



The Source

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The National
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Resource Center

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SPECIAL ISSUE



Celebrating
10 years
of the AIA
Program

FROM THE EDITOR



This special issue of **The Source** celebrates the first ten years of the Abandoned Infants Assistance (AIA) programs. As suggested in the lead article (p.2), the problem of infant abandonment persists. However, programs across the country have developed successful ways to support and strengthen families in order to prevent abandonment and promote the health, safety and permanency for children in families affected by substance abuse and HIV/AIDS. In this newsletter, AIA programs share lessons learned in areas such as: assessing and addressing women's exposure to violence; using peers to provide services to families affected by HIV/AIDS; using interagency collaboration to preserve families, prevent abandonment, and expedite permanency for children; using an interdisciplinary process to serve families affected by substance abuse; and designing a concurrent planning program. AIA program participants and graduates also express their views and opinions of the services they received.

We applaud the exceptional work of all the programs funded through the AIA Act in its first ten years, and all the dedicated individuals who have been willing to move beyond traditional practice and boundaries to support families affected by substance abuse and HIV. We also extend a special thanks to those families who shared their personal experiences in this issue.

■ AMY PRICE, MPA
EDITOR

AIA PROGRAMS: YESTERDAY, TODAY AND TOMORROW

The Abandoned Infants Assistance (AIA) Act (Public Law (P.L.) 100-505), enacted a little over a decade ago, offered a federal response to the child welfare problems associated with the crack cocaine and AIDS epidemics of the 1980's. These dual epidemics gave rise to a dramatic increase in the number of infants exposed to drugs and HIV/AIDS in utero, and to the staggering numbers of "boarder babies" who languished in hospitals across the United States. Boarder babies are infants who remain hospitalized, beyond medical discharge, due to their parents' inability to provide appropriate care coupled with the child welfare system's inability to promptly investigate their circumstances and locate alternative residential placements for them. Although hospitals and child welfare agencies struggled to address systemic barriers, find suitable placements for these children and develop helpful supports for their families, they often lacked the necessary resources to do so.

In 1988, Congress passed P.L. 100-505. The AIA Act authorized the U.S. Department of Health and Human Services (HHS), Children's Bureau, to fund the development of service demonstration programs to respond to the hospital boarder baby crisis. The objectives of these projects included: (1) preventing the abandonment of infants and young children; (2) identifying and addressing the needs of abandoned infants and young children, particularly those with acquired immune deficiency syndrome (AIDS); (3) assisting infants, particularly those with AIDS, to reside with their natural families or in foster families, as appropriate; (4) recruiting, training and retaining foster families; (5) carrying out

residential care programs; (6) carrying out respite care programs for families and foster families of infants and children with AIDS; and (7) recruiting and training health and social services personnel to work with such families and residential programs (Abandoned Infants Assistance Act of 1988).

In 1991, Congress reauthorized the AIA Act. The reauthorization (P.L. 102-236) mandated that programs funded through the Act give priority to infants and young children who were perinatally exposed to dangerous drugs, as well as infected with or exposed to HIV. It also promoted the concept of comprehensive service sites, that is programs offering health, education, and social services at a single geographic location in close proximity to where abandoned infants reside. Additionally, it expanded the focus of the program to prevention, encouraging the provision of services to all family members for any condition that increased the probability of abandonment. In 1996, the AIA Act was reauthorized for an additional four years (P.L. 104-235) under the Child Abuse Prevention and Treatment Act, emphasizing expedited permanency for infants.



Demonstrating Innovation

Since 1990, HHS has funded more than 50 AIA demonstration projects, including five training projects (1990-1992), two resource development programs (1990-1992), and a national Resource Center (since 1991). There are currently 35 projects including the AIA Resource Center. Most of them (25) are compre-

hensive service demonstration projects, six are family support service programs for relative caregivers, and three are recreation programs for children affected by HIV/AIDS.

Located in eighteen states¹ and the District of Columbia, these diverse programs operate out of hospitals, community-based child and family service agencies, universities, public child welfare agencies, and drug and alcohol treatment centers; and they serve families affected by substance abuse, HIV/AIDS, or both. The 25 comprehensive service programs provide a broad set of social and health services which can include: case management; child development services; job training assistance; infant development screening and assessment; permanency planning; prenatal care; residential services; recovery support; financial and entitlement assistance; parent skills training; domestic violence services; HIV education, prevention, counseling and testing; and respite care. Two-thirds of the programs provide in-home support services, which enhance client assessment and service provision by yielding a fuller picture of the client's circumstances and addressing accessibility barriers. Transportation and child care are also typically offered by AIA programs to assist the clients in accessing center-based services.

Many of the projects use multidisciplinary intervention teams, which often include peer workers—individuals who have backgrounds and circumstances that parallel those of the clients they

¹ States include CA, CT, FL, GA, IL, KS, LA, MD, MA, MI, MO, NJ, NM, NY, OK, PA, RI, TN.

serve. AIA programs have adapted therapeutic interventions so that they are culturally appropriate and gender specific to better meet the needs of their clients. The staffing reflects the attempt by these programs to address the multiple needs of families and reach out to them in a sensitive and perceptive way.

Additionally, AIA programs work in collaboration with other community agencies to offer a range of supplementary services, such as housing and rental assistance; HIV treatment; pediatric health care; and residential drug treatment. The comprehensive and collaborative design of the AIA programs addresses the complex and multidimensional needs of the families while reducing costly duplication of services.



A Profile of the Client Families

AIA programs serve a diverse array of clients who are among the neediest in the health and human services systems. For the last three years, staff researchers from the National AIA Resource Center have collected demographic data describing mothers and children who receive AIA services (Newman, in press). A typical family receiving services from an AIA-funded program is headed by a mother of color (82%) who is unmarried (87%), in her early thirties (median age is 31), and has less than a high-school education (58%). The typical AIA family also receives some form of government aid, including Medicaid (58%), food stamps (55%), TANF (45%), and/or WIC (43%) benefits.

Children served by AIA programs face a variety of psycho-social risk factors. For example, 19% of all the mothers served by AIA programs received no pre-natal care. Many of the children served by these programs suffered from low birth weight (38%), had special care needs at birth (30%), and/or were born prematurely (37%). This is not surpris-

ing, as the overwhelming majority (87%) of mothers had a history of substance abuse, and over half (56%) reported using drugs during pregnancy. Additionally, almost half (49%) of the children tested positive for crack cocaine at birth. Furthermore, children served by these programs are more likely to be born HIV positive (10%) than children in the general population (less than 1%).

Mothers served by AIA programs confront related risk factors. They frequently report a history of domestic violence (29%), physical abuse (27%), sexual abuse (27%), and/or psychiatric illness (27%). Almost half of them have engaged in criminal behavior, and one-third (33%) are HIV positive. In addition, a significant proportion (36%) has had children removed from their homes due to abuse or neglect.



AIA in Social Context

By the mid-to-late 1990s, additional social forces had come to impact the phenomenon of infant abandonment. Many grandparents and other relatives began caring for infants and children who were perinatally drug and/or HIV exposed. This trend resulted from a combination of factors including child welfare policies and practices that favored kinship care on philosophical and practical grounds, as well as social and cultural preferences and values. The Children's Bureau recognized this fact and designated AIA funds to develop programs that would address the social, health, and legal needs of kinship caregivers.

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, which imposed time limits and work requirements on mothers receiving federal financial assistance, has also affected the AIA population and programs. Some feared that

the shortened time lines would result in increases in infant abandonment. Currently, almost one-half of mothers served by AIA programs receive public assistance (TANF). Therefore, many AIA programs are coordinating their services with local welfare reform efforts to promote work and assist their clients in meeting other TANF requirements. As the clients approach their maximum participation periods, programs will consider the impact of the TANF requirements on infant abandonment.

In addition, the Adoption and Safe Families Act (ASFA) of 1997 imposed shorter time lines to establish permanent placements for children, especially young children. The disparate time frames for alcohol and other drug recovery, child welfare services, the courts, and a child's development create extensive challenges for AIA providers serving families affected by substance abuse.

Finally, although the last decade has witnessed an increase in the life expectancy for those living with HIV/AIDS and new treatments to prevent maternal-infant transmission, women comprise a rapidly increasing proportion of individuals contracting HIV in the United States. These developments present new issues for service providers who must identify HIV-infected women early in their pregnancies, provide access to anti-retroviral drugs and other innovative health care treatments, encourage compliance with treatment regimens, and address associated social, emotional, legal, and parental concerns. Several AIA programs offer social work and legal collaboration to assist families affected by HIV in developing future care and custody plans for their children, while other AIA projects offer therapeutic recreational opportunities for children from HIV-affected families.

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The Boarder Baby Benchmark

The AIA legislation called for a periodic study of the estimates of the number of infants and young children, under 12 months of age, abandoned in hospitals in the U.S., and an estimate of the annual costs incurred by the federal, state and local governments in providing care for them. In the first national study conducted in 1991, HHS estimated that there were close to 10,000 boarder babies in 865 hospitals throughout 101 counties in the U.S. (James Bell Associates, 1993). The median length of stay after medical discharge was 5 days, but almost one quarter of the infants boarded from 21 to over 100 days beyond medical discharge.

A follow-up study unearthed some significant differences: an overall increase in the number of boarder babies, a decrease in the median length of stay, and distribution of this problem over a larger and more diversified geographic area. Specifically, there were close to 12,000 boarder babies in 926 hospitals throughout 113 counties in 1998 (James Bell Associates, 2001). However, the median length of stay after medical discharge was 4 days and only 12% of the babies stayed from 21 to over 100 days beyond medical discharge. Some cities (i.e., New York City, Chicago, Detroit, the District of Columbia), which initially had high concentrations of boarder babies, experienced a decline in numbers of boarder babies; whereas the problem intensified in other large metropolitan areas and in smaller cities, counties, and rural areas.

Throughout the nation, the overall cost of caring for boarder babies rose from 1991 to 1998. This was due to an increase in the daily hospital rate, as well as the increase in the number of board-

ing infants. Using the median length of stay as a point of comparison, the annual cost of boarder baby care rose from \$23.1 million in 1991 to \$29.4 million in 1998 (James Bell Associates, 2001).



Indicators of AIA Treatment Success

Despite the persistence of the boarder baby phenomenon, there has been a significant improvement with the problem in many communities where AIA programs are located. For example, New York City and Chicago experienced a decrease in the number of boarder babies (James Bell Associates, 2001). In Newark, New Jersey, the length of time children board in hospitals has decreased by 77%; and in Atlanta, boarding costs for babies whose mothers entered the AIA program before they gave birth were less than a tenth of the costs for other babies (Forsyth, in press).

Further, the AIA demonstration programs have had effects on the lives of children that extend well beyond the problem of boarder babies. The research team at the National AIA Resource Center found that children whose families receive AIA services are more likely to reside with their biological parents at termination than at intake. That is, mothers who previously had children removed from their care but successfully completed an AIA program, were more likely to have their children living with them at termination than mothers who did not complete services. However, it was also found that a child is less likely to reside with his or her biological mother at termination if the mother was actively using drugs and/or alcohol at intake, had a history of child removal due to abuse and/or neglect, or if the child tested positive for cocaine (including crack cocaine) at birth.

Generally, parents are better able to care for their children as a result of the

AIA programs (Forsyth, in press). In Los Angeles, for example, 84% of parents who entered drug treatment were clean and sober at the time of termination from the program. Additionally, the programs in Philadelphia and New York City have documented decreased rates of depression among women enrolled in the programs. Further, data from the program in Oklahoma City suggest a substantial reduction in the potential that parents will abuse their children.

Improved care is positively impacting the health and welfare of children affected by substance abuse and HIV. In New Haven, Connecticut, children in the program are now getting the health care that they previously lacked, and there has been a substantial decrease in the rate of child abuse and neglect (Forsyth, in press). AIA programs have also been instrumental in helping parents with AIDS plan for the long-term care of their children and avoid the painful disruptions that these children could face (Forsyth, in press).



Making Sense of the Full Picture

The AIA demonstration program was developed to counteract the abandonment of babies in hospitals and the havoc that substance abuse and HIV/AIDS perpetrates on families, communities, and service systems. Initially, both the problem and intervention were focused upon the needs of the abandoned child, but over time the program adopted a preventative and family focused approach. This re-framing permitted the problem to be addressed on many fronts and from many angles. The AIA programs developed unique models of care that provide coordinated, family-focused, child-centered services. The goal is to promote the safety, well-being, and permanence of children from families struggling with chemical dependency and HIV and,

when feasible, to do that within the context of the biological family.

The boarder baby problem has not gone away—but then neither has chemical addiction or HIV. Observers may point out that the problem has only intensified, with an increase in the number of boarder babies and a wider distribution of the problem. But, the overall decrease in the median length of hospitalization indicates that we are making significant inroads, across systems, in expediting permanence for children. Further, in communities where AIA programs exist, there has been considerable success in preventing and addressing problems and improving the lots and lives of these children and families. This is quite remarkable, given the intractable needs of the client families, the shifting policy contexts, and the shrinking resource base that service providers have encountered.

While challenges in serving these client families will continue, AIA programs have demonstrated effective ways

to address these obstacles. Collaborating across systems, providing support services to all family members, developing innovative practice models to reach more families and reduce relapse risk, developing practice models to assist those living with HIV/AIDS, helping families to establish and maintain economic security in the face of a shrinking governmental safety net, and continuing to advocate for these families in the necessary policy and practice arenas are but a few. In this twenty-first century, AIA programs remain eager, experienced, and up to the task. However, preventing and minimizing the damage from perinatal substance abuse, HIV and abandonment requires even more resources and services to address complex problems associated with poverty, substance abuse, violence and racism. As we move into the next decade, we need to expand the resources and replicate successful AIA programs and strategies in order to reach more children and families in more communities throughout the country.

