The Use of Paraprofessionals in a Prevention Program for Child Maltreatment: History, Practice, and the Need for Better Research

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Although the peer-reviewed home visiting literature has provided little empirical evidence for the effectiveness of home visiting as a means of reducing the risk of child maltreatment (Gomby, 2000; McGuigan, Katzev, & Pratt, 2003; Sweet & Appelbaum, 2004), hundreds of programs continue to recruit and serve families. Further, 76% of home visiting programs in the United States employ at least some paraprofessionals (Chaffin, 2004; Duggan et al., 2004; Powell, 1993; Wasik & Roberts, 1994) in spite of lack of empirical rationale and support for the use of paraprofessionals within a home visiting treatment modality.

This review presents the historical emergence of paraprofessionals as service providers for the prevention of child maltreatment, and is followed by a summary of the empirical literature on paraprofessionals. We then review the research on home visiting using paraprofessionals. One of the challenges in evaluating this literature is that the majority of studies focus on outcome variables (particularly maternal attributes) instead of the seemingly crucial methodological factors regarding the delivery of services (i.e., internal validity). To address this issue, we highlight the large variability in paraprofessionals' job descriptions, training, supervision, and ability and willingness to adhere to specific protocols. We also present future research ideas with the goal of mobilizing the field to implement studies with clear rationales and associated methodologies, so that we can draw meaningful conclusions about maltreatment prevention programs.

History of the Emergence of Paraprofessionals as Home Visitors

The first large-scale home visiting program occurred in the late nineteenth century when private charity organizations dispatched "friendly visitors" (Weiss, 1993, p. 115) to the homes of the urban poor. The home visitors' assignment was to transform the families' character and behavior and, thereby, to attack the growth of urban poverty, class antagonism, and social disintegration. In the 1890s, more than 4,000 volunteer middle- and upper-class women were regularly visiting poor families in the tenements of major cities to provide guidance and to serve as models of how to "live right" (Weiss, 1993, p. 115). A thorough search of this literature revealed no studies of whether these visits had an impact in preventing the onslaught of poverty and its repercussions.

Home visiting reappeared as a remedy for social disparity during the 1960s when the war on poverty was renewed. Home visits were implemented as a way to connect families to community services that were being offered from state- and federally-funded programs. Although still seen as a bridge to the poor, these "friendly visitors" emphasized a personal and generalist helping relationship based on a less hierarchical, more holistic, and friendlier interaction between participant and professional (Halpern, 1993).

The premise of home visiting programs from the 1960s on changed from its earlier view of improving the character of individuals to an emphasis on the early development of children and the belief that it is necessary to intervene at home with parents to support and improve socialization, health, and education practices (Gomby, Larson, Lewit, & Behrman, 1993; Wasik & Roberts, 1994). Some programs relied on home visits as the exclusive or primary means of intervention, whereas others combined them with additional services, such as early-childhood centers. The level of training and education of these visitors is unclear from the literature (Hiatt, Sampson, & Baird, 1997; Roberts & Wasik, 1990). Many of the paraprofessionals were selected on the basis of their personal characteristics (Daro & Harding, 1993). Program efficacy was not studied.

With the social change of the late 1960s and 1970s came awareness that health service access and delivery were limited for poor, inner-city families (Gartner & Reisman, 1972). Health professionals were viewed as being insensitive to the cultural and economic issues of minorities. Paraprofessionals served as "professional-like" individuals with more "street level" experience (Powell, 1993, p. 25). They brought previously unavailable services to families in settings that were comfortable and convenient. The hiring of paraprofessionals in the 1970s became quite popular in the field of education, health, social services, family planning, drug abuse prevention, urban planning, police work, and corrections (Gartner & Reisman, 1974). In the mental health field, paraprofessionals provided a variety of therapeutic services, from peer counseling to suicide prevention (Tan, 1997).

In addition to improving service access, the training of people from the community to have professional skills was economically sound. Having the opportunity to work as paraprofessionals fulfilled a need for more jobs within the community. Paraprofessionals received less pay than professionals and required less job security (Pearl, 1974).

