Evaluation of the HOPE Program

An initiative designed to support young families with complex needs

In partnership with

CatholicCare SYDNEY

HOPE

ACU AUSTRALIAN CATHOLIC UNIVERSITY

ACKNOWLEDGMENT OF COUNTRY

In recognising Aboriginal and Torres Strait Islander peoples' spiritual and cultural connection to Country and in continuing ACU's commitment to Reconciliation, the authors acknowledge the First Peoples and the Traditional Owners and custodians of the Country where ACU campuses and CatholicCare Sydney offices are located. We respectfully acknowledge Elders past and present and remember that they have passed on their wisdom to us in various ways. Let us hold this in trust as we work with and serve our communities.

TO CITE THE REPORT

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Evaluation of the HOPE Program: An initiative designed to support young families with complex needs

PROJECT ACKNOWLEDGMENTS

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We would also like to acknowledge and thank Alex Cahill for her vital role in project establishment and data collection, as well as Amy McPherson who worked with Australian Catholic University's (ACU's) Stakeholder Engaged Scholarship Unit and CatholicCare Sydney to devise the evaluation questions and finalise the project plan.

A special thanks to the program participants who shared their stories to help us understand their experiences of the HOPE Program.

AUTHORS

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PROJECT TEAM

Sebastian Trew is involved in research at the Institute of Child Protection Studies at Australian Catholic University. His research focuses on prevention, intervention, and response to child sexual abuse. He is interested in using research review, synthesis, and analysis as an assessment tool to drive evidenced-informed practices among research, policy, training, and practice. Seb is the co-author.

Jacqui Stewart is Program Manager at the Institute of Child Protection Studies. She supports the successful delivery of applied research, training, and engagement projects within the Institute. Jacqui specialises in monitoring, evaluation, and learning. She has organised, implemented, and supervised monitoring, evaluation, and learning processes in both government and non-government sectors. Jacqui is a co-author.

Melissa Stewart McSeveny is the Evidence, Impact & Research Manager at CatholicCare Sydney. With experience in the not-for-profit sector, and local and state government, Mel has led strategies to deliver infrastructure to support resilient communities, guided complex policy development projects related to the provision of homelessness services and prevention, and early intervention programs for families and communities. Mel analysed and wrote up the routine outcome measurement data included in this report and collected by the CatholicCare Sydney team.

Kirsten Mead is the Director, Child & Family Safety Services at CatholicCare Sydney. The HOPE Program is one of several programs in Kirsten's portfolio, and benefits from her robust skill set which includes systems analysis, leadership, governance, and project and program management. Kirsten provided advice to the ACU project team throughout this project.

Lauren Kadwell is the Director of the Practice Excellence & Outcomes Office at CatholicCare Sydney. Lauren has significant clinical experience working with families affected by domestic and family violence, particularly in men's behaviour change programs and children's contact services. Lauren provides advanced training in male family violence interventions to practitioners across a range of health, government, and NGO settings. Lauren also has conducted research particularly in the field of translational health psychology. Lauren provided advice to the ACU project team in the co-design phase of this project and reviewed the final report.

Vivien Cinque manages community-engaged research at ACU. She managed this evaluation of the HOPE Program, including leading the team to receive research ethics clearance.

Jillian Cox provides administrative and research support within the ACU Engagement team. She provided an expert review of this report.

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Contents

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Abbreviations

Australian Catholic University	ACU
CatholicCare Sydney	CCS
Domestic and family violence	DFV
Focus group discussions	FGDs
Institute of Child Protection Studies (at ACU)	ICPS
Parent Empowerment and Efficacy Measure	PEEM
Participant Information Letter	PIL
Personal Wellbeing Index	PWI
Personal Wellbeing Index – School Children	PWI-SC
Routine outcome measurement	ROM
Stakeholder Engaged Scholarship Unit (at ACU)	SESU

1. Executive summary

Established in 2017 and delivered by CatholicCare Sydney (CCS), the HOPE Program supports young families for up to 14 months. Referrals come from government or non-government service providers or young people themselves. Upon referral, a young person (24 or under) must be at least 20 weeks gestation or have a child under the age of five. The young person must present with at least two complex needs, such as a disability, mental health issues, or a lived experience of domestic and family violence (DFV). The program has multiple aims. It seeks to support young families to address their immediate basic needs, build connections with relevant local services and supports, and explore educational and employment opportunities, where appropriate. It aims to increase confidence, knowledge, and skills in positive parenting practices, children's needs and development, living skills, and financial and literacy management.

CCS commissioned an evaluation of the HOPE Program to test the accuracy of its program logic and identify possible revisions. The CCS team also wanted to know what:

- benefits young people attributed to program participation
- outcomes program practitioners were identifying (using routine outcome measurement tools)
- program elements were contributing to outcome realisation, and
- measures and indicators to use to monitor progress toward key short-term outcomes.

The evaluation involved a mixed-method approach. Qualitative data about the program experience were collected from program participants (n = 16) and program staff (n = 14). An online survey was also used to gather a mix of qualitative and quantitative data about the program experience from an additional nine program participants. Available program documentation and secondary data – collected and analysed by CCS – were also reviewed to help deepen understandings of the program and triangulate (or cross-check) claims about the program, where appropriate.

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Key findings by evaluation question

THE EXTENT TO WHICH THE HOPE PROGRAM LOGIC ACCURATELY DESCRIBES THE HOPE PROGRAM ACTIVITIES AND CHANGES EXPECTED TO RESULT FROM THEM

Parts of the HOPE Program logic align with the evaluation findings. Available qualitative evidence revealed that the program logic accurately defined the complex needs of expecting and parenting young people and key inputs and activities.

There was not good evidence that outcomes were realised within the timeframes specified within the current program logic model. Available qualitative data suggested that young people take longer to adopt the knowledge, skills, and attitudes than what is highlighted in the existing logic model. Consequently, desired behaviour changes also take longer to appear than what is recorded in the existing program logic model.

The existing program logic indicates young families are the intended audience for the HOPE Program. The qualitative data revealed that practitioners predominantly worked with young mothers and their babies. The program logic implies that prioritising the needs of mothers and babies ultimately supports young families. Program participants reported little to no 'flow-on effect' for other family members.

BENEFITS REPORTED BY PROGRAM PARTICIPANTS AND PROGRAM ELEMENTS THAT CONTRIBUTED TO REALISATION OF THESE BENEFITS

The qualitative data revealed that participants (all young mothers) were helped to improve their circumstances and increase their confidence, knowledge, and skills in different areas. Key findings are as follows:

- Most participants were supported to address their immediate basic needs, including support with baby supplies and household items and assistance finding temporary or permanent accommodation
- Some participants received practical help, like resume writing, to address their educational and employment needs
- Some increased their confidence in, knowledge, and use of positive parenting strategies and skills – both through their work with Family Workers and participation in programs they were referred to (e.g., sleep clinics for mothers and babies), and
- There was some evidence of participants gaining greater awareness of other service providers available to support them and connecting with other families in the community.

Participants attributed change in the circumstances listed directly above to the practical supports they received (e.g., coaching on parenting skills) and the quality of their working relationship with program practitioners (i.e., Family Workers or an Education and Employment Specialist). Most participants revealed that practitioners provided the emotional support and encouragement that motivated and inspired them to set and achieve desired goals.

OUTCOMES CAPTURED BY PROGRAM PRACTITIONERS AND PROGRAM ELEMENTS THAT CONTRIBUTED TO OBSERVED OUTCOMES

HOPE Program practitioners routinely administer routine outcome measurement (ROM) tools. These tools capture data on program participants' goal attainment, wellbeing, and parent functioning. Data on wellbeing and parent functioning are typically captured within the first six weeks of service (the initial assessment), around five to seven months later (the interim assessment) and around nine to twelve months (program exit). The data presented here was captured between July 2023 and March 2024.

Regarding goal attainment, 42 HOPE participants had set 164 goals. Of those goals, 45% (74) related to self-determination and empowerment, 30% (49) to increased knowledge and skills, 14% (23) to improved mental health, wellbeing, and resilience, 7% (11) to increased connection and community participation, and 4% (7) related to safety. These goal domains relate to one or more outcomes in the current HOPE Program logic model.

Of the 70 goals that had been reviewed, at the time of reporting, 48% were achieved, 24% were in progress, 17% had become irrelevant for the participant, and 11% were closed without being achieved.

Data for the individual domains of the Personal Wellbeing Index (PWI) reveal that at initial assessment:

- Standard of living received the lowest scores, followed by safety and relationships, and
- Sense of achievement, followed by community connectedness, and future security received the highest scores.

Between initial and interim assessments:

- On average, an increased score was revealed across all domains
- Community connectedness and future security increased the most, and
- Safety increased the least.

Regarding parent functioning, 28 HOPE participants completed an initial Parenting Empowerment and Efficacy Measure (PEEM), and eight participants had completed both an initial and an interim PEEM. Of the eight participants who had completed an initial and interim PEEM assessment:

- Three had significantly lower scores and two had slightly lower scores, and
- Two had significantly higher scores and one had a slightly higher score.

Like program participants, program staff indicated that the quality of their relationship with young people represented the key contributor to positive change. Good process – particularly around intake, assessment, goal setting (including reviews), and case planning and case management – were also identified as the elements most pertinent to realising program outcomes.

Key recommendations

REVISIONS TO THE HOPE PROGRAM LOGIC

Our recommended priority revisions to the HOPE Program logic are as follows:

- Revisit the outcomes and reflect on the timeframes for expected achievement
- Identify outcomes and the path to those outcomes for all family members (presuming the intent and resources to directly work with young families), and
- Write a targeted, specific problem statement for the program.

Other possible revisions to the HOPE Program logic are as follows:

- Split outputs between two categories – Outputs: Participation and Outputs: Activities – to provide a clear distinction between what the program does and who is involved
- Add assumptions about how or why the program will work to help anticipate and mitigate unintended consequences
- Add external factors that interact with the program to aid planning around how to influence these factors or appropriately respond to them
- Highlight causal linkages believed to exist among program components to inform ongoing monitoring, and
- Revisit outputs to ensure processes and relationships identified as most pertinent to realising program outcomes (e.g., intake, assessment, goal setting (including reviews), case planning and case management, along with the client-practitioner relationship quality) are adequately measured and tracked.

REVISIONS TO OTHER PROGRAM DESIGN/ IMPLEMENTATION RESOURCES

Of the program design and implementation resources considered by the evaluation team, our recommended revisions are as follows:

- Revisit the information provided to referral agencies and young people about the program, ensuring it allows each stakeholder to make informed decisions on its suitability
- Review the intake procedure to ensure Family Workers are fully informed about a young person's circumstances in advance of their first meeting with a young person
- Review whether existing systems enable Family Workers to easily share case plans and other relevant materials with young people to deepen their ownership or buy-in to plans
- Consider the value of a bespoke Family Assessment tool for the HOPE Program
- Identify ways to prevent or minimise duplicated effort by Family Workers to find suitable referrals for young people across the geographic area that the team services (e.g., nominate subject matter experts for common referrals like housing or DFV support)
- Identify or review processes for transitioning young people from one Family Worker to another to ensure participants are fully informed about the change and confident it will not impact continuity of care
- Identify or review exit protocols for young people to minimise the potential for their experience of stress and/ or distress from the change and program conclusion
- Reflect on whether the practice principles, theories, ethical guidelines, and so on are fully and appropriately documented to support evidence-informed practice, and
- Consider policies and procedures for how the team will meaningfully engage with young families (if that is a priority for the team).

We suggest that the CCS team carefully consider our recommendations to revise the program design/ implementation resources to determine their appropriateness. These recommendations come from the program documentation we received. Potentially, evaluators have an incomplete knowledge of HOPE processes and systems. Consequently, our suggestions could inadvertently duplicate or overlap with existing activities.

MEASURES AND INDICATORS TO MONITOR SHORT-TERM OUTCOMES

Evidence from the available qualitative data suggests that the HOPE Program consistently realises two short-term outcomes. The outcomes are:

- Young families increase knowledge of local and appropriate services and supports, and
- Young families' immediate basic needs are addressed.

To track short-term outcome realisation the team could collect data for the following indicators: referral uptake, appropriateness of referral, and brokerage uptake. (See p. 34, sub-section titled Monitoring progress toward key short-term outcomes for definitions of these indicators.) Ideally data collection is embedded into existing tools and processes.

OTHER MEASUREMENT OPPORTUNITIES

The evaluation also considered ongoing measurement using the existing ROM tools. Because these tools align with suggested revisions to the existing program logic (see p. 39, Table 4.2), we recommend that the team:

- Continues to conduct PWI assessment (initial, interim, and exit)
- Continues to conduct the PEEM assessment (initial, interim, and exit) with young people who identify goals related to parent functioning, and
- Continues to measure goal attainment, but revises how data are captured and categorised.

We also saw an opportunity to conduct pre- and post-assessments for participants involved in psychoeducation programs as a part of the HOPE Program.

While outside the evaluation scope and therefore not considered in detail, we identified potential for the HOPE team to measure:

- Family outcomes
- Participant self-determination and empowerment
- Participant social connectedness, and
- The relationship quality between the program participant and practitioner.

2. Background

The HOPE Program is designed for young families (parents 24 years or under) with complex needs. The top three client needs at referral are homelessness/risk of homelessness (80%); mental ill health (diagnosed or undiagnosed) (70%), and family and domestic violence (60%). Young families typically participate for up to 12 months.

CatholicCare Sydney (CSS) delivers the program. It is principally a philanthropically funded venture. CCS are exploring options to secure state government funding.

The program is person-centred and delivered by tertiary qualified staff, referred to as Family Workers. Person-centred care means the program activities are guided and informed by young people's goals, preferences, and values. The approach adopted by Family Workers is guided by attachment theory, trauma informed practice, child developmental theories, family systems theory, and strength-based models.

The program has multiple aims. It seeks to support young families to address their immediate basic needs, build connections with relevant local services and supports, and explore educational and employment opportunities, where appropriate. It aims to increase confidence, knowledge, and skills in positive parenting practices, children's needs and development, living skills, and financial and literacy management.

Since its establishment in 2017, over 135 families have completed the program. When setting up the program, CCS estimated (drawing on NSW population data) that close to 300 young mothers resided in the Sydney Archdiocese in 2016.

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3. The evaluation

The overall objective of the HOPE evaluation is to provide a set of formative findings and recommendations that will inform the refinement of the HOPE Program logic, as well as the identification of routine pre- and post-outcomes measures to support ongoing monitoring of progress toward desired results.

CCS commissioned the HOPE Program evaluation as they wanted to determine if the existing program logic and underlying evidence base was aligned with the program's activities and intended outcomes. CCS submitted a successful proposal for research through the annual application round of Australian Catholic University's (ACU's) Stakeholder Engaged Scholarship Unit (SESU) and worked collaboratively with ACU to co-design the project. The program has not been previously evaluated, nor has the HOPE Program logic been externally reviewed or validated.

The evaluation involved collecting information about the experiences of program participants and staff. It sought to understand:

- the social exclusions experienced by young families participating in the program
- what program participants recognised as the most impactful outcomes and elements of the HOPE Program, and
- what practitioners and managers recognised as the most impactful outcomes and elements of the HOPE Program.

The intent was to analyse captured data and use key findings to determine the appropriateness of the HOPE Program logic. Key findings would also inform the identification of routine measures and indicators to monitor progress towards the key short-term outcomes.

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3.1. Evaluation questions

The overarching evaluation question was:

To what extent does the HOPE Program logic accurately describe the HOPE Program activities and the changes expected to result from them?

The evaluation was guided by the following sub-questions:

1. What benefits (if any) did program participants experience from their involvement in the program and what program activities/resources supported realisation of these benefits?
2. What desired outcomes do program practitioners attribute to program participation and which elements of the program are identified as producing these changes?
3. In what ways does the HOPE Program draft program logic and other program design/ implementation resources require revision considering the findings of question one and two?
4. What measures and indicators can CCS routinely seek data for to monitor progress toward key short-term outcomes in the revised draft program logic?