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COMING SOON: TWO NEW PUBLICATIONS ABOUT ABANDONED INFANTS

A recent national study of boarder babies and abandoned infants will soon be available. As a follow-up to the 1991 Report to Congress, ***National Estimates of the Number of Boarder Babies, Abandoned Infants and Discarded Infants*** provides updated statistics from 1998 and 1999. Specifically, it looks at the incidence, characteristics, length of stay, and estimated cost of boarder babies (infants who remain hospitalized beyond medical discharge) and abandoned infants (those unlikely to leave the hospital in the custody of their biological parents upon medical discharge). The report

also examines changes in the nature and extent of the problem since 1991, and, for the first time, estimates the number of discarded infants (those found in public places other than a hospital without care or supervision).

Addressing the Needs of the Neediest: The First Ten Years of the Abandoned Infants Assistance Program is an 18 page report prepared by Brian W.C. Forsyth, MB ChB, FRCP(C), Associate Professor of Pediatrics, Yale University School of Medicine. The report examines the effectiveness of the initiatives

spawned by the AIA Act, and describes ways in which the programs have had a positive impact on the lives of children and their families. Specifically, it describes the two epidemics (crack cocaine and HIV) that led to the creation of the AIA Act, provides an overview of the AIA demonstration programs, highlights their successes, and suggests future needs and directions.

Both reports will be available through the National Clearinghouse on Child Abuse and Neglect (800-FYI-3366 or 703-385-7565).

COLLABORATION: THE PATH TO FAMILY HEALTH AND SAFETY

Women with HIV disease and their affected children and families continue to be a growing population with complex needs and strengths. Lack of decent housing, health care and jobs; poverty; substance abuse; and violence put these children at risk for neglect and abuse. In Chicago, 25% of the 5,000 women diagnosed with HIV have been involved with the state child welfare system (DCFS AIDS Project, 1999; Chicago Department of Public Health, 1999). One-third of the 900 children with HIV have been in foster care (DCFS AIDS Project, 1999; Chicago Department of Public Health, 1999). Clearly, there is a need for child welfare to work with community HIV providers to help preserve families and to prevent future abuse, neglect or abandonment of their children.

The Opportunity

Federal demonstration grants have provided opportunities to local communities to build relationships and resources in the community in order to make service systems work for families with special needs. In 1988, Illinois was awarded a Pediatric AIDS Grant, a precursor to the Abandoned Infants Assistance (AIA) Act. Through that first demonstration project, the Illinois Department of Children and Family Services (DCFS), in collaboration with community partners, developed a family-focused continuum of services known as the DCFS AIDS Project.

Over the past ten years, the DCFS AIDS Project has become the home to three AIA projects: *First Love*, *Aban*,

and *Family Options*. As a national AIA grantee, DCFS has had the opportunity to shape best practices in child welfare, a key purpose of the federal demonstration projects.

The Model

The DCFS AIDS Project designed *First Love*, *Aban*, and *Family Options* in collaboration with Cook County Hospital's Women and Children's HIV Program (WCHP) and other community providers. WCHP was chosen as the primary partner because they are a comprehensive, single-site health care provider offering quality services to women with HIV and their families without regard to their ability to pay, and because they have been nationally recognized for innovative programs reaching pregnant women and adolescents at risk for HIV. WCHP's comprehensive services include outpatient/inpatient pediatric, obstetric, and gynecological care, nutritional support, chemical dependency and mental health services with on-site legal assistance, pastoral care, and consumer advocacy.

In 1989, the partnership between the DCFS AIDS Project and Cook County Hospital's WCHP began with individual staffings of shared clients. Two small, dedicated teams identified a range of client needs, complex systemic barriers, and unique interventions. This work led to our first AIA project, *First Love*, which represented our shared vision of care for women diagnosed with HIV upon delivery of their babies. *First Love* operated at WCHP to demonstrate the value of multi-disciplinary teamwork

to keep families out of the child welfare system, and to advocate for best practice within the system. Specifically, *First Love* used AIA funds to extend the WCHP continuum to provide an HIV Health Educator to pregnant women, expanded family case management, emergency assistance, and outreach. Subsequently, *Aban* used AIA funds to add a WCHP home-based team with a case manager; links to substance abuse treatment; peer supports to mother, father and kin; early childhood intervention; and interactive parenting skills. The primary goal was to wrap more services around high-risk families to prevent placement. Recognizing that not all families would be able to remain together, the third AIA project, *Family Options*, provided social work and legal services to help parents make future plans for their children that would promote permanency within extended families and in their communities.

Lessons Learned

During the process of developing and implementing these programs, we learned the following lessons about collaboration and effective ways of serving families.

- **Collaboration leads to a more fluid system of care and a safety net for the health and well being of families.**

Child welfare clients involved in drug abuse and unprotected sex are at risk of getting HIV; and HIV affected families may well need child welfare services. In

1995, DCFS peaked with 50,000 children in substitute care with 74% of their parents having a substance abuse problem (GAO, 1998). Cook County Hospital is Chicago's largest public hospital where 6,000 women deliver babies each year with an estimated 20% exposure to drugs in utero (Cook County Hospital, 1999). Each of these two enormous institutions began small model HIV programs—DCFS AIDS Project and WCHP. The collaboration between these two programs took advantage of the existing inter-disciplinary expertise and promoted shared responsibility for interventions and outcomes. This led to a vision of a fluid continuum of care for children and families that included: preservation, placement, permanency, and prevention. In 1989, DCFS' Pediatric AIDS grant developed training and foster care for children with HIV because so many people were afraid of these children that they languished in hospitals and group homes. Yet, we realized that placement was not the only solution. As partners with WCHP, we each recognized our roles on the continuum and then sought the resources to fill in the gaps. Project *First Love*, for example, provided supportive services to preserve families. Then, *Aban* wrapped more services around high-risk families to prevent placement, and *Family Options* focused on promoting permanency through relatives and in the community.

■ ***The intervention can begin wherever the family needs help.***

In *First Love*, the interventions often begin at the hospital upon delivery of the newborn. Coordinated assessments bring comprehensive services to the family and a safety net for the children. *Aban* may work with those mothers and children who have both been diagnosed with HIV disease and may have difficulty managing their complex medical care. *Family Options* fills a gap between health care and child welfare to help sick par-

ents plan for the care of their children within families, outside of both bureaucratic systems.

■ ***All the principles of building a good relationship must be applied to developing a collaborative multi-disciplinary team.***

The relationship among the collaborative partners in the AIA projects is based on shared problems, shared values, and a shared vision. This was challenging because the partners represent several different systems—child welfare, health care, substance abuse, and early childhood—who see the same client in many different ways. Initial meetings were used to describe the mission and roles of each team member and rules governing confidential information. Formal cross training provided more clarity about each partner's area of expertise. A review of assessment, intervention, and evaluation tools illustrated the mission of each discipline. There must be respect for one another's roles and a coordinated intervention to reduce the chance of crossing boundaries inappropriately. Communication lines must be kept open through regularly scheduled meetings and phone calls. We strive for representation of each of the partners in smaller committee work and public presentations. A sense of humor and commitment are essential.

However, over the past ten years, we learned never to take these relationships for granted. New service models, new agency priorities, the addition of non-professional staff, and the turnover of team members, especially in leadership positions, have led to small crises and there has been a need for an occasional tune up or an over-haul of our collaborative relationship. Maintenance is necessary for a productive long-term relationship.

■ ***Extend the collaborative relationship to include the family as a member of the team.***

Collaboration also means that the family must be involved as part of the team, and all of the principles of a good relationship should be extended to the family. This includes respect for the strengths that the family brings to the table and their right to self-determination. The parents should be empowered as the heads of the household to participate in the planning process. They are accountable for their part in the process and should be treated with positive regard. They should also be included in every level of the project, from planning, to advising, to cross training, to peer interventions, to evaluating the program. The family often knows better than anyone what their problems are, how to solve their problems, and the systemic problems they face. They can be most effective at teaching others what is real and what is important. They are powerful members of a collaborative team.

■ ***Sooner or later collaborations must address the attitudes we have about each other.***

Each partner has biases and fears about how the other will treat the client. For example, child welfare may be seen as child-focused and punitive with parents; we may fear that substance abuse providers withhold information that could jeopardize children, or that health care will disregard the holistic needs of the patient. In the DCFS/WCHP partnership programs, a decision was made to make the *family* the client. An investment in the parents is an investment for the children. Our work is based upon the principles we agreed on to meet the needs of all family members. Trust can be earned by association, and by latching on to trusted WCHP staff, child welfare can achieve the child health and safety goals that are shared by all the partners. Parents who feared that DCFS would take their children are more willing to talk to AIDS Project staff about their case because the *First Love* social workers say they are safe.

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■ ***Pay attention to the parallel process in collaborative relationships. Aim to treat others as you wish to be treated yourselves, and model positive relationships for families and staff.***

The principles of good relationship building should occur on every level. Imagine a work environment where managers treat their staff according to the same principles that case workers are expected to treat their clients. Imagine that governments, communities, and bureaucracies treat local teams with the same care that a mother nurtures her child. Problems and solutions can be generated by every participant, and progress should be celebrated.

■ ***Collaborative relationships can work between major bureaucracies.***

Different systems can share visions. Different funding streams can share programming. Together, our shared clients with complex needs can be treated holistically with shared programming. The problem solving that began on the individual level developed into a system of care. This required leadership from each agency with the support of a good team that also shared the vision. This small team maneuvered the utilization of resources throughout each of the bureaucracies in order to meet the needs of families. Advocacy meant making the system work for our families and our partners. These small acts have eased the path for a mainstream approach.

■ ***Lessons learned from demonstration projects must be implemented into mainstream policy in order to have a lasting impact on child welfare practice.***

HIV affected families are a more complex sub-group (about 5%) of the huge population of substance affected families which comprises 74% of the 20,000 child welfare cases in Illinois (DCFS

AIDS Project Data, 1999). However, lessons learned about collaboration by the DCFS AIDS Project through AIA federal demonstration projects contributed to the broader implementation of a new statewide policy and practice model for working with substance affected families (SAF) and substance exposed infants (SEI).

To summarize, stakeholders from bureaus in addictions, health care, child development, and child welfare were invited to develop a collaborative model of intervention for families where substance exposed infants are born. The partners cultivated a small community-based model that conducted cross-training, posed systemic solutions, and built a shared vision. The continuum of care identified clients at different stages of recovery and safety providing resources appropriate to those needs. The interventions are holistic and family-focused. The family, which includes fathers and extended kin, participates as part of the intervention team to solve problems and evaluate progress. Successful clients provide training to professionals and peer intervention in treatment; they also sit on advisory boards with the professional partners. Recovery rates have increased in pilot models and the children are safer.

■ ***Collaborative policy and practice take time to develop and implement.***

Similar to the experiences of our four-year AIA projects, it took one year to refine the model for working with SAF and SEI, two years to gather data, and another year to develop a policy and training. This resulted in four years to initiate the mainstream implementation of a model resulting from lessons learned in demonstration projects.

■ ***Collaboration leads to other problem solving projects.***

We've learned from our collaboration between DCFS and WCHP that once the relationship is working, the partners can solve other difficult problems that

clients and systems face. For example, the DCFS AIDS Project identified the issue of repeated unplanned pregnancies with no pre-natal care among a small group of women with HIV that no one could reach. Cook County Hospital Women and Children's HIV Project took a leadership position in the integration of HIV practices with maternal and child health programs. The ultimate goal is the reduction of perinatal HIV transmission. Affected women participated in the development, training, and intervention of the project. Based on lessons learned through the AIA programs, WCHP brought in both the Chicago and Illinois Departments of Public Health along with other stakeholders to help change the model of policy and practice in prenatal health care.



Conclusion

Throughout the past ten years of AIA programs, we have learned that collaboration is a dynamic process with a far-reaching impact. Successful partnerships in one arena lead to other opportunities to interact with one another on other projects. The relationships developed in collaborative projects use existing resources and are a valuable investment for best practice throughout the health and human service system.

Elizabeth Monk, DCFS
AIDS Project Director, Illinois Department of Children and Family Services

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GREAT STARTS . . . FOOTPRINTS ON THE HEART

Child & Family Tennessee's Great Starts Program began in Knoxville, Tennessee in August, 1991. When I arrived at Great Starts in 1992, the facility was struggling to implement the mission of the Abandoned Infants Assistance grant—to support addicted/and or HIV+ women by providing a permanent plan for their children that includes arranging and coordinating foster care and/or adoption. Our customers (clients) represent a population where traditional treatment approaches had failed. Our challenge was to develop a program that would assure more successful outcomes.



Overview

One of the first changes we made was to turn the program from a supportive living community to a licensed intensive outpatient mental health and alcohol and drug treatment center. Today, Great Starts is a comprehensive, therapeutic community, providing a holistic array of services that includes supportive, educational, therapeutic child development, parenting and early intervention services for substance abusing and/or HIV+ women and their children. Our diverse staff includes a parenting educator, case managers, day care and child development workers, and individual, group and child therapists. Together, we provide 24-hour care or “one stop shopping” services for women and children.

Women may reside in our apartment dwellings for six months. While there, they receive many services. Once customers complete their treatment, we have a strong follow-up component with in-home visitation for 90 days. Other



post-treatment services include career counseling, crisis intervention, vocational rehabilitation services, child therapy, and family therapy.

In the past eight years, I have learned the following lessons from our customers:

- Our customers want to keep their children.
- Drug-affected children need early intervention services to prevent residual effects of drugs. Mothers, trying to overcome their addiction, need support in child care and child development. They also need education on effective parenting. We thus began a therapeutic nursery for drug-addicted children and implemented a parenting curriculum for all the parents in our program.
- Effective outcomes are client-driven. If a client is not ready for treatment, no recovery tools will be effective. Clients

will accept treatment more easily when they are pregnant because they do not want to harm their unborn child.

- 95% of all our customers have a dual diagnosis. I have found that each should be treated separately. If the major diagnosis is mental health, the patient must be stabilized on psychotropic drugs and therapy before we can treat the addiction issues.
- Client-staff relationships are most important in building successful outcomes for our customers and for the program.
- A structured, safe, drug-free, therapeutic community is the most effective treatment approach for drug-addicted women and their children.

