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Older Adult Paraprofessionals: Working With and in Behalf of Older Adults

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This critical review is focused on six selected issues relevant to those programs in which older paraprofessionals work with their elderly peers: (a) the overall emphasis on preventive mental health benefits for the helpers via the provision of meaningful roles; (b) the range of roles of older paraprofessionals, including peer counseling, casework and outreach, community organization and gerontological advocacy, and other adjunctive roles in agencies; (c) the wide diversity in recruitment, selection, and training practices; (d) the rationale of indigenousness or helper-helpee age similarity as uniquely enhancing the effectiveness of older paraprofessionals; (e) the marginal integration of elderly paraprofessional programs into the mental health system; and (f) the paucity of program outcome evaluations. In considering each issue, an attempt is made to focus on embedded empirical concerns and the continuing need for establishing a research-oriented literature commensurate with the recent growth of clinical and community interest in elderly peer paraprofessional strategies.

Elderly persons typically are seen as "needy but reluctant" (Schwartz, 1980, p. 147) in relation to the mental health system. Many professionals seeking a solution to getting mental health services to older adults have supported the practice of using older adults as paraprofessionals. Echoing the rationale of the paraprofessional movement in community mental health, older adults, on the one hand, have been identified as underserved and poorly served while, on the other hand, have been seen as a particularly available and suitable source of personnel to meet human service needs (e.g., Waters, Reiter, White, & Dates, 1979). Moreover, just as Mitchell and Hurley (1981) have pointed to parallels between the indigenous paraprofessional movement and natural helping networks, peer counseling has been touted as a natural derivative of the kinds of social support chiefly relied on by older adults (Schwartz, 1980).

At the same time as older adults have been seen as a source of personpower offering advantages to the service recipient, advantages to the paraprofessional helpers themselves also have been cited. For the older helper, working as a paraprofessional is said to provide a meaningful role (Payne, 1977), recapitulating the "helper therapy principle"; i.e., the observation with other age groups that working as a paraprofessional confers status and satisfaction and has a beneficial effect on the self-esteem and personal growth of the helper (Riessman, 1976).

The multiple potential advantages of paraprofessional programming have fueled interest in the idea, as evidenced by the proliferation of programs, professional workshops on the topic, and the many requests for consultation and training materials received by demonstration projects (e.g., Strelow, Buckley, Kleinbaum, & Coles, 1981; Waters, White, Dates, Reiter, & Weaver, 1979). Despite such interest, older adults have figured

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Table 1
Older Adult Peer Paraprofessional Programs

Approach	Authors	Program
Peer counseling	Alpaugh & Haney (1978); Becker & Zarit (1978)	Peer counseling
	Bratter & Tuvman (1980)	Peer counseling for elderly persons (PEP)
	Priddy & Knisely (1982)	Widowhood peer counselor training
	Strelow, Buckley, Kleinbaum, & Coles (1981); Morehouse (1981)	Peer counselor training
	Waters, Fink, & White (1976); Waters, White, Dates, Reiter, & Weaver (1979)	Peer group counseling
Outreach and casework	Friedman (1975)	Nursing home resident welcoming committee
	Gaitz (1977)	Senior information and outreach services
	Gatz, Barbarin, Tyler, Mitchell, Moran, Wirzbicki, Crawford, & Engelman (1982)	Community workers
	Haber (1982)	Senior companions
	Santore & Diamond (1974)	Senior case aides
	Santos (1977)	Mental health outreach program (MHOP)
	Toseland, Decker, & Bliesner (1979)	Neighborhood outreach program (NOP) peer counselors
	Wright, Bennett, Simon, & Weinberg (1977)	ILGWU friendly visitors
Service in community agencies	Cox (1979)	Community health educators
	Faulkner (1975)	"Good Neighbors" and senior center volunteers
	Payne (1977)	Senior center volunteers
	Sainer (1977); Sainer & Zander (1971)	Project SERVE (Serve and enrich retirement by volunteer experience)
	Thune, Tine, & Booth (1964)	Community service worker training
Community organization and advocacy	Blonsky (1973, 1974)	Older adult community action program (OACAP)
	Bolton & Dignum-Scott (1979)	Peer group advocacy counseling
	Lang (1972)	Advocates
	Ruffini & Todd (1979)	Senior block information service (SBIS)
	Sheppard & Valla (1976)	Project V-STRAP (Virginia senior training results in power)

minimally in the paraprofessional literature, providing another instance of the lack of "mutual interpenetration of gerontological and clinical psychological literature" decried by Lawton (1970, p. 154). In their annotated paraprofessional bibliography, Alley and Blanton (1978) listed 26 aging programs. The majority involved older adults as recipients of services provided by paraprofessionals of other ages; in only six of the programs were the paraprofessionals older adults, and in only two were the target group also aged. Gershon and Biller (1977), who reviewed reports of 275 paraprofessional programs, brought up the aged in a section on self-help and the helper therapy principle, but described programs where the older adults were helpers working solely with non-aged populations. Finally, Durlak's (1979) review of 42 studies of the relative effectiveness of paraprofessional and professional helpers included no aging programs.

