

Best Practices in Children's Mental Health:

A Series of Reports Summarizing the Empirical Research on Selected Topics

Report #10 **“Attendant Care For Children and Youth** **with EBD/SED”**

PART I:
REVIEW OF THE NATIONAL LITERATURE
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CONTENTS

ATTENDANT CARE PART 1: EXECUTIVE SUMMARY	1
ATTENDANT CARE IN CHILDREN'S MENTAL HEALTH	4
REVIEW OF EMPIRICAL AND CONCEPTUAL LITERATURE	6
DEFINITION OF PARAPROFESSIONAL	6
HISTORICAL BACKGROUND	6
RESEARCH ON PARAPROFESSIONAL SERVICES	7
<i>THREE MAIN QUESTIONS</i>	7
HOW EFFECTIVE ARE PARAPROFESSIONAL SERVICES AND WHEN, WHERE, AND HOW WOULD THEY BEST BE UTILIZED?	8
<i>MENTAL HEALTH</i>	8
<i>SPECIAL EDUCATION</i>	9
<i>EARLY INTERVENTION</i>	11
<i>SUMMARY</i>	12
WHAT ARE THE ROLES AND RESPONSIBILITIES OF PARAPROFESSIONALS?	13
<i>MENTAL HEALTH</i>	13
<i>SPECIAL EDUCATION</i>	13
<i>EARLY INTERVENTION</i>	15
<i>SUMMARY</i>	16
WHICH QUALIFICATIONS, TRAINING, AND SUPERVISION SHOULD BE REQUIRED OF AND AFFORDED TO PARAPROFESSIONALS TO IMPROVE EFFECTIVENESS, RECRUITMENT, AND RETENTION?	17
<i>MENTAL HEALTH</i>	17
<i>SPECIAL EDUCATION</i>	18
<i>EARLY INTERVENTION</i>	20
<i>SUMMARY</i>	21
IMPLICATIONS FOR ATTENDANT CARE	23
REFERENCES	25
APPENDIX: ABSTRACTS OF ARTICLES	I - XXVI
TABLE 1. LITERATURE REVIEWS	I
TABLE 2. EFFECTIVENESS	V
TABLE 3. ROLES AND RESPONSIBILITIES	XI
TABLE 4. QUALIFICATIONS, SUPERVISION AND TRAINING	XV

Attendant Care Part 1: Executive Summary

Purpose

Attendant Care services are frequently offered to children with emotional and behavioral disorders (EBD) and their families but little is known about best practices in the field. The following pages present a review of the national literature to establish state-of-the-art knowledge about attendant care services. Because no empirical or conceptual literature could be found that specifically described attendant care services for children with EBD, the literature search was broadened to gain knowledge from related fields of practice: specifically, paraprofessional services in mental health, special education, and early intervention. The insights gained from this review have informed an ongoing inquiry into best practices of attendant care in the state of Kansas. Results from the inquiry will be published in a second document (Part 2).

Three main questions recur in the literature:

1) How effective are paraprofessional services and when, where, and how would they best be utilized?

Paraprofessionals are an established part of human services and there is limited empirical support for their effectiveness in improving client outcomes. Paraprofessionals seem most effective in establishing good rapport with clients, providing emotional support, providing information and initiating client contacts with other services, and providing concrete services (such as transportation). Paraprofessional services seem less successful in regards teaching new skills or leading to greater use of other services. The appraisal of paraprofessional services by professional staff and parents is far more positive than outcome data. The primary effect of paraprofessionals seems to be the sense of support experienced by families or professional. There are some indications that the effectiveness of paraprofessional service is influenced by the level of individualization to each client, the level of flexibility adjusting services to changes in client situations, the level of proximity of the attending paraprofessional to the client (how close is too close?), and, the impact of the social position and history of the paraprofessional if he/she is part of the same community as the client.

2) What are the common roles and responsibilities of paraprofessionals and are they appropriate?

Typically, paraprofessional roles and responsibilities include such tasks as assisting a professional in implementing treatment or educational goals, participate in planning and designing of goals, monitoring and managing behaviors, assisting with concrete services such as transportation, teaching living skills, etc.

The roles and responsibilities of paraprofessionals are characterized by high flexibility. Paraprofessionals' tasks tend to change over time and according to field, program and individual client. This flexibility in roles and responsibilities is at once advantage and difficulty. At best it grants a versatility that allows the tailoring of a paraprofessional's role to a specific program or individual. At worst the ambiguity leads to confusions and tensions between involved parties, overwhelms paraprofessionals, interferes with service effectiveness, or alienates the paraprofessional from his or her work. All the more important are a clear initial definition of a paraprofessionals' role and responsibilities,

ongoing communication of these definitions to other involved parties, awareness of cultural and individual factors that influence a paraprofessional's role within his/her community, and the repeated revision and redefinition of roles and responsibilities over time. Notably, the work of paraprofessionals should support but not supplant direct engagement of professionals with the client.

3) Which qualifications, training, and supervision should be required of and afforded to paraprofessionals to improve effectiveness, recruitment, and retention?

Most programs require at least a High School diploma or its equivalent. More important than higher educational degrees are the personal qualities paraprofessionals need to bring, such as empathy and interpersonal warmth, flexibility, patience and persistence, high frustration tolerance etc. Orientation, pre-service and ongoing training are necessary elements to ensure the quality of services. An effective training program should begin with an assessment of learning needs of participants including concerns about safety and comfort, and provide orientation to key components of the program including role and job expectations, needed skills, and confidentiality. The most effective training is based on adult learning principles which allow for self-directed learning and an interactive, hands-on approach focusing on concrete, practical issues. Regular individual or small group supervision by a professional is necessary to ensure the integration of paraprofessionals with the team. Along with content information and oversight, quality supervision allows and encourages reflection upon practice and cultural norms. In order to combat burnout and improve retention, paraprofessionals require monetary and non-monetary signs of respect and appreciation by their teams, supervisors, and administrators, peer support, and opportunities for input, ongoing training and career advancement.

Implications for Attendant Care

It is likely that attendant care workers are most effective and appreciated for establishing rapport, lending emotional support, and providing concrete services. Thus, recruitment of AC workers should ensure they bring not only a High School diploma or its equivalent but personal qualities such as empathy, calmness, flexibility, patience, high frustration tolerance, etc. Pre-service training should include general information about roles and responsibilities, as well as information and exercises about predictable components to their work. Just as important is the understanding that an AC worker's specific tasks will vary with each client's needs, situation, and time. Training and supervision should include detailed assessments of a child's unique situation and frequent re-definitions of AC worker's tasks. A list of individualized skills and skill components should be developed and AC workers will need to adapt and individualize skill training for their client.