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Lessons Our Customers Learned

Great Starts could not have made this journey without the lessons we have learned from our customers and the dedicated staff who worked during difficult and uncertain times to develop Great Starts. Our partners, such as the University of Tennessee School of Social Work, community volunteers, and the Great Starts' TransAgency Committee, also provided invaluable support through our journey to become the innovative, holistic treatment center that Great Starts is today.

The following testimonials provide a brief glimpse into the world of Great Starts' customers and the impact that the program has had upon them "in their own words." To protect these customers' confidentiality, their names have been withheld.

WHERE I WAS VS. WHERE I AM

"By the time I was 13, I started smoking pot. It was an escape I loved and felt I needed. I remember feeling nothing, and nothing was so much better than what I usually felt. By the time I was 16, I was into hard drugs (pills, cocaine, acid, alcohol, etc). I had gone to a treatment center when I was 16 but used the day I got out. I worked in bars and strip clubs for easy money for my drugs. During this time I had a son by one of the many men I slept with unprotected. I started smoking crack, and in just three short months, I left my son with his grandparents and lost custody . . .

This brings me to Great Starts . . . I had gotten pregnant and knew I needed help. I was on the streets with no place to

go. I had heard of a place that will help women, especially women with children, so a woman can get her life back, along with the children's lives back. Luckily, they let me in. I was one of the fortunate ones.

Great Starts taught me structure. They had extensive therapy designed especially for women and women with children. They made treatment a family process instead of treating someone for 30 days then letting them go. We had parenting classes, budgeting, and cultural diversity classes. Also, we learned to work together as women, how to express our feelings in an appropriate manner, and how to be assertive. I would have died on the streets if it had not been for Great Starts. They will always be my family, and I will never be able to pay back what that facility has done for my family and me."

BEFORE GREAT STARTS

"I was just surviving, not living. I was a prostitute, taking a lot of risk with my life. I was getting beat up pretty often. I would go to jail—back to the streets—back to jail—back to the streets.

But then there was Great Starts which helped me learn to respect myself and my body . . . I've got my kids back. I've learned boundaries. I'm living life not just surviving."

WHAT GREAT STARTS MEANS TO ME

"At Great Starts I can learn how to be a parent to my children, be able to spend my money and manage it better, learn how to deal with disappointment that will come in my life and not turn to drug(s), be able to socialize with people and build up my self esteem, and love and respect other(s) as I will have them respect me. To me Great Starts mean(s) to be able to survive out there in the real world being drug-free."

WHAT GREAT STARTS MEANS TO ME

"A new beginning! Yeah! That's what Great Starts means to me. It's a place to go with windows full of opportunities . . . It's a place to teach you how to use the tools that are within your reach.

When a problem you have arises, Great Starts will show you the methods to handle the problem without having to turn to drugs. You will learn a drug-free life and a favorable life. You'll learn to be more responsible, a better parent, have a healthier life.

They will help you with housing when ready and any kind of resources available. There's always someone to listen to your problems. If they can't help you, you can bet that they'll find someone who can.

To me, Great Starts is a . . . place for me to get a great outlook on life . . . to get back what I lost in life due to drugs."



How Our Partners Have Supported Us

A TransAgency Committee, comprised of community agency representatives, was formed in July 1993. A core group have supported and advocated for Great Starts ever since. Members of our TransAgency Committee wrote the following testimonials.

LESLIE REEVES, Probation and Parole Manager, Board of Probation and Parole

"I have been a member of the TransAgency Committee for Great Starts since its inception in 1993. I also served as Chairperson of the committee for 2 years. During those years a core group of dedicated individuals attended monthly meetings to hear updates

about Great Starts, to offer advice and information about community resources, and to plan fundraising and supportive activities.

The collaboration between local agencies has been very important to Great Starts and to the various agencies involved. The staff from Great Starts was often able to learn more about policies of the agencies that were involved with their clients. Without the assistance of TransAgency members, it would be difficult to do some of the extracurricular activities for the clients such as the Red Ribbon fall festival, visits to Dollywood, or the annual Christmas Tea. The TransAgency Committee also acts as an ambassador in the community by educating the public about Great Starts. I feel it has been a rewarding and beneficial experience for everyone involved."

PAIGE CHRISTENBERRY,
Assistant Vice President, Private
Banking Group, SunTrust Bank

"I have been involved with the Great Starts TransAgency Committee for the past five years and I am currently serving as the TransAgency Chairperson. I'm involved in many committees and programs throughout the community, but Great Starts is near and dear to my heart. I think the reason I feel so strongly about Great Starts is the impact I see the program making in the lives of these ladies and their children.

Each year the TransAgency Committee hosts a Christmas Tea for the ladies, where we present them with donated gifts and ask them to tell their story as we present them with gifts. I am still amazed 5 years later at some of the circumstances these women have risen above. Without Great Starts it would not have been possible. The really neat thing about the Christmas Tea is the range of treatment levels each woman is facing. One client may be a 3-year

graduate of the program and the next may be in their first week, but each one is experiencing a new life, a new beginning and a fresh start as a member of our community. I believe Great Starts transforms lives. I have witnessed it first hand through my work with the TransAgency Committee."

BO PIERCE,
Executive Director, Knox County
Housing Authority

"I am always impressed by the courage of the ladies at the Christmas Tea. Some can only offer a simple, but heartfelt 'Thank you.' Others eloquently express thanks for the gifts, the Great Starts Program, the staff, and the support that comes from all involved in the effort to help these ladies obtain a successful outcome. I echo their thanks to the staff and supporters of Great Starts."

DWIGHT VAN DE VATE,
Chief Deputy, Knox County Sheriff's
Department
First Chairman, Great Starts
TransAgency Committee

"Great successes, (or Great Starts), usually have modest beginnings. Sometimes it is little more than an idea or a discussion that somehow begins to circulate among people who find they occupy a little bit of common ground. Most often these ideas or halting initiatives drift off quietly, victims of good intentions but poor execution. But once in a while, from the confluence of the right time, the right people and the right circumstances, something special will develop. Such is the case with Great Starts and the Great Starts TransAgency Community.

The original mission of Great Starts was to provide chemically dependent single mothers and their drug-exposed (in utero)

children with residential care. Here was a way for a drug-addicted mother to seek help without having to fear losing her children to the state. The idea was so powerful, so compelling, that none of us could resist. And now, ten years later, we have a broader mission, a broader constituency, a new set of faces; but we are all still brought together by the power of a good idea and the opportunity to serve in a way that can make a genuine difference. I am proud to have been associated with so many good people over the years, and I am a better person for the experience. A sincere thank you to Judy Pack and all the Great Starts staff and volunteers hardly seems adequate, but it comes from the heart."



Lessons Our Staff Learned

Great Starts has dedicated staff members who have been with the program almost since its inception. In their own words, they discuss their journey and the lessons they have learned from our customers.

LISA SKILES,
Senior Counselor (9 Years)

"After struggling, experimenting, and juggling through the years, we have learned to provide services . . . It's been a long journey and sometimes a hard one, but it's also been a profitable one in learning what works and what doesn't and in providing the services that are needed.

My job as a counselor is a rewarding one. If there are days when I ask myself, 'Why am I here?' an older client will call or show up just to say 'Thank you for saving my life.' In reality they saved themselves. We just provide the place and the services for what they need to do. This type of treatment use to be deemed 'the impossible.'"

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MARGARET REED,
Lead Counselor/Supervisor (12 Years)

“My adventure at Great Starts started as an Independent Living teacher with some case management. The clients taught me what they needed. I learned that they needed more than just classes on budgeting and getting a job. After all, why budget what you don’t have? Why interview for a job when you are so scared you can’t be interviewed? Our clients taught us they needed to be developed personally and to improve their self-esteem and self-confidence. We began curricula that met those needs. We also had clients who didn’t complete high school and couldn’t read well—we then started Pre-GED classes.

Working at Great Starts is the most rewarding job I have ever had. We, as a staff, work on positive changes constantly.”

HARRIET HARTMAN,
Intake/Support Administrator
(6 Years)

“When I applied for a job at Child & Family Tennessee I had no idea what I had done. I entered a world I did not even know existed. I knew there were people who had these problems, but I did not know there were programs such as Great Starts to treat them.

When potential clients call Great Starts seeking help, I am usually the first person they have contact with. I try to make them feel as comfortable as possible and I will go to whatever length it takes to see they receive the care they need.”

SHEENA CURLEY,
Parenting Educator, Nursery Director
and Master Child Development
Specialist (7 Years)

“To date we have served 387 children in our therapeutic nursery. I was given the responsibility of testing and compiling a database to track all the children and their issues with drug withdrawal and developmental milestones. I also coordinated family reunification with the Department of Children’s Services. As Parenting Educator I am able to develop a broader range of parenting labs, and a “Mother Goose” bonding program to enhance the parents’ ability to parent effectively.

I have seen the need for this type of program that brings children together with the parent. Educating and role modeling for our parents is an effective tool to assure successful outcomes. . . . The unique needs of these families make it necessary for a comprehensive program that centers on the entire family unit. We have learned that the family structure and parenting of the mother directs how the child acts and relates to others.”



**Summary of Significant
Outcomes**

Our third party evaluator, the University of Tennessee, School of Social Work and Public Service, provides significant data in determining effective outcomes for the clients we serve. The following is a summary of significant outcomes.

BARBARA BARTON,
Assistant Manager, Program Evaluation
University of Tennessee, School of
Social Work and Public Service

“Since 1991, Great Starts has provided substance-abuse recovery services to over 300

women from Knoxville and the surrounding areas of East Tennessee. In the last three years, success rates for clients’ completion of the treatment program have risen dramatically. From January 1996 through July 1997, Great Starts offered both residential and outpatient treatment services and experienced a respectable 30.8% completion rate. The next year, as Great Starts ended its day treatment option and offered treatment services on a residential basis only, the success rate climbed to 41.5%. However the greatest increase was yet to come. Of the 38 women who left Great Starts from October 1998 through September 1999, 23 completed the 6-month residential program. These numbers point to a current graduation rate of over 60%.

Through its comprehensive services, Great Starts has had a strong impact on the lives of the at-risk, young children whose mothers seek recovery from the nightmare of substance abuse. Although data have yet to be compiled for the most recent program year, follow-up custody statistics are available from the Tennessee Department of Children’s Services for the Great Starts nursery children who left the program from October 1997 through September 1998. Of these 43 children, 39 or 90.7% had never been or were no longer in state custody at least 6 months after leaving Great Starts.

Through maternal substance-abuse treatment and a focus on prenatal care, Great Starts also seeks healthy outcomes for infants born to the women in the treatment program. Between October 1998 and September 1999, a total of 15 women were pregnant while at Great Starts. Of these, 14 gave birth to relatively healthy babies who displayed few or no effects from their mothers’ previous substance abuse.”

Judy Pack
Great Starts Program Coordinator,
Knoxville, TN

THE STAR PROJECT: ACCELERATING REUNIFICATION AND PREVENTING INFANT ABANDONMENT

The Epiphany Center for Families in Recovery has been the recipient of two AIA awards, one in 1991 and another in 1997. Over the years, we have learned that intensive, comprehensive services to birth parents can be the catalyst for families to change their lifestyles, reunify with their children, and become productive members of society. On the other hand, we have also learned that with certain families, no amount or intensity of services helps them change or recover from substance abuse/addiction. They became pregnant by accident, don't know if they want to parent a child, are not ready for recovery, and are hesitant to engage in services where recovery, reunification and family stability are the clear goals.

It is these latter families who have presented the most difficult challenges to the Epiphany Center. Not surprisingly, this is the family profile that has been the norm rather than the exception in our AIA program. In fact, we have rarely encountered a family who was committed to recovery and reunification upon entering the program. More often than not, the women are extremely indecisive about the child they mistakenly conceived, often while under the influence of, or in exchange for, illicit drugs. At the same time, they find themselves under considerable pressure from family, peers and society to assume responsibility for the care of their child. This is a conflict that many women cannot resolve, even with the best counseling and treatment. Nevertheless, our program *has* helped women who were initially ambivalent about their pregnancies and recovery to grow and develop to the point where they were able to make thoughtful decisions about their lives.



Designing a Program for Concurrent Planning

When Child Welfare Services removes a child shortly after birth, the mother is usually informed that if she stays clean and sober, attends a treatment program and finds adequate housing, her child will be returned to her to raise. Frequently, this is happening to a woman who has never been adequately parented herself and who has the emotional age of an adolescent due to long-term drug use and/or physical, emotional, and/or sexual abuse. She may not even know how she feels about being a mother, may be in denial about her chemical addiction, and may not be capable of making a mature decision about her baby or her life.

Thus, it becomes the job of the treatment program (the Epiphany STAR Project) to structure itself so that a decision in the best interest of the child can be made as soon as possible. This means affording families every opportunity to engage in the program, while simultaneously assessing and observing the family's level of functioning and commitment. It is of the utmost importance to team up with the child welfare worker and other providers involved with the family so that the clearest, broadest picture of the family can be drawn in the most expedient way possible. Also, the program must be highly structured with clearly defined goals and established timelines for families to achieve those goals.

California Assembly Bill 1524, as amended on August 23, 1996, requires the courts to order hearings to free

children under the age of 3 for adoption if reunification efforts are not successful by six months from the date of out-of-home placement. We believe that this makes firmly structured programs that emphasize parent accountability more critical than ever. The Epiphany Center designed its most recent AIA program, Services to Accelerate Reunification (STAR), with this time-sensitive legislation in mind.



The Epiphany STAR Project

The STAR Project provides mothers (or fathers) with abundant amounts of bonding time with their children, and attempts to engage the parents in drug treatment. During the first month following placement of an infant in the Epiphany STAR Project, the mother (or father) spends a minimum of six hours per day, five days per week with her child. Parenting and nursing staff work with the parent individually throughout that time to strengthen parenting skills and to develop strategies to provide a healing environment for the infant. Parenting staff, for instance, observe parent-child interactions and coach parenting skills. Instruction in infant massage, which facilitates infant attachment, also begins at this time. Nutritious snacks and a hot lunch are provided daily to parents.

