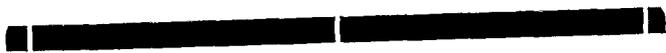


51272



CD-44193

ABANDONED INFANTS ASSISTANCE PROGRAM

PROJECT MILAGRO

(Grant # 90CB0096)

Final Report

Grant Period: October 1, 2000 through September 30, 2004

Submitted to:

U.S. Department of Health and Human Services
Administration for Children and Families
Children's Bureau

By:

Barbara Kappos, M.S.W.
Martha Cristo, Ph.D.
Lourdes Carranza, M.S.

December 2004

Bienvenidos Children's Center, Inc.
Bienvenidos Family Services
5233 E. Beverly Blvd.
East Los Angeles, CA 90022

Table of Contents

Executive Summary.....	3
Introduction.....	4
I. Program Design and Services.....	6
Families Affected by Substance Abuse.....	8
<i>Preventing Out-of-home Placement</i>	
<i>Family Reunification</i>	
<i>Mental Health Services for Families Affected by Substance Abuse</i>	
Families Affected by HIV/AIDS.....	11
<i>Preventing Mother to Child HIV Transmission</i>	
<i>Reducing HIV/AIDS Infections</i>	
<i>Enhancing the Quality of Life: Mental Health Interventions</i>	
Promoting Safety and Permanency for Children.....	15
<i>Treating Pregnant Substance Abusing Women and/or Pregnant Women with HIV/AIDS</i>	
<i>Families Caring for Young Children</i>	
Improving Economic and Living Conditions.....	16
Working with fathers and extended families.....	17
Permanency Planning and Interventions.....	19
<i>Barriers to Permanency Planning</i>	
<i>Alternative Informal Approach to Permanency Planning</i>	
Outreach and Dissemination Activities.....	22
Staff Development.....	23
II. Program Evaluation.....	24
Discussion and Summary	
III. Attachments:
I: Five Stage Model of Permanency Planning	
II: Presentations on Project’s Model, Findings, and Permanency Planning	
III: Spanish Presentation on Future Care and Custody Planning for Families	
“Asegurando El Futuro De Nuestros Hijos”	
IV: Evaluation Instruments	

EXECUTIVE SUMMARY

Bienvenidos Children's Center, Inc., a private nonprofit organization based in Los Angeles, California, has provided culturally responsive comprehensive services under the *Abandoned Infants Assistance Program* since 1992. During the past 12 years, the need for the program not only continues, but has increased. During the first four-year cycle, 1992 - 1996, the participants were primarily Latina mothers impacted by substance abuse. At that time, recovery resources geared towards Latinas with children was extremely limited in the target area. From the results of the *AIA* Program, **Bienvenidos** developed a substance abuse recovery program for Latina mothers. By the second *AIA* cycle, 1996 – 2000, the numbers of Latinas with HIV/AIDS increased. The program built an alliance and collaborated with over 25 local organizations focused on HIV/AIDS services and received increased referrals for *AIA* services. During the 2000 - 2004 cycle, 50% of the families served were affected by HIV/AIDS.

The program recognized that the women affected by HIV had different needs than those with substance abuse. The women impacted by substance abuse were more acculturated, more likely to speak and read English primarily, and represented first and second generation Latinas. The majority were single parents with an average of 2 children younger than 3 years. These women had generational substance abuse and as a consequence to addiction, were often disconnected from family support. In contrast, women affected by HIV/AIDS were minimally acculturated to the United States and many were recent immigrants. They were monolingual Spanish-speaking, and, adhered to Latino cultural practices and beliefs. More than 50% were married and living with the fathers of their children. These women were less educated and as new comers to this country, experienced stress associated with acculturation, discrimination and poverty. They were isolated from their extended families and they had fewer resources than their counterparts. The program identified the need for more intensive home-based services for HIV affected mothers because many were too ill to attend center-based programs. Lack of transportation continued to be an additional barrier to utilizing center based services. The HIV affected families tended to be more transient than the substance abuse impacted families. Because of the extreme poverty, these families continuously relocated to resources. **Bienvenidos** followed these families in order to provide a continuum of services, (e.g. rather than to terminate them because they moved outside of the target area).

Under the *AIA* Program, **Bienvenidos** implemented an innovated home-based model to prevent the abandonment of children and secure their safety by meeting the multiple needs of families impacted by substance abuse and/or HIV/AIDS. The amalgamation of sociocultural, socioeconomic and epidemiological factors delineated the program's framework and the past decade of services to high-risk families. This project successfully provided specialized services and interventions aimed at mediating the detrimental effects of substance abuse and/or HIV/AIDS experienced by Latina women and their children. The multi-level services involved family assessment, family support, case management, advocacy, child assessment, parenting, health education, medical access, child reunification, permanency planning, and alcohol/drug and mental health counseling. The efficacy of a multidisciplinary bilingual/bicultural service team comprised of a case manager, parent educator, child development specialist, family support worker, health educator, group facilitators, clinicians proved crucial in assessing and meeting the economic, social, cultural, legal, health, and psychological needs of families.

Introduction

Project Milagro provided home based services to reduce the risk of child abandonment and secure their safety by targeting at risk Latina women impacted by HIV/AIDS and/or Substance Abuse. Services addressed the recent increase of HIV infection and AIDS among Hispanic women in the United States (CDC, 2003). In 2000, Latina women, second to African American women represented 80% of AIDS cases (CDC, 2004). The HIV/AIDS epidemic poses a significant threat for Latinas. In 2001, AIDS was the fourth leading cause of death for Latinas and the third leading cause of death for their Latino counterparts (Anderson & Smith, 2003). Because this disease disproportionately affects Latinas, the Center for Disease Control has directed its efforts to combat this disease (2004). Several factors have been identified as correlates to HIV/AIDS among Latinas. These include poverty, sociocultural and systemic health issues (Diaz, Chu & Buehler, 1994). The services provided to Latina substance abusers were guided by the over representation of these women in the child protective system, criminal system and medical-drug treatment centers. Mexican and Puerto Rican women have been found to have higher rates of alcohol abuse, drug dependence and treatment needs when compared to the total U.S. population (National Women's Health Center, 2004). *Project Milagro* addressed these factors in designing and implementing its service model.

During the past four years, 182 families participated in *Project Milagro*. Families comprised two distinct groups: Mothers diagnosed with HIV/AIDS (N=79); and mothers impacted with substance abuse (N=94). A third group was identified as relative caregivers (N=9). The HIV/AIDS women were low acculturated Latinas affected by poverty, poor living conditions, and impaired physical and mental functioning. The project's substance abuse group was significantly more acculturated than their counterparts, representing second and third generation Latinas. High stress levels arising from poor parenting skills, unemployment and domestic violence were noted for this group. Both groups were found to experience isolation, psychological distress, depressive symptoms and poor mental health. Socioeconomic, cultural and health related factors negatively affected the quality of life of these women, including their emotional and mental well-being.

Latina women dealing with HIV/AIDS had limited health and financial resources as expected for recent immigrants to the United States (Wallace & Gutierrez, 2004). The stigma of HIV/AIDS among Hispanics has been viewed as a major problem for this group (Suarez, Raffaelli & O'Leary, 2000). This was evident among our families and contributed to the lack of social support. These factors directly or indirectly increased their difficulties in coping with HIV/AIDS, medication therapies and related illnesses. Chronic addictions involving multiple substances leading to unstable incomes, incarcerations, poor parent-child relationships and neglected health care were associated to the poor quality of life among the project's substance abuse group.

In the 4 years of the project, 173 index children, ages 0 to 8 years and 304 siblings participated. Child development assessments and behavioral interventions were the tools used to reduce the multiple risk factors reported for children. Specifically, 53% had behavior or emotional disturbances, 50% were at risk for learning disabilities and 48% were prenatally drug exposed. In

addition, 22% of children were identified with moderate to severe cognitive and/or social developmental delays and 9 children were diagnosed with HIV/AIDS.

Project Milagro's home base service approach was supported by the project's evaluation findings. Significant positive outcomes pointed to improved quality of life for women diagnosed with HIV/AIDS and/or substance abuse at program completion. Women living with HIV/AIDS were found to be more hopeful and more willing to parent their children despite their current health problems. Substance abuse women experienced improved psychological and physical well-being particularly when their health needs were met.

Project Milagro was effective in obtaining medical care for HIV/AIDS and substance abuse women and their children. Medical access was significantly improved for families at the time of program completion. Improved birth weights, receiving prenatal care and sustaining sobriety provided healthy and safe environments for the project's children. Services emphasized medical support and health education; both were essential for connecting HIV/AIDS participants to available medical treatment. The program results also suggested that Latinas experienced high levels of parenting stress when compared to normative parent samples. Latinas reported increased parenting competence, increased attachments to their children and less parental isolation after completing the program. Other key findings of the program included marked decreased levels of depressive symptoms, psychological distress and mental health problems for both HIV/AIDS and substance abuse participants.

The project also attained positive child outcomes that reduced the risks for child abandonment thereby increasing child safety. Reduced multiple foster placements and reunification with biological mothers or relatives were obtained for 99% of children with open DCFS cases. The incidence of child abuse and neglect significantly decreased during program involvement. Benefits in psychological functioning were also noted for these children. After completing the program, a significant decline in child risk factors and behavioral problems was reported. Importantly, child outcomes were associated with family functioning. Families became stable through intensive case management and home based interventions. Supporting parents assisted them in coping with family stressors and improved their child's well-being and safety.

Goals of the Project

The program was designed to prevent the abandonment of infants whose parents were diagnosed with HIV/AIDS or who had a history of substance abuse. The following goals were embraced and were the focus for each family.

- 1. Prevention of abandonment of infants and young children due to substance abuse and/or HIV/AIDS.**
- 2. Improved permanency planning for participating families.**
- 3. Enhanced quality of life for families affected by HIV/AIDS and substance abuse.**
- 4. Improved economic and living conditions among participating families.**
- 5. Strengthen *Project Milagro* through collaborative efforts with community providers, public institutions and private entities.**

I. Program Design and Services

Bienvenidos Children's Center provided comprehensive services for mothers and families of infants and young children at-risk of being abandoned, using a multidisciplinary, inter-organizational, culturally responsive approach. The project was built on **Bienvenidos'** experiences in providing services to this population and on the agency's broader experiences in providing home and center-based services to families at-risk of abusing and neglecting infants and children. *Project Milagro* addressed many of the barriers that impede service delivery and included program elements most often recommended for meeting the needs of Latinas impacted by substance abuse and/or HIV/AIDS (National Abandonment Infants Assistance Resource Center, 2003).

Project Milagro incorporated the underlying philosophies and basic framework of AIA programs:

- a focus on the concurrent needs of parents and children;
- a systems approach in which families are encouraged to define their strengths and needs in the context of their total environment;
- family centered services and strong community collaboration;
- development of long-term, trusting, nonjudgmental relationship between the family and AIA staff team;
- families are empowered, respected and are supported in their decision making and in prioritizing their multiple needs.

Drawing on family systems theory, the project provided culturally appropriate home-based services that coordinated a broad range of health and support services, and facilitated the empowerment of families. Often, families are negatively impacted and at risk for a virtual breakdown if integrated and supportive programs are not available (AIARC, 2003).

According to Minuchin (1998) the deterioration and disconnection of the family system is a natural outcome of substance abuse within a family system. The breakdown of family attachment can lead to the displacement of children, poor communication, high levels of stress and violence, increased poverty and family dysfunction. However, Minuchin (1998) also stated that families in multi-crisis are interconnected and have loyalty and affection for one another. Based on this theory, *Project Milagro* utilized a family centered model that provided a framework to assist families to help themselves.

Project Milagro helped families identify their strengths and internal resources by providing external resources and support. The project strengthened families' capacities to effectively raise their children in spite of the myriad of problems these families faced in dealing with HIV/AIDS and substance abuse. The strong emphasis on permanency planning was a key example of the value of family resiliency: *that the resources for continuity of care reside within the family*. Services focused on providing support and resources to improve families' parenting skills, identify positive adults to interact with their children and increase natural support networks.

The project had two service tracks: one for families affected by substance abusers and one for families affected by HIV/AIDS. Families with a child under the age of 8 years qualified for

services. The women and their families were referred to the program from the following sources; community based organizations, HIV/AIDS related service providers, substance abuse treatment centers, shelters, hospitals, clinics, local schools, courts, the Department of Children and Family Services and self- referrals.

After an initial referral was made, families were thoroughly assessed and screened in their home by the Program Coordinator. The initial session was the point of entry where trust and rapport was developed between the family and the project. During this session, a family assessment was completed and program services were outlined followed by an individualized case plan. The Program Coordinator completed the following baseline measures during the initial session: Agency Intake Form; AIA Cross-site Measure, Medical Access Form and SASH. The Intake form elicited information on client demographics, risk-factors for abandonment, potential supports and/or family resources and health status. In addition, social and health service needs, including medical access and utilization practices were assessed. After enrollment, the Project Coordinator assigned the case to the *Project Milagro* team (either substance abuse or HIV/AIDS specialist) for further assessment and service planning.

Intake and assessment information was reviewed to determine the level of risk and types of services needed for the mother, the targeted infant and/or young children and other family members. Families in need of intensive assistance with multiple issues received priority enrollment. Families were also immediately linked to other supportive services within the agency. Families not eligible for AIA services were referred to other *Bienvenidos'* services or other community service providers. Once a family was determined to be eligible, the Family Support Worker conducted a comprehensive assessment using the Family Assessment Form (distributed by the Child Welfare League of America.). Also, a permanency planning assessment was conducted to first determine readiness of each participant. The intake and assessment information established the baseline against which client progress was measured.

Project Milagro families received services for twelve months and in some cases extended for 18 months. The project utilized a team approach consisting of a Family Support Worker and Health Educator. The Family Support Worker's primary function was to offer support, enhance parenting skills, assists with permanency planning process, link families to appropriate services, and support and design a family case plan. The participants often viewed the Family Support Worker as an extension of their family. Limited supports and broken relationships often increased the family's dependence on their Family Support Worker. Initially the Family Support Worker encouraged and reinforced the building of a healthy and trusting relationship. Eventually family dependency shifted to building a strong circle of support that involved their families, friends and community resources.

Within the team approach the families received individualized **home-based health education** offered by the Health Educator. The families from the HIV/AIDS group received home-based education addressing current health status, medication side effects, compliance to medication, access to medical services, and strengthening communication with their medical provider. The women from the substance abuse group also received home-based health education offered by their Family Support Worker. Health education addressed the importance of routine health visits, safe-sex practices as well as nutrition and exercise. In addition, the Family Support

Worker provided counseling and relapse prevention skills. Education focused on reducing the risk of HIV transmission was offered to couples and families. The health educator assessed sociocultural factors unique to each family, such as the use of folk medicine and alternative healing practices.

Families in need of intensive **counseling** were linked to the therapist whom was bilingual (Spanish/English). The therapist was instrumental in treating women who reported mood disorders, anxiety related to post-traumatic stress, and in need of additional support. Children in need of mental health services were also linked to the project's therapist or to the local mental health provider. Home-based mental health services were offered to families with limited resources and identified as the highest risk. In addition, an array of *center-based services* was offered to project participants. Families were linked to these services to increase their social support and utilization of community services.

As part of the goal to promote **permanency**, the program integrated an interdisciplinary model offering a collaborative effort combined with social workers, legal professionals, clinical and other supportive services to assist families in their planning process.

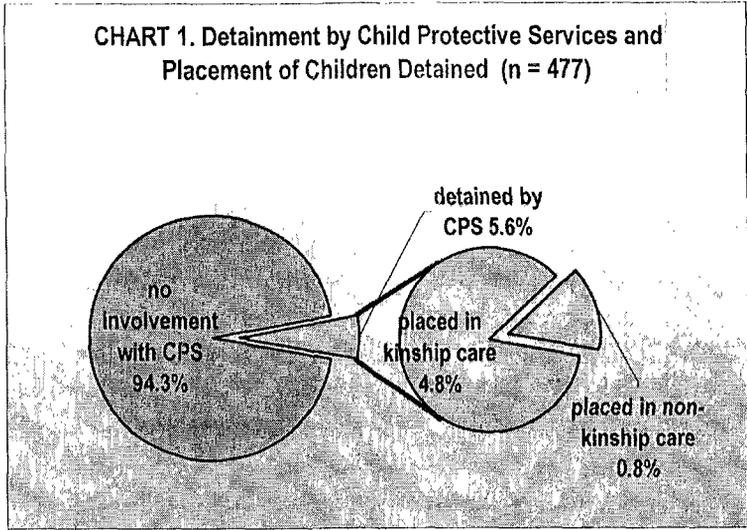
Families affected by Substance Abuse

Preventing Out-of-Home Placements

An average of 225 prenatally drug exposed infants are born each month in Los Angeles (Smith, 1996.) Women who did not receive prenatal care were almost three times more likely to test positive for any drug and/or alcohol; seven times more likely to test positive for illicit drugs and three times more likely to smoke (Vega, 1993). Drug affected infants suffer from many physical and emotional effects. The types of drugs to which the infant was exposed may have varying effects, ranging from visual attention problems, low birth weight, underdevelopment of organ systems, increased sudden infant death syndrome (SIDS), learning disabilities, attention deficits, and impulsivity (LA County Board of Supervisors, 1985; Edelstein, Kropenske & Howard, 1988). The risks for out of home placements resulting from prenatal exposure to drugs and alcohol were evident among the project's child participants. Fifty eight percent of the Substance Abuse women admitted using drugs during at least one pregnancy; 24% reported using drugs during 2 or more pregnancies; and 42% had children born positive to drugs. The detrimental effects of drugs and/or alcohol were also reported for the project's children. Specifically, emotional problems such as extreme anger and depression was identified for 52% of children; 47% had behavioral/aggressive problems; 33% had learning/school problems; and 22% had social problems. Importantly, 58% of these mothers felt that their children's problems were related to substance abuse.

The project served a total of 477 minor children; 296 were affected by substance abuse and 181 were affected by HIV/AIDS. Baseline risk factors for families with young children indicated that the children were "at-risk" for child abuse/neglect and a history of open cases with Department of Children and Family Services. Home-based interventions aimed at decreasing the identified risk factors were successful in reducing child placement into the foster care system. Family Support Workers assisted mothers with parent training, increasing child safety at home

and problem solving techniques. Providing family counseling and increased parental support reduced further out-of-home placements. In addition, improved living conditions, increased access to financial resources and medical care had a positive impact on reduced parental stress thus reducing the risks of child abuse. Families were linked to community resources that specialized in serving young children and children with special needs. For the most part, the health educator accompanied parents to medical appointments to ensure that the mother understood the importance of their child's health. Parents were also encouraged and empowered to increase their involvement in the education of their children. The staff often attended Individualized Education Plan meetings with parents to ensure that the educational needs of the child were met. Through the years of experience, the project learned that the risk of child neglect and/or abuse was prevalent amongst families impacted by substance abuse. The potential for child abuse and neglect was often related to the multiple challenges and stressors that families experienced. The women from the substance abuse group experienced chronic addictions leading to substandard housing, isolation, poor parenting, unemployment and criminal activity. **Of the 477 children served, 5.6% were detained due to the mother's drug abuse and sustained allegations of child abuse by D.C.F.S. Of the 5.6% that were detained, 4.8% were placed in kinship (relative) care. Only .8% of children were placed in non-relative foster care (illustrated in Chart 1).** Several of the women whom were reported continued in the program. Reunification services were provided to mothers and included recovery support,



legal advocacy and ensuring compliance with D.C.F.S. orders. The project worked closely with the relative caregivers who obtained temporary custody of the children. Only five mothers returned to drug use. The number of families reported to D.C.F.S. was significantly low (5.6%). In these cases, children were placed in a safer environment and the project's services were focused on reunifying them with relatives. The agency adopted a protocol to screen all reports made to D.C.F.S. This

protocol served as an emergency response (Suspected Child Abuse and Neglect-SCAN) and was utilized prior to reporting suspected child abuse cases. The SCAN procedure called for the immediate review of the current situation that warranted suspected child abuse. A plan of action was formulated for all cases. The SCAN team consisted of the reporting staff member, program supervisor and clinical director.

