ABANDONED INFANTS ASSISTANCE PROGRAM

NUESTRAS FAMILIAS
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We want to extend our gratitude to Bienvenidos for their technical support, sharing of information and their work in the field of child welfare.

We dedicate the Nuestras Familias Project to all women and children who struggle with substance abuse and HIV/AIDS. Our lives will forever be changed because of their journeys and their participation in the program.

Maria L. Quintanilla, LCSW Executive Director
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EXECUTIVE SUMMARY

Latino Family Institute (LFI), a private nonprofit organization based in Los Angeles, California, provided culturally responsive comprehensive services to pregnant and parenting Latinas who have histories of substance abuse and/or HIV/AIDS under the Abandoned Infants Assistance Program since 2005. LFI provided the Abandoned Infants Assistance Program in Santa Ana and surrounding cities in Orange County, California, for 135 Latino families with children, ages 0-6 that were at risk for abandonment due to maternal substance abuse and/or HIV/AIDS.

Nuestras Familias (AIA) Project proposed to replicate the evidence-based model developed, implemented and evaluated by Bienvenidos Children's Center, which provided AIA services for Latino families in East Los Angeles from 1992 to 2008. During the four year period Nuestras Familias Project successfully replicated the core elements of the service model, evaluation design and data collection plan. However, in order to ensure culturally competent services, Nuestras Familias enhanced and made significant modifications to the service model in order to address the unique needs of families in the Santa Ana and surrounding cities in Orange County.

The project evolved throughout the four years, and it was necessary to adapt the original model to respond to the community needs and the collaborative network. The model adaptations were deemed necessary because of the strong partnership with the Orange County, Department of Public Health, Perinatal Assessment and Coordination Team (ACT). The collaboration with ACT skewed the target population towards pregnant women and mothers with newborns primarily with histories of substance abuse. The implications of that partnership indicated a need to adapt the services and provide a more comprehensive clinical emphasis with supportive interventions appropriate for this population.

LFI implemented an innovated home-based and center-based model to prevent the abandonment of children and secure their safety by meeting the multiple needs of 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 living in Orange County. The multi-level services involved family assessment, family support, case management, advocacy, child assessment, parenting, health education, medical access, permanency planning, and alcohol/drug and mental health counseling. The efficacy of a multidisciplinary bilingual/bicultural service team comprised of a therapist, drug and alcohol counselor, case manager, parent educator, HIV specialist, group facilitator, proved crucial in assessing and meeting the economic, social, cultural, legal, health, and psychological needs of families.

Nuestras Familias developed numerous strong partnerships in order to increase family strengths and decrease the likelihood of child maltreatment and abandonment. Nuestras Familias built alliances and collaborated with over 25 local organizations.
**Introduction**

**Latino Family Institute (LFI),** a private, nonprofit organization, served as lead agency for a consortium providing the Abandoned Infants Assistance Program in Santa Ana and surrounding cities in Orange County, California, for 135 primarily Latino families with children, ages 0-6 that were at risk for abandonment due to maternal substance abuse and/or HIV/AIDS. **LFI,** a full-service Latino adoption, foster care, and family support agency, collaborated with the Orange County, Department of Public Health, Perinatal Assessment and Coordination Team (ACT). The AIA Project **Nuestras Familias** provided comprehensive 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.

**Nuestras Familias (AIA) Project** proposed to replicate the evidence-based model developed, implemented and evaluated by Bienvenidos Children's Center, which provided AIA services for Latino families in East Los Angeles from 1992 to 2008. During the four year period **Nuestras Familias** Project successfully replicated the core elements of the service model, evaluation design and data collection plan. However, in order to ensure culturally competent services, Nuestras Familias enhanced and made significant modifications to the service model in order to address the unique needs of families in the Santa Ana and surrounding cities in Orange County communities.

During the past four years, 135 families participated in **Nuestras Familias.** Families comprised two distinct groups: Mothers diagnosed with HIV/AIDS (24%); mothers impacted with substance abuse (76%). The majority of women with a diagnosis of HIV/AIDS had migrated from Mexico and were low acculturated, 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 first and second generation Latinas. However, a shift was developing with an increasing immigrant population. 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, post traumatic stress disorder and isolation. A number of socioeconomic, cultural and health related factors negatively affected their quality of life including emotional and mental well being.

**Nuestras Familias** approach was supported by the project’s evaluation findings. 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 impacted women experienced improved psychological and physical well-being while maintaining their sobriety.

**Nuestras Familias** was effective in accessing health care for HIV/AIDS and substance abuse women and their children through a strong collaborative network. Although resources are limited in Orange County medical access was 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. 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, post traumatic stress levels, 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. The incidence of child abuse and neglect significantly decreased during program involvement. Benefits in psychological functioning were also noted for the siblings of the index children. Families became stable through intensive therapy, substance abuse counseling, HIV health education, case management, group interventions and home based interventions. Supporting parents assisted them in coping with family stressors and improved their child’s well-being and safety.

I. Goals and Objectives

LFI developed Nuestras Familias to meet the goals set forth by the Administration for Children’s & Families in the Abandoned Infants Assistance Act. The project was designed to prevent the abandonment of infants whose parents are diagnosed with HIV/AIDS or who have a history of substance abuse.

**Goals**

- **Goal 1:** To ensure permanency, safety and prevent the abandonment of HIV and or/ substance abuse affected children.  
- **Goal 2:** To improve the developmental, psychological and emotional well-being of the young infants and children.  
- **Goal 3:** To develop an evidence-based model that can be replicated by other programs.

**Outcome Objectives:**

1. prevent abandonment of infants/young children exposed to HIV and or/ substance abuse;  
2. achieve abstinence from drugs/alcohol;  
3. improve health and mental health outcomes;  
4. decrease stressors;  
5. increase knowledge of health promoting practices, treatment protocols and risk reduction for perinatally exposed children;  
6. improve child developmental and health outcomes;  
7. improve parent/child relationships;  
8. replicate and adapt an evidence-based model of service delivery;  
9. increase knowledge among 250 health and child welfare professionals.

**Expected outcomes are:** to maintain at-risk infants/children in their own homes or those of relatives; to provide children with a safe and stable environment; build healthy relationships and a sense of home, family and security; reduce parental and environmental stress; identify and formally legalize a future plan for HIV affected children; increase voluntary use of community resources; decrease use of drugs and / or alcohol; increase participants’ social support systems; strengthen family’s ability to become self-sufficient; and, disseminate professional findings.

Chart 1: Index child at Termination
II. Program Design and Services

*Replication and Adaptation of Project Milagro Model*

*Nuestras Familias* Abandoned Infants Assistance (AIA) Project proposed to replicate the evidence-based Project Milagro model developed, implemented, and evaluated by Bienvenidos Children’s Center, which from 1992 to 2008 provided AIA services to Latino families in East Los Angeles. During a four-year period, Nuestras Familias Project successfully replicated core elements of the Project Milagro service model, evaluation design, and data collection plan; however, the service model was significantly modified and enhanced to better address the unique needs of families in the Santa Ana and surrounding cities in Orange County and ensure culturally competent services.

Throughout its four years, the Nuestras Familias Project evolved, tailoring the service model to respond more effectively to the needs of the community and to the collaborative network. A strong partnership with the Orange County Department of Public Health Perinatal Assessment and Coordination Team (ACT) extended the target population to pregnant women and young mothers with newborns, most with histories of substance abuse, forming a different population than the Project Milagro model. Consequently, Nuestras Familias Project adapted its services to a more comprehensive clinical emphasis, with supportive interventions appropriate for this population.

The agency contracted with consultant and evaluator Barbara Kappos, Project Director for Bienvenidos AIA Project from 1992 to 2007, and Dr. Martha Cristo, Project Evaluator for Bienvenidos AIA Project from 1999 to 2008, to provide ongoing support to replicate the Project Milagros model.

Key challenges in implementing the evidence-based Project Milagro model while maintaining its integrity were ensuring cultural responsiveness and addressing critical community factors. The Project Milagro model was selected in part because of its cultural appropriateness, which was recognized as critical; however after the Nuestras Familias program was initiated the external and systemic differences between the model and program community, described above, required the model to be adapted. Although both core intervention components and core implementation components were modified in order to adapt to a new community and new partnerships that were responsive the target population. The evaluation was not attenuated, and the project maintained the fidelity of the Project Milagro model. The evaluation (discussed in the evaluation section) of the Nuestras Familias AIA project replicated the Project Milagro’s methodology, design and instrumentation. The current evaluation captured the implementation of the Nuestras Familias replication model, its strengths and weaknesses; successful and unsuccessful strategies; and the culturally competent practices for evaluating Latino families. In this project, the lead evaluator worked closely with project staff to assess progress; identify barriers and challenges; and assist with data collection protocols and instrumentation.

**Latino Family Institute** used a multidisciplinary, inter-organizational, culturally responsive approach to provide comprehensive services to mothers and families of infants and young...
children at risk of being abandoned. Nuestras Familias was built on Bienvenidos’ Project Milagros and influenced by AIA Best Practices (AIA Best Practices: Lessons Learned from a Decade of Service to Children and Families Affected by HIV and Substance Abuse (2003)). Nuestras Familias embraced and integrated the conviction that the child’s family is the most likely entity to provide a continuity of care-giving relationships, a sense of safety, and the consistent nurturing upon which healthy child development depends. The program also incorporated key frameworks and strategies of AIA programs:

- careful risk assessments that reflect an understanding of the physical, psychological, cognitive and emotional needs of infants and children;
- development of a therapeutic alliance between the family and service providers, built upon mutual trust and respect;
- identification of parental strengths and a willingness to build upon them;
- active involvement of parents in treatment planning and goal setting;
- comprehensive, individualized treatment plans for family members;
- strong interagency and interdisciplinary collaboration;
- flexibility in service provision;
- trained, well supervised, and supported staff members;
- and home-based, nonjudgmental intervention strategies that are barrier free and culturally competent.

The project also drew upon the relational model of women’s psychological development to help staff build effective relationships with their clients and initiate change. The relational model uses a comprehensive array of services to help women build positive, fulfilling relationships and decreases a sense of isolation. Services include community outreach, assessment, crisis intervention, trauma-specific counseling, ongoing treatment, parent-skills training, resource coordination, advocacy, and peer support.

Nuestras Familias helped families to identify their internal resources and provided external resources and supports to further strengthen families’ capacities to effectively raise their children, in spite of the myriad problems the families faced. The strong emphasis on helping families identify their strengths was a key example of the emphasis on family resiliency.

**Cultural Competency**

Orange County is a point of entry which borders Mexico. For this reason a large majority (48 %) of the project families were immigrants from Mexico and Central America including Honduras, Panama, and Guatemala. Many of the women had histories of trauma as a result of their migration experience which included; sexual assault, domestic violence and childhood sexual abuse, physical and emotional abuse. All of the women living with HIV/AIDS were foreign born and immigrated into the United States with varying levels of acculturation.
Nuestras Familias integrated LFI’s overall service philosophy which recognizes organizational and culturally based barriers impacting service delivery to Latino families. The model focused on providing services that are congruent to universal Latino values that include the values of respect, personal connections, spirituality, gender roles/expectations, strong work ethic and family celebrations. Special emphasis was placed on how a person’s level of acculturation impacts the integration of these values into their belief system.

Chart 2: Acculturation HAlSA

Main issues of concern primarily revolved around the issues of substance abuse, HIV/AIDS, domestic violence, histories of child sexual abuse, delivery of healthy babies, and receiving mental health services. While in general the project’s families’ levels of acculturation in both groups differed, there were also many similarities. The HIV/AIDS group was primarily families who recently arrived from Mexico. Also their referral source was quite different. They were referred from the clinics and HIV/AIDS providers. Substance abuse impacted families were primarily referred through the public health nurses that provided targeted case management to pregnant women with histories of substance abuse. This allowed our project to offer early prenatal and postnatal interventions and substance abuse counseling. However, both groups identified with their Mexican heritage and the values of family, traditions, cultural celebrations and spiritually.

Critical cultural factors the project considered when working with low acculturated Latina women was parent education in relation to the United States child welfare system and child safety laws. Since there are specific laws governing the safety and the well-being of children in the U.S. the families had to be educated about what was considered abuse or neglect of children for preventative measures. Families were also given information about the county’s services and their authority to investigate families if warranted. Families were provided with information about appropriate parent discipline especially as it related to understanding the concepts of corporal punishment and discipline practices that could be interpreted as abusive or placing children in danger.

Due to families limited incomes many of the project women lived with extended family members or shared housing with others who were non-family members in close living quarters. They rented either a bedroom, living room, motel room or garage space often times with very little privacy. Because of these types of close living quarters, families and children were potentially placed at risk for exposure to sexual abuse, substance abuse, domestic violence, and contact with a significant number of unrelated adults in the homes they shared with their children. At times these circumstances resulted in families moving multiple times throughout the project period. In one case a family comprised of both parents and two minor children moved five times in a period of less than ten months as a result of conflicts arising with people they rented from. Again project staff was mindful of family circumstances, but at the same time interventions were
focused on improving understanding of their dynamics and helping families develop appropriate boundaries.

The high value placed on personal connections, family celebrations and spirituality was integrated in the project's Cultural Structured Family Activities. The project sponsored a variety of different events to bring families together and increase their sense of community connections. One event that was most significant and unique was the project's Day of the Dead Celebration (Dia De Los Muertos). The event was planned each year at the beginning of November close to the customary holiday where the dead are honored by making and decorating traditional Mexican sugar skulls. This celebration was successful in bringing families together and helped facilitate the concepts of death, grief and loss. Families were formed into different groups based upon language and age. The therapists facilitated the process which honored their values and beliefs about death while the families were creative in decorating their sugar skulls.