Following the first 30 days, women begin attending the day treatment program, which includes acupuncture, individual and group counseling, and life

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skills classes. Parent-child interaction, parenting education, and optional visiting after program hours continue. Family and couple counseling services are available as needed. Epiphany families also receive case management services, health assessments and nutrition education, while the infants receive health care, developmental assessments and early intervention services.

After helping to design the treatment plan, the parent is held accountable for meeting the goals and objectives contained in the treatment plan. Once a parent has engaged in treatment, has stabilized her recovery and has acquired safe, stable housing, off-site visits with her infant, both day and overnight, can begin. The goal of this gradual transition of the infant from the STAR program into the parent's home is permanent reunification. The target timeframe for family reunification is six months from the date of placement. Following reunification, the parent continues to attend the Epiphany day treatment program, bringing her child with her to the program. Following reunification, the STAR Project provides regular home visiting services to support the family for up to 12 months.

We have learned that the closer we adhere to the program structure and timelines, the better the outcome for the infant. So many mothers over the years have been unable or unwilling to verbalize their doubts or ambivalence about their situations. Even if they are consciously aware that they are not ready, willing or able to parent a child, social taboos discourage mothers from saying that to the program staff or social workers. Often, the only way to override those social taboos is to put the decision not to parent in the hands of the AIA program and/or the social worker. Clients do this through non-compliance and by "sabotaging" their own program. The client can then rationalize that the program was "unreasonable", "too strict", "didn't

like her", "asked too much of her", etc. This is the scenario we have seen played out many, many times over the years. Therefore, if, at any point, it becomes clear that a parent has not followed through with his or her plan, the program works with the child welfare worker to implement the concurrent plan so the child can be moved to a permanent placement within the six-month timeframe.



Clients' Views

The following excerpts were written by two families who participated in the Epiphany STAR Program, with two very different outcomes. The first woman successfully reunified with her child almost two years ago and continues to maintain a stable family:

"The STAR Program worked for me. I found myself in a loving, supportive and educational environment. I had the time to bond with my child. I learned parenting skills that were crucial to my confidence and competence as a parent. The outstanding care my child was given there set a standard for me and the education I received enabled me to carry on that high standard of care. The gradual reunification process allowed me to accept my responsibilities in a calm way, so I was not too overwhelmed. The program also enabled me to truly focus on the most important business at hand, reunifying with my child. I found it to be a loving, healing place. And I have benefited greatly from the experience."

The second woman, struggling with her recovery, decided to have her child placed with a family member. She continues to participate in treatment and work toward eventual reunification:

"They took care of my baby so excellent—the feeding, the massage and the exercises they showed me how to do with my baby—it helped me feel closer to the baby. And, the baby's going to my sister worked out fine for me too, until I can get somewhere more appropriate. He's with my family instead of in foster care—only until I can get something more appropriate for the both of us. I would recommend the STAR Program to other mothers who need good care for their baby until they can work it out."



Findings

During the Epiphany Center's first AIA project (1992-1996), the successful reunification rate was 73% (41% with biological parents; 32% with relatives). Although some children stayed longer due to extensions granted by the court and the desire to avoid multiple foster care placements, the average length of stay for infants who subsequently reunited with birth parents was 8 months.

In the second AIA project period (1997-2000), we saw a rise in the birth parent reunification rate. Twenty-two of the 27 infants have now been discharged to permanent placements with family, an 82% reunification rate. Twelve of the 22 (55%) were reunified with birth parents and 6 (27%) with relatives. All infants (100%) discharged from the STAR Program have shown improvements in

neuro-behavioral organization and have demonstrated more organizational and self-regulatory behavior based on developmental scores and behavioral observation.

In addition, almost 70% of enrolled families have measurable improvements in family functioning and have increased their family stability. This includes four birth *fathers* who came forward to parent their children, and who have acquired or maintained adequate housing and sobriety. The program also assisted them in improving their overall parenting skills.



Summary

In summary, our experiences over the past ten years have taught us that the Epiphany Center's comprehensive services approach can ameliorate the issues confronted by women and families impacted by substance abuse and/or HIV. This structured program, which holds parents accountable for achieving goals and timelines, reaches out to engage parents in treatment, provides them with parenting skills and support following reunification, and gives parents and children a chance to set off on a healthy life together. At the same time, the program helps parents to make educated and healthy decisions about their readiness and desire to parent, and to expedite permanency for children who are not able to remain with their parents. Ultimately, we believe it is the program model that effectively prevents infant abandonment.

Joanna C. Chestnut
Epiphany Grant Manager
(with help from Epiphany staff)
 San Francisco, CA



UPCOMING CONFERENCE

Establishing Permanent Futures for Children: FUTURE CARE AND CUSTODY PLANNING FOR FAMILIES AFFECTED BY LIFE-THREATENING ILLNESS

New Orleans, LA: Le Pavillon Hotel

September 10 - 11, 2001

This conference, sponsored by the National Abandoned Infants Assistance Resource Center, is designed to bring together lawyers, social workers, advocates, administrators, policymakers, and families to explore the legislative, legal, and clinical issues surrounding future care and custody planning for families affected by illness.

The goal of this conference is to showcase exemplary efforts to provide, improve, and expand future care and custody planning options for families affected by illness.

The conference will also provide a national overview of standby guardianship, standby adoption, and other future care and custody planning options available to families; and highlight successes and obstacles in the implementation and utilization of these options.

The conference is intended to spark discussion about and interest in promoting the effective development, passage, and implementation of legislation designed to assist families in future care and custody planning.

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INTERDISCIPLINARY BEST PRACTICE: LESSONS LEARNED AT LOS PASOS

The needs of children and families served by the Abandoned Infants Assistance (AIA) Programs are complex and multi-faceted. Compounding the issues for families affected by substance use are the difficulties in accessing primary health care, social services, child care, and the Medicaid/welfare-to-work systems. Although programmatic experience has demonstrated that program participation is often determined to be a result of client engagement with one member of the team, it is also recognized that a staff member acting alone cannot adequately identify, comprehend, or respond in a comprehensive manner to the full scope of issues confronting AIA families. It is for this reason that AIA programs have moved towards interdisciplinary practice. In the process, two things happen: 1) the children and families benefit from an innovative, improved, and coordinated service delivery system, and 2) teams are enriched through the knowledge and skills of other disciplines.



Definitions

The term “interdisciplinary” can be confusing. It denotes more than “collaboration,” a concept that suggests that entities, agencies, and departments are working together, cooperating, and engaging in shared decision-making. The relationship and lines of communication in collaboratives tend to be highly structured, and the goal is less driven by a specific client's needs as an effort to work towards meeting the needs of

an identified client population or an issue. Acknowledging that it is more effective to work together than to work separately, agencies or disciplines agree to collaborate to reach a specific goal.

Multidisciplinary, interdisciplinary, and transdisciplinary work places individual clients—i.e., the child and family—at the hub of service planning and service delivery. Each term assumes that, at the agency level, a collaborative climate co-exists and that collaborations are concurrently in place, particularly if more than one agency is involved. The terms are not interchangeable, yet they are often used this way. In a progression, each represents a more intense level of working together and team involvement (McCormick & Goldman, 1979; Woodruff & McGonigel, 1988; Hanson, 1989; Orelove, 1992; Case-Smith & Wavrek, 1993).

- **Multidisciplinary** work can be viewed as a parallel work model. A team member may recognize the importance of the input from various disciplines but each presents an assessment, makes recommendations for services, and provides intervention fairly independently from the others. The family is usually seen separately by each member of the team. Generally led by one member of the team, this model does not involve shared decision-making. However, the term, “multidisciplinary,” is sometimes used by service providers when a team is actually involved in the next level of disciplinary work.

- **Interdisciplinary** work is based upon a profession-based partnership

model, e.g., social workers, nurses, doctors, and mental health workers. Members of the team assume leadership in presenting their viewpoints and in sharing responsibility for the case, but they reach beyond their own perspective and training to embrace what others on the team have to offer. Team meetings are held to develop a single service plan based upon the goals developed by the individual disciplines. The family's role in service planning varies, but the family may meet several members of the team together rather than each one in isolation. At team meetings—as if moving in a spiral fashion—each discipline builds upon another person's knowledge and expertise while continuing to be grounded in one's own reference base. Simply put, this is multidisciplinary work with the addition of group discussion and consensus development.

- The **transdisciplinary** model requires the highest level of team involvement and commitment. It is the most involved and inclusive level of disciplinary work. The model, originally developed in the areas of nursing and special education, has been defined as being “of, or relating to, a transfer of information, knowledge, or skills across disciplinary boundaries” (Hutchinson, quoted by Orelove, 1992, p. 38). The concept relies heavily upon family participation, as a true partnership between the consumer and the rest of the team (service providers), giving the family an equal voice in the assessment, service planning, and program

implementation for their child and family unit. Individual roles are blended as each member of the team teaches the others his or her interdisciplinary skills at regularly scheduled meetings, case conferences, and consultations.

Although teams may aspire to transdisciplinary practice, most have difficulty reaching this level. It has been our experience in the Los Pasos Program and its relative kinship program, the GRO Project (“Grandparents and Other Relatives Project”), in the Albuquerque, New Mexico, area that interdisciplinary work is more compatible with the clientele we serve. Families considered to be at risk because of substance use and mental health problems often have trouble participating at team meetings. They may have difficulty appearing for their appointments, may find the idea of facing an entire team too daunting, or may be reluctant to suggest goals, not having been asked to do so in previous treatment settings. Nevertheless, family input is critical to the planning process. In the Los Pasos experience, the Case Manager or a Family Advocate, who has established a relationship with the family, assists them in developing goals, and acts as their voice—their intermediary—during the meeting.



Los Pasos’ Interdisciplinary Process

Although Los Pasos adheres to the interdisciplinary team model, it also loosely incorporates aspects of the transdisciplinary approach, as the following discussion indicates. Refining its disciplinary approach and building upon it in its ten years of experience, the Los Pasos Program has found it to be a complex, circular and dynamic

process. Because of its expertise in interdisciplinary practice, Los Pasos was awarded an adjunct grant (“UNITE”: “Universities Networked in Interdisciplinary Training and Education”) from the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services, funded under contract through Western Oregon University, Teaching Research Division. This additional funding allowed Los Pasos to move its interdisciplinary practice to a more systemic approach. It also led to the development of an interdisciplinary-transdisciplinary curriculum, based entirely upon the Los Pasos experience of working with families affected by prenatal substance use. This article outlines the key elements needed to succeed in interdisciplinary team work that Los Pasos and its adjunct program, GRO, learned through its clinical practice and experience in working with high risk families.

STEP 1: IDENTIFY THE TEAM

The team varies depending upon the needs of the child and family. Generally, Los Pasos has found that its core team works best when it includes, at a minimum, a pediatrician, a social worker, a case manager/family advocate, a developmental consultant, and a program administrator/clinical supervisor. Other team members (e.g., home health nurses, legal representatives, early intervention specialists) may also attend, depending on specific family needs. It is critical that everyone on the team be committed to working *with*—not *for*—families, and that each member believes that families have the capacity to work on their life situations.

Finding the right mix of team members capable of working on a team

can be a difficult task. Over the years, Los Pasos program administrators have found that there is no magical question to ask during the hiring process that helps to identify these individuals. Using a team interview approach has been found to be helpful and an effective way to identify individuals who, at the very least, are compatible with the rest of the team. However, it is not until staff begin interacting with the family and the team that their capacity for team work surfaces. Fortunately, it does not usually take very long to discover a person’s true interdisciplinary team member “potential.”

In the process of identifying team members, the issue of confidentiality often arises as a professional dilemma. Because each discipline is bound by its own code of ethics concerning confidentiality, agreeing to collaborate with other team members and at the same time keeping certain information about families confidential inevitably emerges as a struggle: to what extent *can* one share information about families? All disciplines must agree that they have a common stake—the welfare of the child and family, and that it is appropriate for team members to examine their professional roles and methods of service delivery in this context. Further, in order to help prevent discomfort for individual members, the team should establish guidelines and protocols for what and how client information is shared. Additionally, the issue of confidentiality should be incorporated into ongoing interdisciplinary training.

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STEP 2: SUPPORT TEAM BUILDING AND REINFORCE IT REGULARLY

Each discipline comes to the table with a specific training and level of experience. Without meaning to be biased, individuals may be suspicious of or have negative attitudes towards another discipline. Los Pasos has found that it is best to identify these negative beliefs at the beginning of working together. In a group exercise developed for this purpose, each individual is encouraged to write one or two thoughts about the other disciplines. Participants then share their answers with the rest of the group, and frequently this becomes a point of amusement, particularly when certain stereotypic words emerge. The point of this exercise is to expose not only the negative experiences or beliefs about another profession but also to recognize when a discipline is being held in the highest regard without reservation. Both can have an impact on the team process. Ultimately, each discipline must come to be respected by others on the team before “inter”-disciplinary work can begin.

As helpful as this exercise might be, however, cohesive team work does not happen automatically. Teams are a fluid entity. They develop in stages, similar to the growth and development of normal group functioning, as described in group process literature (Tuckman, 1965):

- “forming”: a time when the team begins to develop its identity as team members get to know one another, develop relationships, and learn to accept the roles of each group member;
- “storming”: as the group begins to search for group values and norms,

conflict and confusion can arise. Communication at this stage can be erratic and confrontational, but as the group learns to be open with one another, even in the face of conflict, trust among the members increases;

- “norming”: a more productive stage, the group engages in shared values and procedures. Communication is more open, with less concern about giving and receiving feedback because “turf” issues have been resolved; and
- “performing”: a time of group cohesiveness, collaboration and consistency. Lines of communication reveal the willingness to take risks and support other members of the group. The group adopts a strong sense of identification with other members of the team and begins using words such as “our” and “we.”