Family Reunification

The project facilitated the reunification of 30 families (27 from the substance abuse group and 3 from HIV/AIDS group). A total of **80 children** were **reunified** with their **biological** mothers. On an average, the children lived out of the home for a period of twelve months. The majority of the children lived with kinship caregivers. The project has learned through the years of

experience that reunification process was a critical period when parents and children alike, experienced increased stress levels. It was not uncommon for these women to report feeling frustrated when unified with their children. The need for relearning and readjusting to their parenting role was often due to the long period of separation from their children and being on their own. The high incidence of psychological distress coupled with the challenges of staying sober also made it difficult for women to be emotionally available for their children. Separations due to neglectful parenting often increased feelings of incompetence, detachment and negative self-perceived feelings. In fact, 48% of these women were identified as neglectful, abusive or with a history of child abuse. The program found that comprehensive services to these families were crucial during the process of reunification. The project offered specialized strategies such as role modeling parenting-child interactions, positive reinforcement of bonding techniques and age appropriate communication.

Parents received assistance in developing healthy coping mechanisms to reduce their own as well as their children's frustration during the transition process. Mothers were also assisted with reconnecting their children to schools, day care services, health coverage and specialized services, such as counseling. During home visits, the Family Support Worker engaged in therapeutic activities with children. They focused on dealing with their fears, anxieties and reducing behavioral problems. *Project Milagro* was successful in strengthening and facilitating the reunification process for several women and their children.

Mental Health Services for Families Affected by Substance Abuse

The vast majority of the families from the substance abuse group reported experiencing some type of trauma. Early childhood traumas related to physical, sexual and emotional abuse as well as adult victimization related to domestic violence was frequently reported during the initial interview. Home-based mental health counseling was provided to 55% of these women and their families who required clinical interventions. Therapeutic issues commonly addressed for these women were internalized feelings of guilt, shame, isolation and anger. Interventions focused on healing, re-building trust, communication, re-attachments and learning to adjust to a sober lifestyle. Several families received family counseling and provided children the opportunity to express and cope with their feelings of resentments, abandonment and mistrust. Families that were in the process of reunification were automatically referred for mental health services. The project learned that despite a mother's increased readiness to parent and nurture her children, (particularly adolescents) were often resistant, mistrusting and rebellious. The therapist's interventions focused on strengthening bonding and parent-child relationships. In many cases, partners/husbands were engaged in counseling to address relationship and co-parenting issues.

Although the project facilitated access to mental health services at no cost, the project was unable to meet the mental health needs of the entire sample. The project served individuals presenting the most barriers to mental health treatment and that were identified as "at-risk." The most prevalent barriers to mental services were the lack of Medi-Cal and health insurance, limited transportation, minimum trust and resistance to receiving mental health counseling. Despite high levels of psychosocial stressors faced by substance abusing women, mental health interventions were clearly helpful in reducing depression, promoting social support, enhancing quality of life and improving family functioning. The increased need for mental health services

influenced collaborative efforts with other mental health providers. Program participants also received therapeutic services from licensed clinical psychologists at the Institute for Women's Health Substance Abuse Outpatient Program, Bienvenidos Drop in Center, Bienvenidos Children Mental Health Department (for those with Medi-cal), and other community mental health agencies.

Families affected by HIV/AIDS

Latinos have accounted for 20% of reported new AIDS cases in 2002 (CDC, 2004). The majority of the project's target area is within the East Health District. Since 1982, Latinos comprise 30% (14,054) of the cumulative AIDS cases in Los Angeles County and 68 % (1,853) in the East Health District (County of Los Angeles, Department of Health Services, 2004). In 2002, 91 men and 9 women in the East Health District were diagnosed with AIDS; 87 were Latinos and 51 were between ages 20 and 39 years. In 2003, there were 392 individuals living with AIDS, including 42 children less than age 13 and 2,014 females. The rate of persons living with AIDS in the East Health District is 90 per 100,000 (LACDHS, 2004).

An interview study reporting results for Latinos with HIV/AIDS found that 74% were foreign-born. Of the foreign-born Latinos, 15% had lived in the United States for less than five years and 26% for six to ten years. Foreign-born Latino immigrants were the least likely to have known about their HIV status early in the course of their infection and 47% of the interviewees learned of their HIV status six or fewer months prior to their AIDS diagnosis; and, they were less likely to access the health care system for HIV medical, prevention and support services (Smith, 1996).

Throughout the four years of funding, *Project Milagros* learned that the problems faced by families affected by HIV/AIDS were often overwhelming. HIV infection coupled with other factors such as poverty, isolation, housing instability, joblessness, low acculturation and mental illness inhibited the ability of affected families to provide the stability and safety required for the healthy development of children. Unfortunately, for many HIV positive parents, the natural support systems that would ordinarily be in place for these families disappeared because of the social stigma of their illness, their recent immigration and discrimination they experience. *Project Milagro's* services played a key role in strengthening support to these families and in ensuring that their basic needs were met. Specialized strategies focused on enhancing the quality of lives of these families were implemented. Culturally sensitive interventions offered by an interdisciplinary team approach consisting of a Family Support Worker, Health Educator and Family Therapist were instrumental in improving health and mental health outcomes for this group.

Preventing Mother to Child HIV Transmission

The risks of mother to child HIV transmission were an emerging issue for seven Latina participants with HIV. Seven mothers had planned pregnancies despite their HIV positive status. The project learned that advanced medical therapies as well as strong cultural beliefs reinforced the idea that it was "safe" and "the duty of women" to become pregnant. These women expressed a desire to give birth to more than one child and related this desire to "fulfill their role and duty as a Latina woman." The women who strongly adhered to cultural expectations were

low acculturated and isolated. Cultural expectations coupled with limited education and unsafe sexual practices not only led to successful pregnancy but also compromised the health of these women. In addition, the majority of these women reported that they received some support, directly or indirectly from their physician to become pregnant.

The Family Support Worker along with the Health Educator emphasized the importance of healthy eating, self-care, adherence to treatment and prenatal care. Specialized and supportive strategies consisting of counseling and health education addressed these issues. Although it was not the project's goal to prevent pregnancy, ample time was spent addressing the implications of pregnancy on the existing compromised health of these women. Of the children born, although exposed to HIV, none were born with the virus.

Meeting the Needs of Children Diagnosed with HIV/AIDS

A total of thirteen pediatric HIV/AIDS cases were served during the four years of funding. These minors consisted of index and non-index children. At intake, the minors' ages ranged from 6 months to 16 years. Risk factors reported for these cases consisted of environmental stressors such as; poverty, substandard housing and limited transportation. Specific issues for these families were disclosure of minor's illness and limited parental knowledge of pediatric HIV care. Three children resided with both biological parents, 2 lived with grandmothers, and 1 lived with a maternal aunt, and 7 resided with single mothers. The majority of the minors (8) were between the ages of 0-8 years and 5 were between 9-16 years. Of the minors from the 9-16 age group, two were not aware of their HIV status. Both of these minors were led to believe that they suffered from cancer. Parents reported that they did not disclose the illness because they feared that their children would be rejected, ridiculed or harassed, and that disclosure would increase their depression. These parents struggled with their own feelings of shame and fear. These families received intensive home-based Health Education focused on increasing knowledge of HIV/AIDS, importance of medication adherence and other factors related to pediatric HIV/AIDS. In addition, counseling addressing struggles related to caring for a fragile child and fears surrounding disclosure was offered to these families. Also, linkages to specialized services such as Regional Centers and other C.B.O.S (Caring for Children Affected by AIDS, Tuesday Child) were provided to these families.

Reducing HIV/AIDS Infections

One cultural group significantly impacted by the HIV/AIDS epidemic is the Latino community; this population now represents the second highest minority group in demographic research on the disease (Meza, 2002). Latinos "comprise the largest and fastest growing ethnic minority group in the United States, and continue to be disproportionately affected by HIV/AIDS" (Aragon, Kates & Green, 2001). Women represent an estimated 30% of the 40,000 new HIV infections each year (CDC, 1999). *Project Milagro* experienced this growth as reflected by the increase in new referrals of women living with HIV. In addition, the project has had the opportunity to provide services in preventing the spread of HIV by serving heterosexual couples where one parent was infected and the other was not.

Of the project's HIV sample, fifteen families consisted of one parent who was HIV positive (9 females and 6 males), married or cohabitating with a partner who was non-HIV. In all of these cases, the non-HIV partner was aware and remained in the relationship. Although this group was small, they necessitated program services aimed at reducing risks for HIV infection. This small sample of couples revealed that at times they engaged in unprotected intercourse. Home-based health education addressed issues related to HIV transmission and safe sex practices in effort to reduce the risk of HIV infection among program participants. In the cases where there was a need for mental health services the therapist provided couples (marital) counseling focused on safe sex negotiating, addressing fears of infection, trust and infidelity issues. Among positive HIV males, the illness was acquired from an extramarital affair. Strong adherence to cultural and religious beliefs as well as low-self esteem deterred the non-HIV women from leaving their HIV partners. Among the nine positive HIV women, they acquired the virus from previous partners. *Project Milagro's* culturally sensitive approach consisting of education and counseling was effective in reducing the risk of HIV transmission among the 15 individuals who remained negative for the virus.

Enhancing the Quality of Life: Mental Health Interventions

Meeting the mental health needs of families affected by HIV/AIDS required specialized attention and training. Family members caring for persons with HIV/AIDS have experienced similar distress levels (high) as HIV infected individuals (Chesney, 1993). *Project Milagro* implemented a family systems approach where the challenges of the entire family unit were addressed. *Project Milagro* identified several unique challenges faced by families impacted HIV/AIDS were unique due to a number of factors. Psychosocial baseline data indicated that these women were low acculturated, poor (88.9%), isolated (90.7%) and suffering from physical and mental impairments (85.2%). Importantly, these women reported contacting HIV/AIDS through heterosexual partners. In many cases, news of an HIV/AIDS diagnosis as well as the possibility of marital infidelity posed similar threats to the emotional well-being of the women and their children. In addition, the issues associated with the progression of HIV were particularly complex as each stage of HIV illness presented a different challenge for families. For many families, late stage illnesses and death of a parent resulted in the reconfiguration of the family.

Parents' who were HIV positive were often confronted with challenges related to disclosure of their HIV status to children, adolescents and extended family. Latinos are prone to withhold information perceived as laden with adverse consequences, particularly in disclosing an HIV/AIDS diagnosis (Mason, Marks, Simoni, Ruiz & Richardson, 1995). Latinos are less likely to disclose an HIV/AIDS diagnosis to parents and children, primarily out of concern for protecting them, rather than, concern for protecting themselves (Mason, et. al 1995). In addition, the realities of planning for future care of their children often increased their feelings of despair. The project found that this population was hesitant to disclose their illness to family members. This was mainly due to their perceived fears of causing harm and distress to relatives including their children. Home-based mental health addressed the emotional and psychological issues related to disclosure. Because this group was low acculturated, the sociocultural influences of HIV/AIDS were found to impact the mental functioning of these women.

Baseline data reflected that children affected by HIV/AIDS were considerably “at risk” due to maternal reports of severe psychological distress and depressive mood symptoms. As previously reported, several parents’ struggled with disclosure of their HIV status to their children. With the progression of parental HIV illness, children and teenagers often witnessed the physical and mental deterioration of their parents and were forced to cope with these changes with little or no clear information about their parent’s health status. In several cases, parents masked their illness by informing their children that they were suffering from cancer rather than HIV/AIDS.

In providing services to children and families, the project learned that HIV/AIDS still carries an unfortunate and irrational stigma. For the project families, this stigma further complicated the children’s grieving process and often reinforced the parents desire to keep their illness a secret. In a few cases where disclosure to the child was made, the parents required their children to maintain it “a family secret,” fearing that ridicule, rejection and discrimination would occur. These expectations often created feelings of isolation, anger, worry and guilt amongst the children. These feelings were augmented with a number of HIV related symptoms. In some cases, HIV associated dementia impaired the mother’s capacity to function in her parental role, leaving children without adequate care or forcing older children and adolescents into early parental roles. The project provided mental health services to these children due to the risk for psychological complications. The mental health counselor was instrumental in addressing disclosure issues with the parents by offering support and guidance. Children aware of their parent’s diagnosis received counseling services focused on reducing concerns over parental illness and death, and fear about their own mortality.

Although the need for mental health services was evident amongst this group, it was common for these families to refuse traditional mental health services and seek alternative coping mechanisms. Latino culture socializes the individual to believe that “sharing personal information outside the home” is unnecessary. Subsequently, the family is perceived as the primary source of attachment and identification (Mason, et. al. 1995). Cultural factors such as collectivism, *familism*, and *simpatia* influence the disclosure of Latinos diagnosed with HIV/AIDS and how these individuals manage self-disclosure within the context of the family (Meza, 2002). In addition, Latinos often perceive mental health services as a service for the “crazy people.” Subsequently, factors related to shame, stigma, and avoidance in dealing with difficult issues such as mode of transmission of HIV and death increased their resistance to receiving mental health services.

In efforts to increase access and utilization of mental health services by this population, *Project Milagro* provided a culturally sensitive approach. Latino Spanish-speaking staff shared the same cultural values; attitudes and experiences. These cultural similarities provided the setting for open dialogue of the mental health barriers that impede the use of these services. After assessing and identifying the need for mental health services, families were educated on the purpose and benefits of mental health interventions. The decision to receive counseling was left to the mother and family. This sensitive approach was respectful of the family’s views and served valuable in connecting the families. Barriers to accessing mental health services were significantly reduced for these families by providing therapeutic services in their homes.

Promoting Safety and Permanency for Children

Treating Pregnant Women affected by HIV/AIDS and Substance Abuse

Focused on preventing infant abandonment, the project strengthened its outreach by targeting high risk pregnant women with histories of drug use and/or HIV positive. Barriers related to stigma, shame, fear of being reported and lack of knowledge of HIV/AIDS were addressed in efforts to engage these women in services. Specialized strategies promoting health prevention, health education, medical access, family stability and social support were implemented.

During the four years, the project served a total of **14 women (7 substance abuse group, HIV/AIDS group) who were either pregnant at intake or became pregnant during their active participation in the project.** Initial assessments revealed that the unborn children were “at-risk” of abandonment and/or abuse due to reported maternal historical risk factors such as; substance abuse, victim of abuse and domestic violence. In addition, current risk factors such as; marginal education, poverty, compromised health of the mother and substandard housing conditions further increased these risks. *Project Milagro’s* comprehensive approach focused on addressing the risk factors in each of these families in efforts to maximize normal pregnancies as well as promote healthy stable home environments. In addition, strategies were implemented to promote health care, bonding and attachments with their children and unborn child. During home visits, the mothers received individualized health education to increase knowledge on fetal development, nutrition, harmful agents to unborn child (i.e.; drug/ alcohol abuse, second hand smoke, violence) and importance of prenatal care. A developmental assessment (DPII) was performed to evaluate infant development. Staff utilized the test results to design individualized interventions focused on the needs of the index child. Also, the project ensured that all mothers were linked to prenatal care and entitlements (Medi-Cal). When necessary, referrals to other agencies such as Regional Center and Head Start were made.

Additional support was provided to pregnant women with a history of substance abuse by connecting them to the *Institute for Women’s Health Substance Abuse Outpatient Program*. This substance abuse program offered education on fetal/ infant development and drug exposed infant care. Groups such as Parenting, Recovery Support, Relapse Prevention, Drug Education, Family Violence, Co-dependency, Family Therapy, and Anger/Stress Management are also offered.

Families Caring for Young Children

Project Milagro served a total of **172 index children and 305 non-index children.** Infants and young children were the target age group for services. The mean age of child participants was 4 years old. Children impacted by substance abuse were significantly younger (2 years old) than children in HIV/AIDS families (4 years old). Child focused services were aimed at strengthening family stability, increasing their safety, and reducing the risk of abandonment/ abuse. The project’s children were at high risk for several reasons. Approximately 50% of these children had at one point resided with an abusive parent. At the time of program enrollment, 25% of children were living with biological mothers whom were actively abusing drugs and/or alcohol. Among substance abuse families, poor parenting skills were the highest stressor reported. Family instability resulting from previous multiple foster placements affected at least 50% of the

project's children. Overall, children experienced emotional and behavioral difficulties associated with their past separations from biological mothers. Services such as support, parent skills, activities that promoted attachment and bonding, and linkages to specialized services were instrumental in reducing stressors related to parent-child relationships. Interventions modeling healthy relationships increased positive maternal attitudes related to their parenting role.

A Case Illustration: Projects Success in Strengthening Mother-Child Relationship

Lorraine a single mother cared for her 6 year old son who was diagnosed with ADHD and Tourettes Syndrome. Lorraine had a history of substance abuse, domestic violence, incarceration, and previous charges of child endangerment. Lorraine reported experiencing molestation and physical abuse as a child. At intake, Lorraine reported current stressors related to unemployment, poverty, poor self-esteem and limited patience in caring for a child with special needs. Adding to these stressors was Lorraine's bed-ridden mother living with end stage cancer. Reunited in 2000 with his mother, Johnny remained "at-risk" for abuse and of being re-detained by D.C.F.S. Upon referral, Lorraine expressed mistrust towards the agency with reluctance to receiving home-based support. Eventually, her Family Support Worker was able to connect with the mother and addressed the existing risk factors. Interventions consisting of home-based counseling, parent training, education on caring for a child with special needs, along with linkages to substance abuse counseling and support groups for the mother and child, led to reduced maternal stress and increased hopefulness. After receiving 1 year of services, the mother reported a positive attitude towards her role as a mother and improved coping skills in caring for a child with special needs. The minor remained in the care of the mother while the risk for abuse was reduced. Eventually, the mother obtained employment and managed to stay connected to the support system she established with the assistance of her Family Support Worker.

