LATINO FAMILY INSTITUTE, INC.

NUESTRAS FAMILIAS PROJECT

A Culturally Competent Program Model: to Prevent Child Endangerment and Abandonment among Latinas and their Families living with Substance Abuse and HIV/AIDS

Replication Manual

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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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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 design of the service model, evaluation 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 of 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.

The primary purpose of this manual is to provide a guide to implementing the Nuestras Familias model that emerged from the replication study of the Bienvenidos ‘Project Milagro AIA Model. The Latino Family Institute’s Nuestras Familias AIA Model provided effective approaches to reducing child neglect, child abuse and abandonment among families affected by maternal HIV/AIDS and Substance Abuse. The model implemented culturally specific services that identified the heterogeneity of Latinas and provided a framework that illuminated the understanding of the mechanisms and pathways for successfully providing services that address
mediating variables: contextual social environmental factors (poverty, xenophobia, homelessness and unemployment, low wages), cultural factors (immigration, acculturation and language barriers), regional applications (migration patterns, urban housing, community support) and community influences (disparities in health services, discrimination, single head of households).

The Replication Manual outlines the program's services, staffing patterns, recruitment strategies, referral process, community collaborations and the evaluation design including the project's instruments and assessment forms.

I. Program Design and Services

**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.

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 prevention interventions 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.

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.

Nuestras Familias delivered services that were family-centered, client driven and embedded in a humanistic approach to serving families. The staff delivered services aligned with AIA principles: provided developmentally informed parental guidance; individual and family counseling; addressed concrete basic needs; taught tangible skills; assisted families in developing linkages to community resources through direct advocacy and modeling systems navigation; as well as provided information on community resources (AIA, Lessons Learned 2007).

In general, AIA programs have collectively worked towards providing an array of innovative services to underserved and underrepresented communities, women and children. For over 20 years these AIA programs have contributed to the child welfare field a knowledge base by providing intervention strategies that meet the unique needs of communities and families coping with HIV/AIDS and Substance Abuse.

**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.

**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; (7) improve child developmental and health outcomes; (8) improve parent/child relationships; (9) replicate and adapt an evidence-based model of service delivery; (10) increase knowledge among 250 health and child welfare professionals.

Expected outcomes were: 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.

Target Population and Strategies

The Nuestras Familias model provided comprehensive services to primarily Mexican and Mexican American mothers and their young children residing in Santa Ana who were at risk for child neglect, abuse and abandonment due to HIV/AIDS or Substance Abuse. The project's target service area had a large concentration of Latinas and children; many were poor and living below the poverty line. Women with HIV or AIDS were underserved by health care systems in Orange County and they were faced with language and cultural barriers. Nuestras Familias provided services aimed at improving the well being of HIV/AIDS Latino mothers and their children. The project's comprehensive model developed effective strategies to address mediating factors associated with child abandonment and HIV/AIDS within a cultural context. Additionally, service approaches that successfully mitigated child neglect and abuse were supported by the project's evaluation findings.

The project's Substance Abuse women were primarily young (25%) second and third generation Mexican Americans at risk for alcohol and drug addictions. Many of the women were identified at risk for child neglect associated with early onset of drug use, prenatal alcohol/drug use, domestic violence and childhood trauma. Although the project’s Latinas were faced with these challenges, the Nuestras Familias program model was effective in reducing risks for child abuse and child abandonment by providing early intervention services. The collaboration with the Orange County, Department of Public Health, Perinatal Assessment and Coordination Team (ACT) provided referrals of mothers who were pregnant or had just given birth. Early Intervention proved positive outcomes for these women and their children.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.

Culturally Responsive Services

Project Milagro incorporated a culturally responsive approach to serving Latino families affected by substance abuse and HIV/AIDS. 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 is placed on how a person’s level of acculturation impacts the integration of these values in their belief system. In this case, the main issues of concern primarily revolved around substance abuse, HIV/AIDS, domestic violence, histories of child sexual abuse, delivery 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 post natal interventions and substance abuse interventions.
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 spiritually 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 Annual 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.

**Permanency Planning- Five Stage Model of Permanency Planning**

Nuestras Familias replicated the Bienvenidos Five Stage Model of Permanency Planning for only parents living with HIV/AIDS. It is a five stage culturally responsive permanency planning model that was sensitive and critical to the needs of families affected by HIV/AIDS. The model served both as a conceptual framework and practical tool in educating families about future care and custody planning. The Permanency Planning Model included the following stages:

**Stage 1: Assessing the Readiness of the Family** - The goal is that every HIV impacted family would finalize a custody plan for their children in the event that they became incapacitated or died. The model would consider the families’ needs and their willingness to address permanency planning. The model’s approach is responsive to the multiple constraints and stressors that HIV impacted families faced. Due to the nature and focus of permanency planning process, it is presented as a choice for parents and an opportunity to learn about legal rights and options made available to parents who are terminally ill and living in California. In efforts to provide individualized permanency planning each family is assessed as to their interest and willingness to learn about permanency planning. Areas for the provider to assess in Stage 1 include: participants level of trust; cultural and religious implications to permanency planning; family dynamics; families support system; the emotional status of the HIV positive parent; and level of urgency in initiating the planning process.

**Stage 2: Education on Permanency Planning** - There are several options for the parent or family who is wishing to plan for the future care of their children. As a provider, it is important for you to identify what is the best option for the family based on their unique circumstances. There are various options that exist in California both formal (legal) and informal (not filed in a court).

**Testamentary Guardianship** - Testamentary Guardianship is a guardianship preference stated in a will or other writing that takes effect after the parent’s death, following a court approval.

**Caregiver’s Authorization Affidavit** - California Law recognizes a category of adults who assume responsibility for the care of minors living with them. Through the Caregiver’s Authorization Affidavit a caregiver may enroll a minor in public school and make school-related medical decisions. In some circumstances, a caregiver may authorize most kinds of medical care for the child.

**Joint Guardianship** - Joint Guardianship Law allows for the parent who suffers from a terminal illness to designate someone who will participate in the care of the child if and when the parent is no longer able to provide for the daily needs of the child. One of the most important aspects of
this law is that it allows the biological (custodial) parent the opportunity to share custody of the child with the nominated caregiver. Guardians are permitted by law to obtain medical treatment, as well as required to ensure safety and educational needs of the child. Guardians are also eligible to apply for public benefits on behalf of the child. Upon the death of the custodial parent, the Joint Guardian becomes the sole legal guardian of the child without any further court proceedings. Joint Guardianship appointments can be revoked by the caregiver, minor who is of 14 years or older, the parent, and the court.

**Temporary Guardianship** - A petition filed to the court requesting an urgent appointment of a guardian. This appointment is temporary, usually 30 days until a regular guardianship hearing is scheduled. A temporary guardian can be nominated by the parent, the guardian, and the child 14 years of age or older.

**Adoption** - Adoption is a permanent legal option. In adoptions, the rights of both parents must either be relinquished (voluntary given up) or terminated by a court order. Adoptive parents assume all legal rights over the adopted children including religion, education, and medical care.

**Stage 3: Identifying a Future Guardian** - Careful consideration needs to be given to choosing an alternative caregiver. Making choices in times of urgency, do not lend to careful considerations or thoughts to who would best care for their children. Likewise, the nominated caregiver may feel compromised to accept due to the urgency and not really consider the extent of their commitment.

**Involving the Children in the Process** - One of the many challenging decisions faced by parents living with a terminal illness is whether or not to disclose their health status to their children, as well as finding the best time to disclose. Disclosure of a terminal illness to a child is one that requires thought, preparation, as well as support and guidance from professionals. Professional help can assist by reducing the parent’s worries and fears. Parents commonly experience worries related to disclosure such as: is the child old enough to understand? Will the child keep the illness and information confidential? Additionally, parents often fear that disclosing their illness to their child will intensify acting out behavior or emotional problems such as depression.

**Stage 4: Securing the Plan** - Securing the parent’s wishes and plan is one of the most important steps in permanency planning.