Interdisciplinary work follows similar patterns. In learning to be comfortable with each other and to accept each person’s contribution, trust emerges. Trust—in each other and in the team process—takes time and requires ongoing self-monitoring (i.e., “to what extent do I trust the quality of their observations?”). It is crucial to remember this, particularly as the players on the team shift, because of staffing changes and because the service needs of the families require it. Trust and the stages of group development must be developed and nurtured repeatedly.

STEP 3: UNDERSTAND THE ROLE OF INDIVIDUAL TEAM MEMBERS

This step begins by sharing information and the experience of one’s own discipline and then truly listening to the contributions of other team members.

To start this process, Los Pasos has developed seminar sessions on topics that are pertinent to the service needs of its families. Each seminar is presented by a team member with expertise in that area, e.g., a physician offers information about the medical effects of prenatal exposure on infants and children; a developmental specialist outlines the developmental effects of prenatal drug exposure; a therapist provides an overview of solution focused approaches for working with families; a social service representative explains social work and case management practice; and a member of the University’s Clinical Law School addresses legal issues, including a review of the state’s Children’s Code. Dispute resolution was later added to address how to deal with conflict among other team members, and to facilitate working with agencies whose clinical approach or philosophy differs from our own.

STEP 4: INTEGRATE THE LEARNING AND EXPERIENCE OF OTHER DISCIPLINES

If the process of preparing for interdisciplinary practice were to end with Step 3, the final result would be “multidisciplinary” work. To move towards “interdisciplinary” work, the team members must not only understand the contributions and expertise of the various disciplines, they must begin incorporating the information learned from other disciplines into their own assessments and service planning. This is easier said than done. In Los Pasos, there is a weekly clinic where members of the team meet the family and provide services to the child, and they sometimes see children jointly in the University Hospital’s Newborn Nursery. The pediatrician

often sees a child concurrently with a developmental specialist or a social worker present in the examining room. Although no professional presumes to know the other's specific skills, each can contribute to the family's understanding of the procedures and assessments. They complement the other's work and make it more meaningful. Later, if necessary, one can speak for the other during service planning, having been a part of the joint interview and having a more thorough comprehension of the strengths and needs of the family.

STEP 5:
**INCORPORATE THE
 PERSPECTIVES OF OTHER
 DISCIPLINES WHEN MAKING
 INTERDISCIPLINARY TEAM
 DECISIONS**

In Los Pasos, case studies have been used effectively as a way for team members to begin learning how to work more effectively on a team. An interesting exercise used in interdisciplinary team training includes having individuals assume the role of another discipline during the discussion of the cases. Another innovation of the program is its strong technological component. Training sessions may include video-conferencing or multi-user chat rooms to discuss and challenge why decisions are made about a case.

It is not sufficient to have individual team members come together during a service planning meeting and assume that they can work together and make collaborative decisions about a child and family in isolation. "Interdisciplinary" extends to joint clinical experience and even to administrative decisions concerning forms and procedures. In a previous example, the pediatrician and the social worker or a developmental specialist may see the

family together in a clinic setting. Los Pasos and GRO team members also conduct joint home visits, each able to see first-hand what the other is doing. Through collaborative practice, and through the adoption of a mind-set that every team member contributes to interdisciplinary practice, the goals in service planning become clearer and the child and family benefit. Team members do not have to worry that their voices are not heard, because the rest of the team reflects their voice. However, it does not mean that social workers practice medicine nor that the pediatrician starts referring families to social services. What it implies is that the social worker is aware of the schedule of well-baby visits or is concerned when a child is not gaining weight and it means that the physician may discover that a family member is experiencing domestic violence, a situation that somehow was not discussed with the case worker. In both cases, each professional knows when to refer a family to other team members.

STEP 6:
**TRUST THE INTERDISCIPLINARY
 TEAMWORK PROCESS IN
 RESPONSE TO CRISES IN
 FAMILIES**

The development of trust faces the greatest challenge when families are in crisis. The true measure of interdisciplinary work is the change in behaviors of professionals in "letting go" of their personal reactive responses and sense of individual responsibility to family crises to support the work of the team. When families contact program staff in the midst of a crisis, or when clinicians have concerns for the safety of children in the home, individual professionals tend to fall back on crisis intervention approaches. Faced with tight time lines,

clinicians must respond in a way that reflects their application of known best practices. These approaches make team planning more challenging and often result in tensions among team members. Based on the professional training model of each clinician, different aspects of the crisis situation come to the forefront of concern. Often the intensity of one professional's concerns could overwhelm further planning. However, the repertoire of best practices can expand within the interdisciplinary framework. Part of that practice must include detailed communication with the entire team involved with the family. Ideally, the crisis situation initiates a review of services by the team and a unified response.

An example in the Los Pasos clinical setting will help illustrate the different approaches to a child with observed loss of weight at risk of failure to thrive. Without a team to rely on, the medical professional might demand a referral to child protection authorities based solely on the medical findings of poor weight gain and medical problems found at a clinic visit. This tendency to refer had been the standard procedure as the medical provider working in isolation lacked input from others who might have known the family better and had greater amounts of contacts. As the interdisciplinary model evolved, the medical professional could call for a staffing with the team to discuss emergent concerns and possible interventions. With the team present and based on an interdisciplinary approach, further information about family functioning might clarify how to intervene in a meaningful way to correct the medical and family support issues simultaneously. Appropriate intervention might postpone the purchase of expensive nutritional supplements as a medical intervention while the family

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found a place to live or completed an application for financial support of the child. The medical professional arrives at a better understanding of the family's situation when other team members report that, during a home visit, they observed emotionally supportive behaviors of the parents toward the children. Important documentation that the family did not intentionally neglect the needs of the children is produced. With this new understanding, the service plan then undergoes revision to recognize social interventions as the first steps and nutritional and medical interventions delivered in a stable home setting. Although it is difficult for professionals to not have their prescribed interventions recognized as the first priority in the work of a team, this must happen.



Summary

The behavioral changes among professionals in interdisciplinary work have strong practice implications for truly meeting the broader needs of families. It is the willingness of team members to trust their colleagues' professionalism and common goals for the family that distinguishes true interdisciplinary team function. Without committing to the trust in the team, the tendency to apply reactive interventions threatens the integrity of the integrated services model that distinguishes how the Los Pasos and its affiliated programs have achieved successes with families.

Clinicians working with families affected by prenatal substance use or other high risk factors are faced with difficult decisions each day. The complexity of the families' lives and their multiple social, medical, educational,

and legal needs present a program staff member with a burden that is very challenging. One reason that AIA programs have been drawn towards interdisciplinary practice is that working in this mode increases the likelihood that families will be better understood, that they will receive optimal care and services, and they will report greater satisfaction with the care they receive. An equal result is that individual team members will not be individually overwhelmed by the burden of the family's issues and that they, too, will experience greater job satisfaction knowing that the outcomes for their families has improved. In this sense, interdisciplinary practice is a "win-win" model.

The interdisciplinary practice model developed in Los Pasos (and enhanced through the UNITE Project) uncovered several additional important concepts to how teams work. Interdisciplinary team work is arduous and time-consuming. It requires a suspension of belief in one's own invincibility as a professional/paraprofessional in making decisions about families to whom we, as individuals, may be committed. It demands an acceptance of shared decision-making and service planning and a strong belief that through this process, and in collaboration with the families, the families will be better off.

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The Los Pasos and GRO Programs in New Mexico have developed a way to promote interdisciplinary practice through their UNITE curriculum. For additional information concerning this curriculum, refer to its web page at: <http://star.nm.org/unite>.

Special recognition is given to the team of professionals who developed the UNITE curriculum: Dr. Andrew Hsi, Dr. Jane Clarke, Law Professor J. Michael Norwood, Professor James P. Richardson, Dr. Rose Hessmiller, Ms. Bebeann Bouchard, Dr. Alice Chernofsky, and Dr. Leslie Cunningham.

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PEERS AS PROVIDERS: LESSONS LEARNED FROM MIAMI'S PROJECT SAFE

Project SAFE (Stopping Abandonment through Family Empowerment) is an AIA-funded program at Children's Home Society, Inc. in Miami, Florida. Project SAFE uses an intensive family preservation approach to prevent abandonment of children living with or affected by HIV/AIDS and/or drug exposure. This model relies centrally on peer interventionists to provide outreach, client engagement, client advocacy, counseling, and in-home supportive services. Reflecting the targeted population, *peer service providers* (PSPs) at Project SAFE have been primarily women of African American or African Caribbean descent, either living with HIV/AIDS, recovering from substance abuse, or both. These peer staff are paraprofessionals with entry-level academic training, who share with their clients similar life experiences and sociodemographic characteristics. Project SAFE supports PSPs through professional clinical consultation and supervision, training, and supportive group counseling.

Few guidelines exist to assist agencies with the complex issues of PSP staff. The use of recovering persons and persons living with or affected by HIV disease as PSPs requires special considerations and adaptations by both agency and PSPs. Project SAFE has developed an infrastructure to support PSPs. As particular challenges have emerged, the organization has learned to recognize the personal strengths, capabilities, characteristics and needs for support and supervision of these unique personnel. This article highlights some key issues of PSPs and Project SAFE.



The Evolution and Benefits of Peer Roles in Service Delivery

Peer service providers, that is persons who share racial, ethnic, gender, and socioeconomic commonalities and/or life experiences with a program's target population (Cheney and Merwin, 1996; Janz et al., 1997), have long been involved in the delivery of direct services. Programs that use PSPs have been found to positively impact client outcomes—in client awareness of problems, utilization of community resources, enhanced social support, reduced social isolation, retention, and satisfaction (Knox, 1996; Janz et al., 1997; Britt, 1998)—particularly among inner city African-American women (Sung et al., 1997). Since the early years of the AIDS epidemic, persons indigenous to the highest risk populations have become activists, advocates and PSPs, creating appropriate and responsive HIV/AIDS service delivery systems. This is not unlike groups such as AA and NA in the addiction arena, where recovering persons are essential to the recovery process. When adequately supported, PSPs can benefit clients, agencies and themselves.

CLIENT BENEFITS

Services provided by PSPs are informed by direct personal experience, and thus offer clients an understanding that providers not personally affected by these illnesses can only approximate. The life experience legitimizes the PSP in a way

trained professionals are often unable to represent. Thus the chasm between clients seeking services and providers of services is bridged in a more positive, less tentative manner. For the client, the body of shared knowledge and experience exists as a foundation to foster trust building and work toward addressing delicate, critical life issues. PSPs also bring to clients an example of what may be called "balance in life" among health, children/family, some form of spirituality, work, and other responsibilities, with a focus on other-directed action and proactive self-care rather than one's pain, regrets, and oppression. Clients thus see PSPs as models of new behaviors and sources of support and identification.

BENEFITS TO PSPS

The process of mutual aid has reinforcing reciprocity for both recipients and helpers (Festinger, 1954; Jaques and Patterson, 1974). Three key areas of benefit accrue to PSPs. First, regular and meaningful employment can provide PSPs with resources that may enhance their overall functioning, as well as the quality of their lives, by providing a sense of purpose, self-esteem, self-efficacy, and social support. Second, there are financial and job skill enhancement benefits for PSPs such as access to regular income, health insurance, training in transferable job skills, educational possibilities, and opportunities to build resumes for future employment. Finally, PSPs are afforded the opportunity to recognize their capabilities to participate as active

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community members. As role models for others, they are recognized, encouraged, valued, and reinforced for continuing their own struggle for health and life. In turn, their own self-image is bolstered and supports their health care compliance and/or continued recovery process.

BENEFITS TO AGENCIES

Agencies benefit from the presence of PSPs who serve to increase client access to and utilization of available services. Agencies may find that PSPs improve the cost effectiveness of services, expedite client engagement, and lead to more effective intervention based on more holistic knowledge of the client's reality. Finally, PSPs serve as important reminders that bureaucratic health and human service systems exist to humanely respond to the authentic needs of real human beings.



Lessons Learned

Among the greatest lessons learned at Project SAFE is recognition of the complexity of establishing and maintaining PSP involvement. Observations from clinical case consultations, supervision, administrative staff meetings, interviews with PSP staff, and the literature have crystallized three dimensions of working with indigenous PSPs: (1) the benefits and liabilities embedded in the PSPs' and clients' similar life experiences; (2) the PSPs' capacities for critical thinking; (3) and the PSPs' culturally based values of personal reciprocity and collective responsibility. PSPs also face various workplace challenges including their credibility with professional colleagues, and their acculturation to and understanding of agency or workplace demands.

SIMILAR LIFE EXPERIENCES

Work with complex, often hard-to-engage clients and their families, relies upon alliances of trust. Such alliances, in turn, are built upon the type of frank, insightful, mutual relationships that PSPs are uniquely positioned to establish. PSPs can reflect on similar life experiences. They, too, live with HIV, recovery, histories of trauma and violence, homelessness and poverty, discrimination, and oppression. They have been "in the life" and they know its "trade secrets." Peers possess a real life understanding of their clients' experiences that is uniquely theirs and one of the "many ways of knowing" (Hartman, 1990). PSPs recognize this as unique knowledge and their special asset. They rely upon it to engage clients by pointing to their common experiences and circumstances, and to reassure clients of the possibility of an empowered life. PSPs reframe risk behaviors as maladaptations to stressful situations rather than individual pathologies. PSPs confront client behaviors of denying, minimizing, backsliding or covering up, because the PSP knows these behaviors through her own previous repertoire of coping strategies. PSPs also rely upon their specialized knowledge to successfully and relatively safely enter parts of the community that an inexperienced outsider would be unable or unwilling to penetrate.

