

Culturally Responsive Measurement Tool – Protective Factors (CRMT-PF)

Pre-Test Single Assessment
 Post-Test

This survey is being conducted for two reasons: to understand your strengths and needs as a family, and--more broadly--to understand what families in King County (of all structures) need to thrive. In this survey we will ask you some questions that relate to the work you do with our program, but there will also be questions that may not seem to relate. For example, we ask questions to understand what families can and cannot afford with their current financial situations. This is not a judgment, nor is it a promise of services. Your responses are confidential and will not be used against you in any way. If there are questions you do not feel comfortable answering, feel free to select "Prefer Not to Answer" when applicable. Your responses will help us understand where we may need to provide/connect resources to families in the future. **Thank you for your honest responses!**

Thinking about your life right now, select the extent to which you agree or disagree with the following statements.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Prefer Not to Answer
1. In general, my family knows we are strong enough to solve problems in our lives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Our family traditions are important to us.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. In general, my family works together to solve problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In general, my family stays hopeful even in difficult times.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. My family is able to find time for things that matter to us.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I feel like I'm always telling my child(ren) "no" or "stop."	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How I respond to my child(ren) depends on how I'm feeling.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. It is important to show that you understand your child(ren)'s feelings when they misbehave.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Parents/caregivers have a big impact on how their child(ren) turn out.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

These questions help us understand your current support system. Thinking about your life right now...

10. I have someone in my life who encourages me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
11. I have someone in my life who is honest with me about difficult topics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
12. When I'm trying to work on achieving a goal, I have someone in my life who will support me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
13. When I need someone to look after my child(ren) on short notice, I can find someone I trust.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
14. I have people I trust to ask for advice about: <i>(select all that apply)</i>	<table border="0"> <tr> <td><input type="checkbox"/> Money / Bills / Budgeting</td> <td><input type="checkbox"/> Food / Nutrition</td> <td><input type="checkbox"/> Caring for my Child / My Children</td> </tr> <tr> <td><input type="checkbox"/> Relationships</td> <td><input type="checkbox"/> Stress / Worries</td> <td><input type="checkbox"/> None of the above</td> </tr> </table>						<input type="checkbox"/> Money / Bills / Budgeting	<input type="checkbox"/> Food / Nutrition	<input type="checkbox"/> Caring for my Child / My Children	<input type="checkbox"/> Relationships	<input type="checkbox"/> Stress / Worries	<input type="checkbox"/> None of the above
<input type="checkbox"/> Money / Bills / Budgeting	<input type="checkbox"/> Food / Nutrition	<input type="checkbox"/> Caring for my Child / My Children										
<input type="checkbox"/> Relationships	<input type="checkbox"/> Stress / Worries	<input type="checkbox"/> None of the above										

Sometimes it is hard for families to pay for things they need. This is not a judgement or a promise of services, but will help us understand what families need to thrive. We appreciate your honest responses.

Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree Prefer Not to Answer

15. I have trouble affording what I need each month.

16. I am able to afford the food I want to feed my family.

17. In the past **month**, were you unable to pay for: (select all that apply)

- Rent or Mortgage
- Childcare / daycare
- Groceries/food (including baby formula/diapers)
- Utilities or bills (electricity/gas/heat/phone/internet, etc.)
- Medicine, medical expenses, mental health services, co-pays
- Basic household or personal hygiene items (including clothes/shoes)
- Transportation (including gas, bus passes, shared rides)
- Other (*specify*):
- I was able to pay for all of these

18. In the past **year**, have you: (*select all that apply*)

- Delayed or not gotten medical or dental care for you or your family
- Moved in with other people, even temporarily, because you could not afford to pay rent, mortgage, or bills
- None of these apply to me
- Been evicted from your home or apartment
- Lost access to your regular transportation (e.g., vehicle totaled or repossessed)
- Lived at a shelter, in a hotel/motel, or in an abandoned building or vehicle
- Been unemployed when you really needed and wanted a job

The following section focuses on your experiences so far with our organization. Your answers to these questions can help staff improve services for you and others like you, so your honest feedback is appreciated.

NOTE: SKIP THIS SECTION IF YOU ARE TAKING THIS AS A PRE-TEST (see top of Page 1)

Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree Prefer Not to Answer

19. When I talk to staff from this program about my problems, they seem to understand.

20. The staff from this program genuinely care about me.

21. The staff from this program have respect for me.

22. The staff from this program help me when I need it.

Participant Information

These last few questions are about you. They will be used to help us understand the needs of people and families we serve. Remember, your responses to this survey are confidential.

