

INTERVENTION WITH HIGH-RISK ALCOHOL AND DRUG-ABUSING MOTHERS: I. ADMINISTRATIVE STRATEGIES OF THE SEATTLE MODEL OF PARAPROFESSIONAL ADVOCACY

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Administrative components of an effective home visitation program for high-risk alcohol and drug-abusing mothers are described. In this program, the home visitors are paraprofessional advocates who have an historical and cultural background in common with clients, excellent problem-solving skills, and a strong belief in the promise of a difficult clientele. Paraprofessionals can be dynamic members of the community provider system when they build long-term relationships with families, firmly link clients with professionals in the community, and establish strong communication networks among service providers around individual clients. Components of the program important to job satisfaction and retention of paraprofessionals include comprehensive and ongoing training, individualized supervision and consistent feedback from evaluation and administrative staff, group support, encouragement of creativity, and community recognition. © 1999 John Wiley & Sons, Inc.

Home visiting as an intervention strategy for at-risk families is not a new idea. Beginning in the 19th century, "Friendly Visitors" first began home visits to the poor in Philadelphia in order to improve the health and welfare of families (Arnold, Brecht, Hockett,

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Amspacher, & Grad, 1989). It is only recently that randomized clinical trials have provided evidence for the effectiveness of home visitation by nurses in helping disadvantaged mothers and families become healthier and more self-sufficient (Black, Nair, Kight, Wachtel, Roby, & Schuler, 1994a; Kitzman, Olds, Henderson, Hanks, Cole, Tatelbaum, et al., 1997; Olds, Henderson, Kitzman, Eckenrode, Cole, & Tatelbaum, 1986a; Olds, Henderson, Tatelbaum, & Chamberlin, 1986b; Olds, Henderson, Tatelbaum, & Chamberlin, 1988; Olds, Henderson, Kitzman, Eckenrode, Cole, & Tatelbaum, 1998a). Olds and colleagues (1997) have further demonstrated that specific positive effects remain many years after intervention. Based on a review of 31 randomized trials of home visiting programs for pregnant women and parents of young children, Olds and Kitzman (1993) noted that the programs most likely to be successful are those that are comprehensive in focus, have frequent visits, serve families initially at risk for poor outcomes, and are staffed by well-trained professionals. An earlier review by Durlak (1979) suggested that paraprofessionals achieved clinical outcomes equal to or better than professionals, based on 42 studies which compared the effectiveness of professional and paraprofessional helpers over a broad range of client types and helper roles. However, deficiencies and limitations in the methodology of many of the studies, and inconsistent definitions of paraprofessionals were noted.

There has been little research reported on the efficacy and implementation of home visiting programs working with pregnant and postpartum women who are chronic alcohol and drug abusers, and whose children are highly vulnerable to medical, developmental, and behavioral problems. Two studies by Black et al. (1994a,b) have reported some positive effects of home-based intervention with drug-abusing mothers randomized to bi-weekly home visits by nurses. Other findings indicate the efficacy of using trained lay home visitors to intervene during the first year of life with high-risk infants in low-income families, whose problems sometimes included substance abuse (Black, Dubowitz, Hutcheson, Berenson-Howard, & Starr, 1995). The relative effectiveness and merits of professional and paraprofessional models continue to be explored (Hiatt, Sampson, & Baird, 1997).

Intervention research with families affected by substance abuse warrants attention by providers and policy makers because of the tremendous social and economic impact these troubled families have on society (CASA, 1993; Gomby & Shiono, 1991; Jaffe, 1985). In their policy report to the U.S. Senate, the U.S. General Accounting Office (1990) suggested that home visiting is a promising intervention strategy, and that models using either paraprofessionals or professionals can be effective if they are well designed. Both the U.S. Advisory Board on Child Abuse and Neglect (1992) and the National Commission to Prevent Infant Mortality (1989) have proposed that home visitation by paraprofessionals might improve maternal and child health and reduce child abuse. Recommendations about the potential of paraprofessional interventions remain somewhat theoretical because rigorous scientific evaluation of these models is lacking, and therefore there is little in the literature to guide their design and practical implementation.

This paper describes the implementation and administration of the Parent-Child Assistance Program (P-CAP), originally known as the Seattle Birth to 3 Program: a promising paraprofessional home visitation model working with extremely high-risk substance-abusing mothers for 3 years beginning at the birth of the target child (See Ernst, et al., 1999, companion article in this journal, describing evaluation and 3-year findings). Strategies are described for hiring, training, and supervising staff, implementing protocols, and retaining personnel who work under trying conditions with a difficult clientele. The purpose of the paper is to convey the principles and practices we have found effective to other interventionists employing paraprofessional staff.

