENTS FROM 2016-2018:

- Number of families who participated in evidence-based programs:
  - HOPES II
  - SAFECARE

HOPES HAS REACHED FAMILIES AT RISK

**Typical HOPES caregiver in Taylor County:**
- Single mother, 28 years old
- 2 year old child
- White, Non-Hispanic
- English-speaking
- Some College
- Annual income is $10,001-$20,000
- Average time in program is 4.5 months

**FROM 2016-2018:**

6,190 individuals reached at community events
*may include duplicated individuals

**Number of families who participated in evidence-based programs:**

<table>
<thead>
<tr>
<th>SAFECARE</th>
<th>219</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>200</td>
<td>300</td>
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</tbody>
</table>

**RISK FACTORS HOPES CAREGIVERS IN TAYLOR COUNTY ARE EXPERIENCING:**

- 64% had 4 or more Adverse Childhood Experiences
- 64% had a positive screen for a mental health concern
- 14% had a positive screen for substance use
- 6% had a positive screen for domestic violence
- 32% said they felt their neighborhood was unsafe

**ADDRESSING THOSE FACTORS ARE KNOWN TO PREVENT CHILD MALTREATMENT.**

**COLLABORATION OF HOPES PARTNERSHIPS**

Not enough responses were collected from the HOPES Coalition to assess collaboration. There is an opportunity for this coalition to assess their collaboration among coalition members.

**ABOUT THIS SITE**

Taylor County is a HOPES II Site (2016-2020)

**PRIMARY AGENCY:**
BCFS Health & Human Services

**COALITION:**
HOPES Coalition

**EVIDENCE-BASED PROGRAM:**
SafeCare

Taylor County completed 22 pre-caregiver surveys, 22 post-caregiver surveys, 10 online staff surveys, 12 online community surveys, 7 staff interviews and focus groups, 5 client interviews, and 5 coalition member interviews and focus groups throughout our 4 year evaluation. Thank you for your cooperation & time!
**WICHITA**

119,705 Individuals reached in HOPES from FY2016-2018

From 2010 - 2018 the child maltreatment rate among children 5 years old and younger **decreased** by **0.48%** in Wichita County.

**HOPES HAS KEPT FAMILIES SAFE**

**98.9%** of program participants did not have a new CPS case while receiving HOPES services.

**HOPES HAS INCREASED FAMILY STABILITY**

Average scores before and after HOPES participation:

**SOCIAL SUPPORT**

<table>
<thead>
<tr>
<th>BEFORE</th>
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<td>3.1</td>
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</table>

*Increase in perceived social support from family, friends, and peers to help address child needs or caregiver’s own emotional needs.*

**FAMILY RESOURCES**

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<tr>
<th>BEFORE</th>
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<tr>
<td>2.3</td>
<td>2.4</td>
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</table>

*Increase in perceived available resources to assess family concerns and priorities based on the hierarchy of needs.*

**CONCRETE SUPPORT IN TIMES OF NEED**

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<th>BEFORE</th>
<th>AFTER</th>
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<tbody>
<tr>
<td>3.3</td>
<td>3.1</td>
</tr>
</tbody>
</table>

*Increase in perceived ability to identify, seek, access quality services to preserve caregiver’s dignity and promote healthy family development.*

Average scores are from the Caregiver Survey data *(pre-survey n=77, post-survey n=49)*

**HOPES HAS PROMOTED NURTURING ENVIRONMENTS**

Average scores before and after HOPES participation:

**PARENTAL RESILIENCE**

<table>
<thead>
<tr>
<th>BEFORE</th>
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<tbody>
<tr>
<td>3.7</td>
<td>3.6</td>
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</table>

*Increase in perceived ability to manage stress and function well when faced with stressors, challenges, or adversity.*

**SOCIAL CONNECTIONS**

<table>
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<tr>
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<tr>
<td>3.2</td>
<td>3.2</td>
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</table>

*Increase in perceived healthy, sustained relationships with people, institutions, the community, or a force greater than oneself that forge a sense of belonging, attachment, reciprocal positive regard, and a feeling that one matters.*

**SOCIAL & EMOTIONAL COMPETENCE OF CHILDREN**

<table>
<thead>
<tr>
<th>BEFORE</th>
<th>AFTER</th>
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<tbody>
<tr>
<td>3.4</td>
<td>3.2</td>
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</table>

*Increase in perceived ability to provide an environment and experiences that enable children to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.*
HOPES HAS REACHED FAMILIES AT RISK

Typical HOPES caregiver in Wichita County:

- Single mother, 28 years old
- 2 year old child
- White, Non-Hispanic
- English-speaking
- Graduated high school or has GED
- Annual income is $0-$10,000
- Average time in program is 6.9 months

FROM 2016-2018:

119,511 individuals reached at community events
*may include duplicated individuals

Number of families who participated in evidence-based programs:

<table>
<thead>
<tr>
<th>Program</th>
<th>Number of Families Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIPPY</td>
<td>80</td>
</tr>
<tr>
<td>PARENTS AS TEACHERS</td>
<td>66</td>
</tr>
<tr>
<td>24/7 DAD</td>
<td>48</td>
</tr>
</tbody>
</table>

HOPES II Site (2016-2020)

Risk factors HOPES caregivers in Wichita County are experiencing:

- 30% had 4 or more Adverse Childhood Experiences
- 42% had a positive screen for a mental health concern
- 3% had a positive screen for substance use
- 8% had a positive screen for domestic violence
- 31% said they felt their neighborhood was unsafe

Addressing these factors are known to prevent child maltreatment.

Collaboration of HOPES Partnerships

Early Childhood Coalition of North Texas had a moderately-high level of collaboration in 2016.

About This Site

Wichita County is a HOPES II Site (2016-2020)

Primary Agency:
North Texas Area United Way

Subcontractor:
Wichita Independent School District

Coalition:
Early Childhood Coalition of North Texas

Evidence-Based Programs:
24/7 Dad, Home Instruction for Parents of Preschool Youngsters, Parents as Teachers

Wichita County completed 77 pre-caregiver surveys, 49 post-caregiver surveys, 9 online staff surveys, 13 online community surveys, 9 staff interviews and focus groups, 7 client interviews, and 13 coalition member interviews and focus groups throughout our 4 year evaluation. Thank you for your cooperation & time!

Project Healthy Outcomes through Prevention and Early Support is funded by the Prevention and Early Intervention division of The Texas Department of Family and Protective Services. This evaluation is by:

The University of Texas at Austin
Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work
From 2010 - 2018 the child maltreatment rate among children 5 years old and younger increased by 0.52% in Bell County.

100% of program participants did not have a new CPS case while receiving HOPES services.

Average scores before and after HOPES participation:

**SOCIAL SUPPORT**

| BEFORE | 3.0 |
| AFTER  | 3.2 |

Increase in perceived social support from family, friends, and peers to help address child needs or caregiver’s own emotional needs.

**FAMILY RESOURCES**

| BEFORE | 2.4 |
| AFTER  | 2.4 |

Increase in perceived available resources to assess family concerns and priorities based on the hierarchy of needs.

**CONCRETE SUPPORT IN TIMES OF NEED**

| BEFORE | 3.2 |
| AFTER  | 3.3 |

Increase in perceived ability to identify, seek, access quality services to preserve caregiver’s dignity and promote healthy family development.

**PARENTAL RESILIENCE**

| BEFORE | 3.5 |
| AFTER  | 3.5 |

Increase in perceived ability to manage stress and function well when faced with stressors, challenges, or adversity.

**SOCIAL CONNECTIONS**

| BEFORE | 3.0 |
| AFTER  | 3.3 |

Increase in perceived healthy, sustained relationships with people, institutions, the community, or a force greater than oneself that forge a sense of belonging, attachment, reciprocal positive regard, and a feeling that one matters.

**SOCIAL & EMOTIONAL COMPETENCE OF CHILDREN**

| BEFORE | 3.5 |
| AFTER  | 3.4 |

Increase in perceived ability to provide an environment and experiences that enable children to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.

Average scores are from the Caregiver Survey data (pre-survey n=27, post-survey n=14)
HOPES HAS REACHED FAMILIES AT RISK

Typical HOPES caregiver in Bell County:

- Single mother, 28 years old
- 2 year old child
- White, Non-Hispanic
- English-speaking
- Some College
- Annual income is NA
- Average time in program is 2.2 months

FROM 2017-2018:

40,676 individuals reached at community events
*may include duplicated individuals

Number of families who participated in evidence-based programs:

- EXCHANGE PARENT AIDE: 52

Bell County was in the process of collaborating with community partners at the time of this evaluation. There is an opportunity for AWARE Central Texas to establish a collaboration among community stakeholders.

HOPES III Site (2017-2021)

PRIMARY AGENCY:
AWARE Central Texas

EVIDENCE-BASED PROGRAMS:
Exchange Parent Aide, Love & Logic

Bell County completed 27 pre-caregiver surveys, 14 post-caregiver surveys, 2 online staff surveys, 0 online community surveys, 1 staff interviews and focus groups, and 2 client interviews throughout our 4 year evaluation. Thank you for your cooperation & time!

Risk factors HOPES caregivers in Bell are experiencing:

- 62% had 4 or more Adverse Childhood Experiences
- 67% had a positive screen for a mental health concern
- 11% had a positive screen for substance use
- 25% had a positive screen for domestic violence
- 33% said they felt their neighborhood was unsafe

Addressing these factors are known to prevent child maltreatment.

Project Healthy Outcomes through Prevention and Early Support is funded by the Prevention and Early Intervention division of The Texas Department of Family and Protective Services. This evaluation is by:

The University of Texas at Austin
Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work
**HOPES HAS KEPT FAMILIES SAFE**

99.6% of program participants did not have a new CPS case while receiving HOPES services.

**HOPES III**

**BEXAR COUNTY**

-0.19%

From 2010 - 2018 the child maltreatment rate among children 5 years old and younger decreased by 0.19% in Bexar County.

**HOPES HAS INCREASED FAMILY STABILITY**

Average scores before and after HOPES participation:

<table>
<thead>
<tr>
<th>Component</th>
<th>BEFORE</th>
<th>AFTER</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SOCIAL SUPPORT</strong></td>
<td>2.4</td>
<td>2.8</td>
<td></td>
</tr>
<tr>
<td>Increase in perceived social support from family, friends, and peers to help address child needs or caregiver’s own emotional needs.</td>
<td></td>
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<tr>
<td><strong>FAMILY RESOURCES</strong></td>
<td>1.9</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>Increase in perceived available resources to assess family concerns and priorities based on the hierarchy of needs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CONCRETE SUPPORT IN TIMES OF NEED</strong></td>
<td>3.0</td>
<td>3.2</td>
<td></td>
</tr>
<tr>
<td>Increase in perceived ability to identify, seek, access quality services to preserve caregiver’s dignity and promote healthy family development.</td>
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</table>

Average scores are from the Caregiver Survey data (pre-survey n=28, post-survey n=11)

**HOPES HAS PROMOTED NURTURING ENVIRONMENTS**

Average scores before and after HOPES participation:

<table>
<thead>
<tr>
<th>Component</th>
<th>BEFORE</th>
<th>AFTER</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PARENTAL RESILIENCE</strong></td>
<td>3.1</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td>Increase in perceived ability to manage stress and function well when faced with stressors, challenges, or adversity.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>SOCIAL CONNECTIONS</strong></td>
<td>2.7</td>
<td>3.4</td>
<td></td>
</tr>
<tr>
<td>Increase in perceived healthy, sustained relationships with people, institutions, the community, or a force greater than oneself that forge a sense of belonging, attachment, reciprocal positive regard, and a feeling that one matters.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>SOCIAL &amp; EMOTIONAL COMPETENCE OF CHILDREN</strong></td>
<td>3.0</td>
<td>3.1</td>
<td></td>
</tr>
<tr>
<td>Increase in perceived ability to provide an environment and experiences that enable children to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.</td>
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</table>
FROM 2017-2018:

10,171 individuals reached at community events
*may include duplicated individuals

Number of families who participated in evidence-based programs:

- TRIPLE P: 161
- STEP: 153
- Aggression Replacement Training/Skillstreaming: 83
- Parents as Teachers: 33
- Barkley’s Defiant Child: 27

Typical HOPES caregiver in Bexar County:

- Single mother, 31 years old
- 2 year old child
- White, Hispanic
- English-speaking
- Some College
- Annual income is NA
- Average time in program is 3.5 months

Risk factors HOPES caregivers in Bexar are experiencing:

- 48% had 4 or more Adverse Childhood Experiences
- 82% had a positive screen for a mental health concern
- 4% had a positive screen for substance use
- 0% had a positive screen for domestic violence
- 56% said they felt their neighborhood was unsafe

About This Site

Bexar County is a HOPES III Site (2017-2021)

Primary Agency:
United Way of San Antonio and Bexar County

Subcontractors:
Any Baby Can, Catholic Charities, The Center for Health Care Services, The Children’s Shelter, DePelchin Children’s Center, Family Service Association, KLRN, Martinez Street Women’s Center, Respite Care of San Antonio

Coalition:
ReadyKidSA

Evidence-Based Programs:
Aggression Replacement Training, Barkley’s Defiant Child, Skillstreaming, Nurturing Parenting, Parents as Teachers, Systemic Training for Effective Parenting, Triple P

Bexar County completed 28 pre-caregiver surveys, 11 post-caregiver surveys, 22 online staff surveys, 22 online community surveys, 7 staff interviews and focus groups, and 1 client interviews throughout our 4 year evaluation. Thank you for your cooperation & time!
From 2010 - 2018 the child maltreatment rate among children 5 years old and younger **decreased** by **0.79%** in Brazos County.

