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BUILDING UPON THE

UNIQUE STRENGTHS OF PEER WORKERS

In summer 2000, the National Abandoned Infants Assistance (AIA) Resource Center staff conducted a qualitative survey of AIA demonstration projects to learn more about the various intervention strategies and practices they use. The information presented in this article is compiled from both published research in the field as well as the expertise of AIA practitioners that responded to this survey. Currently, approximately one-third of the AIA projects employ paraprofessionals.



Overview

Peer workers are paraprofessionals whose backgrounds and experiences parallel those of the clients they serve. They promote health among groups that traditionally have lacked access to adequate care. Within AIA demonstration programs, peer workers have: assisted clients in identifying needs and accessing resources; worked as outreach workers and parent educators; and functioned as role models. Peer workers also provide substance abuse counseling, personal support, and home visitation services to their clients. Their involvement and support have been shown to have a

positive effect on the following outcomes: infant birthweight; general infant health; interaction between mother and infant; duration of breast feeding; prevention of repeat pregnancies; and the use of prenatal care and community resources by pregnant and parenting women (Flynn, 1999; Schafer, Vogel, Viegas & Hausafus, 1998; Perino, 1992; Chapman, Siegel & Cross, 1990).

In addition to the positive impact that they have on client outcomes, peer workers benefit agencies in other ways. They improve the cost effectiveness of services, facilitate a more holistic understanding of clients, and increase client access to and utilization of services (Dodds, Bryson, Nuehring, Lizzotte, & Abruzzino, 2001). Further, AIA programs have identified the following common strengths of peer workers: unique ability to engage and empathize with clients, and assess client needs and behaviors; willingness and ability to use a wide range of intervention strategies; strong commitment to their work; and a "natural" ability to advocate on behalf of clients (Survey of AIA Programs, 2000).

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However, peer workers' effectiveness depends, in part, on a variety of external factors including:

- targeted recruitment and careful screening,
- clear roles and responsibilities,
- comprehensive initial and ongoing training,
- supportive supervision, and
- prevention and resolution of client/worker boundary dilemmas.

This article addresses some of these program components that are associated with effective peer work.



Recruitment Strategies

AIA programs have relied on varied recruitment strategies. Effective peer worker programs include those that have recruited directly from their client population, as well as those that have recruited from the community at large (Sherman, 1998; Blumenthal, Eng & Thomas, 1999). Among programs that recruit within the community at large, peer workers that are identified by their fellow community members as "natural helpers" are particularly effective (Blumenthal et al, 1999).

The specific recruitment criteria for peer workers will depend, in large part, on the roles that these workers are expected to assume. For example, greater emphasis may be placed on educational achievement if workers are expected to have frequent contact with professionals or act as advocates in the community; conversely, one's personal qualities may be most relevant if the peer will be expected to provide social and personal support to clients (Sherman, 1998).

Similarly, ethnic matching between workers and clients is often advantageous, but the extent to which it should be emphasized should depend on the role that the peer worker is expected to fill. If the peer worker is expected to establish personal relationships with his/her clients or to provide services within a hidden or hard-to-reach community, then some effort should be made to match workers and clients on the basis of ethnicity (Berg & Wright-Buckley, 1988; Elwood, Montoya, Richard & Dayton, 1995). However, ethnic matching may be less critical when the peer worker's role is that of educator (Tom & Cronan, 1998).

In the field of substance abuse treatment, recovery status is often taken into consideration when hiring peer workers. Many program directors and supervisors view recovering and nonrecovering substance abuse counselors as equally competent (Anderson & Wiemer, 1992). However, recovering counselors have been shown to be particularly effective in the following aspects of substance abuse treatment work: early confrontation of denial; role modeling; teaching new habits of sobriety; endorsing a wide range of treatment goals; and using varied interventions (Anderson & Wiemer, 1992; Stoffelmayr, Mavis & Kasim, 1998).

Of course, during recruitment, it also is important to determine if candidates have the necessary skills and abilities to successfully serve clients. One method of eliciting this information is through the use of vignettes (Keim, 2000). For example, program managers can ask prospective peer workers how they would respond to specific situations that accurately reflect the program's work and dilemmas that peer workers face.

"In our program, the recruitment criteria for peer workers are based largely on personal experience. Workers are selected because they are street smart and they know the ins and outs of their clients' communities. For example, when clients need help with public assistance, peer workers know what to do because they have been in the same position."

— *Michele Erazo, Program Coordinator, Leake & Watts Services*



Clear Roles & Responsibilities

AIA programs identified the following most common roles/responsibilities of peer workers: building a relationship, outreach, social support, and education. One of the most important responsibilities of a peer worker is to establish a trusting relationship with his/her client (Rahimian & Pach, 1999).

BUILDING A RELATIONSHIP

Peers that work with substance abusers often find that disclosing their recovery status helps them to establish these relationships. In the words of one peer worker: "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” (O’Brien, 1994, p. 6). However, self-disclosure of the counselor’s recovery status should be used judiciously. Considerations of the reason for the disclosure, the purpose it will serve, and the effects on the counseling relationship should be made before disclosure (Doyle, 1997).

Further, peer workers that initially attend to their clients’ most immediate problems appear to be particularly effective at bonding with them. This might include obtaining clothes and diapers for newborns, locating temporary housing, and assisting with welfare benefits. These activities demonstrate to clients very early that the peer workers care and can be trusted (Grant, Ernst, Streissguth, Phipps & Gendle, 1996).

The duration and frequency of client/worker contact also impacts the ability of peer workers to establish relationships and work effectively with their clients. Drug addicted women that are assigned to peer workers for three years are more likely to enter treatment, stay in recovery, and subsequently address other issues in their lives than drug addicted women who are assigned to workers for less time (Grant et al, 1996). Peers that work as home visitors have a positive impact on infant health when services are provided continuously from birth through infancy, and when the intensity of contact between mother and worker is high (Poland & Giblin, 1991; Poland, Giblin, Waller & Hankin, 1992). Peer workers themselves seem to appreciate the amount of time that must be invested in a client before change can occur. As one peer worker commented, “It takes a long time, six to eight weeks, just to know someone before you can start to take action” (O’Brien, 1994, p. 5). However, the intensity and

frequency of client/worker contact should depend upon the specific needs of the clients. Expecting all clients to commit to a certain number of home visits each month, for example, may contribute to client drop out (Korfmacher et al, 1999).

OUTREACH

Among their many responsibilities, peer outreach workers are expected to penetrate social networks, locate and recruit hidden populations, assess client behavior, respond to client needs, and build the trust necessary to engage clients in risk-reduction interventions (Elwood et al, 1995). In some cases, outreach workers also are expected to provide information to network agencies, fellow staff, and officials of city, state, and federal governments (Poland et al, 1991).

SOCIAL SUPPORT

Peer workers, regardless of the specific work they do, often are expected to provide social support to their clients. The provision of social support appears to be most effective when it includes emotional support on a one-to-one basis, as well as the practical case management that clients need in order to make connections within their local communities. Peer workers who begin helping clients to make these connections during the first few months of pregnancy appear to have a more positive impact on infant health outcomes than those workers who begin providing assistance in the latter part of pregnancy (Tessaro et al, 1997).

EDUCATION

With sufficient training, peer workers also can be relied upon to provide health education services to their clients. These services include nutritional and lactation counseling, information on birth control and safe sex, and details about a wide range of services available in the client’s local community (Blumenthal et al, 1999; Poland et al, 1992; Schafer et al, 1998).

“Overall, peer workers are very effective. They are able to build strong relationships with clients and are therefore able to work with clients in a unique and effective way. On home visits, for example, clients are very open to what peer workers have to say and often take their advice.”

— *Judy Pack, Former Project Director, Great Starts*



Training: An Opportunity for Integration

The training of peer workers provides an opportunity for agencies to foster commonality and respect among professional and paraprofessional staff. To facilitate this, trainings should be interactive and should recognize the unique strengths of peer workers. Supervisors

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and other staff should be involved in peer worker trainings as much as possible. Also, training should be structured around the individual skills, knowledge, and attitudes of peer workers. Gathering this information may require that peer workers complete individual assessments so that their professional strengths and weaknesses can be better understood by supervisors and trainers.

“We attempt to integrate peer workers into our program right away. The current peer worker in our agency attends staff meetings and works as part of a multi-disciplinary team. She is often accompanied by other staff when she is working in the community. One key to training is flexibility which means that trainings need to be adapted to meet the specific needs of the peer worker.”

— *Tina Goodman-Brown,
Former Clinical Supervisor,
Project Stable Home*

Peer workers should receive both initial and ongoing training. The training content, format, and intensity will depend, in part, on the roles that peer workers are expected to assume. Programs that employ peer workers as health educators generally offer intensive initial trainings which might include several months of field and classroom work (Sherman, 1998). When peer workers largely are relied upon for social support, initial

trainings may be less intensive and emphasis may be placed on field experience. Ongoing trainings should take place at least once a month and should include all staff. These trainings may be provided on-site by program staff or other community agencies.

Additionally, opportunities for continuing education outside the agency should be provided through tuition support and time-off. (See Gould article in this issue for more detailed information on training paraprofessional home visitors.)



Supportive Supervision

Supervision often is provided on both an individual and group basis. Peer workers may regard individual supervision as a fact-finding mission in which supervisors aim to point out their failings. Therefore, attention should be paid to the positive traits, skills, and accomplishments of peer workers during individual supervision (Hiatt, Sampson, & Baird, 1997). Individual supervision should be provided to peer workers on a weekly basis. Optimally, individual supervision sessions last between one and two hours. When possible, it is recommended that supervisors be available for informal, unscheduled individual sessions as well (Hiatt et al., 1997).

Group supervision often is used to compliment the achievements made during individual supervision. Group supervision time may be used to: 1) present cases; 2) share coping and stress reduction strategies; 3) clarify the responsibilities of professional and paraprofessional staff and; 4) explore the ways in which the different values and beliefs of staff members can be incorporated into program goals and

GENERAL TRAINING GUIDELINES

- train peer workers and supervisors together to encourage shared skills and perspectives;
- avoid rigid didactic material;
- use informal, practical, and interactive learning methods (e.g., role playing, small group activities, field trips, on-the-job training);
- provide support and model assertive, caring, and problem-solving behaviors; and
- encourage the trainee's contribution to the content and procedures of the training program (Sherman, 1998).

practices (Azar, 2000; Donoghue & Wright, 1994).

Supervisors need to demonstrate flexibility when working with peer workers, as their supervisory roles will change frequently, varying from administrator to teacher to supportive “therapist” (Hiatt et al, 1997). In their role as teachers, supervisors may want to address a wide range of topics including: case discussions; socialization to the work environment; boundaries between clients and staff; organizational and clinical skills; transference and counter-transference; case management techniques; and work ethics.

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INTERVENTION WITH ALCOHOL AND DRUG ABUSING MOTHERS AND THEIR CHILDREN: THE ROLE OF THE PARAPROFESSIONAL



Introduction

Recently, there has been a resurgence in early intervention home visitation programs to improve the health and well-being of disadvantaged families, and a concurrent debate over the relative merits of professional versus paraprofessional home visitors (Korfmacher, O'Brien, Hiatt & Olds, 1999; Musick & Stott, 1990; Olds & Kitzman, 1993). The skills that professionals and paraprofessionals bring to the intervention are distinctly different but complementary (Berlin, O'Neal & Brooks-Gunn, 1998; Wasik, 1993), and both have advantages. Professionally credentialed home visitors carry authority and instill trust on the basis of their expertise. On the other hand, paraprofessionals with shared culture and some common experiences may understand clients in a way that allows them to gain access and build rapport with women who might otherwise be unapproachable (Musick & Stott, 1990; Wasik, 1993). Regardless of professional status, the background, level of training, and personal characteristics of the home visitor may influence program delivery and outcomes (Hiatt, Sampson & Baird, 1997; Korfmacher, 1998).