AC workers should be thoroughly oriented to the team, values and mission of the program, and to the community and its resources. Before an AC worker begins employment it should also be clarified who will best supervise the worker. The complexity of AC and need for reflective practice speaks for supervision by a therapist. As home visitors AC workers are often not visible to other team members. Their integration into the team and input into decisions are important to maximize efficient treatment and reduce stress, burnout and turnover of AC workers. This integration also facilitates role differentiation, and ensures that AC workers supplement, but do not supplant,

professionals. Other ways to maximize retention of AC workers include recruiting people who are more likely to remain in the job and community, and offering AC workers prospects to advance their knowledge, career and reimbursement, such as through a tiered certification system.

Attendant Care for Children and Youth with EBD/SED Part I: Review of National Literature

Attendant Care in Children's Mental Health

As part of the continuum of care, attendant care is one of the means to provide mental health services in children's natural environments and prevent unnecessary out-of-home placements of children with serious emotional and behavioral disorders. Attendant care services consist of individualized, one-on-one personal assistance and supervision for young people in order to achieve one or more predetermined treatment goals. Attendant care is available upon request by families generally on a 24/7 basis, provided by trained individuals under the supervision of qualified mental health professionals.

With the adoption of a Systems of Care philosophy in Children's mental health attendant care (AC) has become a more frequent service component. The *Annual Report to Congress on the Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program* (SAMHSA, 1999), reviewed Milwaukee's service patterns for three years (1996-1998), and found that along with case management and wraparound services, attendant care was the one of the most utilized services. Half of all children received attendant care, and the percentage remained constant over all three years.

In Kansas *Medicaid* policy defines attendant care (AC) as:

One on one support or supervision with the goal of maintaining an individual with severe and persistent mental illness or child with SED in natural community locations, such as where the person lives, works or socializes. All supports provided must relate to the specific goals set forth in the consumer's treatment plan and must be provided under the supervision of a qualified mental health professional. Service may include providing direct support and supervision in accomplishing activities of daily living and supporting the consumer and or the family in maintaining daily routines critical to a stable lifestyle. (Community Mental Health Center Provider Manual, 2002).

The training manual of the Children's Mental Health Training Team at Wichita State University defines the *role* of the attendant care (AC) worker as

to help a child or adolescent with a severe emotional disturbance live and function in the least restrictive setting. By providing one-on-one supervision, the attendant helps the child stay in the community and avoid hospitalization. An attendant also provides a positive relationship to help teach the child appropriate social skills. (online training module 1, Wichita State University, website:

www.kidstraining.org)

Attendant care can be provided as a routine part of a child's service plan or as a stabilization service in times of crisis. Conceptualized as part of a team approach that includes family members, therapists and other formal and informal helpers, AC can be provided in a variety of settings including the child's home or classroom.

Activities of AC workers may include

- Assisting with progress toward treatment goals
- Assisting in developing and providing structured activities
- Maintaining a safe and productive environment

- Furnishing respite to caregivers and families
- Providing a role model
- Supervising the child in class to allow regular school attendance
- Providing opportunities to engage in routine social activities
(online training module 1, www.kidstraining.org)

Experienced Attendant Care workers in Kansas can also provide another, higher level service called Individual Community Support (ICS). ICS consists of face to face interventions in a community setting. This includes activities which assist persons to function more independently in natural community settings of their choice. The need and level of this service is determined by the treatment team in collaboration with the consumer and family. Services include the following:

- 1) Personal support, which shall have as its objective assistance with daily activities necessary to maintain personal stability in a community setting.
- 2) Support provided to an individual adult or child, which shall include education and in-home consultation and shall have as its objective the delivery of specific training in daily living to an individual, which will be needed to provide natural supports, maintain the family support system, improve self-help skills, interpret policies, procedures and regulations that impact the individual living in the community, and monitor progress with treatment plan goals and objectives.
- 3) Under supervision, personal support provided to individuals in crisis situations.
(Community Mental Health Center Provider Manual, 2002).

The Koch Crime Commission of Kansas has also adopted a definition of attendant care for youth in the juvenile justice system:

Attendant care refers to a program/service for youth who are at risk of flight prior to adjudication or court proceedings, or are in need of temporary (usually 24 hours or less) care prior to being placed by SRS in some other type of care. It is designed to be one-on-one direct supervision/service of a child/youth by a trained attendant.
(KCC, http://www.kci.org/publication/srs/srs_terms.htm)

Another term related to attendant care services is “Behavioral Aide Services” which the Substance Abuse and Mental Health Services Administration (SAMHSA) defines as “Interventions which provide trained personnel who are deployed to provide one-to-one supervision and support to a child or adolescent with a serious emotional disturbance in order to avert the need for treatment in a residential or inpatient setting. Includes services provided in the home or school for a specified number of hours per day or round-the-clock for a specified period of time.”
(<http://www.samhsa.gov/centers/csat/content/Tap22/App-cl-01.htm>)

A recent publication of the Bazelon Center for Mental Health Law called “Teaming up: Using the IDEA and Medicaid to Secure Comprehensive Mental Health Service for Children and Youth” (August 2003; available online at www.bazelon.org) outlines how the Individuals with Disabilities Education Act (IDEA) and Medicaid provisions can be used effectively to obtain wraparound services and supports, including behavioral aides, for

children with emotional and behavioral disorders. IDEA provides an important entitlement to educational services for children with serious emotional disturbance and can be used to secure school-based mental health services such as attendant care. However, services are limited to those that provide some educational benefit so that services before and after school or in the home are often rejected. Residential services under IDEA are only available after surmounting several legal hurdles and are most often awarded only when courts find a school district has egregiously neglected a student. For children who are eligible for Medicaid, the gaps left by IDEA can be filled by an entitlement to early and periodic screening, diagnosis and treatment (EPSDT). The Bazelon Center points out that EPSDT is an “exceptionally comprehensive” entitlement to receive “necessary health care, diagnostic services, treatment, and other measures ... to correct or ameliorate defects and physical and mental illnesses and conditions...”(42 U.S.C. § 1396(r)(5), as quoted in Bazelon, 2003, pp. 3-4). Not only are all states required to provide all “medically necessary” services to eligible children, the statute also “requires states to provide outreach and information to eligible families about their child’s entitlement to medical screens to uncover any conditions needing treatment” (Bazelon, 2003, p.4). Unfortunately, the implementation of the program across states is still rather erratic and advocates have only recently begun to use Medicaid’s EPSDT entitlement to address behavioral health needs.