THEORETICAL FRAMEWORK

The Seattle model of paraprofessional advocacy is based on relational theory that has helped shape specific program components and has provided administrative and paraprofessional staff with a guiding philosophy. This theoretical framework recognizes that the consequences of alcohol and drug abuse differ among women and men in terms of physiological effects, social consequences, and forms of psychological impairment (Schneider, Kviz, Isola, & Filstead, 1995; Sullivan, 1994). Relational theory underscores the importance of interpersonal relationships in women's addiction, treatment, and recovery. Because a woman's sense of connectedness to others is central to her growth, development, and definition of self (Miller, 1991; Surrey, 1991), positive relationships within the intervention and treatment setting are critical (Amaro & Hardy-Fanta, 1995; Finkelstein, 1993). The quality of interpersonal relationships may determine whether or not a patient remains in an intervention (Barnard, Magyary, Sumner, Booth, Mitchell, & Spieker, 1988), and may be more important to improvement than concrete services received (Pharis & Levin, 1991).

Building relationships within the context of home visitation alone is not a sufficient response to pregnant and parenting women with serious multiple-risk factors. Ideally, intervention programs recognize and address the wide spectrum of family needs (Ramey & Ramey, 1993) and involve the participation of high-quality and interactive community-based support services (Weiss, 1993). An unfortunate reality is that high-risk families often remain completely outside service delivery systems because they are faced with the overwhelming task of negotiating within multiple, poorly coordinated agencies (Finkelstein, 1990, 1993; Hutchins & Alexander, 1990). We theorized that paraprofessional home visitors could fill a unique niche not consistently provided through other service agencies by bridging the gap between high-risk families and the fundamental services they need, but are unlikely to obtain without help. Paraprofessionals can develop essential relationships and understand clients because of shared history and cultural experiences. They do not experience the distance that experts and professionals often encounter in prescribed roles, and they are able to gain access and build rapport with clients who might otherwise be unapproachable (Musick & Stott, 1990; Wasik, 1993).

The Seattle paraprofessional advocacy model utilizes concepts and practical strategies based on motivational interviewing and stages of change theory. Key theoretical concepts are reflected in our work with substance abusing women: 1) motivation is a process, not a characteristic or personality trait, and clients will be at different stages of readiness for change; 2) client ambivalence about change is understandable and to be expected (Miller & Rollnick, 1991; Prochaska & DiClemente, 1986; Rollnick & Bell, 1991). Motivation for change occurs within the context of interpersonal relationship, and the home visitor's style can be a powerful determinant of client resistance or change. In using motivational interviewing strategies, the home visitor acknowledges the client's own perception of her situation, and encourages her to explore both the positive and negative aspects of the problem behavior. Acceptance and understanding of the client's situation, and trust in the client's perception and judgment, are critical.

The framework of the P-CAP intervention was influenced by harm reduction theory. Harm reduction is based on the assumption that alcohol and drug addiction and the associated risks can be placed along a continuum, with the goal being to help a client move along this continuum from excess to moderation, and ultimately to abstinence, in

order to reduce the harmful consequences of the habit (Marlatt & Tapert, 1993). In this view, "any steps toward decreased risk are steps in the right direction" (Marlatt, Somers, & Tapert, 1993, p. 148). In practice, interventionists focus attention not simply on reducing alcohol and drug use, but on reducing other risk behaviors and addressing the health and social well-being of the clients and their children. For example, an important P-CAP program goal is to reduce the risk of births of future drug- and alcohol-affected children. While not every client will be able to become completely abstinent from alcohol and drugs during her childbearing years, harm can be reduced by encouraging the woman to use effective family planning methods in order to avoid becoming a pregnant if she is still using.

THE PARENT-CHILD ASSISTANCE PROGRAM

The Parent-Child Assistance Program in Seattle, Washington, is a paraprofessional home visitation model for extremely high-risk substance-abusing women. Criteria for inclusion in the program include chronic alcohol and/or drug use during pregnancy, little connection with community service providers, and little or no prenatal care. Most of the mothers in the program are unmarried, unemployed, and have no high school degree. All of the women are polydrug users: most use cocaine and alcohol, with nearly half exhibiting a binge pattern of alcohol use; approximately half use marijuana, a quarter use heroin, and almost all mothers are cigarette smokers. Most are multiparous but are not caring for many of their children because they have been removed from custody. The social networks of the women are tenuous. The typical client has a series of partners who are usually in and out of jail, has few if any close friends, and is rarely connected to any kind of structured social group. Additional details describing the clientele can be found in the companion paper in this edition of the journal.