Nuestras Familias participants received a culturally competent assessment that used cultural values as strengths of the family and integrated their life journey as a pertinent determining factor in the intervention methods. Nuestras Familias gave hope and enhanced the quality of life among Latina women, their children, their families and communities by providing trusted and confidential resources in a manner that respected cultural traditions and sensitivities. The program's focus was to create safe and stable environments and a better quality of life for women and children impacted by HIV/AIDS and Substance Abuse.

**Program Services**

After an initial referral was made, all families were thoroughly assessed and screened in their home by the Program Director. 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 Director completed the following baseline measures during the initial session: LFI Intake Interview; Parent/Child Risk Factor Survey- This is a 25 item checklist that identified parent risk factors and child risk factors based on current stressors, problems and past experiences; Family Assessment Form (FAF) - The form provided a standardized assessment of family functioning and service planning for families; Developmental Profile II, a child development standardized measure that assessed physical, self-help, cognitive, language and social development for children ages 3 months to 10 years old; Medical Access Form; 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; Parent Stress Index Survey – This survey assessed life stress, parenting efficacy, parenting stress, parent-child bond and child behaviors; Health Related Quality of Life – This self-report tool provides perceived level of quality of life using 15 indicators of physical, emotional, psychological and mental well-being for individuals dealing with a health condition. After enrollment, the Project Director assigned the case to the team (either substance abuse or HIV/AIDS team) for further assessment and service planning.

**Intake and Assessment** - The Intake process was administered by the Program Director. The Intake Form elicited information describing client demographics; safety risk assessment; history of substance abuse; risk of child abuse, neglect and abandonment; child developmental and emotional risk factors; potential supports or resources within the family and community; health status; HIV status; history of violence within the family of origin, their self, partner and with
their children; the need and use of social and health services; job and education assessment; and their willingness to accept help. The intake and assessment information established the baseline against which client progress was measured.

The project provided home-based, family focused, supportive services to the families. The families received services for twelve months and in some cases extended for 18 months. The project utilized a team approach consisting of a Therapist, Substance Abuse Counselor or HIV Specialist and Parent Educator. The team offered clinical and family support, enhanced parenting skills, provided education and prevention services, assisted with permanency planning process for families living with HIV, linked families to appropriate services, and supported the family case plan. Limited supports and isolation often increased the family’s dependence.

Within the team approach the families received individualized home-based health education offered by the two counselors. 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 medical provider. The women from the substance abuse group also received home-based health education offered by their substance abuse counselor. Health education addressed the importance of health check-ups, safe-sex practices as well as nutrition and exercise. In addition, the substance abuse counselor provided counseling and relapse prevention skills. Education focused on reducing the risk of HIV transmission was offered to couples and families.

Families in need of intensive counseling were linked to the therapist who was bilingual (Spanish/English). The therapist was instrumental in treating women who reported post partum disorder, depression, mood disorders, anxiety related to post-traumatic stress, and other mental health issues. Children in need of mental health services were also linked to local mental health providers. Home-based mental health services were offered to families with limited resources, and identified as the highest risk. In addition to the intensive home-based services aimed at promoting safety, stability and permanency, center-based therapeutic groups were offered to project participants facilitated by licensed therapist.

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

**Enhancement of Program through Center Based Activities - Group Therapy** - Two types of group therapy was provided: one for mothers infected or affected with HIV/AIDS and one for mothers who had histories of drugs and alcohol. The rationale for two groups was that each set had unique issues and concerns about stigmas, their own mortality and permanency, and issues of trauma and acculturation. The groups were facilitated by licensed therapist and the Substance Abuse Counselor and HIV specialist. The groups met weekly and were open-ended. Therapy Groups provided a safe, non-threatening environment for participants to explore their issues and concerns. Groups enabled participants to engage in mutual support, problem solving, and shared successes. Groups helped to enhance participants’ natural support networks.

Majority of participants experienced trauma, including physical and sexual abuse, domestic violence; and, some will have experienced post partum depression. For this reason the project integrated A Window Between Worlds, a healing program that enables women to explore and release their emotions in a neutral environment through the arts.
Structured Family Activities – These activities convened several times a year to enable families to engage in fun activities with their children, in order to promote parent-child bonding. The activities will also enable participating families to experience camaraderie with others who are experiencing similar problems and help process feelings of isolation.

“Mommy and Me” group for project women and children. The activities focused on supporting positive attachments to their young children through age appropriate play, nursery rhymes, baby massages, and group role plays. Participants were also able to develop positive connections to one another helping to decrease their sense of isolation and expanding their support systems. The group was lead by project’s parent educator who was certified in the evidenced based Nurturing Parent Program. Families were also provided with educational toys for their children to keep and support age appropriate expectations and reinforce the importance of early intervention.

LFI staff saw the need to provide educational trainings related to HIV/AIDS and sex education among the teens of clients. LFI provided 6 Support Group Meetings for the teens of clients. Originally the meetings were meant to be trainings, but upon assessment the staff saw the need for a public forum where the teens can share their issues related to communication with family members, sex education, and school issues. Since the Teen Support Group was not a requirement or goal of the original grant and because of the large time element involved with the group it was terminated with the hope that other funding could be evaluated to host this group. The decision was also based on the fact that all of the teens involved were participating in counseling services with us.

Families affected by Substance Abuse

The project served (309) children, 76% affected by substance abuse and 24% affected by HIV/AIDS. The most frequent risk factor reported was poor or limited parenting skills (89%), followed by history of childhood abuse (81%); 65% reported past or current domestic abuse. Marital discord impacted these families, 67% reported significant conflicts with partners. Overall, risk factors were improved by 28% at termination for this group. In particular, fewer risk factors were reported compared to baseline (program entry). Families were less likely to experience substance abuse and domestic violence. These improvements were due to the program’s services targeting marital relationships and conflict resolution. In addition, substance abuse interventions, group therapy and parenting skills were provided to this group.

The women enrolled in the program for the past four years were poor and living under the poverty level. The yearly mean income was $17,236 and 83% reported that they were unemployed and living on government financial assistance. Among the Substance Abuse Latinas, 80% were Mexican American, first generation to third generation (52%) and born in the United States. This group also reported migrating primarily from Mexico (48%) to the United States as children. The mean number of years in the U.S. was 19 years (for non-U.S. born). The majority was bilingual in English and Spanish; 28% were primarily Spanish speaking and 6% were English speaking only.
The mothers with histories of substance abuse generally had not participated in recovery programs. They stopped using drugs and alcohol during their pregnancies but had not sought formal recovery services. As a result, the potential for relapse was very high and for child neglect and abandonment. Since ACT was referring women who are pregnant or have recently given birth, the ages of the majority of the children are 0 to 3 years old, with the mean age being 9 months. Of the substance abusing group, 34% were pregnant at enrollment and 20% of index children were born after program entry. These women had not fully accepted that their use of drugs and alcohol may have a negative impact on their capacities to parent their young children. The majority of the substance abusers used methamphetamines. Most had not dealt appropriately with the issues underlying their substance abuse. The mean age for the substance abusing mothers was 24.8 years, 45% of women resided with partners living with alcohol or drug abuse; 53% of the women were either married (16%) or living with a domestic partner (37%) and 37% were single mothers (10% separated).

Home-based interventions aimed at decreasing the identified risk factors were successful in reducing child placement into the foster care system. The substance abuse counselor provided individualized in-home counseling and education utilizing Covington’s Substance Abuse Treatment Curriculum. The Parenting Educator helped mothers adapt appropriate parenting, and problem solving techniques by providing the Nurturing Program both in the home and at the center. Mental Health services and increased parental support were provided by a Master’s level Therapist. In addition, to these service supportive services improved living conditions, increased access to financial resources and medical care had a positive impact on reduced parental stress and thus reducing the risk of child abuse. The ACT nurse was especially important for she visited the home and accompanied parents to medical appointments to ensure that the mother understood the importance of their child’s health.

A Case Illustration of a Young Mother. Tiffanie was a single teen mother caring for a six month baby girl. Her childhood was difficult for she was involved in violent relationships and she was incarcerated while Tiffanie was very young resulting in her entering the foster care system. After her emancipation she was homeless and moved from shelter to shelter. She had a history of substance use and was diagnosed with bipolar. At the time of enrollment she was temporarily living with a family she met from her church. During her intake Tiffanie reported a lack of bonding and attachment with her daughter and resentment of having to deal with the responsibilities of being a parent. The family was helpful, but eventually asked her to move out for she is did not follow the rules. Tiffanie wasn’t adherent to her meds and continued engaging in social drinking and taking methamphetamines. She was unstable and not focused on her child. Upon referral, Tiffanie expressed mistrust towards the agency and was reluctant to receiving in home support. She was assigned a therapist she was able to connect with her and accompanied her to her psychiatric appointments where she went back on her meds. Later the Parent Educator was able to incorporate the Nurturing Program to help build a better bond with her child. She also participated in the Therapeutic healing group on a weekly basis and either her therapist or substance abuse counselor worker would provide transportation to and from the group. These interventions led to reduced maternal stress, decreased psychotic symptoms and increased level of functioning. After receiving a year of services, Tiffanie reported a positive attitude towards her role as a mother and eliminated her substance use. Tiffanie is currently married and pregnant with her second child. She became more trusting of others and stabilized her home environment.

Mental Health Services for Families Affected by Substance Abuse
The vast majority of the families from the substance abuse reported experiencing some form 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. Additionally, a majority of participations reported feelings of depression, post partum depression, anxiety and several participants were diagnosed with bi-polar disorder and under the care of a psychiatrist. Home-based and group mental health therapy was provided to a total of 75 women from the substance abuse group who were in need of more intensive counseling. The therapist addressed internalized feelings of guilt, shame, isolation, and anger. Sessions focused on healing, re-building trust, communication, re-attachments and learning to adjust to a sober way of living were provided. In addition, the therapist provided family counseling to these women and provided them with an opportunity to express and cope with their feelings of resentments abandonment and mistrust.

The project successfully implemented a center based program with a Substance Abuse Recovery and Healing Group that enrolled 40 women. Women enrolled in the group were supported by achieving sobriety, healing from trauma, improving family relations, and expanding natural support networks. The Substance Abuse Recovery and Healing Group was offered to women in the program who were impacted by substance abuse in both Spanish and English. A licensed therapist and Substance Abuse Counselor facilitated the groups. Classes covered the following topics: drug and alcohol education, relapse prevention, cycle of violence, power and control, co-dependency, self-esteem, hope, growth and trust, making connections, communication, confrontation and problem solving, managing stress, anger management, and safety and protecting children. The classes met once a week for 2 hours.

The project also integrated A Window Between Worlds, a healing program that enables women to explore and release their emotions in a neutral environment through the arts. Facilitators had been trained by the A Windows between Worlds Trainer. The program promoted stress reduction, raised self-esteem, and helped participants heal. The program was gender specific, and it was culturally sensitive and offered in both English and Spanish.

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<th>Chart 3: Program Participants</th>
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Families affected by HIV/AIDS

A study reporting interview 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 (Ibid.)

The mean age for HIV/AIDS (HA) mothers was 34 years. The mean years of education for the HA participants was 9.4 and approximately 25% had no formal education. Income levels were
obtained for 90% of the sample and showed that the majority of families were poor and living well below federal poverty levels. The yearly mean income was $12,312 for HA families. Most of the families, 76% were not formally employed although 18% stated current full-time employment and 6% reported part-time work. Overall, participants' occupations included day labor, domestic services and retail sales. Two thirds of families resided with other adult family members and were dependent on multiple incomes.

Problems faced by families affected by HIV/AIDS are often overwhelming. HIV infection coupled with other factors such as poverty, isolation, housing instability, joblessness, low acculturation, and mental illness inhibit 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 disappear, often due to discrimination and ignorance, often due to separations resulting from immigration. Nuestras Familias' services played a key role in strengthening support to these women and their families and in ensuring that their basic needs were met. Specialized strategies focused on enhancing the quality of lives of the families were implemented. Culturally sensitive interventions offered by an inter-disciplinary team approach consisting of a HIV Specialist, Parent Educator, and Therapist were instrumental in improving health and mental health outcomes for the sample served.

Enhancing the Quality of Life: Mental Health Interventions

Meeting the mental health needs of families affected by HIV/AIDS required specialized attention and training. The challenges faced by the women living with HIV/AIDS were unique due to a number of factors. On an average, psychosocial baseline data indicated that these women were low acculturated, poor (88.9%), isolated (90.7%), and suffering from physical or mental impairments (85.2%). The women reported mode of transmission of HIV/AIDS was through heterosexual transmission, behaviors of their partners rather than their own. The news of an HIV/AIDS diagnosis as well as the possibility of marital infidelity posed a threat to the emotional well being of the women and their children. In addition, the issues associated with progressive HIV infection in a parent were particularly complex as each different stage of HIV illness — diagnosis, illness progression, late-stage illness, death, and family configuration— presented a different challenge. Upon diagnosis and often throughout the course of illness, parents must confront issues of disclosure of their HIV status to children, adolescents, and extended family. In addition, the realities of planning for future care of their children often increased their feelings of despair. Home-based mental health was instrumental in the processing of these emotions.

Baseline data reflected that children affected by HIV/AIDS were considerably "at risk" due to maternal reports of psychological distress and depressive mood symptoms. Several parents' struggled with disclosure of their HIV status to their children. With progression of parental HIV illness, children and teenagers often witnessed the physical and mental deterioration of their parents' and were often forced to cope with these changes in the absence of clear information about their parent’s health status. In several cases, the parents informed their children of being ill to other illnesses such as cancer or diabetes rather than HIV/AIDS. The mental health counselor was instrumental in addressing disclosure issues with the parents, while offering support and guidance.
A circle of support was also provided to women who were HIV positive women. The group was facilitated by a therapist and a HIV specialist. Over 20 women enrolled in the group and were provided with therapeutic interventions, education and resources and linkages.