We have chosen to focus our review on programs in which older adults work with other older individuals. Table 1 lists 23 illustrative programs, reflecting a broad range of roles or approaches, including both paid workers and volunteers. In the sections below, it is these programs to which we will refer as we consider six issues central to older adult paraprofessional programs: (a) benefits for the helper, (b) role and status of the helper, (c) recruitment, selection, and training, (d) indigenousness, (e) effect on the mental health service system, and (f) outcome evaluation. In most cases, comparisons are drawn between peer programs for the aged and the general paraprofessional literature.

Benefits for the Helper

The single most salient characteristic of paraprofessional programs for older adults may be their emphasis on psychological benefits to the helper. First, the balance between helper and helpee goals appears quite different from programs for younger paraprofessionals. Although the relative emphasis varies from program to program, it is not unusual to find benefits to the helper taking precedence over benefits to the recipient of services. Second, for older paraprofessionals, psychological benefits for the helper are emphasized more than employment; whereas, for younger paraprofessionals, relatively more attention is paid to provision of economic and career opportunities for the poor than to the helper therapy principle (Pearl, 1981). For the aged, working as a paraprofessional tends to be seen as a preventive mental health program for the *helper.*

Specifically, Uhlenberg (1979) states that involuntary loss of social roles is the central issue for aging women, who have time on their hands but need assistance in channeling it constructively. Payne (1977) offers a theoretical description of volunteering as "social reconstruction" (cf. Bengtson, 1973), providing roles that place a value on time and skills. Gaitz (1977, Spring) describes it as a "reclaimed sense of *usefulness*" (p. 20). The central hypothesis of Faulkner's (1975) program was that volunteers would gain improved self-image through giving rather receiving help, although a second criterion was that the help provided by the volunteers had to add to the services being given by the center. Similarly, Friedman (1975) presented three program purposes: meaningful activity, being part of a group, and aiding new residents of a nursing home. Sainer (1977) and Sainer and Zander (1971) likewise attributed their program's success to making primary the goal of providing a significant social role for the older volunteer, one that offered meaning and purpose and also provided social contacts, while at the same time volunteers were aiding community service organizations that needed personnel. However, even among programs that put benefits to the recipient first, there is still explicit recognition of mutual gain (e.g., Bratter & Tuvman, 1980; Lang, 1972; Santore & Diamond, 1974).

How well do data document the benefits to older helpers suggested by the program rationales? On the whole, evidence is sparse. Waters, Fink, and White (1976) rated outcome for peer group leaders and found gains in interpersonal skills, expression of feelings, and ability to evaluate one's own performance. Gatz, Barbarin, Tyler, Mitchell, Moran, Wirzbicki, Crawford, and Engelman (1982) reported that community workers increased significantly more in life satisfaction and in knowing where to get information about community resources than did those who were being helped.

While there is some support for claims of psychological benefits, other data indicate that role loss and the image of older adults as having too much time on their hands may be a bit overrated, at least as a rationale for older volunteer programs. Dye, Goodman, Roth, Bley, and Jensen (1973) reported that their volunteers were distinguished from nonvolunteers by having *less* free time and less difficulty filling it. Blonsky (1974) had difficulty recruiting indigenous community leadership because people were already overcommitted or because they felt they had worked hard their whole life and would like some time to relax. It may be, as Faulkner (1975) suggested, that only the ablest volunteers are being recruited, so that we do not yet have a fair test of the role loss and "social reconstruction" hypotheses.

