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A Program Evaluation of the Hope House

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by

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A Program Evaluation of the Hope House

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Abstract

Research increasingly shows the widespread problem of homelessness in the United States. The purpose of this research is to evaluate the effectiveness of the Hope House, a transitional housing program, in satisfying the needs of the homeless women residents they are serving and to identify areas that may need to be improved. Participants included 67 women the Hope House served and 6 staff who work at the Hope House. A mixed-methods design was employed to explore experiences and common themes related to how the Hope House women residents view the services the Hope House provides. Quantitatively, participants endorsed an overwhelmingly positive experience and perception of experience at the Hope House with needs for improvement in the areas of health related groups, the other supportive services, and the children's program. Furthermore, significant qualitative results were found with 6 significant qualitative themes for the Hope House residents and 4 significant qualitative themes for the Hope House staff. The women resident themes included (a) Suffering, (b) Supportive environment, (c) Goal-driven, (d) Positive self-change, (e) Faith, and (f) Areas of strength and areas for

improvement. The staff resident themes included (a) Client-centered treatment, (b) Skills building, (c) Systemic barriers, and (d) Areas of strength and areas for improvement. The implications of this study may be used to impact the Hope House program, the women the Hope House serves, the staff that provide treatment, and the greater homeless community.

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experiences of the women you serve. I am also grateful to have met and sat with the women who participated in this study. Your honesty, vulnerability, warmth, and resiliency are inspiring. I feel privileged and honored to have worked with you and to hear your journey.

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Chapter 1

Introduction

The Problem: Homelessness

Homelessness is a major problem in the United States. From October 2009 to September 2010 the U.S. Department of Housing and Urban Development (HUD) found that over 1.5 million individuals experienced homelessness (Substance Abuse and Mental Health Services Administration [Substance Abuse], 2011, as cited in U.S. Department of Housing and Urban Development [HUD], 2011). In addition, research indicates that homeless families represent a much larger portion of the total sheltered population than ever before (Pasi, 2011). The HUD report found that 567,334 persons in families were in homeless shelters or transitional housing programs, and of those families, women comprised 77.9% of adults (Paquette, 2010; Substance Abuse, 2011, as cited in HUD, 2011). A more recent record indicates that in January 2013, 610,042 people experienced homelessness in the United States (National Alliance to End Homelessness [National Alliance], 2014). This total population consisted of these categories: 394,698 were sheltered, 215,344 unsheltered, 387,845 individuals, 222,197 people in families, 70,960 family households, 92,593 chronic individuals, 16,539 chronic persons in families, 58,063 veterans, and 46,924 youth (National Alliance to End Homelessness, 2014). While the national homeless assistance system has shown an increase in the number of permanent supportive housing beds and emergency shelter beds, records indicate that in 2013 there were 184,000 more homeless people than available beds.

The Definition of Homelessness

Multiple definitions of homelessness exist. Because there is no one definition of homelessness, agencies have different eligibility requirements (What is the official definition of homelessness? [What is the official definition], n.d.). As a result, each homeless program determines eligibility for individuals and families, which can cause homeless persons or families to be rejected from programs based on their program's definition alone. The current study is based on HUD's definition of homelessness. Programs funded by HUD (What is the official definition, n.d., as cited in the Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009, P.L. 111-22, Section 1003) define homelessness as:

- An individual who lacks a fixed, regular, and adequate nighttime residence;
- An individual who has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;
- An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements;
- An individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided;
- An individual or family who will imminently lose their housing, has no subsequent residence identified, and lacks the resources or support networks needed to obtain other permanent housing;
- And unaccompanied youth and homeless families with children and youth. (What is the official definition, n.d., p. 1)

Homelessness Risk Factors

Individual and structural influences. Homelessness can be conceptualized from two different perspectives: individual influences and structural influences (Wilson, 2005). Individual influences involve personal characteristics contributing to the vulnerability of homelessness, such as gender, educational level, ethnicity, physical and mental health, abuse, and early childhood experiences (Wilson, 2005). A meta-synthesis by Finfgeld-Connett (2010) also found other individual influences of neglect, abandonment, transience, poverty, and parental mental health issues. Structural influences include problems at a societal level that contribute to the risk of homelessness. Some of these structural influences involve unemployment, lack of affordable housing, poverty, and inadequate social services (Wilson, 2005). Ji (2006) also found four major structural risk factors: severe poverty, lack of affordable housing, economic conditions, and the low level or reduction of entitlement benefits.

Populations at risk. The National Alliance to End Homelessness (2014) identified four specific populations that appear to be at risk of homelessness: those in poverty, poor renter households experiencing severe housing cost burden, those unemployed, and poor households living doubled up with friends or family members. Research highlights the interconnectedness of poverty and homelessness (National Alliance, 2014). Additionally, the severe housing cost burden shows the connection between housing affordability and income, and the overall burden increased by 0.7% (National Alliance, 2014). However, the loss of employment rate and the number of people in poor households living doubled up has decreased (National Alliance, 2014). The loss of employment national rate is 8.1%, and the people in poor households living doubled up has changed by -0.3% (National Alliance, 2014).

Homeless Women and Mothers

Factors contributing to homelessness. Many young girls experience homelessness risk factors causing them to develop inadequate problem solving and decision-making skills that transpire into adulthood (Finfgeld-Connett, 2010). These women usually end up living with family or friends but are forced to leave their situations, resulting in abrupt homelessness (Finfgeld-Connett, 2010). Wilson (2005) also found that homeless women report relationship problems and conflict as the primary factor contributing to their homeless state, as well as eviction, insufficient income to pay rent, job loss, violence, drugs, alcohol, and mental illness.

Physical health issues. Homeless women must cope with physical health problems of unmonitored pregnancies, sexually transmitted diseases, malnutrition, diabetes, hypertension, and HIV (Finfgeld-Connett, 2010). When compared to homeless men and the general female population, the risk of being admitted to hospital care for physical diseases was slightly higher for homeless women than men and double the risk of women in the general population (Beijer & Andreasson, 2009). Beijer and Andreasson (2009) also found that homeless women had higher prevalence in infections, diseases of the genitourinary system, skin diseases, diseases of blood, and neoplasm than homeless men. In addition, homeless mothers must also manage their children's illnesses (Finfgeld-Connett, 2010).

Mental health issues. Homeless women wrestle with a multitude of mental health problems such as anxiety, low self-esteem, substance abuse, mood disorders, and psychosis (Finfgeld-Connett, 2010). In addition, research found that homeless women are apt to develop feelings of abandonment, betrayal and rejection, which often result in perceptions of powerlessness, helplessness, shame, and feelings of resentment, fear, and anger (Finfgeld-

Connett, 2010). These thoughts and feelings can increase self-destructive impulses, and these self-destructive impulses can cause homeless women to have difficulty warding off undesirable individuals or situations and react to problems in inefficient ways (Finfgeld-Connett, 2010). On the other hand, homeless women may display independence or defensiveness leading them to deny their homelessness, reject assistance, and be highly vigilant and self-reliant (Finfgeld-Connett, 2010). When looking at the difference between homeless women with dependent children and without dependent children, Chambers et al. (2014) found that both have poor mental health status. In addition, these researchers found that the consistent factors associated with mental health problems for the homeless were perceived access to social support, presence of a chronic health condition, physical or sexual assault in the past 12 months, and presence of a drug use problem in the past month (Chambers et al., 2014).

Stereotypes and stigmatization. Homeless women reported feeling stigmatized by multiple incidents of dehumanizing stereotypes and interpersonal discrimination of service providers (Cosgrove & Flynn, 2005). These mothers also reported feeling highly judged by shelter staff for their parenting behaviors (especially with most shelters requiring attendance at a parenting skills class if they have a child, implying that a mother does not know how to parent because she is homeless) and experiencing conflict between one's previous parenting rules and the shelter's rules (Cosgrove & Flynn, 2005). Homeless women were vigorous in their desire for it to be known that negative stereotypes of homeless mothers are untrue, and the real cause of homelessness is the lack of affordable housing (Cosgrove & Flynn, 2005).

Solutions to Homelessness

Programs and policies. With the growing concern of homelessness, policies and programs aimed at preventing homelessness need to be creative, flexible, and have an understanding of the structural and individual issues that may trigger homelessness (Minnery & Greenhalgh, 2007). Programs and policies must provide prevention, early intervention, crisis intervention, and long-term support strategies that facilitate independence, as well as services that enable homeless clients to gain a skillset that can lead to social competence, maintaining financial stability, securing a "home," and exiting social exclusion (Minnery & Greenhalgh, 2007). Hartnett and Postmus (2010) looked at 97 shelter agencies and found that the primary areas of attention for many sheltering programs are the policies on admissions and length of stay, and activities of daily living. These consist of policies on screening processes, banning or barring from shelters, length of stay in shelters, processes to extend length of stay, designated smoking areas, required participation in chores, regulated telephone access, specified wake up times, lights out times, and restricted access to television and recreational activities (Hartnett & Postmus, 2010). Green (2005) identified a best practices model that had components of a "creation of a local interagency coordinating body with formal decision making authority to ensure the development and implementation of a common mission," an "assigned centralized authority that has decision making capacities for the homeless assistance system," and a "maintained and trained staff with the responsibility to promote systems and service information sharing and integration" (p.10-11). In addition, the National Alliance to End Homelessness has suggested four steps that when taken concurrently, can end homelessness (Minnery & Greenhalgh, 2007). These steps include: planning for outcomes by identifying real needs,

shifting to prevention, helping people exit homelessness quickly, and improving the supply of affordable housing along with providing adequate income and services for the disadvantaged (Minnery & Greenhalgh, 2007). Overall, research showed that when homeless individuals were placed in a housing and supportive services environment, noticeable reductions occurred in shelter use, hospitalization, hospitalization length of stay and time incarcerated (Green, 2005).

Services. Hartnett and Postmus (2010) found that the most on-site services offered by shelters included individual counseling, support groups, case management, parenting classes, drug or alcohol counseling, housing assistance, health care services, employment programs and educational or training services. Green (2005) also found that in addition to substance abuse programs and job readiness programs, the most successful homeless programs also offered prevention, outreach and assessment, transitional housing, emergency shelter, mental health programs, domestic violence programs, permanent supportive housing, and permanent housing. When asking homeless women their suggestions for homeless shelters, they identified a need for access to day care and more space for families (especially in regards to their children's developmental needs, such as enough space to play) as being most critical (Cosgrove & Flynn, 2005; Walsh, Graham & Shier, 2009).

Interpersonal relationships. When looking at the interactions and relationships homeless women have, Finfgeld-Connett (2010) found that service providers can offer support through empowered alliances with homeless women. Enhancing self-sufficiency, displaying respect, considering holistic perspectives and emphasizing strengths can enhance rather than displace power and control (Finfgeld-Connett, 2010). Promoting peer-to-peer bonding and support groups have shown to help homeless women retain perceptions of personal power, and thoughtful

application of rules promotes the understanding of a mutual relationship between the provider and client (Finfgeld-Connett, 2010, Walsh et al., 2010). Research also shows that child-care assistance and access to high-quality physical and mental health care services provide support to homeless women (Finfgeld-Connett, 2010, Walsh et al., 2010). Walsh et al. (2009) found that homeless women stressed the importance of relationship between the community and shelters. These women believed that addressing concerns of community members, developing good neighbor policies in programs, involving the community in shelter planning and development, and respecting the historical context of the community proved very important to the success of a shelter (Walsh et al., 2009).

Shelter site. Another significant factor in the successes and experiences of homeless women was the housing site itself (Walsh et al., 2009; Walsh et al., 2010). Homeless women identified the need for private rooms or apartment style housing in order to accommodate women with children (Walsh et al., 2010). Many homeless women also emphasized strong safety features, "homier" features (e.g., common gathering areas, access to the kitchen and cooking facilities, and aesthetically pleasing design aspects of furniture, painted walls, lighting, plants, wall pictures, etc.), and an enclosed outdoor area like a courtyard or private grass space (Walsh et al., 2009; Walsh et al., 2010). Much importance was also placed on the location of the shelter, as homeless women expressed a huge concern when shelters are located in dangerous areas (Walsh et al., 2010).

Program Evaluation

Given the feedback provided by homeless women in homeless housing, a program evaluation can assess how a program is functioning and collect in depth data from its program's

clients and staff in order to find out what is satisfactory, adequate, and inadequate about the current state of its housing. Evaluation is seen as an essential tool for constant program development and improvement (Lobo, Petrich & Burns, 2014), and it allows for better understanding and improvement of community health and development practice (Section 1. A Framework for Program Evaluation: A Gateway to Tools [Section 1. A Framework], n.d.). The American Psychological Association (APA; 2011) also considers evaluation an important tool in aiding programs with their needs and goals, as evidenced by the APA listing consultation (defined as "the ability to provide expert guidance or professional assistance in response to a client's needs or goals," p.12) as a core competency for professional psychology students to develop during their training.