If similar life experiences are a PSP's signature asset, they are also, at times, her nemesis, for they pose the risk that she may over generalize from her life to clients' lives. She may impose her successes on clients with an 'I did it, and you can too' tone. She may transmit expectations to clients to establish and meet goals that are not reasonable. Work with clients whose experience parallels her own history may precipitate persistent feelings of shame and regret. For example, for some PSPs, the client's story

evokes the insurmountable pain that their own past behaviors and conditions have directly harmed their children through perinatal HIV transmission, drug exposure at birth, physical and/or emotional neglect, physical abuse or failure to protect a child from the abuse of others. Issues of jealousy may confound the working relationship between the client and PSP. Observing her likeness to her "successful" PSP, the client who has not achieved sobriety or health care compliance may see in the PSP not a realistic role model, but someone who has either unattainable strengths, very good luck, or both.

MESSAGE FOR SUPERVISORS

To cope with and serve clients who are "like them" in history, who evoke "old tapes" and trauma remnants, PSPs need skillful, specialized supportive supervision. A central component of supervision is to assist PSPs to recognize, reduce and deal with counter-transference. Supervisors need to guide PSPs to utilize their own experience as a "knowledge base" from which to begin organizing information about clients while simultaneously acknowledging the inherent bias in looking through their own lens at client situations. Client-provider relationship dynamics and boundaries have to be delineated with frank discussions regarding self-disclosure and appropriate responses to client needs or crises. The concept of empathy must be defined; differentiated from the presumption of cognitive, emotional, and behavioral parity with the client; and taught and modeled as an intervention strategy. The "old tapes" and trauma remnants need to be countered actively in supervision. Finally, supervisors of PSPs must be astute about the

impact of substance abuse recovery and HIV/AIDS health maintenance issues, in order to effectively assist PSPs in optimizing and maintaining healthy lives to meet the demands of regular employment.

CAPACITY FOR CRITICAL THINKING

First-hand experience in strategies vital to surviving while “in the life” translate into yet another of the PSP’s signature assets. When behaviors, which may in other contexts be viewed as “manipulations,” are reframed as coping strategies, PSPs are found to bring well-evolved critical thinking and clinical insight to their work. Although their thinking at times is individualistic and based heavily on personal experience, as noted above, it is nonetheless analytical, keen, and penetrating. PSPs see the “meanings behind the words,” and know whether to accept or reject a statement made by the client without accepting or rejecting the person. This is a very basic critical thinking skill that eludes many, including many professionally trained service providers. In a similar vein, PSPs at Project SAFE also demonstrate unique clinical astuteness. While their data may often rest on intuition, and their choice of words to describe their observations of clients and contexts may not be technical, their insights and words are apt and plainly expressed. For example, PSPs at Project SAFE are able to perceptively assess and then be direct and clear when helping women recognize and clarify the impact of painful childhood experiences (e.g., child sexual abuse) on current risk behaviors, or when helping women to see relapse precursors.

MESSAGE FOR SUPERVISORS

Peers, by virtue of their backgrounds, have usually had limited access to educational opportunities that would broaden and enhance their experiential knowledge. Peers may also differ in their aspirations to obtain further formal education. As individuals, PSPs also differ in their ability to think abstractly and broadly, as well as concretely and narrowly—with each level obviously necessary to serve the complex clients seen at Project SAFE. The importance of well-designed, culturally fitting, participatory training and staff development, along with targeted supervision, cannot be underestimated.

Supervisors need to validate PSPs’ ability to do what they do expertly, that is to see the meanings behind the client’s words, while simultaneously: (a) challenging them to consider the subjectivity of interpretation and the need to seek more objective information; (b) helping PSPs to include alternate frameworks and theories for understanding client problems; and (c) moving PSPs from an exclusive reliance on analyzing client situations through their own individualistic and personal experiences to that which is specific to the client.

Second, case-specific clinical supervision and consultation help PSPs to: (a) understand clients who do not acknowledge their needs or accept intervention, and who resist alliance or, in spite of it, are unable to move toward better health and personal management and/or recovery; and (b) think comprehensively about services to clients who require interventions at all levels from the most practical and concrete resources to the

most complex medical, psychological, and social service intervention.

Third, a central supervisory and staff development task entails assisting PSPs to incorporate relevant knowledge from the professional literature, thus widening their capacity for objectivity and understanding. Structured, regularly scheduled in-service training in broader, more generalizable and evidence-based knowledge is necessary for PSPs. This helps to ground them in knowledge about the types of clients they serve, the problems (e.g., counter-transference, occupational stress and burn-out) they themselves may experience as providers, the relative effectiveness of the types of services they provide, and the many confounding factors that operate in clients’ lives to offset the benefits of the best of services and interventions (Hiatt, et al., 1997).

PERSONAL RECIPROCITY AND COLLECTIVE RESPONSIBILITY

Many PSPs come to their jobs with a desire to help people because someone helped them at a critical point in their lives (Jaques & Patterson, 1974). Humanism, altruism, and the desire to “give back” in appreciation for help that they received typify PSPs at Project SAFE. With this intention to give back co-exists the belief that they *can* help and *can* make a difference in clients’ lives. The concept of “giving back” or personal reciprocity, combined with a value of collective responsibility, are fundamental in African American culture in such slogans as, “it takes a whole village to raise a child,” and “I am because we are; we are because I am.”

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Convictions of personal reciprocity and collective responsibility motivate, justify, and sustain PSPs' work with their clients. However, these convictions, at times, can foster unrealistic self-expectations. They can encourage PSPs to try to be available at all times and in all ways to clients, a sure prescription for emotional exhaustion, sense of failure, and ultimately detachment—the classic ingredients of occupational burn-out.

MESSAGE FOR SUPERVISORS

At Project SAFE, the character of the African American community, as any other diverse community, has to be understood and respected by supervisors. It's important to successfully resist imposing Anglo-centric perspectives on the work of PSPs of a culture different from the supervisor's. In a context of cultural acknowledgment, supervision requires emphasis on PSPs' tendency to over-identify with the client, to protect and to "fix" the client, and the discomfort associated with watching a client go through difficult change processes. Supervision spans clinical tasks by helping PSPs to understand their own motivations and behaviors while simultaneously helping PSPs understand how these may impact their work with clients. Supervisors should assist PSPs in reflecting on their own needs and experiences and in translating how, at times, these may interfere with the client's sense of mastery, self-efficacy, and empowerment. Discussion of appropriate interpersonal boundaries is often useful, and this may include discussion of specific behaviors that are appropriate to PSPs' occupational role. Supervisors should also

work with PSPs to rehearse, perhaps in a structured role-play, specific words to use with a client. For example, the boundary of time availability to the client may be communicated by helping the PSP to use phrases like: "I understand that sometimes you might feel very afraid because of HIV, and that you may want to get high to numb the feelings. Let's talk about when you should call your sponsor, when you should call your doctor, and when it's appropriate for you to call me . . ."

STATURE AND CREDIBILITY WITH PROFESSIONAL COLLEAGUES

In programs that employ PSPs, the issue of power cannot be minimized. To serve as a PSP employee, selected for illnesses and attributes that correspond to those of the clientele, and often serving under the direction of those not so affected or so characterized, is to regularly confront credibility problems associated with outsider/insider or amateur/expert issues. Supervisors may be frustrated to find that their expertise is insufficient for supervision of workers whose practical knowledge and skill in engaging and assessing clients far exceeds their own. Peer workers may see themselves "teaching their supervisors" and in some cases helping their supervisors "save face" for their naiveté.

Moreover, PSPs operate in the external interagency environment. Because PSPs are recruited for their similarities to a targeted client population, they may have little formal education, work experience, or formal job training. Moreover, Project SAFE PSPs are assumed, in the human service community, to be women who probably once used drugs, at one time may have been on the streets, may have been jailed, and now may have HIV. Hence, PSPs must continually

reckon with not only a range of accurate and inaccurate negative assumptions about themselves and associated credibility problems when working with academically credentialed professionals (Ashery, 1993; Hiatt et al., 1997), but also with frequent self-confrontations with painful pasts.

Thus, the opportunity to be primarily a human service provider, and not primarily a person co-terminus with a stigmatized history eludes PSPs. There is little opportunity to "simply be," free of a history that actively follows them. Yet the PSP often experiences a shifting identity as a service provider, potentially accompanied by feelings of role conflicts as she leaves "the life" farther behind and her work increasingly differentiates her from the client community she was hired to represent and engage.

MESSAGE FOR SUPERVISORS

To counter issues of credibility, supervisors should structure opportunities for colleagues to witness the contributions PSPs can make. Supervisors should model, in front of other professional providers, behaviors that support and further the credibility of the PSPs. In professional meetings, supervisors should insure that PSPs are fully seated "at the table" with other providers rather than in an outside observation circle. Supervisors should draw the PSP into the discussion, asking for her observations and thoughts about the topics under discussion. At times, the supervisor may "translate" the PSP's observations, or re-phrase them to the group, in a manner that validates the PSP's perspective. One important strategy the supervisor can adopt is to use "plain English" in multi-disciplinary discussions, in an effort to create a language that reduces professional jargon and is more inclusive.

WORKPLACE ACCULTURATION

For some PSPs, their present position may be their first employment in many years or in a lifetime, and challenges may arise not only in learning job-related content and skills, but in areas involving the workplace culture and its norms. These may include the importance placed on arriving to work on time, selecting appropriate workplace attire, tolerating normal workplace interpersonal tensions without personalization, speaking in modulated tones in offices and hallways, controlling coarse language, managing anger effectively, and dealing with authority figures and organizational rules. Particularly for PSPs living with HIV, adherence to medication treatment regimens while on the job, scheduling time off for routine medical appointments, and unexpected illnesses or hospitalizations all comprise another order of work-related issues that must be managed.

The PSP role also has substantive aspects that must be mastered, and which may require special supervisory and training support. For example, for PSPs with educational and literacy limitations, effective documentation of client data, including psychosocial assessments and progress notes, and general case record maintenance, can be difficult. The values and ethics of client confidentiality may also prove confusing and challenging, especially when PSPs find that they “know” some of their clients from past times when they, too, were “in the life,” or when several PSPs are acquainted with a particular client, or when a home visit takes a PSP to a familiar neighborhood where she is recognized. Mandatory reporting laws, agency protocols for critical incident management, and professional liability parameters are especially important areas for supervisor attention.

MESSAGE FOR SUPERVISORS

For newly employed PSPs, individual assessment of basic work-related habits, skills, attitudes, and knowledge, along with direct information and performance feedback, are critical to success. This process requires an open, mutually respectful, collaborative relationship between PSPs and supervisors, in which both share the goal of ensuring the PSP’s personal competency and effectiveness with clients and in the work environment. If indicated, supervisors should intervene in areas as basic as planning what time to set an alarm clock, the colors and styles of a workplace wardrobe, how to establish a bank account, who to call in the event of an unplanned absence, basic telephone skills, and interpersonal communication and conflict resolution skills. PSPs also need instruction and reinforcement in basic liability and risk management issues as well as values and ethics that guide human service work.

Supervisors must also assist supervisees living with HIV and/or recovering from substance abuse to recognize the warning signs of symptomatic illness or relapse, to schedule work responsibilities around planned medical appointments, and to anticipate and deal with disclosure/nondisclosure issues. For example, a client known to the PSP from the past may press the PSP for personal information about her recovery or health status. Similarly, the PSP may need to decide whether disclosure of her own history and present circumstances is a helpful, strategic intervention, or whether and how to disclose to agency and community colleagues, and in what settings and contexts.



Conclusion: The Central Lessons Learned

At Project SAFE, we have learned that:

- Operating PSP-based programs in a manner that simultaneously assigns high priority to clients, agency/program goals, and the well-being of PSPs is a complex endeavor.
- PSPs require skillful, dedicated, and specialized supportive supervision.
- PSPs need help to think holistically about services to clients with multiple needs that range from practical and concrete resources to complex health, mental health, and substance abuse interventions.
- Knowledge from professional literature needs to be incorporated into PSP training.
- Cultural norms of personal reciprocity and collective responsibility can produce self expectations for PSPs that need to be examined and modified in supervision.
- Lack of academic credentials and a personal history of stigmatized behaviors may pose obstacles to comfortable, affirming working relationships with clients, agency and community. Supervisors should support PSPs in their unique status.
- PSP supervision requires an open, mutually respectful, collaborative relationship, based on shared goals of advancing PSPs’ personal competency and effectiveness with both clients and within the work context.

While some may argue that use of paraprofessional staff represents cost savings to agencies, programs that employ PSPs must unequivocally give high priority to task supervision, clinical supervision, educational supervision, emotional support, and a solid training infrastructure.

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To maintain a high level of peer staff efficacy, sufficient resources must be allocated to dedicated and consistent supervision. In the end, however, Project SAFE has learned that PSPs provide unique knowledge and skills that greatly further a program's effectiveness.

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CALL FOR ARTICLES

The National AIA Resource Center is soliciting articles for the winter 2002 issue of *The Source*. The Center publishes this newsletter three times per year and distributes it to over 2,000 administrators, policy makers, and direct line staff throughout the country.

This issue will focus on **partners of substance abusing women**.

Specifically, we are looking for articles that (1) discuss the role of fathers and partners in families affected by substance abuse; (2) discuss challenges and strategies for engaging partners in the recovery process; (3) review model programs that include partners in recovery services for women; and (4) discuss innovative services for partners in recovery.

To be considered for publication, please send/fax/email a brief (150-200 words) abstract of your proposed article to the AIA Resource Center at the address below. Abstracts are due no later than Friday, June 29, 2001. Authors of accepted articles will be notified within a few weeks of the deadline.

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GROUP THERAPY TO ASSESS AND ADDRESS WOMEN'S EXPOSURE TO VIOLENCE

Project Stable Home is a Los Angeles-based, AIA-funded demonstration project that has been in operation as part of Children's Institute International since 1993. The program is designed to assist pregnant women and families of children from birth to age five who are vulnerable to abandonment as a result of parental substance abuse, HIV status, mental illness, poverty or other risk factors. Project Stable Home (PSH) is free of charge to clients and offers a variety of home and center-based services including parenting and child development education, group and individual psychotherapy, developmental assessments, nurse consultations, and speech and physical therapies.



