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Training Community Members to Serve as Paraprofessionals in an Evidence-Based, Prevention Program for Parents of Preschoolers

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Widespread dissemination of evidence-based programs for underserved populations may require non-traditional means of service provision. Collaboration with paraprofessionals from communities that are targeted for intervention holds promise as a delivery strategy that may make programs more accessible and acceptable, especially to parents living in low-income, urban neighborhoods. We describe a paraprofessional training program for individuals living in a community targeted for preventive intervention based on high levels of poverty and community violence. The design and implementation of the training program are described in the context of issues related to the use of paraprofessionals in community-based, preventive interventions with parents of young children. We also provide insight into lessons learned from a feasibility study as well as general guidelines for the development of paraprofessional training programs for delivery of evidence-based programs.

KEY WORDS: paraprofessionals; training program; preventive interventions; evidence-based programs.

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There are now a number of evidence-based programs for parents and preschoolers aimed at preventing or reducing behavior and school problems (e.g., Brestan & Eyberg, 1998). These programs share common elements that are presumed to be active ingredients, such as teaching parents strategies for creating positive play interactions, enhancing parents' reinforcement of prosocial child behaviors, and increasing parents' use of consistent, non-physical disciplinary strategies such as time out. These evidence-based programs now require testing in "real world" settings and eventual dissemination to a broad range of families of children at risk for conduct problems (Spoth, Kavanagh, & Dishion, 2002).

Studies suggest that children from low-income, urban environments are at elevated risk for conduct problems (Duncan, Brooks-Gunn, & Klebanov, 1994; McLoyd, 1998), are traditionally underserved (Dumas, Rollock, Prinz, Hops, & Blechman, 1999), and therefore constitute a potential target population for such programs. ParentCorps is a community-based program that aims to prevent the development of conduct problems by promoting positive parenting and child social competence. Based on cognitive-behavioral parent and child programs with demonstrated efficacy, ParentCorps includes a 13-week parenting series and concurrent children's social competence groups, individualized home visits, and an optional recreational group for school-aged siblings that offers supervised homework time.

ParentCorps was developed to be relevant and appealing to African American and Latino families of preschoolers living in urban, socioeconomically disadvantaged neighborhoods. Enhancements have been made to the content of the program to address issues of life stress, limited resources, potential safety concerns and exposure to community violence. Additionally, a number of program delivery features were developed to engage the targeted population. Specifically, members of the targeted community are hired and trained to deliver the program in concert with professional staff. These community residents serve as paraprofessional "Parent REPs," or as Resource, Educator, and Partner to parents of preschoolers in their neighborhoods.

In this paper, we provide a rationale for the ParentCorps paraprofessional training model, describe the training program content, and relate experience with this training program as part of a feasibility study of ParentCorps in an urban community. We also describe adaptations made to the training program in preparation for a full-scale effectiveness trial that is currently underway.

USE OF COMMUNITY MEMBERS AS PARAPROFESSIONALS

In our previous work with African American and Latino families from low-income, urban communities, one or two parents in each parenting group emerged

as important sources of support and information for other participating parents. This observation led to the idea of engaging parent graduates as paraprofessional staff in our future prevention efforts. There are several reasons why community members who act as paraprofessionals, or "persons with less experience or education than necessary to earn credentials" (Gould, 2000, p. 151) serve an invaluable role in community-based programs, especially those that target underserved populations. Many of the challenges of working within underserved communities may be overcome by capitalizing on the strengths of paraprofessionals who may more easily identify with, recruit, and engage community members than professionals who may be more likely viewed as "outsiders" by community members (Nelson, Prilleltensky, & MacGillivary, 2001). Issues of culture, ethnicity and race, language, and socioeconomics may be more easily addressed by paraprofessionals who share these characteristics with participants than by professionals who typically have fewer similar background experiences. Community members who serve as paraprofessionals can provide valuable information about their community that can be used to tailor an intervention to the needs and goals of community residents. Moreover, the use of paraprofessionals in program delivery allows for the economical and systematic translation of important evidence-based parenting programs into communities that may be in greatest need of this information and support (Keune & Gelauff-Hanzon, 2001).