The Seattle Birth to 3 program began in 1991 as a 5-year federally funded demonstration project. Since 1996, the program has been supported by a combination of private funding and appropriation from the state legislature, and has expanded to a second site in Tacoma, Washington. In state statute the program is now known as the Parent-Child Assistance Program (P-CAP). The program was recently singled out by Drug Strategies, a Washington DC-based policy research institute, as one of a handful of federally funded interventions that are succeeding nationwide (Drug Strategies, 1997). The cost of the P-CAP intervention is \$3,800 per client per year for direct program services, which is consistent with figures reported from other home visitation programs (Barnett & Escobar, 1990; Black et al., 1995). There has been no turnover among the paraprofessional staff for over 6 years in a field which is notable for high rates of burnout among personnel.

Explicit objectives guide the program and are used to evaluate program outcomes. The goals of the Parent-Child Assistance Program, identified at the inception of the program, are: 1) to assist clients in obtaining alcohol and drug treatment, staying in recovery, and resolving complex problems that have arisen within the context of their substance abuse; 2) to assure that the children of these mothers are in a safe home environment and receiving appropriate health care; 3) to link mothers to community resources for the professional services and education that will help them build and maintain healthy, independent family lives; and 4) to demonstrate to community service providers strategies for working successfully with women who are often considered hopeless, in order to prevent the births of future alcohol- and drug-affected children.

The lives of clients enrolled in P-CAP are characterized by poverty, upbringing by substance-abusing parents, childhood abuse, abusive adult relationships, trouble with the law, and chaotic and unstable living conditions. As products of this background they are often distrustful of community service agencies and those representing “the system.” The paraprofessional advocates employed by P-CAP have themselves overcome difficult life circumstances similar to those experienced by their clients, prior to achieving successes in school, employment, and parenting. Because of this they are able to inspire hope and to act as realistic role models and guides towards meaningful change.

P-CAP advocates are frequent home visitors who begin their work by building trust with the client and establishing an alliance with her family and social support system. This early work provides the foundation for a close and productive relationship that can endure for the 3-year program period. The program provides structured services to each client (see Table 1), with additional advocacy intervention services varying with the individual client’s needs. The frequency of home visits depends on specific client issues and client acceptance of the advocate. Advocates persevere in their attempts to engage clients and are motivated by the knowledge that some of the clients who were initially the most difficult to work with eventually achieved the greatest overall success. These

Table 1. Structured Program Activities

Initial visit (as soon as possible after enrollment)

- Meet client and family members in the client’s home and begin establishing a relationship and developing trust; bring gift of baby layette, photo album (advocates use an office camera to take photos of the family at special times)
- Assess basic needs and obtain critical necessities within the next day (food, diapers)
- Conduct the “It Would Make a Difference Game” card sort need assessment (Dunst, Trivette, & Deal, 1988; Grant et al., 1997a) and the Difficult Life Circumstances scale (Johnson, Booth, & Bee, 1989)

Within 6 weeks (at least once a week)

- Obtain releases of information; contact all service providers with whom client is or should be involved
- Review with mother appropriate caregiving techniques tailored to the drug/alcohol exposed newborn; demonstrate techniques at each visit
- Identify initial goals with client using Difference Game/Goals protocol (detailed in Grant et al., 1997a); identify steps to reach first goals and who will be responsible for each item, with a focus on addressing substance abuse problem
- Help mother arrange for public assistance if necessary and enroll new baby
- Help mother identify/select a healthcare clinic, make appointment for maternal postpartum check-up

Ongoing home visitation activities (visit at least twice each month)

- Evaluate and reestablish goals every 4 months with client, identify steps to reach goals, and help client work towards goals
 - Assure that all children in the family have up to date immunizations, are receiving well-child check-ups, and follow-up on referrals for children’s specialist care
 - Discuss reproductive process, family planning options, and ramifications of another pregnancy relevant to individual situation
 - Locate an appropriate treatment facility, with a preference for long-term, women-only inpatient settings that can accommodate the woman’s child(ren)
 - Transport clients and their children to appointments as necessary, until clients are stabilized and able to organize a reliable system themselves
 - Provide childcare while clients are attending appointments
 - Use the small fund available (\$50 per client per year) for special client needs or incentives
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clients attributed their achievements to advocates who simply refused to give up on them. Korfmacher and colleagues (1998) have observed that a home visitor's persistence in staying in touch may be perceived as empathy and helpfulness, and that the expectation that the home visitor will be available on a regular basis over a long period of time may play an important role in improvement, regardless of number of actual visits.

Advocates use concrete, explicit methods to help clients identify personal goals and the incremental steps that must be taken to meet those goals. The client is closely involved in every plan and decision as the intervention proceeds. Our advocacy approach is two-pronged: paraprofessionals provide extensive role-modeling and practical assistance directly in the home with the client, and they connect clients to a comprehensive variety of services in the community, assuring that clients actually receive the services they need (Grant, Ernst, & Streissguth, 1996a; Grant, Ernst, Streissguth, Phipps, & Gendler, 1996b; Grant, Ernst, McAuliff, & Streissguth, 1997a).