Lobo et al. (2014) found that evaluations are most valuable and beneficial when they identify what works well and why, where improvements are needed, and if the program is making a difference. Another program evaluation framework identifies six connected steps in evaluation practice: engaging stakeholders, describing the program, focusing on the evaluation design, gathering of credible evidence, justifying conclusions, and ensuring use and sharing of lessons learned (Section 1. A Framework, n.d.). This framework also describes utility, feasibility, accuracy, and propriety as the standards of a *good* evaluation (Section 1. A Framework, n.d.). Evaluations can help organizations learn which programs are effective for certain clients, in addition to strengthening the program's broader community (Winship, 2001). Program evaluations demonstrate the impact that an organization is making in the lives of the people it serves, as well as making an organization more credible and attractive (Winship, 2001). In addition, program evaluation investigates the worth and importance of activities of community

groups, assists in clarifying program plans, improves communication among partners, and gathers feedback needed for program success (Section 1. A Framework, n.d.). The amount of research done on evaluating programs aimed at preventing or alleviating homelessness is limited (Glisson, Thyer & Fischer, 2001; Winship 2001), and as a result, more homeless program evaluations need to be done in order to understand how to better help homeless individuals and provide assistance with their circumstances.

The Hope House

The idea for the Hope House emerged in 1987 when the Shepherd Center of Alexandria, Louisiana noticed a large increase in single-parent women who became so far behind in bills that they were eventually evicted and rendered homeless (Hope House of Central Louisiana [Hope House], n.d.). The Board of Directors began discussing ways to assist these women and their families. The Hope House was then created when Joanne White donated an old home for these women and their families. The Hope House accepted its first residents in 1989, and the shelter turned into a home for 35 women and children to stay for 45 days while they made plans for a more permanent solution. In 1992 the Hope House was nominated as one of President Bush's Thousand Points of Light, and it has since grown with funding from HUD, United Way of Central Louisiana, and public and private foundations (Hope House, n.d.).

The Hope House is a transitional housing program for homeless women, mothers, and their children (Hope House, n.d.). Clients must be single women or single women with children who can verify their homelessness. All women, including those with children, must be 18 or older. Children must be accompanied by their mother or female legal guardian and be zero to 18 year-old male or female. The Hope House clients cannot be homicidal or suicidal and must be

ambulatory and capable of self-care. If clients present with apparent drug or alcohol use within 24 hours prior to entering the program, they are referred for treatment assessment and placed at the top of the waiting list following treatment, if applicable. Additionally, the Hope House has four emergency beds (Hope House, n.d.). As of this writing, the Hope House is comprised of a total of 18 women and 16 children (S. Ray, personal communication, February 10, 2015). The Hope House has 15 staff members (6 full-time staff and 9 part-time staff), as well as a board comprised of 14 members and 5 officers. Additionally, 75 community member volunteers give over 4,000 hours of time per year (S. Ray, personal communication, February 10, 2015).

The goals for the Hope House align with the expected HUD goals for transitional housing and include: (a) assist clients in obtaining and remaining in permanent housing; (b) help clients increase skills and/or income through client directed education and advocacy, and (c) assist clients in achieving greater self-determination in preparation for transitioning into permanent housing and independence (S. Ray, personal communication, February 10, 2015). The Hope House allows women and their children to remain for up to two years. Furthermore, it offers Common Sense Parenting Classes, Life Skills Training, computer classes, literacy assistance, case management, child care, pre-k readiness program, after school academic tutoring, child financial education, and life skill education (Hope House, n.d.; S. Ray, personal communication, February 10, 2015).

Purpose of Research

The purpose of this research is to evaluate the Hope House in order to understand if the program is effective in satisfying the women residents' needs and any areas that are lacking. By identifying areas of satisfaction, the program can learn which aspects of the program are helpful

to the women and where to implement new approaches to the areas that are found insufficient. The Hope House will also be able to use the findings of this research to gain future grants and fundraising. Lastly, this research will provide information on how to better meet the needs of the underserved individuals in the community so they can receive enhanced care.

Chapter 2

Methods

Participants

The first sample of participants consisted of archival data collected by the Hope House dating back to 2013. This data consisted of 67 women who previously received services from the Hope House within the past 3 years. Information regarding age, ethnicity, highest level of education, religion, previous length of homelessness, and number of children were unable to be obtained, as they were not part of the original data collected.

A second sample of participants included nine women who are currently receiving services from the Hope House. The average age of the women in the study was 35.33 years (*SD* = 9.042), with ages ranging from 23 to 51 years old. All nine of the women were in the transitional housing shelter. Race of the women included White/Caucasian (5), African American/Black (3), and Other (1). For highest degree obtained or highest level of schooling completed, 11.1% completed anywhere between nursery school to 8th grade, 11.1% completed some high school with no diploma, 44.4% graduated high school or obtained their GED, 11.1% of women attended some college but obtained no degree, and 22.2% of women completed trade/technical/vocational training. The percentage of women who identified as Christian was 88.9%, and 11.1% identified as Other. Five of the women had never been in homelessness and four of the women indicated previously experiencing homelessness. The average range of previous length of homelessness was 15.38 months (*SD* = 34.222), with two women experiencing homelessness for 12 months, one woman experiencing homelessness for 99

months, and one woman being unable to report how long she was previously in homelessness. The current average length of time spent in homelessness was 23.56 months (*SD* = 31.009), with a range of 3 months to 99 months. The average number of children is 2.22 (*SD* = 1.093). Of the women 22.2% had one child, 55.6% had two children, and 22.2% had four children. The ages of the children ranged from 2 months old to 29 years. All of these women are comparable to the past residents of the Hope House based on age, gender, ethnicity, education, religion, and previous homelessness.

A third sample of participants consisted of the six full-time staff members. The average age of the staff in this study was 44.17 (*SD* = 17.314), with ages ranging from 26 to 69 years. The staff roles represented are Business Manager (1), Children Services Coordinator (2), Program Manager (1), Resident Assistant (2), and Chief Executive Officer (1). All the staff identified as White, Christian females. One staff member had a Master's degree, two staff had a Bachelor's degree, two staff completed some college with no degree, and one staff graduated high school or received their GED. The average length of time having worked at the Hope House was 68.17 months (*SD* = 66.829) with a minimum of 5 months and a maximum of 137 months.

Materials

Demographics form. A demographics form was designed by the researcher for all current women and staff to complete (see Appendices A and B). The demographic form for women was comprised of seven questions and included age, ethnicity, education, religion, previous homelessness, current length of time spent in homelessness, and their children's demographics. The demographic form for staff contained seven questions, including age, gender, ethnicity,

education, religion, length of employment, and current job title. Both forms took approximately two minutes to complete.

Evaluation/Survey. The Hope House created the Evaluation/Survey in 2005 as a means to gain self-report feedback from their residents. It is comprised of 45 questions and takes approximately 10 to 15 minutes to complete. The survey includes questions regarding general information, facility, food, guidelines, supplies, programs offered, staff, volunteers, and the children's program. The Hope House requires all their clients to complete the Evaluation/Survey (see Appendix C), and at any point during a clients' stays, they may be randomly asked to complete the Evaluation/Survey by a staff member.

Hope House Survey for Staff. The Hope House Survey for Staff was designed by the researcher for all current staff members to complete (see Appendix D). This survey was created to mirror the Evaluation/Survey (2005) and provided comparable data based on the staff's perspective. It is comprised of 28 questions and takes approximately 10 to 15 minutes to complete. The survey focuses on questions regarding general information, facility, food, guidelines, programs offered, staff, volunteers, and the children's program.

Semi-structured interviews. Two semi-structured interviews were written and used with nine homeless women and six staff who were available to participate when this researcher was at the Hope Center (see Appendix E). The women's interviews focused on the benefits the women have gained throughout their stay at the Hope House, how the Hope House has provided care and services to them, specific program benefits and drawbacks, and the hopes they have for their future after leaving the Hope House. Staff interviews focused on the benefits the women are gaining throughout their stay at the Hope House, their role in the Hope House, how the Hope

House provides care and services to the homeless women, and specific program benefits and drawbacks.

Procedures

This study was approved by the George Fox University Human Subjects Review Committee and the Chief Executive Officer of the Hope House. The staff and homeless women were recruited with the help of the Hope House Chief Executive Officer. A group of nine women and six staff participants were randomly selected based on their availability at the Hope House. The researcher met with each participant at the Hope House and obtained informed consent (see Appendix F). Upon completion of informed consent, all the homeless resident participants completed a demographic form and the Evaluation/Survey, and all the Hope House staff participants completed a demographic form and the Hope House Survey for Staff. All measures were provided in English and administered by a researcher, who assisted participants who were unable or having difficulty reading. After participants completed their demographic form and evaluation/survey, they participated in a 20-30 minute semi-structured interview. The women residents were asked 13 interview questions and the staff participants were asked 8 interview questions. All interviews were audio recorded with no identifying information, by this researcher, in a private room at the Hope House. After each homeless woman completed her interview, she received a $10 gift card as an expression of gratitude for participating in the study. After each staff member completed her interview, the staff member was informed that they would be invited to a presentation, upon completion of the study, explaining the results. In addition, part of this study was based on archival data from the Hope House Evaluation/Survey that was collected throughout the past four years. This data was previously gathered by the Hope

House and contains information on past residents. This archival data was added to the data collected from current residents. Upon completion of this study, a formal report will be given to the Hope House Chief Executive Officer, and a presentation will be held for interested staff or board member to share the program evaluation results and ask follow-up questions.

Data Analysis

This research used a mixed method design, with both quantitative and qualitative analyses, in order to better understand how the women residents experience their stay at the Hope House and how the staff perceived the women's stay at the Hope House.

Quantitative data was collected through the administration of three measures (Demographics Form, Evaluation/Survey, and Hope House Survey for Staff). Missing data was encountered and excluded from the data analysis. Descriptive frequencies (means, standard deviations, and percentages) will be reported in order to better understand the women and staff's views.

The qualitative portion of the data was analyzed using grounded theory and collected through semi-structured interviews. All interviews were recorded, transcribed, analyzed, and coded into themes. There was no identifying information in any of the recorded interviews. An outside transcriber was hired to transcribe the data and the researcher read each interview in order to become further acquainted with the qualitative data. With the assistance of two other doctoral level psychology students, the interviews were coded in order to identify various qualitative themes, allow for consistency and inter-rater reliability, and create a preliminary coding system. Themes were continuously discussed and refined by all three parties. Once the initial coding process was completed, the researcher and two students underwent a continuous

progression of comparative analyses by categorizing the codes into larger categories based on similarities. Similarities were analyzed to form more specific categories and themes, for both the women residents and staff separately. Significant themes found for the women residents included: (a) suffering, (b) supportive environment, (c) goal-driven, (d) positive self-change, (e) faith, and (f) areas of strength and areas for improvement. Significant themes for the staff included: (a) client-centered treatment, (b) skills building, (c) systemic barriers, and (d) areas of strength and areas for improvement.

Chapter 3

Results

There were several goals of this study. The first goal was to increase awareness and insight into the lives of homeless women and their children and understand how satisfied the women residents were with the services offered by the Hope House. The second goal was to learn more about how the Hope house staff perceived their own program, and if these perceptions match up to the women resident's perceptions. Further, by understanding both views of the Hope House, the Hope House will be able to identify areas of satisfaction and areas that are lacking in order to better meet the needs of the women they serve. The mixed method design provided opportunities to understand the women's and staff's experiences. Results offer valuable information on the experiences of this population, providing important implications for advocacy, support, and rehabilitation.

Quantitative Results

Women Resident Evaluation/Survey

General information. Twenty-four residents filled out the survey in 2013, 26 residents filled out the survey in 2014, 22 residents filled out the survey in 2015, and 3 residents filled out the survey in 2016; 1 resident did not report the year she completed the survey. The average length of time the women spent residing at the Hope House is 3.25 months (*SD* = 4.58), with a range of .03 months to 24.33 months; two women did not report their length of stay. When asked if their children resided at the Hope House, 51.3% reported *no*, 47.4% reported *yes*, and 1.3% did

not respond. Of those women who reported *yes*, they stated the mean number of children residing there was .97 (*SD* = 1.22), with 52.6% having no children residing there, 14.5% having one child residing there, 19.7% having two children residing there, 10.5% having three children residing there, 1.3% having four children residing there, and 1.3% having five children residing there. Sixty and a half percent reported they did not stay long enough to graduate the program, 15.8% reported they did stay long enough to graduate the program, and 23.7% left the item blank (most women residents reported they wanted to leave the item blank because it did not apply to them, stating they were still living there with the intention to graduate). In relation to the women's personal goals, 57.9% reported completing their goals, 27.6% reported not achieving their goals, and 14.5% left the item blank. For obtaining permanent housing within a two-year time frame, 31.6% reported they were able to obtain housing, 51.3% reported they were not, and 17.1% left the item blank. When the women were asked whether or not they would participate in the follow-up program once they completed their stay, 60.5% reported *yes*, 11.8% reported *no*, and 27.6% left the item blank. Overall, 50% of women reported they would recommend the Hope House to others, 7.9% of women reported they would not recommend the Hope House to others, and 42.1% of women did not answer.