Finally, while older paraprofessionals clearly acknowledge psychological benefits, they also mention the financial boost as a motive. Yet, in the programs we reviewed, it is comparatively rare to be paid, although often the community agency covers transportation and perhaps also lunch (e.g., Bowles, 1976; Sainer & Zander, 1971). Holley, Feild, and Holley (1978) compared reasons for accepting employment given by older and younger paraprofessionals. Older workers were more likely to mention wages and job security, while young workers were more concerned with advancement toward a better job. Using elderly samples matched on demographic characteristics, mental competence, and physical health, Carp (1968) compared workers, volunteers, and persons who were neither. The volunteers were not different from older persons who neither worked nor volunteered, while older workers were significantly different from both other groups on happiness, self-concept, social relationships, and satisfaction with use of time. Carp attributed the difference to both the payment and the greater social value of paid work.

Roles and Status

Typically, it is urged (e.g., Gotbaum & Barr, 1977; Sainer, 1977) that the older paraprofessional be seen as supplementing rather than substituting for the services provided by professional staff. Older adult paraprofessionals fill roles along some continuum of functions that may include counseling, outreach and casework, providing adjunctive sorts of services in community agencies, and community organization and advocacy on behalf of the aged. In Table 1, programs are categorized into these four groups. Those who write about the provision of professional services to older individuals frequently note the need to combine psychotherapy and "practical advocacy" (Blum & Tross, 1980); Settin (1982) argued that paraprofessionals are particularly able to combine various functions, such as counseling, casework, and provision of practical assistance. Furthermore, prevention, outreach, and education—three generally important principles in provision of mental health services to the aged (American Psychological Association, 1980, November)—are important across the entire range of paraprofessional roles.

Most programs are preventive in the sense that they aim to avert premature or unnecessary institutionalization by promoting self-sufficiency among the recipients; an example would be the provision of in-home services to frail elders in the community

(Haber, 1982). Furthermore, many approaches constitute secondary prevention with clientele at risk or involved in a developmentally related transition, such as relocation (Friedman, 1975) or bereavement (Priddy & Knisely, 1982).

Across the set of programs, outreach is another common feature. For instance, Toseland, Decker, and Bliesner (1979) did in-home casework, reaching out to older people who were socially isolated and encouraging residents to become involved in community groups. Waters et al. (1976) held short-term counseling groups at various community centers such as nutrition sites and union halls, taking services to where clients are.

The third feature is use of an educational format, which offers the advantages of being growth oriented and provoking less threat to recipients, as well as providing structure for the paraprofessionals. For example, Cox (1979) used older volunteers to teach health education classes, and education in the form of information and referral is an almost universal service component of the programs we reviewed (e.g., Blonsky, 1973; Gaitz, 1977; Spring, Wright, Bennett, Simon, & Weinberg, 1977-78).

Programs vary in their flexibility about worker roles and levels of involvement. For example, Ruffini and Todd's (1979) network model for the organization of elders offered several different types of volunteer roles so that all older people could comfortably participate at least at a minimal level (e.g., distributing newsletters). Several other programs, mostly peer counseling (Alpaugh & Haney, 1978; Strelow et al., 1981), did not design in the flexibility but have observed a natural drift of the paraprofessional to more specialized roles.

Among younger paraprofessionals, a big issue has been strain between paraprofessionals and professionals. Strain has tended to be most evident in programs employing poor indigenous community workers. In contrast, the relationship of older adult paraprofessionals to professionals has received little attention. Faulkner (1975) found that younger paid staff paraprofessionals took pains to differentiate between their own jobs and those of the older volunteers. Becker and Zarit (1978) reported that in a center that provided psychotherapeutic intervention, care was taken with case assignment, so that peer counselors were given cases for one-to-one supportive counseling, while graduate students did more extensive counseling.

Recruitment, Selection, and Training

Generally among programs in which creating a meaningful role for older adults is a major goal, recruitment is broadly based, few people are screened out, and the focus tends to be less on a core curriculum than on providing on-the-job training. In contrast, programs with a primary focus on service delivery (e.g., peer counseling) tend to place more emphasis on careful recruitment and selection and typically provide extensive preliminary training as well as some form of ongoing supervision.

Demographically, the preponderance of older paraprofessionals are women: 100% (Wright et al., 1977-78), 84% (Sainer & Zander, 1971), approximately 75% (Sheppard & Valla, 1976; Strelow et al., 1981; Thune, Tine, & Booth, 1964), and 57% (Payne, 1977). The majority of peer counselors are white, while some community outreach programs (e.g., Gaitz, 1977, Spring; Santos, 1977, Spring; Toseland et al., 1979) attempt to match the racial composition of the community. Some programs include both middle-aged and older adults (Santos, 1977, Spring), while others draw the line at 50 (Toseland et al., 1979) or at 60 (Santore & Diamond, 1974), with the oldest workers in their 70s or even 80s. Sainer (1977) made a particular effort to recruit "nontraditional" volunteers, but Payne (1977) seems more typical in reporting that 68% of her volunteers had volunteered previously.