Improving Economic and Living Conditions

Project Milagro aimed efforts towards improving the economic and living conditions of the families served. During the four years of funding, baseline data collected for the sample revealed that the families were living in impoverished conditions with minimal financial resources. The project targeted families living in East and South East Los Angeles communities penetrated with gang violence and crime. It is not uncommon for the families to live in unsafe hazardous apartment dwellings and in overcrowded conditions. High rates of unemployment, poor job and education skills, and poor socio-economic status of the families were factors that contributed to limited housing options. In addition, changes in our economy, as well as cuts in funding had an adverse effect in the community. Partnerships were established with Community Based Agencies that specialized in these areas. The Family Support Worker assisted these families by ensuring linkages to the appropriate agencies. Families were also assisted with budgeting, entitlements, completing standardized forms for Public Benefits and resume development. Several families who received twelve months of services made great strides towards obtaining suitable housing, as well as achieving long-term economic stability.

Obtaining stable and suitable housing was a challenging goal to achieve for many of the families served. During the last year, a noticeable cut in legislative budgets offering housing opportunities for people with HIV/AIDS made a devastating impact in the families served by the project. In addition, many shelters have modified housing criteria to include legal residency

status as an eligibility requirement. Such modification in housing criteria, cuts in housing programs, along with increased rent fees, created barriers in obtaining suitable housing for several of the families. Strong collaborative efforts with community based housing agencies (attachment VI) facilitated the placement of **48 families in stable and suitable housing.**

Providing job resources and referrals to employment agencies was an additional task of the Family Support Worker. The project assisted families in achieving self-sufficiency and improved economic conditions. Initial interventions addressed family stability, sobriety, improved health and mental health outcomes of the parents. After individual life circumstances were stabilized, parents received assistance in obtaining employment. In addition, assistance with obtaining affordable childcare, resume development and life skills was provided. Outcome findings indicated a significant decline in unemployment from 74% to 25% (at program completion). During the four years of funding several participants returned to gainful employment. Several other participants were referred to Jobs for A Future, State Department of Rehabilitation or other local employment agencies for possible job leads and vocational assistance.

Returning to school was an alternative goal for the women participating in the project. Barriers to employment along with a desire to increase levels of education made returning to school a more feasible option. Many of the monolingual Spanish-speaking women returned to Adult School programs with the goal of learning English. The Family Support Worker mentored several of the women and as a result a total of **fourteen women enrolled in formal educational programs.**

Working with Fathers and Extended Families

The project has learned that family preservation is the most obvious benefit of kinship care. Kinship care preserves the continuity of care, relationships and environment that are essential to a child's overall well-being. In addition, reducing further trauma by maintaining the family system as the primary provider for a child abandoned due to substance abuse and/or HIV/AIDS, forestalls the child from becoming an institutional and societal responsibility. *Project Milagro* gained considerable recognition from the community and collaborative partners as an ally to keeping orphaned and abandoned children within the bounds of their natural family. The project's favorable reputation led to an increase in referrals of families seeking services that deviated from the target population. These families consisted of children affected by maternal substance abuse and/ or HIV/AIDS who were being raised in kinship care or by single fathers. Similar to the target population, these families were identified "at risk" due to reported baseline stressors. Stressors related to poverty, caring for children with special needs, limited social supports and isolation as well as generational gaps between grandparents and children supported the need for intensive services. The children in these families were also "at risk" of being abandoned or abused. These families were classified into sub-groups and counted in the total number of families served.

During the four years of funding, 11% (N=20) of the total families enrolled were classified into sub-groups. The subgroups consisted of; 3% (N=6) single fathers caring for substance abuse or HIV/AIDS affected children, 6% (N=11) grandmothers caring for abandoned children due to

maternal substance abuse or HIV/AIDS, and 2% (N=3) aunts caring for abandoned children. The largest subgroup was of grandparents caring for their abandoned/ orphaned grandchildren. It was apparent that HIV/AIDS and substance abuse had an impact on the configuration of several of the families served. In six of these families, the mothers died while active participants of the project. Unlike several other agencies that terminate services with the family after the mother's death, *Project Milagro* continued to offer support to the new caregivers and the surviving children. The project embraced these families and supported the new caregivers in their efforts to provide stability and a sense of security to the children. The project learned that relative kinship care was instrumental in reducing psychological trauma of these children while allowing them to live within the bounds of their extended family.

Through the experience of serving grandparent and relative caregiver headed households, the project learned that they too encountered multiple and complex issues. Issues such as lapsed or skipped generation parenting, economic strains on limited incomes and parental recovery issues (including codependency) were prevalent among these families. Other personal challenges such as declining health, lack of affordable and adequate housing, lack of social services support and access to childcare were identified. *Project Milagro* focused on reducing familial stressors by addressing these issues. The child focused services were also effective in reducing psychological problems, stigmatization of HIV/AIDS and preventing children from entering the foster care system.

Services offered by the therapist along with the Family Support Worker addressed familial issues related to loss of a mother (wife, daughter, or sister), parenting, caring for children with traumas and anxieties, economic strains on limited incomes, and impact of mother's substance abuse on minors. In many cases, single fathers and relative caregivers alike, experienced personal challenges such as declining health, lack of affordable and adequate housing, lack of social services support, and access to child-care. Services to single fathers also focused on fatherhood issues, parent training and awareness of community resources available to fathers. In addition, specialized services addressing the emotional and physical needs of the abandoned children and adolescents were provided.

A Case Illustration: AIDS and Relative Caregivers

Yolanda was a 34 year-old single mother of two young children living with advanced AIDS. Her medical provider who was urging assistance with permanency planning due to her expected short life span referred Yolanda to Project Milagro. At intake, it was noticeable that Yolanda had a month left to live. Yolanda lived with her two sisters (one who was a mother of a boy with special needs), and her 3 yr. old daughter and 4 yr. old son. She had recently moved in with her sisters who offered support after being informed of Yolanda's fragile health and diagnosis. Immediate interventions focused on developing a permanency plan and securing the mothers wishes. Unfortunately, the mother's health condition worsened leading to her death a week after enrolling into the project. The project intensified support to the maternal aunts who would assume Joint Custody of the minors. This family was provided counseling to address death of Yolanda, education on HIV/AIDS, a legal permanency plan, and obtaining entitlements (SSI-Survivors Benefits). In addition, the family dealt with health issues; the 3 year old daughter who was diagnosed with a viral infection and the son suffered from developmental delays. The Family Support Worker connected this family to medical care and the Regional Center. Home-based mental health services were provided to the caregivers to address issues of grief and loss. Also, the new caregivers attended parenting classes at the agency. In addition to securing a legal permanency plan, the 4 year old minor who was not a legal resident, was connected to a special project of the INS (Special Immigrant Juvenile Status). The 4 year old minor received his legal residency

card as a result of being orphaned in the United States. Both sisters shared responsibilities for the minors and acted as suitable caregivers. Project's Milagro's comprehensive support prevented the abandonment of these children. The family reported benefiting from the project's services and gratitude for the support. Fortunately, the minors have not exhibited any signs of emotional or behavioral problems and appear to be adapting to the absence of their parents.

Working with Extended Families

Socio-cultural conditions associated to HIV/AIDS, substance abuse and poverty has prompted the redefinition of "family" to include households shared by the enrolled family and extended caregivers. Cultural practices of *Latino families* reinforce kinship care and extended familial support. In the Latino community, extended family support is often utilized and preferred to placing a loved one in residential hospice care or placement of children in Foster Care. It is therefore, not uncommon to find multiple families living in a single family home. *Project Milagro* gained recognition in the community due to its unique and flexible service model that embraced extended families by offering services and support. Although, some of these families were legally unrelated, it was the goal of the project to assist in securing legal support through permanency plans. Permanency plans strengthened the ties of affection and commitment to children.

Project Milagro served a total of **nine extended families**. The rationale for serving these families was based on the following; extended families (also referred to as alternative caregivers) were raising children of their own, lived in the home with the enrolled family and index child, and experienced their own challenges and stressors. In all of the families both the biological parent and extended caregiver shared mutual responsibilities in relation to the care and safety of the children. Importantly, the project identified and connected with extended caregivers when permitted by the enrolled family. The possibilities that the enrolled parent may die or return to drug use reinforced the importance of establishing connections with the extended family. Due to issues of health, substance abuse, and in 5 cases death, the extended caregivers eventually became the primary caregivers. Increased support to these families proved effective in preventing child abandonment and placement into the Foster Care System. Supportive services consisting of case management, counseling, parent training, community linkage to services, and health education were provided to these families.

Permanency Planning and Interventions

Given that approximately half of the parents who die from AIDS related illness die without a permanency plan (Michael & Levine, 1992), interventions are strongly needed to help parents with HIV develop plans for continued care for their children (Chalfin, Tomaszewski, Abruzzino, 2000). *Project Milagro* was instrumental in reducing infant and child abandonment by helping families engage in the voluntary process of permanency planning. During the first year of funding, efforts were focused toward the development of a sensitive approach to permanency planning, as well as training staff and setting up a team of collaborators. The project developed a culturally sensitive Five Stage Model that would serve to assist the project's participants as well as the community. The model served as conceptual framework and practical tool that allowed the tracking of the five permanency planning stages.

The Five Stage Model of Permanency Planning (Attachment I) consisted of:

(1) Assessing readiness of the family, (2) Educating the family on Permanency Planning options, (3) Identifying the future caregiver, (4) Securing the plan, and (5) Aftercare services. A team approach consisted of the project's staff, an attorney from the Los Angeles Children's Court, who specialized in permanency planning and the Project Coordinator assessed each case individually and addressed possible barriers to permanency planning. The attorney served as a consultant to formalize the plan and assist with difficult cases. The majority of the legal services and consultation were obtained from *The Alliance for Children's Rights and Public Counsel Law Center*. Both legal firms offered free legal services, advocacy, information, and assistance in the development of permanency plans. Families prepared to secure a legal plan (Stage 4) were referred to one of these law firms to commence the legal process.

During the four years of funding, a total of **sixty families finalized permanency plans for their children**. Approximately a third of the total families served completed plan, another one-third of the families served remained in stages 2 and 3. Specifically, families from the HIV/AIDS group that did not finalize a plan reached the following stages of permanency planning: Stage 1 n=16; Stage 2 n=10; Stage 3 n=20. Families from the Substance Abuse group that did not finalize a plan reached the following stages: Stage 1 n=32; Stage 2 n=16; Stage 3 n=16.

Barriers to Permanency Planning

Parents with HIV/AIDS face extraordinary burdens and challenges when planning for future care and custody of a child (Coon, 2000). While many parents living with a terminal illness have given thought to what would happen if they became incapacitated or died, few have taken steps to formalize any arrangements. The most frequently reported barriers to permanency planning were cultural, religious, psychological, and lack of appropriate options. In the many of these cases, the barriers interfered with the families' willingness to initiate and finalize a legal plan. First, cultural barriers were of the most prevalent in addressing permanency planning. Permanency planning is a relatively unknown concept within the Latino culture. Cultural and religious beliefs and practices such as "*Padrinos*" (*godparents by baptism*) were often viewed as alternatives and informal ways of identifying a potential future caretaker for a child should parents die. Strong religious beliefs such as *Fatalism*, the notion that "*Gods Will, will prevail*" played a key role in the parents ambivalence towards planning for the future care of their children. Additional barriers such as emotional difficulty in addressing incapacitation, death, surrendering care of their children, disclosure of HIV/AIDS status to children and alternative caregivers were commonly reported. Latinos with lower levels of acculturation, (i.e. those who speak only Spanish) are less likely to disclose their HIV/AIDS status to significant others and family members (Mason, et al., 1995). In addition, mistrust of the legal system due to immigration or previous negative experiences were commonly reported. Other psychosocial stressors such as poverty, homelessness, isolation, and mood disorders made permanency planning a difficult concept to present. In many cases, the concept was not presented due to the existence of other crisis. Careful assessment of the family and their willingness to address permanency planning (Stage 1) was instrumental in implementing a sensitive approach. Both the Family Support Worker and Mental Health Therapist worked as a team in supporting and addressing the parents concerns. Nevertheless, several parents refused to address this concept.

The staff accepted and respected the parents' wishes and avoided adding further distress to the families.

In addition, planning options for families in California are limited. California's Joint Guardianship statute requires that the parent be terminally ill in order to nominate a joint guardian (Coon, 2000). This health status restriction limited several families from the opportunity to make legal plans for the future care of their children. The project learned that the complex and varied needs of the population requires for there to be an availability of suitable options if we are to enhance permanence and stability in the lives of children impacted by HIV/AIDS. The project recognizes that families will have different situations and varying constraints and thus different ways of achieving permanency. Nevertheless, in efforts to meet the proposed objectives of the grant, and to help parents make important progress towards planning the project developed an *Alternative Informal* approach to permanency planning.

Alternative Informal Approach to Permanency Planning

The *Alternative Informal* approach incorporates the Five Stage Model of Permanency Planning. As an alternative to a legal plan, parents were informed of less threatening options. One of the alternative options made available is California's Caregiver Authorization Affidavit (Cal. Fam. Code 6550), which is to be used in the private designation of a relative and non-relative caregiver. In addition, informal approaches consisting of Living Wills, Testaments, and or internal agency form were introduced as alternatives to Legal Guardianships, and adoption plans. Several of the families that engaged in the alternative approach reported that these options were less threatening and cumbersome. In addition, the project developed an internal agency form that was used as temporary document identifying an alternative caregiver in the event of an emergency. Copies of these documents were kept in each file and the originals were given to the families. Although not a legal plan, the families initiated the planning process and made efforts to secure the future of their children. The progress made towards planning, although not legal, was considered significant for these families.

As previously reported, mistrust in the legal system, limitations in California's Joint Guardianship Law, onset of sudden illness, and due to other complexities (open cases with D.C.F.S) interfered with the families ability and willingness to secure a legal plan. Due to these barriers the project focused its efforts towards educating the parents on the benefits of completing a legal plan (*Stage 2*), hoping that the parents would eventually utilize the information and take action. Families received written material offering information on *Alliance for Children's Rights, and Public Counsel Law Center for future use*. The role of these law firms was instrumental in securing legal plans for the families.

During the four years of funding, **six mothers passed away (five due to complications of AIDS and one due to cirrhosis of the liver)**. Legal permanency plans were secured with four families. In the other two cases, the minors remained in the care of their biological fathers who were not HIV positive. In all of the cases the children remained with relative caregivers, and therefore, not abandoned. Aftercare services were provided for the new caregivers consisting of support, counseling, assistance with entitlements, and in securing other basic needs.

Outreach and Dissemination Activities

Throughout the four years of funding the project's staff emphasized on strengthening outreach efforts. The following strategies were developed and implemented to enhance community awareness of the program and to increase recruitment of eligible participants:

- Director-presented at national conferences focused on substance abuse and HIV/AIDS; the National Women's Conference; SAMHSA National Conference, AIA Grantees Meeting, AIA Conference on Partners' Influence on Women's Addiction and Recovery; and was part of a group to write the monograph on Partners' Influence on Women's Addiction and Recovery through the AIA Resource Center.
- Promotoras-Peer Outreach Workers presented to local substance abuse treatment facilities and outreached to eligible participants.
- Project Coordinator conducted several presentations on *Project Milagro's* unique service model, and on permanency planning to local Substance abuse and HIV/AIDS organizations (205 professionals).
- Project Coordinator presented on services offered at Bienvenidos Family Services, including a Power Point Presentation on Permanency Planning for Spanish Speaking families affected by HIV/AIDS (attachment II).
- Project Coordinator participated in several committees focused on meeting the needs of families affected by HIV/AIDS and Substance Abuse (attachment III).
- An agency brochure and program flyer targeting both providers and families were created and used as an outreach tool.
- *Teatro* Groups performed by *Promotoras* (peer counselors) focused on promoting the following: recovery, supportive networks, healthy lifestyle practices, adherence to treatment, and permanency planning. A total of eighteen *Teatro* presentations were offered at the Drop In Center.
- Community Events: The project's staff participated in the planning and delivery of several events throughout the four years of funding. The events consisted but not limited to the following; World AIDS Day 2000- 2003; National Latinos AIDS Awareness Day 2001-2003; Local Community Health and Education Fairs.

Staff Development

Staff development and trainings was an essential element of *Project Milagro*. The project ensured the delivery of appropriate services by strengthening staff development. During the four year funding period, the staff received ongoing trainings offering the latest findings on HIV/AIDS related research, medical advances, updated child and social welfare policies and other topics related to chemical dependency. Collaborative partnerships with Charles Drew University of Medicine and Science along with other agencies offering technical assistance presented important opportunities for trainings.

In addition to educational trainings, the staff received supervision through the following approaches; weekly individual supervision offered by the coordinator, weekly case presentation/ review meetings supervised by the Clinical Supervisor and coordinator, monthly team meetings addressing coordination of team approach, monthly staff meetings addressing administrative and evaluation issues, and a monthly support group to staff to address staff burnout. The Project Coordinator received supervision by the Assistant Director twice a month.

II. Program Evaluation

Evaluation Activities

The evaluation activities focused on implementing the evaluation design, data collection protocol, and outcome analysis. The evaluation team worked closely with the project staff on developing an evaluation plan that was feasible and that was easily integrated into the program's service model. Training sessions were provided on administering, scoring, and interpreting the project's evaluation tools. Project Milagro also assisted in the AIA Resource Center's cross-site evaluation with data collection and data entry. The project provided client data for the cross-site measure, SHIF, Permanency Planning Outcomes Survey, and Parent Stress Index. Semi-annual reports describing project services and evaluation outcomes were submitted during Project's Milagro's funding period (2000-2004).

Evaluation Design

The evaluation assessed the outcomes of home-based services provided to high risk Latino families. Specifically, participants comprised two distinct groups: Children and mothers impacted by HIV/AIDS or substance abuse. The evaluation examined the mediating factors correlated to reducing abandonment, abuse and out of home placement among these children. The mediating factors studied were: (1) Parent and environmental risk factors (stresses) (2) HIV/AIDS and substance abuse/addiction health related issues (3) Depressive symptoms (4) Medical access (5) Quality of life (6) Family functioning (7) Social support and (8) Child development and well being.

Project Measures – The evaluation used surveys, tests and interview assessments to obtain the data. Two factors guided the selection of project instruments. First, measures were required to be culturally sensitive and adhere to cultural competent evaluation standards. The majority of the measures were used with other Latino samples and were available in Spanish. Normative data was available on Hispanics for the Parenting Stress Index, Short Acculturation Scale, CES-D, Parent/Child Risk Factor Survey and Health Interview Form. Second, the utility of the instruments for program services was essential to this evaluation. The program benefited from gathering data from child focused and parent focused assessments. The scores and outcomes for specific measures were helpful to the service planning and mental health teams. In particular, the Developmental Profile II, a child developmental tool, was useful in determining child interventions and case management services. The CES-Depression screening tool and Parenting Stress Index survey assisted AIA staff in identifying mental health services for families. The following measures were used for the outcome evaluation.

Bienvenidos Intake

This interview survey is used to as a point of entry to the Bievenidos Family Service Center. The survey provides demographic data and assigned family case numbers for data entry. The interview intake assessed family history, legal history, financial needs and service needs for families and children.

