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help families affected  
by drugs and/or HIV

IN THIS  
ISSUE

## Peer Mentors: Alliances at Work

*Spring 2010*  
*Volume 20, No. 1*

# THE SOURCE



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The Source is published by the National AIA Resource Center through a grant from the U.S. DHHS/ACF Children's Bureau (#90-CB-0158). The contents of this publication do not necessarily reflect the views or policies of the Center or its funders; nor does mention of trade names, commercial products, or organizations imply endorsement. Readers are encouraged to copy and share articles and information from The Source, but please credit the National AIA Resource Center. The Source is printed on recycled paper.



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# Parent Mentors in Child Welfare: A Paradigm Shift from Traditional Services<sup>1</sup>

Laura Frame, Jill Duerr Berrick, and Judi Knittel

When parents are separated from their children, the experience often engenders profound feelings of anxiety; parents may feel isolated from family and friends, and their sense of hopelessness may interfere with their capacity to engage in services and to fight for reunification (Frame, Conley, & Berrick, 2006). Recent changes in child welfare practice have brought parents into the planning process, giving them voice to help structure the case plan, to identify appropriate alternative caregivers, and to identify natural and informal helpers (Kemp, Marcenko, Hoagwood, & Vesneski, 2009). These are welcome adjustments, and they reflect child welfare's ongoing commitment to develop more family-centered practice strategies that address parents' needs.

In spite of these reforms, however, birth parents participating in the child welfare system are typically surrounded by professionals—social workers, mental health professionals, lawyers, judges, and the like—who may empathize with the parent's psychological and emotional experience of separation from their child, but not from a personal perspective. A new paradigm is taking shape in child welfare designed to address this very issue. Parent

mentors—parents who themselves have experienced child removal and who have successfully and stably reunified with their children—are being included in child welfare practice to help address some of the many barriers parents face as they work toward reunification with their children.

Parent mentors do not provide therapeutic treatment to parent clients, but their similar background, and their experience successfully navigating the child welfare system, may offer hope that reunification and recovery are achievable goals (Cohen & Canan, 2006). Some evidence suggests that clients feel more motivated and hopeful even after viewing a video of former child welfare clients who have entered addiction recovery and have reunited with their children (Young & Gardner, 2002). If hope and motivation are powerful drivers toward individual change, then a model that provides regular contact with a parent mentor may be key to better child welfare outcomes for families.

## A Paradigm Shift

Inclusion of parent mentors in conventional child welfare practice is hardly straightforward, as the model challenges the status quo. Historically, case management has been proscriptive, with child welfare workers designing case plans and services based upon professional assessments of their clients. Because the more traditional approach assumes that professionally trained staff holds the answers to complex family problems, some staff may feel threatened by the inclusion of parent mentors into the web of service providers and/or equate *advocate* with

*If hope and motivation are powerful drivers toward individual change, then a model that provides regular contact with a parent mentor may be key to better child welfare outcomes for families.*

<sup>1</sup> The perspectives shared here are derived from the authors' work with parent mentors in two California counties. In Alameda County, parent mentors are referred to as *parent advocates*, and in Contra Costa County they are referred to as *parent partners*. We use the terminology *parent mentors* throughout for simplicity.



*adversary*. Further, a model that includes parent mentors gives parents a voice, and presses agencies to be more responsive to birth parents' strengths, as well as their needs. While this is usually welcome from a philosophical standpoint, the actual demands of parents may be difficult for agency staff to hear, and harder still to respond to, within the framework of the child welfare bureaucracy.

But as challenging as it may be to introduce parent mentors into child welfare practice, the benefits of this new model may go well beyond those that accrue to birth parents alone. The presence of parent mentors represents a new way of "doing business," one that promotes greater transparency and accountability in the child welfare system and to the vulnerable families it serves. While reunification has long been a primary goal of the child welfare system, biological parents whose children are removed due to maltreatment are generally relegated to a powerless, stigmatized position. This position is often exacerbated by systemic inequities based on race and class. Court processes, case plans and worker relationships intended to support birth parents often unintentionally reinforce these dynamics and intimidate, rather than empowering parents to take action. A child welfare system that embraces parent mentors potentially brings such limitations to light, and challenges workers and managers to be more responsive to parents. For example, traditional child welfare services often require parent clients to remain with their social worker, regardless of their "match." In the ideal parent mentor program, however, parents are empowered when they are offered the choice of both if and when they will begin to work with a parent mentor, and if and when their service relationship should end. In this "no-fault match" approach, parent clients can voluntarily terminate their relationship with their parent mentor, or choose to work with a different mentor at will. For parents in mandated client roles, this freedom of choice can be psychologically powerful.

Similarly, the traditional model of child welfare services is service-rich during times of extreme family crisis, but as family circumstances improve, services are usually withdrawn. Parent mentors can remain available to birth parents well after a case is officially "closed" by the child welfare agency. And if birth parents should return to the agency following reunification (voluntarily or involuntarily), the parent mentor can be available to assist and support the parent during periods of family vulnerability.

But parent mentor services offered to families are not necessarily formal, nor professionally-driven. Instead, parents are approached by peers who use self-disclosure and similar experiences as the springboard to engagement. The experiences of the parent mentors give them enormous credibility in the eyes of the parent, as well as hope

(*"If they could do it, so can I."*). Once connected to a parent mentor, parents are provided with emotional support, mentoring and encouragement, advocacy, concrete services and linkages to referrals. Parents are encouraged to do for themselves what they can, and to develop informal networks of helpers who they can rely on after their formal relationship with the child welfare agency has ended.

Because parent mentors may be part of the communities in which the birth parents live, they tend to have an understanding of parents' culture and neighborhood characteristics, and they speak a shared language. Thus, when parents board a bus, go to church or to the store, they may encounter their parent mentor, having the effect of normalizing their child welfare experience, and giving parents a regular reminder of hope and change.

Finally, in line with other initiatives taking shape across the field of child welfare, parent mentors provide equal attention to mothers and fathers. Rather than relegating fathers to a default position following a child's failed reunification with the birth mother, fathers are engaged early on as potential primary caregivers. Male parent mentors can serve as a voice reminding stakeholders that fathers and mothers are different, and that fathers may parent differently than mothers. Male parent mentors also may be especially effective in supporting fathers' relationships with their children and with their participation in services.

The premise of the parent mentor approach is a relationship-based one—not necessarily the principal ingredient in typical child welfare services. Parent mentors rely upon the human connections of support, trust, and communication. In Contra Costa and Alameda counties, parent mentors do not write reports, cannot testify against families, and are not driven by deadlines or data tracking. This freedom from bureaucratic confines gives them the time to devote singularly to their parent clients, and the opportunity to serve as authentic mentors to their peers.

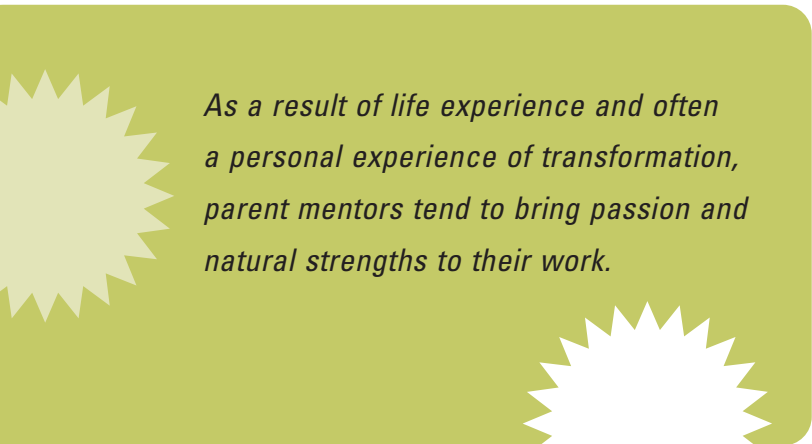
## Organizational Context

Inclusion of parent mentors in child welfare requires strong leadership that promotes a collaborative spirit, in which parent mentors are considered to be legitimately "at



the table” with other child welfare staff. Child welfare workers must be helped to understand and make use of parent mentors, through the agency leadership’s active support of the program’s underlying ideals. Leaders who promote collaboration between workers and parent mentors are more likely to facilitate positive working relationships, as some staff initially may feel mistrustful or dismissive of parent mentors. Workers’ sentiments must be addressed while highlighting the unique and important role of these former clients. Judges, lawyers, and affiliated professionals must likewise be introduced to the parent mentor model and acquainted with their potential benefits.

But strong leadership is also required in part because the organizational framework within which parent mentors work must accommodate a very different type of staff member. Parent mentors are often unconventional individuals by typical public child welfare agency standards. They are unlikely to possess an advanced educational degree, to have strong writing and speaking skills upon employment, and may have little work experience to draw upon to help them adhere to common standards of timeliness, dress codes, or other matters of professional etiquette and discourse. Importantly, some parent mentors may have past criminal convictions that would otherwise preclude their employment in a public child welfare agency. Whether hired in a public or non-profit agency, convictions may prevent parent mentors from having direct contact with children. Due to union contracts or other obstacles, public agencies may not be able to hire parent mentors as part of their staff. Instead, it may be necessary to work cooperatively with a community-based non-profit agency to hire and provide regular HR support to parent mentor staff.



*As a result of life experience and often a personal experience of transformation, parent mentors tend to bring passion and natural strengths to their work.*

These challenges and others often require agency directors to expend significant time and resources to work creatively with community partner agencies. Leadership and fortitude may also be required when agency directors are faced with probing questions from public policy officials, union leaders, or other bureaucrats who may not fully grasp the need for a flexible agency response.

## Supervision and Support

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As a result of life experience and often a personal experience of transformation, parent mentors tend to bring passion and natural strengths to their work. Effective supervision and support of parent mentors involves nurturing these strengths, while committing significant energy and resources toward skill development, and building the capacity of parent mentors to function effectively in the child welfare arena. Several areas of supervision and support stand out.

First, some combination of supervisors, trainers, and/or consultants need to be readily available, personally supportive, and committed to the growth and development of each parent mentor. Supervision and support needs to be individually tailored, in the context of relationships that are thoughtfully built and maintained. Many parent mentors may not have experience with supervision of this type (wherein they are asked to reflect upon their work, and think together with a supervisor about the best course of action), instead having supervision experiences that are purely evaluative, hierarchical, or task-oriented. Because of this, supervisors need to help parent mentors learn to make good use of supervision, and promote an emotionally safe environment in which questions can be asked, struggles can be openly examined, and new skills can be tried out.

Second, parent mentors need support as they change roles from client to employee. For some, entering the child welfare building may feel intimidating, or developing a working relationship with their former social worker may be unthinkable. Walking into the courthouse may cause them to have unsettling memories of walking in during much more troubling times. And working with substance affected families may challenge their own commitment to a clean and sober lifestyle.

Third, many skills basic to functioning in a work environment will need attention including such topics as dress codes, keeping appointment calendars, being on time for meetings, and addressing colleagues and supervisors using appropriate language, humor, and tone of voice. Parent mentors may need coaching on how to effectively commu-

nicate with others in an advocacy context, and help understanding the importance of relationship-building—to avoid burning bridges while expressing their support for a parent they feel has been wronged. This skill set cannot be taught in a one-time training session, and instead needs to become part of the ongoing dialogue between parent mentors and supervisors.

Next, role clarification is a recurring theme. Particularly in the beginning, parent mentors need help clarifying the nature of their role and the definition(s) of advocacy, mentorship, and support. Additionally, they need concrete, “how to” guidance: What are different ways to advocate for someone? What is a mentoring stance? What actions might be considered supportive and best in helping parents to help themselves? A related, important topic involves the parent mentor’s self-definition as a peer mentor versus a professional social worker. It is important to create a culture that avoids over-professionalizing the parent mentor, while simultaneously helping them to develop key skills to be effective in a professional environment. Similarly, parent mentors are likely to experience some understandable ambivalence about working in close relationship with the child welfare agency. Many parent mentors arrive in their position with a desire to facilitate systems change, recognizing ways their journey was made difficult by policies or people in the child welfare system. Parent mentors may struggle, then, with how to work closely with child welfare staff, yet embrace their change-oriented mindset.