Strategies for recruitment include advertising, drawing on an existing pool of volunteers, soliciting from the client population, and peer nomination (cf., Waters, Reiter, White, & Dates, 1979). Selection for older as for younger paraprofessionals tends to rely on some combination of self-selection and of screening for interpersonal skills (Durlak, 1979). Criteria for this process, by and large, have not been systematically developed or applied. The most frequently cited criteria include the mental health of the applicant; level of interpersonal and community skills; depending on the program, a common experiential base with program participants, such as being a widow or having suffered a stroke; motivation and willingness to learn; lack of personal impediments (health, time, transportation); and receptivity to program goals and methods (e.g., Faulkner, 1975; Priddy & Knisely, 1982; Schwartz, 1980; Waters, Reiter, White, & Dates, 1979). Selection often seems to be refined only after some volunteers have worked out better than others. Strelow et al. (1981) developed a more extensive selection protocol after having some problems with attrition and perceived inappropriateness of some of their peer counselor trainees. Thune et al. (1964) had trainers rate employability of the community service workers after training; predictors of employability were high verbal functioning, strong ego defenses, and perseverance. Attrition is commonly reported to be low, from zero (Bratter & Tuvman, 1980) to 25% (Santore & Diamond, 1974), and generally for health reasons.

Extensiveness and format of training varies widely, generally including some combination of didactic and experiential approaches. Content typically includes matters such as listening and communication skills, steps in problem solving, information on normal processes and problems of aging (including feelings about death), information and referral protocol (including when and how to refer a client to a mental health professional), and record keeping (e.g., Alpaugh & Haney, 1978). Bratter and Tuvman (1980), Priddy and Knisely (1982), and Strelow et al. (1981) used the Alpaugh and Haney text in their training.

Length of sessions and duration of training also show wide variation across programs: 30 hours over 10 weeks (Alpaugh & Haney, 1978), 37½ hours over 15 weeks (Strelow et al., 1981), 40 hours over 2 weeks (Haber, 1982), 50 hours over 5 weeks (Waters, Reiter, White & Dates, 1979), and up to 150 hours (Santos, 1977, Spring). Many programs thereafter have weekly group or individual supervision and a few programs have conducted some in-service training as well, although continuity in ongoing training and supervision after the initial training period has been a common problem.

A departure from most paraprofessional programs are projects that function predominantly or entirely as training programs (Bolton & Dignum-Scott, 1979; Santos, 1977, Spring; Strelow et al., 1981). For instance, Bolton and Dignum-Scott provided nine hours of training, then expected the training to catalyze neighborhood networks. Subsequent evaluation indicated that participants felt some need for follow-up and help in translating what they had learned into action.

Training programs have possibly been the most extensively studied aspect of paraprofessional programs, probably in part reflecting the relative ease of evaluation. Becker and Zarit (1978) reported increased empathy and warmth but no significant pre-post change on their other measures. Waters, White, Dates, Reiter, and Weaver (1979) assessed change on 12 variables and found improvement only on one: behavioral ratings of accurate empathy in role playing. On the Minnesota Peer Counseling Questionnaire (see Strelow et al., 1981), peer counselor trainees showed pre-post changes in the direction of a pattern more closely resembling the responses of professional counselors.

Indigenousness

Paralleling the notion of indigenousness for younger paraprofessionals has been the rationale that older adults would be especially effective in working with others of the same generation. With younger indigenous workers, the fact that they know the community and have a common social and cultural background is thought to make them better able to relate to poor disadvantaged clients and to overcome the stigma and reluctance associated with the use of mental health services (Gershon & Biller, 1977; Mitchell & Hurley, 1981). Following similar logic, older adults have been presumed to have some "natural" qualities associated with their age—such as maturity and wisdom—and for there to be several advantages in their peer status. Specifically, it is thought that access is increased because older adults can reach people whom younger adults cannot; acceptability of services is increased because the paraprofessional and peer status of the older helper reduces the stigma of mental health service use; and the effectiveness of the rendered service may improve insofar as older adult paraprofessionals are willing to invest more time and energy, to adopt a more active role as a client advocate, and to present themselves as role models successfully coping with later life transitions (Bratter & Tuvman, 1980; Waters, Reiter, White, & Dates, 1979).