Parent/Child Risk Factor Survey

This is a 25-item checklist that identifies factors that place parents and children at risk to experience stress. Factors are listed as occurring during the past six months, seven to 12 months and more than a year. Such items include past child abuse, domestic violence and poor parenting. The form was completed using an interview format.

Parent Stress Index Survey

This self-report survey assesses life stress, parenting efficacy, parenting stress, parent-child bond and child behaviors. The PSI short form was used in the AIA Cross-Site Evaluation. The PSI long form was used and obtained a reliability of .87 for our current sample.

CES-D

This 20 item self-report measure assesses at risk levels of Depression and has been used with Latinas for the past 2 decades. The project obtained a reliability of .86 for this measure.

Developmental Profile II

This child development measure examined five areas of child development. These were: physical, self-help, cognitive, language and social development for children ages 3 months to 10 years old. Parents and staff complete this assessment by identifying a series of specific age appropriate behaviors.

Health Related Quality of Life

This self-report tool assessed perceived quality of life using 15 indicators of physical, emotional, psychological and mental well being for individuals dealing with a health condition. The HRQOL (Rand, 1999) was developed primarily for HIV/AIDS males although for the past 5 years, this measure has been used with women and minorities. A Spanish version was available. Baseline and termination data was collected for this measure.

Medical Access Form

This 11-item survey assessed the level of access to health care and health providers. This form was used as part of the HRQOL. It was administered at baseline and termination.

Health Survey (Bienvenidos)

A health status survey was used for each of the group sample. For the HIV/AIDS participants, this survey obtained information on participant's medical conditions, physical functioning, diagnosis, medication usage including side effects, and current medical treatment. Among the Substance Abuse women, the Health Survey gathered information on current and past drug use, medical conditions, utilization of health services, and current medical needs. This survey was administered at baseline and termination for the HIV/AIDS group and baseline only for the Substance Abuse group.

Short Acculturation Scale – Hispanic

This survey is a 10-item measure that identifies level of acculturation from low to high. This type of measure was used in addition to identifying demographic variables (number of years in the U.S. and country of origin).

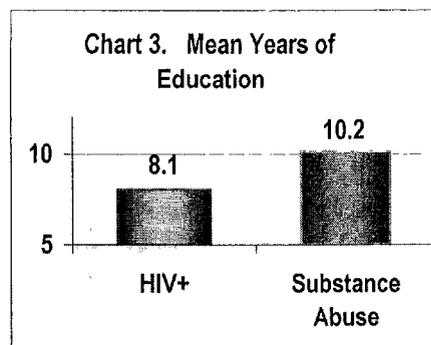
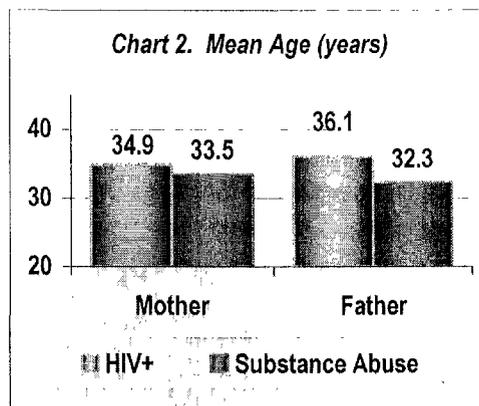
Statistical Analysis

A quasi-non-experimental design using pre-test and 12 month post-test assessment was used. Descriptive statistics, paired t-tests and Analysis of Variance statistical tests were applied to examine program effects. Outcome findings are first presented for the project's total sample followed by HIV/AIDS (HA) and Substance Abuse (SA) groups. Previous reporting indicated that women with HIV or Substance Abuse were two distinct groups. For this reason, our analysis was expanded to include outcomes and changes for each of these groups.

Demographic Characteristics

Project sample – The project's sample was 182 families comprised of 94 Substance Abuse (SA) families, 79 HIV/AIDS (HA) families and 9 extended caregivers. Represented in the sample were 20 caregivers, identified as "primary caregivers" to indexed children during their participation in the 12-month program. This subgroup consisted of 6 fathers, 3 aunts and 11 grandmothers. This subgroup was created because biological mothers were unable to fully participate or complete our program. They were either too ill, left the program or died. Index children and caregivers continued to receive services. Outcomes for these families were qualitatively assessed and when applicable, quantitative data was collected. In most cases, sub-groups were excluded from the data analysis described in this report. The ethnic distribution for the sample was 93% Latino, 5% African American and 3% Caucasian. The total sample was comprised of 39% married/domestic partners, 36% single parents, 20% divorced or separated, and 5% widow reporting widow status. Overall, there were more single parent households (61%) than two parent households (39%) among participating families. The sample mean age for biological mothers was 33 years, 35 years for HIV/AIDS women and 34 years for the Substance Abuse women. The mean age for fathers was 34 years with older fathers representing the HIV/AIDS group ($M=36$ years) compared to the Substance Abuse fathers ($M=32$ years). Reported educational levels were 9th grade for the total sample, 8th grade for the HIV/AIDS group and 10th grade for the Substance Abuse group (Chart 3). A series of t-tests were used to examine the demographic variables. A significant result was found for education. Substance Abuse mothers had higher levels of education than HIV/AIDS women ($p < .001$).

HIV/AIDS families - The women in this group were slightly older ($M=34.9$ years) and significantly less educated (8 years) than their counterparts. Fifty-seven percent of women were single parents and 43% reported married or living with a domestic partner. This group tended to have older index children with a mean age of 5 years. The primary language in the home for the HIV

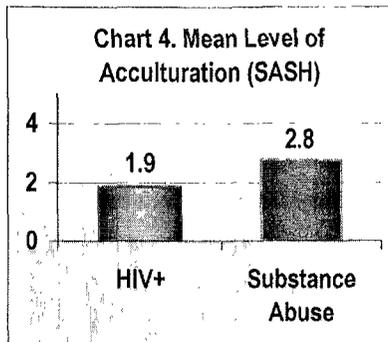


group was Spanish (88%) with only 12% speaking English. The HIV/AIDS sample reported changes in caregivers for 11 index children and their siblings. Relative kinship placement for children occurred during the 12 month program participation period. These kinship relatives included four biological fathers, two maternal aunts and five grandmothers.

Substance Abuse (SA) families – The sample for this group was 94. Substance Abuse families consisted of 43% single mothers, 36% married or living with a domestic partner, 17% separated or divorced and 4% widowed. The mean age for Substance Abuse women was 32.5 years and mean age for their male partners was 32 years. The average educational level was 10th grade and was significantly higher than the HIV/AIDS women. Language preference for this group was English (75%) and 25% were bilingual in English and Spanish. During the twelve-month service period, changes in primary caregivers were identified for 9 families. These families consisted of 6 grandmothers, 1 aunt and 2 fathers.

Index children- Four hundred and seventy seven children consisting of 173 index children and 305 siblings participated in the project. Among the index children, there were 78 males and 95 females with a mean age of 4.1 years. The mean age for index children in the HIV/AIDS group was 5.1 years and 3.3 years for the Substance Abuse group. The average number of children per family was 3 for both groups. Simple t-test statistics were used to examine the child demographic characteristics. Significant differences were found for age. Children impacted by substance abuse were significantly younger ($p < .001$) than their HA counterparts.

Acculturation -Acculturation level was assessed for the project’s sample using the Short Acculturation Scale for Hispanics (SASH). This measure provides a continuum from low acculturation to high acculturation. This tool yields a score from 1 (low acculturated) to 4 (high acculturated).



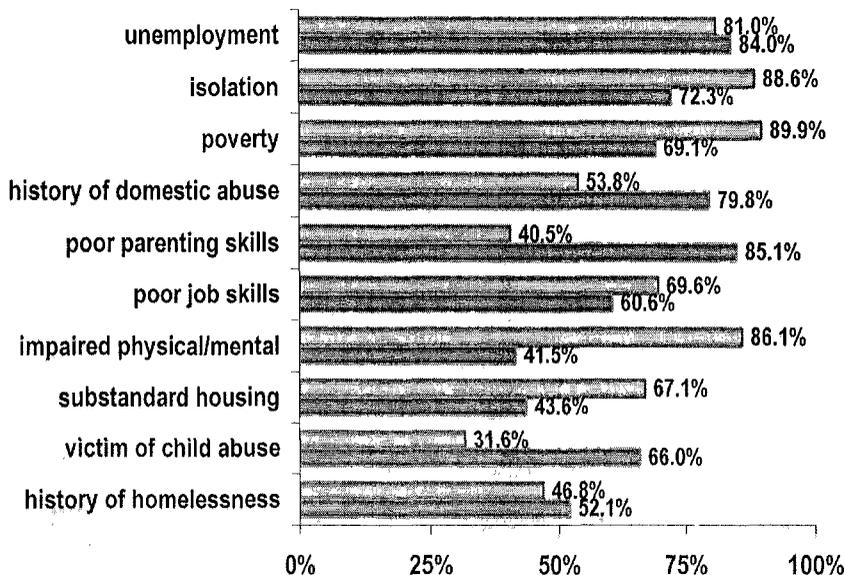
Acculturation was assessed in order to provide services that were culturally sensitive to Latino families. The project adhered to health beliefs, customs, language, religious practices, parent roles, gender roles, family systems and parent-child dyads that were predominately influenced by the Latino culture. The overall mean for the SASH was 2.4 suggesting that there was a range of culture specific practices for this sample. Between group differences were further evaluated. The group means for HA and SA women are presented in Chart 3. The means reported for the HA group and the SA group were 1.9

(SD=1.1) and 2.80 (SD=1.0) respectively. A t-test statistic was applied to examine acculturation differences between the two groups. This analysis yielded significant results ($t=-5.53$, $df=158$, $<.001$). Women in the Substance Abuse group were found to be significantly more acculturated than the HIV/AIDS group. The Substance Abuse women were more likely to speak and read English primarily educated in the United States and tended to socialize with groups whom were more acculturated to American culture. In addition, this group represented second or third generation Latinas and was able to access resources and services available to American born individuals. In contrast, the HIV/AIDS women were minimally acculturated to the United States and many were recent immigrants. They were monolingual Spanish-speaking, adhered to Latino cultural practices and beliefs. The HIV/AIDS women were less educated and as new comers to this country, were less likely to qualify and/or access resources than their counterparts.

Parental and Environmental Stressors

Parent/environmental risk factors - The Parent Risk Factor survey was used to assess the type and number of risk factors at baseline and post 12 months. Families were evaluated at intake to determine if they were at high risk for stress arising from social, economic, environmental and psychological factors. The survey consists of items tapping into history and current risks. For example, historical types of items include “history of abuse, history of domestic violence.” Current risk factor items were “poverty, current domestic violence and identified as an abusive parent.” For the analysis of this survey, items were categorized into two areas; stable items that were not subject to change and current items that are expected to change over time. This reclassification was used to more appropriately measure changes and program outcomes. Using this scheme, the most frequently reported risk factors were ranked (highest 10 factors) and examined at program completion. These baseline risk factors are presented in Chart 5. More than one risk factor is reported for families. A series of paired t-tests on changes in the frequency of reported risk factors from baseline to program completion was used to evaluate the effects of program services. Frequency rates were significantly reduced at program completion for the project’s families ($p<.001$). In addition, significantly lower rates were reported for 7 of the 10 risk factors examined (*Probability levels between .001 to .023*). Families were most likely to improve in obtaining job skills or employment including financial entitlements and report less poverty. These were primary program goals to assist families in becoming self-sufficient and

Chart 5. Top Ten Parent Risk Factors at Baseline
(n=182)



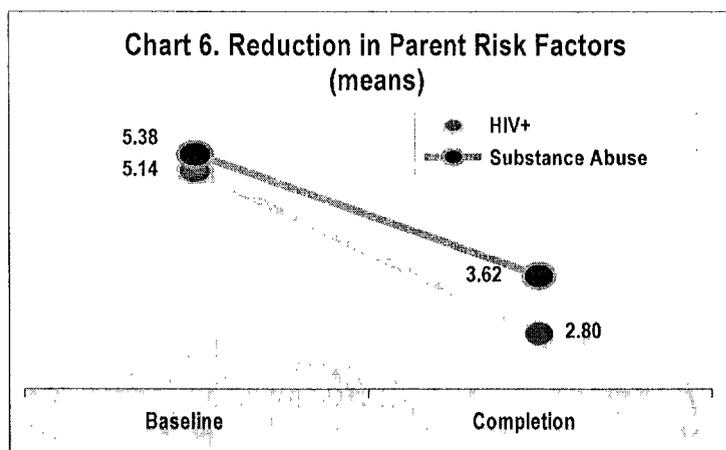
financially stable. Although families continued to live well below the poverty level, our program provided food vouchers, a clothing closet, shelters and basic resources. As shown in Chart 5, homelessness and substandard housing conditions was reported for 46% to 67% of families. Improved parenting skills were an essential part to

the project's services. Parents reported less stress associated with the demands of parenting young children. As a result, parents were more likely to focus on their children's needs and practice safe and age appropriate parenting strategies. This project targeted high-risk for child abuse particularly families with active D.C.F.S. cases. For the total sample, there were 36% identified as neglectful, 13% as abusive and 12% had a child abuse history with D.C.F.S. The significant reduction in parenting risks was supported by the reunification of 80 children (indexed children and siblings) during this program.

HIV/AIDS group - For these families, poverty (89.9%), isolation (88.6%), and unemployment (81%) significantly contributed to the economic stresses experienced by this group. Environmental stress was associated with substandard housing (67%) and a history of homelessness (47%). The families impacted with HIV/AIDS were extremely poor, often living in small garages or hotels. Nineteen percent were homeless when enrolled in the program while other families did not have the necessary provisions (food, clothing) for their children. Because of their low acculturated status (including immigrant status), they were unaware or ineligible for county and/or state funded resources. In addition to this, the chronic unemployment and poor job skills reported by this group reduced their potential to maintain monetary incomes. As previously noted, project services provided linkages to entitlements and temporary housing for many of these families. Another significant stressor was the impact of medical, physical and mental health conditions. Latinas were faced with dealing with multiple health and psychological problems associated to their HIV/AIDS disease. The limitations of HIV infection and AIDS is further augmented by environmental and psychological stressors experienced by these women. Risk factors were evaluated by using paired t-tests for most frequently reported at baseline and program completion. The mean number of risk factors at baseline was 5.1 and 2.8 at program completion. Significant outcome changes were found with probability levels ranging from .001 to .04. The overall mean changes for this group and the substance abuse group are reported in Chart 6. A significant decrease in total risk factors at program completion was found for the HIV/AIDS group ($t=6.7, p<.000$).

Substance Abuse group - The mean number of risk factors at baseline was 5.4 and 3.6 at termination. Paired t-tests analysis resulted in significant reductions in the number of risk factors reported at program completion ($t=4.6, p<.000$). Poor parenting skills (85%), unemployment (84%), and past domestic violence (54%) were the primary stresses for women impacted by substance abuse.

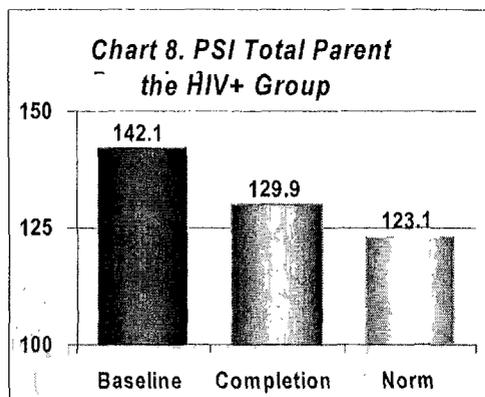
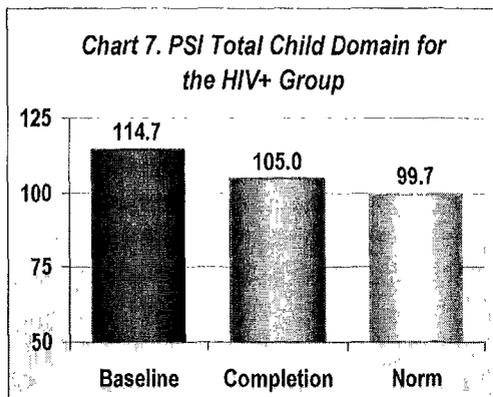
Parenting difficulties were more evident among these women than their counterparts whom reported approximately 50% less (e.g. 85.1% compared to 40.5%). As described above, families experienced stress associated with their parenting roles such as separation from children due to detainment by D.C.F.S. Women often express feelings of loss and guilt over their drug use. For these families, multiple parent and child separation interrupts the process of bonding and attachment for infants and young children. In this project, 24% of index children had a history of



multiple out of home placements. Importantly, 58% of the women in this group were court identified as neglectful and abusive (19%). The tenuous child safety in these families was exasperated by the violence these women reported. Thirty-six percent of women indicated residing with an abusive partner, 80% reported a history of domestic violence and 66% were themselves victims of child abuse. In this program, children impacted by substance abuse were found to be at high risk for unsafe environments and child abuse. This group also experienced isolation (72.3%), poverty (72%), and history of homelessness (52%). These factors increase environmental stress and instability. As shown in Chart 6, significant outcome changes were found in reducing risk factors for this group. A second statistical analysis was applied to examine the impact of program services on 12 factors that permitted measurable changes. A McNemar Test of symmetry was used and yielded significant changes for 9 risk factors. A significant decrease was found for poor parenting skills ($p < .001$), current domestic violence ($p < .003$), court identified as neglectful ($p < .023$), poor job skills ($p < .001$), poverty ($p < .001$), isolation ($p < .001$), substandard housing ($p < .001$) and unemployment ($p < .002$).