Developing collaborative working relationships with child welfare workers and other system representatives can present challenges for parent mentors, for myriad reasons, and these struggles need to become part of the supervision dialogue. Parent mentors are likely, for example, to grapple with tricky confidentiality dilemmas involving parents and child welfare workers. Parent mentors will need support managing their alliance with a parent, while trying to foster a collaborative working relationship with a worker; and guidance in determining what information must be shared. Alliances between child welfare workers and parent mentors can be supported, too, by informing workers about the role parent mentors can play in relieving staff of otherwise time-consuming duties. For example, the parent mentor may coach the parent on several fronts: the court process, communication skills with attorneys and other allied professionals, relationship-building with the child’s foster parent, identification of appropriate services, appropriate dress and behavior, retention and ultimate success in treatment, time management and scheduling of appointments, and returning phone calls. Parent mentors can be uniquely suited to working with parents in a straightforward manner,

using straight talk, and explaining complex concepts concretely. These skills, and others, can offer important benefits for birth parents, but also for child welfare workers who can learn to rely on the unique skill set offered by parent mentors. In those instances when parent mentors encounter difficulties collaborating, it is important that supervisors help to frame the work in terms of relationship-building and gradual systems change.

Parent mentors, by virtue of their peer support role, naturally face many dilemmas around managing boundaries with parents—but may not recognize potential pitfalls without help. Parent mentors tend to prefer flexible, open, familiar relationships with parents and activities that include sharing of cell phone numbers, transportation to appointments, home visits on weekends and odd hours, as well as sharing of personal histories and information. These characteristics undergird many of the strengths of the parent mentor model. At the same time, parent mentors need support around making positive personal choices for self-care, as well as thoughtful boundary decisions vis-a-vis parents. For example, parent mentors may need to feel permission to assess whether certain parents should have their cell number, and suggestions on how to set gentle, respectful limits with parents about phoning at night or excessive phone calls. Parent mentors’ extended availability to parents after case closure is another area that needs attention, so that parents are given clear, realistic messages that are feasible for the parent mentor.

For supervisors, trainers, and consultants, it can be challenging to strike the right balance of content knowledge responding to the thirst for knowledge and skill development, and providing parent mentors with enough information to work effectively, while recognizing the limits of their “scope of practice.” This includes issues such as working with mental health problems, domestic violence, developmental delays, and substance abuse; as well as understanding complex behavior, such as some parents’ ambivalence about reunification. Ongoing training with a concrete emphasis on “what to do” and “how to do it” is essential.

Finally, there is the importance of holding multiple perspectives on child welfare cases, by being able to think flexibly and critically about issues of child safety, parents’



rights and experiences, and children's emotional well-being. While the parent mentor's role may be to maintain the centrality of the parent's perspective, effective mentoring and advocacy within the child welfare system requires an understanding of alternative perspectives and concerns, as well. Concurrent planning cases, and those where reunification is in question due to safety concerns, are examples of complex situations requiring supervisory support.

There are many ways to invite parent mentors to participate in the child welfare system: running parent support groups and making recommendations to the agency regarding policies, programs, or needed resources; as leaders representing the parents' voice in meetings, on committees and panels; as trainers for new staff, interns, foster parents, CASAs, or attorneys; and as mentors helping families navigate their way through the child welfare system. Finding the match between parents' skills and the needs of the agency falls to the skilled supervisor who understands each parent mentor's strengths and capacities.

*Finding the match between parents' skills and the needs of the agency falls to the skilled supervisor who understands each parent mentor's strengths and capacities.*

## Making a Difference

Evaluations of parent mentor programs are growing, but the literature base to support these new models of practice is still scant. Some evidence suggests that parent mentors may be especially helpful in engaging substance-abusing clients in treatment (Ryan, Marsh, Testa, & Louderman, 2006), and other studies—though not definitive—suggest the promise for promoting reunification (Berrick, Cohen, & Anthony, in review). Much more research is needed to better understand the differential outcomes that can accompany parent mentors. As a practice strategy, however, it is clear that many birth parents who work with parent mentors find solace and strength from this relationship. Their shared experience gives parents an ally, a person to trust, and a sense of hope that may inspire the confidence to grow and change.

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# START Family Mentors: Changing the Workplace and Community Culture and Achieving Results

Ruth A. Huebner, Tina Willauer, Audrey Brock, and Yolanda Coleman

## Innovative Response to Complex Needs

Families with substance abusing parents have pervasive and complex needs. Relapse, health problems, and the secondary effects of homelessness, criminality, and job loss compound recovery and child safety (Child Welfare Gateway, 2009; General Accounting Office, 2003; Young & Gardner, 2002; Young, Gardner, Whitaker, Yeh, & Otero, 2005). In Kentucky, parental substance abuse is a risk factor for child safety for 58% of children in cases with substantiated abuse or neglect. Among children, age three years or younger, who are in out-of-home care, 88% have risks to safety because of parental substance abuse. To address these problems, Child Protective Services (CPS) requires potent and innovative strategies.

The use of mentors or advocates in child welfare is an emerging innovation targeting support for the family through the child welfare system (Cohen & Canan, 2006). Since 2004, Kentucky has utilized an “advocate” model for parents of children in out-of-home care, which resulted in higher rates of reunification among families despite relatively higher initial assessments of risk (Davis, et al., 2007).

For families affected by substance use disorder, the Sobriety Treatment and Recovery Team (START) model provides the ground-breaking paradigm shift needed to improve CPS outcomes for them. START developed in Cuyahoga County (Cleveland), OH (Annie E. Casey Foundation, 2002; Young & Gardner, 2002) as an integration of best practices that recognized the tension between parent sobriety and child safety. The START model was designed to intervene rigorously to recruit, engage, and retain parents and caretakers in substance abuse treatment while keeping children safe.

An expansion of the state’s original parent advocacy model, the START program in Kentucky (i.e., K-START) was planned in late 2006 and launched in September 2007. Although a variety of terms (e.g., *parent advocate*, *family recovery advocate*) have been applied to this position (Annie E. Casey Foundation, 2002), the title *family mentor*, was chosen for the K-START program to emphasize the coaching and guidance functions critical to child safety and adult recovery. Services include adult mentoring, teaching and modeling for parenting and sober living, negotiating the child welfare system, and accessing and maintaining treatment and recovery.

The START program in Kentucky employs full-time family mentors and pairs them with specially trained CPS social workers. As of January 2010, Kentucky employed 13 family mentors in four different START sites. On average, family mentors have had seven years of successful recovery, most have children, and all have experiences that sensitize them to child needs.



## Family Mentor Role and Training

Family mentors act as “natural supports,” helping parents progress toward recovery. Each CPS worker/family mentor team shares a caseload of 12 to 15 families. These teams provide or coordinate intensive family services and case management, rapid access to substance abuse treatment, supports for sober parenting, and community wrap-around services.

Family mentors perform many varied duties so that children in the program can live safely with their recovering parent(s). For example, mentors may: (a) escort and/or transport parents to at least the first four substance abuse treatment or community recovery sessions; (b) work with family members in their homes to coach, support, and observe progress in developing and applying skills for sober living and parenting; (c) assist the CPS social worker and facilitate communication and understanding of substance abuse and the child welfare system; (d) locate resources, e.g., housing, food, clothing, and furniture, to meet family needs; (e) complete necessary documentation, and monitor family and adult progress; and (f) communicate weekly with treatment providers. Mentors work directly with community partners both with, and on behalf of, the parent and family members. They accompany families to family team meetings, court hearings, case consultations, and community partner meetings.

## Measuring Family Mentor Activity

Skepticism about hiring persons in recovery as full-time START team members necessitated documentation of the work of the family mentors. Thus, START teams and researchers developed a simple checklist of potential family mentor activities in six domains as displayed in Figure 1. The reporting of family mentor activities began with the first families served. Mentors recorded their activities with each family for every day of contact. The contact was associated with the family as a whole, rather than an individual parent, to capture the family focus and spectrum of the mentor's work. As of November 2009, family mentors provided more than 8,800 contacts to 197 families. The START teams served 319 parents (i.e., mothers, fathers, significant others) affected by substance abuse and 375 children.

*Mentors work directly with community partners both with, and on behalf of, the parent and family members.*

Data collected on family mentor activities was linked to data on the primary adult caregiver in each family. A series of focus groups and key stakeholder interviews was also conducted at each START site. In total, 71 interviews were completed either with individuals or in small focus groups. These interviews included START supervisors, caseworkers, adults served in START, other CPS staff, substance abuse and mental health treatment providers, court personnel, and community partners.

The first set of data reflected 7,048 family mentor contacts recorded for 318 unique families at different points in treatment. Twenty-five percent of families had 17 or fewer contacts, 50% had 37 or fewer contacts, 75% had up to 63 mentor contacts, and the final 25% had up to 127 contacts. During any daily contact, a family mentor might complete several activities, such as a phone call with the substance abuse treatment provider and a meeting with the adult in the home. Figure 1 displays the frequencies of the family mentor's service provision in the six domains measured.

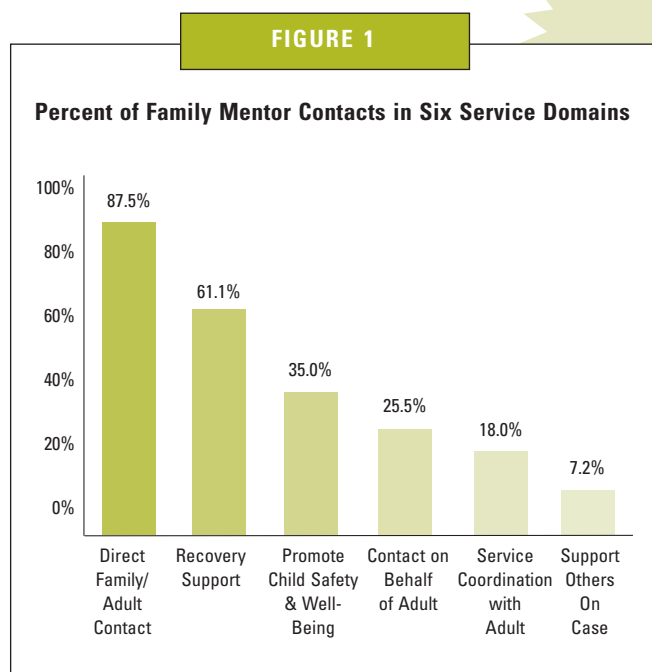


Figure 1 above illustrates that family mentors most often provided direct contact with the adult, followed by recovery support services. Table 1 below displays the specific activities used most frequently by family mentors when providing services in any single service domain; parent mentor services may have included multiple activities in any single domain.

TABLE 1

## SPECIFIC FAMILY MENTOR ACTIVITIES IN EACH SERVICE DOMAIN

Service Domain	Common Family Mentor Activities
Provided direct family/adult contact	Met adult in the home (39.6%) Talked to adult on the phone (32.6%) Met adult in DCBS (child welfare) or provider office (26.2%) Made face-to-face contact with child or children (16.6%)
Provided recovery support	Provided coaching on recovery skills (86.1%) Reinforced/taught skills on daily living (63.3%)
Promoted child safety and well-being	Provided coaching and mentoring on sober parenting (88%) Reinforced plan for child safety with adult (44.9%)
Provided contact on behalf of the adult	Phone call with substance abuse provider (41.8%) Coordinated services on behalf of the adult (39.2%) Sought services for the adult(s) (30.9%)
Supported service coordination with adult	Worked with substance abuse treatment provider and adult (60.4%) Attended family team meeting/staffing with adult (42.1%)
Provided support to others on the case	Supported relatives caring for children (71.6%) Supported non-substance abusing adult in the home (25.7%)

## Evidence of Family Mentor Success

On average, family mentors met with families six times per month, typically spending about an hour on each occasion working with or on behalf of the family. For the 63 families that completed the K-START program, family mentors spent an average of 41 hours with the family over the life of the case that averaged 9½ months. Family mentors serve a population of parents with severe substance abuse, child maltreatment, and multiple co-occurring disorders, with nearly 63% of START primary caregivers (mostly mothers) reporting to have been victims of beatings or rape. Despite these multiple challenges, 72.2% of families kept each and every appointment with their family mentor; only 37.8% failed to attend a single meeting. This result is in contrast to the findings by Green and colleagues (2006) that only 50% of women with substance disorders completed one treatment intervention.