<table>
<thead>
<tr>
<th>A Case Illustration of a Mother’s Inner Strength</th>
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<tbody>
<tr>
<td>Maria, age twenty nine, shares her home with her twenty nine year old partner Jose and their five year old son. Maria learned of her HIV status during her routine pregnancy exam. Her partner was tested shortly thereafter and also learned of his positive status. The couple separated for one year following the initial diagnosis. Maria took medications throughout her pregnancy to minimize the risk to her child. Their son was also treated for quite some time after his birth and tested negative. Jose acknowledges that learning of his positive status did not deter him from continued drug abuse or consistent medical care. Jose’s disease progressed to AIDS and neurological testing confirmed brain lesions. These brain lesions caused disorientation and mood swings which vacillated from laughing to crying episodes. It also appeared that Jose was reacting to internal stimuli. At the time of intake, he appeared lethargic, needing help to walk, and exhibited uncontrolled mood swings. Jose had been hospitalized on three separate occasions for several days. Prior to his hospitalizations he was working full time in construction. Maria reported that she had not been prescribed medication for her status in over two years. The couple was experiencing: lack of understanding of their HIV/AIDS diagnosis, marital difficulties, challenges in their parenting and their son was exhibiting anxious behavior. Maria also reported feelings of extreme shame, anger, depression and isolation. Family obtained supportive case management by HIV counselor to address pressing medical issues, couples and individual counseling, parent education, developmental assessments for their son, school advocacy and referrals for basic needs. Maria also attended the therapeutic HIV support group and developed a network of friends to counter her original sense of isolation. At the time of the case closure Maria expressed having a sense of renewed hope, no longer feeling that her HIV status was a “burden to carry” but rather an opportunity to share with others to prevent further transmission. She gained a sense of confidence, became more active in her medical care, requested that she be placed on antiviral medications and expressed her willingness to become a parent leader. She reported less marital conflicts and increased positive interactions. Their son’s anxious behaviors were eliminated through the support of project staff and collateral referrals. With closer medical supervision, Jose’s brain lesions improved, his mood stabilized and he was in the process of resuming his work schedule.</td>
</tr>
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</table>

Promoting Safety and Permanency for Children

Treating Pregnant Women Substance Abuse

In efforts to reduce the risk of infant abandonment, the project strengthened its collaboration with ACT and targeted at-risk pregnant women with a history of substance abuse. Barriers related to denial, mental health issues, lack of support system and fear of being were addressed in the efforts to engage the mother and for them to accept services. Specialized strategies promoting sobriety and well-being in women who were pregnant as well as prevention of infant abandonment were implemented.

During the four years, the project served a total of 34 pregnant women (all a part of the substance abuse 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 “historical risk factors” of the mother such as; previous history of substance abuse, history of domestic violence and parental stress. In addition, current “risk factors” such as, mental health issues, partner discord, isolation, poverty, unemployment, and substandard housing conditions further increased the risks. Nuestras Familias comprehensive approach and health services provided by the public nurses
addressed the risk factors in each of these families in efforts to maximize a stable and normal pregnancy and promote a healthy home environment. Specialized strategies were implemented to prevent relapse, enhance healthy behaviors, and promote bonding, nurturing and child-well-being. 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. The DPII measure was utilized to assess the infant's development (refer to evaluation section). Staff utilized the findings to design specialized interventions focused on enhancing child development and growth of the index child. Also, the project ensured that all mothers were linked to prenatal care, perinatal substance abuse treatment, and access to entitlements (Medi-Cal) in efforts to increase access to health services. Basic needs of these families were assessed and met through the collaborative network and donations (i.e.; food and shelter).

A Case Illustration of the Project's Success in Strengthening Mother-Child Relationship

Angie a single pregnant mother who also cared for her 5 year old son diagnosed with ADHD. Angie had a history of substance abuse, domestic violence, incarceration, and previous charges of child endangerment. Angie reported experiencing molestation and physical abuse as a child. At intake, Angie reported current stressors related to domestic violence with the father of her children. Upon referral, Angie expressed mistrust in the agency and reluctance in receiving home-based and participating in the healing group. Eventually, the Substance Abuse Counselor assigned to the case was able to connect with the mother and address 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 attended the weekly Healing Group for women impacted by substance abuse. Shortly, after receiving services, she gave birth to her second child and the mother reported increased positive attitude towards her role as a mother and enhanced coping skills in caring for a child with special needs. The minors remained in the care of their mother while she left her abusive relationship and the risk for child abuse was reduced.

III. 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:

On March 10, 2006- LFI co-sponsored with Delhi's (county AIDS Provider) a “National Latina Women’s HIV/AIDS Awareness Conference.” LFI had the opportunity to share program resources and meet prospective families that were targeted for the project.

LFI celebrated its official Open House in September 2006. A representative of Congresswoman’s Loretta Sanchez office was in attendance as well as over 75 representatives of City Officials and neighboring agencies. Lunch was served; tours and presentations of the agency were given. A neighborhood magazine - DOT featured a story on our open house and program services.

LFI and Delhi presented a collaborative workshop at a community forum on April 29, 2006. The workshop included presentations by the Project Director and Project Supervisor on Depression and HIV/AIDS. LFI helped to sponsor the event. Close to forty people attended the forum.
On October 18, 2006 - LFI presented its first in a seminar series “How to Discipline your Child Effectively.” The event took place at the Delhi Center in Santa Ana. LFI’s Clinical consultant Dimas Moncada, LCSW presented. Close to 50 families were in attendance. Child care was provided by a licensed child care provider.

On November 9, 2006 - HIV Specialist gave a class presentation in HIV Education at Fullerton College. 30 students were in attendance.

On January 17, 2007 - LFI presented a third seminar in its seminar series at Delhi Center in Santa Ana. Alejandro Sanchez, MD presented on “Living with HIV.” 30 families were in attendance. Child care was provided.

On June 7 & 8, 2007 - Project Administrator and Project Director attended AIA Conference in Berkeley, California. Executive Director, Project Director and Project Evaluator presented on “Challenges Working with Communities of Color” where a discussion took place among other AIA Projects. A total of fifteen people participated. LFI also participated in the Call to Posters presentation and shared significant data in relation to the project. LFI also composed a photo album of pictures from past cultural and seasonal events and shared it at the presentation and poster presentation.

February 29, 2008 - LFI sponsored a training led by Clinical Supervisor Dimas Moncada, Jr. titled Addressing Ethical Dilemmas in an Era of Complex Practice Issues: HIV/AIDS as a Case Study. Mr. Moncada is a HIV/AIDS Spectrum project trainer for the National Association of Social Workers and led the training based upon one of two curriculums. The goals of the training were to identify principles in making an ethical decision, understanding culturally competent practices throughout the process, and understanding the roles of consultation and documentation. 64 professionals were in attendance and the training facility was provided by the HIV Planning and Coordination Team.

March 12–14, 2008 - Nuestras Familias project staff and consultants participated in Strengthening Connections Conference in San Francisco, CA. The team presented on Immigrant Latina Women & the Mother Child Bond. Based upon significant findings on the project in relation to the Parenting Stress Index the presentation focused on the cultural context of Latino families receiving in-home services and the personal, political and cultural barriers encountered. In attendance were 30 participants.

March 26, 2008 - Project Director led a presentation on Spirituality related to HIV/AIDS to HIV/AIDS support group at AIDS Services Foundation in Irvine, CA. 24 were in attendance of the presentation and were also presented with outcomes of the services NF provides.

August 5, 2008 - Engaging Families in Culturally Appropriate Family Structured Activities at Children’s Bureau Grantees Meeting in Washington DC by Project Administrator – Maria Quintanilla, LCSW , Project Evaluator – Martha Cristo, Ph.D. and Project Director Andy Encinas MFTI. The presentation focused on how the program has integrated into its service delivery a traditional Latino holiday (Day of the Dead) as a tool to introduce to program participants to the theme of grief and loss. Agency has created an annual family structured activity where participants decorate sugar skulls in honor of someone who has died. At the conference the team modeled the decoration of the sugar skulls while processing Grief & Loss issues with the participants.
April 30, 2008 – Project consultants, Barbara Kappos LCSW and Dimas Moncada, LCSW presented in two separate panel presentation workshops. The first panel addressed Cultural Barriers working with HIV/AIDS populations and the second panel topic discussed Case Management Issues related to HIV/AIDS.

April 29, 2009- Participation in HIV/AIDS on the Frontline Conference in Anaheim, CA. Clinical Supervisor Dimas Moncada, LCSW presented on HIV in the Latino Community. LFI staff will served as volunteers for the conference and sponsored a booth for outreach.

Nuestras Familias submitted an article abstract, and it was accepted for Fall 2009 AIA Source issue. Title: Barriers to HIV/AIDS Disclosure for Mexican Mothers: Examining the Impact of Gender Roles, Religion and Cultural Ideals
Authors: Martha Cristo, PhD, Maria Quintanilla, LCSW, Barbara Kappos, LCSW, and Andy Encinas, MFT Intern
Latino Family Institute, AIA Project: Nuestras Familias, Santa Ana, CA

IV. Staff Development

Staff development and trainings was an essential element of Nuestras Familias. 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 UC Irvine, Rite AIDE Pharmacy, AIDS Foundation and ACT 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 supervisor, weekly case presentation/review meetings supervised by the Clinical Consultant and supervisor, 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 Director received supervision by the Agency Executive Director twice a month.

Project staff participated in a variety of trainings throughout the project period most of these trainings were facilitated by Dimas Moncada, LCSW on a monthly basis. The following are a list of trainings conducted by Mr. Moncada; Crisis Intervention and Risk Management, case management for HIV/AIDS clients and substance abuse clients, End of Life/Grief and Loss Issues/Disclosure in relation to HIV/AIDS, Treatment Plans/Case Conferencing, Service Provider Burn Out, Motivational Interviewing, Harm Reduction, Addressing Teen Issues related to communication, socio-economic, sexual development and sense of community. Supportive Group Dynamics, Post Partum Depression, Prenatal Methamphetamine Exposure & Child Outcomes, Couple Dynamics, Working with High Risk Populations, Using a Multidisciplinary Approach, Transference & Counter-transference among clients, Disclosure of HIV/AIDS issues, and Trauma related to HIV/AIDS & Substance Abuse. Mr. Moncada also provided monthly clinical case conferencing and clinical supervision.
Additional training conducted by collaborators and agency consultants included:


The Project Staff attended the AIA "Many Approaches, One Voice" Conference in Berkeley, CA on June 5 – 8, 2006. Staff participated in the conferences as well as created a poster for the agency to display for the Call to Poster session. The conference offered many opportunities for dialogue and support among other AIA Projects. LFI made use of the available training funds to attend the conference. Project Staff traveled to Concord after the conference to meet and consult with the Director and Supervisor of Families First, another AIA Project. Families First gave a tour and presentation of the services they provide. This visit gave LFI’s Staff a better idea of an established working AIA model.

June 12, 2006 LFI staff attended a POZ Seminar at the San Diego Lesbian, Gay, Bisexual, Transgender Center in San Diego, California. The seminar addressed the relationship between HIV/AIDS patients and their doctors. A panel of several people living with HIV/AIDS shared their experiences of how to address issues with doctors. Two doctors were also part of the panel who shared their experiences as well.

June 22, 2006 LFI staff attended Bienvenidos Training on Substance Abusing Women and Psychological Issues presented by Lourdes Carranza, MSW – Project Coordinator and Dr. Cristo, PhD, -Project Evaluator.

July 12, 2006 LFI staff met with Dr. Cristo for Data Training. Dr. Cristo discussed the inclusion criteria for enrollment into the program as well as program evaluation, consent forms, research questions, evaluation design, process variables, data collection and protocols. A second date was reserved for more training.

October 27, 2006 LFI staff was trained by Dr. Alejandro Sanchez on HIV/AIDS in the West Covina office. Dr. Sanchez discussed basic HIV terms, biology, and epidemiology in the Latino population, treatment, opportunistic infections and patient testimonials.

On November 17, 2006 LFI staff attended an HIV/AIDS training given by Alejandro Sanchez, MD. Dr. Sanchez focused his presentation on the cultural impact of medical compliance of Latinos affected or impacted by HIV/AIDS.

On February 7, 2007 LFI staff received training on "Illegal Drugs in Relation to HIV/AIDS" by Alejandro Sanchez, MD at the West Covina office. Dr. Sanchez discussed how methamphetamine is the number one drug of choice for most people. He also talked about the effects of medical marijuana on the chronically ill.
On April 13, 2007 Project Coordinator Lourdes Carranza from Project Milagro – Bienvenidos delivered a training on Permanency Planning to LFI staff. The training was based upon Ms. Carranza’s experience of delivering services to clients in East Los Angeles. LFI staff will access the need for Permanency Planning with clients and sensitively discuss options with them.


On September 28, 2007 Project Consultant Barbara Kappos and Project Evaluator Dr. Cristo led the training to LFI staff titled “Home Based Model and Team Building.” The training discussed the history of home based models and covered the elements of successful home visitation programs including, trust, encouragement to parents, helping families connect with community resources, modeling healthy teaching and parenting behaviors, advocating for and with families and conducting a comprehensive evaluation of program interventions to determine the effectiveness of the program.

Dr. Sanchez training discussed universal precautions in regards to people living with HIV/AIDS. He also talked about the precautions that should be taken to lessen the exposure risk of babies being delivered by HIV positive women.

Dr. Alejandro Sanchez provided the training to staff and collaborators on Nutritional Issues related to the Immune System and HIV/AIDS. Dr. Sanchez also addressed HIV/AIDS related to women’s health and pregnancy.

V. Collaborative Partners

*Nuestras Familias* was successful in establishing and fostering effective partnerships with Substance Abuse and HIV/AIDS service providers. Since the program addressed all of the families’ life issues, many additional systems were critical to comprehensive service delivery. Strong collaborations with HIV/AIDS services providers, Substance Abuse Treatment agencies, Legal Service Centers, and other Community Based Agencies were developed throughout the four years of funding (attachment D). These agencies recognized *Nuestras Familias*’ unique service model and identified it as a crucial resource in the substance abuse and HIV/AIDS community.