During the 1980s and 1990s, the services research field emerged. It maintained a focus on overcoming barriers to service delivery and increasing engagement with families (McCroskey & Meezan, 1998). Services researchers highlighted barriers to service access, including transportation difficulties, absence of child care, and distrust of the medical and mental health systems (Hiatt et al., 1997; Wasik & Roberts, 1994). They argued that paraprofessionals who conducted home visits were able to overcome these barriers. Home visitors actively sought out the families they served, rather than waiting for the families to come to a clinic or agency office. Paraprofessionals were perceived as being more connected and streetwise; they had more experience and knowledge of community services and how to negotiate them and, therefore, provided access to families-in-need more efficiently (Klass, 1996). In turn, paraprofessionals were accepted more readily by families than were professionals, particularly by those high-risk families who distrusted professionals and social agencies (Powell, 1993). There were mul-

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tiple additional advantages: home visitors served as links between the communities and families, addressing the issue of isolation that many of these families experienced; home visitors observed the individual needs of each family and helped parents change or improve their parenting skills, or both; and home visitors, if properly trained and supervised, monitored children's safety.

History of Application of Home Visitation to Child Maltreatment

Modern professional concern about child abuse emerged about 40 years ago with a 1962 publication, titled *The Battered Child Syndrome* (Kempe, Silverman, Steele, Droegenmueller, & Silver, 1962). The first author, pediatrician C. Henry Kempe, brought the medical profession into the movement to protect children and, together with other health professionals, formed a coalition to lobby governmental legislature for change. During the 1970s and 1980s, this coalition of professionals helped to enact child protection and mandatory reporting laws and to clearly establish the guidelines and definitions of child maltreatment.

The 1988 amendments to the Child Abuse Prevention and Treatment Act (CAPTA) called for the creation of an advisory board to evaluate the nation's efforts to accomplish the purposes of the CAPTA and to make recommendations (Krugman, 1993). As a result, in 1991, the advisory board recommended a national home visiting program for children during the neonatal period as a strategy for preventing child abuse and neglect. Home visiting models focus on improving family functioning and parenting behavior (Duggan et al., 2004; Eckenrode & Runyan, 2004; Olds et al., 1997; Wasik, Bryant, & Lyons, 1990). Specifically, home visiting programs aim to prevent maltreatment by addressing the proximal targets of child abuse and neglect, including family characteristics such as conflict, social isolation, and socioeconomic stress as well as caregiver characteristics, such as the use of substances and harsh and inconsistent discipline (Grant, Cernst, & Streissguth, 1999; Guterman, 1999; Peterson, Tremblay, Ewigman, & Saldana, 2003).

The CAPTA recommendations did not specify who should be delivering the home visiting services. Many nonprofit agencies throughout the United States—some of whom are affiliated with the National Committee for the Prevention of Child Abuse and National Parent Aide Association—provide home visiting services using paraprofessionals. There was no definitive explanation for the preference for paraprofessionals over professionals found in the literature; however, it has been demonstrated that paraprofessionals work on a lower pay scale than professionals (Family Strengthening Policy Center, 2007).

Home Visitors: A Complicated Job Description

Home visiting is not a single, specific, uniformly defined service but rather a strategy for service delivery (Powell, 1993). Thus, the home visitor's role is critical. Home visitors are the embodiment of the program for families; they draw families to the program, and they are the vehicles through which the service program is delivered. Home visitors must have a wide range of skills: personal skills to establish rapport with families; organizational skills to deliver the home visiting program, while still responding to family crises that may arise; problem-solving skills to address issues that families present in the moment when they are presented; and cognitive skills to do the paperwork that is required. These are not minimal skills, and there is no substitute for them if service programs are to be successful (Powell, 1993).