The Parent-Child Assistance Program (PCAP) is a paraprofessional model that has consistently demonstrated positive outcomes with alcohol and drug dependent mothers (Ernst,

Grant, Streissguth & Sampson, 1999; Grant, Ernst & Streissguth, 1996, 1999). This article describes PCAP's theoretical underpinnings, the benefits and challenges of employing paraprofessionals, and the administrative components that contribute to the success of the program.



The PCAP Model: Paraprofessional Intervention

The Parent-Child Assistance Program began in 1991 as a 5-year research demonstration project funded by the Center for Substance Abuse Prevention. It was designed to test the efficacy of a model of intensive, long-term paraprofessional advocacy with very high-risk mothers who abuse alcohol or drugs heavily during pregnancy and are estranged from community service providers. Mothers are enrolled in PCAP during pregnancy or shortly after delivery. The primary goal of the program is to prevent the births of future alcohol and drug affected children, either by helping women avoid alcohol and drug use during pregnancy, or by motivating women to prevent pregnancy if they are still using alcohol or drugs. Reducing maternal substance abuse and preventing unwanted pregnancy have positive effects for the mother—by removing barriers that hinder her ability to build a healthy, productive life—and potentially for her children—by improving the quality of the home environment

and redirecting the mother's attention to their care.

In 1996, on the basis of demonstrated positive outcomes, the Washington State Legislature appropriated funds for continuation of the Seattle program and expansion to a second site. In 1999, two additional sites were funded, creating a capacity to serve 360 families statewide. PCAP has since been replicated at a dozen sites in the United States and Canada.

PCAP intervention activities are conducted by paraprofessional advocates who each work with a caseload of 15 families for three years. Advocates receive initial and ongoing training, and are clinically supervised by a master's level professional in social work, mental health, or chemical dependency treatment. The model uses a case management approach to help mothers reduce the spectrum of risk behaviors associated with substance abuse, and to increase protective factors to enhance the health and social well-being of the mothers and their children. PCAP does not provide direct substance abuse treatment or clinical services. Instead the program offers consistent home visitation and links women and their families with a comprehensive array of existing community resources, with an emphasis on alcohol/drug treatment, family planning, housing, health care, parenting, and legal resources. Advocates visit client homes frequently during the first 6 weeks, and then approximately twice a month depending on client needs. They transport clients and their children to important appointments and work actively within

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the context of the extended family. Advocates trace clients who are missing, stay in contact with the clients' family members, and provide advocacy services for the infant regardless of who has custody. Clients are never asked to leave the program because of relapse or setbacks.

Among 156 PCAP clients who have recently completed 36 months in the program: 88% of mothers had completed alcohol/drug treatment programs; 83% had at least one period of abstinence from alcohol/drugs of 6 months or more; 73% were using family planning methods on a regular basis, and 45% were using more reliable family planning methods; 76% of children were living with their own families.



The PCAP Model: Theoretical Foundations

The critical component of the advocacy model is the personalized, caring support over three years, a period of time long enough for the process of gradual and realistic change to occur. When we ask clients what it is that made this program work for them, we hear the concept "persistence" repeatedly: "My advocate never gave up on me. She kept believing in me until I finally started to believe in myself."

The PCAP model draws on concepts of relational theory, which emphasizes the importance of positive interpersonal relationships in women's growth, development, and definition of self (Miller, 1991; Surrey, 1991), and in their addiction, treatment, and recovery (Amaro & Hardy-Fanta, 1995; Finkelstein, 1993). The model puts into operation the idea that paraprofessionals with some common

history and life experiences can play a unique and therapeutic role in two ways: by helping clients become connected to another person in a trusting, healthy relationship for perhaps the first time in their lives; and by bridging the gap between high-risk families and needed services they are unlikely to obtain without help.

Stages of change theory and the constructs of self-efficacy theory dovetail, and both have been useful in explaining how home visitors and paraprofessional peer counselors are able to have a positive influence on clients' efficacy expectations, motivational states, and ultimately on behavior (Olds, Kitzman, Cole & Robinson, 1997; Sherman, Sanders & Yearde, 1998). Clients are recognized to be at different stages of readiness for change at different times, and it is understood that ambivalence about changing addictive behavior is normal (Miller & Rollnick, 1991; Prochaska & DiClemente, 1986; Rollnick & Bell, 1991). Self-efficacy refers to an individual's belief in her ability to accomplish the behaviors required to produce desired outcomes (Bandura, 1977). An individual's efficacy expectations are influenced most powerfully by information from her own performance accomplishments, and by other sources of information such as verbal persuasion, vicarious experiences, and emotional arousal (Bandura, 1977). Paraprofessional advocates can have a positive effect on clients' self-efficacy in several ways: 1) by providing concrete, practical opportunities to accomplish goals of abstinence, recovery, and social adjustment, and by helping clients recognize and celebrate each step toward performance achievements; 2) by offering ongoing verbal and emotional encouragement regardless of temporary setbacks or relapse; 3) by role-modeling from a pragmatic, experience-based perspective; and 4) by

helping clients learn daily coping strategies, including complying with mental health recommendations and medication regimens in order to avoid negative emotional mood states.



The PCAP Model: In Practice

An important characteristic shared by advocates is that they have experienced some of the same types of adverse life circumstances as their clients, but have overcome obstacles and subsequently achieved success in important ways, e.g., by going back to school, maintaining steady and meaningful employment, and staying in long-term recovery if they had an alcohol or drug problem in the past. It is because of this that they are able to be positive role models and offer their clients hope and motivation from a realistic perspective. For example, among the 24 current PCAP advocates, 15 (62.5%) are in recovery from alcohol or drug abuse, but all had been in recovery for at least six years at the time they were hired. Nine of the present advocates are in school completing undergraduate or master's degree programs.

The women hired for these salaried positions meet a standard higher than that required for most paraprofessional models. The PCAP requisite is to have at least four years of prior community-based experience related to prenatal substance abuse or associated problems, or the equivalent combination of education and experience.

TRAINING

Comprehensive training is essential to a successful paraprofessional program. Advocates receive three types of

training: initial 80 hour intensive training from administrative staff on program protocols and working with clients; formal training sessions conducted periodically by professionals on specific issues that advocates encounter; and ongoing training opportunities with representatives from key provider agencies (e.g., Planned Parenthood) who educate advocates about agency dynamics and how to work more effectively with them. For further details on our PCAP advocate hiring and training practices, see Grant, Ernst & Streissguth, 1999.

THE ADVOCATE'S ROLE

In the PCAP model, instead of paraprofessional advocates working in teams with professionals within the same program (a structure that carries the potential for conflict and competition), advocates connect clients with a variety of experts in the community according to client needs.

At the outset, the advocate helps the client identify her own problems and goals (Grant, Ernst, McAuliff & Streissguth, 1997), identifies providers with whom the client may be even minimally involved (most of whom are not aware of each other's involvement), and locates appropriate providers to address unmet needs. In our experience, a community team approach is often touted but infrequently practiced except in crisis situations because no professional provider has the role of convener, or the time to do so. Nor do agencies have the personnel and resources with which to help disadvantaged mothers manage the everyday problems they encounter through the unpredictable process of recovery. A PCAP advocate does these things.

With the clinical supervisor's guidance and participation if necessary, and

after releases of information are signed, the advocate arranges meetings or conference calls to bring members of a client's provider network together (with the client present if possible). The clients typically have little self-esteem and poor negotiating skills. Thus, the advocate models appropriate phone and interpersonal skills conducive to

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eliciting support and help, and she helps the client organize her thoughts and articulate concerns and goals. The advocate functions as a liaison for communication within this group to facilitate development of a service plan that addresses concerns of providers,

yet is realistic for the client and does not impose impossible expectations. The advocate then assists her clients in following through with the service plan.

Within this framework, for example, a mother in recovery will not be faced with trying to comply with the Children's Protective Services stipulation that she attend outpatient treatment five mornings a week in one part of town, while the probation officer requires urine screening twice a week elsewhere, and the housing authority assigns her to a low income unit in a neighborhood that will require her to make two bus transfers to get to these destinations with her three children in tow (a true scenario). When providers communicate and are made aware of relevant factors like these, they can design a plan that will help a mother succeed in her recovery rather than set her up for another failure. Professional and agency effectiveness is improved when a paraprofessional advocate facilitates interaction and manages the complications (e.g., lack of housing, transportation, childcare) that could otherwise hinder or defeat a service provider's aims. The primary care physician, for example, can more fully focus on the family's health care needs because environmental needs are being met by the paraprofessional who understands and can operate within the high-risk setting in which her clients live.

Some PCAP advocates have taken exception to the term "paraprofessional" because of the implication that they are peer counselors, when in fact they are viewed by community providers (and view themselves) as experts in the field of outreach and case management. As one PCAP clinical supervisor states, "It's not the word 'paraprofessional' that bothers advocates, it's the

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shared history part . . . they haven't ever been, except for the rare exception, as impaired as the clients we serve. A better way of saying it would be that the advocates have some aspects of their past which are similar to the clients' struggles. What is valuable is that our advocates can share their struggles and their solutions, and that is one reason why the program works."

SUPERVISION

PCAP clinical supervisors note that challenges can and do arise in managing a paraprofessional staff. Advocates may overstep boundaries by giving advice outside their areas of expertise, or by taking on roles and responsibilities for which they are not trained. Staff have, at times, become overly zealous in their advocacy role, developing unwarranted confidence in a client's capabilities, which can result in diminished credibility from other providers. Experienced advocates have noted that sometimes their own task-oriented efficiency can collide with the model's aims of helping women achieve healthy independence within the context of a supportive mentoring relationship. This can happen in two ways. An advocate may become frustrated with a struggling client and do the work the client should be learning to do for herself, instead of guiding her in a process that will result in the client developing competence and self-confidence. Alternatively, an advocate may be tempted to leave a more competent client to her own devices, failing to remember the importance of the stable, supportive relationship in empowering the woman to achieve goals beyond the basic necessities.

The PCAP administrative/supervisory structure is designed to address issues inherent in working with a paraprofessional staff, while at the same time creating a rewarding work environment (Grant, Ernst & Streissguth, 1999). Advocates note that the opportunity to undertake difficult challenges, work creatively and "think out of the box" is fundamental to their job satisfaction, and they describe three administrative components of the model as contributing to job satisfaction and retention: individual weekly supervision, weekly group staffing, and observation of client success over time.

Individual supervision by clinical supervisor. Clinical supervisors meet individually with advocates at a designated time each week for a minimum of one hour, and they are available for consult throughout the week either by phone or in person. The supervisor acts as an administrator, teacher, and mentor. She reviews advocate paperwork and case notes, discusses each client's status and how the case activities are related to client goals, and makes recommendations. If the advocate appears overwhelmed, she discusses how her work can be redirected toward the bigger picture and away from the small crises that the client might be able to handle herself. She periodically discusses areas of growth the advocate would like to see for herself and opportunities for additional training.

Weekly staffing at each PCAP site. Weekly group staffing meetings are brainstorming, problem-solving sessions intended to leave participants in a positive frame of mind for the challenges they face during the week. As the clinical supervisor discusses the status of cases in individual supervision with advocates throughout the week, she listens for common themes, problems, or service barriers that should be addressed in a group discussion, and

she may ask advocates to present specific clients or situations at the next group meeting.

Advocates may present particularly problematic or unique scenarios to get feedback from colleagues, or they may describe successful strategies and situations resolved. As advocates listen, they learn from each other, provide ideas and support, and reflect on experiences with their own clients. At subsequent staff meetings, they give updates on client status and how suggestions have worked.

Observing individual and aggregate client success. From day-to-day it is sometimes difficult for advocates to see that they are having an effect on clients' lives. PCAP's evaluation process creates a dynamic feedback loop among evaluators, supervisors, and advocates that allows them to look at the data and see that they are indeed helping clients make gains, as well as to note areas for improvement.