Facility. Considering safety at the Hope House, 94.7% reported feeling safe and 5.3% reported not feeling safe. There were 86.8% of women who reported the Hope House conditions were comfortable, suitable, or adequate; although 5.3% of women reported the conditions were not comfortable, suitable, or adequate, and 7.9% of women left the item blank.

Meals/Food. In regards to meals, 84.2% of women reported there was enough nutritional variety in the meals, 13.2% reported there was not, and 2.6% of women left the item blank.

Seventy-five percent of women reported there was enough food for everyone at mealtimes, 23.7% reported there was not enough food at meal times, and 1.3% of women left the item blank. There were 77.6% of women who reported their special dietary needs were met, 13.2% of women who reported their special dietary needs were not met, and 9.2% of women who left the item blank. There were 80.3% of women who reported being satisfied with the guidelines regarding food preparation, 9.2% of women who were not satisfied with the guidelines, and 10.5% of women who left the item blank. Eighty-five and a half percent of women reported they received nutrition education during their stay, 10.5% of women reported they did not receive nutrition education during their stay, and 3.9% of women left the item blank.

Guidelines. When asked about guidelines, 90.8% of women reported thinking the guidelines for communal living were appropriate and fair, and 9.2% of women reported the guidelines were not fair and appropriate. There were 90.8% of women who reported the guidelines were enforced in a fair and impartial manner, 7.9% reported the guidelines were not enforced in a fair and impartial manner, and 1.3% of women did not answer the item. There were 65.8% of women who felt they were never treated unfairly during their stay; however 31.6% of women reported they were treated unfairly during their stay and 2.6% of women left the item blank.

Supplies. There were 90.8% of women who reported that while they were unemployed, the Hope House furnished them with enough personal supplies. However, 5.3% of women reported the Hope House did not provide them with enough personal supplies, and 3.9% of women left the item blank (which may be as a result of the question not being applicable to

them). When asked about staff assistance in helping the women obtain needed items through donations or other resources, 93.4% said *yes* and 6.6% left the item blank.

***Program*.** The program section of the survey was a strictly qualitative section. Eight different programs were listed, asking the women residents to comment on the programs as a whole. There was a significant amount of missing data, therefore information provided may not be representative of the majority of the women's experiences. Regarding case management, every comment written indicated the service provided was very helpful and thorough, and also helped to provide accountability. The life skills group comments indicated that overall, the group was a great experience that was beneficial, had components of other programs (e.g. nutrition and finances), and caused self-improvement. Information obtained for the support groups indicated the groups were good and helpful in building support. Conflict resolution sessions had varied responses, with some women finding the groups helpful and other women reported they were not aware of these groups or they had not been to these groups. For the parenting classes, there were again mixed responses, however the majority of women indicated the group could be improved upon. The nutrition group responses were overwhelmingly positive, with the women also commenting on their enjoyment of the Hope House garden. Regarding health related groups, comments were also diverse; the women indicated they liked the group but there were not enough offered. The women reported they desired consistent health groups with information such as birth control, sexually transmitted infections/diseases, and other health/medical information. Lastly, the other supportive services (e.g., transportation and referrals) feedback was varied, with some women indicating these services were good and others indicating that the

Hope House transportation needed to be improved given the public transportation difficulties in the community.

Staff. There were 89.5% of women who reported the staff were helpful, 5.3% who reported the staff were not helpful, and 5.3% who did not report. The women were asked if the staff empowered them in a positive manner to focus on their personal goals, 85.5% reported the staff did, 9.2% reported the staff did not, and 5.3% did not answer. In regards to staff availability, 90.8% of women reported the staff were available when they needed them, 2.6% of women reported the staff were not available when they needed them, and 6.6% of women left the item blank. There were 84.2% of staff reported the staff treated them with respect, 7.9% of staff reported the staff did not treat them with respect, and 7.9% left the item blank. There were 84.2% of women who reported the staff enforced the guidelines fairly, 10.5% of women reported the staff did not enforce the guidelines fairly, and 5.3% left the items blank. In regards to confidentiality, 85.5% of women reported the staff honored their confidentiality, 10.5% of staff reported the staff did not honor their confidentiality, and 3.9% of staff left the item blank.

Volunteers. There were 92.1% of women who reported the volunteers were helpful, 1.3% of women who reported the volunteers were not helpful, and 6.6% of women left the item blank. The women reported that 86.8% of them felt comfortable with the volunteers, while 6.6% of women reported they did not feel comfortable with the volunteers and 6.6% of women did not answer. Seventy-five percent of women reported they did not have concerns about any individual volunteers, 17.1% of women reported they did have concerns about individual volunteers and 7.9% of women left the item blank.

Children's program. There were 55.3% of women who reported their children participated in the Hope House's programs designed for children, 18.4% of women reported their children did not participate and 26.3% of women left the item blank, perhaps because they did not have children at the Hope House. When rating the Child Care Program, there were 40.8% of women who rated it as excellent, 10.5% of women who rated it as good, 6.6% of women who rated it as fair, and 5.3% of women who rated it as poor. However, 36.8% of women left the item blank. There were 43.4% of women who reported feeling like the Hope House provided adequate activities for children, 18.4% reported the Hope House did not provide adequate activities for children, and 38.2% of women did not answer. When asking about safety, 56.6% of women reported their children felt safe with staff and volunteers, 5.3% of women reported their children do not feel safe with staff and volunteers, and 38.2% did not answer. There were 38.2% of women who reported their children participated in the Tutoring Program, 23.7% of women who reported their children did not participate in the Tutoring Program, and 38.2% of women who did not answer. When asking about the helpfulness of the Tutoring Program, 34.2% of women reported the program was helpful to their child, 19.7% of women reported the program was not helpful to their child, and 46.1% of women did not answer. There were 26.3% of women were reported their child's academics improved while residing at the Hope House; however, 5.3% of women reported their child's grades did not improve and 68.4% of women left the item blank.

Hope House Survey for Staff

General information. Five of the staff members completed the survey in 2015 and one of the staff members completed the survey in 2016. Based on the Hope House Survey for Staff, one

staff had been employed for 5 months, one staff for 7 months, one staff for 10 months, one staff for 122 months, one staff for 128 months, and one staff for 137 months.

Facility. All six staff (100%) reported thinking the Hope House is a safe environment for the women residents. One staff member (16.7%) reported the conditions were not comfortable, suitable, or adequate for residents and staff; however, 83.3% of staff reported the conditions were comfortable, suitable, and/or adequate for the residents and staff.

Meals/Food. One hundred percent of staff reported there is enough nutritional variety in the meals, 100% of staff reported there is enough food for everyone at meal times, and 100% of staff reported the nutrition education has been helpful to the residents.

Guidelines. In regards to guidelines, 100% of staff reported the guidelines for communal living are appropriate and fair and 100% of staff reported the guidelines are enforced in a fair and impartial manner. All staff (100%) reported feeling that the residents are never treated unfairly during their stay.

Program. The program section of the survey was a strictly qualitative section. Eight different programs were listed, asking the staff to comment on the programs as a whole. For case management, the overall message conveyed was that the case management services provided were very strong and individualized. The life skills training program comments indicated that it was a good group but that setting it up based on age group could be an improvement. The support groups and conflict resolution sessions were indicated to be the same groups, and the staff emphasized that the groups were very helpful and the women residents could use more of them. For the parenting classes, the staff members reported these groups were mandatory, helpful, and a group that every women resident could learn from. The nutrition group feedback

indicated that it was an excellent program in which the women had a garden and learned about nutrition; the staff reported the women residents truly embraced this group. The health related group was the program that received the least feedback, and this appeared to be because it was not a group offered but a service that was occasionally provided by a nurse in the community. Lastly, the other supportive services (e.g. transportation and referrals) feedback was geared towards transportation and indicated that the staff had varied opinions regarding transportation being both good and lacking.

Staff. One hundred percent of staff reported feeling the staff are helpful, 100% of staff reported thinking the staff empower the residents in a positive manner to focus on their personal goals, and 100% of staff reported the staff think staff are available when residents need them. One hundred percent of staff reported thinking the staff treat the residents with respect, 100% of staff reported thinking the staff enforce the guidelines fairly, and 100% of staff reported thinking the staff honor resident confidentiality.

Volunteers. All the staff (100%) reported the volunteers are helpful and all the staff (100%) reported feeling comfortable with the volunteers. When asked if the staff think the residents feel comfortable with the volunteers, 83.3% reported yes and 16.7% reported no.

Children's program. When rating the Child Care Program, 66.7% reported the program as *good* and 33.3% reported the program as *excellent*. Thirty-three and one third percent of staff reported the Hope House does not provide adequate activities for children, although 66.7% reported the Hope House does provide adequate activities for children. Fifty percent of staff reported the Tutoring Program is not helpful for the children, 33.3% of staff reported it is helpful

for the children, and one staff left the item blank and indicated she was not familiar enough with the Tutoring Program in order to give an answer.

Recommendations. All staff (100%) reported they would recommend the Hope House to homeless women and mothers, and all staff (100%) reported they would recommend the Hope House to other community members who are looking for a job or an organization to volunteer.

Qualitative Results

Qualitative results allowed for more depth of information and a deeper understanding into the women and staff's experiences in being at the Hope House. Significant themes found for the women residents included: (a) suffering, (b) supportive environment, (c) goal-driven, (d) positive self-change, (e) faith, and (f) areas of strength and areas for improvement. The significant themes found for the staff included: (a) client-centered treatment, (b) skills building, (c) systemic barriers, and (d) areas of strength and areas for improvement.

Women Interviews

Suffering. The theme of suffering arose through all of the women resident interviews (100%). It was apparent that though the women had varied life experiences, they all shared common experiences of psychosocial stress and varied traumatic experiences. Several of these experiences include incarceration, substance use, abuse and/or assault, health issues, and loss, such as severed relationships, job loss, deaths, divorce, etc. Many of the women identified that upon arrival at the Hope House, their emotional state was fragile, hopeless, helpless and low, with two women indicating, "I was just a wreck" and "a basket case […] just depressed and defeated, no self-confidence. You know I just had nothing. I was at the bottom of my rope". Four

of the nine women reported substance use and addiction having impacted their lives. For example, one woman resident reported

> I just disappeared and I got, you know, drug use, and everything … and then eventually when you're on drugs or any type of substance altering mood it stuffs feelings and stuff. You don't even realize how much you're hurting other people and that you don't have friends or anything.

Many of the women identified difficult family relationships that impacted their homelessness. One woman mentioned, "I didn't have nobody, no family…my family gave up on me and everything". Three women residents reported having "lost everything." Multiple of the women also reported having health issues, such as seizures, headaches, heart conditions, hepatitis, human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS), attention-deficit hyperactive disorder (ADHD), post-traumatic stress disorder (PTSD), bipolar, depression, and anxiety that caused hardship in their life. Overall, it was evident that many of these women had endured great suffering in their lives yet through strength and resilience they made it to the Hope House to receive support.

Supportive environment. One hundred percent of the women indicated feeling very supported at the Hope House. The support they experienced came from the staff at the Hope House, the programs the Hope House assisted with, and from the resident women themselves. All of the women indicated receiving assistance with health management (i.e., bringing the women to their doctor's appointments and making sure the women got their prescriptions/ medications filled), transportation, their children (e.g., child care, gifts, etc.) and personal needs (i.e., hygiene supplies and clothes). For instance, one woman resident reported, "And they've

helped me with pretty much everything I've ever needed and if I come to them in a reasonable amount of time they find a way to make it happen."

The Hope House staff appeared to truly support the women by providing encouragement, empowerment, empathy, and client-centered care. One woman resident reported:

> they [the staff] talk to me. They build me up. They tell me how I could achieve all these things, my goals, and they help me. You know they help find us a job and help us. They want us to save money, and they help with day care and they just, they want what's best for us.

Another woman resident indicated that the Hope House was "like a family that I've never had." Moreover, one woman stated, "you're getting better quality of life and then when you leave here, you have the tools and what you need to be able to thrive successfully from the Hope House."

Additionally, the women residents indicated the support they received from each other. One woman indicated finding "really good supports from the women that live here". While another resident explained that the most helpful thing about the Hope House was:

> the family, the people here, the interaction, the skills of the communication with people that are in the same place as you. Everybody I meet here has something in their life that, you know, I can relate with … when you get here, you know, you thrive off, you feed off each other. And when it's a good environment and people are happy, it just it improves your quality of life.

Goal-driven. All the women residents appeared to be goal-driven and had several goals they were working on while residing at the Hope House. Further, it also appeared that the Hope House encouraged women in creating and working towards goals. The women reported having

the following goals: education, financial improvement, health, housing stability, job attainment, transportation, and improved relationships.