Review of Empirical and Conceptual Literature

Despite the increased use of attendant care services, neither published research nor any conceptual publications could be found that specifically examined the effectiveness, roles, appropriate recruitment, training or supervision of attendant care workers. Thus the search for best practices was broadened to related fields. With its preventative, individualized, and community-based focus attendant care has its roots and equivalents in other so called “paraprofessional” services especially in the fields of special education and early intervention. In order to extract state of the art knowledge relevant to attendant care services, this review of the national literature therefore focused on empirical and conceptual publications about paraprofessional services rendered to children with special needs, specifically for those who exhibit emotional or behavioral difficulties, or their families. Implications of this review with respect to attendant care services are discussed in the final section.

Definition of Paraprofessional

Paraprofessionals, alternately also referred to as non-professionals, lay helpers, paraeducators or therapeutic assistants, are individuals who have not received any formal training in traditional university or college based education programs and have not received degrees or professional credits in the field in which they are working (Kalafat & Boroto, 1977, #21).

Historical Background

Since the 1960s and 70s paraprofessionals have found increasing use in a variety of human services including education/special education, early intervention, health care and mental health services. During this period, philosophies and policies in education and mental health changed and demanded the deinstitutionalization of services in favor of less restrictive community based delivery models (Kalafat & Boroto, 1977,#21; Sullivan, 1998,

#4). The lack of available professionals in education or community mental health provided the initial impetus to hire more paraprofessionals (Kalafat & Boroto, 1977, #21; Sullivan, 1998, #4; Musick & Stott, 1990, #38). The shift toward community based philosophies also led to the increased recruitment of paraprofessionals who were indigenous to the communities served. Administrators hoped that indigenous workers who shared background, ethnicity or experiences with clients would be able to gain easier access to clients. Another rationale for the use of indigenous paraprofessionals was Riessman's (1965) "helper therapy principle," i.e. the positive effect of helping on the helper. Paraprofessionals themselves would be empowered by their helping activities and in turn enrich their communities (Kalafat & Boroto, 1977, #21; Durlak, 1973, #22). To this day, paraprofessionals are often expected to serve as "bridges" between the world of professional service systems and the world of clients (Kalafat & Boroto, 1977, #21; Miller & Pylypa, 1995, #17; Wadsworth & Knight, 1996).

Research on Paraprofessional Services

A review of literature on the use of paraprofessionals in services for children or youth with emotional or behavioral disabilities (using the databases ERIC, Exceptional Children, Social Work Abstracts, PsychInfo, WilsonWeb, as well as reference lists) resulted in a wide range of empirical and conceptual literature.

Three main questions recur in the literature:

- 1) How **effective** are paraprofessional services and when, where, and how would they best be utilized?
- 2) What are the common **roles and responsibilities** of paraprofessionals and are they appropriate?
- 3) Which **qualifications, training, and supervision** should be required of and afforded to paraprofessionals to improve effectiveness, recruitment, and retention?

HOW EFFECTIVE ARE PARAPROFESSIONAL SERVICES AND WHEN, WHERE, AND HOW WOULD THEY BEST BE UTILIZED?

Mental Health

Research regarding paraprofessionals' effectiveness in mental health settings is somewhat supportive but mostly outdated. Studies conducted in the 1960s and 70s indicated that paraprofessionals performed as well if not better than professionals and might bring qualities to the service which made them the mode of choice such as enthusiasm, positive expectations, openness to innovative strategies, knowledge and position in the community, and lack of the professional role and technique armor which often distances the helper from the client (Kalafat & Boroto, 1977, #21; Durlak, 1973, #22).

More recently, Koroloff et al. (1996, #10) and Elliott et al. (1998, #35) reported the results of a quasi-experimental study of a program that used paraprofessionals as "family associates" to improve access of low-income families of children with emotional and behavioral disabilities to children's mental health services. Three female workers, one working full time (serving up to 10 families), and two half time (max. 5 families), were recruited and hired by the mental health center. All of them were mothers with own experiences in receiving services or working in mental health support positions, but none had prior training in mental health field. Using an empowerment framework the intervention aimed to increase in the number of families who would initiate child mental health services, and also increase service continuance by addressing barriers such as costs of travel, lack of information, or other caregiver needs. Family associates contacted families to gather and present information, provide social and emotional support and links to community resources, as well as flex funds for transportation or other necessary services. Family associate services ended when the child had participated in three mental health appointments or after three months (whichever came first). Results indicated that the intervention group was significantly more likely to initiate mental health services (i.e. make and keep first appointment) but no more likely to continue services than the comparison group (only 33% of either group kept all appointments, and 20-24% dropped out in both groups). Logistic regression showed that family associate services were moderately associated with higher initiation rate. Families reported that their most commonly experienced barriers to continuance of services were the lack of respite care, transportation problems, lack of recreation opportunities, emotional support and difficulties paying utilities. Family associates were most successful addressing issues of transportation, information about EBD, and emotional support but were less successful in other areas.

Miller and Pylypa (1995, #17) conducted an ethnographic study into the dilemmas of using indigenous paraprofessionals to assist with mental health services in a tribal culture. Examining the complexities of tribal family networks, the authors conclude that the effectiveness of a paraprofessional depends on his/her own status in the family group and the status of her family vis á vis others in the tribe. A respected family member of a

mature, well connected family group can be highly effective but changes in her position, her family's position, or negative histories with other families can impede effectiveness.

Special Education

Although Sullivan (1998, #4) traced the use of paraprofessionals in education as far back as the 1950s, there still is a lack of compelling outcome data and conceptually sound models for the work of paraprofessionals in education (Giangreco, Edelman, Broer & Doyle, 2001, #2). Empirical literature is mostly descriptive in nature, and focuses on roles/responsibilities, as well as orientation and training. Only a few empirical studies, many of which are outdated or lack adequate controls, inquired about outcomes for students (Giangreco & Doyle, 2002, #1; Giangreco et al., 2001, #2; Jones & Bender, 1993, #3). Available findings show no clear empirical evidence to support claims of effectiveness of paraprofessional services to improve student achievement (Giangreco et al, 2001, #2; Gerber, Finn, Achilles, Boyd-Zaharias, 2001, #9). Although there was an increase in publications in the past decade, new articles added little to establish the effectiveness of paraprofessional services in education. Nonetheless, the number of paraprofessionals in special and inclusion classrooms is rapidly increasing. Recent estimates suggest that over 600,000 paraprofessionals currently work in schools nationwide (Gerber et al., 2001, #9).

Early research on paraprofessionals (also referred to as paraeducators, teacher assistants or teacher aides) was concerned with the appropriateness of using paraprofessionals as their roles shifted from clerical tasks to direct interactions with students. Inquiries often compared paraprofessionals' work to those of teachers and found mixed results, i.e. some studies favored paraprofessionals others did not (Jones & Bender, 1993, #3). Yet, as Jones and Bender (1993, #3) point out, current practices in education no longer pose the question whether teachers or paraprofessionals should be used. Rather, the question is whether classes taught by teachers with paraprofessionals are more effective than those without. Research on this question, however, has not yet been published.

