Paraprofessionals* have played an important role in the provision of health and social services to families in other countries for many years. Use of peers as counselors and health educators gained popularity in the United States as a result of the Economic Opportunity legislation and the proliferation of drug treatment programs in the 1960's. Many programs during that time employed peer health workers with cultural and community characteristics similar to the target population to teach prevention and increase the use of maternal-child health services (Aiken et al., 1984; Warrick et al., 1992).

More recently, lay workers have played a large role in outreach associated with AIDS prevention. Additionally, for more than a decade, Resource Mothers Programs across the country have employed paraprofessional women in an effort to help prevent infant mortality and improve birth outcomes and maternal-infant relationships. Increasingly, programs are using peer workers to provide pregnant and parenting women at-risk with home visits and social support in an effort to foster better maternal and child health.

In a recent survey of Abandoned Infants Assistance (AlA) programs, the National AlA Resource Center found that more than a quarter currently employ peer workers (see O'Brien's article on page 4). To supplement the information revealed through that survey, telephone interviews were conducted with administrators of eight non-AlA programs. This article uses information from these conversations, as well as current literature, to explore issues related to the employment of peer workers.

Rationale for Employing Peer Workers
Peer workers generally act as brokers or liaisons between clients and institutions, and between professional and lay attitudes and behaviors. Experience indicates that clients who are of the same race and ethnicity as their counselors have a better rapport, greater trust and higher levels of self-disclosure, especially when their counselors are paraprofessionals (Berg & Wright-Buckley, 1988). Interviewed administrators generally agreed with this and other findings (e.g., Chapman et al., 1990; Gokcay et al., 1993) that low-income families perceive paraprofessionals to be more culturally compatible and communicate information in a way that clients can understand, which may make them more effective in connecting clients with other needed therapeutic interventions and social and health services.

Lay workers can use their networks, personal contacts and knowledge of local "hang-outs" and activity patterns to recruit and locate clients without the suspicion that professionals often evoke. For example, Sharon Scott, Program Director of Miracles and Motion in Cleveland, OH, noted that the Parent Support Workers in her program know the time of day and month that food stamps and welfare checks are delivered to their neighborhood and, if necessary, will go to the food stamp office to find their clients (personal interview, Sharon Scott, 1994). "The underlying assumption is that former addicts will have the street knowledge necessary to better understand and therefore counsel those still addicted" (CSAP, 1993, p. 168).

Peer workers may also be more willing to "go the extra mile" for their clients, and to hug, hold and provide physical as well as...
as verbal support (personal interview, Sharon Scott, 1994; Brown, 1993). Experts generally agree that social support is critical to healthy birth outcomes and maternal-infant relationships, and that many high-risk women are lacking in sufficient social support. “Social support may be understood as the comfort, assistance, and information that persons receive through their contacts with other persons and groups” (Chapman et al., 1990, p. 1060). It may serve as a buffer between stress and its associated physiologic changes, and, as a result, may help improve the well-being of pregnant women and perinatal outcomes (Heins et al., 1987; Spencer et al., 1989).

At the same time, there are limitations to what social support alone can do for pregnant and parenting women at risk. Although peer workers’ personal experience often enables them to identify critical issues for their clients, they may not always know the best way to work out the issues. Therefore, they are most effective when employed as part of a multi-disciplinary team in which the professionals’ and paraprofessionals’ skills complement each other (personal interview, Margaret Burrisie, 1994). In recognition of this, most programs that employ paraprofessionals provide multiple levels of intervention through multi-disciplinary teams which may include nurses, midwives, social workers, nutritionists, psychologists, substance abuse counselors, physicians and child development specialists.

Another rationale for employing indigenous workers is that such hiring allows money and resources to remain in the community (personal interview, Tom Coyle, 1994). Some advocates of the peer worker model contend that paraprofessionals “provide a way of maximizing the acceptability and cultural consonance of supportive services, while holding down the cost of making individual visits to families” (Lerner & Halpern, 1992, p. 92). Others, however, question the actual cost savings realized by employing peer workers when sufficient training and supervision are provided (Wasik, 1993; personal interview, Natalie Levkovich, 1994).

Finally, employment of paraprofessionals can have a profound effect on the self-esteem of workers themselves (Warrick et al., 1992; Poland et al., 1991). Despite the many reasons for employing lay workers, several concerns with this strategy are, to a great extent, attributed to the recognized strengths. Lerner and Halpern (1992) identify four implementation challenges that must be addressed by programs employing paraprofessionals: (1) articulation of a realistic role for lay workers; (2) awareness of skills and personal qualities necessary; (3) establishment of a training system; and (4) provision of a nurturing supervisor. This article explores each of these challenges using examples from various programs around the country.

**Articulating a Realistic Role**

Responsibilities of lay workers must be determined realistically based on their expertise, education and time and case-load expectations. Most experts believe that paraprofessionals can provide general support, referral, advocacy and education if provided with sufficient training and supervision, but that they should not be expected to administer complex, clinical tasks or address specific treatment issues beyond screening and assessment. Regardless of their specific responsibilities, expectations need to be clearly articulated for the paraprofessional as well as other staff.

The most important tasks of lay workers are generally considered to be acting as confidants and providing social support—emotional and tangible. In some cases, their jobs are an extension of the informal helping relationships in which they already take part. As a result, lay workers may be accustomed to providing child care or transportation for their clients, and enhancing clients’ informal and formal social networks (Dawson et al., 1989; Spencer et al., 1989; Warrick et al., 1992). Also, because of their knowledge of the community, and their ability to communicate with clients and deal with client resistance and denial, peer workers frequently are used for outreach work (i.e., recruiting and maintaining ongoing contact with clients). They often serve as the primary link between the client/family and various medical and social services in the community.

In some cases, lay workers go beyond this role and assume significant responsibility for risk-reduction and behavior change efforts such as counseling, education and service coordination (Brown, 1993). In addition to outreach and emotional support, specific tasks of paraprofessionals may include assessing social, health and other needs; assisting women to obtain prenatal and infant health services, entitlements, housing, food, transportation and other necessities; assisting clients to read medical forms; promoting positive attitudes about use and access to health and social services; reducing unhealthy alcohol and drug use; assisting women to set goals and adjust to life’s situations; assisting women with shopping and other domestic chores; and educating women about parenting. Some programs also use indigenous workers to educate network agencies, their own programs, city, state and federal policy makers and other community members about substance abuse and the needs of their clients (Poland et al., 1991; Giblin, 1989; Spencer et al., 1989; Dawson et al., 1989).

Depending on their responsibilities, peer workers’ caseloads range from four to 50 clients, and they tend to perform more activities outside the treatment programs (e.g., in clients’ homes) and meet clients on their own time in public places significantly more often than professionals. Although paraprofessionals typically work an official 32 - 40 hour work week, there appears to be an expectation that they will work longer hours and for less pay than professionals (Aiken et al., 1984).