Exposure to Violence

In recent years, we have learned that the vast majority of Project Stable Home (PSH) clients have had experiences with sexual, domestic and/or community violence. This finding is not surprising given the relationship between exposure to violence and substance abuse (Sampson and Lauritsen, 1994; Miczek, DeBold, et al., 1994). Yet, clients typically do not offer this information readily and it has often been difficult to elicit.

While the specific dynamics of the women's reluctance to divulge their histories were as varied as the individuals with whom we worked, there seemed to be a common thread. That is, many clients appeared to organize their internal world into "little boxes," many of which were carefully buried. This coping strategy, which was originally adaptive and perhaps even necessary for survival,

eventually became a mantra to "leave the past alone." However, without the knowledge of clients' exposure to violence, the acquisition of accurate histories was impossible, the development of effective interventions was limited, and the production of useful research outcomes was adversely affected.

Until a picture of the clients' early environment is available (e.g., in terms of the frequency and severity of violence as well as mediating variables), elements of emotional, behavioral and cognitive development might remain unaddressed. Further, until clients are able to acknowledge that they experienced violence, they cannot fully understand what constitutes a safe environment for them or their children.



Obstacles to Disclosure about Violence

Over time and with the development of long-term relationships with clients, the PSH team was able to identify the following key obstacles to disclosure regarding violence: (1) clients had a restricted definition or conception of what constitutes violence; (2) staff did not inquire whether clients witnessed violence; and (3) client schemas frequently held some variation of the belief that "I wasn't abused, I was just bad." It was often many weeks into a therapeutic relationship, and after considerable dialogue, that clients finally asked if experiences such as having been pushed down stairs, having their pets hanged to death or siblings chained to a post would be considered "violent."



Intervention

To address these obstacles, PSH developed a 12-week psycho-social-educational intervention and prevention group for women who had experienced or witnessed some form of violence, as an adult or a child, or who we suspected had been exposed to violence. As we later learned, about 50% of all these women had become perpetrators of violence as well; so, we subsequently incorporated an anger management component.

To limit distractions, childcare was provided during the group and, to encourage attendance, a weekly raffle of children's toys or supplies was added. The goals of the group included: (1) increasing awareness of what constitutes violence; (2) generating a basic awareness of how violence and fear of victimization may become part of an individual's relationships, internal world, and behavioral repertoire; (3) providing alternative, non-violent strategies and behaviors for problem-solving; and (4) educating clients about the impact of exposure to violence on infants, toddlers and young children. Weekly discussion topics were initially selected on the basis of group members' expressed interests. They included: safety planning; the many ways anger may be expressed; identifying and understanding triggers and cues; the cognitive and physiological elements of anger and rage; gender, culture and social influences as they relate to family violence; stress reduction techniques; trauma and psychological

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symptoms; substance abuse and violence; and the effects of violence on children, with a particular emphasis on infants and toddlers.



Richters' Screening Survey

One tool, traditionally used in research, was introduced to the group and turned out to provide a significant clinical benefit. During the early weeks of the group, the facilitators asked the women to complete an exposure to violence measure called the Screening Survey of Children's Exposure to Community Violence (Richters, J.E., 1990). This instrument is a 51-item profile, with parent and child versions, that assesses 20 forms of violence that children may be victims of or witnesses to in the home and community.

Group members were asked to complete the child-report version for themselves, looking back on their own childhood. This process seemed to expand the clients' understanding of what constitutes violence. It also helped to generate awareness of what their children may have experienced. The result was often enhanced empathic attunement to their children's thoughts and feelings as the mothers recalled memories of their own experiences. This adult-as-child reporting process also appeared to reduce the guilt, fear and denial that the facilitators have found to be elicited when parents complete the measure about their children rather than themselves.



Findings

Results from the Richters' measure suggested that clients had been exposed to violence considerably more than they

had previously reported. For instance, while 50% of the group members reported having been "slapped, hit or punched by a family member" as a child, or "attacked or stabbed with a knife" as an adult or child, only half of these clients had earlier responded affirmatively on AIA intake measures regarding a history of physical abuse. Further, virtually 100% of the group participants reported having "seen someone being slapped, hit or punched by a family member." More than half of the women reported having been "sexually assaulted, molested or raped," most often as a teenager; yet, only 75% of these women had responded affirmatively on the AIA measure's query for sexual abuse history.

The specific and repetitive nature of the questions on the Richters' measure allowed the two group facilitators to learn more about both the parent's and child's histories and present circumstances, as client responses were discussed, elaborated on and processed during the group. In addition, group members realized that they were not alone in their experiences or their feelings about them, and consequently sought or accepted, perhaps for the first time, support and strength from other women.



Shoeboxes

Once clients reached that point, the facilitators provided an opportunity for the mothers to create a picture of some of their internal "compartments," to bring image and light to the "little boxes" created long ago. Group members were each given an empty shoebox and asked to make a collage using magazine words and photographs, tiny objects, crayons and markers. They were asked to decorate the inside to look like their childhood felt. The out-

side was to look like they imagined they appeared to others.

One particular box seemed to speak for many of the women in our groups. The outside was decorated with pictures of cans of paint in many bright colors. On the inside were photographs of an empty bowl, an AK47, a bottle of gin and a skeleton.



Conclusion

Clearly, exposure to community and domestic violence is a crucial, historically under-reported element of our clients' lives that impacts their recovery process. Over the years, we have learned that women struggle in recovery if they do not deal with issues related to their violent pasts. In response, Project Stable Home has created a program that uses tools to help clients understand violence; provides a safe space for women to come to terms with and disclose their violent pasts; and uses creative interventions to help women deal with their pasts and break the cycle of violence.

Janene Boller, M.A.

Program Coordinator, Project Stable Home

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- Richters, J.E. (1990). *Screening Survey of Children's Exposure to Community Violence*. Rockville, MD: National Institute of Mental Health, Child and Adolescent Disorders Research Branch.
- Sampson, R. J. and Lauritsen, J. L. (1994). Violent Victimization and Offending: Individual, Situational and Community Level Risk Factors. In *Understanding and Preventing Violence*, Vol. 3, A.J. Reiss, Jr. and J.A. Roth, Eds. Washington, DC: National Academy Press.

THE NEW START PROJECT: CREATING A SYSTEM OF INTERVENTION

The New Start Project was launched in 1996, with funding provided under the Abandoned Infants Assistance (AIA) Act, to expedite the placement of neonates in Essex County, NJ. By 1995, it was evident that Essex County suffered a serious boarder baby problem. It was estimated that in 1991, Essex County accounted for 10% of all boarder babies identified in the country (James Bell Associates, 1993). Newark, which represents the largest city in the State of New Jersey, accounted for a large portion of these cases.

Several factors contributed to the problem. One was a shortage of appropriate placements for newborns who were ready for discharge but unable to leave the hospital with their parents. Another was inadequate coordination among the state child welfare agency, community agencies, and hospitals serving neonates in the county. A third was poor prenatal planning and care among pregnant women.

The Project developed to address these gaps was originally called the Newark New Start Project and limited to births in the City of Newark. By 1998 the Project had been extended countywide, and the name was shortened to the New Start Project.



The Program

The New Start Project is defined by several important characteristics.

- (1) The lead agency is a public entity. The Division of Youth and Family Services (DYFS) is the child welfare agency for the State of New Jersey, and also serves as the state's adoption agency. The burden of developing a solution to the boarder baby problem fell to DYFS.
- (2) Given the extent of the boarder baby problem in Essex County, the Project represented an attempt to develop a countywide system of intervention. Specifically, all newborns in Essex County who are identified as potentially at risk for infant abandonment by hospital social work staff are targeted for inclusion in the program. In its first three years, the New Start Project was responsible for the evaluation of and placement planning for over 1,900 infants. Given the large number of infants involved in the program and the lead agency's mission, the focus to date has been on expediting permanency.
- (3) Interagency collaboration is integral to the design of the project. As a countywide system for working with the entire population of at-risk

newborns, no single agency would be able to help all the children achieve permanency in a timely manner. It required the cooperation of hospitals for the identification of at-risk infants; the state child welfare agency to provide evaluation and permanency planning services, as well as coordination for the system as a whole; and local agencies to provide family support and expedited community-based evaluation services. The New Start Project now includes all eight hospitals and six DYFS offices serving Essex County, and a series of community agencies offering initial family assessment services, intensive family interventions, and substance abuse treatment.

The Project attempts to expedite permanency in several ways. First, the hospital protocol is intended to raise consciousness among hospital staff about factors that potentially place an infant at risk for abandonment. Second, additional DYFS staff have been placed in the hospitals to expedite referral to DYFS. Third, two community agencies have been contracted to conduct evaluations of the family of origin and, in cases where the family of origin does not represent a suitable placement, alternative placements identified by the family of origin. Fourth, other community agencies have been charged with

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providing family/caretaker support services in the areas of substance abuse and family support. Fifth, efforts have been made to expand the number of available foster care sites and adoptive families in the region.



Interagency Collaboration

One of the major obstacles faced in developing the New Start Project was the lack of existing interagency collaboration at the time it was initiated. Most of the agencies responsible for child and family services in Essex County had never worked together before. In addition, there was a mutual sense of mistrust, based on prior perceptions of each other, that needed to be overcome. Key to the success of the project from the very beginning was overcoming these obstacles to collaboration. The first step was the development of a series of protocols governing interagency collaboration. For example, a protocol was developed for the hospitals listing the characteristics that define an at-risk newborn, guidelines for using external agencies to conduct family evaluations, guidelines for determining appropriate community referrals, and time frames for completion of these evaluations and referrals. Similar protocols were developed for DYFS workers and for each of the key community agencies involved in placement evaluation and service provision. These protocols clarified the responsibilities of each agency, and reduced the opportunities for misunderstandings to occur.

Since the establishment of the protocols, collegial interaction has been fostered by monthly meetings open to all participating agencies. These meet-

ings typically have about 20 attendees, representing at least 10 organizations. All agencies involved in child and family services in Essex County are invited to the meetings regardless of the level of their involvement in the New Start Project. These meetings are used to discuss continuing obstacles to service, review utilization statistics and program outcomes, address problems with the protocols, identify additional community resources, discuss future directions for the program, and (perhaps most importantly) enhance the sense of collegiality and collaboration among participant agencies. Meetings frequently address the unique circumstances that have interfered with placement of a specific child, with the goal of developing a placement plan as a group. The landscape of family services in Essex County is now very different than it was three years ago. The New Start meetings help set the agenda for child welfare services for all newborns in the county.



The Population Served

The population served by the New Start Project is extremely needy. Data gathered in one of the participating hospitals indicated that over 96% of the mothers referred to the program were unemployed, over 92% had no insurance, and over 95% were unmarried. The sample was 91.4% African-American. Despite the high rate of unemployment, over 21% were receiving no public assistance at the time of the birth. At least 77.1% of the mothers were abusing drugs at the time of their child's birth. However, only 28.4% of drug-exposed mothers were receiving substance abuse services at the time of birth. Another 46.7% had

received substance abuse services in the past, while 24.9% had never received substance abuse services of any sort. Despite research demonstrating a very high rate of psychiatric diagnoses in the substance abusing population, only 2.4% of mothers were receiving mental health services at the time of birth, and 90.8% had never received mental health services.

Over 55% of the mothers had been referred to DYFS previously, and there are instances of mothers giving birth three times since the Project's inception in 1996. Almost 54% of the mothers were rated "unprepared for the baby" by hospital social work staff, and almost 70% were rated as having received no (41.0%), late (8.7%), or inadequate (19.6%) prenatal care. In the third year of the program only 49.6% of births were of normal birth weight (at least 5.5 pounds). Almost 4% of newborns were HIV positive, and over 67% were drug-exposed at birth.



Findings

Despite the size and severity of the problems confronted by the families involved in the New Start Project, outcomes to date have been very promising. Prior to implementation of the program, mean length of stay after medical clearance for newborns referred to DYFS was 41.7 days. In the last three years, infants referred to the New Start Project have spent an average of 10.5 days in the hospital after medical clearance. This mean is elevated by a small number of medically fragile infants for whom out-of-home placement is difficult to arrange. The modal number of days after medical clearance was less than one (27.6% of New Start

births), and the median (dividing the top and bottom half) was 4 days.

Although outcome data are sparser than data associated with hospital discharge, there is evidence that caregivers who participate in services after discharge from the hospital on average receive more financial support. The majority referred for substance abuse or other community-based programs participates effectively, and in most cases their children's immunizations are up to date. Furthermore, a substantial number are enrolled in educational programs.

Despite these promising findings, the results are not definitive. The primary obstacle to resolving the boarder baby problem countywide is the sheer enormity of the problem. Only 43% of newborns are discharged to their mothers. Another 28% are discharged to DYFS to seek permanent placement. The remaining newborns are discharged to placements in the community with other family members or significant others. Alternative placements, whether in the community or with DYFS, require more extensive assessment and placement efforts. Furthermore, the available pool of alternative placements, whether in the community or foster care, is insufficient for the number of infants requiring placement.



Future Plans

The continuing nature of the problem, coupled with the large proportion of mothers previously known to DYFS, suggests the need for a more proactive approach to the problem of infant abandonment. Plans are now in progress to intervene more extensively with pregnant women by beginning the permanency planning process in utero with women known to DYFS who are pregnant.



Lessons Learned So Far

The goal of any boarder baby program should be the elimination of infant abandonment. The New Start Project has attempted to tackle this issue head-on. Success for us is nothing less than the end of infant abandonment in Essex County, NJ. So far, the goal has eluded us. However, there are several lessons we have learned in the process that we think are essential to achieving lasting improvements:

- (1) The problem will be insoluble without intensive and active interagency collaboration. The term "active" is used here to suggest something more than the traditional process of referring cases from one agency to another. If the New Start Project has succeeded in anything so far, it has been in molding a broad community collaboration around the boarder baby problem. The monthly meetings, the development of interagency protocols, and the collaborative approach to developing solutions have all created a sense of cooperation among these agencies that never existed before. This has worked in the best interests of the children, as a group of agencies becomes invested in identifying a placement solution for every child.
- (2) Achieving this level of collaboration requires ongoing interaction. Occasional contact does not insure the level of cohesiveness essential for making all stakeholders feel that each boarder baby is the responsibility of the entire community of social support agencies.