3.2. Approach

The evaluation took place between January 2023 and June 2024. It commenced with a planning phase in which SESU staff, the initial lead evaluator and CCS defined the key evaluation questions, along with data sources and methods. The Institute of Child Protection Studies (ICPS) led data collection with program participants and staff, which occurred from August to December 2023.

A mixed-method approach was adopted. Participant interviews, a participant survey, focus group discussions with program staff, and the review and analysis of existing secondary data (existing program documents and resources) were the key data sources and methods. Table 3.1 (p. 14) provides a summary of the data sources and methods and approach to analysis.

CONSENT AND PRIVACY OF DATA

Participant Information Letters (PILs) were provided to all participants. The PILs outlined the benefits and risks associated with the evaluation. The letters explained that participation was voluntary and in no way impacted on people's involvement with the HOPE Program. The evaluators' contact details were provided, along with support services that participants could contact if they experienced discomfort because of participating in the evaluation.

All participants consented to participate. Evaluators went through a verbal consent process at the beginning of participant interviews. The participant survey captured consent. Focus group participants completed hardcopy consent forms.

Findings do not contain information that can be used to identify participants, unless specific consent was obtained for this.

JOINT SENSE MAKING

Evaluators were committed to collaboratively making sense of the qualitative evaluation findings to maximise the potential for CCS to use the findings to inform decision making about program design and delivery. Key CCS team members were invited to a joint sense making session in March 2024. An evaluator presented key findings and the group reflected on the extent to which those findings accorded with current practice and potential reasons for any variance.

LIMITATIONS

There are limitations to the data used to answer the key evaluation questions. Program participants were recruited with support of the HOPE Program staff. Consequently, we only reached people connected to the program. The evaluation findings do not provide a voice to those who chose not to join the program or dropped out. Likewise, while the intent was to recruit a diverse group of young people (e.g., in terms of age groups, family types, psychosocial needs, and stage of parenthood – pregnant or having a newborn or toddler) this goal was not realised. The perceptions, opinions, and beliefs shared in the findings come predominantly from women aged in their early 20s who were pregnant or with a newborn when they joined. They presented with similar psychosocial needs; however, these needs do reflect those identified in the current program logic.

Limited quantitative data (see the section titled Other data and analysis used to inform the evaluation) were available. Therefore, mostly qualitative data were used to answer the evaluation questions.

The evaluation team received the program documentation detailed in Table 3.1 (p. 14). Our recommendations are informed by an analysis of these documents. As the team reviews the recommendations, they need to assess whether there is a different way to proceed given their complete knowledge of program processes and procedures.

3.3. Other data and analysis used to inform the evaluation

CCS routinely collects and analyses deidentified data related to HOPE participants' achievement of goals and select desired outcomes, from the program logic model, as part of its ongoing monitoring and continuous quality improvement efforts. HOPE Program practitioners administer ROM tools. Data collection using these tools commenced in July 2023.

Available data relates to goal attainment, wellbeing, and parent functioning.

The HOPE team analysed goal attainment, Personal Wellbeing Index (PWI) and Parenting Empowerment and Efficacy Measurement (PEEM) data for inclusion in this report. The results of these analysis are used to address evaluation sub-question two.

GOAL ATTAINMENT

The collected goal attainment data provides insights into the degree to which HOPE participants achieve time-limited goals. HOPE participants collaboratively set single and incremental SMART (Specific, Measurable, Achievable, Relevant, and Time-Bound) goals with practitioners. Goals align with outcome domains. These domains are:

- Increased self-determination and empowerment
- Increased knowledge and skills
- Improved mental health, wellbeing, and resilience
- Increased connection and community participation, and
- Improved safety.

Data are colleted on which outcome domain the goal aligns with and whether it is achieved or not.

The HOPE Program logic model makes two references to goal attainment. A listed output is the collaborative goal measure (i.e., goals reached and achieved). A short-term outcome states that young families set goals to address education and employment needs, where appropriate.

PERSONAL WELLBEING INDEX (PWI)

The PWI is a measure of an individual's subjective wellbeing. The PWI is based on the idea that wellbeing is a multi-dimensional construct, and that it encompasses a range of factors that contribute to an individual's overall sense of wellbeing. The scale contains seven items of satisfaction, each one corresponding to a quality-of-life domain: standard of living, health, achieving in life, relationships, safety, community-connectedness, and future security.

The PWI is a valid and reliable measure used in research and practice to assess and monitor individuals' subjective wellbeing, as well as to evaluate the effectiveness of interventions and policies aimed at improving wellbeing.

Multiple versions of the PWI exist for participants of different ages and abilities. They all include the same quality-of-life domains and are scored the same, but the questions are worded in different ways. The HOPE Program uses the Personal Wellbeing Index – School Children (PWI-SC), developed for respondents who are 12 to 18 years old.

Program staff selected the PWI-SC as most suitable for HOPE participants, as many participants fit within this age group, and compared to the PWI-A (for adults), it uses simplified wording suited to a wider range of education levels and cognitive ability.

Data from the PWI items may be used either at the level of individual domains, or the domain scores may be aggregated and averaged to form a measure of Subjective Wellbeing. The Australian normative range for the Subjective Wellbeing score for individuals is between 50 and 100 points. When calculating the mean of a group of respondents, the normative range for Australia is 73.4 to 76.4 points. Any score above 70 is assessed as "well", and 70% of the general population in Australia scores within that range (International Wellbeing Group, 2024).

See Appendix E (p. 65) for a copy of the PWI-SC.

The HOPE Program logic model includes short-term and medium outcomes related to domains in the PWI-SC, namely standard of living, achieving in life, relationships, and community-connectedness.

PARENTING EMPOWERMENT AND EFFICACY MEASURE (PEEM)

The PEEM is a 20-item strengths-based validated tool for measuring parent/carer functioning, focusing on confidence and capacity to manage the challenges of parenting and provide a safe supportive home for their children. The PEEM was developed for parents/carers of toddlers and primary school aged children, which is suitable for some HOPE participants. However, the developers[1] of the tool advised that it can be used for parents/carers of younger children as most of the items are relevant and apply equally well to a parent of any aged child – including infants (e.g., 'I stay calm and manage life even when stressful'; 'I have someone I can rely on to help'; 'I feel good about myself'; 'I feel part of a community'; 'I have good friends outside my family', and so on). For the items that are not yet relevant for parents/carers of infants (e.g., 'I feel good about the way my children behave'; 'I believe my children will do well at school'), practitioners of the HOPE Program were advised to support respondents to imagine how they might feel, rather than base their response on lived experience.

The responses to all 20 items of the PEEM are in the form of a 1-to-10-point scale used to indicate degree of agreement with the statement. The items are all scored in the same direction and a higher score indicates relatively greater strength in each area.

Responses are scored automatically by the CCS client management information system to calculate the total Empowerment Score, which is calculated by adding up the responses to each of the 20 items. The total Empowerment Score is the best indicator of overall parenting efficacy, and the score can range between 20 and 200, with the average score across the population being around 154. PEEM scores below 130 are interpreted as 'low' parent functioning (Freiberg, Homel & Branch, 2014).

However, administrators can also use the measure to derive two sub-scores:

- Efficacy to parent: confident and positive orientation to parenting role and practice. Possible score range: 11-110, and
- Efficacy to connect: capacity to access support and participate in social or other activities that promote positive parenting. Possible score range: 9-90.

A copy of the PEEM is shown at Appendix F (p. 68).

The HOPE Program logic model includes several outcomes related to increasing parenting knowledge, skills, and confidence.

ADMINISTRATION OF THE PWI AND PEEM

Family Workers (i.e., practitioners) administer the PWI to all participants when they enter the program. The PEEM is administered:

- When participants enter the program, if they are already parents, or
- As soon as is appropriate once they've had their first child (often it is most appropriate to wait until the baby has had their first vaccinations at six weeks of age).

The PWI and PEEM are administered again at five to seven months after entering the program, and then when a young person exits the program. The intent is to identify differences in scores, indicating any changes for participants in wellbeing and parenting skills and confidence during their time in the program. Each participant will complete each tool at least twice – at the beginning of the service and at exit.

Figure 3.1 (p. 16) outlines the key points at which the PWI and PEEM are administered during participants' time in the HOPE Program.

[1] *PEEM was developed as part of a 10-year partnership between Griffith University and Mission Australia – Pathways to Prevention (Freiberg, Homel & Branch, 2014).*

TABLE 3.1.

HOPE EVALUATION DATA SOURCES, METHODS, AND ANALYSIS	
DATA SOURCE / METHOD	**DESCRIPTION**
PROGRAM DOCUMENTATION AND RESOURCES	The evaluation team were provided with this program documentation: the HOPE Program logic, HOPE brochure, HOPE referral form, HOPE flowchart (listing processes and systems from an initial enquiry to case closure), living skills assessment, parenting sense of competence scale, family assessment, collaborative goal setting tool, and the HOPE ROM strategy and tool guide. See Appendix A (p. 56) for the program logic model. Evaluators examined and interpreted data to uncover meaning, gain understanding, and come to conclusions about program design and delivery. Document analysis helped evaluators triangulate claims about the program. Evaluators referred to multiple data sources and combined the document review with interviews and focus groups.
PARTICIPANT INTERVIEWS (SEMI-STRUCTURED)	16 current and former program participants (all young mothers) chose to take part in an interview (n = 16). Seven interview participants were still engaged in the program when interviewed. The length of participation ranged from around six months to up to two years. Of the nine interview participants who had exited the program, they had typically participated for around one year and exited between two months to two years prior to the interview. CCS supported their recruitment – advising participants of the opportunity to join the evaluation and how to contact evaluators if interested. Interviews took place via video conference or telephone at a time convenient for the participant. Open-ended questions and prompts in the semi-structured interview guide were informed by the short-term outcomes identified in the HOPE Program logic model. The intent was to uncover evidence of the extent to which program participants had achieved desired outcomes, and, if so, the factors that contribute to realisation (consistent with the sub-evaluation questions). Participants received a $50 voucher in recognition of their time. Appendix B (p. 58) contains the interview questions. Interviews were transcribed using a transcription service. The qualitative data analysis software NVivo was used to sort and categorise the interview data into key themes. Quotes from young people are labelled with a general descriptive phrase – participant – and a randomly chosen number (e.g., Participant 11) to help preserve their anonymity.

HOPE EVALUATION DATA SOURCES, METHODS, AND ANALYSIS CONTINUED	
DATA SOURCE / METHOD	**DESCRIPTION**
PARTICIPANT ONLINE SURVEY	In October 2023, program participants were offered the opportunity to complete a survey about their program experience. The survey was administered to boost participation rates. It mirrored key questions asked in interviews, mostly presenting the same question (e.g., 'How did you hear about the HOPE Program?') but giving participants a pre-defined list of possible answers. As noted directly above, a key objective was to uncover evidence of the realisation of key short-term outcomes, as presented in the HOPE Program logic model. See Appendix C (p. 60) for the survey questions. Nine participants elected to complete the survey from November 2023 to February 2024 (n = 9). Of the nine survey participants all but one was part of the program at the time they completed the survey. Two had participated for less than three months, two for between three and nine months, two for between ten and 12 months, and two for more than 12 months. The one participant who had exited had been in the program for around three months. Participants received a $25 voucher in recognition of their time. Survey results were downloaded into Excel. Evaluators examined the data to uncover meaning, gain understanding, and come to conclusions about program experience. Evaluators combined key findings with the interview data (e.g., using the findings to help verify that most, some, or no participants had experienced X or Y).
FOCUS GROUP DISCUSSIONS (FGDS)	FGDs were held with practitioners and managers. 14 program staff participated in focus groups discussions about the design, delivery, and outcomes of the HOPE Program (n = 14). Participants were recruited from current HOPE Program staff. Focus groups took place in CCS premises. During FGDs, the program team were asked about how they think the program operates and whether it delivers desired results (consistent with the sub-evaluation questions). See Appendix D (p. 64) for the focus group discussion questions. Evaluators used NVivo to aid transcription and analysis of the audio from FGDs and artefacts from the sessions (e.g., small group reflections on observed participant outcomes, which were recorded on butchers paper). They triangulated findings with other data sources to develop a comprehensive understanding of program design and delivery. No identifiers have been used with quotes to help protect the anonymity of participants.

FIGURE 3.1.

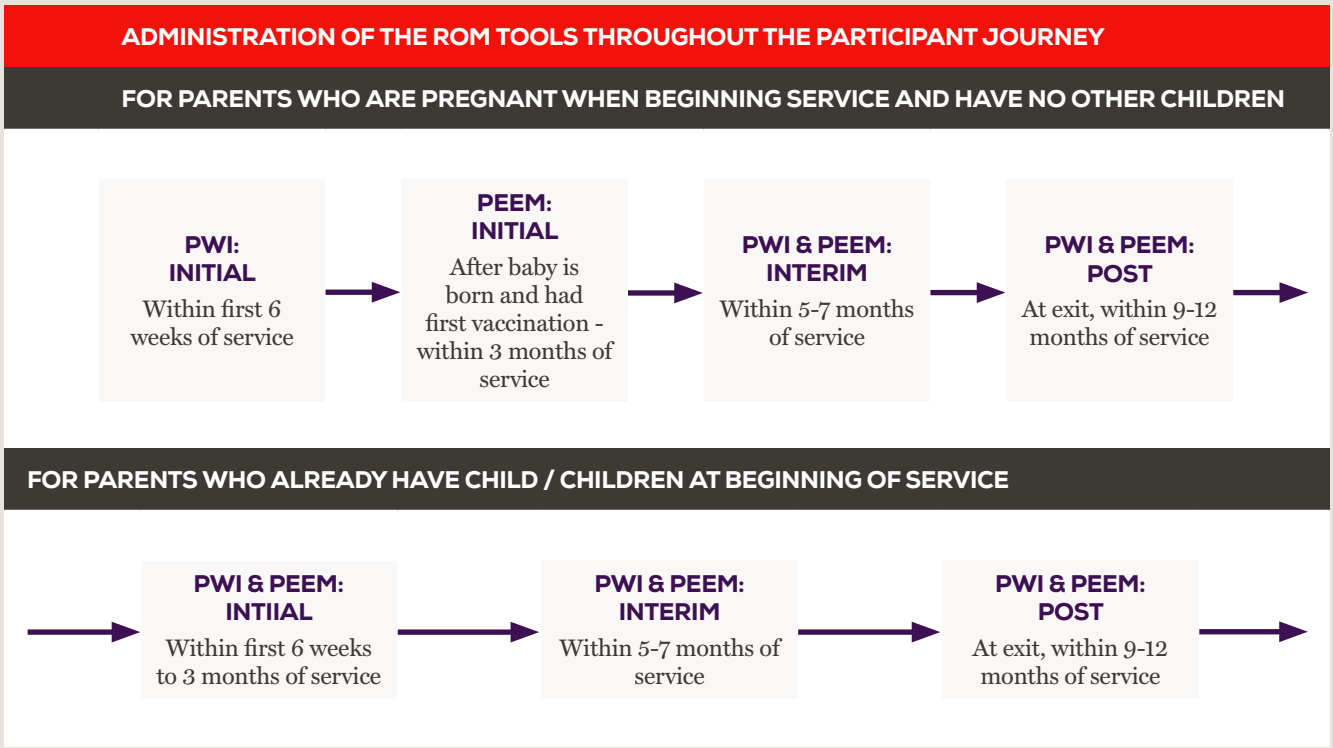
ADMINISTRATION OF THE ROM TOOLS THROUGHOUT THE PARTICIPANT JOURNEY
FOR PARENTS WHO ARE PREGNANT WHEN BEGINNING SERVICE AND HAVE NO OTHER CHILDREN
PWI: INITIAL
Within first 6 weeks of service
PEEM: INITIAL
After baby is born and had first vaccination - within 3 months of service
PWI & PEEM: INTERIM
Within 5-7 months of service
PWI & PEEM: POST
At exit, within 9-12 months of service
FOR PARENTS WHO ALREADY HAVE CHILD / CHILDREN AT BEGINNING OF SERVICE
PWI & PEEM: INTIIAL
Within first 6 weeks to 3 months of service
PWI & PEEM: INTERIM
Within 5-7 months of service
PWI & PEEM: POST
At exit, within 9-12 months of service

Image provided by Pexels/ Tatiana Syrikova.