Overall, 58% of the 63 primary caregivers completing the K-START program achieved sobriety and 55% of

children were placed with their primary caregiver at case closure. Although the impact of the number of family mentor contacts on achieving sobriety and retaining child custody was not statistically significant, it is notable that family mentors had an average of 49 contacts with primary caregivers who failed to achieve sobriety and 52 with those who did achieve sobriety. It is too soon to measure the long term effects of such intensive mentoring.

We also examined the results of the focus groups and key stakeholder interviews mentioned earlier. Notably, every person interviewed, including court personnel, START family members, and substance abuse treatment providers, recognized the family mentors as a key element of change in the START program, though this question was never directly posed. Not surprisingly, the persons interviewed cited the special benefits of the family mentor work. Some of the unique contributions included the fact that they: (a) use their special knowledge and perspective to coach the parent on avoiding relapse, parenting sober, and learning to manage a household; (b) have a special rapport with clients, see signs that others miss, and can say difficult things to clients with credibility; (c) support

the birth parents early through the CPS system and model sober parenting and provide role models for families; (d) offer insights to the families to help keep the clients on track and increase the chances for recovery by relating to the client, being honest about their own experiences, and keeping them motivated; (e) follow-up with clients many times per week, especially early on, offering supports and tangible help through both systems; and (f) persistently engage clients that withdraw from interaction, transport people to appointments, and take clients in for random drug screens.

An unexpected result was the numerous professionals from many agencies and disciplines that discussed how family mentors had changed the workplace and community culture and attitudes related to two matters: what it is to be a person in recovery, and realistic lessons about substance abuse. For this, many mentioned that family mentors had earned the respect of their co-workers. Discussions with professionals revealed the following:

- ✱ Team members, community partners, and service providers learn directly from mentors things they would never learn in academia—street knowledge about the daily life of a person addicted to drugs.
- ✱ Family mentors are role models in communities. Witnessing family mentors in the community instills hope and recognition that people in recovery can remain sober, contribute, and find purpose in life.
- ✱ Family mentors ‘plant seeds’ about the possibility of sobriety for families.
- ✱ Family mentors engender pride in their professional colleagues. As one attorney said, “I am proud to stand with them before the judge.”
- ✱ Family mentors address more of the family’s problem; they address the “whole storm.”

In turn, family mentors say that their work is important to them and reinforces their own recovery.

## Conclusion

Early evaluation findings suggest that the K-START program is achieving promising results, with nearly 60% of primary caregivers attaining sobriety and child custody. The family mentors have proven to be an essential change catalyst in K-START. However, despite the numerous strengths peers in recovery bring to their role as mentors for families, their personal history can create challenges in the workplace. To address this, the K-START director planned for potential mentor relapse, and works directly with mentors to learn to manage work demands and constraints. Work-related performance issues, as with any employee, have occurred. Although the process for mitigating these potential problems is beyond the scope of this article, everyone from state

leadership to front line staff agree that the risks associated with employing peers in recovery are worth the challenges. An ongoing multi-year study of K-START, including the impact of family mentors on outcomes, will serve, no doubt, to support or refute this assertion.

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*Note: This research is funded in part by a grant (90CU0045 RPG) from the Children's Bureau.*

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# Harnessing the Power of Experiential Knowledge: Specialized Treatment and Recovery Services (STARS)

Sharon M. Boles, Nancy K. Young, and Jeff Pogue

## Introduction

Since October of 2001, the County of Sacramento Juvenile Dependency Court in California, in collaboration with the county Human Services Agency, has operated a comprehensive program of intervention, service delivery and monitoring for families in the Division of Child Protective Services (CPS) with a substance use disorder (SUD). A component of those comprehensive services is the judicial oversight of compliance with case plan orders through a Dependency Drug Court (DDC) program. Participants are families whose children have been removed from their parent's custody due to allegations of child abuse or neglect associated with parental SUDs.

The Sacramento DDC model includes early access to treatment and recovery support services, as participation is encouraged at the first court appearance (called a *detention hearing* in California). There are three levels of court hearings to oversee compliance with the recovery plan. Level 1 hearings are held at 30, 60, and 90 days after the *dispositional court hearing*, which establishes both the child's status as a dependent of the court and their temporary placement. For continued compliance, parents receive a 90-day certificate. However, events of noncompliance in Level 1 may result in parents being transferred to Level 2

of the program, which includes more intensive support and court hearing structure. Parents with a 90-day certificate can voluntarily participate in Level 3, an additional 90 days with continued compliance to achieve graduation. Compliance with the recovery plan includes participating in substance abuse treatment, attending self help groups and meetings with recovery support staff, and drug testing.

The DDC uses the power of peers for recovery management through the Specialized Treatment and Recovery Services (STARS) program. STARS uses recovery specialists, professional staff with experiential knowledge, to deliver intensive recovery management and supportive services to parents. STARS provides CPS and the Juvenile Dependency Court with comprehensive case management services for the alcohol and other drug (AOD) components of court-ordered case plans. Participants in the STARS Program are required to meet with their assigned recovery specialist, enter and complete AOD treatment, submit to random alcohol and drug testing, and attend support group meetings. This article highlights the STARS Program and its associated outcomes.

## Roles of the Recovery Specialists

The STARS recovery specialists augment the work of traditional child welfare workers by filling two key roles: a) a strength-based case manager, coach and mentor relationship; and, b) providing clear boundaries, expectations, and accountability on behalf of the court and CPS. The central ingredients include the intangibles of both a supportive relationship and clear accountability for compliance with the parent's recovery plan. Each parent is matched with a recovery specialist, who provides recovery coaching, encouragement and direction; assists in accessing AOD treatment services; develops a liaison role with CPS and other professionals; provides monitoring of and accountability for the parent's compliance with treatment requirements; and

*The central ingredients include the intangibles of both a supportive relationship and clear accountability for compliance with the parent's recovery plan.*

supplies CPS and the Juvenile Dependency Court with accurate and timely reports reflecting parents' progress. Recovery specialists are responsible for face-to-face contacts with parents as outlined by the STARS Program Tracking System. These contacts are vital to the success of the STARS program and the parent's success. Recovery specialists are required to hold at least 50% of these contacts in the field and the rest in the STARS office.

The recovery specialists collect all documentation provided by the participants and treatment providers regarding treatment, drug testing and support group attendance. They arrange, facilitate and attend case conferencing with the parent, AOD treatment provider and CPS social worker within 90 days of intake. They may also attend the DDC with the parent, particularly when the parent receives a 90-day or graduation certificate.

## Goals and Values of the STARS Program

The STARS program assists parents in the process of recovery by removing barriers to treatment and providing support, encouragement and accountability. The Recovery specialists accurately report each parent's progress to CPS and the court system with a commitment to integrity and excellence. The overall goal of the DDC is permanency and safety for the child and recovery of the parent. The focus of the work with parents includes recovery as related to their ability to safely regain custody, but recovery is emphasized as independent from reunification decisions.

The following six beliefs and values are core to the STARS program: 1) people can change and recovery specialists can be instrumental in that change; 2) people should be responsible and held accountable for their behavior and decisions; 3) the family is the core social unit and should, wherever practical, be kept intact; 4) every person is entitled to be treated with dignity and respect; 5) sobriety, dignity and family can be restored; and 6) the workforce should be diverse, reflective of the community served and have the ability to respond to individual needs and circumstances of the parents and their families.

These goals and values are put into place immediately upon intake with the parent. At the detention hearing, the parent is immediately assessed for AOD issues. Each parent is assessed individually, helping to break the denial surrounding the impact of significant others. The parent meets their recovery specialist (who has been matched by gender) immediately following the intake session.

Following the results of the intake assessment, the recovery specialist liaisons with community agencies to provide immediate access to AOD treatment based on the parent's level of need. Services that foster parental involvement and, thus ensure greater continuity and effectiveness of delivery of services and/or systems to the individual, are provided.

## Three Keys to Success

Through their work with the Sacramento DDC, the STARS program has discovered three keys to success in working with substance abusing parents: 1) use of motivational interviewing techniques; 2) role modeling; and 3) accountability.

The STARS program has found that motivational interviewing works well with the target population, as it helps to create a sense of empowerment by the parents. Incorporating these principles in their work with parents, the recovery specialists express empathy, support self-sufficiency, "roll with" resistance and develop discrepancy. They express empathy multiple ways ranging from the use of gender-specific matching, the use of limited self-disclosure, and providing help "no matter what." Most of the recovery specialists are also in recovery themselves and some have also had prior contact with the child welfare system. STARS recognizes that witnessing other people successfully completing goals and objectives is an important source of self-sufficiency. STARS demonstrates that recovery can work by: utilizing former parents as staff; holding alumni groups; holding a support group on site; and providing motivation, encouragement and support as parents proceed through the DDC.

To reduce the parent's resistance to treatment, the parent is involved in the determination of their level in the program and their provider of treatment services. The parent is encouraged to always have a plan for their recovery. To reduce parent resistance, the recovery specialists are trained to never argue with parents, but rather to focus on providing support to them. Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be (Prochaska, DiClemente, & Norcross, 1992). The fact that children have been removed from the home allows for an immediate and tangible discrepancy. The recovery specialists point out behaviors and actions inconsistent with becoming healthy parents.

Each recovery specialist serves as a role model for the parent with whom they are matched. They are certified AOD counselors who are believable and approachable,

comfortable with some self-disclosure, and non-punitive in their methods. STARS believes that when they combine an empathetic, supportive environment with one that stresses accountability, they are able to create change in a profound way. Each parent they work with is encouraged to accept responsibility for every action he/she takes.

## The Intangibles

There are several intangibles to the work of the recovery specialists that cannot be quantified, but are crucial to their success. First is their overall belief in redemption and recovery. They believe that parents can overcome the prejudices that exist toward substance abusing parents through recovery and accountability. The recovery specialists believe in always giving the parents 100% effort in order to obtain the parents' 100% effort. All recovery specialists hired by STARS also have a passion for working with the parents. These intangibles, along with the techniques discussed above, have led to positive outcomes for the parents in the DDC. Below are 36-month pre-and post-STARS implementation findings.

## Pre-STARS, Post-STARS Outcomes

Sacramento DDC program outcomes were assessed in two primary areas: parental treatment status and child placement outcomes. Focus groups with parents were also held to ascertain some of the intangibles that parents experience in the program. The outcome data presented in this article include two groups of participants for which 36-month outcome data are available. The first is a comparison group of families who entered the dependency system in the 6 months prior to the implementation of the STARS program (Pre-STARS) and met the admission criteria for DDC. This sample included 111 parents and their 173 children. This group received standard CPS and AOD Services. Thus, a parent who was identified as having an AOD problem was directed to the AOD services for a preliminary assessment; he or she was then directed to participate in outpatient or residential treatment, without the benefit of a recovery specialist or the specialized court services in the DDC model. The second group consisted of those families who entered the dependency court system and were court-ordered to receive STARS and DDC supervision (while the DDC continues to operate, the time period analyzed for this article includes three years of outcome data). This DDC (Post-STARS) sample included 1,295 parents and 2,086 children.

## Parent and Child Demographic Characteristics

There were no differences between the Pre-STARS and Post-STARS participants on any of the parent demographic characteristics, including gender, age, or race/ethnicity. Approximately 70% percent of the Pre-STARS and Post-STARS parents were women, with an average age of 32.1 years of age. The majority of the Pre-STARS and Post-STARS parents were Caucasian (50.6%), followed by African American (20.6%), Hispanic (20.4%), Asian/Pacific Islander (3.0%), American Indian/Alaskan Native (2.8%), and Other (2.6%).