LFI formed a consortium of public and private health and social services organizations, participated in Ryan White Planning Councils in Orange County, and formed a strong partnership with the Orange County, Department of Public Health, Perinatal Assessment and Coordination Team (ACT) which provides medical assessments and in-home services to new mothers at high risk for child abuse and neglect due to prior histories of substance abuse. ACT referred clients to LFI and participated in joint case planning and some home visits to targeted families.

The following organizations were also collaborative partners and engaged in cross referrals. *Nuestras Familias* had a solid collaborative with other HIV/AIDS providers that included, AIDS Services Foundation, 17th Street Clinic and Delhi. **County Social Services - Orange County**
Social Services located in Orange is responsible for providing a variety of services to dependent children in their foster care system. Domestic Violence - Minnie Street Family Resource Center, a nonprofit agency located in Santa Ana, provides a variety of services in both English and Spanish. Legal Assistance - Legal Aid Society of Orange County has locations in the cities of Santa Ana and Orange and provides bilingual legal advice, counseling and representation on civil matters to low-income individuals; legal forms preparation and filing; domestic violence clinics; legal resolutions; legal bankruptcy; and, community education.

Mental Health - Pacific Clinics/Mental Health, located in the city of Orange, provides Mental Health services to adults with severe and persistent mental illness. Providence Community Services offers child guidance services. Physical Health Services - UCI Family Health Center/Santa Ana Primary Care includes family medicine, obstetricians, and gynecology, pediatrics, dental, lab and pharmacy services St. Joseph’s Mobil Medical Unit/Santa Ana – Free health screenings, immunizations, diabetic testing and health education services. Substance Abuse - Familia Drug Court, Straight Talk, Phoenix House/Santa Ana, is a nonprofit agency that has 85 beds and residential and outpatient treatment program based on behavior modification for drug abuse. La Familia/Santa Ana, is a nonprofit agency serving the specializing in the Latino community for 15 years. Transitional Living HIV/AIDS & - Regina House is a residential center for women with children who are infected or affected by HIV/AIDS and or substance abuse. Supportive services include case management and support groups.

VI. Program Evaluation

Implementation

The evaluation of the Nuestras Familias AIA project replicated the Project Milagro’s methodology, design and instrumentation. The current evaluation captured the implementation of the Nuestras Familias replication model, its strengths and weaknesses; successful and unsuccessful strategies; and the culturally competent practices for evaluating Latino families. The evaluation’s implementation activities consisted of a series of staff trainings focused on data collection protocols, data management, scoring child focused tools and maintaining participant files. Emphasis was placed on adhering to the project’s evaluation plan and timeline. The evaluation team and project staff conducted meetings to discuss data collection issues and implementing the evaluation design. Staff was engaged in the data collection process and technical assistance was provided for completing instruments. The evaluation followed IRB and HIPAA guidelines by securing confidentiality of participants’ identifying information and data. The evaluation applied unique participant identification numbers, obtained signed consent forms for participants and the lead evaluator stored data files in locked cabinets. The evaluation team maintained ongoing data logs for tracking data collection activities and to monitor attrition rates. The evaluation completed the project’s data collection for the AIA Cross-site database and the Children’s Bureau protocol database. Nuestras Familias submitted electronic annual data for the 4 year-grant award period to the AIA Cross-site evaluation.

Evaluation Design

The overarching goal of the evaluation was to capture effective strategies that promote child safety and prevent child neglect, abuse or abandonment. Analogous to the Project Milagro model, the Nuestras Familias replication study evaluated the impact of HIV/AIDS or Substance
Abuse on a number of short and long-term outcomes among Latinas, pregnant women and children ages birth to six years old. Socio-demographic and socio-cultural variables were further examined in the context of culturally competent practices and assessment. Thus, the evaluation provided an enriched measurement of race/ethnicity that expanded general United States Census data, by acknowledging the importance of heterogeneous factors among Latinas. A pre- and post-test design was used to evaluate the efficacy of program services at different time points. Data was collected at program entry (baseline), six months (post-test) and program completion (post-test 12 months). As noted below, the evaluation maintained the fidelity of the Project Milagro model by replicating the evaluation design.

<table>
<thead>
<tr>
<th>Sample</th>
<th>Measurement Time Points</th>
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<tbody>
<tr>
<td>HIV/AIDS Latinas</td>
<td>N  O  X  O  X</td>
</tr>
<tr>
<td>Substance Abuse Latinas</td>
<td>O</td>
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<td></td>
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**Evaluation Instruments**

The evaluation instruments were administered in English or Spanish, and included face-to-face interviews and self-reported forms. Interviews were completed in participants’ homes and observations were utilized to complete child assessments. A list of the evaluation instruments is included in Appendix F.

*Nuestras Familias Intake*

This assessment contained open-ended questions on demographics such as marital status, number of children, income, employment and family composition. This form obtained cultural variables such as language spoken in the home, country of origin and years in the United States. The Intake provided a comprehensive assessment of service needs, presenting problems and child welfare involvement. The intake was obtained for each family using an interview format at program entry.

*Child Risk Factors & Developmental Screening Checklist*

The Child Risk Factor Survey, a 20 item checklist was used to identify experiences or events occurring within the last 12 months (current) and more than 1 year ago (past) that placed children “at high risk” for neglect, abuse and abandonment. The developmental screening assessed medical, emotional and behavioral functioning using history data, diagnosed conditions by a professional provider, parent input and project staff observations. Child risk assessments were conducted for the youngest child (newborns to 6 years old) of each family (index child) at baseline, post-6 months and post-test 12 months. Additionally, information on other minor children was obtained to adequately assess risk factors (among minors).

*Developmental Profile II*

The DPII is a standardized instrument and was used to evaluate developmental functioning levels in five critical areas of functioning: communication, motor skills (fine and gross), socialization,
self-help skills and cognitive development. The DPII yielded nominative scores in each of these domains and were compared with normative samples.

**Parent Risk Factor Checklist**

The Parent Risk Factor Survey was comprised of 40 items that listed events and experiences related to childhood mental health, psychosocial factors, family stability and economic stress. The nature and number of risk factors were used to identify "high risk" levels among program mothers and for some families, among partners. This form assessed recent events occurring during the past 12 months and events occurring over 12 months ago. Risk factors were assessed at baseline and only risk factors affected by change, were evaluated at 6-months and 12-months post-test.

**SAS-Hispanic Scale**

The Short Acculturation Scale - Hispanic (SASH) was utilized to assess level of acculturation among participants. This short 12-item scale taps into language preference and environmental-social practices within the Hispanic (Latino) culture. The SAS-H provided a linear score range from 1 (low acculturated) to 5 (highly acculturated) and was evaluated with comparable relevant socio-cultural variables such as language, country of origin, generation level and years in the United States.

**Health Interview Survey**

The Health Interview was developed by the evaluation and assessed health status for women with HIV/AIDS or Substance Abuse. For the Substance Abuse group, Health Interviews assessed level and history of alcohol/drug addiction; past substance abuse treatment and health problems. The HIV/AIDS Health Interview obtained information on HIV status: such as method of exposure to HIV or AIDS, symptoms, medication compliance, medication side effects and HIV/AIDS related illnesses including physical functioning.

**Medical Access**

This self-reported tool contained 11 items tapping into access to medical services, medical facilities and physicians. Levels of medical access were evaluated using a Likert response scale and a total linear score. This tool was administered at baseline, 6-month and 12-month post-test.

**CES-D**

The Center for Epidemiological Scale-Depression assessed depressive symptoms experienced during the past week. The score range for this measure was 0 to 60 with a score of 16 or higher indicating presence of depressive mood symptoms. Respondents completed this instrument at baseline, post-test 6 month and post-test 12 month assessments.

**Parent Stress Index**

The Parent Stress Index (long form) is a standardized instrument that measured levels of total life stress, parenting efficacy, parenting stress, parental distress, parent-child bond and child
behaviors. The PSI was used to examine the impact of the project's home base model on reducing parenting stress levels associated with child abuse. The evaluation conducted Cronbach reliability analysis for this instrument and obtained Alpha scores ranging from .72 to .89 for our current sample. The PSI contained a Likert response scale with item scores ranging from 1 - 5, with 5 meaning strongly agree. Scores were summed for each domain and ranged from 12 to 180. This tool was administered at baseline and post-test 12 months to biological mothers. The PSI short form version was used in the ALA Cross-site evaluation and the project's evaluation provided summary data.

Health Related Quality of Life Scale

The evaluation assessed the quality of life at baseline, six months and at program completion using the HRQOL measure. This self-reported tool provided perceived levels of quality of life using 15 indicators of physical, emotional, social and psychological well-being for individuals dealing with a health condition. The HRQOL was initially developed to assess quality of life among HIV/AIDS patients. The Cronbach Alpha reliability scores for the 15 domains for our current sample ranged from .72 to .85. This instrument was administered at baseline and 12 months post-test.

Family Assessment Form (FAF)

This standardized instrument measured levels of family functioning and was completed with in-home assessments. The FAF yielded 5 domain scores that measured home environment, child safety, family interaction, social support and child development. FAF assessments were completed at baseline and program completion.

Client Satisfaction Survey

This questionnaire was developed by the evaluation team to assess program satisfaction among participants completing the program and/or prematurely terminating. Respondents were asked to rate the services they received, quality of services and staff knowledge of community resources. This form was implemented during the second year of the project.

Sample

The sample comprised of 337 minor children: evaluation data was collected for 135 index children, 6 years old or younger; descriptive information was obtained for 174 minor siblings and 29 non relative minor children residing with project families. Overall, 135 families were evaluated and included 35 pregnant women (at enrollment). Of the project's families, 76% were identified with Substance Abuse parent (primarily mothers) while 24% of families were affected by HIV or AIDS (mostly biological mothers).

Outcome Evaluation

The evaluation of the Nuestras Familias project consisted of baseline, post 6 months and 12 months assessment of Latinas and their children (index) in order to determine the impact of the program in preventing child neglect, child abuse and abandonment. Data analyses were based on the project's normed and standardized outcome instruments for each of the project's goals. In
this report, descriptive statistics were used to identify demographic and socio-cultural variables. The statistical analysis scheme used to evaluate program effects and participant progress included t-tests and ANOVA statistics. In most cases, comparison analysis were not made between the project’s HIV/AIDS and Substance Abuse groups due to the small sample size among the HIV group (24%). However, changes from program entry to termination were evaluated for each group.

Demographic Profile

The evaluation’s descriptive statistics characterized the project’s families as primarily Mexican Americans or migrated from Mexico, living below the poverty level with young children (newborns) and residing in single dwellings with multiple family members. Among the 135 families evaluated, 133 were biological mothers and 84 were fathers (biological or stepfathers) with a total of 222 parents (includes 2 kinship guardians). Among Latinas, 34 were pregnant at program entry and 24 women gave birth during program involvement. HIV/AIDS mothers represented 24% of families, 22% were diagnosed with AIDS and 29% reportedly were living with HIV positive partners. Substance Abuse families comprised 76% of the sample and half of these families self reported that male partners were substance abusers. Marital status for this sample included 53% of women as either married or living with a domestic partner and 47% were single mothers. The mean age for the total sample was 26.6 years; the average age for HIV/AIDS (HA) mothers was 31.2 years and 24.1 years for Substance Abuse mothers. Mother’s age was found significantly different ($t=30.86$, $p$ value < .001). This finding was mainly due to the younger mothers enrolled in the Substance Abuse group. Among SA women, 24% were 21 years or younger. For partners, the mean age was 29 years for the Substance Abuse group and the mean age for HA partners was 33 years. Education among this sample included a total mean of 10.8 years; the mean years of education for the HA participants was 8.6 and 11.2 for the SA group. The range of education levels for both groups indicated that 11% had less than 6 years of education, 28% completed 8 years of education and 30% stated graduating from high school (mostly SA women). Income levels were obtained for 91% of the sample and showed that the majority of families were poor and living well below federal poverty levels. The yearly mean income was $16, 121 for the total sample, $12,312 for HA families and $17, 344 for Substance Abuse families. Most of the project’s families, 79% were not formally employed although 17% stated current full-time employment and 4% reported part-time work. Overall, participants’ occupations included day labor, domestic services and retail sales. Two thirds of families resided with other adult family members and were dependent on multiple incomes.

Index children – During this reporting period, 76% of children were impacted by Substance Abuse and 24% of children were affected by HIV/AIDS. The age patterns for children indicated that children living with substance abusing mothers were younger than children living with HIV positive mothers. The mean age for index children was 2.9 years for the HIV group and 10.6 months for the Substance Abuse group. SA children were significantly younger than HA children ($t=13.18$, $p$<.001). This difference was mainly due to approximately one quarter of women in the SA group had newborns at program enrollment. The project’s children primarily resided with their biological parents and siblings. Additionally, an average of two adult relatives resided in these households.
Families at Risk

**HIV Parents** - The Parent Risk Factor Survey, a 40-item list of events, childhood experiences and current situations were used as factors placing parents “at high risk.” Current events occurring during the past year and events occurring over 12 months ago including childhood experiences were the life span used in evaluating the type and frequency of risk factors. Among the HIV parents, baseline risk factors most frequently reported were: poverty (89%) and inadequate or no health insurance (74%). Many of these parents, 85% were unemployed for most of the time during the past year and 85% had limited or poor job skills. Many of these families were currently residing in substandard/temporary housing (78%) and 82% were isolated. Adding to their poor social living conditions was family discord. Poor or limited parenting skills were identified for 77% of parents, marital problems was reported for 68% of parents and 44% experienced domestic violence. In addition to coping with HIV/AIDS, 17% reported a mental health diagnosis. Risk factors occurring during childhood that were most frequently reported were associated with child abuse and exposure to violence. Baseline risk factors for the project’s HIV/AIDS families illustrated that these families were at high risk and thus increasing their challenges in dealing with HIV or AIDS. The high frequency rates of poverty, marital discord, unstable home environments and childhood trauma underscore the need to provide supportive services to this group. At termination, families reported less risk factors (mean=3) compared to baseline assessments (mean=5). However, significant differences were not found for changes in poverty, unemployment and limited job skills.

