

NATIONAL CLEARINGHOUSE ON CHILD
ABUSE AND NEGLECT INFORMATION

**“PUEBLO DE APOYO” / “VILLAGE OF
SUPPORT”**

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**ABANDONED INFANTS ASSISTANCE
PROGRAM**

FINAL PROJECT REPORT

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PUEBLO DE APOYO / VILLAGE OF SUPPORT

INTRODUCTION

The Pueblo de Apoyo / Village of Support Project was designed to target the predominantly Latino families at high risk of abandoning their infant or young children due to HIV/AIDS and/or drug and alcohol abuse by their mothers in the Greater East Los Angeles area and the immediate surrounding areas, which include Boyle Heights and Lincoln Heights communities located in the City of Los Angeles and various cities and unincorporated areas in South East Los Angeles.

The primary goal of the Pueblo de Apoyo AIA Project has been to prevent the abandonment of infants and young children whose mothers are infected with HIV or who are substance abusers by providing culturally responsive comprehensive services.

The “Pueblo de Apoyo” Project was inspired by the African proverb, “It takes a village to raise a child.” First Lady Hilary Rodham Clinton, also based her book (Clinton, 1996) on this concept, stating, “Children will thrive only if their families thrive and if the whole society cares enough to provide for them.” Therefore, the “Pueblo de Apoyo / Village of Support Program” has built on the models of the traditional Latino culture and the vision of Bienvenidos Children’s Center by enhancing and strengthening the support network of participating families whose

existing support networks had been shattered due to the diagnosis and stigma of HIV/AIDS or a maternal history of substance abuse.

Need and Benefit to Family and Child

The Pueblo de Apoyo Project has targeted the families who are at high risk of abandoning their infant or young children due to HIV and AIDS and/or alcohol or drug abuse by mothers in the predominantly Latino community of Greater East Los Angeles. East Los Angeles (East L.A.) is generally recognized as the cultural hub of the Latino / Mexican American / Chicano community of Los Angeles. The incidence of HIV/AIDS cases among Latina women has risen steadily in Los Angeles County. (Los Angeles County, HIV Prevention Plan for FY 1996 / 1997 TO 1997 / 1998).

Studies have shown that women who have been infected with HIV tend to be diagnosed later and die sooner than men with HIV Harris, April 29, 1992.) The Los Angeles Times reported that Latinas comprised 32 percent of the cases of women AIDS cases in Los Angeles County from 1981 to 1983 (Aubrey, 1993.) Of the reported AIDS cases of Latina women, 48 percent were exposed through heterosexual contact, 22 percent through injection drug use and 21 percent through undetermined risks. The latter group is largely believed to represent women who were infected heterosexually but who could not identify a sexual partner who was HIV-infected or at high risk of infection. In 1996, Bienestar, an AIDS service provider, neighbor and collaborative partner of the Pueblo de Apoyo Project, reported that out of the 78

Latina women who were HIV positive, 45 were HIV positive with children. In addition, Bienestar served at that time an additional 62 Latina HIV negative women whose partners were HIV positive.

Women with HIV frequently have greater difficulty accessing health care and carry a large burden of caring for their children and other family members who may also be HIV infected. They lack social support and face other challenges that may interfere with their ability to adhere to their own treatment regimens (National Institute of Allergy and Infectious Diseases, 1997.) As of Dec. 30, 1996, the Centers for Disease Control and Prevention (CDC) had received reports of 85,000 cases of AIDS among female adults and adolescents in the United States, 48,186 of whom had died.

Minority women in the United States are disproportionately affected by AIDS:

In 1996, 56 percent of reported female U.S. AIDS cases were among black women, and 20 percent among Hispanic women. These women tend to be poor, young and residents of disenfranchised communities in inner-city neighborhoods (Ibid.)

The Pueblo de Apoyo Program has focused its attention when working with mothers who had a diagnosis of HIV/AIDS to improve the quality of their lives. First, by adhering to their own medical regimen and those of their children who also had a positive diagnosis of HIV/AIDS and then by increasing their support networks beginning with family and friends and then increasing their use of more formal community resources. Finally each family affected by HIV/AIDS was assisted in developing and actualizing a permanency plan for their children.

East Los Angeles has one of the highest incidence of drug use in Los Angeles County (Los Angeles County Sheriff's Department, 1992.) In 1996, in East Los Angeles, there were 73 recorded alcohol-related deaths, 39 drug-related deaths, 1,361 alcohol-related hospital discharges and 1,0341 drug-related hospital discharges (United Way of Greater Los Angeles, 1998.)

In 1997, in the target area of the Pueblo de Apoyo Project, there were 1,324 children, ages five and under, with open abuse and neglect cases with the supervision of the Department of Children and Family Services, the local child protective services agency (United Way of Greater of Los Angeles, 1998) It is estimated that 70 to 80 percent of the children under the jurisdiction of DCFS are in the system due to abuse / neglect surrounding parental substance abuse (Hayes, 1997.)

Addicted women face major barriers in accessing the recovery support that is needed. Some of the institutional barriers to services are: lack of appropriate treatment that is appropriate for pregnant or parenting women, lack of child care and a fragmented approach to care (SAMSHA, 2000.) For Hispanic / Latina women, the lack of culturally and linguistically appropriate substance abuse and pre and post natal care presents a major barrier to accessing needed services (Ibid.) Overall, less than 11 percent of pregnant women in need of substance abuse treatment receive such services (Littlejohn & Thomas, 1989; GAO, 1990; Chavik, 1990.) For pregnant and parenting addicted women, walking through the maze of the numerous services is often discouraging and results in their disengagement from and appropriate use of, these services. For some Latina women, lack of legal immigration status is another barrier to seeking services. Undocumented Latina women often delay seeking

prenatal care and substance abuse treatment for fear they will be deported (SAMHSA, 2000.)

As a direct result of addiction, women who use drugs are often marginalized from mainstream society. Such marginalization often brings with it disengagement from available services such as prenatal care, substance abuse treatment and social services. This alienation is a result of both fears associated with criminal prosecution (GAO, 1990) and the psychological profile of low self-esteem, anxiety, depression, apprehension and suspicion (Reed, 1987; Sutker, 1987.) The psychological state of women addicts and their well founded fears of criminal prosecution and of losing their children present major obstacles to early identification and intervention (GAO, 1990; Chavkin, 1990; Sutker, 1987.) Denial (Cohen, 1981) is another characteristic of addiction, which further compounds both the institutional and individual barriers to accessing treatment.

The Pueblo de Apoyo has been able to successfully benefit the participants of the project meet the challenges posed to the predominantly Latina mothers who are pregnant and or parenting young children by improving the abilities of these mothers to access needed substance abuse treatment, prenatal care, health services for themselves and their children and other social services that they may need in a culturally responsive manner, thereby empowering them to care for themselves and their children as they attain and maintain sobriety.

DEMOGRAPHICS OF THE TARGET POPULATION

SOCIO-ECONOMIC CONDITIONS OF THE TARGET POPULATION

The targeted community, which is comprised of the Los Angeles County's Department of Health Services East Los Angeles and San Antonio Health Districts, is located in east of Downtown Los Angeles and has a population of approximately 601,752 and of that population, 79.9% is of Latino/Hispanic ethnicity. (Los Angeles County, Department of Health Services, 1997.) Approximately 55.7 percent of the population have not graduated from high school. The median income is \$28,438 and 29.15 percent live in poverty (Los Angeles County Department of Health Services, 1997.) Persons above age five who speak Spanish at home comprise 64.1 percent of the target area population and in East Los Angeles 85 percent speak Spanish (United Way of Greater Los Angeles, 1996.) Female head of households with children comprise 22.1 percent of total families.

CHILDREN IN OUT OF HOME PLACEMENT

The rate of children in out-of-home placement ranges from 12.3 children per thousand to 46.7. In 1997, in the target area, there were 1,324 children, ages five and under, with open abuse and neglect cases with the supervision of the Department of children and Family Services, the local child protective services agency (United Way of Greater of Los Angeles, 1998) It is estimated that 70 to 80 percent of the children

under the jurisdiction of DCFS are in the system due to abuse / neglect surrounding parental substance abuse (Hayes, 1997.)

HIV / AIDS Among Latinos and Latina Women

From 1991 to 1995, the rate of AIDS increased from 12.38 to 21.18 per 100,000 in the East Los Angeles Health District and from 8.69 to 17 in the San Antonio Health District (Los Angeles County Department of Health Services, 1997.) In 1998, there were 1,078 reported AIDS cases in the targetted area; 438 living and 640 deaths (United Way of Greater Los Angeles, 1998.) Among AIDS cases diagnosed in 1997, Latinos accounted for the largest percentage of all AIDS cases (39 percent) for the first time.

A study of all Latinos with HIV and AIDS interviewed found that 74 percent were foreign born. Of the foreign-born Latinos, 15 percent had lived in the United States for less than five years and 26 percent for six to ten years. Further analysis indicates that foreign-born Latino immigrants were least likely to have known about their HIV status early in the course of their infection. Of all foreign-born Latinos interviewed, 47 percent learned of their HIV status six or fewer months prior to their AIDS diagnosis. The data suggests that Latino immigrants born outside the United States are less likely to access the health care system for HIV medical, prevention and support services (Los Angeles Department of Health Services, 1999)

The high crime rate also results in high rates of incarceration of the community's residents, especially the males. In June 1992, the California Department of Corrections estimated that 100 HIV-positive inmates are released to parole each month. Forth percent of these parolees were released in the Los Angeles area (Los Angeles Department of Health Services, 1998.) Post incarcerated persons are likely to continue many of the risk behaviors practiced while incarcerated, such as unprotected sexual intercourse. In turn, these behaviors may place their families (wives, husbands, significant others, etc.) at risk.

The absolute number of HIV-infected women at childbirth is greater for Latinas than other ethnic groups, which may be due, in part, to the fact that Latinas give birth more often than other women (Los Angeles Department of Health Services, 1999.) Among children diagnosed in 1992-94, 59 percent were Latino children (Ibid.) Since the implementation of the universal blood donor screening in 1985, nearly all cases of the new HIV infection in children have been associated with mother to child transmission (Ibid.) During the same time frame, 45 percent of children diagnosed with AIDS were Latinos, the highest category for any group of children in Los Angeles County (Ibid.).

The percentage of female AIDS cases resulting from hetrosexual contact has increased from 38 percent of the total female AIDS cases in 1990 to a peak in 1995 of 55 percent to 41 percent in 1997. The percentage of female AIDS cases resulting from injection drug use was 31 percent in 1990 and decreased to 27 percent in 1997 (Los Angeles Department of Health Services, 1999.) The high incidence of

pregnancy among youth is an indicator that youth are engaging in sexual intercourse without using condoms, which puts them at high risk of HIV infection. Latinos have the highest birth rate of teen pregnancy in Los Angeles County (Los Angeles County Department of Health Services, 1995.) Among youth ages 13 to 29, who have been diagnosed, Latinos comprise 38 percent and Latinas comprise 40 percent. Among the females, 55 percent were infected due to heterosexual exposure (Los Angeles County Department of Health Services, 1999.)

SUBSTANCE ABUSE AND LATINAS

In 1996, in East Los Angeles, there were 73 recorded alcohol-related deaths, 39 drug-related deaths, 1,361 alcohol-related hospital discharges and 1,034 drug-related hospital discharges (United Way of Greater Los Angeles, 1998.)

Latinas, living with children, have many of the characteristics of high risk for substance abuse problems compared to women who reported no substance use or abuse. Compared to women who lived with children but did not report problem drug use, female problem drug users who lived with children were:

- About 1.7 times as likely to have less than a high school diploma (28 percent versus 17 percent.)
- About 3 times as likely to live in households in which a family member received welfare assistance in the past year (41 percent versus 12 percent.)
- About twice as likely to be divorced or separated (31 percent versus 13 percent) or never married 21 percent versus 10 percent, but only 0.63 times as likely to be

never married (47 percent versus 75 percent.) (SAMHSA, Department of Health and Human Services, 1997.)

Latinas in the East Los Angeles area exhibit many of the above characteristics, as well as the following characteristics which put them at high risk for substance abuse related problems, which also include: low socio-economic levels, having children at young ages, lower educational levels, language differences, overcrowding and substandard housing, immigration status problems, discrimination and over-represented as single-head of household (United Way of Greater Los Angeles, 1998.)

Latinas are generally reluctant to ask people close to them for help with a substance abuse problem. At the same time, the traditional culture discourages telling problems to “outsiders” such as formal service providers. Latinas may not know where to go or what resources are available. “Too often, there are few options for confidential, affordable, accessible and culturally compatible alcohol or drug treatment services for Mexican American women” (Mora and Gilbert, 1991.)

PROJECT DESCRIPTION

The Bienvenidos Children's Center's Pueblo de Apoyo (Village of Support) project expanded its service model of providing comprehensive in-home and center-based services to prevent infant abandonment in East and South East Los Angeles and to provide support for mothers who have or are high risk of substance abuse and/or HIV/AIDS. The project represents a unique and culturally appropriate prevention and intervention program targeting a population of high-risk Latina mothers and their infants and young children. The program has as its foundation the concept of *familia* and concepts of increasing personal and family resiliency while at the same time reducing family risk factors for abandoning infants and young children. The program interventions were multifaceted and involved bilingual Latina staff as key personnel in the service delivery model. The overall approach was one of family support and the development of a strong and intact family social support system.

The project targeted infants and young children who were at high risk of abandonment by their mothers. Preference had been given to women who are habitual alcohol or drug users or are HIV positive and who were in their third trimester of pregnancy or who had a child under 24 months of age residing with them. Other clients who also received services under the Pueblo de Apoyo Project included: high risk, but not pregnant women with at least one child under the age of nine; pregnant women in their first or second trimester; postpartum women who are

substance abusers or HIV positive; biological fathers who are responsible for caring for their abandoned infants and young children; extended biological families of abandoned infants or young children.

PROJECT COMPONENTS

Intake and Initial Assessment

An initial intake and assessment interview (see Appendix # D) is conducted for every potential applicant of the Pueblo de Apoyo Project by the Intake Coordinator. A careful screening is done to determine risk factors for abandonment, potential supports or resources within the family, health status, need and use of social and health services and areas of concern for the children. The initial intake is then discussed with the Clinical Director to determine eligibility for the project and assignment to a designated Family Support.

Comprehensive Assessment

A comprehensive assessment, utilizing the Family Assessment of Functioning Form (FAF) (see Attachment # C), Ages and Stages Questionnaire (ASQ) (see Attachment # C) and the AIA Programs Client Descriptive and Outcome Data Collection Forms for the Biological Mother and the Index Child (see Attachment #C) is conducted by the Family Support Worker and with the family. Upon completion of the FAF, the Family Support Worker (FSW,) meets with the family and reviews the family

strengths and areas needing strengthening. Likewise, the children's developmental milestones are reviewed with the parents upon completion of the ASQ.

Case Plan

Following the review of both FAF and ASQ assessments, an individualized Family Support Plan (Case Plan) is developed by the family with the assistance of the FSW. The Case Plan outlines the family's most pressing problems, the goals the family will work towards achieving and the methods that will be used to achieve the family's goals.

In-Home Comprehensive Services

In-Home Comprehensive Services are offered to eligible families who have children at home and have demonstrated a need of intensive and individualized services. Each family is assigned a Family Support Worker (FSW) who acts as case manager, counselor, teacher and source of support for the family. Families generally receive services for 12 months, sometimes longer, depending on individual needs of the family, with one to three home visits per week. Support services that families received include: assessment, case planning, parent mentoring, accompanying parents to community resources, counseling, court and legal advocacy, teaching of life and parenting skills, transportation and accessing information and referrals to community resources and support, advocacy and education in regards to health issues, including information about caring for infants who are drug or alcohol impacted, medically fragile or HIV positive and self-care information for mothers.

Center-Based Comprehensive Services

Center-Based Comprehensive Services are usually offered to eligible parents whose children have been placed in out of home care by the Department of Children and Family Services due to neglect or abuse as a result of maternal substance abuse or eligible participants, whose needs are not as intense, but still require support and need personal and family stabilization. . Each family is assigned a Family Support Worker (FSW) who acts as case manager, counselor, teacher and source of support for the family. Families generally received services for 12 months, sometimes longer, depending on individual needs of the family, with a minimum of two contacts per month, which included one home visit per month. Families received the same thorough assessment and case planning with a structured case managed program, as prescribed, for participation in groups, including but not limited to: Substance Abuse Education and Recovery Classes, Relapse Prevention Education, Por Que Te Quiero (Parenting Support Groups for Parents with HIV/AIDS), Los Tweeties (Support and Recreation Program for children and youth affected by parental HIV/AIDS diagnosis), Parenting Classes, Reunification Classes, Fatherhood Classes, Parents Anonymous Groups, Anger Management Classes, Stress Management Classes, Women's Health Workshops. Baby and Me Play Groups. In addition Center-Based Comprehensive Services participants have received support and services in the following areas: reunification services, monitored visitations, job training, referrals, crisis intervention, counseling, housing assistance transportation, legal and court

advocacy and access to the Family Support's Center emergency food and clothing pantry.

FAMILY SUPPORT CENTER SERVICES

The Bienvenidos Family Support Center houses a Family Drop-In Center which is open from 7 a.m. to 9 p.m., 5-6 days per week. The Center historically remains open and expands it's schedule to meet the needs of the community and the families it serves. The Drop-In Center provides an informal comfortable and family friendly environment for families to interact with each other, as well as with other program participants and their families. This center encourages and embraces the principal of the Pueblo de Apoyo / Village of Support amongst it's participants.

Services that are available to all Pueblo de Apoyo participating families include:

Parenting Classes, Reunification Parenting Classes, Substance Abuse Education and Recovery Classes, Relapse Education Classes, Anger Management Classes, Stress Management Workshops, Baby and Me Play Groups, Parents Anonymous Groups, Narcotics Anonymous, Overeaters Anonymous, Women's Health Workshops, Holiday and Traditional Activities for Families (Santa Day, Easter Egg Hunt, Dia de Los Muertos) Respite Services for parents participating in any Center-Based activity or group, Health Screenings for STI's and HIV provided by Planned Parenthood, Literacy Classes, Motherread/Fatherread, Resource and Referral Services, monitored visitation services and a food and clothing pantry.

COLLABORATIONS

The collaborations with community agencies has expanded through the four years in which the Pueblo de Apoyo Project has been implemented. The area that has especially grown within the project grant has been with AIDS services providers.

Initially, in the arena of AIDS services providers, Bienvenidos was seen as a newcomer and perhaps an entity who would attempt to take away clients from these other agencies. As time progressed and with much diligence, we became known as strong allies of other AIDS services providers in working for the holistic well being of mothers impacted by HIV/AIDS and their children. The project emphasis at family stabilization and maintenance was recognized and appreciated throughout the network of HIV/AIDS service providers.

In addition to the HIV/AIDS service providers who provide specialized HIV/AIDS case management, health monitoring, counseling and education, the project has maintained strong collaborations with other agencies within the Pueblo de Apoyo, which include substance abuse recovery services, legal and advocacy services, adoption as a permanency planning service, employment services, health services for women, agencies providing housing assistance and a wide variety of other service providers who help to meet the complex needs of the families served through this project (see Appendix #B.)

PRODUCTS

Revised Intake Form

A revised intake form (Attachment D) was created to capture some needed information to determine eligibility for the Pueblo de Apoyo Project. Information that can be accessed through the Initial Intake Referral Form include: marital status, ethnicity, primary language, education attained, employment status, source of income, demographic information about both biological parents, placement status of the children, child protective status, children's risk factors, parents' risk factors, services needed and requested by potential project candidates.

Assessment and Data Collection Instruments

A combination of local evaluation instruments and national prescribed data collection instruments were selected, modified, utilized and pilot tested for the current project study (Attachment C.) These included:

1. Family Assessment of Functioning Form - This is a multi-sectioned, observational checklist, initially developed by Children's Bureau of Los Angeles. The purpose of the FAF is to provide an assessment of family environment, family relations, family communication, childrearing, and other related family risk and protective factors, associated with health, child development and child rearing. Family Support Workers were trained to do family observation and to rate on a Likert type scale the various family and interactional schemes present in

- the home. The FAF was shortened and modified to meet the needs of the staff and the clients.
2. **Ages and Stages Questionnaire** - This is a standardized assessment of infants and young children (0-48 months) designed to determine the levels of cognitive, social and emotional development of infants and young children. This tool allowed the Family Support Workers to assist parents and/or caregivers in completing this assessment. Item responses were then coded and quantified.
 3. **AIA Programs Client Descriptive and Outcome Data Collection Forms** - These tools were administered by program staff as part of the intake session and at the time of closing a particular case. Variables used from these survey forms served as the basis for determining program impact in the area of drug use, HIV risk and changes in the status of child placement.

Reunification Parenting Curriculum

As a result of working with a population of whom a great majority had involvement with the CPS system and had children in placement at inception. It became apparent that there was a great need for a specific and intensive parenting curriculum that could meet the needs of parents working towards reunifying with their children or parents who wished to strengthen their relationships with their children and solidify the reunification they worked so hard to establish. Therefore, a Reunification Parenting Curriculum, was created and pilot tested during this project cycle (see Attachment #E.) Emphasis in this curriculum was made to acknowledge the impact on the removal and separation of the children from their families on both the parents

and the children. Parents who participated in the pilot program of this curriculum benefited from facing and addressing issues that were difficult to deal with, nevertheless critical in establishing stronger and healthier bonds with their children.

Client Satisfaction / Evaluation Instrument

Client Satisfaction form was developed by the AIA Resource Center in Berkley, but was late in creation. The survey then needed to be translated, which took place at our site towards the end of the second year. The survey was given to clients at closure with a stamped, self-addressed envelope, however few were returned. In the final year, the question of satisfaction was addressed in the AIA Programs Client Descriptive and Outcome Data Collection Termination Form.

Training Materials

During this cycle of the AIA Pueblo de Apoyo Project, a revision of the Substance Abuse Education Curriculum (see Attachment #F) and a new Relapse Prevention Curriculum was compiled (see Attachment #G.)

Revisions of the curriculum were made after noting the special needs of our specific population and to help them to become aware of their own specific areas of vulnerability, but giving them the tools to meet the challenges they will face in their lives.

In addition, a curriculum (see Attachment #H) was developed to help service providers understand the issues of parents who were separated from their children and how to help them to work with the parents in reconnecting with children who had been separated from their children. This curriculum and training was provided to caregivers at a emergency shelter nursery and an emergency respite facility and to foster family social workers.