4. Findings

4.1. Program participants

This section examines the benefits reported by program participants from their involvement in the HOPE Program (evaluation sub-question one). It presents findings garnered from the interview and survey data of current and former participants. The evaluation team collected the data.

As appropriate, the findings are presented against outcomes identified in the HOPE Program logic model.

Benefits experienced by participants

Participants revealed that the program supported them to address their immediate basic needs and increased their confidence, knowledge, and skills in different areas. Regarding immediate basic needs, most participants revealed that the HOPE Program had supported them with material and financial assistance. Most also received help with housing and accommodation. Some reported getting help to set goals to address education and employment needs. Some attributed improved knowledge of parenting strategies and skills to program participation. Some reported improved connection to relevant services and supports because of the program.

IMMEDIATE BASIC NEEDS ADDRESSED

Most participants were supported to address their immediate basic needs. The program provided essential material support including baby supplies (e.g., prams, nappies, and clothing), and household items (e.g., kitchen appliances).

> *They helped me get stuff I needed for my baby, such as the pram, toys, nappies, and they've also helped me with stuff I needed in the house, like kitchen supplies.*
> *- Participant 19*

> *HOPE sometimes give free hampers of food... HOPE referred me to get some free baby stuff from Dandelion or Mums Helping Mums... and I got a crib from them...a pram... [my child] has toys to play with...*
> *- Participant 1*

> *...I didn't have enough money for the nappies and wipes, she [Family Worker] made sure each week I got them... I feel like the benefit of the essentials have been helpful...*
> *- Participant 18*

> *The main thing she's helped us out with is money issues... [she said] 'If you need money for groceries let me know'*
> *- Participant 17*

> *...they gave me a voucher and they gave me a toaster, kettle, a sandwich press ...they gave me a lot of clothes*
> *- Participant 7*

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There was little evidence of enhanced financial management literacy. A few participants reported receiving financial guidance – such as budgeting assistance, connections to financial advisors, or help with getting a childcare subsidy. Only one participant attributed improvements in their personal financial management to program participation. Even so, the financial support and referrals provided were vital in ensuring that mothers had the necessary resources to care for their children and maintain their households.

She [Family Worker] helped me with getting childcare subsidy...I had no idea what to do. My son's in childcare now three days a week... I didn't pay anything [and it was] just to get me on my feet while I work... they [also] linked me with the financial advisor from the Salvos...
- Participant 9

My previous worker, she did help me with a lot of budgeting and now my life has changed with budgeting... I know how to spend my money more wisely and budget it properly...
- Participant 7

HOUSING AND ACCOMMODATION SUPPORT

Most participants reported receiving housing and accommodation support. Family Workers assisted with identifying and securing both temporary and permanent housing. Family Workers provided practical support like helping with the search for affordable housing options, the signing of leases, packing and moving, liaising with landlords for maintenance, handling applications for social housing, and advocacy on their behalf with housing departments. One mother highlighted the program's crucial role in securing housing before her childbirth, attributing her current stable housing situation directly to the program's intervention.

...with the new caseworker, we've just been trying to find new places. There was a couple of houses I applied to, so she was doing the reference letter for me... she will help me sign my lease.
- Participant 1

They helped me when I needed to move place. There was two of them that came to help me pack up the house and load the truck, they also provided the removalists.
- Participant 9

...I was heavily pregnant at 30 weeks...we had this problem with the landlord. He wouldn't come in, fix stuff, and he wouldn't keep his word...he got mad... [my Family Worker] gave me this tenant rights, put me [in] contact [with the right department for help with the maintenance request].
- Participant 16

...they helped me with temporary accommodation... [my Family Worker] helps me with looking for permanent housing. She has spoken to Department of Housing on my behalf...She has transported me to my temporary accommodation a couple of times...
- Participant 14

...they [Family Worker told us] we needed to look on a real estate website and find properties in the private rental market that are affordable for us. What we did is we made a list of housing offers. We put their address down, how many bedrooms and how much it is per week. Then once that piece of paper is full, we hand it over to her and then she passes it on to social housing. It gives us the proof that we aren't able to afford private rentals.
- Participant 4

...she [Family Worker] did a lot of my paperwork, and she always took me to the housing office for whenever I needed to go there and sign papers.
- Participant 7

...they helped me get a house two months before I gave birth, which was very helpful...I feel like if I wasn't with the program, I wouldn't have my house now.
- Participant 19

EDUCATION AND EMPLOYMENT PREPARATION SUPPORT

The program connected some mothers with an educational advisor. The advisor provided practical help with job applications, resume writing, and job opportunities (e.g., exploring apprenticeships). Mothers spoke of personalised help that addressed specific challenges such as expressing themselves in writing or finding suitable educational programs.

... [my Family Worker] connected me to an education advisor to help me navigate these things... because I want to start an apprenticeship...They showed me good places to search them up, and then helped me on applying for them. I struggle sometimes with my words and writing; it doesn't come out. So, they helped me put words in my head onto paper, for a cover letter and my resume...
- Participant 9

She [my worker] was helping me with my CV and jobs... and she was advising me on school...
- Participant 16

I was looking for a job at the time, and there was a worker that helped me write out my resume.
- Participant 12

While the support was designed to enhance employment prospects and help mothers develop career skills, we observed minimal engagement in education, training, or employment as a result of their participation in the program. One former participant did attribute their commencement of studies in health administration to the support received whilst in the HOPE Program.

...They did help me a lot, especially trying to get me into my studying because I'm doing health administration now...
- Participant 1

PARENTING KNOWLEDGE, SKILLS, AND CONFIDENCE BUILT

Some participants revealed that the HOPE Program increased their knowledge and use of positive parenting strategies and skills. They reported learning how to tune in and respond to their child, manage their emotions, practice gentle discipline, and balance their needs.

they helped me understand my kids better, understand what was going on with the kids and how to best deal with situations... [and now I am] more confident with the kids. I really know my kids. I'm very aware. I am aware of all their little sounds and what sound means what.
- Participant 13

I think my parenting to him has improved. I stay calm now, interact with him more.
- Participant 14

... it was easier for him [the father] to understand what needs to be done with the child and how to handle him without disciplining him in a way that hurts him...
- Participant 4

...HOPE did encourage me... I think they're giving me strength in doing this by myself [parenting]...They see me weekly, they come check up on me. I felt before alone and isolated, it just hurts. But I'm finding positive ways to get out of that.
- Participant 1

Some participants also reported learning and adopting specific care techniques. These included good bottle-feeding techniques, baby-led weaning, healthy meal preparation, sleep routines, and play. The hands-on advice provided by Family Workers was important for the mothers who initially felt overwhelmed or inexperienced.

My son was struggling to get on the bottle, she'll [Family Worker] come and help and try get him on the bottle ... [this gave me more] confidence in being a mother ...
- Participant 11

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...teaching me how to do baby-led weaning because I had no idea ... she [Family Worker] did a visit and we cooked food. It was snacks for babies that are healthy, nutritious, and good for baby-led weaning.
- Participant 13

... they helped me introduce a lot of new foods with him... My son used to never sleep, used to sleep really late, and wake up late. My HOPE worker, she helped me put him in that routine, and now he sleeps at 8:00 and wakes up at seven o'clock the next morning.
- Participant 12

She [Family Worker] did help me with some tips and activities for my son's age group. Things for me to do with him at home...
- Participant 9

She gave us pointers on swaddling him and preparing for when he's a toddler.
- Participant 4

There was limited evidence of increased understandings of child development amongst participants. One participant referred to the program helping them to 'understand my son's milestones'. But mostly, participants who were actively working on parenting knowledge, skills and confidence did not appear to equate practical advice about strategies like baby-led weaning with the notion that their child had reached a significant milestone and needed appropriate care.

Some participants did report feeling more confident in parenting. Their confidence seemed to come from having the practical skills to meet their child's needs and from the encouragement provided by Family Workers.

I was very scared when I was pregnant...She always came and said, 'You're doing a good job, you're doing well'
- Participant 11

It helped me expand my knowledge in being a mum, in raising my son... being more confident in my parenting skills and being more confident in myself.
- Participant 9

...what I've learned is that I am a lot stronger than I would usually think of myself. With their help ...
- Participant 4

I'm able to have the independency, confidence to be myself ... I'm able to be a mum, to have a routine again in my life, instead of feeling like I have no hope, or I have no help.
- Participant 1

The available qualitative data suggests that some, not all, young people join the program to strengthen their parenting knowledge, skills, and confidence. While incomplete and from a small sample, the available quantitative data appears to support this finding. Of the 28 participants who had completed an initial PEEM, around 18 (64%) had Total Empowerment Scores above population average2. At the interim assessment five out of eight participants (62%) had a Total Empowerment Score above the population average. (See p. 25, the section titled Parent functioning of HOPE participants for more information.)

CONNECTION TO RELEVANT SERVICES AND SUPPORTS

There was some evidence of participants' engagement with services for support with parenting and caring responsibilities. This engagement occurred because of support provided by the HOPE Program team. One mother benefited from being referred to a specific service for routine and sleep issues with their baby. Other mothers joined programs to improve their capacity to care for their child in case of an emergency.

They referred me to Tresillian... a place to go to get extra help on things you're unsure about... struggling with putting my child into a routine, they help with that... struggling with them not sleeping very well. They help find ways for you to help them sleep better...They have day classes and then they also have weekend stays...
My son was only about four and a half months when we went, so he wasn't even crawling yet...
- Participant 9

...I did one course from the Baby First Aid.
- Participant 13

...when I joined them, it was in the height of the pandemic. A lot of their services had been cancelled ... as the pandemic is starting to ease up a bit more of their programs did start running up again, I was able to [get] my first aid, my CPR [babies and children].
- Participant 7

Some participants were referred to services to support their wellbeing. These services included a specialised hotline for substance misuse support and mental health support.

They gave me a card for the drug and alcohol hotline.
- Participant 1

If I ever needed help, they gave me a few contacts to reach out and ask for help... Mental support and if I wanted to talk to a counsellor they tried to refer me once, and I was like, 'Oh no, it's all right. I'm okay.'
- Participant 16

Three mothers discussed and benefited from the program's support in navigating family and domestic violence situations. Two mothers received assistance with obtaining an Apprehended Violence Order (AVO) and preparing victim impact statements or were provided with ongoing support through court processes. This support helped ensure the safety and legal protection of the mothers involved. The other mother appreciated learning about her options and valued the emotional support provided by the Family Worker.

...when I had a domestic violence relationship, ...she [Family Worker] helped me getting an AVO against my ex-partner... ...Now she's working with me, doing reports for my current court case.
- Participant 14

She mostly just helped me fill out stuff. I was doing the victim impact statement for my domestic violence, to get payment.
- Participant 1

[A family member] started to assault me ... at that time HOPE really helped me ... they can give me accommodation, emergency accommodation ... They also tell me that you can do counselling ... they also give many, many support for ... my mental condition [i.e., the distress caused by the family violence].
- Participant 8

CONNECTION TO FAMILIES AND COMMUNITY

There was some evidence of participants connecting with other families in the community. Participants elected to join programs that facilitate social interactions, such as playgroups, to help their child socialise and to reduce their own feelings of isolation.

...going there once a week, letting the kids play and meet other kids, and we would read a book at the end, they would have a morning tea provided, and I got to talk to adults ... have adult interaction.
- Participant 13

After having my son, my husband, he went back to work. I struggled a lot, so they helped me sign up for mother groups and other little playgroups for my son...one of them was with the HOPE Program and some of them were with outside organisations.
- Participant 12

The Mother's Day group...it was a little program they did... All the mums from the mothers' daycare...He [my child] connected with the other babies.
- Participant 11

[1] *The higher the score the more positive the parent feels in their capacity to connect to essential services, support resources, formal and informal community and social networks, and other parents who may need support.*

For a few participants these community connections were highly significant. One participant shared their fear of leaving their children with others, and the need to manage their anxieties to build a support network.

> *...I struggle with leaving my kids with people. The anxiety. I'm scared they're going to hurt my kids. So, playgroup was very anxious for me, but I needed social interaction, my kids needed social interaction, and they referred me to [organisation's name] ... they introduced us to them and made a referral to playgroup with them, which is really good.*
> *- Participant 13*

Another mother spoke about how getting help to enrol their child in childcare meant they could pursue further education.

> *We've started to work on the childcare for my child. I've applied and got an enrolment form for a childcare that's an eight-minute walk from where I live. And then once [my child] starts that, I can start with my studying.*
> *- Participant 7*

4.2. Outcomes captured by program staff

This section presents findings from the ROM data collected and analysed by the HOPE Program team. The team measure and report on data related to goal attainment, personal wellbeing, and parent functioning. The information in this section addresses evaluation sub-question two, that is, the desired outcomes that program practitioners attribute to program participation. (See p. 12, the section titled Other data and analysis used to inform the evaluation for background on what the team measures and how.)

GOAL ATTAINMENT BY HOPE PARTICIPANTS

Between July 2023 and March 2024, 42 HOPE participants set 164 goals. Of those goals, 45% (74) related to self-determination and empowerment, 30% (49) to increased knowledge and skills, 14% (23) to improved mental health, wellbeing, and resilience, 7% (11) to increased connection and community participation, and 4% (7) related to safety. When goals relate to more than one outcome domain, the goal is assigned to the domain that it most directly relates to. For example, a participant goal to move into their own place is typically recorded against the domain related to self-determination and empowerment as it involves the participant increasing their independence. Figure 4.1, (p. 41) shows the intent of participant goals by outcome domain.

Goals are periodically reviewed to determine their status. Of the 70 goals that had been reviewed, at the time of reporting, 48% were achieved, 24% were in progress, 17% had become irrelevant for the participant, and 11% were closed without being achieved. Figure 4.2 (p. 42) shows the status of reviewed goals.

A count of the status of reviewed goals is shown in Table 4.1, (p. 38).

Figure 4.3 (pp. 43-47) provide a visual representation of goal status by outcome domain.

PERSONAL WELLBEING OF HOPE PARTICIPANTS

Between July 2023 and March 2024, 31 HOPE participants had completed an initial PWI and 12 participants had completed both an initial and interim PWI.

The mean Subjective Wellbeing score for the initial assessments was 65.43, lower than the Australian population normative range (73.4 to 76.4). The mean score of interim assessments was 72.03, much closer to the Australian population normative range.

Noting the small dataset, 37.5% of participants were within the 'well' range (a score over 70) at their initial assessment. By comparison, 75% of participants had scored within the 'well' range at their interim assessment.

Data for the individual domains of the PWI reveal that at initial assessment:

- Standard of living received the lowest scores, followed by safety and relationships, and
- Sense of achievement, followed by community connectedness, and future security received the highest scores.

Between initial and interim assessments, the following findings were observed:

- An increased score across all domains on average
- Community connectedness and future security increased the most, and
- Safety increased the least.

Figure 4.4 (p. 48) shows PWI Subjective Wellbeing scores at initial and interim assessment and Figure 4.5 (p. 48) shows average PWI domain scores at initial and interim assessment.

PARENT FUNCTIONING OF HOPE PARTICIPANTS

Between July 2023 and March 2024, 28 HOPE participants completed an initial PEEM, and eight participants had completed both an initial and an interim PEEM.

The average Total Empowerment Score for initial assessments was 155 and for interim assessments it was 154. Both scores aligned with the population average (154). However, the presented averages disguise the wide range of scores. Scores for individuals varied between 94 and 180 for initial assessments and 78 and 183 for interim assessments.

14% of participants had low scores at their initial assessment. Slightly less, 12%, had low scores at their interim assessment.