**HOPES HAS KEPT FAMILIES SAFE**

100% of program participants did not have a new CPS case while receiving HOPES services.

**HOPES HAS INCREASED FAMILY STABILITY**

Average scores before and after HOPES participation:

- **SOCIAL SUPPORT**
  - BEFORE: 2.5
  - AFTER: 2.1
  - Increase in perceived social support from family, friends, and peers to help address child needs or caregiver’s own emotional needs.

- **FAMILY RESOURCES**
  - BEFORE: 2.3
  - AFTER: 1.6
  - Increase in perceived available resources to assess family concerns and priorities based on the hierarchy of needs.

- **CONCRETE SUPPORT IN TIMES OF NEED**
  - BEFORE: 3.1
  - AFTER: 3.1
  - Increase in perceived ability to identify, seek, access quality services to preserve caregiver’s dignity and promote healthy family development.

Average scores are from the Caregiver Survey data (pre-survey n=7, post-survey n=3)

**HOPES HAS PROMOTED NURTURING ENVIRONMENTS**

Average scores before and after HOPES participation:

- **PARENTAL RESILIENCE**
  - BEFORE: 3.4
  - AFTER: 3.8
  - Increase in perceived ability to manage stress and function well when faced with stressors, challenges, or adversity.

- **SOCIAL CONNECTIONS**
  - BEFORE: 2.4
  - AFTER: 3.4
  - Increase in perceived healthy, sustained relationships with people, institutions, the community, or a force greater than oneself that forge a sense of belonging, attachment, reciprocal positive regard, and a feeling that one matters.

- **SOCIAL & EMOTIONAL COMPETENCE OF CHILDREN**
  - BEFORE: 3.2
  - AFTER: 3.4
  - Increase in perceived ability to provide an environment and experiences that enable children to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.
HOPES III Evaluation Report

HOPES HAS PROMOTED NURTURING ENVIRONMENTS FROM 2017-2018:

- Number of families who participated in evidence-based programs:
  - HOPES III

HOPES HAS REACHED FAMILIES AT RISK

- Typical HOPES caregiver in Brazos County:
  - Single mother, 26 years old
  - 1 year old child
  - White, Hispanic
  - English-speaking
  - No High School Diploma
  - Annual income is NA
  - Average time in program is 8.5 months

FROM 2017-2018:

- 280 individuals reached at community events
  *may include duplicated individuals

- Project Healthy Outcomes through Prevention and Early Support
  is funded by the Prevention and Early Intervention division of The Texas Department of Family and Protective Services.
  This evaluation is by:

- The University of Texas at Austin
  Texas Institute for Child & Family Wellbeing
  Steve Hicks School of Social Work

Risk factors HOPES caregivers in Brazos are experiencing:

- 20% had 4 or more Adverse Childhood Experiences
- 57% had a positive screen for a mental health concern
- 0% had a positive screen for substance use
- 17% had a positive screen for domestic violence
- 43% said they felt their neighborhood was unsafe

COLLABORATION OF HOPES PARTNERSHIPS

- Not enough responses were collected from the Community Partnership Board to assess collaboration. There is an opportunity for this coalition to assess their collaboration among coalition members.

ABOUT THIS SITE

- Brazos County is a HOPES III Site (2017-2021)
- PRIMARY AGENCY:
  Project Unity
- COALITION:
  Community Partnership Board, Early Childhood Coalition
- EVIDENCE-BASED PROGRAM:
  Parents as Teachers

- Brazos County completed 7 pre-caregiver surveys, 3 post-caregiver surveys, 3 online staff surveys, 1 online community surveys, 31 staff interviews and focus groups, and 6 client interviews throughout our 4 year evaluation. Thank you for your cooperation & time!
From 2010 - 2018 the child maltreatment rate among children 5 years old and younger **increased** by **0.08%** in Galveston County.

**Average scores before and after HOPES participation:**

**SOCIAL SUPPORT**

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<tr>
<th>BEFORE</th>
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<tr>
<td>AFTER</td>
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Increase in perceived social support from family, friends, and peers to help address child needs or caregiver’s own emotional needs.

**FAMILY RESOURCES**

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<tr>
<th>BEFORE</th>
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<tr>
<td>AFTER</td>
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Increase in perceived available resources to assess family concerns and priorities based on the hierarchy of needs.

**CONCRETE SUPPORT IN TIMES OF NEED**

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<th>BEFORE</th>
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</thead>
<tbody>
<tr>
<td>AFTER</td>
<td>3.5</td>
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</tbody>
</table>

Increase in perceived ability to identify, seek, access quality services to preserve caregiver’s dignity and promote healthy family development.

**Average scores are from the Caregiver Survey data**

(pre-survey n=39, post-survey n=20)

**HOPES HAS KEPT FAMILIES SAFE**

**100%** of program participants did not have a new CPS case while receiving HOPES services.

**HOPES HAS INCREASED FAMILY STABILITY**

**HOPES HAS PROMOTED NURTURING ENVIRONMENTS**

**PARENTAL RESILIENCE**

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<th>BEFORE</th>
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<tbody>
<tr>
<td>AFTER</td>
<td>3.4</td>
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</table>

Increase in perceived ability to manage stress and function well when faced with stressors, challenges, or adversity.

**SOCIAL CONNECTIONS**

<table>
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<tr>
<th>BEFORE</th>
<th>2.7</th>
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<tbody>
<tr>
<td>AFTER</td>
<td>2.9</td>
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</table>

Increase in perceived healthy, sustained relationships with people, institutions, the community, or a force greater than oneself that forge a sense of belonging, attachment, reciprocal positive regard, and a feeling that one matters.

**SOCIAL & EMOTIONAL COMPETENCE OF CHILDREN**

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<tbody>
<tr>
<td>AFTER</td>
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</table>

Increase in perceived ability to provide an environment and experiences that enable children to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.
Project Healthy Outcomes through Prevention and Early Support is funded by the Prevention and Early Intervention division of The Texas Department of Family and Protective Services. This evaluation is by:

The University of Texas at Austin
Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work

Galveston County is a HOPES III Site (2017-2021)

**PRIMARY AGENCY:**
DePelchin Children’s Center

**SUBCONTRACTOR:**
Collaborative for Children

**COALITION:**
Galveston County Community Resource Coordination Group

**EVIDENCE-BASED PROGRAMS:**
Parents as Teachers, Triple P

Galveston County completed 39 pre-caregiver surveys, 20 post-caregiver surveys, 9 online staff surveys, 9 online community surveys, 5 staff interviews and focus groups, and 1 client interviews throughout our 4 year evaluation. Thank you for your cooperation & time!
HOPES HAS KEPT FAMILIES SAFE

100% of program participants did not have a new CPS case while receiving HOPES services.

From 2010 - 2018 the child maltreatment rate among children 5 years old and younger decreased by 0.08% in Montgomery County.

HOPES HAS INCREASED FAMILY STABILITY

Average scores before and after HOPES participation:

**SOCIAL SUPPORT**

<table>
<thead>
<tr>
<th>BEFORE</th>
<th>AFTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.0</td>
<td>2.9</td>
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</tbody>
</table>

Increase in perceived social support from family, friends, and peers to help address child needs or caregiver’s own emotional needs.

**FAMILY RESOURCES**

<table>
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<tr>
<th>BEFORE</th>
<th>AFTER</th>
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<tbody>
<tr>
<td>1.8</td>
<td>1.1</td>
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Increase in perceived available resources to assess family concerns and priorities based on the hierarchy of needs.

**CONCRETE SUPPORT IN TIMES OF NEED**

<table>
<thead>
<tr>
<th>BEFORE</th>
<th>AFTER</th>
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</thead>
<tbody>
<tr>
<td>2.8</td>
<td>3.0</td>
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</tbody>
</table>

Increase in perceived ability to identify, seek, access quality services to preserve caregiver’s dignity and promote healthy family development.

Average scores are from the Caregiver Survey data (pre-survey n=72, post-survey n=18)

HOPES HAS PROMOTED NURTURING ENVIRONMENTS

Average scores before and after HOPES participation:

**PARENTAL RESILIENCE**

<table>
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<th>BEFORE</th>
<th>AFTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3</td>
<td>3.2</td>
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</tbody>
</table>

Increase in perceived ability to manage stress and function well when faced with stressors, challenges, or adversity.

**SOCIAL CONNECTIONS**

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<tr>
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<tbody>
<tr>
<td>2.8</td>
<td>2.8</td>
</tr>
</tbody>
</table>

Increase in perceived healthy, sustained relationships with people, institutions, the community, or a force greater than oneself that forge a sense of belonging, attachment, reciprocal positive regard, and a feeling that one matters.

**SOCIAL & EMOTIONAL COMPETENCE OF CHILDREN**

<table>
<thead>
<tr>
<th>BEFORE</th>
<th>AFTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2</td>
<td>3.1</td>
</tr>
</tbody>
</table>

Increase in perceived ability to provide an environment and experiences that enable children to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.
HOPES HAS PROMOTED NURTURING ENVIRONMENTS FROM 2017-2018:

- Number of families who participated in evidence-based programs:
  - HOPES III

HOPES HAS REACHED FAMILIES AT RISK

- Typical HOPES caregiver in Montgomery County:
  - Married mother, 33 years old
  - 2 year old child
  - White, Hispanic
  - Spanish-speaking
  - No High School Diploma
  - Annual income is NA
  - Average time in program is 3.9 months

FROM 2017-2018:

1,200 individuals reached at community events

*may include duplicated individuals

Number of families who participated in evidence-based programs:

- PARENTS AS TEACHERS: 104
- ABRIENDO PUERTAS: 65

Not enough responses were collected from the Family and Community Coalition of Montgomery County to assess collaboration. There is an opportunity for this coalition to assess their collaboration among coalition members.

Collaboration of HOPES Partnerships

- Montgomery County is a HOPES III Site (2017-2021)
  - PRIMARY AGENCY: Motivating, Educating, and Training (MET) Inc.
  - COALITION: Family and Community Coalition of Montgomery County
  - EVIDENCE-BASED PROGRAMS: Abriendo Puertas, Parents as Teachers

ABOUDT THIS SITE

- Montgomery County completed 72 pre-caregiver surveys, 18 post-caregiver surveys, 8 online staff surveys, 0 online community surveys, 4 staff interviews and focus groups, and 3 client interviews throughout our 4 year evaluation. Thank you for your cooperation & time!
From 2010 - 2018 the child maltreatment rate among children 5 years old and younger decreased by **0.06%** in Tarrant County.

100% of program participants did not have a new CPS case while receiving HOPES services.

**HOPES HAS KEPT FAMILIES SAFE**

**TARRANT COUNTY**

-0.06%

**Average scores before and after HOPES participation:**

**SOCIAL SUPPORT**

**BEFORE**

2.8

**AFTER**

3.5

Increase in perceived social support from family, friends, and peers to help address child needs or caregiver’s own emotional needs.

**FAMILY RESOURCES**

**BEFORE**

2.4

**AFTER**

3.0

Increase in perceived available resources to assess family concerns and priorities based on the hierarchy of needs.

**CONCRETE SUPPORT IN TIMES OF NEED**

**BEFORE**

3.1

**AFTER**

3.4

Increase in perceived ability to identify, seek, access quality services to preserve caregiver’s dignity and promote healthy family development.

**HOPES HAS INCREASED FAMILY STABILITY**

**PARENTAL RESILIENCE**

**BEFORE**

3.5

**AFTER**

3.7

Increase in perceived ability to manage stress and function well when faced with stressors, challenges, or adversity.

**SOCIAL CONNECTIONS**

**BEFORE**

2.7

**AFTER**

3.3

Increase in perceived healthy, sustained relationships with people, institutions, the community, or a force greater than oneself that forge a sense of belonging, attachment, reciprocal positive regard, and a feeling that one matters.

**SOCIAL & EMOTIONAL COMPETENCE OF CHILDREN**

**BEFORE**

3.3

**AFTER**

3.3

Increase in perceived ability to provide an environment and experiences that enable children to form close and secure adult and peer relationships, and to experience, regulate, and express emotions.

---

1,315 Individuals reached in **HOPES** from FY2017-2018

Average scores are from the Caregiver Survey data (pre-survey n=36, post-survey n=12)

---

**MISSING**

<=.012% RATE DECREASED OVER TIME

>=0.012% RATE INCREASED OVER TIME

-0.06% TO .012% RATE STAYED THE SAME OVER TIME
HOPES HAS REACHED FAMILIES AT RISK

Typical HOPES caregiver in Tarrant County:

- Single mother, 26 years old
- 4 year old child
- White, Non-Hispanic
- English-speaking
- Graduated high school or has GED
- Annual income is $10,001-$20,000
- Average time in program is 6.1 months

FROM 2017-2018:

250 individuals reached at community events
*may include duplicated individuals

Number of families who participated in evidence-based programs:

- Tarrant County completed 36 pre-caregiver surveys, 12 post-caregiver surveys, 23 online staff surveys, 8 online community surveys, 35 staff interviews and focus groups, and 6 client interviews, throughout our 4 year evaluation. Thank you for your cooperation & time!