DATA ANALYSIS AND EVALUATION

The evaluation of the Pueblo de Apoyo Project was headed by Behavioral Assessment, Inc., a local evaluation consulting firm. The evaluation of the program had originally been conducted by Dr. Karen Berliner, who was replaced by Behavioral Assessment, Inc. at the beginning of year 2. Richard Cervantes became the lead evaluator and was assisted by Dr. Juana Mora and other bilingual bicultural evaluation staff. The evaluators met regularly with program staff and assisted staff in operationalizing many of the evaluation factors and variables of interest. Program goals and objectives were quantified and numerous staff trainings were conducted to assist staff in developing an understanding of the role of evaluation and the need to document program activities. Findings from the intake AIA surveys were shared with staff.

Evaluation Design

The evaluation approach for the AIA Project utilized a quasi-experimental single group design with multiple measurements to effectively assess the project's goals and objectives. The scope and nature of the AIA Pueblo de Apoyo Project was comprehensive with a number of expected intermediate and long-term (impact) outcomes. The evaluation design took into account the multi-factors being targeted for change as a result of the project interventions. Despite the need for experimental control to determine causal effects, the current trend in the program evaluation field is to utilize a quasi-experimental research approach that is more realistic and feasible for evaluating community based programs.

Outcome Evaluation Methodology

In contrast to process evaluation, outcome evaluation is primarily concerned with the efficacy of the project. Outcome evaluation measures the attainment of measurable project goals and objectives. The proposed quasi-experimental design contains features of both the between-subjects and the within-subjects comparison methods since the participant group will be compared to the comparison group and within each group, as subjects will be assessed at baseline, termination and follow-up to determine change over time.

The large sample, along with the power of the quasi-experimental design enabled adequate detection of program effect. Such a methodology allowed the sufficient determination of the Pueblo de Apoyo Project's outcome on risk and resiliency variables, alcohol and drug use, HIV/AIDS and other infectious disease risk, and other life functioning such as health status, self-sufficiency, and social support and functioning.

Data Collection Instruments

Various assessment instruments were selected that would assist in determining the intermediate and impact outcomes of the project. These instruments are consistent with project goals and objectives. Initially, it was determined that the AIA national survey instruments, while comprehensive, would not allow for a complete assessment

on the intervention impact. Therefore, a set of local evaluation instruments was selected, modified and pilot tested for the current project study. These included:

1. **Family Assessment of Functioning Form** - This is a multi-sectioned, observational checklist, initially developed by Children's Bureau of Los Angeles. The purpose of the FAF is to provide an assessment of family environment, family relations, family communication, childrearing, and other related family risk and protective factors, associated with health, child development and child rearing. Family Support Workers were trained to do family observation and to rate on a Likert type scale the various family and interactional schemes present in the home. The FAF was shortened and modified to meet the needs of the staff and the clients.
2. **Ages and Stages Questionnaire** - This is a standardized assessment of infants and young children (0-48 months) designed to determine the levels of cognitive, social and emotional development of infants and young children. This tool allowed the Family Support Workers to assist parents and/or caregivers in completing this assessment. Item responses were then coded and quantified.
3. **AIA Programs Client Descriptive and Outcome Data Collection Forms** - These tools were administered by program staff as part of the intake session and at the time of closing a particular case. Variables used from these survey forms served as the basis for determining program impact in the area of drug use, HIV risk and changes in the status of child placement.

FINDINGS

Demographic Characteristics of Participants

Over the course of the 4 year Pueblo de Apoyo Project, Initial Intake Data was collected on 427 biological mothers. Of that number, 179 only made use of the Family Support Center Services. These 179 participants met eligibility requirements, however did not In-Home Services, but instead requested and made use of Family Support Center services, such as a Parenting Class, Substance Abuse Education and Recovery Classes or Information and Referral Services. Only AIA Intake Information was collected on these 179 participants. The remaining 248 received either Comprehensive In-Home or Center-Based Services and completed both intake and termination evaluations on the biological mother. Two hundred twenty- seven (227) child intakes and terminations were completed. A total of 191 Family Assessment Functioning Forms (FAF) were completed at intake and only 185 FAF termination surveys were completed on the project participants.

Demographic baseline tables were divided by year and reported for all program participants. Outcome analysis were done only for AIA evaluations and FAF surveys completed during year three and four because the data for years one and two were not able to be combined due to many changes in the instrument design. Termination summaries and core research data will only be reported for third and fourth year participants.

Mother's Demographic Information (See Table Set 1)

Most mothers were self-referred to the program; community agencies and the Department of Child and Family Services were the second biggest referral source (Table 1-1.) Ethnically, the participants were mostly Hispanic/Latinas (91%) (Table 1-2.) Almost two-thirds (64%) spoke English at home while the rest preferred Spanish (Table 1-3.) Slightly more than half were never married (51%) and almost one-quarter (23%) were separated, widowed or divorced (Table 1-4.) Over 65% did not finish high school (Table 1-5.) Almost 20% were employed while most (67%) received government subsidies (Table 1-6.) The majority (77%) lived in a house or apartment and 5% were homeless (Table 1-7.) Only 30% lived with their child's father or a partner, about 24% lived with their parents, and 25% lived alone with their children (Table 1-8.) About 12% were pregnant or recently delivered (within past 30 days) (Table 1-9.) Sixty-eight percent (68%) had a history of substance abuse, 12% admitted to currently using drugs or alcohol and 45% had a child removed from their home (Table 1-11.) Twenty percent (20%) reported using alcohol while pregnant, 18% used cocaine or crack while pregnant and 12% reported marijuana use while pregnant (Table 1-12.) At intake, about 25% reported some substance abuse treatment during the last 6 months while most reported no treatment at all (Table 1-13.)

Child's Demographic Information (See Table Set 2).

Approximately 45% of the index children were female and 55% were male (Table 2-1.) Over 91% of the index children were Hispanic/Latino (Table 2-2.)

More than seven percent (7%) were reported to have special care needs at birth (Table 2-3.) Only 45% reported a clean toxicology report and 10% did not have a test. Over nineteen percent (19%) showed positive traces of drugs in their system (Table 2-4.) Sixty-eight percent (68%) had active cases with the Child Protective System (Table 2-5.) Over 70% had up-to-date immunizations for the age of the child (Table 2-6.)

Termination Data for Years 3 and 4 (See Table Set 3).

Generally, participating families used services provided by AIA more than those provided by other programs. Case Management, Food and clothing donations, parenting classes and support were the most frequented (over 80% respectively). Legal Advocacy, Outpatient Drug Treatment and Recovery Support were used by more than half (52%) (Table 3-1.) Almost half the terminations (48%) completed the program requirements, 14% were did not complete due to lack of contact, over 9% voluntarily terminated prematurely and sadly 2% died (see Tables 3-2 & 3-3.)

In regard to client satisfaction, over 85% found the program helpful (Table 3-4,) 27% rated the program good and over 60% rated the program excellent (Table 3-5,) note Attachment #J for a sample of client comments regarding satisfaction.

In regard to child risk factors, over 2% were HIV positive at termination (Table 3-6.) Over 11% of the families were reported to CPS during the course of the program (Table 3-7.) Fifty-nine percent (59%) had active cases with the CWS, and over 16% closed their case with the CWS (Table 3-8.) Over 90% had reported having up-to-

date immunizations for their children (Table 3-9.) Lastly, case management was the service most utilized by children (98%). Legal advocacy (56.5%), child development and education services (49%) and infant development screening and assessment were also frequently used (46.8%)(Table 3-10.)

OUTCOME FINDINGS

For the purpose of this outcome study the results will be derived from year three and four of the AIA program, we have chosen to use year three and four data as year two was a transition period where new evaluation instruments and methods were being planned. During years three and four, rigorous evaluation data were collected for all AIA participants using the revised evaluation methods and instruments developed by Behavioral Assessment Inc.

The outcome findings will be summarized below to address each of the AIA program objectives, data were derived from the AIA intake and termination survey, the FAF, and the ASQ tools to best answer each of the AIA Pueblo de Apoyo interventions.

In most cases, findings are based upon an assessment of scores taken at intake baseline as compared with data derived at time of client termination. This allows for an assessment of program impact based on observed and measured changes across a number of important risk and protective factors.

Table Set 4

AIA CORE RESEARCH QUESTIONS

N=110

1. *Did the program maintain infants at risk of abandonment and neglect in their own home with their parents, relatives or provide children plan for permanency?*

Yes – The table below shows substantial changes in placement of index children from intake to termination in years three and four. A moderate change in the children’s placements at home with biological parents with and without CWS involvement were found. A large decrease was found in the percentage of index children placed in foster homes. The findings suggest positive change in the placement of index children from foster care to in-home care with bio-parents from intake to termination.

Placement of Index Child	Years 3 and 4	Years 3 and 4
	Intake	Termination
Table 4-1		
Home with Biological Parents – No CWS Involvement	34.2%	42.2%
Home with Biological Parents – With CWS Involvement	14.4%	21.6%
Home with Relatives	3.3%	3.2%
Formal Kinship Foster Care	20.0%	10.4%
Use of Stand By Guardianship or other Legal plans for permanency	2.4%	5.3%
Foster Care Home	20.9%	7.4%

2. Did the program decrease substance use among mothers?

Table 4-2

Is Biological Mother Presently Using	Years 3 and 4	Years 3 and 4
	Intake	Termination
Drugs or Alcohol	16.1%	4.0%

Yes – The table above shows substantial reduction in current alcohol and drug use from intake to termination in years three and four. These findings suggest that the program reduced drug use for substance using participant mothers.

3. Did the program improve economic and living conditions among participating families, including: Improved housing, finances and employability, and education and literacy?

Table 4-3

Number Of Cases	FAF Variable	Intake Mean	Termination Mean	Paired T-test	Sig.
145	Living Conditions	17.22	13.66	***14.507	.000
137	Financial Conditions	8.70	6.88	***13.796	.000

Table 4-4

Housing Situation	Years 3 and 4 Intake	Years 3 and 4 Termination
House or apartment	69.9%	76.1%
Other temporary shelter	26.0%	15.9%
Source of Income		
Table 4-5		
Employment Earnings	15.5%	32.4%
Government Supplement	66.7%	58.7%
No Income	29.8	12.8%
Level of Education Completed		
Table 4-6		
	Years 3 and 4 Intake	Years 3 and 4 Termination
High School Graduate, GED	15.7%	22.1%
Trade/Vocational School	3.3%	1.8%
Some College	4.8%	18.9%
College Graduate (2 or 4 years)	3.6%	1.9%

Yes – The tables above indicate a large positive change on the FAF in Living Conditions from intake to termination. Housing situation was not substantially changed from intake to termination. Employment increased substantially during years three and four. Participants with no income decreased substantially. The number of high school graduates and college enrolled participants increased substantially from intake to termination. These findings indicate that there have been

large improvements in overall living and economic conditions for participant families.

4. Did the program increase the use of community resources by participating parents?

Table 4-7

Services Received	N=206	N=206
	Majority Provided By AIA Program	Majority Provided by Non-AIA Program
Case management	97.4%	2.6%
Child care	21.1%	15.6%
Domestic Violence services	39.4%	11.0%
Educational/Schooling/GED	13.6%	27.3%
Family Planning	20.9%	11.4%
Financial Entitlement assistance	14.2%	23.25%
Food and/or clothing donations	82.4%	3.6%
HIV education/prevention	35.7%	10.4%
HIV screening/assessment	19.1%	17.8%
HIV services/ treatment	13.4%	19.3%
Housing/rental assistance	17.9%	27.8%
In-Home Services	70.3%	12.6%
Legal services/advocacy	52.2%	9.8%
Mental Health Counseling/Therapy	35.4%	34.1%
Outpatient Drug Treatment	55.6%	14.0%
Parenting Classes/training/support	83.3%	5.9%
Pastoral care	2.9%	7.4%

Peer Counseling	60.1%	6.8%
Permanency Planning	24.1%	8.6%
Postnatal Care	6.6%	1.4%
Pre and post HIV test counseling	15.7%	14.8%
Prenatal care	0.9%	7.2%
Primary Medical Care	5.9%	23.1%
Public health nurse visit	0.0%	13.4%
Recovery support	62.1%	9.3%
Residential facility for women and Children	7.4%	9.4%
a. Residential Drug Treatment	6.4%	11.8%
b. Respite Care	28.9%	4.9%
c. Services to biological father/mother's partner	21.1%	0.9%
d. Transportation	72.3%	1.1%
e. Vocational/employment/job training assistance	25.8%	7.6%
f. Other	24.1%	6.9%

Yes – The table above shows substantial utilization of community resources provided by the AIA program for the highlighted services as compared to community resources not provided by the program. This table suggests that those participants using these AIA services would not seek these out without the program's support.

5. Did the program help ensure that children at risk of being orphaned receive permanency planning?

Table 4-8

Services Used (N=206)	Majority Provided by	Majority Provided by
	AIA Program	Non-AIA Program
Permanency Planning	24.1%	8.6%
Legal Advocacy on behalf of the Child	48.2%	8.3%

Yes – The table above indicates that the AIA program has provided program participants with permanency planning and legal advocacy on the child’s behalf. It also indicates that participants are significantly utilizing these services as compared to non-AIA provided permanency-planning services.

5. Did the program expand the natural support networks of mothers at risk of abusing, neglecting or abandoning their infant children?

Table 4-9

No. of Cases	FAF Variable - Question C1	Intake Mean	Termination Mean	Paired T-test	Sig.
154	Support from friends, neighbors and community members	3.22	2.56	***14.07	.000

Yes – According to the table above participant mothers substantially increased their use of natural support systems from intake to termination.

7. Did the program improve the abilities of mothers who are HIV positive and their families to care for themselves and their infants and young children who may also be HIV positive or medically fragile?

Table 4-10

Number of Cases	FAF Variable	Intake Mean	Termination Mean	Paired T-test	Sig.
19	Living Conditions	14.82	11.42	***4.69	.000
19	Financial Conditions	15.18	12.08	**7.28	.001
16	Support of Caregiver	12.16	9.91	***3.90	.000
19	Parenting Skills	23.66	18.50	***5.34	.000

Yes – The table above indicates that substantial changes were made by participant HIV positive mothers in their abilities to care for their infants and young children as measured by four FAF variables. Living Conditions, Financial Conditions, Supports of Caregivers and Parenting Skills show large improvements from intake to termination.

8. Did the program increase the mothers' knowledge of risk factors associated with infection from HIV and other sexually transmitted diseases and tuberculosis?

Table 4-11

Service Provided (N=206)	Majority provided by AIA Program	Majority Provided by Non-AIA Program
HIV Education/Prevention	35.7%	10.4%

Not Determined – The table above indicates that participant mothers substantially use HIV prevention and education services, including information regarding risk factors

and other STD's. This table does not answer whether the mothers' knowledge is increased from intake to termination.

9. Did the program increase mother's knowledge and practice of health promoting behaviors, such as proper nutrition, hygiene, exercise and preventative care?

Table 4-12

Number Of Cases	FAF Variable - Question C5	Intake Mean	Termination Mean	Paired T-test	Sig.
137	Provides for basic medical/physical care: including proper nutrition, hygiene and preventative care.	2.7	2.2	11.607	.000

Yes – According to the table above the participant mothers substantially improved their ability to promote healthy behaviors such as nutrition, hygiene and preventative care from intake to termination (exercise was not assessed by this variable).

10. Did the program increase the participation of male parent's and relatives in the lives of their children?

Table 4-14

Living Situation (N=206)	Years 3 and 4 Intake Mean	Years 3 and 4 Termination Mean
	Lives with Child's Father or Partner	23.3%

Table 4-15

Services Provided (N=206)	Majority Provided By AIA Program	Majority Provided By Non-AIA Program
Services to Biological Father/Mother's Partner	21.1%	0.9%

Not Determined – The tables above indicate a large increase in participant mother’s living with the index child’s father, and that services for biological fathers’ are significantly utilized. These findings imply a general increase in participation by male parents and relatives but no variable directly measured the level of male involvement in the child’s life.

AIA EVALUATION DISCUSSION (See Table Set 4)

The outcome data addressed ten primary research questions. The findings suggest that the Pueblo de Apoyo Project helped maintain infants at risk of abandonment and neglect in their own home with their parents. The percentage of children living with biological parents (with and without CWS involvement) rose from 48.6% to 63.8% while children placed at foster care decreased from 20.9% to 7.4% from intake to termination.

The participant mothers substantially reduced reported drug use from 16% to 4%. A paired t-test analysis showed significant ($p < .001$) improvement in general economic

and living conditions were from intake to termination. Housing situation, source of income and level of education were also substantially increased from intake to termination.

The data showed increased use of services provided by the AIA data as compared to non-AIA program provided service. This suggests that the AIA services are more accessible to the participants. Case Management, Parenting Classes and Food and Clothing donations are the most frequently used.

The program also helped ensure the provision of permanency planning for children at risk of abandonment by providing Permanency planning services to 24.1% of program participants and by providing Legal advocacy to achieve permanency to 48.2% of participant children.

A paired t-test analysis showed significant ($p < .001$) change in the use of natural support networks of mothers at risk of abusing, neglecting or abandoning their children. More analysis revealed that the program significantly improved the abilities of mothers who are HIV positive to care for their young children. The program significantly improved living conditions ($p < .001$), financial conditions ($p < .010$), Support to caregiver ($p < .001$), and Parenting Skills ($p < .001$).

The program was shown to significantly increase ($p < .001$) mother's knowledge of health promoting behaviors, such as proper nutrition, hygiene and preventative care.

The data was not able to determine whether the mother's knowledge of risk factors associated with HIV, STD's and Tuberculosis was increased, although the inference is positive. The data does show that HIV Education and Prevention services were used by 35.7% of the participants. This is particularly significant in light of the fact that many of the mothers served were in fact HIV positive.

In terms of male participation in the index child's lives, the data does not address whether participation increased, but it does show that the number of children living with their father or mom's partner increased from 23.3% to 36.2% from intake to termination. The data also shows that 21.1% of biological fathers or mother's partners used services provided by the program. This does suggest that participation by male parents or significant others increased and that there was a trend toward more intact and dual parent families as a result of AIA participation.

Overall, the evaluation findings reflect a strong program with multiple impacts that has resulted in improved family functioning, reduced family crisis, and stabilization of families. The program delivery model reflects culturally competent services and has the potential for replication across other similar at risk Latina groups.

DISCUSSION AND SUMMARY

The Abandoned Infants Assistance Project has evolved over the past seven years as the needs and the resources in the community have changed. The changing project names reflect the changes in program emphasis. During the first four years, the project, entitled *Madrinas In-Home Program*, pioneered an intensive model of in-home services for families that were primarily substance abusers or women at-risk for substance abuse and subsequent abandonment of their children. At that time, there were fewer reported cases of HIV/AIDS among Latinas. A diagnosis of HIV/AIDS was thought of as a death sentence at that time. The few women diagnosed generally were at an advanced stage of the disease and had real difficulties with accessing services outside their homes. By 1996, increasing numbers of HIV/AIDS cases were reported for Latinas. However, with the improvement of HIV/AIDS treatment, women infected face a new set of challenges, living with HIV/AIDS. Project participants with HIV/AIDS were often widows, living in extreme shame and isolation with limited financial resources and no permanency plans for their children. Despite the improvements in HIV/AIDS treatment, five participants succumbed to AIDS related illnesses. Efforts were made to create and enforce permanency plans while the mothers were alive, leaving the children with stable and loving homes. For those participants living with HIV/AIDS diagnoses, the issue of permanency planning was also addressed. Families were counseled, educated and assisted in preparing permanency plans for their children. The greatest majority of the HIV/AIDS infected participants were immigrant mothers who had been infected by their husbands or partners. Often these participants were widowed due to the deaths of their partners

from AIDS related diseases. The challenges and problems these women faced were legion and complex: loss of a partner, a sense of betrayal that their inheritance from their partner had been a deadly disease, extreme poverty, isolation, fear of disclosure, fear of treatment and the side effects of treatment, treatment providers in extreme areas of the county, substandard housing issues, single parenthood, not wanting to inform their children, knowing that they could not return to their country because of the stigma of AIDS. These participants who had diagnoses of HIV/AIDS, received Comprehensive In-Home Supportive Services and welcomed their Family Support Workers who offered support, encouragement and directed them to the appropriate resources which were needed to maintain their health and their families.

The project also featured a Family Support Worker (FSW), a paraprofessional / peer counselor who was supposed to provide most of the in-home services. As the program evolved, it became apparent that families were facing very severe, complicated problems and that more experienced, professionally trained staff were needed to assist these families. The role of the Family Support Worker had been expanded in the Pueblo de Apoyo Project to include: Case management, in-home counseling, and parent training. The Family Support Worker position was upgraded and the position now requires a bachelor's or master's degree in social work or a related field and two years of experience providing services for families with multiple problems.

Within the four years of the Pueblo de Apoyo Project, the issue of maternal substance abuse and the child welfare system, went through some radical changes that impacted the project participants with histories of substance abuse and also was the impetus for some strong program changes and responses to meet the growing challenges.

Although, experts in the field of substance abuse, that it is impossible to put a timeframe on the process of recovery. Both Federal and State mandates changed the time frame for reunification from 18 months to one year. In addition, if an infant was removed from their mothers due to neglect caused by substance abuse, the reunification time frame was reduced to 6 months. The notion of concurrent planning was also implemented which mandated that CPS not only work on plan for reunification with the biological parents but concurrently work on a permanency plan on behalf of the child, often placing infants in adopt-foster homes with the intentions of permanent placement. Finally, if a mother, with a prior history of substance abuse and involvement with CPS, re-entered the CPS system, her changes at reunification could be denied, and the child would be fast tracked into permanency planning immediately with no chance at reunification. The system had changed and the Pueblo de Apoyo Project responded accordingly. The Substance Abuse Education and Recovery Program, which was established at the inception of the project was revised and strengthened to include a Relapse Prevention Program. Promotoras, peer counselors, began to spread the word that for mothers with children in the CPS system, this might truly be their last opportunity to reunify with their children, but they attempted to recruit mothers to enter the Pueblo de Apoyo Project.

While drastic changes were taking place in the Child Welfare System that affected mothers with histories of substance abuse, tremendous changes were also taking place in the Welfare to Work movement that equally affected participating mothers, creating anxiety and fear within many of the participants.

To meet these challenges, the project needed to accommodate and adjust to these changes, in order to support and assist participants. The program evolved in order to meet the rapid changes, helping women to make the changes that were required of them. In light of the tremendous pressures placed upon participants, the project has demonstrated a significant number of women who maintained recovery and did not relapse (Table 4-2.)

The AIA Projects have been the core and the foundation of Bienvenidos Family Services. We have become recognized as a strong ally for the underserved and disenfranchised families of our community. We have also gained the respect of our collaborative partners and other service providers by being able to provide comprehensive, culturally competent services that meet the needs of the families we serve, especially the two populations that are the most isolated and stigmatized, HIV/AIDS infected mothers and mothers with histories of substance abuse addictions. We have demonstrated that there is hope and with guidance and support coupled with careful assessment and case planning, changes can happen and fragile families can be restored.