Advocates are trained in data collection methods to assure quality control, and they record information on a monthly and bi-annual basis to track client progress. Client outcomes and advocate job performance are clearly separated. The evaluator presents data reports every six months on outcomes among graduated clients and among those currently enrolled. Advocates and supervisors discuss notable areas of progress as well as areas in which desired outcomes are not being achieved, so solutions can be developed as quickly as problems are observed. While paperwork may not be a favorite part of their job, this feedback helps advocates better understand their work, and they are empowered by active participation in the evaluation process.

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FAMILY SUPPORT WORKERS: PART OF A TEAM APPROACH TO HOME-BASED SERVICES

Peer workers, or family support workers, have always played an integral role at Yale Family Support Service. Since 1985, Yale Family Support Service in New Haven, Connecticut has been providing home based interventions to families through a team model. The team, a master's level clinician and a family support worker, engages, assesses, and provides treatment to high-risk families referred for services. This model was initially developed to provide intensive family preservation services to families, identified by the protective service agency, when a child was at risk for removal from the home. As the needs of the families and social policy have changed over time, Yale Family Support Service has expanded its client base while remaining focused on the emotional and physical needs of children within family units. With AIA funding, this approach has been adapted for the Coordinated Intervention for Women and Infants (CIWI) program, which provides home-based interventions to pregnant women, mothers, and relative caregivers affected by substance abuse and HIV. The intervention, a mix of clinical and concrete services, provides a child focused intervention aimed to support the safety, stability and permanence of children.



Backgrounds of Family Support Workers

Family support workers come to their job with a variety of educational and life experiences. Whereas a high school diploma is required, several of the family support workers have formal education/training beyond high school. Some are working towards a bachelor's degree, while others are working towards certification in drug/alcohol counseling.

A great asset of the family support worker is the unique perspective they bring to the work. Often described as "natural helpers", many family support workers have experience assisting others as part of a natural support system within their own community.

The majority of family support workers in the CIWI program resides in the same community that the program serves and is matched ethnically and culturally. These similarities enable clients to feel understood and appreciated as a member of a larger community. Due to their experiences and connections in the community, family support workers are able to recognize both the positive and negative forces affecting vulnerable families. For instance,

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many of the family support workers have had personal experience advocating for their own family members within the local educational system. These experiences provide an education, beyond what one can learn in the classroom, regarding systems and the dynamics of advocating.



Responsibilities of Family Support Workers

Family support workers have numerous roles as part of the clinical team; recovery support is one of them. Many of the family support workers within the CIWI program have an intimate working knowledge of addiction and recovery. This knowledge, and the lessons learned through their own recovery process, provides a realistic and personal context for their work with families. Clients have reported that the recovering member of the team provided motivation and hope that they too could achieve sobriety. When asked to reflect on the significance of having a recovering person on the team, clients have stated, “If she’s been through it, then she knows what she’s talking about,” and “. . . because my support worker was in recovery . . . that was a big factor in coming to trust the team.” Likewise, some family support workers have felt that their own disclosure regarding their addiction and recovery breaks down barriers and makes the intervention feel more genuine to the client, who may distrust yet another helper in their lives. A disclosure by the family support worker can be disarming to the client, making defensive rationalizations and excuses less powerful.

MANY OF THE FAMILY SUPPORT WORKERS WITHIN THE CIWI PROGRAM HAVE AN INTIMATE WORKING KNOWLEDGE OF ADDICTION AND RECOVERY. THIS KNOWLEDGE, AND THE LESSONS LEARNED THROUGH THEIR OWN RECOVERY PROCESS, PROVIDES A REALISTIC AND PERSONAL CONTEXT FOR THEIR WORK WITH FAMILIES.

Recovery support is only one aspect of the family support workers’ role. For CIWI staff, it is at times difficult to distinguish between the roles of a family support worker and a clinician because both work together as a team. All of the work with the family is clinically informed and considered part of the therapeutic process. During supervision, the impressions and observations of each team member leads to the formulation of a clinical assessment and treatment plan, which informs ongoing work with the family. Each team determines how the work will be shared. At times this division of labor is a natural process based on the set of skills and knowledge family support workers bring to the intervention, such as advocacy, addressing housing needs, and securing entitlements. However, their role is not limited to addressing concrete needs. Family support workers, along with clinicians, also participate in family counseling sessions and parent education. The flexibility of this

approach promotes the best fit between a worker’s style and the needs of the family.



Team Approach

Family support workers and clinicians visit families together as a team initially and, in certain cases, throughout the intervention. In chaotic environments, this approach enables the team members to simultaneously address the recovery goals as well as the competing needs of the adults and children. On other occasions, when the roles are more distinct, the team divides the work through separate visits. For instance, one staff member may work on recovery support while the other addresses the mental health needs of a family member. This approach increases the level of support and intervention a family receives.

An obvious strength to this model is the double resources available to families (Soule, Massarere & Abate, 1992). AIA programs throughout the country see families affected by substance abuse and HIV struggle with a multitude of psychosocial needs, which can be overwhelming and paralyzing to families if left unmet. A team approach provides greater assurance that both the concrete and clinical needs of the family will be addressed, but requires the team members to feel competent and comfortable in their roles and with each other.



Supervision and Training

Supervision and on-going training opportunities are key elements for anyone doing this work, but it is especially true when the themes presented by

families are reminiscent of one's past challenges and obstacles. Just as an ability to identify with a client's difficulties is a strength, identification without professional boundaries creates a barrier. Built into the CIWI program are ample opportunities, both formally and informally, for workers to process the work and its effect on them.

Paralleling the service model, supervision in CIWI is also provided through a team approach. A master's level social worker and an experienced family support worker coordinate and supervise the CIWI team. The aim is to provide clinical supervision in a supportive atmosphere that is flexible

THE MODEL RECOGNIZES THAT EACH TEAM MEMBER BRINGS TO THE PARTNERSHIP AND INTERVENTION A UNIQUE SET OF EXPERIENCES, SKILLS AND KNOWLEDGE.

enough to address relationship issues and the personal challenges that arise out of the work. Supervision provided to the team, by a team, addresses the therapeutic needs of the family as well as the working relationship between the team members. In order for the team to be able to support families from a strength perspective, they themselves must feel supported and valued for their expertise. Therefore, a task of supervision is to nurture the relationship between, and promote the strengths of, the team members.

Each week, in addition to team supervision, a program meeting is held for staff members to share and process their experiences with families through



case presentations. In addition, birthday celebrations and other information gatherings provide the best opportunities for sharing. Further, because CIWI is just one of several programs at Yale Children's Center that employs family support workers and visits high-risk families, ongoing training among all the programs addresses the needs of family support workers and clinical staff, and creates a large peer group for additional support.

Challenges

The work with families is laden with emotionally charged moments and experiences. Because team members all experience the work differently, questions and disagreements arise. Dilemmas related to personal style and recommendations regarding a child's best interest can create tension and strain. Team members are encouraged to address these issues among themselves. Making time for a cup of coffee after a difficult visit is recommended and encouraged to process the work. Naturally, there are times in

supervision when team conflicts are discussed. It has been our experience that, in the context of a supportive environment, these team challenges can be resolved and relationships maintained.

Conclusion

The CIWI program is committed to a team model, which has been a vehicle for encouraging effective communication and strong interpersonal relationships. Family support workers teamed with clinicians have enabled the program's approach to be genuine, balanced and supportive while remaining focused on the clinical and concrete needs of families.

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REFERENCES

Soule, C.R., Massarene, K. & Abate, K. (1992). Evolving practice models. In E.S. Martan & R.K. Grigsby (Eds.), *Advancing Family Preservation Practice*. Thousand Oaks, CA: Sage Publications, Inc.



CALL FOR ARTICLES

The National Abandoned Infants Assistance (AIA) Resource Center is soliciting articles for the spring 2003 issue of *The Source*. This semi-annual newsletter is distributed to over 2,000 administrators, policy makers, and direct staff throughout the country. It is also available on-line at <http://socrates.berkeley.edu/~aiarc/source/source.htm>

The spring issue will focus on **case management with families affected by substance abuse and/or HIV**. Individuals are encouraged to submit abstracts for articles that discuss any of the following issues:

- ★ Key elements, challenges, and unique aspects of providing effective case management to families affected by substance abuse and/or HIV.
- ★ Different models of providing case management to families.
- ★ Defining the role of case managers.
- ★ Characteristics of effective case managers.
- ★ Strategies for developing and maintaining working relationships with other community-based organizations and local systems.
- ★ Effective practice for helping families to identify and prioritize their needs and develop their goals.
- ★ Training, supervision, and support for case managers.
- ★ A case manager's perspective on challenges and effective practice.
- ★ Use and effectiveness of case management by an AIA program.

To be considered for publication, please send/fax/email a brief (150-200 words) abstract of your proposed article to the AIA Resource Center at the address below. **Abstracts are due no later than Friday, November 22, 2002.** Authors of accepted articles will be notified within a few weeks of the deadline.

SEND ABSTRACTS AND DIRECT QUESTIONS TO:

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TRAINING PARAPROFESSIONAL HOME VISITORS

In the vast majority of professions, from plumber to surgeon, the trainee is observed and coached while doing the work he or she will perform independently one day. This hands-on training has always been an accepted way to ensure proficiency. Yet, in the field of home-based mental health services, paraprofessionals frequently are trained in a classroom setting and then sent out alone to a client's home to put their skills to use.

Effective training provides hands-on experiences to address the privacy and challenges inherent in home visiting. While this is true for any home visitor, it is particularly important for paraprofessionals who may be more prone to boundary dilemmas. This article will address the challenges involved in training paraprofessional home visitors. It also will give examples of existing models and outline components of successful training programs.



Challenges inherent in home visiting

Because the home environment is dynamic and unpredictable, it introduces a unique experience for both the client and the worker. Both may be more prone to distraction in the home than in a controlled office setting. A good home visitor needs to remain focused and use his or her observation skills to assess the situation and environment. For instance, it may be relevant how many beds there are in the house and whether there are toys for

the children. A skilled home visitor will note these things in a subtle way that goes unnoticed. However, it is challenging to teach home visitors how to control the interaction while allowing the client to control the environment.

ANY GOOD TRAINING PROGRAM MUST PROVIDE THE OPPORTUNITY FOR PARTICIPANTS TO DISCUSS THEIR FEELINGS ABOUT BOUNDARIES, COMFORT LEVELS IN CLIENT'S HOMES, THE INTIMACY OF THE RELATIONSHIP, AND OTHER DIFFICULT EMOTIONAL ISSUES.

Klass (1996) refers to home visitors as artisans. As artisans, home visitors learn much on the job. It is an evolving practice. Home visiting calls for a sharp set of innate skills to achieve the careful dance between worker and client. There is no office available to protect the worker from emotions or harsh realities. Inexperienced workers may not know how to act “professionally” while displaying empathy and compassion. Some home visitors, particularly paraprofessionals, may not understand their role and the concept of boundaries. For instance, if a client is experiencing stress due to having limited

access to transportation, a volunteer may have to fight the desire to lend her own car. Further, a paraprofessional who is insecure of his or her skills may come on too strong to a client in order to position himself or herself as the expert. This may be magnified in programs where the home visitor is from the same community or shares other similarities with the client.



Implications for training

All of these issues have relevance for training. Most of these issues cannot be taught in a didactic format but must be addressed as part of the training program. Any good training program must provide the opportunity for participants to discuss their feelings about boundaries, comfort levels in client's homes, the intimacy of the relationship, and other difficult emotional issues.

As with most things in this field, becoming a skilled home visitor is a process. Most home visitors' approaches to the work change over time. This calls for initial training for home visitors, as well as ongoing training. Also, because home visitors work in isolation, they need intense supervision. Without support from supervisors and co-workers, it can be challenging to maintain the necessary boundaries with clients when they are the primary source of interaction. To put it simply,

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if no one is asking the workers how they are on a stressful day, they may be likely to vent to the clients and focus on their own issues rather than those of the clients. Thus, programs must provide ongoing support for the home visitor while teaching and continuously reinforcing the skills necessary to get the job done.