Steps to securing a plan: (1) the parent decides on the approach they will take towards securing the appointment of a guardian (legal or an informal appointment through a will or Caregivers Affidavit). (2) In urgent cases (parent is in the end stages of life), filing for a Temporary Guardianship appointment is indicated. Contact the local Probate Court and request procedures for filing Guardianship. Most courts offer assistance either through the clerk or in-house legal clinic. (3) Find out if there is an organization that assists with filing legal Guardianship. Set up an appointment with the legal clinic or walk in during walk in hours. (4) Prior to the appointment ensure that the parent has all the necessary documents required to file a
guardianship (birth certificates, social security numbers, addresses etc.). (5) If eligible the parent may qualify for a fee waiver for filing the petition.

**Stage 5:** *Aftercare services* are crucial for a family that has completed a permanency plan. In cases, where the transition of children to the new caregiver has occurred it is important that comprehensive support is provided to assist in the adaptation process. Counseling, assistance with accessing resources, and obtaining entitlements is important. Additional assistance such as enrollment of children to new schools and identifying medical resources are also important.

**II. Recruitment Strategies**

Nuestras Familias targeted Latinas and their families who were identified “at risk” of abandoning their young children due to substance abuse and/or HIV/AIDS. Families residing in Santa Ana and surrounding cities in Orange County with at least one child 0-6 years of age were eligible for services.

LFI staff met as a team to discuss recruitment issues and as a team developed a plan to increase community visibility and actively recruited clients. The recruitment process included identifying primary HIV/AIDS and substance abuse providers as well as community organizations that served pregnant and postpartum women including community clinics, and the only county contracted Medical Center, University of Irvine AIDS Education – AIDS Grand Rounds. LFI formed a Consortium of members identified and provided enhanced networking, mutual training and referrals among these agencies. LFI also recognized the importance of having to gain community support by cosponsoring and participating in a variety of community events including; health fairs, Latino AIDS Awareness Days, Orange County AIDS Walk, parenting seminars, health and mental health related workshops. In addition, the agency sponsored numerous professional trainings to garner support and increase culturally based practice in working with Latina women impacted by substance abuse and HIV/AIDS. A significant recruitment strategy was the Project Director's membership to HIV Planning Council in Orange County. The Membership process was critical and involved being recommended by the HIV Planning Council Membership Committee and then voted on by Orange County Board of Supervisors. Membership to this council added significant credibility and visibility to the project. Project staff was also very involved in the county run Family Resource Centers in Orange County. These centers are centrally located throughout the county. They provide a variety of services, resources, referrals and linkages. Each center has monthly meetings with community providers. The meeting's objective is to have a round table of shared information from various community agencies. Contacts to these agencies are made in person through monthly meetings or visiting them on site and making contact with referral sources. LFI recognizes that the strong connections made throughout the project period facilitated meeting the goals and objectives of the program.
Nuestras Familias staff took pride in the development of relationships with the community as the cornerstone of their success. It was through relationships that the parents were willing to explore and accept the resources and supports available to them and their families.

III. Referral Process

The project developed numerous strong partnerships in order to create community visibility and obtain participant referrals. The project developed an intake referral form that was widely distributed throughout the county. Community providers were asked to fax their intakes. Project supervisor would oversee the referrals for triage. Families were contacted within three days and an appointment was set up directly with the Project therapist or case managers. By far the strongest collaboration was established with the Perinatal Assessment and Coordination Team (ACT), a Public Health Nursing Case Management Program for infants at risk. Both projects provided early intervention services to mothers and their newborns. The ACT program provided home-based health services and Nuestras Familias provided clinical and supportive home-based and center-based services.

III. Staffing Patterns

Inter-agency, multi-disciplinary services were offered by a bilingual/bicultural team comprised of a Therapist, Substance Abuse Counselor, HIV Specialist, Case Manager and Parenting Educator. Administrative and clinical support was offered by the Executive Director, Project Director and Licensed Clinical Social Worker. Careful consideration was placed on ensuring that the program employed qualified and culturally responsive staff. Consequently, education levels, ethnic and gender considerations were made. Qualities and attributes that the program staff had were: responsible, reliable, flexible, worked well under pressure, and overall had a positive outlook in life. Additionally, the program hired staff with diverse training and educational background in HIV/AIDS, substance abuse, child development, and mental health issues. Staff members were matched with program participants. This was crucial to meeting the proposed goals of the program and overall ensuring program success. Furthermore, the program set priority and funds towards staff development, supervision, and provision of technical equipment.

Project Director was responsible for day-to-day operations of the program. Project Director supervised direct line staff through individual, and group supervision. Responsibilities of the Project Director included: ensuring the program operated at optimum level and was meeting proposed program goals and objectives; conducting intakes for the program; oversight of case load management of staff; coordination of services; oversight of program evaluation;
Implementation of program design and documents; quality assurance (file reviews); conducted program reports; promoted collaborative relationships with other community based providers; and attended Community Collaborative and Networking Meetings.

Therapist provided individual and family counseling to participants identified as having a need and receptive to mental health services. Mental Health Services were offered in the home environment and addressed issues related to substance abuse, HIV/AIDS, domestic violence and dual disorders.

Parent Educator/Case Manager concentrated on engagement of family into the program. The Parent Educator/Case Manager modeled appropriate parenting, household management, and coping skills. The Parent Educator/Case Manager identified the needs of the family by implementing Quarterly Case Plans and presented cases on a weekly basis during Case Reviews. Additionally, she was responsible for completing program documentation (Progress Notes, evaluation assessments), and ensured that files were organized.

Substance Abuse Counselor (CAADAC) offered in-home recovery focused supportive services. Services consisted of substance abuse counseling, relapse prevention, health education, case management, resources and referrals. Additional responsibilities were; development and implementation of Case Plans; participation in weekly Case Reviews; completion of program documentation.

HIV Specialist offered health education, access to medical care and supportive services. Services consisted of counseling, education prevention related to HIV, case management, permanency planning, support in coordinating services, resources and referrals. Additional responsibilities were; development and implementation of Case Plans; participation in weekly Case Reviews; completion of program documentation.

Clinical Supervisor (LCSW) provided clinical supervision both in individual (for Family Therapist) and group (Case Reviews/ Conference) settings. The Clinical Supervisor reviewed and approved Case Plans and Case Review forms.

Case Reviews and Staff Supervision- Program staff received cross-disciplinary training through participation in Case Reviews. Case Reviews were scheduled in advance by the Project Director. Cases were reviewed weekly unless risk factors increased requiring immediate case presentation. Cases presentations were conducted weekly allowing for the latest information on family to be shared. Case Reviews as well as one-on-one clinical supervision was offered by the Clinical Supervisor who acted as a guide and provided support to the team. Additionally, the Clinical Supervisor ensured proper supports and interventions ensuring safety of the children were offered.

New enrollments were presented within a week following intake. Assessment information gathered during the initial intake was presented during the initial Case Review. The initial case
presentation served to initiate an introductory plan of action addressing any high risk issues. Ongoing monthly Care Reviews allow for ongoing group supervision and consultation to take place.

Case reviews were integral to effective service delivery for it ensured the following: delivery of culturally relevant, family and child focused services; interventions were aligned with the goals of the family and the program; guided service delivery; examined family strengths, needs, and presenting problems; identified progress and steps towards family stabilization; provides support to staff dealing with critical issues (i.e., high risk cases, child safety, DCFS and court timeliness, challenging clients, lack of resources); ensured coordination of services across disciplines.

The strength of the program was the inclusion of families in the decision making and providing families with a voice to define their needs and engage in the case planning process. Families were approached with respect and given the opportunity to decide their own lives with the support of the team.

Case Closing- A team agreement on closing cases was important. The agency's policy was to serve families for a period of twelve months. When the families reached twelve months of services, and completed the objectives delineated in the initial and follow up Case Plans, it was time to close the case. Prior to closing cases, families were prepared and informed of the tentative closing date. Additionally, partnering agencies and providers were notified of the programs plans to close the case (i.e., ACT). Prior to closing cases, the program ensured that families had a safety net of services. Families requiring an extension of services beyond twelve months were granted “carry-over” status. Extended services were applicable in cases such as: children were identified to be “at-risk” of child abandonment or abuse at the twelve month mark; unstable home environment; recent reunification; or recent disruption in care and custody of children. Infrequently, cases closed prematurely (prior to 12 months) due to: families’ whereabouts became unknown; parent refused services; parent was non-compliant to services (missing appointments); or family moved out of the service area. Standard program policy was to close cases after 30 days of inactivity.