Public Health Costs of Home Visiting Programs

Due to ethical, empirical, and financial concerns, maltreatment experts have begun to question the efficacy and effectiveness of home visiting interventions (e.g., Chaffin, 2004). In a review of six home visiting programs, Gomby, Culross, and Behrman (1999) estimated that thousands of home visiting programs existed around the country, together serving over 550,000 families each year. Funding for these programs came from a variety of sources. In 2005, the Education Begins at Home Act (EBAH) was introduced in the U.S. Senate to establish the first federal funding dedicated to early childhood home visitation. The EBAH is a 3-year, 500 million dollar program to help states expand and deliver quality home visiting services. The average annual cost for a family involved with a home visiting program, such as Healthy Families America (HFA), is $3,348, with costs ranging from $1,950 to $5,768. The state-to-state allocations for HFA range from $350,000 to over 40 million dollars (http://www.healthyfamiliesamerica.org/home/index.shtml).

Home Visiting Programs for Child Maltreatment Using Paraprofessionals: Program Descriptions

Most articles on paraprofessionals refer to a review by Durlak (1979) as a seminal article. Durlak examined 42 studies that compared the efficacy of paraprofessionals with professionals, and concluded that paraprofessionals achieved clinical outcomes equal to or significantly better than those obtained by professionals. Additionally, Durlak argued that an effective therapist does not need mental health education, training, or experience. Nevertheless, qualifications such as level and type of education, quantity of training, necessity of certification, and presence/absence of supervision, were not evaluated as mediating/moderating influences on outcome. This analysis is warranted due to the vast differences in the definition of paraprofessionals used by the studies included in the review (Nietzel & Fisher, 1983). In fact, among the 42 studies reviewed, paraprofessionals were drawn from a wide variety of backgrounds, including psychiatric aides, nurses, college students, medical students, community volunteers, occupational therapists, psychiatric aids, adult counselors, public health officers, and speech pathologists (Durlak, 1979).

A number of prevention programs using paraprofessionals have been developed, implemented, and disseminated since the Durlak review. Few of these have focused on the prevention of child

maltreatment. Among those with maltreatment as an intervention goal, Olds' program has the strongest methodology (i.e., large sample sizes, multi-informant assessment, randomized controlled trials) and empirical evidence (Olds, Henderson, Chamberlin, & Tatelbaum, 1986; Olds, Henderson, & Kitzman, 1994; Olds et al., 1997; Olds, Hill, Robinson, Song, & Little, 2000; http://www.evidencebasedprograms.org). In a review of home visiting programs for low-income families at risk for maltreatment, Olds and colleagues (2000) reported that only one study found significant effects for the prevention of child maltreatment (Elmira study; Olds et al., 1986). The Elmira study, in which nurses implemented the program, may have shown significant change because the sample was more severely impaired (i.e., pregnant teens at high risk), community was more limited in resources, and turnover of staff was lower than in other studies (i.e., regression to the mean).

Across multiple studies using professionals (i.e., nurses) and paraprofessionals, Olds' program has resulted in improvements in parenting and child outcomes (e.g., health). In the only trial comparing home visitation by nurses versus paraprofessionals, Olds and colleagues (Korfmacher, O'Brien, Hiatt, & Olds, 1999; Olds, 2002) randomly assigned 735 pregnant women to nurse visits, paraprofessional visits, or assessment-only conditions. Nurses completed more visits and focused more on physical health and parenting, whereas paraprofessionals conducted longer visits and focused more on environmental health and safety (Korfmacher et al., 1999). Nurse visits had greater impact on mothers' smoking and return to employment and on infants' emotional functioning and language development than assessments alone. The paraprofessional visits were not more successful than assessment-only on any of these variables. There were no significant differences on involvement with child welfare across conditions.

Other home visitation programs, using program evaluations, also have found limited (if any) efficacy in the prevention of child abuse and neglect. Despite utilizing sound experimental design of the use of randomized control groups, the variability in components and techniques used, as well as the lack of monitoring of fidelity, are problematic, limiting confidence in findings. The possibility of contamination within the randomized trials was present as well (e.g., St. Pierre, Layzer, Goodson, & Bernstein, 1999). There was an availability of community services to control families that was potentially similar to the treatment program. In addition, friendships developed between control and treatment families, introducing the potential for contamination. These home visiting programs are reviewed next.