There is evidence showing that paraprofessionals can be as or more effective than professionals in achieving desired clinical outcomes (Durlak, 1979). The characteristics of effective paraprofessionals appear to be similar to those of effective professionals, including personal maturity and ability to manage emotions (Nielsen, 1995), empathy, warmth and caring (Musick & Stott, 1990), problem-solving skills and flexibility in thinking (Grant, Ernst, & Streissguth, 1999), astute listening and responding skills (Nielsen, 1995), and ability to maintain confidentiality and boundaries (Musser-Granski & Carrillo, 1997). The literature suggests that paraprofessionals can play a crucial role in dissemination research, yet "despite the growing reliance on paraeducators in more complex and demanding roles, limited attention is being paid to the employment, preparation, and management of paraprofessionals" (Hilton & Gerlach, 1997, p. 71). This issue is compounded by inconsistencies in the definition of paraprofessionals and their training (Hiatt, Sampson, & Baird, 1997).

PARAPROFESSIONAL TRAINING PROGRAMS

Approach to Ttraining

Several researchers have suggested an informal and non-didactic approach to paraprofessional training. Hiatt, Sampson, and Baird (1997) found that

paraprofessionals reported feeling uncomfortable with a formal, didactic approach, particularly one that is reminiscent of a school-like environment, and this discomfort may result in insecurity regarding mastery of material (Halpern, 1992). Tan (1997) suggested that training should include modeling by professionals and experiential practice in addition to didactic components such as lectures and reading assignments. Based on a review of several family-based preventive intervention programs, Halpern (1992) recommended that training include an emphasis on role performance rather than didactics. He also suggests that interactive paraprofessional training can offer several advantages, such as allowing program staff on both the professional and paraprofessional level to get to know each other's strengths and weaknesses prior to working with parent participants. Experiential teaching also affords the opportunity to assess skill acquisition and to practice the feedback process (Gould, 2000). Finally, an informal, hands-on approach may help a program avoid "over- professionalizing" a paraprofessional program, thereby losing the desired image and qualities of a nonprofessional (Maierle, 1973).

In addition to adopting an experiential teaching approach, research has highlighted the importance of presenting material in a concrete and practical manner (Gould, 2000) and in an informal style using straightforward, jargon-free language that is familiar to the participants and sensitive to educational differences (Cameron, Peirson, & Pancer, 1994). For programs that serve parents and their children, it is important to include time for discussion of the paraprofessional's own beliefs about children and childrearing (Halpern, 1992). Gould (2000) found that the main challenge in training paraprofessionals as home visitors was the discussion of biases, primarily as related to parenting (i.e., choice of certain strategies). This issue is particularly important in light of the finding that paraprofessionals may be disinclined to teach childrearing skills that feel foreign or unnecessary to them (Hiatt et al., 1997).

Logistics

Program length is a primary logistical consideration in the design of a paraprofessional training program. The optimal amount of training is a complicated issue that depends on the goals of the program, program resources, and characteristics of the paraprofessionals. The degree to which paraprofessionals are effective in their clinical roles depends on the amount of training received (Hiatt et al., 1997). Sufficient training and developing expertise are essential to avoid placing paraprofessionals in the position of providing services for which they are not prepared, and in turn, receiving criticism (from self or others) for their performance. In a study of paraeducators working in the school system, Riggs and Mueller (2001) found that paraprofessionals generally desired *more* systematic training than they received, still, some researchers have cautioned against the natural tendency to try to achieve too much through training (Halpern, 1992). According to Tan (1997),

the ideal length of basic (i.e., classroom) training is between 24–50 hours over several weeks. A basic training program may then be supplemented with supervised field experience (e.g., Kotkin, 1998). This is consistent with a professional training model (i.e., classroom work followed by clinical practica) and maintains an emphasis on experiential rather than didactic learning.

The location of training should take into account potential logistical barriers for paraprofessionals. Training should be held at local community-based centers (Cameron et al., 1994), and if this is not possible, reimbursement of transportation costs should be considered. Adequate financial compensation for training should be provided and be commensurate with the role and responsibilities of the paraprofessional (Musser-Granski & Carrillo, 1997). Clear expectations for performance during training and program delivery should be communicated orally and in writing (Riggs & Mueller, 2001). Moreover, advancement opportunities and career support should be integrated into the training program (Hilton & Gerlach, 1997).