V. Strengthening families through Community Partnerships

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. 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, 1733 Clinic and Delphi. 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. Project Evaluation Design

The evaluation assessed process and outcome variables related to the achievement of the project's goals and objectives. 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. 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.

Qualitative and Quantitative Data Collection

The evaluation replicated the data collection procedures applied in the Project Milagro model. The overarching goal of the evaluation was to assess the model's service strategies and the mediating factors that promoted child safety, child permanency and child well being. Using this framework, the evaluation assessed the psychological and physical well being of children, biological mothers and their families. Additionally, culturally specific influences were evaluated within social, environmental and family contexts. Program impacts were evaluated with instruments that yielded quantitative (measurable) outcomes. Descriptive data was obtained for the sample's socio-characteristics, demographic variables, and cultural variables such as ethnicity, country of origin, primary language and number of years in the U.S., family composition and housing status. The evaluation provided an enriched assessment of race/ethnicity that moved beyond general United States Census data. Thus, acknowledging the heterogeneity among Latino families. Qualitative or process variables included documenting the implementation and replication of the model, nature and quantity of services provided to meet the needs of children and their families; adapted service strategies; and the project's capacity building activities.

Evaluation Methodology

Nuestras Familias through its evaluation efforts examined the replication of the AIA Project Milagro home based model for preventing infant and child abandonment among Latina women and children impacted by HIV/AIDS and/or Substance Abuse. The methodology replicated the evaluation design, sample, process and outcome variables including the instrumentation.
Evaluation Design

The project's comprehensive methodology utilized a non-experimental repeated measures design with a series of measures to effectively assess the project's goals and objectives. The evaluation design utilized a pre and post-test design with baseline, six month and twelve month data collection time points. Participants were assessed as their own control using post – baseline measurements. The design applied to the current project was feasible and most appropriate for community-based organizations. Despite the need for experimental control groups to determine causal effects, the current inclination for evaluating community programs is to apply a utility focused and realistic design.

Sample

Participants comprised of children, 0 to 6 years old, Latina mothers and pregnant women at early stages of alcohol/drug use (at risk for substance abuse) or living with HIV/AIDS. In this study, participants comprised two groups: HIV/AIDS (HA) and Substance Abuse (SA). Data was obtained from biological mothers, children and in some cases, fathers.

Process Evaluation

Process evaluation provided information on project planning, service needs and implementation. This level of evaluation yielded information on the various aspects of the replication process and the project's model. Information collected for process variables included: outreach efforts, staff trainings, participant service utilization rates, participant completion and attrition rates, participant satisfaction with program services and the program's ability of the project to meet the cultural and linguistic needs of the participants.

Outcome Evaluation

The outcome evaluation measured the effects of program services on reducing the risks of child neglect, abuse and abandonment. Measurable outcomes were psychological and physical well being among children, biological and pregnant Latina mothers. The evaluation assessed outcomes at each data collection point and patterns of change over time were examined. The evaluation utilized the project's conceptual framework by identifying outcome variables that quantitatively described the impacts of the Nuestras Familias model. The child well being
construct was measured by child risk factors including birth outcomes, child development screenings and child developmental functioning levels. Psychological and physical well being among Latino biological mothers and pregnant women was measured by risk factors, parenting stress levels, parent and child bonding, family functioning levels, depressive symptoms and psychological distress, health status and self perceived health functioning levels (such as hopefulness), and overall quality of life. Participants comprising the project's two groups: HIV/AIDS and Substance Abuse were assessed at six months and twelve months. Within group changes were evaluated and in some cases, between groups comparisons were made.

Data Collection Protocols

The evaluation team provided "hands on training" for administering and completing the evaluation forms. The project staff was bilingual (English/Spanish) and bicultural (Latino origin) and administered the instruments in English or Spanish. Prior to data collection, each participant was asked to sign a consent form for the evaluation component. Consent forms were available in Spanish and English. As previously noted, data was collected at baseline, 6 months (post-test 1) and 12 months –program completion (post-test 2). Because the project's families were transient, dealt with homelessness, migrated to different counties or challenged with HIV related health symptoms, the 6 month post-test 1 provided termination data for those clients receiving less service or prematurely terminated.

Data Collection Instruments

The evaluation replicated the instruments used in the Project Milagro's evaluation design in order to maintain the fidelity of the model and to meet the linguistic and cultural needs of Latino families. For some measures, normative data for Latino women with children and/or Hispanics was limited. The project administered and collected the A1A cross-site form, PSI and SHIF required by the Children's Bureau A1A evaluation. The following instruments were used for the Nuestras Familias local evaluation:

The project's instruments appear in the Appendices. Spanish versions used are also included. Copyright instruments are not provided in this manual.
Data Collection Instruments

**Nuestras Familias Intake** - Agency form used to enroll clients and identify service needs. Form provides demographics, socio-cultural characteristics and child welfare information (DCFS).

**Parent/Child Risk Factor Survey** - This 25 item checklist consisted of parent risk factors and child risk factors based on current stressors, problems and past experiences.

**Developmental Screening Form** - This screening tool was developed by the evaluator to identify child health, developmental and psychological (emotional and behavioral) problems.

**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 to measure home environments, child safety, family functioning, adult relationships and child development.

**Developmental Profile II** – This standardized instrument assessed child developmental functioning levels across five areas: physical, self-help, cognitive, language and social age among 3 months to 10 years.

**Health Survey Interview** - A short health survey for HIV and Substance Abuse women was developed by the evaluation and assessed health status.

**Medical Access Form** – This self report 10 item scale provided an overall score on the level of access to medical services using a linear score from low to high. This scale was available as a sub-scale to the overall Health Related Quality of Life Inventory (Rand Corporation, 1999).

**CES-D** – This 20 item self-report measure assessed at risk levels of Depression and has been used with Latinas for the past 3 decades. This tool obtained a Cronbach Alpha reliability score of .89 for the project's current sample.

**Short Acculturation Scale for Hispanics** – This measure identified cultural and linguistic practices in the home and social environment. The form provided a linear score from low acculturation to high acculturation among Hispanics.

**Health Related Quality of Life** – This self-report tool provided perceived levels of quality of life using 15 indicators of physical, emotional, psychological and mental well-being for individuals dealing with a health condition. The HRQOL (Rand, 1999) was developed primarily for HIV/AIDS. The reliability scores for the 15 domains for our current sample ranged from .72 to .85.

**Parent Stress Index (long version)** – This standardized instrument assessed life stress, parenting efficacy, parenting stress, parent – child bond and child behaviors. Reliability analysis yielded a Cronbach Alpha score of .82 for our current sample. A Spanish version is available for this instrument. The PSI short form was used for the AIA cross site evaluation.

**Family Services Contact Log** – This tracking log was developed by the evaluation to obtain process data on type and quantity of services provided to families enrolled in this project.

**Client Satisfaction Survey** - This survey was administered at termination and assessed participant's satisfaction with program services and staff knowledge.
VII. Appendices
Appendix A

Presentation: Cultural Barriers for Women living with HIV
Cultural Barriers for Women living with HIV

Barbara Kappos, LCSW
Latino Family Institute
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.
Breaking cultural barriers by addressing the unique needs of Women living with 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.
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
Abandoned Infants Assistance

Nuestras Familias

Status of the Project
November 15, 2007
Nuestras Familias Sample (n = 48)

- HIV+ / partner with SA 2%
- HIV+ / partner with HIV 2%
- HIV+ / partner with HIV and SA 7%
- SA / partner with HIV and SA 2%
- SA / no partner 39%
- HIV+ / no partner 23%
Level of Acculturation in Substance Abuse vs. HIV+ Clients *

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

- One third of the mothers with substance abuse histories were under 21 years old.
- About half of the mothers were single.
- All partners of SA mothers also had SA histories.
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
- meth-amphetamines: 31%
- alcohol: 21%
- cocaine: 12%
- marijuana: 18%
- hallucinogens: 3%
- amphetamines/speed: 12%
- heroin: 3%

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

Clients said they used drugs for:
- under 5 years: 55%
- over 5 years: 29%
- under 1 yr: 16%

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

- HIV+ mothers: 21%
- SA mothers: 4%
- SA mother pregnant at intake: 25%
- Index child of SA mother 1 year old or younger: 42%
- HIV+ mother pregnant at intake: 6%
- Index child of HIV+ mother 1 year old or younger: 6%
- Index child over 1 year old: 2%

- 42% of index children are 1 year old or younger.
Who Cares for the Index Child?