The appraisal of paraeducators' work by parents, students, teachers, administrators, and paraprofessionals themselves (Sullivan, 1998, #4) is unequivocally supportive of paraprofessional services. Educators, administrators and paraprofessionals themselves favor the utilization of paraprofessionals especially for students with moderate to severe disabilities (Jones & Bender, 1993, #3; Marks, Schrader, & Levine, 1999, #18). Sullivan (1998, #4) suspects that the relative satisfaction with paraprofessionals seems related to teachers' perception of support in the classroom, and administrators' hopes for less staff turnover.

A qualitative study by Giangreco, Broer and Edelman (2001, #7) provides some insights as to the question how paraeducators might best be utilized. The authors compared two delivery models for paraeducators' services, and their respective impact on the engagement of teachers with disabled students. They analyzed 56 semi-structured interviews and 51 hours of observational data from 103 school staff (including paraprofessionals, teachers, special education teachers, and administrators) in inclusion classrooms. Findings indicated a substantially different pattern of teacher engagement between the "program-based" approach, in which the paraeducator assists all students in

the classroom according to need, and the “one-on-one” approach in which the paraeducator works exclusively with one individual student. Teachers were markedly less engaged with the student if he/she had one-on-one support. Less engaged teachers seemed to “host” students with disabilities in their classrooms deferring much of the instructional responsibilities as well as communication with parents to the paraeducator. They often addressed students only marginally, or communicated to the student through the paraprofessional. Other phenomena associated with disengaged teachers and one-on-one support was the isolation of student and paraprofessional from the rest of the class. Paraeducator and student were often physically, and metaphorically, located on the fringe of the group, and functioned semi-autonomously. At times, paraprofessionals formed an insular relationship with “their” student, or inadvertently brought about the stigmatization of the student who felt singled out or “spied” upon. Since one-on-one services were more frequently administered to severely disabled students, the model of service delivery alone is not necessarily a causal explanation for the differences in patterns of teacher engagement. Severity of disability may also serve as an explanation for the difference. In a later publication Giangreco and Doyle (2002, #1) conclude that the research indicates the need to individualize the proximity of paraprofessionals to students to ascertain how close is too close, and how close is just right. Too close attendance can be an inadvertent barrier for teacher engagement and social peer engagements. The authors recommend the development of *awareness* of the issue, *assessment*, appropriate *actions*, and *alternatives* that utilize peers as supports rather than overrelying on paraprofessional support.

Ernsperger (1998, #11) provides a thorough case description that illustrates the successful process of paraprofessional support to facilitate the transition of high school student with emotional and behavioral disorders (EBD) from a residential to a regular school setting. The process included the careful selection of a paraprofessional, the provision of pre-service and on the job training, frequent supervision, repeated re-definition of job description with the input of other staff, early crises planning with all parties, and both flexibility and clarity about adjusting the paraprofessional's role according to changes in the student's need. After finding a person whose qualities (positive attitude, initiative, compassion, flexibility) seemed to fit the student's needs, comprehensive pre-service training was offered, including school orientation, review of confidentiality, specifying job responsibility, and role plays to train skills regarding power struggles, de-escalation, etc. Crises scenarios were discussed, and crises plans developed through meetings with teachers, parents and administrators. On the job training to get to know the student started during semester break. The paraprofessional kept notes and received weekly supervision during the training period. As school started, the paraprofessional's roles and responsibilities were defined, refined and discussed with school staff. As the student began attending a vocational training program, the paraprofessional's role was expanded to include job coaching. To reduce the student's dependence, the paraprofessional began to divert her attention to other students during structured times and began “fading”. Difficulties during this process pointed to the need to discuss the fading process early with all staff. The case was deemed successful in regards to student outcome, teacher and administrator attitudes and the paraprofessional's satisfaction. Still, the author suggests improvements in preparing teachers to supervise and

evaluate paraprofessionals while maintaining a collaborative atmosphere, and the consistent implementation of performance evaluations based on the job description.

Early Intervention

The field of early intervention services offers relatively current and methodologically sound research on paraprofessionals. Researched programs used paraprofessionals to increase the access of families to early intervention (EI) or child health services (Rosenberg, Robinson, & Fryer, 2002, #5; Vogler et al., 2002, #6; Dawson, Van Doornick, & Robinson, 1989, #8). Studies showed mixed results as to the effectiveness of such programs. While parents' and paraprofessionals' appraisal of services was, again, positive and supportive of paraprofessional work, programs more often than not failed to achieve their desired outcomes of increasing access to and compliance with EI services. It appears that the strengths of paraprofessional work resided in the building of good rapport with clients/ families, taking a peer position, providing concrete services, information, and emotional support while weaknesses were noted in paraprofessionals' effectiveness to teach clients new skills (Rosenberg, Robinson, & Fryer, 2002, #5; Vogler et al., 2002, #6)

A study of paraprofessional home visitors for mothers of children (ages 0-4) with special health care or developmental needs (Rosenberg, Robinson, & Fryer, 2002, #5; Vogler et al., 2002, #6) randomly assigned 159 families to experimental or comparison conditions. Hoping to improve enrollment in EI services and health outcomes for children and mothers, three home visitors each served 30 families over a 12 months period averaging two visits per month. All paraprofessionals were supervised by a nurse, were mothers of children with special needs, and members of the neighborhoods they served. Results indicated few statistically significant differences between groups. Both groups showed improvements from baseline data. While the intervention group had a higher rate of acquiring Individual Family Service Plans (IFSP), the enrollment rate in actual services was no higher than for the comparison group. However, parents in the experimental group appraised the helpfulness of services significantly higher than those in the comparison group, and scores measuring maternal mental health were better as well. Mothers viewed concrete services they received as most helpful and valued the friendship and support offered by paraprofessionals. They did not view paraprofessionals as people trying to enhance skills but rather as friends and confidants .

An earlier experimental study examined the effects of a home-based social support program to improve infant health (Dawson, Van Doornick & Robinson, 1989, #8). The program aimed its services at low income mothers (N=172) deemed psycho-socially "at risk." A stratified sample was randomly assigned to one of three groups: a control group receiving routine services, a treatment group consisting of paraprofessional home visitors who provided biweekly visits until the infants reached 14 months of age, and a second treatment group, in which parents were visited and invited to join a biweekly parent group. Home visitors offered emotional support, concrete help (rides etc. but avoiding babysitting or lending money), information, and enhanced social networks. Measures of child health included birth weight, medical records (well child visits, immunizations, screenings), family stress during pregnancy, reports on actual or suspected child abuse/ neglect, and

interviews with the home visitor. Findings showed few effects on maternal or child health. No differences were found in perinatal outcomes although high stress families in treatment groups had significantly more reports for child abuse/ neglect (in most cases reported by home visitors). Mothers rated their relationships with home visitors very positively and particularly valued emotional support and concrete services. Home visiting services were deemed more effective than parent groups in that participation was higher and more consistent (Dawson, Van Doornick, & Robinson, 1989, #8).