Risk factors HOPES caregivers in Tarrant are experiencing:

- 33% had 4 or more Adverse Childhood Experiences
- 56% had a positive screen for a mental health concern
- 6% had a positive screen for substance use
- 0% had a positive screen for domestic violence
- 33% said they felt their neighborhood was unsafe

Addressing these factors are known to prevent child maltreatment.

COLLABORATION OF HOPES PARTNERSHIPS

Not enough responses were collected from the Early Childhood Wellness Council to assess collaboration. There is an opportunity for this coalition to assess their collaboration among coalition members.

ABOUT THIS SITE

Tarrant County is a HOPES III Site (2017-2021)

PRIMARY AGENCY:
MHMR of Tarrant County

SUBCONTRACTOR:
Center for Transforming Lives, New Day Services, The Parenting Center, UNT Health Science Center

COALITION:
Early Childhood Wellness Council/Community Advisory Committee

EVIDENCE-BASED PROGRAMS:
Nurturing Fathers, Nurturing Parenting, Trust-Based Relational Intervention

Project Healthy Outcomes through Prevention and Early Support is funded by the Prevention and Early Intervention division of The Texas Department of Family and Protective Services. This evaluation is by:

The University of Texas at Austin
Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work
APPENDIX B: EVALUATION METHODS & STUDY DESIGN
APPENDIX B: EVALUATION METHODS AND STUDY DESIGN

EVALUATION PURPOSE & MIXED METHODS DESIGN

The purpose of this study is to examine the process and outcome measures for the evaluation of Project HOPES, which includes all HOPES sites (HOPES I, HOPES II, and HOPES III) during the time period of September 1, 2014, to August 31, 2018. This evaluation focuses on the impacts of HOPES programming and coalition activities on improving the tenants of safety, stability, and nurturing of community-based child maltreatment prevention across the levels of child, caregiver, community, and policy. Refer to Figure 2 for the Conceptual Framework for more information on the building blocks of community-based child maltreatment prevention.

The evaluation utilized qualitative and quantitative methods to gather and analyze information. Quantitative data were collected through online surveys from 2015, 2016, and 2018, administrative PEI data, administrative CPS data, Caregiver Survey data collected by TXICFW, PEI quarterly reports, and publicly available county-level demographic data. Qualitative methods included semi-structured in-person interviews and focus groups with staff and program participants at each of the 22 HOPES sites. The following sections describe the methods for these data collection activities in greater detail.

ONLINE SURVEY METHODS & SAMPLE SIZES

During this evaluation, online surveys were distributed in 2016, 2017 and 2018 to gather opinions from HOPES staff and community stakeholders. Staff surveys were sent via email to all HOPES primary contacts, who were then instructed to forward to all staff and coalition stakeholders. HOPES staff included parent educators, case managers, administrative staff, supervisors, and program directors. Both of these surveys were voluntary and confidential. For 2016 and 2017, the community survey offered participants the opportunity to enter a drawing to win a $200 gift card for their community’s primary HOPES agency. For 2018, participants of the staff survey had the opportunity to enter a drawing for a $100 gift card for their HOPES site and participants of the community survey had the opportunity to enter a drawing for $200 gift card for their community’s HOPES site. The figures below describes responses collected from online surveys during this evaluation and demographic data collected from the online surveys.

Figure B1. Online surveys and number of responses

<table>
<thead>
<tr>
<th>ONLINE SURVEY TYPE</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of survey</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Survey</td>
<td>122</td>
<td>152</td>
<td>252</td>
</tr>
<tr>
<td>Community Survey</td>
<td>188</td>
<td>141</td>
<td>117</td>
</tr>
</tbody>
</table>

Note: The data above describes the total number of survey respondents who started the survey. Survey questions were voluntary therefore not all respondents completed every survey question.
The surveys used a mixture of validated scales and questions developed by the evaluation team. The staff survey provided contextual information about caseloads, perceptions of program success, staff demographics, 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 Factor Structure of the Counselor Burnout Inventory was used to measure staff strain. Certain EBP implementation questions 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. Ten questions were based on questions from the national Mother and Infant Home Visiting Program Evaluation (MIHOPE), led by MDRC. Two questions were informed by the Implementation Leadership Scale (Aarons et al. 2014) and one question used a modified subset of questions from the Evidence-Based Practice Attitude Scale-50 Item. The remaining items in the staff survey were developed by the evaluation team.

Community survey questions included a measure of collaboration for coalition members, questions about perceptions of the HOPES program, and questions identifying 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, 8 questions were adapted from the Annual Survey of Evidence-based Programs 2014. The remaining items in the community survey were developed by the evaluation team.

FOCUS GROUP AND INTERVIEW METHODS & SAMPLE SIZES

Qualitative methods included semi-structured interviews and focus groups with HOPES staff and program participants from each of the 22 HOPES sites. Interviews and focus groups with staff were completed via telephone and in-person. All interviews and focus groups with program participants were completed via phone. While qualitative interview and focus group data were collected each year, this report covered qualitative data from the last year of qualitative data collection in 2018. In-person interviews and focus groups with staff, program participants, and coalition members occurred from June through November of 2018. An effort was made to speak to representatives and participants from each primary contractor and subcontractor. To select participants to interview, the evaluation team randomly selected 10 client IDs from the PEI database and coordinated with HOPES staff to determine whether the participant would be interested in participating. While the evaluation team attempted to randomize the selection of participants to interview, participants with correct contact information with HOPES agencies were used by the evaluation team.

Each HOPES contractor assisted in coordinating and scheduling interviews and focus groups with staff 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.

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 over the phone. A team of bilingual researchers conducted 15 interviews in Spanish and 120 interviews/focus groups in English. Interviews and focus groups with staff members typically lasted between 45 and 60 minutes and occurred at agency offices or over the phone. All interviews and focus groups with staff were conducted in English except for one staff focus group that was conducted in Spanish. All interviews and focus groups were audio-recorded and transcribed verbatim.

ADMINISTRATIVE DATA

Data from PEI

PEI provided administrative data of HOPES participants to the evaluation team. This data was de-identified and provided to the evaluation team by PEI. The data contain information on the number of target children, primary and secondary caregivers, other participants served, respective demographics and risk factors, and the types and quantities of services received. The data also included the pre- and post-test scores for the Protective Factors Survey. PEI database limitations are described in the Limitations section.

PEI also provided CPS administrative data to the evaluation team that describes CPS intake data for all cases in Texas from FY2010 – FY2017. The evaluation team conducted a match with the PEI administrative data on HOPES participants with CPS administrative data to determine how many HOPES participants had CPS involvement and details of their CPS case disposition.

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) Leveraging resources, (3) Outreach and awareness information, (4) Services available during the quarter, (4) Service delivery, including service provider activity, staffing/training, and resources and technical assistance, (5) Accomplishments and challenges, (6) Issues
with PIERS data, and (7) Successes/Challenges. These reports were reviewed to identify pertinent
information about outreach and community awareness. The evaluation team reviewed all quarterly
reports from all HOPES sites from FY2015-FY2018.

Caregiver Survey Data

The evaluation team implemented the Caregiver Survey and collected data from January
2016 – February 2018. There was a total of 1,855 HOPES participants who completed the pre-
Caregiver Survey, 807 HOPES participants who completed the post-Caregiver Survey, and 534
HOPES participants who completed both the pre- and post-Caregiver Surveys. Figure B2 describes
the type of validated measures included in the Caregiver Survey. DePelchin Children’s Center at the
Harris HOPES site completes a risk factors screen using validated scales to collect adverse childhood
experiences, risk of mental health, risk of domestic violence, and risk of substance use. In an effort to
prevent redundancy of paperwork, DePelchin has shared de-identified data of risk factors collected
from HOPES participants with the evaluation team. All risk factors are collected only at intake, except
for mental health which is collected when the caregiver starts and exits programming. Figure B2
describes the risk factor and the type of validated measure used to assess those risks. Figure B3
describes other validated scales included in the Caregiver Survey. A copy of the pre and post surveys
are included in Appendix G: Surveys.

Figure B3. Validated measures on risk factors in the Caregiver Survey and collected by DePelchin
Children’s Center

<table>
<thead>
<tr>
<th>RISK FACTOR</th>
<th>CAREGIVER SURVEY VALIDATED SCALE</th>
<th>DEPELCHIN CHILDREN’S CENTER VALIDATED SCALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Childhood Trauma</td>
<td>Adverse Childhood Experiences Survey: A total of 19 questions from the Kaiser ACE survey, 2010 Behavior Risk Factor Surveillance System, and Philadelphia Urban ACEs Survey.</td>
<td>Adverse Childhood Experiences</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Mental Health Inventory-5^41</td>
<td>Patient Health Questionnaire- 9 Depression Scale (PHQ-9)^42</td>
</tr>
<tr>
<td>Domestic Violence/Intimate Partner Violence</td>
<td>Hurt, Insulted, Threatened with Harm and Screamed (HITS)^43</td>
<td>Hurt, Insulted, Threatened with Harm and Screamed (HITS)^43</td>
</tr>
<tr>
<td>Alcohol Use/Misuse</td>
<td>Alcohol Use Disorders Identification Test – Consumption Questionnaire (AUDIT-C)^45</td>
<td>Abuse Assessment Scale (AAS)^44</td>
</tr>
<tr>
<td>Substance Use/Misuse</td>
<td>Used, Neglected, Cut down, Objected, Preoccupied, Emotional discomfort (UNCOPE)^46</td>
<td>CAGE-AID^47</td>
</tr>
</tbody>
</table>

Note: DePelchin Children’s Center was previously collecting domestic violence/intimate partner violence using the AAS scale and then shifted to using the HITS scale, which is also used by the Caregiver Survey.
Figure B4. Validated scales assessing protective factors in the Caregiver Survey

<table>
<thead>
<tr>
<th>TOPICS</th>
<th>SCALE USED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived financial stability</td>
<td>Family Resources Scale&lt;sup&gt;48&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>The Caregiver Survey includes select 14 questions from a 30-item scale. Questions were selected by the evaluation team.</td>
</tr>
<tr>
<td>Neighborhood Safety</td>
<td>Perceived Neighborhood Quality/Health Scale&lt;sup&gt;49&lt;/sup&gt;</td>
</tr>
<tr>
<td>Nurturing Assessments</td>
<td>The Parents’ Assessment of Protective Factors Scale (PAPF)&lt;sup&gt;50&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>• Parental Resilience</td>
</tr>
<tr>
<td></td>
<td>• Social Connections</td>
</tr>
<tr>
<td></td>
<td>• Concrete Support in Times of Need</td>
</tr>
<tr>
<td></td>
<td>• Social and Emotional Competence of Children</td>
</tr>
</tbody>
</table>

Publicly Available County-Level Data

County-level data included in this report was gathered from public databases available online. The data sources used include the United States Census Bureau, databases from the Texas government agencies including Texas Health and Human Services Commission, the Texas Department of Family and Protective Services, the Texas Department of Public Safety, and the Centers for Disease Control National Center for Health Care Statistics. The county-level maps showing substantiated cases of child maltreatment was gathered from data.texas.gov to specifically provide confirmed cases of victims who were ages 5 and younger. Details on the maps of county-level child maltreatment data are located in Appendix D.

DATA ANALYSIS

Data from the online surveys was cleaned and consolidated to produce descriptive statistics. Data from the PEI database were also analyzed using R and Excel software to produce descriptive and inferential statistics and data visualizations. 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 evaluation team members who participated in the focus groups and interviews developed three separate coding schemes for program participants and staff, interviews/focus groups. One transcript of each type was coded by the lead researcher and three evaluation team members 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 (caregiver or staff). Each transcript was reviewed by one coder 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.

PEI administrative data of HOPES participants, Caregiver Survey data of HOPES participants,
and CPS administrative data of all investigations in Texas were merged into one database by using the PEI Client ID to link all information for clients. The changes in the PEI data system in FY2017 also resulted in a new system of IDs for HOPES participants. This change in ID for clients and families resulted in challenges to accurately match data from all data sources and also resulted in the loss of data. After merging databases using statistical software programs of SAS and SPSS the evaluation conducted statistical analyses using SPSS.

LIMITATIONS

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 likely do 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 (caregivers) or staff. 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. Additionally, the PFS was not developed to predict child maltreatment.

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 the number of times a client was served, it is not possible to assign responsibility for outcomes (such as a change in PFS score) to any of those potential sources. Finally, reporting errors may also be present in the data. The Tarrant and Brazos HOPES sites did not have any PFS data on families despite that families have been entering and exiting HOPES programming at those sites. It is likely that these conflicting data are due to reporting error, program idiosyncrasies, or both.

HUMAN SUBJECTS’ PROTECTIONS

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 evaluation 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 C: HOPES SITE INFORMATION
# APPENDIX C: HOPES SITE INFORMATION

The table below lists the agencies, counties, and coalitions that participated in HOPES from FY2015-FY2018.