Characteristics of effective training programs

Successful paraprofessionals appear to share at least two important beliefs. The first is that they acknowledge that there are many paths to get to the same place. The second is that they do not feel that others need to make the same life choices they made. Experience suggests that these two "mind-sets" influence the ability of volunteers and paraprofessionals to succeed in helping others.

Effective programs encourage and support these beliefs through training in basic helping skills such as: communicating effectively, giving feedback, active listening, judgments and biases, professional and ethical issues, termination, therapeutic boundaries, and observation skills. As part of this training, workers' feelings also should be addressed. For instance, Alpaugh's and Haney's (1978) training manual for paraprofessionals and beginning counselors in the geriatric field addresses issues such as using confrontation, learning how to make interpretations, developing a feeling vocabulary, and practicing self-disclosure.

In addition, if home visitors understand the rationale behind the home visiting approach, they are more

likely to benefit from training and supervision. Further, Wasik, Bryant, and Lyons (1990) note that it is useful to present information about the program's philosophy and goals to clarify expectations of the home visitors. They also point out that the role(s) home visitors play should be included in that philosophy.

Thus, Wasik et al. (1990) suggest that, in addition to focusing on knowledge and skills of the helping process, the basic content of a home visitor training program also should include:

- History of home visiting
- Philosophy of home visiting
- Knowledge of families and children (e.g., prenatal/perinatal development, child development, child management, family systems therapy, health and safety, special issues, child abuse and neglect, alcoholism, drugs, spouse abuse, chronically ill child)
- Knowledge and skills specific to programs (program goals and procedures, record-keeping and documentation, curriculum)

At the Jewish Children's Bureau, in Chicago, IL, the training curricula for volunteer (paraprofessional) home visitors in a program serving new mothers at risk for difficulty in parenting includes: program procedures, rules, note taking; confidentiality; prevention; history of home visiting; the high risk family; parenting; abuse, neglect and violence; active listening/open ended questions; problem solving; judgments and biases; therapeutic friendships and boundaries; infant care; infant development; special parenting situations (e.g., adoptive parents, premature infants, infants with special needs, multiple births); postpartum issues; and when to call for back up.

The primary challenge in this training is the discussion of biases and having a nonjudgmental attitude, which seems to determine how successful paraprofessionals will be in their work. The trainers explain that everyone has biases, especially when it comes to parenting, and that being aware of one's own biases and judgments is necessary in order to keep them from interfering with the work with clients. To help illustrate this, the trainers use a decorated shoebox labeled a "bias box." All participants are asked to write their biases on slips of paper and put them in the box. The group leaders do the same to insure that common biases are included. When the task is completed, the papers are read aloud. Important biases such as "mothers should stay home with their babies," "all babies should be breast-fed," "all babies deserve to live in two-parent families," and "gay people should not be parents" are discussed by the group. It is crucial that the paraprofessionals gain understanding of their own biases before working with a client. For this activity to succeed, there needs to be an atmosphere of trust between the paraprofessionals and the trainer(s). Paraprofessionals must not fear that having any biases will have them dismissed from the program, but they need to understand and accept the importance of being nonjudgmental with their clients.

- Knowledge and skills specific to communities (cultural characteristics, health and human service resources, other pertinent community resources, transportation issues)

Cultural awareness and sensitivity also is important for home visitors. Thus, Musser-Granski and Carrillo (1997) add that training for bilingual, bicultural paraprofessionals employed in mental health services should address: interpreting both words and affect in various cultures, English language, and American cultural training.

TRAINING FORMAT

Training should be done in a comfortable setting, within reasonable time-frames, and promote an atmosphere of trust and comfort. Norris and Baker (1999) recommend that supervisors do a learning needs assessment prior to training to advise them of safety and comfort issues. For instance, a questionnaire can be distributed to participants asking what they would like to get out of the training, their prior training experiences on the topic, and their preferred training format.

In addition, the format of the training is critical to its effectiveness. Green (1996), citing Jackson and Neighbors (1990), urges trainers to use the principles of adult learning in setting up the training program (see inset).

Norris and Baker (1999) point out that, for paraprofessionals, the least effective training model is one that features a lecture by a trainer with minor support from printed materials. They recommend an interactive, hands-on approach to training. Robin and Wagenfeld (1981) add that "training that stresses the concrete and practical is most effective" (p. 301).

Wasik et al. (1990) strongly recommended three interrelated training procedures: (a) role-playing, (b) experiential learning, and (c) peer teaching. The majority of paraprofessional training models stress the use of role-playing. In addition to being an effective learning tool, role playing is a safe, effective way of determining whether the training material is being absorbed without risk to clients. For

experienced peer workers, can provide an excellent opportunity to learn experientially before going out alone. Close supervision that includes discussion and analysis of actual experiences also can be instructive. Finally, programs should provide opportunities for peer workers to exchange feedback among each other initially through training, and ongoing through group supervision.

PRINCIPLES OF ADULT LEARNING

- Learning is more effective when it is a response to a felt need of the learner.
- There should be active participation on the part of the learner.
- Learning is made easier when the material learned is related to what the learner already knows.
- Learning is facilitated when the material learned is meaningful to the learner.
- Learning is retained longer when it is put to immediate use.
- Period plateaus occur in learning.
- Learning must be reinforced.

instance, demonstrating skills through role-plays that mirror actual practice can prove impossible for some trainees despite their initial indications of comprehension. What is picked up in role-plays most often is subtle evidence of judgmental attitude, offering too many opinions instead of encouraging the client to find her own answers, and communication problems (e.g., asking "yes" or "no" questions instead of open-ended ones).

In addition to role plays, mentorships, e.g., shadowing more



Evaluating Training Programs

Training programs should not be set in stone but should be routinely adjusted based upon feedback from clients and workers. Thus, it is important to build in formal evaluation procedures to determine if training programs have the desired outcomes and to identify

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gaps in the training. In order to do this, trainers need to clearly identify what they intend for the participants to learn and how they will know someone has learned the material (i.e., how they will assess if a participant is learning what is being taught). Danish, D'augelli, Brock, Conter, & Meyer

TRAINING MUST BE ONGOING AND INCLUDE INFORMATION ON BOTH THE TECHNIQUES TO BE A SUCCESSFUL HOME VISITOR AND THE SKILLS/KNOWLEDGE RELATED TO THE SPECIFIC PROGRAM.

(1978) recommend that training programs use a structured systematic format in which, for each identified skill, there is an explicitly stated goal and rationale, assessment of attainment level, guidelines for acquisition of responses and strategies, detailed procedures, and homework.

Joan Wood (1985) illustrates a similar model in her training project for paraprofessionals, *Home Care Providers to Rural Minority Elderly*, which is based on very clear goals and objectives. With each topic, participants complete pre- and post-tests. They also evaluate each day of training

as well as the overall training program. Additionally, this model includes a follow-up questionnaire that is sent to trainees after the training has been completed and the paraprofessionals have had an opportunity to apply their training in the field. This allows participants to identify additional training topics that would have been useful.

Chichin (1992) and others have solicited follow-up data directly from the families served, as well as from the workers themselves. These satisfaction surveys also have implications for training. For example, the families who have received services can identify possible gaps in their home visitors' knowledge or skills.

Additionally, home visitors should be encouraged and taught how to evaluate their own practice; this can be done through the supervision process. Klass (1996) refers to this as "reflection-on-action" and views it as a critical skill in home visiting that parallels the teaching of skills to clients.



Summary

Paraprofessional home visitors must be creative and flexible in their work with clients, and have a heightened sense of boundaries, the skills to control the interaction without controlling the environment, and an understanding of the goals of the program. Their experience and skills in these areas can be enhanced by comprehensive, on-the-job training and close supervision. However, the training must be ongoing and include information on both the techniques to be a successful home visitor and the skills/knowledge related to the specific program. The training program should be evaluated and adjusted based on feedback from trainees and clients. With effective training and

supportive supervision, paraprofessional home visitors can make a tremendous difference in the lives of the people they serve.

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REFERENCES

- Alpugh, P., & Haney, M. (1978). *Counseling the older adult: A training manual for paraprofessionals and beginning counselors*. Lexington, MA: Lexington Books.
- Chichin, E. R. (1992). Home care is where the heart is: The role of interpersonal relationships in paraprofessional home care. *Home Health Care Services Quarterly*, 13, 161-177.
- Danish, S. J., D'augelli, A.R., Brock, G.W., Conter, K.R., & Meyer, R.J. (1978). A symposium on skill dissemination for paraprofessionals: Models of training, supervision and utilization. *Professional Psychology*, 16, 16-37.
- Green, K. (1996). *Home health aide training manual*. Gaithersburg, MD: Aspen.
- Jackson, J. E., & Neighbors, M. (1990). *Home care client assessment handbook*. Gaithersburg, MD: Aspen.
- Klass, C.A. (1996). *Home visiting: Promoting healthy parent and child development*. Baltimore, MD: Paul H. Brookes.
- Musser-Granski, J. R., & Carrillo, D. F. (1997). Critical care update: The use of bilingual and bicultural paraprofessionals in mental health services: Issues for hiring, training, and supervision. *Community Mental Health Journal*, 33, 51-60.
- Norris, J. A., & Baker, S. S. (1999). *Maximizing paraprofessional potential*. Malabar, FL: Keiger Publishing Co.
- Robin, S. S. & Wagenfeld, M. O. (1981). *Paraprofessionals in the human services*. New York: Human Services Press.
- Wasik, B. H., Bryant, D. M., & Lyons, C. M. (1990). *Home visiting: Procedures for helping families*. Newbury Park, CA: Sage.
- Wood, J. B. (1985). *Final Report for Model Training Project for Paraprofessional Home Care Providers to Rural Minority Elderly*. Alberta, VA: Southside Virginia Community College.

TOGETHER EVERYONE ACHIEVES MORE (TEAM) PEER LEADERS REACH OUT TO HIV AFFECTED YOUTH

Adolescents living in HIV affected families experience the realities of coping with HIV disease and its consequences first hand. Together Everyone Achieves More (TEAM) Youth Leadership Services (TEAM YLS) provides a coordinated, community-based response to the needs of HIV affected and infected children and adolescents living in the Greater Rochester Area (GRA) using therapeutic experiential and recreational services including adventure-based interventions. These approaches focus on enhancing the young peoples' assets and strengths and building peer, family and community support. The program aims to increase the coping and adaptation of children and adolescents by enhancing protective factors (healthy relationships with adults, community involvement, positive reinforcement) and reducing risk behaviors (lack of academic engagement, sexual activity, and drug/alcohol use).

In the GRA we have found that traditional approaches do not work for these youth; the last thing they want to do is to talk about the pain they have experienced. What they want to do is to connect with others, have fun and be of service to their community. The youth leader program was designed to provide an opportunity for the young people to move from being the "helpee" to being the "helper". Specifically, youth leaders serve as facilitators for the younger clients in some of the other TEAM programs including a young girls and boys group, our "Verbally Correct" recreational group, and our Family Unity Camp. Being of service provides these young people with an opportunity to have a clear role in the community, valuable skills in taking on adult responsibilities, and an opportunity to demonstrate healthy behaviors.

All the youth leaders have had their lives touched by HIV and they are ready to help other adolescents and youth to cope with the reality of having a family member(s) living with HIV disease while caring for themselves. This is not easy, and increasingly they are coping with life after the death of a parent or family member. Experiencing the death of a family member is hard for any youth to cope with. The stigma of HIV disease compounds the challenges. While they do not want to talk about their own pain surrounding the loss of a parent, TEAM youth leaders do want to help others who are coping with this.