No differences were observed in any of the baseline characteristics, except primary drug. Parents in the Pre-STARS and Post-STARS groups were largely unemployed; 45.7% had less than a high school education; 32.1% had disability impairment; 33.9% self-reported a history of chronic mental illness, and 40.1% were homeless at treatment admission. Almost 21% of the Pre-STARS and Post-STARS women reported being pregnant at treatment admission. Consistent with the changes in the county's drug use patterns overall, significantly more Pre-STARS parents (19.6%) reported using cocaine/crack as their primary drug than Post-STARS parents (10.7%). Almost 52% of the Post-STARS and 44.3% of the Pre-STARS reported methamphetamine as their primary drug problem. Rates of prescription drug use, including Oxycodone, were also examined. While none of the Pre-STARS group reported that prescription drugs were their primary drug, 2.3% of the Post-STARS parents reported that their primary drug was prescription drugs.



## Parental Treatment Status

Significantly more Post-STARS participants (84.6%) participated in AOD treatment compared to Pre-STARS parents (53.2%). There were also significantly more treatment admissions for the Post-STARS ( $n = 5,628$ , Mean = 2.3) parents than the Pre-STARS ( $n = 1,518$ , Mean = 1.4) parents. Post-STARS parents were significantly more likely to have been in treatment in the three months prior and after their start date than the Pre-STARS parents. In contrast, the Pre-STARS parents were significantly more likely to have been in treatment in the four or more months prior to the start date and more than six months after

the start date. There were no differences in the discharge status among Pre-STARS and Post-STARS participants with over 64% of the Pre-STARS and Post-STARS group having satisfactory discharges. The Pre-STARS group (Mean = 293.2 days) had more total time in treatment than the Post-STARS participants (Mean = 200.2 days). The Pre-STARS group (Mean = 114.5 days) also averaged significantly more days per treatment episode than did the Post-STARS parents (Mean = 83.9 days).

## Process Evaluation Outcomes

Focus groups were held with current and past Post-STARS parents. The participants highlighted nine factors they believe assisted their recovery: (1) coordinated care and agency collaboration, (2) forced accountability and responsibility, (3) needed structure, (4) provision of incentives, (5) provision of social support through group sessions and networking, (6) application of the therapeutic court model and an invested judge, (7) supportive STARS recovery specialists and CPS social workers, (8) tailored treatment, and (9) community referrals. Participants also highlighted 12 factors that they believed affected recovery negatively: (1) pressure to leave their support systems, (2) complexity of program language, (3) lack of services for men/fathers, (4) differing/ conflicting rules, (5) open court, (6) need for better information exchange, (7) need for clearer explanations of program components and agency roles at the onset of program, (8) need to assess program intensity and participants' ability to manage/balance all tasks related to DDC, (9) need to expand services, (10) lack of alumni services, (11) need for updated, appropriate parenting classes, and (12) lack of trust in DDC staff.

## Thirty-six Month Child Placement Outcomes

At 36 months after the child's project start date, significantly fewer Pre-STARS (26.0%) children had reunified with their families than Post-STARS children (45.7%). Pre-STARS children were significantly more likely to be in the CPS programs of adoptions, guardianship and long-term placement than Post-STARS children. There was no statistical difference in time to reunification among those who had reunified before 36 months. Of the Pre-STARS children who reunified by 36 months, their average time to reunification was 312.0 days (10.4 months) and among the Post-STARS children it was 301.2 days (10.0 months).

## Summary and Conclusion

The STARS program, as a component of the Sacramento County DDC, has demonstrated the effective use of recovery specialists to engage parents in a supportive community of treatment and recovery, while providing the accountability reporting needed by CPS and the court. The experience of the program staff suggests that engaging parents in a non-traditional, supportive role, using motivational techniques, is effective in ensuring parents' engagement in treatment and results in increased percentages of children reaching permanency through reunification.

Focus group participants expressed extreme appreciation for the family reunification efforts made by both STARS and CPS staff. STARS recovery specialists, in particular, were noted to have come to parks, street benches, and homeless shelters to assist DDC participants. They also expressed gratitude that the DDC, through the STARS treatment umbrella, understood the varying needs of substance users. In regard to treatment outcomes, the increased average number of treatment admissions and lower number of days in treatment may indicate that more successful transitions between levels of care are being managed by the recovery specialists. In the CPS outcomes, the significantly higher number of children who reunify with their parents have led to substantial cost savings in out-of-home care for the county.

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*Acknowledgments: This article is based on the work of an extraordinary group of people who have designed and staffed an innovative, model project. They are the real pioneers in the field, working on behalf of families with substance abuse problems. The authors would like to acknowledge the following people: The Honorable Carol S. Chrisman, Toni Moore, Sharon DiPirro-Beard, and Sanford Robinson.*

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# Using the Peer Recovery Model with Mothers of Substance-Exposed Newborns Identified through CAPTA Requirements

Enid Watson, Kristin Funk, and Liz Twombly

*Sophie gives birth to an infant prenatally exposed to opiates and methadone. She struggles with chronic depression and is a trauma survivor. Her baby remains in the hospital, “detoxing” for several weeks. Because of her drug use, Sophie lost custody of her first child seven years ago. Her guilt over her new baby’s condition, and her awareness that she may lose this child as well, makes it difficult for her to attach to her baby. While awaiting her baby’s discharge, and potential removal, Sophie and her baby’s father are evicted from their home. Sophie is afraid. Whom can she trust? Who will understand her? Her child welfare worker refers her to a peer recovery worker.*

In 2003, Congress passed the *Keeping Children and Families Safe Act*, an amendment to the *Child Abuse Prevention and Treatment Act* (CAPTA) which requires states to: 1) develop policies and procedures to identify infants affected by prenatal illegal substance use; 2) notify child welfare of such infants; and 3) develop plans of safe care for substance-exposed newborns (SENs) and their families. Two demonstration projects, funded by the U. S. Department of Health and Human Services, Administration for Children and Families to implement these new requirements, have utilized a Peer Recovery Worker Intervention Model. This evidence-informed home visiting practice employs staff, whose backgrounds mirror their clients, to assertively engage and support pregnant women and/or mothers of SEN.

*A Helping Hand: Mother to Mother* (AHH) is housed in the Massachusetts Department of Public Health, Division for Perinatal, Early Childhood and Special Health

Needs, which includes the early intervention system established under Part C of the Individuals with Disabilities Education Act. Early Intervention (EI) provides crucial developmental assessment and intervention services for children from birth to three. AHH, in close collaboration with the state’s child welfare agency, aims to provide a comprehensive, coordinated system of care for SENs, their mothers and families, using peers (mothers in recovery) to intervene in the immediate post-partum period.


In Lane County, Oregon, *Project Family Early Advocacy and Treatment* (FEAT) is directed and coordinated by staff at the University of Oregon’s Early Intervention Program, a research and graduate training program. FEAT’s mission is to implement policies and procedures for identifying and providing safe care for SENs and their families, and for working collaboratively with child welfare during the notification process. FEAT employs peers who engage with both pregnant and postpartum substance using women.

Both AHH and FEAT are collaborative efforts that include state public health and child welfare departments, substance use disorder treatment providers, hospitals and medical providers, community agencies, and EI. Both view peers as a central part of their project mission.



## Why Use the Peer Model?

Research demonstrates that peers working with pregnant and postpartum women have promoted the following: positive maternal health outcomes; general infant health



and positive interaction between mother and child; use of perinatal health care; longer breastfeeding; prevention of unplanned repeat pregnancies; and increased use of community resources by pregnant and parenting women (Chapman, Siegel, & Cross, 1990; Flynn, 1999; Perino, 1992; Schafer, Vogel, Viegas, & Hausafus, 1998). Peer workers have been found to have a strong sense of commitment and a positive effect on substance use disorder treatment (Marchant, 2002) through their unique ability to engage and empathize with clients, thereby increasing the use of substance use treatment services and promoting relapse prevention. The peer recovery intervention worker is similar to the community health worker, which is shown to be effective in multiple health care and public health settings (Brownstein et al., 2005; DeFrancesco et al., 2002; Human Resources and Services Administration, 2007).

Similarly, both AHH and FEAT employ peers to engage mothers of SENs during critical perinatal periods to ensure better outcomes for women and their infants. These peers provide emotional support, linkages to resources, and assist women in maintaining or initiating substance use treatment and/or other recovery supports, and treatment for trauma and mental illness.

*Sophie benefits from good communication between her child welfare worker and Heidi, her AHH peer. Heidi not only engages with the families of SENs, but provides an added resource to child welfare workers who have limited time to spend with families. Together, they hold case conferences with Sophie to ensure that they are working toward the same goals. With Sophie's permission, Heidi also communicates with EI and Sophie's mother, giving this grandmother support and information about the addiction and recovery process.*

## What Do Peer Workers Do?

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Sophie's life challenges are congruent with the profile of many mothers of SENs: maternal substance use is associated with a range of environmental factors that are risk factors for healthy child development, including poverty, unstable housing, mental health problems, domestic violence, child abuse and neglect, and compromised parenting (Lester, Andreozzi, & Appiah, 2004; The National Abandoned Infants Assistance Resource Center, 2004;

Ondersma, Simpson, Brestan, & Ward, 2000). Although prenatal drug exposure can have immediate and latent effects on children, current research indicates that the postpartum environment is a critical factor in child outcomes. Early identification and intervention with mothers, infants, and families improves outcomes and can reduce societal costs, while providing substance-exposed newborns the opportunity to achieve their full potential. Pregnancy provides a unique timeframe to reduce or abstain from substance use. In turn, the postpartum period is when many women resume substance use, even though abstaining during pregnancy. It is also a time when mothers of SENs can feel overwhelmed, ashamed, afraid, and confused. They frequently perceive interactions with child welfare professionals as punitive rather than supportive.

One of the greatest supports a peer can provide a new mother is assistance navigating the "resource maze." Peers might help a woman identify goals; support and empower her in developing her child welfare service plan; advocate for her with child welfare, court systems and treatment providers; and provide service coordination before, during and/or after childbirth. Additionally, peers work to ensure that each SEN and his/her mother are referred to EI.

In addition to such practical assistance, the emotional support provided by peers is essential for women attempting to maintain their sobriety and provide safe care for their infants. A mother from FEAT said that, "Emotional support was my biggest help. The peer made this whole process much more tolerable and easy. I was scared to death until I knew she was going to be around." Julie, a peer from FEAT, describes her most important role as "instilling hopefulness in women who don't already have it...and the willingness to change." This shift in motivation often happens in the context of conversation, when a peer listens without judgment and shares her own experience with her client, as she deems appropriate and helpful. Clients appreciate Julie's perspective. "It was really helpful to know about my peer's personal history with substance abuse," said one, while another commented: "My peer knows what she is doing, and the fact that she has been there too makes a big difference from other people that don't really know how it feels to deal with child welfare. And she helped me take my son home."

*To support Sophie's recovery from co-occurring disorders, Heidi referred her for in-depth individual counseling, accompanied Sophie to 12-step meetings and shared recovery readings. After seven months of working with Heidi, Sophie's parenting skills improved considerably. She developed a wonderful, strong bond with her baby. Since Sophie had no access to transportation, Heidi drove her to the welfare office, grocery store, and helped her apply for vocational training. These seemingly simple tasks would have been difficult for Sophie to complete by herself. The "car time" also provided a comfortable setting in which to talk.*

*Though Sophie was difficult to engage initially, Heidi's ability to share her own background as a parent in recovery was significant in breaking through the resistance and establishing trust. Eventually, Sophie told Heidi that she wanted to be like her, a healthy mother in recovery.*

## What Kind of Training and Support Do Peers Need?

Besides having a solid personal recovery background, peers need a familiarity with substance use disorder treatment. It is ideal to hire peers with addictions certification/licensure. Training in motivational interviewing, an evidence-based strategy for working with substance use disorders, is extremely helpful. Peers in both demonstration projects are required to have child welfare system knowledge, as well as knowledge of community resources, particularly those most relevant to

pregnant women, SENs and their families. Basic understanding of child development, healthy attachment and parenting is exceptionally helpful in supporting women as they experience sober parenting. Finally, it is crucial for peers to be trauma-informed. Many women with substance use disorders have significant trauma histories including physical and sexual abuse. Childbirth often triggers memories of these traumas contributing to intense emotional stress. Trauma-informed services are based on an understanding of the impact of violence on the lives of survivors, and include approaches that help women heal from trauma.