**Figure C1. HOPES Site Agency & Program Information**

<table>
<thead>
<tr>
<th>HOPES PHASE</th>
<th>PRIMARY COUNTY</th>
<th>SECONDARY COUNTY</th>
<th>AGENCY</th>
<th>EVIDENCE-BASED PROGRAMS</th>
<th>COALITION NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOPES I</td>
<td>Cameron</td>
<td>n/a</td>
<td>• BCFS Health and Human Services</td>
<td>• SafeCare</td>
<td>Make the First Five Count</td>
</tr>
<tr>
<td></td>
<td>Ector</td>
<td>Midland</td>
<td>• University of Texas Permian Basin</td>
<td>• 24/7 Dad</td>
<td>Early Childhood Coalition</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Harmony Home</td>
<td>• Parents as Teachers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Boys &amp; Girls Club of Midland and Odessa</td>
<td>• Stewards of Children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>El Paso</td>
<td>n/a</td>
<td>• El Paso Center for Children</td>
<td>• AVANCE PCEP</td>
<td>Project LAUNCH</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• AVANCE El Paso</td>
<td>• Incredible Years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Paso del Norte</td>
<td>• Parents as Teachers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• El Paso United Way</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Child Crisis Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gregg</td>
<td>n/a</td>
<td>• Buckner Children and Family Service</td>
<td>• Parents as Teachers</td>
<td>Bridges out of Poverty</td>
</tr>
<tr>
<td></td>
<td>Hidalgo</td>
<td>n/a</td>
<td>• Eastern Seals RGV</td>
<td>• Parents as Teachers</td>
<td>Make the First Five Count</td>
</tr>
<tr>
<td></td>
<td>Potter</td>
<td>Randall</td>
<td>• Family Support Services</td>
<td>• 24/7 Dad</td>
<td>Operation First Five</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Amarillo ISD</td>
<td>• Parents as Teachers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Mesquite Ranch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Travis</td>
<td>Williamson</td>
<td>• SAFE Alliance</td>
<td>• 24/7 Dad</td>
<td>Family Support Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Eastern Seals Central Texas (until FY17)</td>
<td>• Nurturing Fathers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Any Baby Can</td>
<td>• Nurturing Parenting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Parents as Teachers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Triple P</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Webb</td>
<td>n/a</td>
<td>• Serving Children and Adults in Need (SCAN) Inc.</td>
<td>• SafeCare</td>
<td>Project HOPES Stakeholder</td>
</tr>
</tbody>
</table>

Agency name in bold is the primary agency for the HOPES site.
### Abriendo Puertas

*Abriendo Puertas (Opening Doors)* is a culturally-relevant program for parents with children ages 0-5, based on popular education. This program uses a two-generation approach and was co-created by parents to build parent leadership, skills, and knowledge to promote family well-being. It is most often taught in English and in Spanish – and is one of the only programs that teaches early math in Spanish.

#### Goals of the Program
- Honor and support parents as leaders of their families and their child’s first and most influential teacher.

#### Target Population
- For children ages 0-5
- For parents/caregivers of children ages 0-5

#### Length of Program
- 10 interactive sessions

#### Topics Covered
- School readiness
- Family well-being
- Brain development and key aspects of early childhood development (cognitive, language, physical, and social/emotional)
- Early literacy
- Bilingualism
- Positive use of technology
- Civic engagement
- Parent leadership
- Goal setting and planning for family success

For more information, visit: [https://ap-od.org/home/](https://ap-od.org/home/)

---

<table>
<thead>
<tr>
<th>HOPES PHASE</th>
<th>PRIMARY COUNTY</th>
<th>SECONDARY COUNTY</th>
<th>AGENCY</th>
<th>EVIDENCE-BASED PROGRAM</th>
<th>COALITION NAME</th>
</tr>
</thead>
</table>
| II          | Dallas         | n/a              | • United Way of Metropolitan Dallas  
• Parkland  
• Family Care Connection  
• AVANCE Dallas  
• ChildCare Group  
• Dallas Children’s Advocacy Group (until FY2016) | • AVANCE PCEP  
• Nurse-Family Partnership  
• Parents as Teachers  
• Triple P | Child Abuse & Prevention Coalition (CAPCO) |
|             | Harris         | Brazoria Chambers  
Liberty  
Montgomery  
Waller | • DePelchin Children’s Center  
• Collaborative for Children  
• Harris County Protective Services  
• UT Health Science Center  
• Baylor Teen Health Clinic (until FY16)  
• Arrow Family & Ministries (until FY17) | • Centering Pregnancy  
• Family Connections  
• Nurturing Parenting  
• Triple P  
• Parents as Teachers | Parenting Help Coalition |
|             | Jefferson      | n/a              | • Buckner Children & Family Services | • Parents as Teachers | Community Resource Coordination Group (CRCG) |
|             | Lubbock        | n/a              | • Parenting Cottage | • Parents as Teachers | South Plains Coalition for Child Abuse Prevention |
|             | McLennan       | n/a              | • Family Abuse Center | • Parents as Teachers | Alliance for Safe Children |
|             | Nueces         | Kleberg          | • Education Service Center, Region 2  
• HIPPY  
• Parents as Teachers | | Success by 6 Coastal Bend Early Childhood Coalition |
|             | Taylor         | Callahan Shackelford  
Jones | • BCFS Health and Human Services  
• SafeCare | | HOPES Coalition |
|             | Wichita        | n/a              | • North Texas Area United Way  
• Wichita Falls ISD  
• 24/7 Dad  
• HIPPY  
• Parents as Teachers | | Early Childhood Coalition of North Texas |

Agency name in bold is the primary agency for the HOPES site.
AVANCE Parent-Child Education Program (PCEP) is a combination group class and home visiting program that aims to enhance the education and growth of parents and their children through community collaborations and partnerships.

**Goals of the Program**

PCEP goals are to use a bilingual two-generation approach to:

- Increase parents' understanding of child development so they are better able to foster the optimal development of their children.
- Empower parents to view themselves as their child's first and most important teacher and the home as the first classroom.

**Target Population**

PCEP is for parents and primary caregivers:

- With children from birth to age three
- Pregnant women and/or partners of pregnant women
- Parents with challenges such as poverty, illiteracy, teen parenthood, geographic and social marginalization, and toxic stress.

**Length of Program**

The recommended program duration is nine (9) months, and consists of:

- Weekly three-hour small group sessions for parents, while early childhood education is simultaneously provided for children.
- Monthly home visits
- The commencement ceremony for parents/caregivers and their children upon completion of a minimum of 75% of classes
- Parents are encouraged to return for a second year, in which they are assisted with adult education and job training.

**Topics Covered**

PCEP curriculum topics include:

- Child development
- Learning through play
- Parent-child interaction
- Guidance in the home
- Development of parents' personal developmental and educational goals to foster economic stability.

For more information, visit: http://www.avance.org/

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<table>
<thead>
<tr>
<th>HOPESE Phase</th>
<th>Primary County</th>
<th>Secondary Counties</th>
<th>Agency</th>
<th>Evidence-Based Programs</th>
<th>Coalition Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bell</td>
<td>n/a</td>
<td>• <strong>AWARE Central Texas</strong></td>
<td>• Exchange Parent Aide • Love &amp; Logic</td>
<td>n/a at the time of the evaluation.</td>
<td></td>
</tr>
<tr>
<td>Bexar</td>
<td>n/a</td>
<td>• <strong>United Way of San Antonio &amp; Bexar County</strong> • Catholic Charities • The Center for Health Care Services • The Children’s Shelter • DePelchin Children’s Center • Martinez Street Women’s Center • Any Baby Can • KLRN • Respite Care • Family Service Association</td>
<td>• Nurturing Parenting • Parents as Teachers • STEP • Triple P</td>
<td>ReadyKidSA Coalition</td>
<td></td>
</tr>
<tr>
<td>Brazos</td>
<td>n/a</td>
<td>• <strong>Project Unity</strong></td>
<td>• Parents as Teachers</td>
<td>Community Partnership Board -Early Childhood Coalition is a subset of it.</td>
<td></td>
</tr>
<tr>
<td>Galveston</td>
<td>n/a</td>
<td>• <strong>DePelchin Children’s Center</strong> • Collaborative for Children</td>
<td>• Parents as Teachers • Triple P</td>
<td>Galveston County Community Resource Coordination Group (CRCG)</td>
<td></td>
</tr>
<tr>
<td>Montgomery</td>
<td>n/a</td>
<td>• <strong>Motivation, Educating, and Training (MET), Inc.</strong></td>
<td>• Abriendo Puertas • Parents as Teachers</td>
<td>Family and Community Coalition of Montgomery County</td>
<td></td>
</tr>
<tr>
<td>Tarrant</td>
<td>Denton Ellis Johnson</td>
<td>• <strong>MHMR Tarrant</strong> • The Parenting Center • UNT Health Science Center • Center for Transforming Lives • New Day Services</td>
<td>• Incredible Years • Nurturing Fathers • Nurturing Parenting • Parent Café • TBRI</td>
<td>Early Childhood Wellness Council/Community Advisory Committee</td>
<td></td>
</tr>
</tbody>
</table>

Agency name in bold is the primary agency for the HOPES site.
APPENDIX D: EVIDENCE-BASED PROGRAMS OVERVIEWS
## APPENDIX D: EBP OVERVIEWS

### 24/7 Dad

<table>
<thead>
<tr>
<th>24/7 Dad</th>
<th>24/7 Dad is a unique set of programs design to equip fathers with the self-awareness, compassion, and sense of responsibility that every good parent needs. It focuses on building the man first and the father second. It is available in both a basic and a more in-depth version through 24/7 Dad A.M and 24/7 Dad P.M.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals of the Program</td>
<td>The goals of the 24/7 Dad are to increase the capacity of skills to carry out what the fathers learn. These will include better skills in caring for children and building relationships with the mother of their children.</td>
</tr>
</tbody>
</table>
| Target Population | 24/7 Dad is for fathers with children age 18 or younger. The program design varies depending on:  
  - Custodial and non-custodial fathers  
  - Unemployed and underemployed fathers |
| Length of Program | The 24/7 Dad program consists of:  
  - 12 weekly sessions  
  - Session duration is 2 hours  
  - The flexibility of session duration depending on the audience  
  - 24-7 Dad A.M.  
    - Basic version  
    - More appropriate for first-time dads  
  - 24-7 Dad P.M.  
    - In-depth version  
    - For more experienced fathers or those who already completed 24/7 Dad A.M. |
| Topics Covered | Topics addressed in the 24/7 Dad Program include:  
  - Family history  
  - Men’s health  
  - Communication  
  - The father’s role  
  - Discipline  
  - Child interaction & involvement  
  - Child development |

For more information, visit: [http://www.cebc4cw.org/program/24-7-dad/](http://www.cebc4cw.org/program/24-7-dad/)
**Barkley’s Defiant Child**

This program involves training parents in 10 steps through weekly sessions that have proven effectiveness in reducing defiance and ODD symptoms in children ages 4-12 years.

<table>
<thead>
<tr>
<th>Goals of the Program</th>
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<tbody>
<tr>
<td>The goals of Barkley’s Defiant Children are:</td>
</tr>
<tr>
<td>• Increase the value of the parents’ attention generally, and its particular worth in motivating and reinforcing their child’s positive behavior</td>
</tr>
<tr>
<td>• Increase the positive attention and incentives the parents provide for compliance while decreasing the inadvertent punishment they provide for occasional compliance</td>
</tr>
<tr>
<td>• Decrease the amount of inadvertent positive attention the parents provide to negative child behavior</td>
</tr>
<tr>
<td>• Increase the use of immediate and consistent mild punishment for occurrences of child noncompliance</td>
</tr>
<tr>
<td>• Ensure the escape from the activity being imposed upon the child does not occur (i.e., the command is eventually complied with by the child)</td>
</tr>
<tr>
<td>• Reduce the frequency of repeat commands the parents employ as to avoid delays to consequences (act, don’t yak)</td>
</tr>
<tr>
<td>• Recognize and rapidly terminate escalating and confrontational negative interactions with the child</td>
</tr>
<tr>
<td>• Ensure that the parents do not regress to a predominantly punitive child management strategy once training has been completed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target Population</th>
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</thead>
<tbody>
<tr>
<td>Barkley’s Defiant Children is directed toward parents of children ages 4-12 years who are defiant or who may qualify for a diagnosis of oppositional defiant disorder (ODD),</td>
</tr>
<tr>
<td>• For children ages 4-12</td>
</tr>
<tr>
<td>• For parents/caregivers of children ages 4-12</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Length of Program</th>
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</thead>
<tbody>
<tr>
<td>Barkley’s Defiant Children consists of:</td>
</tr>
<tr>
<td>• Once per week for 1 hour of individual parent training or 2 hours of group parent training across 10 weeks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topics Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this program, parents are taught:</td>
</tr>
<tr>
<td>• Systematic steps to reduce non-compliant, defiant, oppositional, or socially hostile behavior</td>
</tr>
<tr>
<td>To reinforce positive change</td>
</tr>
</tbody>
</table>

For more information, visit: https://www.cebc4cw.org/program/defiant-children-a-clinician-s-manual-for-assessment-and-parent-training/
**CENTERING PREGNANCY**

CenteringPregnancy is a group prenatal care bringing women due at the same time out of exam rooms for regular check-ups and into a comfortable group setting. Healthcare providers and support staff lead a facilitative discussion and interactive activities designed to address important and timely health topics while leaving room to discuss what is important to the group.

**GOALS OF THE PROGRAM**

The goals of CenteringPregnancy are:

- Promote healthy behaviors for pregnant women during their pregnancy and after the birth of their child
- Preterm birth at least 1/3 lower than local baselines
- Reduction of black/white preterm birth disparity
- Breastfeeding initiation rates improved by at least 10% vs baseline

**TARGET POPULATION**

CenteringPregnancy brings 8-10 women all due at the same time together for their care. Centering groups are comprised of women of different ages, races, and socioeconomic backgrounds.

**LENGTH OF PROGRAM**

CenteringPregnancy follows the recommended schedule of 10 prenatal visits, each group visit lasts 90 minutes to 2 hours long with the healthcare provider guiding the sessions.