Most of the negative differences between the initial and interim assessments occur within the Efficacy to Parent subscale score. Program staff discussed potential reasons for a drop in score from an initial to interim assessment. They wondered if the differences existed because:

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- Participants had gained an increased knowledge about effective parenting during program participation and increased self-awareness of their own strengths and areas for improvement, and/or
- Participants were cautious about responding honestly in an initial assessment about parenting efficacy, fearing intervention from the Department of Communities and Justice. Perhaps by the interim assessment they had formed more trusting relationships with the Family Worker and felt comfortable reporting more honestly at the interim assessment.

Further investigations are needed to prove these hypotheses. Post assessments (once obtained) will aid a determination of whether low scores increase for participants by program exit. Figure 4.6 (p. 49) shows PEEM total empowerment scores at the initial and interim assessment.

4.3. Program elements contributing to change

The evaluation considered how and why change came about for young mothers in the HOPE Program – both from the perspective of the program participants and the program team. The data from participant interviews and FGDs was used to answer the second part of sub-evaluation questions one and two (i.e., what program activities/resources/ elements supported realisation of these benefits/changes).

The findings from program participants (see section 4.1 Program participants, p. 18) demonstrated the practical supports that Family Workers and the Education and Employment Specialist provided to participants. Examples included assistance with housing applications, help with resume writing, coaching on bottle feeding, and connection to baby first aid courses. These practical supports all contributed to the benefits and outcomes reported by participants.

These practical supports were identified through program elements including good intake process, assessment, goal setting (including reviews), case planning, and case management practice. Expert execution of these elements leads to most other activities (e.g., referrals, advocacy, brokerage, and so on). Further, it is through these critical program elements that practitioners come to understand what knowledge, skills, and attitudes to support young families to develop. As such, these activities serve as the basis for outcome realisation.

The working relationship between HOPE Program participants and practitioners is also vital to the realisation of desired outcomes. Both participants and practitioners acknowledged the importance of the relationships they established. This relationship and its significance are explored below.

Most participants revealed that practitioners within the HOPE Program worked hard to effectively address their multifaceted needs, encouraging their independence, stability, and overall well-being. Practitioners' relational approach met most participants' immediate needs and laid the foundation for those participants to make informed choices about how they want to parent and live.

Most program participants described the relationship as following a trajectory. Initially the Family Worker was someone who helped participants feel less isolated. With time participants came to appreciate the emotional support they received. As trust was established the positive affirmations and encouragement provided by practitioners often motivated and inspired young people to set and achieve desired goals.

Most participants reported feelings of isolation. The availability of Family Workers to visit their homes or meet in community settings provided a crucial connection for many. The visits offered not only companionship but also a break from the routine of home life, helping to address feelings of confinement and loneliness.

> *I was on maternity leave. I wasn't at work, … I had someone come see me instead of seeing the four walls at home, so it was just very helpful… They helped me a lot, the talking…*
> *- Participant 11*

> *… without them coming in, I would've been alone, and I wouldn't have anyone to talk to… it was just me and bubs at home. They would come around and we would just talk. I needed to talk to keep sane.*
> *- Participant 16*

Having company helped many participants recognise and appreciate the need for emotional support. Participants revealed that regular visits, guidance, and advice from practitioners was comforting, especially during challenging and difficult times.

> *I feel like I have someone by my side and someone that will listen to me when I have any problems … I can give them a buzz, or whenever they're free, they can give me a buzz and I can tell them what's happened, and they make me feel so supported and I feel so safe and acknowledged by them.*
> *- Participant 7*

> *…even just little things like reassuring you when your anxiety is going through the roof, and constantly letting you know, 'You're doing a good job,' which was great.*
> *- Participant 13*

> *…even though you're having such difficult days, they change your mood…When she used to come, some days I'd be so down, I'd be overwhelmed, so worked up. She talks to you, she changes everything. She makes you feel like you're back down to earth, you're not in this great sadness, you're not in that depression, anymore. She's like a friend, someone you needed, who you could rely on…*
> *- Participant 12*

Affirmations and positive reinforcement were a feature of most participant-practitioner relationships. This approach enhanced the effectiveness of the support provided. Most mothers reported feeling a sense of safety, acceptance, and being understood. On this basis participants felt ready and able to address challenges and pursue aspirations for a different life of their making.

> *They [Family Worker] always make me feel good about myself. Whenever I tell them I feel insecure, they make me feel good and they say, 'No, you shouldn't feel like that.' They give me words of affirmation … constantly uplifting me and giving a lot of good talks. She would talk to me and motivate me and give me hope.*
> *- Participant 7*

> *…they listen when you need to be listened to, but also being very understanding and not judgmental... Them putting in those stepping stools, I still use to this day. … I'm still using the stuff that I was taught when my boys were babies.*
> *- Participant 13*

> *HOPE really made me change my whole attitude towards my whole life experience… [they said that] it's my strength to show my daughter that you can overcome this, [mental health and domestic violence] and you shouldn't go through this situation alone.*
> *- Participant 1*

Practitioners echoed much of what participants shared about the working relationship. As a practitioner in the focus group discussion explained: 'achieving anything is really dependent on staff's ability to build trust.' Another in the group said: '[the] strength of the program is the relationship built between workers and clients.'

Managers and practitioners described their practice as therapeutic and relational work. They explained that conversations with participants were therapeutic because they focused on unpacking the young person's attitudes and motivations, that if not examined can represent a barrier to change for these young people.

> *Practitioners use a gentle approach. Ongoing conversations with young people. Making suggestions [not telling them what to do and how] …change comes from strong relationships and long-term commitment. The holistic approach is important… The team looks at the whole person. What's important in that person's life.*

> *The HOPE Family Workers working with young people acknowledge they have strengths and have demonstrated resilience. This awareness can improve working relationships between worker and client.*

> *Practitioners help young people to see and eventually recognise that they aren't stuck in a situation. They can change it.*

Practitioners saw the long-term nature of their relationship (typically around 12 months) as important. It allows for experiential learning (i.e., learning by doing). Practitioners can observe, allow young people to 'make interesting decisions', and potentially 'stumble' because a safety net is in place – the participant can seek help at any time and jointly explore why things might not have gone exactly to plan. In that sense the relationship is symbiotic. Practitioners let the young person learn new things, and by doing, the young person can become the teacher. Practitioners gain insights into the young person's values, motivations, and attitudes.

By fostering an environment of understanding, respect, and genuine care, the practitioners described wanting to support mothers through the practical aspects of day-to-day living and offer a platform to enrich their emotional and psychological wellbeing.

> *There is real commitment and connection between worker and mum. Practitioners see mums grow into themselves and gain confidence … the program opens minds of young people to opportunities and hope. 'I can change where I thought I might end up'…. Having hope for themselves and the future. For their children.*

A few participants did not form effective working relationships with their Family Worker. They saw the Family Worker as someone who wanted to have a chat and were not interested in helping them change their circumstances. These examples help reinforce the importance of the therapeutic and relational work carried out by Family Workers. Without this work participants disengaged from the program.

> *In my opinion, it was all talk but not action [referring to support provided by Family Worker].*
> *- Participant 14*

> *… my experience hasn't been the worst. Things could have gone a lot worse than what they were. I don't think there's anything wrong with the program. It's just, they need to look more into who they're employing.*
> *- Participant 15*

Given that the working relationship represents a key mechanism for change, it is important for the team to consider where and how it is documented. The current program logic does not feature much on the working relationship. Potentially other governance and practice guidance helps practitioners understand key practice principles and standards in relation to the client-practitioner relationship.

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4.4. Revising the HOPE Program logic and other program design/ implementation resources

This section presents suggested changes to the HOPE Program logic and program design / implementation resources (evaluation sub-question three). The recommendations are based on the evaluation team's analysis of the available data.

COMPARING THE CONTENT IN THE HOPE PROGRAM LOGIC TO THE AVAILABLE EVIDENCE

The available evidence affirmed much of the information in the current HOPE Program logic (dated November 2022). There was good alignment between the lived experience of expecting and parenting young people as described in the program logic and shared in the interviews and surveys conducted for the evaluation. Interview participants revealed lived experience of complex life challenges, including domestic and family violence, housing insecurity, and mental health concerns. They shared the consequences of these experiences including social isolation, poor physical and mental health, and limited opportunities for education and employment. (See section 4.1 Program Participants, p. 18 for more detail.)

The inputs identified in the current logic model were mostly identified. Interviews with program staff confirmed the team make up (except for administrative support), the various resources required to run the program (ranging from external funding to technology to housing stock) and opportunities for clinical supervision, training, and professional development. The program documentation shared with the evaluation team (see Table 3.1, p. 14) did not provide great insights into current program governance nor practice frameworks.

Program participants largely received the service activities listed in the logic model. As presented in the *Program Participants* section, there was evidence of regular home visits, goal setting and monitoring, brokerage to support immediate material needs, referrals to community services, and advocacy (i.e., support to gain access to information and services). Only some participants spoke about receiving education, training, and employment support but this is not unexpected given the voluntary nature of this service activity. While most participants were aware of available play groups, few joined this activity. If they did, it was typically on one occasion. None of the interviewed participants joined attachment-theory based psychoeducation programs because the courses were largely not available during the timeframe that most of those interviewed were engaged in the program.

Interviews with program staff identified several activities as critical for achieving desired results. They talked about intake, assessment, goal setting (including reviews), case planning, and case management as the conditions most pertinent to realising the program outcomes. Program staff and program participants also highlighted the quality of the working relationship between the program participants and practitioner as vital. The identified processes and working relationship are underrepresented/understated in the current program logic.

Realisation of outcomes (short, medium, and long term) is the key area where the available evidence points to the need for revisions to the program logic. Table 4.2 (p. 39) compares what is in the current logic model with a revised way of thinking about what desired outcomes might be realised/achieved and when. The revised version is mostly informed by findings from the participant interviews and practitioner observations. Contextual factors (like NSW social housing wait list times) and relevant theories (e.g., attachment theory) also informed the revisions.

Participants and practitioners explained how the program experience unfolds. The first 12 weeks of program participation represents a 'getting to know you' phase. Practitioners revealed that for the first few visits the young person is typically on guard – concerned about who the Family Worker might share information about them with (e.g., the NSW Department of Communities and Justice). Initially, the young person might not answer phone calls from their Family Worker. Family Workers need to persevere and work to establish a trusted relationship with the young person. This is done to ensure that the young person feels safe to share their information and lived experience with the Family Worker. When trust is being established, young people can feel overwhelmed by referrals and intimidated by the prospect of joining activities offered by other services. Practitioners also shared that initially, many young people find it hard to look past their immediate basic needs; that they cannot necessarily forecast or predict where they would like to be in the future.

The participant interview findings suggested that young people took time to adopt the knowledge, skills, and attitudes highlighted in the current program logic. Consequently, desired behaviours took time to appear. Initially, most young people told us they wanted support with their immediate material needs, possibly also help connecting with other services and supports. Participants typically only acknowledged that the program had contributed to changes in their knowledge and skills (like positive parenting) late in their working relationship with a Family Worker. Whilst Family Workers told us they start to lay the foundations for outcomes (like positive parenting) in the initial stages of the working relationship (through role modelling and conversations), there was limited evidence to suggest that their work resulted in changes in participants' knowledge and skills until they were close to exiting the program.

Practically speaking, these findings suggest the need for a pragmatic approach to what is achieved and by when. Practitioners seemed to adopt this approach. For instance, determining that an initial focus on something like financial management literacy might prove futile until a trusting and stable working relationship is established, and the young person demonstrates a degree of comfort and safety within the program.

The section in Table 4.2 on new ways of thinking about outcomes and impacts (p. 42) transforms these insights on the program experience into a new way of presenting what outcomes occur and by when. In the short-term (up to 12 weeks), consistent with the available evidence, young people are mainly getting their immediate basic needs met and

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connecting with services. In the medium-term (12 weeks to 12 months), Family Workers and young people have strengthened their working relationship and start setting and realising goals, increasing parenting knowledge and confidence (if prioritised), and improving help seeking behaviours. In the longer-term (12 months plus), the young people typically exit with improved positive community connectedness, increased wellbeing, and improved parenting capacity (depending on their goals and priorities).

IDEAS FOR POSSIBLE REVISIONS TO THE HOPE PROGRAM LOGIC

We recommend revisions to the HOPE Program logic. At a minimum the team should consider revisiting the outcomes. The available evidence suggested that the program experience unfolds in a very specific manner, which has consequences for what outcomes are achieved by when. Ideally, the team updates the program logic model to reflect the reported program experience more accurately and continues monitoring activities to determine progress toward desired outcomes. Table 4.2 (p. 42) provides suggestions on one way to revise the program logic model.

The team might also revisit what outcomes (and the path to those outcomes) to include in the program logic for different types of participants. The current program logic suggests that young families participate in service activities and realise the outcomes. Yet the available evidence does not support this notion. Interview participants (all young mothers) spoke about their involvement in service activities and the outcomes they achieved. When prompted, most participants identified some benefits for their child (largely because of their improved parenting knowledge and confidence). Less than a few thought that anyone else in their immediate family had benefited from the program (and it was an indirect pathway, i.e., not caused immediately or obviously by the program but because of new or different things the young mother was trying because of program participation). So, the program does not appear to be working with young families as suggested in the program logic. Rather, it seems assumed that mothers will 'pay forward' any outcomes they realise (e.g., knowledge of support services will get passed on to other family members).

Therefore, additional revisions are needed to work out how and to what effect multiple members of a family can be directly supported by the program. One option might be outcome mapping, an approach that helps 'map' or set out the steps that link the activities of a program to the outcomes that are important. It can be used as a tool for informing a program logic (or group of logic models) with activities and outcomes relevant to different family members. Figure 4.7 (p. 50) shows a sample format for an outcome map.

The team might consider developing multiple logic models, each describing how the program is intended to work for distinct members of a family. It could adopt a nested approach where the highest-level logic model appears concise (like the current program logic) but there is also multiple, aligned sub-logic models for different family members.

In addition, the write up of clear problem statements for family members would need to form part of the work on determining how and to what effect families are supported. Some practitioners discussed the broad parameters for program participation and implied that nearly anyone can join the program. This almost open-door philosophy poses issues. While funders and agencies were not key informants for this evaluation, experience shows that some or all such stakeholders will want greater clarity on what issues or problems the program seeks to address. The current program logic mostly describes the perceived need for the program (e.g., 'expecting and parenting young people experience complex challenges', and 'young parenthood is associated with poorer outcomes'). Another important element to include is the 'so-what' – a concise explanation of the issue on the target population/s to clearly indicate the purpose of the program. See Figure 4.8 (p. 50) for an example.

Other revisions to the program logic are possible. Whether the team elects to adopt them should depend on the intended purpose of the tool. If the team is seeking a tool to guide reflective practice and continuous improvement, then an updated and more sophisticated program logic will support these aims. Table 4.3 (p. 40) identifies recommended but optional revisions and the intended effects.

INSIGHTS GAINED INTO THE RELEVANCE OF PROGRAM DESIGN AND IMPLEMENTATION RESOURCES GIVEN THE INTERVIEW FINDINGS

Available evidence suggested several areas for attention when it comes to the resources related to the design and implementation of the HOPE Program. The first relates to intake processes. Insights gained from program participants and practitioners suggested the need for review.

Participants largely conveyed that they joined the program with little to no initial understanding of its purpose or value. Those who joined largely did so because they trusted the person who referred them, they saw the program as a means of getting a house, or they identified a low risk to giving it a go. It was the voluntary nature of the program – which some participants interrogated before agreeing to the referral – that informed decision to join the HOPE Program.

Practitioners observed poor knowledge about the program when young people join. They reported getting mistaken for workers from the NSW Department of Communities and Justice and needing to explain the program was not compulsory.

The team might reflect on how to get accessible information about the program to potential participants. Ideally there is tailored information that goes to both the agencies and providers making referrals and to the young mums or families. The format and messaging ideally match the information needs of identified audiences.

Regarding information sharing, practitioners also told us about perceived opportunities to improve communications during program participation. They wanted the option to easily share case management tools with young people. Practitioners reported it was difficult referring to online forms and that having printable versions, designed to aid easy reading, was highly desirable.