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Several examples of this have occurred when members' parents have died of AIDS related complications and the peer leaders went to calling hours or the family member's home to support the young person and their siblings. Thus, they use their experience to build relationships with each other and their younger peers and a vehicle for the younger peers to communicate about the challenges of coping with HIV/AIDS. The youth find that helping others in this way helps them too. As one peer mentor said, "I don't want others to be as scared as I was."



**THE TEAM PROGRAM IS
A DYNAMIC AND VIBRANT
COMMUNITY THAT IS
CHANGING AND GROWING
AS THE YOUTH,
FAMILIES AND SERVICE
PROVIDERS ENGAGE
WITH EACH OTHER.**

In addition to providing support and outreach to affected youth, the peer leaders provide AIDS education in the community. For instance, they recently ran a prevention session at a Medical Academy of Science and Health (MASH) camp for adolescents interested in pursuing health careers. The MASH campers learned about HIV/AIDS through a group exercise delivered in the swimming pool in which they were asked true and false

questions by one of the peer leaders. The campers had to swim to a place in the pool that expressed their level of belief in the statement being true or false and then explain their answers. The peer leaders then provided more information to further educate the young campers. The campers were enthusiastic about learning about the realities of the transmission of HIV/AIDS from peers who had first hand experience with the realities of HIV.

The TEAM program provides opportunities for the youth to develop leadership through participation in the development of an annual conference on HIV/AIDS. The peer leaders also gain advocacy skills through participation in influencing public policy, e.g., meeting with local, regional, and state legislatures, and involvement in other political activities.



Conclusion

The TEAM program is a dynamic and vibrant community that is changing and growing as the youth, families and service providers engage with each other. New needs, areas of service deficiency, and changes in how services are provided all impact the team program and offer opportunities for the program to grow and develop to meet or address these areas. Early evaluative data provides evidence that the program is having an impact on the youth. For instance, ethnographic analysis has begun to show improvement in their communication, leadership, team cohesiveness, and willingness to be of support to others. We are hopeful that the approach of the TEAM program will provide a model for other communities to provide support to those families affected by HIV/AIDS.

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VOICES FROM PEER WORKERS IN THE DRUG-EXPOSED INFANT PROJECT

SANDRA & BRENDA Family Support Workers

In New York, it is not uncommon to walk past a building in your own neighborhood without ever thinking about what goes on inside. For many years, we walked past the building housing Leake and Watts Services and never stopped to think about it. Little did we know that eventually we would work there, that our lives would be changed, and that the lives of total strangers would be impacted.



Our responsibilities

We are Family Support Workers who assist parents who are currently substance abusers, or who have a history of substance abuse, and whose children have entered foster care. It is our job to work with the caseworkers to reach out to these parents and help them develop a permanency plan for their children. If the parents wish to have the children returned to them, we help them access whatever services have been mandated by the courts. This means we may refer them to drug treatment, therapy, social services, housing resources and/or parenting classes. And if the parents are not ready to change their lives around, we help them come up with an alternative plan, such as giving custody to a relative or adoption.

At first, the task seemed “big”—bigger than either of us could fully understand. It was part of a new program; the title “Family Support Worker” was new to the agency, and most agency staff couldn’t figure out how we fit into the system. We didn’t know how we fit in either. We were just single mothers coming off of public assistance with some personal knowledge of foster care. It wasn’t until we read several detailed case records that we began to realize what was needed and how we could help.

One thing that became obvious, early on, is that each parent comes with a unique set of needs and strengths, and each case needs to be

treated differently. While some parents are eager to get help, some are very resistant. Additionally, whether or not the parent is cooperative in the beginning does not determine the outcome of the case; there have been parents that have done all that was mandated of them and then disappeared, just as there have been parents who have “lost” five, six (or even more) children to foster care and adoption, and then worked diligently to get the last child back. The best we can do, then, is to support and respect our parents with whatever is going on in their lives, reserve our judgments, and accommodate each parent so as not to overwhelm him or her. We know that when the clients start to feel good about what they’re doing and what they have accomplished, they can go even further.



Relating to professional staff

Establishing a working relationship with the caseworkers was certainly a challenge. Most of them thought we were interfering in their cases and that we were not needed. Because we don’t have the formal education, many thought that we couldn’t possibly know anything about casework. This was tough to overcome, but we set out to prove ourselves to both the caseworkers and the parents. We started making contacts at different drug treatment centers, mental health

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service facilities, social services centers, shelters, hospitals, real estate agents, churches and charities. We continually reached to the parents, listened to them, and accompanied them to the various centers and court appearances. As the months went by, the caseworkers started to notice that they had more time on their hands because we had taken care of half of what they had to do for the parents. Many cases started to move along faster because the parents were actively involved and completing their mandated services. And we were available as resources for the parents when the caseworkers were out of the office (attending to other cases) so progress would not be held up. Eventually, we gained the respect of the caseworkers, and now they come looking for us even before their case is assigned to us.

The appreciation of our co-workers is gratifying, as is the joy that fills us when we watch our clients grow into confident parents. We established a “Parents Helping Parents” support group, and it is amazing to observe parents, who have already regained custody of their children, come back regularly to meetings to mentor the newcomers. They support each other by sharing stories about the obstacles and victories.

Nothing, however, compares to the sight of a parent being reunited with his or her child. It is one of the most rewarding experiences ever.

MARC Visitation Specialist

When I was hired as a Visitation Specialist at the Drug-Exposed Infant Project, it was both exciting and daunting. I knew nothing about the foster care system, except for the misinformation you get from misinformed people, but I was confident enough to know I would rapidly learn the ins and outs of the foster care system. I also knew I was bringing something to the table no one else knew about. You see, I am a recovering addict. I had worked formally with substance abusers, but I knew my own experience would be the most valuable tool I had in this new setting. After all, I had used for 14 years and was now in my eighth year of sobriety. However, I had never divulged this before to any employer, so I had every intention of keeping this bit of information a secret when I was hired at the Project.

At first, my director gave me a lot of literature to read, to get me up to speed on the foster care system, pertinent legislation, child development, and other information needed to perform my job—assisting birth parents with their visitation needs. I would also be observing visits, helping birth parents and their children interact and bond, and answering questions regarding child development.



Disclosing my history

Once I started getting my feet wet, I noticed some of the parents with whom I was working were members of the same 12-step meetings I attended. This made me feel a bit uncomfortable because, sooner or later, I knew the word would get out to my colleagues and supervisors. At that point, I made a decision to disclose my past to the director. By this time, I felt the staff was open-minded enough to hear about it without being judgmental. I also remembered some of the points made during my interview, about believing in change, especially concerning drug-addicted parents. It was a surprise to me when I revealed this information and found out that the director initially wanted to look for someone who had a substance abuse history. Needless to say, this was a relief.

A year and a half later, this job has been one of the most gratifying experiences for me. I have seen parents get clean, work on themselves, and complete court mandates, eventually to be reunited with their children. I’ve learned to be empathetic, without becoming an enabler. Sometimes just being an example helps clients who are battling drug addiction. They see someone who has overcome obstacles and landed on his feet. Being a peer worker also helps me in my personal recovery. It helps me remember where I was not too long ago, and where I can be if I forget. Those who fail to remember are doomed to repeat.

I am certain that my clients relate to my experiences as I relate to theirs, and

this makes it easier for them to speak about sensitive issues without feeling as though they are being judged. For some, having their children placed in foster care has been a wake-up call. As a male, I cannot say that I know what it feels like being a mother and having my children placed in care, but I can identify. I've had to face my wife and child abandoning me, because, in essence I had abandoned them in the midst of my addiction.



Challenges

Working with substance abusers may come more naturally to me than some others, but it is still challenging. Some

clients, for the first time in their lives, are facing adversity without a chemical to anesthetize their feelings. They come to the agency feeling anger, resentment, shame, guilt, but most of all fear. Some come in complete denial. They sometimes refuse to take responsibility for whatever risk factors resulted in their child coming into care. I can remember how difficult it was when denial played a major part in my addiction. At times, it becomes frustrating, but then I remember all the games I played to get what I wanted when I wanted it. Most of us (substance abusers) want the rewards of hard work, without actually putting in the legwork.



Conclusion

But challenges aside, it is still very gratifying to see a parent go from being an angry, resentful individual to becoming the respectful, responsible and productive parent he or she was meant to be. It is a great feeling to know that you played a small part in a successful family reunification. In the end, knowing you made a positive difference in someone's life makes all the challenges in the process worthwhile.

Sandra Walrond & Brenda Rodriguez,
Family Support Workers
Marc Vega,
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A New Publication:

PARENTS TELL THEIR STORIES

The Journey Back: Parents' Struggles to Overcome Addiction and Regain their Families is a new booklet published by the Drug-Exposed Infant Project at Leake and Watts Services, Inc., which features six inspirational accounts written by recovering substance abusers. The true-life stories describe what led these individuals to use drugs, the chaos they experienced during their drug use, and how they turned their lives around for the sake of their children. The children of five of the six contributors had been removed from their parents and placed into foster care; the sixth contributor eventually became a foster parent.

The concept for the publication came from a support group, "Parents Helping Parents," that the Project has been facilitating for over one year. The participants all have a history of substance abuse and their children have gone into foster care; most have completed a drug rehabilitation/treatment program, are in recovery, and are working diligently to meet the mandates set by Family Court judges so they may be reunited with their children. Michele Erazo, who supervises the support group's facilitators, compiled and edited the stories to share them with other substance-abusing parents as well as foster parents and child welfare staff. "I want others to see that these individuals are not all that different from ourselves or those closest to us. Though they regret the decisions they made in the past, their experiences have made them stronger and wiser, and they want to help the next person." Funding for the publication and the Drug-Exposed Infant Project's activities is provided by the U.S. Department of Health and Human Services.

Copies of the booklet are available free of charge. Contact the Drug-Exposed Infant Project at (718) 794-8314 or merazo@leakeandwatts.org.

GRADUATING FROM CLIENT TO OUTREACH WORKER: ONE WOMAN'S EXPERIENCE

Who I Am

I am a 38-year old African American woman. I am also the mother of six and the legal guardian of two additional children, my niece and nephew. And, I am a part-time Outreach Worker for The Family Center.

Who I Am Not

Since the death of my mother in 1986, my father in 1993, and my sister in 1997, I am no longer a daughter or sister. Because I measured my existence so whole heartedly in these roles, I am not sure if I am still me. If I am, it is definitely a new me, a reborn me, perhaps a stronger, a more empowered me, a phoenix! This "empowered me" was not always the case, especially after all the losses I experienced. I actually credit this empowered me to the work of outreach.

Background

In 1996, I had five children, was pregnant, was caring for my sister and her two children, and was in court hoping to establish myself as standby guardian for my niece and nephew. My sister's health was rapidly deteriorating when Cancer Care referred me to The Family Center for legal assistance related to the guardianship process.

The Family Center agreed to serve us with my sister's consent. A family specialist called her then went to her home to assess her needs. A week later, if that, the family specialist returned with a Family Center lawyer. Soon they began visiting me as well. The Family Center followed up on the guardianship petition that I had already submitted to the court on my own and helped finalize the process. The lawyer also assisted my sister with a health care proxy, a will, and a power of attorney. The family specialist helped my sister obtain information about clinical trials and helped me seek information regarding public housing and finding a larger apartment. Then they just came to support us. Our family specialist, Michelle, came weekly to both my sister's home and to mine. Michelle would come and listen to us cry. She would come and hear the stories of dreams lost and hope fading, and through it all remind us that she would be there for us.



In 1997, I had my last child. A little over a month later my sister died. Michelle, our family specialist and Sarah our attorney came to the funeral. I believed the worst was over, but it was not. I always have joy about my children, but now in one year I gained three more children. I was still on public assistance, still had a drug-abusing partner, had two children who had lost their mother, and a house full of children who were grieving. To my amazement, The Family Center remained in my life like a buoy, a lifeguard, and a support.