Summary: Effectiveness of Paraprofessionals

Paraprofessionals are an established part of human services and there is limited empirical support for their effectiveness in improving client outcomes.

Paraprofessionals seem most effective in

- establishing good rapport with clients
- providing emotional support
- providing information and initiating client contacts with other services
- providing concrete services (such as transportation)

Paraprofessional services seem less successful in regards teaching new skills or leading to greater use of other services. The appraisal of paraprofessional services by professional staff and parents is far more positive than outcome data. The primary effect of paraprofessionals seems to be the sense of support experienced by families or professional.

In the last decades, questions of whether paraprofessionals should have a place in human services have been substituted by the need to know when, where, and how they would best be utilized. The latter questions however are still insufficiently researched.

There are some indications that the effectiveness of paraprofessional service is influenced by

- the level of individualization to each client
- the level of flexibility adjusting services to changes in client situations
- the level of proximity of the attending paraprofessional to the client (how close is too close?)
- the impact of the social position and history of the paraprofessional if he/she is part of the same community as the client.

WHAT ARE THE ROLES AND RESPONSIBILITIES OF PARAPROFESSIONALS?

Mental Health

While authors during the 1960s and 70s were enthusiastic about the use of paraprofessionals, especially those indigenous to the client communities, they already had concerns about the need to specify particular roles and a clearer identity for paraprofessionals in mental health teams (Kalafat & Boroto, 1977, #21; Durlak, 1973). Kalafat and Boroto (1977, #21) warned that unclear job descriptions make evaluations difficult or might lead to inappropriate evaluations that are based on professional standards rather than standards tailored to paraprofessionals. They also cautioned that the selection of paraprofessionals who identify with or are part of the client groups may put the paraprofessional into an “identity limbo” between professional and consumer roles (Kalafat & Boroto, 1977, p. 6). The absence of a clear identity may lead to increased identification with the professional role including its distancing language and behavior, thus losing the beneficial aspects of paraprofessionals who are indigenous to the served community.

Newton (2000, #31) discusses the integration of paraprofessional home health workers (so called “therapeutic assistants”) into treatment teams for adults with severe and persistent mental illness (SPMI). The author also emphasizes the need for clear role definitions for paraprofessionals, and an explicit exchange of information between therapist and paraprofessional about treatment goals and objectives.

Miller and Pylypa's (1995, #17) ethnographic study of indigenous paraprofessionals in a tribal culture highlights the need to consider roles and responsibilities of a given paraprofessional in the context of his/her cultural community and as something that will likely change over time. In Swinomish tribal life, for instance, “family” refers to a unit that collectively carries out certain activities in a reciprocal way, a definition that is not limited to blood relations and allows flexible, multiple membership over time. In addition, family networks change over time going through incipient and mature to fissioning (breakdown) phases posing different challenges for an indigenous worker. The concepts of “boundaries” or “ethics” should also be carefully considered as cultural constructs: While traditional, white mental health boundary concepts and laws hold individual confidentiality as a central good, the indigenous paraprofessional will feel required to follow the ethical mandate of the tribe, and, for instance, never take action without first asking the permission and advice of an elder in the group.

Special Education

To date, disagreements persist about the appropriate scope and nature of paraprofessional supports in the classroom (Giangreco, Edelman, Broer & Doyle, 2001, #12). Most often questions are raised about paraprofessionals' roles in testing and assessment, lesson planning, design of learning activities, extent and nature of instruction,

adaptation and modification of curricular activities, communication and interaction with families (Giangreco, Edelman, Broer & Doyle, 2001, #12). Noting a tendency of paraeducators to supplant rather than supplement instruction by teachers Giangreco and Doyle (2002, #1) raised the question whether it was ethical to have the least trained personnel carry the major burden for educating students with the most complex needs.

Remarkably little has changed in the discussion of roles and responsibilities since the 1980s. As roles and responsibilities for paraeducators have changed rapidly over the decades and now include a wide range of direct services, concerns about appropriate role definitions were consistently expressed in the literature (Sullivan, 1998, #16). Frith and Armstrong (1984, #19) emphasized the versatility of paraprofessionals working with students who exhibit behavior disorders (BD). In an attempt to delineate appropriate and inappropriate roles and responsibilities the authors suggest that paraprofessionals can help gather checklist data for diagnoses but should not administer or interpret standardized instruments unless properly trained. Their job might include recording and monitoring students' behaviors, assisting teachers in record keeping and adding a perspective to teachers' judgment, and assisting with behavior management tasks which should be clearly defined (ultimate responsibility for classroom discipline must remain with teacher). Also, securing needed equipment and materials, modifying curricula, materials, equipment, support team teaching, and assisting the student move through the building can be part of a paraprofessional's job responsibility (Frith & Lindsey, 1980, # 20). While planning learning activities, and one-on-one instruction can be part of a paraprofessional's job it should be clearly assigned, defined, and planned by teacher. If properly trained, paraprofessionals can assist (i.e. monitor, assist with scheduling, share information) in mainstreaming students and serve as intermediary between teacher, parents and community resources (Frith & Lindsey, 1980, #20; Frith & Armstrong, 1984, # 19).

Recent research regarding the roles and responsibilities of paraprofessionals shows that paraeducators are increasingly involved in instructional activities at the same time as the vast majority of them do not receive a clear job description or training (Riggs & Mueller, 2001, #13; Marks, Schrader, & Levine, 1999, #18).

Riggs and Mueller (2001, #13) conducted a study of the employment and utilization of paraeducators in inclusive school settings in two New England states. Analyzing open-ended interviews with 23 paraeducators and descriptive quantitative surveys (n=758) they found that a majority of paraeducators spent more than 50% of time with direct instruction. Seventy percent of survey respondents indicated they spent at least 75% spent on instruction. Other activities included clerical tasks, monitoring, accompanying, and behavior management. Forty-seven percent of survey respondents had no written job descriptions, and those who had them reported they often did not reflect the actual duties they performed.

A qualitative study of paraeducators serving students with moderate to severe disabilities in suburban and rural settings (Downing, Ryndak, & Clark, 2000, #15) found that paraprofessionals felt a high burden of responsibilities for the quality of student learning. Paraeducators often have to make on the spot decisions how to modify material,

or respond to a behavior. They also felt responsible for informing team members, educating general education teacher about the student and informing parents (although communication with parents was very limited). Concerns and challenges included not feeling sufficiently qualified to make adaptations or provide instructions on new academic materials, and the lack of time to make modifications or plans. Most interviewees reported collaborative relations with team members and school staff, felt their input into Individual Education Plan (IEP) goals was welcomed and felt supported and valued by staff. Few indicated that negative attitudes of teachers toward inclusion left them isolated. At times, contradictory advice posed a problem.