In regards to education, some women wanted to return to school while other women were in school at the time of the interview and actively working towards obtaining a degree. For financial improvement, one woman reported wanting "to have enough money saved up to where I don't have to come back here," while others specifically mentioned wanting to "save in order to get a house." Multiple women also reported having worked towards their financial goals by setting up a savings account, learning how to balance a checkbook, learning how to budget, and knowing how to pay bills. Health was also important to a few women, with some wanting to better manage their health issues and medications, and others working on getting all their medical needs completed (e.g., dental work) and staying in substance use recovery. Regarding housing, some women desired to obtain stable housing while other women wanted to work towards buying a house. Multiple women indicated that one goal they already have been able to achieve was to obtain a job, while other women were actively searching for a job that would align with their previous work experiences. Further, some women were working on making themselves more "employable" by receiving help with their resumes. In addition, transportation goals such as buying a car and re-obtaining a driver's license were noted as important. For improved relationships, several women explained previous loss of relationships and/or desire to improve their current relationships. These women mentioned working on building up relationships with the people who they wanted back in their lives (e.g., adult children), the desire to re-obtain custody of their children, learning how to keep friends, and learning how to better interact and play with their younger children. Another woman mentioned a desire to have a

"stable family life" and "start my family back over." Overall, the women residents reported clear goals that they were actively working towards and all women appeared to have a goal-driven mindset.

Positive self-change. All nine women residents reported experiencing a positive change in themselves since being at the Hope House. This included positive changes overall, as well as positive change in mood and affect, development of internal locus of control, increased motivation, and increased responsibility, problem solving skills, interpersonal skills, and processing of emotions. Some residents indicated being ambivalent or skeptical about coming to the Hope House, however, they also stated that after arrival they were very glad and happy that they came.

Several residents reported increased confidence and hope for the future. Another resident emphasized feeling that now she can put herself and her family first, emphasizing "I chose us," in regards to her and her family. Motivation, ambition, and taking control of one's life were evident when women made statements indicating realization "that I can do this on my own. I don't need a man, I don't need a husband, I can do everything that I need to do." Even more so, one woman explained that now she is a "go getter," stating, "I think more about myself. … I'm so much more happier now, you know and it's like I mean, I'm ambitious. I'm ambitious and all because I came here [the Hope House] and I'm glad I did."

Further, many of the women reported learning problem solving skills, interpersonal skills, responsibility, and how to enforce daily structure and routine in their lives. They also indicated having increased social responsibility, understanding of finances, and increased nutrition and health. For example, a woman resident stated:

> I've learned how to better parent my kids. I've learned how to, instead of just like when a problem comes instead of just trying to take care of everything right then, right there by myself.… I've learned how to just slow down, take a break, and you know, which was very hard for me. I had to fix everything right the but now I see that I don't have to. I can slow down and think for a second.

Another resident emphasized "being responsible, taking criticism, managing money, cause I never did that. Not being impulsive and running off my feelings, learning how to control my emotions and what's appropriate." Moreover, the women residents highlighted "I learned about respecting myself … and how to be patient … and you know it's never too late to learn something" and "if you want respect, you got to respect people in order to get respect."

One woman indicated being "full of hope and I have peace and even though everything is not perfect, things are so much better." Moreover, another resident reported:

> I'm optimistic now and I'm very positive about everything. I'm happy, like the first time in my life at peace. You know, everything is not perfect but you know I have goals and I finished things for the first time in all these years and you know I haven't been peaceful like I said in I don't remember a time when I felt more at peace. So I'm happy and I'm very excited and hopeful. … I'm very ecstatic and looking forward to what, you know, everything has to offer the rest of my life.

Overall, when understanding the theme of positive self-change, these women residents' words stood out.

Faith. In many of the women residents' interviews, the impact of God was mentioned and how He has played a role in their lives and their resiliency. Two of the women reported that

their referral to the Hope House was through their involvement in Church. These women also reported that the importance of putting God as a goal to focus on in the Hope House.

One woman mentioned that her first goal was to put God first; she further expanded by saying

> cause you know I accepted Him in my life and that's why my life has turned around, because of Him. Cause um, I mean I realize even when I was in my addiction, God was doing His things for me that I couldn't do for myself.

She continued to emphasize other ways that God continues to be with her and work in her life. Another resident reported, "if it wouldn't have been for Jesus, I'm telling you I wouldn't have made it this far," and she continued by stating that one of her goals was to become more focused on God again. Moreover, another resident reported that without God she would not have made it through the trauma she endured, and she ended her interview by stating that her desire for her future is to "help people … I want to bring people closer to God." Lastly, another woman resident provided a story of a miracle that happened to her throughout homelessness, and she reported that it was Jesus that caused the miracle. Overall, it was evident that these women were strong in their faith and that they believed God was present throughout their life experiences.

Areas of strength and areas for improvement. In all the women resident interviews, it was clear that they had thoughts related to specific aspects of the Hope House program that they enjoyed and areas that they thought could be improved. The women's opinions also varied from individual to individual, for example, some women enjoyed aspects of the program that other women reported needed improvement.

In regards to strengths, there were several areas that stood out, including the nutrition group, the parenting group, the support/peer group, the financial group, and the caseworker/case management support. Four women reported the nutrition group being the most helpful program the Hope House offered as a result of it showing them how to cook healthy meals and grow their own food. Two women reported the parenting group being the most helpful as a result of it improving the parent-child relationship and also incorporating role-plays on how to interact with children. Three residents stated the support/peer group as being the most helpful due to it helping build support and community, stating it "brings people together … people start to open up more and they start to, if they didn't feel like they fit in before, now they fit in." Two residents stated the financial group was beneficial because it allowed them to understand how to build credit, make large purchases (e.g., house), and relearn financial information (e.g., paying bills) that had been "unlearned" as a result of being transient for an extended period of time. Lastly, case management support was indicated to be very helpful with the women residents being directed to appropriate and beneficial referrals in the community.

In regards to areas of improvement, it is important to note that there were no common themes in regards to specific aspects of the Hope House program that needed improvement. Rather, there appeared to be individual perspectives on what aspects of the Hope House program could be improved. The following improvements were obtained from the women residents: desire for an in house substance use program, improved technology resources, desire for a library, improved transportation, increased access to medical support, transitioning support, systemic improvements (e.g., more community involvement and selection criteria), increased community activities, improved parenting group, and overall group improvement.

One woman reported the addition of an in house substance use program would be beneficial in helping the women in their recovery. A suggestion for updated and additional computers was offered, as well as a desire for a library or book donations, stating that having these things would allow the women to improve their life situation faster and get in and out of the Hope House quicker. More help with transportation was also suggested, as one woman touched on the systemic barriers of the public transportation system that interfere with job interviews, running errands, and going to appointments. Further, medical support was an area that one woman suggested being offered at the Hope House because many of the women experience a lack of insurance to cover their needs, such as women's health care. Moreover, support with the transition process into housing was indicated, with suggestion that the Hope House provide more frequent check in with the women during transition into housing in order to better set them up for more success. A desire for more volunteers and community support, as well as better advertising of the Hope House to the community was offered. It was mentioned that a more selective entrance criteria could be beneficial, as one woman reported feeling as though not all women at the Hope House "really need to be here" and the residents that are allowed to stay at the Hope House should be women "who want to do something with their self, to get a better position in their life." Increased community building activities, such as bowling nights, movie nights, exercise classes, going to the zoo, and volunteering at other organizations, was also noted to be an area of improvement. Two women reported a desire for the parenting group to no longer be mandatory, as she reported not having children and not feeling as though it was beneficial for her. Another two women indicated a desire for the psychology based groups to be improved, stating that it was not beneficial and focused too much on the women's emotional

experiences. Further, one woman mentioned that group times often interfere with appointments or employment and that it could be helpful if they were offered at different times.

Staff Interviews

Client-centered treatment. This theme surfaced throughout almost all six of the staff interviewed (83.3%). These staff presented as having great care, respect, and empathy for the women residents they served. Further, these staff exhibited a desire to support and empower them. This theme was evident many times throughout the staff members' interviews and helped to give perspective into how the staff viewed their role in working at the Hope House. One staff member explained that she enjoys supporting the women by giving them life experience. Multiple women reported they try to foster empathy for each woman resident they meet with, stating "if I was in their situation I would want advice too", the importance to "just really put yourself in their shoes to have a better understanding of what they're facing," and "you just have to meet them where they're at." Another staff member explained that she will "build a trust with them, where you they can talk about the things that they haven't been able to process …. and encourage them to learn to make informed choices about the path they want to take." Multiple women mentioned being willing to advocate for the residents for what they need in the community. Furthermore, staff members stated that they help point the women to resources that are line with their current life situation, and find out their specific goals and encourage them in those areas. More specifically, one staff member explained, that the Hope House was an "empowerment based program and that we are here to help them get back on their feet." Overall, the Hope House staff reported they believe in empowering the women they serve, understanding where the women are at in their life, and tailoring services to meet their specific needs.

Skills building. Although the Hope House has specific programs and groups to support the women residents, another theme that arose is that the staff spend much of the time teaching the women residents skills, both formally and informally. This theme was present in 100% of the staff interviews. The skillsets that the staff specifically mentioned teaching were responsibility, emotional processing, problem solving, and interpersonal skills. One staff member mentioned she tries to teach the women how to learn not to judge each other and partner in supporting each other. Another staff member emphasized that her "main goal is for them [the women residents] to become process oriented" and to "talk about the things openly and process it instead of contain it all in." Further, another staff member mentioned teaching organizational skills, social skills, and how to make informed choices. Other specific skills mentioned were how to keep their rooms clean, do chores around the Hope House, how to keep a job, how to do finances, how to be in society, how to use public transportation, and accountability. All the staff emphasized that while the Hope House has formal groups and classes for specific areas (e.g., nutrition and parenting), much of the teaching is done in how the Hope House is setup overall and in the informal daily conversations that the women residents have with the staff members.

Systemic barriers. As the interview process continued, there also appeared to be an explicit understanding that many of the staff held regarding the systemic barriers that affected the lives of the women residents they support. Five out of the six staff indicated this understanding. One staff member reported that the women have life barriers, such as low socioeconomic status, that have impacted their homelessness and resulted in consistent difficulties. Multiple staff mentioned the effects of mental health, the legal system, and substance use on the lives of the women residents and how it was difficult to get treatment and support in the community.

Another staff member highlighted the affordable housing crisis in the community that many of the women residents face; she specifically described the housing process in the community, emphasizing its impracticality for the women the Hope House serves. Further, things like the amount of paperwork organizations need in order to employ a person or give someone housing, and the public transportation system being inefficient and laborious. The staff noticeably acknowledged the multiple barriers that many of their women residents face, explained how these barriers impact the women, and showed how these barriers foster empathy and support in the staff.

Areas of strength and areas for improvement. Similar to the women residents, throughout the staff interviews it became apparent that staff had opinions regarding the specific groups/programs they offered and the overall areas that needed improvement. There were three groups/programs that stood out as having the most positive influence for the Hope House's women residents. These programs were the finance group, life skills group, and parenting group, with the parenting group being endorsed as a positive group by almost all the staff members (five out of six staff). Regarding the finance group, it was explained that financial advisors from a local bank come into the Hope House and provide information such as banking and credit scores to help the women "get back established." Additional staff members explained that "all the components of the life skills" group were beneficial because they helped in teaching budgeting and "how to adapt to sustain independence … and prepares them to handle life's daily issues." Another staff member indicated that the parenting group is the most helpful because those women residents that are not parents still learn a lot of useful information.

In terms of improvement, there were varied opinions amongst the staff regarding their beliefs on what could be improved. There was no common theme regarding the specific program aspects that needed to be improved, nonetheless, there was a common theme that aspects needed to be improved upon. A couple staff mentioned the importance of getting an in house substance use program for the women to participate in, given the impact substance use has with the women residents they serve. Several staff indicated that their roles were mixed and they did not have a clear understanding of what their specific duties and responsibilities were. It appeared that staff roles overlapped and that while each staff member had a specific title, they also participated in various other aspects of the Hope House program. Further, multiple staff members also emphasized the need for an improved childcare program and an improved tutoring program.

Chapter 4

Discussion

The current study sought to build upon the existing research by examining a women and children's transitional housing program, the Hope House. There is very limited research in the field that evaluates homeless programs (Glisson et al., 2001; Winship, 2001) and that, more specifically, gathers information from the individuals these programs serve. As a result, there is not much knowledge, understanding, or information gathered from these programs or the homeless individuals themselves on how to better serve and satisfy their needs. In order to evaluate these relatively under-researched explorations within this vulnerable, underserved population, the current study used an evaluative survey for the women residents that was already established by the Hope House, an evaluative survey that was created for the staff who worked at the Hope House and that mirrored the women residents' survey, and qualitative interviews. The knowledge gained from this research study provides insight into whether or not the Hope House is effective in satisfying the women residents' needs and identifies any areas that are lacking. These results can be used by the Hope House to understand areas they are meeting the needs of the women and children they serve, areas they can implement new approaches, and as a way to gain future grants and fundraising. Overall, these results can also be used to inform the greater community on the needs of transient populations and to hopefully enrich the care this population receives.