Moving from client to advisor and outreach worker

Over the next few years with The Family Center, I received home-based mental health counseling, graduated to in-office therapy, joined the Caregiver Advisory Committee, and was invited to join the Board of Directors. I began

to feel my heart opening and hope re-entering my life. I reveled in my roles on the Caregiver Advisory Committee and the Board of Directors, because I knew I was somehow helping so many others who were affected by many of the same challenges that I was still struggling with.

In the year 2000, The Family Center asked me to publically share my personal story. As a shy person, it was terrifying. I was also reluctant to talk about my sister, but I wanted to do it. I felt it was very important to share our story so that others would know more about young mothers who are ill and their children.

In 2001, I was asked to do outreach as a peer consultant. This meant telling my personal story to more people in many different settings. I have now told my story in the context of an overview of The Family Center's services, at schools, hospitals, clinics, and community based social service agencies. I also participated in a Family Center/Cancer Care teleconference that reached over 600 people nationwide. I even traveled to New Orleans, Louisiana and shared my experiences at an Abandoned Infants Assistance conference. At that conference, my story touched a few to the point of tears. To my relief, I was more comfortable speaking to a group, although I still was glued to the floor in one spot! As only fate would have it, what was supposed to be a weekend in New Orleans became a full week due to the tragic events of September 11th. Like anyone else on that day, I panicked and was overwhelmed with worry about my loved ones back in New York. My children were my greatest concern. I have two children with autism and I especially worried that they would be cared for adequately. Once I spoke to them and knew all eight of them were okay, I was able to

attend the scheduled workshops. I was treated with so much respect and kindness; I felt so empowered to be supported emotionally by strangers and to be able to cope. In 14 years I had not been away from my family and here I was **not** falling apart. I felt like a teenager that had just crossed the threshold to adulthood. I was growing into a new me, a me that could define herself as a mother and someone else: someone who has something all her own.



My role as outreach worker

I have now graduated to part-time employee of The Family Center. My duties consist of calling various hospitals, clinics, community based and non-profit organizations to schedule presentations, workshops and trainings. When my experience is best suited for the population served at a particular agency, I am scheduled to participate in the presentation. I prepare the materials for the presentation, write letters to providers and follow up as appropriate. I am still not comfortable speaking to crowded rooms, but my passion for the mission of outreach pushes past my discomfort. I still believe in The Family Center's mission, and I am proud to help them expand this mission actively to parents and families affected by cancer, HIV and other serious illnesses. I have noticed that I really don't sweat as profusely or feel as tight in my chest once I am past my story and answering questions. I guess all those years of building a hard surface over my feelings of loss will take some time to chisel away; however, it is in the works.

I am now receiving fewer services from The Family Center. My children still have buddies through the agency's mentoring program and participate in

the camping program. I am continuing my counseling through a private therapist as a direct referral from my former therapist at The Family Center. I am finding this change in my life to be fulfilling. My part-time outreach work has also decreased my dependency on public assistance. Although this is a life style change, it too is empowering. I can now see a time soon when I won't need public assistance at all.

My work as an outreach worker is hard, challenging and rewarding. It requires digging deep and opening wounds, but it is also lightening the burden. It is exposing dreams lost, but it is opening the eyes of the public and bringing about awareness. I am losing secrets, but I am helping others.



Moving On

I have talked about graduating throughout this article, not to imply that there have been ceremonies, but rather to reflect the upward climb out of my dark world. It is my hope that my climb will lead to all of my children—nephew, niece, sons and daughters—being productive drug-free adults. It is also my hope that my climb will continue, that I will return to college and possibly become a social worker or family worker helping families more directly.

Tina Pack,

*Outreach Worker, The Family Center,
New York, NY*

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Just as supervisors should understand that life experience is an asset for peer workers, they also should understand that peer workers, who look only to their personal experience to help clients, may encounter problems. For example, peer workers may take an “I did it, you can too” approach with clients, even in cases when this is not effective. Therefore, supervisors should challenge peer workers to seek more objective information, to utilize multiple theories and frameworks, and to tailor their interventions to the specific needs of their clients. Additionally, effective individual supervision requires that supervisors familiarize themselves with the specific work that peer workers are doing. Therefore, it is recommended that supervisors accompany workers on home visits and other fieldwork (Harris & Schmidt, 1993).

Supervisors should also spend time on the personal issues that workers may bring with them to the work place. These personal issues may include family conflicts and health concerns. For recovering staff, special emphasis should be placed on possible triggers for relapse. Supervisors may encourage peer workers to seek outside counseling when necessary and facilitate this through supportive discussions and flexible work schedules. In cases where peer workers are coping with multiple personal issues, it is worthwhile for supervisors to talk to peer workers about how these issues impact their work with clients. Supervisors should assist peer workers in reflecting on their own needs and how these may interfere with their clients’ sense of mastery, self-efficacy, and empowerment (Dodds et al., 2001).

“It is important to realize that peer workers in recovery may need additional support and encouragement. A new job is challenging for anyone, and may be especially challenging for someone who is struggling with recovery.

Supervisors should encourage peer workers to talk about their recovery openly during supervision.”

— *Rosemary Mollinedo, Former Supervisor, Bienvenidos Children’s Center, Inc.*



Worker/Client Boundary Dilemmas: Strategies for Prevention & Resolution

The context in which peer workers operate produces complex boundary dilemmas that require flexible solutions. It is imperative that supervisors help peer workers set boundaries, clarify their roles and responsibilities, and establish a balance between meeting clients’ needs and attaining program objectives (Sherman, 1998). Because many peer workers live in the same communities as the clients they serve, they may need ongoing support in maintaining boundaries (e.g., at church, AA meetings). Countertransference issues also can be problematic among peer workers who have experienced many of the issues that they are helping their clients to address. This issue should be addressed

up-front and continuously through training and supervision. Further, as supervisors and staff learn about the particular boundary problems that peer workers face, agency policies and procedures can be modified to address and minimize these problems (Fisk, Rakfeldt, Heffernan & Rowe, 1999).

Lambert and Davidson (1999) developed a general framework for the resolution of boundary dilemmas between paraprofessionals and clients. The framework is based on the following six points: 1) applicable legal and ethical codes/regulations should be examined; 2) traditional boundaries (e.g., limits on self disclosure and discouragement of dual relationships) should be emphasized; 3) most common boundary crossings in a specific program should be tracked and addressed; 4) client variables (e.g., history, culture, diagnosis) and peer worker roles should be considered; 5) peer workers should articulate the purpose and rationale for any boundary crossing; and 6) personal development of peer staff should be encouraged because boundary violations may occur when staff are attempting to meet their own unmet personal needs.



Conclusion

In conclusion, peer workers bring many unique strengths to the workplace. A review of the literature is testament to these strengths, as are the opinions of those who work directly with peer workers. In order to ensure that these strengths are realized, supervisors and staff must understand that peer workers and professional staff may differ with respect to their beliefs, values, and skills. These differences must be respected and addressed through comprehensive training and supportive

"We have not had many boundary dilemmas between peer workers and clients. In part, this is because peer workers have been utilized more in group formats and have limited one-to-one interactions with clients. Nevertheless, peer workers do have opportunities to develop relationships with clients and may even keep client information confidential (from staff) if the peer worker believes this to be best. While this can lead to problems, particularly boundary violations, attempts are made to limit problems by providing training and utilizing supervision of peer workers."

— Sharon Simpson, Project Director, Oklahoma Infants Assistance Program

supervision if peer workers are to be successfully integrated into programs serving at-risk families and infants. The reward for those programs in which peer workers are given the support and structure they need in order to work effectively is well worth the investment.

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REFERENCES

- Anderson, S.C. & Wiemer, L.E. (1992). Administrators' Beliefs about the Relative Competence of Recovering and Nonrecovering Chemical Dependency Counselors. *The Journal of Contemporary Human Services*, December, 596-603.
- Azar, S.T. (2000). Preventing Burnout in Professionals and Paraprofessionals Who Work with Child Abuse and Neglect Cases: A Cognitive Behavioral Approach to Supervision. *Journal of Clinical Psychology*, 56(5), 643-663.
- Berg, J.H. & Wright-Buckley, C. (1988). Effects of Racial Similarity and Interviewer Intimacy in a Peer Counseling Analogue. *Journal of Counseling Psychology*, 35(4), 377-384.
- Blumenthal, C., Eng, E. & Thomas, J.C. (1999). STEP Sisters, Sex, and STD's: A Process Evaluation of the Recruitment of Lay Health Advisors. *American Journal of Health Promotion*, 14(1), 4-6.
- Chapman, J., Siegel, E. & Cross, A. (1990). Home Visitors and Child Health: Analysis of Selected Programs. *Pediatrics*, 85, 1059-1068.
- Dodds, S, Bryson, B.J., Nuehring, E., Lizzote, J.-M., Abruzzino, E. (2001). Peers as Providers: Lessons Learned from Miami's Project SAFE. *The Source* (special issue), 21-26.
- Donoghue, K. & Wright, T. (1994). The Role of Peer Workers in the P.A.C.T. Program. *The Source*, 4(2), 8-9, 12.
- Doyle, K. (1997). Substance Abuse Counselors in Recover: Implications for the Ethical Issue of Dual Relationships. *Journal of Counseling & Development*, 75, 428-732.
- Elwood, W.N., Montoya, I.D., Richard, A.J. & Dayton, C.A. (1995). To Hang in the Hood: Description and Analysis of Outreach Activities. *Journal of Psychoactive Drugs*, 27(3), 249-259.
- Fisk, D., Rakfeldt, J, Heffernan, K. & Rowe, M. (1999). Outreach Workers' Experiences in a Homeless Outreach Project: Issues of Boundaries, Ethics and Staff Safety. *Psychiatric Quarterly*, 70(3), 231-245.
- Flynn, L. (1999). The Adolescent Parenting Program: Improving Outcomes Through Mentorship. *Public Health Nursing*, 16(3), 182-189.
- Grant, T.M., Ernst, C.C., Streissguth, A.P., Phipps, P. & Gendler, B. (1996). When Case Management Isn't Enough: A Model of Paraprofessional Advocacy for Drug- and Alcohol-Abusing Mothers. *Journal of Case Management*, 5(1), 3-11.
- Harris, M.D. & Schmidt, D. (1993). Medicare and the Nurse: Supervision of Home Health Care Aides. *Home Healthcare Nurse*, 11(4), 51-53.
- Hiatt, S.W., Sampson, D. & Baird, D. (1997). Paraprofessional Home Visitation: Conceptual and Pragmatic Considerations. *Journal of Community Psychology*, 25(1), 77-93.
- Keim, A. L. (2000). Finding and Supporting the Best: Using the Insights of Home Visitors and Consumers in Hiring, Training, and Supervision. *Zero to Three*, October/November, 37-43.
- Korfmacher, J., O'Brien, R., Hiatt, S & Olds, D. (1999). Differences in Program Implementation Between Nurses and Paraprofessionals Providing Home Visits During Pregnancy and Infancy: A Randomized Trial. *American Journal of Public Health*, 89(12), 1847-1851.
- Lambert, S., & Davidson, L. (1999). Providing Consultation About Boundary Dilemmas to Paraprofessional Staff Working With People With Severe Psychiatric Disabilities. *Journal of Educational and Psychological Consultation*, 10(4), 377-383.
- O'Brien, K. (1994). Perspectives of paraprofessionals: A survey of AIA peer workers. *The Source*, 4(2): 4-6, 13.
- Perino, S.S. (1992). Nike-Footed Health Workers Deal with the Problems of Adolescent Pregnancy. *Public Health Reports*, 107(2), 208-212.
- Poland, M.L. & Giblin, P.T. (1991). Development of a Paraprofessional Home Visiting Program for Low-Income Mothers and Infants. *American Journal of Preventive Medicine*, 7(4), 204-207.
- Poland, M.L., Giblin, P.T., Waller, J.B. & Hankin, J. (1992). Effects of a Home Visiting Program on Prenatal Care and Birthweight: A Case Comparison Study. *Journal of Community Health*, 17(4), 1992.
- Rahimian, A. & Pach, A. (1999). Stories of AIDS Outreach and Case Management: Context and Activities. *Substance Abuse and Misuse*, 34(14), 1991-2014.
- Schafer E., Vogel, M.K., Viegas, S. & Hausafus, C. (1998). Volunteer Peer Counselors Increase Breastfeeding Duration Among Rural Low-Income Women. *Birth*, 25(2), 101-106.
- Sherman, B.R. (1998). Sisters: A Social Learning Model of Intervention. In B.R. Sherman (Ed.), *Addiction and Pregnancy: Empowering Recovery through Peer Counseling*. Westport, Connecticut: Praeger Publishers.
- Sherman, B.R., Sanders, L.M. & Yearde, J. (1998). Role-Modeling Healthy Behavior: Peer Counseling for Pregnant and Postpartum Women in Recovery. *Women's Health Issues*, 8(4), 230-237.
- Stoffelmayr, B.E., Mavis, B.E. & Kasim, R.M. (1998). Substance Abuse Treatment Staff: Recovery Status and Approaches to Treatment. *Journal of Drug Education*, 28(2), 135-145.
- Tessaro et al. (1997). State Health Department and University Evaluation of North Carolina's Maternal Outreach Worker Program. *American Journal of Preventive Medicine*, 13(suppl 2), 28-34.
- Tom, T.L. & Cronan, T.A. (1998). The Effects of Ethnic Similarity on Tutor-Tutee Interactions. *Journal of Community Psychology*, 26(2), 119-129.