Some practitioners raised concerns about the intake process. It appeared that the intake process involves two key steps. Initially there is an exchange between HOPE and the agency making the referral. Then there is an initial meeting (or meetings) between a new 'client' and the Family Worker to identify any immediate needs, begin to establish trust, and build a relationship. It was the first exchange between HOPE and the referrer that caused issues for some practitioners.

The team told us they get a referral form completed by another agency. Some of the fields are open for interpretation. For instance, the Family Information field. Practitioners were seeking information like relationship status (to inform risk assessments). Some agencies failed to provide this information. Previously, practitioners explained that referrals were taken over the phone, which allowed for questions e.g., 'Has the young person consented to this referral?'. When referrals were done by phone, practitioners felt they knew more about the young person and had more confidence about their willingness to engage with the program. In the current evaluation, time constraints when collecting data prohibited a detailed examination of possible ways to strengthen the referral process. This information is presented for reflection on whether and how to adjust current tools and/or processes.

Most HOPE practitioners suggested the need for a bespoke Family Assessment tool. The existing tool is used across CCS. Practitioners felt it was not always fit for use with young people. Some questions demand a future focus, which is out-of-step with young people grounded in the present. Some language is inaccessible and key concepts are not explored in any depth. For example, existing assessment asks about whether a young person has experienced domestic and family violence (DFV). Practitioners told us they would prefer to work through a checklist of signs or symptoms of DFV (e.g., partner controls movements) to help young people think about and identify all different types of DFV in their lives.

Issues with referrals (i.e., directing a young mum to a different place or person for information, help, or action) were raised by participants and practitioners. A few participants were disappointed with referrals and experienced the quality of support as unsatisfactory.

Practitioners revealed that making referrals to appropriate community services and supports was challenging. They often worked across a large geographic area. Keeping up to date with what community services and supports existed - along with their eligibility criteria, suitability for the HOPE target audiences, and so on - demanded time, often lacking in their busy work schedules.

One practitioner raised the idea of nominating people within the team to become subject-matter specialists on categories of providers across the service area (e.g., housing, family and domestic violence support, mental health services, and so on). The team could then draw on their knowledge to inform decisions about referrals.

Many of the participants spoke about working with multiple Family Workers. While they were predominantly satisfied with the care provided, most revealed that there was room for improvement in how the program transitions

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participants from one worker to the next. Ideally there is a warm handover, i.e., advance notice of the change and the opportunity for workers to connect with each other, preferably with the young person present, and discuss details of progress and other relevant information.

> *... I changed caseworkers, I'm still trying to get to know my new caseworker...I have no idea [why I have a new caseworker] ...she unexpectedly left...*
> *- Participant 1*

> *...It was weird because she [my Family Worker] told me that she was doing one week of training and then she'll come back to see me the following week. However, that week that she was meant to do her training, her manager sent me a message saying she is not working anymore with the HOPE Program. I was really upset, and I cried because she didn't even call me saying bye.*
> *- Participant 7*

Of the nine participants who had exited the program, most revealed issues with how they exited. All were alert to the fact that their time in the program was coming to an end. They felt satisfied that most (if not all) predefined goals were achieved and there was not much more for them to progress with the worker. But they felt the absence of a ritual or distinct method for drawing the relationship to a close. One day the worker was a part of their life. The next day they were not.

> *...Out of nowhere she sent me a message: 'Oh, sorry, I've quit the HOPE Program. I'm going to go my separate ways.' And I was like, 'Oh, okay.' And then I haven't really seen a worker since.*
> *- Participant 15*

Conversely, practitioners reported that young people often just 'dropped off'. They chose to exit and demonstrated this desire by not returning text messages or phone calls. Practitioners also reiterated that after exiting the program, a young person can call their former Family Worker for advice and the Family Worker may help with a referral to another agency/service. Perhaps the learning here is that every young person will have a preferred method for exiting the program.

The final reflection relates to governance and practice frameworks highlighted in the program logic. Table 3.1 (p. 14) lists the program documents received and reviewed by the evaluation team. Potentially other governance and practice frameworks exist. If so, we see value in the team reviewing these resources as group reflection on the theories, research, ethical principles, and experiential knowledge that inform the everyday work of practitioners, and are presented in governance and practice frameworks, represents an ongoing opportunity to strengthen practice.

4.5. Measuring program effectiveness

This section explores the ongoing monitoring of the HOPE Program. It addresses the measures and indicators that CCS can use to routinely collect data on progress toward key short-term outcomes in the revised program logic model (evaluation sub-questions four).

MONITORING PROGRESS TOWARD KEY SHORT-TERM OUTCOMES

Our recommendation is to revise the program logic to include two short-term outcomes only. The outcomes are:

- Young families increase knowledge of local and appropriate services and supports, and
- Young families' immediate basic needs are addressed.

To track outcome realisation the team could collect data for the following indicators:

- Referral uptake: Number and proportion of program participants who received the service for which they were referred by a Family Worker, regardless of service, during the reporting period
- Appropriateness of referral: Number and proportion of program participants who describe the referral as meeting their needs, regardless of service, during the reporting period, and
- Brokerage uptake: Number and proportion of program participants receiving material support during the reporting period, disaggregated by service provider.

Ideally data collection is embedded into existing tools and processes. We anticipate that there is no need to develop a new tool but rather to ensure existing data sources enable data capture for the proposed indicators. For instance, the Living Skills Assessment provide insights into specific priorities (e.g., the need for drug and alcohol counselling or brokerage). This tool might also become a repository of information on referrals made, referral uptake, and appropriateness of referral.

REFLECTIONS ON WHAT THE TEAM IS CURRENTLY MEASURING

The HOPE Program adopted ROM in July 2023. Currently the program team measures goal attainment, personal wellbeing, and parent functioning.

Goal attainment

We recommend that the program team continue to monitor progress toward and realisation of goals. Available evidence suggested that goal identification and attainment is a reasonably consistent program experience for participants. Consequently, the revised program logic model highlights goal realisation as a medium term goal (see the section in Table 4.2 on new ways of thinking about outcomes and impact (p. 39)).

Measuring goal attainment represents a good way of tracking an important program process and gaining insights into whether participants are achieving results. It also does not matter that desired results might vary between participants. The program team will still get information about effectiveness, i.e., whether program participation is supporting goal attainment.

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A key downside with measuring goal attainment is the potential for bias. For example, goals being too easy to attain or measuring change which does not actually occur. The project team will need to consistently and reliably apply practice guidance related to goal setting and attainment to prevent or minimise the potential for bias.

When it comes to the selection of appropriate performance indicators for goal attainment, we advise the team to keep it simple. We recommend the team set a goal attainment target. For example, 70% or higher (e.g., a participant achieves at least 70% of their goals). The team then needs to measure whether individuals are achieving goals and compare that to the target. They also need to determine goal attainment across the program. Possible indicators are listed below:

- **Percentage of goals achieved by participant at program exit**
  Calculation: The number of goals achieved at program exit divided by the number of goals set during program participation multiplied by 100
  Example: 5/10 x 100 = 50%. Goal attainment for participant is below target, and
- **Percentage of participants who met goal attainment target by program exit**
  Calculation: The number of participants who achieved the goal attainment target by program exit divided by the total number of participants who exited the program multiplied by 100
  Example: 40/50 x 100 = 80%. Goal attainment for program is above target.

The current program logic suggests there is already collaborative goal measures in place. The team might prefer existing measures and indicators over the ones presented above. The main consideration is whether the available measures and indicators inform decision-making. Practitioners need to know whether participants are on track to achieve desired goals and, if not, they need information that will guide collaborative action to ensure progress. Program-wide data on goal attainment will also support assessments of program effectiveness.

Reflections on other ways of reporting goal attainment

There is the option to report goal attainment by outcome domain. The outcome domains are broad. They are loosely connected with outcomes in the current program logic model.

Depending on funding requirements, the team may need to ensure it can provide more nuanced information. For instance, what knowledge and skills increased, and what is the nature of community connection and participation, to help determine sustainability. Potentially, the team may need to revise the outcome domains and identify domains more descriptive of commonly recurring goals. Existing tools could inform this work. For example, the Living Skills Assessment tool includes over ten areas for assessment such as accommodation, education and employment, and budgeting and finance. Presumably goals often relate to some or all areas. Aligning data points in different tools would allow the team to use multiple methods for developing a comprehensive understanding of the program experience and achievement of desired outcomes (i.e., to ability to triangulate data).

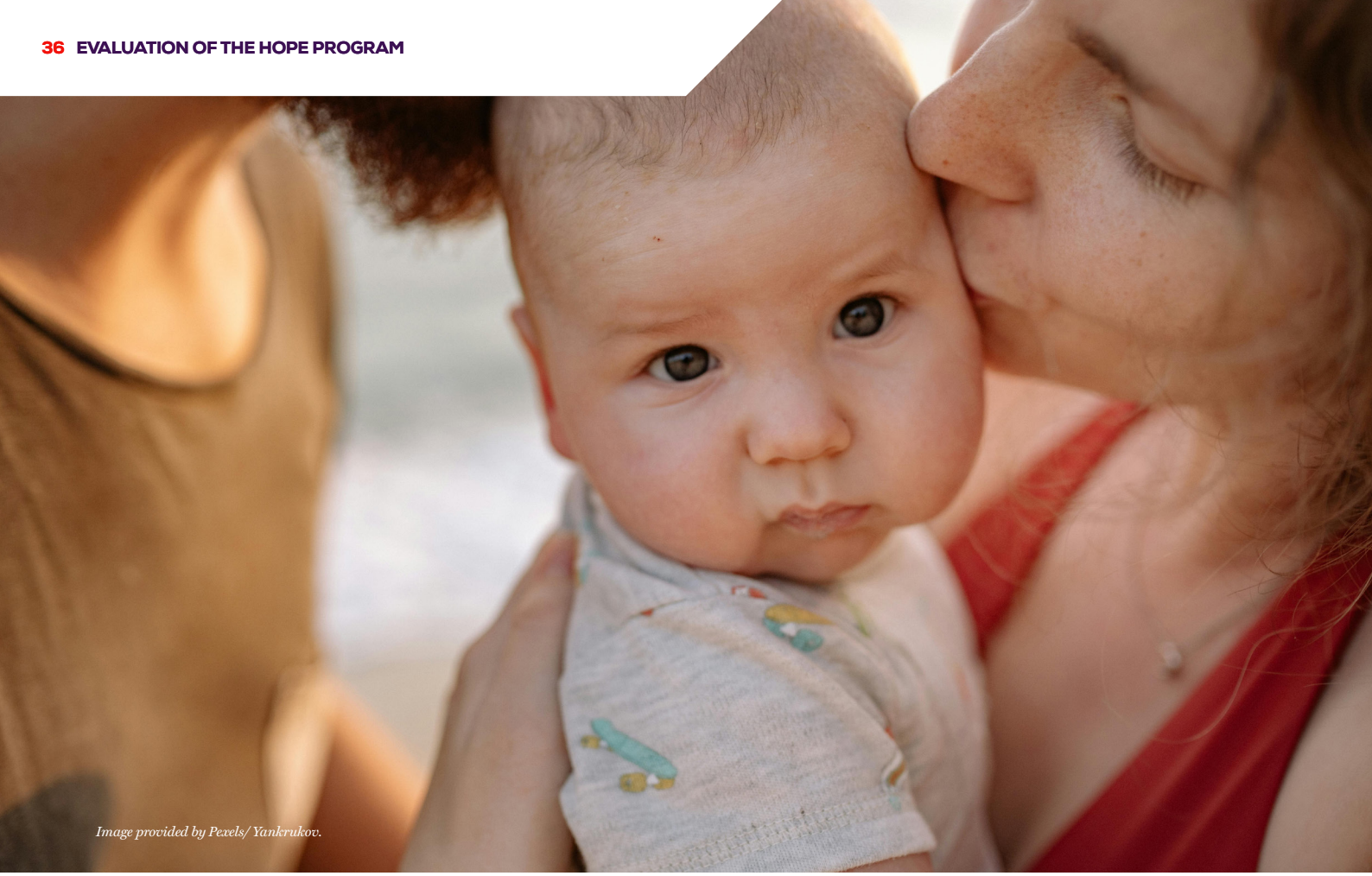

Image provided by Pexels/ Yankrukov.

We recommend more thought around the outcome domain of *increased self-determination and empowerment*. The program design points to self-determination and empowerment as a desired impact or effect of participation. The aim is to support participants to define success for themselves, set goals, understand their abilities, play to their strengths, develop strategies to meet their goals, persevere, and remain flexible. Therefore, it seems unsuitable to identify self-determination and empowerment as an outcome domain that may or may not prove relevant to a participant. Ideally all goals speak to a higher-order purpose of supporting self-determination and empowerment.

We understand that a participant's goals often relate to more than one domain. This poses a challenge when it comes to reporting goal attainment by outcome domain. Family Workers need to determine which domain the goal most directly relates to. There is a risk of inconsistent classification. For example, a goal like 'moving from the family home to my own house' could get classified as relating to improving safety, improving wellbeing, or increasing self-determination and empowerment. Family Workers need clear guidance on what criteria or characteristics (e.g., lived experience of family violence versus overcrowding versus desire for independence) determine what domain a goal like moving house gets assigned to.

Goal attainment can also get reported on according to the status. For instance, is the goal in-progress, achieved or no longer relevant? The last category – no longer relevant – needs further thought. Funders may well ask for explanations of how goals (like knowledge attainment) can become no longer relevant, as opposed to achieved.

PERSONAL WELLBEING

We recommend that the team continue to measure personal wellbeing, presuming participants' consent. Available evidence suggested that improvements in wellbeing are a reasonably consistent program experience for participants. Consequently, the revised program logic model (see the section in Table 4.2 on new ways of thinking about outcomes and impact (p. 39)) highlights improved wellbeing as a long-term goal.

Use of the PWI tool can also support good process. The team might use the tool in two ways. First, using the tool opens an opportunity to discuss wellbeing. Family Workers might introduce the tool as a way of helping participants understand their own wellbeing and identify ways to boost their wellbeing. For instance, shift thinking from 'but I just want a house' to a discussion about building resilience to face future life challenges (which may arise even when housed), thus improving wellbeing over the long term. Second, collaboratively reviewing results presents an opportunity to either celebrate achievements or explore reasons for declining wellbeing. (Potentially, the team is already using the PWI tool in this way.)

PARENT FUNCTIONING

The team assesses parent functioning using the PEEM. The findings presented here assume that administration of the PEEM is about measuring outcome realisation. We presumed that other tools, like the Parenting Sense of Competence Scale, are used for assessment purposes (as opposed to the PEEM).

Ongoing administration of the PEEM makes sense in the short- to medium-term. Collecting more data will enable the team to identify patterns and themes. Currently, there is not enough data to make sense of the extent to which program participation supports improvements in parent functioning.

In the longer-term, there is probably a role for ongoing monitoring of parent functioning using the PEEM. A lot depends on the issue or problem that the program aims to address. As noted, the program logic does not include an explicit problem statement (see Figure 4. (p. 50) and the suggestions made regarding this on pp. 31-32).. The current program logic seems to assume that all young parents need support to build parenting capabilities. The available evidence suggest that some young parents do, and some do not.

Based on the available evidence, we suggest it is only worth administering the PEEM when the young person and Family Worker jointly identify a goal related to parent functioning. Presumably, administration of the Parenting Sense of Competence Scale and the Family Assessment informs decision making. Selective administration of the PEEM is about ensuring the program captures relevant and meaningful data from parents who are actively working to improve their parent functioning.

LEVERAGING EXISTING TOOLS TO HELP MONITOR PROGRESS TOWARD DESIRED OUTCOMES

Family Workers administer the Living Skills Assessment at the first and final home visit. This tool captures information about many of the knowledge, skills, attitudes, behaviours, and circumstances that the program seeks to influence. We recommend the team consider using data from this tool to help demonstrate outcome realisation. As noted earlier, aligning data points in the various tools presents opportunities for data triangulation.