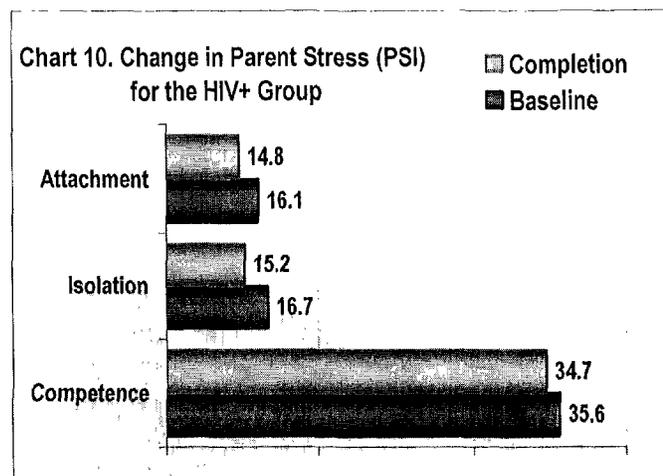
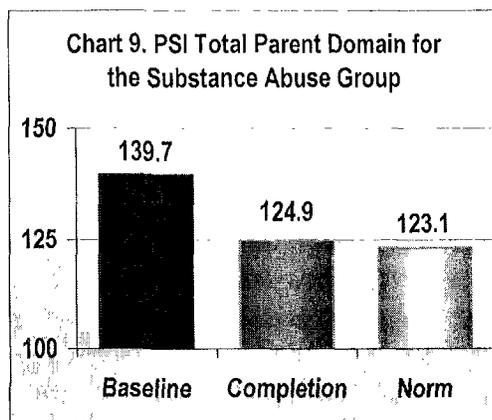
Parenting Stress

The Parent Stress Index (long form) was used to examine program outcome effects on parenting stress levels. Specifically, the project proposed to reduce parent stress among high risk Latina women and their families by providing an array of home base services. The PSI measure taps into various components of parenting including role expectation, competency, accepting the parenting role, attachment to child, depressive mood, isolation and life stress. The PSI provides scores for 17 domains categorized into (a) Parent Domain, (b) Child Domain, (c) Life Stress and (d) Total Stress. The statistical analyses evaluated changes from baseline to termination for the HIV/AIDS and Substance Abuse samples. The analysis included paired t-tests and repeated measures ANOVA statistics to examine between and within group differences at program completion. Significant results for the HIV/AIDS and Substance Abuse groups were obtained

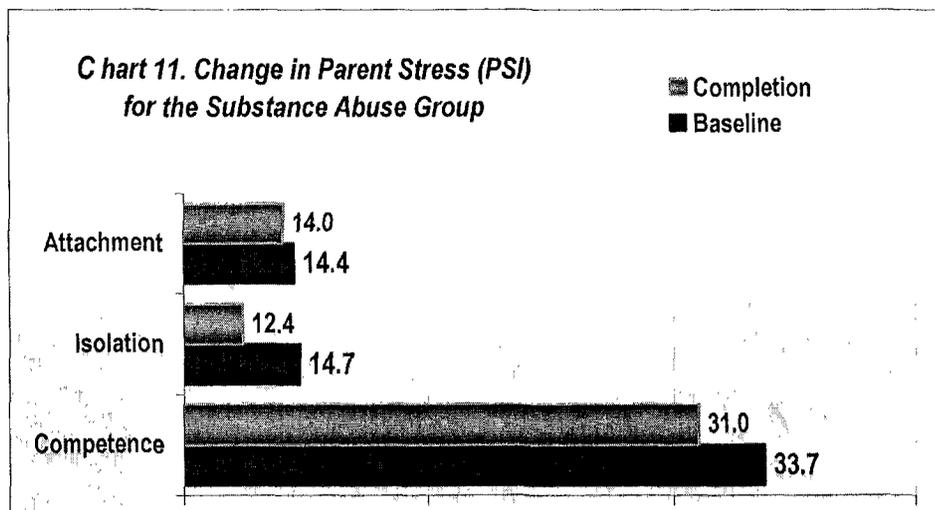


and appear in Charts 7 and 8. Parenting stress associated with a child's characteristics was significantly reduced for the HIV/AIDS group but not for the Substance Abuse women. The results indicated that parents reported less stress in dealing with their children's demanding behaviors ($p < .012$), moodiness ($p < .04$), and accepting ($p < .008$) their child's behaviors. For this group, significant outcome changes were found for the parent domain ($t = 2.91$, $p < .006$) and included changes in Isolation ($t = 2.74$, $p < .010$), Attachment ($t = 2.55$, $p < .015$), Depression ($t = 3.07$, $p < .004$) and Total Stress ($t = 3.22$, $p < .003$). Chart 8 provides means for the parent domain. As shown, there was a significant decrease in parenting stress levels although the project's sample scored above the normative sample mean. Essentially, HIV/AIDS women were found to report less life stressors, fewer depressed symptoms and less isolation after completing the

project. Findings for the Substance Abuse group on the PSI were also significant. The means for this group are reported in Chart 9. Within group analysis yielded outcome changes in the parent domain ($t=2.43$, $p<.023$) and included changes in Competency ($t=2.89$, $p<.008$), Isolation ($t=3.65$, $p<.001$), Depression ($t=2.11$, $p<.045$), Life Stress ($t=2.48$, $p<.020$) and Total Stress ($t=2.34$, $P<.028$). Similar to the HIV/AIDS group, this group experienced lower levels of parenting stress after completing the program. The Substance Abuse group reported a change in Competency although the HIV/AIDS group did not. In contrast, changes in Attachment were found for the HIV/AIDS group but not for the Substance Abuse group. ANOVA statistical analysis detected significant group differences for Isolation. Women in the Substance Abuse group were found to have experienced less isolation than HIV/AIDS women. Competency and Attachment were non-significant for group differences at termination. There were no significant changes in the child domain for the Substance Abuse group. Chart 10 and 11 display the mean changes for the above three domains: Attachment, Isolation and Competence.



Note. "Competence" was n.s.

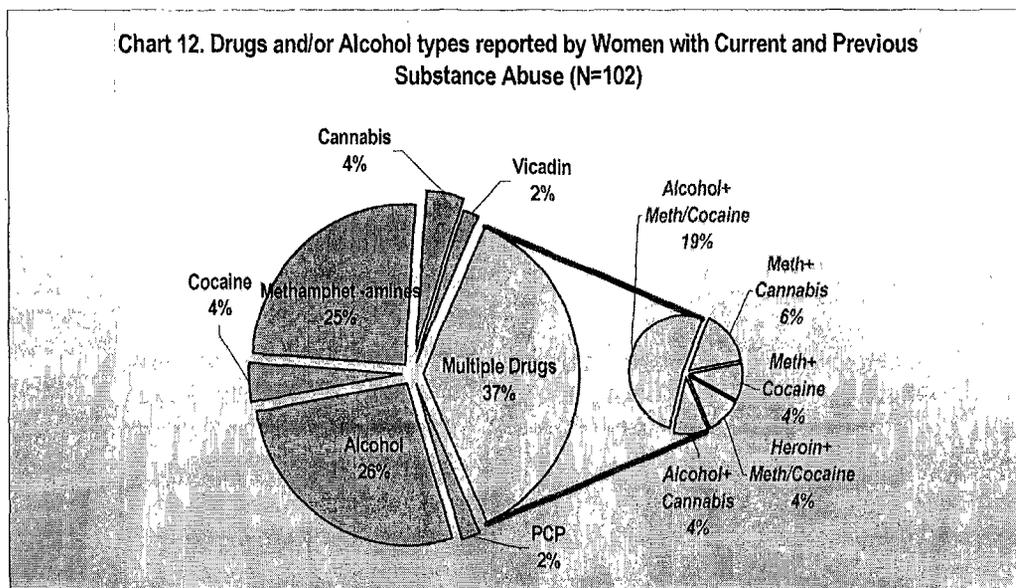


Note. "Attachment" was n.s.

Decreasing Drugs and Alcohol Use

The evaluation outcomes for reducing drugs and/or alcohol were significant. Ninety five percent of women sustained sobriety at the completion of this project. Sobriety and substance abuse history was assessed using the project's health intake. Fifty eight percent of the project's women had a history of drug and/or alcohol use. Among these women, 25% were currently using drugs and/or alcohol. Thirty three percent of women indicated being sober for less than six months while 42% reported "being in recovery" for more than six months. At program completion, 4.7% (5 women) were actively using and prematurely terminated from the project. More specifically, of the 25% of women who reported "current drug and/or alcohol use" at baseline, only 4.7% indicated that they were currently using.

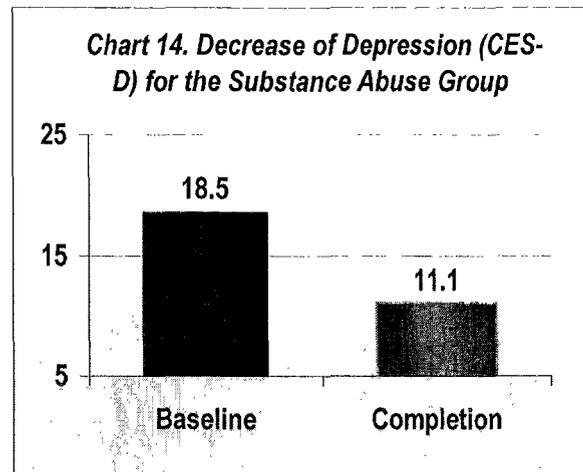
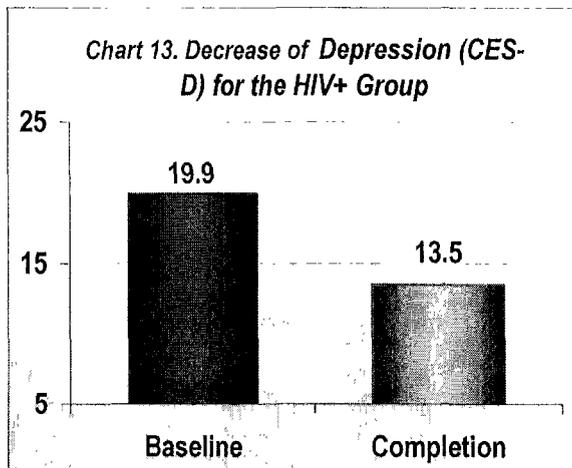
Drugs Used – The majority of women were poly substance users and tended to use alcohol with other drugs. Alcohol dependence was the second highest substance used by this sample (26%) followed by methamphetamines (25%). The types of drugs used are shown in Chart 12. Among the 37% of poly substance users, 23% also used alcohol.



Reducing Depression

Depression outcomes indicating reduced depressive symptoms, psychological distress and depressed mood were significantly supported by the project's findings. The CES-D scale was used to assess at risk cases for depressive symptoms. The score range for this measure is 0 to 60 with a score of sixteen or higher indicating at risk depressive mood symptoms. Baseline and 12 month assessments were obtained for the project's sample. Significant changes were found for the total sample, the HIV/AIDS group and Substance Abuse group. The PSI – Depression domain and the Distress/cognitive function domain in the HRQOL measure also measured

depressive outcomes. Significant baseline to program completion changes were found for both depression domains. The significant CES-D means for each group are presented in Charts 13 and 14. Paired t-tests analysis for change from baseline to program completion provided significant results for the HIV/AIDS group ($t=3.01, p<.006$) and the Substance Abuse group ($t= 3.09, p<.004$). The means obtained for the HIV/AIDS sample indicate that these women were at risk for depressive symptoms at baseline ($M=19.9$). At program completion, the CES-D mean for this group was 10.8 . Reportedly the HIV/AIDS women were significantly less depressed. This pattern was also observed for the Substance Abuse group. The mean changes at program completion were significant and indicated that these women were no longer at risk for depression. Paired t-tests and ANOVA statistics were used to evaluate the program effects on outcome changes and between/within group differences. These analysis were non-significant.



Child Well-Being

Developmental Functioning - The Developmental Profile II was used to assess developmental functioning for the project's index children. Briefly, the DPII identified the developmental functioning level in months for each child's chronological age and targeted those children who were delayed. This screening tool examined five areas of child development: Physical; Self-Help; Social; Academic and Communication. Month differential scores were computed and represent the number of months a child is functioning above or below his/her age. The month differential score yields a negative number (in months) for a potential delay. This screening tool was used to assist parents in their child's development and identifies children at risk for or delayed. Children in the project with six months or more delays in any of the five assessed domains received specialized interventions. Among the children tested with the DPII, 87% were at age level, compared to 13% identified as delayed. Specifically, 22 index children had moderate to severe developmental delays ranging from 15.9 months (*Mean*) to 22.5 months (*Mean*) in at least one of the developmental domains. Nine children had Substance Abuse mothers and 13 children were from the HIV/AIDS group. Eleven were male and twelve female. Five children were under 3 years, 6 children were between 3 and 4 years and 6 children were between 5 and 7 years old. Means for each domain (delayed months) were as follows; Physical = -15.9 months; Self-help = -22.5; Social = -20.7 months; Academic = -17 months and

Communication=22 months. For this sub-sample, children impacted by HIV/AIDS were delayed in Communication (12%) whereas children in the Substance Abuse group were delayed in Academic functioning (10%). T-tests statistics were applied to examine any significant between group differences (HIV/AIDS and Substance Abuse). A significant difference was found between these two groups in *social developmental* functioning. Children in the HIV/AIDS group were found to have significantly lower social functioning than children in the Substance Abuse group ($p < .026$). Other group comparisons indicated that HIV/AIDS children also tended to be more delayed in the area of Communication while Substance Abuse children showed more delays in Physical development (although these trends did not reach significance in the t-tests). Both groups of children were equally delayed in Self-help skills (independence) and Academic functioning. Due to the small sample size, a qualitative review of the project's 22 cases was used to evaluate this finding. Among the Substance Abuse sample, 7 children were prenatally exposed to Alcohol while 9 children were exposed to mother's chronic drug use. Among the HIV/AIDS 13 children, 7 mothers are currently diagnosed with AIDS and 4 are HIV+ symptomatic. These mothers tend to be more advanced with the virus when compared to other HIV/AIDS mothers from our sample. To date, referrals and treatment has been provided to these children and for their parents.

Child Risk Factors-Child risk factors were obtained at baseline and post 12 months for the project's index children. The Child Risk Factor Survey was used to assess risk factor prevalence for the project's 173 index children. The most frequently reported risk factors were categorized as "cognitive and behavior risks." This category included behavior problems, developmental delays, learning disability, speech and motor impairment and emotional disturbance. A second set of risk factors was categorized as "prenatal/biological." These items included low birthrate, neonatal drugs/alcohol, pre-term, failure to thrive and no prenatal care. A third group of items represented "medical/health conditions." This category included HIV/AIDS, hearing and vision impairments, Down's syndrome and seizures. Paired t-tests were used to evaluate changes in risk factors from baseline to program completion. Significant reductions were found in the total number of risk factors after children completed the program ($p < .001$). The risk factor categories described above were examined using paired t-test statistics. Only one category, cognitive/behavior risks were found significant ($p < .005$). This finding indicated that of the 27 children identified as being at risk for behavioral, developmental or emotional problems during enrollment into the project, 21 children no longer presented with these risks after completing the project.

Child Safety – As previously discussed, index children and their siblings were at high risk for abandonment, abuse and neglect based on the data obtained from parent stressors. Close to one fourth of these children had a history of foster placements and slightly over 50% lived (at one point) with an abusive parent. Among the substance abuse group, 25% of index children lived with biological mothers who were currently abusing drugs and/or alcohol. These children were further at risk for abandonment and neglect due to their multiple needs. Index children were identified with behavioral and emotional problems, medical illnesses, and developmental delays. Special needs children often place a burden on parents who live in stressful environments and lack skills to parent their children. These circumstances described the project's families. The significant program outcomes that were previously presented indicated that child safety was obtained for 94.3 % of the project's index children and their siblings. Only 5.6% were detained

and of them, 4.8% were placed in kinship care. Overall, significant outcomes in parenting stresses, parenting skills and environmental stresses were identified by the evaluation. Parenting stressors and environmental stresses were reduced for the project sample. In addition, parents demonstrated improved parenting skills by reduced levels of stress and risks.

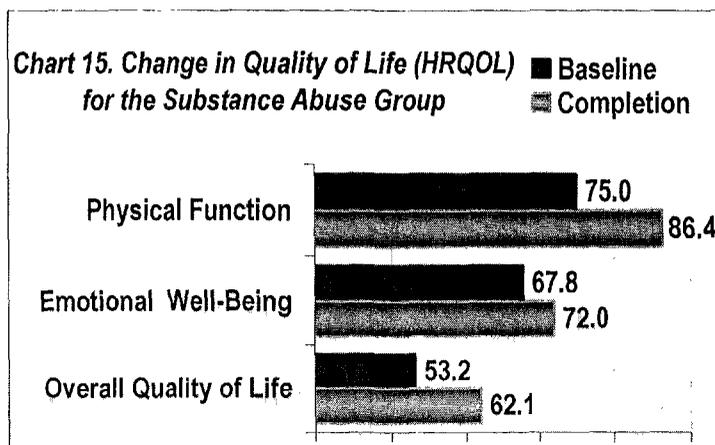
Improving Quality of Life among HIV/AIDS and Substance Abuse women

The Health Related Quality of Life measure was utilized to assess the impact of drug dependency or HIV/AIDS on the quality of life. The measure consists of fifteen domains that define this construct. On this measure, increasing scores from 1 to 100 indicate better health and/or increased quality of life. The effects of the project’s services on increasing the quality of life, improving health and improving mental health among HIV/AIDS and Substance Abuse women was evaluated during this reporting period. Paired t-tests and a Repeated Measures ANOVA were used to examine group differences and changes over time (baseline to 12 month termination). Interactive effects were also tested for these outcome variables. Findings for the total sample indicated significant baseline to program completion changes in Social Function ($t = -2.41, p < .019$), General Health ($t = -2.57, p < .012$) and Quality of Life ($t = -2.01, p < .048$). As a group, families reportedly became more active in social environments (less isolated) and felt better about their health. Program effects on the total quality of life domain were significant at program completion. Participants were found to significantly improve their quality of life after completing program services.

HIV/AIDS women – Health related quality of life among HIV/AIDS women during the four year funding period demonstrated significant program effects on the psychological well being of this group. Significant baseline to program completion changes were found in emotional well being ($p < .016$), cognitive distress ($p < .016$) and mental health ($p < .042$). The multiple symptoms associated with HIV/AIDS illness and medication side effects appeared to impact the physical well being of this group as non-significant changes were found in these domains. However, the program outcomes were aimed at improving the quality of life for these women by providing home base social support, socioeconomic resources and health education within a cultural context. These outcomes were supported by the improved mental health, emotional well being and less cognitive distress reported for this group.

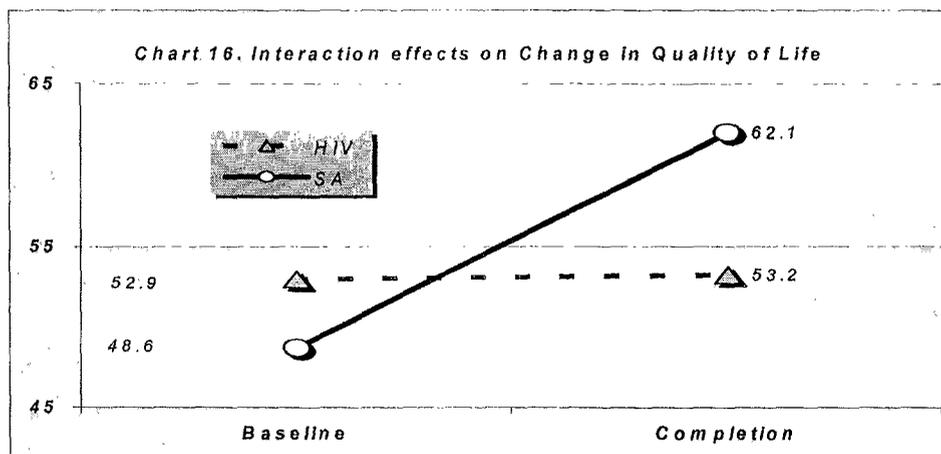
Substance Abuse women – Significant outcomes in improving the quality of life among Substance Abuse women were supported by the data analysis. Significant changes from baseline to program completion were found for seven indicators of quality of life for this group (p levels ranged from .036 to .003). This group had positive increased levels of health, physical

functioning and energy (and less fatigue). Chart 15 provides the most significant factors contributing to improved quality of life. Physical functioning was improved by positive changes in health factors for this group. Emotional well-being was improved as psychological distress, depressive symptoms and substance



abuse decreased. Changes in quality of life were found and were associated with the seven indicators contributing to this domain. This group reported feeling better about themselves and their life circumstances. Reasonably, maintaining a drug free lifestyle will enhance the quality of life for these women. This pattern of change is similar to previous results for this group. The program has targeted health care and psychological support for these women. Chronic substance abuse often results in neglected health care and multiple physical problems including chemical withdrawal. The Substance Abuse sample was assessed at high risk for depression (based on the CES-D) and with increased levels of stressors. Risk factors contributing to psychological distress included domestic violence, history of neglect and separation from their children due to detainment by the child welfare department. As expected, psychological support provided to this group was effective in improving the psychological and emotional factors contributing to the quality of life.