Quantitative results provided information from both the women residents and the staff who worked at the Hope House. When comparing women resident responses to staff responses, it appeared overwhelmingly clear that overall, both the women residents and the staff identified the Hope House facility as being safe and the conditions being comfortable and satisfactory. Other studies that obtained feedback from homeless residents also found safety and comfortableness as being an important factor in the success and experience of their homeless residents (Walsh et al., 2009; Walsh et al., 2010). In regards to the Hope House meals and food, both the women and staff significantly identified that there was enough nutritional variety, enough food for everyone, special dietary needs were met, they were satisfied with food preparation standards, and they received nutrition education during their stay and the nutrition education was helpful. When asking about guidelines, the majority of women and staff indicated the Hope House guidelines were suitable and fair and enforced in an unbiased manner. Further, the majority of both groups reported feeling as though the women residents were never treated unfairly during their stay. Most of the women residents indicated that when unemployed, the Hope House provided them with adequate personal supplies and the staff helped the women when they needed to obtain items through donations or other means.

The Hope House women and staff were asked to comment on different program aspects. It is important to note that for the residents, there was a significant amount of missing data. As a whole, a considerable percentage of women residents and staff identified positive comments for case management, the life skills group, the support/conflict resolution groups, and the nutrition group. For the parenting group, the women residents had varied positive and negative responses, while the staff had all positive comments. The health related group responses from both staff and

women indicated a need for improvement, specifically mentioning a desire for more consistently, regularly run groups that focused on a wide variety of health/medical concerns pertaining to women's health. In regards to other supportive services, such as transportation and referrals, the women and staff had variable responses with feedback indicating a need for improvement in transportation. Reports about staff from the Hope House women and staff were overly positive, indicating staff was helpful, empowering, available when needed, respectful, fair, and abiding by confidentiality rules. The majority of information provided by the women and staff in regards to volunteers indicated that they thought volunteers were helpful, comfortable to be around, and without concerns. The children's program also had a large amount of missing data from the women residents, and as a result was hard to interpret. When taking into account those who did choose to answer the items, variability occurred in information provided by residents and staff. However, most women indicated the program being excellent, while most staff indicated the program as being good. Most of the women and staff identified the program as having enough activities for children, and being safe for them. Whether or not the tutoring program was helpful to the children was varied, with the majority of women feeling like it was somewhat helpful but the majority of staff indicating it was not helpful.

As a whole, it appeared that the women and staff were satisfied with the different aspects of the Hope House; the areas that were identified as needing improvement were the health related groups, the other supportive services, and the children's program. Improvements in the area of health-related groups are crucial; Finfgeld-Connett (2010) and Beijer and Andreasson (2009) both identified that homeless women have much more physical and mental health problems when compared to homeless men. As a result, addition and improvement in this area

could be a highly advantageous aspect the Hope House provides and could also contribute to a decrease in health concerns, which could impact homeless recidivism.

Women and staff qualitative interviews revealed comparable results in three areas, while also revealing unique differences. A theme that arose for the women residents was suffering, and several of the aspects of suffering they identified were also represented in the staff theme of systemic barriers. Examples of this include the difficulties the staff and women acknowledged that the homeless women face which were reported as mental health issues, substance use, physical health issues, low socioeconomic status, abuse and assault, incarceration, lack of affordable housing, and grief and loss (e.g., divorce, job loss, and severing of significant relationships). Interviews indicated the high amount of hardship these women face and the empathy that the staff have for them. The difficulties the women and staff identified are also represented in the literature as being risk factors that contribute to and perpetuate homelessness, especially in women and children (Chambers et al., 2014; Finfgeld-Connett, 2010; Ji, 2006; Wilson, 2005).

The second area of similarity identified were the women indicating the Hope House was a supportive environment and the staff indicating the Hope House being a place of client-centered treatment. It was clear the staff empowers and supports the women residents, while also viewing each resident as an individual. The staff also recognized the need to tailor support to match each woman's needs. This aspect of the interviews contradicted the research that many transitional housing providers stereotype and stigmatize the women they serve (Cosgrove & Flynn, 2005). With this knowledge, it is fundamental that the Hope House staff continue to provide empathy and encouragement to the women they serve in order to continue satisfying and

meeting the women's needs, as this can lead to improvements in following of guidelines, increases in perception of strength and power, and increases in locus of control (Finfgeld-Connett, 2010; Walsh et al., 2010). Moreover, it was evident that the women feel the care from the staff that serves them, as well as in resident-to-resident interactions.

The last theme of similarity identified was the theme of areas of strength and areas for improvement that was exhibited in both the women and staff interviews. However, there was variability within the responses for areas of strengths and improvements. For strengths, both groups identified the financial group and the parenting group as being program strengths. Minnery and Greenhalgh (2007) identify the importance of homeless programs having groups that increase financial stability, and Hartnett and Postmus (2010) identify that many other homeless programs include parenting classes in their curriculum. The Hope House's inclusion of these services is necessary and also helps to make them comparable to other agencies. In addition, the women also identified the nutrition group, the support/peer group, and the casework/case management support, while the staff identified the life skills group as areas of strength. For areas of improvement, women and staff agreed there was a need for an in house substance abuse program. Adding a substance use program to the Hope House curricula would help to target a homelessness risk factor while also adding an area identified as one of the most successful aspects to have in a transitional housing program (Finfgeld-Connett, 2010; Hartnett & Postmus, 2010; Green, 2005). Otherwise, there were no similarities identified. Other improvements included, improved technology resources, desire for a library, improved transportation, increased access to medical support, transitioning support, systemic improvements, increased community activities, improved parenting group, overall group

improvement, staff role improvements, improved childcare program, and improved tutoring program. As previously mentioned, the Hope House providing improvement in the area of medical support is vital. Further, Hartnett and Postmus (2010) and Green (2005) identify that transitioning support helps to make a homeless program successful. Walsh et al. (2009) identified a similar desire for increased community activities in the homeless women population they obtained data from, as those women believed involvement in the community and the relationship between the greater community and the women was very important. This appeared to also be the same for the women the Hope House serves.

Furthermore, the unique differences identified between the women and staff qualitative interviews were the women's themes of goal-driven, positive self-change, and faith, and the staff's theme of skill building. All women residents identified goals they were hoping to achieve and why they wanted to achieve them. All women interviews showed that the women had experienced a positive change in themselves since their arrival at the Hope House. The changes identified included positive change in mood and affect, development of internal local of control, increased responsibility, increased motivation, and acquisition of problem solving, interpersonal and processing skills. Lastly, many of the women indicated faith in God and how God has influenced their life. For the staff, all interviews showed that skills are always being taught to the women residents the Hope House serves and that often times, these skills are taught indirectly (e.g., fluidly being taught in interactions with the staff versus being taught in one of the Hope House programs). The research indicates the importance of homeless women learning skills, such as problem solving and interpersonal skills, as a lack of these skills are also factors that contribute to homelessness (Finfgeld-Connett, 2010; Wilson, 2005).

Through information obtained from qualitative and quantitative data, it appears that two of the three goals for the Hope House are currently being met. The following are the goals for the Hope House, which were identified previously in this manuscript: (a) assist clients in obtaining and remaining in permanent housing, (b) help clients increase skills and/or income through client directed education and advocacy, and (c) assist clients in achieving greater self-determination in preparation for transitioning into permanent housing and independence (S. Ray, personal communication, February 10, 2015). Information for the first goal was unavailable, as this researcher did not have data from when the women residents left the Hope House; rather, this researcher had data from women who were actively living in the Hope House and therefore had not yet obtained permanent housing. The second goal appears to have been met, and this is identified both from resident and staff data. It is clear that the women residents have learned skills, such as problem solving, interpersonal skills, and financial skills; these skills have been acquired both through the structured Hope House programs and indirectly through interactions with the Hope House staff. Lastly, it is also clear that the Hope House is assisting the women in accomplishing self-determination and independence. The interviews with both the women and staff show that the women have seen growth and positive changes in themselves and that the staff empower the women in continuing to grow in their autonomy.

Limitations and Implications for Future Research

Given that this research was with a vulnerable, underserved, and often inaccessible population, the number of women resident interview participants was quite small and convenient ($N = 9$). When collecting interview data, many women residents were working, trying to obtain employment, and/or at their various required appointments (e.g., medical, mental health,

substance use). As a result, a second limitation was the lack of random selection due to scheduling and women resident availability. A third limitation was that many items in the archival data collection were missing and unable to be obtained due to not having access to prior residents. Further, due to staff hours and scheduling, the number of staff participants was also limited and convenient ($N = 6$). As such, this study may not adequately represent the full range of experiences that homeless women and children and homeless program staff might report.

In addition, all the women resident participants completed the survey/evaluation at random points during their stay, which may have impacted their responses. Lastly, there are cultural limitations. All the participants were recruited from a specific transitional housing program, the Hope House), located in a distinct region (Central Louisiana) of the United States. Therefore, results may not be generalizable. Due to the unpredictability and stressful nature of homelessness, these challenges are to be expected when working with this population.

There are limited studies that gather data directly from homeless women, thus there are numerous opportunities for future research. Potential opportunities for future research include, but are not limited to: increasing the number of participants; gathering pre and post data in order to explore comparisons; obtaining survey results for all women at the similar points during their stay; incorporating random selection of women participants; expanding the parameters of the study by extending participation beyond the one specific program evaluated and beyond the cultural region of Louisiana; and gathering data from additional staff, volunteers, and/or board members.

Conclusion

Homelessness is a universal concern that is ever prevalent in the United States and continues to increase as psychosocial stressors continue to rise. This study evaluated a transitional housing program, the Hope House, to determine its effectiveness in satisfying and supporting the women it serves. It gathered quantitative data from 67 homeless women they served and six staff that work at the Hope House and qualitative data from nine homeless women they served and the same six staff. Quantitatively, participants endorsed an overwhelmingly positive experience and perception of experience at the Hope House with needs for improvement in the areas of health related groups, the other supportive services, and the children's program Qualitatively, this study suggests that the women at the Hope House endure suffering and systemic barriers, find support in their faith, are goal-driven, and see themselves as having positive self-change since arriving at the Hope House. Further, qualitative data suggests that the Hope House provides client-centered treatment in a supportive environment that promotes skill building. Furthermore, overall areas of strength and areas for improvement were identified. It is hoped that the results of this study will positively impact the Hope House, the women the Hope House serves, the staff that provide treatment, and the greater transient community as a whole.

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Appendix A

Demographics Form—Women

DEMOGRAPHICS FORM—Women **Participant #_____**

1. Age: _____

2. Ethnicity: (Please circle)

White	Native American or American Indian
Hispanic or Latino	Asian/ Pacific Islander
Black or African American	Other (please specify): _____

3. Education: What is the highest degree or level of school you have completed: (Please circle)

No schooling completed	Nursery school to 8th grade
Some High School, No diploma	High School Graduate or GED
Some College, No degree	Associates Degree
Trade/Technical/Vocational Training	Bachelor's Degree
Master's Degree	Doctoral or Professional Degree

4. Religion—Any Religious or Spiritual Preferences: (Please Circle)

Jewish	Muslim
Buddhist	Hinduism
Christian (Protestant)	Catholic
Unaffiliated	Other (please specify):_____

5. Have you been homeless before? (Please circle) Yes No

   If yes: Please specify when_____

6. Current length of time spent in homelessness:_____

7. Do you have children? (Please circle) Yes No

   If yes: How many children do you have? _____

   If yes: Please specify their age, gender, and highest level of education completed:

Appendix B

Demographics Form—Staff

DEMOGRAPHICS FORM—Staff **Participant #_____**

1. Age: _____

2. Gender: (Please circle)

   Male

   Female

   Other (please specify):_____

3. Ethnicity: (Please circle)

   White Native American or American Indian

   Hispanic or Latino Asian/ Pacific Islander

   Black or African American Other (please specify): _____

4. Education: What is the highest degree or level of school you have completed: (Please circle)

   No schooling completed Nursery school to 8th grade

   Some High School, No diploma High School Graduate or GED

   Some College, No degree Associates Degree

   Trade/Technical/Vocational Training Bachelor's Degree

   Master's Degree Doctoral or Professional Degree

5. Religion—Any Religious or Spiritual Preferences: (Please Circle)

Jewish	Muslim
Buddhist	Hinduism
Christian (Protestant)	Catholic
Unaffiliated	Other (please specify):_____

6. How long have you been working at the Hope House?_____

7. What is your current job title at the Hope House? _____

Appendix C

Evaluation/Survey

This evaluation/survey is designed to serve as a tool for improvement. We recognize that there is always room for improvement and your feed-back is very valuable to us. Please take the time to complete the evaluation and be honest with your responses. Thank you for your willingness to contribute toward making Hope House programs the best that they can be. We are dedicated toward serving the homeless population of our area. We pledge to work diligently toward proving quality delivery of services.