The Parents-as-Teachers (PAT; Wagner & Clayton, 1999) program is a psycho-educational program designed to increase parents' knowledge of child development and parents' feelings of competence and confidence, and to develop home-school-community partnerships. The program originally emphasized the first 3 years of life, and it later expanded to target young parents of preschoolers, teenage parents, and parents of children attending child care centers. The demonstration project in Salinas, California, consisted of monthly home visits, starting prenatally or at birth, and was conducted by paraprofessionals with the title of parent educator. Out of the 10 parent educators for this project, 6 had bachelor's degrees. These individuals received one week of training in the program model, emphasizing the provision of age-appropriate information about child development and helping parents develop skills that promote children's intellectual, language, social, and motor skills development (Pfannenstiel & Seltzer, 1989). Recognizing their limitations, the PAT National Center (PAT-NC; Wagner & Clayton, 1999) recommended future hiring of parent educators with professional education and experience in the fields of education, health care, or social work. They also recommended that all parent educators receive one week of pre-service training in delivering the PAT model by trainers certified by PAT-NC staff. The PAT-NC now credentials the parent trainers annually, "contingent upon the local administrating agency's approval of their service to families and their completion of the required 10–20 hours of annual in-service training" (Wagner & Clayton, 1999, p. 180). The service model has undergone numerous changes since its onset and, therefore, requires more training of its parent educators. In 1996, 15 years after its inception, PAT-NC trademarked the "Born to Learn™" curriculum, which incorporates principles of neuroscience (Wagner & Clayton, 1999). We found no assessment of the frequency or quality of supervision included in the program evaluation.

The Home Instruction Program for Preschool Youngsters (HIPPY; Baker, Piotrkowski, & Brooks-Gunn, 1999), developed in 1969 at the National Council of Jewish Women's Research Institute for Innovation in Education of Hebrew University (Baker, Piotrowski, & Brooks-Gunn, 1998) is a 2-year program with a goal of empowering parents with limited formal education to prepare their preschoolers to attend school by fostering parent involvement in the school and community. Although the prevention of maltreatment is not stated directly in the program's goals, the research includes both parent and child outcome studies. HIPPY paraprofessionals were recruited from the parents' neighborhoods. Baker and colleagues thought that these paraprofessionals would be better able to deliver the program material in a manner consistent with the lifestyles and cultural systems of families, which, in turn, would encourage the families to learn and use the skills that were taught. Descriptive statistics of the paraprofessionals' background could not be found in any of the early demonstrations of the projects; in the 1999 program evaluation description, Baker et al. stated, "Some [of the paraprofessionals] had high school degrees, but few had any college experience" (p. 120). Paraprofessionals are described as having "…intensive, initial training and ongoing weekly training" (p. 193); however, no specific data on training are provided. Baker and colleagues argued that lack of training was balanced by having at each site a professional coordinator, who was "…typically an individual with a background in early childhood education, social work, or social service administration" (p. 120). The developers also did not delineate supervision methods and monitoring of integrity.

Hawaii's Healthy Start Program (HHSP) is a child abuse prevention program with the goal of helping at-risk families by teaching parenting skills that promote children's healthy development (Duggan et al., 1999). The program model is based on Henry Kempe's (1976) lay therapy program and the work of Selma Fraiberg (1980). The two primary components of this program have remained unchanged from its earlier prototypes: (1) the early identification (EID) of families with newborns at risk for child abuse and neglect, and (2)

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home visiting by trained paraprofessionals. "EID workers" (Duggan et al., 1999) screened medical records for at-risk families; no credentials of these workers were specified. Once families were identified and invited to participate in the program, home visitors were assigned to the families. These visitors were "…trained paraprofessionals recruited from the community, with qualities essential for working with vulnerable families: warmth, self-assurance, cultural sensitivity, and good parenting skills" (p. 68). Measurement of these characteristics was not described in the program evaluation. Upon the examination of the limitations of the pilot study, HHSP hired public health nurses and professional supervisors "…with formal training and experience in early childhood education, social work, or nursing" (p. 69) to direct the sites.