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AIA DEMOGRAPHIC TABLES YEARS 1- 4

Table Set 1. Mother's Baseline Demographic Data

Table1-1

Referral Source	Year 1 N=88	Year 2 N=136	Year 3 N=68	Year 4 N=42
Self-referred	31.8%	34.6%	19.1%	26.4%
Family member, Friend, Neighbor	11.4%	17.6%	5.0%	26.4%
Treatment Program	11.4%	2.2%	11.8%	11.3%
Medical/Hospital	0.0%	0.0%	0.0%	1.9%
Law Enforcement, Police	1.1%	0.7%	0.0%	0.0%
Court, Corrections (jail or probation)	1.1%	1.5%	2.9%	1.9%
Public Child Welfare Services/ Child Protective Services	17.0%	19.1%	11.8%	11.3%
Community based agency	18.2%	16.2%	22.1%	9.4%
Other	2.3%	8.1%	7.4%	11.3%
Unknown	4.5%	0.0%	0.0%	0.0%

Table 1-2

Ethnicity	Year 1 N=88	Year 2 N=136	Year 3 N=68	Year 4 N=42
African American/Black	2.3%	1.5%	0.0%	3.8%
Asian/Pacific Islander	0.0%	0.0%	0.0%	0.0%
Hispanic/Latina	92.0%	89.1%	91.2%	90.6%
White-Non Hispanic	5.7%	8.1%	8.8%	5.7%
Native American	0.0%	0.7%	0.0%	0.0%
Other	0.0%	0.7%	0.0%	0.0%

Table 1-3

Primary Language Spoken in the Home	Year 1 N=88	Year 2 N=136	Year 3 N=68	Year 4 N=42
English	64.8%	70.6%	61.8%	64.2%
Spanish	35.2%	29.4%	35.3%	35.8%
Other	0.0%	0.0%	2.9%	0.0%

Table 1-4

Marital Status at Intake	Year 1 N=88	Year 2 N=136	Year 3 N=68	Year 4 N=42
Single, never married	40.9%	48.5%	57.4%	56.6%
Married	19.3%	17.6%	10.3%	11.3%
Separated, Divorced, Widowed	27.3%	16.9%	23.5%	26.4%
Other	11.4%	16.9%	5.9%	3.8%
Unknown	1.1%	0.0%	2.9%	1.9%

Table 1-5

Level of Education Completed	Year 1 N=88	Year 2 N=136	Year 3 N=68	Year 4 N=42
Less than high school	18.2%	28.1%	27.9%	37.7%
Some high school	35.2%	40.7%	35.3%	37.7%
High School Graduate, GED	19.3%	18.5%	22.1%	9.4%
Trade school/Vocational Training	0.0%	1.5%	2.9%	3.8%
Some College	13.6%	5.2%	5.9%	3.8%
College graduate (2 or 4 years)	3.4%	3.0%	1.5%	5.7%
Unknown	10.2%	3.0%	4.4%	1.9%
	Year 1 N=88	Year 2 N=136	Year 3 N=68	Year 4 N=42

Source of Income/Entitlements at Intake Table 1-6	Year 1 N=88	Year 2 N=136	Year 3 N=68	Year 4 N=42
Employment earnings	23.2%	25.6%	10.3%	20.8%
Unemployment benefits	1.5%	6.3%	0.0%	3.8%
TANF/TANF "Child Only"	22.9%	39.3%	32.4%	73.6%
Social Security Disability Insurance (SSDI)	8.8%	9.0%	5.9%	3.8%
Supplemental Security Income (SSI)	11.8%	9.3%	10.3%	7.5%
Foster Care Payments	1.5%	1.0%	0.0%	1.9%
Medicaid	3.0%	1.0%	4.4%	5.7%
Housing subsidy/Public housing	11.6%	4.2%	8.8%	11.3%
WIC (Women, Infants & Children)	13.0%	22.8%	16.2%	15.1%
Food Stamps	-----	-----	38.2%	43.4%
Income from spouse, family or friends (including alimony and child support)	13.0%	24.2%	23.5%	30.2%
Other	-----	-----	26.9%	13.2%
No Income	24.8%	39.1%	38.5%	21.2%

Housing Situation at Intake Table 1-7	Year 1 N=88	Year 2 N=136	Year 3 N=68	Year 4 N=42
House/Apartment	85.1%	83.7%	66.2%	73.6%
Boarding house/SRO Hotel or Motel with support services	1.1%	2.2%	4.4%	1.9%
Homeless shelter, On street	4.6%	3.7%	5.9%	7.5%
Residential Treatment	4.6%	2.2%	8.8%	3.8%
Supported living arrangement	1.1%	1.5%	4.4%	3.8%
Other	1.1%	5.2%	5.9%	5.7%
Unknown	2.3%	0.7%	4.4%	3.8%

Living Arrangement at Intake Table 1-8	Year 1 N=88	Year 2 N=136	Year 3 N=68	Year 4 N=42
Lives with no other adult	30.2%	27.3%	25.0%	17.0%
Lives with child's father or partner	37.5%	38.5%	22.1%	24.5%
Lives with parents or other relatives	24.6%	21.3%	25.0%	26.4%
Lives with non-relative (not including partner)	15.0%	16.8%	17.6%	24.5%
Other (includes group home, shelter, residential treatment, jail, etc.)	8.9%	6.7%	7.5%	13.2%

Pregnancy Status Table 1-9	Year 1 N=88	Year 2 N=136	Year 3 N=68	Year 4 N=42
Pregnant	11.3%	8.5%	8.8%	11.3%
Recently Delivered (within last 30 days)	3.8%	1.7%	1.5%	0.0%

Trimester Prenatal Care began with Index Child Table 1-10	Year 1 N=88	Year 2 N=136	Year 3 N=68	Year 4 N=42
1 st trimester (1-13 weeks)	18.8%	39.4%	54.4%	52.8%
2 nd trimester (14-26 weeks)	13.8%	7.9%	13.2%	22.6%
3 rd trimester (27+ weeks)	3.8%	2.4%	4.4%	1.9%
Received care (length of time unknown)	1.3%	6.3%	4.4%	15.5%
Unknown	3.8%	2.2%	2.9%	0.0%
No prenatal care	58.8%	40.9%	20.6%	7.5%

Does Biological Mother Have A: Table 1-11	Year 1 N=88	Year 2 N=136	Year 3 N=68	Year 4 N=42
History of children removed from home due to abuse/neglect	43.5%	45.3%	50.0%	45.3%
History of psychiatric illness	5.9%	15.0%	11.8%	11.3%
History of being physically abused as a child	18.8%	33.3%	25.0%	17.0%
History of being sexually abused as a child	9.5%	15.4%	19.1%	17.0%
History of adult domestic violence victimization	-----	-----	38.2%	47.2%
History of selling drugs	-----	-----	-----	11.3%
History of prostitution	-----	-----	-----	9.8%
HIV/AIDS diagnosis	21.4%	12.6%	14.7%	17.0%
History of criminal conviction	24.1%	32.8%	20.6%	9.4%
Currently of Probation or parole	16.7%	18.3%	19.1%	5.7%
History of Substance Abuse	65.9%	70.3%	73.5%	64.2%
Presently using drugs/alcohol	7.1%	10.8%	19.1%	13.2%

What substance did biological mother use during pregnancy with index child Table 1-12	Year 1 N=88	Year 2 N=136	Year 3 N=68	Year 4 N=42
Alcohol	28.8%	24.8%	20.6%	9.4%
Amphetamines	12.0%	8.2%	10.3%	5.8%
Barbiturates	2.7%	0.9%	1.5%	0.0%
Cocaine (I. V. or Powder)	24.7%	15.9%	16.2%	11.4%
Crack Cocaine	17.3%	13.6%	17.6%	13.5%
Marijuana	17.8%	12.1%	8.8%	13.5%
Opiates (other than methadone)	9.6%	6.4%	1.5%	1.9%
Methadone	4.1%	7.4%	1.5%	0.0%
PCP	12.2%	6.4%	2.9%	3.8%
Tobacco	5.5%	9.3%	14.7%	9.6%
Other	4.1%	5.7%	4.4%	1.9%
No known substance use	5.2%	16.7%	7.4%	13.5%

Drug/Alcohol Treatment History Table 1-13	Year 1 N=88	Year 2 N=136	Year 3 N=68	Year 4 N=42
Last received treatment within the past 6 months	21.5%	21.4%	26.5%	28.8%
Last received treatment more than 6 months ago	8.9%	13.5%	14.7%	5.8%
Never in treatment for substance use	22.8%	27.0%	44.1%	48.1%
Unknown	46.8%	38.1%	14.7%	17.3%
Drug/Alcohol Treatment Methods Table 1-14				
Inpatient/Outpatient Detoxification	0.0%	0.9%	5.9%	17.3%
Outpatient (includes outpatient methadone)	20.3%	33.3%	26.5%	23.1%
Hospital-based	0.0%	0.9%	4.4%	0.0%
Residential	12.5%	9.9%	14.7%	15.4%
Self-help (e.g., AA, NA)	0.0%	10.8%	-----	36.5%
Other	7.8%	44.1%	5.9%	3.8%
Unknown	43.2%	-----	-----	-----

Note: A line in a box (----) means that this category was not optional in the intake for that year.

Table Set 2. Child's Baseline Demographic Data

Gender Table 2-1	Year 1 N=50	Year 2 N=67	Year 3 N=68	Year 4 N=42
Female	32.0%	55.2%	47.1%	45.2%
Male	68.0%	44.8%	51.5%	54.8%
Race Table 2-2				
African American/Black	4.0%	4.5%	1.5%	2.4%
Hispanic/Latino	90.0%	91.0%	92.6%	92.9%
White- non Hispanic	2.0%	3.0%	4.4%	4.8%
Asian	0.0%	0.0%	1.5%	0.0%
Other	4.0%	1.0%	0.0%	0.0%

Did/Does Index Child Have: Table 2-3	Year 1 N=50	Year 2 N=67	Year 3 N=68	Year 4 N=42
Special Care Needs at Birth	6.4%	6.0%	8.8%	9.5%
Congenital abnormalities at birth	0.0%	3.0%	1.5%	2.4%
HIV Positive at Birth	-----	0.0%	2.9%	2.4%
HIV Positive at Intake	2.2%	0.0%	2.9%	2.4%

Toxicology Screen at Birth Table 2-4	Year 1 N=50	Year 2 N=67	Year 3 N=68	Year 4 N=42
Not tested	4.8%	11.5%	4.4%	19.0%
Clean Toxicology drug screen	26.1%	34.8%	61.8%	61.9%
Positive for crack/cocaine	4.4%	7.8%	5.9%	4.8%
Positive for opiates (other than methadone)	9.1%	1.6%	0.0%	0.0%
Positive for methadone	4.5%	0.0%	0.0%	0.0%
Positive for barbiturates	0.0%	1.6%	0.0%	0.0%
Positive for marijuana	0.0%	4.8%	1.5%	4.8%
Positive for amphetamines	2.3%	1.6%	2.9%	0.0%
Positive for alcohol	2.3%	0.0%	1.9%	4.8%
Positive for other drugs	2.3%	3.3%	0.0%	4.8%

Current CPS Case Status Table 2-5	Year 1 N=50	Year 2 N=67	Year 3 N=68	Year 4 N=42
Active Case	71.4%	67.2%	68.7%	64.3%
Case closed in CWS	2.0%	9.0%	10.4%	9.5%
No involvement with CPS	22.4%	19.4%	3.0%	26.2%
Unknown	4.1%	4.5%	17.9%	0.0%

Are immunizations up-to-date for the age of the child? Table 2-6	Year 1 N=50	Year 2 N=67	Year 3 N=68	Year 4 N=42
Yes	44.9%	83.3%	91.2%	95.2%

Table Set 3**AIA TERMINATION TABLES YEARS 3 - 4**

N=217

Services Received by Participant Mother 3-1

Services Received	Majority Provided By AIA Program	Majority Provided by Non-AIA Program
Case management	97.4%	2.6%
Child care	21.1%	15.6%
Domestic Violence services	39.4%	11.0%
Educational/Schooling/GED	13.6%	27.3%
Family Planning	20.9%	11.4%
Financial Entitlement assistance	14.2%	23.25%
Food and/or clothing donations	82.4%	3.6%
HIV education/prevention	35.7%	10.4%
HIV screening/assessment	19.1%	17.8%
HIV services/ treatment	13.4%	19.3%
Housing/rental assistance	17.9%	27.8%
In-Home Services	70.3%	12.6%
Legal services/advocacy	52.2%	9.8%
Mental Health Counseling/Therapy	35.4%	34.1%
Outpatient Drug Treatment	55.6%	14.0%
Parenting Classes/training/support	83.3%	5.9%
Pastoral care	2.9%	7.4%
Peer Counseling	60.1%	6.8%
Permanency Planning	24.1%	8.6%
Postnatal Care	6.6%	1.4%
Pre and post HIV test counseling	15.7%	14.8%
Prenatal care	0.9%	7.2%
Primary Medical Care	5.9%	23.1%
Public health nurse visit	0.0%	13.4%
Recovery support	62.1%	9.3%
Residential facility for women and Children (not drug treatment)	7.4%	9.4%
a. Residential Drug Treatment	6.4%	11.8%
b. Respite Care	28.9%	4.9%
c. Services to biological father/mother's partner	21.1%	0.9%
d. Transportation	72.3%	1.1%
e. Vocational/employment/job training assistance	25.8%	7.6%
f. Other	24.1%	6.9%

Reason for Termination/Discharge	Table 3-2
Completion of the program requirements	48.5%
Choose to terminate services	9.5%
Whereabouts unknown/unable to contact	14.4%
Referred/transferred to other agency/agency component	4.9%
Deceased	2.0%
Other	29.3%

Reason for Death Table 3-3	
Death due to Illness	40.0%
Death due to Other	40.0%
Death due to Unknown Cause	20.0%

Client Satisfaction and Project Rating

The Services Received Were Helpful Table 3-4	
Strongly Disagree	4.6%
Disagree	0.9%
Agree	27.5%
Strongly Agree	59.6%
Unknown	7.3%
Please Rate Clients' Overall Satisfaction with the AIA Program and its Services Table 3-5	
Poor	2.8%
Fair	1.8%
Good	27.5%
Excellent	60.6%
Unknown	7.3%

Child Risk Factors (N=233)

Was Index Child HIV positive at termination Table 3-6	
Yes	2.2%
Was a known report made to CPS for index child since Intake Table 3-7	
Yes	11.7%
Current CPS Case Status Table 3-8	
Active Case	59.0%
Case closed in CWS	16.7%
No involvement with CWS	17.4%
Unknown	6.7%
Are Immunizations Up-To-Date for the Age of the Child? Table 3-9	
Yes	92.4%

Services Received by Index Child Table 3-10	Majority Provided By AIA Program	Majority Provided By Non-AIA Program
Case Management	98.3%	0.0%
Child Development/Education Services	40.5%	8.5%
Daycare Services	10.8%	23.8%
HIV screening/assessment	10.9%	12.8%
HIV services/treatment	0.4%	12.3%
Infant development screening/assessment	38.8%	8.0%
Infant massage and/or training	11.2%	8.5%
Legal advocacy on behalf of child	48.2%	8.3%
Nutrition Services	13.8%	14.0%
Pediatric health nurse visits	2.6%	34.0%
Public health nurse visits	0.0%	10.0%
Residential facility for infants/children	0.4%	8.0%
Other	30.1%	3.5%

ATTACHMENTS

ATTACHMENT A: PROGRAM BROCHURES

ATTACHMENT B: LIST OF COLLABORATIVE PARTNERS

ATTACHMENT C: DATA REPORT FORMS

ATTACHMENT D: REVISED INTAKE

ATTACHMENT E: REUNIFICATION CURRICULUM

ATTACHMENT F: SUBSTANCE ABUSE EDUCATION CURRICULUM

ATTACHMENT G: RELAPSE EDUCATION CURRICULUM

ATTACHMENT H: CAREGIVER TRAINING MATERIAL

ATTACHMENT I: MOTHEREAD/FATHEREAD DESCRIPTION

ATTACHMENT J: SATISFACTION COMMENTS

ATTACHMENT K: LETTERS OF TESTIMONY AND GRATITUDE

ATTACHMENT L: PHOTOGRAPHS OF PARTICIPANTS



ATTACHMENT A

Bienvenidos Family Services manages its resources and arranges for additional resources to meet the special and individual needs of families. In 1997-1998 we are offering these specialized services:

- ✓ **Prevention**
Individualized focused support to families where child endangerment, without appropriate intervention, will result in court action to remove the children.
- ✓ **Family Reunification**
Assists families in the reunification process by providing intense comprehensive services that allow families to heal and reunite in a safe, loving and healthy environment.
- ✓ **Family Preservation Programs**
Bienvenidos Family Services contracts with local lead agencies to provide in-home counseling, parent skill teaching and demonstrating to the following networks:
- ✓ **Court-Based Support**
From offices at the Edmund D. Edelman Children's Court building, Bienvenidos Family Services provides the Court and families with sensitive, culturally and linguistically appropriate assistance as an alternative to the Court's ordering out-of-home protective placement for endangered children.
- ✓ **Bienvenidos Helps Families**
A program designed to prevent homelessness and assist families in acquiring stability and self-sufficiency. Families receive both comprehensive case-managed in-home support services, center-based support services, job readiness training, and job placement.
- ✓ **Pueblo de Apoyo/Village of Support Abandoned Infants Assistance Program**
A specialized project designed to offer services to families of infants and young children who are impacted by substance abuse or HIV/AIDS. The project reflects the expanded emphasis on community resources, culturally and linguistically responsive services and comprehensive services.
- ✓ **The National Latino Fatherhood and Family Institute**
The NLFF Institute is a collaborative effort of Bienvenidos Family Services, The National Compadres Network and Behavioral Assessment, Inc. The Institute brings together an integrated effort of nationally recognized leaders in the field of Latino Health, education, social services and community mobilization to address the extremely important area: Latino Fathers and Families.
- ✓ **Con Los Padres**
A collaborative effort between Bienvenidos Family Services the District Attorney's Bureau of Family Support, and the Montebello School District that offers teen fathers in the community an opportunity to acknowledge paternity and establish a long-term, positive nurturing relationship with their child. The program provides counseling, mentoring, parenting, tutoring, employment opportunities and case management services.
- ✓ **Adolescent Outreach Program**
A youth outreach program aimed at preventing teen pregnancy, reducing violence, substance abuse, school failure and other related issues through mentoring, outreach, presentations and education.
- ✓ **Male Involvement Teen Pregnancy Prevention Program**
The program seeks to change attitudes and behaviors and to introduce positive values vis-a-vis male paternity responsibility. The project attempts to reduce unintended and intended teen pregnancy by emphasizing values, traditional in the Latino culture.



BIENVENIDOS FAMILY SERVICES

"Keeping Families Together"



BIENVENIDOS FAMILY SERVICES

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National Latino Fatherhood and
Family Institute
5252 E. Beverly Blvd.
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Telephone: (213) 728-7770
Fax: (213) 728-8666



Bienvenidos Children's Center, Inc., (BCC), established in 1986. Our vision is of a world of tomorrow where children flourish and families thrive. Our mission is to assure the safety and well-being of vulnerable children by strengthening the ability of their families to support and encourage their children's healthy development. Our programs offer a continuum of care.

We celebrate our eleventh year of service to children and families in June 1998. Our experiences and the enormous emerging needs shape our priorities for tomorrow.



BIENVENIDOS FAMILY SERVICES

Bienvenidos Family Services outreaches to families through active participation in community-based collaboratives, affiliation with hospitals, substance abuse treatment centers, homeless shelters, community health centers, family welfare agencies, and local schools.

The Children's Dependency Court and the Los Angeles County Department of Children and Family Services refer "at-risk" families to us as the alternative choice to the out-of-home protective placement of children. Many families self-refer. We are recognized for our openness to families, the unconditional support we extend to families and the ability of our staff to encourage parents to protect their children and keep their families together.

WHO WE SERVE

Families come to Bienvenidos Family Services with a variety of needs. Many face daunting challenges both within and outside the family. Family stress is often compounded by poverty, homelessness or crowded living conditions, social isolation, substance use, HIV risk or infection, unemployment, underemployment, inadequate job skills, illiteracy, lack of parental child nurturing skills, teen parenthood, violence in the home, community crime, gang behavior, and fragile child health. A majority of the more than 1200 families who come to Bienvenidos Family Services annually for assistance have a commitment towards improving the quality of their lives and are able to provide an environment to allow their children to thrive and develop.

WHERE WE SERVE

Bienvenidos Family Services assists families in the greater East Los Angeles area from the Bienvenidos Family Support Center in East Los Angeles, and families in the northwest San Gabriel Valley communities from the Bienvenidos Family Service Center at the Bienvenidos Village for Children in Altadena. Families in the Pomona Valley area are assisted at the Bienvenidos Family Services Center in Pomona.



The program supports the family's right to have a choice and self-determination in matters that affect their children, their integrity as a family, their future and their community.

HOW WE SERVE

Bienvenidos Family Services uses a variety of service strategies and individualized interventions honoring the language, culture and traditions of the families served.

Services are delivered in any one or a combination of the following approaches:

FAMILY SUPPORT CENTER SERVICES

The Bienvenidos Family Support Center offers Case Management, Crisis Intervention, Parenting Classes, Fatherhood Programs, Teen Parent Classes, Parents' Anonymous, Narcotics' Anonymous, Overeaters' Anonymous, Support Groups, Family Counseling, Women's Therapy Group, Domestic Violence groups, Resource and Referral Services, Drop-In Center, Respite Services, Emergency Food Bank, Family Resource Center and Family Recreation Activities.

IN-HOME SUPPORT SERVICES

Families are assigned a Family Support Team who work closely with each family in reaching goals, stabilizing and enriching family life while minimizing risk factors.

OUTREACH SERVICES

Bienvenidos Family Services reaches out to the community to provide a variety of services to parents, youth and children.

Mentoring/Rites of Passage Programs are provided both pre-adolescent and adolescent youth.

Teen Pregnancy Prevention Programs

Youth of the community reach out to their peers in a variety of teen pregnancy prevention interventions.



Community Presentations are provided to other agencies, institutions and parent groups to inform them of the many of supportive services offered by Bienvenidos Family Services.

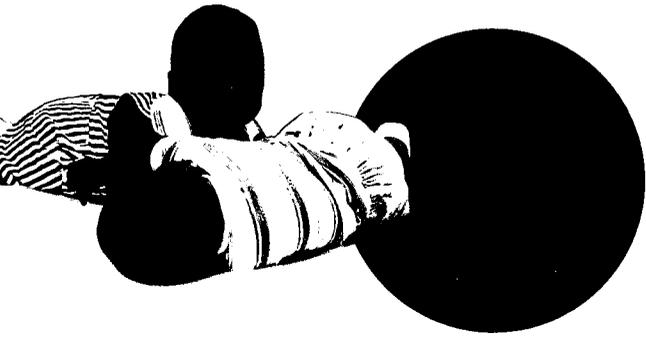
If you want to make
some big changes in Los Angeles,
start with some little ones.