- (3) Unlike many AIA programs, the New Start Project was not intended to intervene with a child until after birth. We now recognize that this is insufficient to eliminate infant abandonment, and are moving to implement a prenatal, proactive component. However, there is no way to insure that all at-risk mothers are involved in services prior to birth. For this reason, we believe that expedited planning at the time of birth is an essential component in a comprehensive program for dealing with infant abandonment.
- (4) The previous goal, prenatal programming, cannot be achieved without the involvement of the local child welfare agency. We recognize that at times the relationship between community agencies and child welfare services can be contentious. However, such negative relationships cannot work in the best interests of children. Through our experience, we have learned that close cooperation and an active, collaborative relationship with child welfare is an essential component in resolving the problem of infant abandonment.

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WAITING TO EXHALE: EXPRESSIONS FROM PARTICIPANTS IN THE TIES PROGRAM

The TIES Program is an AIA funded program that works closely with pregnant and postpartum women affected by drugs and/or HIV and their families in their homes for a period of 18-25 months. Many of the women participate in a bi-weekly “Waiting to Exhale” Women’s Support Group. The members of this group accepted the invitation to prepare something for this special edition of *The Source*. The unity, commitment, and excitement of the TIES moms was amazing. Their camaraderie, creativity, and writing skills were evidenced as they came together and completed this project. Their expressed gratitude and identification of their strengths encouraged the TIES staff. Most of the families have or will graduate from the TIES Program soon. Their collective and individual expressions below illustrate one thing in common: a determination to face and overcome even more of life’s challenges.

Oneta Templeton McMann
TIES Program Director
Kansas City, MO

We have all had babies that have been exposed to drugs. Family Services has entered our lives. We were told to enter a treatment center; we were told of a program called TIES. At first, all of us felt that we had enough people in our lives. Each one of us entered the TIES Program for our own reasons. The TIES Program helped us with lots of things, such as diapers, food for the babies, and rides to the doctors. They also help us with our problems in everyday life. They are there when we need someone to talk to.

I am a 28 year old woman, who had a baby that was exposed to drugs. This was my third child and the first one I ever did drugs with. I am now with my fourth child and have been drug free for over a year. I have been with the TIES Program almost as long. They helped me believe in myself, by believing in me. They have asked me to help with this article and at first I really did not think that I could do it. They had faith in me when I did not. My TIES worker Janice has been a great friend to me and my family. I thank her for that. I am looking forward to having my fourth child and he/she being a drug free baby. I know that drugs were not the answer I was looking for. I just need to believe in myself.

— Julie Taft

My name is Aundretta Gilmore. I am 28 years old, and have three children. The TIES Program came into my life when I used drugs while pregnant. TIES to me is very supportive, fair, and caring. And as far as my own TIES Support Worker—her name is Bonnie Frazier—I can call her day or night, and she is there whatever the case may be. Bonnie and TIES are concerned, and I can tell her anything. She will tell me her opinion, or best judgement. It’s the best thing, and keeps me on the right foot with them and also my Higher Power and my Recovery. Thank You.

My name is Ann Ziegler. My TIES workers are Jackie Metheny and Julie Donelon. The thing I like best about being involved in the TIES Program is the one-on-one interaction with my caseworker, knowing that someone is always available whether it be an emergency, diapers, or just someone to talk to.

My name is Tessie Lewis, and my experience with the TIES Program has helped me to create a support network. Working with my TIES worker Bonnie Frazier, I have found lasting friendship that she expresses by

visiting me at home. She helps me set up appointments for my children such as immunization and special educational needs.

I, Marva Johnson, got involved with the TIES Program when my baby and I were positive for drugs at Truman Hospital. I was very blessed to have a program like TIES to help me in my recovery. I wouldn't be as far as I am today without the TIES Program. They've helped me as far as transportation when I had no way or means. Also when I was in need of personal items for my children, TIES was there. They've made me a better responsible person. I've learned I can do it even when I'm in doubt. I think the TIES Program is wonderful, they can get through to you even just by word of mouth. The TIES Program can reassure you, make you a better, independent person. They also motivate you to strive harder for your goals. They also devote their time and advice to you. Without the TIES Program, honestly I don't know where I would be today. I truly thank God for TIES and Corrie Lange who is my Social Worker.

I met Janice Wiggins in March of 1998, when I went into drug treatment. I was apprehensive about any more workers being involved in my life. As time went on I began to trust and rely on Janice for a

number of things. She became someone I could talk to and tell my everyday hassles to. Even when I took my vacations from everyone and almost gave up on everything, Janice was always encouraging and supportive. As time for me to graduate moves closer I am saddened, because aside from all the help TIES has given myself and child, I will miss Janice and the other women most of all. I have been blessed to be involved with such a kind and beautiful group of women. In conclusion, if anyone is offered to be involved with the TIES program or any other AIA program, I would strongly recommend going for it. I hope that other women in these same circumstances will try to hook up with a TIES program in your area. It could be your only friendly lifeline to get you back on track and back to a better life. With great admiration, Robin and A.J. Shoot

Hi! My name is Rosario Coronado, mother of a 19 year old son, 15 year old daughter and now a beautiful baby girl, the joy of my life, Antonia Rosa-Maria, 16 months old. Reality hit very hard when she was diagnosed positive for drugs at birth and DFS stepped into my life. One of my court ordered requirements was to get into an inpatient treatment center—one that would take both me and my baby. There I met other moms. One who I met told me about her experience with a program called TIES. It sounded good, but at the time I was sort of reluctant. I really did not want any more

people on my butt, (as I put it). So then I met with this extraordinary lady who has been my shoulder to cry on, my Ann Landers for advice, my best friend I can count on for being there for me and my family. She has seen me through my family troubles as well as the accomplishment of moving on with my life. And she is Ms. Bonnie Frazier. When I met her, like I said, I was reluctant. But one thing she did for me, was not to PUSH! herself or the program on me. It wasn't 'til the most darkest of days, alone, that I recalled her and the program. So I picked up the phone and called her. She was there and has been here for me 100 percent, to brighten the darkest of days, ever since then. I feel lucky, thankful and very blessed that she has been part of my life. Today I have grown a little more because she has shared. Like my S.O. says, "Ms. Bonnie is part of our family, which we feel very privileged and honored to have!" As for the TIES Program itself, I have nothing but good things to say about all the ladies and their children and the experience I have had with them. I am very happy I became involved. I've been able to exchange ideas, life experiences, problem solving and just good old cries and pain with them. I will have treasured memories I will never forget. I look forward to my every other Friday meetings and invite you to come and get involved. It sure is well worth it.

Mothers in the TIES Program
Kansas City, MO

AIA PROGRAMS ACROSS THE COUNTRY



Currently, 35 AIA programs are funded through the U.S. Department of Health and Human Services' Children's Bureau under the Abandoned Infants Assistance (AIA) legislation. This includes one National Resource Center and 34 demonstration programs in three different categories: service demonstration programs, relative caregiver programs, and recreational programs for families affected by HIV/AIDS. Following is a list of all of the programs. The programs with an asterisk (*) were awarded new four-year grants on October 1, 2000. Those with two asterisks (**) were awarded four-year continuation grants on October 1, 2000.

NATIONAL RESOURCE CENTER

National AIA Resource Center
 University of California at Berkeley
 School of Social Welfare
 1950 Addison St., Suite 104
 Berkeley, CA 94704-1182
 Ph (510) 643-8390
 Fax (510) 643-7019
<http://socrates.berkeley.edu/~aiarc>
aia@uclink4.berkeley.edu

SERVICE DEMONSTRATION PROGRAMS

Best Beginnings**
 Alianza Dominicana, Inc.
 2410 Amsterdam Avenue, 2nd Floor
 New York, NY 10033
 Ph (212) 923-5440
 Fax (212) 923-5509
ea6@columbia.edu

Bienvendidos Children's Center's, Inc.**

5233 E. Beverly Boulevard
 East Los Angeles, CA 90022
 Ph (323) 728-9577
 Fax (323) 728-3483

Children's Support Network

35 Bird Street
 Dorchester, MA 02125
 Ph (617) 287-1150
 Fax (617) 282-9367

Coordinated Intervention for Women and Children**

Yale Child Study Center
 230 South Frontage Road
 P.O. Box 207900
 New Haven, CT 06520-7900
 Ph (203) 785-4947
 Fax (203) 785-7402
jean.adnopoz@yale.edu

Drug-Exposed Infant Project

Leake and Watts Services
 1529 Williamsbridge Road
 Bronx, NY 10461
 Ph (718) 794-8314
 Fax (718) 794-8201
cmitchell@leakeandwatts.org

Epiphany STAR Project

Mt. St. Joseph-St. Elizabeth
 100 Masonic Avenue
 San Francisco, CA 94118
 Ph (415) 351-4052
 Fax (415) 292-5531
Epiphcntr@aol.com

Family Centered Services Home Visitation Program**

The Health Federation of Philadelphia
 1211 Chestnut Street, Suite 700
 Philadelphia, PA 19107
 Ph (215) 977-8999
 Fax (215) 557-2100
Heloise@hfedu.org

Family Options**

Illinois Department of Children and Family Services
 1921 South Indiana, 8th Floor
 Chicago, IL 60616
 Ph (312) 328-2284
 Fax (312) 328-2714

Family Ties Project**

Consortium for Child Welfare
 300 I Street, NE, Suite 106
 Washington, DC 20002-4389
 Ph (202) 547-3349
 Fax (202) 547-7148
jmenzer@familytiesproject.org

Great Starts

Child and Family Tennessee
 2601 Keith Avenue
 Knoxville, TN 37921
 Ph (865) 525-4794
 Fax (865) 521-5632
jpack@child-family.org

Healthy Families Wichita/Hutchinson

Kansas Children's Service League
 1365 North Custer
 Wichita, KS 67203
 Ph (316) 942-4261
 Fax (316) 943-9995

Los Pasos**

University of New Mexico
 Department of Pediatrics
 Health Sciences Center — Los Pasos
 Albuquerque, NM 87131-5311
 Ph (505) 272-6843
 Fax (505) 272-6847
Gfelton@salud.unm.edu

Mission Inn

Arbor Circle Corporation
 1101 Ball Avenue, NE
 Grand Rapids, MI 49505
 Ph (616) 458-2133
 Fax (616) 458-5430
kgietzen@arborcircle.org

Newark New Start Project**

153 Halsey Street, 3rd Floor
Newark, NJ 07102
Ph (973) 648-3997
Fax (973) 648-7326

Oklahoma Infants Assistance Program**

University of Oklahoma Health Sciences Center
CHO 3B 3406
940 NE 13th Street
Oklahoma City, OK 73104
Ph (405) 271-8858
Fax (405) 271-2931
sharon-simpson@ouhsc.edu

Project ABAN

Illinois State Department of Children and Family Services
100 West Randolph, Suite 6-200
Chicago, IL 60601
Ph (312) 814-6832
Fax (312) 814-1905
dbridge@idcfs.il.state.us

Project Babies

256 North 7th Street
Newark, NJ 07107
Ph (973) 481-2855
Fax (973) 481-1010

Project Lagniappe

Children's Hospital of New Orleans
3308 Tulane Avenue, 6th Floor
New Orleans, LA 70119
Ph (504) 821-4611
Fax (504) 822-2084
bargbrown@aol.com

Project Prevent**

768 Juniper Street, NE
Atlanta, GA 30308
Ph (404) 616-4924
Fax (404) 872-6138
dcarson@emory.edu

Project Protect

The Family Center, Inc.
66 Reade Street, 4th Floor
New York, NY 10007
Ph (212) 766-4522 ext.65
Fax (212) 766-1696
bdraimin@thefamilycenter.org

Project SAFE**

3000 Biscayne Blvd., Suite 210
Miami, FL 33137
Ph (305) 573-2141
Fax (305) 573-3080
evento@chsfl.org

Project Stable Home

Children's Institute International
21810 Normandie Avenue
Torrance, CA 90502
Ph (310) 783-4677
Fax (310) 783-4676
jodennis@childrensinstitute.org

Pro Kids Plus*

Connecticut Department of Children and Families
282 Washington Street
Hartford, CT 06102
Ph (860) 550-6527
Fax (860) 545-9301

Team for Infants Endangered by Substance Abuse (TIES) Program**

Children's Mercy Hospital
2401 Gillham Road
Kansas City, MO 64108-9898
Ph (816) 234-3719
Fax (816) 460-1091
Omcmann@cmh.edu

Vulnerable Infants Program of Rhode Island*

111 Plain Street, Suite 203
Providence, RI 02903
Ph (401) 276-7887
Fax (401) 453-7639
rsoave@lifespan.org

RELATIVE CAREGIVER PROGRAMS

Care for the Caregivers*

New York Council on Adoptable Children
666 Broadway, Suite 820
New York, NY 10012
Ph (212) 475-0222
Fax (212) 475-1972

Family Matters*

Baltimore Pediatric HIV Program, Inc.
2800 Maryland Avenue
Baltimore, MD 21218
Ph (410) 235-3220
Fax (410) 225-0742
bphivp@aol.com

GRO Project

University of New Mexico Health Sciences Center
317 Commercial, NE, Suite 100
Albuquerque, NM 87102
Ph (505) 272-3469
Fax (505) 272-3461
bbouchard@salud.unm.edu

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Bigger Than This Manhattan, 1999. 15 minutes. Available from The Family Center, 66 Reade Street, 4th Floor, New York, NY, 10007. (212) 766-4522, ext. 24; Fax: (212) 766-2779. Email: jhudis@thefamilycenter.org. www.thefamilycenter.org. Cost: \$10.00.

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