**Substance Abuse Parents** - baseline risk factors were identified for families impacted by Substance Abuse using the same assessment scheme as with the HIV/AIDS group. The most prevalent risk factor reported was poor or limited parenting skills (89%), followed by history of childhood abuse (81%); 69% reported marital discord and 65% of women reported past or current domestic abuse. Overall, risk factors were improved by 26% at termination for this group. In particular, fewer risk factors were reported (4 at termination) compared to baseline (7 at program entry). Families were less likely to experience substance abuse and domestic violence. These improvements were due to the program’s services targeting marital relationships and conflict resolution. In addition, substance abuse interventions and parenting skills were provided to this group.

**Children at Risk**

An initial baseline and post-test child risk factor assessment was conducted for all indexed children. The Child Risk Factor Survey, a 20 item checklist was used to identify experiences or events occurring within the last six months (current) or more than six months (past) that placed children at “high risk” for child abuse, neglect or abandonment. Developmental screenings were also completed and assessed medical, emotional and behavioral functioning based on history data, diagnosed conditions, parents input and staff observations. **Children in the HIV/AIDS group** were currently at high risk due to poverty (82%), overcrowded housing (52%), exposure to domestic violence (38%) and poor parent-child relationships (32%). Risk factors reported as occurring prior to birth and/or up to 12 months ago indicated that HIV/AIDS children were at risk due to past "neglect or risk of abuse” (21%), "chronic unstable housing" (19.2%) and "exposure to substance abuse in the household (19.2%). The risk factors experienced by index children (and siblings) indicated that these children were faced with family violence, unstable family and home environments, and parental medical conditions. Among this group, the exposure to family violence and family instability continued to place these children at high risk for neglect, abuse and abandonment. The HIV/AIDS families lived in poverty and multiple
family dwellings. Prevalence rates at post-test 6 months and 12 months for this group indicated an improvement of 25% in the number of risk factors reported after program completion. At termination, 73% of children did not report domestic violence exposure and poor parent-child relationships as risk factors.

Risk factors reported for children impacted by substance abuse at baseline included; 81% were exposed to substance abuse; 71% resided in poverty; 65% were exposed to domestic violence; 38% resided in overcrowding housing; and 24% were victims of abuse or neglect. Past risk factors occurring at least more than 12 months or prior to birth were; 65% were at risk for abuse or neglect and 85% had poor parent/child relationships. As noted, approximately one quarter of the Substance Abuse mothers were pregnant or had newborns at program entry. Mothers in this group were also significantly younger than HIV women. Overall, SA children were at high risk due to mothers’ substance abuse, poverty and poor living conditions including at risk for abuse and neglect. Post test assessments indicated a significant improvement of 69% at 6 months and 75% at program completion. Significant reduced risks for child abuse, substance abuse exposure, domestic violence and improved parent-child relationships were found for this group (p<.05).

A developmental screening and assessment using the Developmental Profile II was completed at program entry for children at least age three months. A total of 14% of children were screened and assessed with medically fragile conditions, 12% were identified as at risk for developmental delays and 9% had emotional/behavioral problems. Due to the very young age of our project’s index children as most were less than a year old, developmental assessments were conducted at baseline and post-test (at least six months of services). Overall, few cases were detected with developmental delays based on the Developmental Profile II, a standardized instrument that assessed five areas of child development. At baseline, 18% of children were assessed as delayed in at least one area of functioning. The most common delays were in communication and self help skills. Parent-child interventions that promoted language development, independent age appropriate tasks and self care were provided to the project’s young mothers, particularly in the Substance Abuse group. At termination, developmental functioning levels were improved by 45% for the total child sample. Children assessed with developmental delays were referred to the Regional Center in Santa Ana for follow up interventions. Additionally, medical referrals were provided to children with medical conditions.

Ensuring Cultural Competency

The AIA Nuestras Familias project adhered to providing services that were culturally sensitive and linguistically appropriate. In line with this framework, the evaluation obtained data that identified socio-cultural characteristics that offered a more enriched evaluation of Latinas and their children impacted by HIV/AIDS or Substance Abuse. Country of origin, language preference, and years in the United States, generation levels and acculturation levels were the variables of interest. Among the Substance Abuse Latinas, 65% were Mexican American, first generation to third generation and born in the United States. Among this group, 35% reported migrating primarily from Mexico to the United States as children. The mean number of years in the U.S. was 19 years (for non-U.S. born). These Latinas were bilingual in English and Spanish; 28% were primarily Spanish speaking and 6% were English speaking only. The majority of HIV Latinas, 82% were born and migrated from Mexico, 9% were born in Guatemala and 18% were first generation Mexican Americans (born in the United States). The mean number of years in the United States for this group was 14.5 years. The range in residing in the U.S. was less than 5 years to 30 years. Monolingual Spanish speaking was the primary language spoken for the HIV
group at 59%, bilingual in English and Spanish was 36% with no HIV women reporting English as their primary language.

**Acculturation Level**

The evaluation assessed levels of acculturation among HIV and Substance Abuse Latinas. Significant group differences were found using the Short Acculturation Scale-Hispanic (SAS-H) \((F=23.14, p<.001)\). Parallel to socio-cultural variables discussed above, HIV Latinas were found to be significantly less acculturated than their counterparts. The SAS-H assessed the degree in which traditional Latino language preferences, socialization practices and public communication (media) were utilized. Interestingly, although the majority of HA participants were born in Mexico, the wide range of years in the U.S. from recent migration to long-term residency did not impact the SAS-H scores. The SA group in contrast were significantly more acculturated, educated, born in the United States and were first and second generation Mexican Americans. This group was bilingual in English and Spanish. This finding delineates biculturalism among the sample's Substance Abuse women. Importantly, successful migration involves resourcefulness and adaptation to change. Among Substance Abuse Mexicans and Mexican Americans, learning the language and obtaining skills for successful integration was achieved at the same time while retaining their Mexican cultural values. This was evident by their language preference (bilingual), generation status and living situations that included extended families. In comparison, HIV women were less likely to be integrated into the United States despite the number of years of residence. This group may have been impacted by their immigrant status and the stigma of HIV prevalent in the Latino community. While these mothers retained the more traditional values and beliefs of their country of origin, they lacked multigenerational support since older generations tend to stay behind and they were more apt to be isolated, live in poverty and have limited social support.

**Health Status among HIV/AIDS Latinas**

Health interviews were obtained for 78% of the HIV/AIDS participants. For this group, 28% were diagnosed with AIDS, 54% were HIV positive with symptoms and 18% were HIV asymptomatic. The mean number of years participants reported living with HIV/AIDS was 5.6 years with 100% reporting contacting the virus by heterosexual transmission (partner). The project's HIV/AIDS women reported being informed of their diagnosis by a medical physician, 38% were re-tested and 42% stated seeking a second opinion. HIV/AIDS related illnesses were experienced by 28% of women and 68% reported taking medications. This group described approximately 16 different medical symptoms as "side effects" to medications. These ranged from skin irritation (38%), lipodystrophy (34%), peripheral neuropathy (25%) and fatigue/weakness (91%). Most of the women had difficulty describing their HIV/AIDS condition (e.g. medications, last lab work, and viral load). The mean CD4 count for this group was 495 and viral loads varied among HIV women. Using physician completed forms (54%), viral load ranged from <50 for 39%; <5000 for 48% and <70,300 for 10%. Karnofsky scale ratings indicated that 48% were at Stage I (asymptomatic), 32% were placed in Stage II and 19% were in Stage III. Approximately 89% of women self reported as not disabled due to HIV and 18% (4) reported disability status. Hospitalizations during the past year due to HIV or AIDS were reported for 14% of women. HIV and AIDS related illnesses were reported for one quarter of women. Table 4 provides a list of most frequent health conditions reported by this group.
Table 5. HIV/AIDS related Health Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>wasting syndrome</td>
<td>33%</td>
</tr>
<tr>
<td>gynecological problems (abnormal PAP, yeast infections)</td>
<td>37%</td>
</tr>
<tr>
<td>meningitis</td>
<td>17%</td>
</tr>
<tr>
<td>dementia (memory impairment)</td>
<td>17%</td>
</tr>
<tr>
<td>mood disorders (anxiety disorders)</td>
<td>62%</td>
</tr>
<tr>
<td>dizziness, nausea</td>
<td>56%</td>
</tr>
</tbody>
</table>

Overall, the project's HIV sample was found to have limited access to medical or health services compared to Substance Abuse women. The findings also revealed that HIV women significantly benefited from program services focused on HIV education, HIV counseling and case management referrals. The program has targeted services at improving medical access and resources for HIV women and their children.

Health - Alcohol/Drug Dependent Latinas

Health interviews were completed at program enrollment for 75% of Substance Abuse clients. Among this group, 79% reported Methamphetamine as the primary drug of choice followed by Alcohol, 68%, Marijuana, 46%, "Speed", 32% and Crack, 26%. The average length of drug/alcohol abuse was 6 years with the majority reporting 1 to 5 years dependence (50%). The mean age of onset of substance abuse was 17 years with 89% of clients reporting being currently "sober." Close to 22% reported participating in a drug/alcohol outpatient treatment although 48% of clients indicated being sober for less than 12 months. Health conditions associated with substance abuse included 54% reporting back pain, 29% stated a history of headaches and 29% self reported as having a mental health condition. Among this group, 24% were 21 years or younger. Approximately one third of women had recently delivered a baby, 25% were pregnant at enrollment and close to two thirds were in the post partum phase.

Medical Access Outcomes

The Medical Access form, administered at baseline and termination, assessed access to medical services such as physicians, clinics, bilingual staff and flexibility of medical provider among HIV and Substance Abuse participants. For this outcome, the results appear in Table 6 for both HIV and Substance Abuse mothers. Group comparisons indicated that Substance Abuse women had significantly more access to medical services compared to their HIV counterparts. As shown, this group test was significant at program completion. This finding was associated with the project's referral source for Substance Abuse participants. The Public Health Department in Santa Ana - PACT program has provided 72% of the referrals to our project.

Table 6. Medical Access among HIV and Substance Abuse Participants at Program Termination

<table>
<thead>
<tr>
<th>Medical Access</th>
<th>HIV+</th>
<th>Substance Abuse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>34</td>
<td>73</td>
<td>107</td>
</tr>
<tr>
<td>Mean</td>
<td>3.43</td>
<td>4.19</td>
<td>3.77</td>
</tr>
<tr>
<td>SD</td>
<td>0.71</td>
<td>0.63</td>
<td>0.76</td>
</tr>
<tr>
<td>F</td>
<td>7.19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p value</td>
<td>0.009</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The ACT program provided home-based adjunct medical services to infants and pregnant women at high risk. Many of the ACT referrals were a result of positive drug tests among pregnant or new mothers. The low health care access and limited resources identified for the project's HA sample demonstrated the paucity of services available to Latinos living with HIV and AIDS in the Orange County Community. This group continues to be underserved and underserved, particularly in the area of medical services. Although the project's sample was limited due to the small sample size, the baseline to termination analysis did not detect any significant differences for the HIV women.

Depression among Project Latinas

The evaluation assessed depressive symptoms using the Center for Epidemiology-Depression Scale at baseline, 6 months and 12 months. The CES-D assessed depressive symptoms reported during the past four weeks. A score of 16 or higher suggests "at risk" rates for depressive symptoms. Additionally, the mental health composite score from the Health Related Quality of Life (HRQOL) instrument was evaluated as an indicator of depressive symptoms and psychological distress. For this outcome, statistical analysis included non-parametric t-tests change tests at baseline, 6- and 12-months post-tests data. For the total sample, small but significant changes were found from baseline to 6 months ($N=84, t=4.17, p<.044$). Significant changes were also detected at post base 12 months ($N=115, t=3.77, p<.003$). The baseline and 12-month means were 29.26 and 17.69, respectively. These findings suggest that steady patterns of improvement and reduced depressive symptoms were significant among Latina mothers particularly at program termination. The evaluation examined changes in depression for HIV and Substance Abuse women. SA and HA group comparisons for the CES-D were found significant at baseline despite the small HA sample. The results indicated that at program entry, HIV women were significantly more depressed compared to Substance Abuse women. The results are presented in Table 7.

Table 7. CES-D Group Differences at Baseline

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>F</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CES-Depression HIV+</td>
<td>37</td>
<td>28.10</td>
<td>10.43</td>
<td>4.70</td>
<td>0.014</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>78</td>
<td>21.34</td>
<td>11.60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>115</td>
<td>29.26</td>
<td>11.63</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Within group differences were detected at 6 months for the HA sample but not the SA sample. Baseline to 12-months changes were also found significant for the HA women. These findings suggest that among the HIV women, depressive symptoms were high at program entry and significantly reduced at 6-months and 12-months. Between group differences were significant for HA women and SA women, overall. HIV women were found to report significantly less symptoms at 6 months and at 12 months, particularly when compared to Substance Abuse women. Among Substance Abuse women, significant changes were found at program completion (10 to 12 months of program services).
The Mental Health composite score obtained from the HRQOL instrument was also evaluated as an outcome indicator for depression and psychological distress. Items tapped into mood, affect, dysphoria and anxiety. Participants rate these items as occurring within the previous month. Significant results were obtained using change tests for the total project sample. These results appear in Table 8. At baseline, women in both groups experienced mental health distress and were below the norm as shown. At termination, participants significantly improved their scores and were more align with the normative sample.