Date:_____ Participant #:_____

Sandy G. Ray
Executive Director

General Information:

How did you learn about Hope House services?

_____
_____

How long did you reside at Hope House?_____

Did your children reside with you at Hope House? YES NO

If yes, how many children?_____

Did you stay long enough to graduate the program? YES NO

If no, why not?_____
_____
_____

Did you achieve your personal goals? YES NO

If no, why not? _____
_____
_____
_____

Did you obtain permanent housing within a two-year timeframe? YES NO

If no, what barriers did you encounter? _____
_____
_____
_____

Did case managers assist you in your housing process? YES NO

Will you participate in the follow up program once you complete your stay? YES NO

If no, why not? _____
_____
_____
_____
_____

Facility:
Did you feel safe at Hope House? YES NO
If no, tell us why you did not feel safe _____
_____
_____
_____
Were the conditions comfortable/suitable/adequate? YES NO
If no, tell us why not
_____
_____
_____
Additional Comments:_____
_____
_____
_____

Meals/Food:
Was there enough nutritional variety in the meals? YES NO
Was there enough food for everyone at meal times? YES NO
Were your special dietary needs met? YES NO
Were you satisfied with the guidelines regarding food preparation? YES NO
If no, how can we improve? _____
_____
_____
_____
Did you receive nutrition education during your stay? YES NO
If no, why not?
_____
_____
_____
Additional Comments:_____
_____
_____
_____

Guidelines:
Were the guidelines for communal living appropriate and fair? YES NO
Were the guidelines enforced in a fair and impartial manner? YES NO
Do you feel you were ever treated unfairly during your stay? YES NO
If yes, explain_____
_____
_____
_____

Additional Comments:_____
_____
_____

Supplies:

While you were unemployed (if applicable), did Hope House furnish you with enough personal supplies? YES NO

Did staff assist you with obtaining needed items either by donations or other resources? YES NO

Additional Comments:_____
_____

Program:

Please comment on the following programs offered at Hope House. Please let us know how they helped or how they did not help. Comment on what you learned, if applicable.

Case Management including discharge planning and ISP development	
Life Skills Training	
Support Groups	
Conflict Resolution Sessions	
Parenting Classes	
Nutrition Groups	

Health Related Groups	
Other Supportive Services such as transportation, referrals, etc.	

Staff:
Was the staff helpful? YES NO
Did the staff empower you in a positive manner to focus on your personal goals? YES NO
Was the staff available when you needed? YES NO
Did the staff treat you with respect? YES NO
Did the staff enforce the guidelines fairly? YES NO
Did the staff honor your confidentiality? YES NO
Additional Comments:_____
_____
_____

Volunteers:
Were the volunteers helpful? YES NO
Did you feel comfortable with the volunteers? YES NO
Did you have concerns about any individual volunteer(s)? YES NO
If yes, describe:_____
_____

Children's Program:
Did your children participate in any of the programs designed for children? YES NO
How would you rate the Child Care Program? Excellent Good Fair Poor
Do you feel Hope House provides adequate activities for children? YES NO
Did your children feel safe with staff and volunteers? YES NO
Did your children participate in the Tutoring Program? YES NO
Was the Tutoring Program helpful to your child? YES NO
Did your child's academics improve or fail to improve while residing at Hope House?
Improved Did Not Improve
What could we do differently to help if did not improve?_____
_____
_____
_____

If you could change one thing in the Hope House Program, what would it be and why?

Would you recommend Hope House to others? YES NO
If no, why not?

Appendix D

Hope House Survey for Staff

This evaluation/survey is designed to serve as a tool for improvement. We recognize that there is always room for improvement and your feedback is very valuable to us. Please take the time to complete the evaluation and be honest with your responses. Thank you for your willingness to contribute toward making Hope House programs the best that they can be. We are dedicated toward serving the homeless population of our area. We pledge to work diligently toward proving quality delivery of services.

Date:_____ Participant #:_____

Please complete only those areas that pertain to you.

General Information:

How long have you worked at the Hope House?_____

What is your job title?_____

What responsibilities do you have?_____

_____

_____

_____

Facility:

Is the Hope House is a safe environment for residents? YES NO

If no, tell us why not:_____

_____

_____

_____

Are the conditions comfortable/suitable/adequate for residents and staff? YES NO

If no, tell us why not:_____

_____

_____

_____

Meals/Food:

Is there enough nutritional variety in the meals? YES NO

Does the Hope House offer enough food for everyone at meal times? YES NO

Has nutrition education been helpful to the residents? YES NO

Why?_____

_____

_____

_____

Guidelines:

Are the guidelines for communal living appropriate and fair? YES NO
Are the guidelines enforced in a fair and impartial manner? YES NO

Do you feel that residents are ever treated unfairly during their stay? YES NO
If yes, explain:

_____
_____
_____

Program:

Please comment on the following programs offered at Hope House. Please let us know how they help or how they do not help the residents.

Case Management including discharge planning and ISP development	
Life Skills Training	
Support Groups	
Conflict Resolution Sessions	
Parenting Classes	
Nutrition Groups	

Health Related Groups	
Other Supportive Services such as transportation, referrals, etc.	

Staff:
Are the staff helpful? YES NO
Do you think the staff empowers the residents in a positive manner to focus on their personal goals? YES NO
Is the staff available when residents need them? YES NO
Do you think the staff treats residents with respect? YES NO
Do you think the staff enforces the guidelines fairly? YES NO
Do you think the staff honors resident confidentiality? YES NO

Volunteers:
Are the volunteers helpful? YES NO
Did you feel comfortable with the volunteers? YES NO
Do you think the residents feel comfortable with the volunteers? YES NO

Children's Program:
How would you rate the Child Care Program? Excellent Good Fair Poor
Do you feel Hope House provides adequate activities for children? YES NO
Do you think the Tutoring Program is helpful for the children? YES NO

If you could change one thing in the Hope House Program, what would it be and why?

Would you recommend the Hope House to homeless women and mothers? YES NO
If no, why not?

Would you recommend the Hope House to other community members who are looking for a job or an organization to volunteer in? YES NO
If no, why not?

Appendix E

Semi-Structured Interviews

Semi-Structured Interview for Homeless Women and Mothers

1. When did you come to the Hope House? Who referred you?
2. What are some events that may have led to you being where you are and eventually coming to the Hope House?
3. What was your emotional state when you got to the Hope House? What would you say your emotional state is now?
4. What are your health issues (psychological and physical)? How has the Hope House helped you with your health issues?
5. What has been most helpful about living at the Hope House?
6. What new skills have you learned since coming to the Hope House?
7. What specific program do you find most helpful and why?
8. What specific program do you find the least helpful and why?
9. What are the areas that the Hope House can improve upon? Do you have any suggestions on how these areas can be improved?
10. Is there anything you need that the Hope House does not provide you or help you with?
11. What are your current goals at the Hope House? How has the Hope House helped you achieve these goals so far?
12. What are your top priorities when you leave the Hope House?
13. Is there anything else you think would be helpful for me to know?

Semi-Structured Interview for Staff

1. What is your job and responsibilities with the Hope House?
2. What types of skills do you help the women to acquire during their time at the program?
3. Do you think the women leave the Hope House having mastered these skills?
4. Which program do you find most helpful to the women and why?
5. Which program do you find to be least helpful to the women and why?
6. What common challenges do the women face? How do you think the Hope House helps the women overcome these challenges?
7. Are there any aspects of the program that you find could be improved upon?
8. Is there anything else you think would be helpful for me to know?

Appendix F

Informed Consents

THE HOPE HOUSE
INFORMED CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Graduate Student Researcher: Andrea Rabie, George Fox University

You are invited to participate in a research study conducted as a part of my graduate student dissertation at George Fox University in Portland, Oregon, USA. The purpose of this study is to find out more information about the actual and perceived services and care provided at the Hope House, with the hopes of learning how to better meet the needs of the homeless women's overall experience, care, and services provided.

INFORMATION

If you agree to take part in the study, you will be asked to complete a 2-minute demographic survey asking questions about yourself. You will also be asked to complete a 10-15 minute, 45-item questionnaire about your experience at the Hope House. All responses will be kept confidential.

In addition to the survey and questionnaire, you will be asked to take part in an interview asking about your experience at the Hope House, which will take approximately 30 minutes. This interview will be audio recorded so that the interviewer can better understand and remember what is said. All responses will be kept confidential.

BENEFITS

As a token of appreciation, you will be given a $10 gift card for your involvement in this study. Additionally, while there may or may not be direct benefits to you, we hope that the information we learn will help with the support of homeless women in the future and the services and care they receive at the Hope House.

RISKS

There are no physical risks associated with this study. Some of the questions we will ask you as part of this study may make you feel uncomfortable. You may refuse to answer any of the questions, and you may take a break at any time during the study. You may stop your participation in this study at any time.

CONFIDENTIALITY

If you decide to be involved, it is important that you answer all questions as honestly as possible. All of the information you provide will be confidential. Individual participants will not be

identified. Please do not write your name or any other identifiable information anywhere on the surveys.

Deciding to participate gives me permission to use the information you share in this study for presentations at professional meetings or in published articles or books. I am only interested in group data, and I will not use your name or personal information in any such presentations or publications. This assures your privacy.

MY RIGHTS AS A RESEARCH PARTICIPANT

- Your participation in this study is voluntary. You do not have to join this study. You are free to say yes or no.
- Your decision to participate or to not participate in this study will not affect your relationship with anyone at the Hope House.
- If you do decide to withdraw, we ask that you contact Andrea Rabie at (318) 623-9809 to let her know that you are withdrawing from the study.

DO YOU HAVE QUESTIONS ABOUT THE STUDY?

If you have questions about this study (including complaints and/or requests for information), you may contact:

Graduate Student Researcher Andrea Rabie (318) 623-9809 arabie13 @georgefox.edu	**OR**	Dissertation Supervisor Winston Seegobin, PsyD wseegobin@georgefox.edu

STATEMENT OF CONSENT

By signing my name below, it means that I have decided to participate in this study as a research participant. I read and understand the information on this consent form, I understand the purpose of this research study and what my participation in it will involve, and that all my questions are answered to my full satisfaction. I understand that I will be given a signed and dated copy of this consent form.

_____

Printed Name of Participant

_____ Date_____

Signature of Participant

SIGNATURE OF THE PERSON CONDUCTING THE INFORMED CONSENT DISCUSSION

I attest that all elements of informed consent described in this consent form have been discussed fully in nontechnical terms with the participant. I further attest that all questions asked by the participant were answered to their satisfaction. The participant will be provided with a fully signed copy of this consent form.

_____ Date_____
Signature of Principal Investigator

You will get a copy of this form.
If you want more information about this study, please ask the researcher.

THE HOPE HOUSE
INFORMED CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Graduate Student Researcher: Andrea Rabie, George Fox University

You are invited to participate in a research study conducted as a part of my graduate student dissertation at George Fox University in Portland, Oregon, USA. The purpose of this study is to find out more information about the actual and perceived services and care provided at the Hope House, with the hopes of learning how to better meet the needs of the homeless women's overall experience, care, and services provided.

INFORMATION
If you agree to take part in the study, you will be asked to complete a 2-minute demographic survey asking questions about yourself. You will also be asked to complete a 10-15 minute, 28-item questionnaire about your experience at the Hope House. All responses will be kept confidential.

In addition to the survey and questionnaire, you will be asked to take part in an interview asking about your experience at the Hope House, which will take approximately 30 minutes. This interview will be audio recorded so that the interviewer can better understand and remember what is said. All responses will be kept confidential.

BENEFITS
A presentation will be given regarding the general findings of this study in which you will be allowed to attend. Additionally, while there may or may not be direct benefits to you, we hope that the information we learn will help with the support of homeless women in the future and the services and care they receive at the Hope House.

RISKS
There are no physical risks associated with this study. Some of the questions we will ask you as part of this study may make you feel uncomfortable. You may refuse to answer any of the questions, and you may take a break at any time during the study. You may stop your participation in this study at any time.

CONFIDENTIALITY

If you decide to be involved, it is important that you answer all questions as honestly as possible. All of the information you provide will be confidential. Individual participants will not be identified. Please do not write your name or any other identifiable information anywhere on the surveys.

Deciding to participate gives me permission to use the information you share in this study for presentations at professional meetings or in published articles or books. I am only interested in group data and I will not use your name or personal information in any such presentations or publications. This assures your privacy.

MY RIGHTS AS A RESEARCH PARTICIPANT

- Your participation in this study is voluntary. You do not have to join this study. You are free to say yes or no.
- Your decision to participate or to not participate in this study will not affect your relationship with anyone at the Hope House.
- If you do decide to withdraw, we ask that you contact Andrea Rabie at (318) 623-9809 to let her know that you are withdrawing from the study.