Adequate supervision and personal support are essential to peers' success. Peers need help working with these families to manage and prioritize complex and overwhelming problems. Since a family's trauma history may "trigger" memories of a peer's own experiences of violence and abuse, peers need support to address secondary trauma. FEAT's peers are housed at the Relief Nursery, a local family-support agency focused on reducing child abuse and neglect with high-risk families, while AHH peers are housed in community-based organizations. Both programs provide training and supervision, as well as peer supervision and mentoring.

*Heidi's reflections on working with Sophie underscore the importance of supportive supervision. As Heidi found herself connecting deeply with Sophie, the relationship triggered turbulent emotions for her, including guilt stemming from her own past substance abuse. Heidi sometimes called her own sponsor from her car after meeting with Sophie. Despite this, Heidi has not felt roused to use: she attends 12-step meetings regularly, has a solid relationship with her sponsor, and receives excellent supervision. With these support systems in place, Heidi has been able to develop personal and professional boundaries and maintain healthy self-care.*

## What Are the Challenges and Strengths of the Peer Model?

A major challenge of the peer model has been the maintenance of professional boundaries and appropriate sharing. Peers may over-identify with mothers because of their own experiences with child welfare, incarceration, depression, homelessness, or trauma. Peers need to be clear about their role, and well-informed about issues related to boundaries,



mandated reporting, and primary allegiances and alliances. Peers must remember that child welfare agencies are collaborators in these projects, not “the enemy” that needlessly takes children away from their families. Supportive supervision and comprehensive training can address these issues.

Community and client response to peers has been positive for both projects. Community referrals from prenatal providers, hospital staff, child welfare and other agencies have increased during the three-and-a-half years that FEAT peers have been practicing in the community. Since FEAT peers often work with pregnant women, child welfare may not open a case when a SEN is born if they know that the peer will continue with the mother. Child welfare lawyers and judges have been more willing to allow SEN to accompany their mothers into residential treatment directly from the hospital after delivery, rather than placing them immediately in foster care. In FEAT, court representatives have, in fact, begun to refer women directly to peers themselves. AHH peers also provide support to child welfare, early intervention and other community professionals who recognize the important role they play in the lives of women with substance use issues. One child welfare professional said, “The peer has experienced similar challenges which allow an increased ability to both empathize and respectfully confront. The peer isn’t a loaded professional who might be seen by the client as the enemy.” An EI professional wrote about the peer model: “Providers and administrators are offered an invaluable perspective on the challenges and recovery processes that are not available through other avenues.”

*After a number of relapses, loss of custody, and a few days living in a car, Sophie signed herself into an inpatient mental health facility. Heidi sent her a note of encouragement while she was there. After completing that treatment, Sophie moved to a residential program where she received integrated treatment for substance dependence, mental illness, and trauma. Her mother continues to have custody of her child, but child welfare hopes to reunify Sophie and her toddler in treatment. Heidi will work with her until she is stable and has increased resilience.*

## Alternate Peer Worker Models

This article describes two approaches that incorporate the use of peers in the service mix for pregnant and parenting women who have substance use disorders. A variety of such models exist across the country. For example, the newly emerging role of the recovery coach in the evidenced-based Recovery Management Model (White, Kurtz, & Sanders, 2006) is based on a long history of approaches to recovery that integrate peer support (White, 2004a, 2004b). In this model, peers act as recovery coaches, focusing on engagement and motivation, rather than supportive services or 12-step sponsorship. Services are tailored to support lifestyle change along the pre-treatment, treatment, and post-treatment continuum, with the understanding that for some, recovery is attainable by means other than treatment. Peer recovery workers assist each mother in finding her individual pathway to recovery and working together toward the goals of reduction/elimination of substance use and risky behavior, improved health and social functions, and strengthened parenting skills. Peers build on a mother’s strengths, using motivational strategies to address a mother’s ambivalence while supporting her personal recovery goals. Research has shown that motivation-enhancing approaches are associated with greater participation in treatment and positive outcomes, including reduced consumption, increased abstinence rates, and successful referrals (Miller 1999; Miller & Rollnick, 2002).

Recovery coaches are not always in recovery themselves. In Illinois, child welfare has experimented with using social workers as recovery coaches with mothers of SENs to good benefit and reduced costs (Ryan, Choi, Hong, Hernandez, & Larrison, 2008).





## Key Programmatic Recommendations

The two projects' experiences in operating peer recovery programs have prompted them to offer the following guidance:

- ✱ **Develop collaborative relationships with key agencies, i.e., child welfare, treatment, courts, medical, community parent support.**  
AHH has found that being "housed" in public health has facilitated cross-state agency systems collaboration.
- ✱ **Hire peers with recovery experience.**  
FEAT originally hired parents without a recovery history, but found that the peers in recovery were especially effective with pregnant and postpartum substance using women. The peers should have at least two solid years of recovery and, ideally, credentials in addiction treatment.
- ✱ **Support peers in practicing good self-care.**  
Overcoming the stigma of being an identified woman in recovery can be challenging. Support the peer in maintaining her own recovery, and allow time for both supervisory and peer-to-peer support.
- ✱ **Provide broad training.**  
Topics may include: home visiting protocols and safety, motivational interviewing, CPR, local resources, substance use disorders, trauma-informed services, maintaining personal boundaries, and cultural competence.
- ✱ **Provide ongoing supportive and reflective supervision.**  
Crucial in any position, this is particularly important when distinctions between identities as a peer and as a clinician may be blurred.
- ✱ **Enjoy and value your peer workers!**  
As associates, they can enrich your shared work and you can provide them another step in their career ladder.

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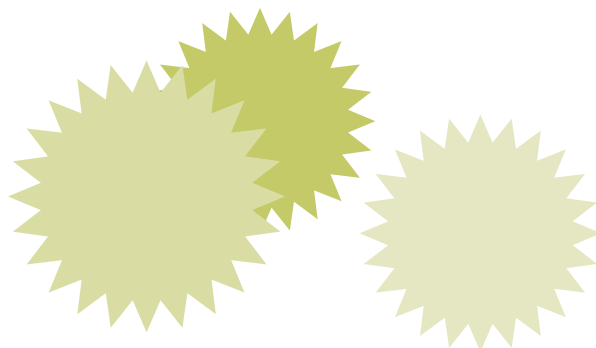
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# In Their Own Voices: Why Peer-to-Peer Mentoring Works

Ruth Taylor, Angelina Rivera Richart, Leah Hall, Christine Stolebarger, Mark Held, Deb Rau, Char Hooper, and Shelly Harding

In Oregon, substance abuse is the single largest contributor to child abuse and neglect. Morrison Child and Family Services' Parent Mentor Program was created in 2004 with the goal of reducing the length of time children remain in foster care because of parental substance abuse. Implementing an innovative peer-to-peer support model, mentors help parents successfully complete treatment and reunite with their children. The program is guided by the principal that "having walked in someone else's shoes" makes a person uniquely able to connect, support and inspire. Parents are paired with a parent mentor who has conquered similar challenges; mentors help parents stay on track, become clean and sober, work through the child welfare system, learn positive parenting skills, build self-esteem, connect to the recovery community and ultimately return to parenting. This model believes in creating fresh starts: parents get a fresh start at both living and parenting in a life of recovery, children are reunited with parents in safe and nurturing homes, and mentors themselves give back to their communities and offer a message of hope—that recovery is possible.

The following gems of wisdom are from parent mentors about their experiences of being peer-to-peer mentors to other parents faced with the challenge of overcoming addiction and regaining custody of their children.

## All It Takes is One Person to Believe in You

When I first started my journey of recovery after 20 years of heroin addiction, I faced the severe consequences of losing my daughter and my family. Everyone had given up on me, including myself. In total devastation, I entered a treatment program in hopes of finding the person I lost inside myself after years of trauma. On the second day, I met Ruth Taylor who facilitated a weekly parent support group. Ruth believed in me when no one else did, until I could believe in myself. Somewhere in the process of working on staying clean and becoming the parent my daughter deserved, I started to believe in myself and realized that I was my best advocate; I had the power to change my life. My story led Ruth to develop the Parent Mentor Program. I now work as a parent mentor and get to be that one person who believes in a client when no one else does, *because all it takes is one person!*

— Angelina Rivera Richart

## Setting the Stage

In the first meeting with a parent, it is critical to set the stage that a mentoring relationship will be different than the other professional relationships in his or her life. Recently, I met a mom who appeared distrustful and resistant. She didn't make eye contact, left the TV on, and sat with her arms crossed. She asked, "How is working with you going to be different than everyone else? Don't you work for the State?" I answered that I work in collaboration with the state but ultimately, "I work for you." As I do with all clients, I asked her to tell me a bit about herself. I listened to her story to find similarities within my own to build a stronger bond. After she described her criminal past, I shared that, "I had been there," and was once so desperate that crime was the only way to survive. Hearing my story, she uncrossed her arms, looked into my eyes and softened. As we said goodbye, I knew that the things were okay when, with a smile on her face, she said "Okay, see you later hon'!"

— Leah Hall

## The Power of Shared Life Experience

Kathy became my client after she gave birth to her daughter in prison. I sent her a letter introducing myself and noted that I was not allowed to visit her in prison because of my criminal background. Like Kathy, I was incarcerated for almost two years. Upon my release, my son was waiting at the prison gates and I needed to parent him. This shared life experience forged our relationship; Kathy knew I truly understood where she was and the struggles she faced. Being a mentor has taken every negative experience in my life, particularly having my children removed from me, my addiction, and my criminality, and turned those into positives because I can share with a client how I was ultimately able to succeed. These experiences form the building blocks I use to develop my relationships with clients. I went from being an inmate to a healthy mom and I can role model this for her. When she describes me, Kathy says it best: "You know where I've been and you are now where I want to be." One year later, Kathy is reunited with her daughter and attends college with a goal of one day becoming a mentor.

— Christine Stolebarger

For the past two years, I have worked as a mentor with dads. The biggest challenge has been getting them to open up, to ask questions, to ask for help. When we first meet, I share my story which is one of addiction and criminality that engulfed most of my adult life. These men are in very similar positions to mine five-and-one-half years ago. Before I share my story, they are closed off and don't know what to think of me. But once I share, they see the similarities which give me credibility and builds trust. After all, the only difference between them and me is clean time. I have overcome a life of criminality and addiction, and now work on a life of recovery. It is this change that gives the men I work with hope.

— Mark Held

## Mentoring Fills the Gap

When I became clean and sober 12 years ago, the Parent Mentor Program didn't exist. After treatment, I felt alone and didn't know how to raise my son. Today, mentors fill this gap between drug treatment, child welfare, and social services. I have been a parent mentor for three years while completing my Bachelors in Social Work. As a mentor, I can show another mother the way to recovery. I am there to guide them and show them the doors that they may open and walk through. Today, I work with three parents enrolled in college. Each overcame great obstacles, including addiction, domestic violence and a lack of knowledge of the support services in their community. Overcoming these barriers enabled them to achieve their goals of regaining their right to raise their children and go to college. The Parent Mentor Program provides a bridge; aiding moms to succeed at becoming the strong healthy parents they always wanted to be.

— Deb Rau

## Helping on the Road to Recovery

The most important part of my life is being in recovery. As a parent mentor, I am able to share my experience, strength and hope with others and help them get into recovery. I come from a long line of alcoholics and I am breaking the cycle of addiction and dysfunction in my family. I now know how to have a clean and sober lifestyle and can pass this knowledge on to other parents. The fact that I have been where they are makes it easier to connect with clients. I know what it's like to feel alone, confused and unworthy and think things will never change. When I first meet a mom, I can feel her desperation and hopelessness. I help her realize that she too, can have a life without drugs and alcohol, chaos or domestic violence. If I could do it, she can do it! It's truly amazing to be part of a women's journey on her road to recovery and I am so thankful for the opportunity.