BIENVENIDOS

children's center, inc.

Your extended family.



Bienvenidos Children's Center, where shelter is more than a roof and a bed.

*M*ost of us have wonderful memories of childhood, filled with laughter and good times in a loving home, surrounded by family and friends.

This scene, however, is a far cry from the reality of thousands of children who are victims of child abuse, prenatally exposed to drugs or left homeless night after night.

Meeting the needs of these innocent children is the basis of everything we do at Bienvenidos. We are their extended family, providing love, nurturing and a place of safety for infants and children at risk.

Since 1987, Bienvenidos Children's Center has provided emergency 24-hour residential shelter to thousands of children, with clinical assessment and personalized treatment plans as an integral part of their care. In addition, our program has included critical support and guidance to families in need.

As we outgrew the physical bounds of our original facility, we envisioned a beautiful state-of-the-art facility in a park-like setting. That dream became a reality with the opening of our sparkling new shelter nestled in the hills of Altadena, surrounded by stately oaks and pines.

This 4.3 acre campus provides therapeutic residential care to endangered and victimized infants and young children, specializing in care to sibling groups in cozy home-like cottages.



We're the "immediate family" when a family is needed immediately.

In an average day in Los Angeles, 35,000 children need more family than they've got. The primary challenge of Bienvenidos Children's Center is to provide these children with skilled and compassionate shelter and foster family care, while at the same time offering their families access to a rich continuum of services.

Child Protective Services places children with Bienvenidos to provide a nurturing environment while the family situation is being evaluated. For some the stay is a few days, for others it is a month or more before they are released, either to their parents, a relative or for long term foster care.

Bienvenidos means “Welcome”
in many different ways.

Our Shelter Nursery Program interfaces seamlessly with our licensed Foster Family Agency and Family Service Programs, with offices in West Covina, Pomona, Altadena and East Los Angeles, providing a continuum of care for the entire family. This means families have access to a combination of integrated services and resources.

The Family Services Program welcomes over 1200 families each year, providing a combination of In-Home and Center-Based Services, including Baby and Me groups, our Mother/Father Read Program, and the Teen Father Program, as well as crisis intervention, parenting education, family counseling, support groups, and housing assistance.



Our care extends to foster parents.

At our Bienvenidos Foster Family Agency (BFFA), foster parents must complete a 32-hour education program focusing on the skills and insights needed to parent abused, neglected and abandoned children. Their homes are inspected to assure child safety and they must successfully complete First Aid/CPR training. No stone is left unturned to protect the well-being of the children in our care.

We're an extension of the community.

In addition to our many alliances with community organizations, Bienvenidos has working relationships with Cal State University, UCLA, USC, Loma Linda University Medical Center and Long Beach State University. We encourage graduate students in social work, pediatric nursing, special education, psychology, and health education to do their residencies and internships in our program. And there is an ongoing, lively exchange of ideas between our staff and local scholars and children practitioners.





We can't help...if you don't help.

Over the years, we've been most fortunate to have received support from people in all walks of life, as well as from various fraternal organizations, corporations and foundations.

However, looking to the future, changes within the social welfare system will require an even greater emphasis on the involvement, compassion and financial support from within the communities we serve. *We urge your participation.*

As a 501 (c) (3) charitable organization, your contributions are tax deductible.

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BIENVENIDOS

children's center, inc.

Your extended family.

205 East Palm Street
Altadena, CA 91001
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PUEBLO DE APOYO / VILLAGE OF SUPPORT

ABANDONED INFANTS ASSISTANCE PROJECT

FACT SHEET

The "Pueblo de Apoyo" / "Village of Support" Project is a specialized project designed and offered by **Bienvenidos Family Services** and funded through the Federal Department of Health and Human Services to expand services to families of infants and young children who are at risk of being abandoned due to:

- habitual alcohol or drug abuse by the mother
- mother's infection of HIV/AIDS
- pregnant women incarcerated in jail or juvenile hall
- single fathers, extended families or foster families raising their children, who have been abandoned by their mother
- pregnant or parenting mothers, who are at high risk for child abandonment

The project's name, "Pueblo de Apoyo" / "Village of Support" reflects the expanded emphasis on mobilization of community resources. Culturally and linguistically responsive services will be delivered to achieve the project's primary objectives, which include:

- increasing the family's capacity to care for at risk infants and young children
- increase mothers' ability to sustain and maintain recovery and healthy lifestyles
- expand the family's awareness and use of appropriate resources
- increase the involvement of fathers in the lives of their children
- expand the awareness and knowledge of services to networking service providers

Comprehensive Intensive In-Home Support and Center- Based Services will be made available to eligible participants, which will include the following approaches:

- | | |
|---|--|
| <input type="checkbox"/> Comprehensive Assessment | <input type="checkbox"/> Parenting Classes |
| <input type="checkbox"/> Case Management Services | <input type="checkbox"/> Recovery Education Classes |
| <input type="checkbox"/> Individualized Family Support Plan | <input type="checkbox"/> Recovery Support Groups |
| <input type="checkbox"/> Information and Referral Services | <input type="checkbox"/> Parent-Child Play Groups |
| <input type="checkbox"/> Reunification Services | <input type="checkbox"/> Youth Support Groups |
| <input type="checkbox"/> Permanency Planning | <input type="checkbox"/> Respite Services |
| <input type="checkbox"/> Individual \ Family Counseling | <input type="checkbox"/> Court Advocacy |
| <input type="checkbox"/> follow-up services | <input type="checkbox"/> workshops for networking agencies |

For more information about or referral to the:
"Pueblo de Apoyo" / "Village of Support" Project
Contact: Noemi Corral: (213) 728-9577
BIENVENIDOS FAMILY SERVICES

PUEBLO DE APOYO/VILLAGE OF SUPPORT

PROYECTO DE AYUDA PARA BEBES ABANDONADOS

HOJA INFORMATIVA

El Proyecto "Pueblo de Apoyo"/"Village of Support" es un proyecto especializado que ha sido diseñado y es ofrecido por **Servicios para Familias de Bienvenidos** y fué fundado por medio del Departamento Federal de Servicios Humanos y de Salubridad para ofrecer servicios a familias con bebés y niños pequeñitos que están en riesgo de ser abandonados debido a:

- * Abuso habitual de alcohol y drogas por parte de la madre.
- * La madre está infectada con SIDA o VIH.
- * Mujeres embarazadas que están en centros juveniles o en la cárcel.
- * Padres solteros, familia ampliada o familias de crianza encargadas de criar a los niños que han sido abandonados por su madre.
- * Mujeres embarazadas o madres que están criando a sus hijos, que están en alto riesgo de abandonar a sus hijos.

El nombre de este proyecto "Pueblo de Apoyo"/"Village of Support" refleja el énfasis global de movilizar los recursos de la comunidad. Se proporcionarán servicios que sean adecuados tanto a la cultura como al idioma hispano para así poder lograr las metas principales del proyecto, que incluyen:

- * Aumentar la capacidad de la familia para cuidar de bebés que están en riesgo y de niños pequeñitos.
- * Aumentar la capacidad de la madre para lograr y mantener su recuperación y una manera sana de vivir.
- * Aumentar la participación de los padres en la vida de sus hijos.
- * Aumentar la percepción y conocimiento de servicios por aquellos que proporcionan una red de servicios.

Los Servicios Completos Basados en el Centro y los Servicios de Apoyo Intensivo en el Hogar estarán disponibles para aquellos participantes que reúnen los requisitos, e incluirán:

- | | |
|--|---------------------------------------|
| * Evaluación global | * Clases para Padres |
| * Servicios de Administración del Caso | * Clases de Educación de Recuperación |
| * Plan de Apoyo Familiar Individualizado | * Grupos de Apoyo de Recuperación |
| * Servicios de Información y Referencias | * Grupo de Juego Padres-Niños |
| * Servicios de Reunificación | * Grupos de Apoyo para la Juventud |
| * Planeamiento Permanente | * Servicios de Respiro |
| * Consejería Individual/Familiar | * Defensa en el Tribunal |
| * Servicios Complementarios | * Talleres para red de agencias |

Para mayor información sobre el Proyecto "Pueblo de Apoyo"/"Village of Support"

Llame a: Noemi Corral: (213) 728-9577



Bienvenidos Family Services El Pueblo de Apoyo

COMPREHENSIVE FAMILY SUPPORT SERVICES
FOR
FAMILIES WITH YOUNG CHILDREN AFFECTED BY
HIV/AIDS

FAMILY SUPPORT SERVICES

PARENT DEVELOPMENT
WEEKLY HOME VISITS
FAMILY SUPPORT PLANNING
ADVOCACY
EDUCATION
FAMILY CRISIS INTERVENTION
PERMANENCY PLANNING
HOUSING ASSISTANCE
NETWORKING
RESOURCE AND REFERRALS
FAMILY ACTIVITIES

SUPPORT AND EDUCATION

PARENT SUPPORT GROUP,
"PORQUE TE QUIERO"

YOUTH SUPPORT
"LOS TWEETIES"

PARENTING CLASSES

BIENVENIDOS FAMILY SERVICES
(323) 728-9577



ATTACHMENT B

The project staff attends several community meetings every month. The purpose of attending these meetings is to build and enhance resources for the families we work with. This also allows for staff development and builds cohesiveness within the community.

The following are the community meetings we attend monthly:

HIV & AIDS Homeless Task Force – Bethesda House
Los Angeles Children’s Planning Council-SPA 7
L.A. County Adolescent HIV Consortium
Children’s Dependency Court Resource Meeting
Round Table Community Resource Meeting – East Los Angeles
L.A. Family Preservation Meeting
Community Resource Meeting -BHS- East Los Angeles
East L.A., Boyle Heights Latino Family Preservation Project
Inter-Agency Council on Child Abuse and Neglect
(LICA) Early Intervention Council
Roybal Comprehensive Health Care Advisory Board Meeting
Safety Belt SAFE Meeting
Healthy Start Advisory Meeting

COLLABORATING AGENCIES

HIV/AIDS AGENCIES

Women’s Links
Trinity Care
The Serra Project (casa modona)
Caring for Babies with Aids (CBA)
Bienestar
Aids Service Center
Aids Project L.A. (APLA)
MAP (Minority Aids Project)
Tania’s Children

Legal

Public Council
The Alliance for Children’s Right

Housing /Shelters

L.A. Family Housing
CHOISS
BETHESDA House

Medical Facilities

Jeffrey Goodman Clinic
Valley Community Clinic
L.A. Free Clinic
Watts Health Foundation
Maternal/Child Clinic

5P21 Maternal Child Clinic (USC Medical C/T)
5P21 USC Medical Center (Rand Schradel HIV Clinic)
Alta Med
Beverly Hospital-Montebello
East Valley Community Health Center and Mental Health Services
El Monte Comprehensive Health Center
Elias Chico Community Health Foundation (Dental)
Garfield Medical Center
Harbor – U.C.L.A. Medical Center
Huntington Hospital
Kaiser Permanente Hospital
North East County Health Services
Pivot Program for Children with vision problems
Royal Family Health Services
St. John's Well Child Center
Tracey Infant Center
USC Women's Hospital
Visiting Nurses Association
White Memorial Medical Hospital
Children's Hospital
East L.A. Doctors Hospital
Clinica Medicina/Women's Clinic
Planned Parenthood

Housing/Food Banks

Aid for Aids
L.A. Family Housing Corp.
Project Angel Food
Bienestar Human Services
LA Shanti
Tuesday Child
Tanya's Children
Bethesda
Whittier Rio Hondo Aids Project
Minority Aids Project
El Proyecto del Barrio
El Centro del Pueblo
Cara a Cara Latino Aids Project
Spa 4 Community Assessment Services Center
Casa Madonna
Serra Project
CHOISS
H.O.P.W.A.
Agape
Salvation Army Homeless Shelter & Food Banks
Beyond Shelter
Para Los Ninos
Chernow House
Hestia House

YWCA – Rape Crisis Program
Casa Maria
Union Station
Rio Hondo Homeless Shelter
Eastmont Community Center
L.A. Regional Food Bank
Haven Hills
Haven House
St. Ignatius Church
Our Lady of Lourdes
Wings for Battered Women
Catholic Charities
Lutheran Social Services
House of Ruth

EDUCATION/JOB TRAINING

Los Angeles Skills Center
Puente Learning Center
California State University, Long Beach
Charo Pre-School/Job Training Referral
East Los Angeles Community College
Pasadena City College
Women at Work
Mexican-American Opportunity Foundation

MENTAL HEALTH SERVICES

Catholic Charities
Pacific Clinics
YWCA –Rape Crisis Program
Project Info.
All Saints Aids Services
Aids Project L.A.
Counseling Rape Hot-Line – East Los Angeles
Downey Family Services
El Centro Human Services Corporation – E.L.A.
Foothill Family Services – Pasadena
Parents United
Roybal Family Mental Health Services
Plaza Community Center

LEGAL AID

One Stop Immigration
El Rescate
Legal Aid – Pasadena
CHRLA
Legal Aid – East L.A.

SUBSTANCE ABUSE TREATMENT

Tarzana Treatment Center
Serenidad Sober Living

La Madonna Counseling Center
Behavioral Health Services (Drug Treatment Program)
Latinas Recovery Home
Esperanza Drug Treatment Program
Hispanic Alcohol Drug Counsel
Shields for Families
Community Health Foundation
Mariposa
La Cada
Prototypes
Patterns

CHILD CARE/EARLY INTERVENTION PROGRAMS

Para Los Ninos
Amar Pre School –Head Start
Azteca Head Start Pre Schools – E.L.A.
Centro de Ninos – Cal State University Los Angeles
Charo Pre-School/Job Training Referral
Mexican American Opportunities Foundation (Pre-School)
Almansor Center
ABC Child Development
Options
Regional Center-East Los Angeles

ADVOCACY

Alliance for Children's Rights
Legal Aid of Los Angeles
Children's Advocate Office

PUBLIC AGENCIES

Children's Dependency Court
American Red Cross
L.A. Unified School District
Montebello Unified School District
Housing Authority
Los Angeles County Headstart
Los Angeles Parks & Recreation
Department of Children's Services
Department of Public Social Services
East Los Angeles Regional Center

FAMILY PRESERVATION PROGRAMS

Plaza Community Center
Children's Home Society
Home Safe Child Care
Children's Bureau
Shields for Families

YOUTH AGENCIES

California Youth Authority

SEA

Boys & Girls Club of East Los Angeles
Roosevelt High School – Teen Program E.L.A.
Teen Parent Program – M.U.S.D.

FOSTER CARE AGENCIES

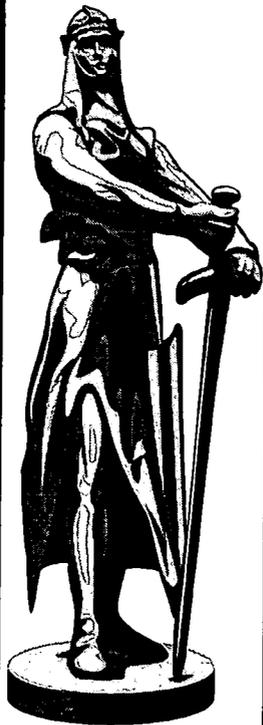
Bienvenidos Foster Family Agency
Children's Bureau of Los Angeles
St. Harriets Emergency Shelter
Hillsides Home for Children
Guadalupe Homes

RESOURCES (PREVENTION & EDUCATION PROGRAMS)

AIDS Project Los Angeles
AIDS Service Center
Minority AIDS Project
Prototypes
L.A. County STD Program
L.A. Pediatric Aids Network



ATTACHMENT C



AIA

FAMILY ASSESSMENT
FORM

PUEBLO DE APOYO

REVISED FOR AIA USE
10-1-98

Face Sheet

Time 1

Time 2

CASE # _____ WORKER _____

PROGRAM/OFFICE _____

Persons Assessed*	Age	Relationship
Caregiver A _____	_____	_____
Caregiver B _____	_____	_____
Child 1 _____	_____	_____
Child 2 _____	_____	_____
Child 3 _____	_____	_____
Child 4 _____	_____	_____
Child 5 _____	_____	_____
Child 6 _____	_____	_____
Child 7 _____	_____	_____
Child 8 _____	_____	_____

Others in Home	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

* NOTE: List children from youngest to oldest.

PRESENTING PROBLEMS(s): Code # _____ Referred by: _____

For what reason: _____

CHILD PROTECTIVE SERVICES INVOLVEMENT

Number of past involvements with CPS _____

Length of current involvement with CPS _____

OUT-OF-HOME PLACEMENT(S)	CIRCLE	NAME(S)
Past out-of-home placement(s)?	YES/NO	Child(ren) _____
Current out-of-home placement(s)?	YES/NO	Child(ren) _____
At risk of out-of-home placement(s)?	YES/NO	Child(ren) _____

Comments: _____

MEDICAL/PSYCHIATRIC INVOLVEMENT CIRCLE AND EXPLAIN

Significant or chronic medical problems? YES/NO _____

Contact with mental health system/professionals? YES/NO _____

Comments: _____

INITIAL ASSESSMENT

IN-HOME

Dates _____ Hours _____

YES/NO

Dates _____ Hours _____

YES/NO

Dates _____ Hours _____

YES/NO

Comments: _____

Family Functioning Factors

Sections A through F

SECTION A: LIVING CONDITIONS*

A1. Cleanliness/Orderliness—Outside Environmental Conditions

Refers to environmental health and hygiene factors (e.g., litter, garbage, vermin, clutter, odors around the exterior of the home) that are NOT WITHIN the family's control. Need to consider intervening with owner/landlord, county health department, city code enforcement, and/or other regulatory agencies.

STRENGTHS:

CONCERNS:

Score

Operational Definition

1

Consistently clean and orderly; property very well maintained by owner/landlord and other tenants if a rental

1.5

2

Generally clean and orderly; no health hazards; property well maintained by owner/landlord and other tenants if a rental

2.5

3

Some lack of cleanliness; some disorderliness or clutter; other tenants or neighbors create messiness; slow response to problems by owner/landlord; occasional roach problem

3.5

4

Inadequately clean or organized; potential health hazards present; a great deal of clutter or litter/garbage; or offensive odors; consistent roach problem; property poorly maintained by owner/landlord and other tenants; very difficult to reach or get response from owner/landlord

4.5

5

Health hazards and violations present, e.g., overflowing trash bins/barrels, rotting food, flies; multiple vermin present; property essentially ignored by owner/landlord; other tenants do not do their part to maintain clean, healthy environment

A2. Cleanliness/Orderliness—Outside Home Maintenance

Refers to environmental health and hygiene factors (e.g., litter, garbage, vermin, clutter, odors around the exterior of the home) that ARE WITHIN the family's ability to control. Assesses family's willingness and ability to maintain clean, orderly environment.

STRENGTHS:

CONCERNS:

1

Consistently clean and orderly; family takes very good care of their home or, if an apartment building, takes lead among tenants to keep property clean and neat

1.5

2

Generally clean and orderly; no health hazards; if in an apartment, family takes good care of area around their unit

2.5

3

Some lack of cleanliness; some disorderliness or clutter; family does not routinely clean up area around their unit or home

3.5

4

Inadequately clean or organized; potential health hazards present; a great deal of clutter or litter/garbage, or offensive odors; family rarely cleans-up area around their unit or home

4.5

5

Health hazards present, e.g., overflowing trash bins/barrels, rotting food, toxins exposed; family does nothing to clean up area around their unit or home, or contributes to lack of cleanliness/orderliness

* The term *home* is used to denote any dwelling in which the family may live, including but not limited to a single family home, town home, apartment, and shelter.

<p>A3. Cleanliness/Orderliness—Inside Home Maintenance</p> <p>Refers to litter, garbage, cleanliness, feces, vermin, clutter, and odors in home. Does not refer to cleanliness of people in home. Assesses health hazards and physical neglect issues that ARE WITHIN the family's control.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	<p>1</p> <p>1.5</p> <p>2</p> <p>2.5</p> <p>3</p> <p>3.5</p> <p>4</p> <p>4.5</p> <p>5</p>	<p>Consistently clean and orderly; family takes very good care of their home</p> <p>Generally clean and orderly; family takes good care of their home</p> <p>Some lack of cleanliness and orderliness, e.g., some clutter, trash, full garbage bags, noticeable but tolerable odor; occasional roach problem due to lack of cleaning; could be improved with a couple of hours of work</p> <p>Generally not clean and orderly, e.g., food particles on floors, tables, chairs; dirty diapers laying around; consistent odors; grease and grime evident; potential health hazard; consistent roach problem despite fumigation</p> <p>Extremely dirty, e.g., multiple vermin, urine-soaked furniture, sticky floors, feces on floor, rotting food, overflowing garbage, intolerable odors; health hazards present</p>
<p>A4. Safety—Outside Environmental Conditions</p> <p>Refers to condition of building in terms of danger as well as functioning of utilities. If a rental, assesses conditions that are generally NOT WITHIN family's control.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	<p>1</p> <p>1.5</p> <p>2</p> <p>2.5</p> <p>3</p> <p>3.5</p> <p>4</p> <p>4.5</p> <p>5</p>	<p>Building in consistently safe condition; extra safety precautions provided (e.g., locks, good lighting, clear access); property very well maintained by owner/landlord</p> <p>Building generally in good condition; some basic safety precautions provided; no obvious problems; property well maintained by owner/landlord</p> <p>Some safety concerns present, e.g., cracks in walls, cracked windows, mold on wall, minimal lighting or missing lights, plumbing problems; property minimally maintained by owner/landlord; slow response to problems by owner/landlord</p> <p>Generally not safe; noticeable safety hazards, e.g., uncovered or unfenced bodies of water, broken windows, rotting floors or walls, poor lighting, blocked access ways, poorly operating elevators, property poorly maintained by owner/landlord; very difficult to reach or get response from owner/landlord</p> <p>Extremely dangerous; obvious safety hazards, e.g., broken windows within child(ren)'s reach, holes through walls, missing steps, broken glass in hallways and play area; dangerous materials all around, i.e., rusting metal, broken glass, sharp tools; no exterior lighting; code violations; property essentially ignored by owner/landlord</p>

A5. Safety—Outside Home Maintenance	Score	Operational Definition
<p>Refers to caregiver's thoughtfulness as regards to safety precautions. Assesses conditions that ARE WITHIN family's control.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	1	Extra safety precautions taken by family, e.g., locks, closed gates, child fencing, guards around rough edges, well organized exterior of home or area around unit
	1.5	
	2	Good basic safety precautions taken by family no obvious problems; generally organized exterior of home or area around unit
	2.5	
	3	Some safety concerns present, e.g., unlocked gates, unprotected access to stairwells, balconies; minimal organization of exterior of home or area around unit; minimal precautions taken
	3.5	
	4	Generally not safe; noticeable safety hazards; poorly organized exterior; dangerous materials accessibility to children, e.g., toxic waste, old freezer, lots of junk; few precautions taken
	4.5	
	5	Extremely dangerous; obvious safety hazards; no precautions taken
A6. Safety—Inside Home Maintenance		
<p>Refers to caregiver's thoughtfulness as regards to safety precautions in the home. Assesses conditions that ARE WITHIN family's control.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	1	Extra safety precautions taken, e.g., poisons and medications locked away, outlets plugged; plans for emergency situations; child proofed
	1.5	
	2	Most precautions taken; no danger to child(ren), e.g., poisons and medications out of reach but not locked; mostly child proofed
	2.5	
	3	Some precautions taken but potential hazards obvious, e.g., poisons and medications out of sight but within reach of child(ren), overloaded outlets, matches and knives accessible but out of sight; no emergency plans established
	3.5	
	4	Generally not safe, e.g., poisons and medications visible and accessible, broken glass on floor, wires frayed, no screens on second floor windows for toddlers; few precautions taken
	4.5	
	5	Extremely dangerous; no apparent safety precautions taken, e.g., many hazards within reach, such as guns, hunting knives, street drugs, open medication bottles

SECTION B: FINANCIAL CONDITIONS

B1. Financial Stress

Refers to degree of financial stress experienced by family regardless of income. Contributing factors might include unemployment, high debts, inadequate income, e.g., AFDC, minimum wage, etc.