In interviewing administrators, we found that peer worker salaries in eight non-AIA programs across the country ranged from $12,000 - $26,000/year, all with full benefits. Some experts express concern that providing full salaries to paraprofessionals may result in lost credibility with clients who may perceive them as part of the establishment (Swift et al., 1993). A more serious concern is that low salaries above a certain level may jeopardize a peer worker’s eligibility for public benefits without providing them with sufficient income. This proved true with Sisters Intervention Services in the Bronx, NY. “Sisters” are paid $18,000 - $24,000/year, which disqualifies them from AFDC and Medicaid benefits, but
leaves them with no more expendable income than when they received public assistance (personal interview, Barry Sherman, 1994). The Healthy Start Program in Maryland, and Miracles and Motion and Healthy Families/Healthy Start in Cleveland, OH, were able to avoid this problem by developing agreements with their county welfare departments which enable peer workers to continue to receive AFDC supplemental employment benefits for a certain period of time.

Several therapeutic community programs have taken another approach to the salary issue by establishing a principle of equal pay for equal work regardless of educational background (Brown, 1993). Nevertheless, while salaries vary widely among regions and programs, most program administrators and AA peer workers report that paraprofessionals are underpaid for the work they do (personal interviews, 1994; O'Brien, this issue).

Skills and Personal Qualities

Peer workers typically are individuals who share the ethnic/cultural qualities, beliefs and values of their clients, have similar educational and life experiences and live in the same community as their clients. Selection is also based on subjective characteristics such as personal warmth, empathy and an interest in helping people, as well as some knowledge of community resources. In addition, although paraprofessionals are not chosen based on specific academic preparation, some programs require that they have a high school diploma or equivalent, or some experience in the social service field.

While these general characteristics typify most lay workers, specific recruitment criteria depend to a great extent on the role each worker will assume. Experience indicates that programs in which lay workers have frequent contact with professionals in other agencies and play a more public role as advocates tend to place more emphasis on educational achievement. Programs which rely on paraprofessionals for social support and interpersonal work with families are likely to be more concerned with personal qualities (Lamer & Halpern, 1992).

Programs which specifically target substance-abusing women often hire peer workers who are in recovery themselves. Some program administrators, however, express concern that recovering counselors may relapse, or that their overidentification with a client can compromise their effectiveness. As a result, some programs attempt to hire counselors who have been in recovery for a minimum length of time, typically one to three years. This issue often creates a dilemma for program administrators who are prohibited by the Americans with Disabilities Act from asking job applicants questions regarding sobriety. Moreover, most program directors view education and experience as being more significant than substance abuse history (Anderson & Wiemer, 1992). While some programs hire former clients, others recruit peer workers through tenants’ associations, clinics, churches and other neighborhood networking channels—especially word of mouth (Swift et al., 1993; personal interviews, 1994).

Training

Training is a critical component to any program that employs paraprofessionals, but it varies widely in content, format and intensity. Programs which focus on lay home visitors as educators typically provide extensive structured initial training with regular ongoing training, while some programs in which home visitors primarily provide social support may offer less structured, shorter training sessions (Chapman et al., 1990).

For instance, Parent Support Workers (PSWs) at Miracles and Motion (Cleveland, OH) use a variety of specific protocols to educate pregnant and postpartum women who use drugs and/or are mentally ill. To prepare PSWs for this and other tasks, the program provides them with a ten-week classroom training, followed by a one-month on-site interactive orientation to the program. The training is funded by Job Training Partnership Act (JTPA).
Perspectives of Paraprofessionals: A Survey of AIA Peer Workers

Paraprofessionals or peer workers play an important role in programs serving families affected by substance abuse and HIV. This article provides the perspective of paraprofessionals on their effectiveness in working with clients, challenges they face working in their respective agencies and in the field, and ways in which programs can improve staff relationships and effectively use the unique experience and knowledge peer workers bring to the job.

The AIA Resource Center conducted in-depth telephone interviews with 21 peer workers from the nine AIA programs employing paraprofessional staff. Paraprofessionals or peer workers are defined here as staff who are employed for reasons other than their academic preparation. Although the survey results are not necessarily generalizable to other programs, they offer formative information regarding the use, development, and support of paraprofessional staff in family support programs.

Paraprofessional Respondent Characteristics

The peer workers interviewed included 19 women and two men who had been employed at their respective programs for an average of one and a half years. Of the paraprofessionals interviewed, 76% currently resided, and 10% had previously resided, in the community served. Almost half (48%) of the peer workers were in substance abuse recovery with an average length of recovery of just under five years. Other personal attributes paraprofessionals mentioned as preparation for their work included teenage motherhood, graduation from the program and being (or having been) in a relationship with a substance abuser.

In addition to personal experience, the majority of paraprofessionals (67%) had relevant work experience including employment in the fields of substance abuse treatment (14%), case management and home visiting (14%), other social services (14%), elementary and secondary school education (14%), and nursing and medical assisting (10%). Less than a fifth (19%) of the peer workers interviewed had obtained a college degree.

All the paraprofessionals interviewed had aspirations for continuing their education. Just over three-quarters (76%) planned to obtain college degrees in related fields such as social work and education, and approximately a quarter (24%) had plans to become certified in areas such as alcohol and drug counseling and rape counseling. Most of the respondents stated that their programs provided encouragement for them to address their educational and professional goals, however, the degree of support varied. Nearly half of the paraprofessionals reported that their program provided some type of support for continued education. Specifically, paraprofessionals were provided: certification while working in the program (19%), financial assistance with college (10%), paid time off to attend college classes (10%), and flexible time to attend college classes (10%).

Service Provision

In general, paraprofessionals believed that they provide a "bridge" between the world of the client and the world of the professional staff. The majority (67%) indicated that they assisted clients with resources and referrals to appropriate services (e.g., drug treatment). Some peer workers advocated for and accompanied clients applying for public assistance, while others transported the clients to drug treatment. Modeling a drug-free lifestyle and parenting skills were other services commonly provided, with two-thirds providing some type of parenting education. Additional services provided include: home management skills, often involving assistance with shopping and cleaning, and supportive counseling. Nearly all (90%) of the paraprofessionals interviewed provided these services in the clients' homes.

On average, paraprofessionals interviewed were responsible for a caseload of 13 clients, with a range from four to 36. The majority (62%) were employed full-time (37 to 40 hours per week), over a third (38%) worked overtime, and 14% stated that they were available to clients on-call.

Training

It is generally believed that training of paraprofessionals should follow the same principles as professional preparation, including pre-service training, which ideally includes field training, and ongoing in-service training. Although the intensity
and type of pre-service training received by paraprofessionals interviewed varied among the programs, the majority of respondents (57%) indicated that they had received training prior to providing clients services, 38% indicated that they had not received any pre-service training, and one paraprofessional could not recall whether training was provided prior to service delivery (see Figure 1). Of those peer workers interviewed who had not received pre-service training, two stated that they had been employed in similar positions in the past, three were given written information or told procedural information, and one had attended conferences. Among the 13 paraprofessionals who had received formal pre-service training, the average length of training was three weeks with a range from four days to six weeks.