In addition, the Substance Abuse group demonstrated significantly higher levels of quality of life than the HIV/AIDS group. Significant interaction effects of time and group changes were found and are presented in Chart 16. This result indicates that the Substance Abuse group appeared to benefit more from services aimed at enhancing quality of life. While both groups improved, the Substance Abuse women showed more change at program completion than the HIV/AIDS women.



Improving Medical Access

Access to health services was assessed using the 11 item Medical Access form. The project provided health related services and assisted with medical access for women and children in both the HIV/AIDS and Substance Abuse groups. Many of the women affected by HIV/AIDS required health education on medication protocols and medication side effects. For the Substance Abuse women, they required routine medical exams, STD tests and medical treatment for specific health issues (e.g. Hepatitis). Paired t-tests and ANOVA statistics were used to evaluate outcome changes in medical access from baseline to program completion for the project sample. In addition, within groups and between groups analysis were conducted for the HIV/AIDS and Substance Abuse samples. The findings from the ANOVA analysis indicated that there were significant changes from baseline to termination for the total sample ($p < .002$). Families were found to improve their medical access to health care providers and services at the end of the

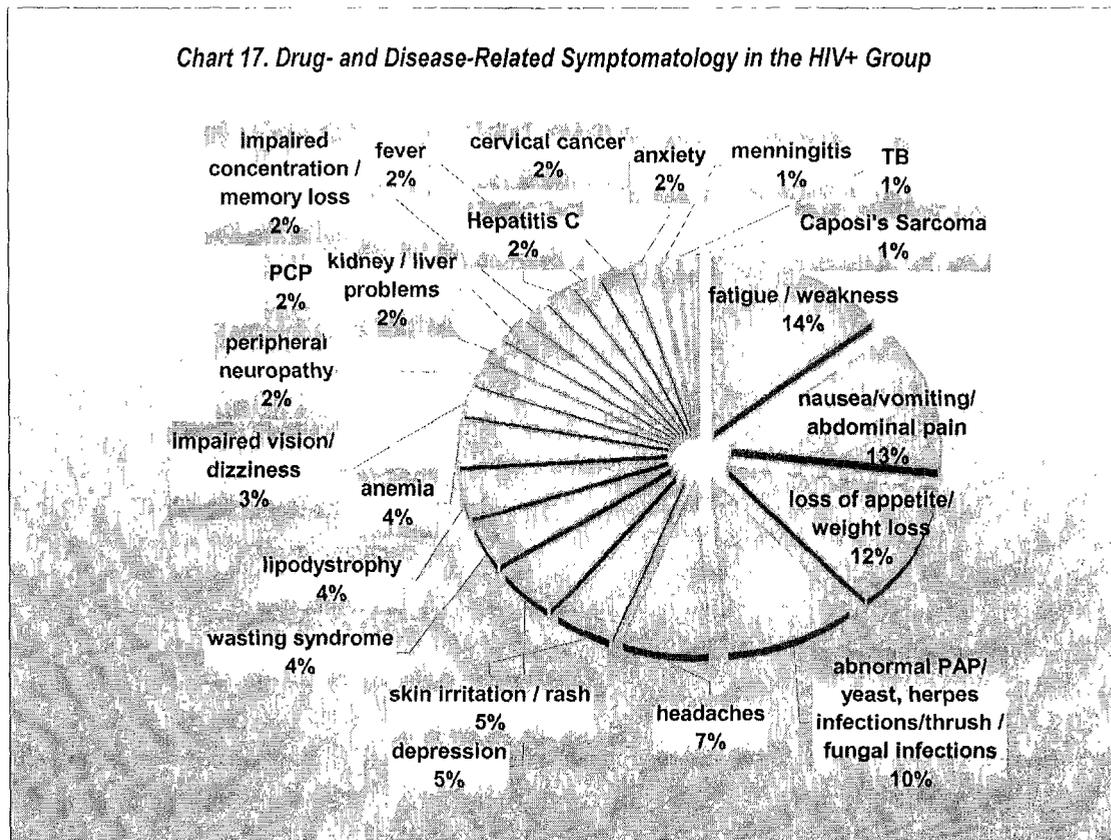
project. The Substance Abuse group was found to significantly increase medical access at program completion when compared to the HIV/AIDS group ($t=-2.37$, $p<.021$). The SA mean at project completion was 74.3 compared to the HIV/AIDS group mean of 61.7. The ANOVA analysis also yielded similar significant group differences at program completion for the Substance Abuse group ($F=4.31$ (month) $p<.042$ & $F=5.95$ (group), $p<.018$). In reviewing these results, the HIV/AIDS group has consistently maintained medical services and access to services. Their medical needs in this project, have focused on health education, medication education and medication compliance. In contrast, Substance Abuse women enrolled in the program with poor health. They have had minimal medical care and they often neglected their health. Associated with their active drug use, many of these women reported not receiving prenatal care, health insurance, dental care and a pap smear for several years. In addition, many of the Substance Abuse women have untreated medical conditions resulting from chronic drug use. Health care and medical access were improved by the program's services.

Assessing and Improving Health

Baseline Health Interviews were obtained for the HIV/AIDS and Substance Abuse samples during this reporting period. The Health Interview was developed by the project to identify health status and health needs for mothers impacted by HIV/AIDS and Substance Abuse. For the HIV/AIDS women, Health Interviews were also conducted at termination (Post). HIV status and symptoms, medication effects and associated HIV characteristics were used to monitor and assess women's health needs and medical condition at baseline and at program completion. This data was used to establish varying service goals for each of the families. For the Substance Abuse women, Health Interviews were conducted at baseline only to assess entry level and history of drug addiction; drug treatment needs; health status and medical needs. Process data using tracking methods were obtained for the Substance Abuse group. Service plans targeting improved health outcomes were based on these assessments and the HIV/AIDS Physician's report collected for each HIV/AIDS participant. Descriptive statistics was used to examine this data.

HIV/AIDS Group - Thirty-eight percent of the women suffer from AIDS and 51% are HIV+ with symptoms. They have been diagnosed for an average of three years ($M=2.77$). A physician informed the majority of women of their HIV/AIDS with only two women stating their partner informed them. Ninety-one percent (91%) were infected by heterosexual contact either by a partner or husband. Thirty percent (30%) of these women are disabled due to HIV/AIDS and forty-three percent (43%) report being hospitalized during the past year with twenty-seven percent (27%) reporting hospitalizations during the past month. Karnofsky Scale ratings were obtained for our sample. In California, physicians rate patients with HIV from Stage I (asymptomatic/few symptoms) to Stage IV (AIDS-severe). Forty-three percent of our women were rated at Stage I, fifty-four percent were at Stage II and only one at Stage III. Thirty-five percent (35%) of women reported illness secondary to HIV/AIDS. Forty-one women (93%) are taking HIV/AIDS medication with only four women currently using AZT. Three fourths of these women report medication side effects with fatigue/weakness reported most often. The use of alternative treatments is reported for over sixty percent of women and included nutritional supplements (41%) as the most common. Twelve women used medication for their HIV/AIDS during pregnancy; twelve children were identified with neonatal exposure to AZT. Five women

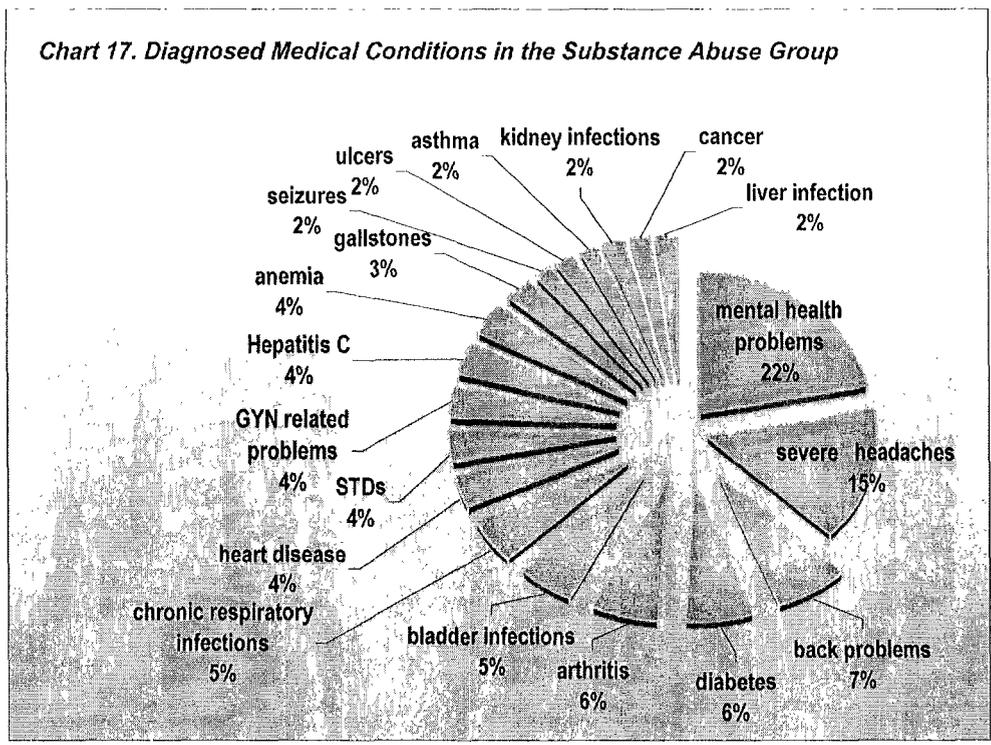
have died from AIDS during the 4 year funding period. Specific medical illnesses and medication side effects appear in Chart 17. As shown in this chart, women experienced multiple medical symptoms often resembling medication side effects. The need for health education and improved knowledge was crucial to the health care of these women. The majority of HIV/AIDS participants (94.5%) were compliant to their medication routine at program completion. Despite the costly side effects, women became informed of the therapeutic benefits. Medical appointments and follow-up care was also increased for 92% of this group. Hospitalizations and illnesses were primary reasons for missed appointments.



Substance Abuse Group – Participants in this sample reported medical conditions secondary to drug dependency. Four women were positive for Hepatitis C and two women had Cirrhosis of the liver. Specific medical and mental health conditions appear in Chart 17. There was a significant presence of health related symptoms for this group. As previously mentioned, these women necessitated health care for some time. Many of them experience medical difficulties that required health interventions including medication.

More than half the sample reported drug use during the past six months. The most frequently used drugs were alcohol (63%) and Methamphetamines (57%). Thirty seven percent of women were poly-substance users with alcohol identified as the second substance. Characteristics of

their drug dependency indicated that most women were long-term drug users (62%) with only twelve percent (12%) reporting drug use for less than one year. Sobriety among these women indicated that at the time of enrollment, 54% were sober for more than six months and twenty-nine percent (29%) were sober between two to six months. Twenty-five percent reported current drug and/or alcohol use. The mean age for onset of drug use was eighteen years old. Fifty percent of the sample reported using drugs during pregnancy and included Alcohol, amphetamines or tobacco (most prevalent). Drug treatment history for our Substance Abuse sample indicated that most women utilized self-help groups (64%) followed by outpatient treatment (50%) and residential treatment (19%).



Improved Economic and Living Conditions

The impact of home-based services on economic and living conditions was evaluated by examining family functioning levels. The Family Assessment Form (FAF) was used to assess family functioning levels at baseline and program completion. This measure examined six areas of family functioning in the home environment. These were; Living Conditions: Financial Conditions: Supports to Caregivers: Caregiver-child Interactions: Developmental Stimulation: and Interactions Between Caregivers. Ratings range from a score of one (positive and healthy functioning) to a score of 5 (child's health, safety and well-being is threatened). Statistical analysis using paired t-tests and repeated measures Analysis of Variances (ANOVA) was applied to examine baseline to termination changes, and within and between group differences for the project's sample. The paired t-tests results for the sample yielded significant changes in family functioning levels at program completion. These changes were found in the six areas assessed. These findings indicate that the project's services had an effect on improving family functioning,

improved economic conditions and living conditions. An ANOVA analysis was used to examine between group differences and the effects of time (12 months of service). These results were significant and similar to the t-test analysis. Four areas of family functioning were significantly improved; Living conditions: Financial conditions: Supports to caregivers: and Caregiver-child interactions. These results are shown in Table 1. As previously discussed, program services aimed at assisting families with basic needs of shelter and food were also found to have positive effects in helping families become stable. The program was effective in improving financial support through entitlement resources by providing hotel vouchers and housing referrals. The outcome of these services was improved living conditions at program completion. While families continued to live below the poverty level, they were able to benefit from stable living conditions. Social support was also significantly improved for families. Increasing social support networks had a positive impact on family interactions and parent/child relationship. In some cases, families also received home base family therapy.

The ANOVA analysis provided significant social support outcomes. Interaction effects for between group changes (from baseline to program completion) were found. The two domains were: Living Conditions ($F=4.26, p<.042$) and Supports to Caregivers ($F=9.62, p<.003$). The group effects found indicated that while living conditions improved for both the HIV/AIDS and Substance Abuse families, program services had a greater impact on the HIV/AIDS sample. In contrast, social support measured by the Supports to Caregivers domain, was more significantly improved for the Substance Abuse families than their counterparts. Significant results in family functioning are illustrated in Charts 18 and 19 for each group.

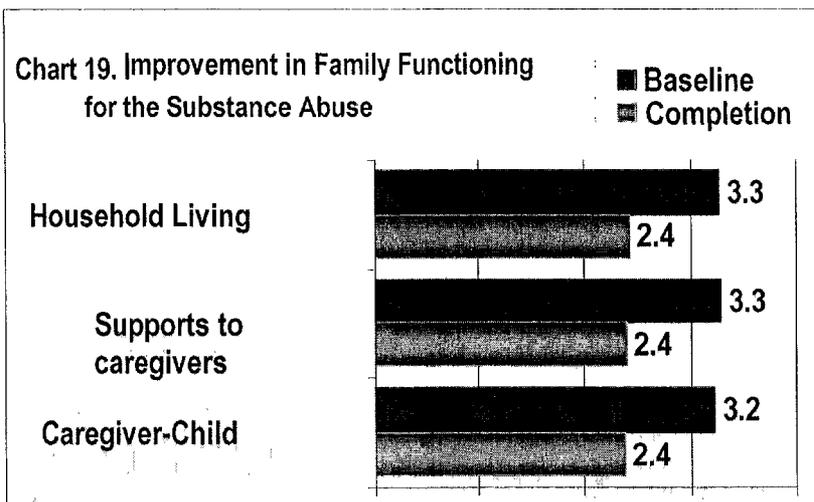
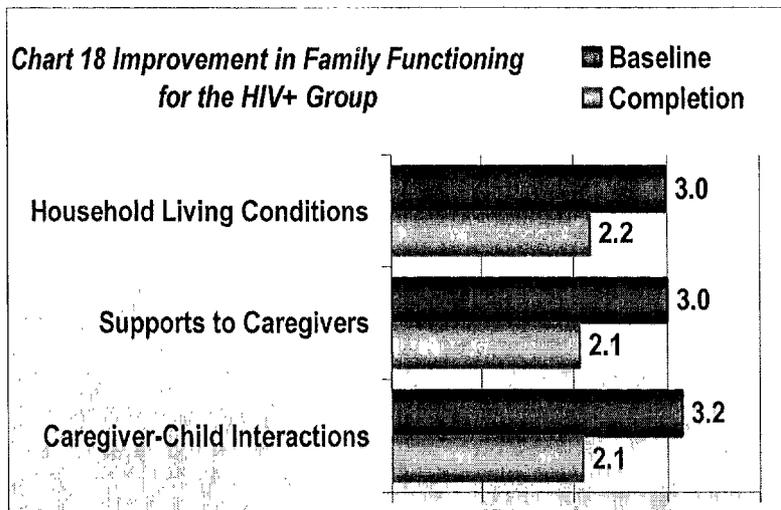


Table 1. Significant changes in family functioning levels at program completion.

FAF DOMAINS	CHANGE	
	F	P-VALUE
Living Conditions	103.96	0.000
Financial Conditions	167.28	0.000
Supports to Caregivers	138.00	0.000
Caregiver-Child Interaction	153.61	0.000

Discussion and Summary

Bienvenidos is recognized in the community as a leader in providing culturally responsive programs for Latinos. Bienvenidos provides services that meet the cultural and linguistic needs of the target area's families by using bilingual /bicultural staff that has roots in the community. The agency serves Latino families who are monolingual Spanish speaking and bilingual English and Spanish speaking. Approximately 40% of clients served in the East Los Angeles center are monolingual Spanish speaking. Bienvenidos Family Services honor and respect the strengths of Latino families by building on a foundation of cultural pride and traditional values. Programs support the integrity and the future of families with services that respect language, culture, values and community.

Project Milagro helped families identify their strengths and internal resources by providing external resources and support. The project strengthened families' capacities to effectively raise their children in spite of the myriad of problems faced by families dealing with substance abuse or HIV/AIDS. The strong emphasis on permanency planning was a key example of the value of family resiliency: *that the resources for continuity of care reside within the family*. Services focused on providing support and resources to improve families' parenting skills, identify positive adults to interact with their children and increase natural support networks.

Project Milagro's evidence-based service model had a positive impact on decreasing child maltreatment. Fifty four percent of project families were impacted by Substance Abuse. Ninety five percent of Latinas remained free from drugs and/or alcohol during program participation. The majority of these women reported a history of prenatally exposing their children to drugs and/or alcohol and 50% of children were born positive. Close to half of these women had active open cases with the Department of Children/Family Services (DCFS) at the time of program enrollment and 58% were at one point, court identified as a negligent parent. At the end of the program, 95% of children were reunited with their biological mothers and/or their cases were closed. In addition to their Substance Abuse, these women were at risk for multiple stressors. The risk factors identified were poor parenting skills (85%), unemployment (84%), domestic abuse (80%) and isolation (72%). The inclusion of supportive and mental health services proved successful in meeting the needs of Substance Abuse families. Latinas experienced high levels of parenting stress associated with parent competency skills, parent isolation and depressed mood. Depression was also found as a major mental health problem for this group and impacted the quality of life for Substance Abuse women. Significant findings for these women indicated that after completing the program, they were less depressed, reported improved quality of life, and improved physical and mental well being.