Continued from page 8 . . .

EXAMINING THE PROCESS

What is it that makes this paraprofessional model work? We attribute PCAP's success to a number of characteristics that may distinguish it from other paraprofessional programs. PCAP paraprofessionals are hired at a high standard. While they have some history in common, they are able to form enduring and healthy relationships with their clients because they have accrued the time and the achievements that confer a level of emotional objectivity and competency. This type of perspective allows for a relationship that is more therapeutic than sympathetic, more professional than peer. Other PCAP hallmarks that account for program success include the strong evaluation feedback loop, excellent, ongoing training and close supervision; the recognition that comes with opportunities for advocates to give community presentations about their work; and the sense of pride that comes with being affiliated with a successful, university-based project.



Conclusion

The Parent–Child Assistance Program is a focused, theoretically based intervention for high risk mothers in the community. Within the context of a relational model that enhances the mothers' ability to change, it provides a framework in which carefully selected, trained, and supervised paraprofessional advocates work. Advocates link mothers with community providers as needed, and support them as they grow and change in order to prevent another generational cycle of hopelessness and deprivation.

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REFERENCES

- Amaro, A. & Hardy–Fanta, C. (1995). Gender relations in addiction and recovery. *Journal of Psychoactive Drugs*, 27, 325–337.
- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84, 191–215.
- Berlin, L.J., O'Neal, C.R., & Brooks-Gunn, J. (1998). What makes early intervention programs work? *Zero to Three*, 18(4), 4–15.
- Ernst, C.C., Grant, T.M., Streissguth, A.P., & Sampson, P.D. (1999). Intervention with high-risk alcohol and drug-abusing mothers: II. Three-year findings from the Seattle model of paraprofessional advocacy. *Journal of Community Psychology*, 27(1), 19–38.
- Finkelstein, N. (1993). Treatment programming for alcohol and drug dependent pregnant women. *International Journal of the Addictions*, 28, 1275–1309.
- Grant, T. M., Ernst, C. C., & Streissguth, A. P. (1996). An intervention with high-risk mothers who abuse alcohol and drugs: The Seattle advocacy model. *American Journal of Public Health*, 86(12), 1816–1817.
- Grant, T. M., Ernst, C. C., McAuliff, S., & Streissguth, A. P. (1997). The difference game: Facilitating change in high-risk clients. *Families in Society: The Journal of Contemporary Human Services*, 78(4), 429–432.
- Grant, T.M., Ernst, C.C., & Streissguth, A.P. (1999). Intervention with high-risk alcohol and drug-abusing mothers: I. Administrative strategies of the Seattle model of paraprofessional advocacy. *Journal of Community Psychology*, 27(1), 1–18.
- Hiatt, S.W., Sampson, D., & Baird, D. (1997). Paraprofessional home visitation: Conceptual and pragmatic considerations. *Journal of Community Psychology*, 25(1), 77–93.
- Korfmacher, J. (1998). Examining the service provider in early intervention. *Zero to Three*, 18(4), 17–22.
- Korfmacher, J., O'Brien, R., Hiatt, S., & Olds, D. (1999). Differences in program implementation between nurses and paraprofessionals providing home visits during pregnancy and infancy: A randomized trial. *American Journal of Public Health*, 89, 1847–1851.
- Miller, J.B. (1991). The development of women's sense of self. In J.D. Jordan, A.G. Kaplan, J.B. Miller, I.P. Stiver, & J.L. Surrey (Eds.), *Women's growth in connection* (pp. 11–26). New York: Guilford.
- Miller, W.R. & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.
- Musick, J.S. & Stott, F.M. (1990). Paraprofessionals, parenting, and child development: Understanding the problems and seeking solutions. In S. Meisels & J. Shonkoff (Eds.), *Handbook of early childhood intervention* (pp. 651–667). Cambridge, UK: Cambridge University Press.
- Olds, D.L., & Kitzman, H. (1993). Review of research on home visiting for pregnant women and parents of young children. *Future of Children*, 3, 53–92.
- Olds, D., Kitzman, H., Cole, R., & Robinson, J. (1997). Theoretical foundations of a program of home visitation for pregnant women and parents of young children. *Journal of Community Psychology*, 25(1), 9–25.
- Prochaska, J.O. & DiClemente, C.C. (1986). Toward a comprehensive model of change. In W.R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Processes of change*. New York: Plenum Press.
- Rollnick, S. & Bell, A. (1991). Brief motivational interviewing for use by the nonspecialist. In W.R. Miller & S. Rollnick (Eds.), *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.
- Sherman, B.R., Sanders, L.M., & Yearde, J. (1998). Role-modeling healthy behavior: Peer counseling for pregnant and postpartum women in recovery. *Women's Health Issues*, 8, 230–238.
- Surrey, J.L. (1991). The "self-in-relation": A theory of women's development. In J.D. Jordan, A.G. Kaplan, J.B. Miller, I.P. Stiver, & J.L. Surrey (Eds.), *Women's growth in connection* (pp. 51–66). New York: Guilford.
- Wasik, B.H. (1993). Staffing issues for home visiting programs. *The Future of Children*, 3(3), 140–157.



GOOD BETS



Pathways to Competence: Encouraging Healthy Social and Emotional Development in Young Children

In this comprehensive guide, professionals, paraprofessionals, home visitors, and students address social and emotional development in young children, discovering not only how to interact positively with children and their families, but also how to improve parents' interactions with their children. The author explores nine social and emotional domains of children from birth to 6 years.

Cost: \$54.95

S. Landy, 2002. 582 pages. Available from Brookes Publishing Co., Customer Service Department, P.O. Box 10624, Baltimore, MD 21285-0624. Ph: (800) 638-3775. Fax: (410) 337-8539. Email: custserv@brookespublishing.com. www.brookespublishing.com

Addictions and Trauma Recovery: Healing the Body, Mind, & Spirit

This hands-on book outlines a 12-week program to address problems linked to trauma and addiction. Each session includes suggested activities, handouts, and overviews for the group leader. The addictions and trauma recovery integration model (ATRIUM) used in this book consists of psychoeducation, process, and expressive activities, all of which are structured to address key issues linked to the experience of both trauma and addiction. In addition, this book addresses the physical and spiritual impact of trauma. Cost: \$25.00

D. Miller & L. Guidry, 2001. 240 pages. Available from Norton Professional Books, 500 Fifth Avenue, New York, NY 10110. Ph: (800) 233-4830. www.npbcatalog.com

Intimate Betrayal: Domestic Violence in Lesbian Relationships

This book includes a review of strategies to prevent domestic abuse among lesbians, the link between domestic abuse and homophobia, feminist models of lesbian battering and responses of feminist counselors to abuse in lesbian relationships. It suggests exciting new models for freeing women from domestic violence, including the use of liberation theology.

Cost: \$19.95

E. Kaschack, Ed., 2001. 138 pages. Available from The Haworth Press, Inc., 10 Alice Street, Binghamton, NY 13904-1580. Ph: (800) 429-6784. Fax: (800) 895-0582. Email: orders@haworthpressinc.com. www.haworthpress.com

Recovering from Sexual Abuse, Addictions, and Compulsive Behaviors: "Numb Survivors"

This book clearly describes the lengths survivors of sexual abuse will go to in attempting to avoid dealing with their pain. Knauer addresses this denial and its developmental connection to other disorders such as addiction and other compulsive behaviors. Rather than providing a step-by-step recipe for treating clients with dual diagnosis, she shows the process of health and recovery. The book, which is based on Knauer's success with her own personal treatment and in treating others, offers practical concepts for assessment and a durable model for positive growth. Cost: \$34.95 soft cover

S. Knauer, 2002. 367 pages. Available from The Haworth Press, 10 Alice Street, Binghamton, NY 13904-1580. Ph: (800) 429-6784. getinfo@haworthpressinc.com; www.haworthpress.com.

Substance Abuse Treatment and the Stages of Change: Selecting and Planning Interventions

This book provides a clear framework for conducting treatment within the context of the stages of change model. It presents, in clear and accessible language, a coherent integration of the model with the entire process of treatment for substance use disorders, from assessment and treatment planning to the management of relapse. It is useful for both clinicians and researchers. Cost: \$35.00

G. J. Connors, D. M. Donovan, & C. C. DiClemente, 2001. 274 pages. Available from Guilford Publications, Inc., 72 Spring Street, New York, NY 10012-9902. Ph: (800) 365-7006. www.guilford.com.

Motivational Interviewing: Preparing People for Change, 2nd Edition

This book explains how to work through client ambivalence to facilitate change. It presents detailed guidelines for using motivational interviewing (MI) with a variety of clinical populations. The book is broken down into four parts: context, practice, learning, and applications for MI (e.g., using the approach with groups, couples and adolescents; and applications to general medical care, health promotion, and criminal justice settings).

Cost: \$35.00

W. R. Miller, & S. Rollnick, 2002. 420 pages. Available from Guilford Publications, Inc., 72 Spring Street, New York, NY 10012-9902. Ph: (800) 365-7006. www.guilford.com.

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Seeking Safety: A Treatment Manual for PTSD and Substance Abuse

This manual presents the first empirically studied, integrative treatment approach developed specifically for PTSD and substance abuse. It is divided into 25 treatment topics, each of which forms the basis for one or more sessions. The volume includes helpful, reproducible handouts and forms. Cost: \$35.00

L. M. Najavits, 2002. 389 pages. Available from Guilford Publications, Inc., 72 Spring Street, New York, NY 10012-9902. Ph: (800) 365-7006. www.guilford.com.