**HIV+ Group**
- Partner: 54%
- 33%
- 13%

**Substance Abuse Group**
- Mother & partner: 46%
- Mother & relatives: 36%
- Formal non-kinship foster care: 3%
- Mother: 15%
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%
Changes in Home Environment During the Project

<table>
<thead>
<tr>
<th>Change Description</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</td>
<td>1</td>
</tr>
<tr>
<td>bottle of ampicillin</td>
<td></td>
</tr>
</tbody>
</table>

(all these changes were for SA clients except 2 HA partners who were jailed)
Appendix D

Collaborating Agencies and Networking/Planning Meetings
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
Hermandad 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
Appendix E

Article: Barriers to HIV Disclosure for Latino Mothers: Gender Roles, Cultural Ideals, and Religion
"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 (Letteney & 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.

**Nuestros 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, Nuestros Familias (Our Families), an AIA-funded project sponsored by the Institute, has served HIV-positive Latino 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 (71%), low educational attainment (9 years on average), unemployment (68%), limited job skills (75%), and substandard housing (73%). Over two-thirds of the mothers have reported histories of childhood...
abuse (67%) and intimate partner violence (71%). Due to
their immigrant status and language barriers, these
women have had poor access to health care, limited
knowledge of health resources, and no medical insurance.
At program enrollment, they have often reported a poor
quality of life, depressed mood, and stress in parenting.

Despite the bleak circumstances presented by Latino
mothers, Nuestras Familias has made significant strides in
providing clinical and psycho-educational interventions
that have effectively reduced their mental health problems.
The project has also developed an understanding of
culture-specific barriers to disclosure for Latina mothers
and found ways to address them, as described below.

**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; Perez-Jimenez, Seal, & Serrano-Garcia,
2009).

Additional cultural factors, such as low acculturation
and immigration status, also pose obstacles to disclosure.
Latina 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 (Carmona, Romero, & Loeb, 1999).
Moreno, 2007). Problems with disclosure are also linked to
traditional sex roles, intimate partner violence, and sub­
stance abuse (Amaro & Raj, 2002; Gomez, Hernandez, &
Fajide, 1999; Moreno, 2007; Wyat et al., 2002;
Zambrana, Cornelius, Boykin, & Lopez, 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 partic­
ularly 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 (Perez­
Jimenez, 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 meant to
describe a “real man”—one who is hard working, responsible,
and caring to his family, children, and community. In con­
trast, Machismo has often ascribed Latino men as inflexible
in both male-male and male-female relations, violent, and
exerting 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

...
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.

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 counteracts 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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Barbara Kappes, LCSW
Andy Encinas, MFT Intern
Latino Family Institute
mcristo.phd@gmail.com
www.lfiservices.org

REFERENCES


Appendix F

List of Evaluations Instruments

Copyright Instruments

Intake Interview and Parent/Child Risk Factors
a. Family Assessment Form
b. Developmental Profile II
c. Health Status Interview – HIV/AIDS and Substance Abuse

Baseline Self Report Inventory – English and Spanish
a. Medical Access Form
b. Center for Epidemiology Scale - Depression
c. Short Acculturation Scale-Hispanic
d. Health Related Quality of Life Scale
e. Parent Stress Inventory (sample items)

Follow up Parent & Child Risk Factors Survey
a. Family Services Contact Log
b. Client Satisfaction Survey
Copyright Instruments used for AIA Nuestras Familias evaluation component were:

**Developmental Profile 2 Scale**

Alpern, G. (2002). Developmental Profile 2 User's Guide. Western Psychological Services, Los Angeles. *Note: DP3 is now available and has replaced the DP2. Contact information for this instrument: [https://wps.com](https://wps.com).

**Family Assessment Form**


**Parent Stress Index**:

# NUESTRAS FAMILIAS

## INTAKE INTERVIEW

<table>
<thead>
<tr>
<th>Names</th>
<th>Today's Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewer:</td>
<td></td>
</tr>
<tr>
<td>Client:</td>
<td></td>
</tr>
<tr>
<td>Partner:</td>
<td></td>
</tr>
<tr>
<td>Index Child:</td>
<td></td>
</tr>
</tbody>
</table>

### Client's Relationship to the Index Child

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>biological mother</td>
</tr>
<tr>
<td>2</td>
<td>biological father</td>
</tr>
<tr>
<td>3</td>
<td>grandmother</td>
</tr>
<tr>
<td>4</td>
<td>aunt</td>
</tr>
<tr>
<td>5</td>
<td>client is pregnant – due date:</td>
</tr>
<tr>
<td>6</td>
<td>other, specify:</td>
</tr>
</tbody>
</table>

### Client's Children Under 18 Years of Age

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Date of Birth</th>
<th>Gender (M/F)</th>
<th>Relationship to the Index Child</th>
<th>Resides with *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index Child (named above):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* 1=client  2=client & partner  3=parent & relatives  4=relatives only  5=formal kinship foster care  6=formal non-kinship foster care  7=other placement, specify: |

### Other Adults Living with the Client (don’t include partner and list children over 18 years of age)

<table>
<thead>
<tr>
<th>Adult's Name</th>
<th>Age</th>
<th>Gender (M/F)</th>
<th>Relationship to the Index Child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Client's Current Living Situation

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>lives in own residence</td>
</tr>
<tr>
<td>2</td>
<td>rents a room</td>
</tr>
<tr>
<td>3</td>
<td>resides in a shelter</td>
</tr>
<tr>
<td>4</td>
<td>lives with relatives</td>
</tr>
<tr>
<td>5</td>
<td>lives in a temporary residence (e.g., hotel)</td>
</tr>
<tr>
<td>6</td>
<td>homeless</td>
</tr>
<tr>
<td>7</td>
<td>other, specify:</td>
</tr>
</tbody>
</table>

Is the client caring for a **child** in the same household who is medically fragile, disabled, or HIV/AIDS?

- 1 yes, please describe: ____________________________
- 2 no

Is the client caring for an **adult** in the same household who is disabled/ill (includes HIV+)?

- 1 yes, please describe: ____________________________
- 2 no

### Combined Household Income per Year

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Amount: $</td>
<td>Sources of income:</td>
</tr>
</tbody>
</table>

*note:* an accurate estimate of the total number of people living in the household (pg 1) and combined annual income (above) will be used to determine if the family is living in poverty according to the US poverty guidelines.

### Client's Marital Status

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>married and living with spouse</td>
</tr>
<tr>
<td>2</td>
<td>living with domestic partner</td>
</tr>
<tr>
<td>3</td>
<td>single</td>
</tr>
<tr>
<td>4</td>
<td>separated</td>
</tr>
<tr>
<td>5</td>
<td>divorced</td>
</tr>
<tr>
<td>6</td>
<td>widowed</td>
</tr>
</tbody>
</table>

### Client/Primary Caregiver vs. Partner (if applicable)

#### Date of Birth

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Client/Primary Caregiver</td>
<td>Partner</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>month</td>
<td>day</td>
</tr>
<tr>
<td>month</td>
<td>day</td>
</tr>
</tbody>
</table>

#### Ethnicity

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>White</td>
</tr>
<tr>
<td>2</td>
<td>Hispanic, specify group</td>
</tr>
<tr>
<td>3</td>
<td>Black</td>
</tr>
<tr>
<td>4</td>
<td>Other, specify:</td>
</tr>
</tbody>
</table>

#### Language

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>English only</td>
</tr>
<tr>
<td>2</td>
<td>Spanish only</td>
</tr>
<tr>
<td>3</td>
<td>Bilingual English/Spanish</td>
</tr>
<tr>
<td>4</td>
<td>Other, specify:</td>
</tr>
</tbody>
</table>
### INTAKE INTERVIEW