**TOPICS COVERED**

Topics addressed in CenteringPregnancy include the following:

- Nutrition
- Common discomforts
- Stress management
- Labor and delivery
- Breastfeeding
- Infant care

For more information, visit: [https://www.centeringhealthcare.org/what-we-do/centering-pregnancy](https://www.centeringhealthcare.org/what-we-do/centering-pregnancy)

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**EXCHANGE PARENT AIDE**

This program consists of trained, professional supervised individuals (volunteer or paid) who provide supportive and educational in-home services to families at risk of child abuse and neglect. Parent Aides provide services based on their community needs and resources. Services are strength-based and family-centered.

**GOALS OF THE PROGRAM**

The goals of Exchange Parent Aide are:

- Assure child safety
- Improve parenting skills
- Improve problem-solving skills
- Enhance social supports

**TARGET POPULATION**

Exchange Parent Aide is directed toward families who have at least one child age birth through 12 years in the home (services may also be offered prenatally), considered at-risk for abuse (either through presence of dynamics common in abusive families or the presence of substantiated abuse or neglect), and willing to participate in services.

- For children ages 0-12
- For parents/caregivers of children ages 0-12

**LENGTH OF PROGRAM**

Exchange Parent Aide consists of:

- 1 to 2 home visits per week, with each lasting 1 to 2 hours across 9-12 months
- Telephone contact occurs between home visits

**TOPICS COVERED**

Exchange Parent Aide addresses the following:

- Children’s development or behavioral issues
- Parenting behaviors leading to child abuse or neglect
- Family issues creating stress for parents/caregivers
- Environmental issues creating stress for parents/caregivers

For more information, visit: [https://www.cebc4cw.org/program/exchange-parent-aide/](https://www.cebc4cw.org/program/exchange-parent-aide/)
### FAMILY CONNECTIONS

Family Connections is a multifaceted, community-based service program that works with families in their homes and in the context of their neighborhoods to help them meet the basic needs of their children and prevent child maltreatment. The program is designed to increase protective factors, decrease risk factors and target child safety, well-being, and permanency outcomes.

| **GOALS OF THE PROGRAM** | The goals of Family Connections are:  
- Help families meet the basic needs of their children  
- Reduce the risk of child neglect |
|--------------------------|------------------------------------------------------------------------------------------------------------------|
| **TARGET POPULATION**   | Family Connections is directed towards families who are at risk for child maltreatment.  
- For children/adolescents ages 0-17  
- For parents/caregivers of children ages 0-17 |
| **LENGTH OF PROGRAM**   | Family Connections recommends a minimum of:  
- Weekly meetings for 3-4 months  
- One hour face-to-face weekly contact between the client and social worker  
- An optional 90-day extension if needed. |
| **TOPICS COVERED**      | The curriculum is intervention-focused with the use of:  
- Individualized family assessment and emergency assistance tailored change-focused intervention  
- Progress assessment  
- Outcome driven service plans with SMART goals |

For more information, visit: [http://www.cebc4cw.org/program/family-connections/detailed](http://www.cebc4cw.org/program/family-connections/detailed)

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### HOME INSTRUCTION FOR PARENTS OF PRESCHOOL YOUNGSTERS (HIPPY)

Home Instruction for Parents and Preschool Youngsters (HIPPY) is a primarily in-home parenting support program that consists of home visits, peer parenting education and group meetings and is designed to support parents by providing books, activities, and skills to help them prepare their children for school.

<table>
<thead>
<tr>
<th><strong>GOALS OF THE PROGRAM</strong></th>
<th>The goals of the HIPPY program are to help vulnerable children achieve long-term academic success, improve parent-child relationships, and increase parent's involvement in their children’s schools and communities.</th>
</tr>
</thead>
</table>
| **TARGET POPULATION**   | HIPPY is designed to serve:  
- Parents of children ages 3-5  
- Families from diverse ethnic and geographic groups across the nation  
- Particularly those most at risk because of poverty, parents’ limited education or social isolation. |
| **LENGTH OF PROGRAM**   | HIPPY is a two- to (preferably) three-year program with thirty weeks of activities per year. During this period, peer parent educators deliver high-quality school readiness curriculum activities and books directly to parents, who then work each day with their children |
| **TOPICS COVERED**      | Instruction includes developmentally appropriate school readiness activities for parents to do with children using role-play as the method of instruction. |

For more information, visit: [https://www.hippyusa.org/](https://www.hippyusa.org/)
### Incredible Years

Incredible Years is a combination group classroom and in-home visit program for parents, teachers, and children, consisting of three components: The BASIC Parent Training Program, the Child Training Program, and the supplemental ADVANCE Parent Training Program.

### Goals of the Program

The goal of the program is to prevent, reduce, and treat behavioral and emotional problems in young children, with the long-term goals of preventing conduct disorders, academic underachievement, delinquency, violence, and drug abuse.

### Target Population

Incredible Years is for:
- Parents of children aged 4-8 years
- Teachers of children aged 4-8
- Children ages 4-8

Incredible Years specifically targets parents of high-risk children and those displaying behavior problems.

### Length of Program

The BASIC Parent Training Program consists of:
- 14 weeks for prevention populations
- 18-20 weeks for treatment populations
- 2-hour weekly sessions for children and parents
- Group classes are offered 2-3 times weekly for a total of 60 lessons.

The Child Training Program is 18-22 weeks.

The ADVANCE Parent Program is recommended as a supplemental program for treatment populations; BASIC and ADVANCE programs together have a duration of 26-30 weeks.

### Topics Covered

Topics covered in the BASIC Parent Training Program include:
- Building strong relationships with children through child-directed play
- Being a coach for children
- How to handle misbehavior
- How to set limits/establish rules
- Topics covered in the Child Training Program include:
  - Emotion management
  - Social skills
  - Problem-solving
  - Classroom behavior
- Topics in the ADVANCE Parent Training Program address:
  - Interpersonal skills such as effectively communicating with children and other adults
  - Handling stress
  - Problem-solving
  - How to provide and receive support

For more information, visit: [http://www.incredibleyears.com/](http://www.incredibleyears.com/)
<table>
<thead>
<tr>
<th><strong>LOVE &amp; LOGIC</strong></th>
<th>The Love and Logic Institute, Inc., developed training materials designed to teach educators and parents how to experience less stress while helping young people learn the skills required for success in today’s world. This approach is called Love and Logic and is based on the following two assumptions: that children learn the best lessons when they’re given a task and allowed to make their own choices (and fail) when the cost of failure is still small; and that the children’s failures must be coupled with love and empathy from their parents and teachers.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOALS OF THE PROGRAM</strong></td>
<td>The overall goal of Love and Logic is: A program to help parents avoid negative interactions with their children that lead to neglect and abuse.</td>
</tr>
</tbody>
</table>
| **TARGET POPULATION** | Love and Logic is directed towards parents, grandparents, teachers, and other caretakers working with children.  
• For children/adolescents ages 0-18  
• For parents/caregivers of children ages 0-18 |
| **LENGTH OF PROGRAM** | Love and Logic recommends a minimum of:  
• One-day seminar, or 3-day, 5-day, or 6-day conference  
• 1 day to 6 days depending on the length of training |
| **TOPICS COVERED** | All of the Love & Logic programs are based on the following four principles, which are designed to enhance the relationship between the adult and the child:  
• Build the Self-Concept: Help children feel good about themselves.  
• Share the Control: Give children choices that do not cause problems for others.  
• Provide the Empathy: Provide a strong dose of empathy before delivering consequences.  
• Share the Thinking: Allow the child to think and solve their own problems.  
For more information, visit: [https://www.cebc4cw.org/program/love-and-logic/](https://www.cebc4cw.org/program/love-and-logic/) |

<table>
<thead>
<tr>
<th><strong>NURSE-FAMILY PARTNERSHIP</strong></th>
<th>Nurse-Family Partnership empowers first-time moms to transform their lives and create better futures for themselves and their babies. Expectant mothers benefit by receiving necessary care to have a healthy pregnancy through a partnership with specially trained nurses who provide tools necessary to assure a healthy start for their babies, and envision a life of stability and opportunities for mothers and their children.</th>
</tr>
</thead>
</table>
| **GOALS OF THE PROGRAM** | The primary goals of the Nurse-Family Partnership are:  
• To improve pregnancy outcomes by promoting health-related behaviors  
• To improve child health, development and safety by promoting competent care-giving  
• To enhance parent life-course development by promoting pregnancy planning, educational achievement, and employment |
| **TARGET POPULATION** | NFP aims to serve:  
• First-time, low-income mothers  
• Their children |
| **LENGTH OF PROGRAM** | NFP program is designed to serve women as early in their pregnancy as possible.  
• As early as 16 weeks gestation  
• 60-90 minute visits every other week  
• The last 4 visits are monthly  
• Continue through child’s second birthday  
• Nurses use their professional nursing judgment to increase or decrease the frequency and length of visits based on client needs. |
| **TOPICS COVERED** | Topics addressed in the NFP program are:  
• Improving women’s diets  
• Helping women monitor their weight gain  
• Eliminate the use of cigarettes, alcohol, and drugs  
• How to identify signs of pregnancy complications  
• Encouraging regular rest, appropriate exercise & good personal hygiene, related to obstetrical health  
• Preparing parents for labor, delivery, and early care of newborns  
For more information, visit: [https://www.nursefamilypartnership.org/](https://www.nursefamilypartnership.org/) |
### Nurturing Fathers Program

The Nurturing Fathers Program is a group-based program for fathers and is an adaptation of the Nurturing Program philosophy designed to be implemented specifically for dads to teach nurturing skills to men.

**Goals of the Program**
The Nurturing Fathers program aims to develop attitudes and skills for male nurturance.

**Target Population**
The Nurturing Fathers program is designed for fathers and their partners.

**Length of Program**
The Nurturing Fathers program length is
- 13 weeks
- 2.5 hour classes

**Topics Covered**
Topics addressed in the Nurturing Fathers Program include:
- The secrets for creating safe, loving, stable, and nurtured families
- Positive discipline tools through a unique father-friendly method for successful child behavior management
- Effective family communication techniques to strengthen the father-child and father-mother relationships
- How to stop fighting and arguing by using proven-effective strategies for conflict resolution and problem solving
- How to achieve cooperation and teamwork in family life

For more information, visit: http://nurturingfathers.com/

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### Nurturing Parenting Program

Nurturing Parenting Programs are a family-centered initiative designed to build nurturing parenting skills as an alternative to abuse and neglecting parenting and child-rearing practices. A set of family-based programs that can be delivered in the home only, in group only, or in combination.

**Goals of the Program**
The long-term goal of Nurturing Parenting Programs is to stop the intergenerational cycle of child maltreatment. This is accomplished through empowering family self-sufficiency, increasing parental knowledge and skills in child development, as well as increasing parent-child attachments and positive family experiences.

**Target Population**
The Nurturing Parent Programs target families at risk for abuse and neglect with children from prenatal to age 18.

**Length of Program**
The home-based only model for adult and young parents and their infants, toddlers, and preschoolers.
- Contains up to 55 home sessions
- Each session lasts 1.5 hours
- The group-based model program
- Contains 27 sessions
- Each session lasts 2.5 hours
- The combination group-based and home-based model program
- Contains 16 group sessions
- Minimum of 7 home sessions

**Topics Covered**
Topics addressed in the Nurturing Parenting Program include:
- Philosophies of nurturing parenting
- Information on brain development, discipline, building empathy, and self-worth
- Creating a safe home environment
- Positive ways to deal with anger and stress
- Improving parent quality of life

For more information, visit: https://www.nurturingparenting.com/
### PARENTS AS TEACHERS

Parents as Teachers is an early childhood parent education, family support, and well-being, and school readiness home visiting model based on the premise that “all children will learn, grow and develop to realize their full potential.” Parent educators work with parents to strengthen protective factors and ensure that young children are healthy, safe, and ready to learn.

#### GOALS OF THE PROGRAM

The four goals of Parents as Teachers are:
- Increase parent knowledge of early childhood development and improve parenting practices
- Provide early detection of developmental delays and health issues
- Prevent child abuse and neglect
- Increase children’s school readiness and school success

#### TARGET POPULATION

Parent as Teachers is directed towards families with an expectant mother or parents of children up to kindergarten entry (usually 5 years).
- For children ages 0-5
- For parents/caregivers of children ages 0-5

#### LENGTH OF PROGRAM

Parent as Teachers recommends a minimum of:
- At least 12 home visits annually to families with one or no high-needs characteristics
- At least 24 home visits annually to families with two or more high-needs characteristics
- Home visits last approximately 60 minutes
- At least 12 group connections (or meetings) annually
- Annual screening of children for developmental health, hearing, and vision problems each year
- Recommended duration is at least 2 years

#### TOPICS COVERED

Parent as Teachers curriculum deliver services that emphasize:
- Parent-child interactions
- Development-centered parenting
- Goal setting
- Family wellbeing

For more information, visit: https://www.cebc4cw.org/program/parents-as-teachers/

### PARENT CAFÉS

The Parent Café program is a nationally recognized peer-to-peer learning process to keep children safe and families strong. Cafés are structured discussions that use the principles of adult learning and family support. Parents and caregivers explore their strengths and learn from themselves and each other how to use the Strengthening Families Protective FactorsTM with their families.