DO YOU HAVE QUESTIONS ABOUT THE STUDY?

If you have questions about this study (including complaints and/or requests for information), you may contact:

Graduate Student Researcher Andrea Rabie (318) 623-9809 arabie13 @georgefox.edu	**OR**	Dissertation Supervisor Winston Seegobin, PsyD wseegobin@georgefox.edu

STATEMENT OF CONSENT

By signing my name below, it means that I have decided to participate in this study as a research participant. I read and understand the information on this consent form, I understand the purpose of this research study and what my participation in it will involve, and that all my questions are answered to my full satisfaction. I understand that I will be given a signed and dated copy of this consent form.

_____

Printed Name of Participant

_____ Date_____

Signature of Participant

SIGNATURE OF THE PERSON CONDUCTING THE INFORMED CONSENT DISCUSSION

I attest that all elements of informed consent described in this consent form have been discussed fully in nontechnical terms with the participant. I further attest that all questions asked by the participant were answered to their satisfaction. The participant will be provided with a fully signed copy of this consent form.

_____ Date_____

Signature of Principal Investigator

You will get a copy of this form.
If you want more information about this study, please ask the researcher.

Appendix G

Curriculum Vitae

Andrea N. R. Hartman

formerly Andrea Rabie
3655 Motor Avenue Apt. #6 ◆ Los Angeles, CA 90034
(318) 623-9809 ◆ ahartman13@georgefox.edu

Education

Expected May 2018	**Doctor of Psychology, Clinical Psychology** *Emphases: Child & Adolescent and Health Psychology* George Fox University**,** *Newberg, OR* Graduate Department of Clinical Psychology: APA Accredited
May 2015	**Master of Arts, Clinical Psychology** George Fox University, *Newberg, OR* Graduate Department of Clinical Psychology: APA Accredited
May 2013	**Bachelor of Arts, Psychology** **Minor: Educational Psychology** Baylor University, *Waco, TX*

Supervised Clinical Training and Experiences

July 2017 – Present **Children's Hospital Los Angeles (CHLA)/University of Southern California University Center for Excellence in Developmental Disabilities (USC UCEDD) – *Pre-doctoral APA Accredited Internship***
Los Angeles, CA

Title: *Therapist, Pre-Doctoral Psychology Intern*
Treatment Setting: *Children's Hospital and Community Mental Health Center*
Population: *Diverse populations of youth ages 0-22 and families*
Supervisors: *Hannah Miller, PsyD; Bridgid Conn, PhD; Oscar Donoso, PhD; Amy West, PhD (Associate Training Director); Sarah Sherer, PhD (Training Director)*
Clinical Rotations and Duties:

- Common presenting problems of all rotations include but are not limited to: mood disorders, anxiety disorders, obsessive compulsive disorder, attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), learning difficulties, trauma-related disorders, suicidal/homicidal ideation, disruptive behavior disorders, medical conditions, other developmental disabilities (e.g. language, intellectual disability), etc.
- *Specialty Rotation: Adolescent Medicine (12 months)*

- Conduct intake interviews, develop treatment plans, and provide long-term weekly psychotherapy to clients ages 13 to 21 years old and their families in individual and family formats.
- Engage in multidisciplinary collaboration with members of client's treatment team (e.g. occupational therapists, psychiatrists, developmental behavioral pediatricians, case workers, etc.) and provide case management (i.e. attending Individual Education Plan (IEP) meetings, advocating for Regional Center services, etc.).
- Participate in weekly Grand Rounds pertaining to Adolescent Health and weekly individual supervision.
- Participate in Leadership Education in Adolescent Health (LEAH) Program as a medium-term trainee. Program provides multidisciplinary leadership training and prepares professionals to be leaders in clinical care, research, public health policy, and advocacy as it relates to adolescent health.

- *Child and Family Therapy Rotation (12 months)*
  - Conduct intake interviews, develop treatment plans, and provide long-term weekly psychotherapy to clients ages 6-13 years old in individual, family, and dyadic formats.
  - Engage in multidisciplinary collaboration with members of treatment team and provide case management for all clients.
  - Complete training in Evidence-Based Practice, Incredible Years Group Therapy (IY) and co-lead 2 hour, 24 week Incredible Years group therapy program for children ages 3-8 focused on the treatment of conduct disorders, attention deficit hyperactivity disorder, and internalizing problems.
  - Participate in weekly individual and group supervision and didactic training.
- *Psychological Assessment Rotation (12 months)*
  - Complete comprehensive psychological evaluations (total of 6 by the end of internship), including multiple feedback sessions (e.g. with therapist, with parents, with school, etc.) for children with co-occurring developmental disabilities ages 7-18.
  - Common referral questions include but are not limited to: ASD, intellectual disability, mental health concerns, chronic medical conditions, learning difficulties, exposure to trauma, ADHD, mood disorders, anxiety disorders, etc.
  - Comprehensive psychological evaluations typically include: standardized psychological and academic achievement tests; structured parent, child and teacher self-reports instruments; observation of play and parent-child interactions; clinical interviews (child, parents, teacher, etc.); school observations; record review; use of DSM-5 criteria; writing integrated reports; consulting and collaborating with referring therapists, medical providers, etc.; and engage in case management pertaining to assessment as needed.
  - Receive live proctoring, weekly group supervision/case conference, and weekly individual supervision.

July 2016 – May 2017 **Childhood Health Associates of Salem**

Salem, OR
Title: *Behavioral Health Provider, Pre-Intern*
Treatment Setting: *Pediatric Primary Care*
Populations: *Diverse populations of children 0-21 and families*
Supervisors: *Joy Mauldin, PsyD; Joel Lampert, PsyD, LPC, NCC*
***Clinical Duties*:**

- Provide brief intervention using empirically supported practice, such as Cognitive Behavioral Therapy, Motivational Interviewing, and Acceptance & Commitment Therapy and train parents in evidenced-based parenting skills.
- Common presenting problems include: toilet training, picky eating and healthy eating, cutting/self-harm, crisis management, anger, sleep problems, tantrums, pill swallowing, medication compliance, developmental disabilities, ADHD, healthy lifestyle changes, anxiety disorders, mood disorders, social/peer concerns, and life adjustments (i.e. divorce, new siblings, etc.).
- Provide warm hand-offs and engage in cold hand-offs (e.g. going in to each medical visit with a physician and providing immediate intervention based on presenting concerns) with providers to increase workflow and patient/provider health and coordinate care among a multidisciplinary team (e.g. physicians, nurses, medical assistants, caseworks, and administrative staff).
- Teach psychoeducational classes/groups for clinic and community and engage in program development projects to increase workflow, patient and provider knowledge and understanding of behavioral health, and behavioral health services delivered.
- Engage in monthly peer-to-peer supervision and county meetings.

Jan 2015 – May 2017 **Behavioral Health Crisis Consultation Team**
Newberg, OR and McMinnville, OR

Title: *Behavior Health Crisis Consultant, QMHP*
Treatment Setting: *Providence Newberg Medical Center; Willamette Valley Medical Center*
Populations: *Children, adolescents, adults, and geriatric patients from culturally and socioeconomically diverse backgrounds*
Supervisors: *Mary Peterson, PhD, ABPP; Bill Buhrow, PsyD; Joel Gregor, PsyD*
Clinical Duties:

- Conduct empirically validated and evidenced-based suicide and homicide risk assessments, cognitive evaluations, and other assessments of patient mental health concerns and risk factors, including self-injurious behaviors, substance-induced psychiatric diagnoses, and psychosis in order to determine level of risk for the Emergency Department, Intensive Care Unit, and Medical/Surgical Unit at local hospitals.
- Consult with physicians, supervisors, and other medical staff to provide recommendations regarding patient risk and discharge plan, document evaluations in electronic medical charts, and coordinate resources with county mental health employees.

- Case management experience: arranging inpatient psychiatric hospitalizations, contacting respite care facilities, collaborating with county mental health agencies and local agencies/resources, and contacting and coordinating with drug and alcohol detoxification facilities.
- Engage in, plan, and facilitate monthly didactics for continuation of training and development.

Aug 2013 – Apr 2017 **Clinical Conceptualization and Application Team**
George Fox University, Newberg, OR

Title: *Doctoral Candidate*
Treatment Settings: *All practicum sites*
Populations*: Children, adolescents, adults, and geriatric patients from culturally and socioeconomically diverse backgrounds*
Supervisors: *Roger Bufford, PhD; Mark McMinn, PhD, ABPP; Mary Peterson, PhD, ABPP*
Clinical Duties:

- Yearly teams consisting of first, second, third, and fourth year graduate students who work collaboratively as a group to engage in consultation and promote clinical skills and professional development.
- Participate in formal presentations and team dialogue of clinical case conceptualizations, practical issues of assessment, psychotherapy, professional development, and ethical and legal issues of practice to a team of approximately 7 students and a licensed clinical psychologist.

Aug 2015 – Aug 2016 **Good Samaritan Family Medicine Resident Clinic**
Corvallis, OR

Title: *Behavioral Health Provider, Practicum II*
Treatment Setting: *Family Medicine Primary Care*
Populations: *Children, adolescents, adults, and geriatric patients from culturally and socioeconomically diverse backgrounds*
Supervisor: *Michael Herman, PsyD*
Clinical Duties:

- Provide short- and long-term behavioral health services to patients, administer and interpret brief screeners and assessments, assist in crisis management, and participate in warm handoffs.
- Administer and interpret interviews and assessments to write evaluations for bariatric pre-surgical evaluations. Participate in a one-month rotation at Samaritan Neuropsychology Albany Clinic and conduct neuropsychological assessments (common presenting problems include cognitive decline and ADHD) in a primary care setting.
- Common presenting problems include: depression, anxiety, panic disorder, bipolar, stress, adjustment to life transition, ADHD, grief, cognitive decline, insomnia, obesity, diabetes, medication compliance, substance use, and chronic pain.
- Engage in monthly psychologists' meetings, providers' narcotics case review meetings, and consultation and care coordination as part of a

multidisciplinary team of physicians, residents, medical students, nurse practitioners, nurses, social workers, behavioral health providers, and administrative staff.
- Implement clinic program development projects to increase provider, staff, and patient satisfaction.

June 2015 **Good Samaritan Athletic Medicine at Oregon State University (OSU)**
Albany, OR

Title: *Assessor/Evaluator*
Treatment Setting: *Samaritan Neuropsychology Albany Clinic*
Populations: *Freshman-Senior OSU football players*
Supervisor: *Robert Fallows, PsyD, ABPP*

Clinical Duties:
- Individual and group administration of neuropsychological tests in order to establish baseline concussion data and screen for ADHD, learning disorders, and possible psychiatric distress for 32 OSU football athletes.
- Data obtained is placed in a repository in order to be obtained if an athlete has a concussion in the future. Data will be used to ensure that players are safely returned to play only when fully recovered.

Aug 2014 – June 2015 **Oak Grove Elementary School**, **North Clackamas School District**
Milwaukie, OR

Title: *School Therapist, Practicum I*
Treatment Setting: *Public K-5 School*
Populations: *Diverse populations of students, parents, and staff of K-5 multi-systemic school setting*
Supervisors*: Carol Howe, EdS, NCSP; Fiorella Kassab, PhD*
Clinical Duties:
- Provide weekly, individual, long-term therapy; develop treatment plans; and implement evidence-based interventions for elementary school students in general and special education.
- Common presenting problems include: crisis management, ASD, anxiety disorders, mood disorders, ADHD, developmental disabilities, disruptive behavior disorders, and trauma related disorders.
- Plan and facilitate a social skills group and girl's group, and co-facilitate a friendship group and anxiety group.
- Conduct and interpret psychological assessment for Individualized Education Plans (IEP) including behavioral observations, standardized assessments and file reviews; co-facilitate IEP meetings; and provide feedback sessions.
- Engage in multidisciplinary consultation and collaboration as part of a team of teachers, learning specialists, occupational therapists, speech therapists, school psychologists, and school administrative staff.

Aug 2014 – June 2015 **Early Childhood Testing and Evaluation Center, North Clackamas School District**
Milwaukie, OR

Title: *Evaluator, Practicum I*
Treatment Setting: *Early Childhood Evaluation Center*
Populations: *Diverse populations of children 0-6 and families*
Supervisor: *Fiorella Kassab, PhD*
Clinical Duties:

- Work in a multidisciplinary setting in order to assess for developmental and/or intellectual concerns of children ages 0 to 6 years old.
- Conduct and interpret psychological assessments, and write formal reports consisting of behavioral observations, standardized assessments and interpretation, and developmental interview.