#### Client/Primary Caregiver

<table>
<thead>
<tr>
<th>Country of Origin</th>
<th>Partner (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 born in another country, specify:</td>
<td>0 born in another country, specify:</td>
</tr>
<tr>
<td>If client was born in US, what is family’s country of origin?</td>
<td>If partner was born in US, what is family’s country of origin?</td>
</tr>
<tr>
<td>How many generations of client’s family were born in the US?</td>
<td>How many generations of partner’s family were born in the US?</td>
</tr>
<tr>
<td>1 1st generation (just client born in US)</td>
<td>1 1st generation (just partner born in US)</td>
</tr>
<tr>
<td>2 2nd generation (client’s parents born in US)</td>
<td>2 2nd generation (partner’s parents born in US)</td>
</tr>
<tr>
<td>3 3rd generation (client’s grandparents born in US)</td>
<td>3 3rd generation (partner’s grandparents born in US)</td>
</tr>
<tr>
<td>4 4th generation (great grandparents born in US)</td>
<td>4 4th generation (great grandparents born in US)</td>
</tr>
<tr>
<td>5 more than 4th generation</td>
<td>5 more than 4th generation</td>
</tr>
</tbody>
</table>

#### Years Living in the US (or age if born in US)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Employment Status

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 not working</td>
<td>1 not working</td>
</tr>
<tr>
<td>2 temporary day work</td>
<td>2 temporary day work</td>
</tr>
<tr>
<td>3 working part-time (fixed number of hours)</td>
<td>3 working part-time (fixed number of hours)</td>
</tr>
<tr>
<td>4 working full time</td>
<td>4 working full time</td>
</tr>
</tbody>
</table>

#### Current Occupation

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Client’s current occupation is (specify):</td>
<td>Partner’s current occupation is (specify)</td>
</tr>
</tbody>
</table>

#### Years of Education*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*examples: 0=never attended school  In U.S., 6=completed elementary school 8=completed junior high school 12=completed high school 14=2 years post high school 16=college graduate 18=Master’s degree; If educated in country of origin, count number of years attended school. |

### Client/Primary Caregiver

<table>
<thead>
<tr>
<th>College/School Attendance</th>
<th>Partner (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 not going to school/college</td>
<td>1 not going to school/college</td>
</tr>
<tr>
<td>2 currently attends college full time</td>
<td>2 currently attends college full time</td>
</tr>
<tr>
<td>3 currently attends vocational/certificate training school full time</td>
<td>3 currently attends vocational/certificate training school full time</td>
</tr>
<tr>
<td>4 currently attends college part time</td>
<td>4 currently attends college part time</td>
</tr>
<tr>
<td>5 currently attends vocational/certificate training school part time</td>
<td>5 currently attends vocational/certificate training school part time</td>
</tr>
</tbody>
</table>
**Child Welfare Involvement**

1. Client's DCFS involvement:
   - 1 has never been involved with DCFS
   - 2 has been involved in the past, but case is closed
   - 3 is involved in a volunteer DCFS case plan
   - 4 has an open DCFS case

2. Index child detained due to abuse or neglect:
   - 1 never detained
   - 2 detained in the past and returned to client
   - 3 currently detained and placed with relatives (kinship care)
   - 4 currently detained and placed in non-kinship foster care

2a. If child detained, check reason(s):
   - □ neglect
   - □ physical abuse
   - □ sexual abuse
   - □ emotional abuse

3. Siblings of the index child under 18 years detained due to abuse or neglect: □ N/A (no siblings)
   - 1 never detained
   - 2 detained in the past and returned to client
   - 3 currently detained and placed with relatives (kinship care)
   - 4 currently detained and placed in non-kinship foster care
   - 5 adopted

5. Client had "hotline child abuse" calls
   - 1 never
   - 2 yes, once only
   - 3 yes, multiple calls

---

**PAST Parent Risk Factors (occurring during childhood or more than 12 months ago)**

--- Be sure to fill in the gray boxes for any applicable items ---

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>client</th>
<th>partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Witnessed domestic abuse (between adults) as a child</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Victim of spousal abuse in the past (over a year ago)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. Grew up in a household with substance abuser(s)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. Past substance abuse (over a year ago)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. Substance abuse during previous pregnancies</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. Victim of childhood abuse (type: physical__ sexual__ emotional__ neglect__)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>7. Involved with DCFS as a child</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>8. Lived in foster placement(s)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>9. Court identified in the past as abusive/neglectful</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>10. Any incarcerations (specify number: ___)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>11. Homelessness/unstable living situation</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>12. Substandard living conditions or temporary housing</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>13. Chronic unemployment</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>14. Trauma(s) (specify: ____________)</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
**INTAKE INTERVIEW**

### Parent Health & Mental Health Risk Factors*

~~~ Be sure to fill in the gray boxes for any applicable items ~~~

<table>
<thead>
<tr>
<th></th>
<th>client</th>
<th>partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Developmental delay/learning disability</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Physical disability (specify type &amp; onset:</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. Mental health disorder (specify type &amp; onset:</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. Taking medication for a mental health disorder (specify if known:</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. Chronic medical illness* (specify:</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. Taking medication for a chronic medical condition (specify if known:</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>7. HIV positive or AIDS (specify:</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

*note: use this section to record only those conditions diagnosed by an appropriate professional*

### CURRENT Parent Risk Factors (within the past 12 months*):

~~~ Be sure to fill in the gray boxes for any applicable items ~~~

<table>
<thead>
<tr>
<th></th>
<th>client</th>
<th>partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Marital/Partner discord</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Victim of spousal abuse (specify:</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. Substance abuse (specify drug(s):</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. Exposure to substance abuse in the household (specify drug(s):</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. Poor or limited parenting skills</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. Poor or limited job skills</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>7. Isolation</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>8. Inadequate or no health insurance</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>9. Recent medical illness, expected to improve (specify:</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>10. Incarceration within the past year</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>11. On probation or parole during the past 12 months</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>12. Illiteracy: unable to read in any language</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>13. Illiteracy: unable to write in any language</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>14. Recent traumatic event (specify:</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

*note: use this section to record only those conditions that have occurred within the past year*
## Index Child's Prenatal/Neonatal Risk Factors

--- Be sure to fill in the gray boxes for any applicable items ---

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Biological mother did not have prenatal care.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>2. Prenatal exposure to drugs/alcohol (specify: ________________________)</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>3. Born positive to alcohol or drugs (specify: ________________________)</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>4. Preterm and/or low birthweight</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>5. Fetal alcohol syndrome</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>

---

## Index Child's Health & Mental Health Risk Factors

--- Be sure to fill in the gray boxes for any applicable items ---

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medically fragile (specify: ________________________)</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>2. Developmental delay/learning disability (specify: ________________________)</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>3. Physical disability (specify: ________________________)</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>4. Child mental health disorder (specify: ________________________)</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>5. Chronic medical illness* (specify: ________________________)</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>

* including HIV/AIDS, asthma, seizure disorder, etc.

---

*note: use this section to record only those conditions diagnosed by an appropriate professional

## Index Child's CURRENT Risk Factors (within the past 12 months*)

--- Be sure to fill in the gray boxes for any applicable items ---

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Exposure to domestic violence (between adults)</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>2. Exposure to substance abuse in the household (specify drug(s): ________________________)</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>3. Multiple foster placements</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>4. Lack of &quot;well child&quot; pediatric care</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>5. Victim of abuse or neglect (specify type: ________________________)</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>6. Inadequate nutrition, caloric deprivation or anemia (specify: ________________________)</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>7. Taking medication for a mental health disorder</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>8. Medical illness, expected to improve (specify: ________________________)</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>9. Taking medication for a medical condition</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>10. Recent traumatic event (specify: ________________________)</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>

*note: use this section to record only those conditions that have occurred within the past year

<table>
<thead>
<tr>
<th>Index Child's CURRENT Emotional/Behavioral Problems:</th>
<th>Source (check one or both)</th>
<th>Severity (check one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>reported by parent</td>
<td>observed by examiner</td>
</tr>
<tr>
<td>1. Impulsive/hyperactive</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Aggressive/destructive</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. Attention difficulties</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. Defiant/oppositional</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. Anxious/fearful</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. Depressed/withdrawn</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>7. Other problems?</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

specify:
<table>
<thead>
<tr>
<th>Case History &amp; Client Interview Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>
### Medical Diagnosis