STRATEGIES FOR BUILDING THE PARAPROFESSIONAL STAFF

Paraprofessional models are generally considered to be cost-effective because staff are compensated at lower salary rates than professionals. However, this is only true as long as there is little turnover among the paraprofessional staff, given costs of rehiring, re-training, and shifting caseloads.

Advocate Characteristics and Hiring

The Parent-Child Assistance Program has hired a total of 16 advocates since 1991. Three of the original five advocates hired left the position within 6 months by mutual agreement. Another, who had the least similarity in background to the clients, left after a year to take a better paying position in a clinical research project. Of the twelve advocates who have remained with the program, five have been at the Seattle site since 1992 (over 6 years since this writing), five have been at the second P-CAP site in Tacoma, Washington since it opened in July 1996, and two were hired in July 1997. These advocates represent diverse ethnic backgrounds (African American, Caucasian, Native American, Pacific Islander), with an average age in their early thirties at the time of hire. Ten of the twelve advocates have children of their own, and eight of these ten are single parents.

Advocate turnover and the resultant transfer of a caseload to different advocates can have serious psychological consequences for clients and can compromise outcomes in a model that is based on the development of a consistent, long-term trusting relationship between advocate and client. An evaluation of qualities and characteristics of advocates who left and those who remained with the program helped to determine a basic set of skills and attitudes important to the position. This information allowed us to better assess person-job fit prior to subsequent hiring.

The most important background characteristic of advocates is their shared history with clients, and their subsequent personal achievements. Over half of the advocates had been in recovery from alcohol or drug addictions for at least 6 years at the time they were hired, and the others grew up in families or reservation communities where substance abuse was a profound problem.

Successful advocates have varied styles and approaches to working with clients, but share the characteristics of having empathy, excellent problem-solving skills, tenacity, and

a direct, honest, but nonjudgmental manner. A most important conviction shared by successful advocates is a strong belief in the essential worth and promise of each client regardless of her past. Advocates understand that for women who have never experienced security, competence, and accomplishment, each small step toward rebuilding her life is a risk the client takes deserving of attention and encouragement. Advocates understand at the time they are hired that they will be working with clients who are often difficult and manipulative, but they are excited and challenged by the opportunity to work with these women for a period of time long enough to allow for the process of realistic and gradual change to occur.

Successful advocates have all had at least 2 years employment experience working in a social services field with high-risk populations. Those with more direct experience with alcohol or drug abusers (either through work or personal experience) are more prepared and comfortable with the types of clients they encounter. All have high school diplomas, and most have had at least 2 years of college. Six of the twelve advocates have continued to pursue their education on a part-time basis during their employment with P-CAP in the fields of chemical dependency certification, psychology, and social work.

The three advocates who were not successful in the position taught administrators important lessons:

1. Former alcohol or drug abusers must be in recovery for at least 6 years and, equally important, must be maintaining a stable, recovery-oriented lifestyle with a solid support system. They must have moved well beyond chaotic circumstances that may have accompanied the former lifestyle.
2. The advocate home visitor position is not a desk job with a predictable schedule. Advocates cannot expect clients to come to them, or to be on time and consistent. Those who cannot flexibly manage multiple issues and prioritize quickly as crises arise will find this work stressful and disheartening and are unlikely to form successful relationships with clients.
3. A judgmental or apprehensive attitude on the part of the home visitor is not conducive to building an open relationship with the client.

In advertising for the advocate position, administrators ensure that notification of job openings reaches diverse populations, but the most successful advocate recruitment has occurred through word-of-mouth by service providers who have worked with advocates and understand the scope of the role, and through recommendations of current advocates who know what the position requires. Four successful advocates came from other home visitor programs they found frustrating because they permitted only short-term contact with clients who clearly needed more consistent, long-term support in order to achieve positive outcomes.

Advocate Training and Safety

Comprehensive ongoing training is essential to a successful paraprofessional program. One of the challenges in developing a training plan is that staff may not all start their jobs at the same time. At the outset of the Seattle Birth to 3 Program, recruitment of clients was staggered, with advocates hired at different times to accommodate increasing client enrollment. Formal training sessions covering specific issues that advocates encounter are conducted by professionals in their respective fields at the beginning of the

project and throughout the program (see Table 2). Additional options for providing equal training opportunities to advocates hired later include enrolling advocates in trainings offered in the community, utilizing teaching videos, and conducting repeat, abbreviated trainings in which new staff receive training and established staff receive a refresher course.