Content

Although we could not identify any literature specifically on training content for paraprofessionals involved in cognitive-behavioral preventive parent training programs, there is some relevant literature with regard to childcare, school-based interventions and home visitation. Based on a review of the literature and qualitative data from paraprofessionals who work with children, Shealy (1996) identified several essential knowledge areas and requisite abilities that contribute to successful work in the field of childcare. Key content areas include child development, counseling theories and techniques, and professional and ethical standards. Others have suggested that psychopathology (Tan, 1997), and in particular the role of environmental stressors in the development of pathology (Prater, 1987), be covered in training. Process skills are at least as important, particularly as related to relationship-building and basic helping skills including effective communication, observation skills, boundaries and termination (Gould, 2000; Halpern, 1992). Finally, paraprofessionals should be trained in skills relevant to community work such as engaging in community outreach and empowerment (Prater, 1987), becoming familiar with the participants and agency with whom they will be working (Shealy, 1996), facilitating the referral process (Halpern, 1992; Tan, 1997), recognizing existing support networks and creating new ones (Prater, 1987), and promoting cultural awareness and sensitivity (Prater, 1987). Within each of these content areas, specific behavioral objectives are more useful than global program objectives (Gould, 2000; Halpern, 1992).

An important component of ongoing training is supervision. Supervision should meet several goals, and above all, should ensure that the intervention protocol is followed and carried out with integrity (Hiatt et al., 1997). Additionally, supervision gives paraprofessionals the opportunity to receive feedback,

evaluate their progress, recognize their strengths and weaknesses, and receive support (Halpern, 1992). Finally, supervision can be used to reinforce appropriate boundaries and to deal with relationship issues related to interventionists and participants living in the same communities (Gould, 2000).

THE PARENTCORPS PARENT REP TRAINING PROGRAM

The overarching goal of the Parent REP training program was to prepare paraprofessionals to effectively engage and recruit parents in their community into the ParentCorps program and to deliver program services alongside professional staff. The Parent REP training program was divided into four phases, each designed to be consistent with its particular goals. Basic training, as distinguished from fieldwork and supervision, was held during Phases I and II. Within these phases, several modules were offered, each of which was manualized and led by a doctoral-level psychologist. Fieldwork and supervision occurred during Phases III and IV.

Phase I (i.e., Basic Training) of training covered the basic skills and concepts on which ParentCorps is based. Training was dedicated to teaching effective parenting strategies for parents of preschool-aged children and introducing other topics such as child mental health, crisis management, and cultural issues. The primary goal of Phase I was to provide an overview of the topics and skills relevant to the ParentCorps program and more specifically, to the Parent REP role. This phase also allowed for an informal assessment of the level of interest and the strengths and weaknesses of the trainees. Trainees were paid hourly based on their attendance. Following the completion of Phase I training, Parent REPs were selected for specific positions. Parent REPs were employed as full-time, half-time or quarter-time employees, and selected as parent group co-leaders, children's group co-leaders and/or home visitors. All trainees were guaranteed a position as a Parent REP contingent on the completion of Phase I training. The decision to hire trainees at varying levels was based on the program's commitment to the Parent REPs balanced against the financial constraints of the program. Phase II (i.e., Basic Training) was tailored to the individual position of the trainees and is described in more detail below.

Phases III and IV (i.e., Field Work and Supervision) were based on a clinical practicum training model. During Phase III, Parent REPs assisted in service provision to the families in their community. They served as co-leaders for groups and home visits and attended supervision. The goal of Phase III was to provide paraprofessionals with direct clinical experience while working alongside a professional who could model and provide feedback throughout the process. Initially, Parent REPs primarily observed the professional leaders in groups and on home visits, but over time and with supervision, they were encouraged to become increasingly active in their clinical roles. Parent REPs were responsible for referrals and

advocacy for families with whom they conducted home visits, and for maintaining clinical records (i.e., progress notes).