Presumably any young person working on parent knowledge and skills will consider whether to participate in attachment theory-based psychoeducation programs with their Family Worker. When young people do join, we suggest the application of surveys to assess knowledge pre- and post-program participation. For instance, the team could use the Circle of Security Parenting Participant Survey.

OTHER MEASUREMENT OPPORTUNITIES TO CONSIDER

We suggest the team revisit ROM tools following reflection on whether and, if so, how the team will seek to directly support young families (see section 4.4 Revising the HOPE Program logic and other program design/implementation resources, (p. 29) for more information). Understanding exactly how the team will engage with family members (other than young mothers) and to what effect, will shed light on suitable measures and indicators.

We recommend the program team reflect on the value of measuring self-determination for all participants and explore the tools available for measurement. No detailed findings are provided here about suitable measures because the evaluation scope excluded considerations of how to monitor long-term outcomes and impacts. A determination of whether to proceed depends a lot on the appetite to seek data on long-term outcomes and impacts.

We recommend the program team reflect on the need for new or different ways of measuring social connectedness. The available quantitative data showed a rise in the community connectedness domain in the PWI between the initial and interim assessments for 12 participants. Yet interview participants (n = 16) consistently talked about social isolation. Social isolation was an issue pre-, during, and post-program participation. While it is impossible to triangulate (or cross-check) the quantitative and qualitative data (because the data were collected from different people at different times for different purposes), the contrasting findings point to the need to know more about the extent to which the program contributes to community connectedness. No detailed findings on how else to measure social connectedness are provided here because the evaluation scope excludes considerations of how to monitor long-term outcomes and impacts.

Finally, we recommend the team consider measuring the relationship quality between the program participant and the practitioners supporting them. While the net promoter score provides some sense of participant satisfaction, it does not speak to the quality of the relationship from both the participants and practitioners' perspective. Given the participant-practitioner relationship represents a mechanism of change, information about the quality of the relationship could inform decision making on whether and, if so, how to strengthen the therapeutic alliance. No detailed findings are provided here because the evaluation scope excludes considerations of how to monitor process. We also recognise that the team may have existing tools that speak to relationship quality.

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TABLE 4.1.

A COUNT OF REVIEWED GOALS BY STATUS					
DOMAIN	REVIEWED	IN PROGRESS	ACHIEVED	NO LONGER RELEVANT	NOT ACHIEVED - CLOSED
INCREASED SELF-DETERMINATION AND EMPOWERMENT	5	0	1	2	2
INCREASED KNOWLEDGE AND SKILLS	45	12	22	10	1
IMPROVED MENTAL HEALTH, WELLBEING, AND RESILIENCE	8	2	5	0	1
INCREASED CONNECTION AND COMMUNITY PARTICIPATION	9	3	4	1	1
IMPROVED SAFETY	3	1	2	0	0
TOTAL	70	18	34	13	5

TABLE 4.2

PRESENTING HOPE PROGRAM OUTCOMES: COMPARING CURRENT APPROACH TO NEW WAY

CURRENT HOPE PROGRAM LOGIC (NOVEMBER 2022)

SHORT-TERM OUTCOME	MEDIUM-TERM OUTCOME	LONG-TERM OUTCOME
NOT SPECIFIED	*NOT SPECIFIED*	*NOT SPECIFIED*
Young families are supported to address their immediate basic needs Clients perceive the service to be accessible, inclusive, and culturally safe Families are satisfied with service Young families increase knowledge of positive parenting strategies and skills Young families increase knowledge of local and appropriate services and supports Young families increase understanding of child development and their children's needs and feel more confident in parenting Young families show improved living skills and financial management literacy Young families set goals to address education and employment needs where appropriate	Improved parent/child attachment Young families have improved capacity to protect children from risk and support their development Increased engagement with support networks and services when experiencing parenting/caring difficulties Meaningful connection with other families in the community (e.g., through playgroups) Family is housed in accommodation that is suitable and does not negatively impact them Young families report using positive parenting strategies to engage confidently with the challenges of parenting/caring Parents are engaged with education/ training/employment as appropriate	Keeping children safely with their families Children are safe, healthy and are supported to achieve appropriate milestones Sustained safe, stable housing Increased self-determination and empowerment

NEW WAY OF THINKING ABOUT OUTCOMES AND IMPACTS

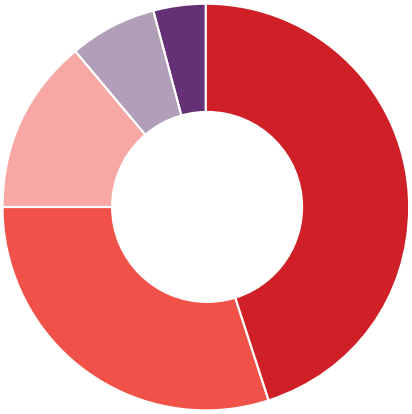
SHORT-TERM OUTCOME	MEDIUM-TERM OUTCOME	LONG-TERM OUTCOME	IMPACT (EFFECT OF CHANGE)
0 TO 12 WEEKS	*12 WEEKS TO 12 MONTHS*	*12 MONTHS TO 5 YEARS*	*5 YEARS PLUS*
Young families increase knowledge of local and appropriate services and supports Young families' immediate basic needs are addressed	Improved help seeking behaviours Increased parenting knowledge Increased confidence in role as parent/carer Increased community connectedness Improved wellbeing Improved ability to set and achieve life goals	Improved parenting capacity Improved individual and family wellbeing Parents are engaged with education/training/ employment Improved positive community connectedness	Child and family safety maintained or surpassed Children reach developmental milestones Sustained safe, stable housing Families have support systems Parents are resourced and empowered to help their children develop and learn

TABLE 4.3.

GETTING TO A MORE SOPHISTICATED PROGRAM LOGIC TO SUPPORT CONTINUOUS QUALITY IMPROVEMENT	
POSSIBLE ADDITION	**RATIONALE/BENEFIT**
OUTPUTS: PARTICIPATION	As noted, ensuring that the program supports young families involves careful thinking around who will be reached and affected by the program. Clearly defining targeted participants (e.g., primary carer, child, partner, and so on) within the logic or group of logic models can support this process. Including this section also means the team has a place to highlight service or process related outcomes, like 'families are satisfied with the service and clients perceive the service to be accessible, inclusive, and culturally safe'.
OUTPUTS: ACTIVITIES	Adding a separate section on the essential actions required to produce program outputs (e.g., Outputs: Activities), will help the team tease apart activities from target populations (in line with the suggested revision presented earlier).
ASSUMPTIONS	Interviews with staff revealed assumptions around participants engagement and activities. For example, program staff told us they do not have strong evidence that the program is reaching those with the highest need. Yet a key unspoken assumption in the program logic is that the program is reaching the desired target group. Another implicit assumption in the existing program logic is that all participants need support with parent functioning. While a small and incomplete sample, preliminary findings from administration of the PEEM indicate that some young people record Total Empowerment Scores above the population average. (See the Outcomes Captured by Program Staff section for more information.) Assumptions underline and influence program decisions (like allocated resources and staff). Unexamined assumptions present a risk to program success. Identifying and reflecting on assumptions can help the team to anticipate and mitigate unintended or unforeseen consequences.
EXTERNAL FACTORS	Interviews with practitioners and managers revealed many external factors interact with the program. These factors influence how the program is delivered and what outcomes the program can achieve. For instance, high demand for social housing and low rental vacancy rates influences the availability and length of tenancy in transitional housing dwellings managed by CCS. Assessing external factors can help the team answer questions like: What can we manipulate to positively influence program delivery and outcomes? What risk management strategies or contingency plans do we need to put in place?
CAUSAL LINKAGES	The team could consider more clearly articulating the path to expected change, that is, emphasising the causal linkages thought to exist among program components (see Figure 10 for an example of an outcome approach to a program logic model, that can help achieve this.) This level of detail can help the team explain, track, and monitor operations, processes, and functions. It can serve as both a management tool and a framework to monitor fidelity to the plan.

FIGURE 4.1.

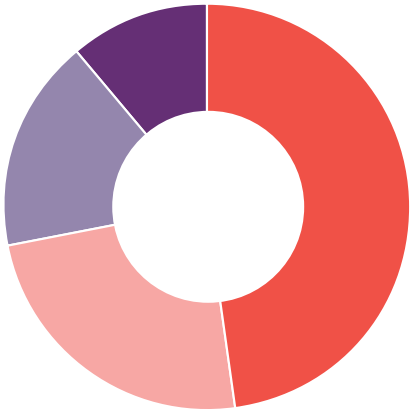
INTENT OF PARTICIPANT GOALS BY OUTCOME DOMAIN BETWEEN JULY 2023 AND MARCH 2024



- Increased self determination and empowerment 45%
- Increased knowledge and skills 30%
- Improved mental health, wellbeing and resilience 14%
- Increased connection and community participation 7%
- Improved safety 4%

FIGURE 4.2.

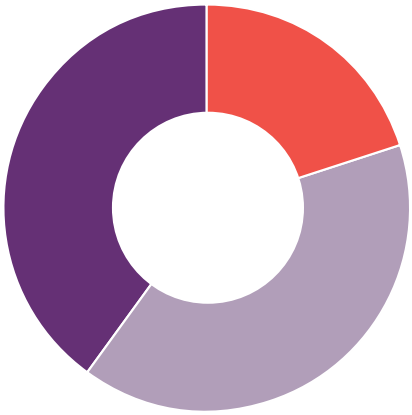
STATUS OF REVIEWED GOALS AT TIME OF REPORTING



- Achieved 48%
- In progress 24%
- No longer relevant 17%
- Not achieved - closed 11%

FIGURE 4.3.A..

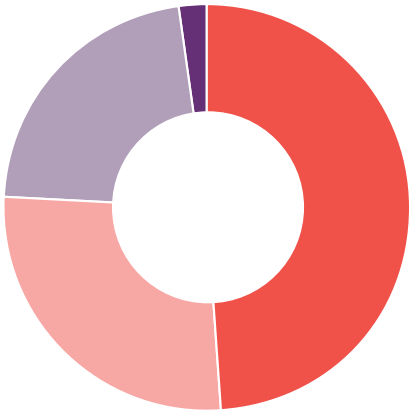
GOAL STATUS BREAKDOWN BY OUTCOME DOMAIN: INCREASED SELF-DETERMINATION AND EMPOWERMENT



- Achieved 20%
- In progress 0%
- No longer relevant 40%
- Not achieved - closed 40%

FIGURE 4.3.B.

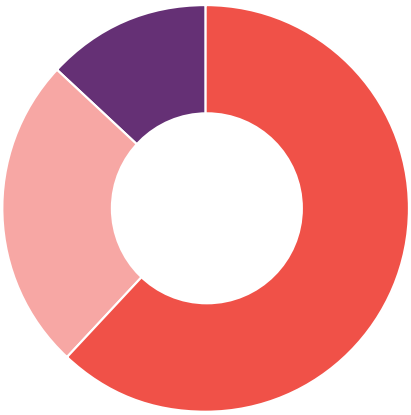
GOAL STATUS BREAKDOWN BY OUTCOME DOMAIN: INCREASED KNOWLEDGE AND SKILLS



- Achieved 49%
- In progress 27%
- No longer relevant 22%
- Not achieved - closed 2%

FIGURE 4.3.C.

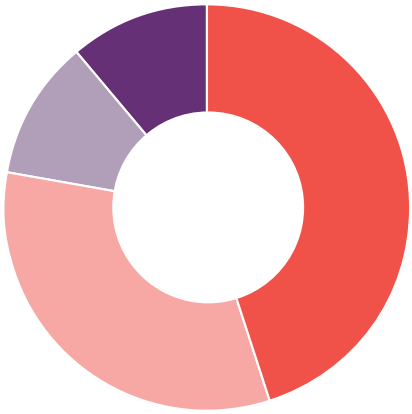
GOAL STATUS BREAKDOWN BY OUTCOME DOMAIN: IMPROVED MENTAL HEALTH, WELLBEING, AND RESILIENCE



- Achieved 62%
- In progress 25%
- No longer relevant 0%
- Not achieved - closed 13%

FIGURE 4.3.D.

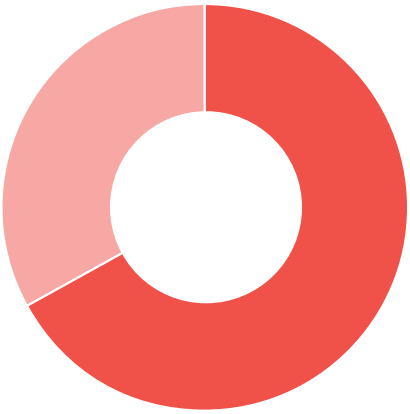
GOAL STATUS BREAKDOWN BY OUTCOME DOMAIN: INCREASED CONNECTION AND COMMUNITY PARTICIPATION



- Achieved 45%
- In progress 33%
- No longer relevant 11%
- Not achieved - closed 11%

FIGURE 4.3.E.

GOAL STATUS BREAKDOWN BY OUTCOME DOMAIN: IMPROVED SAFETY



- Achieved 67%
- In progress 33%
- No longer relevant 0%
- Not achieved - closed 0%

FIGURE 4.4.

VISUAL REPRESENTATION OF PWI SUBJECTIVE WELLBEING SCORES AT INITIAL AND INTERIM ASSESSMENT

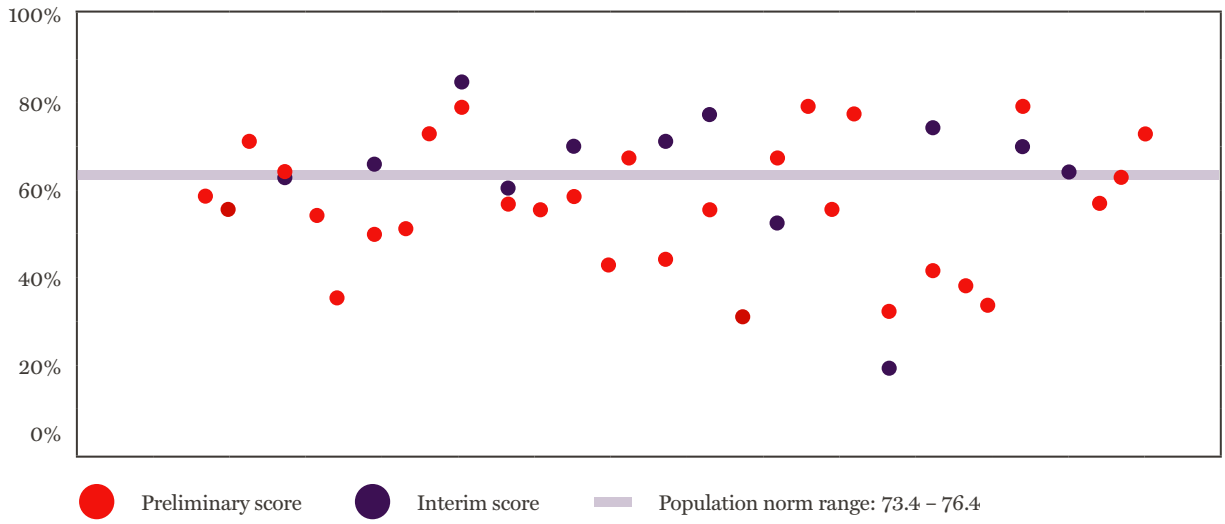


FIGURE 4.5.