— Char Hooper

## Beating the Odds

As a parent mentor, it is rewarding when I see a mom who was just like me "beat the odds." I worked with Christine for two years. In the beginning, she was hostile towards others and in an outburst of anger, threatened to kill her caseworker. Attorneys banned her from court and she was kicked out of her drug treatment center. While others had given up on her, I could see that behind the tough act was a broken and scared little girl. I knew this because I had been that scared little girl too. Others tried to convince her that it was too late to get her kids back, but with my support, she prepared to fight. The odds were stacked against her and chances were slim that she would win her trial, but she refused to relinquish her rights. With my encouragement, she started to make changes in her life. Through hard work, luck and a change of circumstance, her trial was postponed and eventually dropped. All along I just knew that beneath that hard shell was a soft shining star that could succeed. Without my own experience of beating the odds, I may have been like everyone else and missed a chance to support this mom towards being the success she is today.

— Shelly Harding

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# The Teen Peer Academy: Providing Relevant Peer Services for HIV Positive Youth

**Jill Foster, Theresa Parrino, Maria Frontera, and  
Maureen Davey**

The provision of peer services to HIV positive youth, ages 14-24, requires locating HIV positive peers with the necessary skills, experience, and maturity to deliver services to other teens. A teen with perinatal HIV may have many years of experience living with HIV and a good working knowledge of HIV medical issues, but may not relate well with a teen newly diagnosed with HIV. Conversely, a newly diagnosed teen may have more street skills, but will likely have little useful knowledge about HIV.

The following cases illustrate two contrasting circumstances where finding the correct “fit” with an appropriate peer counselor might prove difficult.



*Angie is a 17-year old born with HIV and now pregnant with her first child. She was raised in foster care after being abandoned by a mother who soon after died. She has moderate developmental challenges due to HIV and in utero drug exposure, but has fared relatively well medically, having an undetectable viral load and good immune functioning. She neither drinks alcohol nor uses illegal drugs. With the help of her case manager and an AIA sponsored home visitor's program, she is preparing for the birth of her baby, but asks to be assigned to a peer counselor.*

*Tamika is a 16-year old teenager newly diagnosed with HIV. She does well when she attends school, but is frequently absent due to her role as primary child care provider for two younger siblings while her mother is absent and using crack cocaine. She trades sex for food and clothing for herself and her siblings. She smokes marijuana several times per week, but has no other substance abuse issues. She is afraid to discuss her HIV diagnosis with any of her friends because she does not trust their discretion and feels that they have negative attitudes about people with HIV. She asks if there is another HIV positive teen that she could talk to one-on-one. She is reluctant to join a support group.*



TABLE 1

TEEN PEER ACADEMY OVERVIEW		
TPA Component	Target Clients	Curriculum
Academy (Core)	14-18 years	TLC modules “Stay Healthy” and “Act Safe”—group activities for health education, development of coping skills related to HIV, and improved communication skills regarding HIV status to others
Academy Prep	11-13 years	Activities that prepared pre-teens to be able to participate in group activities including taking turns, respecting others; some basic TLC modules included without sexual education components—more play-based than core curriculum
Academy Plus	16-20 years	Activities designed for clients who had already completed cycle(s) of TLC modules and/or had less time available for regular groups—included helping out at community outreach events, meeting newly diagnosed HIV positive teens

Trained peer counselors available for these clients locally are women in their thirties to forties who have been living with HIV for 5–10 years, have children, and frequently are in recovery. In short, in better circumstances, these women could be the teens’ mothers. These women, who are older and of a different generation, might be able to provide valuable psychosocial support, but not *peer* support services.

In adolescence, social relationships are centered around *peer* groups, group values guide individual behaviors, and perceived acceptance by peers is important to self-esteem. Teens are beginning to develop their own value systems, but their thinking is predominantly concrete rather than abstract. They have a limited ability to think hypothetically and to take multiple perspectives (Rycus, Hughes, & Ginther, 2004). Designing HIV prevention programs (both primary and secondary) for teens requires attention to their developmental stage. It must be concrete, peer driven, and encourage the development of self-efficacy and analytical thinking.

The goal of peer counselor services for HIV positive youth, beyond providing emotional support, is to deliver the following secondary HIV prevention messages: (a) Follow your medical care plan (including taking your medicine), (b) practice risk reduction around sexual and substance use behaviors, and (c) disclose your HIV status to sexual partners. Teen peer counselors must have accurate information, be willing to disclose their diagnosis to peers, and have at least rudimentary communication skills, such as active listening.

The Teen Peer Academy (TPA) was established as a health education group level intervention to: (a) empower

teens to provide better self-care, (b) arm them with risk reduction strategies, and (c) train a sub-group of the more skilled youth in the group to become peer counselors. A pilot group consisted of eight teens between 15 and 18 years of age with both perinatal and newly acquired HIV. Groups met weekly with an experienced HIV social worker or young workers from a community group. Every other week, the curriculum was either delivered by the social worker using “Teens Learning Together” (TLC), the only Centers for Disease Control and Prevention (CDC) approved evidenced-based prevention curriculum for HIV positive youth (CDC, 2009; Rotheram-Borus et al., 2001), or by youth workers providing their own counseling curriculum. Evaluation from the pilot demonstrated improved HIV knowledge, an improved sense of self-efficacy and HIV self-care, and improved adherence to medical plans, including more kept appointments and self-reported adherence (unpublished data). Following these successes, a wider implementation of the basic curriculum was made with more client groups, and an expansion of curriculum components (see Table 1).

Over the eight years of the project, 90 clients have participated in the TPA. A formal assessment of outcomes has been difficult given that we made a decision to prioritize the clinical needs of the patients over the needs of the evaluation plan. We did not have a control group, clients were allowed to join groups mid-cycle in the curriculum, and teens with developmental challenges, who would predictably have difficulty understanding some of the content, were included. Without a control group, it is difficult to determine the impact on certain measures, i.e. how many STDs or HIV transmissions to others were prevented,

TABLE 2

## PROGRAM SUCCESSES AND CHALLENGES

Successes	Challenges and Lessons Learned
<b>Improved health.</b> Improved knowledge about HIV, including HIV risk reduction strategies, seen in pilot data and anecdotally working with teens. Improved adherence to medical care plans.	Difficulty measuring longitudinal change as teens naturally acquire more experience/risk over time. Difficulty in measuring dose effect of curriculum. Lack of a control group compromised the evaluation.
<b>Useful application of evidenced-based curriculum.</b> Provides a framework to build on for activities, and provides uniformity over time and among groups.	Difficulty keeping the curriculum “fresh” for participants over time. Learning the curriculum is time consuming for facilitators (3-4 hours p/ session).
<b>Improved social functioning.</b> Regularly scheduled groups offer opportunities for youth to have regular check-ins with each other and program staff. Establishes support network that transcends official group structure.	Establishment of cliques and sharing of some negative behaviors. Collusion in discouraging disclosure of HIV to partners. Sharing experiences (rarely) with experimenting with drugs; offered opportunities for facilitators to shift curriculum to pertinent topics affecting group. Occasional external disclosures of HIV status to non-HIV related peer groups; interfered with client well-being, group cohesion, and recruitment to groups.
<b>High buy-in from program clients.</b> Resulted in an ever-growing need to add new group sessions.	Substantial creativity required to assign clients to groups with curriculum and peers appropriate to their knowledge base and age. Required dedication and commitment of social workers staffing groups as an add-on to their other tasks.
<b>Increased availability of pool of teen peer counselors.</b> Older teens mentor younger teens and newly diagnosed teens successfully. Model evolves such that teens begin to provide peer services to each other in group.	Older teens move on to careers and higher education with new skill sets, and become unavailable to the program. Teens providing direct peer services to others require significant supervision due to issues that arise for them.
<b>Effective retention strategy.</b> Teens are offered incentives for good work habits and retention by earning points for group participation that they exchange for gift cards at 1 month intervals. Teens not keeping clinic appointments were not allowed to attend group.	Providing incentives leads to a need to ensure funding to continue stipends/incentives. Over time, with funding changes, teens continued to come to group without incentives. Linking group participation with adherence to clinic appointments became a useful tool for retention in medical care.
<b>Real life opportunities to negotiate diversity and conflict.</b> Mixed groups (i.e., perinatally acquired HIV; newly diagnosed) promote teens understanding of others’ perspectives. Learn that HIV unites them more than their differences divide them.	Requires skilled facilitators who can negotiate “land mines,” particularly in cases of homophobia and with perinatal clients who believe their history (i.e., HIV at birth) affords them different responsibilities for their own care and to others

especially as teens age and acquire new exposures. Chart reviews, however, based on medical indicators such as viral load and immune function showed improvement over time. Focus groups with teens additionally revealed great satisfaction with the group, as many of them stated that it was the highlight of their week. Table 2 provides a qualitative program assessment.

In the current model, consistent with adolescent development, TPA administrators view the academy less as a way to spawn teen peer counselors, than as a system to provide supervised peer counseling in a group setting. With this model, group participants learn the curriculum while simultaneously providing and receiving support from their peers. This outcome requires program staff to ensure that groups are appropriately balanced and distributed so that teens are: (a) in groups where this dynamic is fostered; (b) provide facilitation, (i.e., presenting the curriculum *and* refereeing); and (c) tracking where each participant is in relation to meeting his or her own health education needs and adherence to a treatment plan.

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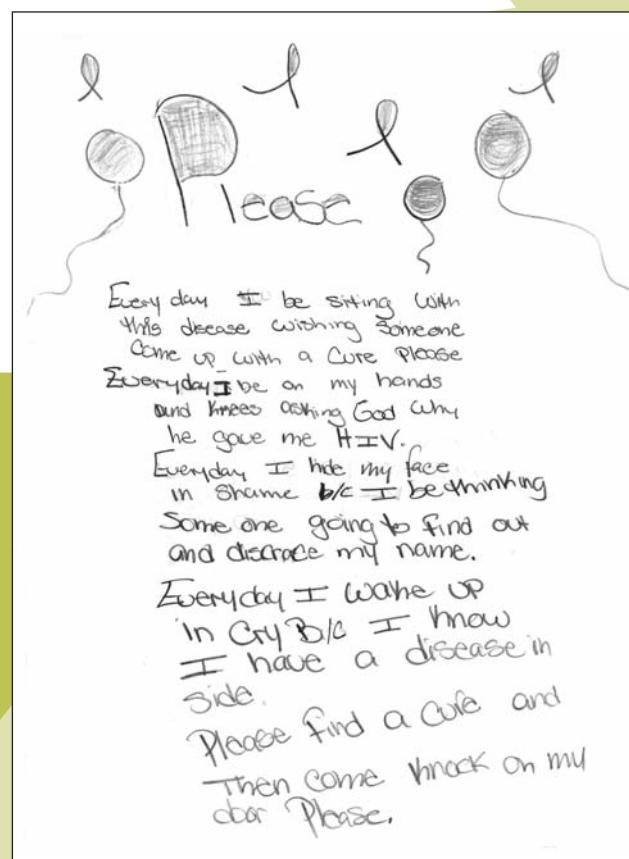
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*Acknowledgments: The program's success is due to the ongoing support by the social work staff members who facilitate groups, in addition to their other tasks, requiring late nights and weekends. Special thanks to Lisa Esterline, MSW, Nilda Claudio, BSW, Andrea Russell, Dorian White, MHA, and Breena Berte, MSS.*

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## Art and Poetry from Teen Peer Academy Members



# A Supportive Approach to Supervision for Peers Living with HIV

Janie M. Riley

## Introduction

Liz Bates is a peer working in the field of HIV. When asked how supportive supervision has helped her, she said, “Sometimes clients come to me in crisis. I recently had a client who was homeless and refusing to go to a shelter. In supervision, I’ve learned how to help without getting too involved. But that is hard emotionally. I need to be able to talk about how it feels when I can’t help someone enough.” Most peers like Liz have a heartfelt passion for their work, so it is perplexing that peers in HIV programs nationwide often leave their positions within a few months. Programs nationally have been addressing the issue by taking a closer look at the supervisory needs of peers (Raja et al., 2008).