All clinical experiences were supplemented with formal group supervision led by doctoral-level clinical psychologists. Explicit goals of supervision were to: (1) ensure the appropriate care of participating families, (2) maintain intervention integrity, (3) provide support to all interventionists, including Parent REPs, (4) provide opportunity for ongoing learning via discussion of clinical issues, (5) highlight and enhance the use of the Parent REPs' strengths, (6) maintain communication between Parent REPs and professional staff, particularly as related to cultural and community knowledge, and (7) ensure adequate record-keeping for ethical (i.e., confidentiality) and research-related (i.e., protection of data) reasons. Individual cases were presented and discussed, intervention plans were formulated, and records were reviewed. In addition, Parent REPs completed self-evaluation forms to facilitate developing self-monitoring skills and to evaluate progress towards their individual goals.

The final phase of training, Phase IV, consisted of a summer placement program where Parent REPs volunteered in agencies throughout the targeted community. The goal of the summer placements was to provide opportunities for Parent REPs to: (1) utilize newly learned skills and knowledge about parenting, child development, and community resources; (2) supplement their work experience and enhance their resumes; (3) network with other community members; (4) increase their sense of affiliation with and ownership of ParentCorps by acting as program ambassadors to the community; (5) further familiarize the community-at-large with ParentCorps; and (6) provide local community agencies with highly trained staff, thereby providing a valuable "free" service to the community. Toward this end, Parent REPs identified potential placement sites based on their interests and knowledge of community needs. Professional staff met with agency leaders and the Parent REPs to establish a common understanding of the goals of the placement and to agree upon roles and responsibilities. Supervision was provided by the host agency staff and was supplemented by ParentCorps professional staff. Parent REPs remained on ParentCorps payroll during the placements.

Approach to Training

The specific approach to the Parent REP training program was primarily influenced by the targeted audience of trainees. It was expected that the Parent REPs would have varying educational and occupational backgrounds, family compositions, and socioeconomic and cultural backgrounds—factors that may influence learning style (Hilliard, 1992) and attitudes toward parenting (McGroder, 2000). Thus, efforts were made to create a curriculum that would be effective and acceptable to Parent REPs regardless of background. As a result, the Parent REP training program emphasized an informal yet structured learning environment. Sessions

began with a didactic component (i.e., lecture, slides, handouts) that encouraged trainee participation in the form of discussion. Sessions also included an experiential component in which individual and group activities, modeling, and role-plays allowed trainees the opportunity to observe and practice using new skills and to receive feedback. All sessions ended with a set of review questions that highlighted the key concepts of the topic and served as a mechanism to provide feedback on performance. Review questions were accompanied by an answer key and were discussed in a later session as a group.

Lectures and materials were presented in jargon-free language that was sensitive to various educational and cultural backgrounds. Moreover, an emphasis on the role of culture and community in parenting, child development, and family functioning was incorporated into all aspects of training through the use of role plays and discussions about hypothetical situations of families that differed in composition, ethnicity and socioeconomic status.

Logistics

The full training program included 38 weeks of training that occurred over approximately one year (see Table I). Over the course of the training program,

Table I. Overview of ParentCorps Training Program

Phase	Duration	Number and length of Sessions	Structure and Content
I	10 weeks	• 10 2-hour sessions • 10 2-hour sessions	• Parenting group • Professional issues
II[a]	10 weeks	• 10 8-hour sessions • 10 6-hour sessions • 10 4-hour sessions • 20 2-hour sessions • 10 2-hour sessions • 10 2-hour sessions	• Parenting group • Children's social competence group • Home visiting • Peer counseling • Recruitment • Computer training
III[a]	10 weeks	• 10 2-hour groups ○ 10 1-hour sessions • 10 2-hour groups ○ 10 1-hour sessions • 10 2-hour groups ○ 10 1-hour sessions • 5 90-minute visits ○ 10 2-hour sessions • 10 1-hour sessions	• Parenting group ○ Supervision • Children's social competence group ○ Supervision • Sibling recreational group ○ Supervision • Home visiting ○ Supervision • All staff clinical meetings
IV	8 weeks	5; 14; or 21 hours per week • 8 1-2 hour sessions	• Practicum in community agency ○ Supervision

[a]Not all sessions attended by all trainees.

full-time employees received 240 hours of basic training, 196 hours of direct service provision, and 46 hours of supervision. Half-time employees received 220 hours of basic training, 140 hours of service provision, and 38 hours of supervision. Quarter-time employees received 100 hours of basic training, 60 hours of direct service provision, and 18 hours of supervision. Thus, the number of hours spent in training, service provision, or supervision totaled between 178 and 482 hours over one year.