AVERAGE PWI DOMAIN SCORES AT INITIAL AND INTERIM ASSESSMENT

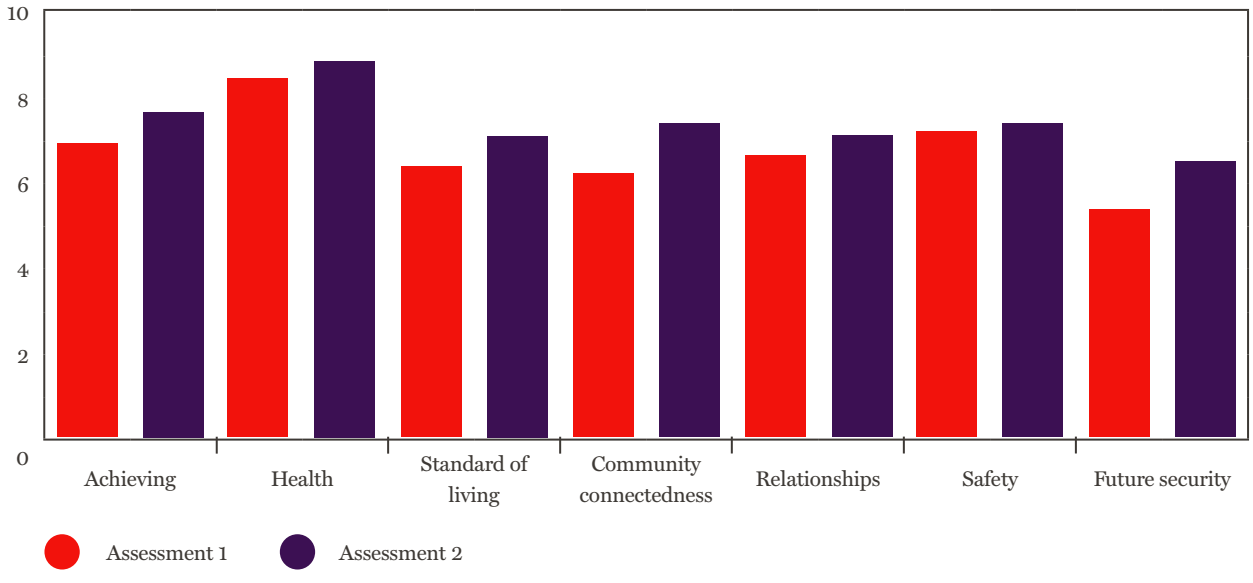


FIGURE 4.6.

PEEM TOTAL EMPOWERMENT SCORES AT THE INITIAL AND INTERIM ASSESSMENT, IF AVAILABLE

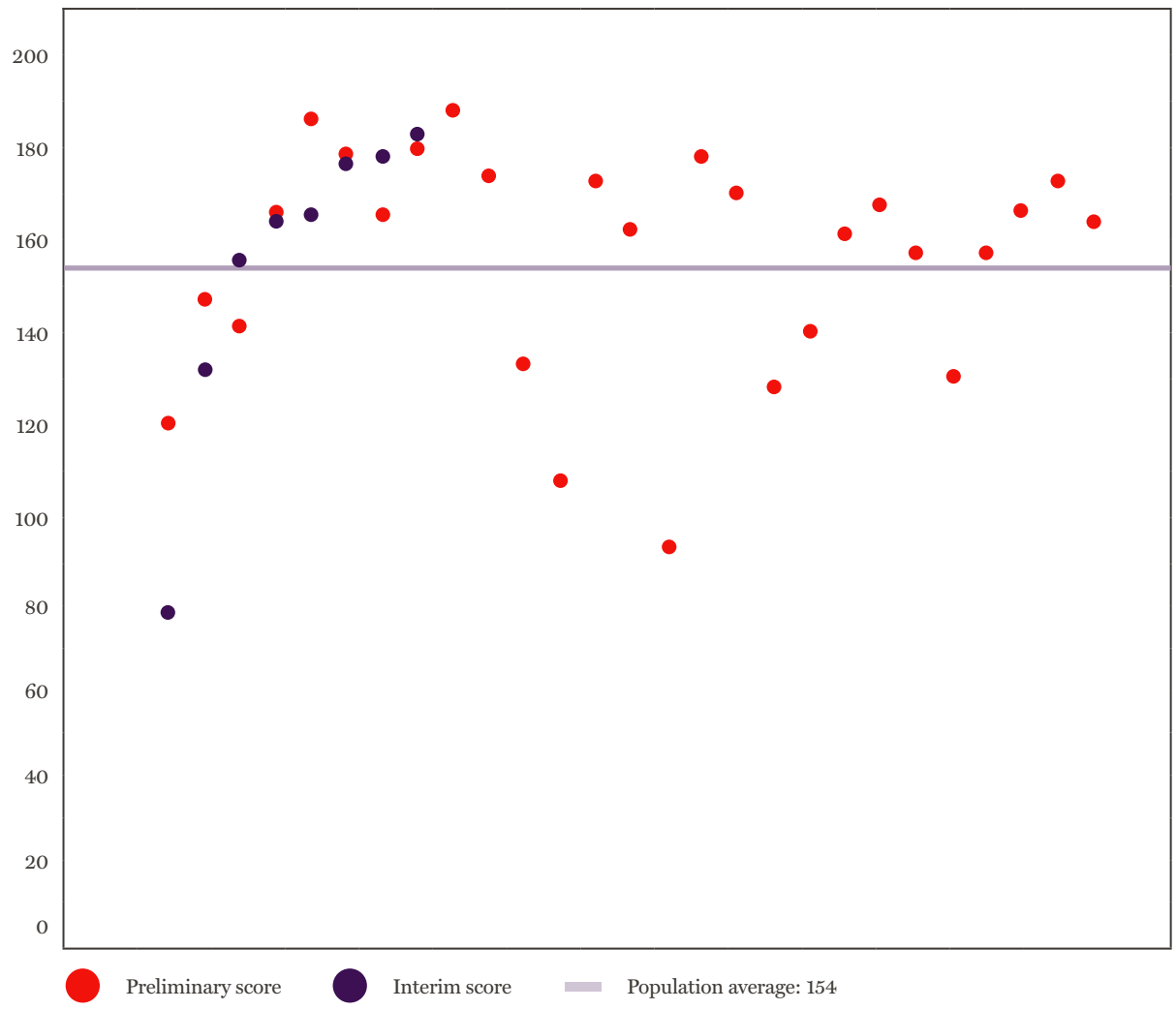


FIGURE 4.7.

EXAMPLE OF AN OUTCOME MAP

WHAT WE DO	WHO WITH	HOW THEY FEEL	WHAT THEY LEARN AND GAIN	WHAT THEY DO DIFFERENTLY	WHAT DIFFERENCE DOES IT MAKE
Have good conversations with families about factors impacting on their wellbeing and what they can do to change	Young father	Ready to make a change	Father knows what matters to them and their family	Father actively takes on tasks like night time feeds or house cleaning to help promote the wellbeing of their partner	Father gains confidence in care giving capabilities Mother has improved wellbeing

FIGURE 4.8.

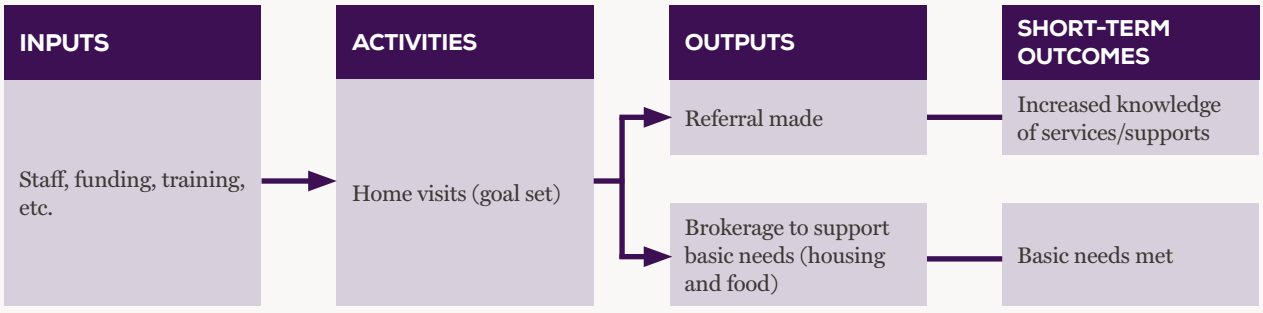
EXAMPLE PROBLEM STATEMENT

Young people aged 14-16 years in South Coast NSW are experiencing high rates of co-occurring mental health conditions and substance use which is impacting their cognitive and emotional development. Young people who do not have their mental health or substance use supported can be at risk of educational and employment challenges, risk early engagement with the justice system, and are at risk of experiencing acute mental illness.

Source: CMHDARN, 2022

FIGURE 4.9.

SIMPLE EXAMPLE OF AN OUTCOME APPROACH TO THE LOGIC MODEL



5. Conclusions and recommendations

CCS partnered with ACU in an evaluation of the HOPE Program with the overarching priority of testing the HOPE Program logic. The team wanted to understand the extent to which the program logic accurately described the HOPE Program activities and the changes expected to result from them. This section addresses key findings, summarising available evidence from program participants, program staff, analysis of program documentation and the available ROM data as relevant.

The available evidence supports parts of the HOPE Program logic. There was good alignment between the complex needs of expecting and parenting young people as described in the current program logic and those shared by participants and practitioners. The inputs identified in the logic model were mostly identified and program participants largely reported receiving the listed service activities.

Outcomes in the program logic (both what is achieved and by when) could get updated. Evidence from participants and practitioners suggested that significant time is needed for young mums to adopt the knowledge, skills, and attitudes highlighted in the current program logic. Updating the program logic to better reflect the program experience – around what happens and by when – presents an opportunity for strengthened monitoring. The team will gain a better sense of when to expect an observed change and can act more quickly if desired results are not observed.

Available evidence suggested that mostly young mothers benefited from program participation. The existing program logic indicates young families are the intended audience. The qualitative data revealed little meaningful engagement with anyone other than young mothers and their babies. The program logic implies that prioritising the needs of mothers and babies ultimately supports young families. Evaluation participants reported little to no 'flow-on effect' for other family members. Without changes to the program design and delivery, it is problematic to suggest the program supports young families.

Our recommended priority revisions to the HOPE Program logic are as follows:

- Revisit the outcomes, adjusting both what the team expects to change and by when
- Identify outcomes and the path to those outcomes for other family members (presuming the intent and resources to directly work with all family members), and
- Write a targeted, specific problem statement for the program.

If the team wants to use the program logic as a tool to guide reflective practice, then revisions that move toward a more sophisticated program logic are also recommended. These revisions are as follows:

- Split outputs between two categories – Outputs: Participation and Outputs: Activities – to provide a clear distinction between what the program does and who is involved
- Add assumptions about how or why the program will work to help anticipate and mitigate unintended consequences
- Add external factors that interact with the program to aid planning around how to influence these factors or appropriately respond to them
- Highlight causal linkages believed to exist among program components to inform ongoing monitoring, and
- Revisit outputs to ensure processes and relationships identified as most pertinent to realising program outcomes (e.g., intake, assessment, goal setting (including reviews), case planning and case management, along with the client-practitioner relationship quality) are adequately measured and tracked.

The evaluation team also considered the need for revisions to program design and implementation resources. The recommendations are as follows:

- Revisit the information provided to referral agencies and young people about the program, ensuring it allows each stakeholder to make informed decisions on its suitability
- Review the intake procedure to ensure Family Workers are fully informed about a young person's circumstances in advance of their first meeting with a young person
- Review whether existing systems enable Family Workers to easily share case plans and other relevant materials with young people to deepen their ownership of or buy-in to plans
- Consider the value of a bespoke Family Assessment tool for the HOPE Program
- Identify ways to prevent or minimise duplicated effort by Family Workers to find suitable referrals for young people across the geographic area that the team services (e.g., nominate subject matter experts for common referrals like housing or DFV support)
- Identify or review processes for transitioning young people from one Family Worker to another to ensure participants are fully informed about the change and confident it will not impact continuity of care
- Identify or review exit protocols for young people to minimise the potential for their experience of stress and/or distress from the change and program conclusion
- Reflect on whether the practice principles, theories, ethical guidelines, and so on are fully and appropriately documented to support evidence-informed practice, and
- Consider policies and procedures for how the team will meaningfully engage with young families (if that is a priority for the team).

The CCS team need to carefully consider our recommendations to determine their appropriateness. These recommendations come from the program documentation we received (detailed in Table 3.1, p. 14). Potentially, we have an incomplete knowledge of HOPE processes and systems.

The evaluation also considered what measures and indicators CCS can routinely seek data for to monitor progress toward key short-term outcomes. We found evidence of two short-term outcomes:

- Young families increase knowledge of local and appropriate services and supports, and
- Young families' immediate basic needs are addressed.

To track outcome realisation the team could collect data on indicators like referral uptake, appropriateness of referral, and brokerage uptake. Ideally, data collection is embedded into existing tools and processes.

The evaluation also considered ongoing measurement using the ROM tools. We recommend that the team:

- Continues to conduct PWI assessment (initial, interim, and exit)
- Continues to conduct the PEEM assessment (initial, interim, and exit) with young people who expressly identify goals related to parent functioning
- Revise how goal attainment data is captured and categorised, and
- Conduct pre- and post-assessments for participants involved in psychoeducation programs as a part of the HOPE Program.

While outside the evaluation scope and therefore not considered in detail, we identified potential for the HOPE team to measure:

- Family outcomes
- Participant self-determination and empowerment
- Participant social connectedness (in addition to existing measures like the PWI), and
- The relationship quality between the program participant and practitioner.

Image provided by Pexels/ Keira Burton.

References

Community Mental Health Drug and Alcohol Research Network (CMHDARN) 2022, *Using program logic in evaluation and translational research: A short guide*, Mental Health Coordinating Council, Sydney, NSW.

Freiberg, K., Homel, R., & Branch, S. (2014). The Parent Empowerment and Efficacy Measure (PEEM): A tool for strengthening the Accountability and Effectiveness of Family Support Services. Social Work, 67(3), 405418. http://dx.doi.org/10.1080/0312407X.2014.902980

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International Wellbeing Group. (2024). Personal wellbeing index manual: 6th edition, Version 1 (R. A. Cummins, Ed.; pp. 149). Australian Centre on Quality of Life, School of Psychology, Deakin University – Melbourne Campus. http://www.acqol.com.au/publications#Open-access

Appendix A.
HOPE Program Logic Model

HOPE PROGRAM LOGIC DIAGRAM TAKEN FROM CCS DRAFT PROGRAM LOGIC DOCUMENT (NOVEMBER 2022)

INPUTS	SERVICE ACTIVITIES	OUTPUTS
Funding provided by NSW Health and Access EAP, Private Donors Program management is based at Lewisham Office and caseworkers are based at Lewisham and South West Sydney Staff includes: Executive Manager Practice Manager Caseworkers Education specialist Administration support Additional support as required by - philanthropy, marketing, funding, etc. Telecare technology (telephone, video, online services) for video or phone services Staff training, clinical supervision, professional development Minimum of six transitional housing dwellings Governance documents and practice frameworks	Engagement with potential referrers to service Intake, V, and goal setting Case planning tailored to individual needs of mother and child, involving other important family members as appropriate Case management Routine utilisation of clinical assessment and ROM tools Home visits/telecare service Reviews of client goals and circumstances every three months Advocacy Brokerage to support immediate needs and tenancy Referral to appropriate community services and supports Facilitating supported playgroups Attachment-theory based psychoeducation programs, such as Circle of Security, and Emotion-coaching Education, training, and employment support offered to mothers after two months of initial service provision Case notes securely managed in CMIS Exit planning three months prior to end of service Clinical file audits to support compliance, quality of clinical work and continuous improvement	Reporting for funders on outputs and outcomes, including: # of referrals made # service types offered # of risk assessments/safety plans Collaborative goal measures (e.g., goals reached/achieved) Satisfaction feedback # of clients participating in the program who are experiencing such things as DFV, homelessness, addiction, mental health issues # of clients who identify as having a disability # of clients who identify as CALD # of clients who identify as ATSI # of occasions of service Total # of clients/families

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SHORT-TERM	MEDIUM-TERM	LONG-TERM/ IMPACT
Young families are supported to address their immediate basic needs	Improved parent/child attachment	Keeping children safely with their families
Clients perceive the service to be accessible, inclusive, and culturally safe	Young families have improved capacity to protect children from risk and support their development	Children are safe, healthy and are supported to achieve appropriate milestones
Families are satisfied with service	Increased engagement with support networks and services when experiencing parenting/caring difficulties	Sustained safe, stable housing
Young families increase knowledge of positive parenting strategies and skills	Meaningful connection with other families in the community (e.g., through playgroups)	Increased self-determination and empowerment
Young families increase knowledge of local and appropriate services and supports	Family is housed in accommodation that is suitable and does not negatively impact them	
Young families increase understanding of child development and their childrens' needs and feel more confident in parenting	Young families report using positive parenting strategies to engage confidently with the challenges of parenting/caring	
Young families show improved living skills and financial management literacy	Parents are engaged with education/ training/ employment as appropriate	
Young families set goals to address education and employment needs where appropriate		

Appendix B.
HOPE participant interview questions

Introduction

The main intent of the interviews was to uncover evidence of the extent to which program participants had achieved desired outcomes, and, if so, the factors that contribution to realisation (consistent with sub-evaluation question one). Therefore, the included questions and prompts were informed by the content of the HOPE Program logic model, particularly the short-term outcomes.