Administrators arrange training sessions with representatives from key provider agencies (e.g., Children's Protective Services, Planned Parenthood) in order for advocates to learn the dynamics of the agencies and work more effectively with them, and for agency staff to be introduced to the role of the advocates. Their familiarity with the paraprofessional model and with individual advocates enhances our ability to address specific service barriers encountered by clients and resolve them more quickly.

Advocates regularly attend the community trainings offered by health and social services agencies in the area. The purpose of the trainings is twofold: to increase advocates' knowledge base, and to allow an opportunity for them to establish contacts and share strategies with providers who encounter similar issues working with a substance-abusing population.

New advocates have an initial training period of 80 hr before they receive their first client. The program training manual includes required readings by Grant et al. (1996a,b, 1997a), Nadwairski (1992), and Wasik, Bryant, & Lyons (1990), and instruction on program philosophy and protocols. Materials are presented on structured program services for home visits, protocols for working with community resources most frequently used by clientele, tracing lost clients, advocate standards of behavior (mandated reporting of child abuse, duty to warn, and client suicide protocols), strategies for working with clients on specific goals, and administrative procedures.

Advocates are trained by the program director and the program evaluator on administration of forms they will use for client assessment and evaluation. Each advocate completes for herself the forms she will be asking her clients to complete in order to give advocates first hand experience with reading and thinking about sensitive items. Advocates practice administering forms and role-playing scenarios they might encounter with clients.

Initial advocate training also includes an additional 40 hr spent accompanying experienced advocates as they perform typical activities. On home visits, they observe client-advocate interactions, the types of issues that might be covered in a typical visit, techniques for approaching resistant clients or wary boyfriends, and how to assess personal safety in potentially risky areas. Beginning during training, all advocates keep case

Table 2. Topics for Initial Advocate Training Provided by Community Professionals

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- Infant developmental stages and caregiving techniques (e.g., Sumner et al., 1990), with a particular emphasis on alcohol- and drug-affected children
 - Substance abuse (including behaviors associated with specific drug use, the process of recovery, and relapse prevention techniques)
 - Alcohol and drug treatment issues
 - Motivational interviewing strategies (Miller & Rollnick, 1991; Rollnick & Bell, 1991)
 - Mental health (particularly related to substance abuse, dual diagnosis, childhood sexual abuse)
 - Domestic violence
 - Family planning (methods, contraindications, and side effects)
 - HIV and AIDS prevention and screening
 - Advocate safety
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Table 3. Paraprofessional Advocate Activities

Type of activity	Average time spent per week		
Service	(Total)	81%	32.4 hr
Face-to-face with client	40%	16.0	
Transportation	17%	6.8	
Agency contacts	13%	5.2	
Extended family contacts	7%	2.8	
Correspondence to clients	1%	.4	
Special projects: newsletter, client social activities	3%	1.2	
Administrative	(Total)	19%	7.6hr
Supervision, training, staff meetings, retreats	8%	3.2	
Casenotes, client evaluations, and administrative forms	8%	3.2	
Consultation with community, presentations, meetings	3%	1.2	

Note: Data were derived from Advocate Time Summary Sheets, for 1-year period, September 1996 through September 1997, averaged over the five advocates for Seattle P-CAP during that period.

notes and a contact record documenting time spent with the client and content of the visit; both are reviewed regularly by the clinical supervisor for content and accuracy and are used to monitor program accountability. Table 3 illustrates advocate activities and the proportion of time, on average, that advocates spend on these activities.

Advocate safety is addressed with an emphasis on prevention. Advocates are trained by police and drug enforcement agency officers on how to conduct themselves in potentially dangerous areas. They leave information about their whereabouts on a daily office tracking sheet, go in tandem on home visits when there is any question about personal safety, and carry cellular telephones. Staff are susceptible to certain medical risks because of their close and frequent contact with a high-risk population, and have received Hepatitis B vaccinations, tuberculosis screening, and Tetanus boosters administered by a public health nurse at staff meetings. Recommendations for immunizations and other precautions can be made by local public health departments.

Advocate Satisfaction and Retention

We have experienced little turnover among paraprofessional advocates, although staff burnout is a common administrative problem among home visiting programs (Wasik et al., 1990). Strategies were developed early in the program to encourage ongoing support and growth, to promote a sense of meaning and satisfaction, and to prevent attrition.

Caseload. Original plans for a 1 to 20 advocate to client ratio were found to be unrealistic as enrollment progressed; therefore, the ratio was reduced to a more manageable 12–15 clients per advocate to permit the time necessary to do intensive work. This caseload size is the most frequently reported by programs in a national survey of home visiting programs (Roberts & Wasik, 1990).