STRENGTHS:

CONCERNS:

Score	Operational Definition
1	No stress; money not an issue; enough money to meet responsibilities and spend on leisure activities; no employment worries
1.5	
2	Minor stress; manageable debts; some limitations on luxuries but not on necessities
2.5	
3	Consistent worry; just making ends meet, i.e., AFDC, SSI, minimum wage job; income equals debts/bills; working poor
3.5	
4	Very stressful; frequently running out of money; unmanageable debts; unable to stay current on bills/debts; employment worries; suffering emotionally due to financial stress
4.5	
5	Extremely stressful; money problematic on daily basis; necessities not provided; creating significant conflicts in relationships; seems hopeless; "no light at the end of the tunnel"

B2. Financial Management

Refers to ability to plan, budget, organize, and spend money wisely and responsibly.

STRENGTHS:

CONCERNS:

1	Above average; good at bargain hunting; plans budgets; organizes in a way that gets best value for money and meets family needs consistently
1.5	
2	Minimal and manageable debts; generally has planned use of money; generally spends money wisely
2.5	
3	Some problems in planning or budgeting for use of money; occasional impulse buying; doesn't deprive child of necessities but problem if there is an emergency; limited planning for future needs; debts occasionally unmanageable
3.5	
4	In debt over their heads; irresponsible spending; often buys luxuries rather than necessities; cannot account for money/spending
4.5	
5	No plan or budget for use of money; without necessities; frequently broke; money used for betting, gambling, or alcohol/drugs rather than on family necessities

B3. Financial Problem Due to Welfare System/Child Support	Score	Operational Definition
<p>Refers to financial problems that result from errors, delays, etc., in welfare or child support system that are out of client's control.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	1	Not financially dependent on welfare system or child support
	1.5	
	2	Isolated problems that are quickly resolved or do not create major problems
	2.5	
	3	Regular problems with eligibility worker or other responsible caregiver
	3.5	
	4	Irregular or late AFDC, Medi-Cal or food stamps; child support sporadic
<p>B4. Adequate Furniture</p> <p>Refers to amount of furniture and whether or not it meets the needs of the family; also refers to condition of the furniture.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	1	Above average; new or in excellent condition
	1.5	
	2	Basic, sufficient furniture for family needs; functional; good condition
	2.5	
	3	Limited amount of furniture; meets some but not all family needs; fair condition
	3.5	
	4	Sparse furnishings; furniture generally inadequate in meeting family needs; only able to sleep on floor; missing furniture but may have luxuries; no furniture in some rooms; broken, nonfunctional furniture
<p>B5. Availability of Transportation</p> <p>Refers to availability or access to a car, bus, or rides.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	1	No problem with transportation
	1.5	
	2	Adequate access to transportation
	2.5	
	3	Limited access to reliable transportation
	3.5	
	4	Minimal access to reliable transportation
<p>CONCERNS:</p>	4.5	
	5	Transportation unavailable and presents a major problem

SECTION C: SUPPORTS TO CAREGIVERS

C1. Support from Friends and Neighbors and Community Involvement

Refers to involvements/connections in society and community that offer positive support for family.

STRENGTHS:

CONCERNS:

	Score	Operational Definition
	1	Maintains strong support and reciprocal network of friends and neighbors; active in community; regularly attends community functions (e.g., church, recreational, cultural)
	1.5	
	2	Adequate social support; friends or neighbors supportive; some community involvement
	2.5	
	3	Limited social support; few friends or only acquaintances; seeks or offers no concrete help from people; goes to community resources in crisis; occasional contact in community (e.g., school, church)
	3.5	
	4	Minimal social support; limited friendships; no connection with neighbors or neighbors nonexistent; very limited social/community contact
	4.5	
	5	No friends; extremely isolated; negative impact or involvement; leaves home for necessities only; may not leave home at all

C2. Available Child Care

Refers to availability, affordability, and adequacy of child care.
Note: If caregiver says, "I never leave my child" question why: Past problems? Current resources?

STRENGTHS:

CONCERNS:

	1	Available and affordable; relative, other person, or child care provider willingly provides good care
	1.5	
	2	Some difficulty finding and affording good child care, but has adequate resources
	2.5	
	3	Caregiver not always available or affordable as needed; baby sitter/ relative/friend does it but complains
	3.5	
	4	Rarely able to find available, affordable, adequate child care
	4.5	
	5	None; no family, friends, neighbors; no child care; no money for it

C3. Chooses Appropriate Substitute Caregivers	Score	Operational Definition
<p>Refers to caregiver's planning for safe and appropriate child care. Keep in mind age appropriateness and need of child(ren). If no money, resources, or adequate child care available, indicate N/A and make note in comments as to what problem is, so it can be addressed.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	1	Caregiver very careful and conscientious; checks things out, e.g., obtains and talks with references; makes sure child(ren) is comfortable and safe with substitute caregiver
	1.5	
	2	Generally adequate and careful about child care decisions; concerns may exist but do not create risk
	2.5	
	3	Inconsistencies in decisions about child care (e.g., sometimes for convenience v. appropriateness); some pattern of questionable decisions, e.g., leaves young child(ren) with inappropriate caregivers; leaves child(ren) at home alone for periods essentially unsupervised
	3.5	
	4	Leaves child(ren) in chaotic care situations; physical care all right but emotional deprivation or cruelty suffered; left with casual acquaintances; relies on known drug or alcohol users as caregivers
	4.5	
	5	No thinking about or planning for child care; child(ren) left with strangers or known child abuser; child(ren) left totally alone with no supervision or anyone watching over; child(ren) left with person currently under the influence of drugs or alcohol
	<p>C4. Available Health Care</p> <p>Refers to availability, affordability, and accessibility of health care.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	1
1.5		
2		Adequate availability and access to affordable health care including preventive care, e.g., immunizations, well-child care, dental care
2.5		
3		Limited availability and access to affordable health care; only go to doctor when sick; difficulty affording prescription medication; generally uses same medical care providers, e.g., local community clinic
3.5		
4		Minimal availability and access to affordable health care; no form of insurance making cost very prohibitive; uses emergency rooms for routine care; has to wait too long to seek medical care due to lack of money
4.5		
5		No access, availability, or ability to afford health care of any kind

C5. Provides for Basic Medical/Physical Care

Refers to caregiver's provision of good home health care; good nutrition; personal hygiene; as well as caregiver's accessing and follow-through on preventive well-child medical care and treatment. This item refers to issues that ARE WITHIN the ability of the caregiver to control, influence or change.

STRENGTHS:

CONCERNS:

1

Very attentive to health care and hygiene issues; nutritionally planned meals; child(ren) receive routine well-child medical care and immunizations are current; child(ren) receive routine preventive dental care

1.5

2

Adequate medical and physical care provided; caregiver generally reacts appropriately to symptoms of illness; generally keeps regularly scheduled checkups/appointments; adequate nutrition, grooming, and hygiene

2.5

3

Occasional problems; inadequate home health care practices; child(ren) often sick; Immunization not on schedule; limited attention to nutrition; inconsistent personal hygiene or appropriate dress for the weather; do not receive preventive dental care

3.5

4

Minimal attention to medical/physical care; generally inadequate; poor home health care practices or practices have potential for harm; waits too long to go to doctor when child(ren) is sick; child(ren) has not been immunized; poor follow-through on recommended treatment

4.5

5

Child(ren)'s health is endangered; extremely inadequate home health care, e.g., food, clothing, malnutrition, inappropriate clothing for weather; child(ren) not receiving needed medical care; appearance of failure to thrive

SECTION D: CAREGIVER/CHILD INTERACTIONS

D1. Understands Child Development

Refers to all areas of development including physical, emotional, cognitive, and social.

STRENGTHS:

CONCERNS:

Caregiver Score

A B

1 1

1.5 1.5

2 2

2.5 2.5

3 3

3.5 3.5

4 4

4.5 4.5

5 5

Operational Definition

Above average understanding of child(ren) and child development

Adequate knowledge of child development leading to age appropriate expectations

Limited knowledge in some areas leading to parental frustration over age-typical child behavior

Limited understanding; could place child(ren) at high risk for emotional and/or physical abuse or neglect; sees problems that are not there; has unrealistic expectations of child(ren)

Little knowledge or inappropriate understanding of child development which has resulted in some type of abuse or neglect

D2. Daily Routine for Child(ren)

Refers to all areas of child(ren)'s life such as bedtime, meals, naps, homework, baths, etc.

STRENGTHS:

CONCERNS:

1 1

1.5 1.5

2 2

2.5 2.5

3 3

3.5 3.5

4 4

4.5 4.5

5 5

Consistent routine for child(ren) that is age appropriate and recognizes individual differences

Reasonably consistent, flexible, and age appropriate daily routines

Has some daily routines; some inconsistency or rigidity

Minimal routine with little consistency or overly rigid or overly permissive

No routine; no consistency; no flexibility

D3. Use of Physical Discipline		
Refers to use, frequency, and severity of physical punishment. Assess for age and vulnerability of child(ren) and potential for harm.	1	1
	1.5	1.5
	2	2
	2.5	2.5
	3	3
STRENGTHS:	3.5	3.5
	4	4
	4.5	4.5
	5	5
	5	5
CONCERNS:	1	1
	1.5	1.5
	2	2
	2.5	2.5
	3	3
3.5	3.5	
4	4	
4.5	4.5	
5	5	
5	5	
D4. Appropriateness of Disciplinary Methods		
Refers to a planned approach appropriate to child(ren)'s age; caregiver is in emotional control and uses discipline to teach rather than punish.	1	1
	1.5	1.5
	2	2
	2.5	2.5
	3	3
STRENGTHS:	3.5	3.5
	4	4
	4.5	4.5
	5	5
	5	5
CONCERNS:	1	1
	1.5	1.5
	2	2
	2.5	2.5
	3	3
3.5	3.5	
4	4	
4.5	4.5	
5	5	
5	5	

Only uses nonphysical forms of discipline

Generally does not use physical discipline but may infrequently swat with hand or spank

Uses physical discipline in response to specific behaviors; spanking, pinching, pulling ears or hair

Regular use of physical punishment which could endanger child(ren)'s safety; use of belts, shoes; throws things at child

Regular and severe physical punishment; explosive and out of control; shaking of infants or toddlers; behavior endangers child(ren)'s safety.

Well thought out, age appropriate, nonpunitive educational approach; uses variety of positive techniques as part of regular routine

Generally practices rules, natural consequences, positive reinforcement when disciplining; caregiver in emotional control

Some inappropriate expectations; some potential for emotional or physical harm, tendency to focus on negative aspects of child(ren)'s behavior, i.e., "serves you right" attitude; sometimes ignores child(ren) inappropriately; sometimes does not discipline when needed

Unplanned punitive approach; mostly reacts emotionally and with inappropriate age expectations; emotionally abusive; overreacts to behaviors and situations; rarely sees positive in child(ren); does not discipline most of the time; means of discipline has great potential for harm

Past or current severe emotional and/or physical abuse or no discipline at all

D5. Consistency of Discipline	Caregiver Score		Operational Definition
	A	B	
<p>Refers to predictability; child(ren) has been made aware of consequences and feels secure about caregiver's response. Misbehavior is corrected each time it occurs and in a similar manner.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	1	1	Well thought out consistent plan appropriate for situation; not negatively impacted by caregiver's mood or stress level
	1.5	1.5	
	2	2	Generally consistent and predictable response to behavior; appropriate to age and situation; infrequently impacted by caregiver's mood
	2.5	2.5	
	3	3	Some consistency; caregivers unaware of importance of consistency; occasionally dependent on caregiver's mood; sometimes inappropriate for age or situation
	3.5	3.5	
	4	4	Mostly inconsistent or unpredictable; little flexibility related to age or situation; mostly dependent on caregiver's mood or stress level
	4.5	4.5	
	5	5	No consistency or predictability; no flexibility related to age or situation; totally dependent on caregiver's mood or stress level
D6. Bonding Style with Child(ren)			
<p>Refers to emotional investment and attachment of the caregiver to the child(ren).</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	1	1	Encourages appropriate attachment and independence; attentive; responds appropriately to needs; reads child(ren)'s cues correctly; sends consistent messages to child(ren)
	1.5	1.5	
	2	2	Adequate emotional involvement and support; occasional difficulty allowing separation/ differences; reads cues correctly most of the time
	2.5	2.5	
	3	3	Some inconsistency in emotional support; some ambivalence; responds to physical and/or social needs inconsistency; difficulty reading child(ren)'s cues; some over involvement or lack of appropriate involvement
	3.5	3.5	
	4	4	Minimal responsiveness to child(ren)'s needs; little emotional investment; irritable; over-identifying; often misinterprets cues; frequently does not respond or responds inappropriately; minimal response to child(ren)'s approach/attachment to other people
	4.5	4.5	
	5	5	Inappropriate attachment (e.g., unable to see child(ren) as separate individual); resentful; rejecting; detached; promotes child(ren)'s attachment to other people rather than self; child(ren) endangered by nonresponsive or inappropriate responses; total lack of involvement with child(ren)

D9. Quality and Effectiveness of Communication [Caregiver to Child(ren)]	Caregiver Score		Operational Definition
	A	B	
<p>Refers to caregiver's ability not only to make own desires known but foster child(ren)'s understanding and communication abilities.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	1	1	Open two-way verbal communication without fear; praises and supports appropriately
	1.5	1.5	
	2	2	Generally good communication with some difficulty verbalizing in some areas (i.e., sex, deep feelings); usually supportive; sometimes does not listen to child(ren)'s attempt to communicate; no verbal abuse
	2.5	2.5	
	3	3	Limited communication; gives some mixed messages; some ignoring or discounting of child(ren)'s attempt to communicate; some criticism of child(ren)
	3.5	3.5	
	4	4	Minimal communication; primarily negative, harsh, and ineffective; or child(ren) is discouraged from communicating thoughts or feelings; rarely supportive
	4.5	4.5	
	5	5	Communication is negative, critical, and abusive; child(ren) not allowed to talk about feelings; or absence of verbal communication; nonsupportive
D10. Quality and Effectiveness of Communication [Child(ren) to Caregiver]	Caregiver Score		Operational Definition
A	B		
<p>Refers to child(ren)'s verbal or nonverbal ability to communicate needs and feelings to caregiver.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	1	1	Open verbal communication and appropriate affection; child(ren) able to express feelings and needs
	1.5	1.5	
	2	2	Child(ren) can generally communicate feelings and needs appropriately
	2.5	2.5	
	3	3	Child(ren) has some difficulty communicating own feelings and needs to caregiver(s); hesitant in initiation and response; gives only brief answers; sometimes ignores caregivers
	3.5	3.5	
	4	4	Extremely limited ability to communicate; frequently ignores or verbally provokes caregivers; frightened or withdrawn; rarely shares ideas, feelings, or needs with caregiver
	4.5	4.5	
	5	5	No effective or constructive communication with caregiver; constant fighting or provoking or active avoidance or verbally abusive towards caregiver

D12. Bonding to Caregiver			
<p>Refers to child(ren)'s emotional attachment to caregiver(s). To help in assessing, note to whom the child(ren) seems most bonded and the qualities of the attachment. These qualities can be seen in language, facial expressions, tone of voice, content of communications, visual contact, physical closeness or distance and amount of time spent with the caregiver and depends on the developmental stage of the child(ren).</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	1	1	Child(ren) exhibit consistently appropriate attachment and bonding to caregiver
	1.5	1.5	
	2	2	Child(ren) exhibit adequate bonding; show occasional tensions or anxieties
	2.5	2.5	
	3	3	Child(ren) exhibit some signs of ambivalence, anxiety or hostility toward caregiver; child(ren) may demonstrate insecure attachment (e.g., may appear overly needy)
	3.5	3.5	
	4	4	Minimal appropriate attachment with caregiver; behavior indicates anger, uncertainty, reluctance, or indifference toward caregiver; child(ren) may seem needy of attention from strangers
	4.5	4.5	
	5	5	Inappropriate attachment; child(ren) exhibit extreme dependence or independence; consistently hostile, rejecting or provocative stance towards caregiver; or excessive fearfulness of caregiver; or indiscriminate attachment to strangers

SECTION E: DEVELOPMENTAL STIMULATION			
E1. Appropriate Play Area/Things—Inside Home		Score	
<p>Refers to adequacy and safety of play area; number and condition of playthings; age appropriateness or developmental appropriateness of playthings.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	1	Child safe play area present; a wide choice of age appropriate learning playthings in good and safe condition available	
	1.5		
	2	Age appropriate learning playthings generally available; adequate play area generally available	
	2.5		
	3	Some age appropriate learning playthings for each child; limited play area with some potential dangers	
	3.5		
	4	Very limited or no playthings available; play items in poor condition or unsafe; very limited or unsafe play area available	
	4.5		
	5	Nothing to play with; or inappropriate/potentially dangerous items used as playthings; no play area available	
E2. Provides Enriching/Learning Experiences for Child(ren)		Caregiver Score	
<p>Refers to caregiver's investment in child(ren) social and academic growth and development.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	A	B	
	1	1	Interacts with enjoyment; plans reading or story telling time; carefully selects experiences; plans outings (i.e., park, museum); avoid involvement with school; appropriately help to attain expected developmental tasks (i.e., walking, talking, self-care skills)
	1.5	1.5	
	2	2	Reads to child(ren) as time allows; monitors what child(ren) watches on TV; occasionally planned learning activity; checks homework; talks to teacher
	2.5	2.5	
	3	3	Inconsistently provides enriching learning experiences; lets kids watch any program on TV, although may verbally disapprove; interacts with school only at school's request; rarely reads to child(ren); allows child(ren) to develop with minimal guidance and/or with unrealistic expectations (i.e., child must read before starting school)
	3.5	3.5	
	4	4	Little interest in child(ren)'s activities, learning, and development; avoids school contact; child(ren) on own or excessive pressure to achieve
	4.5	4.5	
	5	5	Blocks and rejects child(ren)'s need for learning; keeps child(ren) at home to meet own needs; interferes with child(ren)'s attempts to achieve normal developmental tasks (i.e., keeps child in crib 90% of the time, holds excessively, only talks baby talk); or pressures child(ren) to perform/achieve to degree that child(ren) develops emotional or physical problems

E3. Ability and Time for Child(ren)'s Play			
Refers to caregiver's understanding of the value of play and creating or allowing it.	1	1	Understands importance of play; sets aside time; plays with child(ren); encourages playfulness and spontaneity; encourages creative play
STRENGTHS:	1.5	1.5	
	2	2	Understands the value of children's play; sometimes sets up play situation; or sometimes makes helpful suggestions regarding play activities; or plays with children occasionally as time allows
CONCERNS:	2.5	2.5	
	3	3	Sees little importance in play; seldom plays with child(ren) but allows child(ren) to play; some dampening of spontaneity
	3.5	3.5	
	4	4	Ignores child(ren)'s need for play; makes no provisions for space or time; doesn't play with child(ren); puts unnecessary restrictions on play; puts down spontaneity; feels children should be working or studying rather than playing
	4.5	4.5	
	5	5	Resents need for play; thwarts playfulness and spontaneity in child; "I never got to play, all he/she ever does is play"; does not want or allow child(ren) to play
E4. Deals with Sibling Interactions			
Refers to caregiver's ability to cope with sibling conflicts and structure positive interaction. Mark N/A if no siblings.	1	1	Aware and sensitive to sibling interactions; teaches problem solving appropriate sharing and respect; appreciates individual differences; fairness is important
STRENGTHS:	1.5	1.5	
	2	2	Limits fighting; encourages appropriate sharing and verbal conflict resolution; generally assists with problem solving; tries to be fair
CONCERNS:	2.5	2.5	
	3	3	Inconsistent; sometimes assists with conflicts and problem solving; fairness not generally considered important
	3.5	3.5	
	4	4	Indifferent; leaves to own devices; tends to ignore sibling interaction both positive and negative; or does not treat children equitably
	4.5	4.5	
	5	5	Favors or rejects one; or fosters rivalry; or scapegoats one child; or allows one to rule; or compares children negatively

Caregiver History and Characteristics

Sections G through H

SECTION G: CAREGIVER HISTORY

	Caregiver Score		Operational Definition
	A	B	
G1. Stability/Adequacy of Caregiver's Childhood			
Refers to stability, consistency/continuity, and emotional adequacy of caregiver's own upbringing during childhood.	1	1	Self-worth and individualization were supported and fostered by own parents; received consistent and stable caregiving
STRENGTHS:	1.5	1.5	
	2	2	Some instability during childhood, but not enough to cause problems; received adequate emotional support and nurturing
	2.5	2.5	
CONCERNS:	3	3	Received limited nurturing; traumatic loss of contact with one parent; physically or emotionally remote parent(s); somewhat conflictual relationship with parent(s) as a child
	3.5	3.5	
	4	4	Little or no nurturing; changing parental figures; long-term parental absence; chronically tumultuous relationship with parent(s) as child
	4.5	4.5	
	5	5	Mainly raised in foster home(s) or institution(s)
G2. Childhood History of Physical Abuse/Corporal Punishment			
Refers to use of corporal punishment, severity, and physical abuse by caregiver's parents during childhood.	1	1	None
STRENGTHS:	1.5	1.5	
	2	2	Occasional spanking, not the routine method of punishment
	2.5	2.5	
CONCERNS:	3	3	Spanking was regular method of discipline; occasional incidents of excessive corporal punishment
	3.5	3.5	
	4	4	Routine excessive corporal punishment; physical abuse; hit with fist or objects
	4.5	4.5	
	5	5	Life-threatening physical abuse; hospitalization