During the past four years, 48% of the women served by *Project Milagro* were affected by HIV/AIDS. The majority of these women were infected by their partners (91%). The project's findings indicated that these families were low acculturated, more isolated, transient and in need of a broader range of services than the substance abuse families. The challenges faced by Latinas living with HIV/AIDS in this project were their physical/mental conditions and their impoverished lives. As low acculturated women and newcomers to the United States, the access

to resources including medical services was limited. The findings clearly identified that socioeconomic and cultural factors were related to poor physical and mental health well being. Meeting the basic needs of food and shelter were entry points to enhancing their quality of life.

Importantly, there were many factors associated with their HIV infection and AIDS, some beyond the scope of this project. Approximately one third of these women were living with AIDS and the remaining two thirds were HIV positive with multiple symptoms. As immigrant women, the availability of medical care has been an emerging concern for health policy research (Wallace & Gutierrez, 2004). Program services focused on accessing medical care, health education and medical compliance. The program's culturally sensitive approach assisted in effectively engaging families to access treatment.

Project Milagro provided counseling services including family therapy to reduce the psychological distress reported by HIV/AIDS women. These women experienced parenting stress related to the parent-child relationship. Child characteristics involving behavioral and emotional problems contributed to the reportedly high levels of stress. Significant changes indicated that families had healthier relationships with their children and utilized appropriate parenting behaviors. Quality of life was improved for these families and was associated with improved social support, reduced depressive symptoms and reduced isolation. Despite their medical conditions, these women were more hopeful and more positive about their lives.

Permanency planning services were based on a model of social support. This framework was effective in engaging HIV/AIDS families to identify appropriate caregivers for their children. As isolated families with few support systems, identifying guardians and finalizing plans was challenging. However, all families received permanency-planning counseling.

The significant findings pointed to improved family stability for both HIV/AIDS and Substance Abuse families. The program was successful in reducing environmental stressors, parenting stress, improving economic and living conditions.

REFERENCES

Anderson, R. & Deaths: leading causes for 2001. National Vital Statistics Report, 52 (9): 51. Available at: <http://www.cdc.gov/nchs/data>. Retrieved December 3, 2004

Aragon, R., Kates, J., & Greene, L. (2001). Latins' views of the HIV/AIDS epidemic at 20 years. Menlo Park, CA: Henry J. Kaiser Foundation.

Centers for Disease Control and Prevention (1999). Fact Sheet – HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk.

CDC-HIV/AIDS Surveillance Report 2002; 14: 1-40; Available at:
<http://www.cdc.gov/hiv/stats/hasrlink.htm>. Accessed December 4, 2004

Chalfin, S., Tomaszewski, L. & Abruzzino, E. (2000) Effective Practices for Empowering Parents with HIV/AIDS Through Peer Support. *The Source*, 10, No. 2

Chesney, M. (1993). Health Psychology in the 21st century Acquired Immunodeficiency Syndrome as a harbinger of things to come. *Health Psychology*, 12, 259-268

Coon, L. (2000). Legal Permanency Planning for HIV-Affected Families: The Need to Plan, Current Legal Options, and Future Direction. *The Source*, 10, No. 2

County of Los Angeles, Department of Health Services. Health Profile Report for East Service Planning Area. Los Angeles, CA: Public Health, 2002.

County of Los Angeles, Department of Health Services. HIV/AIDS Surveillance Summary. Los Angeles, CA: Epidemiology Program, 2004.

County of Los Angeles, Department of Health Services. HIV/AIDS Surveillance Report. Los Angeles, CA: Public Health Web site, 1999.

Diaz, T., Chu, S. & Buehler, J. (1994). Socioeconomic differences among people with AIDS: results from a multistate surveillance project. *American Journal of Preventive Medicine*, 10:217-222.

Edelstein, Susan; Kropenske, Vickie and Howard, Judy. "Project T.E.A.M.S.; Social Work. July 1990.

Los Angeles County, Board of County Supervisors. "Transcribed Testimony from a Public Hearing Concerning Drug Addictive Babies." Los Angeles, CA: December, 1995

Mason, H., Marks, G., Simoni, J., Ruiz, M., & Richardson, J. (1995). Culturally sanctioned secrets? Latino men's non-disclosure of HIV infection to family, friends, and lovers. *Health Psychology*, 14, p. 6-12. Retrieved January 10, 2005 from <http://spider.apa.org/ftdocs/hea/1997/september/heal165458.htm/>

Meza, G., (2002). HIV/AIDS: Challenges for Health Psychologists. Unpublished manuscript provided to The Fielding Graduate Institute, Los Angeles, California.

Michaels, D. & Levine, C. (1992). Estimates of the number of motherless youth orphaned by AIDS in the United States. *Journal of the American Medical Association*, 268, p. 3456-3461.

Minuchin, Salvador (1996) *Families and Family Therapy*. Harvard University Press, Cambridge, Massachusetts.

National Women's Information Center; Health Problems in Hispanic American/ Latina Women. Retrieved December 15, 2004 from <http://www.4woman.gov>.

Suarez, A., Raffaelli, M. & O'Leary, A. (2002). Influence of abuse and partner hypermasculinity on the sexual behavior of Latinas. *AIDS Education and Prevention*, 12:263-274

Templeton-McMann, O., Currier-Ezepchick, J., Bouchard, B., Adnopoz, J., Pack, J. & Abruzzino, E. (2003). Development of Successful Treatment Interventions. AIA Best Practices: Lessons Learned from a Decade of Service to Children and Families Affected by HIV and Substance Abuse. Berkeley, CA: University of California at Berkeley, School of Social Welfare, and National Abandoned Infants Assistance Resource Center, Berkeley, California.

Wallace, S. & Gutierrez, V. (2004). Mexican Immigrants lack health services in the U. S. Health Policy, 1-2. Retrieved December 2, 2004 from [http://www. HEALTHPOLICY.UCLA.EDU](http://www.HEALTHPOLICY.UCLA.EDU).

**ABANDONED INFANTS ASSISTANCE
PROGRAM**

PROJECT MILAGRO
(Grant # 90CB0096)

ATTACHMENT I

Five Stage Model of Permanency Planning

Program's Model

- ❖ **Family-centered services**
- ❖ **Home-based**
- ❖ **Combines a comprehensive legal and family support approach**
- ❖ **Interdisciplinary team approach:**
 - **Family Support Worker**
 - **Mental Health Clinician**
 - **Consulting Attorney**
 - **Project Coordinator**
 - **Clinical Supervisor**

Five Stage Model of Permanency Planning

- ❖ **Stage 1: Assessing The Readiness of
The Family**
- ❖ **Stage 2: Educating The Family –
Identifying A Plan**
- ❖ **Stage 3: The Future Caregiver**
- ❖ **Stage 4: Securing The Plan**
- Stage 5: Aftercare**

Purpose of Future Care and Custody Planning

- ❖ **Ensure child well-being, safety, and stability**
- ❖ **Minimize family disruption**
- ❖ **Reduce child abandonment or placement into the Dependency System**
- ❖ **Empowerment of families**
 - ❖ **Offer families a “peace of mind”**

Barriers to Permanency **Planning**

Client Challenges

Psychosocial:

- ❖ **Poverty, isolation, limited resources, immigration factors**

Psychological:

- ❖ **Natural responses to grief (anxiety, avoidance, fears, denial, anger)**
- ❖ **Drug use**
- ❖ **Mental disorders (depression, anxiety, adjustment disorders)**
- ❖ **Impaired cognitive function (dementia)**

Other limitations:

- ❖ **Joint Guardianship Law**
- ❖ **Custody disagreements**
- Children dependents of DCFS**

Stage 1: Assessing The Readiness Of The Family

Assess the client's:

- ✓ **level of trust**
- ✓ **perspective**
- ✓ **family dynamics (single parent, custody arrangements)**
- ✓ **circle of support (see handout)**
- ✓ **appropriateness (to file for Joint Guardianship)**
- ✓ **emotional and health status**
- ✓ **cultural/ religious considerations**

Stage 2: Educating The Family

“Benefits of Permanency Planning”

- ❖ **Parents hold absolute control (not an obligation)**
- ❖ **Their wishes will be expressed/ considered**
- ❖ **Provides family “a peace of mind”**
- ❖ **Offers children stability and security**
- ❖ **Options to choose from**
- ❖ **Plans can be modified (except in adoption)**

Types of Permanency Plans

Informal Plans

(not filed in court)

- ❖ **Caregiver Authorization Affidavit**
- ❖ **Naming a guardian in a Will, Power of Attorney**
- ❖ **Notarized document**

Formal Plans

(filed in court)

- ❖ **Joint Guardianship**
- ❖ **Legal Guardianship**
- ❖ **Adoption**

Stage 3: The Future Caregiver

Issues to Consider

Who is the potential guardian?

- **Is he/she appropriate? (health, emotional status, legal)**
- **Is he/she aware of the plan (option)?**
- **Is he/she interested in assuming the responsibility?**
- **Is he/she aware of parents HIV status?**

Do the children have a relationship with the potential guardian?

Would the other parent object?

Identify individuals who are absolutely NOT potential guardians?

Stage 4: Securing The Plan

Formal Plan

- ❖ **Referral to Public Counsel, Alliance for Children's Rights**
- ❖ **Offer support in court hearings & process**
- ❖ **Provide ongoing support**

Informal Plan

- ❖ **Caregiver Affidavit**
- ❖ **Living Wills, Power of Attorney**
- ❖ **Notarized Document**
- ❖ **Revisit the issue in the future if possible**

Stage 5: Aftercare

- ❖ **Provide supportive services (extend services if needed).**
- ❖ **Services to reconstituted family:**
 - **immediate supportive interventions**
 - **linkages to relevant services (mental health, grief counseling)**
 - **assist with transition of: financial entitlements (Survivors Benefits, TANF), school transfers and childcare**
 - **support to the new caregiver, provide education on caring for children who have lost a parent(s)**
 - **If eligible referral for Special Immigrant Juvenile Status**

Referrals

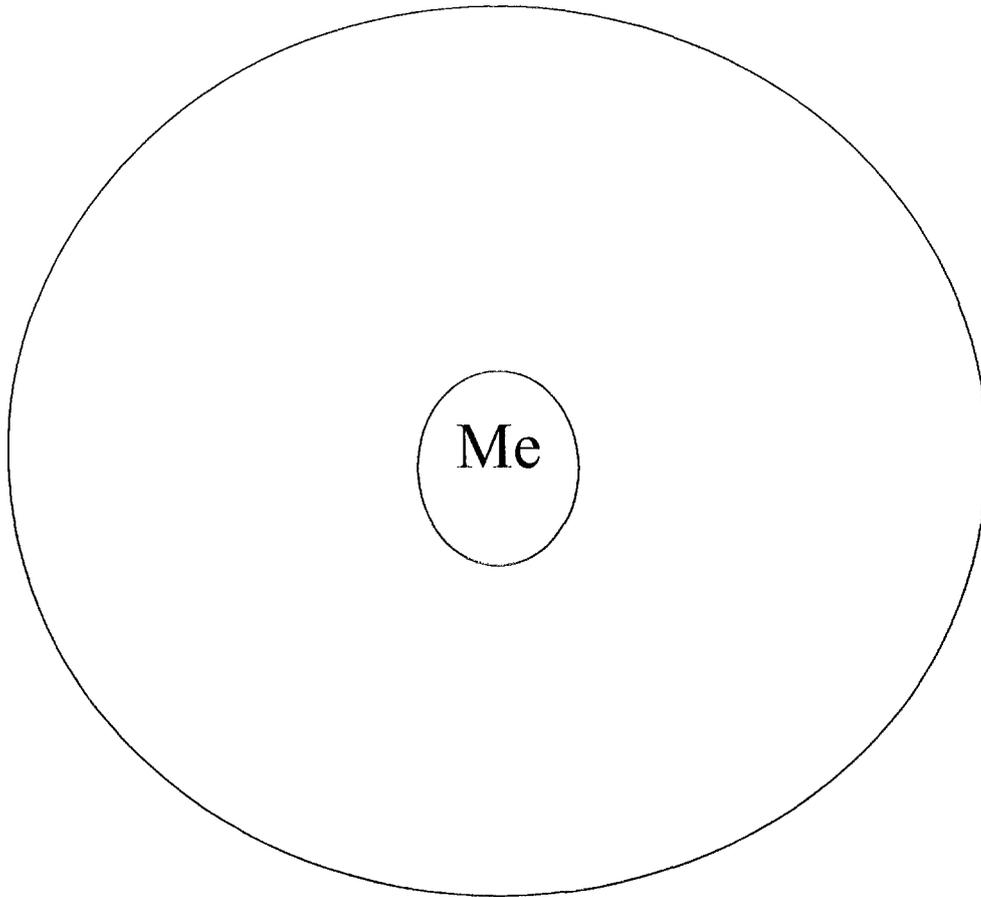
Support and counseling

- **Bienvenidos Family Services
(323) 728-9577**

Legal Assistance

- **Public Counsel (213) 385- 2977**
- **HALSA (213) 201- 1640**

Circle of Support



**ABANDONED INFANTS ASSISTANCE
PROGRAM**

PROJECT MILAGRO

(Grant # 90CB0096)

ATTACHMENT II

Presentations on Project's Model, Findings, and Permanency Planning

Presentations on Project Milagro's Model and Findings

Year I October 2000 – September 2001

- Quarterly Presentations at Dependency Court to Attorneys and Judges
- Quarterly presentations at HIV Homeless Task Force Meetings
- Presentation's at the following HIV/AIDS C.B.O.'s; Bethesda House, Casa Madonna, Prototypes, and Bienestar located in Los Angeles, CA.
- Presentation's at the following Drug Treatment Centers; Institute for Women's Health, Casa Serenidad, Latinas Recovery Home, and El Centro located in Los Angeles, CA
- Teatro Presentations – two presentations capturing a total of 50 families highlighting the importance of permanency planning took place at Bienvenidos Family Services (B.F.S.)
- Permanency Planning Presentations to HIV/AIDS service providers

Year II October 2001- September 2002

- Quarterly presentations at Latino HIV/AIDS Mental Health Task Force Coalition
- Quarterly presentations at HIV Homeless Task Force Meetings (including presentations on Permanency Planning).
- Conducted three “Provider Networking Meetings” at Bienvenidos Family Services at total of 45 agencies representing HIV/AIDS and Drug Treatment agencies attended.
- Director presented in the AIA Symposium: “*The Role of Partner's In Women's Recovery.*”
- Teatro Presentations- ten presentations capturing a total of 100 families highlighting the importance of permanency planning took place at B.F.S.

Year III October 2002- September 2003

- Quarterly presentations at the HIV Homeless Task Force Meetings and Latino HIV/AIDS Mental Health Task Force Coalition (presented on Permanency Planning).
- Teatro Presentations- six presentations emphasizing the impact of substance abuse on the family capturing 30 families took place at B.F.S.
- Director, Project Coordinator and Evaluator presented two workshops at 13th National AIA Grantees' Conference “Connecting with Families: Pathways To Well-being
- Director and Assistant Director presented at the Spirituality: A Powerful Force in Women's Recovery Conference, San Francisco, CA

Year IV October 2003- September 2004

- Public Service Announcements – Project staff in collaboration with Charles Drew University of Medicine and Science conducted several public service announcements focused on HIV/AIDS prevention in the communities of color.
- Presentation on Permanency at ALIANZA National HIV/AIDS Conference in Los Angeles, CA.
- Quarterly presentations at the HIV Homeless Task Force Meetings and Latino HIV/AIDS Mental Health Task Force Coalition

**ABANDONED INFANTS ASSISTANCE
PROGRAM**

PROJECT MILAGRO

(Grant # 90CB0096)

ATTACHMENT III

**Spanish Presentation on Future Care and
Custody Planning for Families
*“Asegurando El Futuro De Nuestros Hijos”***



Asegurando El Futuro De Nuestros Hijos

ALIANZA

24 de abril, del 2004

Lourdes Carranza, M.S.
Martin Ambriz, F.S.W.
Antonieta Poncedeleon, MFT
Bienvenidos Family Services

Objetivos De La Presentación

- Promover el concepto de la planificación del futuro de nuestros hijos.
 - Estabilidad/ bienestar de los hijos
 - Tranquilidad de conciencia para los padres
 - La responsabilidad de los padres que aseguran el futuro de los hijos.
- Informar a padres, familias, y profesionales sobre opciones que existen en CA.
- Reducir inquietudes que los padres pudieran tener.

Opciones Para Padres

Plan Informal

- ❖ Informar a alguien sobre mis planes
- ❖ Carta Notarizada
- ❖ Testamento
- ❖ "Carta Poder" (Affidavit)
Autorización del Guardián

Plan Formal (legal)

- ❖ Tutela compartida
- ❖ Tutela (individual)
- ❖ Adopción

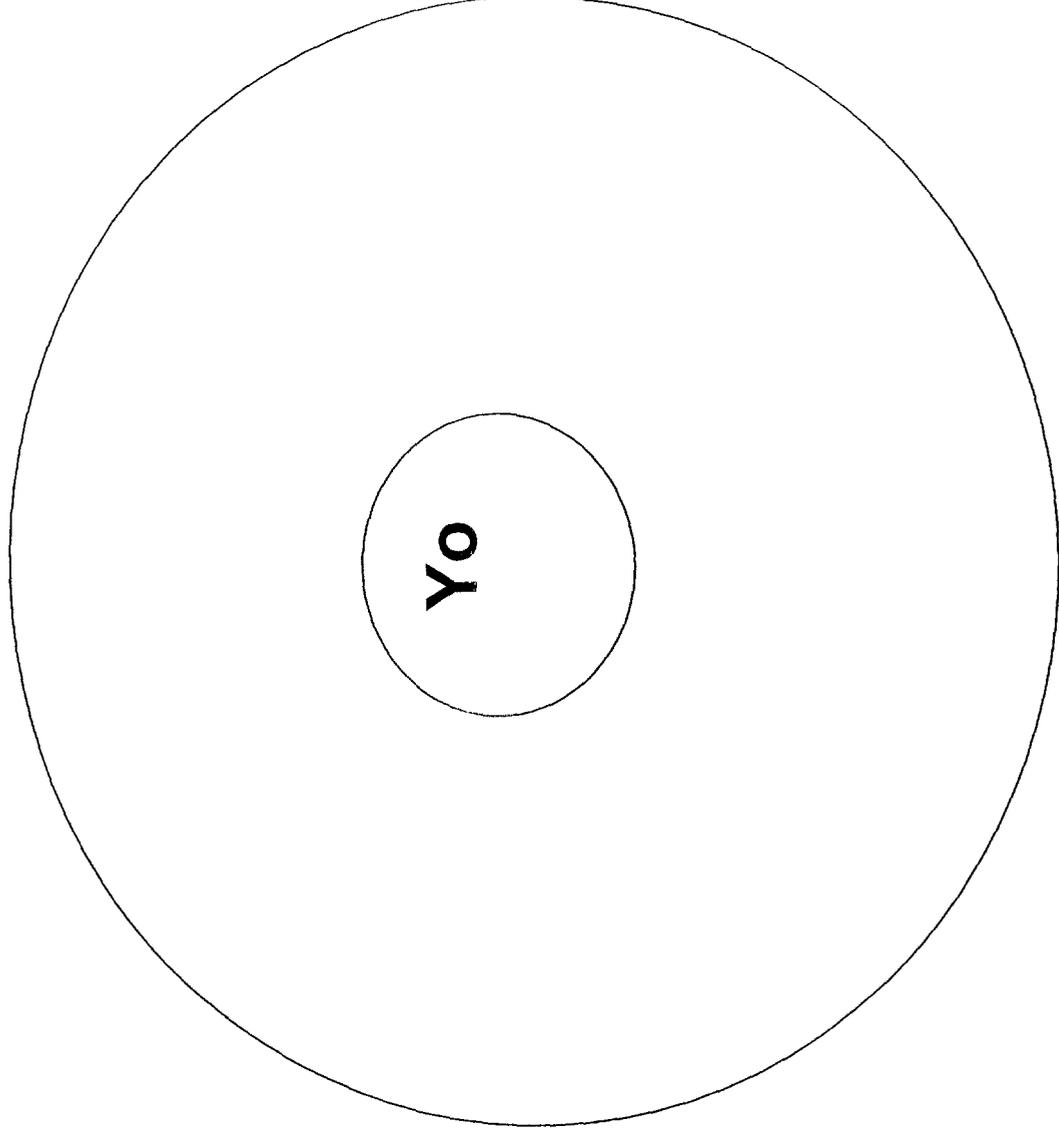
Obstáculos Más Comunes...