1. Medical Diagnosis is:  
   - [ ] AIDS  
   - [ ] HIV Symptomatic  
   - [ ] HIV + Asymptomatic

2. Date of Diagnosis: [ ] (When client was informed)

3. Transmission Category:  
   - [ ] Homosexual  
   - [ ] Bisexual  
   - [ ] Heterosexual  
   - [ ] I.V. Drug User  
   - [ ] Blood Transfusion  
   - [ ] Hemophiliac  
   - [ ] Birth

4. Client was infected by: [ ] (specify):

5. Client was informed of HIV/AIDS diagnosis by:  
   - [ ] Partner  
   - [ ] Physician  
   - [ ] Lab Tests (routine)  
   - [ ] During a Hospitalization  
   - [ ] HIV/AIDS Test  
   - [ ] Parent(s)  
   - [ ] Relative/Friend

6. Was a retest conducted to confirm the client's positive HIV results?  
   - [ ] Yes  
   - [ ] No

7. Did client (or child's parent) seek a "second opinion"?  
   - [ ] Yes  
   - [ ] No  
   - If yes, where?  
     - [ ] United States  
     - [ ] Other Country, specify if possible:

### Present Medical Status

8. Client's most recent laboratory results:
   - CD4 as of [ ]
   - CD4%  
   - Viral Load

9. Karnofsky Scale assessment:  
   - [ ] Stage I=100-80  
   - [ ] Stage II=70-60  
   - [ ] Stage III=50-40  
   - [ ] Stage IV=30-20

10. Is client presently disabled due to HIV/AIDS?  
    - [ ] Yes  
    - [ ] No

11. Has this client been hospitalized in the past:  
    - [ ] week  
    - [ ] 30 days  
    - [ ] 6 months  
    - [ ] year  
    - [ ] no

### AIDS-related Illnesses

Please check any AIDS-related illnesses or co-existing illnesses the client is experiencing currently:

- [ ] PCP
- [ ] wasting syndrome
- [ ] gynecological problems (abnormal PAP, yeast infections)
- [ ] cervical cancer
- [ ] Kaposi's Sarcoma (lesions in the skin or internal organs)
- [ ] thrush (fungal infection)
- [ ] toxoplasmosis (swelling, lesions in brain)
- [ ] meningitis
- [ ] dementia (memory impairment)
- [ ] mood disorders (anxiety disorders)
- [ ] TB
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] other, specify:
**Medication Treatment**

Note: questions 12-15 apply to the pregnancy & birth of the child identified as the AIA Index Child only

<table>
<thead>
<tr>
<th>question</th>
<th>yes</th>
<th>AZT</th>
<th>yes, other</th>
<th>no</th>
<th>n/a</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Did client take medication for HIV/AIDS during pregnancy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, give start &amp; end months: ___ (month began meds) to ___ (month ended meds)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Was newborn placed on HIV/AIDS medication?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, how long was medication given to newborn?: ___ weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Did the newborn test positive for HIV?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Was the newborn breastfed by the mother?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Is client currently taking medication for HIV/AIDS?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Is the client currently compliant to medication treatment?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no, why not?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medication Side Effects**

Please check any medication side effects the client is experiencing currently:

- Lipodystrophy (redistribution of body fat)
- Skin irritation, rash
- Peripheral neuropathy (pain, numbness in hands, feet)
- Dizziness
- Headaches
- Fatigue, weakness
- Numbness around mouth
- Swelling around mouth
- Taste perversion
- Oral ulcers
- Nausea
- Vomiting
- Diarrhea
- Loss of appetite
- Weight loss
- Abdominal pain, discomfort
- Anemia
- Low blood pressure
- High blood pressure
- Menstrual irregularities
- Kidney stones
- Pancreatitis
- Fever
- Delusions
- Impaired concentration
- Insomnia
- Mood disorders
- Other, specify: __________________________

**Alternative Treatments**

Please check any alternative treatments for HIV/AIDS the client is seeking currently:

- Herbal/homeopathy
- Nutritional supplements
- Acupuncture
- Proper nutrition/diet
- Healer/curandera
- Other, specify: __________________________
HEALTH INTERVIEW

Substance Abuse Participants

Today's Date: ________________

Medical Conditions

1. Please check any medical conditions the client is experiencing currently:
   - tuberculosis
   - heart disease
   - seizures
   - blood clots
   - ulcer
   - gallstones
   - diabetes
   - thyroid irregularities
   - asthma
   - emphysema
   - chronic bronchitis
   - kidney stones
   - kidney infections
   - tuberculosis
   - heart disease
   - seizures
   - blood clots
   - ulcer
   - gallstones
   - diabetes
   - thyroid irregularities
   - asthma
   - emphysema
   - chronic bronchitis
   - kidney stones
   - kidney infections

   - bladder infections
   - STDs
   - arthritis
   - gynecological problems
   - Hepatitis A
   - Hepatitis B
   - Hepatitis C
   - HIV/AIDS
   - severe headaches
   - mental health disorder
   - cancer
   - back problems
   - other, specify: ________________________

2. Has client received medical treatment for the above condition(s)? [ ] yes [ ] no

3. Has this client had any surgeries during the past year? [ ] yes [ ] no

Drug History

1. Please check the client's primary drug of choice in the primary column. (Check more than one drug in the primary column only if the client is or was a polydrug user (i.e., client used more than one drugs on a regular basis). In the recent column, please check any drugs client has used in the past 6 months.

<table>
<thead>
<tr>
<th>primary</th>
<th>recent</th>
<th>primary</th>
<th>recent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>alcohol</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>cocaine/crack</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>marijuana</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>heroin</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PCP</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>amphetamines/speed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>methamphetamines</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>hallucinogens (LSD, mushrooms)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>club drugs (roofies, ecstasy, Special K, GHB)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>inhalants (whippets, poppers, etc.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>prescription meds (Vicodin, Valium, etc.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>other, specify: ________________________</td>
<td></td>
</tr>
</tbody>
</table>

1. How long did the client use drugs? [ ] less than 1 year [ ] 1-5 years [ ] over 5 years

2. How long has the client been drug-free? [ ] less than 1 month [ ] 1-6 months [ ] over 6 months

3. At what age did client first started drinking alcohol or using drugs? ________ years
Por favor contesta las preguntas que siguen. Avisa/os si necesitas ayuda.

### Acceso al servicio médico

<table>
<thead>
<tr>
<th>Pregunta</th>
<th>Estoy muy de acuerdo</th>
<th>Estoy algo de acuerdo</th>
<th>No estoy seguro</th>
<th>Estoy algo de desacuerdo</th>
<th>Estoy muy en desacuerdo</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Si necesito cuidado de hospitalización, me pueden ingresar sin ningún problema</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Me resulta difícil obtener cuidado médico en una emergencia</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. De vez en cuando es problemático cubrir mi porción del costo de una visita de cuidado médico</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. De vez en cuando no recibo el cuidado médico que necesito porque es demasiado caro</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. La clínica debería estar abierta más horas de lo que está abierta en actualidad</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Tengo acceso fácil a los médicos especialistas que necesito</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Los lugares donde puedo recibir cuidado médico están ubicados en lugares locales</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Si tengo una pregunta médica, puedo comunicarme con un médico o enfermero para que me presten ayuda</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Puedo recibir cuidado médico cuando lo necesite</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. El personal médico entienden mi cultura hispana(o)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. El personal médico se comunican con migo en mi idioma (Español/Inglés/otro.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Número</td>
<td>Descripción</td>
<td>Raramente o ninguna vez</td>
<td>Alguna o poca vez</td>
<td>Ocasionalmente o una cantidad moderada</td>
<td>La mayor parte o toda el tiempo</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>------------------</td>
<td>----------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>1.</td>
<td>Me molestaron cosas que usualmente no me molestan</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>No me sentía con ganas de comer; no tenía apetito</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>Me sentía que no podía quitarme de encima la tristeza aún con la ayuda de mi familia o amigos</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
<td>Sentía que yo era tan bueno/a como cualquier otra persona</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
<td>Tenía dificultad en mantener mi mente en lo que estaba haciendo</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6.</td>
<td>Me sentía deprimido/a</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7.</td>
<td>Sentía que todo lo que hacía era un esfuerzo</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8.</td>
<td>Me sentía optimista sobre el futuro</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9.</td>
<td>Pensé que mi vida había sido un fracaso</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10.</td>
<td>Me sentía con miedo</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11.</td>
<td>Mi sueño era inquieto</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12.</td>
<td>Estaba contento/a</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13.</td>
<td>Hablé menos de lo usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14.</td>
<td>Me sentí solo/a</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15.</td>
<td>La gente no era amistosa</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16.</td>
<td>Disfruté de la vida</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.</td>
<td>Pasé ratos llorando</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18.</td>
<td>Me sentí triste</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19.</td>
<td>Sentía que no le caía bien (gustaba) a la gente</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20.</td>
<td>No tenía ganas de hacer nada</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
### Idiomas Preferidas (SAS-H)