Healthy Families America (HFA; Daro & Harding, 1999) an extension of HHSP, was launched in 1992 by the organization Prevent Child Abuse America, whose main goals are to promote positive parenting and to prevent child abuse and neglect. Guided by the Hawaii Healthy Start Program, HFA focuses on enhancing parent-child interactions, fostering children's development, and improving family functioning in areas such as problem solving, social support, and use of community resources. Home visitors are hired based on their ability to engage families and establish trusting relationships; personal characteristics are considered to have more importance than level of education (Daro & Harding, 1999). None of these traits is formally assessed. Most HFA home visitors (82%) have attended or graduated from college, specializing in child development, social work, nursing, or education. HFA home visitors receive intensive, didactic training specific to their roles and receive ongoing supervision (of no specified frequency or intensity) to effectively assist families and "protect themselves from stress-related burnout" (p. 156).

The Comprehensive Child Development Program (CCDP; St. Pierre & Layzer, 1999) offers case management by home visitors for low-income children and their parents to enhance the social, emotional, and intellectual level of children and self-sufficiency of the families. The paraprofessionals who were hired initially had "life experiences…similar to those of the program's families" and "some familiarity with parenting, but very limited post-high school education" (p. 137). Reportedly, the severity of family crises hindered paraprofessionals' ability to engage families and implement the program, resulting in a new requirement of post-high-school education and training for the position. In addition, a management information system was put in place to help monitor the service provision and identify technical assistance needs.

Results From Child Maltreatment Programs Using Paraprofessionals: Lack of Internal Validity

An adequate evaluation of any intervention requires a clear description of each component (e.g., assessment tools, therapists, material provided to families, supervision methods) and consistent implementation of each component across participants (i.e., treatment integrity). Although the aforementioned home visiting programs may be theoretically strong and clinically informed, the methodological variability within and across programs is striking. Job requirements and the frequency and intensity of training and supervision of paraprofessionals differ across studies. In most studies, paraprofessionals were asked to provide support and information; techniques used (e.g., behavioral rehearsal, modeling) were unspecified. These programs also lack assessment of integrity to treatment protocols, particularly process and content of treatment delivery, yielding results that may be biased and inaccurate (Lichstein, Riedel, & Grieve, 1994). Thus, we cannot be sure whether the inability of these programs to prevent child abuse and neglect is due to the content of the programs or the method of implementation (i.e., use of paraprofessionals).

Among the many inconsistencies across home visiting prevention programs are the definitions of paraprofessionals. Lacking any standardized credentials or licensing, home visitors often are hired based on personal attributes thought to contribute to an effective helping relationship (Wallach & Lister, 1995). In a national survey of home visitation programs (Wasik, 1993), staff identified maturity, warmth, empathy, and a nonjudgmental orientation as essential home visitor attributes. HHSP (Duggan et al., 1999) defined paraprofessionals as "individuals from the community with qualities essential for working with vulnerable families: warmth, self-assurance, cultural sensitivity, and good parenting skills" (p. 68). CCDP defined paraprofessionals as individuals from the local community who have life experience with and report knowledge of parenting (St. Pierre & Layzer, 1999). For HFA (Daro & Harding, 1999), paraprofessionals were described as service providers selected on the basis of their ability to demonstrate a combination of personal characteristics, such as compassion, ability to establish a trusting relationship and empathy, and knowledge base. In PAT (Wagner & Clayton, 1999), paraprofessionals (i.e., parent educators) selected were an ethnically diverse group, mostly female, ranging in age from 22 to 60 years, with between 1 and 12 years of home visiting experience" (Wagner, Spiker, & Linn, 2002, p. 5).