**Table 8. Mental Health Composite Mean Changes**

![Mental Health Composite Mean Changes Graph](image)

Among the project's HIV Latinas, mental well being and quality of life were impacted by their health conditions. Substance Abuse women were also experiencing distress associated with post partum depression and cessation of alcohol and drugs. These conditions appeared to improve while participating in the projects home base services targeting mental health and depression. Psychotherapy, group therapy, drug counseling and parenting support were key program services.

**Family Functioning**

The evaluation assessed family functioning levels at baseline and termination using the Family Assessment Form. This instrument is comprised of six domains that tap into home environmental factors and family interactions. These are: Living Conditions; Financial Conditions; Supports to Caregivers; Caregiver-child interactions; Developmental Stimulation; and Interactions between Caregivers. For this reporting period, statistical analysis for the FAF scale included a series of t-tests to examine pre-post changes for the project's sample, SA and HA groups. For the total sample, significant baseline to 12 months changes were found in the areas of; supports to Caregivers and Caregiver-Child Interactions. These results are shown in Tables 9 and 10.

**Table 9. Significant FAF Changes in Supports to Caregivers**

![FAF Changes in Supports to Caregivers Graph](image)
The results showed that family functioning levels improved at program completion among families. As shown in Table 9, a lower mean score indicated improved functioning with a score of 1 as optimal and 3 as midrange. The project's families obtained a mean baseline score of 2.64 suggesting poor functioning in Supports to Caregivers. At termination, improved FAF ratings yielded a significant mean of 2.04. The program's interventions targeting parenting, life skills and general support were effective in improving overall family functioning specifically in the areas of seeking social support and parent-child bonding. Social support group interventions for HIV and SA participants were conducted on a weekly basis by a program clinician and second group facilitator. Parenting classes aimed at fostering nurturing behaviors, increasing child development knowledge and providing safe environments, emotional stability, positive parent/child interactions were provided to all program participants.

**Table 10. Significant FAF Changes in Caregiver-Child Interactions**

<table>
<thead>
<tr>
<th>Average Rating</th>
<th>Baseline</th>
<th>Termination</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.00</td>
<td>2.11</td>
<td>1.76</td>
</tr>
</tbody>
</table>

As displayed in Table 11, Caregiver-child Interactions scores were significantly improved among families. Comparisons between the HA families and SA families on family functioning yielded non-significant results. Within group changes were only found among the HIV mothers at termination. This group significantly improved family functioning levels in the following domains; Caregiver-Child Interactions, Financial Conditions, Supports to Caregivers and Interactions between Caregivers.

**Health Related Quality of Life**

The evaluation assessed the quality of life measured by the HRQOL. This instrument consisted of 15 domains that measured physical and emotional well-being. Each domain provided a score from 1 to 100; higher numbers indicated higher levels of quality of life and positive well-being. The evaluation examined the baseline to termination changes for the 15 domains among the total sample. Additional within/between group comparisons for the SA and HA women were completed using statistical change t-tests. Significant results (shown in Table 12) were found from baseline to termination for the total sample on the Quality of Life domain ($N=85, t=-3.21, p<.001$). Families reported improved quality of life after participating in program services (at termination). Noteworthy, families were found to score below the normative mean.
However, the significant increased mean score at program completion supported the effectiveness of the program's model of services for women living with HIV/AIDS and Substance Abuse.

The General Health Perceptions was also found significant at termination for the total sample ($N=85$, $t=3.21$, $p<.001$). This domain assessed perceived self-report of health status. The results (shown in Table 13) indicated that women improved in their perception of general health status. Despite their diagnosis of HIV/AIDS or Substance Abuse, including post partum conditions, the project's women demonstrated positive attitudes towards health. Tables 14 and 15 display significant changes detected for Social and Role Functioning levels at program termination.
Table 13. Significant Changes in Social Functioning

Both SA and HIV participants significantly increased their social interactions and activities during program involvement. Role functioning was also significant and suggested that participants tended to increase their physical activities associated with their roles as mothers. As previously mentioned, the baseline means for these two domains were 10 to 20 points lower than the normative mean. While these results were modest due to the small sample of HA women, participants overall living with HIV/AIDS or Substance abuse particularly mothers with newborns were found to have limited social and physical functioning levels that impacted their overall quality of life at program entry. The significant improvements detected at termination may be due to in part, with participants’ engagement in project activities, services and interventions. The project’s model emphasized cultural activities, celebrations and social interactions with children, families and friends. It is important to note that the positive impact of social interactions has been detected on a number of outcome measures especially at the post test assessments and among the total sample. No significant group differences were found for the HRQOL IS domains. Within group differences were also evaluated and results were not significant.

Table 14. Significant Changes in Role Functioning
**Family Contact Services**

The "family contact log" was used to capture program dosage data and to determine what aspects of the project's model were most effective and yielded positive outcomes. This tool obtained type of contact, duration, frequency and person receiving services. This data was evaluated during this reporting period and examined number of contacts, type of services and duration of services. The results yielded client level aggregate outcomes for Substance Abuse and HIV families. The average number of service hours was 58.1 for the total sample: 64.2 hours for Substance Abuse families and 73.2 hours for HIV families. Individual face-to-face contacts for SA women averaged 16.2 hours and 21.4 hours for HA women. Phone contact means for HA and SA groups were 31.7 hours and 26 hours, respectively. Group intervention contacts such as parenting classes, parenting support or group therapy had an average of 36 hours for HA families and 31 hours for SA families. Significant results were detected using Wilcoxon non-parametric tests for HA and SA families at termination. The findings indicated that services provided to HA women: HIV counseling, HIV group therapy, health education focused on mother's health, case management referrals and socio-cultural recreational activities were significant at program termination \( p < .05 \). Among Substance Abuse women, services targeting drug counseling, group therapy, referral linkages and supportive telephone contacts were also significant at termination \( p < .05 \).

**Client Satisfaction**

Overall, families expressed satisfaction with program services, program staff and resources received during program involvement. Specifically, 78% indicated that services were very helpful, 82% agreed strongly with receiving services promptly and 91% stated that they felt staff was sensitive to their culture. Among the 48% of families surveyed, 88% reported that they received the services they were promised at program entry. Comments provided by respondents were positive and described the supportive relationships they established with staff members, their counselors and group interventions/activities.

**Discussion**

Nuestras Familias successfully replicated a home base model (Project Milagro). The results of this study underscored the multitude and complex risk factors for child abandonment, abuse and neglect among Latinas and their children living with HIV/AIDS or Substance Abuse. The evaluation findings of this project supported the project's conceptual framework based on family systems and cognitive behavioral interventions. Additionally, cultural-specific services were significant in meeting the needs among Latinas and their children living in the Santa Ana community. The vulnerabilities of children residing with Substance Abuse women included domestic violence, parent-child difficulties and parenting stressors. Among children residing with HIV mothers, risk factors associated with violence, poverty, multiple family dwellings and limited medical access were delineated as affecting child safety, child permanency and child well being. Latinas in this program were more likely enrolled prior to obtaining child protection services or child detainment. The project's services targeted these families by providing child focused services and parent efficacy training. The program was successful in supporting SA women with having drug and alcohol free births, reducing risk factors among young Latinas (21 years and younger) with an early onset of Substance Abuse and maintaining healthy prenatal care. The risk for abandonment among children living with HIV Latina mothers was due to their...
mothers' impeding health, depression and domestic violence. Poverty, unsafe and unstable home environments, and exposure to substance abuse increased risks for abuse and neglect among these children. The underlying socio-cultural challenges and barriers associated with immigrant status and low acculturation further augmented their social conditions. Significant improvement in stable housing, family functioning, quality of life and psychological well-being was obtained at termination for HIV/AIDS families.

Heterogeneity among Latinas was reflected between the project's two groups. Substance Abuse women were second and third generation Mexican Americans, English speaking and more acculturated. In contrast, HIV/AIDS Latinas migrated primarily from Mexico, monolingual Spanish-speaking, less acculturated and were affected by their immigrant status. Similarities between these groups were found in the socioeconomic factors that interfered with positive outcomes. Latinas were faced with poverty, unemployment or underemployment, inadequate health insurance, poor housing, low education levels and limited job skills. Psychosocial factors shared among these women included childhood abuse, trauma and chronic domestic violence. The program's interventions were significant in reducing depressive symptoms at program completion. The findings also revealed that parenting stress was extremely high for both groups although significantly improved.
VII. Appendices

A. Presentation: Cultural Barriers for Women living with HIV

B. Presentation: Home-Based Model and Team Building

C. Presentation: Challenges Working with Communities of Color

D. Presentation: Nuestras Familias-Status of the Program

E. Presentation: Engaging Families in your Project through Culturally Appropriate Family Structured Activities

F. Collaborating Agencies and Networking/Planning Meetings

G. Article: Barriers to HIV Disclosure for Latino Mothers: Gender Roles, Cultural Ideals, and Religion

H. List of Evaluations Instruments
Cultural Barriers for Women living with HIV

Barbara Kappos, LCSW
Latino Family Institute
Women-Mujeres-Setoch

Our gender, our culture and our experiences shape our identity.

Cultural Barriers will continue to exist when the unique needs of women living with HIV are not addressed globally, nationally, and on the community level.

Socioeconomic factors contributing to women’s quality of life include: gender inequality, poverty, immigration status, social marginalization, lack of economic and educational opportunity, and lack of legal and human rights protections.

Social cultural factors such as: cultural norms, gender roles and disempowerment increases a woman’s risk factors for acquiring HIV.

Influencing risk factors such as childhood trauma, sexual assault, intimate partner violence, and alcohol and substance abuse increases women’s risk for HIV.
Women are the care-givers of the world, and they usually focus on others rather than seeking services for themselves.

Cultural barriers can only be addressed systemically by:

- Focusing on the concurrent needs of parents and children;
- Utilizing a systems approach in which families are encouraged to define their strengths and needs in the context of their total environment;
- Providing family centered services and strong community collaboration;
- Development of long-term, trusting, nonjudgmental relationship between the family and staff team;
- Women are empowered and respected and are supported in their decision making and in prioritizing their multiple needs.
Journey of migration is life changing for many women and their families. Many have endured trauma, loss, grief and stress associated with acculturation, discrimination, and poverty. 

Cultural Competency- Women and HIV

The Cultural Tree (indicators for life)
- country of origin
- migration journey, identify if there was trauma and loss.
- identify the significant people in your lives- who gave you power, values learned and roles of your family.
- a history of your experience in this country; how many years; economic, political and social issues.
- generational history
- educational history
- religion, spirituality and faith

Journey of migration is life changing for many women and their families. Many have endured trauma, loss, grief and stress associated with acculturation, discrimination, and poverty.
Barriers

Living “behind closed doors”

Barriers to utilization of health, social and recovery services include: lack of insurance, limited access to health care resources, language barriers, lack of culturally sensitive services, lack of literacy and anti-immigrant sentiments.

Isolated from extended family and community

Breaking the Barriers

Supporting women to “open the doors”

Provide a safe environment that treats women with respect and dignity.

Build a circle of support

Treatment & Healing
Images of America were beautiful and hopeful.

Irma came to the United States to join her husband in order to have a better life for her family. Her journey was difficult, her life here was difficult. Upon six months of her arrival her husband passed away. Shortly after his passing she was informed that she was HIV positive – she did not know how this happened to her and to her family?

She needed to take care of her two children, but soon she was hospitalized and her children had nowhere to go. Her children were provided with respite, and she was given time to make a plan for her children. She lived one more year with her children. Her strength and courage was immense..............she left this world knowing her children were safe.
Coming full Circle

Women against AIDS
Home-Based Model and Team Building

Barbara Kappos, LCSW
Latino Family Institute
Overview:

History of Home-Visitation programs

- **Charity Organization Society** - formed in 1890's "helping persons" provided direct home based services, offering families charity and relief.
- **Visiting Teacher** - Early 1900's reached out to disabled and troubled children. Up to now it was a helping person, it evolved to a teacher and later to the social worker. At some point social workers were investigators, checking the applications of eligibility for pensions and public assistance.
- **In the 1970's** - home visitations were drastically reduced. An emphasis on therapy placed clients in the offices of mental health and clinic providers.
- **Child Welfare** - 1980's home visits were dominated by child protective services, investigations for child abuse and neglect.
- **Homebuilders Model** - 1974, it is the oldest and best-documented Intensive Family Preservation Services (IFPS) program in the United States. The goal is to prevent the unnecessary out-of-home placement of children through intensive, on-site intervention, and to teach families new problem-solving skills to prevent future crises.
Overview:

History of Home-Visitation programs (con’t)

Home visiting provides a unique opportunity to transmit information and support families. Since home visiting delivers services where the family’s life takes place, it is an especially useful strategy for reaching families who are geographically, socially, or psychologically isolated. In addition, home visiting accommodates families’ needs and schedules and allows the home visitor to better consider family circumstances when tailoring interventions.

- Home-Visitation Models- Today home-based programs are integrated within most of the Children and Family Service Agencies and is considered- a Family Strengthening Intervention, some of the models include:
  - Solution –Focused Model
  - Ecological and Family System Approaches

Home visitation uses a systemic, family-centered approach for improving and sustaining healthy functioning within the family unit. The emphasis is prevention of out of home placements and mobilizing community resources.
Home Visitation: Most Promised Practices

- **Intervention at the crisis point**
  Home Visitors reach families when the families are in crisis. Client families are seen within 24 hours of referral.

- **Treatment in the natural setting**
  Almost all services take place in the client's home or the community where the problems are occurring and, ultimately, where they need to be resolved.

- **Accessibility and responsiveness**
  Home Visitors are on call to their clients 24 hours a day, 7 days a week. Families are given as much time as they need, when they need it. This accessibility also allows close monitoring of potentially dangerous situations.