Community recognition. Over time, advocates have been recognized in the community for making a difference in individual client's lives. They have been invited to speak at local meetings, as well as at national conferences sponsored by our federal funding agency.

The opportunity to plan presentations and speak publicly broadens their skills, enhances self-esteem, and increases diversity in their roles and interest in their work. Recognition and a sense of pride help the staff remain positive in the face of client setbacks.

Diversity and creativity. Advocates work beyond routine agency protocols when necessary in order to solve problems, and supervisors support and foster creative solutions (or as advocates call it, "thinking out of the box"). Because advocates are in a position to observe many aspects of a client's life and recognize strengths or problems that may have gone unnoticed, recommendations they make to professionals are valued. For example, one advocate intervened on behalf of a client who was arrested on an old warrant for forgery. The client had been in our program for 2 years, had completed a treatment program and had been abstinent from drugs and alcohol for over a year, and was successfully parenting her child. The advocate organized professionals to attend a hearing in support of this client, and the judge accepted a recommendation that the client be sentenced to 8 months of home electronic monitoring where she and her son could continue to live together, instead of the planned 18 months in a medium security prison with her son in foster care. This solution resulted not only in a very positive outcome for mother and child, but also in substantial cost savings to the public. Had the original sentence been imposed, the prison and foster care costs incurred would have amounted to \$43,950, versus the \$2,630 cost of home electronic monitoring. In other instances, advocates routinely negotiate arrangements for clients to be sentenced to long-term inpatient treatment instead of jail.

Administrators support advocates' offers to take on special projects (e.g., a monthly client newsletter including articles written by clients, a summer picnic for clients and children), even though these projects require additional time and energy. Advocates find that it is invigorating and stimulating to move beyond the daily management of a caseload to try out new ideas.

Staff retreats. Periodic half-day retreats are held away from the office at a staff member's home in order to give administrative and paraprofessional staff an opportunity to step back and examine the overall progress and direction of the program and discuss issues of concern to the group. Advocates are encouraged to incorporate a wider perspective, a view that is vital when working with a clientele in which relapse is frequent and progress rarely steady. Retreat topics are identified in advance by administrators with advocate input, and advocates may be given an article to read for discussion. Later, the project director produces a document for distribution to advocates incorporating ideas crystallized at the retreat. Examples of retreat products that are of practical use to advocates include how advocates walk the fine line between enabling and empowering clients, and how they identify and maintain personal boundaries in order to avoid burnout.

Performance evaluations. The program director and clinical supervisor conduct individual performance evaluations with advocates annually. While it is understood that advocates are not ultimately responsible for the choices their clients make, administrators do provide them with quantitative feedback on time spent and progress of clients within their individual caseload relative to overall findings. Though research protocol precluded this type of performance evaluation in the original demonstration, we have found this strategy to be useful in highlighting strengths, and pinpointing areas that need work. In ad-

dition, performance evaluations give advocates an opportunity to express opinions and personal goals.

Advocate salary and benefits. Advocates are university employees affiliated with a research office respected in the community. They are paid well and receive full medical and dental benefits for the family, aspects of the job that contribute to retention and commitment.

STRATEGIES FOR ADMINISTERING THE PARAPROFESSIONAL PROGRAM

Individual Supervision

Individual advocate supervision occurs for 1-1/2 hr each week with an experienced clinical supervisor who has a master's degree in social work and experience in the field. Advocate and supervisor together examine the amount of time spent and activities with each client, the client's progress toward meeting goals, specific problems and potential solutions, completion of paperwork, and job concerns.

One of the ongoing challenges faced by the supervisor is management of personnel who are paraprofessionals, but who must act in a manner that is credible to the professional community. Advocates occasionally become biased champions for the client's cause, and have made questionable judgments or statements to service providers. In these cases, the clinical supervisor provides objective assessment and mediates a resolution between the provider and the advocate. The clinical supervisor performs the same role when conflicts arise between clients and advocates.

It has been advantageous to hire advocates who have work experience and who understand behaviors expected within the context of an office culture. Even so, problems still arise—including inappropriate venting of frustrations in the office that can be overheard when others are on the phone; leaving the shared state cars in unacceptable condition for the next driver; inconsistency in completing paperwork in a timely manner; inappropriate smoking behavior; and so forth. When relevant to the group, problem areas are discussed at staff meetings and advocate input is sought in resolving issues (e.g., advocates as a group devised a checklist and delegated tasks for upkeep and monitoring of state cars, and advocates suggested assigning paperwork catch-up days for those who were behind).