Professional qualifications also differ among prevention programs. A home visiting survey found that 40% of programs serving low-income families required a bachelor's degree, whereas 60% did not (Roberts & Wasik, 1990). HHSP paraprofessionals (Duggan et al., 1999) were required to have at least a bachelor's degree. CCDP paraprofessionals were required to have a high school diploma (St. Pierre & Layzer, 1999). In the initial phase of its program, HFA paraprofessionals were described as having a wide range of education, experience, and expertise, from postundergraduate training to less than a high school diploma (Daro & Harding, 1999). PAT paraprofessionals had associate, bachelor, or advanced degrees.

There is also considerable variability with regard to the training and ongoing supervision of paraprofessionals. HHSP paraprofessionals received one week of pre-service training and ongoing supervision with a professional in a child-related field (e.g., nurse, social worker) and 30 hours of in-service training (Duggan et al., 1999). Following problems with paraprofessionals who received minimal training, HFA developers recommended one week of pre-service training, one day of continuing education each quarter, and 80 hours of additional training in the first 6 months (Gomby et al., 1999). PAT paraprofessionals received one week of pre-service training, one additional day of training during the first 6 months of work, 20 hours of in-service training, and opportunities for other trainings. CCDP paraprofessionals participated in extensive in-service training on conducting needs assessments, accessing services, and maintaining confidentiality (St. Pierre & Layzer, 1999). The

only program that incorporated ongoing supervision was HIPPY. HIPPY paraprofessionals received pre-service training in the HIPPY program plus weekly ongoing supervision.

Definitions and professional qualifications of paraprofessionals vary across home visiting programs, from individuals with high school equivalency to those with master's degrees in social work or early childhood education. Titles of the home visiting paraprofessionals include parent educators, case managers, and EID workers. Supervisors' credentials range from public health nursing degrees to experienced home visitors with associate or bachelor's degree. Training and supervision vary from one week of pre-training to "…training in areas such as conducting needs assessment, accessing services, and maintaining confidentiality" (St. Pierre & Layzer, 1999, p. 137). Given the diversity of personal qualifications, it is problematic that these constructs are not measured in any standardized manner that would allow for assessment of whether these attributes affect program retention and outcomes (McGuigan et al., 2003).

Efficacy of Use of Paraprofessionals

In two recent systematic reviews of the literature, differences in the measurement of decreased maltreatment of children are presented comparing paraprofessional and professional delivery of services. The Centers for Disease Control and Prevention (2003) found that the rate of maltreatment decreased when professionals conducted home visitation. In contrast, Sweet and Applebaum (2004) found that the impact was greater for programs staffed by paraprofessionals targeting at-risk families and focusing on child abuse prevention. That said, overall, neither direct measures of child abuse nor caregiver indicators of child abuse yielded average effect sizes significantly greater than zero.

More recent studies have compared the efficacy of paraprofessionals versus professionals for several mental health problems, including depression, substance abuse, and externalizing behaviors. Weisz and colleagues (Weisz, Weiss, Alicke, & Klotz, 1987; Weisz, Weiss, Han, Granger, & Morton, 1995) conducted two meta-analyses and found differential effects for professional and paraprofessionals treating children on the basis of diagnostic category. Specifically, professionals were more efficacious with internalizing disorders, whereas paraprofessionals were more effective with externalizing disorders. In an updated meta-analysis of treatment outcome studies, Stein and Lambert (1995) found that level of training was a significant moderator of therapy outcome; well-trained therapists experienced fewer dropouts than less well-trained therapists, especially in outpatient settings. Kendall, Reber, McLeer, Epps, and Ronan (1990) found similar results favoring professional experience in the use of manualized interventions with conduct-disordered children (cf., Tan, 1997). Researchers compared the impact of 20 individual sessions of cognitive-behavioral therapy (CBT) with those receiving supportive/psychodynamic therapy in a day-hospital setting while using a crossover design. Greater therapist experience providing CBT was associated with more symptom reduction.