Peers who receive supportive supervision are likely to stay in their positions longer, thus benefitting programs from the value that peers bring over time. WORLD (Women Organized to Respond to Life Threatening Diseases) has provided its peer staff with supportive supervision for more than seven years. Located in Oakland, California, WORLD offers local and national

programs designed to support HIV+ women, their families, and communities, and inspire a compassionate response to the HIV pandemic. Founded by Rebecca Denison in 1991, WORLD originally consisted of a network of women infected and affected by HIV/AIDS. Together, they helped each other survive and cope with the many losses that occurred during the early years of the AIDS crisis.

## WORLD’s Peer Advocacy Program

In 1997, federal funding allowed for WORLD’s first paid peer position. WORLD joined the Family Care Network (FCN), a Title IV funded collaboration of clinics and social service organizations serving women and families infected and affected by HIV/AIDS. As more peers were hired, they began collaborating with FCN and other local providers. Job descriptions were created to include the provision of emotional and practical support to clients in HIV care, or in need of care, helping them overcome barriers to managing HIV. Currently, five peers have been on staff for an average of four years.

Supervisory staff includes a program manager who was once a WORLD peer and a licensed mental health therapist who is contracted to provide clinical consultation to peer staff and the manager. The therapist and manager co-facilitate a weekly meeting that serves as a forum for all to come together to share support, discuss key issues, and learn from each other via case consultation. Time is allotted to review the functioning of WORLD’s women’s support group, so peer facilitators can receive ongoing facilitation training.

Two of the job qualifications for WORLD peers are an HIV-positive status and the demonstrated ability to address personal challenges related to living with HIV. Because clients respond so favorably to peers living with HIV, the program is dedicated to hiring HIV-positive peers. The

*Peers who receive supportive supervision are likely to stay in their positions longer, thus benefitting programs from the value that peers bring over time.*

expectation is that peers will continue to address personal challenges and use their expanding knowledge to help clients. While peers are held responsible for managing their own self-care, supervision is considered to be a place where they can receive encouragement and ideas about how to do so. Formal check-in periods within meetings provide the space for peers to share personal triumphs and struggles; it is accepted that referring to one's personal feelings and experiences while discussing work-related subjects can be helpful in elucidating client and workplace dilemmas.

## The Supportive Supervisory Approach

Supportive supervision is an adaption of the clinical model in which mental health interns are provided with a comprehensive level of supervision and training (Fizek, Riley, & Colson, 2009). Supervision is comprised of support for peers: personal and work-related. Training is designed to strengthen the allied relationship between peer and client, as well as provide direction for topics related to the professional helping role (e.g. confidentiality).

The most important function a supportive supervisor can play is witnessing the powerful work that peers do, and reflecting to them how they are helping clients and the community by using illustrative examples from peers' own narratives. In this way, peers develop a keen sense of their value and feel motivated to keep going even when the work gets tough. More specifically, based on lessons learned at WORLD, there are four key components of supportive supervision.

Supervisors teach and support peers to:

1. Balance the multiple roles involved in being a peer.
2. Build and maintain positive alliances with clients.
3. Learn about and utilize the concept of countertransference.
4. Find and value one's voice and ways of knowing.

## Multiple Roles

Peers ally themselves with clients, communicating a sense of togetherness while also serving them in a helping capacity. Within a context of mutuality, both helper and "helpee" initiate new levels of strength in each other (Shainberg, 1983). Sharon Gambles, a WORLD peer, explains, "Sometimes I am a shining star. Sometimes my

clients shine more than me, and I tell them that. I let them know that I need to hear what they have to say, and I am no different—I am a normal human being." In WORLD's support group, peers alternate between aligning with clients and playing a mentoring role. Balancing these contrasting functions is one of the key skills that peers develop on the job.

As peer work becomes more integrated into systems of care, HIV peers nationwide also are increasingly expected to fulfill collaborative roles with providers (Fizek et al., 2009). Additionally, peers usually must keep up with clerical tasks and documentation, which may be new to those with limited work experience. Many peers, particularly those who are heads of households or natural leaders in the community, must also balance their work responsibilities with many others.

Supervisors can help peers identify, understand, and balance the array of roles they play. Peers benefit when supervisors give them latitude to figure out how they will work with clients, providing feedback and ideas about how to work in an authentic way while learning new skills (e.g. evidence-based interventions).

Clients are usually the primary focus of peers, and fulfilling roles that are related to collaboration and workplace functioning can feel unimportant, especially when peers lack training. Peers benefit when given full explanations about *why* these functions are worthwhile, as well as opportunities to receive training and/or ongoing supervisory support to enhance job skills.


Supervisors also can help peers balance their roles by helping them take an active stance in managing their workload. Those drawn to a helping role often have histories in which they have taken on more than their share of responsibility and have experienced guilt when they haven't been able to do so. As one WORLD peer has said, "Supervision reminds us of our limitations. I am not as gullible as I used to be." When peers do not set limits, their work and health can suffer—and so do their relationships with others when they set up expectations they aren't prepared to meet. Supervisors can help peers determine what they can handle and find words to communicate to clients and colleagues what roles and responsibilities they can take on, beyond what is required. As peers master these skills, supervisors can also help peers accept and prepare for new challenges.





## Positive Alliances

Peers who are successful in their work often report that they are grateful to be able to help others the way they have been helped. Forming relationships with clients often feels deeply satisfying. However, clients may generate difficult feelings for peers, especially if the client's difficulties mirror those that the peer has experienced. At WORLD, peers work with many clients with histories of unstable relationships due to the effects of childhood abuse, family or community violence, poverty, discrimination, and chronic drug use. This reflects the finding that people living with HIV tend to report more traumatic life events than do the general population (Gore-Felton, 2008). When affected by trauma, one's basic sense of autonomy, competence and trust in others can be



*Peers benefit when supervisors give them latitude to figure out how they will work with clients, providing feedback and ideas about how to work in an authentic way while learning new skills.*

damaged (Herman, 1992). Dependency and/or needs for control can result in behaviors that may seem overwhelming or manipulative to peers and other service providers (Gore-Felton, 2008). Peers can feel rejected, devalued, overly needed, manipulated, or falsely idealized by clients; and in turn, can develop complementary feelings that when left unexamined, may cause them to under-serve clients or work too hard for them. When these feelings are left unaddressed, job "burnout" can ensue.

Supervisors can help peers recognize symptoms of trauma in clients and teach peers to anticipate problems that may arise, setting clear boundaries and expectations for clients who are trauma survivors (Gore-Felton, 2008). Supervisors can empathize with peers when feelings arise, allowing their expression so that they may more easily pass. When necessary, supervisors can help peers explore whether or not personal experiences are affecting their emotions and behaviors towards clients. While supervision is not a place to analyze a peer's emotional life, it can be a place in which peers identify problems so they can seek additional support.

Supervisors also can help peers reframe clients' maladaptive behaviors as coping strategies they have adopted as a result of difficult and/or traumatic life experiences (Dodds, Bryson, Nuehring, Lizzotte, & Abruzzino, 2001). This can help peers shift from a judgmental to compassionate stance, which has the result of reducing stress and improving the peer-client alliance. A WORLD peer explains how this supervisory strategy has helped her: "I thought one of my clients was greedy because she always wanted something from me, like food vouchers. In supervision, we talked about how the client may have had to struggle in her life to get what she needed. After this, I talked to my client more and found out that she had a lot of trauma in her background and had to fight for basic things. In supervision, we talked about how I can both show understanding for her and set boundaries to take care of myself and our program's resources."

## Countertransference

Peers can learn to use the clinical concept of countertransference as a way to address client-related emotional stress. Countertransference here is used to refer to a peer's personal reactions to a client that relate to the peer's own history, beliefs, or experiences. The concept encourages peers to self-monitor their feelings and set emotional boundaries. For example, one WORLD peer has described how she can get caught up with clients who are in intimate partner violence similar to those she has been in, pressuring them to leave the relationship instead of helping them to develop their own resources. With supervision, she has learned to separate her feelings from her responses to her client. The Lotus Project, a HRSA-funded joint program between WORLD and the Center for Health Training, has been providing training and education to HIV peer programs nationwide. The training curriculum teaches peers how to manage countertransference. Peers respond favorably, reporting that being trained to do so has benefited their client work as well as their collegial and personal relationships.

## Finding One's Voice

For WORLD peers, finding one's voice includes discovering how to value, use, and articulate the wealth of knowledge they have as a result of their life experiences and any formal training they have received. In many settings, peers are expected to be the "voice of client advocacy" which entails balancing one's own experiences and those

of others to articulate key themes. Peers are better positioned to skillfully participate in meetings and public forums when they have been coached or trained to feel confident in what they have to say and have practiced how to say it within safe forums, such as supervisory meetings—group and/or individual.

Supervisors can demonstrate the value inherent in peers' experience and knowledge by holding conversations that encourage peers to think critically about what they say. As one WORLD peer explains, "When I use vague words, my supervisor will ask me what I mean by that, or she'll ask me to give an example. Or when I say I don't know about something, she will ask me to take a moment to think about what I *do* already know and see if I can build on that. It is very empowering."

However, peers report that they want supervisors to bring their own professional experiences and knowledge to bear and to share them. Asking peers for their feedback after giving input is an additional step towards creating a supervisory dialogue that allows for mutual learning between the supervisor and peer.

## Accommodation of Peer Setbacks

Peers may suffer setbacks that affect their work performance. For example, temporary relapses of old behaviors, such as an increase in drug or alcohol use, may arise when they feel a dramatic increase in stress related to work or personal circumstances. With supportive supervision in place, peers are more likely to share difficulties with their supervisor to re-initiate positive self-care. In cases in which peers need additional support, supervisors can encourage peers to seek it outside of the workplace. In cases in which a peer doesn't re-establish good work habits, supervisors may need to place a peer on probation or consider termination. Peers who are given the time to address crises and retain their position most often transfer lessons learned to their work with clients.

## The Supervisor's Rewards and Challenges

Supervisors report that working with peers is inspiring and enriching. However, supervisors will likely encounter both personal and professional challenges. Specifically, supervisors may feel humbled by peers' vast and firsthand understanding of clients and the community (Dodds et al., 2001). Embracing this as an opportunity to learn can

strengthen the relationship between supervisor and peer. Finally, supervisors cannot always draw on specialized training to address the unique challenges faced by peers, and must think "outside of the box" and alongside peers to determine best courses of action. While this can be daunting, it is often a way in which supervisors feel stimulated by their supervisory work.

## Conclusion

Well-practiced supportive supervision benefits peers, as well as peer programs. Supportive supervisors can play a role in integrating peers into systems of care in a way that allows for full utilization of peers. Those drawn to peer work have a tremendous contribution to make to their communities. Supportive supervision is a model and style of direction that helps peers fulfill their dreams for their work. When peers succeed, programs succeed—and so do clients.

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*Acknowledgments: Special thanks to WORLD's Peer Program Manager Sylvia Young and peer staff: Agripina Alejandres, Lizabeth Bates, Sharon Gambles, and Felecia Greenly for their contributions to this article.*

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# Good Bets

## Books, Guides, and Reports

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### Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation

This monograph provides a synthesis of current knowledge about the history, theoretical foundations, methods, and scientific status of peer-based recovery support services.

Cost: Free online.

W. White (2009). *Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services*, 1640 W Roosevelt Road, Suite 511, Chicago, IL 60608-1316. Ph: 312-996-1373. <http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=510&rcID=3>

### What Are Peer Recovery Support Services?

An introduction to substance abuse peer recovery support services, this report describes how they help people become and stay engaged in the recovery process and how support services can be implemented. Cost: Free online.

Office of the Director, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Administration (2009). 1 Cherry Choke Road, Rockville, MD 20857. Ph: 1-877-726-4727. <http://download.ncadi.samhsa.gov/prevline/pdfs/sma09-4454.pdf>

### Community Health Workers National Workforce Study

Community health workers (CHW) are lay community members who usually share ethnicity, language, socioeconomic status, and life experiences with those they serve. This report describes a comprehensive national study of the CHW workforce.

Cost: Free online.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions (2007). 5600 Fishers Lane, Rockville, MD 20857. Ph: 301-443-5794. <http://bhpr.hrsa.gov/healthworkforce/chw/>

### Building a Bridge for Change

A step-by-step instruction guide on how to create, plan, implement, and evaluate a peer education training program for

people living with HIV disease and AIDS. Cost: Free online.