	Caregiver Score		Operational Definition
	A	B	
G3. Childhood History of Sexual Abuse			
Refers to degree of sexual abuse experienced.	1	1	Parents proactively taught self-protection skills
STRENGTHS:	1.5	1.5	
	2	2	No exposure to inappropriate sexuality
	2.5	2.5	
	3	3	Some inappropriate exposure to sexuality
CONCERNS:	3.5	3.5	
	4	4	Incidents of exposure to sexual activity (fondling, flashing, oral sex) causing confusion and/or problem, but no physical force or threat involved
	4.5	4.5	
	5	5	One or more traumatic events, e.g., rape, incest, sodomy, oral copulation, chronic long-term sexual abuse; physical force or threat involved
G4. History of Substance Abuse			
Refers to use and abuse of alcohol and/or drugs in the past.	1	1	None; never used anything
STRENGTHS:	1.5	1.5	
	2	2	Social, recreational use or experimentation; no resulting social/emotional problems
	2.5	2.5	
	3	3	Frequent pattern of abuse resulting in social/emotional problems; currently recovering in or out of a program
CONCERNS:	3.5	3.5	
	4	4	Routine use, e.g., every weekend or daily use
	4.5	4.5	
	5	5	Chronic addiction; daily use over time

G5. History of Aggressive Act as an Adult			
<p>Refers to severity of physically violent acts toward people or property. Assesses propensity toward violence.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	1	1	History of appropriate assertiveness; no history of verbal assaults
	1.5	1.5	
	2	2	No aggressive/violent acts
	2.5	2.5	
	3	3	Tantrum-like behavior which may have resulted in minimal property damage, but not directed at people (e.g., throwing objects; verbal threatening); no child abuse
	3.5	3.5	
	4	4	History of property damage; fighting with peers; physically threatening; pushing, shoving, shaking people
	4.5	4.5	
	5	5	Beating of people, causing injury or serious property damage
G6. History of Being an Adult Victim			
<p>Refers to being victimized as an adult either emotionally or physically.</p> <p>STRENGTHS:</p> <p>CONCERNS:</p>	1	1	Never a victim
	1.5	1.5	
	2	2	Isolated incident, e.g., mugged, robbed by a stranger
	2.5	2.5	
	3	3	Moderate verbal abuse as in hurtful teasing or name calling; constant put downs by spouse or family member; some pushing or shoving in relationships
	3.5	3.5	
	4	4	Chronic verbal or emotional abuse; isolated serious incidents of physical abuse, e.g., violent rape or domestic violence; regularly physically threatened, pushed and/or shoved in relationships; pattern of serious incidents of domestic violence resulting in injury
	4.5	4.5	
	5	5	Chronic, consistent victim; puts self in life-threatening situations and/or exploitative relationships; allows self to be used as a prostitute, drug runner, etc.; domestic violence resulting in hospitalization; multiple rapes

G7. Occupational History			
Refers to history of occupation/work for pay. Write N/A if a homemaker.	1	1	Has career; history of promotions and upward movement in field
	1.5	1.5	
STRENGTHS:	2	2	Long-term full-time employment
	2.5	2.5	
	3	3	Long-term part-time employment; some pattern or consistency in types of jobs; intermittent employment; frequent unemployed periods
CONCERNS:	3.5	3.5	
	4	4	Irregular jobs; seasonal jobs; disabled; unable to hold job for more than six months; work doing anything to survive
	4.5	4.5	
	5	5	Chronic unemployment
G8. Extended Family Support			
Refers to emotional, social, and concrete help provided by family. Also assesses positive or negative nature of the relationship(s).	1	1	Family is positive influence and lives nearby
	1.5	1.5	
STRENGTHS:	2	2	Family is positive influence but lives far away
	2.5	2.5	
	3	3	Minimal support; a few or one relative(s) nearby; emotional support but no concrete help
CONCERNS:	3.5	3.5	
	4	4	No extended family or no follow-through on commitments
	4.5	4.5	
	5	5	Negative influence or effect by extended family involvement; more trouble than help

SECTION H: CAREGIVER PERSONAL CHARACTERISTICS

	Caregiver Score		Operational Definition
	A	B	
H1. Learning Ability/Style			
Refers to ability to understand instructions, directions, ideas, etc. Assesses motivation to learn.	1	1	Above average; quickly catches on to complex and/or abstract ideas; has ability to anticipate consequences; able to learn through any means
STRENGTHS:	1.5	1.5	
	2	2	Average; generally understands; minimal repetition/explanation needed for complex and/or abstract idea; able to learn from a variety of means
	2.5	2.5	
CONCERNS:	3	3	A little slow to comprehend; concrete thinking; understands simple concepts, but has problems understanding abstract ideas
	3.5	3.5	
	4	4	Mildly to moderately retarded; difficulty in understanding simple concepts; moderate to major learning disabilities
	4.5	4.5	
	5	5	Thought disorder; severely retarded; minimal comprehension; severe learning disability
H2. Paranoia/Ability to Trust			
Refers to degree of paranoia or ability to trust.	1	1	No paranoia; generally tends to trust within appropriate and realistic limits
STRENGTHS:	1.5	1.5	
	2	2	A little cautious or overly trusting on occasion
	2.5	2.5	
CONCERNS:	3	3	Guarded; has difficulty trusting; question staff's need to know certain basic things; or tends to trust and divulge too quickly
	3.5	3.5	
	4	4	Suspicious; extreme difficulty trusting; hesitant to reveal any information; or over trusting of strangers; suspiciousness or over trustfulness that causes major problem(s) for person or family
	4.5	4.5	
	5	5	Extreme paranoia; client feels everyone is against him/her without basis in reality; or inappropriate and dangerous trusting of strangers (that threatens own or child(ren)'s welfare)

	Caregiver Score		Operational Definition
	A	B	
H3. Current Substance Use			
Refers to current use and abuse of alcohol and/or other drugs.	1	1	No use
STRENGTHS:	1.5	1.5	
	2	2	Social, recreational use or experimentation; no interference with daily functioning
	2.5	2.5	
CONCERNS:	3	3	Frequent use or experimentation; some current interference in functioning; recovering (in or out of a program)
	3.5	3.5	
	4	4	Daily, habitual use and abuse; significant interference in ability to function
	4.5	4.5	
	5	5	Chronic addiction; unable to function without drugs or alcohol
H4. Passivity/Helplessness/Dependence			
Refers to emotional dependence on someone as well as ability to make daily decisions, write checks, buy food, fulfill job expectations, etc.	1	1	Functions independently for daily living needs; appropriate emotional independence
STRENGTHS:	1.5	1.5	
	2	2	Minor areas of dependence
	2.5	2.5	
CONCERNS:	3	3	Relies on others for routine help; some emotional dependence; does not like being alone; prefers to be in company of others and vigorously seeks a companion; uses child(ren) for companionship
	3.5	3.5	
	4	4	Minimal independent functioning; cannot live alone; needs help with money management, buying food; uses child(ren) for emotional support; is easily exploited
	4.5	4.5	
	5	5	Unable to function independently; cannot survive without outside help; requires help with all daily activities; totally emotionally dependent on other(s); stays in relationships at whatever cost to self or child(ren); no independent decision making; pattern of exploitative threatening relationship(s) or living situation(s)

H5. Impulse Control			
Refers to ability to tolerate <i>frustration or control destructive acts.</i>	1	1	Ability to delay gratification of needs; high level of frustration tolerance
	1.5	1.5	
STRENGTHS:	2	2	Sometimes a little "short-fused" when tired, but does not act out frustration
	2.5	2.5	
	3	3	Generally "short-fused" or "high-strung", inconsistent impulse control, e.g., binge eating, drinking, or shopping; slaps child(ren) with hand; yells and screams a lot
CONCERNS:	3.5	3.5	
	4	4	Very "short-fused"; verbal rages; throws things; often out of control
	4.5	4.5	
	5	5	Inadequate impulse control; fights; steals; substance abuse; suicide attempts; hurts self and others; limited ability to care for child(ren)
H6. Cooperation			
Refers to degree of cooperation with program measured by actions and statements.	1	1	Actively seeking help; provides information with minimal questioning; brings examples of problems; open to new ideas about solutions
	1.5	1.5	
STRENGTHS:	2	2	Willingly cooperates in answering questions; gives additional information; keeps appointments; is punctual; calls to reschedule if necessary; tries suggested ideas
	2.5	2.5	
	3	3	Some reluctance or hesitance; needs to be pushed or prodded to give information; passively cooperates; doesn't call if late or to cancel
CONCERNS:	3.5	3.5	
	4	4	Participates only to please other (or follow court order); comes late; answers questions only "yes" or "no"; give excuses; minimizes problems; refuses to answer some questions
	4.5	4.5	
	5	5	No cooperation; refuses to answer most questions; attitude leads to questionable honesty of responses



H7. Emotional Stability (Mood Swings)			
Refers to consistency and range of moods or emotions, appropriateness of emotions and/or behavior, speed of reaction. Assesses whether emotions or emotional behavior interfere with daily functioning. STRENGTHS: CONCERNS:	1	1	Emotionally stable
	1.5	1.5	
	2	2	Occasionally moody with minimal consequences; unaware of feelings; some restricted range
	2.5	2.5	
	3	3	Moderately moody; significantly limited in emotional range; some inappropriateness in emotional responses; short-tempered; confused circular thinking; mild manic features
	3.5	3.5	
	4	4	Extreme moodiness; unpredictable; frequent inappropriateness that often interferes with functioning
	4.5	4.5	
	5	5	Grossly inappropriate emotional reaction to situation; emotion interferes consistently with daily life; lack of emotional stability
H8. Depression			
Refers to degree of depression and its interference with functioning. Assesses emotional affect, appearance of self and home, level of activity, and verbal statements regarding feelings. STRENGTHS: CONCERNS:	1	1	Not depressed/upbeat attitude toward life
	1.5	1.5	
	2	2	Periods of mild depression; "feeling blue", but functioning adequately; no impact on child(ren)
	2.5	2.5	
	3	3	Frequently depressed but functioning without treatment; past suicidal thoughts; "tired" all the time
	3.5	3.5	
	4	4	Seriously depressed but functioning minimally; recent suicidal thoughts; past suicidal attempts or activities intended to hurt self
	4.5	4.5	
	5	5	Chronic, long-term depression; treated psychiatrically; current suicide attempts; using medication; unable to function currently

	Caregiver Score		Operational Definition
	A	B	
H9. Aggression/Anger			
Refers to current expressions of aggression and anger.	1	1	Above average ability to be assertive; exercises healthy ways of releasing aggressive feelings or anger
STRENGTHS:	1.5	1.5	
	2	2	Adequate; generally appropriate expressions of aggression (i.e., sports, gardening, hobbies, exercise) and anger (i.e., controlled verbal expression not causing physical or emotional harm); occasional verbal barb or slammed door
CONCERNS:	2.5	2.5	
	3	3	Passive aggressive or withholding behaviors; yelling a lot at child(ren); using foul language to excess around child(ren); minimal property damage (i.e., kicking a door)
	3.5	3.5	
	4	4	Verbally explosive; ranting and raving at child(ren); pattern of provocative statements or behaviors; no injury-causing physical abuse, but harsh (i.e., pushing, pulling, grabbing); more serious property damage (e.g., punching holes in walls); denies anger
	4.5	4.5	
	5	5	Violent; threatening with some injury-causing physical aggression; threatening abandonment; emotional cruelty; regular violent acts toward people and property causing damage or injury requiring hospitalization or resulting in serious harm
H10. Practical Judgement/Problem-Solving and Coping Skills			
Refers to ability to develop options and make appropriate decisions/choices in areas such as child care, discipline, money management, personal relationships; ability to cope with daily stress. Also assesses awareness of own abilities and limitations.	1	1	Uses excellent judgment; able to develop and build options; proactive approach to problem solving; has a variety of appropriate coping techniques; aware of and able to compensate for own limitations; excellent insight
STRENGTHS:	1.5	1.5	
	2	2	Generally good ability to problem solve and cope with stress; some ability to anticipate and develop options in advance; knows and works around own limitations; some insight into own problem-solving style
CONCERNS:	2.5	2.5	
	3	3	Difficulty seeing options; makes good choices in some areas but not in others; some difficulty in acknowledging limitations; little insight into problem-solving style
	3.5	3.5	
	4	4	Poor judgement in many minor areas or one major area (e.g., leaves child with alcoholic friend); very limited ideas on problem solving and coping; difficulty seeing options even with help; no insight into own problem-solving style
	4.5	4.5	
	5	5	Grossly inappropriate judgment; unable to develop options to solve problems; unable to cope with daily stress; denial of own limitations

H11. Meets Emotional Needs of Self/Child			
Refers to healthy balance between meeting own needs and child(ren)'s needs.	1	1	Maintains healthy balance between own and child(ren)'s needs
	1.5	1.5	
STRENGTHS:	2	2	Some imbalance at times; marital relationship sometimes gets lost in family and child(ren)'s needs; child(ren)'s needs occasionally secondary to parent's, but causes no harm
	2.5	2.5	
CONCERNS:	3	3	Frequently meeting own needs first with some emotional consequence but no physical consequence to child(ren) (e.g., mother rushes child(ren) so she can see boyfriend), uses child(ren) to avoid being alone; uses child(ren) for emotional support
	3.5	3.5	
	4	4	Pattern of meeting own needs first with potential endangerment (e.g., leaves latency age child(ren) in charge of toddler); refuses to acknowledge special needs child to the child's detriment; overly self-sacrificing ("My whole life is these children", "I do everything for them", "I am nothing without them")
	4.5	4.5	
	5	5	Meets own needs at expense of child(ren)'s emotional, physical, or medical welfare and child(ren) is currently suffering due to this
H12. Self-Esteem			
Refers to current feelings about self.	1	1	Able to make positive self comments; likes self
	1.5	1.5	
STRENGTHS:	2	2	Tends to be self-critical but can take positive feedback
	2.5	2.5	
CONCERNS:	3	3	Low self-esteem; difficulty taking positive feedback
	3.5	3.5	
	4	4	Consistently self-deprecating; cannot identify positive in self
	4.5	4.5	
	5	5	No self-esteem; self-hatred

L. HEALTH AND DEVELOPMENT PROBLEMS:

THE INTERVIEWER MAY WANT TO START OUT BY ASKING QUESTIONS REGARDING OVERALL HEALTH AND DEVELOPMENTAL STATUS, AND THEN PROCEED TO SPECIFIC QUESTIONS.

Reported By:

Staff *Caregiver*

	<i>Behavior</i>	<i>Behavior Description</i>
	<p>Health Problem(s)—Chronic CHILD(REN): _____ NOTES:</p>	<p>Ask about long-standing conditions like asthma, allergies, skin rashes, digestive ills, and heart defects. Ask about onset, current medications, medical procedures, ongoing medical care. Attend to anything that does not seem normal (e.g., wheezing, odd posturing or way of walking, skin color, weight, height, crossed or wandering eyes, oddly shaped ears, etc.).</p>
	<p>Health Problem(s)—Current CHILD(REN): _____ NOTES:</p>	<p>Ask about recent illnesses, flu, fevers, colds, childhood diseases. Ask how these were treated by the family and if medical attention was sought. Look for lethargy, color, temperature of skin, weight, and height.</p>
	<p>Dental Problems CHILD(REN): _____ NOTES:</p>	<p>Observe the child(ren)'s teeth, look for missing teeth, badly decayed front teeth (baby bottle syndrome), tongue thrust (tongue protrudes forward during speech), misalignment. Ask if child(ren) has seen the dentist. Ask also about teeth brushing and frequency of sweets.</p>
	<p>Developmentally Delayed/Mentally Retarded CHILD(REN): _____ NOTES:</p>	<p>Ask the caregiver(s) if they have any concerns, at which level they think the child(ren) is functioning, major milestones (i.e., walking, speech), comparisons with siblings. Ask about school performance and reports. Observe the child(ren) closely, especially infants, toddlers, or preschoolers.</p>
	<p>Adopted CHILD(REN): _____ NOTES:</p>	<p>There is a higher incidence of maladjustment among adopted children. Ask when the child(ren) was adopted, why the family chose adoption, and what they know of the child(ren)'s history.</p>

Reported By:

Staff Caregiver

	<i>Behavior</i>	<i>Behavior Description</i>
	<p>Premature Labor/Difficult Pregnancy or Delivery CHILD(REN): _____ NOTES:</p>	<p>Ask how premature the child(ren) was (term +40 weeks), birth weight, Apgar scores, condition at birth, hospital treatment (e.g., respirator, jaundice), age at discharge. Ask about prenatal care, medications or drugs during pregnancy, bleeding, premature rupture of the membranes, type of presentation (head v. feet first), type of delivery (vaginal v. C-section), fetal distress.</p>
	<p>Asthma CHILD(REN): _____ NOTES:</p>	<p>Ask about age of onset, medications, emergency procedures, current physician care, type and severity of symptoms, frequency, duration, and how the caregiver handles this stress.</p>

M. TEMPERAMENT:

A STYLE OF THINKING, BEHAVING, AND REACTING THAT CHARACTERIZES AN INDIVIDUAL. UNDERSTANDING A CHILD'S TEMPERAMENT HELPS A CAREGIVER KNOW HOW TO RESPOND TO THE CHILD EFFECTIVELY AND HOW TO HELP OTHERS, SUCH AS TEACHERS, UNDERSTAND THE CHILD. *The following are four temperament characteristics to discuss with caregivers.*

Reported By:

Staff Caregiver

	<i>Behavior</i>	<i>Behavior Description</i>
	<p>Shy (Introverted) v. Outgoing (Extroverted) CHILD(REN): _____</p> <p>NOTES:</p>	<p>A shy child has a more difficult time meeting new people or entering new situations, like child care or school. A shy child may hide from new people, fuss a lot in new situations, or be afraid to try to new things. An outgoing child smiles and laughs around new people. explores new places, enters new situations easily, joins other children in play, i.e., at a park. Look for child's ability to separate from caregiver, dress, care for self or complete tasks that other children of the same age do. Look to see if caregiver rewards dependent behavior or encourages independence. (Note: children age 6-30 months often fuss if separated from caregiver; 3-6 year olds are often shy with strangers).</p>
	<p>Activity Level CHILD(REN): _____</p> <p>NOTES:</p>	<p>Many caregivers think their toddlers and young children are hyperactive. Observe for yourself. Ask if activity level varies with what child is doing. Can child sit through a meal? Sit still for a story or song or movie? Does child fidget, swing, legs, gesture with hands, always seem in motion? Does school report the same problem? Has a doctor been consulted and/or medication prescribed (which medicine and dose)? Some children tend to run v. walk, prefer running and jumping games v. sitting games, prefer quiet activities like crafts, reading, or looking at pictures. What are the child's preferences? Is the child impulsive, acts without thinking, i.e., run into the street without looking, take risks, accident prone?</p>
	<p>Attention Span/Persistence CHILD(REN): _____</p> <p>NOTES:</p>	<p>How able is the child to stay on task or stick with something that is difficult? Can the child work on puzzle or drawing until done? When learning a new skill, does child practice it for a long time? When a toy or game is hard, does child switch to another activity? Does child seem to get bored sooner than other children of the same age? Can child remain at tasks like other children of same age? Does child's ability to stay on task vary with the activity, i.e., homework v. play?</p>

Reported By:

Staff Caregiver

	<i>Behavior</i>	<i>Behavior Description</i>
	<p>Demanding/Irritable/Difficult CHILD(REN): _____ NOTES:</p>	<p>How intense is the child's mood and how negative? Does child cry a lot? Is child hard to comfort or calm down when upset? Does child stay disappointed for a long time when taken away from an activity the child likes? Does child protest loudly and for an extended period? How easily is child distracted when doing something wrong? Will child accept something other than what child wants, i.e., candy v. a toy at the store? From verbal or nonverbal cues of caregiver and your own observations, note frequency of crying, frustration, tolerance of the child(ren), frustration of the caregiver, reactivity level of the child(ren) (e.g., overreacts to slight stimuli), fussing in infants, colic.</p>

Service Plan

CASE # _____ WORKER _____ PROGRAM/OFFICE _____

1. Problem: _____ Rating _____

Goal: _____ FAF Item # _____

Method: _____

2. Problem: _____ Rating _____

Goal: _____ FAF Item # _____

Method: _____

3. Problem: _____ Rating _____

Goal: _____ FAF Item # _____

Method: _____

4. Problem: _____ Rating _____

Goal: _____ FAF Item # _____

Method: _____

5. Problem: _____ Rating _____

Goal: _____ FAF Item # _____

Method: _____

Estimated Duration of Service: _____ Estimated Frequency of Contact: _____

AIA CLOSING SUMMARY

Case Name: _____

Case I.D.# _____

F.S.W.#1: _____

F.S.W.#2: _____

Date Opened: _____

Date Closed: _____

Date Reopened: _____

Date Closed: _____

Reason for closing:

- Family completed program successfully
- Family moved from area
- Family refused services / dropped out
- Family Support team terminated services

Reason: _____

- Other: Explanation: _____

AIA SERVICES RECEIVED:

- Substance Abuse Education
- Substance Abuse Recovery
- Parenting
- Reunification Parenting
- Parenting with HIV/AIDS
- HIV/AIDS Parent Support Group
- Youth Affected by HIV/AIDS Support Group
- HIV/AIDS Screening
- HIV/AIDS Education
- Family Health Education
- Employment Development Services
- Parent-Child Play Group
- Permanency Planning Services
- Respite Services
- Housing Assistance
- Transportation Assistance
- Emergency Food / Clothing
- Resource and Referral Services
- Case Management
- Parent Support Group
- Domestic Violence Prevention Education
- Other: _____

Grant Assignment: _____

In-Home Services: _____

Center Based Services: _____

Assessments completed:

FAF/PRE: _____ FAF/6mos.: _____ FAF/POST _____

AIA/INTAKE: _____

AIA/6 MONTHS: _____

AIA/TERMINATION: _____

AIA/FOLLOW-UP: _____

ASQ/4mos.: _____ ASQ/8mos. _____

ASQ/12mos. _____ ASQ/16mos. _____

ASQ/20mos. _____ ASQ/24mos. _____

ASQ/28mos. _____ ASQ/32mos. _____

ASQ/36mos. _____ ASQ/40mos. _____

ASQ/44mos. _____ ASQ/48mos. _____

CHILDREN'S HEALTH SCREENING: _____

OTHER CHILD DEV. ASSESSMENT:

Instrument: _____

Pre: _____ Post: _____

OTHER ASSESSMENT:

Instrument: _____

Pre: _____ Post: _____

FSW RATING

In my opinion progress was / was not made in this case because:
(circle one)

FAMILY'S OPINION

In our opinion progress was / was not made in this case because:
(circle one)

OUTCOME ON GOALS

Goal #1 / Related FAF Item & # _____

Assessment Rating:	6 months Rating:	Termination Rating:
--------------------	------------------	---------------------

Goal #2 / Related FAF Item & # _____

Assessment Rating:	6 Months Rating:	Termination Rating:
--------------------	------------------	---------------------

Goal #3 / Related FAF Item & # _____

Assessment Rating:	6 Months Rating:	Termination Rating:
--------------------	------------------	---------------------

Goal #4 / FAF Item & # _____

Assessment Rating:	6 Months Rating:	Termination Rating:
--------------------	------------------	---------------------

Goal #5 / FAF Item & # _____

Assessment Rating:	6 Months Rating:	Termination Rating:
--------------------	------------------	---------------------

DISPOSITION

Did any children leave home or go into any type of out of home placement? _____ Yes _____ No

If yes, please specify: _____

Center Based Follow-Up Services recommended? _____ Yes _____ No

Comments: _____

BIENVENIDOS FAMILY SERVICES

PUEBLO DE APOYO

FAF PARENTING SKILLS; PARENT-CHILD INTERACTION SCORES; ASQ & GPA RECORDING FORM

NAME		CLT. I.D.#	Date of Intake	Date of Term.	Date of Post Follow-up	FSW#1			FSW #2							
PARENTING SKILLS					PARENT CHILD INTERACTIONS					ASQ			GPA REPORT CARDS			
#	ITEM	Intk	trm	pfu	#	ITEM	Intk	trm	pfu	ITEM	Intk	trm	pfu	Intk	trm	pfu
D-1	Understanding Child Development				D-4	Bonding style with Child(ren)				C						
D-2	Daily Routine for Child(ren)				D-9	Caregiver to Children: Quality and effectiveness of communication				GM						
D-3	Use of Physical Discipline				D-12	Bonding to Caregiver				FM						
D-4	Appropriateness of Disciplinary methods									PSL						
D-5	Consistency of Discipline									PSC						
D-6	Bonding Style With Children															
E-1	DEVELOPMENTAL STIMULATION Appropriate Play Area/Things (inside)															
E-2	Provides Enriching/ Learning Experiences for Child(ren)															
E-3	Ability and time for Child(ren)'s Play															
TOTAL SCORE					TOTAL SCORE					ttl						
MEAN SCORE (TOTAL+ #-MEAN)					MEAN SCORE (TOTAL+ #-MEAN)					ms						

AIA - FAF DATA REPORTING FORM

CLIENT NAME: _____

I.D.# _____

F.S.W. #1 _____

F.S.W. #2 _____

INTAKE _____

TERMINATION _____

FOLLOW-UP _____

#	G	ITEM	INTAKE RATING		TERMINATION RATING		FOLLOW-UP RATING	
			A	B	A	B	A	B
A-1		LIVING CONDITIONS: Cleanliness- Orderliness: Outside Environmental Conditions						
A-2		Cleanliness-Orderliness: Outside Home Maintenance						
A-3		Cleanliness-Orderliness: Inside Home Maintenance						
A-4		SAFETY: Outside Environmental Conditions						
A-5		Outside-Home Maintenance						
A-6		Inside Home Maintenance						
B-1		FINANCIAL CONDITIONS Financial Stress						
B-2		Financial Management						
B-3		Financial Problems Due tot. Welfare System/Child Support						
B-4		Adequate Furniture						
B-5		Availability of Transportation						
C-1		SUPPORT OF CAREGIVERS Support from Friends and Neighbors and Community Involvement						
C-2		Available Child Care						
C-3		Choose Appropriate Substitute Caregivers						
C-4		Available Health Care						
C-5		Provides for Basic/Medical Physical Care						
#		ITEM	INTAKE RATING CAREGIVER		TERMINATION RATING		FOLLOW-UP RATING	
			A	B	A	B	A	B
D-1		CAREGIVER/CHILD INTERACTIONS Understands Child Development						
D-2		Daily Routines for Children						
D-3		Use of Physical Discipline						
D-4		Appropriateness of Disciplinary						
D-5		Consistency of Discipline						

#	ITEM	INTAKE RATING CAREGIVER		TERMINATION RATING		FOLLOW-UP RATING	
		A	B	A	B	A	B
D-6	Bonding Style with Children						
D-9	Caregiver to children: Quality and effectiveness of communication						
D-10	Child(ren) to Caregiver: Quality and effectiveness of Communication						
D-12	Bonding to Caregiver						
E-1	DEVELOPMENTAL STIMULATION Appropriate Play Area/Things-Inside						
E-2	Provides Enriching/Learning Experiences for Child(ren)						
E-3	Ability and Time for Child(ren)'s Play						
E-4	Deals with Sibling Interactions						
G-1	Stability/Adequacy of Caregiver's Childhood						
G-2	Childhood History of Physical Abuse/Corporal Punishment						
G-3	Childhood History of Sexual Abuse						
G-4	History of Substance Abuse						
G-5	History of Aggressive Act as an Adult						
G-6	History of Being an Adult Victim						
G-7	Occupational History						
G-8	Extended Family Support						
H-1	CAREGIVER PERSONAL CHARACTERISTICS Learning Ability/Style						
H-2	Paranoia/Ability to Trust						
H-3	Current Substance Abuse						
H-4	Passivity/Helplessness/Dependence						
H-5	Impulse Control						
H-6	Cooperation						
H-7	Emotional Stability (Mood Swings)						
H-8	Depression						
H-9	Aggression/Anger						
H-10	Practical Judgement/Problem Solving and Coping Skills						
H-11	Meets Emotional Needs of Self/Child						
H-12	Self-Esteem						

**AGES & STAGES QUESTIONNAIRES:
A PARENT-COMPLETED,
CHILD-MONITORING SYSTEM**



by

Diane Bricker, Ph.D.

Jane Squires, Ph.D.

and

Linda Mounts, M.A.

with assistance from

LaWanda Potter, M.S.

Robert Nickel, M.D.

and

Jane Farrell, M.S.

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Center on Human Development
University of Oregon, Eugene

· P A U L · H ·
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PHOTOCOPYING RELEASE

*Users of the **Ages & Stages Questionnaires (ASQ): A Parent-Completed, Child-Monitoring System** are granted permission to photocopy the questionnaires as well as the sample letters and forms in **The ASQ User's Guide** in the course of their service provision to families. The questionnaires and samples are meant to be used to facilitate screening and monitoring and to assist in the early identification of children who may need further evaluation. Although photocopying for the purposes of service provision is unlimited, none of the ASQ materials may be reproduced to generate revenue for any program or individual. Programs are prohibited from charging parents, caregivers, or other service providers who will be completing and/or scoring the questionnaires fees in excess of the exact cost to photocopy the master forms. Likewise, the ASQ materials may not be used in a way contrary to the family-oriented philosophies of the ASQ developers. *Unauthorized use beyond this privilege is prosecutable under federal law.* You will see the copyright protection line at the bottom of each form.*



Ages & Stages Questionnaires:

A Parent-Completed, Child-Monitoring System

This box contains the following:

- 11 color-coded, reproducible questionnaires for use at 4, 6, 8, 12, 16, 18, 20, 24, 30, 36, and 48 months of age
- 11 reproducible, age-appropriate scoring sheets—1 for each questionnaire
- 1 reproducible mail-back sheet

In addition to the enclosed English version of the *Ages & Stages Questionnaires*, other products in the ASQ system include the following:

• **The Ages & Stages Questionnaires—Spanish version:**

- 11 color-coded, reproducible questionnaires for use at 4, 6, 8, 12, 16, 18, 20, 24, 30, 36, and 48 months of age
- 11 reproducible, age-appropriate scoring sheets — 1 for each questionnaire
- 1 convenient storage box
- 1 reproducible mail-back sheet

By Diane Bricker, Ph.D., Jane Squires, Ph.D., and Linda Mounts, M.A., with assistance from LaWanda Potter, M.S., Robert Nickel, M.D., and Jane Farrell, M.S.

• **The ASQ User's Guide**

By Jane Squires, Ph.D., LaWanda Potter, M.S., and Diane Bricker, Ph.D.

• **The Ages & Stages Questionnaire on a Home Visit—Video**

Developed by Jane Farrell, M.S., and LaWanda Potter, M.S.
Produced by Arden Munkres, M.F.A.

To order, contact Paul H. Brookes Publishing Co., Post Office Box 10624, Baltimore, Maryland 21285-0624 (1-800-638-3775) or photocopy the reorder form on the back of this page.

An Introduction to Using the ASQ System



In this box is a series of 11 *Ages & Stages Questionnaires (ASQ)*, which were developed to assist with the monitoring and identification of children with developmental delays from 4 months to 4 years of age. The *Ages & Stages Questionnaires* are designed to screen young children for developmental delays—that is, to identify those children who are in need of further evaluation and those who appear to be developing typically. The ASQ system represents a novel approach to screening because the questionnaires are designed to be completed by the parents or caregivers of young children, rather than by trained professionals. (For more information about the development and developers of the ASQ system, see *The ASQ User's Guide*.)

THE ASQ USER'S GUIDE

The ASQ User's Guide is a companion to these questionnaires and contains necessary information for using the entire ASQ monitoring system. Procedures for planning a monitoring program, using and scoring the questionnaires, making referrals, and evaluating the monitoring program throughout implementation are included in the *User's Guide*. A number of useful sample letters and forms also are provided—in both English and Spanish—in the *User's Guide*, which also chronicles the development of the ASQ products since 1979. The *User's Guide* also includes suggested intervention activities for distribution to families, as well as a compilation of the data and analyses conducted on the questionnaires. In particular, validity, sensitivity, specificity, and overreferral and underreferral rates are addressed. An optional component, *The Ages & Stages Questionnaires on a Home Visit*, is a videotape that describes using the questionnaires in the home environment with families. (Ordering information for the ASQ products is provided on page iii in this box.)

THE QUESTIONNAIRES

The *Ages & Stages Questionnaires*, which are also available in Spanish, are color coded for easy reference. They are intended to be photocopied in the course of service provision to families. (Please see the Photocopying Release on page ii in this box.) The questionnaires can be mailed to parents and completed in the home environment, completed with the assistance of a nurse or social worker on a home visit or during a telephone interview, completed by

child's performance on a questionnaire. Cutoff grids appear on each Information Summary Sheet that can easily be compared with the child's performance at that age interval to determine if the child should be referred for further evaluation. At the bottom of the page, for programs with digital scanning capabilities, ovals may be darkened so that scores can be automatically scanned into computer records.

The questionnaires are scored by converting each answer to a numerical equivalent and comparing the totals for each area (e.g., communication, fine motor) with the empirically derived cutoff points for that area. The responses—*yes*, *sometimes*, and *not yet*—are converted to points—10, 5, and 0, respectively. If a child's score for any area is at or below the cutoff point, the child is recommended for a referral for further developmental evaluation. Again, more explanation of how to score the questionnaires and how to determine when to refer a child for further evaluation can be found in *The ASQ User's Guide*.

A MESSAGE FROM THE AUTHORS

The *Ages & Stages Questionnaires* were designed to encourage screening of large numbers of children in an economical and efficient way. Our goal is to assist you in establishing a system that can identify children in need of intervention services in a timely and cost-effective manner. We hope that you will find these materials of use and that, ultimately, the developmental outcomes of young children and families will be improved.

ABANDONED INFANTS ASSISTANCE (AIA) PROGRAMS

CLIENT DESCRIPTIVE AND OUTCOME DATA

COLLECTION FORM*

AIA project evaluators are required to report data on biological mothers and/or index children who receive services from AIA programs. *Index children are designated by the program as the infant at risk for abandonment, the youngest child in a family or the primary target infant for program services. If the mother is pregnant at intake, the unborn child will be the index child. An intake for that child should be conducted after the baby is delivered.* There is only one index child per family. (Due to problems of tracking, children of multiple births (e.g., twins) are being excluded from the data set.)

Information on each client will be collected at multiple points in time:

INTAKE
TERMINATION
POST-TERMINATION

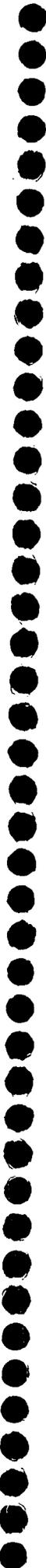
There are instructions and glossary of terms throughout the form.

Provide client level data on diskette in a format that is readable by either SPSS or Microsoft Excel by the end of December after the close of the federal fiscal year. Do not send data via e-mail. Please complete and enclose an *AIA Evaluation Tracking Form for Submitted Data*.

Mail diskettes to:
Evaluation Team
The National Abandoned Infants Assistance Resource Center
1950 Addison Street, Suite 104
Berkeley, California 94704-1182

If you have any questions when completing the form, please call the Evaluation Team at (510) 642-0744 or (510) 643-8834, or send e-mail to aia@uclink4.berkeley.edu.

*These forms are updated for the period October 1999 through September 2000 (Year 4 of the Cross Site Evaluation). Data are due to the AIA Resource Center by December 31, 2000.



ATTACHMENT D

Bienvenidos Family Services
Initial Intake Referral

I.D. # _____

Taken By _____

Date _____

Time _____ am/pm

Referring agency _____ Contact _____
Referred by 1-Hospital/2-Substance abuse program/3-DCFS/4-Self/friend/relative/5-Mental Health/6-WIC/7-Judicial/8-Regional Center/9-BFFA/10-Other

Name _____ Signature: _____

Address _____

City/State/Zip _____

Phone _____ Message Phone _____

Marital status code _____ Ethnic Code _____ Social Security # _____

Primary language in home 1-English 2-Spanish 3-Other Bilingual 1-Yes 2-No

Educational status _____ Work/Employment status _____
 00 Never attended school 0 Does not work
 01-12 First through 12 grades 1 Seeking employment
 13 Graduated from high school 2 Working part-time
 14 Completed GED or CHPSE 3 Working full-time
 15 Schooling above high school 4 Unknown

In School 1-Full-time 2-Part-time 3-No Source of Income: TANF _____ Food Stamps _____ SSI _____
 Other _____ Date Received _____

Mother _____

Father _____

In-Home? 1-Yes 2-No 3-N/A

In-Home? 1-Yes 2-No 3-N/A

Marital Status Code _____

Marital Status Code _____

DOB _____ Age _____

DOB _____ Age _____

<p>Program 1-In-Home services 2-Center-based services 3-Information/referral 4-Court</p>	<p>Grant assignment 1-AIA 2-1733 3-CALWORKS 4-Family Preservation 5-FEMA 6-CLP 7-CSBG 8-Other</p>	<p>Assigned to 1-Supervisor _____ 2-Family Support Worker _____ Opening date _____ / _____ / _____ Closing date _____ / _____ / _____</p>
---	--	--

Code Box

<p>Ethnic Code 1-White 2-Hispanic 3-Black 4-Asian 5-Pacific Islander 6-American Indian 7-Other 9-N/A</p>	<p>Marital Status 1-Married 2-Divorced 3-Separated 4-Widowed 5-Domestic Partner 6-Single 9-N/A</p>	<p>Resides with(Current Placement List) 1-Home w/ parent, no CPS involvement 2-Home w/ parent CPS involvement 3-Adoptive home parent 4-W/relative, informal placement 5-W/relative, foster care 6-Non-relative, informal placement</p>	<p>7-Foster Family Care 8-Group home/shelter 9-Residential treatment with 10-Residential treatment w/o parent 11-Hospital 12-Homeless shelter w/parent</p>
---	--	---	---

DCFS Case # _____ Office _____

CSW _____ Phone# _____

Date of Initial Involvement _____ Date of Initial Placement _____

Reason for initial placement _____

Attorney's name _____ Phone# _____

Next court date: _____

CHILDREN						
#	Name/Ethnic Code	F / M	DOB/ AGE	Father	Placement Code	Date of Reunification
1		F / M				
2		F / M				
3		F / M				
4		F / M				
5		F / M				
6		F / M				
7		F / M				
8		F / M				
9		F / M				
10		F / M				

CHILDREN'S RISK FACTORS

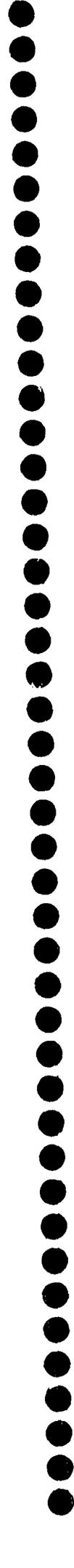
Risk Factor	Child #	Risk Factor	Child #
Behavior problems.....None	1 2 3 4 5 6 7 8 9 10	Low birth weight.....None	1 2 3 4 5 6 7 8 9 10
Caloric deprivation.....None	1 2 3 4 5 6 7 8 9 10	Motor impairment.....None	1 2 3 4 5 6 7 8 9 10
Cardiac anomalies.....None	1 2 3 4 5 6 7 8 9 10	Neonatal drugs or alcohol.....None	1 2 3 4 5 6 7 8 9 10
Is placed out of the home.....None	1 2 3 4 5 6 7 8 9 10	No prenatal care.....None	1 2 3 4 5 6 7 8 9 10
Developmental delays.....None	1 2 3 4 5 6 7 8 9 10	Prematurity.....None	1 2 3 4 5 6 7 8 9 10
Down's Syndrome.....None	1 2 3 4 5 6 7 8 9 10	Seizures.....None	1 2 3 4 5 6 7 8 9 10
Failure-to-thrive.....None	1 2 3 4 5 6 7 8 9 10	Severe emotional disturbance.....None	1 2 3 4 5 6 7 8 9 10
Hearing impairment.....None	1 2 3 4 5 6 7 8 9 10	Sleep apnea syndrome.....None	1 2 3 4 5 6 7 8 9 10
History of placements.....None	1 2 3 4 5 6 7 8 9 10	Vision impairment.....None	1 2 3 4 5 6 7 8 9 10
Learning disability.....None	1 2 3 4 5 6 7 8 9 10	Other.....None	1 2 3 4 5 6 7 8 9 10

PARENTS RISK FACTORS N/A

Teen Parent.....	1-Yes	2-No	Poverty.....	1-Yes	2-No
Pregnant (Due Date _____).....	1-Yes	2-No	Isolation.....	1-Yes	2-No
Current Substance abuse.....	1-Yes	2-No	Presently homeless.....	1-Yes	2-No
History of substance abuse(last used _____)..... Drug of Choice: _____	1-Yes	2-No	History of homelessness.....	1-Yes	2-No
History of substance abuse during pregnancy.....	1-Yes	2-No	Substandard living/temporary housing.....	1-Yes	2-No
Domestic abuse-emotional or physical..... History: _____ Present: _____ TRO _____	1-Yes	2-No	Impaired physical or mental health..... Diagnosis _____ Medication: _____	1-Yes	2-No
Victim: childhood physical, emotional sexual abuse.....	1-Yes	2-No	Developmentally disabled.....	1-Yes	2-No
History of being identified as abusive.....	1-Yes	2-No	Illiterate.....	1-Yes	2-No
Court identified as abusive.....	1-Yes	2-No	Unemployed.....	1-Yes	2-No
Court identifies as neglectful.....	1-Yes	2-No	History of Employment.....	1-Yes	2-No
Poor parenting skills.....	1-Yes	2-No	History of incarceration.....	1-Yes	2-No
Poor/limited job skills.....	1-Yes	2-No	Criminal status.....1-Probation(Summary - Formal) 2-Parole 3-No		

Resource and Referrals

FAMILY SUPPORT CENTER	REFERRED TO:	
Baby & Me Class	After School Program	Legal Aid
Case management	Child Protective Services	Literacy
Community Advocacy	Childcare/Day Care	Mommy & Me
Counseling	Domestic Violence	Out-Patient Drug Treatment
Crisis Intervention	Drug Testing	Parent Education
Domestic Violence Group (English - Spanish)	E.S.L.	Prenatal Care
Educational Counseling	Education	Psychological Evaluation
Employment Counseling	Educational Evaluation	Recovery Support
English Women's Support Group	Family Counseling	Regional Center
Fatherhood Class	Family Planning	Rehabilitation Program
Food Pantry	Financial Assistance	Residential Drug Treatment
In-Home Services	Food Assistance	Sexual Abuse Counseling
Narcotics Anonymous	Healthcare	Shelter Assistance
Parenting Class (English - Spanish)	HIV/AIDS Services	Special Education
Parent Anonymous	Housing Assistance	Support Groups
Respite Services	In-Home Support	Transportation Services
Spanish Women's Support Group	Independent Living Program	Tutoring
Substance Abuse: Education - Recovery	Individual Counseling	Youth/Gang Intervention
Teen Girl's Support Group	Job/Vocational Training	Other(Specify)
Teen Mother Support Group		
Transportation		
Other(Specify)		



ATTACHMENT E

FAMILY REUNIFICATION - PARENTING CURRICULUM

- WEEK #1: ORIENTATION: WHY THIS PROGRAM IS DIFFERENT**
- WEEK #2: DIS-SPELLING THE DEMONS / FACING THE REALITIES**
- WEEK #3: FAMILY HISTORIES**
- WEEK #4: THE IMPACT OF REMOVAL FOR PARENT & CHILD**
- WEEK #5: SEPARATION THROUGH THE EYES OF THE CHILD
THROUGH THE DIFFERENT STAGES OF DEVELOPMENT – 1**
- WEEK #6: SEPARATION THROUGH THE EYES OF THE CHILD
THROUGH THE DIFFERENT STAGES OF DEVELOPMENT – 2**
- WEEK #7: RE-CREATING A FUNCTIONAL FAMILY
THE HEALING OF FAMILY BONDS**
- WEEK #8: REALISTIC EXPECTATIONS**
- WEEK #9: COPING WITH THE CHALLENGES**
- WEEK #10: UNDERSTANDING ACTING OUT BEHAVIOR**
- WEEK #11: BUILDING RELATIONSHIPS WITH FOSTER PARENTS**
- WEEK #12: STAGES OF REUNIFICATION**
- WEEK #13: SUCCESSFUL VISITATIONS**
- WEEK #14: DEVELOPMENTALLY RELATED
RE-CONNECTION ACTIVITIES**
- WEEK #15: DEVELOPMENTALLY RELATED
RE-CONNECTION ACTIVITIES**
- WEEK #16: NEW APPROACHES TO DISCIPLINE**
- WEEK #17: NEW APPROACHES TO DISCIPLINE**
- WEEK #18: NEW BEGINNINGS**
- WEEK #19: STRESS MANAGEMENT FOR PARENT AND CHILD**
- WEEK #20: GRADUATION / CELEBRATING FAMILY**



ATTACHMENT F

16 Week Drug Education Program

- Week 1. Introduction to Program
- Week 2. Reconnecting With Values, Establishing Hope
- Week 3. Who am I? Am I an Addict?
- Week 4. Disease Model of Addiction
- Week 5. Drug Classifications, Physical, Mental Effects
- Week 6. Long Term Consequences of Addiction (illnesses)
- Week 7. Emotional Stages of Addiction
- Week 8. Human Development and the Development of Recovery
- Week 9. Substance Abuse and Families: A Family Disease
- Week 10. Personality Development and Change
-Adult Children of Alcoholics
- Week 11. Feelings: Process of Emotions
- Week 12. Anger Management in Sobriety
- Week 13. Resentments: "Letting Go and Healing"
-Losses in Life (Life-line)
- Week 14. Self Esteem
- Week 15. Relationships:
-With Mothers
-Co-Dependency; Setting Personal Boundaries
-Interpersonal Violence
- Week 16. Recovery and Reunification



ATTACHMENT G

16 Week Relapse Prevention Program

- Week 1. Introduction to Course
- Week 2. Understanding Relapse
- Week 3. Why Do I Want to Change?
- Week 4. Alcohol/Drug Use vs. Treatment
- Week 5. Reasons for Relapse
- Week 6. Areas of Recovery that Individuals Struggle With
- Week 7. Creating a Historic Calendar of Alcohol Drug Use, Recovery and Relapse
- Week 8. Recognizing Relapse:
- Week 9. Red Flags, Triggers (internal and external)
- Week 10. Cravings and Urges
- Week 11. Identifying High Risk Situations
- Week 12. Scenarios, Strategies to Handle High Risk Situations
- Week 13. Relapse Prevention Plan
-Crisis Intervention Plan
- Week 14. What to Do In Case of Relapse
- Week 15. Use of Leisure Time in Sobriety
-Circle of Support
- Week 16. Lifestyle Balancing and Sobriety
- Final Project Role Play



ATTACHMENT H

In-Service Curriculum **Discipline**

1. Defining Discipline

1. discipline -vs- punishment
2. exploring myths

2. Techniques/Methods

- | | |
|------------------------------|--|
| 1. ignoring | 10. provide alternatives to destructive behavior |
| 2. reward/consequences | 11. anticipate situations |
| 3. clear expectations | 12. time-out |
| 4. consistency | 13. listening |
| 5. problems-solving | 14. use humor |
| 6. behavior management | 15. encourage self-control |
| 7. praise | 16. develop effective communication |
| 8. re-direction | 17. help children express themselves |
| 9. develop behavioral charts | |

3. Using Techniques Effectively

1. understanding temperament
2. age-appropriation
3. goals of discipline
4. factors

4. Additional Suggestions

1. responding to the angry child

5. Review of Handouts

- Goals of Effective Discipline
- Factors Affecting the Choice of the Disciplinary Techniques
- Responding to the angry child
- 201 Rewards children love to work for!

