
BENEFITS AND CHALLENGES OF PARAPROFESSIONAL ADVOCACY

With Mothers Who Abuse Alcohol and Drugs and Their Children

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PHOTO: MARILYN NOLT

There were times when I felt like I was going to relapse and my advocate would be there for me, and she'd keep checking on me and I'd get through it. I've learned so much about myself and being responsible again and being a good mother. It was all what she taught me — she changed my life for me.
— Parent-Child Assistance Program Client

My advocate taught me a lot of things. She knew what it was like to be a single parent — showing me that I couldn't do the drugs and parent at the same time.
— Parent-Child Assistance Program Client

When a mother abuses alcohol and drugs, she places her child at great risk. Prenatal exposure to alcohol and drugs can have lifelong effects on the health of a child. A mother who abuses substances may have dif-

ficulty caring for her child and providing a safe, stable environment. Moreover, mothers who abuse alcohol and drugs tend to continue to bear children, each of whom will be exposed and affected in turn.

Unfortunately, mothers who are dependent on alcohol and drugs — many of whom have concurrent mental health problems — may be those least likely to seek and receive help from community service providers. These mothers sorely need comprehensive services and support and are likely to deliver children at risk for a host of problems. Yet mothers feel alienated from health and social

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service agencies and professionals, and professionals typically experience working with these women as challenging, difficult, or, in some cases, "impossible."

The Parent-Child Assistance Program (PCAP) disproves the notion that mothers who are dependent on alcohol and drugs are hopeless or impossible, and demonstrates how paraprofessional advocates can work effectively with these women (Ernst, Grant, Streissguth, & Sampson, 1999; Grant, Ernst, & Streissguth, 1999). This article describes the theoretical framework and operationalization of the PCAP model, explores the viewpoints of paraprofessional advocates as they put the model into practice, and describes the nature of the relationship between client and paraprofessional home visitor from both a quantitative and a qualitative perspective. The client comments in this article came from planned program exit interviews. Advocate comments came both from interviews conducted with the first author (PCAP's program director) that complemented the client's exit interview and from interviews taped for a 30-minute informational video about the program.

Paraprofessional Intervention

The Parent-Child Assistance Program (PCAP, originally known as the Seattle Birth to 3 Project) began in 1991 as a 5-year federally funded research demonstration project 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 within a month after delivery. The primary goal of the program is straightforward — to prevent alcohol and drug exposure among the future children of these mothers. 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, 2 additional sites were funded, creating a capacity to serve 360 families statewide. PCAP has been replicated at a dozen sites in the United States and Canada.

In the PCAP model, paraprofessional advocates are the interveners.¹ Each advocate works with a caseload of 15 families for 3 years, beginning at enrollment. Advocates receive initial and ongoing training, and are clinically supervised by a master's degree-level professional in social

¹ The recent resurgence of early intervention home visitation programs to improve the health and welfare of disadvantaged families has been accompanied by debate regarding the relative merits of professional versus paraprofessional providers (Korfmacher, O'Brien, Hiatt, & Olds, 1999). Both models have advantages. On the one hand, professionally credentialed home visitors carry authority and instill trust on the basis of their expertise. Paraprofessionals with shared history and cultural experiences, on the other hand, may understand clients in a way that allows them to gain access and build rapport with women who might otherwise be unapproachable. Regardless of professional status, the background, level of training and supervision, personal characteristics of the home visitor, and staff turnover rate may influence program delivery and outcomes (Gomby, Culross, & Behrman, 1999; Hiatt, Sampson, & Baird, 1997).

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 and 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 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 relapses or setbacks.