Pre-service training addressed such skill-building areas as: charting and client documentation, dealing with families in crisis, conducting an intake and needs assessment, locating community resources, managing stress, using safety precautions, maintaining client confidentiality, and reporting to Children’s Protective Services. Content areas covered in trainings included: substance abuse, HIV, pregnancy, birth control, sexually transmitted diseases, cultural diversity, nutrition and child development.

Two paraprofessionals indicated that their programs used a buddy system of training where new paraprofessional staff were accompanied by seasoned peer workers in the field. These workers found this approach very helpful. Subject areas that paraprofessionals indicated they would like more training in were: substance abuse, how to work with clients in community agencies, locating resources, field observation, concrete counseling skills, coping with stress, HIV and foster care.

Overall, paraprofessional staff agreed about the importance of being trained to work effectively with professionals in community agencies and of having their role clearly delineated within their agency. Additionally, training should reflect the different needs between recovering and non-recovering staff in the area of substance abuse: recovering staff stressed the importance of learning the disease concept of addiction as a framework for working with clients, while non-recovering staff suggested that they needed more basic training on substance abuse signs and symptoms. Finally, paraprofessionals should be given the opportunity to train paraprofessional and professional staff, who can learn from the experience of peer workers.

Supervision

All but two of the peer workers interviewed received regular supervision; the vast majority (80%) received supervision at least weekly and 10% received it monthly. Supervision was most commonly provided by a social worker (63%), followed by a nurse, program director, and substance abuse counselor. Supervision was viewed by nearly all of the peer workers (90%) as helpful. One worker explained that “it is always better to have two or three heads. I am not willing to make decisions about these families alone. I have someone’s life in my hands—it is so crucial to have support.” Paraprofessionals did, however, have suggestions on how supervision could be more helpful, especially that supervisors should go on home visits in order to understand the work of the paraprofessional. As one worker explained, home visiting would allow her supervisor to “be more plugged in and know what it is the peer workers are doing and be able to understand and get a feeling for the work.” Another paraprofessional suggested that “the supervisors need to have a dialogue with us rather than give instructions.” Supervision or outside facilitation may also be needed to address the tensions that arise between professional and paraprofessional staff. Finally, in addition to formal supervision, one worker suggested that paraprofessionals be allowed time for a peer support group without supervisory staff.

Benefits of Paraprofessional Staffing

Building trusting relationships

The types of benefits most often noted by paraprofessionals revolved around the close and trusting relationships formed between paraprofessional and client. There was agreement among two-thirds of the paraprofessionals interviewed that spending time with the client was the primary contributor to improved client trust. Peer workers explained that they have more time than other program staff to spend with clients, and therefore are able to build a relationship before making suggestions or taking actions. As one paraprofessional commented, “It takes a long time, six or eight weeks, just to know someone before you can start to take action, and the case coordinator comes

Continued on next page...
right in and tells them what has to be done.” In order to ensure that peer workers have sufficient time to develop these critical relationships with clients, it is suggested that small caseloads (4-13 clients) be maintained.

Peer workers also stressed the importance of soliciting clients’ self-identified needs and addressing those needs, in addition to the explicit program objectives. “The social worker has specific things that she needs to solve,” explained one peer worker, “like doing the CPS intervention plan, versus the resource mom who can talk about general needs.” Paraprofessionals acknowledged that social workers have a different role in the program and often have many more cases and pressing objectives to accomplish. One peer worker suggested that the paraprofessional and social worker can complement one another—the paraprofessional can prepare the client for the social worker’s visit and help ease the introduction of this new worker.

**Client identification with paraprofessionals**

Another benefit of employing paraprofessional staff is the positive identification clients make with peer staff. “They forget that other people are recovering just like them,” explained one peer worker. “They see us doing what we need to do, not just what we want to do. We are a role model and clients start to change the way they dress, walk, talk, and parent.” The commonality of experience between peer worker and client not only allows them to be a positive role model for the client, but also lends them credibility when giving advice and making suggestions. As one peer worker stated, “[The clients] are more receptive to us because the first thing that comes out of my mouth is that I am in recovery and they let their guard down. They are more willing to take advice and suggestions.” Another emphasized the importance of this role: “We can reinforce what clinic staff wants reinforced in a positive way. . . . They don’t take offense if we say, ‘Give this baby a bath,’ but if the social worker came in and said that she would take offense. We can reach our goals without clients taking offense.”

**Support in recovery**

One concern raised by some professionals in practice and literature—that recovering peer staff working in communities where they once used drugs would jeopardize their recovery—was rejected by paraprofessional staff interviewed. Nine of the ten recovering paraprofessionals interviewed indicated that their work had a positive effect on their own recovery. Only one respondent intimated that working with substance abusing clients “triggered” her desire to use drugs; most emphasized the opposite—that working in the community made recovery easier for the simple fact that it reminded them of what they do not want. One peer worker remarked that her work “makes me grateful for what I have and keeps me in touch with where I came from. It makes me feel good to give some of it back.” Another paraprofessional commented that “it encourages you to take care of yourself and stay in your own recovery because otherwise you wouldn’t be able to function successfully on the job; there is not a lot you can do for the client if you are not sound in your own recovery.” Paraprofessionals also stressed the positive effect seeing someone in recovery can have on the clients they serve: “If I get a client that I knew before and they see me, it is a spark of hope. They see me and think about how my life was and then see how I am now—it is an incentive for the client.” Additionally, paraprofessionals in recovery cited the value of their ability to predict issues that would arise for clients in the process of recovery.

Although there was consensus among recovering paraprofessionals that recovery is a personal issue separate from their work and best addressed outside of the workplace, a few did mention the need for supportive staff and a flexible schedule for outside recovery meetings.

**Working in one’s own community**

Providing service in one’s own community was also viewed positively by paraprofessionals. Two-thirds of the peer workers who were from the community served by the program had worked with a client they knew outside of work. The majority of these workers (60%) had no difficulties in serving clients they already knew. Peer workers did agree, however, that they should be given the option to refuse the case of a client they already know. As one worker explained, “It could be dangerous to work with a neighbor in the case where children may be removed, especially if it is a violent family—they know where you live. One time I had my car messed up, it was a CPS case and the client couldn’t find the CPS worker so they messed up my car.” Similarly, peer workers agreed that the client should have the option to request a different worker; as one peer worker pointed out, a client may not feel safe disclosing information to someone they already know.