23. Gender Identity Woman Non-Binary Prefer to Self-Identify (*fill in*): Prefer not to answer
 Man Two-Spirit
24. Age in years Prefer not to answer
25. Family Structure *Select all that apply* Single Parent Kinship Care Multigeneration
 Two Parent Foster Care Teen Parent
26. Primary language(s) spoken at home: Prefer not to answer
27. Is there a child with a disability in your care? Yes No Unsure Prefer not to answer
28. Age(s) of Children *Select all that apply* 5 and Under 6 to 12 13 to 17 18 and Over
29. How do you self-identify your race or ethnicity? Prefer not to answer
30. Race/ethnicity details: (*please select as many as apply*) Prefer not to answer

American Indian/Alaska Native

Tribal Affiliation/Indigenous Identity (*fill in*):

Asian (*select details if applicable*)

- | | | | | |
|--|-------------------------------------|---------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Chinese | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Bangladeshi | <input type="checkbox"/> Burmese |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Laotian | <input type="checkbox"/> Filipino | <input type="checkbox"/> Indonesian | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Pakistani | <input type="checkbox"/> Sri Lankan | <input type="checkbox"/> Malay | <input type="checkbox"/> Mongolian | <input type="checkbox"/> Nepalese |
| <input type="checkbox"/> <i>Indigenous Identity (fill in):</i> | | <input type="checkbox"/> Taiwanese | <input type="checkbox"/> Thai | <input type="checkbox"/> Vietnamese |
| | | | <input type="checkbox"/> <i>Other (fill in):</i> | |

Black, African or African American (*select details if applicable*)

- | | | | | |
|--|--|------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Batswana | <input type="checkbox"/> Cameroonian | <input type="checkbox"/> Congolese | <input type="checkbox"/> Algerian | <input type="checkbox"/> Angolan |
| <input type="checkbox"/> Gambian | <input type="checkbox"/> Ghanaian | <input type="checkbox"/> Haitian | <input type="checkbox"/> Eritrean | <input type="checkbox"/> Ethiopian |
| <input type="checkbox"/> Liberian | <input type="checkbox"/> Mali | <input type="checkbox"/> Nigerian | <input type="checkbox"/> Jamaican | <input type="checkbox"/> Kenyan |
| <input type="checkbox"/> Somali | <input type="checkbox"/> South African | <input type="checkbox"/> Sudanese | <input type="checkbox"/> Rwandan | <input type="checkbox"/> Senegalese |
| <input type="checkbox"/> <i>Indigenous Identity (fill in):</i> | | | <input type="checkbox"/> Tanzanian | <input type="checkbox"/> Ugandan |
| | | | <input type="checkbox"/> <i>Other (fill in):</i> | |

Hispanic, Latinx, or Spanish (*select details if applicable*)

- | | | | | |
|--|---------------------------------------|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Bolivian | <input type="checkbox"/> Brazilian | <input type="checkbox"/> Chilean | <input type="checkbox"/> Argentinian | <input type="checkbox"/> Belizean |
| <input type="checkbox"/> Cuban | <input type="checkbox"/> Dominican | <input type="checkbox"/> Guatemalan | <input type="checkbox"/> Colombian | <input type="checkbox"/> Costa Rican |
| <input type="checkbox"/> Peruvian | <input type="checkbox"/> Puerto Rican | <input type="checkbox"/> Salvadorian | <input type="checkbox"/> Mexican | <input type="checkbox"/> Panamanian |
| <input type="checkbox"/> <i>Indigenous Identity (fill in):</i> | | | <input type="checkbox"/> Spanish | <input type="checkbox"/> Venezuelan |
| | | | <input type="checkbox"/> <i>Other (fill in):</i> | |

Middle Eastern or North African (*select details if applicable*)

- | | | | | |
|--|-----------------------------------|-----------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Armenian | <input type="checkbox"/> Egyptian | <input type="checkbox"/> Iranian | <input type="checkbox"/> Afghan | <input type="checkbox"/> Algerian |
| <input type="checkbox"/> Kuwaiti | <input type="checkbox"/> Lebanese | <input type="checkbox"/> Libyan | <input type="checkbox"/> Iraqi | <input type="checkbox"/> Israeli |
| <input type="checkbox"/> Saudi Arabian | <input type="checkbox"/> Syrian | <input type="checkbox"/> Tunisian | <input type="checkbox"/> Moroccan | <input type="checkbox"/> Palestinian |
| <input type="checkbox"/> <i>Indigenous Identity (fill in):</i> | | | <input type="checkbox"/> Turkish | <input type="checkbox"/> Yemeni |
| | | | <input type="checkbox"/> <i>Other (fill in):</i> | |

Native Hawaiian or Other Pacific Islander (*select details if applicable*)