#### GOALS OF THE PROGRAM

The goals of Parent Café sessions are to help parents help each other to:
- Grow stronger and more flexible
- Build friendships and relationships of mutual support
- Learn about resources and obtain support
- Add to parenting knowledge
- Build appreciation for the essential role they play with each of their children in helping them achieve their potential

#### TARGET POPULATION

Parent Café is directed toward parents and caregivers with children under the age of 18.
- For parents/caregivers of children ages 0-17

#### LENGTH OF PROGRAM

Parent Café consists of:
- Varied, on a weekly or monthly basis

#### TOPICS COVERED

A strong focus of the Parent Café is to help parents/caregivers strengthen the protective factors identified in the Strengthening Families Model, including increasing parental resilience, strengthening social connections, identifying concrete resources within the community, increasing knowledge and understanding of child development, and on supporting the social and emotional competence of children and youth.

For more information, visit: https://www.bestrongfamilies.org/parent-cafes & http://tpcu.org/parent-cafes/
SAFE CARE

SAFE CARE is a strictly in-home parenting program designed for parents at-risk for child neglect and/or abuse and parents with a history of child neglect and/or abuse. Parents in the program are taught ways to more positively interact with their children, how to improve their home environment and better respond to their children’s symptoms of illness.

GOALS OF THE PROGRAM

The program goals are to reduce future incidents of child maltreatment, increase positive parent-child interaction, improve how parents care for their children’s health, and enhance home safety and parental supervision.

TARGET POPULATION

SAFE CARE is for parents who are at-risk for child neglect and/or abuse and parents with a history of child neglect and/or abuse.
- Participants of the SafeCare program are parents of children ages 0-5.

LENGTH OF PROGRAM

The recommended program duration is 18-20 weeks and includes a weekly home visit. Home visits typically last 60-90 minutes each week.

TOPICS COVERED

In the program, parents are taught:
- How to interact in a positive manner with their children, to plan activities, and respond appropriately to challenging child behaviors.
- To recognize hazards in the home in order to improve the home environment.
- To recognize and respond to symptoms of illness and injury, in addition to keeping good health records.

For more information, visit: http://safecare.publichealth.gsu.edu/

SYSTEMIC TRAINING FOR EFFECTIVE PARENTING (STEP)

STEP (Systematic Training for Effective Parenting) is a multicomponent parenting education curriculum. The three STEP programs help parents learn effective ways to relate to their children from birth through adolescence by using parent education study groups. By identifying the purposes of children’s behavior, STEP also helps parents learn how to encourage cooperative behavior in their children and how not to reinforce unacceptable behaviors. STEP also helps parents change dysfunctional and destructive relationships with their children by offering concrete alternatives to abusive and ineffective methods of discipline and control.

GOALS OF THE PROGRAM

The goals of STEP are:
- Increased ability to identify goals of misbehavior
- Increased alternatives to misbehaviors
- Increased encouragement skills
- Increased skill in communication
- Increased skill in cooperation (parental and child)
- Increased skill in discipline
- Increased skill in choosing parenting approach
- Increase child self-esteem and confidence
- Decreased inappropriate parental behaviors in disciplining children and teens

TARGET POPULATION

STEP is directed toward parents of children - birth through adolescence.
- For children/adolescents ages 0-17
- For parents/caregivers of children ages 0-17

LENGTH OF PROGRAM

STEP recommends a minimum of:
- Weekly sessions, 60-90 minutes each
- 7 weeks

TOPICS COVERED

STEP addresses the following:
- Dysfunctional and destructive relationships with children; abusive and ineffective methods of discipline and control

For more information, visit: https://www.cebc4cw.org/program/systematic-training-for-effective-parenting/
### STEWARDS OF CHILDREN

Stewards of Children is an adult-focused child sexual abuse (CSA) prevention training program offered in a classroom format.

### GOALS OF THE PROGRAM

- Increase knowledge about child sexual abuse
- Improve attitudes about preventing child sexual abuse to lead the long-term outcomes of changed child protective behaviors
- Improved childcare codes of conduct for youth-serving organizations
- Improve childcare policies and procedures for youth-serving organizations

### TARGET POPULATION

- School staff & volunteers
- Youth-serving organizations
- Parents and caregivers
- Other concerned adults

### LENGTH OF PROGRAM

The program consists of 1 two-hour training led either by an in-person facilitator (often works in the workplace) or on the web.

### TOPICS COVERED

To provide practical guidance for adequately preventing, recognizing and reacting responsibly to child sexual abuse, the Stewards of Children includes commentary from:

- Sexual abuse survivors
- Experts in the field
- Other concerned adults

For more information, visit: [https://www.d2l.org/education/](https://www.d2l.org/education/)
| **TrusT-baSed RelaTional InTerventIOn (TBRI)** | TBRI Caregiver Training is a group in-person parent training program. TBRI is a holistic approach that is multidisciplinary, flexible, and attachment-centered. It is a trauma-informed intervention that is specifically designed for parents and caregivers of children who come from ‘hard places,’ such as maltreatment, abuse, neglect, multiple home placements, and violence but is an approach that can be used by parents and caregivers with all children. |
| **GOALS OF THE PROGRAM** | The goals of Trust-Based Relational Intervention (TBRI) – Caregiver Training are:  
- Help caregivers create an environment of physical, social, and psychological safety  
- Help caregivers recognize and meet children’s physiological needs (e.g., hydration)  
- Help caregivers structure experiences to enhance emotional and behavioral self-regulation  
- Enhance caregivers’ mindful awareness and mindful caregiving  
- Build and strengthen secure attachments between caregivers and children  
- Build and strengthen resilience in caregivers and children  
- Help caregivers master the use of proactive strategies for behavioral change  
- Help caregivers master the IDEAL Response (Immediate, Direct, Efficient, Active, Leveled at behavior, not child)  
- Help caregivers master Levels of Response (Playful, Structured, Calming, Protective) |
| **TARGET POPULATION** | TBRI is for parents (e.g., birth parents, foster parents, kinship parents, adoptive parents, etc.) and caregivers of children who come from ‘hard places,’ such as maltreatment, abuse, neglect, multiple home placements, and violence:  
- For children/adolescents ages 0-17  
- For parents/caregivers of children ages 0-17 |
| **LENGTH OF PROGRAM** | TBRI recommends a minimum of:  
- 6-hour training sessions |
| **TOPICS COVERED** | The essential components of Trust-Based Relational Intervention (TBRI) - Caregiver Training include:  
- **TBRI® Connecting Principles**  
  Connecting Principles help children build trust and meaningful relationships. These include:  
  - Engagement strategies  
  - Mindfulness strategies  
- **TBRI® Empowering Principles**  
  Empowering Principles help children learn important skills like self-regulation. There are two types of Empowering strategies:  
  - Physiological strategies  
  - Ecological strategies  
- **TBRI® Correcting Principles**  
  Correcting Principles help children learn behavioral and social competence so that they can better navigate the social world they live in. Correcting Principles include:  
  - Proactive strategies.  
  - Responsive strategies. |

For more information, visit: [https://www.cebc4cw.org/program/trust-based-relational-intervention-tbri-caregiver-training/](https://www.cebc4cw.org/program/trust-based-relational-intervention-tbri-caregiver-training/)
<table>
<thead>
<tr>
<th><strong>TRIPLE P (POSITIVE PARENTING PROGRAM)</strong></th>
<th>Triple P is a multi-level system of support for parents/caregivers of children and adolescents. The purpose of the program is to prevent and treat behavioral and emotional problems in children and teenagers.</th>
</tr>
</thead>
</table>
| **GOALS OF THE PROGRAM** | The goals of Triple P are:  
• To intervene before problems arise in the family, school, and community  
• Create family environments that encourage children to realize their potential |
| **TARGET POPULATION** | The Triple P system is delivered to:  
• Parents/caregivers of children younger than 12 years old  
• Teen Triple P targets:  
• Parents/caregivers of children 12-16 years old.  
• Specialist programs also target:  
• Stepping Stones: Parents of children with a disability  
• Family Transitions: Parents going through separation or divorce  
• Lifestyle: Parents of children who are overweight  
• Indigenous: Indigenous Parents |
| **LENGTH OF PROGRAM** | The levels of Triple P determine the intensity and duration. |
| **TOPICS COVERED** | Topics included in Triple P interventions include:  
• One-off discussion groups addressing most common parenting problems  
• Brief and short-term primary care consultations for specific problems  
• Groups or online courses for a comprehensive understanding of Triple P strategies  
• One-on-one personal support program for tackling serious behavior problems  
• Complex family and/or mental health issues, including child maltreatment |

For more information, visit: [http://www.triplep.net/glo-en/home/training/](http://www.triplep.net/glo-en/home/training/)

<table>
<thead>
<tr>
<th><strong>WRAPAROUND</strong></th>
<th>Wraparound is an evidence-based, intensive approach to care planning and case management for individuals with complex needs. During the wraparound process, a team of people relevant to the child or family works collaboratively to develop an individualized plan of care, implement this plan, monitor the effect of the plan, and work towards success over time.</th>
</tr>
</thead>
</table>
| **GOALS OF THE PROGRAM** | The overall goal of Wraparound is to help the child or family realize their desired outcome by incorporation:  
• Formal services  
• Community services  
• Interpersonal support & assistance |
| **TARGET POPULATION** | Since the Wraparound process is individualized, the target population is variable. |
| **LENGTH OF PROGRAM** | Since the Wraparound process is individualized, the length of service is variable. |
| **TOPICS COVERED** | The plan should reflect the goals and ideas about what sorts of services and support strategies are most likely to be helpful to clients in reaching their goals. |

For more information, visit: [http://www.cebc4cw.org/program/wraparound/detailed](http://www.cebc4cw.org/program/wraparound/detailed)
APPENDIX E:
SURVEYS
APPENDIX E: SURVEYS

A copy of the Protective Factor Survey used for HOPES programming is provided below.
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: ______

This survey was developed by the FRIENDS National Resource Center for Community-Based Child Abuse Prevention in partnership with the University of Kansas Institute for Educational Research & Public Service through funding provided by the US Department of Health and Human Services.
**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)
   - □ A Native American or Alaskan Native
   - □ B Asian
   - □ C African American
   - □ D African Nationals/Caribbean Islanders
   - □ E Hispanic or Latino
   - □ F Middle Eastern
   - □ G Native Hawaiian/Pacific Islanders
   - □ H White (Non Hispanic/European American)
   - □ I Multi-racial
   - □ 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:**
   - □ A $0-$10,000
   - □ B $10,001-$20,000
   - □ C $20,001-$30,000
   - □ D $30,001-$40,000
   - □ E $40,001-$50,000
   - □ F more than 50,001

8. **Highest Level of Education:**
   - □ A Elementary or junior high school
   - □ B Some high school
   - □ C High school diploma or GED
   - □ D Trade/Vocational Training
   - □ E Some college
   - □ F 2-year college degree (Associate's)
   - □ G 4-year college degree (Bachelor's)
   - □ H Master's degree
   - □ I PhD or other advanced degree

9. **Which, if any, of the following do you currently receive? (Check all that apply)**
   - □ A Food Stamps
   - □ B Medicaid (State Health Insurance)
   - □ C Earned Income Tax Credit
   - □ D TANF
   - □ E Head Start/Early Head Start Services
   - □ F None of the above

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

<table>
<thead>
<tr>
<th>Gender</th>
<th>Birth Date (mm/dd/yy)</th>
<th>Your Relationship To Child (check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Child 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child 4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

---

This survey was developed by the FRIENDS National Resource Center for Community-Based Child Abuse Prevention in partnership with the University of Kansas Institute for Educational Research & Public Service through funding provided by the US Department of Health and Human Services.
**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.

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Mostly Disagree</th>
<th>Slightly Disagree</th>
<th>Neutral</th>
<th>Slightly Agree</th>
<th>Mostly Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. There are many times when I don’t know what to do as a parent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>13. I know how to help my child learn.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>14. My child misbehaves just to upset me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Very Rarely</th>
<th>Rarely</th>
<th>About Half the Time</th>
<th>Frequently</th>
<th>Very Frequently</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. I praise my child when he/she behaves well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>16. When I discipline my child, I lose control.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>17. I am happy being with my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>18. My child and I are very close to each other.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>19. I am able to soothe my child when he/she is upset.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>20. I spend time with my child doing what he/she likes to do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>
A copy of the Caregiver Survey Pre-test and Post-test is provided below.

AGREEMENT TO PARTICIPATE IN RESEARCH

PLEASE READ THE FOLLOWING INFORMATION ABOUT THIS SURVEY.

Identification of Investigators and Purpose of Survey:
You are invited to participate in this survey, because you are participating in services funded by the HOPES program. The purpose of this study is to help us better understand the impact of parenting programs and how to best help and support families to improve outcomes for young children and caregivers.

If you agree to participate:
The survey will take approximately 20-25 minutes of your time. You will be asked questions about your family and your personal experiences. You can skip any question you don’t want to answer.

Risks/Benefits/Confidentiality of Data:
There are no known risks to participating in this survey. There will be no costs for participating, nor will you benefit from participating. Your responses are confidential. We will use your program’s case id to match your responses to information in the program database. After we do that, identifying information will not be kept to link you to your responses. Data will be reported in an aggregated way that will preserve your confidentiality.

Participation or Withdrawal:
Your participation in this study is voluntary. You can skip any question and you have the right to withdraw from participation at any time. You can stop your participation at any time and your refusal will not impact your relationship with the agency from which you are receiving services, the University of Texas at Austin, or any other participating entities.