- **Intensity**
  Provided with the time needed and not designed with time constraints.

- **Low caseloads**
  Home Visitors carry only 8-10 cases at a time. This enables them to be accessible and provide intensive services. Low caseloads also allow therapists the time to work on specific psycho-educational interventions, as well as the basic hard service needs of the family.

- **Research-based interventions**
  Home Visitors utilize a range of research-based interventions, including crisis intervention, motivational interviewing, parent education, skill building, and cognitive/behavioral therapy.

- **Flexibility**
  Services are provided when and where the clients wish. Home Visitors provide a wide range of services, from helping clients meet the basic needs of food, clothing, and shelter, to the most sophisticated therapeutic techniques. Home Visitors teach families basic skills such as using public transportation systems, budgeting, and where necessary, dealing with the social services system. They also educate families in areas more commonly associated with counseling, such as child development, parenting skills, anger management, other mood management skills, communications, and assertiveness.
Home Visiting - Essential Components

- **Voluntary** - Parents who are voluntarily involved are more receptive to services.
- **Family focused** - Effective programs respond to the unique needs of each individual family. Optimally, parents are involved in choosing service design and content.
- **Respect for diversity** - Families are more likely to engage in services that are culturally and linguistically appropriate. Effective programs value diversity. Quality programs recognize and appreciate the cultural bases of parenting and avoid stereotyping.
- **Connection to other community services** - Effective programs collaborate and coordinate with other community services to ensure that families are receiving all the services they need.
- **Targeted** - Scarce resources are most effectively utilized when services are targeted to those families with the greatest need.
- **Begin early** - Effective programs begin services as early as possible, optimally prenatally.
- **Intensive** - Interventions that are frequent and occur over a long period of time have more significant and sustained effects.
- **Long term** - Optimally, services continue until child is at least 2 years old.
- **Promote preventative health care** - Effective programs support and encourage families to utilize preventative health care and connect with a primary health care provider.
- **Promote delay of subsequent pregnancies** - Effective programs support and encourage participants to delay subsequent pregnancies when appropriate.
- **Limited caseloads** - Service providers with limited caseload are better able to meet the needs of their clients. Caseload limitations will vary with program purpose and focus.
- **Well-trained staff** - Effective programs employ well-trained staff. Program staff is selected based on their education, work, and life experiences, as well as their ability to communicate and establish trusting relationships.
- **Ongoing supervision** - Effective programs provide staff with continuous, high quality supervision.
- **Strength based** - Effective programs build on family strengths and work to empower parents.
- **Promote education** - Effective programs support and encourage participants to finish high school.
Elements of successful home Visitation Programs

Home visitation is a program of ongoing, consistent support that builds a trust relationship with parents in the interests of helping them create the best possible healthy start for their children by doing the following:

- providing encouragement to parents in all aspects of their parenting roles
- affirming and helping families build on their strengths
- recognizing achievements of the family
- helping families connect with appropriate community resources
- helping families make appropriate connections with other families
- modeling healthy teaching and parenting behaviors
- providing culturally relevant information and resources
- advocating for and with families
- being a liaison for the family when they deal with other service providers
- conducting a comprehensive evaluation of program interventions to determine the effectiveness of the program.
Engagement: Developing a Positive Partnership between the Home-visitor and the parent/client

- **What is the relationship, and how is it developed?**
  It is initiated at the first contact—it is strengthened with on-going consistency with hope that trust will be established and a professional bond will be developed.

- **Personality of the Home-Visitor**
  - Demonstrates genuine concern & caring attitude
  - Is understanding & non judgmental
  - Is an active listener
  - Praises, validates and follows-through
  - Demonstrates humility, respect for the client's life, and their decisions.
  - Possesses cultural awareness and sensitivity
Additional Considerations for the Provider:

- **Provides encouragement**
  - Encourage parents in their parenting roles
  - Recognize and build on families' strengths
  - Recognize achievements of families

- **Offers encouragement**
  - Help us to care for ourselves and find other supports
  - Build trusting relationships
  - Build positive relationships with family members
  - Use a positive, friendly, non-judgmental approach
  - Respect families where they are at
  - Be culturally sensitive/responsive
  - Honor confidentiality

- **Provides a listening ear**
  - Offer neutrality—someone to discuss difficulties and challenges with
  - Build a trusting relationship—know we can count on the home visitor
  - Create a relaxed environment that is educational and enjoyable
  - Make connections
  - Create supportive groups

- **Makes referrals to other supports and offer information on community resources**
  - Offer learning through role modeling
  - Offer information/knowledge about child development to strengthen our parenting skills
  - Respond to our questions and concerns
  - Provide opportunities for hands-on real learning experiences
  - Be aware of potential problems and pointing these out
  - Teach to problem solve
  - Advocate for and with families
  - Help families overcome barriers
Benefits to a Team Approach:

- Provides balance and support to the staff
- Reduces the load when serving overburdened families
- Allows for the team members to have expertise in relevant areas
- Reduces the effects of counter-transference
- Allows for the whole family to be served
- Creates a "Holistic Approach"
In Conclusion:

Home Visitation is an effective strategy, however the home visitor can sometimes experience the impact of the multiple issues faced by the families. Value the importance of self-care in response to the "cost of caring". Be cautious of workplace stressors and the impact of burnout and vicarious trauma. Recognize the impact of emotions evoked from ongoing work with overburdened families. What can you do as group to care for yourselves? What can you do to care for yourself?

*The true meaning of life is to plant trees,*

*under whose shade you do not expect to sit.*

Nelson Henderson
Challenges Working with Communities of Color

AIA National Conference Berkeley California
June 8, 2007
Latino Family Institute, Inc.
“Nuestras Familias”
Maria Quintanilla, LCSW, Andy Encinas, MFTI and Martha Cristo, Ph.D.
Objectives of Discussion Group

- Provide a working model that has been effective with agency’s target population
- Gain a clearer understanding of the varying barriers in service delivery to communities of color
- Engage participants in sharing lessons learned in working with communities of color
Organizational Barriers

Bureaucratic System
1. Historical implications
2. Paperwork
3. Legal status
4. Appointment only requirements
5. Community politics – local, state, national
6. Realities of our families – education, finances, employment, housing
Organizational Barriers

Eligibility
1. PR materials having a “one size fit all approach”
2. Materials taking a medical model approach

Misinformation/Myths
1. Families may place high value on informal communication
2. Information not accurately relayed or perceived
Cultural Barriers impacting HIV & Substance Abuse

Stigma
1. Of target issue
2. Stigma of other services or programs offered by agency

Negative Portrayals-
1. Messages from community, media, soap operas
2. Client’s internalized messages

Conflicts with Agency
1. Miscommunication
2. Our own assumptions
3. Is information really clear?
4. Ask for feedback
Cultural Barriers

Misconceptions
1. About agency’s mission & services
2. About other agencies & service providers

Medical vs. Folk Etiology/Treatment
1. What is their belief system?
2. Curanderismo/Folk Healing/Natural remedies/Homeopathic
3. Placebo effect
Cultural Barriers

Extended Family

1. Family “buy in” is crucial
2. Program serves the whole family system reinforces value of “interdependence”
3. Program needs to reinforce value placed on “family centeredness”
Effective Work with Communities of Color

1. Cultural values of our target population need to be integrated throughout service delivery
2. Identify the organizational and culturally based barriers particular to your target population
3. How long in the U.S.?

Tips in working specifically with Latino Families
1. Identify level of acculturation
2. Inquire about their migration history
3. Inquire/research important facts about their country/culture
4. The “5 minute Tourist Overview”
5. Contact local Universities
Core Values of Latino/Hispanic Culture

Family Centered: The Latino Family is one with a sense of obligation and support towards its family members.

Child Centered: The Latino Family is invested in their children.

Language Communication styles vary by region, levels of education, acculturation and assimilation. Special emphasis placed on personal boundaries and nonverbal communication.

Patriarchal/Matriarchal: The concept of "machismo" and "marianismo" define gender roles in the Latino culture.

Strong Work Ethic: Latino culture values hard work, loyalty and sacrifice.

Celebrations: Celebrations are a special time of sharing with family and friends important life events.

Spirituality: Spirituality and religion are a reflection of our shared history, personal and community values and beliefs.

Personalismo: High value placed on personal relationships. A sense of connection is vital for effective working relationships.
Interaction Between Caregivers (FAF) in Younger vs. Older Mothers *

* groups are different at the .01 level of significance
Changes in Home Environment During the Project

<table>
<thead>
<tr>
<th>Event</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>index child detained</td>
<td>2</td>
</tr>
<tr>
<td>other children detained</td>
<td>2</td>
</tr>
<tr>
<td>partner moved out</td>
<td>1</td>
</tr>
<tr>
<td>partner jailed</td>
<td>3</td>
</tr>
<tr>
<td>moved to new apartment</td>
<td>5</td>
</tr>
<tr>
<td>client couldn't make rent; moved back with mother</td>
<td>1</td>
</tr>
<tr>
<td>increased income from new renter</td>
<td>1</td>
</tr>
<tr>
<td>shared custody of index child determined</td>
<td>1</td>
</tr>
<tr>
<td>DCFS called: older sibling hospitalized for ingesting bottle of ampicillin</td>
<td>1</td>
</tr>
</tbody>
</table>

(all these changes were for SA clients except 2 HA partners who were jailed)
Engaging Families in your Project through Culturally Appropriate Family Structured Activities

2008 Children’s Bureau Grantees Meeting
Marriot Wardman Park Hotel
August 5, 2008
Washington, DC
Latino Family Institute
Project Nuestras Familias
Maria Quintanilla, LCSW
Andy Encinas, MFTI
Martha Cristo, PhD
Effective Work among our Communities

- Cultural values of our target population need to be integrated throughout service delivery
- Identify the organizational and culturally based barriers particular to your target population
- What are the stories that are shared from one generation to the next?
- What stories have passed down from their country of origin?
- How many generations in the U.S?
- Migration/Immigration History
- Family/cultural/Religious traditions (Kwanzaa, Lunar New Year, Juneteenth, St. Joseph’s Table etc.)
Why Family Structured Activities?

- Reinforce core values – Celebrate major holidays/celebrations by validating their experience
- Opportunity for a teachable moment, processing theme, or specific training tailored to client’s needs
- Gathering of families that integrates commonalities, promotes support and dialogue among families
- Creates an opportunity for mutual sharing in the context of a non traditional therapeutic environment
- Positive & creative outlet for children to interact with peers
- Counters sense of isolation that many of our families experience
- Models positive family/child interactions and skills building
- Opportunity to celebrate an event that they cannot afford - Majority live below the poverty level
- To have FUN!!!
Planning Effective Family Structured Activities

- Selecting Theme & Goals— Based on Clients needs & Project Objectives
- Preparing Staff with the content and the process of activity – what is their reaction?, Is it outside of their comfort zone?, Do they think it’s superficial? Anticipating clients/staff reactions and possible resistance
- Budget – collaborations with other agencies, corporate sponsorships
- Location and reservations
- Weather
- Transportation
- Food/caterers
- Staffing
- Co-leadership – share and delegate responsibilities
- Invitations given both informally and formally
- Plan for family incentives?
- Activities that promote project goals
- Be open for extra participants
- Debrief
Group Activity

- History of Día De Los Muertos
- Introduction to Group Exercise
- Instructions on Calavera / Sugar Skull Making
- Debriefing Group Activity
Family Structured Activity

Barriers

- Staff perceptions/issues related to theme – we don’t want our families to feel uncomfortable or staff feels uncomfortable
- Needing to balance project objectives with family needs remembering it’s not just about content there is a purpose, a process and we cannot discount the therapeutic experience
- Project goals may guide theme; recognize staff and clients will participate at their comfort level
- Isolation and underlying dynamics of families impacts their level of participation and attendance
- Co-leading group activity is important; need to prepare for participants reactions
- Resources
- Transportation
Core Values

- Identifying the Core Values of the people we work with?
- Family Centered
- Child Centered
- Language
- Gender Roles
- Work ethic
- Celebrations
- Spirituality/Religion
- Personalismo/ Personal connections
Effective Work among our Communities

- Cultural values of our target population need to be integrated throughout service delivery
- Identify the organizational and culturally based barriers particular to your target population
- What are the stories that are shared from one generation to the next?
- What stories have passed down from their country of origin?
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- Resources

- Transportation
Collaborating Agencies

HIV/ AIDS Agencies

Delhi Community Center
AIDS Services Foundation (ASF)
Orange County Shanti
The Villa Center
HIV/ AIDS Caring Community

Medical Facilities

Orange County 17th Street Program
UC Irvine Medical Center
Latino Health Access
Laguna Beach Community Clinic
AIDS Families and Friends Center
Children Hospital Orange County Grove Medical Plaza

Housing Agencies

ASF Housing Program
Mercy House Center
Start House
Casa Teresa
Housing with Heart

Substance Abuse Treatment

Perinatal Substance Abuse Program
La Familia
Casa Elena Recovery
Orange County Research Program
Straight Talk

Child Care- Intervention Program

Regional Center- Orange County
Orange County Head Start
Orange County Family
Resource Centers
Moms Program
Legal Services and Advocacy Center
Orange County Social Services:
Public Law Center- Orange County
Orange County Bar Association
Hermanidad Mexicana

**Mental Health**

West County Counseling Center
Orange County Behavioral Health
Pacific Clinics Orange County Providence

**Networking Meetings**

Orange County HIV Planning Council

Orange County HIV/AIDS Roundtables

National Latino Health Awareness Day Committee

Buena Clinton Roundtable Committee

National Latino HIV/AIDS Statewide Advisory Board

HIV Preventing Planning Committee

Orange County AIDS Walk Committee
"A lucha por mis hijos" ("to struggle for my children") is often stated by Latino mothers as their paramount motivation for living after being diagnosed with HIV. However, the plight of these mothers has rarely been investigated in spite of the fact that Latinas comprised 14% of deaths due to AIDS and 15% of newly reported AIDS cases in 2006 (Centers for Disease Control and Prevention [CDC], 2008). Additionally, Latinas are second only to African American women in their overrepresentation in HIV prevalence rates.