Paraprofessionals described their effectiveness not only in terms of benefits to the client, but also in terms of improvements in the program. The trust and positive identification clients develop with peer workers lends greater credibility to the program and draws more clients to the program. As one worker said in reference to the number of clients reached, “We did in six months what [professionals] did in three years.” Additionally, peer workers can influence other staff members as one worker explained, “We are a catalyst for change—we’ve brought a lot of humanness to the job, we make people want to change. We’ve caused other staff to look at their own ideas, agendas and prejudices . . .”

**Issues of Concern**

While paraprofessionals described their work as very effective in serving clients, they also described challenges they had experienced both in the field and within their respective agencies.

**Challenges in the field**

Provision of services in the clients’ home, an integral part of paraprofessionals’ service delivery, posed some challenges for workers, particularly when clients were homeless or in substandard living arrangements. Workers explained that it is difficult to work with clients who are living in garages, motels or shelters where there is no room for privacy and no room to play with the children. One paraprofessional described a situation where a “client was living in a motel room with nine people. It is hard to work in that environment. There

__**continued on page 13 . . .**__
Connie sits across from me relaxed and happy. She has just completed her first large speaking engagement — to participants of the 4th Annual National AIA Grantees Meeting. Connie has two and a half years of working a twelve step program, and uses her experience to help other women in their recovery process. At a petite five feet, she has both a commanding presence and a gentleness.

Where do you get your strength? I need all the strength I can find to cope with the challenges of raising my six children (age four to 19) and assisting my 19-year old daughter in raising her four-month old. I depend on my inner, spiritual strength to deal with these challenges as well as my own issues—the ones that I ran from by “drinking and drugging” since my childhood—and to make my relationships more positive. I also draw on the friendship and support of my significant other, Gabino, my late sister, Hopie, and all my children, who have always been there for me. For so long, my 19-year old had the role of parenting my other children, and at times, me as well. Now we’re friends and we support each other.

Why did you become a peer counselor? My relationship with my peer counselor at Project MPPACT (an AIA project in Dallas, Texas) was one of the major turning points in my recovery and my life. This person, a recovering addict, understood my addiction and identified with my problems without letting me get away with too much. After several months of sobriety, I became a peer substance abuse counselor at a local residential addiction recovery center where I could help others overcome their struggles which I could so closely identify with.

What makes you effective as a peer worker? Being a peer counselor is not always easy. There are heart breaks to deal with like having to evict an abusive client from the residential program, and having clients relapse soon after leaving the program. But I am clear about the program’s goals and my ability to help these women. I draw on my own experiences getting clean to support other women. These women are really dealing with a lot as mothers who took drugs or drank during pregnancy. As a woman and parent in recovery, I can identify with the problems of other parents in recovery including the guilt and anxiety over exposing children to drugs during pregnancy, as well as the guilt of raising children in a household affected by drug-ging. My insight as a past addict also gives me an edge with clients trying to manipulate me. I am a strong survivor; I was once referred to as “dragon lady” by one of my clients who could not snow me. But I have hope for all my clients—even those in the most difficult situations—and try to give each of them the kind of support and acceptance that was crucial to my own recovery.

How has being a peer counselor helped you in your recovery and your personal life? Being a peer counselor has helped me maintain my own recovery because I look at [my clients] and see how far I’ve come and how much I’ve accomplished. It’s a constant reminder of where I came from that keeps me moving forward on track. Being a peer counselor has also helped me identify and develop new strengths in myself as a parent, individual, friend and counselor. It feels good to be able to help people achieve sobriety and get their lives together.

What are your future goals? My first goal is to stay sober on a day-to-day basis. Raising my family is also very important to me. My children continue to learn that I am a parent, someone to depend on, and I do my best to provide them with love, support and guidance. Surrounding myself with women facing similar challenges helps me with these goals. I also volunteer as a parent mentor at Project MPPACT, but I recently moved to a new job as an Education Specialist (at the Tarrant Council on Alcoholism and Drug Abuse in Fort Worth, TX), where I educate families and individuals with substance abuse about recovery. I feel blessed to have the opportunity to share my experience and advise professionals working with addicts.

— Ruth Ann Vosmek, MSW
The Parents and Children Together Program (P.A.C.T.) at Children’s Hospital of Buffalo is a primary pediatric care clinic for children who have been prenatally exposed to cocaine and/or HIV. In addition to the medical care provided to children, the program offers a wide range of social services for the entire family. Perhaps the most unique aspect of the program is its use of peer workers employed by the clinic to provide home-based support services. Originally, the peer workers' job title was Resource Mother. Recently, however, their title was changed to Maternal Infant Specialist to reflect the enhanced training they have undergone as well as their years of experience.

Maternal Infant Specialists

The Maternal Infant Specialists at P.A.C.T. were hired to reflect the population served by the program. The majority of the clients served are African-American, therefore women were recruited and hired from that community. The program currently is looking for a Spanish speaking Hispanic woman to hire because the Hispanic population at P.A.C.T continues to grow, as does the Caucasian population. P.A.C.T. staff are also discussing the possibility of hiring a male, as more fathers are being given custody of their children.

All the peer workers at P.A.C.T. are mothers and were, at some time, single parents. They all have a high school diploma or its equivalent, and several have associate degrees. They are generally from working class families, and a few have admitted to being recovering substance abusers and/or having a significant other with a substance abuse history.

Responsibilities

The Maternal Infant Specialists’ main function is to provide home-based support services to help the client meet both her immediate needs and future goals. Before a peer worker is assigned, the client and social worker meet to develop a service plan and discuss what the role of the Maternal Infant Specialist will be in assisting the client to achieve her goals. The Maternal Infant Specialists provide assistance with concrete needs, such as housing, as well as issues around parenting and child development, and they provide education on HIV risk reduction.

The Maternal Infant Specialists are required to accompany all their clients to their children’s medical appointments and developmental evaluations so they can clarify and reinforce the health care providers’ instructions. They also advocate for their clients as they interface with a multitude of service providers who are not always sensitive to clients’ needs. For example, the majority of women P.A.C.T. works with are required by Child Protection Services to seek drug counseling. However, their need for assistance with transportation and day care are often not addressed. The Maternal Infant Specialist, along with either a social worker or case manager, helps the client gain access to needed services.

Training

The Maternal Infant Specialists completed an initial six week training program that focused on the following areas: infant development, effects of prenatal cocaine use on the mother and child, comforting techniques for cocaine exposed infants, social services (e.g., WIC and public assistance), illegal and legal substances and their effect on individuals and families, domestic violence, HIV transmission, and strategies to engage drug using women.

In October 1993, new training needs were identified and P.A.C.T. decided to provide enhanced training in the following areas: (1) child development from infancy to adolescence; (2) HIV transmission and prevention and the psychosocial impact of the disease; (3) life management skills (e.g., budgeting, problem solving and decision making); and (4) identifying and meeting the needs of pregnant substance abusing women. The child development training was provided by Buffalo State College and consisted of a total of 32 hours of training. The majority of the HIV training was provided by the New York
State Health Department and consisted of six half-day workshops. Children's Hospital of Buffalo's Women's Health Center provided the training on the needs of pregnant substance abusing women, which consisted of twelve hours of training over the course of a month. P.A.C.T. is still in the process of developing the training curriculum for the life management section. In addition, monthly trainings take place during weekly group supervision and are generally provided by program staff or other community agencies.