6. Closure

Q & A

July, 1999

Resources for Caregivers

1. Playful Parenting: Turning the Dilemma of Discipline into Fun and Games
- Denise Chapman Weston, MSW
Mark S. Weston, MSW

2. Building Self-Esteem in Children
- Patricia H. Berne
- Louis M. Savary

3. The Nurturing Program
- Fran Kaplan, MSW
- Stephen J. Bavolek, Ph.D

In-Service Training Curriculum
Taking Care of our Children and Ourselves

II. Positive Reinforcement

- A. Using breath control as a coping mechanism (interactive exercise)

II. Who Are Our Children

- A. Understanding Learning Styles
- a. tactile (touch)
 - b. visual (sight)
 - c. auditory (hearing)
 - d. proprioception (muscles & gravity)
 - e. vestibular (movement & gravity)

III. Maslow's Hierarchy of Needs

- | | |
|--------------|-----------------------|
| A.. Physical | E. Love |
| B. Safety | F. Self-Esteem |
| C. Belonging | G. Self-Actualization |

IV Review Stages of Grief

IV. Behavioral Outcomes

- A.. What happens if needs are unfulfilled?

V. Responses To Behaviors

- A.. Children
- B. Caregivers

VII. Music As An Intervention

- A. Using different musical styles to promote psychological well being in children and caregivers

II. The importance of Preparing/Planning

- A.. Supervision
- B. Predictability
- C. Structure

II. Role Plays

- A. Based on Handouts, current situations, etc.

III. Review & Closure

Q & A

Month/Year: November, 1999
In-Service dates: 11/16, 11/23, & 11/30

Agenda

I Review of BVC philosophy & history

II Families and Stress

- A. Stressors
- B. Risk Factors

III Empowerment Needs

- A. Children
- B. Families

IV Q & A

Handouts

- Stress and the family system
- Empowerment

Resources

National Resource Center for Family Central Practice

In-Service Curriculum
Crisis Respite

- I. Defining Crisis Respite**
 - A. background
 - B. purpose
 - C. history

- II Risk Assessment**
 - A. definition
 - B. purpose
 - C. core values

- III Developing Teams**
 - A. defining teams
 - B. styles
 - C. trust factors

- IV Cultural Competency**
 - A. What is a culturally competent provider?
 - B. Ingredients

- V Role Definition**
 - A. caregivers
 - B. children and families

- VI Quality Assurance**
 - A. strengths
 - B. concerns

- VII Outcomes**
 - A. child
 - B. family
 - C. community
 - D. supportive services

- VIII Review**
 - Q& A

Handouts

- Crisis Nursery Care
- Respite
- Ingredients of a culturally sensitive provider
- Cultural Group
- The cultural competent practitioner
- Defining teamwork terms
- Requirements for teams
- Team players styles
- Developing trust
- Responding to Parental Concerns
- Crisis Nursery Services: Responding to Ongoing Family Crisis
- Respite Services to Support Grandparents Raising Grandchildren

Resources

1. LBJ School of Public Affairs
2. National Resource Center for Family Centered Practice
3. National Resources Center for Respite and Crisis Care Services

In-Service Curriculum
Caring for Children with Emotional Disturbances

I Review of Stages of Development

- A. physical
- B. intellectual
- C. emotional
- D. social

II Eriksonian Stage Theory

- A. infant
- B. toddler
- C. preschooler
- D. child

III Separation & Logs

- A. effects (short & long terms)
- B. how to minimize

IV Review (previous in-service)

- A. Additional characteristics & behaviors of emotionally disturbed children
 - A. hyperactivity
 - B. withdrawal
 - C. immaturity
 - D. learning difficulties
 - E. depression

V Harm Reduction Techniques

- A. de-escalation
- B. behavior management
- C. conflict resolution
- D. stress management

VI Review

- Q & A
- Closure

Q & A
Closure

Handouts

- Summary of stages of child growth and development
- The emotional development of children
- Effects of separation and loss on children's development

Resources

The Nurturing Program: Fran Kaplan, MSW
Stephen J. Bavolek, Ph.D.

ATTACHMENT I

MOTHEREAD is a private, non-profit family literacy organization that researches, designs, and implements programs for families. Combining critical thinking skills with a highly personal approach to language development, the organization's instructional model emphasizes the connection between learning, human relationships, and the power of stories.

PROGRAMS

ABIYOYO/MOTHEREAD classes provide a special learning environment where parents improve their literacy skills at the same time they learn about parenting issues. Using a support group structure, they use children's literature and personal experience as the basis for learning. In MOTHEREAD classes, speaking, listening, reading, and writing skills are integrated and equally emphasized. They also serve as a catalyst for discussion on child development and other parenting issues and concerns. The recently developed ABIYOYO curriculum is based solely on African American children's literature and stresses how the themes found in these stories can help build literacy skills and community.

The **STORYSHARING** curriculum for use with children emphasizes critical thinking and emotional themes. It includes reading a story and involving the children in discussions and activities related to its main themes. Handouts for each book are sent home with the children to encourage parent/child discussion and provide instructions for related educational activities.

AWARDS

- James B. Hunt, Jr. 1990 Literacy Award
- International Reading Association Honor Award for Services in the promotion of literacy
- Selection by New Readers Press as one of 8 exemplary family literacy programs nationally
- Selection by the Barbara Bush Foundation as one of 10 model literacy programs nationally



ATTACHMENT J

Client Satisfaction Survey for AIA-funded Programs
Summary

1	My case worker and other staff we're very helpful and supportive.
2	Everybodys here was very helpful and very good to me. I am very thankful. If I had to do it again I would come back here for help.
3	I think that this was the best program I have ever been involved in. The women at Bienvenidos have been more then just worker's to me. When I see them hugs and kisses are just natural and if I'm feeling down once I walk in Bienvenidos I walk out feeling much better. Some day I will be able to do what the women at Bienvenidos do for the women like me. That is my goal and I will fulfill it, one day.
4	They are very nice people. And I was very glad to have them.
5	I very well because I learn very much with these program.
6	All my experiences have been very good in this program. All staff and services are respectful and very helpful.
7	Very successful in completing my programs because of the support of staff and concern for self and family of overall needs personal as well.
8	I was helped a lot with their services. Thank you for giving me attention and helping me. I am willing to help out and I am very satisfied with everything that I learned all this time. I give thanks to show my appreciation. <i>(Pues me ayudaron muchos con sus servicios. Gracias por tomarme atencion por atenderme. A la orden siempre y estoy satisfecha con todo lo que me brindaron todo este tiempo. Yo se los agradezco dando todas mis gracias.)</i>
9	I wish I would have known about your agency sooner. It has enforce and encourage my thinking, behavior to be consistant has help me heal some issue I was unable to let go. I want to thank everyone in your staff for being there for me and my family. Love in Christ.
10	This is a wonderful program and it has helped me unconditionally, Thank you Bienvenidos. You are God given sent.
11	I think everyone's been extra helpful and reassuring. Thank you very much.
12	Im grateful for this program that's helping me solve my problems and deal with them and I just say thank you.
13	Bienvenidos has a very good program. This program has done a lot for my family. I just would like to thank them for everything. I was very happy that I choose them!
14	This program is a Godsend, and I want to thank you for all you for everyone.
15	The services I have received have helped me stop using drugs and get out of an abusive relationship and I have a better relationship with my children.



ATTACHMENT K

5-15-00

To whom it may concern,

My name is Jessica O'Donoghue and I have a son named Joseph who is seventeen months old. He was taken into custody at twelve months old. I did not realize that I was had a problem with alcohol or drugs. One day I asked my mother to baby sit, she said yes and I did not pick up the baby when I said I was, so she took him over to his other grandmas house and she called child services.

Benvenidos was brought to my attention by some friends of mine who also benefited by Benvenidos. At that time I did not have any plans of stopping what I was doing. I just knew I wanted my son back, and this is what I had to do to get him back. I sat in the classroom not wanting to be there, I started realizing that everything that the counselor was saying was very true. I felt very emotional and began to open up and share about about my situation.

I was able to be understood by the other women there, some were in the same situation as mine, and some had already gotten their children back and still continue to attend the classes.

I know that there are people out there right now who need Bienvenencias help and encouraging support, and I believe that it should continue to help the public restore families. I really thank Bienvenencias and the Staff for being there for me when I needed them. And hope that Bienvenencias can be there for others who need them like me.

Sincerely,
Jessica
Ordóñez

5-12-00

Hello

My name is Maria J. Limas, I'm a mother of two girls, ages 22 yrs. & a 11 year old. When my first daughter, who was 8 yrs. old at the time, I started to use drugs heavily at the age of 34 yrs. old. A few years after that, I became pregnant with my 11 year old. And soon as she was born, I became so lost all over again in my addiction, and as the years went by, it seem like heroin wasn't my only choice of drug, I also got myself into more of different drugs. And now at 48 yrs. old, I've realize, bein sober, how I rob myself an most of all my family of 15 yrs. behind the drug abuse. An in those times, I was never aware of any support groups, like the one I attend now, which is Bienvenidos Family Services. The services has been a blessing to me & my family. They have showed me & other women like myself, much love & support in more ways then one. They provide us with bus tokens, so that we can attend our group meetings, which are Drug Education, Relapse Prevention, Women's Support, Clarity, Parenting & much more. They also transport us, to & from, to our Doctor appointments, which I am very grateful. We are also bless, with a Food Bank that they provide. My many thanks to you & Bienvenidos Family Services. I ask you, please, to continue to help provide Bienvenido Family Services with the funds that are needed, for the women that have a problem like me.

I started my six month programs in January
24th 2000, I will continue + complete my programs
as provided. And when I complete my programs,
I would like to continue to come back, to any
support groups that can be offer to me, while
living + staying in recovery. Thank you very
much for taking the time to read my letter.

May God Bless you
Maria Jesus Limas

5/1-100

To whom it may concern
my name is Belen Torres,
I am a former client of
Bienvenidos Family Services.
Bienvenidos was a very good
experience for me as far as
all my classes like parenting
Drug substance abuse and
the excellence guidance toward
my sobriety. I had a very
very wonderful Case Manager
Sandra as well as my
Drug Counselor, Julie. Since
I had history of substance
abuse, I strongly recommend

any one to Bienvenidos
Family Services. The staff
at Bienvenidos is very
caring and devoted to
their clients. I really want
to thank Rosemary the
Clerical Director, for being
so caring and understanding
not just for me but for
other clients. I hope that
Bienvenidos Family Services
gets extra funds to ~~their~~
continue their excellent
Drug Program and extra
support than ^{you} Belator

Joann
5/16/00

To whom it may concern
here I am an addict in
recovery. I come from a
family of 11. I have 7 kids
who were taken by the system
with I'm trying to get back.
I heard about this program
being verified from a gang youth
counselor. I've been here since
the end of last year. I'm graduating
on June.

This program is a great
success it's helped me find my-
self and know how important
my kids are to me. It helped
me to love, respect, and have
patience with whomever. Especially
respect myself. Appreciate that I
whomever God made me.
I should have respect that.

I am young and I have a future
ahead of me & my kids that is what's
going to keep me strong. I would
not betray my kids for the
world.

If there is anybody out
there who is lost just like

God Bless you!

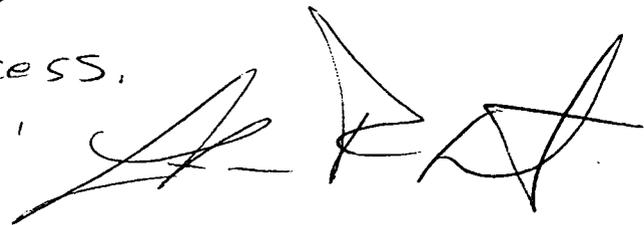
may this program always
be open for many Reels & adults
because we need it.

To Pham IT May Conner:

I would like to express my utmost gratitude to Bienvenidos Family Services and it's most kind and helpful staff.

I have been attending classes at Bvd's for almost two years now. I have attended classes in Substance Abuse, Parenting (most excellent & informative!), Stress Management, Anger Management, Womens Health, Mother Read - Father Read, and a weekly parents support group - Parents Anonymous in which I am currently the group's Parent Leader. I have grown and benefitted immensely and thusly my children have benefitted. The staff's support and continuous efforts have been cornerstone to my success.

Thank you,



5-14-00

I've been going to Bienvenidos since '98 and from the beginning everyone there has been kind and helpful. I attended the Drug Ed. program along with the women's group, also the anger management and motherhood/fatherhood. I know for a fact that I benefited greatly from all these classes. I learned things that I didn't know before. I am applying all that I've learned into helping me raise my 1yr old son.

The people who run the groups are also great and knowledgeable so are the case workers. Everyone ~~tries~~ ^{tries} their best to help in every area in a person's life and if they can't they try to find someone who can for me. Bienvenidos classes helped to give me the strength to try and go for the things that I want to do. The classes and people help me through rough times and they still are.

I hope that in the future other families can benefit from these classes and the wonderful people who run them. I intend to keep going to

To whom it may concern:

My name is Rebecca Perez: I am a addict in Recovery. My drug of choice is Marijuana. Sept 30, 1999 my daughter was born positive, of substance abuse. Social Services placed my son and daughter into a foster home due to my addiction. Since Oct. 8, 1999 I've joined La Modonna Counseling Center. There I meet a girl who told me about BIENVENIDOS. I enrolled my self in this program Nov. 24, 1999. I started this program that has helped me put my life back together. I am a better person, mother now than I was before. I entered this new environment with bad thought and now with the help of my facilitators, I found that there is hope for women like me. I have been clean for eight months, thanks to the support of Lourdes, Lupe, Sherry, Maria and Della from BIENVENIDOS. I am asking BIENVENIDOS to stay supportive with other women as they did for me. I am asking to Please SUPPORT BIENVENIDOS.

Thank You.
Rebecca Perez

5-15-2006

To Bienvenidos
Family Services:

I Virginia Vasquez would like to inform
you Faculty how wonderful all
of the programs and workshops worked
in me. I had enrolled in
parenting class year was April 1999
I learned how to practice
patience and to release children
learn all habits from their parents.
The Anger and Stress mgmt classes
helped me a great deal
I have learned that I have
a choice of how I will react
to situations and how to deal
with stressful situations. By breathing
and meditation exercises I highly
recommend the program to anyone
who wants help ⁱⁿ learning to
change their way of ^{life} help for
themselves and their children.

5-12-00

To whom it may concern,
My name is Karyn Sattergren,
I was a cocaine addict,
I was clean one year.

Living with me.

Then I lost the children
due to the children

going outside until curfew
in Alhambra, C.A.

The police did not bring back
my children to my apartment,
they put them in a foster
home. I visit my children.

Hug them. Kiss them. When I
started programs that the
social worker wanted me
to do. When I did that.

It still was not a even
fox her. I did not

know what to do for them.

My children, "Said to me

"I want to go home."

I said, "I love you!"

I am doing my best

I doing my classes.

The social worker did
not want us to be a family.

She lied in the courtroom.

Said, "I did not show

her where I lived. I still

tried my best. I did not

know what to do. My

Attorney wasn't helping me

either. A Lady in court
had told me about
Bienvenidos on my court date.
I then went to a class.
Then started a program.
That is how I came
here. I am still going
to court for my
children, still visiting.
Until Reunification soon.
Recovery Addict

To who it may Concern

My name is Magdalena Rivera and I've been involved with Bienvenido family services for almost two years I was referred to Bienvenido through a friend, this was one of the biggest blessings I've ever received. I am a mother of six, 3 of my children are in the system, DCSF. I am also a grateful addict and alcoholic thanks to the support and educational classes that bienvenido have offered me I've been able to stay clean and become a positive productive ~~person~~ ~~being~~ person in society. Bienvenidos have even supported me when my case was not even in this County my worker has supported me throughout this whole ordeal not to mention the rest of the stuff I've taken almost all the classes Bienvenido has to offer. Bienvenido also helped me when I was financially down with tokens, vouchers, food bank which was a tremendous blessing. I can honestly say I have become a better person through Bienvenidos. We need more organizations like this to help

all the suffering families out
there I would recommend Beauvends
to anyone in need of almost
anything. It has been a second
home for me and now my family.
I give all my support to the people
of Beauvends as they do for me.

Beauvends
Thank you so much
for helping me find the
best person in my self.

Magdalena Rivas
Grateful Client.

5-15-00

Hello,

My name is Priscilla
H. Mackel. I'm 22 years old a
mother of 4 boys. I was once
a drug user and unsure how
to raise four boys the right
way. As children services got into
my life, I been doing programs
I've learn alot on how to be
a better parent and also about
my addiction and other ways
to handle life clean and sober.
I've come to be a better person
in society. I am no longer a
threat anybody, I've made big
changes in my life. It really
wasn't easy but I got through
it and I know how to not dwell
on negative things that happen
cause they all shall pass in
time. I take it one day at
a time and do my best to
live happy, joyful and free.
The people at Bienvenidos Family
Services have really been there
for me.

They have taught me so much
and I am ~~am~~ very thankful. I had
in home services as while
a substance abuse treatment.
It's really worked for me
and my boys being a single
mother and all. I suggest that
you would continue to provide
services to help out those in need.
If it can work for me it can
work for other in need.

Thank you
Drisilla
& family

5-11-00

To whom it may concern:

Bienvenidos to me means a blessing from above because of the services it offers to the low-income and less disadvantaged people like my self. They are truly there for you. The support from the staff is always there even after the agency closes they have a 24 hr number to call. They offer from the programs needed for food transportation and legal assistance.

I myself am a person to say that if given the right information and helped in the right path there is hope and you can change. I am an example of that because I can truly say that I have change my self esteem has gone from 0 to 100. I feel more confident as a person and what I have to offer as a parent. I learned the importance we have as a parent in our children's life. I've also learned that there is better ways of viewing life even if you've been through life's turmoils.

I can truly from the bottom of my heart stand up and say through this letter that by supporting this agency such as bienvenidos you are putting your money

in the right place and truly helping
the future mum's who will not
furtherly be faced with this
circumstances and help them re-
solve their issues like we did. Please
don't change what is making a
difference for all the women as
well as children by not supporting
^{the} where they support is truly
needed.

Thank you,
Alan Luo

To whom it may concern

May 16, 2000

My name is Arleen Cruz, I'm forty years old, I have a four year old son named Sky. When we came to Bienvenidos Family Services we were in a domestic violence situation. I had just found out that my dearest sister was dying of gallbladder cancer. I also had to leave my new job because of these things going on in my life. I was very depressed and unhappy and it was affecting my son. I felt like I would never be able to feel good enough to do something good with my life. I love my son very much, but felt like a failure as a Mother because I realized that I couldn't provide a happy healthy environment for my son and I with out help. I was truly lost. Bienvenidos helped me learn and understand that I was lost and I could be helped by people who truly care. I have learned so much about myself and my son as well as others, why things were the way they were and how to change them by changing myself. I participated in domestic violence, parenting, stress and anger management, drug education, relapse prevention classes and individual counseling. All this help gave me the keys to having a better quality of life and our life will keep getting better. The staff at Bienvenidos care about us and teach us more than our family ever did. I feel Bienvenidos can help anyone that wants to learn how to help them selves. Bienvenidos has so much to offer. Being lost in life is an awful feeling. Bienvenidos can help you find yourself and a better life. We love this place and we need this place.

Sincerely
Arleen Cruz

10 Whom it May Concern

I am writing this letter to let you know how I got to Bienvenidos. First of all I'm here because of Children social services. They took away my children because they said I was not capable of taking care of my children do to my depression and they thought I had an alcohol problem. Well then I needed to take a parenting class and substance abuse program. Then I found Bienvenidos. They really helped me see what substance abuse was all about I was really ignorant when it came to substance abuse. But this program helped to prevent a relapse to my substance abuse problem. Last of all they have helped me with good parenting skills that I did not have and they helped strengthen some of the ~~skills~~ good skills I already had. To finish this letter of I feel like a stronger woman ever since I came to Bienvenidos.



ATTACHMENT L