Research has suggested that the interplay of cultural factors, disclosure, and HIV is complex and must be understood in order to provide culturally competent services to Latinas (Amaro & De la Torre, 2002; Moreno, 2007; Scott, Gilliam, & Braxton, 2005). However, to date, the racial and ethnic influences on maternal disclosure have been understudied and have also yielded mixed results. For example, stigma, perceived discrimination, secrecy, and feelings of being devalued have been associated with nondisclosure to children among African American, Latino, and White non-Hispanic mothers, but without any clear ethnic or demographic differences (Lettency & LaPorte, 2004). In contrast, in a study of maternal HIV disclosure and mental health, foreign-born (immigrant) Latino mothers reported higher levels of anxiety and depression compared to African American mothers (Brackis-Cott, Mellins, Dolezal, & Spiegel, 2007).

Only a small number of studies have focused exclusively on disclosure to family members by HIV-positive Latina mothers (Moreno, 2007; Simoni et al., 1995). Although some studies describe the outcomes of maternal HIV disclosure to children and families (e.g., Murphy, 2008; Tompkins, 2007), the direct effects on Latino children have not been clearly delineated.

**Nuestras Familias Project**

The Latino Family Institute prides itself on its pioneering work with the Latino community in Southern California and for offering services that are culturally relevant and guided by the values and beliefs of the community it serves. Since 2005, Nuestras Familias (Our Families), an AIA-funded project sponsored by the Institute, has served HIV-positive Latina mothers and their children (0-6 years old), targeting the role strains associated with immigration and acculturation.

Project participants are low acculturated, monolingual Spanish-speaking immigrants living in poverty or in multiple family households. Having migrated to the United States from Mexico (82%), Central (7%) and South America (11%), they have resided in the city of Santa Ana, in close proximity to the U.S.-Mexico border, for an average of ten years. Almost all (97%) are heterosexual women who became infected with HIV through sex with male partners, as have growing numbers of women nationally (CDC, 2008). Their socio-demographics include poverty (83%), isolation (77%), low educational attainment (9 years on average), unemployment (68%), limited job skills (73%), and substandard housing (71%). Over two-thirds of the mothers have reported histories of childhood
Barriers to Disclosure

A number of cultural factors function as barriers to disclosure in Latino communities. For one, "SIDA" (AIDS) carries with it profound stigma. Disclosure threatens the women’s self esteem by raising suspicion of drug abuse or promiscuity and causing shame and embarrassment. Consequently, Latino mothers are reluctant to disclose their HIV status and also receive little social support for coping with the disease (Amaro & De la Torre, 2002; Moreno, 2007; Pérez-Jiménez, Seal, & Serrano-Garcia, 2009).

Additional cultural factors, such as low acculturation and immigration status, also pose obstacles to disclosure. Latino mothers’ willingness to disclose can be affected by discriminatory laws preventing access to treatment, the threat of deportation, high levels of poverty, and low education levels (Carrona, Romero, & Loeb, 1999; Moreno, 2007). Problems with disclosure are also linked to traditional sex roles, intimate partner violence, and substance abuse (Amaro & Raj, 2000; Gómez, Hernández, & Paigeles, 1999; Moreno, 2007; Wyatt et al., 2002; Zambrana, Cornelius, Boykin, & López, 2004).

In providing services to immigrant HIV Latino mothers, Nuestras Familias has found that many of them endure intimate partner verbal and physical abuse out of the need for economic support or immigration documents, and particularly because they fear being ostracized from their community. As a result, they are reluctant to disclose their HIV status and, despite the need to establish formal guardianship plans for their children, few of the women have done so.

Three cultural determinants—traditional sex roles, cultural ideals of motherhood, and religion—can be particularly potent impediments to HIV disclosure for Latinas, and all three were found to be operative barriers for the mothers in the project.

### Traditional Sex Roles

Grasping the impact of traditional sex roles is critical to understanding HIV disclosure among low acculturated Latino mothers, especially because traditional male sex roles are more likely practiced by low acculturated men (Pérez-Jiménez, Seal, & Serrano-Garcia, 2009; Scott, Gilliam, & Braxton, 2005).

The concepts of Machismo and Marianismo, rooted in Spanish Catholicism and gender construction, play important parts in defining gender among Latino men and women. In general, the word “macho” in its original form was meant to describe a “real man”—one who is hard-working, responsible, and caring to his family, children, and community. In contrast, Machismo has often ascribed Latino men as inflexible in both male-male and male-female relations, violent, and excelling virility onto women. Because this negative view has prevailed in the American mass media, the original ideal has often been lost.

The epitome of Marianismo, the female counterpart to Machismo, is the pure, honorable, and selfless Virgin Mary. Marianismo is an ideal that traditional and low acculturated Latina women are expected to uphold through their attitudes, beliefs, and behaviors. Moreover, Latinas are socialized to be self sacrificing for their husbands or partners and children and to endure infidelity.

The direct relationship between traditional sex roles and disclosure of HIV among Latino mothers has not been thoroughly examined (Amaro & De la Torre, 2002; Simoni et al., 1995). However, a number of negative outcomes for infected Latino mothers have been associated with traditional sex roles. First, low acculturated Latinas experience intimate personal violence that is often exacerbated by disclosure of HIV (Moreno, 2007). Second, traditional sex roles may underscore the inability of heterosexual Latinas to protect themselves from being infected because of the culturally sanctioned expectations of sexual purity and sexual naïveté (Amaro & De la Torre, 2002; Moreno, 2007; Scott, Gilliam, & Braxton, 2005). Third, isolation linked to immigrant status has been associated with HIV stigma in the Latino community (Marín & Marín, 1990; Pérez-Jiménez, Seal, & Serrano-Garcia, 2009). Disclosure among immigrant Latino mothers has also been related to levels of social support; mothers with poor social support are less likely to disclose.
CULTURAL IDEALS AND RELIGION

The role of Latino cultural ideals in creating barriers to disclosure is illustrated in the migration process. In a large national sample of 2,554 Latino and Asian respondents, the primary reason for migration to the United States was to better the lives of their children (Guarnaccia et al., 2007). This view is related to the culturally sanctioned maternal ideal, which in turn is rooted in traditional sex roles and Marianismo. Latinas in their roles as mothers are ascribed reverence and adulation and internalize high culturally sanctioned maternal standards.

When these standards confront the reality of a stigmatized disease that threatens their capacity to uphold them, immigrant mothers often feel that they have failed their children, preventing them from achieving the American dream. From this perspective, disclosure threatens the risk of additional feelings of failure and guilt.

Catholicism brings with it a long history of religious traditions and beliefs that can affect disclosure. Some Catholics believe that they must "cargar nuestra cruz" ("carry our cross"), which can translate into bearing their diagnosis with stoicism and silence. In addition, Catholics may believe that their diagnosis is a punishment from God, an idea further perpetuated by the stigma of HIV. Fearing rejection by the church can reinforce the tendency against disclosure.

Latinas in their roles as mothers are ascribed reverence and adulation and internalize high culturally sanctioned maternal standards.

Nuestras Familias' Culturally Competent Approach

The positive HIV mothers served by Nuestras Familias subscribe to traditional sex roles and the maternal ideals of Marianismo and, for many women, strict Catholicism. In developing culturally sensitive services for this population, the project has applied service strategies that emphasize the importance of Latino values and beliefs and reflect an awareness of traditional sex role practices and their potential impact on disclosure. Nuestras Familias provides health education and support groups that assist the women in learning about HIV/AIDS, coping with the perceived stigma of the disease, and addressing traditional cultural beliefs that may pose barriers to disclosure.

For example, one educational intervention involves displaying a pile of unwrapped condoms and asking the mothers to describe different categories of at-risk persons who should be using protection. The activity has been successful in opening up discussion about the fears of revealing their HIV status while increasing their knowledge of disease transmission.

The mothers also participate in support groups to share their economic hardships, acculturation stress, and emotional distress. A Nuestras Familias' project clinician uses problem-solving techniques and role plays to help the mothers cope with their feelings about disclosing to their children and for some, their partners. It should be noted, however, the mothers are never pressured into disclosing their status.

The program's interventions incorporate universal cultural values by honoring the Latino family: mothers, fathers, children, and extended families. Social and recreational structured activities bring participant families together as a collective community to celebrate traditions and customs, including Mother's Day, a children's Easter egg hunt, and "Los Tres Reyes" (The Three Kings), a Christmas celebration. These activities are used to increase social support among the program's isolated immigrant families. At times, Latino mothers have used these safe and structured opportunities to informally disclose their HIV status to extended family and friends.

Nuestras Familias provides alternative views and practices to counteract the mothers' feelings of failure when they cannot meet the cultural ideals of motherhood. For example, Latina mothers place a high value on breastfeeding and express a sense of loss when they are unable to nurse because of the disease. The project counters feelings of failure by teaching them infant massage as a way to enhance bonding with their babies and reinforce their sense of self as good mothers. Nonetheless, the women still risk
unintended disclosure when family members ask them why they are not nursing. The mothers have difficulty dealing with these situations and, if unprepared to disclose, tend to explain that the baby is allergic.

The Catholic Church plays a central role in the lives of most Nuestras Familias' families. The project respects that role by including priests in the program's recreational activities and supporting family involvement in the Church. However, disclosure of HIV to children is not sanctioned by the Church, and women often fear rejection by their priests. Nuestras Familias encourages the mothers to seek out progressive priests who are supportive and willing to challenge some traditional beliefs. The project also helps mothers reframe restrictive or punitive religious beliefs. For example, viewing their HIV as "carrying the cross" is reframed as the possibility of becoming "stronger" in "carrying the cross" by learning to advocate for themselves, their HIV medical treatment, and/or communicate about their illness.

Understanding the cultural aspects of disclosure is a critical component in providing culturally competent services to Latina mothers living with HIV. Nuestras Familias has done groundbreaking work in identifying traditional sex roles, cultural ideals, and religion as barriers to disclosure and in developing approaches to address them with sensitivity and respect. However, further research and program development are needed before the needs of this seriously challenged population will be adequately met.

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www.lfservices.org

REFERENCES


Tompkins, T. L. (2007). Disclosure of maternal HIV status to children: To tell or not to tell... that is the question. Journal of Child Family Study, 16(6), 797-818.


Copyright Instruments used for AI A Nuestras Familias evaluation component were:

**Developmental Profile 2 Scale**


**Family Assessment Form**


**Parent Stress Index:**

Resources

www.mexicansugarskull.com
El Dia de los Muertos – The Day of the Dead A Mexican Celebration
by Ann Stalcup – illustrated by Pam Smallcomb

Calavera Abecedario – A Day of the Dead Alphabet Book
by Jeanette Winter

The Festival of Bones – El Festival de las Calaveras
by Luis San Vicente

El Dia de Los Muertos by Linda Lowery

Clatter Bash! A Day of the Dead Celebration by Richard Keep
Abandoned Infants Assistance

Nuestras Familias

Status of the Project
November 15, 2007
Nuestras Familias Sample (n = 48)
Level of Acculturation in Substance Abuse vs. HIV+ Clients *

* groups are different at the .01 level of significance
Maternal Age and Partners

- Under 21 years of age:
  - Partnered with SA: 14%
  - Unpartnered and under 21 years of age: 24%

- 21+ years of age: 34%

- Under 21 years of age: 28%
Maternal Age and Partners

- Unpartnered and 21+ years of age: 34%
- Partner with SA and 21+ years of age: 28%
Maternal Age and Partners

- Partner with SA and under 21 years of age: 14% 
- Unpartnered and under 21 years of age: 24% 
- Partner with SA and 21+ years of age: 25% 
- Unpartnered and 21+ years of age: 34%
Interaction Between Caregivers (FAF) in Younger vs. Older Mothers *

* groups are different at the .01 level of significance
Characteristics of Substance Abuse

Primary Drugs of Choice

- hallucinogens: 3%
- alcohol: 21%
- cocaine: 12%
- marijuana: 19%
- meth-amphetamines: 31%
- heroin: 3%
- amphetamines/speed: 12%

Clients said they used drugs for:

- under 5 years: 55%
- under 1 yr: 49%
- over 5 years: 16%
- over 7 yrs: 4%

Only 7 clients said they had used drugs (3 alcohol, and 4 methamphetamines) in the past 30 days.

Over 87% of SA clients stated they were currently sober at intake.
Depression (CES-D) in Substance Abuse vs. HIV+ Clients *

* groups are different at the .01 level of significance
Medical Access in Substance Abuse vs. HIV+ Clients *

* groups are different at the .05 level of significance
Life Stress Index (PSI) in Substance Abuse vs. HIV+ Clients *

* the substance abuse group (but not the HIV+ group) is significantly higher than the norm ($p < .001$)
Recent and Current Pregnancy at Intake

- index child over 1 year old
- HIV+ mothers 21%
- SA mothers 2%
- HIV+ mother pregnant at intake 4%
- index child of SA mother 1 year old or younger 42%
- index child of HIV+ mother 1 year old or younger 6%
- SA mother pregnant at intake 25%
Who Cares for the Index Child?

*HIV+ Group*
- Mother & partner: 54%
- Mother & relatives: 33%
- Other: 13%

*Substance Abuse Group*
- Mother & partner: 46%
- Mother: 15%
- Formal non-kinship foster care: 3%
- Mother & relatives: 36%
DCFS Involvement

HIV+ Group

- Never: 87%
- In the past: 13%

Substance Abuse Group

- Never: 67%
- In the past: 21%
- Involved in a volunteer DCFS case plan: 3%
- Has an open DCFS case: 9%