Potential logistical barriers to participation in training were addressed by conducting training in the community, by providing pre-paid transportation cards, and by establishing a flexible training schedule. Full- and part-time paid positions with a range of roles and duties were made available. All trainees were provided with written employment materials including a general job description, job expectations, and employment guidelines (i.e., attendance/sick policy, vacation package). Trainees were also provided with the opportunities for promotion as job openings became available so that part-time Parent REPs who were performing exceptionally well were offered a position with higher pay or more hours. Finally, an effort was made to provide trainees with educational and occupational advancement opportunities (e.g., Grand Rounds).

Content

Table II illustrates the weekly topics covered within each module of Phases I and II.

Parenting Group

The goals of the Parenting Series training were to: (1) teach scientifically-based parenting strategies for use with young children; (2) explore cultural issues underlying the acceptance and use of certain parenting strategies; and (3) teach skills related to facilitating a parenting group. The first half of the training session was a mock parent training group in which Parent REPs participated as parents. This model served to familiarize the Parent REPs with the content of the series and to help them understand the perspective of participants. Also, approaching trainees as participants was designed to help Parent REPs become more confident and effective parents to their own children, thereby becoming models within their communities.

The second half of the session provided more comprehensive coverage of the parenting skills and covered clinical process issues. Each skill was presented from a cognitive-behavioral model so that Parent REPs would understand its use and application in terms of "thinking, feeling, and doing." For example, in teaching the use of praise with children, Parent REPs were prompted to consider

Table II. Weekly Topics of Basic Training Program

	Paraprofessionalism[a]	Parenting[b]	Children's group[c]	Home visits[c]	Peer counseling[c]
1	Introduction	Parenting in context	Introduction	Introduction	Introduction
2	Child development	Routines, roles, responsibilities	Teamwork; communicating with children	Building rapport	Leading a group
3	Child development	Parent-child interactions	Playing with children	Safety; appropriate boundaries	Building collaborative relationships with parents
4	Diversity training	Positive reinforcement	Positive reinforcement	The initial contact	Self-awareness; monitoring
5	Community issues	The art of ignoring	Ignoring mild misbehavior	Self-Monitoring	Self-awareness; monitoring
6	Mental health issues	Time-out	Setting limits	Working with diversity	Safety
7	Peer counseling skills	Dealing with feelings	Giving effective commands	Giving parents feedback	Abuse & Neglect
8	Peer counseling skills	Other discipline tools	Dealing with feelings	Dealing with resistance	Mental health issues
9	Crisis management	Support for parents	Structure/content of group	Time management	Mental health treatments
10	Review; graduation	Planning for the future	Review; graduation	Review; graduation	Referrals; advocacy

Note. Phase II also included Basic Computer Training for all trainees.
[a]Phase I only.
[b]Phase I and II.
[c]Phase II only.

the effect that praise would have on a child's thoughts ("Yes, I am a good helper."), feelings (pride) and behavior (increase the behavior praised). Process issues that were covered included: establishing rapport, facilitating discussion, dealing with difficult or personal questions, managing parents who are resistant or aggressive, and maintaining confidentiality.

Each topic was taught didactically and followed by discussion that centered around ways to make each parenting skill more appropriate and acceptable to the targeted parent participants. Parent REPs were seen as an important community resource and thus were encouraged to share their views on what language and teaching strategies might be more effective in presenting the skills to participating families. Finally, to end each training session, a selected Parent REP facilitated a mock session, which required familiarity with both content and process issues, and was given feedback on his or her performance.