The concern about the burden of responsibilities felt by paraeducators is echoed in a qualitative study by Marks, Schrader, & Levine (1999, #18). Study participants felt it was their responsibility to manage all negative behaviors of students so that they are not a “bother” to the teacher. In addition they wanted to meet the student’s immediate academic needs and often assumed tutoring roles, making on-the-spot modifications of curricular activities for student. Paraprofessionals saw themselves as the “hub” and the “expert” who needs to incorporate suggestions by parents and teachers, serve as liaison, and as a main contact person for parents while they do not have much official decision making power. Finally, paraeducators found themselves in an advocacy role not only for students but also for the idea of inclusion itself leading to feelings of isolation.

A qualitative study inquiring about themes of respect and acknowledgement for paraeducators (Giangreco, Edelman & Broer, 2001, #24) found that paraeducators appeared to value instructional tasks more highly than clerical or personal care tasks. Though most paraeducators seemed comfortable doing noninstructional tasks some distanced themselves from being grouped with “those who take down bulletin boards” leading to a sense of hierarchy among paraeducators based on their duties.

In a conceptual article, Carroll (2001, #14) includes some paraeducators’ activities that extend beyond the school setting. Along with inclusion skills (modifying material, instructing, taking and recording data, monitoring behavior, relaying information) and facilitating social interactions (modeling and coaching interpersonal/social skills such as effective communication), paraprofessionals assist and teach students daily living skills, assist with personal or medical care where necessary, and teach community skills, such as assisting the student navigate community, college, work, public transportation, shopping etc. The author points out that activities which take place outside the confines and structure of a school setting require careful planning and safety plans because no immediate assistance by teachers is available.

Early Intervention

In contrast to the extensive literature on paraprofessionals’ roles and responsibilities in education, the literature in early intervention does not focus on this aspect. Notably, paraprofessionals in early intervention programs tend to perform their duties in the homes of clients. The tasks paraprofessionals performed in the researched projects were only briefly circumscribed as providing emotional support, concrete help (such as transportation), information, and enhancing social networks.

Summary: Roles and Responsibilities of Paraprofessionals

Roles and responsibilities of paraprofessionals are characterized by high flexibility. Paraprofessionals' tasks tend to change over time and according to field, program and individual client. This flexibility in roles and responsibilities is at once advantage and difficulty. At best it grants a versatility that allows the tailoring of a paraprofessional's role to a specific program or individual. At worst the ambiguity leads to confusions and tensions between involved parties, overwhelms paraprofessionals, interferes with service effectiveness, or alienates the paraprofessional from his or her work. All the more important are

- the clear initial definition of a paraprofessionals' role and responsibilities
- ongoing communication of these definitions to other involved parties
- awareness of cultural and individual factors that influence a paraprofessional's role within his/her community,
- and the repeated revision and redefinition of roles and responsibilities over time.

Typically, paraprofessional **roles and responsibilities** in work with disabled children include

- assisting a professional in implementing treatment or educational goals
- Participate in planning and designing of goals
- Monitor behaviors
- Manage behaviors
- Provide structure
- Observe and record behavioral data
- Provide information
- Connect client with other resources
- Provide concrete services (transportation etc.)
- Assist/ teach client with daily living skills
- Accompany/ support client in community settings
- Model/ teach communication and social skills
- Facilitate client-peer group interactions
- Communicate with team member and families
- Communicate with other professionals in the community
- Modify materials or environments
- Advocate for client/ or community-based service
- Clerical tasks

The work of paraprofessionals should **support but not supplant** direct engagement of professionals with the client.



WHICH QUALIFICATIONS, TRAINING, AND SUPERVISION SHOULD BE REQUIRED OF AND AFFORDED TO PARAPROFESSIONALS TO IMPROVE EFFECTIVENESS, RECRUITMENT, AND RETENTION?

Mental Health

Home visiting paraprofessionals run the risk of becoming isolated from other agency staff and often lack opportunities to observe or receive feedback from co-workers (Gould, 2000, #32). In addition, home visitors work so closely in a client's environment that they will develop stronger relationships with the client than with the agency (Newton, 2000). Ongoing training and supervision thus become the main avenue to support paraprofessionals.

Gould (2000, #32) suggests that an *effective training program*

- Begins with assessment of learning needs of participants including concerns about safety and comfort
- Incorporates adult learning principles
- Provides initial and ongoing training sessions
- Includes clear program philosophy
- Provides clear expectations, policies and procedures
- Utilizes interactive, hands-on approach focusing on concrete, practical issues
- Incorporates role plays, encourages group feedback, and how to give feedback to clients
- Includes information on cultural difference, child and adult development, different family structures, social systems
- Provides information on community resources
- Offers opportunities to practice skills within or outside agencies
- Offers trainee support system (for instance mentorship by more experienced paraprofessionals)
- Decreases long delays between completion of training and begin of placement
- Provides individual, supportive, insight-oriented supervision
- Evaluates training program upon completion
- Evaluates training through feedback from former trainees (after they had several home visiting experiences)

The Family Associates program (Elliott, Koroloff, Koren & Friesen, 1998, #35) held two multiple-day training sessions for paraprofessionals and their supervisors, covering philosophy, roles, family support concepts and services, an introduction to community resources, discussion of ways to implement roles and the definition boundaries. After three months of a trial period, paraprofessionals took part in a second training session to share common strategies and experiences. The discussion revealed an ongoing need to clarify the family associate's role in relation to traditional mental health services. Supervision for family associates was provided by staff of mental health center. The authors noted that the supervision needs of participants typically changed over time from locating resources and information to dealing with the more complex needs of families being served.

Pazaratz (2000a, #33; 2000b, #34) outlines elements of a training program for youth workers in a residential setting that uses milieu therapy and a variety of cognitive and behavioral approaches. He suggests paraprofessional youth workers need skills in assessing and prioritizing needs, involving youth in planning, recording behaviors, modeling constructive problem solving, maintaining structure and program objectives, providing support, nurturing, direction, conflict resolution, and responding reflectively. Interviewing and counseling skills are needed to monitor and intervene, and to assist youth in understanding feelings, reactions, and assuming self-control. Communication skills include teaching social skills, listening, attending to feelings, giving feedback, addressing developmentally common issues like identity, sexuality, spirituality, substance abuse, and violence with sensitivity to culture, race, gender, or ethnicity. A youth worker's skills should further include the ability to design fun activities that will allow for self-directed learning, and tapping into community resources to help youth gain life skills (money management, job search, housing, shopping, transportation, etc.). The author also emphasizes the need to build personal and collaborative relations with parents, integrate the family's strengths into treatment, and assist parents in replicating successful strategies. To these ends, appropriate supervision is needed to allow youth workers to reveal, describe, and reflect upon their actions, attitudes, beliefs and effectiveness. Supervision also serves to create coherence among staff, further staff self-esteem and relieve pressures.