**Supervision**

Two MSWs supervise six peer workers each and provide individual supervision twice monthly. They use this time to assign and discuss cases, evaluate job performance, develop goals based on clients’ needs, and express feelings around clients and the impact of their work on their personal life. Group supervision led jointly by both social workers is provided weekly. This time is used to share difficult cases with the group and brainstorm solutions. It also enables staff to share the burden of working with a stressful population and coping and stress reduction strategies. For recovering staff, a special emphasis is placed on monitoring stress and possible triggers for relapse. At the same time, it is necessary to encourage outside counseling and/or a leave of absence if a relapse occurs or if the peer worker feels one is imminent.

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**A Peer Worker's Perspective: More Than Just a Client-Worker Relationship**

Kelsey* (a 27 year old woman with a prenatally exposed infant) and I met the day after the birth of her son, Danny*. I was nervous, but luckily Kelsey was receptive and we set up a time to get acquainted.

Kelsey and I became close really fast. I think this was because I presented a friendly, exuberant image, made her laugh, and was different from the professional hospital staff. My training as a Resource Mother (currently termed Maternal-Infant Specialist) made it a goal to become friends with clients and guide them in parenting and remaining clean.

As time went on Kelsey considered me more than just a friend and I considered her more than just a client. I was her one “clean” friend who showed her she could make it without drugs. She, in turn, taught me about drugs and the street life as she knew it.

My training emphasized reconnecting our clients to the community. Kelsey became more involved with her church. She then began volunteering in the soup kitchen. I tried to emphasize that she had a lot to offer the world. Just because Kelsey had been a drug addict and a thief did not mean she had to stay one. I pointed out her success with her older child and the success she was having with Danny. This message had to be repeated many times before Kelsey could even begin to hear it.

For a period of a year Kelsey was doing really well. Danny was a bright and well cared for toddler. I visited once or twice a week. Generally we would spend the entire day together. Often Kelsey and Danny would come to my house.

A couple months after Danny’s first birthday things took a turn for the worse. Danny’s father, who was due to be released from prison, began harassing Kelsey. Kelsey was very frightened and I was scared for her safety so I began to spend extra time with her. I knew stress could bring on drug cravings.

I made it a habit to talk to Kelsey every day. One weekend I could not contact her. I was frantic. That Monday, I found out that Kelsey had been raped. I knew that Kelsey was in danger of relapsing. I met with my supervisor to plot out the best course of action. I wanted to act before Kelsey relapsed and hopefully prevent it.

I began to see Kelsey daily and made sure she attended her NA groups. Slowly, her behavior changed. She became unreliable. She would not be home for our visits and would miss Danny’s doctors appointments. I was increasingly frustrated in trying to influence her in maintaining her recovery. Finally, because she saw me as a friend who cared about her, I was able to confront her about her relapsing. Kelsey tearfully admitted to it. I relied on my training for the right approach to take—non-judgmental and non-punitive. I assured Kelsey that I still loved her but we had to make decisions about the drug usage. I opened up the possibility of a 28-day in-patient rehabilitation program. Kelsey agreed and we made arrangements for the care of her children. Her drug counselor got her admitted within three days.

Kelsey successfully completed her program. She has enjoyed seven months of being clean. Without my training to fall back on I wouldn’t have been able to cope or understand the nature of addiction. With training I was able to help Kelsey, and, at the same time, gain from the support and care she gave me.

*names have been changed

— Jeri Becton
Maternal-Infant Specialist
P.A.C.T. Program

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**Benefits and Challenges**

Employing peer workers has enabled P.A.C.T. to serve larger numbers of families by hiring more staff at less cost. Another benefit of having peer workers on staff is their knowledge of and involvement in the community, which improves both service delivery and future program planning. The home-based services provided by P.A.C.T.’s peer workers increase the professionals’ knowledge of both the strengths and weaknesses of the families served. In addition, because all the program’s peer workers are mothers themselves, they serve as positive role models of women coping with the stress...
Effective Strategies/Techniques in the Supervision of Lay Health Workers

What effective strategies, skills or techniques are needed in the supervision of lay health workers? Based on the experience of the Healthy Family/Healthy Start Program in Cleveland, OH, this article offers supervisors several strategies to incorporate and pitfalls to avoid.

The First Year
In the first year of employment of lay health workers, supervision should be provided on a weekly basis and at a minimum, bi-weekly. Some of the topics that should be part of supervisory sessions include: proper/improper conduct on the job, instructions on directives within a specific organizational setting, case management techniques, how to obtain community resources and educational materials, supervisor/employee relations, work ethics (e.g., time management), targets of program and individual improvement, acknowledgment of personal improvements and strengths, and goal setting to provide a framework and goal(s) to work towards.

Also, mechanisms should be put in place to monitor the "new" lay staff in a positive manner, allowing for constructive criticism and encouraging continued growth and development, i.e., discussing personnel policies/procedures in the form of an educational in-service. Generally, the natural tendency is to focus on what the employee did wrong, but not enough attention is given to their positive traits and the knowledge about "street" and "survival" skills that they bring with them to a more structured and program-driven job.

Street Skills
Background/previous work experience should be considered in supervising indigenous outreach workers. If their experience includes unemployment or underemployment, their professional work habits (e.g., attendance, tardiness) may be based on previous "life survival skills" where they had to use their community/street knowledge in their own daily survival. If they bring these experiences/techniques to the work environment it may not be "in-sync" with the expectations of their immediate supervisor.

This street knowledge, however, can be extremely valuable. It encompasses skills that are not taught in a classroom setting, but can be refined, enriched and developed in a work setting in order to achieve programmatic goals, e.g., "reaching into" a low-income community in need of health care and wellness-based services.

Personal Issues
Supervisors also should spend some time on personal issues (e.g., family conflicts or personal health concerns) that the indigenous workers may bring with them to the workforce. As their length of employment increases, the amount of time spent on personal issues should decrease. An investment in personal issues is not made early on, however, indigenous workers may not learn how to address their personal problems and how to cope with these issues through new methods of conflict/crisis management.

Individuals who have been out of the workforce for a number of years should not be expected to turn around past life management behavior during a 90- or 180-day probationary period. Supervisors must be able to provide "case management" services to these employees to enable them to resolve personal problems or, at the very least, separate personal problems from their professional lives.

Humanistic Approach
There is not one particular style that should be used in the supervision of indigenous outreach workers—they are human, like anyone else, and deserve the type of mutual respect that other staff persons are given. Some of the techniques that may be used are: group and individual orientation; an open-door policy; joint case review (if applicable); weekly staff/team meetings; task review/follow-up; observation and review of staff job performance; probing questions; solicitation of their input and suggestions; "buddying" with more experienced employees; and, more often than not, praise for a job well done.