Duke University Medical Center (DUMC), Adult Infectious Diseases, Clinic and Partners in Caring (2006). DUMC Box 3112, Durham, NC 27710. Ph: 888-842-9469. <http://hdwg.org/files/resources/Duke-peer-training-BuildingaBridgeforChange.pdf>

### How to Build Your Own Peer-to-Peer Recovery Center from the Ground Up!

A manual for developing a peer-to-peer recovery center for individuals suffering from substance use disorders, including information on staffing, fundraising, and establishing policies. Cost: Free online.

J. Grasmere (2006). *The Recover Project*, 68 Federal Street, Greenfield, MA 01301. Ph: 413-774-5489. <http://www.facesandvoicesofrecovery.org/pdf/Recover%20Project-%20How%20to%20build%20recovery%20center.pdf>

### Clinical and Recovery Practice Protocol: Peer Workers/Recovery Support Specialists within Behavioral Health Agencies

A protocol providing guidance to behavioral health agencies in implementing peer worker/recovery support services within their organizations and to enhance their effectiveness through the expansion of peer-delivered services. Cost: Free online.

Arizona Department of Health Services: Division of Behavioral Health Services (2007). 150 N 18th Avenue, 2nd Floor, Phoenix, AZ 85007. Ph: 602-364-4558. <http://www.azdhs.gov/bhs/guidance/peer.pdf>

### On Our Own, Together

This book describes the inner workings of eight successful peer-run services for mental health consumers, including drop-in centers, educational programs, and peer support/mentoring programs. Cost: \$27.95 (soft copy); \$69.95 (hard copy).

Edited by S. Clay, B. Schell, P. W. Corrigan, & R. O. Ralph (2005). Vanderbilt University Press, VU Station B #351813, Nashville, TN 37235. Ph: 615-322-3585. [www.vanderbiltuniversitypress.com](http://www.vanderbiltuniversitypress.com)



### **Intentional Peer Support: An Alternative Approach**

This curriculum details the difference between peer support and other helping practices for serving persons with mental illness. Cost: \$35.00.

S. Mead (2005). Sherry Mead Consulting, 302 Bean Road, Plainfield, NH 03781. Ph: 603-469-3577. [www.mentalhealthpeers.com](http://www.mentalhealthpeers.com)

### **Youth-to-Youth-Peer Workers in HIV/AIDS Youth Programs: A Peer Development Guide**

Seven national demonstration projects focusing on youth and adolescent HIV/AIDS services collaborated to assemble this guide of the best practices and lessons learned about using peers to support young people with HIV. Cost: Free online.

The Measurement Group (2005). 5753 Uplander Way, Culver City, CA 90230. Ph: 888-864-4636. <http://www.themeasurementgroup.com/publications/reports/peermanual/cover.htm>

### **Peer Support for HIV Treatment Adherence: A Manual for Program Managers and Supervisors of Peer Workers**

Capitalizing on the experiences of persons living with HIV/AIDS, this manual guides managers in developing a peer adherence support intervention within an existing program. Cost: Free online.

Harlem Adherence to Treatment Study, Harlem Hospital Peer Support for HIV Treatment Adherence (2003). Harlem Hospital Center, Division of Infectious Diseases, 506 Lenox Avenue, Room 3101A, New York, NY 10037. Ph: 212-939-2940. [http://www.peernyc.org/Assets/web\\_docs/Peer%20Adherence%20Support%20Manual%20\(HIV\).pdf](http://www.peernyc.org/Assets/web_docs/Peer%20Adherence%20Support%20Manual%20(HIV).pdf)

### **Toronto Harm Reduction Task Force Peer Manual**

This guide challenges current conceptions, clarifies ideas about peer work, and encourages the further development of harm reduction peer programs. Cost: Free online.

Toronto Harm Reduction Task Force (2003). The Canadian Harm Reduction Network, 666 Spadina Avenue, Suite 1904, Toronto, ON M5S 2H8, Canada. Ph: 800-728-1293. [http://www.canadianharmreduction.com/readmore/ichip\\_peerManual.pdf](http://www.canadianharmreduction.com/readmore/ichip_peerManual.pdf)

### **A Clinician's Guide to 12-Step Recovery: Integrating 12-Step Programs into Psychotherapy**

This book helps mental health professionals better understand what their clients might experience in rehabilitation programs offering both twelve-step treatment and psychotherapy. Cost: \$29.00.

M. Schenker (2009). W. W. Norton & Co., 500 Fifth Avenue, New York, NY 10110. Ph: 212-354-5500. [www.wwnorton.com](http://www.wwnorton.com)

### **Preventing Child Maltreatment: Community Approaches**

The contributing authors in this book are leading authorities who present a range of exemplary programs designed to strengthen communities while also helping individual parents to meet their children's needs. Cost: \$45.00.

Edited by K. Dodge & D. L. Coleman (2009). The Guildford Press, 72 Spring Street, New York, NY 10012. Ph: 800-365-7006. [www.guilford.com](http://www.guilford.com)

### **Protecting Children in Families Affected by Substance Use Disorders**

This manual provides an overview of how child welfare and other related professionals can assist families affected by substance use disorders (SUDs). Cost: Free online.

Child Welfare Information Gateway (2009). 1250 Maryland Avenue, SW, 8th Floor, Washington, DC 20024. Ph: 800-394-3366. <http://www.childwelfare.gov/pubs/usermanuals/substanceuse/>

### **Toby Visits Mommy: A book for children who see their parents only during scheduled visitations.**

This therapeutic children's book acknowledges a child's experience during a visit with a non-custodial parent. Provides opportunities for children to open up about their life experiences, and gives adults and professionals insight to help children cope and adapt.

Cost: \$9.95

E. Solomon (2010). AuthorHouse, 1663 Liberty Drive, Bloomington, IN 47403. Ph: 888.519.5121. <http://www.authorhouse.com>

## **Videos & Other Resources**

### **Building Blocks to Peer Success: A Toolkit for Training HIV-Positive Peers to Engage in PLWHA in Care**

The purpose of this toolkit is to support the training of HIV-positive peers who work to engage and retain people living with HIV in health care. Cost: Free online.

The Peer Center, Boston University School of Public Health (2009). 715 Albany Street, Boston, MA 02118. Ph: 617-638-1930. [http://www.hdwg.org/peer\\_center/training\\_toolkit](http://www.hdwg.org/peer_center/training_toolkit)

### **Employer Tool-Kit: Employing Peer Workers in Your Organisation**

This toolkit provides information on the contributions peer workers can make to an organization, a model for training peer workers, and other advice on how to employ peer workers in your organization. Cost: Free online.

The Peer Work Project Team (2009). Baptist Care, PO Box 39, Glen Osmond, South Australia 5064. Ph: 08-8338-6799; & Mental Illness Fellowship of SA, PO Box 310, Marleston, South Australia 5033. Ph: 08-8378-4100. [http://www.peerwork.org.au/wp-content/uploads/2009/03/toolkit\\_-\\_20091.pdf](http://www.peerwork.org.au/wp-content/uploads/2009/03/toolkit_-_20091.pdf)

### **"Transitions" Film Series**

The Infant-Parent Institute is offering VHS copies of the "Transitions" film series at a fraction of their original prices. Cost: \$19.95 per video.

M. Trout (1997-2004). The Infant-Parent Institute, 328 North Neil Street, Suite B, Champaign, IL 61820. Ph: 217-352-4060. [www.infant-parent.com](http://www.infant-parent.com)

# Conference Listings



## **National Association of Perinatal Social Workers Annual Conference**

**Dates:** May 5-8, 2010 **Location:** Midway UT

**Contact:** [www.napsw.org](http://www.napsw.org)

## **18th Annual Children's Justice Conference**

**Dates:** May 10-11, 2010 **Location:** Seattle, WA

**Contact:** [www.dshscjc.com](http://www.dshscjc.com)

## **Voices 16th Annual Conference**

**Dates:** May 15-18, 2010 **Location:** Washington, D.C.

**Contact:** [www.aids-alliance.org/education/voices](http://www.aids-alliance.org/education/voices)

## **2010 Prevent Child Abuse America National Conference**

**Dates:** May 17-19, 2010 **Location:** Jacksonville, Florida

**Contact:** [www.preventchildabuse.org](http://www.preventchildabuse.org)

## **22nd Annual National Conference on Social Work and HIV/AIDS**

**Dates:** May 27-30, 2010 **Location:** Denver, CO

**Contact:** [www.bc.edu/schools/gssw/academics/ce/conferences.html](http://www.bc.edu/schools/gssw/academics/ce/conferences.html)

## **Black Administrators in Child Welfare 2010 Annual Conference**

**Dates:** May 27-29, 2010 **Location:** Chicago, IL

**Contact:** [www.blackadministrators.org](http://www.blackadministrators.org)

## **NADCP 16th Annual Training Conference**

**Dates:** June 2-5, 2010 **Location:** Boston, MA

**Contact:** [www.nadcp.org/learn/about-nadcp/annual-conference](http://www.nadcp.org/learn/about-nadcp/annual-conference)

## **12th Annual International Fatherhood Conference**

**Dates:** June 15-18, 2010 **Location:** New Orleans, LA

**Contact:** [www.npclstrongfamilies.com](http://www.npclstrongfamilies.com)

## **Head Start's 10th National Research Conference: "Research on Young Children and Families: Launching the Next Decade for Policy and Practice"**

**Dates:** June 21-23, 2010 **Location:** Washington, DC

**Contact:** [www.acf.hhs.gov/programs/opre/hsr](http://www.acf.hhs.gov/programs/opre/hsr)

## **18th Annual APSAC National Colloquium**

**Dates:** June 23-26, 2010 **Location:** New Orleans, LA

**Contact:** [www.apsac.org](http://www.apsac.org)

## **International Family Violence and Child Victimization Research Conference**

**Dates:** July 11-13, 2010 **Location:** Portsmouth, NH

**Contact:** [www.unh.edu/fri/conferences](http://www.unh.edu/fri/conferences)

## **2010 Georgetown University Training Institutes**

**Dates:** July 14-18, 2010 **Location:** Washington, DC

**Contact:** <http://gucchd.georgetown.edu>

## **4th National Conference on Women, Addiction and Recovery: Thriving in Changing Times**

**Dates:** July 26-28, 2010 **Location:** Chicago IL

**Contact:** [www.samhsawomensconference.com](http://www.samhsawomensconference.com)

## **36th Annual North American Council on Adoptable Children Conference**

**Dates:** August 5-7, 2010 **Location:** Hartford, CT

**Contact:** [www.nacac.org/conference/conference.html](http://www.nacac.org/conference/conference.html)

## **National Conference on Addiction Disorders**

**Dates:** September 8-11, 2010 **Location:** Washington, DC

**Contact:** [www.naadac.org](http://www.naadac.org)

## **18th ISPCAN International Congress on Child Abuse and Neglect**

**Dates:** September 26-29, 2010 **Location:** Honolulu, HI

**Contact:** [www.ispcan.org/congress2010](http://www.ispcan.org/congress2010)

## **NACC 33rd National Juvenile and Family Law Conference**

**Dates:** October 20-23, 2010 **Location:** Austin, TX

**Contact:** [www.naccchildlaw.org/?page=National\\_Conference](http://www.naccchildlaw.org/?page=National_Conference)

## **National Perinatal Association Conference 2010**

**Dates:** November 4-6, 2010 **Location:** Washington, DC

**Contact:** <http://www.nationalperinatal.org/conference.php>

## **2010 Conference on Differential Response in Child Welfare**

**Dates:** November 8-10, 2010 **Location:** Anaheim, CA

**Contact:** [www.americanhumane.org/protecting-children/conferences-trainings/differential-response-conference.html](http://www.americanhumane.org/protecting-children/conferences-trainings/differential-response-conference.html)

## **8th National Harm Reduction Conference**

**Dates:** November 16-21, 2010 **Location:** Austin, TX

**Contact:** [www.8thnationalharmreductionconference.com](http://www.8thnationalharmreductionconference.com)



# Visit the National AIA Resource Center at <http://aia.berkeley.edu>

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