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Experiential Critique of Paraprofessionals

Experts have identified a number of limitations to the use of paraprofessionals, particularly when they are hired from the same community as those families who are serviced (Halpern, 1992). According to Halpern, "lay" workers are often still wrestling with the choices, issues, and problems they are to address with the families they visit. Korfmacher et al. (1999) have found that because paraprofessionals often have their own histories of housing problems, domestic violence, and substance abuse, they are unable to maintain a professional distance from their clients. Paraprofessionals may be unable to reconcile their own beliefs, experiences, and feelings in key areas with the demands of their helping role. As a result, supervisors reportedly spend a significant amount of time addressing counter-transference issues (Korfmacher et al., 1999).

When lay workers develop close connections with the families they work with, there can be negative consequences as well as beneficial ones, especially in small, closely-knit communities such as Mexican-American families. In the Migrant Project (Halpern, 1992), the home visitors lived in the same migrant labor camps as the program participants, and sometimes they found themselves players in the same family and community dramas. On one or two occasions, family feuds even forced individual home visitors to stop working with certain clients.

Another limitation relates to the closeness paraprofessionals develop with their families. Although paraprofessionals are hired specifically because they are thought to have the ability to build trust and rapport, the boundaries between the families and paraprofessionals often become blurred. Without proper supervision, many workers foster dependence with their families, preventing families from doing for themselves. They often became overinvolved with particular families, at times continuing to provide direct assistance rather than encouraging families to do for themselves when they are able. Overprotectiveness can pose serious problems if it results in reluctance to make referrals to other providers (Halpern, 1992). In a randomized trial of a multi-site HHSP home visiting program to prevent child abuse, Duggan et al. (2004) indicated that the home visitors often failed to recognize parental risks and seldom linked families with community resources. Further, the researchers found HHSP training programs to be underdeveloped in preparing staff to address risks and to link families with community resources.

The relatively limited training of paraprofessionals (i.e., lack of an advanced degree) also may result in lack of preparation for the complex issues experienced by families at risk for maltreatment. In an examination of home visiting programs, Gomby (2007) found that home visitors felt ill-prepared to address crises they might encounter and were not always willing or able to identify and respond

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to maternal depression, domestic violence, and substance abuse, the very risk factors that must be addressed to prevent child abuse and neglect. They also may have difficulty collaborating with team members who are established professionals (St. Pierre & Layzer, 1999). In a rare empirical examination of attributes associated with retention in a home visiting child abuse prevention program, McGuigan et al. (2003) found that giving staff more hours of supervision was associated with increased retention rates of "at risk" families. Not surprisingly, following initial implementation, some of the aforementioned programs have increased paraprofessionals' job requirements.

Many paraprofessionals experienced difficulty in adapting to the professional environment in terms of time management, organization, and workplace social skills (Korfmacher et al., 1999). This factor may have both affected their ability to implement the intervention and contributed to the high rate of paraprofessional staff turnover. It is likely that this turnover also made it more difficult for families and paraprofessional visitors to form strong working alliances, which was the hypothesized value of using paraprofessionals.

The delivery of the intervention protocol is another area of concern. Paraprofessionals have not been sufficiently monitored with regard to fidelity of the proposed protocol. Programs that have examined the way paraprofessionals have administered the interventions have found that paraprofessionals may be uncomfortable promoting certain messages or intervening to address beliefs that contradict program messages when those are beliefs that they themselves still hold, such as the belief that one can spoil an infant by responding immediately to any bids for attention (Halpern, 1993).

An alternative explanation of findings is that home visiting is a model of service delivery, not an intervention in and of itself. In an invited commentary on the state of home visiting research, Gomby (2007) argued that home visiting as a mode of service delivery is associated with modest improvements in children's cognitive development, behavior, and home environment, but not in maltreatment or risk for maltreatment. Based on extant research, Gomby concluded that program content, not method, drives program results.
Program content needs to be standardized (through manuals) and monitored (through integrity). Duggan and Caldera (Duggan et al., 2007) enrolled 325 families in a total of six HFA-Alaska sites, for which the program manual included descriptions of the home visitors' responsibilities and curricula. To ensure integrity, an evaluation and self-evaluation of home visitors was conducted. They found that the degree of program success was associated with integrity to program content and goals measured using standard, consistent procedures. In turn, paraprofessionals' training and ongoing supervision were related to integrity. That said, no overall effects were found for maltreatment prevention.