Whenever a supervisor has the time, individual supervision is more productive than group supervision as a way of addressing personal issues. The benefits of group supervision are that creativity can be used to turn the process into an in-service or training session. Also, one can disseminate program information and requirements more expeditiously. On the other hand, group supervision does not allow for individual conversation and personalized feedback, and, because of various personalities within the group, it requires more patience and group facilitation skills.

Cultural Diversity
Indigenous outreach workers bring with them unique cultural characteristics and values that add to the overall flavor of the whole team. At the same time, these traits and characteristics can also cause tension between members of the team, as individuals maintain their own ideas, beliefs and attitudes. Their backgrounds may be similar, but they still have individual experiences that they consider more important to their own value system.

Situations where these differences may cause unintentional conflict can be turned into educational sessions in which cultural awareness and various values can be shared. "Cultural awareness" becomes one of the educational tools that helps a staff/team become more enlightened and thus enhances their ability to work with other cultural groups throughout the community.
Interaction With Professionals

When lay health workers are placed in a setting with professionals from different disciplines, it has to be made clear, to the professional as well as the indigenous worker, what the lines of responsibility are. Focusing on specific job descriptions helps clarify and delineate individual responsibilities, thus removing the feelings from the worker that they lack certain professional and behavioral skills.

Joint team meetings/conferences help to address this issue, and the supervisors of these teams need to meet and communicate with other supervisors representing the different professional disciplines. Team building in-services become a need instead of a want.

The Recovering Worker

If a staff person is recovering from substance abuse, systems should be in place where he/she can receive ongoing counseling and support (i.e., employee assistance or in-house counseling programs). Supervisors may also provide additional support by accompanying a recovering staff person to a support group. The supervisor's immediate expectations of recovering staff also have to be clearly communicated, and he/she needs to work with those staff persons to ensure that they have the needed resources to accomplish their job duties.

Conclusion

Indigenous outreach workers need to be included in staff/team meetings, in which part of the agenda is designed to obtain their input. This allows them to utilize their firsthand expertise to help determine program policies and activities.

In summary, indigenous workers are crucial in the overall programmatic planning, policy and decision-making that governs program operations. If they are not in agreement with or do not clearly understand such policies and program activities, they cannot carry them out in an effective and sincere manner. They can become "part of the problem or part of the solution" and I am sure that all managers would like to see their community workers as part of the solution.

— Jameela A. Aji-Leigh, MPA
Manager of Outreach Services
Maternity & Infant Health Care

Training Paraprofessionals to Work with Pregnant and Parenting Women

Training of paraprofessionals is accomplished within the context of a specific program’s definition of needs, programmatic emphases and rationale for employing paraprofessionals. I will address these three issues prior to describing a training program for paraprofessionals providing home visiting services to pregnant and parenting women and their infants.

Since 1986, maternal child health advocates have been employed as paraprofessionals in home visiting case management programs developed by Wayne State University’s Institute of Maternal and Child Health. The overriding intention of these programs is to reduce Detroit’s infant mortality rate (20.3 deaths per 1,000 live births—1990 Infant Death Report) and to enhance the health and welfare of mothers and infants.

Programmatic emphases of maternal and child health advocates were developed through interviews of prenatal patients, postpartum mothers and a case comparison study of medical records of infants whose mothers did or did not receive prenatal care. These emphases were: (a) the continuity of deficiencies in the pre- and postnatal periods suggesting the need for a continuity of service through this period; (b) a broad spectrum of women’s needs requiring a needs assessment procedure sensitive to a multitude of problems; (c) the absence of social supports to address these problems suggesting that an effective program must establish an ongoing personal relationship between the client and advocate providing emotional, tangible and informational resources; and (d) systemic barriers to health and human services requiring that advocates act as brokers or liaisons between their clients and institutions (Poland, et al., 1991).

Given these programmatic emphases, we used paraprofessionals who were indigenous to the communities in which services were provided and who shared life histories similar to their clients. We chose the term “advocate” to reflect the importance of their role as culture brokers.

An advocate, as an indigenous paraprofessional, shares with her client a verbal and nonverbal language, an understanding of a community’s health beliefs and barriers to health care services, and an enhanced empathy with, and responsibility towards, a community and its health service needs. Indigenous qualities of advocates were thought to enhance their role as a liaison between professional and lay language, attitudes, and behaviors and their ability to establish an active and credible role in the life of a client (Giblin, 1989).

Training of Indigenous Paraprofessionals

Training of paraprofessionals is described in four phases.

Selection and Recruitment

Selection of advocates emphasized personal characteristics including warmth, ability to learn, evidence of natural leadership, demonstrated ability to accept responsibility, desire to help others and knowledge of community resources. A caution in selecting and employing paraprofessionals drawn from a disadvantaged population is that they may share many of their clients’ problems and deficits thereby hampering the performance of project tasks (Health, 1967).

Training

Training of indigenous paraprofessionals is less the acquiring of specific program skills and more the effort to preserve the indigenous essence of the person. To preserve indigenous values while inculcating
agency priorities urged approaches to training which fostered mutuality and cooperation including: (a) training paraprofessionals and supervisors concurrently to facilitate mutual valuing of skills and perspectives; (b) initially avoiding rigid didactic material; (c) employing informal and practical learning experiences that encourage the sharing of collective experiences (e.g., role-playing, small group activities, field trips, and on-the-job training); (d) providing support and modeling assertive, caring, and problem-solving behaviors and positive self-esteem; and (e) providing a classroom atmosphere that supports a trainee’s contribution to the content and procedures of the training program.

To obtain these objectives, we developed a six-week training curriculum divided into four modules:

A. Enhancement of Interpersonal Skills: to assist pregnant women and new mothers to use human enhancement skills, i.e., value clarification, decision making, self-esteem, and assertiveness.

B. Identification and Use of Community Resources: to interact with project staff, health care agencies, and pregnant women, new mothers and their families to develop strategies to reduce barriers to care.

C. The Role of the Paraprofessional: to demonstrate effective skills for client recruitment and needs assessments, as well as knowledge of the paraprofessional role in an urban setting.

D. Human Growth and Development: to demonstrate knowledge of human growth and development during pregnancy and from birth to young adulthood, and of nutritional needs and parenting skills to improve pregnancy outcomes and infant growth.

**Supervisor and Staff Development**

Indigenous paraprofessionals’ continuing contribution to and growth within a program may be fostered by: involvement with program planning, ongoing evaluation of their technical skills by the professional staff and a review of their social and behavioral skills by their clients, continuing in-service programs to upgrade their skills and responsibilities, and the addition of curative activities and tasks with readily available accomplishments to paraprofessionals’ repertoire rather than limiting their responsibilities to health promotion.