In a conceptual publication about the selection, training and supervision of paraprofessionals serving as "therapeutic assistants" in in-home mental health care for adults, Newton (2000, #31) suggests that basic *personal qualities and interactional skills* are crucial for selection of effective home visitors. The author claims that more important than educational background or credentials are empathy and interpersonal warmth, the ability to take charge without being controlling, and flexibility. Newton's own program offered twelve hours of training in groups of five to six home visitors using role plays and discussion of cases to relay information on diagnoses, psychotropic medications, and psychological issues. Senior therapeutic assistants served as training consultants and made sure the training focused on real life events.

Special Education

The reauthorization of the Individuals with Disabilities Education Act Amendments of 1997 (IDEA, 20 U.S.C., § 1400 et sequ.) allows for "paraprofessionals and assistants who are appropriately trained and supervised" (U.S.C., § 1412 (a) (15) (B) (iii)) but does not specify what qualifications, training or supervision are deemed appropriate (Giangreco, et al., 2001, #23). Subsequently, many training, supervision or certification issues are unresolved despite the general agreement of state education officials that pre-service, and in-service training as well as certification are desirable (Sullivan, 1998, #36; Jones & Bender 1993, #3).

In most states paraprofessionals are hired without training, or required certification (Jones & Bender, 1993, #3). Twelve states (including Kansas) are in the process of introducing or passing legislation for certification or level certification that allows for career advancement (Beale, 2001, #29). Only six states and the District of Columbia provide formal training plans for school districts (Gerber et al., 2001, #9). Pre-service

training is virtually nonexistent and in-service training and supervision are marginal at best (Giangreco et al., 2001, #23). In light of these findings, Giangreco and Doyle (2002, #1) raised serious ethical questions about the expanding use of paraprofessionals, namely: Is it ethical that the least trained personnel instructs students with the highest complexity of needs?

Training Needs

Studies of paraeducators in New England (Riggs & Mueller, 2001, #25, Riggs, 2001, #26) indicated a dire need for more training and orientation, especially before beginning services. While available training seemed to address the most commonly performed duties, the most frequent type of training was received informally on-the-job or in the form of advice and assistance from other more experienced paraprofessionals. Only eight to twelve percent of respondents attended formal in-service training or the statewide paraprofessional conference. Barriers to partake in existing training included difficulties in getting time release, lack of resources to pay, and the lack of available and accessible training. In regards to supervision and evaluation, paraprofessionals were uncertain about policies and procedures. Most of them received daily guidance from teachers but the quality of supervision varied widely. Twenty-five percent of survey respondents said they had no daily supervision and 26% received no formal evaluations. Paraeducators were often unsure by whom, when and how they were evaluated. The most frequently named training needs were managing challenging behaviors, modifying/adapting materials or curricula, understanding a specific disabilities' effect on learning, interaction and teaching strategies, personal care, basic academic skills, computer skills, interpersonal skills to collaborate with team members knowledge of program vision, goals, guidelines, assisting families with accessing resources and knowledge of best practices (Riggs & Mueller, 2001, #25, Riggs, 2001, #26; Downing, Ryndak, & Clark, 2000, #30; Killoran, Templeman, Peters, & Udell, 2001, #28)

The lack of orientation and training, clear role descriptions, only limited opportunities for advancement, low pay, and lack of administrative support increase the difficulties in recruiting and retaining paraeducators, who all too often feel burned out, confused, and isolated (Sullivan, 1998, #36; Giangreco, Edelman, Broer & Doyle, 2001, #23). A qualitative study by Giangreco, Edelman, and Broer (2001, #24) explored paraeducators' perceptions of being appreciated, respected and acknowledged. The authors analyzed 53 interviews and 51 hours of observational data from 103 school staff in four Vermont schools. Paraeducators indicated the perceived nonmonetary signs of appreciation such as kind words, small gifts, written acknowledgements as signs of respect. These gestures were especially meaningful if they came from people whom paraeducators considered very knowledgeable about their daily work such as teachers, special education teachers, parents, or students themselves. Kind words of administrators were welcomed but seemed less meaningful. Another indicator of respect was being listened to when decisions about the student are made. The extent of orientation and ongoing support offered by professionals was also viewed as a sign of appreciation. In most cases, however, orientation was minimal or "on the run."

Orientation should occur before paraeducators enter the classroom and include philosophies, mission, culture and values, clear roles and responsibilities, expectations, start and end times, parking permits, map of building, tour of building, emergency procedures, attendance policies, confidentiality, copy of schedule, student IEP goals, safety and medical concerns on students. Paraeducators also need to plan on times to share information before the arrival of students and in between classes. Participation in training meetings should be imperative even if they take away from time with students (Carroll, 2001, #27).

Steckelberg and Vasa (1998, #37) describe a **web-based training program** for paraeducators that is based on adult learning principles. Field tested by 69 paraeducators, the program received positive evaluations by teachers and paraprofessionals although it required substantial time commitment (40 hours, time to complete averaged 4-5 months). Tailored to paraprofessionals' on-the-job needs, the program uses local schools as partners in training, is easily accessible, and fits paraeducators' work schedule. Using a range of materials and methods the program combines online self-study with onsite learning. Instructional modules are supplemented with regularly scheduled group activities at local school sites, and include activities between the paraeducator and his/her supervisor to apply materials and seek additional information from supervisor, classroom or school.

Early Intervention

The early intervention program studied by Vogler et al. (2002, #6) selected their home visitors for their interpersonal skills, dedication, experiences as mothers, and being bilingual. Paraprofessionals received an initial three months training during which they served a small group of families. Training included topics such as family-centered, culturally sensitive services, child and family assessment, service coordination, child safety and development, educational programs, and description of services and supports for families (transportation, childcare, etc.). Throughout their work paraprofessional home visitors were supervised by a nurse.

Musick and Stott (1990, #38) point out that the greatest strengths of utilizing paraprofessionals who share background and social status of clients is also a potentially weakness. Influenced by shared cultural norms paraprofessionals might avoid certain "hot" or loaded issues in work with clients (e.g. sexuality, domestic violence, child abuse etc.) thus creating domains of silence. Effects of cultural embeddedness, alikeness, or countertransference must be adequately addressed in training and supervision.