Group Staffing

Weekly staffing meetings are a forum for the lively exchange of information, ideas, and encouragement, and are a vital part of work as a team. The 2-hour meetings are held at the same time each week, attendance is required, and phones and pagers are not answered during these sessions. The most important component of the weekly meetings is staffing clients for feedback from other advocates. Each advocate discusses one individual client with whom she is experiencing problems or successes, and coworkers offer comments and suggestions. As advocates listen to each other describe scenarios and how they were handled, they learn from each other, provide support, and are able to reflect on experiences with their own clients. A special asset of the weekly staffing is that it provides a standard time when outside visitors and community professionals can sit in to get a flavor of the scope of P-CAP activity. Business matters are addressed weekly and minor problems are resolved as they occur.

Communication and Accountability

Most of the advocates' time is spent in the field with clients; therefore, mechanisms have been instigated for purposes of accountability. If they are not going to be in the office, advocates leave information indicating their destination and expected return time. This information is logged on a daily tracking sheet and updated during the day along with any messages the advocate has for her incoming callers. Advocates and administration staff wear voicemail pagers and are expected to return pages as soon as possible, and always within 24 hr.

All advocates work full-time with flexible hours, because important client events and crises do not necessarily occur on weekdays between the hours of eight and five o'clock. Advocates alert the clinical supervisor by phone or voicemail if it becomes necessary to work evening or weekend hours, and they are discouraged from working more than 40 hr per week. If they do so, they record these hours and take them off as soon as possible. Preferably, they do not wear pagers during time off.

Linkages With the Community

One of the most important components of P-CAP is the development of working relationships between advocates and client service providers. While this is a process that continues to develop over time, mechanisms were implemented early in the program to lay the foundation for these relationships.

Formal memoranda of understanding (MOU) were drawn up between P-CAP and key agencies at the onset of the program as one way of introducing the program within the community and clarifying roles. MOUs describe services an agency could be expected to provide to our clients, and what the agency could expect from the paraprofessional advocates.

Individualized client management plan. Beginning with a new client's enrollment, each advocate systematically contacts service providers who are currently involved with her client and locates additional professionals and providers whose skills and services will be necessary to help the client meet personal and program goals. After obtaining necessary Releases of Information from the client, she links providers with each other by organizing case consultations or conference calls, and acts as a liaison for communication within this network in order to avoid duplication of services or working at cross-purposes, and to alleviate manipulation by the client. Advocates help clients manage multiple life problems that will otherwise complicate and interfere with service provision by the professionals. Clients' service networks change over time. Early in the intervention, services commonly include alcohol/drug assessment and treatment, Children's Protective Services (CPS), legal services including management of child custody issues, family health-care, housing, family planning services, and basic needs. Later, clients in recovery begin to utilize education and vocational training resources in the community.

Reports to the community. Research findings from programs for children and families must be effectively disseminated in order to have an impact on communities and policy makers (Olds, O'Brien, Racine, Glazner, & Kitzman, 1998b). We keep professional colleagues and service providers updated on the program by producing brief, periodic status reports describing what we are learning about working with this population—including

specific strategies advocates have found effective, observations and recommendations about services available, and service barriers experienced by our clientele (e.g., Streissguth et al., 1994). In these reports, we pose questions that compel the reader to think about problems and potential solutions we might implement as a community. Succinct reports termed “Action Plans,” specifically oriented toward state lawmakers, included outcomes at the conclusion of the demonstration project, examples of potential cost savings of intervention, and client comments about their experiences in the program (e.g., Grant et al., 1997c).

STRATEGIES FOR EVALUATION

Program evaluation has played an important role in the implementation and administration of the Parent–Child Assistance Program. Having a dedicated program evaluator within the administrative staff has proven to be an effective strategy for evaluating client progress, stimulating assessment and improvement in programming, and communicating effectively with the community. Evaluation has been employed at three levels: quantitative and qualitative evaluation to determine the effectiveness of the intervention in changing client’s lives and the processes associated with change, program development evaluation to determine and refine elements of the theory-based model as it is put into practice, and ongoing program evaluation activities to maintain a healthy, functional organizational operation.

Outcome Evaluation

The original demonstration project compared 65 mothers who received advocacy services for 3 years after the birth of the target child with a control group of 31 mothers who received the community standard of care (for example, physician or court referrals to public health nurses, Children’s Protective Services, or substance abuse treatment). At the completion of the demonstration project, clients and controls were compared on a holistic composite summary variable consisting of five domains: alcohol/drug treatment, abstinence from alcohol and drugs, family planning, child well-being, and involvement with health and social services. Women in the intervention had significantly higher composite summary scores, and their scores were better than the control group on each of the five domains. Clients who had spent more time with their advocates over the 3 years had more positive outcomes. (See companion paper by Ernst et al., 1999, in this journal for details on methodology and outcomes).