**Institutionalization of Paraprofessionals**

In Michigan, based upon the programmatic contributions of maternal and child health advocate programs, state funded outreach programs for mothers and infants are now required to include indigenous paraprofessionals as members of health and human service teams. Training developed by the Institute of Maternal and Child Health has been employed statewide for the past five years.

— Paul T. Giblin, PhD  
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**REFERENCES**


of parenting while remaining drug-free.

While there are many benefits to hiring peer workers, there are also challenges. Virtually all of the Maternal Infant Specialists at P.A.C.T. have struggled with becoming too personally involved with their clients. The nature of their job requires them to become very close to the families they follow, which in some cases has blurred their objectivity. For example, many of the peer workers take on responsibilities of the mother rather than assisting her in carrying them out herself. In a few extreme cases, this has enabled ongoing drug use.

Another difficulty with peer workers is maintaining boundaries. Some peers have the tendency to not seek the advice of professional staff when handling difficult situations, such as a relapsing client, because they do not want to jeopardize the trust they have built with their clients. However, this may delay the provision of needed services, as well as place children in the family at increased risk for abuse and neglect. Issues such as this create tension between the professional and paraprofessional staff.

A difficulty specific to hiring peer workers who are in recovery is the possibility of relapse. Working with drug-addicted mothers is very stressful and recovering peer workers may find it even more so because they have first hand knowledge of the drug using lifestyle. In many ways this is a benefit because recovering peer workers are examples of the success that can be achieved by stopping drug use. However, by working with women who many times are not in recovery, the peer may be repeatedly exposed to triggers that may have caused their drug use in the past.

Even though there are challenges in employing peer workers, the benefits of having staff indigenous to the population served are great. As stated throughout this article, peer workers are able to more readily overcome barriers related to differences in race and culture. The benefits can be maximized and the challenges minimized by providing ongoing training and supervision for peer staff.

— Kim Donoghue, MSW  
Terry Wright, MSW
was no room for me. We did our work sitting on the bed or on the floor.”

Safety while conducting home visits was another concern expressed by over half of the paraprofessionals (57%). Only a third of the workers indicated that they always felt safe on the job. One worker stated that she “felt safe in all the homes I visit because I have a good relationship with the clients. But in the neighborhoods, I’m scared as hell.” Peer workers were emphatic in rejecting the assumption that they are inherently safer in the client environment than professionals; over three-quarters (79%) asserted that the dangers they face on home visits are just as great as those that professionals would face. One peer worker explained that professionals may feel more afraid in the neighborhoods, but the dangers are the same. Another worker noted, “Outside the clients’ homes no one has control over that situation, you could just be in the wrong place at the wrong time.”

Peers employ various strategies for dealing with these dangers. One peer worker explained that a strategy used by many of the workers is to “make a telephone contact first so that the client is expecting you and to make visits in the morning. Also, have a client looking for you to arrive and get to know the neighborhood and what times of day there are fewer groups hanging around.” Another worker added that when he goes into the neighborhood with his partner they “pull up and get out of the car laughing and acting natural to show that we are relaxed around you so you can be relaxed around us. They can sense that we are no threat.” Other commonly mentioned strategies were to work in pairs, carry or wear nothing of great value (e.g., purses, briefcases, jewelry), and meet in safer locations (e.g., a park or the office).

**Overidentification**

While one of the great strengths of peer staff is their ability to understand and identify with the clients’ world, one of the risks mentioned by a fifth of paraprofessionals interviewed was the potential for overidentification and loss of the distance that allowed them to be a helper. One peer worker said that it is “very difficult for me to detach emotionally from the work and I need to learn not to take the clients home with me emotionally.” Another peer worker explained that “we can get too close and become enablers and not be objective. We can overidentify with someone’s anger instead of addressing it.”

Staff tension

Other difficulties paraprofessionals experienced in their work occurred within the agency or program where they were employed. The majority (62%) of paraprofessionals interviewed reported some degree of tension between the peer and professional staff. Some of this tension may stem from the peer workers’ feeling of being underpaid and, in some cases, undervalued. Only 14% thought that their salary was fair for their job responsibilities. One peer worker pointed out that he “had experience in human services and minority populations and I think people should be paid for that.” Another paraprofessional added that “we get jilted out of money: what we do is dangerous and [although] we may not have degrees we are out on the front line like everyone else and that needs to be taken into consideration more.”

Another source of tension reported by paraprofessional staff was a lack of respect—one worker described “not being respected enough” because “other staff perceive us as just one step above the client.” In some instances, paraprofessionals felt that their understanding and awareness of client issues was not appreciated by the professional staff. Just under half (42%) of the paraprofessionals indicated that they were not included in programmatic decision making. Peer workers stated that their opinions were asked but not always listened to. One peer worker commented that “higher ups are telling us how to do the work when they have never gone on one visit. They can’t tell others what to do if they haven’t ever done it themselves.” And another paraprofessional emphasized that programs are losing the benefit of having workers who are more aware of the clients’ needs.

A few paraprofessionals described how their programs have responded to this problem by including them in program planning. This can inform the professional staff of client and community needs and help programs identify prevention opportunities and ways to rejuvenate the community’s capacity to support recovery and successful parenting. One worker also described the staff’s reliance on her knowledge: “The professionals rely on me. I am the one who knows what is going on in the home. I am really included in the family and trusted and the team knows that.”

In addition to including paraprofessionals in staff meetings and program planning, programs should adequately pay peer workers for the work they do, provide sufficient orientation and in-service training, and offer them opportunities for professional growth. Each of these strategies will complement the peer workers’ capacity to meet the extraordinary challenges of their jobs.

— Kathleen O’Brien, MSW, MPH
which also provides transportation and child care for participants. *Miracles and Motion* pays for all PSWs to become state certified counselors, and, upon request, provides them with tuition reimbursement and time off for ongoing education (personal interview, Sharon Scott, 1994).

Similarly, the Health Federation of Philadelphia’s *Home Visiting Program* employs lay home visitors to, among other tasks, provide health education to families in high risk areas. The program provides lay home visitors with a four-week, full-time initial training program with half-day in-services nine to ten times per year. They also provide money for tuition and expenses for community college courses, and are currently working with the community college to develop a 32 credit certificate program for paraprofessionals (personal interview, Natalie Levkovich, 1994).

In addition, South Carolina’s *Resource Mothers Program*, which uses specific learning objectives to guide Resource Mothers in their home visits with pregnant adolescents, provides an intensive six-week training program as well as bi-weekly continuing education sessions and two, two-day statewide training sessions each year (Heins, 1987; Robinson, 1992).