Theoretical Foundations

Case management and practical assistance alone do not meet the needs of mothers who have experienced as children many of the devastating circumstances their own children are now experiencing: chronic familial substance abuse, poverty, violence, and neglect. Therefore, the PCAP advocacy model offers personalized, caring support over 3 years, a period of time long enough for the process of gradual and realistic change. When we ask clients who are graduating from PCAP what made this program work for them, we hear one consistent response: the advocate's persistence. Over and over again, clients voice a version of this statement: "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 a woman's growth, development, and definition of self (Miller, 1991) during her addiction, treatment,

at a glance

- Mothers with alcohol and drug problems may be those least likely to seek help and most likely to be considered "hopeless" or "impossible" by programs.
- Advocates in Seattle's Parent-Child Assistance Program (PCAP) help clients negotiate their treatment and learn to trust.
- Each PCAP advocate has faced at least 1 significant obstacle, such as domestic violence, and overcome it.
- PCAP clients ascribe the program's success to its 3-year span; PCAP advocates to ongoing training, weekly staff and supervisor meetings, and client feedback.

and recovery (Finkelstein, 1993). It proposes the idea that paraprofessionals who share some history and life experiences with their clients can play a unique and therapeutic role in 2 ways: 1) by helping clients become connected to another person in a trusting, healthy relationship for perhaps the first time in their lives, and 2) by bridging the gap between high-risk families and the services they need, but are unlikely to obtain without assistance. The intervention also incorporates stages-of-change theory and motivational interviewing strategies. The PCAP approach recognizes that clients will be at different stages of readiness for change at different times, and that ambivalence about changing addictive behavior is normal (Miller & Rollnick, 1991).

This work takes a lot of mental energy. You have to be feeling, you have to be knowing and understanding. You need to have a plan, but you have to let the client figure out the plan for herself. You wait for that tiny indication that she sees the way and is ready to change. Then you reach out at the right time to help her move along. I have hope and faith in people. I really believe they want to change if they say they do. — PCAP advocate

Stages-of-change theory and the constructs of self-efficacy theory dovetail. Both help to explain how home visitors and paraprofessional peer counselors are able to have a positive influence on clients' efficacy expectations, motivational states, and, ultimately, behavior (Olds, Kitzman, Cole, & Robinson, 1997; Sherman, Sanders, & Yearde, 1998). 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 expectations about self-efficacy are influenced most powerfully by her own history of accomplishment, 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 by doing the following:

1. providing concrete, practical opportunities to accomplish goals of abstinence, recovery, and social adjustment;
2. helping clients recognize and celebrate each step toward performance achievements;
3. offering ongoing verbal and emotional encouragement regardless of temporary setbacks or relapses;
4. pragmatic role-modeling, as someone whose personal history is at least partially shared with the client, and who has achieved personal goals similar to those toward which the client may be aiming; and
5. helping clients learn daily coping strategies, including compliance with mental health recommendations and medication regimens, in order to avoid negative emotional mood states.

In exit interviews from the program, clients reaffirmed the validity of PCAP's theoretical constructs as they described how their advocates helped them believe in themselves:

She has taught me how to stand on my own two feet, and how to believe in myself. — PCAP client

She helped me establish goals; she's helped me achieve my goals. She's taught me responsibility, dependability. After 3 years of working with her, I see myself as a strong, independent woman. — PCAP client

This program really helped me think about my life. They showed me the right direction. They showed me that I am responsible. That no matter who I am or what I do, I am somebody. It is never too late. — PCAP client

Clients also spoke to the critical role of the advocate as role model:

My advocate handled a lot of situations, and I learned through her how to deal with and talk to people. — PCAP client

My advocate had a big influence on me and how I deal with things in my life. — PCAP client

The Advocate, the Client, and the Client's Provider Network

In many intervention models, paraprofessionals work in teams with professionals within the same program. This structure implies a hierarchy and carries the potential for conflict and competition. In PCAP, advocates connect clients with a variety of experts in the community. At the beginning of their relationship, the advocate helps the client identify her own problems and goals (Grant, Ernst, McAuliff, & Streissguth, 1997). The advocate then identifies the community providers with whom the client may be even minimally involved (most of whom are not aware of each other's involvement). Next, the advocate locates appropriate providers to address unmet needs. In our experience, a community team approach is often touted but infrequently practiced, except in crisis situations. No professional provider has the role of convener, or the time to convene the people working with a client. 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 from dependence on alcohol and drugs.