Summary: Qualifications, Training, and Supervision of Paraprofessionals

Given the complexities and range of difficulties children with EBD experience, it is imperative that attendant care workers and other direct-service paraprofessional staff receive appropriate pre-service and ongoing training as well as supervision.

State Standards/ Certifications. To date state standards and/or certifications for paraprofessionals are not sufficiently defined or developed. Existing efforts in special education could serve as starting points for the development of statewide standards for attendant care workers. A level certification system would allow attendant care workers to increase their skills, and advance their career over time.

Qualities and Qualifications. Most programs employing paraprofessional supports require at least a High School diploma or its equivalent. More important than higher educational degrees seem the personal qualities paraprofessionals need to bring, such as

- Empathy and interpersonal warmth
- Remaining calm in unclear situations
- Ability to take charge without being controlling
- Flexibility
- patience and persistence
- high frustration tolerance
- creativity, enthusiasm and a sense of humor

In addition, programs committed to culturally competent services favor the recruitment and selection of multilingual/ multiethnic paraprofessional staff.

Orientation and Training

Although often only insufficiently provided, orientation, pre-service and ongoing training are considered necessary elements to ensure the quality of services. An effective training program should begin with an assessment of learning needs of participants including concerns about safety and comfort, and provide orientation to key components of the program such as

- Clearly articulated description of role and job expectations
- Clarity on the skills (or skill components) needed to perform the job
- Issues regarding confidentiality

Knowledge and Skill training in

- child development,
- disability specific information
- behavior management strategies,
- Problem solving
- Different learning styles
- cultural sensitivity, family-centered, strengths based approaches
- communication and collaboration within the system, building working relationships,
- team building with professionals

- communication and collaboration with families, professionals and members of the community
- locating and accessing community resources, and
- record keeping

The most ***effective training*** is based on adult learning principles which

- allow for self-directed learning
- Utilize interactive, hands-on approach focusing on concrete, practical issues
- Incorporate role plays, encourage group feedback, and how to give feedback to clients
- Offer opportunities to practice skills within or outside agencies
- Offer trainee support system (for instance mentorship by more experienced paraprofessional or making connections to local and state support networks)
- Decrease long delays between completion of training and begin of placement
- Offer ongoing training and supervision
- Evaluate training programs upon completion
- Evaluate training through feedback from former trainees
- Include supervisors and other team members in the training

Supervision

Regular individual or small group supervision by a professional is necessary to ensure the integration of paraprofessionals with the team. Along with content information and oversight, quality supervision allows and encourages reflection upon practice, cultural norms, difficult topics (e.g. sexuality, domestic violence, child abuse etc.), and struggles with clients or staff. Supervisors can also ensure that paraprofessional work does not supplant direct services by professionals. Primary therapists or case workers should keep in contact with clients.

Staff Retention and Development

In order to combat burnout and improve retention, paraprofessionals require

- monetary and non-monetary signs of respect and appreciation by their teams, supervisors, and administrators,
- peer support
- opportunities for creative input and ongoing training
- opportunities to advance their careers.

Implications for Attendant Care in Children's Mental Health

Based on the literature on paraprofessional services, the following implications can be inferred to optimize training and work of attendant care workers:

It is likely that attendant care workers, like other paraprofessionals, are most effective and appreciated for establishing rapport, lending emotional support, and providing concrete services. To these ends, **recruitment** of AC workers should ensure they bring not only a High School diploma or its equivalent but **personal qualities** such as empathy, calmness, flexibility, patience, high frustration tolerance, creativity, enthusiasm and a sense of humor.

Because attendant care workers can be utilized to lend a wide range of support and assistance **pre-service training** should include general information about roles and responsibilities, as well as information and exercises about predictable components to their work with EBD children, such as behavior management, monitoring and recording behaviors, providing structure etc. Just as important, however, is an understanding that **an AC worker's specific tasks will vary with each client's needs, strengths, situation, and time**. Therefore, pre-service training, ongoing training, and supervision should include detailed discussions about a child's unique diagnosis, behaviors, and strengths, and periodic re-assessments. In addition, AC workers, supervisors and families must be prepared to **define and re-define concrete roles and responsibilities** as needs or situations change. The question "**how close is too close, and how close is just right?**," for instance, can only be answered in response to each particular client and will likely change with time. Attendant care workers and their supervisors should be aware that too close attendance could inadvertently isolate and stigmatize children and adolescents, and may also keep other professionals from engaging with the client directly.

When attendant care workers are expected to teach children particular skills, this intent should be clear and agreed upon by the family, the child, and the worker. A list of individualized skills and skill components should be developed. AC workers will need general training in the skill areas (social skills training, communication skills, living skills etc.) as well as hands-on training in **how to adapt and individualize** skill training for their client.

Web-based **training** is an efficient way to reach trainees in various geographic areas as long as trainees have easy access to the internet. Theoretical knowledge about diagnoses, child development etc. should be supplemented with concrete, hands-on, and self-directed learning units in groups and with supervisors.

At the beginning of an AC worker's employment, he/she should be thoroughly **oriented** to the team, the mental health center, the values and mission of the program, and to the community and its resources. Before an AC worker begins employment it should also be clarified whether he/she will **best be supervised by case managers, or individual or family therapists** (all of whom should keep in contact with clients themselves). While the decision may vary with the tasks afforded to the AC worker, the complexity of attendant care and need for reflective practice speaks for supervision by a therapist. In any case, it should be clear to the AC worker who will provide regular supervision, when, where, and how he/she can reach her supervisor in crisis situations. Since clients tend to view paraprofessionals as friends and confidants, training and supervision should regularly **address issues of confidentiality, mandatory reporting, and ethical boundaries**. When attendant care personnel is recruited who live in the same neighborhood or share other

characteristics with their clients, supervisors should be aware of benefits as well as the potential dilemmas and boundary problems.

The ***integration of AC workers into the mental health or wraparound team*** requires particular attention because as home visitors AC workers are often not visible to other team members. It needs to be clarified early which tasks belong to the AC worker, and which belong into the realm of other team members. Because AC workers often hold knowledge to which other providers have no access, their integration into the team and input into decisions are important. Team integration can also reduce stress, burnout and turnover of AC workers.

Other ways to ***maximize retention*** of AC workers include recruiting people who are more likely to remain in the job and community rather than, for instance, students who will predictably move on, and offering AC workers prospects to advance their knowledge, career and reimbursement. Ongoing training, and input into decisions which training is most useful should be part of an AC worker's job. Career advancement toward a mentor/trainer function for less experienced AC workers or similar step-up opportunities may help reduce staff turnover and further a longer term integration of AC workers into mental health teams. A level certification system could also allow attendant care workers to increase their skills, and advance their career over time.

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