- **Falta de información**
- **Situaciones individuales/ familiares**
 - * mantener el diagnóstico confidencial
 - * falta de apoyo
 - * problemas; económicos, vivienda, matrimoniales
 - * problemas físicos y mentales
 - * conflicto con el padre(s) ausente
 - * concepto de vivir "día l día"
- **Falta de tutor disponible**
- **Evitar procedimientos legales**
- **Factores culturales/ religiosos**

Factores A Considerar Cuando Se Elije un Tutor

- **Persona/ familia:**
 - *Responsable*
 - *hogar estable*
 - *comparta sus valores*
 - *historia criminal*
- **Consciente de su diagnóstico o a quién usted piensa informar en un futuro**
- **Mantenga una relación positiva con sus hijos/ familia**

Círculo De Apoyo



El Tutor: Responsabilidades y Los Derechos

Responsabilidades

Proveer:

- ✓ Cuidado económico
- ✓ Cuidado físico/ mental
- ✓ Educación
- ✓ Estabilidad familiar

Derechos

Manutención Económica

- ✓ Cuidado de Crianza
(1-800-540-4000)
- ✓ CalWorks (Welfare)
- ✓ SSI

El Tutor asume estas responsabilidades solamente cuando existe incapacidad o fallecimiento.

Factores A Considerar Cuando Incluya a Los Hijos En Este Proceso

- Edad
- Madures mental, emocional
- Revelación del diagnóstico
- Relación con el tutor propuesto
- Conseguir servicios de consejería

Realidades Existentes

- **VIH/SIDA es una enfermedad crónica y manejable aún así la enfermedad sigue cobrando vidas e impactando la vida de niños sobrevivientes.**
- **La infección de VIH es la tercera causa de muerte de mujeres entre las edades de 25 a 44 años (CDC).**
- **El concepto de realizar un plan para el futuro cuidado de hijos no es común en la comunidad Latina.**
- **La mayoría de padres piensan en el concepto, pero no realizan un plan sino hasta que su salud es crítica.**

**ABANDONED INFANTS ASSISTANCE
PROGRAM**

PROJECT MILAGRO
(Grant # 90CB0096)

ATTACHMENT IV

Evaluation Instruments

BFS ID #: _____	PROJECT MILAGRO	Today's Date: _____
ET SEQ #: _____	Abandoned Infants Assistance	Intake Date: _____
Child's Name: _____		Child's Age: _____

Baseline Child Risk Factors/Developmental Screening

Please complete this assessment during the **Initial Intake/Referral** for **index** child participating in Project Milagro

Please check any of the following factors which may impact age-appropriate development in the areas of social (behavioral, relationship), emotional, physical (motor), cognitive (learning, language) and independent (self-help skills) functioning.

Section 1: Past Risk Factors (occurring prior to birth or longer than 6 months ago)

	Yes	No
1. Lack of prenatal care or "well baby" pediatric care (date of last physical exam ___/___).....	<input type="checkbox"/>	<input type="checkbox"/>
2. Preterm birth	<input type="checkbox"/>	<input type="checkbox"/>
3. Low birth weight	<input type="checkbox"/>	<input type="checkbox"/>
4. Prenatal drug exposure (specify drug(s): _____)	<input type="checkbox"/>	<input type="checkbox"/>
5. Exposure to substance abuse in the household (specify drug(s): _____).....	<input type="checkbox"/>	<input type="checkbox"/>
6. Exposure to domestic violence	<input type="checkbox"/>	<input type="checkbox"/>
7. Victim of abuse or neglect (specify type: _____)	<input type="checkbox"/>	<input type="checkbox"/>
8. Out-of-home placement(s)	<input type="checkbox"/>	<input type="checkbox"/>
9. Unstable housing (homelessness, shelters, more than 2 moves in a year)	<input type="checkbox"/>	<input type="checkbox"/>

Section 2: Current Risk Factors (occurring within last 6 months)

	Yes	No
10. Lack of "well child" pediatric care/ immunization (date of last physical exam ___/___).....	<input type="checkbox"/>	<input type="checkbox"/>
11. Inadequate nutrition, caloric deprivation or anemia (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>
12. Chronic health problem (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>
13. Exposure to substance abuse in the household (specify drug(s): _____)	<input type="checkbox"/>	<input type="checkbox"/>
14. Exposure to domestic violence	<input type="checkbox"/>	<input type="checkbox"/>
15. Victim of abuse or neglect (specify type: _____)	<input type="checkbox"/>	<input type="checkbox"/>
16. Death of a parent or other member of household with significant relationship to child.....	<input type="checkbox"/>	<input type="checkbox"/>
17. Other significant traumatic event (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>
18. Lack of stable family composition (absentee parent, changing caregivers)	<input type="checkbox"/>	<input type="checkbox"/>
19. Out-of-home placement.....	<input type="checkbox"/>	<input type="checkbox"/>
20. Unstable housing (homelessness, shelters, more than 1 move in past 6 months).....	<input type="checkbox"/>	<input type="checkbox"/>

BFS ID #: _____	PROJECT MILAGRO	Today's Date: _____
ET SEQ #: _____	Abandoned Infants Assistance	Intake Date: _____
Child's Name: _____		Child's Age: _____

Baseline Child Risk Factors/Developmental Screening

Section 3: Developmental Screening

Please indicate any of the following conditions that have been formally diagnosed by a medical or other professional, or which have been observed or suspected by either the intake examiner or the child's caregiver. For undiagnosed conditions, check only if the problem is expected to have a significant impact on the child's normal development.

	Formally	Observed / Suspected by:	
	Diagnosed	Examiner	Caregiver
Physical conditions:			
1. Cardiac anomaly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Motor/physical impairment (specify: _____) ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Asthma/respiratory problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Vision impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Failure-to-thrive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Fetal Alcohol Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Other neurological disorder (specify: _____) ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Congenital HIV – asymptomatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Symptomatic HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Other chronic medical condition (specify: _____) ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental and Emotional/Behavioral conditions:			
14. Down syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Pervasive Developmental Disorder/Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Other developmental delay (specify: _____) ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Severe emotional disturbance (specify: _____) ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Attention Deficit Disorder (or ADHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Other learning disability (specify: _____) ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Behavioral problem (specify: _____) ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Other mental health disorder (specify: _____) ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If the examiner or child's caregiver suspects that the child has special needs based on a condition not listed above, please provide a detailed description below:

BFS ID #: _____	PROJECT MILAGRO	Today's Date: _____
ET SEQ #: _____	Abandoned Infants Assistance	Intake Date: _____

Baseline Parent/Caregiver Risk Factors

*Please complete during the **Initial Intake/Referral** for those parents/primary caregivers who are currently residing with child(ren) participating in Project Milagro*

<i>Name</i>	<i>Relationship to child</i>
Caregiver 1: _____	_____
Caregiver 2: _____	_____

*Please check the following items that place **parents/caregivers at risk** and thereby potentially limit the child(ren)'s ability to develop normally (within the social, emotional, physical, cognitive and adaptive domains)*

Section 1: Past Risk Factors (occurring during caregivers' childhood or longer than 6 months ago)

	Caregiver	
	1	2
1. Witnessed domestic abuse as a child (specify type: physical__ emotional__)	<input type="checkbox"/>	<input type="checkbox"/>
2. Victim of domestic abuse (specify type: physical__ emotional__)	<input type="checkbox"/>	<input type="checkbox"/>
3. Grew up in a household with substance abuser(s) (specify drug(s): _____)	<input type="checkbox"/>	<input type="checkbox"/>
4. Substance abuse (specify drug(s): _____)	<input type="checkbox"/>	<input type="checkbox"/>
5. Substance abuse during pregnancy (specify drug(s): _____)	<input type="checkbox"/>	<input type="checkbox"/>
6. Victim of childhood abuse (specify type: physical__ sexual__ emotional__ neglect__)	<input type="checkbox"/>	<input type="checkbox"/>
7. Court identified as abusive /neglectful	<input type="checkbox"/>	<input type="checkbox"/>
8. Homelessness/shelter/unstable living situation	<input type="checkbox"/>	<input type="checkbox"/>
9. Developmental delays/learning disability	<input type="checkbox"/>	<input type="checkbox"/>
10. Physical disability (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>
11. Mental disorder (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>
12. Chronic/long term medical illness (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>
13. Multiple incarcerations	<input type="checkbox"/>	<input type="checkbox"/>

continued on next page

BFS ID #: _____	PROJECT MILAGRO	Today's Date: _____
ET SEQ #: _____	Abandoned Infants Assistance	Intake Date: _____

Baseline Parent/Caregiver Risk Factors

Section 2: Current Risk Factors (occurring within last 6 months)

	Caregiver	
	1	2
14. Victim of domestic abuse (specify type: physical___ emotional___)	<input type="checkbox"/>	<input type="checkbox"/>
15. Marital/Partner discord	<input type="checkbox"/>	<input type="checkbox"/>
16. Pregnant (Date due: _____)	<input type="checkbox"/>	<input type="checkbox"/>
17. Substance abuse (specify drug(s): _____)	<input type="checkbox"/>	<input type="checkbox"/>
18. Court identified as abusive/neglectful	<input type="checkbox"/>	<input type="checkbox"/>
19. Children detained by DCFS (during the past year)	<input type="checkbox"/>	<input type="checkbox"/>
20. Poor/limited parenting skills	<input type="checkbox"/>	<input type="checkbox"/>
21. Poor/limited job skills	<input type="checkbox"/>	<input type="checkbox"/>
22. Poverty	<input type="checkbox"/>	<input type="checkbox"/>
23. Isolation	<input type="checkbox"/>	<input type="checkbox"/>
24. Presently homeless	<input type="checkbox"/>	<input type="checkbox"/>
25. Substandard living/temporary housing	<input type="checkbox"/>	<input type="checkbox"/>
26. Unemployed for most or all of the past year	<input type="checkbox"/>	<input type="checkbox"/>
27. Inadequate or no health insurance	<input type="checkbox"/>	<input type="checkbox"/>
28. Developmental delays/learning disability	<input type="checkbox"/>	<input type="checkbox"/>
29. Physical disability (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>
30. Mental disorder, asymptomatic (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>
31. Symptomatic mental illness (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>
32. Medical illness, expected to improve (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>
33. Taking medication for medical or psychological condition	<input type="checkbox"/>	<input type="checkbox"/>
34. Incarcerated during the past year	<input type="checkbox"/>	<input type="checkbox"/>
35. Probation/parole during the past 12 months	<input type="checkbox"/>	<input type="checkbox"/>
36. Illiteracy: unable to read	<input type="checkbox"/>	<input type="checkbox"/>
37. Illiteracy: unable to write	<input type="checkbox"/>	<input type="checkbox"/>
38. Caring for a disabled/ill person in the same household	<input type="checkbox"/>	<input type="checkbox"/>
39. Caring for a medically fragile child or child with special needs	<input type="checkbox"/>	<input type="checkbox"/>
40. Experienced a traumatic event (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>

Client ID: _____

Group: HA SA HS

Date of Intake: _____

Today's Date: _____

PRE only

Total Score= _____

SASH

A. English

1. In general, what language(s) do you read and speak?

- | | | | | |
|--------------------------|-----------------------------|--------------------------|-----------------------------|--------------------------|
| 1 | 2 | 3 | 4 | 5 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Only Spanish | Spanish better than English | Both Equally | English better than Spanish | only English |

2. What was the Language(s) you used as a child?

- | | | | | |
|--------------------------|-----------------------------|--------------------------|-----------------------------|--------------------------|
| 1 | 2 | 3 | 4 | 5 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Only Spanish | Spanish better than English | Both Equally | English better than Spanish | only English |

3. What language(s) do you usually speak at home?

- | | | | | |
|--------------------------|-----------------------------|--------------------------|-----------------------------|--------------------------|
| 1 | 2 | 3 | 4 | 5 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Only Spanish | Spanish better than English | Both Equally | English better than Spanish | only English |

4. In which language(s) do you usually think?

- | | | | | |
|--------------------------|-----------------------------|--------------------------|-----------------------------|--------------------------|
| 1 | 2 | 3 | 4 | 5 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Only Spanish | Spanish better than English | Both Equally | English better than Spanish | only English |

5. What language(s) do you usually speak with your friends?

- | | | | | |
|--------------------------|-----------------------------|--------------------------|-----------------------------|--------------------------|
| 1 | 2 | 3 | 4 | 5 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Only Spanish | Spanish better than English | Both Equally | English better than Spanish | only English |

6. In what language(s) are the TV programs you usually watch?

1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Only Spanish	Spanish better than English	Both Equally	English better than Spanish	only English

7. In what language(s) are the radio programs you usually listen to?

1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Only Spanish	Spanish better than English	Both Equally	English better than Spanish	only English

8. In general, in what language(s) are the movies, TV, and radio programs you prefer to watch and listen to:

1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Only Spanish	Spanish better than English	Both Equally	English better than Spanish	only English

9. Your close friends are:

1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Only Latinos	More Latinos than Americans	About half and half	More Americans than Latinos	All Americans

10. You prefer going to social gatherings/parties at which the people are:

1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Only Latinos	More Latinos than Americans	About half and half	More Americans than Latinos	All Americans

11. The persons you visit or who visit you are:

1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Only Latinos	More Latinos than Americans	About half and half	More Americans than Latinos	All Americans

12. If you could choose your children's friends, you would want them to be:

1	2	3	4	5
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Only Latinos	More Latinos than Americans	About half and half	More Americans than Latinos	All Americans

Bienvenidos Family Services
Initial Intake Referral

ID. # _____

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-Shelter
7-Judicial 8-Regional Center 9-BFFA 10-Other

Name _____ D.O.B. (If non-bio. Mo.) _____

Address _____

City/State/Zip _____

Phone _____ Message Phone _____

Marital status code _____ Ethnic Code _____ Years in U.S. _____ Country of Origin _____

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

Educational status _____ Work/Employment status _____ S.S.# _____

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	Rent\$
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/GR _____ Food Stamps _____ Employment _____ SSI _____ Spouse _____

<p>Biological Mother</p> <p>In-Home? 1-Yes 2-No 3-N/A (Complete below only if applicable)</p> <p>Marital Status Code _____ Ed. Code _____ Work Code _____</p> <p>DOB _____ Age _____</p>	<p>Biological Father</p> <p>In-Home? 1-Yes 2-No 3-N/A (Complete below only if applicable)</p> <p>Marital Status Code _____ Ed. Code _____ Work Code _____</p> <p>DOB _____ Age _____</p>
--	--

<p>Program</p> <p>1-In-Home services</p> <p>2-Center-based services</p> <p>3-Information/referral</p> <p>4-Court</p> <p>Previous BFS client: Y / N If yes, list svs: _____</p>	<p>Grant assignment</p> <p>1-AIA</p> <p>2-1733</p> <p>3-IWH</p> <p>4-Family Preservation</p> <p>5-HEAL/ Clarity</p> <p>6-CLP</p> <p>7-CSBG</p> <p>8-Other</p>	<p>Assigned to</p> <p>1-Supervisor</p> <p>2-Family Support Worker</p> <p>Opening date _____ / _____ / _____</p> <p>Closing date _____ / _____ / _____</p>
--	---	---

Code Box – on next page-

<p>Ethnic Code</p> <p>1-White</p> <p>2-Hispanic</p> <p>3-Black</p> <p>4-Asian</p> <p>5-Pacific Islander</p> <p>6-American Indian</p> <p>7-Other</p> <p>9-N/A</p>	<p>Marital Status</p> <p>1-Married</p> <p>2-Divorced</p> <p>3-Separated</p> <p>4-Widowed</p> <p>5-Domestic Partner</p> <p>6-Single</p> <p>9-N/A</p>	<p>Resides with(Current Placement List)</p> <p>1-Home w/ parent, no CPS involvement</p> <p>2-Home w/ parent CPS involvement</p> <p>3-Adoptive home parent</p> <p>4-W/relative, informal placement</p> <p>5-W/relative, foster care</p> <p>6-Non-relative, informal placement</p>	<p>7-Foster Family Care</p> <p>8-Group home/shelter</p> <p>9-Residential treatment with</p> <p>10-Residential treatment w/o parent</p> <p>11-Hospital</p> <p>12-Homeless shelter w/parent</p> <p>13-W/relative - Legal Guardianship</p>
---	--	---	---

STATUS OF DCFS CASE:

1-None/2-Family Preservation/3-Permanency Planning/4-Emergency Response/5-Adoptions/6-Closed case/7-Reunification/8-Maintenance

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 / Code	Ethnic	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 illicit 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.....N/A	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	Neonatal (Rx. Meds.).....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

PARENT/ CAREGIVER 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 (drug of choice Last used _____).....	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..... (Hx: _____ Present: _____)	1-Yes	2-No	Impaired physical health.....	1-Yes	2-No
Victim:childhood physical, emotional, sexual abuse.....	1-Yes	2-No	Developmentally disabled.....	1-Yes	2-No
Impaired Mental Health.....	1-Yes	2-No	Illiterate.....	1-Yes	2-No
Court identified as abusive (Hx: _____ Present: _____).....	1-Yes	2-No	Unemployed.....	1-Yes	2-No
Court identified as neglectful (Hx: _____ Present: _____)....	1-Yes	2-No	History of employment.....	1-Yes	2-No
Poor Parenting Skills.....	1- Yes	2. No	History of incarceration (Date: _____)....	1-Yes	2-No
Poor Job skills.....	1-Yes	2-No	Criminal Status.....1. Probation(Summary/ Formal) 2. Parole 3. None		

Resource and Referrals

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