Contacts:
The study is being conducted by Dr. Monica Faulkner at the Texas Institute for Child & Family Wellbeing at the School of Social Work at The University of Texas at Austin. If you have any questions about the study, please contact Dr. Faulkner at mfaulkner@austin.utexas.edu or (512) 471-7191.

Do you agree to participate in this survey?

If you agree to participate, please continue on to the next page to begin the survey.

If you decline to participate, please place the blank survey in the envelope and return it to the person who gave it to you. Do not begin to take the survey.
Evaluation of Healthy Outcomes through Prevention and Early Support (HOPES)

HOPES PRE-SURVEY (ENGLISH)

Instructions: Your responses to this survey are voluntary and confidential. You can skip any question you do not wish to answer. Your responses will not impact the services you receive. Please respond truthfully to each question, there are no right or wrong answers.

Section 1: Family Characteristics

Living Arrangement [check all that apply]:
- I am the only adult in my household
- I live with my partner or spouse
- I live with my parents or other relatives
- I live with non-relatives (other than partner)
- Other (ex. group home, shelter, residential treatment): _____________

Are you or your partner currently pregnant?  □ Yes  □ No

Are you currently the primary caregiver of any children aged 0-5 years?  □ Yes  □ No

If you answered “no” the previous question, please skip to Section 3.

For how many children are you currently the primary caregiver?
- 1
- 2
- 3
- 4 or more

Target Child: Some questions in this survey will refer to a “target” child. If you have more than one child, please answer these questions for your youngest child. If you do not yet have any children, you may skip those questions. Please answer these questions to the best of your knowledge.

Section 2: Target Child Characteristics

Birth weight  _____________  Gestational age at delivery:  _____________  # weeks at delivery

Does the target child have a disability?  □ Yes  □ No  □ Unknown

If yes, primary disability: ____________________________

Are immunizations up-to-date for the age of the child?  □ Yes  □ No  □ Unknown

Does your child regularly receive routine check-ups from a pediatrician, family doctor or clinic?  □ Yes  □ No  □ Unknown

Does target child live with you?
- All of the time
- Some of the time
- None of the time

Do you have additional help raising the target child (from a grandparent, sibling, spouse, friend, etc.)?  □ Yes  □ No

If you answered “no” to the previous question, please skip to Section 3.
## Evaluation of Healthy Outcomes through Prevention and Early Support (HOPES)

<table>
<thead>
<tr>
<th>Who else helps you take care of the target child? [check all that apply]</th>
<th>How often do they help?</th>
<th>How much do you disagree with this person regarding the care of the child?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s other parent</td>
<td>Daily</td>
<td>A lot</td>
</tr>
<tr>
<td></td>
<td>A few days a week</td>
<td>Some</td>
</tr>
<tr>
<td></td>
<td>A few days a month</td>
<td>None</td>
</tr>
<tr>
<td>Child’s step-mother</td>
<td>Daily</td>
<td>A lot</td>
</tr>
<tr>
<td></td>
<td>A few days a week</td>
<td>Some</td>
</tr>
<tr>
<td></td>
<td>A few days a month</td>
<td>None</td>
</tr>
<tr>
<td>Child’s step-father</td>
<td>Daily</td>
<td>A lot</td>
</tr>
<tr>
<td></td>
<td>A few days a week</td>
<td>Some</td>
</tr>
<tr>
<td></td>
<td>A few days a month</td>
<td>None</td>
</tr>
<tr>
<td>Child’s sibling</td>
<td>Daily</td>
<td>A lot</td>
</tr>
<tr>
<td></td>
<td>A few days a week</td>
<td>Some</td>
</tr>
<tr>
<td></td>
<td>A few days a month</td>
<td>None</td>
</tr>
<tr>
<td>Child’s grandmother</td>
<td>Daily</td>
<td>A lot</td>
</tr>
<tr>
<td></td>
<td>A few days a week</td>
<td>Some</td>
</tr>
<tr>
<td></td>
<td>A few days a month</td>
<td>None</td>
</tr>
<tr>
<td>Child’s grandfather</td>
<td>Daily</td>
<td>A lot</td>
</tr>
<tr>
<td></td>
<td>A few days a week</td>
<td>Some</td>
</tr>
<tr>
<td></td>
<td>A few days a month</td>
<td>None</td>
</tr>
<tr>
<td>Other relative:</td>
<td>Daily</td>
<td>A lot</td>
</tr>
<tr>
<td>____________</td>
<td>A few days a week</td>
<td>Some</td>
</tr>
<tr>
<td>____________</td>
<td>A few days a month</td>
<td>None</td>
</tr>
<tr>
<td>Other non-relative:</td>
<td>Daily</td>
<td>A lot</td>
</tr>
<tr>
<td>____________</td>
<td>A few days a week</td>
<td>Some</td>
</tr>
<tr>
<td>____________</td>
<td>A few days a month</td>
<td>None</td>
</tr>
</tbody>
</table>

## Section 3: Stability

### Section 3A: Family Resources

To what extent do you and your family have enough of the following resources? (circle best response)

<table>
<thead>
<tr>
<th>Resources</th>
<th>Not at all</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Almost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money to pay for necessities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Money to pay monthly bills</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Good job for yourself or spouse/partner</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Medical care for your family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Dependable transportation (own car or provided by others)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Time to be by yourself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Time for family to be together</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Child care/day care for your child(ren)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Someone to talk to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Time to socialize</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Money to buy things for yourself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Money for family entertainment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Money to save</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Travel/vacation</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
### Section 3B: Social Support

Below are some statements about the people who are important to you. Please circle the best response.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never True</th>
<th>Rarely True</th>
<th>Sometimes True</th>
<th>Often True</th>
<th>Usually True</th>
<th>Always True</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I need an errand, I can easily find a friend, relative, or neighbor to watch my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>If I need a ride to get my child to the doctor, there are friends, relatives, or neighbors I could call.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>If I need to buy something for my child but I am short of cash, there is someone who will lend me money.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>If I'm feeling exhausted or depressed, like at the end of a long day, I have to cope alone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>If I have an emergency I can easily find a friend, relative, or neighbor to watch my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

### Section 4: Nurturing

#### Section 4A: Parental Resilience

Read each statement and circle the option that best describes you during the last couple of months.

<table>
<thead>
<tr>
<th>Statement</th>
<th>This is NOT AT ALL like me</th>
<th>This is NOT MUCH like me</th>
<th>This is A LITTLE like me</th>
<th>This is MUCH like me</th>
<th>This is VERY MUCH like me</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel positive about being a parent/caregiver.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I take good care of my child even when I am sad.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I find ways to handle problems related to my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I take good care of my child even when I have personal problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I manage the daily responsibilities of being a parent/caregiver.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have the strength within myself to solve problems in my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am confident I can achieve my goals.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I take care of my daily responsibilities even if problems make me sad.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I believe that my life will get better even when bad things happen.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
**Section 4B: Social Connections**

Read each statement and circle the option best describes you during the last couple of months.

<table>
<thead>
<tr>
<th>Statement</th>
<th>This is NOT AT ALL like me</th>
<th>This is NOT MUCH like me</th>
<th>This is A LITTLE like me</th>
<th>This is MUCH like me</th>
<th>This is VERY MUCH like me</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have someone who will help me get through tough times.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have someone who helps me calm down when I get upset.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have someone who can help me calm down if I get frustrated with my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have someone who will encourage me when I need it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have someone I can ask for help when I need it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have someone who will tell me in a caring way if I need to be better parent/caregiver.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have someone who helps me feel good about myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am willing to ask for help from my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have someone to talk to about important things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Section 4C: Concrete Support in Times of Need**

Read each statement and circle the option that best describes you during the last couple of months.

<table>
<thead>
<tr>
<th>Statement</th>
<th>This is NOT AT ALL like me</th>
<th>This is NOT MUCH like me</th>
<th>This is A LITTLE like me</th>
<th>This is MUCH like me</th>
<th>This is VERY MUCH like me</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t give up when I run into problems trying to get the services I need.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I make an effort to learn about the resources in my community that might be helpful for me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>When I cannot get help right away, I don’t give up until I get the help I need.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I know where to go if my child needs help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am willing to ask for help from community programs or agencies.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I know where I can get helpful information about parenting and taking care of children.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Asking for help for my child is easy for me to do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I know where to get help if I have trouble taking care of emergencies.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I try to get help for myself when I need it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
## Section 4D: Social and Emotional Competence of Children

Read each statement and circle the option that best describes you during the last couple of months.

<table>
<thead>
<tr>
<th>Statement</th>
<th>This is NOT AT ALL like me</th>
<th>This is NOT MUCH like me</th>
<th>This is A LITTLE like me</th>
<th>This is MUCH like me</th>
<th>This is VERY MUCH like me</th>
</tr>
</thead>
<tbody>
<tr>
<td>I maintain self-control when my child misbehaves.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I help my child learn to manage frustration.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I stay patient when my child cries.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I play with my child when we are together.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can control myself when I get angry with my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I make sure my child gets the attention he or she needs even when my life is stressful.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I stay calm when my child misbehaves.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I help my child calm down when he or she is upset.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am happy when I am with my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

## Section 5: Safety

### Section 5A: Neighborhood Safety

Please indicate how much each of the following statements describes your neighborhood.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel safe being out alone in my neighborhood during the daytime.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I feel safe being out alone in my neighborhood at night.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>People in my neighborhood are willing to help their neighbors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>People in my neighborhood can be trusted.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### Section 5B: Family Safety

In the past 12 months, have you been in a relationship with someone (for example: spouse, boyfriend, girlfriend)?

- **Yes**
- **No**

*If you answered “no” to the previous question, please skip to Section 5C.*

Please circle the option that best indicates the frequency with which your partner acts or acted.

<table>
<thead>
<tr>
<th>How often does/did your partner</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Fairly Often</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physically hurt you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Insult or talk down to you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Threaten you with harm?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Scream or curse at you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
**Section 5C: Mental Health**

Please read each question and circle the option that best describes how things have been for you during the past month. There are no right or wrong answers.

<table>
<thead>
<tr>
<th>Question</th>
<th>All of the time</th>
<th>Most of the time</th>
<th>A good bit of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the past month, how much of the time were you a happy person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>During the past month, how much of the time have you felt calm and peaceful?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>During the past month, how much of the time have you been a very nervous person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>During the past month, how much of the time have you felt downhearted and blue?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>During the past month, how much of the time have you felt so sad or depressed that nothing could cheer you up?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

**Section 5D: Alcohol and Substance Use**

The following questions ask about your current alcohol use and substance use. Some of these questions may or may not apply to you. Circle the most appropriate response based on your drinking and substance use in the past 12 months.

- **a.** In the past 12 months, how often have you had a drink containing alcohol? | Never | Monthly or less | 2-4 times per month | 2-3 times per week | 4+ times per week |
- **b.** In the past 12 months, how many drinks* containing alcohol did you have on a typical day when you were drinking? | 0-2 | 3-4 | 5-6 | 7-9 | 10 or more |
- **c.** In the past 12 months, how often did you have 4 or more drinks (women)/ 5 or more drinks (men) on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |

*1 drink= 12 oz. beer 5 oz. wine 1.5 oz. hard liquor 8 oz. malt liquor

**In the past 12 months...**

- Have you spent more time drinking or using drugs than you intended to? Yes No
- Have you neglected some of your usual responsibilities because of using alcohol or drugs? Yes No
- Have you felt you wanted or needed to cut down on your drinking or drug use? Yes No
- Has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use? Yes No
- Have you found yourself thinking a lot about drinking or using? Yes No
- Have you used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom? Yes No
## Section 6: Primary Caregiver Trauma History

The following questions are about events that happened during your childhood. This is a sensitive topic and some people may feel uncomfortable with these questions. Please keep in mind that you can skip any question you do not want to answer.

### Looking back before you were 18 years of age...

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you live with anyone who was depressed, mentally ill, or suicidal?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you live with anyone who was a problem drinker or alcoholic?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you live with anyone who used illegal street drugs or who abused prescription medications?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you live with anyone who served time or was sentenced to serve time in prison, jail, or other correctional facility?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you experience repeated bullying as a child?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you repeatedly experience discrimination based on ethnicity, skin color or sexual orientation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you live in a neighborhood that experienced gang related violence?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you ever live in a foster home or group home?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Once</th>
<th>More than once</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were your parents separated or divorced?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? Don’t include spanking.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did a parent or adult in your home swear at you, insult you, or put you down?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did anyone at least 5 years older than you or an adult ever touch you sexually?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did anyone at least 5 years older than you or an adult try to make you touch them sexually?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did anyone at least 5 years older than you or an adult force you to have sex?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did you feel that no one in your family loved you or thought you were important or special?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did you feel that your family didn’t look out for each other, feel close to each other, or support each other?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did you feel you didn’t get enough to eat, had to wear dirty clothes, and had no one to protect you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did you feel that your parents were too drunk or high to take care of you or take you to the doctor if you needed it?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did you feel uncomfortable answering any questions in this section?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
## Section 7: Additional Demographics

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently in school?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are you currently employed?</td>
<td>Yes, full time</td>
<td>Yes, part time</td>
</tr>
<tr>
<td>Sources of income your household receives [check all that apply]:</td>
<td>Employment earnings</td>
<td>Unemployment benefits</td>
</tr>
<tr>
<td>Other benefits your household receives [check all that apply]:</td>
<td>Medicaid</td>
<td>Housing subsidy/public housing</td>
</tr>
<tr>
<td>Health Insurance:</td>
<td>Private insurance</td>
<td>Other</td>
</tr>
<tr>
<td>Your place of birth (City, State):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you or your partner currently serving in the U.S. military?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you ever been in prison or jail?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you ever been on probation?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you ever been in juvenile detention?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

## Section 8: Referral Information: How Did You Hear About This Program?

- Self-referred
- Family member, friend, neighbor
- Treatment program
- Doctor’s office/hospital
- Law enforcement, police
- Court, corrections (jail or probation)
- Public Child Welfare Services/Child Protective Services
- Community based-agency
- School counselor or teacher
- Community presentation or public event
- Other: ______________
- Unknown

Thank you for filling out this survey. Please put your survey in the provided envelope and return it to the person who gave it to you.
HOPES POST-SURVEY (ENGLISH)

Instructions: Your responses to this survey are voluntary and confidential. You can skip any question you do not wish to answer. Your responses will not impact the services you receive. Please respond truthfully to each question, there are no right or wrong answers.