Home Visits

The goals of this training component were to: (1) familiarize Parent REPs with the content of each manualized home visit, (2) teach counseling skills that facilitate rapport and trust between Parent REPs and the families they serve, and (3) teach problem-solving skills that would help them address individual family needs and the generalization of parenting skills to the home. Didactics focused on developing observation skills, understanding family dynamics, promoting parents' self-sufficiency and problem-solving skills, being culturally sensitive, and keeping records. There was also extensive discussion and problem-solving about maintaining boundaries (e.g., socializing with clients outside of the home visits).

The experiential component consisted of modeling and role-plays that were conducted for each of the planned home visits and that allowed Parent REPs to practice all aspects of the Home Visitor's role. Role-plays were done by every trainee in the presence of the group and were followed by feedback from both peers and trainers; this promoted both skill-acquisition and self-awareness. The impromptu nature of the role-play scenarios (i.e., the person playing the parent could choose to act out any situation, such as getting into a fight with her partner) helped Parent REPs become increasingly adept at handling unexpected and challenging situations.

Children's Social Competence Group

The goals of the children's social competence training component were to: (1) apply the skills of effective parenting to leading a children's group, (2) teach, model, and practice the behavior management techniques that would be used during the children's groups, and (3) explore the developmental achievements, goals

and needs of preschoolers. For example, Parent REPs learned how to manage the behavior of a group of preschool-aged children through the use of preventive strategies such as rules and routines as well as intervention strategies such as ignoring and time out. Training incorporated both didactics and experiential teaching. Role-plays centered around scenarios in which the group leaders had to balance the needs of all the children (particularly in situations in which one child would need individual attention) as well as attend to the structure and content of the group (e.g., completing an activity, serving dinner), and were followed by individual feedback.

Peer Counseling

The goal of this training was to prepare participants for clinical challenges that would likely arise during interactions with program participants in parenting groups, children's groups or home visits. Specific aims toward this goal were to: (1) build a knowledge base about basic mental health issues, (2) teach skills for coping with challenges involved in working with others, and (3) encourage constant self-awareness during interpersonal interactions. Topics included: building collaborative relationships with parents (e.g., maintaining confidentiality, viewing parents as partners, empowering parents), monitoring reactions to others (e.g., how to respond appropriately when a parent "pushes your buttons"), being aware of how others react to them, and crisis management skills (e.g., assessing safety of self and others, procedures for handling suspected abuse). Training drew heavily on the experience Parent REPs encountered as parents living in the targeted community. This module relied primarily on experiential strategies. Role-plays and videotaped feedback were used throughout the training to provide opportunities to practice skills and promote self-awareness in a supportive environment.

Complementary Modules

Parent REPs also received training in basic computer skills and recruitment, advertisement, and engagement skills. These applied modules included activities such as devising recruitment strategies, role-playing a recruitment speech, creating fliers and posters for program advertisements, and researching resources on the Internet.

LESSONS LEARNED

Overall, Parent REP training was designed to provide Parent REPs with an intensive and comprehensive but manageable program that was individually

tailored to their roles. Upon completion of the training, Parent REPs were expected to have a general knowledge and skill base and applied experience in working with families of young children from urban, socioeconomically disadvantaged neighborhoods, and these goals were largely accomplished through the training program. Still, there were lessons learned from our initial training experience that may inform future Parent REP training programs and other developing paraprofessional training programs.

First, it seemed that selecting paraprofessionals for distinct positions (i.e., full-, half-, and quarter-time) created natural division and hierarchy. Based on observations by professional staff and trainers, it appeared that full-time Parent REPs were envied for their positions while quarter-time Parent REPs had difficulties being integrated into the larger group of Parent REPs (because they spent less time at work). Still, it is important to grant flexibility within any given job position and to reward excellent performance with increased responsibilities and financial compensation. Perhaps selecting trainees into different positions so early in the training process (after Phase I) was premature as the delay of this selection process would have allowed more time for the group to coalesce and trust each other. Alternately, it may have been less detrimental to the group dynamic if all Parent REPs had been hired as half-time employees. Such decisions must be made with careful consideration of the needs of the program and balanced with the consequences inherent in selecting trainees for different positions.