Questions

1. How did you find out about the HOPE Program?
2. What was happening for you at the time that made you think the HOPE Program was worth trying? Share whatever is comfortable for you.

   Aim: Enrich understandings about experiences of social exclusions (i.e., the combination of linked problems they faced such as unemployment, low incomes, poor housing, poor health, crime, low skills, and family breakdown).
3. Please tell me about your involvement with the HOPE Program:
   - What type of support and help have you received?
   - What activities have you joined?
   - Please share examples of how workers have helped you get involved with support.
   - How often have you been joining activities/seeing a worker?
   - Who else from your family has been involved in the program?
   - What other services were you linked in to while you were with the program?

Image provided by Pexels/ William Fortunato.

4. How happy or satisfied are you with the service you received?
   - What have you liked most about the service you received? Why?
   - What would you have liked more (or less) of?
   - How easy or hard has it been for you to connect with a worker or join activities?
   - We are interested in knowing how well the program supports people from different cultural backgrounds and with special needs related to a disability. Would you like to share any thoughts about how well the program responds to special needs?
5. What do you think CatholicCare could do to improve the program it provides?
6. What benefits (if any) do you see from getting involved in the HOPE Program?
   - Benefits for you?
   - Benefits for your child/ren?
   - Benefits for other family members?
   - Which parts of the program helped bring about these benefits?
7. What (if anything) has changed for you because of joining the HOPE Program?
   - What have you learned?
   - What new things are you doing?
   - What things are you doing differently?
   - Which parts of the program helped you bring about these changes?

   Examples / prompts for types of changes:
   - *Parenting knowledge or skills*
   - *Knowledge of child development*
   - *Confidence as a parent*
   - *Knowledge of/connection with local services/ supports*
   - *Living skills*
   - *Financial management/literacy*
   - *Education or employment opportunities*
8. What did you like the most about the HOPE Program?
9. Anything else you would like to share about your experience of the HOPE Program?

Appendix C.
HOPE participant online survey

Introduction

In October 2023, program participants were offered the opportunity to complete an online survey about their program experience. The survey was administered to boost participation rates. It mirrored key questions asked in interviews, mostly presenting the same question but giving participants a pre-defined list of possible answers. Consistent with sub-evaluation question one, a key objective was to uncover evidence of the realisation of desired outcomes, as presented in the HOPE Program logic model.

CONSENT

A Do you agree that you have read (or had it read to you), the Participation Information Letter and had any questions answered?

- ☐ Yes
- ☐ No

B Do you agree that the information you provide may be used in a report to CatholicCare, in public and academic documents (such as papers, presentations and media releases) and provided to other researchers in a form that does not identify you in any way?

- ☐ Yes
- ☐ No

Please answer the survey questions as far as you are comfortable. If you are not comfortable to answer a question, you can leave it unanswered.

Questions

ACCESSING THE PROGRAM

1 How did you come to join the HOPE Program?

- ☐ I contacted the program and asked to join
- ☐ A service provider put me in touch with the program
- ☐ Other. Please detail:

2 Please select the service provider that let you know about the HOPE Program:

- ☐ NSW Health
- ☐ NSW Department of Communities and Justice (DCJ)
- ☐ A non-government organisation / service provider. Please tell us which one:
- ☐ Other. Please tell us who referred you:

3 What was happening in your life that made you think the HOPE Program could help? Share whatever you are comfortable with.

4 Tell us why you decided to give the HOPE Program a go. What convinced you it was worth trying?

5 How long have you been in the HOPE Program?

- ☐ Less than 3 months
- ☐ 3 to 9 months
- ☐ 10 to 12 months
- ☐ More than 12 months
- ☐ I have exited the program. Please tell us how long you took part in the program:

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SERVICES RECEIVED

6 What type of support have you received through the HOPE Program? Please choose all that apply to you.

- ☐ Home visits/telecare service
- ☐ Help with goal setting
- ☐ Support with accommodation
- ☐ Help accessing Government benefits and payments
- ☐ Referrals to community services and supports
- ☐ Advocacy i.e., help promoting and defending my rights, needs and interests
- ☐ Information or advice about general life skills
- ☐ Information or advice about parenting
- ☐ Information or advice about managing money and budgeting
- ☐ Supported playgroups
- ☐ Education programs (e.g., Baby First Aid or Circle of Security)
- ☐ Support from an education, training, and employment specialist
- ☐ Vouchers (e.g., for groceries or other household items)
- ☐ Practical items (e.g., baby clothes or household items)
- ☐ Work Development Order sponsorship (engage with the HOPE Program to pay off or reduce a fine)
- ☐ Exit planning prior to end of service
- ☐ Other. Please detail:

SATISFACTION WITH THE HOPE PROGRAM

7 How happy or satisfied are you with the service you received?

- ☐ Satisfied
- ☐ Mostly satisfied
- ☐ Neutral
- ☐ Mostly unsatisfied
- ☐ Unsatisfied

8 What have you liked most about the HOPE Program, and why?

9 Any ideas on how to change or improve the HOPE Program?

PROGRAM IMPACT

10 What, if anything, did you learn from participating in the HOPE Program? Please choose all that apply to you.

- ☐ I've learnt new positive parenting strategies and skills
- ☐ I've learnt new things about child development
- ☐ I've learnt new things about managing money
- ☐ I've learnt about educational opportunities available to me
- ☐ I've learnt about employment opportunities
- ☐ I've learnt about local services and support agencies
- ☐ I've learnt about living skills and household management

- ☐ I've learnt how my past experiences have impacted myself and my child/children
- ☐ Other. Please detail:
- ☐ No new learnings from the program

11 How have your circumstances changed because of the HOPE Program? Please select all that apply.

- ☐ I feel more connected to other families in the community
- ☐ I am living in accommodation better suited to me and my family's needs
- ☐ I am more focussed on my health and general wellbeing
- ☐ I started or finished an education / training program to help me improve my employment options
- ☐ I found a job
- ☐ I am a more confident as a parent
- ☐ I am more positive about my future
- ☐ I have more confidence to handle life challenges
- ☐ My relationship with my partner has improved
- ☐ My relationship with my child/children has improved
- ☐ I have been able to access more support services

12 Is there anything else you would like to say about how the HOPE Program has changed things for you or your family?

ACCESSIBILITY

13 We are interested in how easy it was for you to use (or access) the service. Please indicate whether you agree or disagree with the following statements.

A I understood what the program was about, when first referred

- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Not applicable

B I found it easy to get to HOPE Program activities offered outside of my home

- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Not applicable

C I felt safe joining HOPE Program activities

- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Not applicable

D I got HOPE Program support at times that suited me

- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Not applicable

E HOPE Program staff respected my cultural beliefs and practices

- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Not applicable

F HOPE Program staff considered my needs as a person with a disability

- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Not applicable

G I received help and support with issues that were important to me

- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Not applicable

14 What made it easy for you to participate in the program?

15 What was the biggest obstacle you faced to participate in the program?

ADDITIONAL COMMENTS

16 Anything else you'd like to share about your experience of the HOPE Program? Add your comments below.

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Appendix D.
HOPE focus group discussion questions

Introduction

The focus groups discussion guide focused on the design, delivery, and outcomes of the HOPE Program. It was informed by the key evaluation questions and the content of the HOPE Program logic.

Questions

1. Let's start with each of us sharing something about our role and background:
   - Your role with the HOPE Program
   - How long you have been part of the program
   - Your professional background and qualifications
2. Tell me about the key characteristics of the young people/families you've seen participate in the program.

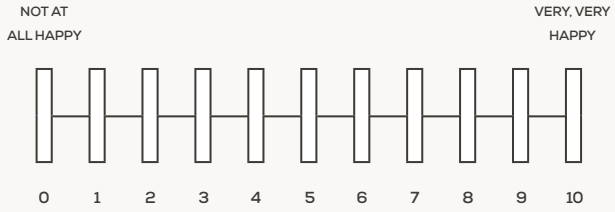
   Aim: Enrich understandings about young people's experiences of social exclusions (i.e., the combination of linked problems they faced such as unemployment, low incomes, poor housing, poor health, crime, low skills, and family breakdown).
3. How happy or satisfied are you with the service you received?
4. How satisfied are you the program is reaching the intended target audience?
5. How satisfied are you with that the activities and processes of the HOPE Program are 'right' (or fit-for-purpose for the young people/families in the program?
   - What is working well?
   - What key challenges or barriers do you or the team face in delivering the program to families?
   - What improvements or changes would you recommend?
6. What changes do you see happening in the lives of participants due to their involvement in the program?
7. How do you think the program helped bring about these changes? What parts of the program are making a difference for participants?
8. Any observed changes that surprised you? Anything unforeseen or unexpected?
9. What do you think is the most impactful aspect of the HOPE Program?
10. What do you enjoy the most about working in the HOPE Program?
11. Anything else anyone wanted to say about the HOPE Program?

Appendix E.
Personal Wellbeing Index-School Children (PWI-SC)

The PWI-SC is a measure of an individual's subjective wellbeing. The HOPE Program logic model includes short-term and medium outcomes related to domains in the PWI-SC, namely standard of living, achieving in life, relationships, and community-connectedness.

HAPPY WITH LIFE AS A WHOLE [OPTIONAL]

1. HOW HAPPY ARE YOU ... WITH YOUR LIFE AS A WHOLE?

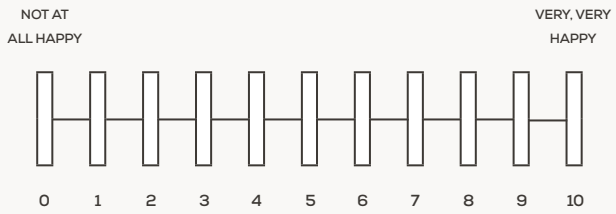


PERSONAL WELLBEING INDEX - SCHOOL CHILDREN/ ADOLESCENTS [LIFE DOMAINS]

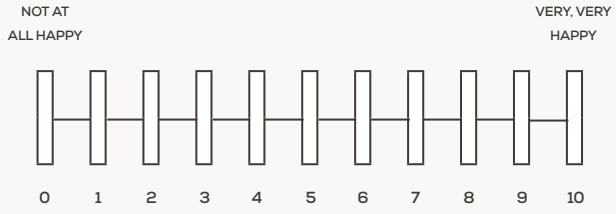
1. [DOMAIN: STANDARD OF LIVING] HOW HAPPY ARE YOU ... ABOUT THE THINGS YOU HAVE? LIKE THE MONEY YOU HAVE AND THE THINGS YOU OWN?

Image provided by Pexels/ Ann Tarazevich.

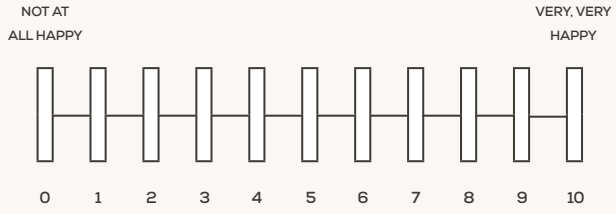
2. [DOMAIN: PERSONAL HEALTH] HOW HAPPY ARE YOU ... WITH YOUR HEALTH?



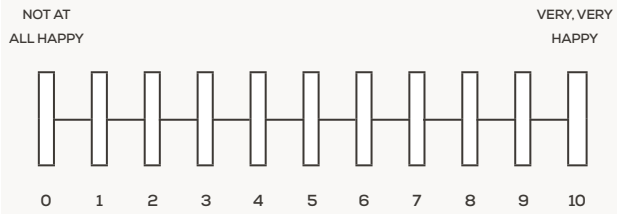
3. [DOMAIN: ACHIEVEMENT IN LIFE] HOW HAPPY ARE YOU ... WITH THE THINGS YOU WANT TO BE GOOD AT?



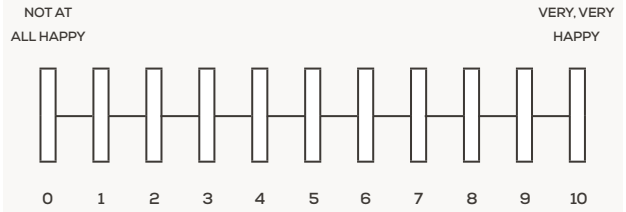
4. [DOMAIN: PERSONAL RELATIONSHIPS] HOW HAPPY ARE YOU ... ABOUT GETTING ON WITH THE PEOPLE YOU KNOW?



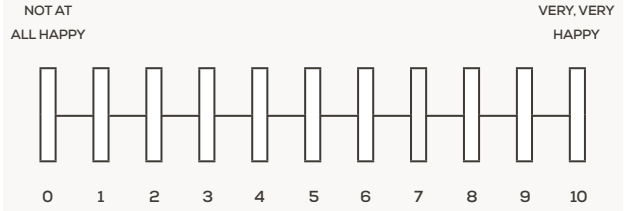
5. [DOMAIN: PERSONAL SAFETY] HOW HAPPY ARE YOU ... ABOUT HOW SAFE YOU FEEL?



6. [DOMAIN: FEELING PART OF THE COMMUNITY] HOW HAPPY ARE YOU ... ABOUT DOING THINGS AWAY FROM YOUR HOME?



7. [DOMAIN: FUTURE SECURITY] HOW HAPPY ARE YOU ... ABOUT WHAT MAY HAPPEN TO YOU LATER IN LIFE?



Appendix F.
Parent Empowerment and Efficacy Measure (PEEM)

The PEEM measures parent/carer functioning, focusing on confidence and capacity to manage the challenges of parenting and provide a safe supportive home for their children. The HOPE Program logic model includes several outcomes related to increasing parenting knowledge, skills, and confidence.

A PARENT'S VOICE

THINK ABOUT EACH OF THE FOLLOWING STATEMENTS: FOR EACH ONE, TICK THE BOX THAT SHOWS WHETHER THE STATEMENT DESCRIBES THE WAY YOU HAVE BEEN FEELING ABOUT THINGS LATELY.	DEFINITELY NOT		NOT REALLY		KIND OF		MOSTLY		DEFINITELY	
	1	2	3	4	5	6	7	8	9	10
1. I find it easy to talk to people like teachers, doctors and nurses about my children										
2. I know how to get useful information about how my children's needs change as they grow										
3. I feel good when I think about the future for my children										
4. I can work out what to do if any of my children have a problem										
5. We have clear rules and routines in my family										
6. I can find services for my children when I need to										
7. In my family there is more to enjoy than to worry about										
8. I stay calm and manage life even when it's stressful										
9. I believe my children will do well at school										
10. I can help make this community a better place for children										
11. I can help other families find help when they need it										
12. I have someone I can rely on to help with my children if I need it										
13. I know good parenting tips that I can share with others										
14. I feel that I'm doing a good job as a parent										
15. I feel good about myself										
16. I feel good about the way my children behave										
17. I feel part of a community										
18. I have good friends outside my family										
19. I can make time for my children when they need it										
20. I know my children feel safe and secure										

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