A PCAP advocate does these things. With, if necessary, the clinical supervisor's guidance and participation, and after releases of information are signed, she arranges meetings or conference calls to bring members of a client's provider network together, with the client present, if possible. Our clients typically have little self-esteem and poor negotiating skills. The advocate models phone and interpersonal behavior that is likely to elicit support and help. She helps the client organize her thoughts and articulate her concerns and goals. The advocate functions as a liaison for communication within the

client's provider network. She works to facilitate development of a service plan that addresses providers' concerns but does not create unrealistic expectations. The advocate then helps her client follow through with the plan.

In practical terms, the PCAP model means that a mother in recovery will not be faced with trying to comply with the Child Protective Services stipulation that she attend outpatient treatment 5 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 2 bus transfers to get to these destinations with her 3 children in tow (a true scenario). When providers communicate and recognize the realities of a family's circumstances, 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 increase when a paraprofessional advocate facilitates provider interaction and tackles the barriers (e.g., lack of housing, transportation, and/or child care) that could otherwise hinder or defeat a service provider's aims for a client. A primary care physician, for example, can focus fully on a family's health care needs when a paraprofessional who understands and can operate within the high-risk setting in which her clients live is addressing environmental issues. The skills that professionals and paraprofessionals bring to the intervention are distinctly different, but they are complementary (see, for example, Berlin, O'Neal, & Brooks-Gunn, 1998).

The Advocates

PCAP advocates have all experienced some share of the same adverse life circumstances as their clients, although seldom to the same extreme degree. Each advocate has faced at least 1 significant obstacle to well-being such as domestic violence, poverty, single parenting, an alcoholic parent, or personal alcohol or drug abuse. More importantly, each advocate has overcome the obstacle and achieved significant success: for example, by going back to school, or maintaining steady and meaningful employment. Their own struggles and successes enable PCAP advocates to be positive and credible role models, offering their clients hope and motivation grounded in reality. For example, of the 24 current PCAP advocates, 15 formerly used or abused alcohol or drugs, but all had been clean and sober for at least 6 years at the time they were hired. Nine of the present advocates are completing undergraduate or master's degree programs.

PCAP requires more of its advocates than most programs that use paraprofessionals. In order to be hired by PCAP, women must have at least 4 years of prior community-based experience related to prenatal substance abuse or associated

problems, or the equivalent combination of education and experience. Some current PCAP advocates had worked, for example, in direct case management or outreach for youth, outpatient mental patients, families at risk of child abuse and neglect, women in prison-release programs, or medically underserved populations. Others had provided maternity support services or counseling in outpatient domestic violence or chemical dependency settings. One advocate had been a housemother for adults with developmental disabilities; another had been a cook

in a women's substance abuse treatment facility.

Advocates explain how their experience helps clients:

I've lived through the things they've been through, so I'm not afraid or intimidated. I've lived with domestic violence. For someone to tell a client in a domestic violence situation to just up and go, it's not that easy. There are lots of plans to think about. I understand when someone says, "I can't just leave right now." But I can help plan a strategy, because I've lived it. — PCAP advocate

I know what it's like to be a single parent, homeless, and on welfare. I share a common ground with my clients as far as those things go. The difference is that I saw what the obstacles were, and overcame them. I just kept moving ahead and learned that where there's a will, there's a way. — PCAP advocate

I do [this work] in large part because I am the biological mother of a fetal alcohol effect son. I am a recovering alcoholic. I'd like to be part of the process by which other women can make changes in their lives, and prevent more of these kids from being born. I really do love my job. There are a lot of rewards. Women do get their lives turned around, and I know that when a woman gets her life turned around, it affects everybody in the circle of her life. So, we're breaking a lifecycle for these kids. These kids are not going to have to grow up and do exactly what their mothers are doing, who are generally doing exactly what their mothers did. — PCAP advocate

Although PCAP advocates can identify with their clients and share some similar experiences, some take exception to the term "paraprofessional." They do not like the implication that they are peer counselors, but rather view themselves (as do other community providers) as experts in outreach and case management. As one PCAP clinical supervisor observes:

It's not the word "paraprofessional" that bothers advocates, it's the shared history part...they haven't ever been, except

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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. For example, many used but did not abuse drugs. Most were able to stop without treatment, and those who did go to treatment were successful the first time. This is a very different profile than the clients'. However, what is valuable is that our advocates can share their struggles and their solutions, and that is one reason why the program works.