On the other hand, a demonstration program, which employed paraprofessionals to provide social support in an effort to enhance mother-infant interaction, provided lay home visitors with 30 hours of initial training (Dawson et al., 1989). Similarly, the *Home Visitor Program for Chemically Dependent Pregnant and Postpartum Women and their Children*, which employs paraprofessional case coordinators primarily to provide “therapeutic friendship” and social support to women in Cleveland, OH, offered a two-week initial training. Additionally, the program provides monthly education sessions and is paying for the case coordinators to become certified as substance abuse counselors (personal interview, Kathleen Farkas, 1994).

Regardless of the content, length and intensity of training, experts generally agree that it should be an interactive process which considers the knowledge, attitudes and experience of the lay workers. To facilitate this, supervisors and other staff should be included in as much as possible, if not all, of the training in order to foster feelings of mutuality and cooperation. This also helps to establish the supervisor’s supportive role, to facilitate the development of teamwork, and to enable the supervisor to become familiar with the skills, values and knowledge level of her staff (Giblin, 1989; Poland et al., 1991; Swift et al., 1993).

Opportunities for continuing education also should be provided through tuition support and time-off (Swift et al., 1993). Since indigenous workers typically live in communities characterized by few, if any, employment opportunities, many of them see their jobs as an opportunity to advance professionally (Lerner & Halpern, 1992). However, administrative responsibility seems to be inextricably linked to education, and there does not appear to be a clear career path for paraprofessionals. As a result, although many programs provide opportunities for education or advancement within their agencies, the career ladders for paraprofessionals are typically short (Brown, 1993).

### Supervision

Close, regular, interactive supervision is a key element to a successful paraprofessional program. Lay workers typically are supervised by social workers, nurses, health educators or substance abuse counselors on a one-to-one and group basis. Supervisors generally are expected to oversee cases in addition to providing support, education, mentoring, guidance and, frequently, therapeutic counseling to paraprofessionals (Harris & Schmidt, 1993; Wasik, 1993). They should help lay workers to: (1) understand the limits of their role and responsibility and how they fit into the service team; (2) learn effective ways to work with clients; (3) remain objective and non-judgmental; and (4) recognize how their own feelings and experiences may influence their work (Lerner & Halpern, 1992; Robinson, 1992).

Supervisors also must help peer workers straddle two cultures and find a comfortable balance between professional intervention (typically circumscribed, disciplined, goal-oriented and knowledge-based) and informal social support (relatively unbound, reciprocal, multi-faceted and based on exchanges of personal experience) (Lerner & Halpern, 1992). Frequently, as lay workers transition from being friends or relatives in the neighborhood to upwardly mobile, “professional” intervenors, they are viewed differently by the community. This may affect the client/worker relationship by jeopardizing the clients’ acceptance of the worker (Lerner & Halpern, 1992; Giblin, 1989). On the other hand, or possibly to compensate for this, peer workers often become consumed with personal concerns of their clients and less focused on their roles of educator and facilitator. Therefore, program administrators believe that supervisors must help peer workers set therapeutic boundaries (e.g., understanding why not to lend money to clients), clarify their roles and responsibilities, and find the balance between their responsiveness to family interests and needs and attainment of program goals (personal interviews, 1994).

Lay workers also may have difficulty adjusting to their new personal lifestyle as professionals. This proves true in *Sisters Intervention Services* in the Bronx, NY, where peer counselors (all of whom are graduates of the substance abuse program) become ineligible for AFDC or Medicaid when they become employed, and consequently must learn to make monthly rent payments and use regular health insurance, often for the first time (personal interview, Barry Sherman, 1994). Peer workers in Baltimore’s *Healthy Start Program*, on the other hand, maintain their AFDC benefits in addition to a salary, but as a result, often experience the confusion of “serving two masters”—the program and the welfare system (personal interview, Tom Coyle, 1994).

Additionally, indigenous workers may share some of the problems, behavioral patterns or beliefs characteristic of the client population, and be resistant to or uncomfortable with the values and practices of the agency. For instance, program administrators note problems of missed appointments, tardiness, absenteeism, lack of follow through on assignments, poor documentation and organization and short
notice of vacation or resignation. While these habits may be incompatible with program expectations, they often come hand-in-hand with the fundamental intent of hiring indigenous workers (Giblin, 1989; Lamer & Halpern, 1992). Herein lies a paradox for supervision of peer workers: increased education and adoption of program objectives may socially and psychologically distance lay workers from their clients and result in a gradual deterioration of their indigenous essence, thus losing an important element of the therapeutic relationship (Giblin, 1989; Brown, 1993). This change, however, may be more than counterbalanced by even greater effectiveness and advanced career opportunities for paraprofessionals.

Along with training and close supervision, inclusion of lay workers in programmatic decisions, and mutual respect and reciprocity between the professional and paraprofessional staff, are critical. To significantly empower indigenous workers, they must assume program tasks such as goal setting, prioritization of clients' needs, participation in developing and implementing service protocols, and participation and review of program evaluation (Giblin, 1989). For example, all paraprofessional staff of the Home Visitor Program for Chemically Dependent Pregnant and Postpartum Women and their Children (Cleveland, OH) were included in the development of the program's policies and procedures manual through a group consensus model, and they participated in the hiring of all new professional staff (personal interview, Kathleen Farkas, 1994). Cocaine Use in Pregnancy: A Comprehensive Care Project in Springfield, MA, also provides paraprofessional case managers with the chance to influence program policies. In addition to weekly staff meetings, the paraprofessionals meet weekly with the program evaluator and participate in all-staff semi-annual retreats (personal interview, Susan McQuiston, 1994).

Some professionals caution that indigenous workers may not accurately represent the true needs of their communities because they are too engulfed in its problems; that they may express community concerns in the form of criticisms of the project's objectives; and that by serving as a liaison between provider and client, they may further separate the professional from direct contact with the community (Giblin, 1989). Most experts believe, to the contrary, that including peers in programmatic decision-making tends to improve their sense of value to the program which, in turn, encourages them to work harder and more effectively. Programs also may benefit from new ideas for program improvement and community representation in program and policy development (Giblin, 1989; Swift et al., 1993).

Evaluation/Conclusion

Various comparative studies have been conducted to determine the effect of paraprofessionals on the health or behavior of clients. Most program administrators believe that peer workers increase the subjective well-being of their clients. There also are reports of paraprofessionals affecting changes in health habits, health outcomes or health knowledge of clients, and improving the way they view themselves (Poland et al., 1991). Still, evidence on various clinical effects of using peer workers (e.g., health and birth outcomes) and their impact on behavior modification and participation in prenatal care remains inconclusive. Additionally, little reliable information exists on the relationship between specific indigenous characteristics, services provided by peer workers, and specific client outcomes.

Therefore, while the employment of paraprofessionals appears to positively influence work with women who are at risk of abandoning their children, more evaluative research must be conducted to confirm the specific factors that make these programs work and the clientele that is most likely to benefit from such programs. In the meantime, experience indicates that peer workers can play a major role in identifying and serving families at-risk if sufficient staff support and training are provided.

— Amy Price, MPA

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