<table>
<thead>
<tr>
<th>Pregunta</th>
<th>Sólo Español</th>
<th>Español mejor que Inglés</th>
<th>Ambos por igual</th>
<th>Inglés mejor que Español</th>
<th>Sólo Inglés</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Por lo general, ¿qué idioma(s) lee y habla usted?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. ¿Cuál fue el idioma(s) que habló cuando era niño(a)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Por lo general, ¿en qué idioma(s) habla en su casa?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Por lo general, ¿en qué idioma(s) piensa?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Por lo general, ¿en qué idioma(s) habla con sus amigos(as)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Por lo general, ¿en qué idioma(s) son los programas de televisión que usted mira?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Por lo general, ¿en qué idioma(s) son los programas de radio que usted escucha?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Por lo general, ¿en qué idioma(s) prefiere oir y ver películas, y programas de radio y televisión?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Las siguientes preguntas le preguntarán sobre sus amigos y su familia. En estas preguntas, la palabra "Latinos" incluye a la gente de México, Puerto Rico, Cuba, y otros países latinoamericanos. La palabra, "Americanos", incluye a la gente que no son Latinos.

<table>
<thead>
<tr>
<th>Pregunta</th>
<th>Sólo Latinos</th>
<th>Más Latinos que Americanos</th>
<th>Casi mitad y mitad</th>
<th>Más Americanos que Latinos</th>
<th>Sólo Americanos</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Sus amigos y amigas más cercanos son:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Usted prefiere ir a reuniones sociales/fiestas en las cuales las personas son:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Las personas que usted visita o que le visitan a usted son:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. Si usted pudiera escoger a los amigos(as) de sus hijos(as), ¿cuántos(as) fueran:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
HEALTH-RELATED QUALITY OF LIFE

1. Voy a leerle una lista de actividades. Por favor digame si su salud le ha limitado mucho, un poco o nada al hacer cada una de estas actividades en las últimas cuatro semanas (Circle One Number on Each Line)

<table>
<thead>
<tr>
<th></th>
<th>SI, LO HA LIMITADO MUCHO</th>
<th>SI, LO HA LIMITADO UN POCO</th>
<th>NO, NO LE HA LIMITADO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td></td>
<td></td>
<td></td>
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<td>c</td>
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<td>d</td>
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<td></td>
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<tr>
<td>e</td>
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<td>f</td>
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<td>g</td>
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<tr>
<td>h</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>i</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Durante las últimas cuatro semanas, ¿le ha impedido su salud (READ ACTIVITY) todo el tiempo, algunas veces, o nunca?

<table>
<thead>
<tr>
<th></th>
<th>SI, TODO EL TIEMPO</th>
<th>SI, ALGUNAS VECES</th>
<th>NO, NUNCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Durante las últimas cuatro semanas, ¿cuántos días se tuvo que quedar en la cama por 1/2 día o más a causa de su salud?

DAYS: ______________

4. Durante las últimas cuatro semanas, ¿cuánto interfirió el dolor con su trabajo normal (incluyendo el trabajo fuera de la casa y los quehaceres de la casa)? Diría Ud.:

(Circle One)
- Para nada, ................................................................. 1
- Un poquito, ................................................................. 2
- Moderadamente, ......................................................... 3
- Bastante, o ................................................................. 4
- Mucho? ................................................................. 5

5. Durante las últimas cuatro semanas, ¿en cuánto ha interferido su salud o sus problemas emocionales con sus actividades sociales normales con su familia, amigos, vecinos, o grupos? Diría Ud.:

- Para nada, ................................................................. 1
- Un poco, ................................................................. 2
- Moderadamente, ......................................................... 3
- Bastante, o ................................................................. 4
- Mucho? ................................................................. 5

6. En general, diría Ud. que su salud en estas últimas cuatro semanas fue:

- Excelente, ................................................................. 1
- Muy buena, ................................................................. 2
- Buena, ................................................................. 3
- Regular o ................................................................. 4
- Mala? ................................................................. 5

7. Por favor digame que tan ciertas o que tan falsas han sido las siguientes frases para Ud. durante las últimas cuatro semanas:

<table>
<thead>
<tr>
<th>DEFINITIVAMENTE</th>
<th>MAS O MENOS</th>
<th>MAS O MENOS</th>
<th>DEFINITIVAMENTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIERTO</td>
<td>CIERTO</td>
<td>SABE</td>
<td>FALSO</td>
</tr>
</tbody>
</table>

a. ........... Parezco enfermarme más fácilmente que otras personas. 1 2 3 4 5

b. .................. Me he estado sintiendo mal últimamente. 1 2 3 4 5

8. ¿Cuánto tiempo durante las últimas cuatro semanas (READ ITEM). Diría Ud. todo el tiempo, la mayor parte del tiempo, una buena parte del tiempo, alguna parte del tiempo, un poco de tiempo, o nunca?

LA MAYOR    UNA BUENA    ALGUNA    UN POCO
a. Se ha sentido calmado/a y tranquilo/a? 1 2 3 4 5 6
b. Se ha sentido desanimado (desconsolado/a) y triste? 1 2 3 4 5 6
c. Se ha sentido cansado/a? 1 2 3 4 5 6
d. Ha sido Ud. una persona feliz? 1 2 3 4 5 6
e. Ha sido Ud. una persona muy nerviosa? 1 2 3 4 5 6
f. Ha tenido suficiente energía para hacer las cosas que quería hacer? 1 2 3 4 5 6
g. Se ha sentido tan triste que nada le podía alegrar? 1 2 3 4 5 6
h. Ha estado ansioso/a o preocupado/a? 1 2 3 4 5 6
i. Se ha sentido deprimido/a? 1 2 3 4 5 6

9. Durante las últimas cuatro semanas, ¿cuánto ha interferido su salud física o sus problemas emocionales con sus actividades sociales (como visitar amigos, parientes, etc.)? Estas respuestas son un poco diferentes. Diría Ud.:

(Circle One)

Todo el tiempo, .................................................. 1
La mayor parte del tiempo, .................................. 2
Parte del tiempo, ............................................... 3
Un poco del tiempo, o ......................................... 4
Nunca? .......................................................... 5
10. ¿Cuánto dolor de cuerpo ha tenido durante las últimas cuatro semanas? Diría Ud. que:

(Circle One)

Nada ............................................................... 1
Muy poco, ........................................................ 2
Poco, ............................................................... 3
Moderado, ......................................................... 4
Grave, o ............................................................. 5
Muy grave? ......................................................... 6

Por favor complete las preguntas que siguen en la última parte de este cuestionario. Muchas gracias por su ayuda.

Instrucciones

Read each statement carefully. For each statement, please focus on your youngest child, and circle the response that comes closest to describing how you feel.

<table>
<thead>
<tr>
<th>Estoy muy de acuerdo</th>
<th>De acuerdo</th>
<th>No estoy seguro</th>
<th>No estoy de acuerdo</th>
<th>Completamental en disacuerdo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Al veces me siento que no puedo tratar con las cosas de la vida muy bien</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Me encuentro dehando cosas de mi vida por las necesidades de mi niño</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Me siento estafada por las responsabilidades de mi niño</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Cuando nací mi niño, no hay pudieron ser nueva o diferente cosas</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
# Changes in Parental Risk Factors

Please review the client’s intake interview. For each item below, circle one number for “occurred”:

1. reported/observed during the intake interview
2. disclosed after the intake interview but may have been present prior or at time of intake
3. occurred after intake interview (during program participation)

Check the “improved” box for any items that have improved since occurrence.