Since PCAP began in 1991, a total of 39 advocates have been hired at 4 sites. Among the 15 advocates who are no longer with the program, 6 advanced to better positions after an average of 4.5 years. Two of the 6 earned MSW degrees during their tenure as PCAP advocates. Two other advocates left after several years because of medical problems. Seven left the position less than a year after beginning because of an obviously poor job fit, attributable to a range of factors — for example, difficulty fitting into a work culture; too little time in recovery and residual lifestyle complications; feeling intimidated by clients; and preference for a desk job.

Training and Supervision of Advocates

Comprehensive training is essential to a successful paraprofessional program. PCAP advocates receive 3 types of training:

1. initial 80-hour intensive training from administrative staff on program protocols and working with clients;
2. formal training sessions conducted periodically by professionals on specific issues that advocates encounter; and
3. ongoing training opportunities with representatives from community agencies (e.g., Planned Parenthood) who educate advocates about their agencies and how to work more effectively with them. (See Grant, Ernst, & Streissguth, 1999, for a detailed description of PCAP advocate hiring and training practices.)

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 overzealous in their advocacy role, developing unwarranted confidence in a client's capabilities; when this happens, advocates may lose credibility with other providers. Experienced advocates have noted that sometimes their own task-oriented efficiency can collide with the model's goal of helping women achieve healthy independence within the context of a supportive mentoring relationship. Two types of scenarios are common. In the first, 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. In the second, an advocate may be tempted to leave a more competent client to her own devices, failing to remember the importance of a stable, supportive relationship in empowering the woman to achieve goals beyond the mundane.

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. Advocates note that the opportunity to undertake difficult challenges, work creatively, and "think outside of the box" is fundamental to their job satisfaction.

Experienced advocates observe that sometimes their own efficiency can collide with the goal of helping clients achieve healthy independence.

I like this work because I like challenges. In this project, I've been able to make independent decisions and be creative, and that's important to me. I have a

vision of how it can be. I believe in miracles because I've seen it happen. This is what has spurred me on and given me the drive to work with these women even when I wanted to quit.
— PCAP advocate

Working in this position has helped me grow as a person. I'm constantly learning new things. — PCAP advocate

Advocates describe 3 administrative components of the PCAP model that ensure job satisfaction and retention: weekly group staffing; individual, weekly supervision; and receiving feedback on client success over time.

Weekly group staffing meetings at each PCAP site are brainstorming, problem-solving sessions intended to leave participants in a positive frame of mind for the challenges they face during the week.

I look forward to the staff meetings, particularly when I'm stuck on a particular client. I need a lot of positive reinforcement and I get a lot of that at the staff meetings.
— PCAP advocate

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

We each staff a client each week, so that gives us a chance to know about other people's clients, how they're doing, to get feedback from the other advocates and from the supervisor about problems that I might be having with a client that I need some fresh views on. Very, very helpful. It's just essential. If we didn't do it once a week I think we'd fall apart. — PCAP advocate

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. A continuing challenge supervisors face is maintaining a balance between spontaneity (keeping meetings flexible and interesting) and structure (they are required to limit the meetings to 2 hours, yet cover project business and hear from each advocate within the time allotted).

Advocates sometimes voice frustrations or grief during this time together, and supervisors use these expressions as springboards for developing responses that can sustain staff. For example, at a staff meeting at her home, one supervisor asked her staff to write their frustrations and regrets on small cards, which they ceremoniously burned. They then wrote their aspirations on balloons and released them. In the ensuing discussion about common goals, they identified the importance of self-care, and subsequently have been better able to role model self care for their clients.

Individual supervision occurs weekly when clinical supervisors meet individually with advocates at a designated time for a minimum of 1 hour. Supervisors are available for consultation throughout the week either by phone or in person.