Faulkner (1975) most explicitly designed an indigenous program, defining volunteer tasks within the construct of neighboring. Her program was aimed at low-income blacks, who had a history of informal helping. However, her volunteers rejected door-to-door outreach in favor of assisting the staff of the senior center in organizing activities, where their role was most similar to the staff, and where they felt safer, had more visibility, and got more recognition. Ruffini and Todd (1979) have questioned the appropriateness of expecting many older adults to work as volunteer social workers and to help strangers on a regular and extended basis.

With younger paraprofessionals, program developers have been concerned not to overprofessionalize indigenous workers, whose natural skills and helping style were thought to contribute to their effectiveness. Concerns about overprofessionalizing older adult workers are only rarely expressed (e.g., Gatz et al., 1982). It is hard to know how much training is right or what makes an elderly paraprofessional a good helper. We do know that informal helpers naturally do some things just like professionals would do, but they also do other things that trainers would discourage, such as giving advice, changing the topic, telling the person to count his or her blessings, or presenting alternatives rather than having the helpee come up with them (Cowen, 1982).

Mental Health System

Historically, younger paraprofessionals have been faced with the contradictory expectations of representing the interests of consumers from the community as well as of professional staff from the agency, and of challenging a system in which they aspired to rise (Arnoff, 1981). In large part, the poor (and minority) have ended up serving the poor (and minority), thus perpetuating the existing order in the form of two-status situation (Cleckley, 1981). The political climate of today does not aspire to the sweeping social goals of the new careers program or the activist community worker (Pearl, 1981). Still, dissatisfaction with the present mental health system and echoes of the same rationale figure into setting up paraprofessional programs today.

Older adult paraprofessionals have not truly become part of the mental health system, probably reflecting the pervasive disjunction between mental health programs

and aging network services. Program auspices have included both universities and agencies, with some training programs fostering alliances among community agencies in order to place trainees (e.g., Sainer & Zander, 1971; Santos, 1977, Spring; Strelow et al., 1981). However, there has been little expectation that the older adult paraprofessional would represent the aged constituency and reform service provision (e.g., Lang, 1972). Usually the only goal mentioned is sensitizing professionals to issues of aging (e.g., Waters, Reiter, White, & Dates, 1979). The lack of tension on this point may reflect the historical difference suggested by Pearl (1981) or appropriate self-selection (e.g., activists may join the Gray Panthers). The literature implies that this state of affairs derives from the success with which professionals have engendered an atmosphere of mutual respect. It could also reflect that older adults are being very skillfully "cooled out" by well-intentioned program planners.

In terms of power, virtually none of the programs shared responsibility with the older adult paraprofessionals for crucial administrative duties such as fund raising, policy making, and program development. Blonsky (1974) and Santore and Diamond (1974) were exceptions, but even here the older adult board described by Blonsky ultimately did not have decision-making power.

A number of programs seem to be examples of getting an apparently effective program underway only to have it flounder for lack of administrative and economic support (Oriol & Affeldt, 1977). Many of these programs were demonstration projects. Typically, grant support encompassed the development of training materials and dissemination of the project model (e.g., Strelow et al., 1981). Why is there not a more stable source of long-term support? Perhaps the most difficult challenges have been to establish broad-based community support for projects (with operating budgets funded by various sources, private as well as public) and to maintain a professional staff who have the time and requisite administrative or clinical skills to provide continuous leadership. It is important to underline the tremendous amount of staff energy required to sustain a program.

Outcome Evaluation

In their review, based mostly on paraprofessional programs for younger adults, Gershon and Biller (1977) found that only 13% of the studies they reviewed actually dealt with helpee outcome. Likewise, Blanton and Alley (1981) noted the lack of attention to evaluating the economic effectiveness of paraprofessional programs, despite the fact that it is a central justification for instituting the programs in the first place. With older adults, although evaluation of benefits for the clients seems to be of interest with respect to program goals, the empirical literature is also meager. In particular, prevention of institutionalization appears in statements of program goals but not among measures of program effectiveness. In a similar vein, cost-effectiveness frequently appears as a program rationale but not in program evaluations.

Toseland et al. (1979) found that, out of clients receiving over two visits from a peer counselor, 86% reported the problem reduced or alleviated. Further, the average size of the social network increased from six to eleven relationships. The ILGWU friendly visitors (Wright et al., 1977-78) made home visits to retired union members to identify health and social service needs and to provide referrals and assistance. Follow-up in four to six weeks found no differences in service needs between those visited and a control group. However, 63% knew how to get in touch with the program, compared to only 9% of the controls. Gatz et al. (1982) found increased knowledge of community services in

residents who had had contact (from 1 to 24 visits) with community workers. Residents also increased in sense of personal control, with increased internality related to increased knowledge.