Target Child: Some questions in this survey will refer to a “target” child. If you have more than one child, please answer these questions for your youngest child. If you do not yet have any children, you may skip those questions. Please answer these questions to the best of your knowledge.

Section 1: Family Characteristics

<table>
<thead>
<tr>
<th>Living Arrangement [check all that apply]:</th>
<th>I am the only adult in my household</th>
<th>I live with my partner or spouse</th>
<th>I live with my parents or other relatives</th>
<th>I live with non-relatives (other than partner)</th>
<th>Other (group home, shelter, residential treatment, etc.): ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you or your partner currently pregnant?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you currently the primary caregiver of any children aged 0-5 years?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you answered “no” the previous question, please skip to Section 2.

Does the target child live with you? ☐ All of the time ☐ Some of the time ☐ None of the time

Do you have additional help raising the target child (from a grandparent, sibling, spouse, friend, etc.)? ☐ Yes ☐ No

If you answered “no” to the previous question, please skip to Section 2.

<table>
<thead>
<tr>
<th>Who else helps you take care of the target child? [check all that apply]</th>
<th>How often do they help?</th>
<th>How much do you disagree with this person regarding the care of the child?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Child’s other parent</td>
<td>☐ Daily ☐ A few days a week ☐ A few days a month</td>
<td>☐ A lot ☐ Some ☐ None</td>
</tr>
<tr>
<td>☐ Child’s step-mother</td>
<td>☐ Daily ☐ A few days a week ☐ A few days a month</td>
<td>☐ A lot ☐ Some ☐ None</td>
</tr>
<tr>
<td>☐ Child’s step-father</td>
<td>☐ Daily ☐ A few days a week ☐ A few days a month</td>
<td>☐ A lot ☐ Some ☐ None</td>
</tr>
<tr>
<td>☐ Child’s sibling</td>
<td>☐ Daily ☐ A few days a week ☐ A few days a month</td>
<td>☐ A lot ☐ Some ☐ None</td>
</tr>
<tr>
<td>☐ Child’s grandmother</td>
<td>☐ Daily ☐ A few days a week ☐ A few days a month</td>
<td>☐ A lot ☐ Some ☐ None</td>
</tr>
<tr>
<td>☐ Child’s grandfather</td>
<td>☐ Daily ☐ A few days a week ☐ A few days a month</td>
<td>☐ A lot ☐ Some ☐ None</td>
</tr>
<tr>
<td>☐ Other relative: ___________________________</td>
<td>☐ Daily ☐ A few days a week ☐ A few days a month</td>
<td>☐ A lot ☐ Some ☐ None</td>
</tr>
<tr>
<td>☐ Other relative: ___________________________</td>
<td>☐ Daily ☐ A few days a week ☐ A few days a month</td>
<td>☐ A lot ☐ Some ☐ None</td>
</tr>
<tr>
<td>☐ Other non-relative: ___________________________</td>
<td>☐ Daily ☐ A few days a week ☐ A few days a month</td>
<td>☐ A lot ☐ Some ☐ None</td>
</tr>
</tbody>
</table>
**Section 2: Stability**

### Section 2A: Family Resources

To what extent do you and your family have enough of the following resources? (circle best response)

<table>
<thead>
<tr>
<th>Resources</th>
<th>Not at all</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money to pay for necessities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Money to pay monthly bills</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Good job for yourself or spouse/partner</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Medical care for your family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Dependable transportation (own car or provided by others)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Time to be by yourself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Time for family to be together</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Child care/day care for your child(ren)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Someone to talk to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Time to socialize</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Money to buy things for yourself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Money for family entertainment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Money to save</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Travel/vacation</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### Section 2B: Social Support

Below are some statements about the people who are important to you. Please circle the best response.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never True</th>
<th>Rarely True</th>
<th>Sometimes True</th>
<th>Often True</th>
<th>Usually True</th>
<th>Always True</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I need an errand, I can easily find a friend, relative, or neighbor to watch my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>If I need a ride to get my child to the doctor, there are friends, relatives, or neighbors I could call.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>If I need to buy something for my child but I am short of cash, there is someone who will lend me money.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>If I’m feeling exhausted or depressed, like at the end of a long day, I have to cope alone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>If I have an emergency I can easily find a friend, relative, or neighbor to watch my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
### Section 3: Nurturing

#### Section 3A: Parental Resilience

Read each statement and fill in the circle that best describes you during the last couple of months.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel positive about being a parent/caregiver.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take good care of my child even when I am sad.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I find ways to handle problems related to my child.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take good care of my child even when I have personal problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I manage the daily responsibilities of being a parent/caregiver.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have the strength within myself to solve problems in my life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am confident I can achieve my goals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take care of my daily responsibilities even if problems make me sad.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I believe that my life will get better even when bad things happen.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Section 3B: Social Connections

Read each statement and fill in the circle that best describes you during the last couple of months.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have someone who will help me get through tough times.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have someone who helps me calm down when I get upset.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have someone who can help me calm down if I get frustrated with my child.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have someone who will encourage me when I need it.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have someone I can ask for help when I need it.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have someone who will tell me in a caring way if I need to be better parent/caregiver.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have someone who helps me feel good about myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am willing to ask for help from my family.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have someone to talk to about important things.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Section 3C: Concrete Support in Times of Need

Read each statement and fill in the circle that best describes you during the last couple of months.

| I don’t give up when I run into problems trying to get the services I need. | 1 | 2 | 3 | 4 | 5 |
| I make an effort to learn about the resources in my community that might be helpful for me. | 1 | 2 | 3 | 4 | 5 |
| When I cannot get help right away, I don’t give up until I get the help I need. | 1 | 2 | 3 | 4 | 5 |
| I know where to go if my child needs help. | 1 | 2 | 3 | 4 | 5 |
| I am willing to ask for help from community programs or agencies. | 1 | 2 | 3 | 4 | 5 |
| I know where I can get helpful information about parenting and taking care of children. | 1 | 2 | 3 | 4 | 5 |
| Asking for help for my child is easy for me to do. | 1 | 2 | 3 | 4 | 5 |
| I know where to get help if I have trouble taking care of emergencies. | 1 | 2 | 3 | 4 | 5 |
| I try to get help for myself when I need it. | 1 | 2 | 3 | 4 | 5 |

### Section 3D: Social and Emotional Competence of Children

Read each statement and fill in the circle that best describes you during the last couple of months.

| I maintain self-control when my child misbehaves. | 1 | 2 | 3 | 4 | 5 |
| I help my child learn to manage frustration. | 1 | 2 | 3 | 4 | 5 |
| I stay patient when my child cries. | 1 | 2 | 3 | 4 | 5 |
| I play with my child when we are together. | 1 | 2 | 3 | 4 | 5 |
| I can control myself when I get angry with my child. | 1 | 2 | 3 | 4 | 5 |
| I make sure my child gets the attention he or she needs even when my life is stressful. | 1 | 2 | 3 | 4 | 5 |
| I stay calm when my child misbehaves. | 1 | 2 | 3 | 4 | 5 |
| I help my child calm down when he or she is upset. | 1 | 2 | 3 | 4 | 5 |
| I am happy when I am with my child. | 1 | 2 | 3 | 4 | 5 |
## Evaluation of Healthy Outcomes through Prevention and Early Support (HOPES)

### Section 4: Safety

#### Section 4A: Neighborhood Safety

Please indicate how much each of the following statements describes your neighborhood.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel safe being out alone in my neighborhood during the daytime.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I feel safe being out alone in my neighborhood at night.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>People in my neighborhood are willing to help their neighbors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>People in my neighborhood can be trusted.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

#### Section 4B: Family Safety

Since starting this program, have you been in a relationship with someone (for example: spouse, boyfriend, girlfriend)?  

- **Yes**
- **No**

*If you answered “no” to the previous question, please skip to Section 4C.*

Please circle the option that best indicates the frequency with which your partner acts or acted.

<table>
<thead>
<tr>
<th>How often does/did your partner</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Fairly Often</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physically hurt you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Insult or talk down to you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Threaten you with harm?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Scream or curse at you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

#### Section 4C: Mental Health

Please read each question and circle the statement that best describes how things have been for you **during the past month**. There are no right or wrong answers.

<table>
<thead>
<tr>
<th>Question</th>
<th>All of the time</th>
<th>Most of the time</th>
<th>A good bit of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the past month, how much of the time were you a happy person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>During the past month, how much of the time have you felt calm and peaceful?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>During the past month, how much of the time have you been a very nervous person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>During the past month, how much of the time have you felt downhearted and blue?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>During the past month, how much of the time have you felt so sad or depressed that nothing could cheer you up?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
Evaluation of Healthy Outcomes through Prevention and Early Support (HOPES)

### Section 4D: Alcohol and Substance Use

The following questions ask about your current alcohol use and substance use. Some of these questions may or may not apply to you. Circle the most appropriate response based on your drinking and substance use **since starting this program**.

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Monthly or less</th>
<th>2-4 times per month</th>
<th>2-3 times per week</th>
<th>4+ times per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Since starting this program, how often have you had a drink containing alcohol?</td>
<td>0-2</td>
<td>3-4</td>
<td>5-6</td>
<td>7-9</td>
<td>10 or more</td>
</tr>
<tr>
<td>b. Since starting this program, how many drinks* containing alcohol did you have on a typical day?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>c. Since starting this program, how often did you have 4 or more drinks (women)/ 5 or more drinks (men) on one occasion?</td>
<td>12 oz. beer</td>
<td>5 oz. wine</td>
<td>1.5 oz. hard liquor</td>
<td>8 oz. malt liquor</td>
<td></td>
</tr>
</tbody>
</table>

*1 drink =

**Since starting this program...**

- Have you spent more time drinking or using drugs than you intended to?  
  - Yes  
  - No
- Have you neglected some of your usual responsibilities because of using alcohol or drugs?  
  - Yes  
  - No
- Have you felt you wanted or needed to cut down on your drinking or drug use?  
  - Yes  
  - No
- Has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use?  
  - Yes  
  - No
- Have you found yourself thinking a lot about drinking or using?  
  - Yes  
  - No
- Have you used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?  
  - Yes  
  - No

### Section 5: Additional Demographics

- Are you currently in school?  
  - Yes  
  - No
- Are you currently employed?  
  - Yes, full time  
  - Yes, part time  
  - Unemployed  
  - Retired

Sources of income that your household receives [check all that apply]:

- Employment earnings
- Unemployment benefits
- TANF/TANF “child only”
- Social Security Disability Insurance (SSDI)
- Social Security Retirement (OASI)
- Other retirement or pension
- Supplemental Security Income (SSI)
- Foster care payments
- Income from spouse, family, or friends (including alimony, child support)
- Other cash income
- No income
### Evaluation of Healthy Outcomes through Prevention and Early Support (HOPES)

Other benefits your household receives [check all that apply]:
- Medicaid
- Housing subsidy/public housing
- WIC (Women, Infants & Children)
- Food stamps or SNAP
- Other non-cash income
- None

Health Insurance:
- Private insurance
- Medicaid/CHIP
- Medicare
- No insurance
- Other
- Unknown

### Section 6: Program Impact

#### Section 6A: Agency/staff satisfaction

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Unsure</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I like the services that I have received so far from this agency.</td>
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<tr>
<td>If I had other choices, I would still get services from this agency.</td>
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<tr>
<td>I would recommend this agency to a friend or family member.</td>
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<tr>
<td>The location of services was convenient.</td>
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<tr>
<td>Staff was willing to see me as often as I felt it was necessary.</td>
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<tr>
<td>Staff returned my call within 24 hours on weekdays.</td>
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<td>Services were available at times that were good to me.</td>
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<tr>
<td>I was able to get all the services I thought I needed.</td>
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</tbody>
</table>

#### Section 6B: Program Length

The length of this program was:
- Much too short
- A little too short
- Just right
- A little too long
- Much too long

#### Section 6C: Impact

Since starting this program....

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Unsure</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I deal more effectively with daily problems.</td>
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<td>I am better able to control my life.</td>
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<tr>
<td>I am better able to deal with a crisis.</td>
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<td>I am getting along better with my family.</td>
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<tr>
<td>I do better in social situations.</td>
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<tr>
<td>I do better in school and/or work.</td>
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<tr>
<td>My housing situation has improved.</td>
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</tbody>
</table>
What additional resources do you think would help support you as a parent?

Thank you for filling out this survey. Please put your survey in the provided envelope and return it to the person who gave it to you.