Shattered Bonds: The Color of Child Welfare

This book documents the disproportionate representation of Black children in the U.S. foster care system and its effects on Black communities and the country as a whole. The author includes moving accounts of mothers battling the Chicago child welfare system for custody of their children. Cost: \$27.50

D. Roberts, 2002. 341 pages. Available from Perseus Books Group, Customer Service Department, 5500 Central Avenue, Boulder, CO 80301. Ph: (800) 386-5656. Fax: (720) 406-7336. Email: westview.orders@perseusbooks.com. www.perseusbooksgroup.com

Recreating Partnership: A Solution-Oriented, Collaborative Approach to Couples Therapy

This book introduces a new concept in couples therapy called the “good story/bad story continuum.” This concept draws together ideas and techniques from solution-focused, narrative and other constructionist therapies. The authors show clinicians how to use this narrative concept in conducting effective and efficient relationship therapy that will help couples build solutions collaboratively and invigorate partnership. Cost: \$32.00

P. Ziegler & T. Hiller, 2001. 256 pages. Available from Norton Professional Books, 500 Fifth Avenue, New York, NY 10110. Ph: (800) 233-4830. www.npbcatalog.com

Enhancing Early Emotional Development: Guiding Parents of Young Children

This book helps professionals who work with families of young children nurture those bonds, giving parents the support and guidance they need to identify their children's needs, enhance interactions with their children, and address any factors that may prevent them from building a strong relationship with their infant or toddler. The authors give an in-depth look at children's emotional development at five stages from birth to 24 months, examine challenges to effective parenting, and present vignettes that demonstrate appropriate interventions. Cost: \$29.95

J. W. Gowen & J. B. Nebrig, 2002. 400 pages. Available from Brookes Publishing Co., Customer Service Department, P.O. Box 10624, Baltimore, MD 21285-0624. Ph: (800) 638-3775. Fax: (410) 337-8539. Email: custserv@brookespublishing.com. www.brookespublishing.com

Alternative Approaches to Assessing Young Children

This book offers ways to meet the needs of young children who are culturally, linguistically, or developmentally diverse. Six alternative assessment methods are included: naturalistic, focused, performance, portfolio, dynamic, and curriculum-based language. The authors offer a detailed description of each approach, specific guidelines for implementation, and sample data collection forms. Cost: \$29.95

A. Losardo & A. Notari-Syverson, 2001. 272 pages. Available from Brookes Publishing Co., Customer Service Department, P.O. Box 10624, Baltimore, MD 21285-0624. Ph: (800) 638-3775. Fax: (410) 337-8539. Email: custserv@brookespublishing.com. www.brookespublishing.com

Communication and Symbolic Behavior Scales Developmental Profile

This manual is an easy-to-use, norm-referenced screening and evaluation tool that helps determine the communicative competence (use of eye gaze, gestures, sounds, words, understanding, and play) of children with a

functional communication age between 6 months and 24 months (chronological age from about 6 months to 6 years). The manual comes with a one-page Infant-Toddler Checklist, a four-page follow-up Caregiver Questionnaire, and a Behavior Sample that is taken while the child interacts with a parent present. Cost: \$65.00

A. M. Wetherby & B. M. Prizant, 2002. 177 pages. Available from Brookes Publishing Co., Customer Service Department, P.O. Box 10624, Baltimore, MD 21285-0624. Ph: (800) 638-3775. Fax: (410) 337-8539. Email: custserv@brookespublishing.com. www.brookespublishing.com

Infant-Toddler and Family Instrument (ITFI) and Manual

This tool helps to evaluate the strengths and vulnerabilities of children from 6 months to 3 years, and their families. The ITFI helps to organize the users impressions about the child, family, and the environment, enabling the user to decide whether further referrals and services are needed. The Manual provides guidelines to help family service providers, including home visitors, determine whether the family and child are at sufficient risk to require referrals for further evaluation to other professionals or agencies. The Manual includes four case studies to illustrate the use of the ITFI. Cost: \$50.00

N. H. Apfel & S. Provence, 2001. Instrument: package of 15, 24 pages each, Manual: 88 pages. Available from Brookes Publishing Co., Customer Service Department, P.O. Box 10624, Baltimore, MD 21285-0624. Ph: (800) 638-3775. Fax: (410) 337-8539. Email: custserv@brookespublishing.com. www.brookespublishing.com



CONFERENCE LISTINGS



10th National Roundtable on Outcome Measures in Child Welfare Service

Building on the previous annual Roundtables, AHA strives to bring together administrators, practitioners, researchers, and advocates in the field to share their experiences and knowledge about effective elements of outcome-based models of service delivery.

DATE: October 21-23, 2002

LOCATION: San Antonio, TX

SPONSORING AGENCY: American Human Association

CONTACT: Mickey Shumaker, American Human Association, 63 Inverness Drive East, Englewood, CO 80112-5117.
Ph: (303) 925-9416. Fax: (303) 792-5333.
Email: Mickey@americanhumane.org.
www.americanhumane.org.

18th Annual Conference on Developmental Interventions in Neonatal Care

This conference will examine the multi-disciplinary challenges posed by the high-risk newborn population, and provide strategies for improving outcomes. A specialized faculty of clinicians and researchers from the fields of medicine, nursing, psychology, education and rehabilitative medicine will discuss the applicability of research findings and appropriate intervention strategies during hospitalization and following discharge.

DATE: October 24-26, 2002

LOCATION: San Francisco, CA

SPONSORING AGENCY: Contemporary Forums

CONTACT: Registrar, Contemporary Forums, 11900 Silvergate Drive, Dublin, CA 94568-2257. Ph: (800) 377-7707, Ext. 3.
Fax: (800) 329-9923.
Email: info@cfforums.com.
www.contemporaryforums.com.

National Black Child Development Institute's 32nd Annual Conference

This conference is an opportunity to meet with and learn from a broad range of experts working to develop new and imaginative ways to more effectively serve the needs of African American children and strengthen their families. The conference theme is *Collective Will and Imagination: Responding to Today's Children*.

DATE: October 27-29, 2002

LOCATION: Atlanta, GA

SPONSORING AGENCY: NBCDI

CONTACT: NBCDI, 1101 15th Street, NW, Suite 900, Washington, DC 20005.
Ph: (800) 556-2234 or (202) 833-2220.
Fax: (202) 833-8222.
Email: moreinfo@nbcdi.org. www.nbcdi.org.

The GAINS Center Year 2002 National Conference

This conference will expand the dialogue from the GAINS 2000 National Conference, *Building on Our Successes*. It will highlight diversion and community re-integration models for adults and juveniles with co-occurring disorders in contact with the justice system, and strategies for expanding access to community based services. The conference will revolve around two major themes: *Diversion to Community Based Services*, and *Institutional*

Programs and their Linkages to Community Based Services. Each day of the conference will feature juvenile and adult tracks incorporating a wide spectrum of workshops and panel presentations.

DATE: October 28-30, 2002

LOCATION: San Francisco, CA

SPONSORING AGENCY: The Substance Abuse and Mental Health Services Administration (SAMHSA), the Center for Substance Abuse Treatment (CSAT), the Center for Mental Health Services (CMHS) and the Florida Mental Health Institute, USA

CONTACT: Policy Research Associates, 345 Delaware Avenue, Delmar, NY 12054.
Ph: (800) 311-4246. Fax: (518) 439-7612.
Email: gains@prainc.com.
www.gainsctr.com/conference/.

Lifetime Connections: Achieving Excellence in Adoption Conference

The conference will feature workshops and information on all facets of adoption: special needs adoption, domestic (private infant agency) adoption, and intercountry adoption. It is designed to provide high quality training for beginning and experienced frontline staff and supervisors, administrators of child welfare and related programs, and professionals in related disciplines.

DATE: November 6-8, 2002

LOCATION: Fort Lauderdale, FL

SPONSORING AGENCY: Child Welfare League of America

CONTACT: Ada White, Director of Adoption Services, CWLA. Ph: (202) 942-0255.
Email: awbite@cwla.org. www.cwla.org

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International Society for Traumatic Stress Studies (ISTSS) – 18th Annual Meeting

The ISTSS Annual Meeting is the premiere trauma conference, with presentations and workshops on a wide variety of trauma-related topics offered by researchers, clinicians, and others. This year's conference will focus on complex psychological trauma and its psychosocial effects. In addition, in the wake of the 9/11 terrorist attacks, a special track will address clinical response to mass trauma.

DATE: November 7-10, 2002

LOCATION: Baltimore, MD

SPONSORING AGENCY: ISTSS

CONTACT: International Society for Traumatic Stress Studies, 60 Revere Dr., Suite 500, Northbrook, IL 60062 USA.
Ph: (847) 480-9028. Fax: (847) 480-9282.
Email: conf@istss.org. www.istss.org.

American Public Health Association 130th Annual Meeting & Exposition

The theme of this conference is *Putting the Public Back into Public Health*. It will focus on improving the services and infrastructure that promote and protect the health of the public.

DATE: November 9-13, 2002

LOCATION: Philadelphia, PA

SPONSORING AGENCY: APHA

CONTACT: Edward Shipley, APHA Meeting Coordinator. Ph: (202) 777-2478.
Fax: (202) 777-2530. Email: edward.shipley@apha.org. www.apha.org.

2002 NOAPPP/CACSAP Conference

The theme of this joint conference is *Communities Connecting for Youth: Research, Trends and Innovations in Adolescent Pregnancy, Parenting and Prevention*.

DATE: November 20-23, 2002

LOCATION: San Diego, CA

SPONSORING AGENCY: National

Organization on Adolescent Pregnancy, Parenting and Prevention (NOAPPP) and California Alliance Concerned with School-Aged

Parenting and Pregnancy Prevention (CACSAP)
CONTACT: National Organization on Adolescent Pregnancy, Parenting and Prevention (NOAPPP), 2401 Pennsylvania Ave., NW, Suite 350, Washington, D.C. 20037.
Ph: (202) 293-8370. Fax: (202) 293-8805.
Email: noapppp@noapppp.org. www.noapppp.org.

4th National Harm Reduction Conference

Conference highlights include: harm reduction efforts in Latino and African-American communities, with a Spanish track; user-to-user interventions, education, organizing and advocacy; practical interventions for methamphetamine and crack cocaine users; new research on drug use, AIDS, hepatitis C, syringe exchange and harm reduction; methadone information and advocacy; advocacy and community organizing, including the faith community; how to start and maintain a syringe exchange program; and overdose intervention and response. The theme of the 2002 conference is *Taking Drug Users Seriously*.

DATE: December 1-4, 2002

LOCATION: Seattle, WA

SPONSORING AGENCY: Harm Reduction Coalition

CONTACT: Harm Reduction Coalition, 22 West 27th St., 5th Floor, New York, NY 10001.
Fax: (212) 213-6582. Email: conference@harmreduction.org.
www.harmreduction.org

The Role of Faith-Based Organizations in the Social Welfare System

This 20th anniversary research forum seeks to address the following questions: What measurement and evaluation tools are needed to assess the effectiveness of faith-based organizations offering social services? What are some of the effects of "charitable choice" legislation? What is the capacity of religious congregations to provide complex social services such as counseling teens about pregnancy and treating drug addiction? What strengths or weaknesses do religious congregations possess in building social capital? Is there any indication that either increasing competition or collaboration for federal funds among faith-based

organizations, public agencies, and nonprofits will lead to more effective service to communities in need?

DATE: March 6-7, 2003

LOCATION: Washington, DC Metro Area

SPONSORING AGENCY: Independent Sector; Roundtable on Religion and Social Welfare Policy at the Rockefeller Institute of Government
CONTACT: Jocabel Michel, Independent Sector, 1200 Eighteenth Street, NW, Suite 200, Washington, DC 20036. Ph: (202) 467-6100.
Fax: (202) 467-6101.

Email: jocabel@independentsector.org.

www.independentsector.org.

www.independentsector.org.

The 14th National Conference on Child Abuse and Neglect

This conference will examine the past, present, and future of prevention. Attendees will have the opportunity to learn from demonstration projects and from the experiences of colleagues who are working to engage both families and communities in preventing the occurrence and recurrence of child maltreatment. The theme for this conference is *Gateways to Prevention*.

DATE: March 31-April 5, 2003

LOCATION: St. Louis, MO

SPONSORING AGENCY: Office on Child

Abuse and Neglect, Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services
CONTACT: The 14th National Conference on Child Abuse and Neglect, 1901 North Moore Street, Suite 204, Arlington, VA 22209.
Ph: (703) 528-0435. Fax: (703) 528-7957.
Email: 14Conf@pal-tech.com.

www.calib.com/nccanch/cbconference/index.cfm.

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