Individual supervision is so important because so often you get bogged down with the details of what you're doing, and the supervisor can give you a broader perspective of what you're doing. She can come in with some ideas that maybe you're weren't thinking of at the time and some different avenues you might pursue. Sometimes she'll even tell you, "Why don't you back off? You've been doing what you can, and not getting anywhere — back off, and let the client call you." — PCAP advocate

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 explore for herself and opportunities for additional training.

Feedback on client success, embedded in 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 observe areas for improvement. The process recognizes that from a day-to-day perspective it is sometimes difficult for advocates to see that they are having an effect on clients' lives.

I feel really great when I see a client change, when we were here at this point, and now slowly but surely, we're getting to that point. It's just so satisfying to see that the work that we do, and that this program does, is actually effecting change in someone's life. — PCAP advocate

I just get so much from seeing change occur. People say, "You've got to break the cycle — you've got to break the cycle." People talk about it but they don't want to break themselves outside of the molds and the boxes to make it happen. We're able to do that here. We're seeing it happen and it works. — PCAP advocate

Advocates are trained in data collection methods to assure quality control, and they record information monthly and semi-annually to track client progress. Client outcomes and advocate job performance are clearly separated. The program evaluator reports to the PCAP staff every 6 months on

outcomes among clients who have graduated from the program 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 that solutions can be developed as quickly as problems are observed. While paperwork may not be a favorite

part of the job, this feedback helps advocates better understand their work, and they are empowered by active participation in the evaluation process.

Examining the PCAP Process

Is the PCAP intervention as conceptualized in theory what the families actually receive? We have used 2 assessment instruments that attempt to "open the black box" and answer this question (see *Zero to Three*, February/March 1998).

The PCAP model holds that the relationship between advocate and client is central to the success of the intervention, because it is the path through which change occurs. As a quantitative proxy measure for the extent of relationship, advocates document the amount of time they spend with clients each week using the Advocate Time Summary Sheet. Recent findings indicate that among 146 clients who completed the program, advocates and clients spent an average of 64.2 (SE = 4.0) minutes per week together over the 3-year intervention. In general, clients who spent more time engaged in the relationship with their advocates (> 90 minutes per week on average) were more likely to achieve positive outcomes than those who spent less time (< 30 minutes

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per week on average). They were more likely to: 1) complete inpatient treatment (86% versus 39%, respectively); 2) abstain from alcohol and drugs for at least 1 year at exit from PCAP (44% versus 36%); and 3) use a reliable form of birth control such as Depo Provera injections or tubal ligation (53% versus 45%). Thirty-eight women had a subsequent birth during the program; babies born to women who spent more time with their advocates were less likely to be exposed to alcohol or drugs *in utero* (33% versus 55%). These findings concur with outcomes in the original demonstration project (Ernst et al., 1999).

When clients leave PCAP, we ask each to report on the quality of her relationship with her advocate using the Advocate-Client Relationship Inventory, a 27-item questionnaire adapted from an instrument developed for the Memphis New Mothers Project (Barnard, 1998). Among 146 PCAP clients who completed the Inventory, 85% agreed or strongly agreed with 16 items:

- Half of these fell within the "caring" construct (as conceptualized by Barnard): Clients viewed their advocates as emotionally involved, present, doing for, enabling, and giving hope. These items reflect PCAP's relationship framework.
- Four of the top items were in the "coaching" construct: Clients viewed their advocates in a supportive role, as a coach who helps a woman reach her potential.
- Four items were in the "ongoing developmental" construct: Clients viewed their advocates as assisting them with the developmental issues of a mother in her various roles.

These coaching and ongoing developmental constructs are analogous to the stages of change and self-efficacy philosophy incorporated by PCAP.

None of the top 16 items was in the "harmony" category (harmony among the mother, her family, and the intervener). This was not surprising: PCAP advocates help clients make major changes in dysfunctional behaviors, a role that may create disruption in dysfunctional family patterns.

Conclusion

What is it that makes the PCAP 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 with their clients, 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 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 affil-

iated with a successful, university-based project.

The Parent-Child Assistance Program is a focused, theoretically-based intervention for the highest 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 cycle of hopelessness and deprivation. ♣

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