<table>
<thead>
<tr>
<th>Item</th>
<th>Client Occurred</th>
<th>Client Improved</th>
<th>Partner Occurred</th>
<th>Partner Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Marital/Partner discord</td>
<td>1 2 3</td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>2. Victim of spousal abuse within the past year</td>
<td>1 2 3</td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>3. Substance abuse</td>
<td>1 2 3</td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>4. Exposure to substance abuse in the household</td>
<td>1 2 3</td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>5. Poor or limited parenting skills</td>
<td>1 2 3</td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>6. Poor or limited job skills</td>
<td>1 2 3</td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>7. Isolation</td>
<td>1 2 3</td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>8. Inadequate or no health insurance</td>
<td>1 2 3</td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>9. On medication for a mental health disorder</td>
<td>1 2 3</td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>10. Acute medical illness</td>
<td>1 2 3</td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>11. On medication for an acute or chronic physical condition</td>
<td>1 2 3</td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>12. Incarceration or on probation or parole</td>
<td>1 2 3</td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>13. Illiteracy: unable to read in any language</td>
<td>1 2 3</td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>14. Illiteracy: unable to write in any language</td>
<td>1 2 3</td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>15. Experiencing stress due to a recent traumatic event</td>
<td>1 2 3</td>
<td></td>
<td>1 2 3</td>
<td></td>
</tr>
</tbody>
</table>
Please review the client's intake interview.

For each item below, circle one number for "occurred":
1 = reported/observed during the intake interview
2 = disclosed after the intake interview but may have been present prior to intake or at time of intake
3 = occurred after intake interview

Check the "improved" box for any items that have improved since occurrence.

### Changes in Index Child Risk Factors

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>occurred</th>
<th>improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Exposure to domestic violence</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>2. Exposure to substance abuse in the household</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>3. Lack of &quot;well child&quot; pediatric care</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>4. Victim of abuse or neglect</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>5. Inadequate nutrition, caloric deprivation or anemia</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>6. Taking medication for a mental health disorder</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>7. Acute medical illness, expected to improve</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>8. Recurring health problem</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>9. Taking medication for an acute or chronic physical condition</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>10. Experiencing stress due to a recent traumatic event</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>11. Index child detained</td>
<td>1 2 3</td>
<td></td>
</tr>
</tbody>
</table>

### Changes in Index Child's Emotional/Behavioral Problems

<table>
<thead>
<tr>
<th>Behavioral Problem</th>
<th>occurred</th>
<th>improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Impulsive/hyperactive</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>2. Aggressive/destructive</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>3. Defiant/oppositional</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>4. Anxious/fearful</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>5. Depressed/withdrawn</td>
<td>1 2 3</td>
<td></td>
</tr>
</tbody>
</table>
# Latino Family Institute, Inc.

**FAMILY SERVICES CONTACT LOG**

## Instructions

- Please record every type of contact between project staff and families enrolled in the project.
- The evaluation team uses this log to capture program services and track ongoing family involvement. Please submit a copy of the log whenever other forms for this family are submitted to the evaluation team. Please add notes and/or services that are not listed below. Mark date form was submitted at bottom of form.

## Codes for Types of Service and Contact with Families

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assessment (Intake, Parent Risk factors, PSI...)</td>
</tr>
<tr>
<td>2</td>
<td>Parenting with Discipline Curriculum</td>
</tr>
<tr>
<td>3</td>
<td>Concrete Services (resources-food bank, clothes)</td>
</tr>
<tr>
<td>4</td>
<td>Parenting Support</td>
</tr>
<tr>
<td>5</td>
<td>Substance Abuse Support Group</td>
</tr>
<tr>
<td>6</td>
<td>HIV Support Group</td>
</tr>
<tr>
<td>7</td>
<td>Drug Counseling-Individual</td>
</tr>
<tr>
<td>8</td>
<td>HIV Counseling-individual</td>
</tr>
<tr>
<td>9</td>
<td>HIV Education</td>
</tr>
<tr>
<td>10</td>
<td>Health-Mother</td>
</tr>
<tr>
<td>11</td>
<td>Health-Index child</td>
</tr>
<tr>
<td>12</td>
<td>Health-Siblings</td>
</tr>
<tr>
<td>13</td>
<td>Health-Partner</td>
</tr>
<tr>
<td>14</td>
<td>Health-Prenatal Mother</td>
</tr>
<tr>
<td>15</td>
<td>Health-Prenatal Teen</td>
</tr>
<tr>
<td>16</td>
<td>Referral (contact name only)</td>
</tr>
<tr>
<td>17</td>
<td>Referral &amp; Linkage</td>
</tr>
<tr>
<td>18</td>
<td>Social/Recreational</td>
</tr>
<tr>
<td>19</td>
<td>Health-Other relatives</td>
</tr>
<tr>
<td>20</td>
<td>Psychotherapy</td>
</tr>
<tr>
<td>21</td>
<td>Other, specify below</td>
</tr>
</tbody>
</table>

*Note: Referral & Linkage case management services include at least 2 of the following: (1) identifying service provider to meet service need (2) calling and scheduling an appointment (3) transporting client/family (4) attending first visit and assisting with paperwork/intake process.*

## Contact Log

<table>
<thead>
<tr>
<th>Contact Date</th>
<th>Type</th>
<th>Duration</th>
<th>Location</th>
<th>Contact Level</th>
<th>Modality</th>
<th>Initials</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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AIA Nuestras Familias

Client Satisfaction Survey

Client ID: ______________

Today's Date: __________

Date of Program Termination: __________

Is this the first time client has received HOME BASED services? □ Yes □ No

If NO, Is client currently receiving HOME BASED services from a different program? □ Yes □ No

The person being interviewed is: □ the biological mother □ the mother's partner/husband

Format completed

[ ] Face-to-face Interview
[ ] Telephone Interview
[ ] Self Report

read instructions below, and continue with questions on the next sheet

fill in CLIENT ID and DATE on the next sheet then give that sheet to the client or partner to complete

Verbal Instructions

"Nuestras Familias is interested in knowing how satisfied families were with our services and program."

"I would like to briefly ask you some questions about the services you received and the program staff."

"Agreeing to answer these questions is strictly voluntary and your responses will be confidential. This questionnaire will be given to our project's evaluator, Dr. Cristo, who completes the evaluation of our federally funded program."

"You will only need to choose one response (verbal) to each question after I have read them to you."

"Do you agree to participate?" __ Yes __ No

"Do you have any questions before we begin?" Please answer any questions, repeat response choices before beginning and thank client for agreeing to participate.
In order to improve our project, Nuestras Familias is interested in knowing how satisfied families were with the services they received. Please rate each of the following services by placing a check mark (✓) in the column that shows your level of satisfaction with the service. Select only one rating for each question. Your answers are very important to our program and strictly voluntary. The information you provide is confidential and will only be provided to the project's evaluation team.

Please do not write your name on this form.

<table>
<thead>
<tr>
<th>Program Services</th>
<th>Completely Satisfied</th>
<th>Mostly Satisfied</th>
<th>A Little Bit Satisfied</th>
<th>A Little Bit Dissatisfied</th>
<th>Mostly Dissatisfied</th>
<th>Completely Dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting (classes/home-based)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Education</td>
<td></td>
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<td></td>
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<tr>
<td>Counseling</td>
<td></td>
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<tr>
<td>Substance Abuse Education</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>HIV Education</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Referrals to other services for my family and/or myself</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Access to other services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latino Cultural Family Activities or Structured Family Social Events</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>CQI</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Staff level of knowledge</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Staff level of support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff level of knowledge of Community resources</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Resources provided through the program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response time for receiving resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please rate your overall satisfaction with the services you have received</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please add any comments you would like to make:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Appendix G

References
References


The Women's Alcoholism Center. "Raising the Roof: Building an Alcoholism Treatment Program for Women and Children." San Francisco, CA.

The Source Vol. 19 No. 2 The National Abandoned Infants Assistance Resource Center