In addition, our approach to training, with its emphasis on experiential over didactic teaching, while appropriate, could have benefited from even less didactic teaching. We strongly recommend reducing the didactic component of training to the minimum necessary for achieving a program's training goals. For the Parent REP training program, which aimed to prepare paraprofessionals to act as co-facilitators of services *alongside* professionals, there was little need for trainees to have complete and extensive knowledge of all mental health topics. Moreover, achieving such a level of knowledge is unrealistic given practical considerations (e.g., time).

In contrast, there was a strong need for Parent REPs to be prepared for and comfortable with their role as representatives of the ParentCorps philosophy. Thus, the training program could have dedicated more time to understanding the ideas, values, and biases of paraprofessionals as related to the training topics. Certainly, a deeper understanding of *every* staff person's biases may have allowed the staff as a whole to reconcile differences between trainers and trainees and may also have promoted a stronger working alliance amongst staff. Creating a program that relies heavily on discussion would encourage an environment wherein: (1) the learning process is reciprocal between trainers and trainees rather than exclusively from trainer to trainee, (2) trust and respect is better established, and (3) a team approach to the delivery of the program is instilled upfront.

To this end, it would have been helpful for the Parent REP training program to incorporate a more formal assessment of the acceptability of each topic as presented, particularly as related to parenting. We found that it was often insufficient to merely ask the trainees their opinions on a topic (e.g., spanking) after presenting it. Gould (2000) has addressed this issue using a "bias box" into which trainees and professionals anonymously place a written description of their biases and then discuss them as a group. This more creative, structured approach may lead to better discussions and ensure that all participants share their views in some format.

Similarly, more emphasis on the individual, pre-existing strengths of trainees would have been beneficial to the training program on multiple levels and in particular, may have helped the professional staff convey a stronger sense of respect and appreciation for the trainees. This may be achieved by creating a form asking trainees to describe their strengths and then finding creative ways to incorporate those strengths into the trainee's role. The involvement of paraprofessionals in mental health services is based on the advantages inherent in their role as community members (and as persons *without* professional training) and it is crucial to capitalize on such skills. While it can be difficult to maintain a focus on strengths that are not traditionally emphasized within the professional world (e.g., a particular communication style), it is imperative to establish a team in which each person's role complements, rather than replicates, the others.'

FUTURE DIRECTIONS

We are currently testing the ParentCorps model in the context of a partnership between university researchers and public schools. Specifically, ParentCorps is being provided through the pre-Kindergarten programs in one large urban school district by school staff (e.g., teachers, teacher's aides and family workers) and local community members (serving as Parent REPs). Parent participants who successfully complete the ParentCorps program will be recruited and selected into the Parent REP position. Importantly, this model should be more cost-effective than the one described above because prior to employment, Parent REPs will have participated in the program and in this way, essentially completed Phases I and II of training.

Despite its advantages, this model also introduces new conceptual and logistical considerations for training. For example: what kind of relationship do community members have with the school? Do community members trust school staff and the school system as a whole? Is the demographic background of the school staff similar to that of the community? What school policies or guidelines will influence the training and employment of Parent REPs?

As a general guideline, it may be useful for training program developers to consider the following issues: What are the characteristics of the targeted

community (e.g., cohesive, active)?; What are the characteristics (e.g., demographic) of the community members who will serve as paraprofessionals?; What local institution is highly visible, accepted and respected by community members?; What are the opinions of the community about health, mental health, and education issues?; What are the individual needs and goals of the community and how can the program be adapted to meet these needs and goals?; How would community members design a training program in terms of approach to training (i.e., strategies they would use to share information), logistics (i.e., where they would host it), and content (i.e., relevant topics)?

An assessment of the above issues can be critical in creating the most acceptable and successful approach to training for a given group of community members who will serve as paraprofessionals. Moreover, the effort put forth by university researchers in assessing such issues before implementing a program conveys an appreciation for the unique characteristics of the community and communicates the researchers' desire for collaboration rather than exploitation. A partnership in which each collaborator has an *equal* voice and an *equal* stake will promote the most complete understanding of how to best serve families (Himmelman, 2001).

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