- | | | | | |
|--|---|--|--|------------------------------------|
| <input type="checkbox"/> Mariana Islander | <input type="checkbox"/> Marshallese | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Chamorro | <input type="checkbox"/> Fijian |
| <input type="checkbox"/> Samoan | <input type="checkbox"/> Solomon Islander | <input type="checkbox"/> Tahitian | <input type="checkbox"/> Palauan | <input type="checkbox"/> Saipanese |
| <input type="checkbox"/> <i>Indigenous Identity (fill in):</i> | | | <input type="checkbox"/> Tokelauan | <input type="checkbox"/> Tongan |
| | | | <input type="checkbox"/> <i>Other (fill in):</i> | |

White (*select details if applicable*)

- | | | | | |
|--|------------------------------------|----------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Dutch | <input type="checkbox"/> English | <input type="checkbox"/> Belgian | <input type="checkbox"/> Bosnian | <input type="checkbox"/> Croatian |
| <input type="checkbox"/> Greek | <input type="checkbox"/> Icelandic | <input type="checkbox"/> Finnish | <input type="checkbox"/> French | <input type="checkbox"/> German |
| <input type="checkbox"/> Polish | <input type="checkbox"/> Russian | <input type="checkbox"/> Irish | <input type="checkbox"/> Italian | <input type="checkbox"/> Portuguese |
| <input type="checkbox"/> <i>Indigenous Identity (fill in):</i> | | <input type="checkbox"/> Swedish | <input type="checkbox"/> Ukrainian | <input type="checkbox"/> Welsh |
| | | | <input type="checkbox"/> <i>Other (fill in):</i> | |

Culturally Responsive Measurement Tool – Protective Factors (CRMT-PF) Program Information Form

*This form is for staff use only and should be completed by a staff member who is familiar with the program participant.
Please remove this form prior to giving the survey to the participant to complete.*

Interviewer Name:	Type of Interview:	<input type="checkbox"/> Virtual (online) <input type="checkbox"/> In-person	Level of Support Given:	<input type="checkbox"/> A. Fully Supported <input type="checkbox"/> B. Partially Supported <input type="checkbox"/> C. Self-Administered
Date Client Started Services:	Date Client Stopped Services (if applicable):	Estimated Service Hours in Program*:		
Date Survey Completed:	Survey Start Time:	Survey End Time:		
Is English the participant's first language? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, what is the participant's first language?			

**Est. Hours (Post-Test or Single Assessment) Calculation: # of hours per contact x # of times per week/month of contacts x # of weeks/month in program*

Surveyor Reflections – Implementation Testing

*This space is for you to take notes on your thoughts about implementing this tool in your practice with your families.
You will be completing an online survey after you have administered the survey at least 5 times.
You can use these notes to help you remember your thoughts, then use them to complete our survey.
Thank you for your honest feedback!*

Think about all of the assessments you use in your program (Examples: PHQ-9, ASQ, Edinburgh, HOME, PICCOLO). Could the CRMT-PF replace any of those tools?	<input type="checkbox"/> Yes → <input type="checkbox"/> No	If yes, which one(s)?
Would you want your program to use this tool, even if it wasn't required by a funder?	<input type="checkbox"/> Yes <input type="checkbox"/> Maybe <input type="checkbox"/> No	Notes:
How would you describe the purpose of this tool in your own words?	Notes:	

How would your program use the CRMT-PF, and the data it collects? (select all that apply)

- To improve relationships/connections with clients (trust building, getting to know them better)
- To better understand what resources and referrals our clients need
- To better understand why some clients may succeed in our program and others might not
- To better understand family protective factors
- To better advocate for our clients
- My organization would not use the data collected from the CRMT-PF
- Other:

Would implementing this survey into your practice impact your relationships with your clients, either negatively or positively?	<input type="checkbox"/> Yes <input type="checkbox"/> Maybe <input type="checkbox"/> No	Notes:	
When would you want to administer the CRMT-PF in your work with your clients? (select all that apply)	<input type="checkbox"/> During intake <input type="checkbox"/> After client is receiving services <input type="checkbox"/> At exit from services <input type="checkbox"/> Other	Notes:	
How often would you want to administer this survey?	<input type="checkbox"/> Just once per client <input type="checkbox"/> Multiple times per client (to see changes over time)	Notes:	
How would you want to deliver the survey to families?	<input type="checkbox"/> Electronically (online) <input type="checkbox"/> In Person <input type="checkbox"/> Video Call (e.g. Zoom)	<input type="checkbox"/> Phone <input type="checkbox"/> Other (specify):	In what format would you want to deliver the survey? <input type="checkbox"/> Interview style (staff member reads questions and client answers) <input type="checkbox"/> Client completes on their own

Other thoughts about the tool:

Thank you for your support!