If the research shows that paraprofessionals require many hours of supervision by professionals to be more effective in retaining families and maintaining fidelity with implementation of the protocols, are paraprofessionals still the economically wiser choice? Programs that hire professionals, such as the Nurse-Family Partnership program (Olds et al., 1986), cost significantly more than programs that use paraprofessionals (e.g., HIPPY). In a cost-benefit analysis, the Family Strengthening Policy Center (2007) argued that the Nurse-Family Partnership saves the general public $17,180 per family due to fewer child protective services calls, fewer experiences with the justice system, and higher income for (and tax revenues from) caregivers. In contrast, HIPPY saves $1,476 per family. The benefits derived from the HIPPY program result from an increase of earnings and tax revenue among children served.

Remaining Research Questions

With the larger goal of establishing efficacious and effective prevention programs for child maltreatment, preventive scientists (e.g., Olds et al., 2000) encourage the field to expand its study of home visitors and to develop comprehensively designed programs staffed by paraprofessionals and professionals. Paraprofessionals are likely to be assets to prevention treatment programs, given the logic that the initial rapport with families may be easier when people share a common sense of community. Paraprofessionals may be better suited for certain portions of the preventative services, such as recruitment and retention. Nevertheless, assumptions that similarities in culture and ethnicity between paraprofessionals and families facilitate the delivery of the intervention need to be tested empirically. Measures of the constructs associated with some of the aforementioned challenges need to be developed (LeCroy & Whitaker, 2005). Given the minimum-to-moderate level of success of home visiting programs at this point, it behooves researchers to examine the effectiveness and efficacy of the ways in which services are being delivered. Remaining research questions include the following:

1. What are the professional (e.g., level of education, prior experience in mental health settings) and personal (e.g., maturity, empathy, good communication skills) qualifications necessary for home visitors?
2. What are the type and amount of training and ongoing supervision needed for home visitors?
3. Are there differences between paraprofessionals and professionals in their ability to engage and retain families?
4. Are there differences between paraprofessionals and professionals in their ability to assess risk and safety?5. What are the rates of maintaining integrity to established intervention protocols for paraprofessionals and professionals?

5. What are the rates of maintaining integrity to established intervention protocols for paraprofessionals and professionals?
6. Are there differences between paraprofessionals and professionals in their ability to identify and mobilize wraparound services?
7. What are the evidence-based preventive interventions for child maltreatment?
8. What are the relative outcomes achieved by paraprofessionals versus professionals?
9. What are the families' satisfaction ratings when served by para professionals versus professionals?
10. What is the cost-benefit ratio (e.g., salaries, cost and intensity of training, outcomes) of using paraprofessionals versus professionals?
11. Can enough paraprofessionals with the aforementioned characteristics be recruited, hired, trained, and retained in the home visitor role?

Conclusion

The use of home visitation as a preventive intervention continues to be under debate. Extant research is critical of the effectiveness of home visitation (Chaffin, 2004); nevertheless, a robust conclusion about the role of paraprofessionals is limited by lack of internal validity of the published studies. There is no cross-program consistency in hiring, training, and supervision practices; administration of intervention protocols; and measurement of outcomes. As a result, little is known about retention and efficacy. If we identify evidence-based prevention practices and training models, perhaps paraprofessionals are the cost-effective choice.

Based on this literature review, it remains unclear what role, if any, paraprofessionals should have in home-based programs to prevent child abuse and neglect. So, why should we continue to explore their utility? Given the era of high health insurance costs, limited mental health coverage, and cuts in public programs, the economic benefit of using paraprofessionals is compelling. In fact, the cost savings may motivate local, state, and federal agencies to fund the proposed empirical examination. Perhaps advocates for the prevention of child maltreatment need to better inform those in public office of the aforementioned limitations and needed research agenda.

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