How successful have paraprofessional programs been at extending and increasing access to mental health services? Blonsky (1973, 1974) found that OACAP was not reaching over 25% of the area's elderly; people seemed to be taking care of their own needs. He also found that providing direct supportive services was far better received than a community action methodology, and that it was confusing to combine the two. There also is potential contradiction between the goals of increasing access to services and of promoting self-sufficiency, which includes reducing reliance on formal services (Ruffini & Todd, 1979).

Part of the explanation for the lack of outcome studies may include all the difficulties in conducting community research (such as quasi-experimental designs and the intrusiveness of the evaluation) plus all the problems of aging research (such as age-appropriateness of measures and representativeness of samples at different ages). Morehouse (1981), writing as an outside consultant contracted to conduct an outcome evaluation of a peer-counseling program, provided a discussion of problems encountered in her efforts.

Despite the challenging nature of research in this area, we view such efforts as essential. Clearly, there is little gain in striving to strengthen the continuity of extant paraprofessional programs unless some credible evidence of program efficacy is available. However, it has been the exception rather than the rule to find that empirically based feedback loops inform programming decisions. Often evaluation seems to have been added as an afterthought or because of requirements of funding agencies. A few innovative programs present arguments for the experiential utility of evaluation processes to their paraprofessional staffs and even have used some of their older workers in evaluation roles, as data collectors and as consultants on external validity issues and practical matters of evaluation implementation (Blonsky, 1973; Faulkner, Heisel, & Simms, 1975; Gatz et al., 1982).

Haber (1982), among others, has recently posited that more is needed beyond the accumulation of program evaluations. To echo the precedents in psychotherapy outcome research, aging programming decisions should be based on data suggestive of what types of services provided by what types of helpers are beneficial to what degree and in what manner for what populations of older adults. Such indications regarding efficacy ideally would be descriptive and comparative, assessing outcomes relative to other formats of human service delivery for the same types of goals.

Conclusion

We have noted the considerable heterogeneity of older adult peer paraprofessional programs. Given the diversity of older adults, there should not be reliance on any one type of program as the solution to meeting the mental health needs of the aged. There are, however, some cross-program commonalities, also reflecting themes found within the paraprofessional movement in general and in the general literature concerning provision of mental health services to older adults. Specifically, most programs emphasize community outreach efforts with prevention-oriented goals, often delivered in contexts of educational presentations and informal interpersonal support.

In our survey of programs, four issues emerged as warranting further attention:

1. Harking back to the general rationale and goals of paraprofessional mental health programming, elderly peer projects have been touted as a prime cost-effective source of personnel. However, the arguments of cost-effectiveness and effective supplementation of services are empirical issues without a data base. Moreover, a concern is to avoid creating a two-class system that exploits less powerful older adults as a source of cheap, and even free, labor.

2. Programs have been represented as providing preventive mental health services to the older helper in the form of meaningful work roles and other psychological benefits. However, a concern is to refrain from patronizing the older person through too exclusive a focus on helper effects.

3. Another concern entails problems of peer programs not being integrated into the mental health system and related weaknesses on the part of programs to sustain continuity over time with respect to leadership and fiscal support. This situation may by attributed in part to the unimpressive visibility of empirical justification and articulation for older adult programs in the general paraprofessional literature. Moreover, the absence of a centralized organizing body or clearinghouse may contribute to a lack of unity among the many extant programs.

4. Important questions remain to be addressed regarding the usefulness of older adult paraprofessional programs as a viable service strategy: (a) In terms of cost-effectiveness, do paraprofessionals effectively reduce the shortage of service providers or are such services in nonessential or duplicated professional functions? (b) In terms of goal development, to what extent are helper and helpee effects mutually enhancing within a given program and under what conditions, if any, does focusing on one goal detract from another? (c) In terms of service accessibility to potential recipients, are an increasing number of needy and high risk elderly persons being reached and, if so, what accounts for such success (e.g., reduced cost, geographical propinquity)? (d) In terms of service acceptability, is there less stigma or more relevance associated by potential recipients in dealing with a paraprofessional peer and, if so, does this enhance clinical effectiveness? (e) In terms of therapeutic effect, once a paraprofessional helping relationship or network is established, to what extent is impact positive or negative for the recipient and how does this compare to contact with other service providers or service delivery strategies?

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