In the original, federally funded demonstration project, quantitative outcome data were collected by research assistants who were blind to the status of subjects, and who interviewed clients at intake and at scheduled annual follow-up visits at a University of Washington research facility. In the current state-funded program, advocates are trained to record outcome information regarding client progress monthly. Emphasis is placed on the advocates’ role in quality control in collecting data, and in assuring that outcomes reflect reality as closely as possible.

While we were able to train paraprofessionals to collect process data on amount of time spent and topics discussed at each home visit in a reliable manner (Ernst, 1997), the time and effort required to collect detailed content data proved to be unwieldy for continued program use. We continue to collect data on quantity of contact. We did not attempt to have the paraprofessional advocates assess the more subtle quality of contact

variables such as the mothers' emotional state or engagement, mothers' understanding of the material, and family context, because of concerns about bias and lack of professional training.

Program Development Evaluation

The Seattle model of paraprofessional advocacy includes the staff-centered program goal of creating and maintaining an organization capable of supporting and empowering advocates in their difficult work with clients. To this end, program development evaluation involves generating information about a specific issue, evaluating that information, and making a policy decision or adjustment based on the information generated. This process relies on consistent and ongoing communication (feedback loops) among program evaluator, program director, clinical supervisor, advocates, and, when appropriate, clients. During early phases of the project, as the theory-based paraprofessional model was being put into practice, program development evaluation was used in making decisions regarding caseload size, job roles, advocate characteristics, and the best techniques for approaching and working with specific types of clients. Monthly meetings among administrators and weekly staff meetings with advocates provide an ongoing structured environment for program development activities to occur.

Ongoing Program Evaluation Activities

Ongoing program evaluation can be a collaborative, nonadversarial process. We have incorporated the following practices in order to maintain a sense of teamwork: evaluation activities are introduced as important program components from the beginning in terms of documenting effectiveness of the program, identifying problems, and securing ongoing funding; the importance of paraprofessional staff to the evaluation process is emphasized at staff meetings and through discussions of preliminary data reports; a good working relationship is consistently demonstrated between administrative staff and the evaluator; and advocate ideas and perspectives on their work are routinely encouraged. For example, advocate input was actively solicited in the development of many of the forms they would be using, resulting in an enhanced sense of teamwork. While advocates still may not enjoy doing paperwork, they have an improved understanding of the importance and the means by which their work is documented.

The combination of sound administrative principles with ongoing program evaluation decreases job stress and staff attrition, and increases group morale, staff effectiveness, and individual job satisfaction, which in turn have positive effects on the quality of service clients receive from the program.

DISCUSSION

The Parent-Child Assistance Program, the Seattle model of paraprofessional advocacy, is an intervention that has achieved promising outcomes with alcohol- and drug-abusing mothers, has experienced little staff turnover, has gained the confidence of the professional community with which it works, and has the financial support of state lawmakers. Principles and practices we have found effective concur with observations made by oth-

ers in the home visitation field, including the importance of providing ongoing training and supervision; addressing a comprehensive, broad spectrum of family needs; making frequent home visits; limiting caseload size; hiring empathic home visitors; and communicating and collaborating with community service providers. This model is now being adapted to serve mothers who themselves have Fetal Alcohol Syndrome and who make tremendous demands for community services that are unable to be met by most communities (Grant, Ernst, Streissguth, & Porter, 1997b).

The model addresses some of the typical problems identified with paraprofessional programs. Models in which paraprofessionals are teamed with nurses or social workers within the same program can be fraught with problems of role clarification, competition for a client's loyalty and confidence, different standards for appropriate boundaries and demeanor with clients, perceived prestige of the professional, and lack of confidence in the paraprofessional's ability to perform aspects of the job. On the other hand, models in which paraprofessionals work alone can result in workers taking on roles and responsibilities for which they are not trained (and which may place their clients at risk), and lack of credibility from other providers.

In the P-CAP model, instead of pairing nurses or social workers in teams with the paraprofessional advocates, the advocates are assigned independently to families but work as a small, cohesive, highly trained and supervised staff with explicit and clearly defined goals. Instead of competing with professionals within the same program, they build linkages and networks with the service providers who work in the client's own neighborhood or community. In essence, advocates connect clients with experts in the community according to client needs. Health needs are addressed by health care providers, for example; but environmental needs are met by the paraprofessional who understands and can operate within the high-risk setting in which her clients live.

The program described in this paper has been implemented with a troubled population that is generally noncompliant and whose children have a devastating prognosis if their families cannot be successfully embraced by a caring community. The program has appealed to clients, who have demonstrated promising outcomes; to community providers, who have incorporated the paraprofessional advocates into service networks; and to state lawmakers, who have committed funds to maintain and expand the program. Our experiences in organizing and administering this paraprofessional model can provide practical guidelines to other interventionists who are committed to solving difficult problems in their own communities.

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