Jan 2014 – Apr 2014 **George Fox University, Pre-Practicum Therapy**
Newberg, OR

Title: *Pre-Practicum Therapist*
Treatment Setting: *University Counseling*
Populations: *George Fox University undergraduate students*
Supervisors: *Carlos Taloyo, PsyD; Heather Ambroson, MA*

Clinical Duties:

- Provide outpatient individual psychotherapy services to volunteer young adult university students, conduct intake interviews, prepare treatment plans, write formal intake reports, make diagnoses, complete termination summaries, and present case conceptualizations.
- Engage in video review and individual and group supervision.

Specialized Trainings and Certifications

Trainings

- Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training, *George Fox University*
- Incredible Years (IY) Group Therapy Evidenced-Based Practice – Dina Child Small Group and Parent Group, *Children's Hospital Los Angeles*
- RAINBOW/Child- and Family-Focused Cognitive Behavioral Treatment (CFF-CBT) for Pediatric Bipolar Disorder, *Children's Hospital Los Angeles*

Certifications

- *C*AMS: Collaborative Assessment and Management of Suicidality Training – ***CAMS Certified Clinician****, George Fox University*
- Workforce Development For Integrated Behavioral Healthcare and Primary Care Behavioral Health Boot Camp – ***Certification of Completion*** *(40 hour training), George Fox University*
- Trauma-Focused Cognitive-Behavioral Therapy, (TF-CBT Web) – ***Certification of Completion****, Medical University of South Carolina (MUSC)*

Awards & Honors

Diversity Scholarship, *George Fox University* 2013 – 2016
Deans List, *Baylor University* 2009 – 2013

President's Gold Scholarship, *Baylor University* 2009 – 2013

Supervision Experience

Sept 2015 – May 2017 **Behavioral Health Crisis Consultation Team**
George Fox University, Newberg, OR and McMinnville, OR
Yamhill County Mental Health, Yamhill County, OR

Position: *Team Coordinator, Graduate Department of Clinical Psychology*
Supervisors: *Mary Peterson, PhD ABPP; Bill Buhrow, PsyD; Joel Gregor, PsyD*
- Recruit and train crisis consultants to evaluate suicide and homicide risk, psychosis, and cognitive problems using empirically validated and evidenced-based assessments and live-layered supervision.
- Train and supervise crisis consultants to appropriately document procedures utilizing electronic medical records.

July 2016 – May 2017 **Childhood Health Associates of Salem**
Salem, OR

Position: *Peer Supervisor*
Supervisors: *Joy Mauldin, PsyD; Joel Lampert, PsyD, LPC, NCC*
- Provide peer supervision to and alongside a group of 3 practicum students who are behavioral health consultants in pediatric primary care.

Aug 2016 – May 2017 **Clinical Conceptualization and Application Team**
George Fox University, Newberg, OR

Position: *Fourth Year Oversight, Graduate Department of Clinical Psychology*
Supervisor: *Mary Peterson, PhD, ABPP*
- Provide clinical oversight of second year PsyD student including supporting the development of their clinical and assessment skills and professional development.
- Provide formative and summative feedback on clinical and professional skills in formal and informal evaluations.

Research Experience

Aug 2014 – Present **Doctoral Dissertation**
Title: *A Program Evaluation of the Hope House*
Summary and Purpose of Research: To evaluate the Hope House (a homeless transitional rehabilitation housing program for women and children) in order to understand the effectiveness of the program in satisfying and meeting the needs of the women and children they serve, and to identify any areas that are lacking. By understanding the Hope House's effectiveness in these areas, the program can learn which policies are effective/satisfactory and where to implement new approaches in the areas that are found insufficient. The Hope House will also be able to use the findings of this research to gain future grants and fundraising.

Lastly, this research will provide information on how to better meet the needs of underserved individuals in the community so they can receive enhanced care.
Committee Chair: *Winston Seegobin, PsyD*
Committee Members: *Mary Peterson, PhD, ABPP; Mark McMinn, PhD, ABPP*
Relevant Dates:

Proposal Approved: May 2015
Data Collection Completed: December 2016
Expected Date of Defense: January 2018

Sept 2015 – Present **Lead Consultant/Research Assistant, Juliette's House**
Faculty Advisor: *Marie-Christine Goodworth, PsyD*

- In response to Oregon legislative changes (Oregon Senate Bill 856) regarding implementation of child sexual abuse prevention instructional programs in public school, lead researcher consults with Juliette's House (a child abuse intervention center in McMinnville, OR) in order to research, design, and implement a teacher curriculum that assists the state schools in meeting the requirements of the new Senate Bill.
- Developed a sexual abuse prevention manual consisting of four developmentally appropriate, research-dependent chapters, which include 4 teacher lesson plans per chapter, as part of a child sexual abuse prevention instructional program for students in grades K-12.
- Chapters include: teacher informationals, parent handouts, and lesson plans that incorporate developmentally appropriate lecture material e.g. in-class activities, role-plays, and additional resources/access to materials to educate teachers, parents, and students about how to understand, prevent, and communicate incidents of sexual abuse.
- Manual is currently being implemented and piloted in several public schools in Oregon and outcome data is currently being collected and analyzed for review.

Sept 2015 – Apr 2017 **Research Assistant, Implicit Association Test (IAT)**
Faculty Advisor: *Winston Seegobin, PsyD*

- Study consists of George Fox University undergraduate students and uses the Race IAT and several religiosity measures in order to study the relationship between religion and racial prejudice.

Apr 2014 – Apr 2017 **Member, Research Vertical Team**
Faculty Advisor: *Winston Seegobin, PsyD*

- Bi-monthly group for developing research competencies that consists of dissertation development, participation in collaborative supplemental research projects, and development of fellow colleagues' areas of research interests.
- Various areas of team interest and focus: Resiliency, Trauma, Hope, Religion/Spirituality, and Diversity/Multiculturalism.

Publications and Presentations

Publications

McMinn, M.R., Shumway, K.T., **Rabie, A.N.**, Rose, A. (2017). Technology in Practice. *In Reference Module in Neuroscience and Biobehavioral Psychology*, Elsevier Science. ISBN 9780128093245

Rabie, A., Barr, B., Peterson, M. (2017). Impact of cognitive behavioral pain management group on depression, anxiety, pain severity, and opioid use in an inpatient population. *Journal of Pain Management,10*(2), 00-00. (In press).

Rabie, A. (2016). Tracking your hours to maximize your training (and with internship in mind). *Foxtale*. George Fox University Graduate Department of Clinical Psychology.

Rabie, A., Coleman, K., Goins, L., Winterrowd, M. (2017). Speak up! The right to refuse abuse: A school program for child sexual abuse prevention. Juliette's House. (In press).

Rabie, A. (2017). Resilliency: What is it, why is it important, and how to foster it. Childhood Health Associates of Salem.

Presentations (National)

Brewer, A., **Rabie, A**., Chang, K. & Seegobin, W. (2015) *Benefits of Residential Group Home on At-risk Children and Adolescents in Nicaragua.* Presented at the American Psychological Association Conference, Washington, D.C., August 6-9, 2015.

Copeland, B. & **Rabie, A.** (2014). *Sexual Development & Dysfunction: The Sexual Interdependence & Sexual Progression Model*. Presented at the October 2014 annual meeting of the Society for the Advancement of Sexual Health, Portland, OR.

Egger, A., Seegobin, W., Thurston, N., Gathercoal, K., **Rabie, A**. (2016) *How Sexually Trafficked Victims and Survivors Experience Hope and Resilience.* Presented at the American Psychological Association Conference in Denver, CO, August 4-7, 2016.

Seegobin, W., Han, S., Smith, S. M., Hoose, E., Brewer, A., Rodriguez, D., **Rabie, A**., Egger, A., & Chang, K. (2016). *A comparative study of religion and racial prejudice using the Implicit Association Test (IAT)*. Presented at the American Psychological Association Conference in Denver, CO, August 4-7, 2016.

Presentations (Regional/Local)

Copeland, B**.** & **Rabie, A.** (2014). *Sexual Development & Dysfunction: The Sexual Interdependence & Sexual Progression Model.* Presented to Latter-Day Saints Family Services and associated mental health providers, Renton, WA.

Rabie, A. (2016). *How to Address, Prevent, and Manage Burnout, Stress, and Anxiety in the Workplace: A Four Session Module for Medical Assistants.* Presented to Samaritan Family Medicine Resident Clinic, Corvallis, OR.

Teaching Experience

Sept 2015 – May 2017 **Team Coordinator, Behavioral Health Crisis Consultation Team**
Faculty: Mary Peterson, PhD ABPP; Bill Buhrow, PsyD; Joel Gregor, PsyD

George Fox University, Yamhill County Mental Health

- Manage on-call coverage for team of 18 Behavioral Health Crisis Consultants including: assist in developing training materials, provide live-layered supervision, recruitment, organize shift schedules, provide didactic trainings, and train consultants in evaluation of suicide and homicide risk, psychosis, and cognitive problems and documentation procedures.
- Coordinate with Emergency Department physicians and licensed clinical supervising psychologists to organize orientation trainings and continued educational trainings and engage in program development and evaluation projects.
- Develop standardized protocol for documentation, hospitalization protocols, and to train Behavioral Health Crisis Consultants.

Apr 2016 – Dec 2016 **Graduate Teaching Assistant, Cognitive Behavioral Psychotherapy**
Faculty: Mark McMinn, PhD, ABPP
George Fox University

- Provide guest lectures, demonstrate role-plays, and give students feedback on in-vivo training exercises.
- Course provides framework in conceptualization and treatment from first through third wave cognitive therapies, including Rational Emotive Behavior Therapy, Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, and Dialectical Behavior Therapy.

Aug 2014 – Apr 2016 **Graduate Teaching Assistant, Psychometrics**
Faculty: Mark McMinn, PhD, ABPP
George Fox University

- Assist in making and updating online quizzes and provide training and understanding of psychometrics to first year Doctorate of Psychology graduate students in weekly, hour long teaching assistant meetings.

Jan 2015 – Dec 2015 **Graduate Teaching Assistant, Cognitive Assessment**
Faculty: Celeste Flachsbart, PsyD, ABPP
George Fox University

- Lead a semester-long group consisting of 6 graduate students focused on training and ensuring competence of cognitive, achievement, and memory assessment, including reviewing and grading all students' video tapes, protocols, and reports, and providing feedback to students.
- Assist in planning curriculum for the George Fox University Doctorate of Psychology Cognitive Assessment class and demonstrating administration of various cognitive, achievement, and memory assessments.

University and Professional Service

Aug 2016 – Apr 2017 **Student Wellness Committee Coordinator, Student Council**
George Fox University Graduate Department of Clinical Psychology

- Listen and respond to student body concerns that affect wellness and sustainability, leading meetings, allocating student body funds, recruiting, and stocking supplies.

Apr 2016 – Apr 2017 **Member-at-Large, Student Council**
George Fox University Graduate Department of Clinical Psychology
- Represent the student body, participate in planning and organization of student events, conduct yearly elections of new members, and facilitate communication between student body and department.

Aug 2015 – Apr 2017 **Member, Child and Adolescent Special Interest Group**
George Fox University Graduate Department of Clinical Psychology
- Attend monthly meetings designed to increase knowledge of child and adolescent development, intervention, case conceptualization, and research.

Jan 2014 – Apr 2017 **Member, Clinical Health Psychology Network**
George Fox University Graduate Department of Clinical Psychology
- Network of graduate students, practicum sites, and other health psychology student groups aimed at enhancing professional relationships and consultation resource accessibility.

Feb 2014 – Feb 2017 **Student Volunteer, Graduate Department of Clinical Psychology Admissions**
George Fox University Graduate Department of Clinical Psychology
- Assist in interviewing prospective candidates with faculty, participate in interview day activities (e.g. special interest committee panel and student panel), and partake in orientation activities (e.g. meet and greet).

Sept 2013 – Apr 2017 **Administrative and General Member, Multicultural Committee**
George Fox University Graduate Department of Clinical Psychology
- Attend monthly meetings designed to increase knowledge, skills, and attitudes; training; awareness; outreach; and research of multicultural aspects of psychology.

Aug 2014 – Apr 2016 **Member, Community Worship Team**
George Fox University Graduate Department of Clinical Psychology
- Assist in developing, preparing, and setting up monthly community worship gatherings for the George Fox University Graduate Department of Clinical Psychology Program.

Dec 2014 – May 2015 **Member, Banquet Planning Committee**
George Fox University Graduate Department of Clinical Psychology
- Attend monthly meetings designed to plan and coordinate the end of the year banquet for the George Fox Graduate Department of Clinical Psychology.

Professional Memberships and Affiliations

American Psychological Association—Student Affiliate

Division 38 Society for Health Psychology Member
Division 54 Society of Pediatric Psychology Member
Baylor University Alumni Association

Volunteerism

Sept 2013, 2014, 2015, 2016 **Volunteer, George Fox University Annual Community Service Day**
Juliette's House Child Abuse Center
McMinnville, OR

- Work alongside other students to provide landscaping, gardening, and mail packaging services for Juliette's House Child Abuse Center.